Course Learning Objectives

Given the complexity of healthcare problems and the diversity of needs of the American public, new solutions are required to integrate interventions at the levels of public policy; medical practice; and community environments, resources, and values. HS266AB Community Based Participatory Research: Methods and Applications offers an exposure to working with communities to improve health and health services in innovative partnered ways. For the purposes of this course, “communities” are defined as people who share a social or cultural identity, a particular illness, common resources (including geographic proximity), or communication channels (such as media, internet) pertaining to health. At the end of HS266A, fellows should be able to understand the practical/ethical issues of CBPR and put into practice the guiding principles of Community Based Participatory Research for collaborating with communities in health-related research. At the end of HS266B, fellows should be able to put into practice various quantitative and qualitative methods used in partnered research and in implementing partnered interventions and evaluations.

HS266 Community-Based Participatory Health Research: Methods and Applications is a two-part course structured as a weekly seminar for two quarters. Each quarter confers four units course credit, for a total of eight units over the two quarters. The course will combine mentoring from field experiences and a seminar style introduction to critical issues in conducting partnered research in community settings. The first quarter covers general principles of community-based participatory research (CBPR) and practical and ethical issues in collaborating with communities in health-related research. The second quarter focuses on quantitative and qualitative methods used in partnered research and in implementing partnered interventions and evaluations. The course will also provide an opportunity for Scholars to receive immediate feedback and guidance on their partnerships and projects from community and academic mentors that are associated with each main partnering agency, as well as community leaders and academic faculty participating in the seminar sessions. In addition, the course will allow Scholars to learn from each other's experiences and thus broaden the practical aspects of their education. This course also draws from materials and presentations in other courses and seminars as shown in the figure below.
<table>
<thead>
<tr>
<th>HS266A Learning Objectives/Competencies</th>
<th>Learning Objectives</th>
<th>ASPH Competencies</th>
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</thead>
</table>
| 1. Understand the practical/ethical issues of CBPR | D.6. Apply principles of strategic planning to public health.  
D.10. Demonstrate leadership skills for building partnerships.  
E.1. Identify basic theories, concepts and models from a range of social and behavior science disciplines that are used in public health research and practice. | |
| 2. Put into practice the guiding principles of CBPR for collaborating with communities in health-related research | D.6. Apply principles of strategic planning to public health.  
D.10. Demonstrate leadership skills for building partnerships.  
E.4. Identify critical stakeholders for the planning, implementation, and evaluation of public health programs, policies, and interventions.  
H.5. Demonstrate team building, negotiation, and conflict management skills.  
K.9. In collaboration with others, prioritize individual, organizational, and community concerns and resources for public health programs. | |

<table>
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<th>HS266B Learning Objectives/Competencies</th>
<th>Learning Objectives</th>
<th>ASPH Competencies</th>
</tr>
</thead>
</table>
| 1. Put into practice quantitative methods used in partnered research and in implementing partnered interventions and evaluations | D.6. Apply principles of strategic planning to public health.  
H.5. Demonstrate team building, negotiation, and conflict management skills.  
H.9. Develop strategies to motivate others for collaborative problem solving, decision-making, and evaluation. | |
| 2) Put into practice qualitative methods used in partnered research and in implementing partnered interventions and evaluations | D.6. Apply principles of strategic planning to public health.  
H.5. Demonstrate team building, negotiation, and conflict management skills.  
H.9. Develop strategies to motivate others for collaborative problem solving, decision-making, and evaluation. | |
Other Research Methods Courses/Seminars

Meetings w/ Instructors
Community Partner Meeting
Field Trips
Faculty Luncheons

CSP’s Survey* Design Seminar
Sandra Berry
October

CSP’s Qualitative Methods Seminar
Gery Ryan
Spring

HS225A Health Services Research Methods Summer

HS266AB CBPR and Health Services Methods and Applications
Fall - Winter

Leadership Guest Lecture Series Summer - Spring
HS200AB Health Policy, Jose Escarce

* Because we maintain the Survey Design Seminar as a small group workshop of 10 fellows and prioritize graduating fellows, most fellows take this course in their second year (For Fall 2011/October, there are 3 slots available for students in this course. as of Aug 24, 2012)

Course Format

In each quarter, there are 5-6 group sessions and 5 mentor meetings in the field. During each of the group sessions, 2-3 Fellows will present material assigned for that session, and describe their own work as an example, if relevant. Other activities may include presentations from scholars in other years, community members, faculty or former scholars who have conducted relevant work. The course culminates with a poster-feedback session for partner organizations and faculty involved in the course, as well as a paper by each fellow on their partnered work. Feedback from the academic and community mentor is obtained through a written form and through in-progress telephone calls periodically during the course. Fellows are responsible for setting up meetings with community partners and faculty mentors.

In the summer before the class begins, activities such as visits to various community partner sites and meetings with the professors, are planned with students taking the course. While it is preferable that partnership is identified prior to or at the beginning of the course, in practice it may take a month or so to determine the best fit, and for various reasons sometimes fellows change their project or partner over the course of the first quarter because of feasibility or fit issues. Sometimes, fellows select a community partner that is not one of the regular partners for the course. That case, the same requirements apply for an identified community member and academic faculty member who participate as part of the course for the two-quarter period. For more information, please contact the Clinical Scholars Program at (310) 794-2268.

Course Requirements

***Fall Quarter***

a. Scholars develop an internal leadership mechanism to decide how to divide up the reading and other assignments and how to structure and lead sessions, which they may do working with the community partners for the seminars. In the past we have randomly assigned reading leaders for each session and these are listed in the schedule below. Please make any changes
including any switches in dates for reading leaders among yourselves and email your plan or switch to cpunzalan@mednet.ucla.edu.

b. By Nov 16, 2012, Scholars must submit a Community Project Plan describing their community partner, specific contact person, plans to meet with contact person, description of the topic, and the project timeline. See Community Project Plan outline below.

c. As soon as the faculty mentor and community partner are confirmed or by Dec 7, 2012, Scholars are required to submit the signed Roles and Responsibilities agreement.

d. Scholars must submit a 5-7 page proposal for a final project by Dec 7, 2012. The project proposal must be submitted to kwells@ucla.edu and anishmahajan@mednet.ucla.edu and cc cpunzalan@mednet.ucla.edu by 5 PM and requires the following sections (5-7 pages):

1) Specific aims
2) Background
3) Methods
4) Development of relationship with community partner
5) Relationship with faculty mentor
6) Progress to date
7) Challenges/solutions
8) Dissemination plan
9) Timeline
10) Budget and justification

e. Mentor evaluations are required for each Scholar from at least one community and one faculty mentor by Dec 7, 2012.

***Winter Quarter***

f. Scholars must sign up to present a group of readings for each session. Send your preferences #1-3 to the course administrator by Dec 7, 2012. A final list of reading presenters will be distributed to the course by email and via course website.

g. Scholars will complete the project described in the project proposal from the first quarter.

h. Scholars are required to submit a 10 page paper discussing the progress on the project by March 15, 2013. The project paper must be submitted to kwells@ucla.edu and amahajan@dhs.lacounty.gov and cc cpunzalan@mednet.ucla.edu by 5 PM and requires the following sections (10pages):

1) Specific aims
2) Background
3) Methods
4) Development of relationship with community partner
5) Relationship with faculty mentor
6) Progress to date
7) Results
8) Implications
9) Dissemination plan (including plans for an academic publication and reporting back to the community)
10) Sustainability plan for interventions and other projects that should continue in the future
11) Challenges/solutions
i. Scholars must submit an abstract of their work at least two weeks prior to the final session of the quarter and must present/discuss the project during the last session of the quarter. See specific dates in the quarter in the course schedule below.

j. Mentor evaluations are required for each Scholar from at least one community and one faculty mentor by Mar 15, 2013.

**What is a “Project”?**

Projects selected by scholars and fellows with the partners will vary considerably. A good project either aligns the interests of fellows with that of partner organizations or allows the fellow to learn about how to partner with an organization on an issue of importance to the community, from their point of view. Projects can vary from planning to a website, a proposal for funding, a secondary data analysis, intervention development or planning, evaluation of a program, or a step toward those ends. Regardless, there should be a defined product or report that is suitable for the course time period. Projects may be suitable for leading toward a later main project or working on the problem with another partner or another issue with the same project based on partnership development.

**Grading**

Grades for the first quarter will be based on the project proposal (40%), class participation (40%), and mentor evaluations (20%). Grades for the second quarter will be based on the project paper (20%), poster presentation (20%), class participation (40%), and mentor evaluations (20%). In this course, the course directors follow a policy that all scholars/fellows begin with an A and with successful progress maintain that A. It is understood that not all projects can be completed within the time frame, but the progress plan/poster should provide the plan to complete the project and progress to date. Abstracts of work completed by prior scholars for the course are available for review.

**Reading**

Required reading materials per session are listed in the course schedule below. Readings include a combination of book chapters from the required books listed below as well as articles and manuals which can be found on the course website. Other useful reading materials are listed in the Resource Guide for Course Themes/Core Principles at the end of this document.


This year, we are taking a somewhat different approach to reading than in prior years. We are assigning readings necessary to cover topics, but there are many other useful readings for particular types of projects or methods issues. We recommend that each scholar at least do a preliminary read-through of all the sources above to be oriented to the range of issues; read the assigned readings (which typically the fellow leading the reading outlines); and then select some
additional readings most related to the issue/community/methods for their project in consultation with their mentors for the course.

**Community Partners**

If you are partnering with a community that is not one of our Clinical Scholars Program partners, please let us know. Academic and/or community course instructors (Ken, Anish, Jim, Carol, Andrea) need to meet with you and the community partner to provide an orientation to the course and project involved. Academic and/or community course instructors need 1) to meet with partners on a quarterly basis to understand each others’ goals, review progress and 2) need an written evaluation of progress (see page 27 and 28). To help us ensure that we all have the same understanding of the course expectations, the Roles and Responsibilities pg 22-23 needs to be reviewed/signed by the course participant, faculty mentor, and community partner. The list below provides information on our Clinical Scholars Program partners.

<table>
<thead>
<tr>
<th>Organization</th>
<th>CSP Community Advisory Board Member</th>
<th>Contact Info</th>
<th>CSP Faculty Contact</th>
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<tbody>
<tr>
<td><strong>Main Program Partners</strong></td>
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<tr>
<td>Behavioral Health Services 15519 Crenshaw Boulevard Gardena, CA 90249</td>
<td>James Gilmore, MBA, Director of Corporate Development and Training</td>
<td>p: 310 679 9126 x1244 f: (310) 679-2920 <a href="mailto:jgilmore@bhs-inc.org">jgilmore@bhs-inc.org</a></td>
<td>Kate Watkins (Psychiatry, RAND) (310) 393-0411 x6509 <a href="mailto:katherine_watkins@rand.org">katherine_watkins@rand.org</a> Alison Moore (Geriatrics/IRB, UCLA) (310) 825-8253 <a href="mailto:aamoore@mednet.ucla.edu">aamoore@mednet.ucla.edu</a></td>
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<tr>
<td>Charles R. Drew University of Medicine and Science 1731 East 120th Street Los Angeles, CA 90059</td>
<td>Keith Norris, MD, FACP, Interim President Nell Forge, PhD, MPH, Director of Division of Community Engagement</td>
<td>p: (323) 249-5702; f: (323) 357-3618; <a href="mailto:knorris@ucla.edu">knorris@ucla.edu</a> p: (323) 563-9382; <a href="mailto:nellforge@cdrewu.edu">nellforge@cdrewu.edu</a></td>
<td>Carol Mangione (GIM, UCLA) (310) 794-2298 <a href="mailto:cmangione@mednet.ucla.edu">cmangione@mednet.ucla.edu</a></td>
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<tr>
<td>Healthy African American Families (HAAF) 4305 Degnan Blvd., Suite 105, Los Angeles, CA 90008</td>
<td>Loretta Jones, MA, Executive Director Andrea Jones, Project Specialist</td>
<td>p: (323) 292-2002 f: (323) 292-6209 <a href="mailto:ljoneshaaf@aol.com">ljoneshaaf@aol.com</a> <a href="mailto:dreahaaf2@aol.com">dreahaaf2@aol.com</a></td>
<td>Arleen Brown (GIM, UCLA) (310) 794-6047 <a href="mailto:abrown@mednet.ucla.edu">abrown@mednet.ucla.edu</a> Carol Mangione (GIM, UCLA) (310) 794-2298 <a href="mailto:cmangione@mednet.ucla.edu">cmangione@mednet.ucla.edu</a></td>
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<tr>
<td>Kaiser Permanente Medical Group, Southern California 100 S Los Robles, 2nd Floor Pasadena, CA 91101</td>
<td>Steven J Jacobson, MD, PhD, Director of Research</td>
<td>p: 626-564-3723 (Tie-line 8-338-3723) f: 626-564-3430 <a href="mailto:steven.j.jacobsen@kp.org">steven.j.jacobsen@kp.org</a> <a href="mailto:jennifer.x.wong@kp.org">jennifer.x.wong@kp.org</a></td>
<td>Ken Wells (Psychiatry, UCLA) (310) 794-3724 or (310) 794-2268 <a href="mailto:kwells@mednet.ucla.edu">kwells@mednet.ucla.edu</a></td>
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<tr>
<td>LA County Department of Health Services 313 N. Figueroa Street, Room 912D Los Angeles, CA 90012</td>
<td>Jeffrey Guterman, MD Director of Clinical Resource Management</td>
<td><a href="mailto:iguterman@ladhs.org">iguterman@ladhs.org</a> <a href="mailto:oandrade@dhs.lacounty.gov">oandrade@dhs.lacounty.gov</a></td>
<td>Allison Diamant (GIM, UCLA) (310) 794-0124 <a href="mailto:adiamant@mednet.ucla.edu">adiamant@mednet.ucla.edu</a></td>
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<tr>
<td>LA County Department of Mental Health 550 S. Vermont Avenue Los Angeles, CA 90020</td>
<td>Roderick Shaner, MD, Medical Director</td>
<td>p: (213) 738-4603 f: (213) 386-1297 <a href="mailto:rshaner@dmh.co.la.ca.us">rshaner@dmh.co.la.ca.us</a> p: (213) 738-6152</td>
<td>Bonnie Zima (Child Psychiatry, UCLA) (310) 794-3714 <a href="mailto:bzima@mednet.ucla.edu">bzima@mednet.ucla.edu</a></td>
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<tr>
<td>LA County Department of Public Health</td>
<td>Jonathan Fielding, MD, MPH, MA, MBA, Director of Public Health and Health Officer</td>
<td>p: (213) 240-8117</td>
<td>Allison Diamant (GIM, UCLA) (310) 794-0124</td>
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<td>Jeffrey D. Gunzenhauser, MD, MPH, Medical Director, LA County Department of Public Health</td>
<td><a href="mailto:jgunzenhauser@ph.lacounty.gov">jgunzenhauser@ph.lacounty.gov</a> f: (213) 742-8303</td>
<td><a href="mailto:adiamant@mednet.ucla.edu">adiamant@mednet.ucla.edu</a></td>
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<td><a href="mailto:pia.escudero@lausd.net">pia.escudero@lausd.net</a></td>
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<td>Pia Escudero, LCSW, Director</td>
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<td>LAUSD School Mental Health Services</td>
<td>Kim Uyeda, MD, MPH, Medical Director</td>
<td>p: (213) 765-2830</td>
<td>Sheryl Kataoka (Psychiatry, UCLA) (310) 794-3727</td>
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<tr>
<td>Trauma Services Adaptation Center for Schools</td>
<td></td>
<td>f: (213) 274-8259</td>
<td><a href="mailto:skataoka@mednet.ucla.edu">skataoka@mednet.ucla.edu</a></td>
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<td>333 South Beaudry Ave, 29th Floor Los Angeles, CA</td>
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<td><a href="http://www.tsaforschools.org">www.tsaforschools.org</a></td>
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<td>P: 213.742-8259</td>
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<td>F: 213.742-8303</td>
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<tr>
<td>LAUSD Student Health &amp; Human Services</td>
<td>P: (562) 826-5963</td>
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<td>Steve Asch (GIM, VA, RAND) (310) 478-3711x41425</td>
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<tr>
<td>Student Medical Services</td>
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<td><a href="mailto:kdezeew@mednet.ucla.edu">kdezeew@mednet.ucla.edu</a></td>
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<td>644 W. 17th Street, Bldg B Los Angeles, CA 90015</td>
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<td>Greater Los Angeles VA and VA Medical Center Long</td>
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<td>Michael Rodriguez (Family Medicine, UCLA) (310) 794-0294</td>
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<tr>
<td>Beach 5901 E. 7th St. Long Beach, CA 90822</td>
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<td><a href="mailto:mrodriguez@mednet.ucla.edu">mrodriguez@mednet.ucla.edu</a></td>
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<td>Mid-Valley Family Practice Program</td>
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<td>P: (310) 825-8234</td>
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<td>Clifford Ko (Surgery, UCLA) (310) 206-7572</td>
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<td>f: (310) 267-2529</td>
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<td><a href="mailto:eko@mednet.ucla.edu">eko@mednet.ucla.edu</a></td>
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<td><a href="mailto:pinedinamartinez@mednet.ucla.edu">pinedinamartinez@mednet.ucla.edu</a></td>
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<td>UCLA Healthcare System</td>
<td>Thomas Rosenthal, MD, Associate Vice Chancellor and Chief Medical Office, UCLA Healthcare</td>
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<td>JWCH Clinic at the Weingart Center</td>
<td>Paul Gregerson, MD, Chief Medical Officer, JWCH Clinic at the Weingart Center</td>
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<td>515 East 6th Street Los Angeles, CA 90021</td>
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<td>QueensCare Health and Faith Partnership</td>
<td>Elizabeth Dixon, RN, PhD, Vice President</td>
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<tr>
<td>1300 N. Vermont Avenue, Suite 307 Los Angeles, CA</td>
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<td>Venice Family Clinic</td>
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<tr>
<td>604 Rose Avenue Venice, CA 90291</td>
<td>Eleni Manouselianakis, MPH, Director of Program Development and Quality Improvement</td>
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***Fall Quarter 2012 Sessions/Reading Schedule***

