

**Comprehensive, Integrated Models of Women's Care:
What Does it Mean and How Does it Work?
May 4, 2004
Sheraton Premiere – Vienna, Virginia**

Meeting Overview

Purpose

Interdisciplinary collaboration and enhanced linkages/partnerships are effective ways to improve the delivery of comprehensive care to women. Several Federal agencies fund programs to improve women's health status which include, as key components, such collaboration and partnerships. On May 4, 2004, the Federal government held a meeting so that grantees implementing programs that embraced this approach to caring for women could:

- discuss approaches that work well, especially those which incorporate cultural competency into programs and activities that address women's health disparities;
- share lessons learned based on their experiences in the field;
- learn about common challenges and effective strategies in evaluating these programs; and
- explore strategies for continued collaboration.

Participating programs

Programs participating in the meeting, and their Federal funders, are:

- Border Models of Excellence, supported by the U.S.-Mexico Border Health Commission;
- Health Disparities Among Minority Elderly Individuals--Technical Assistance Centers, supported by the Administration on Aging (AoA);
- Indian Women's Health Demonstration Program for American Indians and Alaska Natives, supported by the Indian Health Service (IHS);
- Integrated Comprehensive Women's Health Services in State Maternal and Child Health Programs, supported by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau;
- The National Centers of Excellence in Women's Health (CoE), supported by the Office on Women's Health (OWH); and the
- National Community Centers of Excellence in Women's Health (CCOE), supported by the Office on Women's Health (OWH).

Comprehensive, Integrated Services – The Common Approach

While all the programs have different strategies for promoting women's health, they share a commitment to comprehensive and integrated services. As Arlene Bierman, MD, MS, of the Ontario Women's Health Council, noted in her keynote address, the U.S. has historically used a specific disease-focus when attempting to improve public health. The programs represented at the meeting have moved beyond this narrow focus, adopting a

holistic approach that takes the entire patient – and her relationship with her community – into account. These programs excel at making connections and fostering practices that

The **National Community Centers of Excellence in Women's Health** (CCOE) have as their goal: (1) to reduce the fragmentation of services and access barriers by coordinating and integrating comprehensive health services with research, training, education, and leadership activities; (2) create integrated and coordinated women's health delivery system; (3) empower underserved women as health care consumers and decision-makers; (4) increase the women's health knowledge base using community-based research; (5) increase the number of health professionals trained to work with underserved communities; (6) increase the number of young women who pursue health careers; (7) replicate the CCOE model; and (8) eliminate health disparities for women.

benefit women's health beyond a specific condition (e.g., encompassing nutrition's effect on obesity as well as diabetes). They also address community factors that contribute to a woman's health and her ability to seek services (e.g., lack of culturally competent care in the community). Finally, many of these programs connect the mind and body, helping empower women to be effective consumers and advocates for their own welfare.

For all their benefits, comprehensive and integrated service programs are complex and difficult to implement (as will be

further described in the *Challenges* section, below). They require complicated and long-term collaborations across multiple agencies on both the local and state levels. In the case of programs that address health concerns on the borders, collaboration must extend between nations as well. Comprehensive services require time, money and effort.

To succeed, these programs must examine and resolve issues at multiple points of service delivery that affect women. First, programs must address women's primary access to services – these are barriers resulting from cost, accessibility, and transportation issues. Programs must also address secondary access to services – whether, if a woman can get to the health care provider, whether she can get an appointment and see the necessary specialists. Finally, programs must address tertiary access issues – if, once the woman has arrived for her appointment, the care she receives is appropriate and culturally sensitive. Tertiary issues address whether providers have the skills and competence to provide care that is appropriate and meaningful for women. Many of the program strategies encompass all three levels of access, and focus on ways to ensure that women receive the best possible care when they enter the health system.

Creating such approaches is not simple. It requires an informed patient, an educated medical team, and partnerships within the health system. It demands community involvement and engagement, to ensure that services reach the women most in need, and are provided appropriately. This means a shift by both the medical entities and consumers: wherein health care professionals reach out respectfully to involve their patients and communities in fostering health – and consumers become co-producers of their own care, who are adept not at making decisions, but also at requesting and managing information.

Key Concepts

Participants agreed that there are several key concepts that must be addressed for programs to succeed in ensuring women's access to integrated, comprehensive care. These concepts include a focus on sex and gender, culture, and income. Such a construct goes beyond the traditional medical model and recognizes that much about a woman's health is determined by her external life.

Sex & Gender Matter

After centuries of essentially ignoring women's health, treating women identically to men, or focusing solely on their reproductive capacities, the medical and public health fields finally concur that women's health matters, differs from men's health, and extends beyond pregnancy and child-bearing.

The **Ontario Women's Health Council** definition of women's health is: "Women's emotional, social, cultural, spiritual and physical well-being; determined by the social, political and economic context of women's lives as well as by biology; defined by women's perceptions and life experiences of health and illness, their values and knowledge, and their role both as users and providers of health care."

