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Table of Contents

Letter from the Program Directors

PROJECT VIDA

3607 Rivera Avenue, El Paso, Texas 79905
(915) 533-7057 (915) 533-7158 *FAX*

Dear Colleague:

As a winner of the ***Models That Work*** competition, we are deeply aware of the unique nature of each situation and the need to fit appropriate actions into the local context. Our intent in sharing our story with you is to join in a conversation rather than a presentation.

Project Vida emerged from conversation—with community residents, other providers, and with ourselves. We began by choosing a community of visible need, few services, and leaders ready to work with "outsiders." In the fall of 1990, the Presbyterian Church sponsored the purchase of a small home in the community where two of us began meeting with children and parents. We set up a small volunteer clinic. We used a Community Congress to develop priorities, and worked with a broad range of agencies and resources to develop programs to respond to those priorities. Now sixty people work in a primary health care clinic, provide housing, education, and youth recreation activities, and a full range of community social services. Over twelve hundred families are currently maintaining registration with us. Almost half of the staff are community residents and former or current clients. We have been a central part of developing city wide linkages among providers in many arenas.

What we have learned is how to think through local needs, the obstacles to responding to those needs, and strategies to overcome the obstacles. The particular structures and models we developed may be of help, but the process of developing those models is central to maintaining their flexibility and responsiveness.

If our work and experience seems interesting or helpful to you, please contact us. We would appreciate the chance to work with you in crafting ways to involve the community in its own care and linking it to the resources of a wider society.

Sincerely,

Bill and Carol Schlesinger
Co-Directors
Project Vida

A Program of
The Presbyterian Church (USA)
The Cumberland Presbyterian Church

Introductory Statement

Dear Colleague:

On behalf of the Health Resources and Services Administration's Bureau of Primary Health Care and "Models That Work" (MTW) Campaign co-sponsors, I am pleased to present this Strategy Transfer Guide. This document is intended to assist you in replicating the innovative and creative strategies used by the Comprehensive Community Health Services Program of Project Vida, one of the 1996 MTW Competition winners. This program represents a creative community-driven solution to significant health challenges, developed by building partnerships and maximizing existing capacities within the community. I encourage you to learn as much as you can from this document.

Although the strategies outlined in this document may be used as guidelines, they should in no way be interpreted as a step-by-step procedure for solving access and service delivery challenges in your community. This document is simply intended to provide viable ideas to support your efforts in providing effective primary health care services to underserved and vulnerable populations.

If you need explanations, advice, or would like additional information, contact the program representative listed in the "Project Overview" or consult the "Models That Work Campaign Information" section of this Strategy Transfer Guide.

We hope you find this information useful.

Marilyn H. Gaston
Assistant Surgeon General
Director

Project Overview

Name of Program: Project Vida

Parent Corporation: Project Vida

Location: El Paso, Texas

Annual Budget and Funding Sources: $1.2 million--Texas Department of Health, AmeriCorps, Community Development Block Grant, Presbyterian Church (USA), Cumberland Presbyterian Church, El Paso Community Foundation, Maternal and Child Health Bureau.

Community Need and Target Population: Very low income Hispanic community in a medically underserved area of the Texas/Mexico border.

Primary Care Services Provided:

- Immunizations (adult and children)
- Early prevention, screening, diagnosis, and treatment (EPSDT)
- Cancer screening
- Health education
- Targeted case management and home visiting
- Women, Infants, and Children (WIC)
- Parenting education
- Dental care
- Corrective lenses
- Family planning
- Sick care
- Women's health
- Pediatric care

Partner Organization: Thomason Hospital, City/County Health District, El Paso Cancer Consortium, Family Pride Collaborative, Community Development Department (City of El Paso), Case Management Association, Sierra Optical Company, Presbyterian Church (USA), Cumberland Presbyterian Church, Project Ayuda, AmeriCorps USA, Texas Department of Health.

Health Related Outcomes:

- 97 percent of children are on schedule for immunizations.
- 250 families that previously used emergency room services for primary pediatric care have not returned in more than 1-1/2 years since entering case management and home visitation programs.
- More than 1,000 families now have a primary care health home.
- More than 100 women walk at least 3 times a week for at least 20 minutes at a time.
- Eight families have obtained permanent, safe, affordable housing.
- Juvenile crime is down in the immediate neighborhood served by the project.