Overview of Approach to Community-Based Participatory Research

All lectures sessions will be held at 10940 Wilshire Blvd suite 700 unless otherwise noted.

Session#1 - Introduction: Why CBPR? How to do CBPR?
-Fri Sept 28 at 1:30-3:30 PM
-Reading presenters*:
-Readings: Daskivich, Dixit
Jones L. CPPR Manual Chapter 1, 2

Session #2 – Working through the Valley (Do and Evaluate) and Celebrate Victory: The Process – Setting up workgroups and running meetings
- Fri Oct 12 at 1:30-3:30 PM Rescheduled on Nov 02 at 1:30-3:30 PM
-Reading presenters*: Stey, Probst
-Readings:
Jones L. CPPR Manual - Chapter 5, 6, 7
Discuss the work you are doing, how decisions are made and who is involved in the decision making process.
Review 1-2 “valley” relevant Program Alumni publications as an example of this stage of CPPR.
Contact the Alumni author to see if they would be willing to join the session by phone or in person. A list of program alumni publications can be found on page 13. Names in bold are Program Alumni and Community Partners are in blue.

Session#3 – Developing a Vision and a Plan for a Partnered Project
-Monday Oct 15 at 1:00-3:00 PM
-Reading presenters*: Parameswaran, Talamantes
-Readings:
Jones L. CPPR Manual -Chapter 3, 4
Minkler and Wallerstein. CBPR for Health - Chapter 5 (assigned in HS237A Summer: Be prepared to discuss important themes)
Chung B, Jones L, Dixon EL, Miranda J, Wells K. Using a Community Partnered Participatory Research Approach to Implement a Randomized Controlled Trial: Planning Community Partners in Care. Journal of Health Care for the Poor and Underserved. 21:3, August 2010
Review 1-2 “vision” relevant Program Alumni publications as an example of this stage of CPPR.
Contact the Alumni author to see if they would be willing to join the session by phone or in person. A list of program alumni publications can be found on page 13. Names in bold are Program Alumni and Community Partners are in blue. Let Nancy know what articles you chose a week in advance so she can distribute to instructors, community partners and scholars.

Session #4 Meet with Community Partner
-Week of Oct 15, 2012 (to be scheduled by students)

Session #5 w/ Gery Ryan: Overview of Qualitative Methods: What is data collection and analysis tool kit
- Fri Oct 19 at 1:30-3:30 PM
-Readings:

REMINDER DUE Nov 9: Community Project Plan (email to Ken, Anish, and CC: Cristina). Request evaluation from Community and Faculty Mentors and ask them to send it directly to CSP by Dec 7. See Course Requirements page for copies of the project plan and evals to send to your mentors.

Session #6 Meet with Community Partner
-Week of Oct 22 (to be scheduled by students)

Session #7– Working through the Valley (Do and Evaluate) and Celebrate Victory Action – What happens to results
-Fri Oct 26 at 1:30-3:30 PM
-Reading presenters*: Barnert, Kanzaria
-Readings:
Jones L. CPPR Manual - Chapter 5, 6, 7
Review 1-2 “victory” relevant Program Alumni publications as an example of this stage of CPPR. Contact the Alumni author to see if they would be willing to join the session by phone or in person. A list of program alumni publications can be found on page 13. Names in bold are Program Alumni and Community Partners are in blue.

Session #8 Meet with Community Partner
-Week of Oct 29 (to be scheduled by students)

Session #9 Meet with Community Partner
-Week of Nov 5 (to be scheduled by students)

Session #10 w/ Gery Ryan: Overview of Conducting a Needs Assessment: Basics of elicitation and rudimentary analysis techniques
-Fri Nov 9 at 1:30-3:30 PM
-Readings:
Israel et al. Methods in CBPR for Health - Chapter 7, 10
Other Readings: Same as Session #3
DUE Dec 7, 2012: 1) Roles and Responsibilities Form signed by mentors, 2) Community and Faculty Mentors Evaluations, 3) Final Project Proposal
OTHER RECOMMENDED READINGS:

Glanz et al. Health Behavior and Health Education: Theory, Research, and Practice, Chapters 2, 13, 14, 15. It is also recommended that you select one from each of the remaining parts of the book that may be relevant to your project. For more guidance on this, please contact course instructors.
Session#1 – Building a team and working together around a conceptual framework
-Wednesday Jan 16 at 3:30-5:30
-Reading presenters*: Anne, Tim
-Readings:
Minkler Chapters 4 and 21
Pick one chapter relevant to your work or of interest to you in the Glanz book (talk with course instructors for guidance)
Chung B, Jones L, Jones A, Corbett CE, Booker T, Wells KB, Collins B., "Using community arts events to enhance collective efficacy and community engagement to address depression in an African American community", *American Journal of Public Health*, 99(2) 237-244, 2009

DEADLINES Jan 9 and Jan 18, 2013:
Students need to sign up to talk about their project during consultation sessions #3 Qualitative Consult or session # 5 Quantitative Consult (due Jan 09). These sessions provide an opportunity to present your work and get feedback from various faculty with Qualitative or Quantitative methods expertise. We can only have max of 5-6 people per session because we need an even distribution between the two sessions. Tell Nancy which one you will do by Jan 09 and submit a 1 paragraph description of the project and 2-3 questions for discussion with the group and the consultants coming (due Jan 18).

Qualitative consultant bios can be found here:
Gery: [http://www.hsrcenter.ucla.edu/people/ryan.shtml](http://www.hsrcenter.ucla.edu/people/ryan.shtml);
Paul: [http://www.hsrcenter.ucla.edu/people/koegel.shtml](http://www.hsrcenter.ucla.edu/people/koegel.shtml);

Quantitative consultant bios can be found here:
Susan: [http://gim.med.ucla.edu/ettner/](http://gim.med.ucla.edu/ettner/)
Chi-Hong: [http://www.domstat.med.ucla.edu/index.php/about-domstat/48?9935f8b1fbfb01c47e90d09c0a361635=02c0afab9cfec20ea9829214e67cc4c7](http://www.domstat.med.ucla.edu/index.php/about-domstat/48?9935f8b1fbfb01c47e90d09c0a361635=02c0afab9cfec20ea9829214e67cc4c7).
Session #2 Meet with Community Partner
- To be scheduled by students

Session #3 – Qualitative Methods Consultation with Gery Ryan, Paul Koegel, and David Kennedy
- Wednesday Jan 23 at 3:30- 5:30
- Reading presenters*: Ravi, Liz
- Readings:
  Minkler Chapters 10, 11
Each scholar selects 1 chapter relevant to their work from Israel text. Suggested chapters include
  Israel Chapters 4, 7, 10, 15. Consult mentors and/or course instructors for guidance.

Session #4 Meet with Community Partner
- To be scheduled by students

Session #5 – Project Design and Quantitative Methods Consultation with Jack Needleman and Susan Ettner
- Wednesday Jan 30 at 3:30- 5:30
- Reading presenters*: Hemal, Alissa
- Readings:
  Israel Chapter 8 and 9. Each scholar selects 2 chapters relevant to their work from Israel text.
  Consult mentors and/or course instructors for guidance.
- Optional/Skim:
  Minkler Chapter 16
  Chapter 4 in the CEAL-UNC CBPR manual
  (http://www.shepscenter.unc.edu/research_programs/aging/publications/CEAL-UNC%20Manual%20for%20Community-Based%20Participatory%20Research-1.pdf)

Session #6 Meet with Community Partner
- To be scheduled by students

Session #7 – Partnered Analysis and Product
- Wednesday Feb 06 at 3:30-5:30
Guests: Bowen Chung, Nazleen Bhamal
Reading presenters*: Sharu, Efrain
Readings:
  Minkler Chapter 16, 17
Israel Chapters 16, 17
Due Feb 10: Abstract of work to be presented/discussed at Session #10.

Session #8 Meet with Community Partner
- To be scheduled by students

Session #9 Meet with Community Partner
- To be scheduled by students

Session #10 – Practicing Victory: Project presentation/discussion on current status with invited faculty and community partners)
- Wednesday March 6 at 3:30-5:30

DUE Mar 15, 2013: Community and Faculty Mentors Evaluation; Final paper discussing project process and plans for the future or completion

BACKGROUND: Malaria is the leading cause of morbidity and mortality in children younger than 5 years old and pregnant women in sub-Saharan Africa. Insecticide-treated nets (ITNs) reduce clinical malaria by more than 50% and all cause mortality in young children by 15% to 30%. However, use of these nets is poor across sub-Saharan Africa, limiting the potential impact of this effective tool in the fight against malaria.

OBJECTIVE: We sought to improve the use of ITNs using a community-created and -implemented approach, and measure the change in ITN use over the year after implementation.

METHODS: Using a community-based participatory research approach, we created and implemented an intervention to improve ITN use in a rural village. Our intervention involved providing hands-on instructions and assistance in hanging of nets, in-home small group education, and monthly follow-up by trained community members. ITN use was measured for all individuals in a subset of the community (61 households, 759 individuals) at baseline and at 6 months and 1 year after distribution.

RESULTS: Rates of individual usage increased significantly from 29% at baseline to 88.7% (p < .001) at 6 months and to 96.6% (p < .001) at 12 months. For children under age 5, usage rates increased from 46% at baseline to 95.7% (p < .001) at 6 months and 95.4% (p < .001) at 12 months.

CONCLUSION: Our study demonstrates that rapidly achieving and sustaining almost universal ITN usage rates is possible using a community-based approach. Closing the gap between ITN ownership and use will help communities to realize the full potential of ITNs in the prevention of malaria.

Key words: CPPR - Valley


Key words: CPPR - Vision


BACKGROUND: Numerous studies have shown that patients without insurance lack coordinated health care and access to surgical procedures. Operation Access (OA) has coordinated uncompensated, low-risk outpatient surgical and specialty services to the uninsured in a volunteer setting for 15 years. Our objective was to evaluate the quality of outpatient surgical care provided by OA volunteers.

STUDY DESIGN: Retrospective cohort study using data from OA's secure database to evaluate the quality of care provided to all patients eligible for OA services from 1994 through 2008. Primary outcomes included quality of care as measured by the Institute of Medicine's six quality aims, ie, safety, efficiency, effectiveness, timeliness, patient-centered care, and equity.

