

Notes from the Field

JESSIE BALL
DU PONT
FUND



Improving the Health of Marginalized Populations

NO. 11 — SUMMER 2004



Investing in organizations
and communities that were
important to Mrs. duPont.

About the cover – Amelia Carter, 75, lives in a fourth-floor walkup apartment in Washington, D.C. – an inappropriate environment for one with congestive health failure and severe arthritis. Through the Washington Hospital Center Medical House Call Program, she is receiving medical care and social services to help improve her physical health and living conditions.

Photo by Ingrid Damiani.

Notes from the Field

No. 11 – SUMMER 2004

*Improving
the Health
of
Marginalized
Populations*



Contents

Introduction	Page 1
St. Vincent's Medical Center Mobile Health Outreach Ministry	Page 5
Washington Hospital Center Medical House Call Program	Page 11
Episcopal Diocese of Delaware La Red Health Center at La Esperanza	Page 20
University of Pennsylvania Men's Health Outreach Initiative	Page 26
Massachusetts General Hospital Visiting Moms Program	Page 32

Introduction

One assumes, maybe even expects, that healthy democratic societies provide for the health needs of their citizens. Common sense and common experience suggest that a people who do not enjoy good physical and mental health, and who cannot access medical services that help people maintain such physical and mental health, cannot easily learn or work, participate in maintaining healthy communities, or enjoy a relatively good quality of life in one's old age. Furthermore, public health practice informs us that human infectious diseases do not respect the proverbial boundaries that we construct to divide us from one another - age, income, wealth, color, ethnicity, national origin, sexual orientation. The health of the whole is determined by the health of its individual parts.

The delivery of adequate health care services and an individual's financial ability to access the health care system in the United States have for some years now been hot political topics. We don't argue about the value of annual physical checkups and practicing preventive medicine, about a doctor visit when we're sick, or the importance of using pharmaceuticals to fight disease. We know these medical services are good for us and we know that all human beings need these services. We do argue, however, about how to pay for these services.

Some argue the employer should finance accessing the health care system for those employed and the public should finance access through its tax dollars for those not employed or retired, with partial costs being assumed by the individual in both cases. Others argue that financing one's access is entirely up to the individual, employed or not employed or retired, and that neither employers nor taxpayers have an obligation to finance the system.

Several things are abundantly clear: All Americans both need and want access to the health care system; all individual Americans cannot afford to pay for this access; those who do not enjoy health insurance disproportionately access medical care through emergency rooms, shifting the cost of that care to hospitals and those with health insurance through higher premiums; a growing number of Americans are living and working without the

**All Americans need
and want access to the
health care system;
all individual Americans
cannot afford to pay
for this access.**

benefit of health insurance; and a consensus on who should pay for access has not been formed, making it impossible for the political system to respond appropriately.

Troubled by the financing barriers that exist between themselves and the people who need their services, doctors, nurses, and hospitals are entering partnerships with churches, traditional nonprofits, and just plain folks to create a variety of alternative health care delivery “models” in communities across the country. The context in which these people and organizations operate is complex:

- 43 million non-elderly Americans live without health insurance;
- Medicaid’s safety net for adults is limited, covering only low-income adults who have dependent children, are pregnant or severely disabled;
- Medicare coverage does not begin until age 65, and until recently enacted federal legislation, did not include the cost of pharmaceuticals;
- New immigrant populations who clean our hotel rooms, cook our restaurant meals, and pick our fruit and vegetables too often do not speak English well enough to understand a doctor’s orders;
- A growing “frail” elderly population is living longer and living alone, in what some call an epidemic of isolation.

The so-called “medically underserved” population is diverse. Reaching and serving these people is a challenging task, made more difficult by people’s fear and isolation and a faceless bureaucratic health care system. Yet, human creativity abounds.

- In the Boston community of Chelsea, staff at Massachusetts General Hospital reach out to new mothers who are immigrants and refugees to provide in-home support during a child’s first years;
- In Philadelphia, staff and students from the University of Pennsylvania encourage young urban males to take advantage of preventive health care services offered in their neighborhoods;
- In Washington, D.C., two doctors at Washington Hospital Center deliver health care to frail elderly patients at home, improving health, decreasing hospitalizations, saving precious dollars, and easing a sense of isolation;

- In rural southern Delaware, the Episcopal Diocese helps a local partner expand access to health care among Hispanic farm workers, bridging language barriers and providing health clinics in an effort to strengthen the health of the entire community; and
- In rural northeast Florida, St. Vincent's Medical Center built a relationship of trust with migrant, seasonal farm worker families through the provision of basic health care to children who otherwise would never see a doctor.

In addition, the Jessie Ball duPont Fund itself has played a role in addressing inequities in health care. Throughout 2002, the Fund convened Jacksonville community and business leaders, hospital chief executives, the mayor and city council representatives, and members of the local medical community for a series of community forums on Health Care and the Uninsured. Working in partnership with the Robert Wood Johnson Foundations' Communities in Charge program, forum participants drafted an innovative plan for expanding access to medical care among the city's low-wage working uninsured. Called JaxCare, this program helps uninsured workers access a network of community services that create access to primary and specialty services and help doctors better manage people's care. After clearing numerous state regulatory hurdles, the program now is in its first year of a two-year pilot that supporters hope will serve as a "test drive" for a more long-term initiative.


Whether through the work of the Fund or its eligible organizations, we grapple continuously with the challenge of providing equitable access to care. The increasing diversity of population, our growing elderly population, intractable poverty and elected officials' preference for reducing public benefit funding all combine to make the challenge greater.

The eligible organizations featured here have been successful in their work in part because they have engaged in good practices along the way: using reliable research and data,

**The increasing
diversity of population,
our growing elderly
population,
intractable poverty
and elected officials'
preference for reducing
public benefit funding all
combine to make the
challenge greater.**

building networks of concerned parties, engaging folks around a common agenda, engaging multiple funders, and working with government and policymakers to develop pragmatic, non-ideological solutions to challenging human problems. We see over and over again the importance of these practices.

We're proud of the work covered in this issue of Notes from the Field. As a funder, we are indebted to the people who have developed these programs and brought them to our attention. We are also indebted to Tracy Constantine for writing these stories, to Ingrid Damiani and Mary Kress Littlepage for reporting on Washington Hospital Center's Medical House Call program and to Ms. Littlepage for her editorial and creative oversight.

A handwritten signature in black ink that reads "Sherry P. Magill". The signature is written in a cursive, flowing style.

Sherry P. Magill, Ph.D.
President

Mobile Health Outreach Ministry

Filling in gaps for farm workers and their families

Hermelinda cuts and bunches ferns from half past six in the morning to three or four o'clock in the afternoon in the hot Florida sun. During the busy season, she works longer, until six or seven in the evening. Hermelinda came to the United States from Mexico after her husband died, leaving her to support 10 children. She first found her way to Texas, where she picked oranges for several years, before moving to Crescent City, Florida, 13 years ago. She lives in a tiny four-room home with one of her daughters and four grandchildren, ages four, five, eight, and 10, and she supports the six of them with her fern wages - about \$40 a day. Hermelinda is 78 years old.

Hermelinda suffers from high blood pressure and seasonal allergies (exacerbated by her exposure to pollen in the fields), but for a long time she was hesitant to seek out medical assistance. She feared that local health department programs were traps set by agents of the Immigration and Naturalization Service to catch undocumented workers. Eventually, she came to know and trust Inez Mecutchen, a Putnam County Health Department outreach worker, and received occasional care and medication for her health problems. When Inez told her that St. Vincent's Medical Center in Jacksonville, Florida, was sending a mobile health unit to Crescent City to address the health care needs of fernery workers, Hermelinda decided she would go.