Kind of Model: Community-based, multiple service, private non-profit agency.

For Additional Information Contact: Bill Schlesinger, Co-Director

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Project Description

PROJECT DESCRIPTION

In winter and spring 1989, Project Vida conducted interviews in 100 homes to assess the needs of the El Paso community. Beginning in fall 1989, Project Vida worked with La Mujer Obrera, an advocacy and service organization for garment industry workers, to establish a clinic run by volunteers. One year later, Project Vida moved into a small duplex near the center of its focus area and obtained funding for a physician assistant to provide full-time family clinic services under physician supervision. Community residents became involved first as visitors, then as volunteers.

In 1991, five community residents conducted extensive interviews with over 100 households. The University of Texas at El Paso School of Nursing and Allied Health helped develop the questionnaire and tabulated the results. Project Vida then convened the first community congress for low-income families registered with Project Vida to review and evaluate programs and set priorities for future development. These annual congresses currently average 100 adults.

Project Vida now provides health care, housing, education, and afterschool activities to low-income community residents who are almost entirely Hispanic.

POPULATION SERVED AND EXPECTED OUTCOMES

El Paso is 70 percent Hispanic and is the fifth poorest metropolitan area (SMSA) in Texas. Project Vida's service area includes all Zip Code 79905 in El Paso, Texas, with a primary focus on Census tracts 28 and 29. Project Vida's service area is located immediately on the Texas/Mexico border and is a primary port of entry for legal and undocumented persons. Ninety-nine percent of the service area is Hispanic.

The median income of the focus area is less than $7,000 for a family of four, rising to about $14,000 in the wider service area. Median age in the focus area is 15. The area has triple the violent crime rate of the city. Gangs have been part of the community social system for three or four generations. Sixty-five percent of the adults (25 and older) have less than a ninth-grade education. Housing is dilapidated and overcrowded; more than 500 families in the service area are "doubled up" in apartments or single-family homes. Employment in the traditional garment industry has been shrinking as a result of companies moving their operations to Mexico and other parts of the world. The population of the focus area is 12,000.

The entire service area is a Federally Designated Medically Underserved Area (MUA) and a Health Professional Shortage Area (HPSA). The population of the service area is 45,000, and about 70 percent of the families in this service area have no medical insurance. The county hospital, R.E. Thomason General Hospital, is located within the service area and is about six blocks from the focus area. The clinic at the adjacent Texas Tech Health Science Center has a 3-month waiting list for appointments. As a result, families historically have used the emergency department for primary care. Families have at best pieced together disjointed services.

OUTCOMES

Project Vida's programs focus on involving families in increasing control and responsibility for their own future. Little is "given." A thrift shop charges nominal prices for clothing and household goods. Children earn credits that allow them to buy presents for their families. Parents buy new jackets and Christmas gifts for $3 rather than having them donated directly to the children. The eight apartments built by Project Vida and the 12 now under contract for construction have a small fenced yard for each unit, allowing families a sense of control and ownership of space.

Interconnected programs. Project Vida's programs are interconnected. It is normal for a family to come to the clinic, attend a health education presentation, shop in the thrift shop or food co-op, and have a child in a preschool class and a parent in the English as a Second Language class. Such interconnectedness allows Project Vida to work with a whole family and provides staff a way to assess needs and problems with help from a variety of disciplines. Families are "known" and become part of the network of care as they in turn help others.

Primary care for women, infants, and children. Although the El Paso City/County Health District provided prenatal care, it had no facilities to provide primary care for the mother or her family. Project Vida's space was limited to its small building. The Health District agreed to lease its clinic building in the community to Project Vida at no cost for evening primary care and agreed to refer primary care to project Vida and accept referrals for prenatal care. This was the first such agreement to share space by the Health District, which has since led to the Health District contracting with other providers. Project Vida now provides space for the Woman, Infants, and Children (WIC) program to serve clients, eliminating a 7-mile trip for many of them. About 1,000 families are registered with Project Vida, and the primary care clinic sees about 350 patients a month who would otherwise have no primary care service.