Biological research increasingly shows that sex differences are important in terms of health and health outcomes. Molecular and genetic mechanisms exist that underpin sex differences in illnesses. Beyond sex, *gender* matters; the experience of being a woman has profound effects on the context of women's lives and the way in which women seek and manage health care. The context of women's lives impacts their health. The primary strategy utilized by the participating programs is a recognition of the importance of sex and gender in women's health, and programming that incorporates these factors.

Income Matters

Socio-economic status has an enormous impact on an individual's health. Poor health can lead to reduced income: a person who is unexpectedly injured and loses her job will suffer economic losses that would not have occurred without the injury. But research demonstrates that, in most cases of poverty and ill health, the opposite influence is more critical: those who are low-income are more likely to experience poor health status than those who are wealthier. Poverty is a risk factor in illness. Dr. Bierman noted that there is a continuum from excellent to poor health that varies along income levels. This continuum is found internationally, regardless of the data set. Dr. Bierman remarked that, in Canada, income-related deaths are the second leading cause of death (in terms of potential number of years of life lost).

Dr. Bierman presented some startling statistics on this subject. Among women over age 65, 47 percent of those with less than an 8th-grade education report having "fair" or "poor" health, compared to just 16 percent of college graduates. Adjusted for age, 59 percent of women with less than an 8th-grade education have three or more chronic conditions, compared to 42 percent of college graduates. She noted that income is more

important than race or ethnicity in terms of health effects. Income is also associated with mental health: 21 percent of low-income women report that they are depressed “most of the time”, compared to just 8 percent of high-income women. The highest burden of illness is among low-income women, who are likely to have the poorest access to health care and the lowest quality of care.

Culture & Context Matter

Beyond gender and income, women's health determinants are affected by other factors that include: social networks, the physical environment, education, employment levels, working conditions, personal health practices and culture. The individual is affected not only by her own life, but also by what is happening with her family, neighborhood, community and State, as well as the nation as a whole.

“All diseases have two causes: one pathological and the other political.”
-- Rudolph Virchow

In terms of culture, this is the realm of the “isms”—classism, sexism, racism, ageism and other prejudices—that profoundly influence women's health. As an example, Dr. Bierman quoted a study published in *The New England Journal of Medicine*, in which actors describing chest pain presented for health care. African American women were much less likely to receive correct referrals than were other patients. In another example, luncheon speaker Dr. Diane Rowley, MD, MPH, from Morehouse College's Research Center on Health Disparities, noted that African American mothers are much less likely to be given information on preventing Sudden Infant Death Syndrome (SIDS) than Caucasian women are.

Research findings indicate that health care providers demean and alienate women of color, fail to answer their questions, and do not spend adequate time with them. It is not surprising that, for these women, health care becomes a stressor. Women who are not treated with respect and sensitivity by their providers are much more likely to avoid seeking care, to receive inadequate care, not to understand their providers' instructions, and to mistrust the medical system. A recent study found that 15 percent of patients with lower educational levels reported not understanding “all” or “most” of what their doctor said, compared to only four percent of those with higher educational levels. Thus, accessibility problems are compounded by the context in which care is provided to women.

As Dr. Rowley noted, higher exposure and risk prevalence is not an inherent quality of any particular population. It is a consequence of powerlessness and societal neglect. She suggested that poor health status among low-income and minority populations is acceptable in the U.S. because it conforms to the biased perception that these populations are “inferior” to the dominant, middle-class and Caucasian culture. Such a construct exempts society from addressing the enormous gaps in health outcome between the two groups.

Rectifying these problems requires adopting a more holistic view that explores and addresses the *context* in which care and services are provided. Comprehensive services are the only way to address the myriad factors that affect women's health and to ensure that they receive the mental, physical, and psycho-social services they need. The only way to create this type of model is through collaboration.

Strategies to Address Women's Health

The **Integrated, Comprehensive Women's Health Services in State Maternal and Child Health (MCH) Programs** has as its goal: to improve women's health and expand capacity in State MCH programs by (1) creating a focal point for the coordination of women's health programs and (2) establishing an infrastructure to improve women's health services through the creation of sustainable linkages and partnerships with community-based organizations, academic institutions, and federal, state and local agencies.

All of the programs represented at the meeting recognize the role of gender, income and culture on the women they serve. While they have differing strategies for how to reach their client populations, there are commonalities among the successful strategies to enhance women's health. These include promoting community-based empowerment; using appropriate materials and outreach methods; training program staff; fostering linkages on multiple levels; and

conducting advocacy to policy-makers and other stakeholders. The common strategies are described below, with examples generated from the participating programs. The examples are by no means exhaustive of the programs using a particular strategy – they are meant simply to provide an illustration of programs that use a given strategy or approach.

Community-Based Empowerment

As Dr. Rowley noted, too often public health professionals believe they do not need guidance on how to reach the community they serve. The participating programs know better, and recognize that the community itself must be an active participant in creating appropriate care. Community-based empowerment involves creating connections with community members. While there are many ways to be effective at this, participants agreed that the content of the efforts has *to be specific* to the community.

