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Introduction

Rural Missourians, like others across the nation, have witnessed a tremendous growth in the Latino population. Newcomers from Mexico and Central America are seeking economic and educational opportunities for their families, and many find work in the local poultry processing, building construction, furniture industries, and small businesses. Despite full-time employment, however, many do not receive the health care services they need to improve their lives. Given the poor health status of many low-income Latino families and the strain this places on health service systems, the importance of community health outreach becomes apparent. Social workers and allied health professionals are in the unique position to provide needs assessment, networking, and educational resources for human service providers and thus improve access for at-risk populations (Walker & Dollar, 2002).

A Culturally Sensitive Model

The Salud Para La Vida (Health for Life) project was designed to reduce health disparities among Latinos in five rural counties identified as either a geographic or low-income primary care Health Professional Shortage area. The project used a collaborative model involving several academic disciplines (social work, nutrition, nursing, audiology, physician assistant), as well as community agencies, University Extension, a federally qualified health center, and area churches to plan, deliver, and evaluate program components. Health disparities and access to care were addressed through the following program goals:

A) Educating health profession students about the rural and Hispanic cultures and attracting health professionals into medically underserved areas;

B) Developing cultural competency and medical Spanish skills among existing rural health care professionals; and

C) Providing culturally appropriate preventative health services and clinical follow-up of chronic conditions among low-income Hispanics.

Literature Review

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The Hispanic population in the five targeted rural counties of Barry, Newton, McDonald, Jasper, and Lawrence counties in southwest Missouri has increased by 290% over the last ten years. In 2,000 there were 268,020 residents; 59,883 were Hispanic (4.8%). In the year 2007, there were 248,217 residents; 41,245 residents (6.0%) were Hispanic (Missouri Census Data Center, 2007). Findings of an area survey (n=300) conducted by Dollar and Walker (2002) indicated that the majority of Hispanic respondents migrated from Mexico within the past five years to work in poultry processing and factory jobs. Over three-fourths of respondents had an annual household income of less than $25,000 (19% less than $10,000). Three-quarters reported that they spoke and read English poorly or not at all. Most (72%) did not have a doctor and could not afford health care (69%), experienced language barriers (72%), did not have transportation (19%), or could not take time from work (15%). Fifty-five percent listed discrimination as one of the barriers as well. These barriers to health care are similar to those found in other published studies (Riffe, Turner & Rojas-Guyler, 2008; Stone, Viruell-Fuentes & Acevedo-Garcia, 2007; Agency for Health Care Research and Quality, 2006 [AHRQ], 2006). Results of the Dollar and Walker survey also indicated that Hispanics underutilized health services, and (compared to the total population) were more seriously ill with secondary and complex health problems including: high blood pressure, diabetes, asthma, tuberculosis, respiratory problems, and arthritis (Walker & Dollar, 2002).

Significant geographic, financial and cultural barriers exist in rural areas concerning health care information and services. Rural residents in general, face more impediments to accessing human services than their urban counterparts, due in part to the scarcity of health services in rural areas and transportation difficulties (Betancourt, Carrillo, Greem & Maina, 2004). A large percentage of rural Hispanics are recent immigrants compared to their urban counterparts; 39.1% compared with 13.4% respectively, which may deter them from seeking services due to their immigration status or ineligibility for employee-based coverage (Rochin, 1997). A lack of health insurance is one major reason underutilized health services (AHRQ, 2006). Hispanics have the highest uninsured rates of any minority group with more than one third under the age of 65 without insurance (AHRQ, 2006). Rural Hispanics are even more likely to be uninsured than their urban counterparts **(**DeNavas-Walt, Proctor, & Smith, 2008; Valdez, Giachello, Rodriguez-Trias, Gomez, & de la Rocha, 1993). Finally, many have difficulty finding culturally appropriate treatment options; interpreters and bilingual providers; and the needed outreach activities to inform them about services (Blewett, Smaida, Fuentes, & Ulrich-Zuehlke, 2003). Negative attitudes and perceptions of Hispanics among non-Hispanic whites are seen as another significant barrier to accessing services (Cristancho, Garces, Peters, & Mueller, 2008; Jackson, 1995)

Methods

The three-year project required a number of planning steps. Initially, a local Latino advocacy group was contacted regarding the project to enlist their support with advice concerning inter-agency collaborations and important locations to target for health screenings and educational sessions. Next, focus group material from a previous study (Walker & Dollar, 2002) was analyzed to determine the key health indicators and other access issues needing to be addressed. This analysis formed the Salud para la Vida project design and evaluation plan, which developed systematic activities under each of the three program components:

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Program Component A: Educating health profession students about the rural and Hispanic cultures and attracting health professionals into medically underserved areas.

Recruiting university students for the Rural Health Course involved collaborating with academic departments and direct contact with health professions students. A cross-listed method allowed credit within their major from two different departments. Students were introduced to rural health concepts, identified major health care problems of rural residents, evaluated current rural health care delivery systems, and discussed economic, political, social, and cultural factors affecting rural health care. Each student in the classroom participated in a fifteen-hour service learning experience while attending health fairs. Health Insurance Portability and Accountability Act (HIPAA) and National Institutes of Health (NIH) research training was provided to students to ensure that client confidentiality and informed consent were maintained.

Program Component B: Developing cultural competency and medical Spanish skills among existing rural health care professionals.

A total of 838 Latinos were recruited over three years for free health screenings and medical referral assistance in the five county region. Health fairs were advertised through church bulletins, local Latino radio and newspaper announcements, workplace flyers, and word-of-mouth. During the health fairs, bilingual/bicultural interpreters were available to assist voluntary participants with the free clinical assessments, informed consent forms, and referral assistance. A full-time case manager was hired to monitor those with chronic health conditions. Key indicators in the assessment included: Body Mass Index, blood pressure, cholesterol reading, blood sugar reading, vision, hearing, and immunizations. A health risk assessment for diabetes was also collected from participants along with demographic characteristics.