Now because of the regular care she receives from the Mobile Health Outreach Ministry, Hermelinda's conditions are under control. "The services they give us are the best we have ever gotten," she says through an interpreter. "We are very happy when the unit is coming to help because we make little money and can't go to the doctor. Now I feel okay most of the time, and I am so thankful for the wonderful care I am getting."

Hermelinda's situation is not unique. Between 600 and 800 low-income agricultural workers and their families live in and around Crescent City, where they tend and harvest ferns year-round for local growers. Their work is repetitive and demanding,

St. Vincent's Medical Center Jacksonville, Florida

March 2002

\$147,067 to expand the hospital's Migrant Health Outreach Program to target unmet pediatric needs of Hispanic agricultural workers and their families in northeast Florida.

often requiring that they work under the hot sun for 10 to 12 hours as a time. Workers are exposed to pesticides, sharp tools, insects, snakes, and vermin. Yet, these jobs attract workers from Mexico and Central America, where economic opportunities are few. Crews of Hispanic workers often underbid African American crews that have traditionally harvested Florida's fern crops.

While their need for consistent and high-quality health care has been great, these workers and their families have been reluctant and unable to participate in public health programs. Even beyond their lack of money, insurance, and transportation, most are paralyzed by language barriers and serious fear of government agencies that might "get them in trouble." In 2002, the Florida Nurserymen and Growers Association in Orlando estimated that between 40 and 70 percent of agricultural workers in the state were undocumented. Without access to or information about public health care, some patients rely on folk remedies and practices from their native cultures when more effective medical treatments are available. Their need for education spans the health care continuum, from physical and mental health to basic hygiene, from diabetes screenings to anger management and hand-washing techniques.

St. Vincent's Medical Center had been addressing some of the needs of male agricultural workers in the northeastern part of the state with its Migrant Health Program since 1991, but in 2000, St. Vincent's recognized that the families of agricultural workers were slipping through the cracks. With a \$147,067 grant from the Jessie Ball duPont Fund in March 2002 the program was able to expand its services to reach out to families and to serve fernery workers with greater frequency and continuity of care.

On the Road with the Mobile Health Unit Crew

At 42 feet long, St. Vincent's mobile health unit resembles a large recreational vehicle as it rolls into the Crescent City area. The unit houses two examination rooms, a waiting room/reception area, a bathroom, and a pharmacy. The crew can perform basic laboratory tests on board, like urinalysis, screening for sexually transmitted diseases, basic blood work, and cholesterol and vision screenings. They keep a supply of donated and refurbished eyeglasses to give out to people with vision problems and donated medications for high blood pressure, indigestion/acid reflux, and pain.

Ben Eli, an emergency medical technician, drives the unit

120 miles from its lot in Orange Park, Florida, to various pre-scheduled destinations in Crescent City two full days each week. Some days Eli parks the unit at Forest Grove Fernery, one of the area's largest, other days at church parking lots or near agricultural worker housing units.

"We distribute a schedule two months ahead of time so the workers and their families will know when and where we'll be," says Brenda Luna, the nurse practitioner for the unit. "We use an electronic record system to retrieve patient histories, so we can operate on a no-appointment-necessary basis. We've learned that an appointment system doesn't really work, because patients react more to acute, immediate concerns than to preventive health care measures." The unit's crew has treated patients ranging in age from one month to 90 years old with acute and chronic illnesses.

Along with Luna and Eli (who is responsible for handling and distributing medication as well as basic maintenance on the unit), the mobile team includes a secretary, Lillian Delvalle; a registered nurse, Catherine Shields; and an interpreter and outreach worker, Inez Mecutchen. Mecutchen, a Putnam County Department of Health employee working with the mobile unit staff who had referred Hermelinda to the unit, acts as a liaison between fernery supervisors and workers, helping to negotiate time for the workers to receive medical attention. She also makes important links between the unit's patients, social services agencies, and programs that can help meet their living and medical needs. Mecutchen drives patients to the service providers, helps them fill out forms, follows up to make sure they are receiving care, and completes blood sugar and TB screenings in their homes. Members of the unit coordinate specialty health care that goes beyond the scope of the mobile unit, including surgery and other treatments, making sure patients have transportation to St. Vincent's or to local doctors who have agreed to donate their services.

Last summer, a family with 12 children - ages four months to 15 years old - arrived in Crescent City from Mexico one week before the opening of public school. "There was so much paperwork to do," recalls Mecutchen. "They couldn't fill out all of the forms and figure out all of the steps they needed to take to get help. They needed someone to walk them through it." The mother had been feeding her four-month-old powdered milk from a rusty can; the baby looked small for her age and seemed to be suffering from gastrointestinal problems. Within one day of meeting

the family, the mobile crew arranged for a visit to a pediatrician and supplied proper nutrition for the baby. Within one week, the crew saw all 12 children, completed their school physicals, and began their immunization protocols in time for them to enter school on schedule. But the crew didn't stop there. They signed up the eligible children for WIC (Women, Infants, and Children - a program to provide nutritional food), gave them donated school supplies and groceries, entered them into a migrant education program, and introduced them to the Residents Christian Migrant Association for support services.

Signs of Success

The duPont Fund grant has made it possible for St. Vincent's to provide more extensive, much-needed follow-up and support services, according to Jane Lanier, executive director and vice president for St. Vincent's Foundation, Inc. "The follow-up work necessary for these patients is extensive - and expensive," says Lanier. "We consider our outreach programs to be a long-term commitment and, hopefully, to be part of the solution to the intractable problems of the medically-underserved in North Florida, not merely a short-term fix."

St. Vincent's has made a commitment not to turn patients away, ensuring that patients get the specialty care they need. Patients of the Mobile Health Outreach Ministry have benefited from heart and eye surgery, hernia repairs, and treatment for kidney problems, diabetes, and other chronic conditions. A portion of the cost of these treatments is covered by the duPont Fund grant; the balance is donated by the hospital and local health providers. All medical care - whether primary or referral - and all medications and supplies are provided to patients without charge.

Of the \$803,400 annual budget for the program, St. Vincent's Health System contributes \$317,051 and the St. Vincent's Foundation contributes \$375,000. The City of Jacksonville contributes \$15,000 a year and foundations, including the duPont Fund, contribute the balance.

The duPont Fund grant - which provides funding over three years - has enabled the mobile unit to expand outreach efforts for fernery workers by increasing the number of days it could travel to Crescent City and surrounding farms, and consequently the number of patients it could treat. In its first year, the mobile unit made 74 trips, but with duPont funding was able to increase that to 102 trips in fiscal 2003 and 131 through February 2004.

Focusing on Children and Advocacy

An increasingly important objective of the mobile health unit is its outreach to children. The unit more than doubled the number of children it was able to serve during the first two years of the duPont Fund grant. “We went from seeing 228 children in 2001 to seeing more than 1,200 in the past two years,” says Lanier. The unit has dedicated some of its visits to families with 10 or 12 children, so that all of the children could be seen on a single day. St. Vincent’s coordinates “blanket drives” for such days to provide essential goods like shoes, socks, blankets, soap, and shampoo to larger families. “The blankets are received like gold,” says Lanier.

During one such day, when the mobile crew saw a family with 10 children, Brenda Luna noticed something black in many of the children’s mouths. With the help of Mecutchen, as interpreter, she learned that the family was unable to provide enough food for all of the children. “They were feeding them dirt in order to fill the children’s tummies,” she recalls. As a result, many of the children were suffering from gastroin-

testinal problems and malnourishment, among other problems. The crew arranged for immediate medical care for the children. Then they returned to St. Vincent’s and collected food and clothing for the family. They

alerted the Putnam County Health Department, which has provided ongoing services to the family to ensure that all of the children have proper nutrition and care. Other nonprofit agencies also have provided support.

St. Vincent’s hopes the Mobile Health Outreach Ministry will enable earlier detection of the dire circumstances so many agricultural workers and their families are facing. “We think the increasing numbers of patients is an indicator that some of the workers and their families are beginning to trust and rely on St.