RESULTS: Six-thousand five-hundred and forty-two patients were referred to OA during the past 15 years; 83.4% met eligibility criteria. Of these, 3,518 unduplicated patients received 3,098 surgical, endoscopic, and minor procedures. Only 12 of 1,880 surgical patients experienced a complication requiring hospitalization. Patient care was efficient, with a 95.3% overall compliance rate; approximately $7.56 of services were provided for every dollar of philanthropic support. OA's strong emphasis on case management, focus on continuity of care, and patient-selection criteria contributed to the organization's provision of safe, efficient, effective, timely,
and patient-centered care. A higher percentage of Latinos and a lower percentage of African Americans relative to the geographic demographics received OA services.

CONCLUSIONS: A volunteer program providing low-risk outpatient operations using the OA model delivers safe, efficient, effective, timely, and patient-centered care.

Keywords: CPPR- All stages


Promoting health and preventing illness among African American men, who die disproportionately from preventable diseases, is a challenging health disparity that has seen limited progress. However, focusing our efforts in places outside of traditional clinical and community settings such as the barbershop has shown promise for ameliorating these disparities. In particular, barbershop-based health promotion as conducted by the Black Barbershop Health Outreach Program has successfully reached nearly 10,000 men nationwide through a grassroots, volunteer-driven effort. At the same time, researchers have begun to conduct formal clinical trials in barbershops in order to explore interventions targeting this at-risk population. Herein, we describe, in brief a review of barbershop-based health promotion and the experience of this novel community-based organization. We argue for continuing to integrate evaluation and research using community-partnered principles into successful grassroots initiatives without dulling the practical impact of these programs is a crucial next step as we move beyond simply acknowledging health disparities and seek to find solutions.

Keywords: CPPR- Vision


OBJECTIVES: To review the success of barbershops as vehicles for health promotion and outline the Black Barbershop Health Outreach Program (BBHOP), a rapidly growing, replicable model for health promotion through barbershops.

METHODS: BBHOP was established by clinicians in order to enhance community level awareness of and empowerment for cardiometabolic disorders such as diabetes and cardiovascular disease. At coordinated events utilizing existing infrastructures as well as culturally and gender-specific health promotion, BBHOP volunteers screen for diabetes and hypertension and reinforce lifestyle recommendations for the prevention of cardiometabolic disorders from the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. Patrons with abnormal findings are referred to participating physicians or health care facilities. We performed a selective review of the literature in order to place this model for health promotion in the context of previous efforts in barbershops. BBHOP is among several successful programs that have sought to promote health in barbershops. Combining a grassroots organization approach to establishing a broad-based network of volunteers and partner agencies with substantial marketing expertise and media literacy, the BBHOP has screened more than 7000 African American men in nearly 300 barbershops from more than 20 cities across 6 states.

CONCLUSIONS: The BBHOP is an effective method for community level health promotion and referral for cardio-metabolic diseases, especially for AA men, one of the nation's most vulnerable populations.

Keywords: CPPR- Vision, Valley (possibly Victory as well)


BACKGROUND: Data used for evaluating quality of medical care need to be of high reliability to ensure valid quality assessment and benchmarking. The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) has continually emphasized the collection of highly reliable clinical data through its program infrastructure.
STUDY DESIGN: We provide a detailed description of the various mechanisms used in ACS NSQIP to assure collection of high quality data, including training of data collectors (surgical clinical reviewers) and ongoing audits of data reliability. For the 2005 through 2008 calendar years, inter-rater reliability was calculated overall and for individual variables using percentages of agreement between the data collector and the auditor. Variables with > 5% disagreement are flagged for educational efforts to improve accurate collection. Cohen's kappa was estimated for selected variables from the 2007 audit year.

RESULTS: Inter-rater reliability audits show that overall disagreement rates on variables have fallen from 3.15% in 2005 (the first year of public enrollment in ACS NSQIP) to 1.56% in 2008. In addition, disagreement levels for individual variables have continually improved, with 26 individual variables demonstrating > 5% disagreement in 2005, to only 2 such variables in 2008. Estimated kappa values suggest substantial or almost perfect agreement for most variables.

CONCLUSIONS: The ACS NSQIP has implemented training and audit procedures for its hospital participants that are highly effective in collecting robust data. Audit results show that data have been reliable since the program's inception and that reliability has improved every year.

Keywords: Project with American College of Surgeons, CPPR- Vision, Valley (possibly Victory as well)


Keywords: CPPR- Vision (lit review)


OBJECTIVES: To document the feasibility of a cross-border community based integrated malaria control programme implemented by internally displaced persons in eastern Burma/Myanmar.

METHODS: This pilot study was conducted from February 2003 through January 2005 in seven villages of displaced ethnic Karen. Interventions comprised early diagnosis of Plasmodium falciparum and treatment with mefloquine and artesunate, distribution of long-lasting insecticide treated nets (LLITNs), and educational messages. The primary outcome measure was P. falciparum prevalence during bi-annual universal screenings with the Paracheck-Pf (Orchid Biomedical Systems, Goa, India) device. Secondary outcomes were P. falciparum incidence and process indicators related to net use and malaria knowledge, attitudes and practices (KAP).

RESULTS: P. falciparum prevalence in original programme areas declined from 8.4% [95% confidence interval (CI) 8.3-8.6] at baseline to 1.1% (95% CI 1.1-1.2) in the final screening. Annual incidence in original areas declined from 232 to 70 cases/1000/year [incidence rate ratio 0.30 (95% CI 0.24-0.39)]. The proportion of household members sleeping under a LLITN improved from 0% to 89% and malaria KAP improved in all areas.

CONCLUSIONS: Integrated malaria control organized and implemented by displaced persons is feasible in eastern Burma/Myanmar. The decline in P. falciparum prevalence and incidence suggest that it may be possible to reduce the burden of disease and the reservoir of malaria in eastern Burma/Myanmar, with implications for malaria control in the greater Mekong region.

Keywords: CPPR- Vision

The wide array of questions and opportunities for surgical health services research offers important prospects for inquiry into surgical disparities. In this essay we discuss research that directly or indirectly addresses disparities in surgery, highlighting the strengths and the future directions such research efforts intimate as potential foci of collective attention. We then consider possible research approaches—including community-based participatory models—for confronting disparity and the potential role of research in quality improvement to help achieve the ultimate aim, an optimal level of health care for all.

Keywords: CPPR – Vision, Project partner = ACS


Acknowledging the growing disparities in health and health care that exist among immigrant families and minority populations in large urban communities, the UCLA Department of Family Medicine (DFM) sought a leadership role in the development of family medicine training and community-based participatory research (CBPR). Performing CBPR requires that academic medicine departments build sustainable and long-term community partnerships. The authors describe the eight-year (2000-2008) process of building sustainable community partnerships and trust between the UCLA DFM and the Sun Valley community, located in Los Angeles County. The authors used case studies of three research areas of concentration (asthma, diabetes prevention, and establishing access to primary care) to describe how they established community trust and sustained long-term community research partnerships. In preparing each case study, they used an iterative process to review qualitative data. Many lessons were common across their research concentration areas. They included the importance of (1) having clear and concrete community benefits, (2) supporting an academic-community champion, (3) political advocacy, (4) partnering with diverse organizations, (5) long-term academic commitment, and (6) medical student involvement. The authors found that establishing a long-term relationship and trust was a prerequisite to successfully initiate CBPR activities that included an asthma school-based screening program, community walking groups, and one of the largest school-based primary care clinics in the United States. Their eight-year experience in the Sun Valley community underscores how academic-community research partnerships can result in benefits of high value to communities and academic departments.

Keywords: CPPR-Vision, Valley, Victory


OBJECTIVE: Few studies have examined access to a regular source of medical care and preventive medical care among adults being treated for substance abuse. This report describes the prevalence of a usual source of care, use of preventive care services, and self-reported chronic conditions among adults in a publicly funded substance abuse treatment program.

METHODS: The investigators partnered with a large behavioral health organization in Los Angeles County to conduct an interviewer-administered survey during June 2008.

RESULTS: A total of 254 clients completed the survey. Fifty percent reported having a usual source of medical care, and 70% reported at least one visit to a physician within the prior 12 months. Participants reported low receipt of most preventive care screening measures. Half had at least one chronic condition, with hypertension, asthma, and arthritis most often reported.

CONCLUSIONS: Although this middle-aged sample with substantial medical need reported having access to care, receipt of preventive care was low and unaddressed health concerns were reported.

KEYWORDS: CPPR Vision

BACKGROUND: Latino youth in low-income households have a higher likelihood of poor educational and health outcomes than their peers. Protective factors, such as parental support, improve chances of success for youth. A community-academic partnership used community-based participatory research principles to examine perceptions of resilience among Latino young people in low-income households.

METHODS: Semi-structured qualitative interviews were conducted in 2007 with Latino young people living in an urban low-income housing complex (n=20); their parents (n=10); and representatives from local community-based organizations (n=8) to explore their definitions of youth "success," and barriers to and facilitators of success. Interviews were audiotaped, transcribed, coded, and analyzed using content-analysis and grounded theory in 2007.

RESULTS: Participants identified self, family, and community factors as potential sources of support. Parents appeared to de-emphasize community resources, expressing that success resulted primarily from a child's individual desire, bolstered by family support. All stakeholder groups perceived peers more as potential barriers to achieving success than as potential sources of support.

CONCLUSIONS: These findings raise the possibility that in this community, low-income Latino parents' beliefs about community resources may act as a barrier to seeking assistance outside the family. Results also suggest that Latino youth recognize the benefits of interacting with adults outside the family and are accepting of help from the community. Resilience promotion programs in this population may benefit from engaging parents and community members in addition to young people. Parent-focused programs could explore parental beliefs about youth success, and youth programs could engage adult community members to generate positive interactions and messages.

KEYWORDS: CPPR Valley


BACKGROUND: School nutrition policies are gaining support as a means of addressing childhood obesity. Community-based participatory research (CBPR) offers an approach for academic and community partners to collaborate to translate obesity-related school policies into practice. Site visits, in which trained observers visit settings to collect multilevel data (e.g., observation, qualitative interviews), may complement other methods that inform health promotion efforts. This paper demonstrates the utility of site visits in the development of an intervention to implement obesity-related policies in Los Angeles Unified School District (LAUSD) middle schools.

METHODS: In 2006, trained observers visited four LAUSD middle schools. Observers mapped cafeteria layout; observed food/beverage offerings, student consumption, waste patterns, and duration of cafeteria lines; spoke with school staff and students; and collected relevant documents. Data were examined for common themes and patterns.

RESULTS: Food and beverages sold in study schools met LAUSD nutritional guidelines, and nearly all observed students had time to eat most or all of their meal. Some LAUSD policies were not implemented, including posting nutritional information for cafeteria food, marketing school meals to improve student participation in the National School Lunch Program, and serving a variety of fruits and vegetables. Cafeteria understaffing and costs were obstacles to policy implementation.

CONCLUSIONS: Site visits were a valuable methodology for evaluating the implementation of school district obesity-related policies and contributed to the development of a CBPR intervention to translate school food policies into practice. Future CBPR studies may consider site visits in their toolbox of formative research methods.

KEYWORDS: CPPR Valley

Patel AI, Bogart LM, Uyeda KE, Rabin A, Schuster MA. Perceptions about availability and adequacy of drinking water in a large California school district. Prev Chronic Dis. 2010
INTRODUCTION: Concerns about the influence of sugar-sweetened beverage consumption on obesity have led experts to recommend that water be freely available in schools. We explored perceptions about the adequacy of drinking water provision in a large California school district to develop policies and programs to encourage student water consumption.

METHODS: From March to September 2007, we used semistructured interviews to ask 26 California key stakeholders - including school administrators and staff, health and nutrition agency representatives, and families - about school drinking water accessibility; attitudes about, facilitators of, and barriers to drinking water provision; and ideas for increasing water consumption. Interviews were analyzed to determine common themes.

RESULTS: Although stakeholders said that water was available from school drinking fountains, they expressed concerns about the appeal, taste, appearance, and safety of fountain water and worried about the affordability and environmental effect of bottled water sold in schools. Stakeholders supported efforts to improve free drinking water availability in schools, but perceived barriers (eg, cost) and mistaken beliefs that regulations and beverage contracts prohibit serving free water may prevent schools from doing so. Some schools provide water through cold-filtered water dispensers and self-serve water coolers.

CONCLUSION: This is the first study to explore stakeholder perceptions about the adequacy of drinking water in US schools. Although limited in scope, our study suggests that water available in at least some schools may be inadequate. Collaborative efforts among schools, communities, and policy makers are needed to improve school drinking water provision.

KEYWORDS: CPPR Vision


INTRODUCTION: Although several studies suggest that drinking water may help prevent obesity, no US studies have examined the effect of school drinking water provision and promotion on student beverage intake. We assessed the acceptability, feasibility, and outcomes of a school-based intervention to improve drinking water consumption among adolescents.

METHODS: The 5-week program, conducted in a Los Angeles middle school in 2008, consisted of providing cold, filtered drinking water in cafeterias; distributing reusable water bottles to students and staff; conducting school promotional activities; and providing education. Self-reported consumption of water, nondiet soda, sports drinks, and 100% fruit juice was assessed by conducting surveys among students (n = 876), preintervention and at 1 week and 2 months postintervention, from the intervention school and the comparison school. Daily water (in gallons) distributed in the cafeteria during the intervention was recorded.

RESULTS: After adjusting for sociodemographic characteristics and baseline intake of water at school, the odds of drinking water at school were higher for students at the intervention school than students at the comparison school. Students from the intervention school had higher adjusted odds of drinking water from fountains and from reusable water bottles at school than students from the comparison school. Intervention effects for other beverages were not significant.

CONCLUSION: Provision of filtered, chilled drinking water in school cafeterias coupled with promotion and education is associated with increased consumption of drinking water at school. A randomized controlled trial is necessary to assess the intervention's influence on students' consumption of water and sugar-sweetened beverages, as well as obesity-related outcomes.

KEYWORDS: CPPR Valley

BACKGROUND: Hurricane Katrina and levee failures disrupted healthcare access for hundreds of thousands of New Orleans residents. Few models exist to explain community stakeholders' priorities for post-disaster recovery while building capacity for response. This project engaged community stakeholders in a rapid, participatory assessment of health priorities 1 year post-disaster, to inform the policy process and build capacity for recovery planning among community members.

