

2009 Annual Forum

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Sample Abstracts

Mobile Child and Adolescent Psychiatry in an Underserved Rural Area

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Since Hurricane Katrina, mental health providers in the Greater New Orleans have been making the gradual transition from crisis intervention services toward the re-establishment of sustainable, comprehensive, community-based child and adolescent psychiatric clinics. Many underserved rural areas, where only half the pre-existing population has returned, are unlikely to have public, brick-and-mortar mental health clinics in the near future. One such area is Plaquemines Parish, a narrow strip of land running from the suburbs of New Orleans to the mouth of the Mississippi River, which was the location of Katrina's first U.S. landfall. There, the Algiers Mental Health Clinic, a branch of the New Orleans Adolescent Hospital, began a mobile mental health clinic (NOAH's ARC) to address the needs of Plaquemines Parish.

Time management is the most challenging aspect of the mobile operation. On travel days, the clinic staff, which consists of a child and adolescent psychiatrist, a psychiatric social worker, a nurse, and a clerical person/driver, works a 10-hour day. In order to schedule the 10 hours, consideration must be given to the following: thirty minutes are required at the beginning and end of the day for loading/unloading the vehicle and transferring/securing medical records. The total travel time is four hours, and an hour for staff breaks/meals is a conservative estimate. In total, only four hours are left for direct clinic services. Abbreviation of time allotted for evaluation and provision of treatment services has been considered, in light of the limited timeframe. While this would be acceptable for a crisis unit, it is considered a compromise for an ongoing clinic, and would result in a two-tiered system stratifying those who receive services in the mobile clinic and those served in the brick-and-mortar clinic. The mobile clinic staff must also consider that child and adolescent mental health patients have chronic problems requiring at least monthly medication visits, family therapy, psychological interventions, and psycho-education. Managing follow-up visits while still leaving time for new evaluations initially seems impossible.

In order to address these concerns, NOAH's ARC staff has abandoned the traditional mental health clinic model for a collaborative, community-based treatment model. Existing mental health providers in Plaquemines Parish have limitations, particularly child psychiatrists and social support services, which impede their ability to provide comprehensive care. The mobile clinic provides the missing services and, in addition, supplies child psychiatric oversight for all cases. The community-based organizations provide psychotherapies, in-home services, and patient advocacy. The Plaquemines Parish school system partners with NOAH's ARC to provide the services of a school nurse and a brick-and-mortar reception/waiting area for the mobile clinic. LSU Health Science Center Division of Child and Adolescent Psychiatry staff provides psychological supervision and direct patient care.

The presentation addressed the challenges facing mobile mental health service providers, discussed the theoretical models of mental health care delivery, and described in detail the formulation and execution of operating procedures for NOAH's ARC.

Defining "Mobile" in Community-Based Health Services

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Increasing health care access poses many challenges. With limited resources, health care leaders must be innovative in developing and/or adapting programs to meet the extensive needs of disenfranchised populations while maintaining a respectful and compassionate service.

Defining and implementing successful mobile health services requires outside-the-box thinking to ensure that the ultimate goal – access to health care – is realized. "Mobile" can mean a mobile unit that moves from location to location. It can also mean equipment that is easily portable and set up to provide services in a number of communities.

Many challenges arise in the implementation of community health programs. Moving creatively through the challenge can often produce results better and more far-reaching than anticipated. Flexibility and collaboration within the organization and in the community are keys to ensuring success, regardless of circumstances.

Nurturing a smoothly functioning continuum of care between the hospital and the community is a vital area that can be easily overlooked. Closing the loop of care for patients initially served at the community level is crucial. Along with ensuring that connections are made between hospitals and community partners, the maintenance of respect, compassion and effective advocacy must also be valued as an essential element in creating the plan of care for every patient served.

How Healthcare Disparities in Houston Spurred the Development of the Breast Health Collaborative of Texas

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Houston is the nation's fourth-largest city, and it is also the city with the highest mortality rate from breast cancer for African-American women. The rate of uninsured patients was nearly twice that of the national average in 2004, at 28.6%, and only about 67% of women in the county who qualified had received a mammogram in the past two years.

In 2005, presenting partners The Rose and the Houston affiliate of Susan G. Komen for the Cure held the first Breast Health Summit in Houston to help address local issues and provide resource information to breast health providers, survivors, and advocates looking to make a difference in the dismal statistics coming from Harris County and Texas. From the Summit, a core group of participants emerged, forming the Breast Health Collaborative of Texas. The Collaborative's mission is to unite breast health advocates and providers to educating, advocating, and leveraging resources in Texas.