Reduced use of the Emergency Department. Thomason Hospital's emergency department records indicated that about 500 families were using it two or three times a year for non-emergency pediatric purposes. The families were receiving poor primary care, and the hospital incurred excess costs as a result of this practice. The planning department of the hospital and Project Vida proposed funding for a nurse case manager and a community outreach worker to visit families using the emergency department for pediatric care. The program was put into place in January 1995. Families using emergency department services that sign a release form are referred to Project Vida. The nurse case manager and the outreach worker attempt to contact the families in home visits. With the family's cooperation, the nurse case manager develops a case management plan with them.

Only three of the 250 families contacted by the program have returned to the emergency department. Clients report a greater sense of control of their own family and less a sense of helplessness. They report satisfaction with being able to use basic health care tools and procedures. If 250 families had used the emergency department three times during the year for primary case, cost to the county hospital would have been $262,500 at $350

per visit. Cost for the primary health care is $48 per visit. The same 250 families visiting the clinic cost $36,000. The cost for the outreach program is $70,000. For a total cost of $106,000, the program saves more than twice that much in expenses.

Immunizations for children. As part of the city/county's Immunization Action Plan, Project Vida proposed receiving the birth records of newborn infants in its service area from the county hospital. An outreach worker and case manager coordinate visits to families with newborns, offering registration and follow up for immunization and Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) services. Families who accept services are offered a full variety of support services directly or by referral based on their case management plan. To date, 97 percent of the infants and children registered with Project Vida's programs are on schedule for immunizations.

Incentives. About one-third of Project Vida's participants have Medicaid. Few, if any, have private insurance; most are covered under indigent care plans. While Project Vida provides services to all registered clients, without regard to ability to pay, clients can receive "service units" for volunteer work with Project Vida, for attending particular health educational programs, or for participating in exercise activities. Participants can use service units to pay for food purchases in the food buying program, clinic fees ($6 per visit), counseling, or purchases in the thrift store. Children also receive service units for reading and can exchange them for Christmas presents for their families and other incentives. To date, more than 10,000 service units have been issued.

COMMUNITY PARTNERSHIPS

Project Vida began by working with the community to help define its own vision, then developed programs that made that vision real, and finally it involved other agencies as "partners" in the process. In so doing, Project Vida found ways to cooperatively solve joint problems.

In addition to the city/county Health District and the Thomason Hospital's Emergency Department, Project Vida has negotiated low-cost laboratory services with Thomason Hospital's laboratory. Project Vida participates in joint El Paso Title V funding for medical services for women and children not covered under any other program. WIC contracts with Project Vida to provide space for weekly services. Project Vida is a "charter member" of the El Paso Cancer Consortium, which provides early detection services to uninsured women and men, and funds Project Vida's clinical breast and prostate exams and referrals for mammography.

Project Vida is a member of the Sun County Recreation Collaborative that coordinates the city's summer recreation program and provides support for Project Vida's program for 50 children at the local elementary school. Project Vida is also a member of The El Paso Coalition for the Homeless and has received their support in obtaining funds to begin a transitional living center and building additional permanent housing. Project Vida also provides services to residents of the Salvation Army's Transitional Living Center and Emergency Shelter. Project Vida is a member of the Family Pride Coalition, which has been funded by the Texas Children's Defense Fund to provide

parenting and preventive education for children. Project Vida provides parenting education services as part of that program.

Zavala Elementary School regularly makes space available for Project Vida's programs at no charge and refers children to Project Vida for services. Project Vida serves as a preceptor site for advanced nurse practitioner students from the University of Texas at El Paso School of Nursing and Allied Health and as a research site for the University of Texas School of Public Health in El Paso. Project Vida provides work sites for older citizens under Project Ayuda. It is an AmeriCorps site and is finishing its fifth and final year as a VISTA project. Project Vida coordinates programs with La Mujer Obrera, EPISO (a community organizing project) and the Coalition for Affordable Housing.