Program Component C: Providing culturally appropriate preventative health services and clinical follow-up of chronic conditions among low-income Hispanics.

Advertising through local hospitals and clinics proved to be the most effective means for recruiting health professionals for both educational programs. Many were interested in the continuing education units (CEUs) available for attending the cultural competency workshops. Another appealing aspect of the workshops was the fact that they were conducted in small towns which were easily accessible from their home or workplace. Over the three-year period, 348 rural human services professionals attended workshops on topics ranging from migrant health issues, food and culture, diabetes and heart disease prevention, and communication practices. A 2005 pre-test/post-test comparison (n=26) showed an increase of reported knowledge gained in cultural competence for the Jasper and McDonald county participants: on a 5-point scale, knowledge increased an average of 1.35 for participants which was a strong statistically significant change for increased knowledge (Wirth, 2007).

Results

Program Component A: Educating health profession students about the rural and Hispanic cultures and attracting health professionals into medically underserved areas.

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Rural Health Course: A total of forty-one (n=41) undergraduate and graduate students from nursing, social work, dietetics, biomedical science, and public health were enrolled in the Rural Health course over a three-year period. An online version of the rural health course was later developed and continues to be successful in recruiting a range of academic majors and interests. A pre-test/post-test comparison (n=16) showed an increase of reported knowledge gained in cultural competence for students who attended the "Rural Health" course (on a 5-point scale where 5 = extremely informed, the pre-test average = 2.4 while the post-test average = 3.9).

Program Component B: Developing cultural competency and medical Spanish skills among existing rural health care professionals.

Medical Spanish and Cultural Competency Training: The medical Spanish course was taught through several mediums, including a classroom setting in a federally qualified health center, to a self-study Medical Spanish module. The CD-ROM self study course proved to recruit and retain more participants than the classroom setting, suggesting this type of technology may be more attractive to many with busy and varied work schedules. Fifty-one (n=51) health professionals successfully competed the courses over a three-year period. Evaluation pre/post testing in 2005 suggests there was not increased learning on the 11 learning objectives for the 5 respondents who took both pre/post-test assessments of the Spanish class. Even though the means showed increases of learning, the sample of 5 respondents was too small to attain statistical significance (Wirth, 2007).

Program Component C: Providing culturally appropriate preventative health services and clinical follow-up of chronic conditions among low-income Hispanics.

Health Screenings: It was determined that improvements in healthcare access did occur among low-income Hispanics as a result of outreach education and referral services (including Medicaid enrollment) taking place in nontraditional, church settings and in a clinical setting.
A demographic profile gathered from 383 health fair participants in 11 health fairs from five rural counties showed the following characteristics: average age of 33, lived in southwest Missouri for three years, from 24 different towns, 67% Hispanic, 79% Catholic, 77% female, 67% from Mexico as country of origin, Spanish is primary language for 63%, rated their personal health (54% excellent or good, 42% fair, and 4% poor), 58% do not have a doctor, 32% said they didn't go to a doctor when they needed to and when asked why 41% said they couldn't afford to (Wirth, 2007). Variables included are socio-demographic characteristics and health care questions related to access to care.

Lessons Learned

There were two themes that emerged from the 3-year project which might benefit others involved in community outreach:

Stay connected with your audience

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- Make connections in the community with those who have established records of success in working both formally and informally with leaders in the Latino community. These individuals will often help with interpreting or translating materials if needed.

- Conduct health fair screenings in conjunction with other planned community events. Examples include: providing screenings and educational materials at employee worksites during break times, following religious services, school, or festivals or other community events.

- Allow ample time to interact with participants. *Personal connection,* while important to all of us, may need further definition within a professional context and require additional training for volunteers or staff regarding cultural belief systems and practices. It was also important to train volunteers and staff regarding the Informed Consent form, voluntary participation and client confidentiality.

- Publicize events in Spanish and English through various media. Latino radio, newspapers, flyers in local shops and churches were useful outlets. Word of mouth proved to be the most effective means of communicating the importance and the legitimacy of the sponsoring organization. A bilingual services resource directory was also developed for health fair participants and area agencies.

Use of distance education technology

- University students enrolled in the rural health course and health practitioners in the medical Spanish course preferred online classes and CD ROM materials to classroom instruction. Both methods allowed them flexibility to complete their training at their own pace, and consultation was available via telephone and the email.

- The online rural health course required a community assessment through a photonovel assignment. The photonovel involved visiting a rural community to explore its makeup in terms of economic, geographic, demographic and community characteristics. Interviews were conducted to gain perspective on a chronic health condition or access issues and its impact on the community member.

Conclusion

The Salud para la Vida project was successful because of community support, but the importance of forming an effective consortium should not be overlooked. An early understanding among consortia members regarding their long-term commitments to the project was critical; particularly after grant funding had expired. All members carried out their commitments and this has lead to other collaborative activities. Academic departments continue their collaborative grant writing to fund Latino health outreach, University Extension remains active in new immigrant community integration related to health, literacy and economic opportunities. The Area Health Education Center coordinated medical interpreter training in the region. The health clinic has a permanent bilingual nurse to provide referrals, clinical screenings and outreach. And the university continues to offer its rural health course and continue to seek additional funding for

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Latino health outreach and research. The relationships that were built during the pilot project have remained healthy and will continue to be an integral component to sustaining efforts to improve health access and care for Latinos.

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