A Breast Health Portal was developed through a grant from St. Luke's Episcopal Health Charities in order to help connect navigators, providers and patients to resources for screenings, clinical breast exams, and education. The Portal features a mapping system and lists each participating partner's requirements and guidelines in order to help those searching to identify the most appropriate partner within the community. This Portal includes information about mobile mammography providers in the area, and allows mobile programs to search for partners for screening and education.

As the influence of the Breast Health Collaborative has grown, so has the impact for breast health providers across the state. The Breast Health Collaborative, as a presenting partner of the 2008 Breast Health Summit, was able to highlight the struggle of providers and

advocates in the Big Bend region of Texas and their needs for a mobile program to provide much-needed screenings in the area. The Collaborative was also influential in advocating for the State of Texas to adopt the least restrictive options for the BCCS Medicaid program, allowing any provider to refer to contractors of the program and increasing the number of women in the treatment program from 486 to 990. This opened doors for mobile mammography programs across the state to refer abnormal screening patients for further testing, with the continuum of care in place through the BCCS for those who qualified.

As needs continue to be identified within Texas and the Greater Houston area, the importance of mobile mammography becomes more apparent, as does the importance of collaboration. Currently, the Breast Health Collaborative of Texas includes more than 70 organizations participating in leveraging resources and collaborating to provide information and services to those in need. As the organization continues to grow, it is our hope that we will be a model to other cities and states that have healthcare disparity needs and truly desire in order to make an impact through collaborative efforts.

Launching a Private Mobile Dental Health Clinic

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You must have good oral health to be healthy! Even though safe and effective ways exist to maintain oral health, many citizens still suffer the needless pain and complications of dental diseases that affect their overall health and well-being. Oral diseases create financial and social costs that diminish quality of life and burden society. Increased awareness is needed for the public and policymakers to better understand that good oral health is essential for overall health and is achievable for all.

Inequities and disparities affect the very people who are least able to access the resources to attain optimal oral health. Today, our most vulnerable citizens – the elderly and the disabled – suffer the bulk of dental diseases. The reasons for disparities in oral health are various and complex. Socioeconomic factors, a lack of community infrastructure and programs, workforce issues, physical and mental impairments, behavioral and psychosocial factors, funding issues, a lack of awareness concerning oral health, the perception that oral health is not important, and many other factors act as barriers to providing and attaining optimal oral health care.

To serve this population, hampered by limited access to traditional dental care, “Therapeutic Dental Care” has developed the “doctor to the door” program. The idea of establishing a mobile dental health clinic has been innovative and unique to our company, since prior to our launch there was no private mobile dental office in Puerto Rico offering the full array of odontologic services.

Some reference points on the demographics of the island and the dental practice: Puerto Rico is a U.S. Commonwealth with a population of 3.7 million. Our legal, educational, medical, mercantile and transportation systems (to name a few) are subject to both local and US federal regulations. Medical doctors and dentists require licenses from the local health department as well as other applicable specialty boards. Once qualified, they may also practice medicine in the United States.

“Therapeutic Dental Care” mobile dental clinic has focused its services on the elderly and business people, two populations in need of the convenience of bringing the “doctor to their doors,” one because of its physical limitations and the other due to its time limitations. It is important to mention that the elderly make up almost half of the island’s population. Currently our patient roster includes approximately 100 elder homes as well as various multinational companies. Due to our success, we are in the process of expanding operations to serve the rural public schools and other sectors in need.

Improving Access to Primary Care with Rural Mobile Health Clinics: the VA Experience

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The Veterans’ Health Administration (VHA) provides comprehensive healthcare to over five million veterans nationwide with 40% living in rural or highly rural areas. Rural veterans experience more chronic disease, greater degrees of poverty, and lower physical and mental health-related quality-of-life scores than their urban counterparts. Recent research has shown that enlistment rates are higher in rural areas; in 2004 it was reported that 44% of soldiers killed in Iraq were from rural communities with populations under 20,000. Despite greater need, rural veterans continue to face barriers in accessing VA healthcare.

In 1988, the VHA funded six Mobile Health Clinics (MHC) in order to improve access to VA healthcare for rural veterans. At that time, VA medical care was highly centralized, and the goal was to bring VA primary care services to local communities. As part of a research protocol, data was collected on all six MHCs for a period of two years (1991-1994). Researchers concluded that mobile clinics did increase access to VA healthcare (defined as increased enrollment), were well received by veterans, and provided a flexible method of assessing local service needs when establishing a fixed site was not feasible. However, there were staffing challenges and frequent mechanical problems on the vehicles. The data also showed that it was more cost-effective to deliver care from a community clinic. All the original units have been decommissioned as primary care clinics, but are still used for outreach, health fairs and emergency response.