SERVICE DELIVERY SYSTEM

Broad-based programs emerged following Project Vida's interviews with the community and the annual community congress meetings. These programs include the following:

- Peer-provided health education in homes and at central location
- A food-buying coop
- A bilingual, licensed family therapist
- Developmental pediatric consultations
- An optical program for buying prescription eyeglasses
- Home visitation for newborns for enrollment in EPSDT and monitoring of immunizations
- Family practice clinic
- An outreach home visitation program for families using the emergency room for pediatric primary care
- Construction of 20 apartment units
- Homeless prevention program
- Gang prevention (includes an after-school program for 50 students)
- Preschool classes
- One-on-one reading program for early elementary school children
- Multimedia computer lab
- Adult education classes (English as a Second Language, GED, citizenship)

ORGANIZATIONAL STRUCTURE

Project Vida uses a team approach to its organizational design. The two co-directors each take primary responsibility for various aspects of the program, making consensus-based decisions. The financial officer makes financial decisions with the co-directors. Three education coordinators jointly shape Project Vida's educational policies. Decisions affecting more than one workgroup—such as an outreach project to increase registered clients—are made by a team combining affected workgroups, such as home visitors, registration, and social services. Project Vida leadership staff include a social worker/case manager, day care director, afterschool director, health coordinator, financial officer, coordinators of other program areas and two co-directors. Administrative support is provided by three staff members who share financial and secretarial responsibilities. Program implementation staff includes a thrift shop supervisor, two home visitors (one registered nurse and one community outreach worker), one lead preschool teacher, an English teacher, a lead clinician (family nurse practitioner), "wellness" clinic staff (two registered nurses—one child and one adult specialist) with one clinic aide, a part-time women's health provider (nurse

practitioner), a part-time licensed family therapist (MSW), two part-time physicians (family practice and general practice), community health promoters, a registration clerk, a billing coordinator, and a receptionist.

Project Vida uses 42 AmeriCorps members in a variety of its programs, including adult education, children's education, afterschool tutoring and recreation, environmental improvement, clinic care and home visitation. In addition, an average of 15 members from the community and from local churches regularly volunteer in various program areas.

Project Vida's staff are predominately female, and most are Hispanic. Many staff members began as clients with Project Vida, became volunteers, and eventually were hired as staff members.

Project Vida is open five days a week, Mondays through Fridays. Some programs are held during evening and weekend hours.

Lessons Learned

Bill and Carol Schlesinger, co-directors of Project Vida, have designed a program that provides housing, education, youth recreation activities and other social services to over 1,200 families. Their program has been innovative in developing city-wide linkages among local health providers.

PROJECT **VIDA**

ISSUES, PROBLEMS, AND STRATEGIES AT THE OUTSET

We had to find a community which was not being served, which was in visible need, and which would accept us. Our initial response to this problem was to talk with the people in the agencies around the inner city of El Paso, and drive the streets in the different communities to locate a building and determine what kind of facilities were available. This also helped us to get a sense of the people in the community. We found a building, close to the school where the children could walk without crossing a busy street.

Our starting strategy for providing health care to the community was to gather volunteers who were willing to work to find doctors and other resources that we needed to operate a clinic. Even before we had located a building, we were operating a free medical clinic one night per week in space borrowed from another agency. By working initially with community volunteers, some who became staff, we were able to build a great deal of trust between the Project and the community.

Part of our philosophy was to do things one at a time. Once a program caught hold we were able to hand it over to others and move on to something else. As co-directors we did "break-open" stuff . . . some of it would work and some wouldn't, but we just kept on trying new things. A lot of our adult education classes did not work until we found a teacher who everybody liked.

Barbara Shull helping children wrap Christmas presents for their parents. Children "earn" these presents for their families by completing daily reading assignments. Project Vida focuses on involving families and empowering them to take responsibility for controlling their own future.

Now her classes are loaded.

OUR PHILOSOPHY FOR SERVICE DELIVERY

From the outset we wanted to make sure that we built a project that could serve all the needs of the people in the geographic area. We also wanted to involve our partners, the Presbyterian Church and the Cumberland Presbyterian Church. The other part of our philosophy was to make Project Vida feel like it belonged to the community. So, we worked hard at making the atmosphere relaxed and found ways to get the local children involved. Starting a thrift shop drew people in and helped us to get to know them. Our style communicated our interest in helping people. If we couldn't help with a particular problem, we helped them make plans elsewhere where they could get help. We even drove them over to the other agency.