Engaging community members as leaders

Lauren Wolf, from the National Caucus and Center on Black Aged, noted that change comes from grass-roots control and local responsibility. Her program, the Healing Zone, was built on the recognition of the systems that are important to people. For many in the African American community, for example, churches are key in the community and seniors' lives. The Healing Zone builds upon this factor by engaging seniors as Health Advocates who run the program's Healing Circles and are trained to provide information and enhance participants' skills. The Healing Circles expand community-based empowerment and include the participants in information sharing and program activities.

The program has found that the senior participants are essential to the functioning of the Healing Circles.

Several programs used community health workers, also known as *promotoras de salud* (*promotoras*) who serve as program facilitators. These health workers are peer educators who come from the community and conduct outreach back into the community. Positive relationships and peer mentors are important in fostering women's health. The *promotoras* have walked in the same path as program clients and reflect the attributes of the people they serve. They are extremely successful in generating trust and connections with the community and the target client populations. Community health workers have been shown to improve clinical outcomes among program participants. Programs utilizing *promotoras* include the Mariposa Community Health Center, the St. Barnabas Hospital and Healthcare System, the Border Models of Excellence Initiative, Minnesota Department of Health, and *Border Vision Fronteriza*.

Several programs – including Alaska's Department of Health and Social Services and the Mariposa Community Health Center—noted that women are the primary stewards and gatekeepers for their families' health; by engaging women, the programs are able not only to provide women with health care, but also reach out to her entire family.

Sandra Gonzales reported that *Border Vision Fronteriza* (BVF) relies on the *promotoras* to provide outreach, health education, case management, and referrals. They are placed at strategic locations in the county, such as Federally Qualified Health Centers, public health offices, public schools, and behavioral health organizations. She noted that the women who serve as *promotoras* for the Mariposa Community Health Center were recruited from the community neighborhoods; about 40 percent of them previously had been health center clients. Dorii Gbolo, of the Minnesota Department of Health, noted that the *promotoras* model can work with both rural and urban communities; her program has found the model to be effective in encouraging immigrant populations to access care and increase their service utilization.

Fostering ownership among participants

Meeting with program participants is an important way to engage and involve community members. Sharon Leahy-Lind, of the Maine Department of Human Services, described her program's efforts to survey Maine state employees on their care-giving needs. Conducting the survey served as a catalyst for the program to hold meetings throughout the community. At the meetings, people had the opportunity to learn more about State programming, and get connected to appropriate services such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Janet Schadee noted that the Indiana Women's Prison also engages and fosters participants' ownership. The incarcerated women in the program are responsible for keeping the prison safe for their visiting children. The Prison's Children's Center was, in fact, built by the female inmates.

Placing decision-making power in the hands of participants

Maria Girlando, from the Research Triangle Institute's Center for Health Promotion, noted that community members must be engaged not only in program activities, but also in other aspects such as program design and evaluation. It is important to have a community member look at the evaluation tools and be involved in the process to ensure cultural competency and sensitivity. Many tools are not culturally sensitive, and making materials appropriate involves more than just translating them from English.

To ensure inclusiveness, programs ensure that community members have real decision-making power and leadership positions. Diana Chiaverini, of the Magee Women's Hospital of the University of Pittsburgh Medical Center, described the involvement of women with disabilities on their Advisory Committee. Eva Moya, of the Border Models of Excellence Initiative, reported that the program turned to the *promotoras* to select the best intervention models in a recent competition. These community health workers

The Indian Women's Health Demonstration Project for American Indians and Alaska Natives has, as its goal: (1) to enhance the health services for American Indian and Alaska Native women by expanding on existing services or programs or by building new capacity through activities that integrate or promote collaboration among existing services and, (2) to fund community-based and culturally appropriate programs with measurable outcomes.

selected the 16 finalists to receive grants from the 62 applications the Initiative received.

Appropriate Materials & Methods

Another effective strategy adopted by the programs is the use of appropriate outreach and educational materials and methods. Use of

community health workers/*promotoras* is one example of using an effective, appropriate outreach method. As noted, these peer educators can provide health education, training, and link clients with care in a way that traditional health professionals cannot.

Using culturally appropriate outreach materials and methods

Providing materials in native languages is a critical way to disperse information in underserved communities. Dr. Maria Hernandez Peck, of the Eastern Washington University Center on Aging, described how the Center used the input of Spanish physicians to develop culturally and linguistically appropriate materials focused on specific health topics. Zavi Brees-Saunders, from the Kokua Kalihi Valley CCOE, noted that the Center's staff speak 17 languages and uses community volunteers (including students) as translators. When a client comes to the clinic, the staff member—even senior staff—who can speak the client's native language serves as an interpreter. She noted that it is not culturally appropriate to use family members as translators, as this jeopardizes confidentiality.

Fostering health literacy is a key goal of providing materials to the community. Even women with good skills can find it difficult to understand health care providers and access information and services. Translation may be only the first step in information provision. Using innovative formats can also help reach populations. For example, Dr.

Hernandez Peck reported that the Center on Aging uses *photo-novellas* – a popular publication that is part comic book, part soap opera – to provide information in Hispanic communities. Spanish-language CDs and audiocassettes are also used for cancer education. The CDs/audiocassettes explain screening, diagnoses, and interventions in a format that fosters privacy and enables repeated listening.