METHODS: This project combined community-based participatory research methods and rapid assessment procedures to engage diverse community members in design, conduct, data interpretation, and dissemination of results. Thirty stakeholders in the health and healthcare fields were interviewed in Summer 2006, and four grassroots community discussion groups were held in New Orleans neighborhoods to assess perceptions of the disaster's impacts on healthcare access. Interview transcripts were reviewed in Summer 2006, and themes were elicited using methods rooted in grounded theory. Findings were shared at a public community feedback conference, and recovery-relevant community action steps were set in motion.

RESULTS: Three main themes emerged from the data: (1) healthcare access challenges; (2) unmet needs of specific vulnerable populations; (3) opportunities, resources, and community adaptations to improve healthcare access.

CONCLUSIONS: This rapid, community-based participatory assessment provided new information on diverse community members' concerns and priorities, and it produced a sustainable community-academic partnership dedicated to improving both access to care and the public's health following this major disaster.

KEYWORDS: CPPR Vision

* Corita and others below worked with community partners at LA County and co-wrote the following papers with partners (in blue).


OBJECTIVE: The vast majority of out-of-hospital cardiac arrest victims do not survive or suffer severe neurological impairment. We sought to develop a set of straightforward clinical indicators that paramedics could use to better match resuscitation attempts to those most likely to benefit.

METHODS: In partnership with the Los Angeles County Emergency Medical Services, we used the RAND/UCLA appropriateness method of quantifying expert opinion regarding the risks and benefits of medical procedures. We presented available scientific evidence related to potential indicators of the quality of resuscitative care to stakeholder-nominated experts. Forty-one candidate indicators incorporated key variables, including initial rhythm, patient preferences, presence of witnesses, and place of arrest. Nine panelists, including palliative care and emergency medical specialists, rated the appropriateness of paramedic use of each indicator by using a 1-9 scale. An indicator was considered appropriate if the potential benefits outweighed the potential harm to the patient or their family. Indicators were retained if median score was ≥7.

RESULTS: The expert panel voted to retain 28 quality indicators. Three addressed signs of irreversible death (e.g., dependent lividity), 8 addressed patient preferences (e.g., inquiring about DNR status), and the remainder addressed combinations of initial rhythm and other prognostic signs (e.g., "If initial rhythm is asystole and patient is known by apparent surrogate decision maker to have a terminal illness, then forgo resuscitation."). Our experts recommended a series of much more liberal criteria for forgoing resuscitation than is currently practiced. This includes ascertaining and honoring patient preferences, either through written documents or family members, and combinations of clinical criteria that predict poor neurological outcome, such as asystole, terminal illness, age greater than 70, and response time greater than 15 minutes.
CONCLUSIONS: These quality indicators expand on the previously limited circumstances in which paramedics might forgo field resuscitation and implementation could reduce future harm from such procedures among seriously ill patients. Our current efforts focus on using these indicators to aid implementation of a new resuscitation policy for seriously ill patients in our county.

KEYWORDS: CPPR Valley


Despite being part of a large and legal industry in Los Angeles, little is known about adult film performers’ exposure to health risks and when and how these risks might occur. The objective was to identify exposure to physical, mental, and social health risks and the pathways to such risks among adult film performers and to determine how risks differ between different types of performers, such as men and women. Semi-structured in-depth interviews were conducted with 18 female and ten male performers as well as two key informants from the industry. Performers and key informants were recruited through Protecting Adult Welfare, adult film venues, and snowball sampling. Performers engaged in risky health behaviors that included high-risk sexual acts that are unprotected, substance abuse, and body enhancement. They are exposed to physical trauma on the film set. Many entered and left the industry with financial insecurity and suffered from mental health problems. Women were more likely than men to be exposed to health risks. Adult film performers, especially women, are exposed to health risks that accumulate over time and that are not limited to sexually transmitted diseases.

KEYWORDS: CPPR Valley


BACKGROUND: Despite potential harm to patients, families, and emergency personnel, a low survival rate, and high costs and intensity of care, attempting resuscitation after prehospital cardiac arrest is the norm, unless there are signs of irreversible death or the presence of a valid, state-issued DNR.

OBJECTIVE: To determine whether there was a change in the rate of forgoing resuscitation attempts in prehospital cardiac arrest after implementation of a new policy allowing paramedics to forgo resuscitation based on a verbal family request or the presence of certain arrest characteristics.

METHODS AND RESULTS: All prehospital run sheets for cardiac arrest in Los Angeles County were reviewed for the first seven days of each month August 2006-January 2007 (pre-policy) and January-June 2008 (post-policy). Paramedics were more likely to forgo resuscitation attempts after the policy change (13.3% vs. 8.5%, p<0.01). In addition, the percentage of patients with documented signs of irreversible death decreased post-policy, from 50.4% to 35.8%, p<0.01. After adjustment for potential confounders (patient demographics, clinical characteristics and EMS factors), as well as exclusion of patients with signs of irreversible death, paramedics are significantly more likely to forgo a resuscitation, and less likely to attempt resuscitation, after the policy change (OR 1.67 [95% CI 1.07, 2.61], p=0.024).

CONCLUSIONS: Paramedics are more likely to forgo, and less likely to attempt, resuscitation in victims of cardiac arrest after implementation of a new policy. There was also an associated decrease in the percentage of patients who had signs of irreversible death, which might reflect a change in paramedic behavior.

KEYWORDS: CPPR Valley

OBJECTIVES: The objective was to assess paramedic and emergency medical technicians (EMT) perspectives and decision-making after a policy change that allows forgoing or halting resuscitation in prehospital atraumatic cardiac arrest.

METHODS: Five semistructured focus groups were conducted with 34 paramedics and 2 EMTs from emergency medical services (EMS) agencies within Los Angeles County (LAC), 6 months after a policy change that allowed paramedics to forgo or halt resuscitation in the field under certain circumstances.

RESULTS: Participants had an overwhelmingly positive view of the policy; felt it empowered their decision-making abilities; and thought the benefits to patients, family, EMS, and the public outweighed the risks. Except under certain circumstances, such as when the body was in public view or when family members did not appear emotionally prepared to have the body left on scene, they felt the policy improved care. Assuming that certain patient characteristics were present, decisions by paramedics about implementing the policy in the field involve many factors, including knowledge and comfort with the new policy, family characteristics (e.g., agreement), and logistics regarding the place of arrest (e.g., size of space). Paramedic and EMT experiences with and attitudes toward forgoing resuscitation, as well as group dynamics among EMS leadership, providers, police, and ED staff, also play a role.

CONCLUSIONS: Participants view the ability to forgo or halt resuscitation in the field as empowering and do not believe it presents harm to patients or families under most circumstances. Factors other than patient clinical characteristics, such as knowledge and attitudes toward the policy, family emotional preparedness, and location of arrest, affect whether paramedics will implement it. KEYWORDS: CPPR Valley


OBJECTIVES: We compared the prevalence of condom use during a variety of sexual acts portrayed in adult films produced for heterosexual and homosexual audiences to assess compliance with state Occupational Health and Safety Administration regulations.

METHODS: We analyzed 50 heterosexual and 50 male homosexual films released between August 1, 2005, and July 31, 2006, randomly selected from the distributor of 85% of the heterosexual adult films released each year in the United States.

RESULTS: Penile-vaginal intercourse was protected with condoms in 3% of heterosexual scenes. Penile-anal intercourse, common in both heterosexual (42%) and homosexual (80%) scenes, was much less likely to be protected with condoms in heterosexual than in homosexual scenes (10% vs 78%; P < .001). No penile-oral acts were protected with condoms in any of the selected films.

CONCLUSIONS: Heterosexual films were much less likely than were homosexual films to portray condom use, raising concerns about transmission of HIV and other sexually transmitted diseases, especially among performers in heterosexual adult films. In addition, the adult film industry, especially the heterosexual industry, is not adhering to state occupational safety regulations.

KEYWORDS: CPPR Valley


BACKGROUND: Forgoing resuscitation in prehospital cardiac arrest has previously required a written prehospital do-not-resuscitate (DNR) order. Some emergency medical services (EMS) agencies, including Los Angeles County (LAC), have implemented policies allowing surrogate decision makers to verbally request to forgo resuscitation. The impact of a verbal DNR policy is unclear, given the absence of information about how often cardiac arrest occurs at home, or in the presence of a family member.

OBJECTIVE: To determine the prevalence of written DNR forms, rate of resuscitation, location of cardiac arrest, and availability of a family member in nontraumatic cardiac arrest prior to implementation of the new policy in LAC.
METHODS: All prehospital run sheets for nontraumatic cardiac arrest in LAC were reviewed for the first seven days of each month (August 2006-January 2007) for DNR status, location of cardiac arrest, presence of family members, and whether resuscitation was attempted.

RESULTS: Of the 897 cardiac arrests, 492 occurred at home, 111 in a public place, and 93 in a nursing home (location was unknown for 201). Fifty-five patients (6%) had a written DNR order, although it was not always available. Of these 55 patients, ten were resuscitated, the majority of the time because the family could not produce the paperwork. A family member was listed as present 29% of the time (261 of 897 cases). A medical history was obtained in an additional 465 cases (52%), indicating that someone familiar with the patient's medical history was present more than half the time, even when a family member was not mentioned.

CONCLUSIONS: A written DNR order is uncommonly used in the prehospital setting as a reason to forgo resuscitation in LAC. Even when family members state that the patient has a DNR order, patients are often resuscitated. A majority of cardiac arrests occurs at the patient's home, and in many cases in the presence of family members, some of whom may be able to express a patient's preferences regarding end-of-life care.

KEYWORDS: CPPR Valley


Using a community-based participatory research approach, we explored adolescent, parent, and community stakeholder perspectives on barriers to healthy eating and physical activity, and intervention ideas to address adolescent obesity. We conducted 14 adolescent focus groups (n = 119), 8 parent focus groups (n = 63), and 28 interviews with community members (i.e., local experts knowledgeable about youth nutrition and physical activity). Participants described ecological and psychosocial barriers in neighborhoods (e.g., lack of accessible nutritious food), in schools (e.g., poor quality of physical education), at home (e.g., sedentary lifestyle), and at the individual level (e.g., lack of nutrition knowledge). Participants proposed interventions such as nutrition classes for families, addition of healthy school food options that appeal to students, and non-competitive physical education activities. Participants supported health education delivered by students. Findings demonstrate that community-based participatory research is useful for revealing potentially feasible interventions that are acceptable to community members. KEYWORDS: CPPR Vision


BACKGROUND: To improve medication adherence in cardiac patients, in partnership with a safety-net provider, this research team developed and evaluated a low-literacy medication education tool.

METHODS: Using principles of community-based participatory research, the team developed a prototype of a low-literacy hospital discharge medication education tool, customizable for each patient, featuring instruction-specific icons and pictures of pills. In 2007, a randomized controlled clinical trial was performed, testing the tool's effect on posthospitalization self-reported medication adherence and knowledge, 2 weeks postdischarge in English- and Spanish-speaking safety-net inpatients. To validate the self-report measure, 4 weeks postdischarge, investigators collected self-reports of the number of pills remaining for each medication in a subsample of participants. Nurses rated tool acceptability.

RESULTS: Among the 166/210 eligible participants (79%) completing the Week-2 interview, self-reported medication adherence was 70% (95% CI=62%, 79%) in intervention participants and 78% (95% CI=72%, 84%) in controls (p=0.13). Among the 85 participants (31%) completing the Week-4 interview, self-reported pill counts indicated high adherence (greater than 90%) and did not differ between study arms. Self-reported adherence was correlated with self-reported pill count in intervention participants (R=0.5, p=0.004) but not in controls (R=0.07,
There were no differences by study arm in medication knowledge. The nurses rated the tool as highly acceptable.

CONCLUSIONS: Although the evaluation did not demonstrate the tool to have any effect on self-reported medication adherence, patients who received the schedule self-reported their medication adherence more accurately, perhaps indicating improved understanding of their medication regimen and awareness of non-adherence. KEYWORDS: CPPR Vision Valley Victory


OBJECTIVE: To measure the effect of faith community nurse referrals versus telephone-assisted physician appointments on blood pressure control among persons with elevated blood pressure at health fairs.

METHODS: Randomized community-based intervention trial conducted from October 2006 to October 2007 of 100 adults who had an average blood pressure reading equal to or above a systolic of 140 mm Hg or a diastolic of 90 mm Hg obtained at a faith community nurse-led church health event. Participants were randomized to either referral to a faith community nurse or to a telephone-assisted physician appointment. The average enrollment systolic blood pressure (SBP) was 149 +/- 14 mm Hg, diastolic blood pressure (DBP) was 87 +/- 11 mm Hg, 57% were uninsured and 25% were undiagnosed at the time of enrollment.

RESULTS: The follow-up rate was 85% at 4 months. Patients in the faith community nurse referral arm had a 7 +/- 15 mm Hg drop in SBP versus a 14 +/- 15 mm Hg drop in the telephone-assisted physician appointment arm (p = 0.04). Twenty-seven percent of the patients in the faith community nurse referral arm had medication intensification compared to 32% in the telephone-assisted physician appointment arm (p = 0.98).

CONCLUSIONS: Church health fairs conducted in low-income, multiethnic communities can identify many people with elevated blood pressure. Facilitating physician appointments for people with elevated blood pressure identified at health fairs confers a greater decrease in SBP than referral to a faith community nurse at four months. KEYWORDS: CPPR Vision Valley Victory
RESOURCE GUIDE FOR COURSE THEMES/CORE PRINCIPLES
(NOTES: web resources and other books, articles, examples of current and former scholars work)

GENERAL OVERVIEW AND PRINCIPLES OF CBPR
Methods in Community-Based Participatory Research for Health (Israel et al.) Chapter 1:
Introduction to Methods in Community-Based Participatory Research for Health Behavior and Health Education: Theory, Research, and Practice (Glanz et al.)
Chapter 13: Improving Health Through Community Organization and Community Building

COMMUNICATION

COMMUNITY PARTNERSHIPS: IDENTIFYING COMMUNITIES DEVELPONG PARTNERSHIPS AND WORKING TOGETHER
Methods in Community-Based Participatory Research for Health (Israel et al.)
Chapter 2: Developing and Maintaining Partnerships with Communities
Chapter 3: Strategies and Techniques for Effective Group Process in CBPR Partnerships
Jones L. "Partnership Building." Institute of Environmental Health Sciences (article).

