INCREASING ACCESS TO PRIMARY CARE IN WEST BALTIMORE

A Summary of Community Engagement and Workgroup Activities to Develop Strategies to Increase Access to Care

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I. BACKGROUND

The access and delivery of quality healthcare services is essential to enhancing the quality of life for individuals and communities. Concern over poor health outcomes and the lack of coordinated health care services in the West Baltimore community has brought many stakeholders from throughout the region together to begin examining how a collective strategy might be developed to improve access to primary care and promote better health outcomes in West Baltimore.

The enclosed report summarizes community engagement activities undertaken over the last year to begin the process of increasing access to primary care in West Baltimore. The Office of Senator Verna Jones and Bon Secours Health System have spearheaded these community engagement efforts with support from numerous community partners. Special thanks are extended for the valuable time and input provided the following key partners:

- Associated Black Charities
- M. Gourdine & Associates
- Light Health and Wellness Comprehensive Services, Inc.,
- Mid-Atlantic Association of Community Health Centers,
- Morgan State University, School of Community Health and Policy,
- University of Maryland School of Social Work

These efforts have been undertaken to provide community and provider-informed strategies for increasing access to primary care in the West Baltimore community.

II. WEST BALTIMORE HEALTH CARE SUMMIT

Under the aegis of the Office of Senator Verna Jones a West Baltimore Health Summit was held on January 7, 2010 at Coppin State University. Over 75 participants were in attendance representing community residents; federal, state and City elected officials; higher education institutions; the philanthropic community; federally qualified health centers; hospitals; insurers and others. (See Appendix for Listing of Organizations Represented).

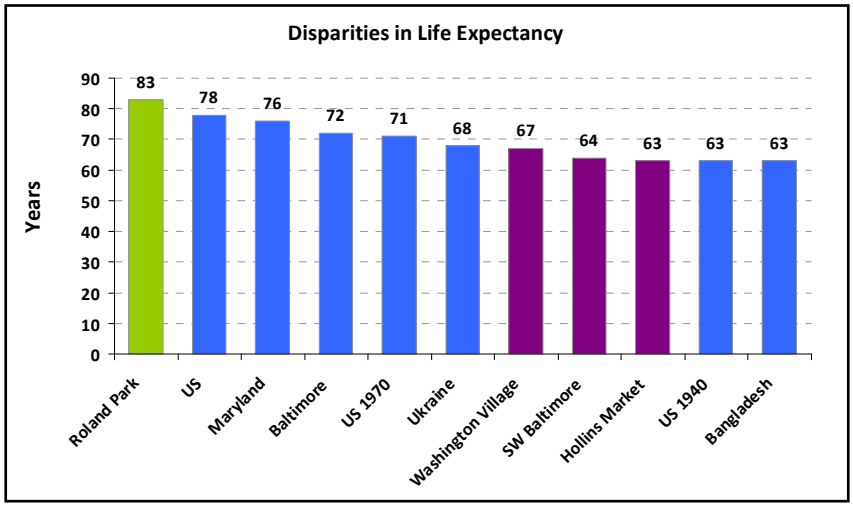
The Summit was intended to provide participants an overview of the current state of health in West Baltimore; to examine challenges and opportunities with the current health care delivery system in West Baltimore; and to explore the role stakeholders could play in improving health outcomes through increasing access for local residents.

The State of Health in West Baltimore

Michelle A. Gourdine, M.D. provided Summit participants an overview of the State of Health In West Baltimore highlighting current demographics, data trends, and underlying causes of health disparities in the region. Dr. Gourdine highlighted Southwest Baltimore demographics[1] noting the following:

- 71 % African American (64% Baltimore City)
- 33% with High School diploma only (29% Baltimore City)
- 43% not in the labor force (34% Baltimore City)
- $23,000 median household income ($30,000 Baltimore City)

A major issue of concern highlighted by Dr. Gourdine was the huge disparity in life expectancy between neighborhoods in Baltimore. A 20-year disparity exists between the Hollins Market neighborhood in Baltimore and that of Rollin Park. It was noted that a 19-year disparity exists between Southwest Baltimore and the more affluent Roland Park neighborhood (see graph below).[2]



Dr. Gourdine also highlighted the strong correlation between income and the self-reported health status of Baltimore City residents, as well as the impact of educational levels on overall life expectancy.

These disparities were attributed to the social determinants of health, defined by the World Health Organization as "…the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities."

[1] Source: 2008 Southwest Baltimore Health Profile, Baltimore City Health Department (BCHD)
[2] BCHD analysis of 2002-2006 Maryland Vital Statistics Profile Data and 2000 US Census Data; National Center for Health Statistics; United Nations Development Program

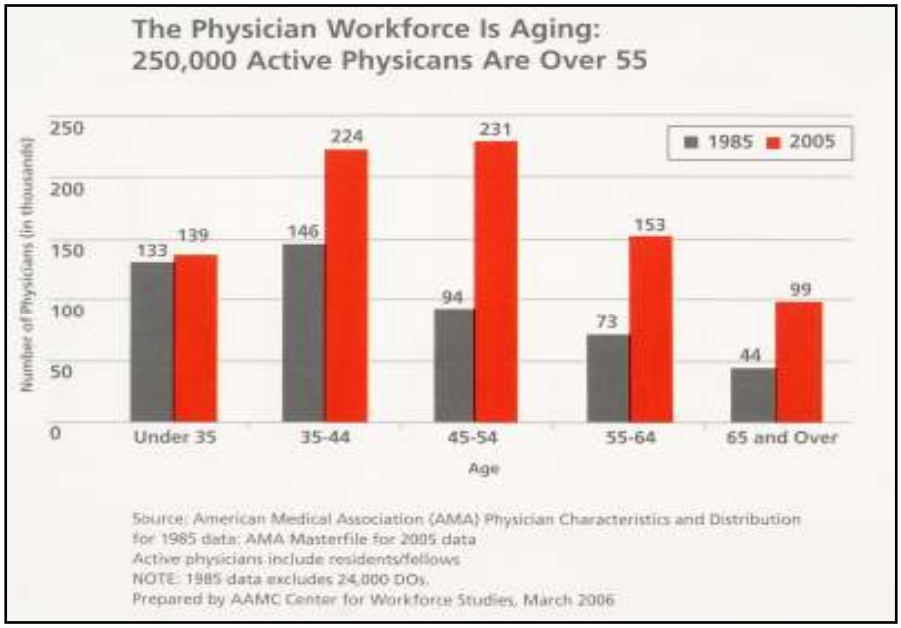
In the Baltimore context, the lack of access to healthy foods, high rates of vacant buildings linked to high rates of crime, and the presence of liquor stores all contribute to high rates of homicide, heart disease and HIV/AIDS death rates. It was emphasized that everyone could play a role in achieving better health outcomes for West Baltimore by working to promote safer streets, healthier food options, access to quality health care and better education and employment opportunities for residents.

Challenges and Opportunities

Summit presentations by Miguel McInnis, of the Mid-Atlantic Association of Community Health Centers, and Carmela Coyle of the Maryland Hospital Association highlighted the challenges and opportunities in the current health care delivery system in West Baltimore.

Highlighting "The Role of Federally Qualified Health Centers in Addressing Access to Care in West Baltimore," Miguel McInnis described FQHCs as local, non-profit, community owned health care providers serving predominantly low-income, uninsured and medically underserved populations. Expected growth trends anticipate an increasing number of FQHC patients in Maryland and Baltimore City through 2015. Currently the West Baltimore estimated penetration rate of FQHC is less than 30%. It is anticipated that the number of people with health care insurance in Maryland will increase with current health care reform efforts, thus putting increasing demand at FQHCs. Current efforts are focused on support and advocacy of state programs to ensure capacity building to meet the burgeoning demand, strengthening of existing health care centers, and long-term efforts to address the primary care workforce shortage.

Carmela Coyle of the Maryland Hospital Association noted that in West Baltimore, hospitals provide a safety net with emergency departments offering a guaranteed but often inappropriate point of access. The challenge is often to provide better primary and preventive care for patients, in the midst of a serious physician shortage nationally and in Maryland. The aging physician workforce (see chart below) and projected retirement of physicians by 2015 will further exacerbate the physician shortages nationally and in Maryland.



Maryland suffers a serious physician shortage with 16 percent fewer physicians (clinical full-time equivalent) per capita than the United States. Shortages are particularly acute for primary care physicians. West Baltimore poses particular challenges because of difficulties in recruiting, retention, location and financial compensation of physicians in the community. Summit participants were encouraged to work to develop innovate solutions to these challenges with new partnerships, a network of care and strategies to meet primary care needs in new ways.

