

# Compendium of Rural Best Practices/Models

Communities along the border,  
including practices in clinical setting



National Rural Health Association



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**Compendium of Rural Best Practices and Models**

**Communities along the border, including practices in the clinical setting**

A document developed by the Border Health Initiative

## Preface

The National Rural Health Association (NRHA) Border Health Initiative is continuing activities to encourage the development of improved access to quality health care services for rural Hispanic populations along the U.S.-Mexico Border. The basis of these efforts is the ongoing collaboration with groups dedicated to the same mission. This *Compendium of Rural Best Practices and Models* is a product of that collaboration. The initiative's effort is primarily intended to share and highlight communities along the border with models that can be built upon. It is a structured document designed for their ongoing use and modification to meet their specific needs. It can also be used in a prescriptive manner by federal agencies, states and local health and health-related agencies for setting priorities for rural border communities.

The compendium is representative of the NRHA Border Health Initiative's activities to encourage the development of improved access to quality health care services for rural populations along the U.S.-Mexico Border.

**Community Access Program of Arizona-Mexico**  
**www.rcfbh.org**

**Service area: Arizona**

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**Purpose:**

The Community Access Program of Arizona-Mexico (CAPAZ-MEX) discount network membership is a program available to Yuma County residents who have income levels too high to qualify for health programs such as AHCCCS, yet cannot afford traditional health insurance. The discount network is not an insurance program; members will self-pay based upon pre-negotiated discounted rates.

**Overview:**

CAPAZ-MEX is a medical safety net to the uninsured and vulnerable residents of Yuma County. The program facilitates access to professional health care at a discounted price to uninsured population on both sides of the border in Yuma County, Ariz., and San Luis Rio Colorado, Sonora, Mexico.

The system provides members with a medical home for primary and preventive health care. In addition, CAPAZ-MEX discount network provides a discount for specialty, diagnostic and inpatient care. It is an opportunity for members to participate in their own care by allowing affordable care, provided by Yuma County health care providers, at a greatly reduced price. CAPAZ-MEX is a discount network in which the member is responsible for payment to the health care provider at the time of the visit.

Perspective members are screened to insure the 100-400 percent of the federal poverty level and then enrolled in a low annual fee health care discount program. The member is made aware of his/her responsibility for payment for health care at a discount rate.

The qualified member is then assigned a medical home for primary health care with one of the participant primary care health providers in Yuma County and/or San Luis Rio Colorado, Sonora, Mexico. If the member needs a specialty health care provider, diagnostic, testing or inpatient care arises, the member is referred to a participant health care specialist where the member will obtain services at a discounted rate.

**Summary:**

The Regional Center for Border Health (RCBH) faced several challenges to the success of the CAPAZ-Mex program. The challenges were to have enough staff to promote the program and enroll members of the community, to convince and recruit doctors to provide the 65 percent discount of Medicare rates as well as to recruit doctors in Mexico. However, the challenges still continue in ensuring members re-enroll in the program and having enough personnel to complete the task. RCBH staff constantly update the list of doctors, adding new providers and deleting any who no longer wish to participate.

**Effectiveness:**

RCBH has more than 3,000 members enrolled in the program. The program has been a success where members benefit from obtaining health care discount services in both Yuma County, Arizona and in San Luis Rio Colorado, Sonora, Mexico.

**Funding:**

The program is self sustainable. Members pay their annual fee out of pocket to belong to the CAPAZ-Mex network and receive discounted health care.



# Chiricahua Community Health Centers Pediatric Center of Excellence

[www.cchci.org](http://www.cchci.org)

Service area: Arizona

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## Purpose:

Chiricahua Community Health Centers Inc. (CCHCI) set out to establishment of a high quality medical home that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective for children and their families who reside in the rural borderlands of southeastern Arizona.