ETHICAL ISSUES AND GUIDELINES FOR CBPR AND CASE EXAMPLES
Community-Based Participatory Research for Health (Minkler/Wallerstein)
Chapter 12: Ethical Challenges in Community Based Participatory Research: A Case Study from the San Francisco Bay Area Disability Community
Ruth E. Malone, RN, PhD, FAAN, Valerie B. Yerger, ND, Carol McGruder, BA and Erika Froelicher, RN, PhD, FAAN "It’s Like Tuskegee in Reverse": A Case Study of Ethical Tensions in Institutional Review Board Review of Community-Based Participatory Research. American Journal of Public Health, November 2006, Vol 96, No. 11
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Methods in Community-Based Participatory Research for Health (Israel et al.) Informant Interview, Focus Group Interview, and Community Forum

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Chapter 5: CBPR Approach to Survey Design and Implementation: The Healthy Environments Partnership Survey

Chapter 8: Application of CBPR in the Design of an Observational Tool: The Neighborhood Observational Checklist
Chapter 9: Mapping Social and Environmental Influences on Health: A Community Perspective

QUALITATIVE METHODS: Overview Of Conducting Needs Assessments
(Include The Basics Of Elicitation And Rudimentary Analysis Techniques
ASK GERY RYAN

INTERVENTIONS USING CBPR
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Chapter 13: Issues in Participatory Evaluation
*Methods in Community-Based Participatory Research for Health* (Israel et al.)
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DISSEMINATION OF CBPR FINDINGS AND PUBLIC POLICY APPROACHES
Community-Based Participatory Research for Health (Minkler/Wallerstein)
Chapter 19: Participatory Action Research with Hotel Room Cleaners  OPTIONAL
*Methods in Community-Based Participatory Research for Health* (Israel et al.)
Chapter 13: Developing and Implementing Guidelines for Dissemination: The Experience of the Community Action Against Asthma Project
Chapter 16: Policy Analysis and Advocacy: An Approach to Community-Based Participatory Research
Community Project Abstracts

Investigator: Alejandra Acuña, MSW
Community Partner: LAUSD
Project Title: Nuestra Voz - From Client to Agent of Change: Working with trauma-exposed youth to develop and evaluate health communication products

Currently, efforts are made in LAUSD to offer Cognitive Behavioral Intervention for Trauma in Schools (CBITS), an evidence-based and trauma-specific treatment, to students who have recently immigrated to the U.S. One of the treatment goals of CBITS is to promote parent-child communication. This is challenging in the best of circumstances, but when adolescence, a history of immigration-related parental separation and other types of trauma are layered over it - it can be difficult to bridge the gap. Open communication between parents and adolescents about trauma and feelings is often avoided due to the distress it can cause for all involved. Yet, studies have demonstrated that open communication about emotions within the family is related to children's social interactions and relationships with peers, children's emotional resilience and the ability to cope constructively with challenging situations (Lutz, 2007). Talking about feelings associated with traumatic or distressing events is linked to psychological well-being, improved functioning, better self-reported health, and better immune responses (Pennebaker, 1986). Open communication within the home is associated with higher academic performance, better social skills, and more positive attitudes among adolescents (Green, 2008). An engaging trigger for this type of discussion may prove helpful to initiate these difficult conversations.

The purpose of this investigation is to develop and evaluate health communication products and a social media campaign using personal resiliency reflections from multi-culturally diverse elementary and high school students who are graduates of the CBITS program. Over the summer of 2010, 18 students were originally asked to participate in this project in an effort to create a Youth Advisory Board for product development for the Trauma Services Adaptation Center for Resiliency, Hope and Wellness in Schools. Seven students completed this video project incorporating words and images related to their personal resiliency factors, traumatic experiences and aspects of their cultural identity. A series of trigger videos and accompanying discussion guides are intended to promote discussions between youth and their parents about protective factors, traumatic experiences, and coping. It is aimed at conveying the benefits of working through traumatic memories both for parents and for students. This video is the first product of a larger prevention/early intervention campaign in schools aimed at various target audiences including parents, teachers and students.

Evelyn Chang, MD
Mentors: Kate Watkins, Lillian Gelberg
Community Partners: Department of Mental Health (Carol Eisen)
Behavioral Health Services, Inc (James Gilmore)

I have had the good fortune of working with LA County Department of Mental Health (DMH) and Behavioral Health Services (BHS) towards a shared vision of an integrated model of primary care with behavioral health. Mental health and substance abuse problems are common and often
under-recognized in the primary care setting. These conditions can impair treatment of other medical conditions. Most mental health treatment is provided in the primary care setting, but generally primary care physicians do not provide adequate treatment and follow-up of these conditions. Integrated approaches or collaborative care have been shown to be more effective than usual care.

These two community partners have historically not worked together in the past aside from serving clients with co-occurring disorders. In the photo, the partners are represented as oil and vinegar. While they may not mix well given their different priorities and interests, they have unique flavors. When combined together, they make a tasty salad dressing. During the past several months of working together, both DMH and BHS have had wonderful insights into the current state of mental health and substance abuse treatment in LA County.

For this project, we are working together to ascertain the capacity of safety net clinic to provide behavioral health care for the newly insured population. At this point it is unknown how primary care clinics in LA County manage patients with mental health and substance abuse problems, since there are very few resources for safety net providers. What mental health and substance abuse services are being provided in primary care? What sort of training do primary care providers receive to support patients with behavioral health problems? What services will the clinics need to support these patients? How will DMH and BHS have to adapt their outpatient services in anticipation of serving the newly insured population or perhaps integration of primary care and behavioral health? These questions will continue to be developed jointly with DMH and BHS.

Robin Clarke, MD
The patient-centered medical home (PCMH) model

The patient-centered medical home (PCMH) model seeks to redesign the delivery of primary care chronic disease management around a collaboration between an accessible provider team and an activated patient. The developers of this new system drew the PCMH constructs extensively from research on practices that operated within closed networks and treated insured patients. Questions remain regarding how the PCMH model applies to safety net community health centers (CHCs), which function within a very different healthcare environment.

The NCQA has operationalized the PCMH model in a certification tool, the PPC-PCMH. This tool has been successful to the point of shaping the definition of the medical home model. However, there is little research to indicate that higher scores on the PPC-PCMH are associated with improved patient outcomes, increased patient/provider satisfaction, or cost savings.

Therefore, this study attempts to evaluate how the PCMH model – and specifically the NCQA’s definition – applies to CHCs. Do scores on the PPC-PCMH predict quality of care provided by CHCs? How relevant are the PPC-PCMH components to the services provided by and populations treated by CHCs? Are there services that CHCs currently provide that would in fact be more predictive of quality of care?
We have partnered with many (20-30 of a possible 40) CHC agencies within LA County. Chief medical officers from each of agencies are completing the PPC-PCMH. We are using descriptive statistics to explore the readiness of CHCs for PCMH certification and then correlating scores with diabetes quality of care measures. We are then planning a qualitative study to explore ways to improve the intersection of these two big elements of the primary care system.

Michael Hochman, MD
Developing an Inpatient Quality Improvement Program at Martin Luther King Hospital

A group of Robert Wood Johnson Clinical Scholars has proposed working with the Martin Luther King Hospital Board of Trustees to help develop an effective quality improvement infrastructure at the hospital when it reopens in 2013. Like other California hospitals, Martin Luther King hospital will collect and report data on inpatient quality metrics developed by the California Hospital Assessment and Reporting Taskforce. A full list of these quality measures is available at: https://chart.ucsf.edu/.

Our group has proposed researching quality improvement programs at other safety net institutions for the Board. The end product would be a report summarizing our findings, as well as recommendations for implementing an optimal quality improvement program at MLK. The report would likely include:

- Discussions about other quality improvement programs at other safety net hospitals
- Interviews with quality improvement directors at other safety net institutions
- A review of successful quality initiatives at other safety net hospitals (e.g. What programs have successfully reduced the rates of iatrogenic infections? What programs have successfully reduced 30-day readmission rates?)
- Recommendations about how to build a quality improvement team at MLK and how to create a “culture of quality” among providers and staff
- Recommendations about which quality improvement programs to promote

In developing the report, we hope to work closely with those from the University of California who are involved in overseeing quality improvement at MLK. We hope to present an initial report to the Board in July 2011.

Joyce Javier, MD
Engaging Filipino Immigrant Parents in Faith-Based Preventive Parenting Interventions

The mediating role of parenting for child behavioral problems is well-established, motivating the development of evidence-based parenting interventions. However, participation rates in parenting interventions among all ethnic groups are low (Goodman & Knight, 2004; Spoth & Redmond, 2000). Filipino American youth exhibit higher rates of behavioral problems and substance use than their White counterparts (Javier 2007) and other Asian American subgroup populations (Chung 2007). Despite these findings, few interventions have focused on prevention of behavioral problems and substance use in Filipino youth, and existing research shows that Filipinos underutilize mental health care and preventive care services (Sanchez & Gaw, 2007,
The proposed research aims to develop and evaluate a theory-based engagement intervention to increase participation in a faith-based preventive parenting program by Filipino immigrants, the second-largest immigrant group in the U.S. The proposed research plan includes two specific aims: 1) To identify the social determinants, cultural values, and perceptions of child behavioral problems that facilitate or impede participation in parenting interventions by Filipino immigrant parents of young children and 2) Design and pilot test the feasibility and acceptability of a brief, theory-based intervention to increase enrollment and participation in a faith-based preventive parenting intervention.

**CBPR project:**

**Aim 1a - Dr. Javier will initiate and co-lead a partnered workgroup of faith-based leaders to**

1) Review findings from a pilot study (Filipino Youth Initiative, FYI) regarding unmet mental health need among Filipino youth and recommendations for prevention
2) Obtain feedback from stakeholders regarding feasibility of piloting parenting program in the spring **without** an engagement intervention (a method providers can use to assist families in overcoming obstacles in seeking behavioral health services) to assess feasibility and acceptability of Incredible Years for the target population.
3) Review the evidence-based parenting intervention; resource and materials; patient brochure and education videotapes; training resources for groups and individuals; outreach strategies; social service and community agency screening, education, and referral resources) and modify the intervention protocols.

We will use meeting minutes and field notes to capture main themes and issues, summarize group feedback, and develop an overall set of recommendations using a modified Delphi process to arrive at a group consensus.

**Scott A Kaiser, MD.**

**NRSA Primary Care and Health Services Fellow**

**Aging in Los Angeles: Patient Empowerment**

Utilizing broadcast media as a health promotion tool, the “Aging in LA: Patient Empowerment Programming,” aims to improve the health and quality of life of older adults in Los Angeles. In partnership with the Los Angeles City Department of Aging, our team of UCLA investigators will develop content for the “Aging in LA” television program addressing topics in healthy aging. Providing a platform for experts in the field of aging, promoting existing evidence-based resources available through the aging services network, profiling older adults who have adopted healthy lifestyles, we aim to inform and activate viewers. To assess the efficacy of this innovative approach to health promotion, we intend to perform a rigorous evaluation of its impact on knowledge, attitudes, behaviors, and a variety of related health and quality of life outcomes.

**Faculty Mentor:** Catherine A. Sarkisian, MD MSPH. Associate Professor, UCLA Division of Geriatrics; Director, Los Angeles Community Academic Partnership for Research in Aging (L.A. CAPRA).

**Community Mentor:** Laura Trejo, MSG, MPA. General Manager City of Los Angeles Department of Aging.
Investigator: Lorraine Kelley-Quon, MD  
Community Partner: Northridge Medical Center Department of Trauma  
Project Title: The Impact of a Dedicated Pediatric Trauma Center on Clinical Outcomes: A Prospective Study

The delivery of high quality, timely trauma care for injured children is paramount. Consequently, pediatric trauma centers (PTCs) have been established to address the specialized needs of injured children. However, due to geographic disparities, the vast majority of children live many miles from the nearest PTC. This results in delayed treatment and resuscitation for many injured children. In Los Angeles County, Northridge Medical Center recently received accreditation to become a level 2 PTC. Northridge Medical Center serves the San Fernando Valley, an area home to over one half million children. This provides a unique opportunity to take advantage of a natural experiment occurring in the San Fernando Valley. This will be the first prospective study to examine how the presence of a local pediatric trauma center changes the quality of pediatric emergency care delivered.

The primary aim of the proposed study is to explore the clinical effects of establishing a PTC in a community previously without local access to pediatric trauma care. Specifically, we anticipate a significant decrease in complication rates, hospitalization and readmissions due to shortened EMS transport times and pediatric trauma specialty care.

Investigator: Christoph Lee, MD  
Determining Patient Perceptions and Concerns Regarding Providing a Genetic Sample at Screening Mammogram for Breast Cancer Research

Photographed are an informational poster, patient pamphlets, and partners (Roslynn McGill with Christoph Lee) for ATHENA. The ATHENA Breast Health Network is a large-scale project among five University of California health centers which aims to revolutionize breast cancer care by merging research, technology, financing, and health care delivery in a manner that will reduce the time needed to translate research findings into improvements in patient care. Specifically, ATHENA has ambitious plans for recruiting 150,000 women throughout California who will be screened for breast cancer and followed over a period of several decades. The resulting database of information will shape breast cancer care in an analogous fashion as the Framingham heart study shaped cardiovascular care in the U.S.

The primary aim of my community-partnered research project is to assess patients’ attitudes and perceptions pertaining to submitting a genetic sample (e.g., blood and/or saliva) for research purposes during a routine visit for screening mammography. With nearly 1,000 patients already enrolled at UCLA in a matter of only two months, it’s clear that the hard work and dedication of Roslynn and her staff have made the team’s goals a reality. It’s been humbling to witness the willingness of a large number of women to participate in and help research efforts in the fight against breast cancer.