Materials must be available throughout the community. The Center on Aging provides information over the radio and distributes immunization materials in numerous local stores, such as bakeries and grocery stores. The Mariposa Community Health Center distributes materials at food banks, WIC offices and senior centers. The Center uses *promotoras* to conduct outreach, and has also had success with mailings. While mailings are often cost-prohibitive in urban centers, they can be an effective outreach tool in rural areas.

Kim Sanders, of the Northeast Ohio Neighborhood Health Center, noted that her program for incarcerated women uses weekly workshops as a way of providing regular information and skills to participants. Health topics include pregnancy, family planning, smoking cessation, child abuse, self-esteem, relationships, and fatherhood. Additionally, the workshops offer motivational movies and poetry readings to engage the participants.

Ms. Brees-Saunders listed several other tips for ensuring that encounters are culturally appropriate for immigrant populations. These include allowing sufficient time for interpreted sessions, avoiding the use of jargon and technical terms, being prepared to repeat questions, and recognizing that clients may have different health belief systems.

Engaging with participants at appropriate times

Appropriate methods include the timing of program delivery. The Indiana Women's Prison links incarcerated women and their families with services both during and after incarceration. Discharge activities are an important consideration, Ms. Schadee noted, as the first 72 hours after release are very stressful for women and is the time when re-incarceration is most likely. The Northeast Ohio Neighborhood Health Center also conducts assessments for women about to leave prison so they can adjust to life outside of prison and be linked with health care, housing, and family and child services.

For some programs, being attentive to appropriateness means holding back and waiting for an invitation to become involved in the community. Tracy Weitz, of the University of California at San Francisco, noted that her CoE waits for an invitation from the community, so the university is not seen as pushy. The Center is very cognizant of the need to demonstrate that it is not continuing a traditional academic role in which the community is used for research and the university does not give back in exchange. The Center is working to promote a shift into a system where research is used to support relationships and the community. Dr. Weitz stated that the Center undertakes projects only when there is a community-defined need; appropriate and important roles exist for all partners; the project supports established relationships; and resources are shared. Using appropriate methods, in this instance, meant that the Center engaged in a skills

transfer with the community. The researchers shared how they look at data and the community described what the data meant. Because of the respectful approach, both sides benefit.

Administering programs effectively

Appropriate methods can effect program delivery for clients, or the way the program is administered. The Alaska Department of Health and Social Services is conducting a pilot project with a local Community Health Center (CHC). This project uses a Continuous Quality Improvement (QI) model to ensure appropriate delivery of services at the center. The QI model is being used to improve services and create a client-centered, comprehensive health and social service system that is responsive to the individual needs of the clientele. As part of the QI model, the program created a "how to" manual that can be used by other CHCs and health care settings, and has hired a full-time Disparities Coordinator.

The Health Disparities Among Minority Elderly Individuals – Technical Assistance Centers has, as its goal: to advance knowledge and increase the effectiveness of future efforts to eliminate health disparities among racial and ethnic minority populations.

Staff & Volunteer Training

Training for community health workers

Many programs are committed to training the program implementers to enhance their skills and abilities. The Health Zone's Senior Health

Advocates, for example, are trained in developing topics for use in the Healing Circle and in how to lead the groups. Participants noted that community health workers may not see themselves as having skills and competencies, and that part of the training process involves building their confidence. Programs that use community health workers provide training and some expand training with the goal of helping promote the health workers into administrative functions and jobs. The Eastern Washington University Center on Aging conducts Training of Trainers, which is lead by bilingual staff with a public health background. The Minnesota Department of Health conducts a training program, sponsored by Blue Cross/Blue Shield and the Robert Wood Johnson Foundation, that includes a certification program for community health workers.

Training for service providers

Service providers may also need training on the culture, language, and health beliefs of the clientele. Providers need help learning how to talk with their patients and give instructions so that patients receive the best possible care and are empowered to promote their own health. Dr. Stacie Geller, of the University of Illinois CoE at Chicago's Center for Research on Women and Gender, noted that her program works on training professionals, providing them with clerkships and other opportunities to learn better skills.

Linkages Between Partners

A key strategy used by all programs is to foster linkages. Multiple levels of intervention are necessary and should address personal, organizational, community, health system, environmental, and policy factors. Dr. Bierman described most health determinants as existing outside the health care delivery system – these determinants include education, housing, and social policies. To foster health, linkages between researchers and the community are essential to creating community-based and participatory research that is truly collaborative and demonstrates best practices.

Dr. Bierman also noted that the health system needs to shift to promoting linkages across the life course, and focus on women's life stages rather than disease conditions. Linkages among different health providers – such as physical and mental health care providers— are critical to an effective and holistic approach. Working across disciplines and sectors — and conducting parallel efforts among basic, clinical, social science, public health and health services—will aid in this effort.