<i>Mobile Health Outreach Ministry</i>			
	<i>July 2001- June 2002</i>	<i>July 2002- June 2003</i>	<i>July 2003- February 2004</i>
<i>Pediatric Patients</i>	228	418	849
<i>Adult Patients</i>	1,462	1,175	1,206
<i>Total</i>	1,690	1593	2,054
<i>Adult Care</i>		\$106,250.00	\$87,581.00
<i>Pediatric Care</i>	\$91,651.00*	\$23,678.50	\$55,528.50
<i>Adult Medications</i>		\$17,355.60	\$10,538.01
<i>Pediatric Medications</i>	\$17,553.30*	\$559.50	\$780.15
<i>Total</i>	\$109,204.30	\$147,843.60	\$154,427.66

* Includes adult and pediatric care

Vincent's for the care they need," says Lanier. "But we know that the problems have deep roots. St. Vincent's continues to be an active and enthusiastic member of both the regional initiative on migrant health and the Northeast Florida Farmworker Rural Health Care Coalition. Through our advocacy efforts, we hope to help build innovative partnerships with both public and private organizations to further our work - and improve the lives of those who are too often invisible among us."

Learning Lessons to Help Meet the Challenges Ahead

The crew of the Mobile Health Outreach Ministry says they have learned a lot, but have miles to go in reaching vulnerable populations in the area. "Our most obvious challenge has to do with record keeping," says Luna. "The more comprehensive data we have on our patients, the better we can treat them." The unit has expanded its technology to be able to keep medical records and notes. They also are conducting patient satisfaction surveys to find new and better ways to serve their clients.

Another challenge, Lanier notes, is remaining sensitive to the concerns of the small towns and communities where the farm workers live. St. Vincent's has learned that they can't just address the acute needs of rural residents and their families; they must take a comprehensive approach to meeting their health care needs. "Otherwise, we really won't make a dent in ameliorating the rural health care crisis," says Lanier. "And we've learned that we must be reliable and sensitive to cultural differences if these patients are going to trust us enough to come back. Unfortunately, the poor are not used to being given those considerations. Neither are they used to having a safety net to catch them when they're in trouble. We're aiming to be that."

Medical House Call Program

Reaching the frail elderly where they live

The practice of doctors making house calls may be unfamiliar to anyone younger than 30. But in northwest Washington, D.C., physicians and nurse practitioners are making house calls daily, and significantly improving the lives of their frail, elderly patients.

Begun in 1999 by Drs. Eric De Jonge (right) and George Taler, the Medical House Call Program at Washington Hospital Center serves elderly residents in eight zip codes surrounding the hospital east of Rock Creek Park. Residents in these zip codes have roughly the same age distribution as those in wealthier zip codes west of the park, but a much higher rate of disability.

For these patients, the limits of mobility and income often mean they don't receive regular health care because they are physically unable to visit a doctor or clinic. Left untreated, their conditions can worsen until they become acute and require emergency care or hospitalization, which are both traumatic and costly.

The House Call Program takes advantage of state-of-the-art medical technology to deliver regular care in the patient's home, thereby improving quality of life and minimizing the need for hospitalization. "We fill the gaps on the home care side and tie together the system of care," says Dr. Taler. "We're at the bleeding edge of change."

Earlier this year, Notes From the Field traveled with Dr. De Jonge and the House Call Program staff as they visited patients and dealt with a variety of medical issues.



Nora Armwood, a 94-year-old former domestic worker, lives alone in her home of 50-plus years, sustained by a network of support provided by her family and the Medical House Call Program.



Patients enrolled in the House Call Program are visited by a physician usually every six to eight weeks and by a

nurse practitioner every two to four weeks in between physician visits. In addition, staff social workers help connect the most needy patients with in-home care and other services to provide additional support. Mrs. Armwood, for example, requires round-the-clock care because of her risk of falling. The House Call Program provides that care 16 hours a day, with Mrs. Armwood's family covering the remainder.

**Washington Hospital Center
Washington, D.C.**

March 2000

\$94,000 to initiate a physician house call program for elderly patients in Washington, D.C.

May 2001

\$150,000 to evaluate the house call program.

November 2002

\$110,000 to promote the house call program.

May 2004

\$150,000 to provide training to other hospitals wishing to establish a house call program.

On his regular visit, Dr. Eric De Jonge is concerned about Mrs. Armwood's chest congestion. After listening carefully to her self-assessment, and checking her vital signs, he asks her to walk from room to room as he monitors her blood-oxygen levels. If she requires medicines or medical equipment, New Hampshire Pharmacy & Medical Equipment, a key community partner in the House Call Program, will fill the need. "They deliver everything," said Dr. De Jonge. "They are an important piece of the program."

Before leaving Mrs. Armwood's home, Dr. De Jonge telephones Mrs. Armwood's goddaughter, her primary caregiver, to report his findings.

Connections with family members are not uncommon in the program: social worker Jenna Crawley says she talks with Mrs. Armwood's goddaughter two to three times a week. "We get to know the whole person," she says. "We make time to learn their stories."





Nurse practitioner Michelle Culver starts her day conferring with Dr. George Taler (left) about the patients on the day's call list. Among them is Lessie Jackson, 91, almost blind from glaucoma, who lives in a neighborhood typical for House Call Program patients.



Ms. Jackson has no family in Washington; her caregivers are friends and church members. Within days, she will be moving to southern Virginia, where she will live with her niece.

"I'm stressed about this move," she tells Michelle, "and when I get stressed, my belly hurts."

After having her abdomen examined, Ms. Jackson complains to Michelle about her swollen feet. Michelle checks her feet, takes her blood pressure and talks with her about the pending move.

Since 1999, the House Call Program has enrolled nearly 1,000 patients. About 425 patients were actively enrolled in late winter, 2004, when Notes from the Field visited, with about 20 new patients enrolling each month. Marketing is strictly by word of mouth. "We don't want to market it," says Dr. De Jonge. "We just

want to provide a service and meet a need."

As the patient population grows, staff is challenged to maintain the intimacy of the program. Their solution? Mitosis: dividing the large cell into two smaller cells. The program now has 425 patients served by three physicians. Staff feels clusters of 300 patients with two physicians are ideal. Later in 2004, the program plans to add its fourth physician and divide into two clusters, with two physicians each.

With the examination complete, Michelle and Ms. Jackson pose for a photograph together before saying a poignant farewell. After a year of care, the relationship has reached its end.





When House Call Program patients are hospitalized, either through emergency room admissions or scheduled admissions, they continue to be seen by the doctors who visit them at home.



Amelia Carter (below), 75, suffers from congestive heart failure and severe arthritis. During her hospitalization, Dr. Patricia Harris (below) and program social workers have worked to improve her living conditions: she lives on the fourth floor of a building with no elevators and has been on the waiting list for public housing for more than a year.

Benoit E. Muise (right center), 73, came to the ER after falling and injuring his hip. Because of his Parkinson's disease and dementia, it was difficult for his wife, Louise, to ascertain his condition immediately. By day's end, Dr. Taler (right bottom)

determined the hip was broken.

The economics of the House Call Program are, in some ways, contradictory: the program both saves money and generates revenues. Its unique structure makes it appealing to government, which must pay for Medicaid and Medicare, and Washington Hospital Center, which needs revenue for financial stability.

The program has reduced hospital utilization and the average hospital stay for program participants is shorter: 5.9 days vs. 8.3 days for similar, non-participating patients. Moreover, the program keeps patients out of nursing homes, saving dollars and improving quality of life. Nationally, 75 percent of deaths occur in a hospital or nursing home; in the House Call Program, only 25 percent of deaths occur in those settings. The House Call Program participates in the Elderly/Physically Disabled Waiver Program,



developed by D.C. Medicaid to provide home care alternatives to more expensive nursing home placements.