QUALITATIVE AND QUANTITATIVE PROGRAM OUTCOMES

Outcomes of our project are many. New buildings are up, housing is in place, the number of immunizations has increased. But, perhaps it is the stories that best illustrate our program outcomes. There's the PTA president who first came snooping around and ended up liking us. The elementary school principal sent the PTA president and vice president to visit to find out who we were and what we were doing. A few days later the vice president came back and volunteered to help. She is now a permanent staff member. Volunteers tell us they like being at Project Vida. There are friendships instead of TV soap operas and useful things to do other than housework. They practice English and develop other skills. For people who are coming from really troubled situations, there's a sense of satisfaction that they have a place to go to, a place where they feel better about themselves by helping others, which helps them to deal with the problems that they return to.

EFFECTIVE CONSENSUS-BUILDING STRATEGIES FOR CONFLICT RESOLUTION BETWEEN PARTNERS

We found it takes a while to get the chemistry functioning, but as far as conflict between partnership members, we don't remember that there was a lot. Any conflict happened when we set limits and made it

Corina Najera reads to a child from the local community. Project Vida has created several programs that respond to the unique and overwhelming needs and possibilities in the nation's fifth poorest metropolitan area.

clear that we were not prepared to go beyond them. Maintaining our geographical focus has been a major issue.

When agencies wanted us to do something that meant going beyond our geographical area, we said "no." We're attempting to build a community network. It does not make sense to use our resources beyond the people in our community. And yet it is this commitment to our geographical focus that has strengthened our relationship in some areas with our partners. The city has been really happy that we have not tried to spread ourselves too thin.

Our sense of where Project Vida has needed to be has sometimes conflicted with people bringing in their own history and traditions of doing things, or individual passions about doing their part in Project Vida. We have had to keep everybody in balance rather than letting *one* program, or *one* staff member, or *one* philosophy become established and set the pace for others. Regular weekly staff meetings have contributed to achieving this balance and the creation of consensus, but most of the consensus building happens in small groups. As co-directors, we spend a lot of time talking about the project and why we do the things we do. We also triangulate and de-triangulate, talking to people individually and getting people together to talk. We try to build a shaped response rather than impose an arbitrary decision.

STRATEGIES FOR BUILDING COOPERATION BETWEEN COMMUNITY PARTNERS

One of our strategies for building a stronger sense of cooperation between partners has been to be fairly up front about institutional needs in balance with the broader community goals. We have tried to figure out what each partner needs to get out of the deal rather than just what one partner needs. A second strategy has been to emphasize absolute accountability—we don't slide the numbers and we don't play around even with the pennies. We can back up all our numbers. This has made community agencies feel better about supporting us.

OVERCOMING BARRIERS, LEVERAGING PARTNER RELATIONSHIPS AND BUILDING ALLIANCES FOR SUCCESS

We have overcome barriers and built alliances for success through a willingness to work authentically with agencies and with funding bodies. This starts with writing proposals and ensuring that we are addressing with absolute clarity the problems we want to solve in this community. For us, it is important that the proposal expresses our concerns and solves local problems, and not just what the funding agency wants to hear. We also

ensure that we do what has been stipulated in the agreement. Sometimes when we have asked agencies to redirect or make adjustments because of our findings, we have found that being direct and open has made it easier for them to redirect expenditures. We have not found the partner agencies difficult to work with, but realize that open communication is essential. Our co-leadership has been an asset, because there are two of us that are committed to the promises that have been made. This co-leadership is replicated in several levels of teams throughout the Project. We value picking up different styles and making use of a variety of perspectives and skills as we develop our systems.