## Overview:

CCHCI's rapidly developing pediatric programs are based on an ambitious adoption of the pediatric medical home model, as defined by the American Academy of Pediatrics at [www.medicalhomeinfo.org](http://www.medicalhomeinfo.org). Although the medical home is a concept and not a building, the actual renovation of a historic school building (15<sup>th</sup> Street School in Douglas, Ariz.) into a pediatric center of excellence (PCE) will provide the quality space and inspirational environment conducive to innovative program development, recruitment of highly-qualified personnel and funding acquisition. Although high-quality medical care will be the basis to planned services, much more comprehensive services are woven in the fabric of the PCE's design, including care coordination, specialty clinics, ancillary medical services (dental, speech/physical therapy, etc), community outreach, prevention programs, research, medical education/mentorship and advocacy. In addition, the PCE recognizes not all children and their families are able to travel to the physical location of the

PCE, and therefore the same quality pediatric services will be integrated throughout the CCHCI network of health centers. Of note, a state-of-the-art mobile medical clinic brings care to populations that for whatever reason do not currently have a medical home.

## Summary:

**Successes:** Incredible community support as evidenced by the overwhelming vote in November for the transfer of the 15<sup>th</sup> Street School to CCHCI, featured as a charity on the program *American Idol Gives Back*, gift of a state-of-the-art mobile medical clinic from The Children's Health Fund.

**Challenges:** The established medical community feels threatened by the success and notoriety of this program. Patients are choosing this practice model over the more limited traditional medical clinic.

## Effectiveness:

The impact of risk factors on children is cumulative. Multiple risk factors (deficient access to

care, continuity of care and comprehensiveness of care) have a clear relationship to suboptimal health status. Children with the highest level of health care need are often those with the most compromised access to care. The key environmental determinants of a child being medically underserved include economics (family income below 200 percent of the federal poverty line and no or inadequate insurance), geographic (low density rural residents, HPSA, limited or no access to public transportation, lack of safety net providers), and psychosocial elements (vulnerability, domestic violence, maternal depression, limited English language proficiency, single parent households, low health literacy and toxic stress).

CCHCI's Pediatric Center of Excellence is not a building, house or hospital but rather an approach to providing care in a high-quality, cost-effective manner.

## Funding:

Bureau of Primary Health Care/Health Resources Services Administration, The Children's Health Fund, American Idol Gives Back



# Cochise County Health Department-Binational Border Health Program

[www.cochise.az.gov](http://www.cochise.az.gov)

## Service area: Arizona

### Contact information:

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### Purpose:

The program links the Cochise County Health Department (located on the U.S.-Mexico border) and its counterparts at the Ministry of Health in Sonora, Mexico, and at Mexican clinics along the border to provide solutions to issues that may arise between these health systems.

### Overview:

In response to cross-border needs, the Cochise County Health Department maintains the Binational Border Health Program, the only program of its kind, at a local health department in Arizona. In 1992, the Northeast Sonora/Cochise County Bi-National Health Council was established, and the program coordinator of the Binational Border Health Program serves as co-president. The Binational Health Council serves as a forum where health care professionals and community members from both sides of the border address mutual health concerns. The Council's purpose is to establish, cultivate, and promote interest and mutual assistance among different disciplines and groups for the United States-Mexico border community. It also promotes mutual cooperation on local, regional or international health problems and facilitates local education and training of health care professionals and community members. Specifically, the Health Department's Binational Border Health Program Coordinator works with the Health Department's Bioterrorism Preparedness Program in the area of cross-border disease surveillance. During quarterly Council meetings, health care providers from Sonora and Cochise County share syndromic surveillance information and data.

### Summary:

One product of this partnership was the development of a fact sheet distributed to all local health departments in Arizona to address myths and facts surrounding vaccines

and immunization schedules in Mexico and identify which Mexican vaccinations are acceptable in Arizona. This fact sheet provides succinct information about the norms and protocols that health care providers follow in Sonora and reviews the jurisdictional issues for Arizona clinicians and providers. Another accomplishment was the invitation to contribute an article regarding the binational program by the National Association of County and City Health Officials' quarterly publication for their spring 2009 issue on the theme of international public health.

Other joint projects of the Binational Health Program are the Binational Teen Mazes, sponsorship of an annual National Infant Immunization Week campaign in conjunction with the Centers for Disease Control and Prevention, and Border Binational Health Week, a partnership with the U.S.-Mexico Border Health Commission; events with either a binational health conference or binational health fair to promote sustainable partnerships to address border health problems which include diabetes, obesity, teen pregnancy and immunization just to name a few.