On the hospital side, however, the program is a positive revenue stream. The admission rate is 20 times higher than the admission rate for patients in a typical primary care practice. The House Call Program population is a high-risk population, and one that, through their involvement in the program, becomes loyal to Washington Hospital Center. Many House Call Program patients live in the shadow of another city hospital, but come to Washington Hospital because of their relationships with their physician.

“We are shrinking the pie [of patients going to the hospital] overall, but we’re giving this hospital a bigger share of that pie,” says Dr. Taler. And, he adds, “There remain untapped opportunities. If we could get around the reimbursement issues, one-half to two-thirds of hospital care could be done at home.”

Both in-hospital and in-home care are coordinated by a small core staff (top right) who rely on computers, cell phones, laptops and the latest medical technology to fully integrate the program.

Most of those House Call patients admitted to the hospital are housed in the geriatric wing, overseen by Sheila Williams, RN, (upper left). She says at least half of her patients have active psychological issues, many stemming from isolation. The program includes a psychiatric social worker who makes home visits to address patient mental health needs. Other patients are brought in for group social time in Psychiatry’s DayBreak Program.



Nurse Practitioner Michelle Culver's second call of the day is to Mary Young, who suffers from schizophrenia and sarcoma, and is a cancer survivor and an amputee (left leg).

Ms. Young lives in a downstairs room in the home of a neighbor, who takes Ms. Young's social security check as payment (inadequate payment, the neighbor points out). Ms. Young's family members do not actively participate in her care.

Michelle recalls asking Ms. Young once about her landlady. Ms. Young's assessment: "She feeds me and she doesn't beat me."

On this visit, Ms. Young is not conversational. She mentions shoulder pain. She says her skin itches and her tooth hurts. Michelle detects some dental problems and coaches the caregiver through the process of making a dental appointment.

For Michelle and her colleagues, their daily work with patients is part of their broader vision for delivering patient-centered care, both in Washington and elsewhere. Drs. Taler and De Jonge have worked with hospitals in other cities interested in developing similar house call programs. And Dr. Taler has been deeply involved in Congressional efforts to change federal health care policy to better embrace and enable such programs.

"This is the essence of patient-centered care," Dr. Taler says. "Physicians' offices are centered on the needs of the physician. At hospitals, the major customer is the physician, not the patient. Managed care and capitated programs put money at the center of the equation. Even disease management programs put the disease at the center, not the patient. We did this because we thought it was what the patient needed."

As Michelle leaves Ms. Young's home to travel to her next stop, she acknowledges the difficult circumstances she confronts with some of her patients. The work has made her philosophical: "When you start [this work] you really want to change the world," she says. "I still do, I just give it more time."





La Red Health Center at La Esperanza

Providing a health care “safety net” for rural Sussex County residents

Like many agricultural communities in the United States, rural Delaware has seen a dramatic increase in its Latino population during the last decade. Immigrants from South and Central America, many from Guatemala and Mexico, find a better quality of life in what most Americans would consider undesirable living and working circum-

stances. “People think rural America means white farmers,” says Brian Olson, executive director of La Red Health Center, “but that’s changing. In Sussex County, we’ve had a 400 percent increase in Latino and other immigrant population in just the last two years.” Unlike many rural counties, however, the coastal communities of Sussex County attract a million or more tourists to

the area each year. Growing tourism has placed a significant strain on the residents and infrastructure of the county, as towns of 8,000 residents swell to more than 50,000 during the summer season.

Immigrants come to Sussex County to work in the farming, poultry, landscape, construction, and service industries, where much of the work is either part-time or seasonal to accommodate tourism, and many of the employers do not provide benefits such as health insurance. According to U.S. Census Bureau data, more than 30 percent of the county’s residents live below 200 percent of the Federal Poverty Level (\$37,700 for a family of four in 2004), compared with 23 percent for all Delaware residents. Nearly 20 percent of the county’s residents have no health insurance, almost twice as many as in the state. In addition to the high number of uninsured, Sussex County suffers from a dearth of health care providers. The county is federally designated as a Medically Underserved Area and a Dental Health Professional Shortage Area, and part of the county is designated a Primary Care Health Professional Shortage Area. Language barriers and cultural differences also prevent many Latinos from seeking and getting appropriate medical attention.

In the mid-1990s, the Episcopal Diocese of Delaware responded to the growing need for rural health care by creating the Sussex County Mission of the Episcopal Church and sponsoring La Esperanza, an organization whose goal is to connect vulnerable populations in Sussex County – Latinos in particular – with social services available to improve

Episcopal Diocese of Delaware Wilmington, Delaware

January 2000

\$132,000 to support a partnership with La Red Health Center at La Esperanza, a medical clinic for the underserved population of southern Delaware.

their health and quality of life. La Esperanza (which means “Hope” in Spanish) teamed up with the state Division of Public Health to collect data on the health care needs of the Latino population. The study resulted in a plan for improving access to primary and preventive health services for this population. The first phase of the plan was The Latino Health Hotline, which in 2000 provided more than 350 telephone services each month, linking patients to health care programs and providers.

The next phase of the plan called for creating a bilingual setting where underserved patients in the county could come for medical attention. Thus, La Red was born.

Out of La Esperanza Springs La Red

Brian Olson shares a joke: “People around here say that when La Esperanza gave birth to La Red, it was similar to a mouse giving birth to an elephant!”

La Red opened its doors on February 21, 2001, and incorporated itself separately as a nonprofit organization in 2002. “The people who ran La Esperanza did the groundwork,” says Olson. “They learned a lot about the Latino community and their specific needs, and they continue to provide important social services and medical referrals. Because of their efforts, we are able now to serve the county’s underserved and to offer affordable, high-quality, on- and off-site medical care.”

La Red (literally “The Network”) is a network that includes Nanticoke Health Services, La Esperanza, the Division of Public Health, and the Rural Physician Network (which is comprised of a number of community physicians). The private physicians have agreed to see patients at discounted rates.

The network operates out of a Nanticoke Health Services facility centrally located in the county seat, Georgetown, Delaware, and serves vulnerable populations, including recent immigrants, the uninsured, and the under-insured throughout Sussex County and beyond. La Red’s seven full-time employees coordinate primary medical care, acute and chronic care, 24-hour on-call service, and preventive health care, including immunizations, well-baby care, and developmental screening. Prenatal and mental health services are provided on-site by contracted physicians and nurse midwives. The network offers a continuum of pediatric, adolescent, and adult primary care services, in addition to outreach programs for diabetes and HIV prevention. La Red is the only community health center in Delaware to offer mental health and substance abuse counseling, as well as transportation and translation services when patients need to go off-site for care.

For 2004, the annual budget is \$756,141. Of that total, \$370,244 comes from contracts with the state (Division of Public Health, Division of Substance Abuse & Mental Health, Delaware Health Care Commission); \$177,097 from private contributions and fundraising; \$57,000 from private grants; \$58,080 from third-party insurances; and \$93,720 from patient revenue.

The Episcopal Diocese of Delaware, supported by \$132,000 from the Jessie Ball duPont Fund, has provided financial support and has played a critical role in spreading the word to the Latino community that La Red is available to help with their medical needs. According to Olson, many of the Episcopal and Catholic churches in the county have combined services in Spanish for the Latino population. The Right Reverend Wayne Wright, bishop of the Episcopal Diocese of Delaware, asked priests in the county to open their doors to La Red's outreach programs. Working through churches, La Red has established credibility in the community.

The Diocese of Delaware took on La Esperanza and has continued to support La Red because of its mission to care for those people who are often overlooked by mainstream society. Bishop Wright says La Red "has been a tremendous success as it has served those without a medical home, the uninsured and the under-insured in Sussex County." Working out of a sense of mission, the Diocese has been instrumental in creating for Delawareans what the Institute of Medicine calls a "health

care safety net" - "providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients. [...] either by legal mandate or explicitly adopted mission they maintain an 'open door,' offering access to service for patients regardless of their ability to pay." Free clinics, Federally Qualified Health Centers, public health departments, and programs that offer free or reduced-fee services are among the most common "safety net" providers.