Local partnerships

Partnerships among local health care providers and other service sectors is an important strategy used by many participants. The Indiana Women's Prison's program goal is to develop an agency infrastructure that promotes positive health behaviors and simplifies integration of health education and services. The community and prison work together to provide integrated education and services. Community-based organizations, which are used to a high level of "no-shows", are happy to provide services to prisoners, because these women actually attend their sessions. The collaboration works because it builds on assured access to a high-risk population that needs the services that the community agencies are required to provide. The prison staff are accessible to the community service providers to assist in service delivery as well.

The Northeast Ohio Neighborhood Health Services program also uses a community collaboration model to provide services to incarcerated women. The "High Risk Team" consists of five social workers who collaborate with the health center and the prisons. Program strengths depend upon forging close relationships with multiple health and social agencies. The program works closely with the medical team to provide health services, and also partners with the Cleveland Department of Public Health and the Cuyahoga County Corrections Center. Important additional partnerships include the juvenile detention center, AIDS Task Force, Residential [substance abuse] Treatment Center, Children and Family Services, the Department of Justice Affairs and Hospice of Western Reserve.

Gina Gilliland, of the Northeast Missouri Health Council CCOE, stated that their program has created linkages among six community-based providers, each of which offers specific services to the clientele in eight rural counties. The CCOE specifically works to overcome the traditional system of fragmented care that existed in the area and has been successful in integrating services in the area. The CCOE funds six partners to

address key areas: a research coordinator, domestic violence service provider, health council, mental health counseling, the Area Health Education Center (AHEC) and the hospital. Ms. Gilliland noted that the key to success was to build partnerships early and formalize them through Memoranda of Understanding (MOUs). The group members communicate regularly and have created an effective Advisory Board.

In order to keep collaborations like this working, it is important to communicate on a regular basis. The Minnesota Department of Health's Collaborative Partnership provides vision, guidance and advisory support to the Women's Health Coordinator. The Partnership's Project Management Team meets on a regular basis to plan, implement and assess the work needed to meet the goals and objectives of the grant. The Partnership also has a Literature Review Work Group, whose members analyze research to identify best practices in women's health and share this information with the demonstration sites and the Partnership.

Partnerships across governmental agencies and academic institutions

Many programs attempt to foster collaboration among different sectors of the same institution – usually State government agencies or academic departments in a university.

The National Centers of Excellence (CoE) in Women's Health Program has, as its goal: to develop and evaluate model health care systems that integrate clinical and preventive health care services, research, community outreach, professional education and training, program evaluation on women's health, and initiatives to foster the recruitment, retention and promotion of women, including minority women, in academic medicine.

These are segments of a larger community that has not typically collaborated to promote women's health.

Dr. Geller noted that the Centers of Excellence (CoE) are intended to transform the culture of academic centers and enable them to improve women's health. The model has expanded the scope of service provision and improved the

system's responsiveness to patients with conditions that require input and consults from several disciplines. It has fostered linkages between specialties that usually do not communicate, such as cardiology, internal medicine and family medicine. In Illinois, the Center has helped to establish a focal point for women's health in the state and increased awareness of women's health issues across program areas. Dr. Geller noted that there was no State-wide department of Women's Health before this project created a home for one.

The Alaska Department of Health and Social Services' Women's Health Program has enhanced the infrastructure of women's health within the State government and improved collaboration, efficiency, and program effectiveness. The Program supports and coordinates the Alaska Women's Health Partnership (which includes governmental and non-governmental members) and works to foster coordinated and culturally competent care. The program holds bi-monthly meetings that are open to all and focus on methods for improving services. The members take turns presenting on local service delivery, a practice that fosters discussion and information-sharing. The Partnership also convenes workgroups and subcommittees focused on defined topics (current subgroups include Unintended Pregnancy Prevention, Preventive Health Services, and Women's

Advocacy.)

Ms. Gonzales' program partnerships serve to identify and resolve issues around access to Medicaid services. The program has built strong collaborations across government agencies that include the Office of Border Health, Members of Congress, Children's Youth & Family, Juvenile Justice Services, public schools, the Social Security Administration, the Vital Statistics Department, and—most recently—the Children's Court Judge.

Cooperate across borders

Health and social problems are not confined by national boundaries. Several meeting participants represented Canadian and Mexican programs. These participants were eloquent on the need to share information, resources, and best practices across borders.

Representatives from across the Northern border concurred that the Canadian health care system faces many of the same challenges that the U.S. does. While Canada's national health system provides at least some coverage to all individuals, the country has the same form of fragmented and medical model as the U.S., and disparities follow the same orders of magnitude in both countries. Moreover, the same "isms" and barriers result in unequal access to quality health care—particularly for minorities—on either side of the border. There is much the two nations can learn from one another about overcoming disparities and ensuring that all individuals have access to appropriate and timely care.

Meeting participants also described the enormous needs of those who live along the U.S.-Mexico border, especially those residing in *colonias*. Immigrant minority women face numerous challenges to protecting their health. Eva Moya stressed that if the U.S.-Mexico border area was a State, it would rank first in the nation for levels of poverty, tuberculosis, children living in poverty, and the number of under- or uninsured residents. Any effort to address the multiple social, economic, public health, environmental, and educational problems in the region must involve cooperation between the two national governments. The Border Models of Excellence Initiative was specifically created to identify and promote best practices across the borders.