Following the 1992 project, the VA focused its efforts on establishing local clinics in rural communities nationwide. Despite this initiative, access to care continues to be adversely affected by transportation barriers, fewer health care providers per capita, and difficulties attracting and retaining health professionals. In response to these challenges, and in the setting of soldiers returning with significant medical and mental health needs, the VA created the Office of Rural Health (ORH) in 2007.

The mission of the ORH is to coordinate VA efforts nationally to improve access to care. One of its first initiatives was to fund four new rural Mobile Health Clinics in 2008. Based on previous experience, this initiative allows for greater flexibility to meet local needs. To address challenges in continuity of care, extensive use will be made of home telemonitoring technology for chronic disease management. The VA has had success with telepsychiatry programs in rural community clinics, and this technology will be disseminated and used to support additional specialty consultation services. Above all, the VA is committed to collaborating with local community organizations to implement creative solutions that improve the quality of care for all rural veterans.

Survey of Mobile Clinic Programs In American Dental Schools

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Although a number of dental schools across the United States have functioning mobile dental units, detailed information on these clinical outreach programs had never been compiled prior to this survey. Collecting and analyzing data was deemed beneficial to understanding mobile programs as replicable models for increasing access to care for underserved and inaccessible populations and for developing clinical practice and public health experience for students.

In the fall of 2007, a survey was developed with questions from the USCSD Office of Community Health, as well as questions adapted from the USSF School of Dentistry "Mobile Dental Program Survey." The resultant survey totaled 81 questions which targeted such different characteristics of mobile dental programs as detailed information on vehicles, costs, personnel, student rotations, clinical procedures, patient demographics, community partnerships and dental access. All 57 dental schools in the US were contacted using an internet-based survey site; 43 schools responded after three contact attempts. Twelve different dental schools from across the United States reported having mobile programs and reported on these outreach dental programs.

Despite the limitations of the research, the data collected through the Mobile Clinic Survey proved to reveal a significant amount of information about the participating programs. It can be noted that clinics provide crucially needed oral health care and play an important role in expanding community-based clinical training of students. Additionally, the mobile clinics' inherent ability to move from location to location, and flexibility in care modalities, improve their ability to decrease oral health care disparities in poor communities. Information gathered about the complex, interconnected components of mobile clinics suggests that the survey can be useful in evaluating the success and challenges of programs in providing health care, in supporting sustainability and alleviating difficulties faced by the clinics themselves, and in providing models of care for other educational institutions and community agencies.

The Mobile Clinic Survey data indicate that effective program development, vehicle deployment, student staffing, and faculty supervision have been achieved to operate these mobile clinic services. Diverse resources combine to sustain these projects: university support, community contributions, volunteer involvement, foundation grants, government contracts and reimbursements. The programs seem to be successful not only in increasing access to care to underserved, rural and inner-city populations, but also in increasing clinical competency and community service for university dental schools. Each year, hundreds of dental students participate in these activities, and thousands of patients throughout the nation benefit from these partnerships.

Capitalizing on Your Needs Assessment: Turning Outcomes into Dollars

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Needs assessment is the process of obtaining and analyzing information to determine the current status and service needs of a defined population and/or geographic area. Conducting a needs assessment provides advantages to organizations, including the generation of new ideas and alternatives for dealing with identified needs. Supporting the organization's mission statement, these ideas or alternatives are often used to develop business plans, to design programming, and to plan strategically. It is as important, if not more, to use information gleaned from a needs assessment in meaningful and effective ways.

How is this done? First, the findings should be framed as important and needing to be addressed. Next, the findings should be communicated in a timely and understandable format. Lastly, the findings should be utilized to develop and maintain a system of metrics for the organization to routinely monitor its progress. Successful integration of these three strategies will ultimately lead to increased and more successful funding opportunities for organizations.

Mobile C.A.R.E. Foundation (MCF) is dedicated to providing free and comprehensive asthma care and education to children and their families in Chicago's underserved communities via mobile medical units – the *Asthma Vans*. Since 1999, MCF has implemented its Comprehensive Asthma Management Program in partnership with over 100 schools and Head Start Programs. Over that period of time, our medical staff has treated over 5,000 patients in the course of more than 25,000 medical appointments, and has helped to screen nearly 48,000 children for asthma.

Objectives

Using Mobile C.A.R.E. Foundation as a case study, this presentation:

1. Provided examples of practical needs assessment activities, including epidemiologic research and stakeholder involvement, used to illustrate the importance of an identified need;
2. Outlined how findings from the needs assessment were used to create a system of metrics;
3. Highlighted the importance of ongoing data collection;
4. Illustrated how findings from the needs assessment and data analysis can be translated into understandable and impactful formats; and
5. Reviewed successful funding initiatives directed to various funding sources, such as foundations, local/state government, and federal government.