Session Themes

Four facilitated breakout sessions were held with participants representing a cross-section of organizations to explore the role stakeholders could play in improving health outcomes through increasing access to care for local residents. Session participants were asked to address the following questions:

- What would access to better care look like in West Baltimore
- What is needed to ensure increased access?
- What can my organization/ I as a community member do to ensure improved access to healthcare?
- How does/do my organization/I (residents) benefit from increased/improved access?

Across the various breakout groups major themes emerged:

- At the community level, participants expressed the need for changes in the retail environment in West Baltimore including less liquor stores and better access to healthy affordable food. The need for accessible and affordable transportation for all was also mentioned.

- Residents expressed interest in greater community education and outreach efforts, as well as increased partnerships with churches, schools and community organizations to enable the co-location and delivery of services in a timely and accessible manner around institutions frequented by local residents.

- Among providers, the need for the expansion of Medicaid, adequate reimbursement of services, medical home models of delivery, and one-stop shops providing quality, culturally sensitive care in accessible settings was discussed.

- The need for greater policy analysis, advocacy and changes in legislation was emphasized and was the need for sustainable funding.

- The increased use of technology and collaborative efforts to address the pipeline development for more physicians were also seen as promising opportunities to improve access to care.

To further explore key access issues and areas highlighted in the West Baltimore Summit, subsequent Workgroups were formed in the areas of: Community Education, Outreach

and Prevention; the Healthcare Workforce; and Service Delivery. Workgroups provided needed input and engaged community residents, providers and stakeholders to inform preliminary strategies to increase access to primary care in West Baltimore.

III. WORKGROUPS

A. Community Education, Outreach and Prevention

Focus Groups

As part of efforts to better understand West Baltimore community needs, interests, and gaps in services, the Community Education, Outreach and Prevention Workgroup held a series of three focus groups and conducted a community survey in 2010. The first focus group was composed of a cross section of community leaders representing the wider West Baltimore community. A second focus group held at VIVA House, a Catholic Worker soup kitchen in West Baltimore, included a low-income, homeless and a predominantly male population. The final focus group was composed of youth primarily 13-17 years of age. In total, approximately 125-130 individuals participated in the focus groups representing a cross section of incomes, ages and genders.

The goals of the focus groups were the following:

- To confirm our understanding of community needs and interests regarding healthcare services (i.e. primary care, community education and preventive care)
- To better understand the community's knowledge of existing services and why they are utilized or underutilized; and
- To determine perceived gaps in services and/or barriers in service delivery (.i.e. cost, awareness, technology, transportation and or cultural barriers.)

A consistent series of questions was asked of each group (See Appendix) to gather information aligned with the abovementioned goals of the focus group. Focus groups meetings were organized and conducted by Associated Black Charities with leadership from Debbie Rock of Light Health and Wellness Comprehensive Services, Inc.

Focus Group Results

Community Issues, Needs and Interests (Primary care, community education & preventive care)

Among all groups, the two most serious issues or healthcare concerns facing individuals in the community were: substance abuse and obesity/nutrition. Substance abuse was consistently identified by all three focus groups as a serious issue. The issue of obesity/nutrition was also identified as a major issue, particularly among community leaders.

Issues impacting specific populations were also identified: teenage pregnancy; the lack of viable job and recreational opportunities for young men; and the need for services to aid elderly persons with diabetes and cardiovascular disease. Other key issues included domestic violence, HIV AIDS and mental illness. Participants also cited the need to address environmental issues such as trash and safety.

When asked "When you don't feel well, where do you go for medical care?" the predominant response among all focus groups was "my (primary care) doctor." The University of Maryland and Total Healthcare were most often cited as the location of the doctor, although numerous other locations were noted

When asked "Where do people go to receive the services or help that they need?" Total Healthcare, Healthcare for the Homeless and the hospital emergency were most commonly mentioned. Youth also identified school as a place where one could find help.

Knowledge of Existing Services and Utilization

In general, participants were aware of healthcare facilities in their neighborhood: University of Maryland, Bon Secours, St. Agnes, Total Healthcare and Mercy were most commonly mentioned. The utilization of facilities was impacted by perceptions of quality of service, range of services, reputation of the healthcare professionals and the facility.

Gaps in Services and/or Barriers in Service Delivery

Participants often mentioned the need for more preventive services, particularly focused on nutrition and obesity prevention. The need for additional dental services, a local pharmacy, and a one-stop shop/ mini-clinic were often cited as needed services to improve healthcare delivery in the community.

Barriers to service included: economic barriers such as the cost of care and lack of insurance; environmental barriers including the access, convenience and cost of obtaining healthy foods; communication barriers such as lack of access to information on available services and long wait times for services.

Common Themes

PREVENTIVE CARE: While obesity/nutrition is consistently identified as a major issue among all groups, community participants mentioned that there is not enough preventive care and learning opportunities for children and adults focused on nutrition and exercise. Participants recommended partnerships with churches, schools and soup kitchens to address this issue. (i.e. Need for Collaboration/Partnerships)

PRIMARY CARE: Need for a one-stop shop or "mini-clinic" where patients, especially seniors, can speak with a nurse or doctor and receive follow-up care. Participants also expressed an interest in locally accessible services where they can develop a rapport with a doctor of healthcare provider for regular care.

SPECIALTY/ANCILLIARY CARE: The need for dental services, a neighborhood pharmacy, substance abuse/recovery services, and family planning services was noted by focus group participants.

COMMUNICATION/ INFORMATION/ MARKETING: Participants expressed a need for more information – such as a resource directory or on-line interactive map that informs people of available services, locations, and hours of operation.

OTHER: Lastly, participants expressed the need for bold, collective, long-term community planning to address community and healthcare needs in West Baltimore.

Community Survey Results

In addition to the three focus groups, the Community Education, Outreach and Prevention Workgroup also conducted surveys from a limited sample of participants. A summary of Survey results is included in the Appendix. Highlights include the following:

- 62% of respondents indicated that they go to their Doctor's office when they are sick or need advice about health; 29% go to the Hospital Emergency Room and only 9 % to a Community Health Center.

- Location is the main reason cited for going to current doctor or clinic (20%); Other common reasons are reputation of doctor or clinic (16%) good hours of operation (13%) and ease in getting an appointment (13%).

- Three-quarters of respondents indicated that they had health insurance and Medicaid was (53%) the type most identified.

- 86% of survey respondents indicated that there was not a time in the past 12 months when they needed medical care, but could not get it. Those who did indicate such a time, cited cost (33%) as the reason they did not get medical care.

- While only 5% of respondents indicated their inability to get needed mental health or substance abuse care in the past 12 months, 57% of respondents indicated that there was a time in the past 12 months when they needed dental or oral health care, but could not get it.

- When asked which medical, oral and/or mental health services they would consider using if available at a location near them, respondents most frequently cited adult routine check-ups or physical exams (17%), followed by emergency dental care (14%) and follow-up care (such as for high-blood pressure or diabetes) 13%.

While representing a small sample size, survey respondents were able to access primary care services though a doctor's office or emergency room and often cited location as the

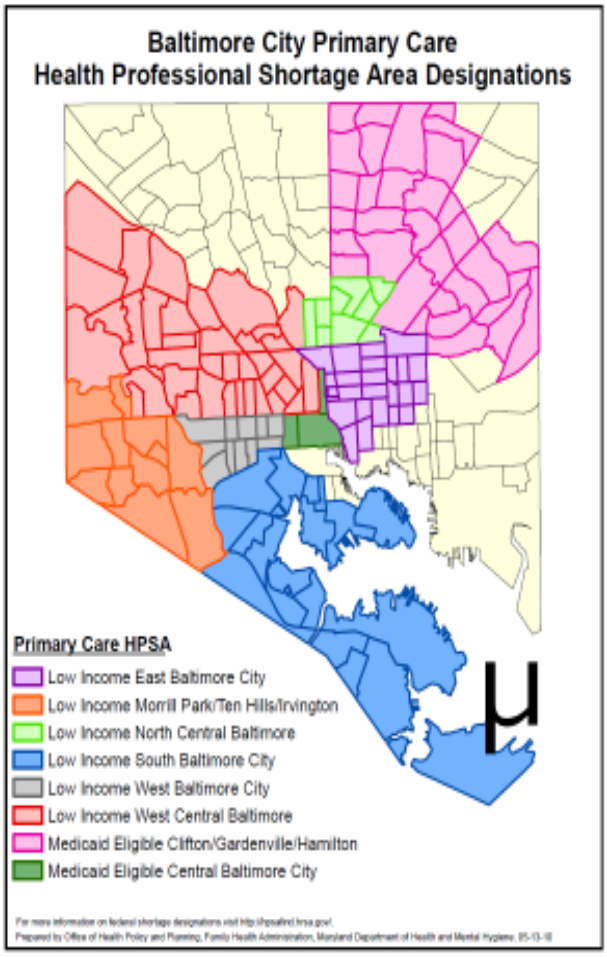
main reason for going to the doctor or clinic. For those unable to access medical care, cost was the major barrier.