"Despite growing awareness of the need for them, there are glaring gaps in services for vulnerable populations in Sussex County, particularly for non-English speakers," Olson notes. "For example, only one-third of all primary care providers in Sussex County report having staff who speak Spanish. At La Red, our fully bilingual staff helps meet a critical need in the county."

As patients visited La Red and experienced the care of bilingual medical staff who were sensitive to cultural differences, they spread the

There are glaring gaps in services for vulnerable populations in Sussex County, particularly for non-English speakers.

word. Without any marketing expenditures, La Red has gone from caring for 1,009 patients in its opening year (2001) to seeing 2,138 patients in 2002 and more than 4,000 patients in 2003. "It's been word-of-mouth referrals that have allowed us to grow, because our patients trusted us and were served well," says Olson.

In its first year, 86 percent of La Red's patients were Hispanic. In 2002 and 2003, the number of Hispanic patients held at about 69 percent, with the number of white and African-American patients increasing to 19 and 12 percent, respectively. "This demographic shift certainly supports the need for improved access to medical care for all low-income people," says Olson.

Building Trust

Along with providing translation services through a bilingual outreach worker, offering transportation and creating trust have been critical factors in reaching the underserved in Sussex County. Olson relates the story of a Guatemalan woman who came to La Red on a Thursday complaining of abdominal pain. The woman spoke no English and was relieved to find a translator who could relay her worries. "She thought she had cancer," he recalls, "but initial tests at La Red showed she was pregnant." La Red referred her to a private obstetrician in the network, who agreed to see her the next day. La Red's full-time outreach worker drove the patient to the obstetrician's office and served as a translator. The obstetrician diagnosed her pain as the result of an ectopic pregnancy, and said she needed surgery immediately. "Had the surgery not occurred that very weekend," says Olson, "she would have died. Now, she is healthy, and she continues to come to La Red for medical services."

Important Lessons Learned

Funding from the Jessie Ball duPont Fund enabled La Red to offer a number of services to vulnerable residents in Sussex County, including some that previously had not been available. The Division of State Service Centers and the Delaware Foundation for Medical Care, along with the Episcopal Diocese (through the Bishop's Discretionary Fund) also contributed start-up funds, which helped pay for two part-time internists, a part-time nurse, a case manager, and a medical receptionist. Due to overwhelming demand for low-cost medical services, the staff of La Red has grown in its first three years to include a full-time medical director, full-time nurse practitioner, a contract psychiatrist, and a contract obstetrical group (physicians and nurse midwives).

As La Red has gone from a telephone hotline demonstration project to a comprehensive medical center, the employees and advisory board members have learned many lessons about caring for the underserved in rural Sussex County:

- Providers need to be sensitive and responsive to cultural differences when treating patients from other countries. Olson says the staff at La Red has learned that people from Central and South America seek out care only for acute problems – “when the pain or discomfort is so great that they can no longer tolerate it.” They are reluctant to come for preventive care. Many Latinos believe in herbal and holistic approaches to health maintenance; they distrust and lack a clear understanding of commercial pharmaceuticals. Patient education also requires a different approach. “Although it’s beginning to change, the ingrained sense of

The word “once” in English means “eight” in Spanish. “Once a day” is a common prescription in English, but for Spanish-speaking individuals it could be interpreted as “eight a day.”

machismo still makes Latino men uncomfortable when, for example, we have to discuss STDs or HIV and AIDS – especially in mixed [male and female] company,” he says. Staff also has learned that Spanish words have different meanings in different countries. For example, the word “once” in English means “eight” in Spanish. “Once a day” is a common prescription term in English, but for Spanish-speaking individuals it could be interpreted as “eight a day.”

- Rural poverty leads to a vicious cycle of conditions that exacerbate the health care needs of the poor. Olson offers the following example: “We’ve learned that sometimes two or three families will share a one-family rental unit. The family members work different shifts in the poultry or service industries, so they share beds and bed linens. Once one person gets lice or scabies or some other infectious disease, it’s not long before everyone in the unit has it.” In this way, the prohibitive cost of housing compounds social and medical issues for the poor. Other problems, such as substance abuse, infant mortality, low birth-weights, late entry into prenatal care, high incidence of teen pregnancy, and suicide rates suggest that, without appropriate intervention, the repercussions of these problems will affect generation after generation.

- Not being able to afford prescription medication is almost as debilitating for the underserved as not being able to afford medical attention. The high cost of prescription medication sometimes forces patients – especially those with chronic illnesses – to neglect taking care of or managing their health conditions. Not caring for serious condi-

tions increases the incidence of urgent-care situations, which are more expensive, and jeopardizes the long-term health of the patients. La Red works with pharmaceutical companies to obtain free samples for patients whenever possible, but the need for affordable pharmaceuticals exceeds their donations. When samples are not available, staff at La Red complete enrollment forms with pharmaceutical companies' indigent drug programs, or in extreme cases, La Red purchases the medications.

Out of La Red Springs More Hope ... and Opportunities

La Red hopes to tackle the problem of affordable medication by being designated as a Federally Qualified Health Center - the only such center in Sussex County and the fourth in Delaware. As an FQHC, La Red would be able to partner with local pharmacies to purchase medications at cost, and could pass those savings on to its patients. The designation would bring with it federal funds of \$650,000 that would ensure the financial sustainability of La Red and allow it to expand its program, services, and outreach.

As an FQHC, La Red would become a full voting member of the Mid Atlantic Association of Common Health Centers, which does lobbying and advocacy work for improved health care conditions for the underserved (at present, La Red is an associate member, without voting rights). To date, advocacy work has been an identified need, but because of sheer numbers (having only seven full-time employees who have been busy providing health care and outreach) La Red has been unable to tackle it. "It's a challenge to educate policymakers about the needs of the uninsured and underinsured when they are reluctant to deal with the rights and needs of undocumented workers," says Olson. "We've started building relationships with our congressmen and senators, but the federal designation would certainly help us make a stronger case."

Olson hopes the designation also would help La Red expand to address the growing Haitian community in the towns of Seaford and Laurel in the western part of Sussex County. "We've been successful at helping the Latino community because everyone on our staff is bilingual with English and Spanish. But none of us speaks the Patois French of the Haitians," says Olson, who admits disappointment that his early training as a French teacher hasn't helped him communicate with Haitian patients. "If we want to serve this growing population, we'll need to hire outreach workers and staff they can talk to and trust."

Men's Health Outreach Initiative

Using a community nursing center model to address critical health care needs of urban men

National health care statistics for men, especially for men of color, are alarming. The May 2003 issue of the American Journal of Public Health notes, for example, that 17 percent of white American men, 28 percent of African American men, and 46

**University of Pennsylvania
Philadelphia, Pennsylvania**

July 2001

\$150,000 to develop and implement a health outreach program to young males in southwest Philadelphia, using students in the School of Nursing in partnership with community organizations, to provide primary care, prevention services, mental health assessments, relationship counseling and assistance with insurance.

percent of Hispanic men in America lack health insurance. Lack of insurance contributes to poorer quality and consistency of care, more severe health problems, and shorter life expectancies. In 2001, the Urban Institute reported that only 56 percent of young men had had a physical exam in the last year. The number of African American and Hispanic men who die prematurely of heart disease is almost twice that of white men; the life expectancy of African

American men is nearly 7 years shorter than for all American men and 12 years shorter than for white American women. "The disparities are a national disgrace," says Margaret Cotroneo, Associate Professor of Psychiatric-Mental Health Nursing at the University of Pennsylvania School of Nursing.