Implementation of Model Program/System

1. IMPLEMENTATION ASSUMPTIONS

- Assume that human problems are interrelated. Services are more effective if several aspects of a situation can be tackled at once. Improved housing conditions can result in better health. Attention to mental health as well as other basic needs can reduce child abuse. The well-being of children depends on the well-being of the adults around them. Similarly both process and content have to be addressed. How people learn, how people make decisions, and how people act together cannot be separated from what they learn, what decisions they make, and what actions they take. This model provides a broad variety of services and programs rather than focusing on one category of service, and it attempts to fit process and content together.
- Designate a specific geographical area. Resources can then be focused on the unique configuration of the needs of a particular community. Services and programs can be physically accessible to members of the community, allowing them to participate in shaping their form and style.
- Develop the local vision first, before bringing in outside partners. Use available resources to initiate programs that implement a coherent vision with as much community involvement as possible and then link resources from the wider community to implement the community's vision.
- Address the underlying contradiction that has prevented the community from unifying and resolving its own problems in the past. This contradiction usually resides in the community's image of itself and others. It may be reflected in narrow and divided loyalties of "we" and "they," in a sense of fatalism and impossibility, or in a short-sighted individualism that sees self-interest only in immediate gain.

2. COMMUNITY-BASED EMPOWERMENT

- **Site selection**: In the process of selecting the local community, disturb as little as possible and do not raise false hopes. Select a geographically defined service area in the context of other providers and the wider community as a whole.
- **Research**: Conduct entry research--interviews, surveys, and focus groups--to discuss all priority issues. If time or resources do not permit conducting all three, decide which will provide the most insight given the particular community.
- **Strategy**: Look at the needs of the community and work with the community to set broad goals for responding to each need. Analyze the obstacles to achieving those broad goals, plan to work around obstacles, and at the same time demonstrate possibility in each need area.
- **Program development**: After conducting the entry research, develop initial programs using available resources. These programs should address an immediate need and be sustainable for at least one year. Involve community participation in implementing these programs in various roles, such as hosting a program, providing space for it, or help-

ing lead or work in the program. Address each major need or goal area in

at least part of an initial program during the first three months.

Community-wide meetings: Community participants need to meet regularly to evaluate and plan the program and conduct annual community-wide meetings at a time that allows the widest participation possible. Such a meeting may be as brief as two hours or as long as a day.

- **Community Involvement**

a) Inform the community. Conduct open houses for people in the surrounding neighborhood; set up a thrift shop or food program that pulls people in; develop a cordial, welcoming atmosphere. Train community speakers who can speak about programs and issues and interpret the desires of the community.

b) Make community members volunteer or paid staff. Begin new programs with top staff (including the director) matched with local community staff or volunteers who are jointly responsible for getting the program up and running. Local community staff then pick up increasing levels of responsibility as the system is put in place, fitting in additional professional staff as necessary. Top staff eventually pulls out but continues to monitor activities and acts as internal consultant and back-up. For example, at Project Vida the co-director operated a thrift shop with community volunteers, including one volunteer who was particularly faithful and respected by community residents. Through several stages, the co-director began cutting back time in the thrift shop and the volunteer is now a staff person who runs the thrift shop.

c) Build services around the skills of community participants and providers as much as possible. For example, Project Vida recruited a graduate student in public health who worked with a community volunteer to identify health care issues. Together they developed presentations that included hands-on activities and practical incentives, such as teaching people how to read a thermometer that they can then buy for a quarter.

d) Recruit volunteers from clients. Project Vida recruited for AmeriCorps, VISTA, or similar programs with stipends to allow strong community volunteers to become full-time providers.

e) Whenever possible select new staff from active volunteers.

f) Use a coordinating team rather than a single person for program leadership. Partner technically prepared persons with wise community persons. For example, three women coordinate the children's education program. One is a gifted teacher, another strong in administration, the third a community resident who is very good at relating to parents. The three meet and deal with decision-making in the program.

g) Conduct weekly staff meeting that includes key staff, support staff, and volunteers. Discuss motivation and context as well as procedures, tasks, and policies.