The survey confirmed unmet dental or oral care needs and, if available at a location near them, utilization of emergency dental care services.

With regard to prevention, respondents also indicated that if available at a location near them, an interest in utilizing facilities for preventive care services for adult routine check-ups or physical exams, as well as follow-up care.

B. Workforce

Under the leadership of Michelle Gourdine, M.D. efforts were undertaken to further examine healthcare workforce issues impacting access to care. According to the map below prepared by the Office of Health Policy & Planning, Family Health Administration, Maryland Department of Health and Mental Hygiene, West Baltimore and most areas of Baltimore City are designated as Primary Care Health Professional Shortage Areas. While this overall designation confirms that the demand for primary care health professionals exceeds the available supply, information on the exact professional career areas where shortages exists (i.e. nurses, physicians assistants, doctors, etc.) and the location of where these are most prevalent in the West Baltimore community was not readily available during the period of review.



Given the overall shortage and need to increase healthcare workforce jobs, efforts focus on how to:

- Attract and retain healthcare professionals serving the West Baltimore community;
- Increase healthcare workforce pipeline for jobs requiring 2-year certification, college degrees & professional degrees;
- Increase access to jobs for West Baltimore residents.

Attract, Retain and Increase Healthcare professionals

Information was gathered regarding existing programs and strategies currently being undertaken by others to attract, retain and increase healthcare professionals in the Baltimore region. The Baltimore Alliance for Careers in Healthcare (BACH) was identified as a key catalyst in helping to address the local workforce shortage, particularly for entry-level positions and in assisting in career upgrade opportunities for existing workers at acute care facilities. Currently BACH funds career coaches at eight hospitals in the region to assist targeted groups of incumbent workers move up to a higher level position. As a result of the coaches, hospitals have experienced increased rates of retention and advancement progress with existing employees. Within West Baltimore, the University of Maryland and Bon Secours have been partners with BACH and strategies to expand these efforts may address shortage needs in the region.

To increase the pipeline of healthcare workers, the Community College of Baltimore County was identified as the largest provider of healthcare training in the region. While many for-profit training programs and on-line university programs exists, these programs are more costly for students than community colleges, and they can leave students in greater debt with no degree or certification.

Many entities such as the University of Maryland work with BACH and community-based organizations to increase opportunities for under-employed workers and offer internship opportunities for youth. According to administrators, the underlying challenge in increasing the workforce pipeline for entry-level opportunities is the lack of academic preparation of job seekers. Efforts to address overall academic preparation will bode well for all career fields in the region and healthcare in particular. One-stop employment centers have been receiving government funds to develop pathways for healthcare workers and could be another potential partner, along with academic partners, in efforts to build the local healthcare workforce. Beyond the healthcare field, wider opportunities may exist to increases access to jobs for West Baltimore residents through transit-oriented development efforts connected with construction of the MTA Red Line in the West Baltimore community.

To determine what is needed in the West Baltimore context, further information is need on existing providers, services and workforce in the region to determine the professional areas of greatest need. A mapping of existing West Baltimore acute and community providers, services, and workforce could help make this determination of workforce needs and inform the design of appropriate strategies to address shortages.

C. Service Delivery

Under the leadership of Miguel McInnis of the Mid-Atlantic Association of Community Health Centers, the Service Delivery Workgroup focused on developing strategies to increase access to care and improve health outcomes in West Baltimore. The workgroup undertook a series of activities to:

- Assess current community access issues

- Identify national models and best practices to increase access
- Develop applicable short-term strategies to increase access to care in West Baltimore; and
- Explore opportunities to leverage public and private resources to support implementation of strategies.

Access issues: Barriers to care in West Baltimore

The workgroup reviewed qualitative data collected through West Baltimore community engagement efforts. With data and input generated from community residents, providers and stakeholders through focus groups and other activities, workgroup members began to identify key access issues and barriers to care in West Baltimore. The following key themes were identified as access issues and barriers to care in West Baltimore: Cost

- Availability of Services/ Quality of Care
- Education/Communication
- Collaboration

Cost

The cost of care including the cost of related services and health care needs such as prescription drugs was identified as a barrier to care. Within the West Baltimore survey, for the 14% of respondents who indicated that there was a time in the last 12 months when they sought medical care, but could not receive it, cost was identified as the major reason. Nationally, the mean annual expense for an office-based medical provider per person in the United States was $1,235 in 2007, compared to the mean expense for emergency room services in the U.S. that was $1,038.[3] For low-income persons, particularly those living at 200% of the federal poverty line and less likely to qualify for public health insurance such as Medicaid, office-based medical provider expenses present a heavy financial burden leading many to forgo or delay medical care due to costs.

The workgroup identified the cost of pharmaceutical drugs and supplies as a significant issue for residents of West Baltimore. Due to the cost, many residents forgo the purchase of needed medications and supplies to manage chronic and acute conditions, further compromising their health. While many large retailers such as Wal-Mart and Target now offer $4.00 prescription drug programs for many commonly used generic drugs, these retail outlet are currently limited with only one Target location in the City of Baltimore (outside of West Baltimore) and no Wal-Mart stores.

Availability of Services/Quality of Care

The supply and availability of preventative, ancillary and primary care services in West Baltimore was a key issue identified by the Workgroup. Access and availability to the full spectrum of these services ensures the availability of a continuum of care to address the healthcare needs of area residents. Preventative services such as immunizations, checkups, screenings enable residents to stay healthy. Focus groups consistently

[3] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey Household Component Data, U.S. Mean expense per person with an expense by type of service, 2007

identified the need for such preventive care and educational opportunities focused on nutrition, exercise and obesity prevention. Residents also mentioned the need for additional preventative services such as dental care, family planning, substance abuse and neighborhood pharmacies. Ancillary services, including case management workers and enrollment specialists, can assist individuals and families in overcoming barriers to care and services.

While many Federally Qualified Health Centers have to provide these preventative, ancillary and primary care services, many hospitals and large institutions also offer a range of these services. Knowledge of the full breadth of these services is not well documented in West Baltimore. The workgroup recommended a thorough inventory of the types of preventative, ancillary and primary care services in West Baltimore to more accurately determine service gaps and needs based upon quantitative data and analysis. Such documentation could confirm current qualitative data and illuminate the current type, location and utilization of existing services, thus enabling a more informed strategy to address documented gaps and needs.

Education/Communications

The workgroup's identification of education/communication as a barrier to care may be linked to the idea that current residents' perceptions of the supply of preventative, ancillary and primary care services may be a function of their knowledge or awareness of the available services within the community. In the discussions among the workgroup and in the summit sessions with stakeholders, it was acknowledged that patients of health centers are often not aware of all the services available at a health center (i.e. case management, dental services, etc.) and improving communications between service providers and residents is therefore essential to improve utilization rates. Similarly, residents in focus groups indicated an interest in greater information including an on-line directory with information on services available, hours of operation and other information. The workgroup encouraged the use of on-line tools and social media technology to enhance communication of available services to residents.

Collaboration

A final access issue emerging from the Healthcare Summit and Service Delivery Workgroup concerned the operation of the current delivery system and the idea that many providers do not collaborate in intentional ways that enhance accessibility of services to community residents. The silo approach of many providers creates barriers to access for services. Suggestions for improving efficiencies and collaborations included: shared efforts across agencies and organizations; better involvement with schools and churches; improved utilization of community based organizations to expand capacity; and partnerships between agencies to improve the patient continuum of care. While collaboration can present challenges in term of shared costs, responsibility, staffing and accountability, they also offer opportunities to increase outreach, services, innovative programming and to address the healthcare needs of underserved population groups.

National Models and Best Practices to Increase Access

Having identified key cost, availability, communication and collaboration barriers to access in West Baltimore, workgroup members reviewed various local and national models to address these barriers. Key models and best practices to address identified barriers are highlighted below and a full summary of National and Local Models reviewed by the Service Delivery Workgroup is provided in Appendix D.

Addressing Cost Barriers: Legislative Solutions

- ***Patient Protection and Affordable Care Act of 2010*** – fundamentally reshapes the U.S. health care system by insuring millions of uninsured and previously uninsurable individuals by 2015; Key provisions will expand Medicaid coverage to all persons under 65 years of age at or below 133% of the federal poverty level and provide for the development of health insurance exchanges; The individual mandate will reduce the number of uninsured; Provides for increases in funding for FQHC sites and services.