Mentor: Lawrence Bassett; Partner: Roslynn McGill
Lauren Patty, MD

Project: Implementing a diabetes educator intervention into a primary-care based teleretinal screening protocol

My community partnership is a demonstration project examining the impact of implementing a teleretinal screening protocol into a Los Angeles safety-net primary care clinic on the number of patients screened for diabetic retinopathy and presenting for ophthalmic follow-up care and treatment. The goal of this project is to increase access to specialty ophthalmic care for a large proportion of diabetic patients in LA county. To date, the effect of teleretinal screening on appropriate ophthalmic follow-up care and definitive treatment in an urban medically underserved, or safety net, population has not been evaluated. Teleretinal screening has the potential to create a more effective triage system for this population, allowing for the earlier detection of disease and increasing the ophthalmologist’s ability to provide prompt and crucial treatment.

The benefit of integrating teleretinal screening into the primary care visit is to eliminate the need for a separate visit to an eye care provider and thereby augment the number of diabetics screened. Some patients may not need to see an eye doctor at all, which helps to decrease both the backlog of patients waiting for eye appointments and in-clinic wait times, as well as allowing better use of the patients’ limited resources. The aims of this project are two-fold: first, to determine whether a primary care based teleretinal imaging system will affect the number of diabetic patients screened for diabetic retinopathy, and second, to investigate whether this teleretinal protocol results in the actual receipt of appropriate ophthalmic follow-up care and, ultimately, improved clinical outcomes in urban underserved populations. I hypothesize that this primary care-based teleretinal imaging system will provide another route of access to the limited resource of ophthalmic specialty care, thereby greatly increasing the number of patients screened and, by means of more effective patient triage, leading to earlier detection of disease and increased use of appropriate treatment (i.e. laser photocoagulation) in this safety net population. I hope the outcomes of this study will demonstrate the impact teleretinal screening could have in improving clinical outcomes and decreasing the safety net backlog of diabetic patients, including those with treatable disease slowly going blind while waiting for ophthalmic evaluation.

Cate DeCarlo Santiago, PhD

A Family Treatment Component for Low-income Latino Children Exposed to Violence

The long-term research program objective of the present proposal is to develop and evaluate a family and culturally informed treatment component for low-income Latino children exposed to violence and who are participating in the Cognitive Behavioral Intervention for Trauma in Schools (CBITS). To achieve this objective, I am partnering with Los Angeles Unified School District (LAUSD) clinicians and with Latino parents in the community to develop the program. Through these partnerships, we will utilize research-based interventions, along with community identified needs and goals to inform the development and pilot-test of a culturally competent family treatment program. I have chosen to focus on violence exposure in Latino low-income youths because: 1) 20-50% of American children have been exposed to violence in their homes, schools, and communities (Finkelhor & Dziuba-Leatherman, 1994), 2) poor and ethnic minority
youth are at highest risk for exposure to violence and other poverty-related stressors (Evans, 2004; Perkins, 1997), 3) exposure to violence has long-term negative health consequences for children including anxiety, depression, PTSD, behavioral problems, poor school performance and attendance, decreased cognitive functioning, and decreased rates of high school graduation (Jaycox et al., 2002; Saigh et al., 1997; Singer et al., 1995), 4) family involvement has the potential to enhance treatment effects and increase positive family dynamics, increase adaptive family coping, and target chronic and ongoing stressors in poor families’ lives, and 5) this population is traditionally underserved, with striking health disparities, making this project of high importance for reaching a long-term goal of reducing health disparities and increasing effective and sustainable community interventions.

Partnering with identified LAUSD schools, we will compare CBITS as usual to CBITS plus the newly developed family component. The family treatment component will focus on involving and engaging parents of children participating in CBITS, in addition to increasing positive parent and family coping. Parents and children in both conditions will complete pre- and post-treatment measures that assess mental health, family coping, child and parent coping, parent satisfaction, and parental attitudes toward treatment and school.

We have made great progress in both the development and implementation of the project. We have collected data on three CBITS as usual groups and are currently implementing CBITS plus the family component in three additional groups.

Mentor: Sheryl Kataoka; Partners: Karla Alvarado-Goldberg, Lauren Maher, Maria Cordova, Joshua Kaufman, Lorena Vega, Alex Acuña, Ailleth Tom, Martha Márquez, Pia Escudero, Marisa Fenarjían, and LAUSD parents.

Erin Saleeby, MD
Assessing and addressing the family planning needs of female adolescents in the correctional system: a pilot program for family planning service provision

Young women in the juvenile detention system represent a large population of at-risk youth for whom interventions that facilitate rehabilitation can have substantial impacts. Some 2.18 million juveniles are arrested annually in the United States, according to the 2006 Department of Justice census, 29% of whom are female. Many programs, both within the correctional system and in the community setting, focus on the rehabilitation of these youth through education, job opportunities and building life skills.

This rehabilitation approach, however, does not address needs specific to women and girls as they rebuild their lives. Incarcerated adolescents are known to have engaged in particularly high-risk sexual behaviors when compared to their non-incarcerated counterparts. A 2004 cross-sectional survey of 8 juvenile detention facilities found the mean age of sexual debut for incarcerated females was 13. Mean number of sexual partners was 8.8, and 32% had ever been pregnant. Both the United Nations and the International Council for Population and Development have recognized control of fertility as central to ensuring women’s self-determination, access to education and both independence and advancement in society.
This research aims to assess and address the family planning needs of youth transitioning from the juvenile justice system to the community, and provide services as an adjunct to community-based programs already in place. Partnering with these community organizations and the Department of Corrections, this program will serve to bolster current efforts to facilitate a successful transition for teens. The specific aims of the research are to:

1. Conduct formative research to assess the decision-making of incarcerated adolescents about pregnancy prevention. Comparisons between teens who have ever been pregnant and those who have not will illuminate differences between these groups.
2. Establish a youth advisory board of adolescents released from juvenile detention centers to guide the development, implementation and evaluation of a program to address the family planning needs of incarcerated youth prior to release.
3. Collaborate with the youth advisory board and stakeholders in the rehabilitation and correctional system to design and pilot an educational intervention to improve the initiation and continuation of contraceptive methods.

A mixed methods approach will utilize both qualitative and quantitative data to explore decision-making for pregnancy prevention in this group and to design and evaluate programs aimed to improve the initiation and continuation of contraception. Engagement of the community group and establishment of the youth advisory board will occur concurrently. Ultimately, study findings of this pilot program will inform future initiatives for policy making and program planning for the care of women and girls in correctional facilities.

**Luwam Semere, MD**

**Determinants of Prenatal Care Utilization Among Refugees**

The proposed project consists of a retrospective chart review using explicit review methods to examine the prenatal care utilization patterns of refugee women and identify variables associated with inadequate prenatal care utilization in this population.

The inclusion criteria for the study will be: 1) women with self-reported refugee or asylee status; and 2) women of reproductive age who have received prenatal care and delivered at the Maricopa Integrated Health System (MIHS).

A list of eligible women will be obtained from the Refugee Women’s Health Clinic (RWHC) at MIHS. The RWHC has started the process of tracking birth outcomes of women who receive care at the clinic by establishing a database with their medical information. This database is not yet complete but contains information for more than 100 refugees who have delivered at MIHS over a two-year period. I will work with the RWHC to complete this database by extracting missing and additional information from the MIHS Electronic Medical Records.

The primary outcome variable will be prenatal care utilization as measured by the Adequacy of Prenatal Care Utilization (APNCU) Index. The APNCU Index assesses prenatal care utilization using month of initiation of care and total number of visits adjusted for gestational age at delivery to characterize prenatal care utilization as inadequate, intermediate or adequate, and intensive or adequate plus care.
Variables which will be explored include age, race/ethnicity, nativity, number of years since migration to the United States, primary language spoken, education level, marital status, primary language spoken, area of residence (measured by distance from the clinic represented by the subject’s zipcode), marital status, substance use (alcohol, tobacco, and illicit drugs), and history of previous abortions.

Additional variables of interest will include other descriptors: income level, employment status, insurance status, immigration status, regular source of health care before pregnancy (measured by number of visits to a primary care provider in the 12 months prior to pregnancy), residential instability (measured by number of moves made in the 12 months prior to pregnancy), use of transportation services, use of interpreter services, access to child care, time of pregnancy recognition, body mass index, involvement in the Women, Infants, and Children’s (WIC) program, intentions for pregnancy, consideration of abortion, intention to become pregnant, symptom distress, mode of delivery, delivery outcomes (maternal complications, and reason for delivery, gestational age at time of delivery), family history, number of living children, number of prior pregnancies, prior pregnancy outcomes, surgical history, medical history, medications, allergies, pregnancy weight gain, breastfeeding status, contraception use, religion, maternal comorbidities (medical conditions prior to pregnancy, occurrence of hypertensive disorders of pregnancy and gestational diabetes), and neonatal outcomes (birth weight, gestational age at time of delivery, Apgar scores at five minutes, NICU admission, and occurrence of meconium aspiration syndrome).

Adam Richards, MD and Marlom Portillo, IDPESCA
Airing Our Dirty Laundry: Community Based Participatory Methods To Explore Occupational Hazards Coping Mechanisms Among Latina Household Workers (Community Project)

Background: High demand for low cost labor in the United States has led to a rapid rise in the number of Latin American immigrants working in the informal sector. Evidence suggests that male day laborers experience dramatically high rates of occupational injury and death, but little is known about the hazards faced by their female counterparts working in households. Community partnered participatory research (CPPR) provides an opportunity to generate new knowledge about marginalized populations. The only published survey among household workers in Northern California suggests that non-payment of wages and exposure to toxic chemicals and violence is common. However, much remains unknown about the context of these risks, their relationship to mental health and chronic disease management, or the coping strategies employed by household workers to reduce these risks. We used CPPR methods to develop a qualitative study to explore occupational exposures and to identify coping strategies female household workers use to promote their own health. Methods: The study arises out of a novel partnership between the Institute of Popular Education of Southern California (IDEPSCA), the UCLA Robert Wood Johnson Clinical Scholars Program, the UCLA Department of Family Medicine, UCLA-Labor Occupational Safety and Health (LOSH), and RAND Health. The partnership identified gaps in knowledge related to household work health, and the need to broaden the scope of occupational health among household workers to include the impact of work on life outside the workplace. This qualitative study comprises the formative stage of a CPPR project whose primary aim is to develop a mobile phone platform for the surveillance of occupational hazards, their precipitating factors and health-related consequences among Latina immigrant workers in Southern California. We plan to conduct five focus groups and twenty semi-structured interviews with female household workers. Focus groups will combine a qualitative discussion guide format and the Freierian pedagogy of popular education familiar to IDEPSCA staff. Semi-structured interviews will use specific exposure events to explore in depth the context and sequelae of
occupational risks of household work, and how these risks compare to those experienced in previous jobs. Primary exploratory domains include exposure to toxic chemicals, violence and non-payment of wages, and their perceived relationship to mental health, chronic disease, and access to care. IDEPSCA will participate in all stages of research, from the development of focus group and interview guides to the transcription of audio recordings, thematic analysis and presentation of data. Results: Anticipated findings include descriptions by Latina household workers of numerous resilient coping strategies to navigate the constrained risk environments at home and at work in order to maximize their health. For example, participants may report negotiating work conditions with employers and partners to minimize occupational exposure to violence; and may identify creative approaches to overcome barriers to access formal and informal health care systems. Conclusions: The qualitative study explores the context of occupational risk among household workers and highlights strategies for mitigating that risk, with implications for occupational safety education and regulation among immigrant women working in the informal sector. Keywords: occupational health; community partnered participatory research; household worker; Latina immigrant; access to care

Stan Frencher, MD and Dr. Bill Releford, Barbershop Health Outreach Program/CDU
Cutting Through The Uncertainty Of Prostate Cancer For Black Men Using Barbershop Outreach (Main Research Project)

Background: African American (AA) men diagnosed with prostate cancer are typically younger in age, with more aggressive disease and with higher likelihood of dying from this disease. Nevertheless, screening remains controversial because the mortality benefit of population-based screening, even for AA men, remains unclear. However, given the disparities in prostate cancer among AA men, aggressive outreach may still be warranted. Patient decision-aids have been developed and tested in clinical settings to assist men in making this preference sensitive decision. But neither their effectiveness in community settings has been established, nor have these men been followed to determine if once informed they have access to prostate care, use it, and if the care received is appropriate given their individual preferences. Purpose: To develop a collaboration between UCLA and the Black Barbershop Health Outreach Program (BBHOP) and assess the impact of prostate cancer decision aids in Los Angeles barbershops on decisions made by AA men about prostate cancer screening. Methods: BBHOP, founded by Bill Releford, DPM, currently works to address cardiovascular disease (CVD) in black men by partnering with AA-owned barbershops to provide health education and screening services. Since 2007, BBHOP has screened nearly 10,000 men in barbershops across 13 states. In response to a call from AA men in the community to address their concerns about prostate cancer screening, BBHOP and UCLA researchers formed a collaboration to evaluate methods of promoting active, informed participation in prostate cancer screening decision-making. Using a community-partnered participatory approach, we will use a cluster-randomized design to compare AA men over age 40 years exposed to a prostate cancer decision aid to those exposed to the standard (CVD) BBHOP. Barbershops will represent the unit of randomization. The primary outcome of the study will be to determine if exposure to a prostate cancer decision aid in barbershops, complemented by a clinical referral network, leads to AA men consulting with a healthcare provider in order to arrive at a shared-decision about prostate cancer screening. Secondarily, using validated survey instruments, we will develop an understanding of the determinants of AA men’s preferences in making decisions related to prostate cancer screening and treatment by measuring decision quality, knowledge, resultant prostate cancer care (i.e., screening, diagnosis, treatment and follow-up) and participation in other medical care. Data will be collected at baseline, post-intervention and at 3 months follow-up. Trained community members, employed by and integrated into the research team, will facilitate data collection and recruitment. We aim to demonstrate that by disseminating prostate cancer information to men in a credible, convenient setting, such as barbershops, we will enable AA men to cope better with the uncertainties and participate more fully in this difficult clinical decision—whether or not they decide to undergo prostate screening. Key words: barbershop outreach, community-based participatory research, prostate cancer, decision-aids
Background: The prevalence of sexually-transmitted diseases is disproportionately high among adolescents, especially within minority communities. However, adolescents face several social and logistic barriers to accessing reliable information and resources regarding sexual health. Innovative means are necessary to overcome these barriers. Since the vast majority of adolescents have a personal cell phone and use text messaging extensively, texting might be utilized to relay relevant health messages to teens. “The Hookup”, developed by the California Family Health Council (CFHC) and Internet Sexuality Information Services, Inc. (ISIS), is a sexual health text messaging service for California adolescents. This free service sends weekly informational messages about sexual health and responsible decision making to subscribers; it also offers a teen clinic locator service. While similar programs exist nationwide, none have evaluated the perceptions of this type of service among adolescents who are concerned about their sexual health.