Advocacy to Decision-Makers

Several participant programs also engage in advocacy to policy-makers and other stakeholders. Many noted that legislators need information about women's needs, effective programs, and the critical lack of funding for preventive services. Milta Vega-Cardona, of the St. Barnabas Hospital and Healthcare System CCOE, described how her program educates legislators through hearings on women's health. The program also examines state and national policies and regulations to assess how much funding is directed at prevention and education compared to intervention. Their goal is for State legislators to designate funding for community-based education and intervention using peer educators. The Magee Women's Hospital CoE of the University of Pittsburgh Medical Center engages in advocacy to State leaders and legislators as often as possible.

For example, the program has highlighted for legislators the need to fund emergency transportation, such as in instances of domestic violence.

Ken Bostock, of the National Asian Pacific Center on Aging, described advocacy as critical to the Center's efforts to expand services (such as food stamps) to immigrants. The organization has held town hall meetings that connect policy-makers with community members, and feature sessions that help legislators learn about problems faced by Asian/Pacific Islanders. The meetings use simultaneous translation to reinforce the populations' needs. Mr. Bostock noted that a major challenge in conducting advocacy is to overcome legislators' lack of awareness about the realities of the lives of low-income, minority, and other disenfranchised people. It may be hard for legislators to understand the difficulties that immigrants have, for example, in understanding the social service system and nomenclature. He cautioned that any organization that engages in advocacy must be prepared to pick their battles carefully and sustain their energy creatively.

Common Challenges

Funding & Sustainability

By far, the biggest challenges faced by the programs are insufficient funding and uncertain sustainability. Resources are, generally, lacking for programs that focus on comprehensive, integrated, preventive services for women. It is hard not to view this lack

The Border Models of Excellence, U.S.-Mexican Border Health Commission has, as its goal, to recognize community-based health programs/projects and initiatives along the U.S.-Mexico border that feature Community Health Workers/Promotoras.

of funding as a reflection of the relatively low value society places on women – particularly those who are low-income, minority, disabled, and/or incarcerated. As one participant noted, “We’ve found that it’s possible to raise *lots* of money for research, but not for prevention. This comes from the

top levels of academic institutions, which value research as a way to get money from the federal government.” The low levels of funding mean that staff engage in a significant amount of uncompensated work, which is another stressor.

Despite the cost-effective nature of these programs, funding issues affect the national, State and local levels. For example, Dr. Geller noted that Illinois currently has an hiring freeze for government positions and faces a multi-year budget deficit, both of which affect funding for her program and partners. Dr. Bierman noted that the best strategy for funding is to build the evidence that *proves* something works. Documenting partnerships, innovation and effectiveness are key to getting resources. Potential funding sources referenced include HRSA; State family service programs, health department, Title X programs, perinatal networks, and local community groups.

Evaluation

Evaluation that assesses the implementation, effectiveness, and efficiency of public health programs is essential to continued support for such programming. Evaluation results are used by policymakers and program planners to make decisions about administration and funding of different public health strategies. Evaluation results also impact changes that can improve programming, replication of effective strategies, and dissemination of best practices to others.

Overcoming the lack of data

Despite the importance of evaluation, it remains a challenge for program participants. The meeting attendees noted that there is a dearth of national data that are relevant to women's health and life experiences. Without solid national data, it is hard to draw conclusions about the risks faced by sub-populations, or the effectiveness of specific interventions. Dr. Wanda Jones, Deputy Director Assistant Secretary for Women's Health, noted that the federal government is poised to release a tool that offers State- and county-level data for both genders, categorized by race, ethnicity, socio-economic status, education, and other factors. The tool is available at www.4woman.gov.

Programs have found that they may need to create new data collection tools to effectively measure their work. The University of Illinois at Chicago's (UIC) Center for Research on Women and Gender's health services task force develops measures across the women's programming to streamline data collection. The program has developed a template for health care providers in the State. Dr. Carol Weisman, of the Hershey Medical Center's College of Medicine, stated that her program had to develop its own gender-appropriate women's primary care satisfaction tool because none previously existed.

The UIC Center for Research on Women and Gender collaborates with other researchers and departments (both within and outside of the sciences) that have not worked together before. The Office of Women's Health created the Research Coordinating Centers to link CoEs and CCOEs. These collaborations have helped the Center recruit more diverse populations into research programs, foster broader research across sites, and facilitate the Center giving back to the community as well.

Engaging stakeholders in a meaningful way

The participants all stressed the need to engage community members in programming, and evaluation is no different. Ms. Girlando noted that it is important for community members to be involved in the evaluation process and examine the evaluation tools. This will both foster engagement among community members, and help ensure cultural competency and sensitivity of the tools. Many tools are not culturally sensitive and she stressed that creating effective tools requires more than translating something into another language. Nuances of meaning, dialect, and health beliefs must also be factored into tool development.