- **Family-controlled access**

a) Emphasize participation in many program areas. Project Vida encourages parents to stop by the thrift shop when they bring their children for reading, and social work clients to better manage

their money by participating in the food-buying program. Clinic clients can be referred to exercise classes and the walking program to help reduce the need for medication for high blood pressure. Emphasizing participation in many program areas helps clients develop lifestyles rather than getting quick "Band-Aids" or one-time handouts.

b) Empower families by encouraging families to invest in the variety of services and programs. Charge a nickel or dime to buy healthy snacks or to help with other expenses. Allow purchases in a thrift shop with money, credits for volunteering, or credits for having children up-to-date on immunizations, walking or exercising, having health screenings regularly, or attending a health education class.

c) Treat volunteer slots as jobs with job description, supervisor, and schedule. "Hire" community volunteers and award a service credit for every hour of service. Take service credits as pay for other services. This removes participation from "charity"--arbitrarily controlled by donor--to "using a service" in response to certain actions by the client. Clients--community participants--are not objects to be processed or manipulated. They are partners and colleagues in problem-solving and developing a community. Developing a system of investment response builds a pattern for future growth and development. For example, Project Vida's reading program provides an incentive for children to read by also offering the chance to buy Christmas presents for their families, which also reinforces a sense of empowerment in children and their responsibility for others.

3. MULTIPLE SERVICE INTEGRATION

a) Link programs to other programs in the community. Once programs are under way, they are ready to "spiral" larger by seeking support and cooperation from the wider community. Choose target programs that address the key contradictions, link to other issues, have high visibility, and will be used often and regularly.

b) Determine the next critical step in developing programs. What are the space, staff, and material needs? Pursue support in the wider community for expansion.

c) Develop a framework of providers, resources, and decision-makers that relates to the community. Look for mutual benefits. For example, the county hospital was concerned about having supported community clinics and feeling it had gotten nothing in return. The hospital was facing long emergency room waits because of its use for primary care by nonpaying clients. The hospital was willing to negotiate funds for Project Vida for a nurse case manager to visit families using the emergency room for non-emergency pediatric care. The hospital tracked the families, referred them to Project Vida, and screened to see if they came back to the emergency room again. Project Vida agreed to report its visits monthly. The hospital benefited, the community benefited, and a new program was created.

d) Create opportunities for partner programs. Some potential partners will extend their services into the community if offered space, outreach support, or other incentives. Include a community accountability component in such agree-

ments, since on-site staff may not always share values on the style of service the community requires. Establish a primary contact between partner programs and the local project--one person in each system who handles issues and concerns. This person should be at a sufficient level to make needed changes or adaptations in staffing, scheduling or program scope. Conduct community-wide meetings at least annually to review and evaluate partner programs as well as the project's own program development. Conduct regular client satisfaction surveys for the partner's services.

e) Periodically conduct random surveys within the community to determine program recognition and use of the programs as well as reasons why any respondents do not use the program.

f) Document program outcomes. Project Vida tries to track what programs touch what families in addition to total numbers seen in each program. This information helps determine the combination of programs that seem to be effective as well as the popularity of individual programs and how well services are integrated. We also use this survey to determine the most active clients for using resources and developing as volunteers.

g) Measure actual outcomes (qualitative or quantitative) based on the objectives established for the program. A quantitative example is the number of children immunized on schedule versus those immunized late; a qualitative example is comments from participants about what they learned or received from a health presentation.

h) Coordinate referrals and follow up with other services. Identify a key contact with other agencies or programs who will coordinate referrals you send. Clarify the rules of the other agency or program (for example, what clients will they accept, what services will they provide). Develop a process for agency-to-agency feedback on client information. Develop a process to review both the adequacy of the service and the client's satisfaction with it.

i) Maintain systems for fiscal integrity. This has been one of the most dangerous areas for non-profits in our community. Active programs have been destroyed because of lack of systems to remove the temptation on fiscal integrity. At Project Vida one person authorizes a purchase, another writes the check and enters the transaction in the books, yet another co-signs every check.