- ***The Lorraine Sheehan Health and Community Services Act (HB832 and SB717)*** – Legislation would increase the alcohol tax by a dime per drink in the state of Maryland and the estimated $214 m in new revenue would provide funding for the extension of Medicaid coverage to childless adults until the Medicaid extension is completed, as well as funding for substance abuse and mental health services.

Addressing Drug Cost Barriers

- ***340B Drug Pricing Program*** – Requires drug manufacturers to provide outpatient drugs to certain covered entities at a reduced price (roughly 50% of the average wholesale price) so that savings can be passed along to consumers. While currently operated by many West Baltimore FQHCs, program could be expanded to disproportionate share hospitals eligible to purchase outpatient drugs through the 340b program.

- ***Maryland Prescription Assistance Discount Drug Card Program*** – a discount drug program for use at participating pharmacies and available to all Maryland residents at no cost. Originally designed for the uninsured and those in need of drugs not covered under their insurance.

Quality of Care

- ***Harvard School of Public Health, Cherishing Our Hearts and Souls (COHS) Coalition*** – Viewing the examination of cultural competency as a means of achieving improved quality of care, members of the workgroup recommended the COHS antiracism project launched in the Roxbury section of Boston to improve cardiovascular health of African Americans. The project develops, implements, and evaluates anti-racism training workshops for healthcare staff, patient groups and other community members. Also helps participants understand the linkage between racism and health.

- ***Patient-Centered Medical Home (PCMH)*** – Seen as a model of healthcare delivery that can improve quality of care while reducing costs, this model is being piloted in Maryland in a statewide effort to bring together primary care providers, patients and payers to provide continuous, comprehensive coordinated care through a partnership between patients and their personal healthcare team.

Availability of Preventative, Ancillary and Health Education Services

- ***Patients Pharmacists Partnerships (P3) Program – University of Maryland School of Pharmacy***- A model of patient-centered health education and chronic disease self-management, this program trains pharmacists to provide patients guidance in medication adherence, lifestyle change and self-care skills.

- ***Howard County Health Plan – Health Coaches*** - combines healthcare services with compulsory health coaching to assist participants in achieving patient-developed action plans to improve their health.

Improving Communication between Providers and Residents

- ***Newer Technology Marketing Ventures*** - Different types of health-related marketing technology using mobile phones, MMS technology and internet based services. Examples include :Text4baby is a maternal child health information service; Hot 97 a successful smoking cessation mobile and internet campaign, and the BrdsNBz Text Message Warm Line, an adolescent pregnancy prevention campaign of North Carolina; and the National Cancer Institute's Four Digital Divide Projects designed to help underserved groups access computer based cancer information.

Collaboration

- ***Total Health Care: Immediate Care Program*** – Funded by the American Recovery Reinvestment Act in response to increased demand for primary care services, this program funds outreach personnel stationed in the hospital ER to educate patients about primary health care services available at Total Healthcare, a FQHC.

- ***The Urban Health Initiative and the South Side Healthcare Collaborative*** – The Urban Health Institute (UHI) is a partnership between the University of Chicago Medical Center and community doctors, clinics, and hospitals to connect residents with a primary care medical home and to improve access and other health and social supports of residents. The program seeks to ensure that patients get the right care, at the right time, in the right setting.

- ***Sanofi-Aventis and the Baltimore Community Health Partnership*** Focused on improving health outcomes in the African American community, and one of five sites nationally, the Community Health Partnership in

Baltimore is designed to connect local community health-related resources with each other and to help patients better manage their health. Key program elements include a free Health Resource Guide, educational materials, a speakers network, a community health action team (CHAT) and customized, city-specific slide kit presentations, all designed to raise awareness and improve patients access to local health services.

Strategies to Increase Access

Based upon qualitative data collected through engagement efforts, identification of access barriers, and a review of local and national best practices to address barriers to care, the following tentative strategies were recommended to increase access to care in West Baltimore:

Policy: Revenue Generating Legislation to Reduce the Cost of Care

1. **Support the Full and Timely Implementation of the Patient Protection and Affordable Care Act of 2010.**
   - Implementation of this ground-breaking federal legislation will substantially reduce the number of uninsured and ensure greater access to care for thousands of Maryland residents. The expansion of Medicaid, development of health insurance exchanges, and increases of FQHC sites and services will further ensure long-term cost reductions and greater access to care.

2. **Support the Lorraine Sheehan Health and Community Services Act (HB 832 & SB 8717)**
   - Proposed Increases to the alcohol tax by 10 cents would raise an estimated $214 in new revenue to support the expansion of Medicaid benefits to childless adults, a development disabilities fund, addiction and mental health services.

Addressing Drug Cost Barriers

3. **Expand the 340 B Drug Pricing Program to Eligible Entities in West Baltimore**
   - Expansion of the 340B program beyond current FQHCs to nine disproportionate share hospitals in the region could significantly reduce drug costs for West Baltimore residents.

4. **Promote the Maryland Prescription Assistance Discount Drug Program**
   - This no cost discount drug program available at participating pharmacies could provide significant cost saving on medications to area residents.

Quality of Care/Service Availability

5. **Promote Wider Adoption of Evidence-based pilot Programs to Enhance the Quality of Care and Reduce Health Disparities in West Baltimore.**
   - Implementation of evidence-based models such as the Patient Centered Medical Home (PCMH) could improve the quality of care and reduce costs;
   - Models such as Harvard School of Public Health's Cherishing Our Hearts and Souls (COHS) program could enhance cultural competency training to improve the quality of service and address health disparities in West Baltimore.

Education/Communication & Outreach

6. **Expand the University of Maryland's Patients, Pharmacists Partnerships (P3) Program**
   - This model of patient-centered health education and chronic disease management led by pharmacist coaches and teams trains patients in medication adherence, lifestyle changes and self-care skills;

7. **Expand Social Media Efforts to Improve Communications Between Providers and Residents**
   - Use of health-related marketing technology using mobile phones, MMS technology and internet based services could enhance communication between providers and residents.