Making the connection with the policy realm

Participants specifically noted that evaluation is important in shaping policies that affect the health care system. Evaluation can assess not only programmatic effects on specific women, but also on the health care environment as a whole. Evaluation should explore the financial incentives and other organizational issues that drive health care delivery and outcomes. Useful research questions include: how does the way in which the system is funded affect individual outcomes? What is the most cost-effective approach to solving specific problems? Participants noted that evaluation and data gathering must be included in projects from the very beginning, or sustainability will be jeopardized.

To this end, linkages between researchers, policymakers and providers can help increase our understanding of the impact of health care policies. This, in turn, will build evidence for effective policy interventions. As Ms. Leahy-Lind noted, in describing Maine's state employee survey on care-giving, evaluating the current situation was a necessary first step in demonstrating a need and galvanizing a political response.

The Difficulty in Showing Results

Demonstrating effectiveness through impact assessments

Dr. Weisman noted that there are several major threats that challenge these programs' ability to demonstrate effects. Soliciting information from participants during the pre-test may have changed them, even without the impact of program components. Changes might have happened anyway, regardless of the program's existence. Alternatively, something else might have occurred in the community to caused changes. External factors (such as funding, resources, and politics) can influence programming and clients. In addition, the program participants may be different from their peers in some way that led them to participate in the program.

The lack of control groups and randomization also makes it hard to specify changes that resulted from particular programs. It also takes a long time for changes to become visible; many evaluations do not last long enough to identify these programmatic effects. In short, because comprehensive women's health programs usually encompass multiple components, evaluation must address complex logical and research questions.

Tracking client outcomes through process assessment

It is much easier to track individual client outcomes than to assess the broad scope of a program. This is time-consuming, however, and can require persistence. For example, the Northeast Missouri Health Council has been successful in following CCOE clients and linking outcomes to evidence-based outcomes. The program tracks how many patients have been seen, the number of referrals made, and what the impact has been on the individual client. The program is forced to collect utilization data by hand and over the telephone, however, to compensate for a lack of an electronic medical system. *Border Vision Fronteriza* uses a contact form to identify client needs, systematize the referral

process, and provide information to clients. The program follows-up with the family after 30–45 days to ascertain enrollment and ensure enrollees are accessing services.

Forging Connections to Increase Effectiveness & Access

As noted, these programs recognize that linkages and partnerships are key to effective services. But networking requires ongoing communication and effort, which can sometimes challenge over-worked staff.

Generating buy-in among partners

It is essential to ensure that all collaborating partners are committed to the program goals. Without this buy-in, the program will eventually lose energy and fall apart. Educating staff about the program, involving them in decisions, and making sure that they feel comfortable with the process are all critical steps in creating an effective program.

Dr. Geller noted that this can be particularly challenging when the partnership involves a dominant organization and subcultures among members. Efforts take time and sometimes require a shift in organizational cultures. Ms. Weitz also noted that collaboration is challenging when the partners are not equals. Part of this is an economic issue – where one partner gains more from the project, the inequities must be discussed and understood in order to prevent resentment from interfering with the program. There are also inequalities in power – decision-making, hiring, setting programmatic directions – that must be clarified, accepted, or altered before partnerships can become smooth.

Part of generating commitment is to persevere with organizational relationships despite frequent turnover among staff. Ms. Weitz noted that relationships are with people, not the organizations themselves. Changes in staffing and leadership necessitate forging new relationships, which is time-consuming. Without making this effort, however, the entire partnership will weaken and eventually become ineffective.

The High Need for Services

Clients' needs are often overwhelming, which also present challenges in delivering effective services. Sandra Gonzales, of *Border Vision Fronteriza*, noted that common barriers for women include language and translation issues, lack of health insurance, unfamiliarity with available services, and shortage of transportation. She commented that migrant, factory and service workers are particularly vulnerable to these barriers. In addition, rural and immigrant women are likely to experience both social and cultural isolation that impact their health.

Immigrant minority women face numerous challenges to protecting their health. Eva Moya described the stark health conditions for those who live along the U.S.-Mexico border area. These residents need assistance with challenges that may well include lack of housing, education, insurance; daunting health risks such as obesity, diabetes, and mental illness; and high levels of stress, poverty and unemployment. The attempt to address

these multiple factors can be overwhelming for even the most effective program. Although only comprehensive and integrated services have the capacities to meet these enmeshed needs, it is difficult to fund and coordinate these programs.

Meeting participants described other specific populations that have very high needs for targeted and integrated services. Ms. Chiaverini noted that, to effectively serve disabled women, medical and social services must communicate and triage clients into the most efficient services. Dr. Michelle Berlin, of the Oregon Health and Science University CoE, stated that age-adjusted unintentional death rates are 80 percent higher in rural areas as compared to urban areas, and that rural women are more likely to suffer from coronary artery disease, hypertension, and cancer than urban women.

Incarcerated women also have enormous needs for integrated services. Programs that work with incarcerated women report that most were physical or sexually abused as children, compounding their physical and mental health challenges. The Northeast Ohio Neighborhood Health Center CoE has discovered that women who are released from prison often have multiple health problems (including mental illness) and very few supports. The Indiana Women's Prison found that many women in the prison have only elementary-school level educations. These women, who have multiple physical and mental health needs and lack education and skills, have high needs for integrated services.