The biggest challenge is communication, both linguistic and systemic. In addition, travel restrictions have been a constant challenge. On the U.S. side, the ability of staff to travel to Mexico is limited due to the uncertain security system. On the Mexico side, the ability of some professionals to travel to the U.S. to attend meetings in Cochise County has been a logistical challenge.

### Effectiveness:

The person-to-person communication between professionals in Cochise County and Sonora provides the immediacy and continuity that solutions to mutual challenges require. Formally structured programs and cross-border organizations combined with interpersonal professional relationships and deep mutual respect provide the basis upon which two different health care systems interface with one another along the border; not only is this a public health necessity, it is also a symbiotic and mutually enriching partnership.

**Funding:**

Cochise County Health Department, Cochise County Health Department's Bioterrorism Early Warning Infectious Disease Surveillance (EWIDS) Program, Cochise County Health Department's Teen Pregnancy Prevention Program for the Teen Maze, the U.S.-México Border Health Commission.



**Southwest Public Health Leadership Institute: Leaders across Borders  
at the University of Arizona Mel and Enid Zuckerman College of Public Health  
[www.publichealth.arizona.edu/healthleadership/leadersacrossborders](http://www.publichealth.arizona.edu/healthleadership/leadersacrossborders)**

**Service area: Arizona**

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**Purpose:**

To improve the health of communities and promote health equity in the United States-Mexico border region.

**Overview:**

Leaders across Borders is an advanced binational leadership development program designed for health professionals and community leaders working in the United States-Mexico border region. Its purpose is to improve the health of communities by strengthening public health leadership capacity, addressing transborder health concerns, and developing a dynamic network of public health professionals in the United States-Mexico border region. It does this through a unique, multifaceted program that empowers participants to hone their personal, team and transborder collaboration skills. The program includes:

- Three face-to-face learning events featuring expert speakers from both the U.S. and Mexico addressing border/binational culture, health systems and leading health concerns; leadership; health diplomacy; and advocacy. Simultaneous translation is provided for all face-to-face events, and written program materials are available in English and Spanish.
- Optional web-based coursework leading to a diplomado (certificate) in public health awarded through the National Institute of Public Health in Mexico.

- Binational action-learning teams that meet to select and address complex border health concerns during face-to-face events, via monthly distance team meetings and through independent work.
- Personal leadership development through a 360-degree leadership assessment of key leadership practices, team coaching, self-reflection and the development of personal action plans.
- Networking opportunities to develop and expand binational professional networks.

**Summary:**

- Our first class of 18 participants (nine from the U.S. and nine from Mexico) graduated in October 2010.
- We are recruiting for our 2011 class on our website via an online application.
- To date, our participants have been satisfied with our program offerings.
- We have an outstanding advisory board with members from the U.S. and Mexico.
- Our partners have helped us work through many potential barriers including funding, language and cultural differences, logistics, etc.

**Effectiveness:**

We are just completing our first year of operation and will be measuring outcomes and impact for this and future classes.

**Funding:**

Our primary funding support has been from the U.S.-Mexico Border Health Commission. We also have funding from the Centers for Disease Control and Prevention under Cooperative Agreement #U14WC000110 and from the Pan American Health Organization El Paso Field Office.



**Tohono O'odham Nursing Care Authority:  
Archie Hendricks Sr. Skilled Nursing Facility and Tohono O'odham Hospice  
www.toltc.org**

**Service area:** Arizona, Tohono O'odham Nation

**Contact information:**

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**Purpose:**

To respond to the skilled nursing, long-term care, rehabilitative, palliative and hospice care needs of the tribal members of the Tohono O'odham Nation.

**Overview:**

The Tohono O'odham Nation determined it was not acceptable for their elders to be forced to live in urban, non-Indian nursing care facilities. They found that this practice was demoralizing to their elders, contributed to separation of family members and in many instances resulted in premature morbidity and mortality. The decision was made to develop and operate their own skilled nursing facility. Once that decision was made, the Tohono O'odham Nation assessed elders for their primary medical, nursing, palliative and hospice care needs. The outcome identified by those assessments resulted in the development of health care services offered by the Archie Hendricks Sr. Skilled Nursing Facility (AHSSNF) and the Tohono O'odham Hospice (TOH). Further, the assessment assisted in targeting specific priority health care services. These prioritized services included state-of-the-art long-term care, wound care, diabetic care, post hospital and rehabilitation, palliative and hospice care.