A "Silent Health Crisis"

Dr. Cotroneo has been part of a University of Pennsylvania School of Nursing program to research and act on what former U.S. Secretary of Health and Human Services Dr. Louis W. Sullivan has called a "silent health crisis" for men that could be "hazardous to the nation's long-term health." The School of Nursing's decision to focus on men coincided with growing national awareness of men's lack of participation in preventive health care programs, as well as firsthand experience with its community-based health center. In 1995, the School of Nursing opened the Myers Health Annex, a community nursing center, in a poor, urban southwest Philadelphia neighborhood. "In our first five years, I'd have to say that almost 95 percent of the people who came in for health care were women and children," says Cotroneo. "We spent so much energy extending health care to women - and rightly so - but we

weren't seeing the men. Low-income men tend to shy away from public health programs and services because they are ashamed of not having health insurance."

In an attempt to figure out why men from the community were not using the Annex, Dr. Cotroneo began conducting focus groups with men in the neighborhood. She found that the lack of health insurance and misconceptions about preventive health were the biggest issues keeping men from coming to the Annex. In response, she created a partnership between the Myers Health Annex and Neighborhood United Against Drugs to target men's health as a community concern. She wrote a grant to fund a community outreach effort that would train and hire a male resident of the community to work with her.

Community-Based Outreach

In July 2001, Cotroneo's work, through the University of Pennsylvania School of Nursing, was partially funded by a three-year grant of \$150,000 from the Jessie Ball duPont Fund. The project aims to address the men's health crisis in southwest Philadelphia by attempting to increase awareness and use of preventive health services by African American men between the ages of 16 and 40. "The duPont Fund really took a chance on us," says Cotroneo. "They allowed us to bring community partners on board - without whom we couldn't have made any inroads into the neighborhood." The funds allowed the University of Pennsylvania to partner with NUAD (Neighborhood United Against Drugs), a nonprofit organization in the community that was already working to reach and mentor young males with substance abuse and violence problems. In addition, the grant enabled her to hire and train a community resident, Michael Rhoads, to assist with outreach, and helped the Annex cover the cost of health services for the underinsured men in the initial outreach cohort.

The Men's Health Outreach strives, through "intensive and targeted outreach activity," to link men with the following types of health care:

- Primary care services, including physical exams; reproductive health assessments; STD screening, testing, treatment, and partner referral; HIV testing and counseling and family planning and care;
- Mental health assessment and relationship counseling;
- Referral to other health-related resources such as community support groups for young fathers, work and socioeconomic resources, and substance abuse services;

- Access to health information on men's health issues;
- Assistance for uninsured participants to obtain health care insurance, if possible.

In particular, the Men's Health Outreach attempts to educate and link men to services that address four healthcare issues that come up regularly in the focus groups conducted by Cotroneo and Rhoads: hypertension, smoking, substance abuse, and depression.

Lorraine Thomas, an outreach worker for the Myers Health Annex, confirms that hiring a male to work with men in the community has increased their utilization rates: "For years, I've seen men come by the Annex to drop off women and children for medical care, but since we hired a male outreach worker, we've seen a remarkable increase in the number of men who are coming in for themselves."

"I live in this community, too," Rhoads notes, "so I know where to find the men who need to know about the Annex. I've seen the street life - the hustling, the substance abuse, people raising kids without the support of two parents in a home, the way the young boys look up to the older boys in the neighborhood who might be selling drugs or stealing for support and love. It's a hard life." Rhoads says he has been able to "connect" with men in the neighborhood in a number of places and on a number of levels. He meets them at recreational centers, at parks, in barber-shops, in their housing developments, and on the streets. He conducts health education forums twice a month at Outley House, a 300-bed community shelter for men, ages 18 to 65, who are homeless, who have been released from prison, or who abuse substances. These forums have allowed Rhoads to link seven to 10 men a month to health services. The men of Outley House are among those with the greatest need for health services and who face the greatest barriers to access. In addition to providing information and encouraging men to take advantage of free screening programs or seek attention for nagging health problems, he talks to them about getting their lives together, finding work, and completing their GEDs.

Challenges and Rewards

Rhoads faces a number of challenges, even for someone familiar with the local community and its residents. "Health is not the first concern for a lot of the men I meet on the street," he says. "And in the winter, it's especially hard to find the people who are

usually on the street. Timing can be an issue, too. Some of the men go to community or neighborhood meetings at night, and I miss them because I've been working all day. We're looking at ways to address these issues." One issue that has emerged as a challenge is mental health. Last year, two men in the community committed suicide. The other men have looked to the focus groups and to Rhoads to offer support as they deal with the suicides and talk about what might have been done to help their peers. "There are a lot of taboos about talking about mental health and feelings like grief," says Rhoads. "These guys aren't used to opening up about their problems. We take it a step at a time."

Despite the challenges, Rhoads has made impressive inroads in reaching the men in the neighborhood. In each of the first two years of the grant, he reached more than 1,000 men with information about the Annex. More than 100 men between the ages of 17 and 30 kept the appointments they made through Rhoads to come in for health care. "Keeping appointments is a big deal," says Thomas. "It's a whole different way of taking care of themselves than these men have been used to." Thomas tells the story of one man recruited by Rhoads to bring his pregnant girlfriend to the Annex for prenatal care. In working with him, Rhoads learned that both the man and his girlfriend, who had several other children, also had mental health issues that needed attention. Rhoads helped the man apply for state health care assistance through the Welfare Office, and educated the family about the resources at the Annex. "Now, they all come regularly for checkups and health care—the man, the woman, her newborn, and the other children. It's changed the quality of their lives," says Thomas.

"Michael has done some very innovative outreach," says Cotroneo. "He has developed and handed out CD-ROM programs about health and CDs that use culturally sensitive language to address STDs, cancer, smoking cessation, diabetes, and depression. He's upbeat, and he 'talks straight' with the men he's meeting." One of the unexpected outcomes of the grant has been that Rhoads has been able to reach out to younger men than originally targeted. During the grant period, on July 1, 2003, the Myers Health Annex became a Federally Qualified Health Center affiliate of the Family Practice and Counseling Network, increasing the financial sustainability of the Annex and the breadth and continuity of services it can offer. (More of the services provided are federally reimbursable.) The change in status has allowed the Annex

to expand the scope of its men's health outreach to boys ages 11 to 17. The program now conducts summer programs at two local schools, and Rhoads is developing materials for youth he meets on the streets. Cotroneo is hopeful that reaching young men sooner will ameliorate the severity of the health problems that finally bring them in for care.

“It’s a whole different way of taking care of themselves than these men have been used to.”

Rhoads takes special pride in his work with the youth he has met through the Men's Health Outreach. He recalls the story of a 14-year-old boy he met while doing workshops as a health ambassador for a NUAD after-school program. “He was having nightmares about shootings, and they were affecting his schoolwork and his behavior toward others,” Rhoads recalls. “The boy was already seeing a social worker at the Annex, but I spoke with Dr. Cotroneo and hooked him up with a mental health doctor there. Having access to those additional resources made a real difference for him. He went from being really negative and violent to being more positive. His grades improved, and now he’s in high school. It’s been a remarkable change. People don’t always think about how good physical and mental health translate into better success at school – and when you really help somebody, there’s a feeling you get that’s great.”

Real Life Informs the Academy

As part of the next phase of its evolution, the Men's Health Outreach has linked with other public health initiatives at University of Pennsylvania. These initiatives are spearheaded by a series of seminars called “Ameliorating Health Disparities: Searching for Success.” The seminar series brings together students, faculty and community members in an attempt to come to a better historical understanding of health disparities; gain comprehensive data about the causes and effects of health disparities; use an interdisciplinary approach to address disparities through teaching, research, service, and policy making; and demonstrate that combining the resources of the academy and the surrounding community can foster mutual learning about public health conditions. Ultimately, Cotroneo and her colleagues hope that projects like the Men's Health Outreach Project will provide data to help inform the public health agenda of ameliorating health disparities.