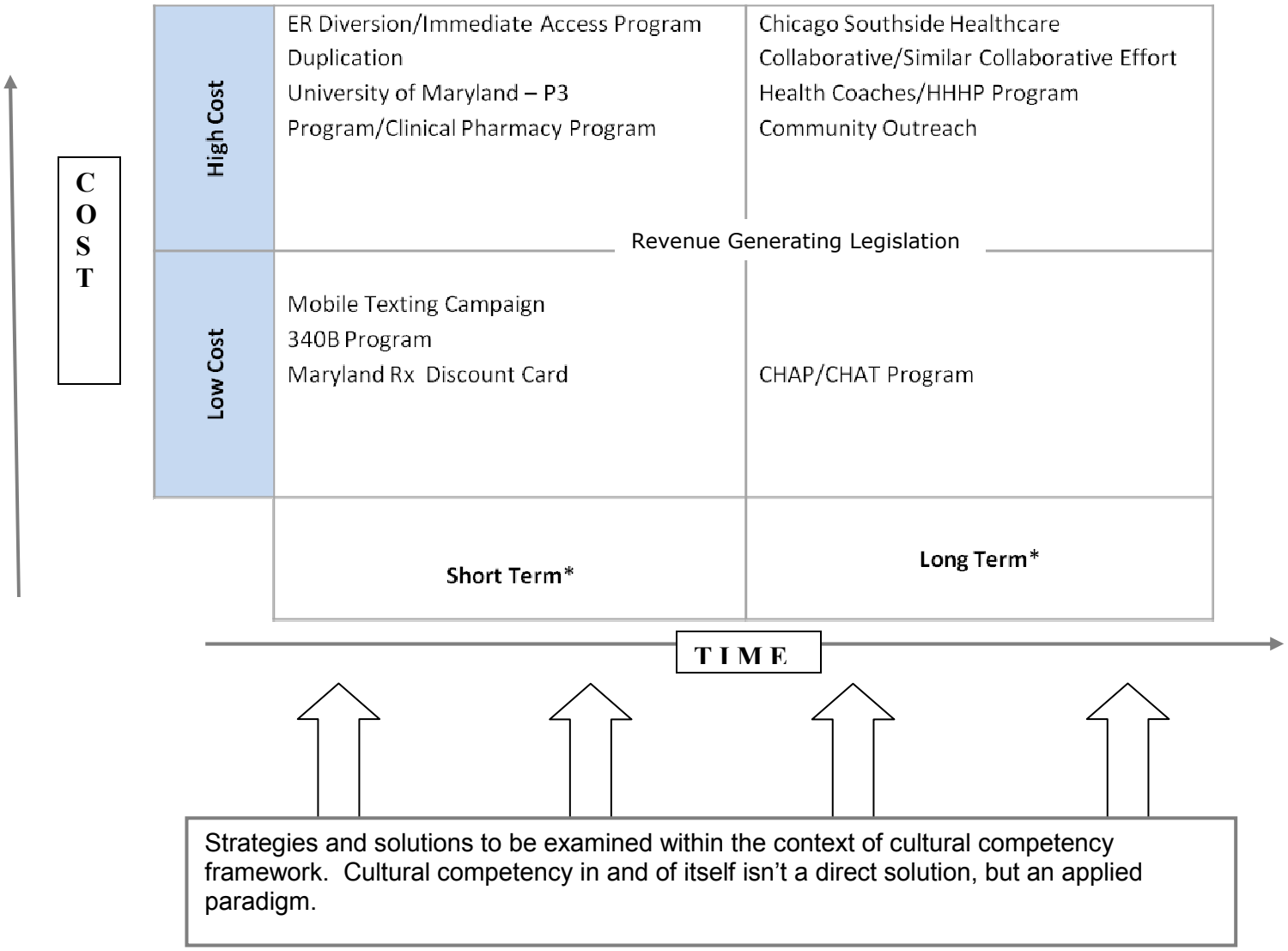
Collaboration

8. **Conduct a Comprehensive Assessment to Guide Development and Implementation of Evidence-Based Collaborative Models to Enhance Service Delivery in West Baltimore.**
   - Based upon a needed quantitative assessment, evidence-based collaborative models such as the Chicago South Side Health Collaborative could be implemented in West Baltimore with partners such as the Community Health Partnership to leverage existing community health resources and to enhance communication, outreach, service delivery, and health outcomes for West Baltimore residents.

Prioritization of Short-Term Strategies and a Plan

With a focus on viable short-term strategies, the Service Delivery Workgroup prioritized recommended strategies based upon cost and time. The accompanying diagram summarized short and long-term priorities:

Summary of Strategies by Cost and Time



*Short term defined by the work group is less than 36 months. Long term is greater than 36 months.

IV. NEXT STEPS: A QUANTITATIVE ASSESSMENT

While community engagement efforts informed by community leaders, residents and youth and key stakeholders has provided valuable *qualitative* data on access issues, barriers, local and national models to increase access and tentative strategies, there is a need for accurate *quantitative* data, that resource constraints did not allow during the current period, to better confirm proposed strategies.

It is recommended as a next step, that a through and comprehensive inventory and analysis of existing providers and services be conducted in West Baltimore to quantify gaps in service, utilization, as well as workforce needs, particularly with the implementation of Patient Protection and Affordable Care Act. It is recommended that a competitive Request for Proposals (RFP) process be launched to identify a public sector consulting firm to undertake such an analysis. It is hoped that such an analysis will further confirm some tentative strategies, provide the necessary quantitative data to more fully engage new and existing partners, and illuminate additional innovative strategies to increase access to care for residents of West Baltimore.

V. APPENDICES

APPENDIX A: List of Summit Participating Organizations

The Afro
Amerigroup
Associated Black Charities
Baltimore Business Journal, The
Baltimore City Community College
Baltimore Community Foundation
Baltimore Medical Systems, Inc.
Baltimore Sun, The
Bon Secours Health System, Inc.
Bon Secours Hospital Baltimore
Bon Secours of Maryland Foundation
Bravo Health
Brown Capital Management
Carefirst Blue Cross and Blue Shield
Carrolton Ridge Community Association
Casey Foundation, The Annie E.
Central Baptist Church
COIL
Community Health Integrated Partnership
Coppin State University
Daily Record
Druid Community Association
Druid Park Alliance
Family Health Centers
The Hatcher Group
Irvington Community Association
Johns Hopkins University
Johns Hopkins Urban Health Institute
Jones Tabernacle Church
Howard Consulting Group
HRSA, Bureau of Primary Care
Maryland Citizens' Health Initiative
Maryland Commission of Human Relations
Maryland General Hospital
Maryland Hospital Association
Mid-Atlantic Community Health Centers
Morgan State University
Morgan State University, School of Public Health
NeighborCare Professional Pharmacies
New Southwest Community Association
Office of Senator Benjamin Cardin
Operation Reachout Southwest
Park West Health System
Peoples Community Health Centers
Recovery in Community
Sanofi-Aventis Community Health Partnership
Seton Hill Association
Seton Hill Organization Together
Shipley Hill Community Association
St. Agnes Hospital
Total Health Care
U.S. Dept of Housing and Urban Development
Union Square Community Association
United Way of Central Maryland
University of Maryland Medical Center
University of Maryland School of Social Work
Upton Planning Commission
Upton West Community Association
Violetville Community Association
Weinberg Foundation, The Harry and Jeanette

APPENDIX B: Focus Group Questions

Sample Focus Group Questions:

Community Needs and Interests (re. Primary Care, Community Education & Preventive Care)

1. When you don't feel well, where do you go for medical care?

2. What serious issues and /or healthcare concerns (such as domestic violence, pregnancy prevention, substance abuse, asthma, etc.) are facing individuals in your neighborhood or community?

3. Where do people go to receive the services or help that they need?

Existing Services and Utilization

4. What healthcare resources do you know about in your neighborhood?

5. Name two to three from which you would or a family member would get care.

Gaps in Services and/or Barriers in Service Delivery

6. Do you think there are enough good healthcare resources in your neighborhood?

7. Of these resources and services, what isn't working? What are some of the barriers to care? (cost, location, transportation, etc.)

8. What types of additional resources or services are needed in your neighborhood?

9. What would make you go to a healthcare provider in your neighborhood?

10. Do you trust the healthcare providers in your neighborhood?

11. Is there anything else that you would like to tell me about the services in your community?

12. Is there anything else about your community that you have not mentioned yet that you feel is important?

APPENDIX C: Summary of Survey Results

ACCESS AND USE

1.When you are sick or need advice about your health, to which one of the following places do you go? (Please Select Only One)

Doctor's Office	62%
Community Health Center	9%
Hospital Emergency Room	29%
Urgent Care Center	0%
Some Other Kind of Place	0%
No Usual Place	0%
Don't Know/Not Sure	0%
Refused	0%

2. If you have a usual place you get care, what are the main reasons you go to your current doctor or clinic? (Select all that Apply)

The **location i**s easy for me to get to	20%
Doctor or clinic has a good **reputation**	16%
The **hours** it is open are good for me	13%
Getting an **appointmen**t is easy	13%
The **cost** is reasonable	10%
The staff speak my **language**	8%
Doctor or clinic accepts my health **insurance**	8%
Doctor or clinic offer the **services** I/my child need	7%
O**ther** (Please Specify)	5%

3. Do you have any kind of health coverage, including health insurance, prepaid plans- HMOs or government programs such as Medicaid or Medicare?

Yes	76%
No	19%
Don't know/Not Sure	5%
Refused	0%

3a. If yes, what type?

Medicaid (including United Healthcare, HealthChoice, Priority Partners, Maryland Physicians Care)	53%
Medicare	27%
Private Insurance	20%

4. Thinking about the last 12 months, how much do you agree or disagree with the following statement *My out-of pocket medical expenses are affordable for me and my family.*

I strongly Agree	14%
I Agree	19%
I Am Neutral	38%
I Disagree	10%
I Strongly Disagree	19%

5. Was there a time in the past 12 months when you needed <u>medical care</u>, but could not get it?

Yes	14%
No	86%
Don't know/Not Sure	0%
Refused	0%

5a. If yes, what are the reasons you did not get medical care (Please select all that apply)

Cost	33%
Too long a wait for an appointment	17%
Too long a wait in the waiting room	17%
No transportation	17%
My insurance wasn't accepted	17%
Distance	0%
Office was not open when I could get there	0%
No childcare	0 %
No access for people with disabilities	0%
Medical provider did not speak my language	0%

6. Was there a time in the past 12 months when you needed <u>dental or oral health care</u>, but could not get it?

Yes	43%
No	57%
Don't Know Not Sure	0%
Refused	0%

6a. If yes, what are the reasons you did not get dental care?

Cost	100%

7. Was there a time in the past 12 months when you needed <u>mental health or substance abuse care</u>, but could not get it?

Yes	5%
No	81%
Don't know/Not Sure	0%
Refused	14%

7a. If yes, what are the reasons you did not get mental health/substance abuse care?

No reasons given.