For all of these women, the lack of accessible, appropriate, affordable, and culturally sensitive care can be an insurmountable barrier to good health. Programs work to translate their messages, reach out to the community, and link providers to yield comprehensive care. Regardless of how well the programs work, however, the enormous challenges faced by the clients and their high needs for services can be overwhelming and tax the system.

Lessons Learned

Both the common approaches/strategies and the typical challenges faced by these programs yield important lessons for those wishing to provide integrated, comprehensive services. These lessons are listed below:

Collaboration is key, but difficult

- Partnerships and connections are essential to generating funds and ensuring sustainability.
- Multiple levels of linkages between programs and organizations are necessary to address the myriad personal, organizational, community, health system, environment, and policy factors that impact health.
- These collaborations should include partnerships between and among community-based organizations, academic departments, governmental agencies, and other entities.

- Addressing bureaucratic systems (whether they are academic, governmental or organizational) is time-consuming, but vital to laying the groundwork for effective and sustainable programs.
- Documenting partnerships—including innovative and effective processes and programs—is key to getting resources and support.
- Inequities between partners (such as those around funding and/or decision-making power) must be discussed and understood in order to prevent resentment from interfering with programmatic goals.
- Powerful organizations (such as universities) might need to address past inequities or problematic relationships with other community members before true collaborations can occur.
- Staff buy-in is essential; partnering programs' staff need to be trained and engaged so that they understand the program, share in the mission, and can work effectively to serve clients.
- Programs must expect turnover among key staff and be prepared to foster new relationships to keep collaborations strong.

Information sharing is essential

- Programs should report their own experiences and research results, as a means of helping others to learn best practices based on evidence.
- Publishing research results and information about best practices can help other programs institutionalize effective strategies and avoid reinventing the wheel.
- Advocacy to policy-makers and other stakeholders helps share information about women's needs, raise awareness about effective programs, and engender support for funding for comprehensive and integrated services.
- Community members can be effective advocates in educating and reaching stakeholders who make the final decisions on program funding, administration, and implementation.

Community involvement can make all the difference

- Program participants and other community members can be critical assets for making programs stronger and outreach more effective.
- Clients and community members must be valued by staff; treated with respect, and involved in program design, administration, outreach, and evaluation.
- Community health workers, also known as *promotoras de salud*, are an important way to engage hard-to-reach communities and provide information and linkages to care.
- Outreach materials and methods must be culturally appropriate and sensitive. Examples include community health workers, materials in native languages, *photo-novellas*, CDs/audiocassettes, and interactive workshops.

Effective program administration requires both focus and direction

- Program planners must remain focused on selected goals and pick their battles to prevent burnout and diffusion of energy.
- When multiple implementation sites are used, each one is likely to be unique and to face specific challenges that require attention; a one-size-fits-all approach is unlikely to be successful.
- It is important for programs to have an advocate and protector—preferably located within the administering organization—who can serve as a broker for the program.

Evaluation matters, but can be challenging

- Evaluation activities should be built into program plans from their initiation; funding evaluation activities is an important way to demonstrate success and access additional program funds.
- Lack of data on women and various sub-populations makes evaluation hard; program staff may have to create new data collection tools to effectively measure their work.
- Evaluation plans must address challenge that include lack of control groups, high expenses, and the long time frame for expected behavioral and health impacts.
- Many find that tracking client outcomes through process assessment is simpler than conducting impact assessments, but programs may need technical assistance on both facets of evaluation.

Programs must address underlying and tertiary causes of poor health

- Addressing the “isms”—classism, sexism, racism, ageism, and other prejudices—is essential to promoting women's health.
- Effective programs address the role of gender, race, ethnicity, income and other factors on their female clients. These programs seek to ameliorate negative factors that may arise from her harmful physical environment, low educational level, lack of employment, poor working conditions, and non-beneficial personal health practices.
- Comprehensive programs must address women's primary access to services, such as barriers resulting from cost, accessibility, and transportation problems.
- Programs must also address secondary access to services, such as a woman's ability to make an appointment with a necessary specialist.
- Tertiary access issues are also critical; programs must ensure that women are treated with respect and receive appropriate and culturally sensitive care.

Conclusion

The challenges faced by those who wish to provide integrated, comprehensive services are daunting, but the rewards are enormous. Programs of this nature can be effective in

overcoming the myriad social and environmental problems women face, and in making real differences in the lives of their clients.

Interdisciplinary collaboration and enhanced linkages and partnerships improve the delivery of comprehensive care to women. These programs also provide a blueprint for necessary changes in how health care is provided and how clients are treated in this country. An integrated, comprehensive model for women's health care is, at its core, about fundamental systems change.

The six programs featured in the meeting are laying the groundwork for demonstrating that providing preventive health care that is both community focused and engaged can eliminate the unequal consequences of poor health care and raise the standard of living for women and their families.