The students at the University of Pennsylvania benefit from the outreach effort as well. Students from Cotroneo's Introduction to Public Health and Community Health courses make site visits to

the Annex and surrounding neighborhood to gain insight into the people and problems they will work to help. Interdisciplinary groups of students also have been involved with providing clinical services at the Annex, co-facilitating focus groups, analyzing focus group findings, designing and implementing plans for follow-up services, and learning about public health methods such as community outreach.

During the duPont Fund grant period, the annual cost to the Health Annex of delivering services to this underserved community averaged \$380,000. Medical assistance and other insurance funds accounted for only about 40 percent of the cost. When the Health Annex became a Federally Qualified Health Center affiliate on July 1, 2003, its new status allowed it to bill for more of the services provided, thus accounting for approximately \$300,000 of the actual annual cost of services. Foundation assistance is needed to target health problems such as men's health disparities, thereby strengthening the public health infrastructure at the community level.

Reflecting on the lessons learned through the Men's Health Outreach, Cotroneo says the list is long: "We have learned a lot so far about the importance of community involvement in health education, the benefits of partnering with community groups (like NUAD), the success that outreach can have in improving access to preventive services, the effectiveness of targeting specific groups, and the need for community-based education efforts that address real people in ways they understand. We have been able to identify the barriers to access like lack of health insurance, mental health problems, racism, incarceration and unemployment, and the association of 'weakness' with having health problems. But," she admits, "one of the most important aspects of programs like the Men's Health Outreach is that they help us academics translate numbers into real life. We don't often get to do that. The motivation for us to help solve the problems is so much greater, because we see the people who are being affected."

MGH Chelsea Visiting Moms Program

Providing a healthier start to the children of immigrants and refugees

Since 1811, Massachusetts General Hospital has been providing high-quality health care to individuals in the greater Boston area, contributing to the field of medicine through a notable research program, and training future health care practitioners through its affiliation with Harvard Medical School. In addition, MGH has a long history of caring for the poor and underserved, regardless of their ability to pay for health care services. The hospital provides the greatest amount of uncompensated care among the Massachusetts private hospitals, is among the Commonwealth's top five Medicaid providers, and has maintained health centers in the low-income communities of Chelsea, Revere, and

***Massachusetts General Hospital
Chelsea HealthCare Center
Chelsea, Massachusetts***

December 2001

\$176,000 to develop a pilot program of home visitation for high-risk mothers who deliver babies at the hospital.

Charlestown for more than 30 years.

In 1995, the MGH Community Benefits Program was founded to improve access to health care for, and consequently improve the health status of, underserved communities in the greater Boston area. Because the hospital was experiencing an increase in the number of low-income women delivering babies at MGH who had received prenatal care at the local health centers, one of the program's specific charges was to assess the needs of expectant and new mothers in these communities. About one-third, or approximately 1,200, of the women who deliver their babies at MGH each year have Medicaid or Healthy Start insurance, making obstetrics the service with the "highest proportion of patients with public payers" in the hospital. Twenty-five percent of all women who deliver their babies at MGH are immigrants (many undocumented) or refugees from war-torn countries. These women and their families speak little or no English.

A Closer Look at Chelsea

In 2000, the Community Benefits Program collaborated with the chief of obstetrics, director of social services, and the department of nursing at MGH to look more closely at the needs and circumstances of the low-income women who were receiving their prenatal care at MGH's local health centers. The study found that 475 deliveries per year (more than 13 percent) originated in Chelsea, a communi-

ty with the second highest rate of child abuse and neglect in the Commonwealth of Massachusetts.

According to the Harvard Medical Center Network, “Chelsea has the Commonwealth’s highest percentage of families living in poverty, of people unemployed, and of families headed by a single parent.” Of the community’s 35,000 residents, almost half are Hispanic. Many are recent immigrants from Central America, Cambodia, Vietnam, Somalia, Bosnia, and the Dominican Republic. They settle in Chelsea because of its proximity to the multicultural city of Boston (two miles south) and to Boston Logan International Airport (three miles away). A January 2000 bulletin from the U.S. Department of Justice’s Bureau of Justice Assistance offers additional insight into the challenges facing the Chelsea community: “Nearly half of the city’s children under the age of four live in poverty. Chelsea leads the Boston region in unemployment, has the state’s highest crime rate, and is home to an estimated 10,000 undocumented Hispanic and Southeast Asian immigrants. These problems are compounded by the fact that Chelsea’s population is squeezed into fewer than 3 square miles. More than 30 percent of the population lives in one 10-block area of cramped, rundown dwellings.”

Many parents in Chelsea face daily concerns about housing, overcrowding, immigration status, post-traumatic stress (especially among those who have fled war), domestic violence, depression, and isolation – serious concerns that affect mothers’ ability to care for their unborn and newborn children.

Offering More than Medical Attention

“The immigrant and refugee mothers we work with are particularly vulnerable,” says Sarah Abernethy Oo, director of Community Health Programs at MGH Chelsea, “because they have lost much of their cultural framework, and many of the parenting techniques traditional to their native cultures are difficult to maintain in the United States.” The hospital’s assessment concluded that someone needed to address the “cultural, economic, and psycho-social barriers to a positive experience of the pregnancy and post-partum period” for immigrant and refugee populations in the greater Boston area.

Committee members began by researching “home-visiting programs” and other resources for expectant and new mothers in low-income areas surrounding Boston. They discovered that virtually no services existed for mothers over the age of 20 in Chelsea, and consequently they recommended the creation of a long-term home-visiting program for high-risk mothers in Chelsea.

In January 2002, the MGH-Chelsea HealthCare Center received a \$176,000, three-year grant from the Jessie Ball duPont Fund to begin such a program. The grant has allowed the pilot program to hire four paraprofessional, bi-cultural mothers who have been trained to visit and support new mothers over the age of 20. Currently the program costs about \$130,000 to run each year. Besides the duPont Fund grant and two \$20,000-per-year contributions from the Ladies Visiting Committee at MGH, all other funding comes from MGH. Office space, computers, and medical and office supplies are contributed in-kind by MGH as well. Of the annual budget, \$15,000 is set aside for evaluation. The remainder covers salaries.

The overall goal of the program is to help families achieve stability in order to enable healthy, long-term outcomes for the child, the mother, and the family. Specifically, the program aims to accomplish the following objectives:

- To develop an effective, caring, culturally appropriate relationship with the parent that increases self-esteem and feelings of self-confidence;
- To increase parents' abilities to care for their children;
- To reduce isolation and the stresses that stem from isolation;
- To increase social supports and access to community resources;
- To help parents learn to help themselves;
- To prevent child abuse and neglect by supporting positive, effective parenting skills; and
- To advocate with public officials for reimbursement for this service from public funds.

The "Visiting Moms" team consists of women with a high-school degree or equivalent; some have been to college in their home countries. All have been hired for their compassion and tendency to want to help others. They receive training in a variety of areas, including prenatal care, early childhood development, attachment and bonding issues, basic social work skills, and how to access the public and private resources available for low-income families.

The Visiting Moms work 30 hours a week, with caseloads of approximately 10 to 12 families each. "The work is too hard to be full-time or 40 hours," says Oo. "We've found that 30 hours a week helps prevent burnout." The women share an office near Oo's and have become a support group for each other. "They cry together, get coffee, talk about cases," says Oo. "We meet as a group often to help each other process the issues and possible solutions for our families. We're a team."

Each of the Visiting Moms is paired with expectant and new

moms in Chelsea who speak her language. One of the Visiting Moms speaks Spanish, one speaks Somali and Swahili, one speaks Arabic and French, and one speaks Portuguese and Spanish. Having a shared language and culture helps to reduce social distance between the Visiting Mom and the participating mother or family. Visiting Moms also serve as role models, since they have been through some of the same situations as their clients. They demonstrate ways to adapt to a new country and culture.

