APPENDIX A

The Baltimore Health Mobility Project

A coalition of organizations, including the Poverty and Race Research Action Council (PRRAC), the Medical-Legal Partnership for Children/Boston Medical Center, the ACLU of Maryland, and the Harvard School of Public Health, have come together to propose a new health intervention specific to the needs of public housing residents moving to higher opportunity neighborhoods in Baltimore.

Building on the efforts of MBQ, the project would incorporate health planning into the overall Baltimore housing mobility program, and would also implement and assess a more intensive pilot health intervention for up to 100 families moving from high to low poverty neighborhoods. The program would include:

Health assessment of participating families

- Creation of a health intake form to be used with all families coming into the *Thompson* mobility program.

Incorporating health-related resources into the housing mobility program

- Additional integration of health information into the existing components of housing mobility counseling, e.g. housekeeping and family budgeting.
- Training of housing mobility program staff to communicate health-related information to new clients.
- Educating housing mobility program staff about the Maryland Medicaid managed care and S-Chip systems, including transferring health care coverage from county to county.
- Undertaking targeted outreach to identify suburban primary care providers for families that need help finding health care in their new neighborhoods

Medical/Legal Partnership Intervention and assessment of selected families

- Create and administer a follow-up participant health survey to track changes in families' health status. The Urban Institute will contribute its vast expertise conducting surveys among low-income families on housing assistance.
- Provide a voluntary ongoing intensive family health improvement intervention – provided by a trained public health specialist—to assess family needs, develop a plan for the families to benefit from health resources available in their new communities and conduct regular follow-up to assess progress.
- Per the Medical-Legal Partnership model, a health specialist will work in tandem with a trained legal specialist to assist clients with specific problems related to health (e.g., access to providers and social determinants of health (e.g. food insecurity). Families in this pilot will have a comprehensive legal needs intake, which will cover analysis of all basic needs, including food, income supports, education or childcare needs, family stability and safety needs.
- A team of housing and public health researchers would be selected to provide scientific guidance to the project, and be responsible for designing, monitoring and evaluating the intervention.