After a multiyear period of development, the preceding services were developed and have been in place for the past eight years. Numerous challenges were overcome ranging from developing the staff and requisite expertise in a very rural location, to establishing linkages with Indian Health Service and other urban providers.

Importantly, these services were identified as tribal-wide priorities. As a result, the facility and services have thrived since opening in 2002.

**Effectiveness:**

More than 450 tribal members ranging in age from 25 to 100 have received care through the AHSSNF and TOH. Almost 100,000 days of care have been provided. Mexican O'odham have received care at AHSSNF. In some instances these tribal members have remained receiving long-term care.

**Funding:**

Two-thirds of the funding is through from the Tohono O'odham Nation. The remaining funding is through Arizona Health Care Cost Containment System, Arizona Long Term Care System, Medicare, Veterans Administration, private insurance and private payment.



## Lifestyles and Values Impact Diabetes Awareness

[http://hmsnm.org/lv\\_index.htm](http://hmsnm.org/lv_index.htm)

Service area: New Mexico

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### Program:

Lifestyles and Values Impact Diabetes Awareness (La VIDA), a program administered through Hidalgo Medical Services (HMS), is designed to raise the level of diabetes awareness and demonstrate that lifestyle choices and changes can have a positive impact on overall health. Raising awareness is particularly important in our region because statistical trends show Hispanic Americans are at a greater risk of diabetes. Hispanics represent approximately one half of the population in southwest New Mexico.

The La Vida project is a collaboration of many community partners. This collaboration has resulted in a Holistic Integrated Diabetes Intervention offering more than 30 services, including outreach, community prevention, pre-education barrier reduction and post-education support. Partners include HMS, Grant County Department of Health, Gila Regional Medical Center, Southwest Outreach for Diabetes and the New Mexico Department of Health.

### Purpose:

Diabetes in Hispanic Americans is a serious health challenge because of the increased prevalence of diabetes in this population, the greater number of risk factors for diabetes in Hispanics, the greater incidence of several diabetes complications, and the growing number of people of Hispanic ethnicity in the United States.

The La VIDA program began in 2001, designed to reduce the health disparity in Grant and Hidalgo counties in New Mexico. The program is managed and operated by HMS, the central coordinating agency of the REACH 2010 grant.

The following statistics illustrate the magnitude of diabetes among Hispanic Americans:

- In 2000, of the 30 million Hispanic Americans, about 2 million had been diagnosed with diabetes.

- About 10.2 percent of all Hispanic Americans have diabetes.
- On average, Hispanic Americans are 1.9 times more likely to have diabetes than non-Hispanic whites of similar age.
- Diabetes is particularly common among middle-aged and older Hispanic Americans. For those age 50 or older, about 25 to 30 percent have either diagnosed or undiagnosed diabetes.
- Diabetes is twice as common in Mexican American adults as in non-Hispanic whites.

Having risk factors for diabetes increases the chance that a Hispanic American will develop diabetes. Risk factors that seem to be more common among Hispanics include a family history of diabetes, gestational diabetes, impaired glucose tolerance, hyperinsulinemia and insulin resistance, obesity and physical inactivity.

Higher rates of the diabetes complications nephropathy (kidney disease), retinopathy (eye disease) and peripheral vascular disease have been documented in studies of Mexican Americans, whereas lower rates of myocardial infarctions (heart attacks) have been found.

La VIDA is a bilingual public awareness campaign that encourages people at risk for diabetes to have a simple, painless test done by a clinic or a doctor. In this way, diabetics or people at risk of diabetes can understand the condition and the lifestyle choices they make which may impact their health.

The vision of La VIDA is to see "generations of people free of the impact of diabetes through innovation and ownership of family health." La VIDA's mission is to build a team of community members and health professionals working to improve the quality of life for people living with diabetes through community outreach and family participation.

### Overview:

**Mission:** LaVIDA is a team of community members and health professionals working to improve the quality of life for people living with diabetes through community outreach and family participation.

The LaVIDA project was formed in October 2000. It is a program provided through Hidalgo Medical Services and it is funded by the Centers for Disease Control.