Since the Visiting Moms Program began in 2002, nearly 50 women have participated. They range in age from 20 to 44, but most are under age 30. Half of the women are married, and close to 40 percent were pregnant when they were referred (usually by an obstetrician at MGH Chelsea). Most of the fathers (70 percent) are involved with the children. Close to half of the women are new mothers. Some have children who remained in their home countries with relatives. Seventy-two percent of the women are from Latin America and the Caribbean (50 percent from Central America); 22 percent are from Africa; and four percent are from the Middle East. Sixty-four percent speak Spanish; the rest speak Somali, Arabic, Portuguese, Swahili, Ugandan, Dari, Haitian Creole, and French. Approximately 60 percent of the women rely on some form of public assistance and have less than an elementary school education; 22 percent have completed high school; and eight percent have attended some college or trade school.

While their demographics are diverse, the stress factors the participating mothers experience as they attempt to adapt to life in the United States are very similar. The five most prevalent “stressors” noted by the Visiting Moms are lack of sufficient financial assets, unemployment, language barriers, mental health problems, and difficulty accessing benefits. Many of the couples argue excessively or struggle with emotional or physical abuse; some families are divorced or separated; many families include a close family member with serious illnesses. Geographically separated from their extended families, these families lack support networks, making it difficult to balance work and family needs. Interviews conducted by the Visiting Moms reveal that 68 percent of the participants are mildly to moderately uncomfortable caring for their infants and lack confidence in that process. Approximately 71 percent have some attachment difficulties

Chelsea’s population is squeezed into fewer than 3 square miles. More than 30 percent of the population lives in one 10-block area of cramped, rundown dwellings.

with their babies. Most have little to no knowledge of child development.

The Visiting Moms develop supportive relationships with the participating mothers by visiting regularly at home (usually two hours a week), seeing them at the clinic, or accompanying them to other appointments as needed. Visiting Moms offer emotional support, advocacy, and referrals to resources to enhance the functional stability of the families. They educate families about the physical and emotional needs of parents and babies, and they maintain these supportive relationships for up to three years, by which time many of the mothers have returned to work and have fewer needs for support.

One of the hazards of the job, notes Oo, is that participating mothers sometimes grow too attached to their Visiting Moms – and vice versa. “Visiting Moms have been asked to be bridesmaids in weddings and godparents for the children they’ve helped to nurture,” Oo

says. “We try to teach the Visiting Moms how to be mentors, not friends, to the mothers they are serving. They have to turn down invitations to participate in family events to keep a healthy distance – and to encourage the participating families to become more independent.” But the successful cases offer other rewards.

Geographically separated from their extended families, these families lack support networks, making it difficult to balance work and family needs.

Marta’s Story

Marta, a 23-year-old woman from Mexico, speaks no English. Her obstetrician referred her to the Visiting Moms program when she was 2 months pregnant. In addition to having little formal education and few social or economic resources, Marta suffered from severe depression and anxiety, exacerbated by an abusive relationship with her baby’s father. When she was diagnosed with a sexually transmitted disease, for example, her partner said she must have contracted it while receiving medical care at MGH Chelsea.

The Visiting Mom assigned to Marta made weekly home visits in the beginning. She made sure Marta understood the necessity of completing a full course of antibiotics to treat her sexually transmitted disease and of taking medication prescribed to treat her depression – both of which she had been reluctant to take. The Visiting Mom helped educate Marta about fetal and neonatal development and provided information about nutrition for both mother and baby. Marta followed the Visiting Mom’s suggestion to work as a volunteer for the

Salvation Army, which allowed her to meet other people and to earn a bag of groceries each week until her baby was born.

Initially, Marta's high level of anxiety interfered with her ability to bond with her newborn. The Visiting Mom continued making home visits after the birth of the child and invited Marta to join a group of new mothers who were meeting weekly at a local park. With ongoing support, Marta's confidence increased, and she began to enjoy her time with her new baby. She also acknowledged the violence in her relationship with the baby's father, and felt strong enough to leave. She is now raising her baby in a safer, healthier environment.

Marta's story illustrates one of the biggest lessons of the Visiting Moms program, according to Oo: that intervention and education at the pre- and neonatal stages can produce significant health and quality of life benefits for the baby and family. "The numbers may be small, but the Visiting Moms are making a huge difference in the lives they're touching."

Halima's Story

Trust and consistency, achieved through common language and culture, are essential ingredients in delivering health care to immigrant and refugee populations. These ingredients pervade the story of Halima, a married Somali woman with three children (ages 6 and 18 months and 4 years old).

Halima was raising her baby, as she had the other children, according to traditional Somali customs. She kept a cloth filled with herbs around the baby's wrist to "ward off evil spirits." She played an instrument similar to those played by Islamic clerics directly into the baby's ear to "awaken the child to the Islamic faith." The Visiting Mom supported her use of these positive cultural traditions. However, Halima also believed that holding an infant would spoil the baby. The Visiting Mom, who also is from Somalia and on that basis had developed a very trusting relationship with the family, continues to work with Halima to encourage more interaction and affection with her newborn in the context of positive child development and the importance of bonding. At first, Halima only allowed the Visiting Mom to shower the baby with attention. But, over time, Halima has begun to hold the baby more frequently and is less worried about spoiling her. The Visiting Mom has helped Halima learn to manage her four-year-old child's asthma, ending habitual emergency room visits for upper respiratory problems, and has linked the family to numerous community resources.

Operating at Capacity . . . For Now

While these stories and others inspire MGH Chelsea to continue developing its Visiting Moms Program, a number of challenges remind Oo and the Community Benefits Program to proceed slowly and methodically. While demand is great (there's a waiting list of hopeful participants), the program is at capacity, according to Oo.

"Four is a good number for now," she says.

"We try to teach the Visiting Moms how to be mentors, not friends, to the mothers they are serving. They have to turn down invitations to participate in family events to keep a healthy distance — and to encourage the participating families to become more independent."

"The Visiting Moms require a lot of support and training. Their work is hard, often involving serious domestic violence and other emotionally draining issues. If we were to expand the number of families, we'd need to find and train more Visiting Moms - and we'd need to find ways to continue to support them to keep them from burning out."

Expansion would require additional funding. MGH Chelsea hopes to continue to receive the support of funders who recognize the value of high-quality pre- and neonatal care and support services, in addition to continued support from MGH (whose Community Benefits Program contributes more than \$500,000 annually to Chelsea for violence prevention, refugee and immigrant health, and public health concerns such as asthma, substance abuse, HIV/AIDS, and breast cancer screening programs). "We hope the program's success will capture the attention of the state and local elected officials and agency personnel who control public funding for support services," says Oo. "We want to do more advocacy work for public support as we collect data that show the powerful impact the Visiting Moms Program can have."

notes
from
the
field:

Jessie Ball duPont Fund

One Independent Drive, Suite 1400

Jacksonville, FL 32204

904-353-0890 - 800-252-3452

Facsimile: 904-353-3870

www.dupontfund.org

President

Sherry P. Magill

Program Staff:

Sally Douglass

Sharon Greene

Edward King Jr.

Credits:

This issue of Notes from the Field was written by

Tracy Constantine of CCGI, Inc., Durham, NC,

and edited by Mary Kress Littlepage of

KBT & Associates, Jacksonville, FL

Photography by Ingrid Damiani, Jacksonville, FL

Design provided by

Glenn Ivie Advertising, Art & Design, Jacksonville, FL

Printing by The Hartley Press, Inc., Jacksonville, FL



One Independent Drive, Suite 1400
Jacksonville, FL 32204
904-353-0890 - 800-252-3452
Facsimile: 904-353-3870
www.dupontfund.org