8. What language do you prefer your doctor to speak?

English	90%
Spanish	5%
Other	5%
Any, as long as I understand	0%
No Answer	0%

9.Which medical, oral and/or mental health services would you consider using if available at a location near you? (Please check all that apply)

Adult routine check-ups or physical exams	17%
Obstetrical care (pregnancy care)	3%
Follow-up care (such as for high blood pressure or diabetes)	13%
Urgent Care or Sick Visits	11%
Women Health or Family Planning	7%
Health Screenings or Education	10%
Preventative Dental Visits (such as cleanings and fluoride treatments)	11%
Emergency Dental Care	14%
Mental Health Services	7%
Substance Abuse Services	6%

10. What is your age?

25 – 39 years old	0.5 %
40 – 49 years old	19%
50-59 years old	28.5%
60-69 years old	14 %
70-79 years old	14%
No Response	24%

11. What is your gender?

Male	57%
Female	33%
No Response	10%

12. Are you Hispanic/Latino?

Yes	0%
No	100%

13.Which one or more of the following would you say is your race (Select All That Apply)

a . American Indian or Alaskan Native	0%
b. Asian	0%
c. Black or African American	90%
d. Native Hawaiian or Pacific Islander	0%
e. White	5%
f. Other	0%
g. Refused	5%
h. Don't Know/ Not Sure	0%

14. What is the name of the neighborhood where you live? Please provide zip code.

Franklin Square	21223
Evergreen	21216
Midtown	
Boyd Booth	21216
Cherry Hill	21225
Penrose	21211
Shipley Hill	21213
Irvington	21229
Bentalou Smallwood	21223
Emerson	21201
Shipley Hill	21213
Northeast Baltimore	

No Neighborhood listed, but zip codes listed as: 21201, 21211, 21213, 21216, 21223, 21225, 21229.

15. Including yourself, how many people live in your household?

1	19%
2	14%
3	29%
4	14%
5	0%
6+	10%
No Response	14%

16. In the last year, that is in 2009, what was your total household income from all sources?

Under $10,000	28%
$10,001 - $15,000	10%
$15,001 - $25,000	0%
$25,001 - $35,000	10%
$35,001- $50,000	4%
$50,001 - $75,000	10%
$75,000+	10%
Refused	28%

APPENDIX D

NATIONAL AND LOCAL MODELS TO ADDRESS ACCESS TO PRIMARY CARE

As part of the charge to the workgroups, investigation of models to overcome existing issues to access primary care were examined. The following is a summary of different "solutions" or models to address the identified access issues/barriers to care in West Baltimore.[4] The models that were investigated were identified by the Service Delivery Workgroup during conference-call meetings and were then researched and discussed by the workgroup as to the relevance of each within the West Baltimore context. This is not an exhaustive list of the different solutions that have been used, merely a window into some of the currently employed methods, nationally and locally, to address access to primary care issues similar to those found in West Baltimore.

COST OF CARE

Legislative Solutions

The Patient Protection and Affordable Care Act of 2010

The Patient Protection and Affordable Care Act will fundamentally change our health care system by insuring millions of previously uninsured and uninsurable individuals by 2015, helping to alleviate one of the greatest barriers to care facing our healthcare system in general and West Baltimore, in particular.

The following are a few key provisions of the Act that will help to extend access to health care and health insurance coverage to Marylanders.

(1) Medicaid to all persons under the age of 65 who are at or below 133% the federal poverty level, ending categorical accessibility to this program for the poorest Americans.

(2) Individual mandate for health insurance coverage is expected to substantially reduce the number of uninsured in Maryland. Individuals who do not maintain health insurance coverage will be subject to a penalty-fine.

(3) Development of Health Insurance exchanges for the purchase of coverage when an individual or family is not offered coverage by their employers. The act provides for subsidies to individuals and families who make less than 400% the FPL to help purchase this insurance.

[4] Summary compiled by Melissa Noyes, Mid-Atlantic Association of Community Health Centers.

(4) Increases to the Federally Qualified Health Center program that will allow for competitive expansion of sites and services. It is expected that the FQHC program will double its currently patient capacity by 2015, to 40 million patients nationally.

The Maryland Health Care Reform Coordinating Council is developing its plan for the implementation of the Patient Protection and Affordable Care Act for Maryland.

The Lorraine Sheehan Health and Community Services Act of 2010 (HB 832 and SB 717)

While health care reform will help to extend health care coverage to most Marylanders, full implementation will not occur until 2015. The Lorraine Sheehan Health and Community Services Act of 2010 (HB 832 and SB 717) was put forth to the Service Delivery workgroup as a means to help finance the extension of Medicaid coverage to childless adults until the Medicaid extension was completed. Succinctly, this particular piece of state legislation would do the following:

- Increase alcohol taxes by a dime per drink in the state of Maryland.
- Raise $214 million in new revenues. The existing tax (which goes to the General Fund) will comprise 12.75% of total revenues after the increase; the remainder (new revenues) would be divided as follows:
    - 15% to Development Disability Support Fund, § 7-207 of the Health – General Article
    - 15% to the Addiction Treatment and Prevention Fund, § 8-207 of the Health – General Article
    - 15% to the Mental health Care Fund, § 10-209 of the Health – General Article
    - 42.25% to the Maryland Medicaid Trust Fund, § 15-103.6 of the Health – General Article, to fund health care coverage for childless adults

Proponents of the Lorraine Sheehan Health and Community Services Act predict that the legislation could save $249 million annually in healthcare costs, avert 15,000 cases of alcohol abuse, 316 assaults, 67 incidents of severe violence against children, 37 premature deaths every year and reduce drinking among young people and heavy drinkers.

This type of legislation and tax levied against commodities considered physically or morally harmful to society such as tobacco, alcohol, or gambling is not new to Maryland. In 2008, the state of Maryland raised its cigarette tax from $1 to $2 per pack. The tax increase brought in an additional $144 million dollars to the state. This additional revenue has been used to help fund the Working Families and Small Business Healthcare Coverage act of 2007. This new legislation has been responsible for providing healthcare coverage to over 50,000 uninsured Marylanders, and moving Maryland up the ranks to 16th in the nation for adult healthcare coverage. In the year following the tax increase there were 74 million fewer packs of cigarettes sold in the state of Maryland [i].

Also according to the Center for Disease Control and Prevention, the number of smokers in Maryland decreased 5.8 percent between 2007 and 2008 [ii] .

Programs to Address the Costs of Drugs/Pharmaceuticals

340B Drug Pricing Program

The "340B Program" requires drug manufacturers to provide outpatient drugs to certain covered entities specified in the statute 42 U.S.C. 340B(a)(4)at a reduced price, also defined in the statute. The 340B price defined in the statute is a ceiling price, meaning it is the highest price a covered entity would have to pay for a given outpatient drug. Entities can negotiate below ceiling prices with manufacturers. As a result, 340B prices have been found to be roughly 50% of the Average Wholesale Price *(Schondelmeyer, Prime Institute, University of Minnesota (2001).* Those organizations that are eligible to purchase drugs through the 340B program are then able to pass these savings onto patients.

Currently, there are 11 federally qualified health centers with locations in West Baltimore that operate pharmacy services which allow access to discounted outpatient pharmaceuticals through the 340B Program. Additionally, disproportionate share hospitals are also eligible to purchase outpatient drugs through the 340b program.[iii] The following hospitals in West Baltimore meet the definition of a disproportionate share hospital[iv]:

- University of Maryland Medical Center
- Mercy Medical Center, Inc.
- The Johns Hopkins Hospital
- Sinai Hospital of Baltimore
- Bon Secours Hospital
- Union Memorial Hospital
- Johns Hopkins Bayview Medical Centers
- Maryland General Hospital
- James Lawrence Kernan Hospital, Inc.

Maryland Rx Card - Maryland's Prescription Assistance Discount Drug card Program
The Maryland Rx Card program is a discount drug program is available to all residents of Maryland at no cost. It is not insurance or a Medicare drug plan, just simply a card that can be used at pharmacies across the country to receive discounts on drugs. The program was launched in Maryland in June of 2009 and in September of 2009 added MedChi, Maryland's State Medical Society, as a key partner.

This program has "LOWEST PRICE" logic to guarantee that you pay the lowest price on your prescriptions (you pay the lower of a discount off the Average Wholesale Price-AWP, a discount calculated off MAC Pricing, or the Pharmacy Promotional/Retail price). Average savings are roughly 30%- and can be as high as 75**%.** The online program allows residents to download and print a free MDRx card below and take to any participating pharmacy to be eligible for a discount on your prescriptions**.** MDRx is accepted at over 50,000 pharmacies around the country, including major chain

pharmacies such as Rite Aide, CVS and grocery store based pharmacies such as Safeway and giant. This card is pre-activated and can be used immediately.