**Demographics:**

- The total population of Grant and Hidalgo counties is more than 61,000 people.
- Over half of this population is of Hispanic origin.
- It is estimated that over 14 percent of people living in the area may have diabetes.

**Since its inception, LaVIDA has:**

- Established diabetes resource centers in Grant and Hidalgo counties.
- Staffed these resource centers with promotoras that are supported by contractors, volunteer agencies and community members
- Continuously evaluated its activities
- Provided services, such as
  - diabetic education classes offered through Gila Regional Medical Center.
  - diabetic patient support.
  - peer/family support.
  - development of change agents.
  - improving the availability of healthy foods in public places.

**Consumer benefits:**

- Free diabetes education classes,
- Cooking classes,
- Resource centers equipped with English and Spanish pamphlets, brochures, books, magazines, newsletters and Internet access and
- Referral services to other agencies and resources in the community.

**Summary:**

La VIDA education classes are the foundation of the program. These four intensive classes, developed by diabetes educators, provide the ultimate learning experience for people with or at risk for diabetes.

Supermarket tours help participants learn how to read and understand food labels enabling them to choose healthy options.

Tobacco cessation classes are offered in eight sessions of information and support designed to help participants quit smoking. Nicotine replacement is available.

The "Active and Alive" program teaches people how and why to be active and how activity fits into their lives and awards prizes along the way. Residents may join classes led by experienced instructors or join community activity clubs.

La VIDA support groups were developed to expand on La VIDA education classes. They include 12 sessions designed to empower you to take control of many aspects of their health care.

The VIVA NM Restaurant Program was implemented to give community members diabetes- and heart-friendly menu options at local restaurants.

**Effectiveness:**

Many diabetics in our communities have benefited greatly by taking advantage of La VIDA. The diabetic populations in Grant and Hidalgo counties are learning how to manage their illness through lifestyle changes.

**LaVIDA results:**

- 55.8 percent of participants indicated they follow a healthful eating plan at least five days a week.
- 90 percent of participants stated they had their HbA1c levels checked at their most recent medical visit.
- 44.1 percent of participants indicated they engage in at least 30 minutes of physical activity for at least five days a week.
- 55.8 percent of participants indicated that they follow a healthful eating plan at least five days.
- 67.9 percent of participants surveyed stated that they tested their blood sugar level daily for at least five of the last seven days.

At HMS, providers refer these diabetic patients to our LaVida Diabetes Resource Center for education and support. Patients benefit from the following tools:

- One-on-one sessions with a promotora for assessment and further referrals,
- One-on-one sessions with a diabetes educator,
- Diabetes education classes (four sessions),
- Supermarket tours (hands-on label reading),
- Support groups,
- Active and Alive (physical activity program),
- Home visits,
- Advocacy and follow-up with providers and clients,
- Care coordination

**Funding:**

Centers for Disease Control – REACH US program



**Healthy Environment, Healthy Lungs:  
Environment and asthma education program  
www.ncfh.org**

**Service area:** Communities along the United States-Mexico border

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**Purpose:**

The National Center for Farmworker Health Inc. (NCFH) is a nonprofit organization in Buda, Texas, dedicated to improving the health status of farmworker families through appropriate application of human, technical and information resources.

In 2005, NCFH began working on a border environmental health project (BEHP) to support HRSA-funded community and migrant health centers (C/MHC) responsible for providing access to high quality primary health care to individuals living along the U.S.-Mexico border.

In order to carry out some of the goals set for this project, NCFH selected three health centers in border communities to participate: Sunset Community Health Center in Arizona, La Clinica de la Familia in New Mexico and Nuestra Clinica del Valle in the Lower Rio Grande Valley of Texas. Promotora programs that also participated in these communities included Campesinos Sin Fronteras in Yuma, Ariz., La Clinica de la Familia in New Mexico and Migrant Health Promotion in the Lower Rio Grande Valley in Texas. The goals of this project were to assess currently available resources and knowledge levels regarding environmental impact on respiratory disease among selected C/MHC in these communities and to develop and test a curriculum and training tool to address the needs as identified by health professionals, paraprofessionals and community members in the border area.