Objectives: To explore adolescents’ perspectives about The Hookup and describe their opinions about the weekly messages, the clinic locator service, and the overall convenience and potential effectiveness of a sexual health text messaging service.

Methods: Participants will be recruited from two teen clinics in Los Angeles serving predominantly Black and Latino communities. Twenty male and twenty female adolescents aged 16-19 years old will be enrolled. Focus groups will be separated by gender at each site, resulting in four groups. After one month of subscribing to The Hookup, the participants will convene to discuss their experiences. Discussion domains will include: relevance and understandability of the messages, concerns about subscribing, usefulness of the clinic locator service, and suggestions for changes. Qualitative analysis of the focus groups will be conducted using Atlas.ti, and the findings will be discussed with participants to ensure accurate interpretation of the results.

Results: We hypothesize that participants will find The Hookup to be a reliable, confidential, and teen-friendly source of sexual health information; that the clinic locator service effectively encourages use of health care services; and that The Hookup has a strong potential to raise awareness about sexually-transmitted diseases among adolescents. We also hypothesize that participants will express concerns about parental disapproval of the service, the possible need for gender-specific messaging, and the potential for messages to be overlooked among high-volume text-message users. Conclusions: Text messaging services may be an important new way to improve access to sexual health information and resources for adolescents. “The Hookup” is an innovative and potentially useful text messaging service aimed at increasing adolescents’ understanding of sexual health issues and health services resources. The results of this exploratory study will help CFHC and ISIS improve The Hookup in order to optimize uptake and effectiveness among California teens. The findings will also contribute to the general understanding of text messaging for health communication with adolescents, particularly within minority communities. Additional studies in preparation will quantitatively examine the impact of subscribing to The Hookup on adolescent knowledge, attitudes, and behaviors related to sexual health.

Keywords: Adolescents, sexual health, text messaging
Studies of Human Papillomavirus (HPV) knowledge and vaccine decision-making are limited to small cross-sectional studies of Caucasian samples. Positive predictors for HPV vaccination in these studies include awareness of HPV and belief of vaccine effectiveness with physician recommendation. Because there are few studies of minority groups in relation to medical communication about HPV, our specific aims are: 1) To determine if having a usual source of medical care increases HPV infection awareness and HPV vaccine awareness 2) To determine if hearing about the HPV vaccine from a medical source and physician discussion will increase perception of HPV vaccine effectiveness.

Data for this analysis comes from a survey of 490 women who called into the LA County Office of Women’s Health (OWH) hotline for general medical information. Between January 2009 and January 2010, operators recruited callers who were medical decision-makers for girls that were age-eligible for the HPV vaccine (9-18 years). Women answered questions about HPV knowledge, awareness, attitudes, sources of information, barriers to vaccination, vaccine acceptance and uptake. We conducted unadjusted and adjusted logistic regression analyses to examine the relationship between usual source of care and HPV infection/vaccine awareness, and the impact of physician communication on perceived HPV vaccine effectiveness.

Out of 2233 women invited to be screened, 99% agreed to the study, and 490 women met the eligibility criteria and completed the survey. Over 95% of the sample consisted of minority women. Results from unadjusted analyses show that respondents who had a usual source of medical care had 1.55 odds of having heard of HPV infection versus those that did not have a usual source of medical care. Those that responded that the girls they care for had a usual source of medical care had 1.52 odds of having heard of HPV infection. These associations were both statistically significant. Usual source of medical care for respondents and the girls they care for also increased the odds of HPV vaccine awareness, although this was not statistically significant. Among the women who had heard of the HPV vaccine (n=294), having heard about the HPV vaccine from a doctor and having discussed the HPV vaccine with a doctor significantly increased the odds of perceiving the HPV vaccine as very or somewhat effective (OR 2.11 and 2.03, respectively). Results for the fully adjusted models will be included in the final presentation.

Having a usual source of medical care for both the respondent and the girl in question increased the respondent’s interaction with the medical system, and likely increased her chances of hearing about HPV infection and the HPV vaccine. Hearing about the vaccine from a doctor or reporting a discussion with a doctor was significantly associated with a perception that the vaccine was very or somewhat effective. Altogether these findings highlight the importance of having a usual source of medical care among a low-income minority population of women in Los Angeles, who are making a decision about this relatively new vaccine for the girls they care for. KEY WORDS: Minority HPV Vaccine Communication Medical-access.
Queencare Program Evaluation (Main project)
Arshiya Baig, MD
Queenscare is one non-profit organization in Los Angeles whose primary mission is to deliver healthcare to the underserved, and, to accomplish this mission, they have established faith community nursing clinics throughout Los Angeles. Since no evaluation exists of faith community nursing, Queenscare is taking the lead in evaluating its program as a quality improvement project. An evaluation is necessary to better identify which populations are served and which diseases are managed and to better understand how well the cases are managed. In this project we have one specific aim: to better understand the usefulness of the Queenscare’s Faith Community Nursing program in delivering care to the uninsured and minority populations of Los Angeles. The parish clinic sites have an archived database of all visits from 2000 to 2005 that they have not analyzed. This database can be used to better understand the population served or diagnoses and treatments given through the clinic sites and to understand trends by year.

The Patient Flow Task Force (Community Project)
Kristina Cordasco, MD
Over the past two decades, decreasing length of inpatient hospital stay has been both a feature and strategy of cost containment in health care. Improving efficiency in the process of patient discharge, through measures such as enhancing effective discharge planning and communication, is one potential aspect of achieving decreased length of stay. LACDHS has convened a task force, known as “The Patient Flow Task Force” (referred to below as Task Force), to identify and address barriers to efficient patient flow through all of the county hospitals. One of the processes being addressed is that of discharge. The Task Force, comprised mainly of nurse managers, social workers, and administrators, has been charged with identifying current barriers to the efficient flow of this process, performing a root cause analysis of these barriers, and suggesting system changes that diminish these barriers. Resident physicians, although integral to the process of preparing for and implementing patient discharge, were not initially included in the discussion. With the mentorship of Dr. Allison Diamant, I am conducting discussion groups with medicine residents at each of the LACDHS acute inpatient facilities in order to obtain their perspectives and suggestions for improvement on these issues. I will make a report of my findings at these discussion groups and present this report to the administrative leaders and LACDHS and the participating hospitals.

Preventable Hospitalization Report Card for Los Angeles County (Main Project)
Jamila Davison, MD
An important and frequently used indicator of primary care access is the number of ambulatory care sensitive (ACS) admissions in a population. Ambulatory care sensitive conditions are set of medical diagnoses for which timely and effective outpatient care can help to reduce the risks of hospitalization by either preventing the onset of an illness or condition, controlling an acute episodic illness or condition, or managing a chronic disease or condition. This project will use OSHPD, Office of Statewide Health Planning and Development, data to determine the rates of ambulatory care sensitive hospitalizations among adults in Los Angeles County for 2005 (the most recent year available). The analysis will be presented as a Preventable Hospitalization
Report Card for Los Angeles County. As a representative from HAAF will conduct the data analysis with me, they will produce this report card on an annual basis using updated OSHPD data.

Health/sex education program for children with moderate to severe cognitive impairment (Main Project)
Veronica Meneses, MD
(combination community project and main research project for Clinical Scholars Program)
Several meetings with educators, administrators, case managers and other professionals who work with Children with Special health Care Needs in the LAUSD elucidated a need within the Division of Special Education. There currently exists no established health/sex education program for children with moderate to severe cognitive impairment (they may also have other disabilities but what they have most in common is the cognitive impairment). The high risk of these children for sexual abuse provides a powerful impetus for this project. At this time the focus is on generating a program that would be highly family/care-giver centered given the cognitive level of the scholar/course participants and their strong reliance on caregivers. Central themes identified thus far include self-care, self-protection, prevention of sexual abuse, and enhancement of social/peer interaction skills to reduce social isolation. Some of the students are in one of the eighteen special education centers while others are in the "mainstream" (general education) campuses. The Division would like to begin by conducting focus groups with parents and likely teachers/educators for this population to determine what would be included in such a program. Another priority is a survey of parents to assess attitudes, beliefs, concerns and needs surrounding the children’s transition to puberty/adolescence. These community-based investigative activities would inform the design of the program and its implementation, beginning with a pilot in the four special education centers that are primarily secondary schools (late middle school and high school) which would allow modification of the program as needed before a larger-scale intervention.

Community Academic Partnership to Address Disparities in Obesity Among Youth (Community Project)
Anisha Patel, MD
An NIH funded project entitled, “Community Academic Partnership to Address Disparities in Obesity Among Youth” sets the stage for a formative research project including key informant interviews and focus groups. As part of this formative research stage, I have led four site visits at LAUSD middle schools. The purpose of these site visits was to observe the context of physical activity and dietary behaviors in the schools, talk to school employees and students, collect documents, and synthesize data to allow for an understanding of the daily functioning and organization of the school. These site visits supplemented focus group and stakeholder interviews and helped to gauge the appropriateness of proposed obesity interventions. Upon completion, site visit results were presented to LAUSD administrative staff and local school faculty.
Community-academic coalitions that follow participatory research principles commonly take action to benefit a community, but ways of mobilizing such partnerships post-disaster have rarely been described. Disasters pose challenges to implementing community-based participatory research, including foreshortening the time necessary to establish trust and limiting availability of local resources to support responses to many visible and pressing unmet needs. The absence of community leadership may lead to sole reliance on top-down decisions that may be poor fits with changing population needs and preferences. Following the Gulf Storms, we developed a community-academic coalition in New Orleans to assess health care needs one-year post-Katrina. This project identified the post-Katrina health needs, healthcare system gaps and policy solutions in Louisiana and New Orleans in particular, through two methods: 1) community discussion groups with citizens of New Orleans and 2) key informant interviews with health system administrators and providers, community health leaders and advocates as well as health policy planners. After that assessment, the group considered ways to weigh competing options for action, leverage resources, create infrastructure, and develop sustainable leadership. We blended community-based participatory research models, rapid evaluation methods and seat-of-the-pants decision making to arrive at a modified participatory leadership approach, including: assuming trust among partners with a history of service to New Orleans and their partners; respectful deliberation; attending to data; broad delegation of authority; and transparent communication. The process was documented with partnership records and minutes. Common values and demonstration of commitment to improving access to health care were the basis for partnership formation. Two working groups (women’s health; mental health) were formed based on matching top priorities across stakeholders from the project data, with potential capacity of partners to respond. Infrastructure was stabilized through combining in-kind resources from local partners with support from academic partners outside of damaged areas with matching program development goals. Action items for working groups were based on combining strengths of all partners: free clinics, mobile health units; faith-based programs, formal services authorities, and availability and experience with evidence-based programs. Leadership was developed through all partners seeking venues to represent the work of the coalition. This approach lead to a major proposal for health and resilience centers within six months, and requests to present the coalition’s work in academic, community, and policy circles. Community-academic partnerships following modified participatory research principles can provide sustained leadership for emergence of community-driven solutions to health needs following a major disaster, by linking resources within and outside of damaged areas based on shared personal and institutional values. Impact will depend on critical next steps.
RWJ Scholar-Community Partnerships: 
Roles and Responsibilities

Clinical Scholars/Course Participants
- Spend 8 hours per week working with the community partner. This time can be divided in a manner that works for both the scholar and the community partner. A typical division will be for two 4-hour blocks.
- Apply principles of community-based participatory research (CBPR) to the partnership with the community.
- Meet weekly with the community partner liaison or another member of the community designated by the liaison.
- Meet biweekly with the faculty mentor.
- Get to know a wide range of members of the community.
- Define, implement, and complete a project relevant to the community’s needs and the scholar’s interests, using the principles of CBPR.
- Present the project’s findings or products to the community.
- Participate in the Community-Based Participatory Health Research Methods and Applications course, including reporting on and discussing partnership experiences.
- Write and submit a paper to an academic journal based on the final project in the above course.

Community Partner Liaisons
- Orient the scholar to the community.
- Provide a desk and phone access for the scholar (if appropriate).
- Work with the scholar to determine what the community’s needs are and what project(s) the scholar might develop that would help address those needs.
- Meet with the scholar each week or designate another member of the community to do so. These meetings do not have to be long, but will provide an opportunity to make sure that the partnership is progressing as planned.
- Assist the scholar in making research relevant and accessible to the community.
- Report to the faculty mentor, faculty liaison, and clinical scholars directors on the scholar’s progress.
- Attend the orientation session.
- Review and grade the scholar’s written product.

Faculty Mentors
- Meet at least every other week for the equivalent of a 1.5-hour educational session. The time can be divided in various ways, and meetings do not always need to be in person.
- Help the scholar learn from the community partnership.
- Assure that the scholar is producing methodologically sound research that will be of use to him/herself, the community, and other researchers and communities.
- Visit the community partner with the scholar at least twice, once early in the project.
- Help the scholar identify additional faculty mentors who provide methodological or content expertise as needed.
• Assist the scholar in developing and maintaining a working partnership with the community members.
• Check in regularly with the scholar and the community partner liaison to make sure the relationships are progressing well. Help troubleshoot when challenges arise.
• Report to the community partner liaison on the scholar’s progress.
• Report to the clinical scholars directors on the scholar’s progress and the community partner’s role.
• In instances where the faculty member working with the scholar is not the primary faculty mentor for the particular community partner, the primary mentor should maintain contact with the faculty member and community mentor to assure that the partnership is going well.
• Sign a contract that outlines responsibilities.
• Attend the orientation session.
• Review and grade the scholar’s written product.