The program was designed specifically for those without health insurance and for those who need certain drugs that are not covered under their insurance. [v]

QUALITY OF CARE

Harvard School of Public Health and the Cherishing Our Hearts and Souls Coalition

From the perspective of the access workgroup, examining cultural competency as a means to achieving improved quality of care was a logical path. Dr. Brian Gibbs, associate dean for Diversity and Cultural Competence at Johns Hopkins University shared articles and information related to work completed while at Harvard University and in conjunction with the Cherishing Our Hearts and Souls (COHS) – a collaborative of local agencies and leaders in the Roxbury neighborhood of Boston, MA. Much of this information related to reducing health disparities by helping to address the institutional, interpersonal and internalized racism that exists today both in the healthcare system and across society.

The COHS Anti-Racism Project endeavors to improve the cardiovascular health of African Americans living in Roxbury. In collaboration with the Harvard School of Public Health, (HSPH), Cherishing Our Hearts and Souls Coalition (COHS), and Visions Inc., the project develops, implements, and evaluates anti-racism training workshops for healthcare staff, patient groups, and other community members. It also tackles the larger issue of helping participants understand the relationship between racism and health.

COHS initially began in 2000, with one year of funding from the Center for Disease Control's REACH 2010 program. COHS has worked through cluster groups focusing on Health Promotion, Anti-Racism, Clinical Care and Research, and Policy. These cluster groups are now joined under the umbrella of CHOICE and will continue supporting the Community Outreach and Information Dissemination, Research, and Training Cores of CHOICE.[vi]

Patient Centered Medical Home Model (PCMH)

The patient-centered medical home model is not necessarily new, but has been gaining considerable recognition over the last 10 years as a model of healthcare delivery that can improve quality of care while reducing costs.[vii] In 2001, the Institute of Medicine included patient-centered as one of its 6 core aims for health system improvement in their report "Crossing the Quality Chasm". The definition developed jointly by the American Academy of Family Physicians (AAFP) et al states[viii]:

"The patient-centered medical home is a health care setting that facilitates partnerships between individuals patients and their personal physicians, and when appropriate, the patients family."[ix]

PCMH as a model for health care delivery that focuses on primary care and preventative, while linking pay-for-performance and other quality measures is a means to improving quality of care and creating long-term access. The long-term access link comes from the development of a working relationship between primary care providers and their patients, the keystone being the relationship between provider and patient.

Currently, Maryland is launching a Patient-Centered Medical Home model pilot program to bring together primary care providers, patients and payers together in a coordinated state-wide effort. The pilot launched in early 2010 through a series of outreach and educational events throughout the state for practice/provider recruitment.

According to the Maryland Patient Centered Medical Home Pilot website, the aim of the model is to provide **continuous, comprehensive, coordinated care,** through a **partnership** between patients and their personal healthcare team. Participating practices will provide patient centered care through:

- Evidence-based medicine;
- Expanded access and communication;
- Wellness and prevention;
- Care coordination and integration; and,
- Culturally and linguistically sensitive care.

Maryland's pilot program will include 50 practices across the state and will incorporate all major insurance providers in the state. It will be a three-year program that will launch its program in January 2011. The program will be administered by the by the Maryland Health Care Commission.[x]

AVAILABILITY OF PREVENTATIVE, ANCILLARY & HEALTH EDUCATION SERVICES

Patients Pharmacists Partnerships (P3) Program -University of Maryland School of Pharmacy

The University of Maryland School of Pharmacy operates the Patients Pharmacists Partnerships (P3) Program. The Patients Pharmacists Partnerships (P3) Program is a model of patient-centered health education and chronic disease self-management. Specially trained pharmacist coaches apply a model of care that provides step-by-step guidance in medication adherence, lifestyle changes, and self-care skills.

Briefly, the P3 Program began in 2006 with one employer in Western Maryland and has since expanded to many self-insured employers across the region. The P3 Program collaboration involves the University of Maryland School of Pharmacy, the Maryland

Pharmacists Association, HealthMapRx LLC, the Maryland General Assembly, and the Maryland Department of Health and Mental Hygiene. The Department of Pharmacy Practice and Science at the University of Maryland School of Pharmacy coordinates the partnership and trains licensed pharmacists working in the P3 Pharmacist Network.

The P3 Program team translates research findings into practical knowledge for individuals with chronic diseases - an important step to improving health outcomes through pharmacotherapy adherence. Patients participating in the P3 Program show clinical, economic, and humanistic improvements when comparing key indicators prior to enrollment. P3 patients with diabetes reduce their hemoglobin A1c levels though better self-management. Employers benefit from a healthier workforce with a reduction in absenteeism. Health care costs are reduced when compared to projected costs.

Based on results reported in the Diabetes Ten City Challenge, the total annual average health care cost per P3 Program patient was reduced by 7.2 percent. Cumberland, Maryland was the local P3 site involved in the challenge which demonstrated increased adherence to the American Diabetes Association's standards of medical care.
http://www.pharmacy.umaryland.edu/pps/centers-programs/p3/

Howard County Health Plan - Health Coaches

The Health Coaches is part of a larger program of patient centered care, the Healthy Howard Health Plan http://www.healthyhowardplan.org/. The Healthy Howard Health Plan (HHHP) is a public□private health care program designed to connect uninsured residents of Howard County, Maryland, to an affordable and comprehensive network of health care services.
According to the HHHP, this is the first plan in the nation to couple health care services with compulsory health coaching. The purpose of the Health Coach Model is to provide prevention-focused and evidence-based coaching to HHHP members in an effort to decrease the risk of future disease development, maximize social capital and self efficacy and improve quality of life. Coaches use the Trans-theoretical model and Motivational Interviewing, to help members to identify health-related changes they wish to make in their lives and to develop six-month plans for working toward those changes. The professional expertise of the coaching staff, a host of community resources and the Plan's health care providers coordinate to help members reach their goals. Coaches develop a rapport with members through a series of in-person meetings and regular telephone check-ins. Meetings are conducted in community settings, not in the doctor's office. (Healthy Howard, Inc., 2010b.)
The Health Coach role centers around helping the patient develop action plan's around their own goals. The health coach helps to facilitate the action plan, but for the most part works to empower the patient to do the things necessary to make the changes on their own and take control of these issues. Action plans can focus on any issue, not just health related issues (i.e housing or fiancé issues maybe more pressing than loosing weight). Plan enrollees are required to meet with their health coaches every three months to assess where they are in their plan and what else needs to be done to meet their goals.

Findings from the first year evaluation – indecently conducted by Johns Hopkins, found the following:

- Goals identified from HAPs focused on one or more of these six categories – smoking;
  exercise/physical activity; food/diet; weight management; manage health condition
  (e.g. diabetes); and social factors (e.g. education, employment, finances).
- The most common HAP goal focused on exercise/physical activity (33% of members).

More complete evaluation information is not available at this time, thus the efficacy of this particular program is still not understood.[xi]

IMPROVING COMMUNICATION BETWEEN PROVIDERS AND RESIDENTS

Newer Technology Marketing Venues:

- Blogs
- Wikis
- RSS
- Podcasts
- Networking sites (Facebook, LinkedIn)
- Videocasts / Vlogs (YouTube)
- Moblogs
- Multimedia Messaging Services MMS (including SMS- Including Short Message Service)
- Internet telephony
- Cell Phones

Examples of some different types of health related marketing and outreach using mobile phones, MMS technology and internet based services.

Text4baby

Text4baby is a National free mobile information service designed to promote maternal and child health. An educational program of the National Healthy Mothers, Healthy Babies Coalition (HMHB), text4baby provides pregnant women and new moms with information they need to take care of their health and give their babies the best possible start in life. Women who sign up for the service by texting BABY (or BEBE for Spanish) to 511411 will receive free SMS text messages each week, timed to their due date or baby's date of birth. More than 16,000 users signed up for the free text messaging service within the first three weeks of its launch, according to Judy Meehan, executive director of the National Healthy Mothers, Healthy Babies Coalition. (APHA, April 2010) As of May 24, 2010 42,518 text4baby enrollees, with 94% of enrollees reporting that they would recommend the service to a friend. [xii]
In addition to the use of text messages to support pregnant women, the program also has a website, Facebook page and weekly blog it uses to help outreach and connect the program to other outlets.

Text4baby is a collaborative effort made possible through a broad, public-private partnership that includes government, corporations, academic institutions, professional associations, tribal agencies and non-profit organizations. http://www.text4baby.org/

Hot 97 Smoking Cessation Mobile & Internet Campaign

The Hot 97 Smoking Cessation Campaign leveraged the mobile/internet to engage its listeners in the health benefits of not smoking. As a the most popular radio station in NYC and largest listening base between 13 and 45, the radio station, in collaboration with the NYC Health Department, launched this campaign using two popular NYC based DJ's Cipha Sounds and Rosenberg that have radio shows during the 2-6 pm drive time.