**Overview:**

By 2007, as part of the BEHP Project, NCFH developed the Healthy Environment, Healthy Lungs program, a bilingual educational program that can be used by migrant health centers or any other farmworker serving

agency to train their lay health workers who in turn, will reach, educate and respond to the needs of individuals living in polluted areas and/or who have been affected by asthma. The program includes a training curriculum with three modules and PowerPoint presentations: "The Environment and our Health," "All about Asthma" and "Community Empowerment". The first module of this curriculum provides general information on the environment and its elements, addresses the importance of the land, air and water in our daily lives; what pollution is; types of pollution; and how to prevent it. The second module focuses on the topic of asthma, risk factors, causes, symptoms and how to control them. The third module provides participants with the necessary knowledge on environmental laws related to air, water and land pollution; who enforces the environmental laws; the role of the local government and our responsibility, as individuals and a community, towards the overall improvement of the environment. A bilingual flipchart is also available to assist lay health workers while conducting education sessions in the community.

**Summary:**

NCFH conducted formative work which included a comprehensive literature review, a community assets mapping, and a series of focus groups with key stakeholders. The purpose of this formative work was to guide the development of the educational materials to effectively serve the needs of individuals whose respiratory health has been compromised by environmental air pollution.

A comprehensive literature review on the relationship between air pollution and asthma as well as research on public health interventions that address asthma in the US-Mexico border region was conducted. NCFH also conducted nine focus groups on the U.S.-Mexico border with local stakeholder groups. The objective was to determine the community's environmental health needs, the target audience and appropriate dissemination strategies for a subsequent environmental health education intervention. Three types of stakeholder groups were included in the focus groups: community residents, health promoters and health care providers.



Based on the findings collected, NCFH published a report on "Health Effects of Air Pollution on the U.S.-Mexico Border: Results of a Series of Focus Groups with Stakeholders". The report can be accessed through the NCFH resource center or through the NCFH website.

In order to help other interested parties to avoid duplication of their efforts in creating intervention programs relevant to their communities, NCFH has also produced a border-wide comprehensive assessment of local assets including best practices currently in place along the border and local area, resources and contact information of parties with environmental health responsibilities. Some local resources included air quality control agencies, border health associations and organizations, community/migrant health centers, border county government information, border county hospitals and medical centers, EPA border agencies, federal agencies, health education and training centers and state departments of environmental health.

As a result of this formative work, findings were considered to be helpful not only to NCFH but also to other interested parties in developing effective intervention programs for communities along the U.S.-Mexico border. This work is currently available through the NCFH resource center and library and through the NCFH website at [www.ncfh.org](http://www.ncfh.org).

#### **Challenges:**

The scarcity of published research and the inconsistency of study designs, terminology and experimental outcomes make it difficult to draw decisive conclusions to guide public health interventions. There are unknown factors in the literature review that need to be addressed by researchers such as 1) the prevalence of asthma in populations other than children such as agricultural workers and the elderly and intervention strategies for these groups, 2) comprehensive information on air pollution and asthma interventions on the Mexican side of the border and in rural areas on both sides of the border, 3) the influence of the social, economic, cultural,

environmental and residential diversity of the border region on effective asthma intervention strategies. This shortage of research and published literature indicates a need for financial support for researchers with expertise in this area.

While migrant health centers have found this program to be of value in terms of meeting the needs of risk groups, the reproduction and dissemination of the training curriculum and its educational materials among migrant health centers have been limited by the lack of funding.

The lack of community empowerment was an issue. Efforts to promote education in this regard are needed to increase awareness about the laws in place and of the local agencies that can help community members protect the environment in which they live.

#### **Effectiveness:**

During the development phase of this program, 19 lay health workers were trained. They conducted 44 educational sessions at different settings such as homes, clinics and other local community settings and groups. They reached a 202 community members of different ages and educational backgrounds. As a result of this intervention and input received from community members in the area of Mission, Texas, a cleanup campaign was organized. The local television and print media and city authorities helped promote this event. As a direct consequence of this campaign, a larger number of community members were reached with basic information about the environment and asthma. This program has also been disseminated via on-site trainings with community and migrant health centers nationwide and through various conferences.

#### **Funding:**

Environmental Protection Agency and the Health Resources and Services Administration



## Health without Borders: Door-to-door immunization campaign www.bahcnm.org

Service area: New Mexico

### Contact information:

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### Purpose:

The purpose of the project is to increase the rates of immunization coverage within the village of Columbus in Luna County, N.M., through a door-to-door campaign to provide immunizations, especially to children 0-3 years of age.