4. CULTURALLY INCLUSIVE SPIRIT

a) Maintain a vision beyond the immediate community. Many of the contradictions in low-income communities are related to a reduced vision and sense of possibility. Narrowed geography unrelated to a global context leads to assuming the impossibility of anything ever being different. Community participants need to place themselves in the widest possible context.

b) Demonstrate respect for everyone, including children and the poorest people. Clarify that there is no tolerance for harassment or lack of courtesy to anyone, including sexual harassment, homophobia, comments about clothing or body type.

c) Problem solve at all levels by encouraging communication among all involved, including the smallest children. Problem solving should be an inclusive process rather than a hierarchical chain of command. This does not mean abandonment of leadership responsibilities by supervisors and directors. It means that the circle of participation is widened rather than referred "up" to others for action. Those directly involved remain in the conversation, and their data are presented directly, at each step of the process. At the same time, it is clear that cultural contexts contribute to the ability to participate in problem solving. Some cultures place value on the ability of an individual to adapt to a situation, some cultures place a strong value on relationships, and others on adherence to formal process.

d) Reflect. Project Vida staff meetings include a conversation of issues and concerns facing the staff and volunteers. The community is Hispanic and predominately Catholic, which means it draws many of its motivating values from traditionally Christian writings. Practical issues can emerge from any staff member or volunteer. The discussion focuses on clarifying the issue, identifying alternative solutions, and selecting a next step. Sometimes the next step is to refer the issue to appropriate staff to work on details. At other times there is a general discussion of what would work best. The Co-directors often ask for reflection or comments on a particular issue before making a plan of action.

Funding/Resource Development

Provides salaries and expenses for children's programming, afterschool activities, a health coordinator and homeless case manager, and funds to construct apartments and a transitional living center.

The Texas Department of Health provides community-oriented primary care and Title V services, as well as financial support for the clinic and preventive health care staff.

Texas Commission for National and Community Service AmeriCorps

Provides salaries for a supervisor and the 42 members who provide direct community services.

Presbyterian Church (USA)

Assists with administrative funding and, through the Women's Birthday Offering, helped establish the Early Childhood Development Center.

Maternal and Child Health Bureau

Supports systems and organizational development as a "Community Integrated Service Systems" (CISS) project.

Meadows Foundation	Funded acquisition and remodeling of the local clinic and the Early Childhood Development Center.
Thomason Hospital	Sponsors the home visitation program to follow up on families who use the emergency room for pediatric primary care.
Federal Home Loan Bank Fund	Supplied funds to acquire and construct low-income rental housing.

Models That Work Campaign Information

The Health Resources and Services Administration's Bureau of Primary Health Care, in collaboration with 39 co-sponsoring foundations, associations, and nonprofit organizations, has identified winners and special honorees in the 1996 **Models That Work** Campaign. To obtain strategy transfer guides for the programs listed below, contact the National Clearinghouse for Primary Care Information (NCPCI) at (800) 400-2742.

1996 Winners

PROGRAM NAME	KIND OF PROGRAM
Abbottsford and Schulykill Falls Community Health Centers	Nurse-Managed Community Health Center
Camp Health Aide Program (CHAP)	Culturally-Attuned Community Outreach
Comprehensive Community Health Services Program of Project Vida	Integrated Family Health and Social Services
Hillsborough County Health Care Plan	Countywide Managed Care for Indigent Residents
The Los Angeles Free Clinic Hollywood Center	Peer Outreach and Access for High-Risk Youth

1996 SPECIAL HONOREES

PROGRAM NAME	PROGRAM CATEGORY
Accomack County School-Based Dental Program	Oral Health
Chicago Health Corps	Health Professions Program Participation
Children's FACES (Family AIDS Clinic and Educational Services)	HIV/AIDS
Growing Into Life Task Force	Maternal and Child Health
Independent Care	Managed Care
Marion County Child Health Initiative	City- or County-Level Coordination
MOM's Project	Substance Abuse Prevention and Treatment
Rotacare Free Clinics	Business Participation
The Rural Prevention Network	Rural Health
St. Agnes Hospital Domestic Violence Program	Hospital Participation

In addition to the **Models That Work** video (available June 1997) and other resource materials, the Bureau of Primary Health Care has published the 1996 **Models That Work** Compendium. This publication describes unique features of more than 275 community-based primary health care programs that participated in the 1996 competition. To obtain a copy of the compendium, video, or other materials, call (800) 400-2742. (Residents of the Washington, DC, metropolitan area, dial 703-821-8955, extension 248.)

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