This health campaign allowed for an intimate, interactive and immediate connection with the population. The campaign was designed to capitalize on the population's fascination with celebrities and the demand to be engaged through non-traditional channels. The campaign used technology that allows the population to receive personalized phone calls from celebrities and or public officials to be sent directly to their friends and family. The audio platform allows many customizable choices that can be created to make the campaign's phone call as personalized, educational and entertaining as needed.

The BrdsNBz Text Message Warm Line

The BrdsNBz Text Message Warm Line is run by the Adolescent Pregnancy Prevention Campaign of North Carolina. The BrdsNBz Text Message Warm Line is a way for teens to get sexual health answers on their turf – via text message. Teens can text their question to BrdsNBz, and an APPCNC staff member will provide a medically accurate, non-judgemental, confidential and free* answer within 24 hours. BrdsNBz was the first service of its kind in the US, and has been featured by the New York Times, Fox News, Family Circle and others. BrdsNBz is available to any teen in North Carolina. To use it:

- Text "NC" to 36263 to opt in. You only need to opt in once.
- Text your question to 36263.
- You'll get an auto response and then your personalized answer within 24 hours.

BrdsNBz maintains a presences on Facebook and Twitter that helps support their work.

The National Cancer Institute's and Four Digital Divide Projects

The National Cancer Institute has funded four different programs that examined providing cancer related information to people and families typically found to be lacking access or skills to use internet or computer based resources. These programs, The Head Start Project, The Harlem Project, the CHESS project and the Low Literacy User Cancer Information Interface Project (LUCI) were designed to help underserved groups access computer based cancer information . The evaluation of these programs found that Libraries can facilitate online access to health information among vulnerable and underserved populations. Library education programs can help consumers recognize the need for health information by identifying problems associated with lack of relevant information for guiding good health decisions and achieving desired health outcomes. Libraries, by building on the information exchange relationship that they already have

with many consumers, can help promote changes in health information–seeking intentions and practices. Libraries can help institutionalize adoption of online health information by establishing viable programs for dissemination that evolve into sustainable, long-term, health-promoting relationships with consumers.[xiii]

IMPROVING COLLABORATIONS

The following are programs, both in Baltimore city currently and elsewhere that demonstrate ways in which collaboration and outreach have merged to create better access for consumers.

Total Health Care - Immediate Care Program

The Immediate Care program is funded by the American Recovery Reinvestment Act, in response to an increased demand for Primary Care services. The program has multiple dimensions with a team that consist of 2 Outreach Workers, 1 Patient Navigator, 2 Nurses, 2 Nurse Practitioners, 2 Medical Assistants, 1 Eligibility Coordinator and 1 Program Director.

The Outreach personnel are stationed in the ER, at Maryland General Hospital and educate patients about the Primary Care services that are available at Total Health Care. They also provide information about how to access primary care, obtain insurance and the appropriate use of the Emergency Room. There is also a Patient Navigator who guides patients on how to access our services and makes new and existing patients aware of the services available at THC.

The clinical team manages a growing walk-in center. Total Health Care has the capacity to provide same day and walk in primary care to patients who have difficulty accessing their PCP, as well as those who do not have a PCP. The THC Services are provided regardless of the patients ability to pay.

- We arrange free transportation for those patients who need it.
- We provide medication for those who can not afford their medication.

We have earmarked funds for medication, imaging studies and laboratory studies for uninsured patients. The patients are taken care of by 2 Family Nurse Practitioners and Family Physicians. This allows us to provide immediate care for non emergency patients at the time the need arises. Because the providers are trained in the specialty of Family Medicine, we can accept Adult, Pediatric, Geriatric, Dental and GYN patients.

The hours of operation are M-F 9am -9pm. and Saturday 10am-2pm. These hours were chosen to mirror the times that were busiest for inappropriate utilization of Maryland General Emergency Room.

The Urban Health Initiative and the South Side Healthcare Collaborative

The Urban Health Initiative (UHI) is a partnership between the University of Chicago Medical Center and community doctors, clinics and hospitals to improve the long-term health of South Side residents. Together, they have created a more rational health care system in which patients can get the right care at the right time in the right place. The Collaborative's mission is to help residents make a long-term connection with a primary

care medical home and improve access to other health and social support services that help maintain optimal health and well-being.

The first program of the SSHC has focused on patients who rely on the University of Chicago Medical Center Emergency Room (ER) for healthcare because they do not have a regular doctor or health provider. Patient advocates in the ER talk one-on-one with patients to help them understand the benefits of having a primary care medical home--a place where a regular doctor or health professional manages and coordinates their care. The primary medical homes where local FQHCs that entered into a Memorandum of Understanding and contracting agreement with the University.

Since 2005, more than 27,000 patients have received information about SSHC resources, and more than 13,000 have been connected to those services. The University of Chicago Medical Center has facilitated and staffed the SSHC, since its inception.

***Sanofi-aventis and the Baltimore Community Health Partnership*:**
Sanofi-aventis U.S. has developed the Community Health Partnership, an innovative solution that seeks to improve health outcomes in the African American community. This program is designed to connect local community health–related resources with each other and help patients better manage their health by raising awareness of and improving access to the local services they need. Further, the program aims to motivate patients to better follow provider's instructions and be more proactive in managing their health effectively. Currently, Baltimore city is one of five cities to implement this program.

Key elements to this program include the following:

- Health Resource Guide: pocket-sized guide that improves your patients' awareness of health-related resources in Baltimore and connects them with services they need to manage their health and that of their families . This is a free resource for residents and providers in the community.

- Patient Education Materials: culturally competent and ethnically relevant bilingual disease-state patient education materials

- Speaker Networks: networks of physicians, other healthcare professionals, and patient ambassadors" that will give presentations designed to motivate patients to be more proactive with their healthcare and provide recommendations on how to navigate the healthcare system

- Community Health Action Team (CHAT): a network of community health–related stakeholders in Baltimore working together to improve your patients' access to local services

- Customized, City-Specific Slide Kits: presentations used to augment community health–related stakeholder outreach initiatives and designed to empower and motivate patients to utilize available health-related resources in Baltimore.

[i] Demarco, Vincent . " Maryland Cigarette Tax, boosts budget, health". Baltimore Sun. Feb, 3, 2010. Retrieved on June 7, 2010 from : http://articles.baltimoresun.com/2010-02-03/news/bal-op.cigarettes0203_1_cigarette-tax-cigarette-sales-tax-increase

[ii] Kilmer, Mark. " Did cigarette tax increases do more harm than good". Baltimore Sun. March 17, 2010. "Retrieved on June 7,2010 from: http://www.mdpolicy.org/research/detail/did-cigarette-tax-increase-do-more-harm-than-good"

[iii]) A disproportionate share hospital (as defined in section 1886(d)(1)(B)) of the SSA -

> (i) is owned or operated by a unit of State or local government, is a public or private non-profit corporation which is formally granted governmental powers by a unit of State or local government, or is a private non-profit hospital which has a contract with a State or local government to provide health care services to low income individuals who are not entitled to benefits under title XVIII of the Social Security Act or eligible for assistance under the State plan under this title; (ii) for the most recent cost reporting period that ended before the calendar quarter involved had a disproportionate share adjustment percentage (as determined under section 1886(d)(5)(F) of the Social Security Act) greater than 11.75 percent or was described in section 1886(d)(5)(F)(i)(II) of such Act; and (iii) does not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.

[iv] *HRSA and CMS, http://www.hrsa.gov/opa/introduction.htm*

[v] *http://www.marylandrxcard.com/index.php*

[vi] *http://www.communityservice.harvard.edu/programs/cherishing-our-hearts-and-souls-coalition-cohs-anti-racism-project. CHOICE website: http://www.projectchoice.org/outreach.cfm?portion=projects&art=cherish*

[viii], American Academy of Pediatrics (AAP) , American College of Physicians (ACP) and the American Osteopathic Association (AOA):

[ix] American Academy of Family Physicians (AAFP) , American Academy of Pediatrics (AAP) , American College of Physicians (ACP) and the American Osteopathic Association (AOA) Joint Principles of the Patient-Centered Medical Home, March 2007. Available at http://www.ncqa.org/tabid/631/Default.aspx

[x] Maryland's Patient Centered Medical Home Pilot At-a-Glance available at http://mhcc.maryland.gov/pcmh/documents/PCMH_Pilot_glance_Maryland.pdf

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