__________________________________________       _______________________
Scholar Signature                                      Date

__________________________________________       _______________________
Faculty Mentor Signature                              Date
Please write name, email, phone, and address:
__________________________________________
__________________________________________
__________________________________________

__________________________________________       _______________________
Community Partner Signature                          Date
Please write name, email, phone, and address:
__________________________________________
__________________________________________
__________________________________________
Community-Based Participatory Health Research:
Methods and Applications

Course Leaders: Kenneth Wells, M.D., M.P.H. & Anish Mahajan, M.D.

Community Project Plan

A. Community

1. Description of the community with which you will work:

2. Community partner(s):
   a. Organization:
   b. Community partner liaison:
   c. Additional community contacts:
   d. Schedule of meetings with community partner(s):

B. Topic

1. Description of your topic (or possible topics):

2. Date by which the topic will be finalized:
C. Creating the project

1. Type of project expected (e.g., needs assessment, media campaign, legislative testimony, etc.):

2. Resources to be used:

3. Methodologies to be used (e.g., key informant interviews, focus groups, windshield tours, etc.):

4. Timeline of community project activities:

5. Publication and dissemination plans:

__________________________________________________________  ________________
Scholar’s Signature                                      Date

__________________________________________________________  ________________
Advisor’s Signature                                      Date
Faculty Mentor Evaluation of Scholar/Course Participant Performance  
Deadlines: December 9, 2011 and March 16, 2012  
Please submit directly to csp@mednet.ucla.edu or fax to (310) 794-3288

Scholar /Course Participant ___________________________ Date __________

Mentor ___________________________

1. How many times did you meet with the scholar/course participant during the term (October 2 to December 8)?
   
   A. 0-2  
   B. 3-4  
   C. 5-6  
   D. 7-8  
   E. 9-10  
   F. 11 or more

2. Please describe the scholar/course participant’s progress over the course of the term on the community project.

3. Please define as closely as possible the particular community in which the scholar’s research is based. How well did the scholar/course participant get to know the community?

4. Please discuss the quality of the scholar/course participant’s community work and its responsiveness to the community. To what extent did the scholar/course participant make an effort to define and develop the project collaboratively?
5. What is the project’s level of creativity?

6. What are the potential scholarly contributions of the project?

7. What are the potential contributions of the project to the community?

8. How will the project enhance the scholar/course participant’s education?

9. Overall, how satisfied are you with the progress of this Scholar in their partnership work? (10 very satisfied to 1 not at all satisfied)

10. What feedback did you provide on the community project plan and final paper?

11. Other Feedback to the Course Faculty:
Community-Based Participatory Health Research: Methods and Applications

**Community Partner Evaluation of Scholar/Course Participant Performance**

**Deadlines:** December 9, 2011 and March 16, 2012

Please submit directly to csp@mednet.ucla.edu or fax to (310) 794-3288

Scholar/Course Participant ___________________________ Date _____________

Mentor ___________________________

Community Organization _____________________________

1. How many times did you meet with the scholar/course participant during the term (October 2 to December 8)?
   
   G. 0-2  
   H. 3-4  
   I. 5-6  
   J. 7-8  
   K. 9-10  
   L. 11 or more

2. Please describe the scholar/course participant’s contributions to your organization during the term, such as work they have done, skills and/or knowledge provided, etc.

3. How well did the scholar/course participant get to know the community?

4. Please discuss the quality of the scholar/course participant’s community work and its responsiveness to the community. To what extent did the scholar/course participant make an effort to define and develop the project collaboratively?
5. What is the project’s level of creativity?

6. What are the potential scholarly contributions of the project?

7. What are the potential contributions of the project to the community?

8. How will the project enhance the scholar/course participant’s education?

9. What feedback did you provide on the community project plan and final paper?

10. Other Feedback to the Course Faculty
Healthy African American Families
Community Participatory Research Collaboration Agreement
DRAFT 1/26/04

Healthy African American Families (HAAF) promotes community participatory research in service of improving the health of communities of color. This Collaboration Agreement establishes the principles of community participatory research that are generally applied in HAAF projects with academic partners. Under this agreement, HAAF serves as a guardian for these research principles on behalf of community, and facilitates the equal participation in community research of collaborating communities and academic partners. Each project may involve different partners and a different scope of work. An agreement for a particular project consists of the following:

1) A research collaboration agreement concerning the principles and broad terms of research;
2) a specific project description, including any special features that affect the scope of the agreement or modify its participatory nature;
3) a signature list for the main academic partners and HAAF on behalf of its community partners (with other signatures possible depending on project scope); and
4) a list, updated as the partnership expands, of participatory community partners on the Support Council who assert by signing the partnership list, that they have read and agree to the terms of partnership under this agreement.

PART I: Partnership Principles and Procedures

Community Participatory Research Principles: This project will follow principles of community participatory research (Minkler and Wallerstein, 2002). The underlying principles are:

1) The project seeks to enhance the community’s welfare through empowering the community to address its own health issues.
2) The project will be designed to increase community knowledge of the issue.
3) Community and academic participants will be involved in all project phases, including planning, implementation, research and evaluation, analysis, interpretation, and dissemination.
   a. Community participants and academic researchers contribute to the shaping of the project issues and scope.
   b. Interested members of the community and community agencies will be provided opportunities to participate in the research process.
   c. Project membership is considered to be open or inclusive of those who wish to join and are willing to participate actively, rather than closed or exclusive in membership.
   d. Each project will have a Support Council, consisting of HAAF, its academic partners for the project, and major participating community organizations who agree to commit to regular meetings and an oversight role. The Council will be co-lead by HAAF and an academic partner; a community organization co-lead
may also be designated if appropriate to the particular project. This is most likely when that partner has initiated the request for a particular project. The Council will be convened by the co-chairs or their designees from within the same organization. The Council which will attend to barriers to participation, and uphold the principles of this agreement. Depending on scope of the project, the project may also have an Executive Council as a subset of the Support Council that sets the frame for key stages of the project.

e. All participating members (academic and community participants) are acknowledged as having expertise and commitment that is relevant to the scope of the project.

f. Community participants will be partnered with academic participants in analytic issues, including interpretation, synthesis, and verification of conclusions, and supported as needed in the research and scientific methodology.

g. Community participants will be partnered with academic participants in identifying the relevant project outcomes.

h. The project will periodically assess the experience of participating for community and academic participants and attend to their concerns.

4) The project may consider the political, social, and economic determinants of the main health issue addressed by the project.

Mechanisms to voice and resolve differences of opinion or concerns about fairness of the process will be implemented through the Support Council, and each participating agency will have one vote.

5)

6) Dissemination of the research results will be the responsibility of all project participants, and academic and community partners will have opportunities for presentations and publications, under the governing conditions of the Council (see below).

**Rights, Conflicts, and Responsibilities:** Acknowledging that conflicts in partnership most commonly arise over financial matters, credit for work, and responsibility and opportunities for publication and dissemination, the following sections present principles and models for handling those issues within the project.

**Financial Arrangements:** Each partnership agency contributes to the project at least in part through in-kind contributions, particularly in development phases. Academic and community partners will work together to consider their specific needs for funding activities related to the project and their overall needs for financial stability. Participation in high-quality research evaluations of community projects may help achieve funding or other needs of participating partners. Most projects will require development of a funding plan. Plans for developing financial support for the project, including services and research, will be submitted to the Support Council for review for fairness and equity in relation to partner need given the project, prior to submission.

**Authorship for Product and Publications Development and Presentations:** This is a community-based participatory research project, in which academic centers and community agencies participate as full partners in all phases of the research and community project. This means that the project design, data collection, analysis and interpretation of data, publications, presentations,
and other products will be generated with community participation. Participation of individuals in particular products will be based on participation in the work supporting the product, with oversight of the relationships and resolution of any disputes through the Council. We will follow usual journal guidelines regarding authorship on papers. Authors will be expected to contribute to papers and be responsive to reviewer concerns in a timely manner (i.e., within two weeks or as designated by the Council). Some papers may have a group of participants acknowledged with a shorter list of authors, spanning the major categories of participants. Research Works developed jointly by academic centers and community partners shall be jointly owned by all contributing partners, and decisions regarding marketing and distribution shall be jointly made by all contributing partners. In general, research works shall be disseminated for public benefit, either freely or at nominal charge to cover distribution/processing fees.

Ordinary journal policy is for the paper’s first (or senior, sometimes last) author to decide on authorship list and order, but the Support Council will resolve disputes and has the right to review overall fairness of the process. At the Council level, the full Council will discuss and act as advisory, but the final resolution will be by majority vote among the main partners who have executed the Collaboration Agreement.

The Council may designate a committee to provide oversight for product and dissemination issues, and that committee will report to the Support Council. The Council will set a policy for authorship of products from that project, after the formal project phase is concluded. The usual expected policy will be circulating the product/press release/presentation abstract to the co-signatories of the agreement for comments. A broader circulation list may be designated by majority vote of the Support Council.

Data Ownership: At the end of the project or at reasonable interim stages, each academic site, HAAF, and other community sites as appropriate, based on Council review and recommendations, will retain a copy of the full data file, de-identified appropriately. Issues of ownership of the data will be regulated by the Council. Any site owning data, or participating in collecting data for the project, must review its participation and role through their internal IRB and/or sign a certificate of compliance with the lead academic IRB for the project. All participating sites/partners will receive a summary of the data even if their involvement is minimal and they are not entitled to the de-identified, full data file.

Internal Review Board Responsibility: It is requested that each participating community partner have at least one participating member (i.e., the Council representative) complete a certification of training for human subjects research through the lead academic partner’s Internal Review Board (IRB) website (e.g., UCLA). Each participating partner should determine the status of its own IRB board, and develop plans to coordinate any IRB review through its agency with the review(s) of other participating IRBs.

Review of Papers, Products, and Press Releases: During the life of the project, submitted research papers and abstracts for presentations will be circulated to the Council and to lead participants of partner sites at least one week and preferably two weeks prior to their submission for review and comment. There will be a 5-10 day turn around time for comments to the lead author. Each product will have one or two lead individuals to permit accountability.
While input and full exchange among participating partners is encouraged, consistent with usual scientific policy, partners will not have the right to block submission or enforce changes on scientific papers. Rather, it is expected that the first or senior author of each project will review comments from partners, discuss major differences of opinion with the partners involved, and circulate the final version to partners. If substantial disagreements over interpretation remain, then the lead author (first and/or senior) will include a statement in the discussion section, clarifying the nature of the disagreement in interpretation among Council members for the project. The dissenting Council member(s) also have the right to submit a letter to the journal’s editor for publication concerning their disagreement in interpretation.

Similarly, products for community release and presentation will be circulated for comments to community and academic partners, providing a one-to-two week turn around time.

Disputes concerning fairness in authorship or concerning the fairness of internal review, including adherence to the principles of this agreement, will be resolved in discussion by the Council. The deciding vote is by majority vote among the co-signatories of the Collaboration Agreement. The Council also has the right to request a review of disputes over scientific issues by outside scientists and community members. An author/project participant who is not a member of the Council also has the right to request that the Council grant an independent review.

The intent of this agreement is that a balanced consideration will be given to community and academic perspectives in interpretation and presentation. If necessary, the Council has the right to request, in advance of project development, equal academic and community co-leaders.

The Council will develop a plan for handling press releases to ensure coordination with press offices of academic and community partner agencies. For example, press release responsibilities may be handled by the organization of the lead author of a given product; may rotate among participating agencies with press offices; or be delegated to one agency’s press office, with coordinating support from other agency press offices. This issue may also be delegated to a dissemination subcommittee.

**PART II Project Description: Witness for Wellness**

The project “Witness for Wellness” is a community participatory research partnership project involving Healthy African American Families, UCLA Neuropsychiatric Institute, Charles R. Drew University, RAND, and the community agency partners of Healthy African American Families (HAAF)(see Part IV).

The purpose of the project is to improve the health of the South Los Angeles community, particularly among African Americans and Latinos, through improving community awareness of depression and the ability of community members and organizations to problem-solve to overcome barriers to detection and treatment of depression at the community level. An additional goal is to document the methods, processes, and outcomes of the project, through rigorous science within a community-based participatory research framework.
The project is expected to have several phases.

Phase One was a planning phase establishing a multi-agency Community Mental Wellness Council and framing the issue. This phase was initiated in May, 2003 and is ongoing.

Phase Two was the Witness for Wellness community conference at the Los Angeles Science Museum, July 31, 2003. This conference provided continuing education on depression and its treatment in communities of color and promoted dialogues among community members about the framing of depression, barriers to care, and strategies to improve care at the community level. The conference was evaluated by a pre- and post-survey and by recording the themes discussed in community break-out sessions.

Phase Three is post-conference planning for community work groups, under the direction of the Support Council.

Phase Four involves the tasks of several community-academic partnership work groups. The scope and membership of these groups are the subject of the post-conference planning, and will be shaped by the themes that emerged from the July Conference. Work groups, with facilitation by the Support Council, will have 12-18 months to conduct their community tasks, leading to at least one product for each work group, such as a community toolkit, policy brief, or media release. The work group process and outcomes will be the subject of a qualitative and quantitative evaluation. Some work groups may focus on evaluation issues, such as studying barriers to care at the community level.

During this phase, planning will also occur for a broader research evaluation of the changes expected to occur, and occurring, within the community as the result of the project. This will involve exploring alternative research designs and outcome measures, development of a logic model, and development of a funding plan for the research and program development, through the Support Council and Executive Council.

Phase Five will be a summative community conference to present the work and products of all the work groups, develop overall recommendations that incorporate community feedback, and formulate plans for implementation of recommendations. Prior to or at the time of this report, research funding will be sought for broad-based evaluation of implementation, using the design and outcome indicators developed and piloted in Phase Four. Other communities may be involved in this research, depending on the design.

PART III: Agreement Signatures

The following parties represent the main participating academic partners and HAAF on behalf of the community partners in this agreement. The signatures indicate agreement with the terms of this agreement.

(LORNETTA JONES, HEALTHY AFRICAN AMERICAN FAMILIES)

DATE
PART IV: Participating Community Partners

The following community partners are participating in the project described in this agreement as voting members of the Support Council (or other major role designated in the project). The signatures indicate that the terms of the agreement have been reviewed and will be adhered to while participating in this project.

HAAF STAFF:

LIST SUPPORT COUNCIL AGENCIES AND REPRESENTATIVES