### Overview:

Ben Archer Health Center (BAHC) is a federally qualified health center that provides medical, dental and behavioral health services to the underserved of New Mexico's Doña Ana, Sierra, Otero and Luna Counties. The mission of BAHC is to significantly improve the health status of its population through the prevention of illness, the promotion of health education, the provision of quality primary care, access to the underserved and a strong commitment to chronic disease and pain management.

BAHC has provided immunizations to the rural communities since 1971. BAHC participates on the Doña Ana Immunization Coalition, and has been a VFC provider for many years. BAHC has been recognized by the Statewide Immunization Coalition for exceeding 90 percent of the immunization rate for children 24-36 months for the past three years. In April 2010, BAHC conducted a door-to-door immunization campaign in Luna County with positive results. The door-to-door method has been used in Mexico and other many other countries throughout the world to provide on-site immunizations in homes of residents of both urban and rural areas.

Planning for the immunization campaign started in July 2009; meetings were held no less than monthly and a variety of topics were brainstormed. The dates chosen for the campaign in April intentionally coincided

with National Infant Immunization Week. Some of the specific topics addressed included recruiting participation of local agencies that had vested interest in immunizations of the target population, media and advertising, supply of vaccinations, staffing needs and availability, transportation, dates and times of the event, mapping, and logistics, such as accessing immunization data and how to keep vaccines cold or frozen.

During the event, there were a total of two teams; each team had a coordinator/driver, an evaluator, two nurses and four community health workers (CHWs). Each team had a van, bags containing information and brochures on a variety of health topics and incentives (thermometers, hand sanitizer, etc.), a variety of children's vaccines and necessary medical items. In addition a car with a clerk and a computer to access the state immunization database was available. Everyone received a list of expectations as well as a script in English and Spanish and sign-in sheets to track data.

Community health workers dispersed in pairs throughout the community canvassing homes street-by-street under the directions of the coordinator who used a city map to assure community saturation. Each CHW knocked on every door in the village of Columbus, asking the occupants if they had children living at the home, and if their children were home. If there were children found to live in the home, the CHW would then contact a nurse who would go to the identified home and check the immunization record. If a deficit was found, the nurse would administer the appropriate vaccinations on site at each respective home. All houses were provided a bag of health information as well as donated incentive items that included brochures on a variety of health topics. If no one answered the door, the bag was left at the residence.

### Summary:

Overall, the door-to-door immunization campaign was found to be a success. One successful effort was in preparing the community for the upcoming event. The community was made aware of the campaign by a variety of means, including radio announcements on a variety of stations, newspaper announcements, bilingual



inserts into all utility bills and notification of key persons to include local law enforcement. Due to this promotion, the teams found good reception at all homes and were not turned away by anyone. Where children required vaccinations their parents or guardians agreed to have them administered on the spot.

The organizers faced several challenges. Some agencies that had originally agreed to participate backed out with short notice. Even though planning was methodical, conditions in the field, including the need for remote communications (cell phones) and the weather (high winds and dust in the afternoons) required operational adjustments. It is believed that because the local elementary school was on intersession, many of the local families were not available because of travel; however it was also recognized that among those who were not traveling during the intersession, a greater number of children were home. For future door-to-door immunization campaigns some of the lessons learned include:

- Identify key agencies in the community with vested interest in target populations.
- Engage representatives from key agencies early on in planning meetings.
- Solidify roles of each agency in the event through letters of understanding as needed.
- Train team leaders for each role prior to event to train other volunteers as needed.
- Hold a walk-through of the process prior to event.

### **Effectiveness:**

In total 340 houses, essentially every single home in the village of Columbus, were visited all of which received health information on a variety of health topics. Of the 340 houses visited, about half (178) were occupied at the time of the campaign, and 62 of these houses had children present. In total, 41 homes with children had up to date immunization records; there were 17 children immunized and a total of 38 immunizations given to children in the remaining 21 homes. The estimated minimum cost for labor for 12 hours of door-to-door immunizing is \$815; the estimated cost of potentially containing a measles outbreak is \$167,685.

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