Increasing children's access to and use of preventive care

Appendix: Additional documentation for the final Growing Up Healthy in Minnesota evaluation report to the Blue Cross and Blue Shield of Minnesota Foundation

MARCH 2005

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March 2005

Prepared by:
Michelle Decker Gerrard and Greg Owen

Wilder Research
1295 Bandana Boulevard North, Suite 210
Saint Paul, Minnesota 55108
651-647-4600
www.wilder.org

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Introduction to Appendix

This appendix contains additional documentation collected as part of the evaluation of *Growing Up Healthy in Minnesota*, an initiative of the Blue Cross and Blue Shield of Minnesota Foundation. This appendix supplements information contained in the final report for *Growing Up Healthy in Minnesota* by Wilder Research staff. Information in this appendix details *Growing Up Healthy's* initiative-level evaluation design. It also contains a summary of each of the nine grantees progress in their project-level goal areas over the course of the grant period. This appendix is not designed for public dissemination.

A. Wilder Research evaluation plan for the initiative

The following is an edited version of the evaluation plan presented to the Blue Cross Foundation board committee in September 2002. It has been edited to remove redundancy in tables and descriptions of projects that have already been provided in the body of this report.

Growing Up Healthy in Minnesota

Overview of the evaluation design

September 2002

Prepared by:
Greg Owen and Michelle Decker Gerrard

Wilder Research
1295 Bandana Boulevard North, Suite 210
Saint Paul, Minnesota 55108
651-647-4600
www.wilder.org

Introduction

In its request for proposals, the Blue Cross and Blue Shield of Minnesota Foundation identified two primary goals as part of its *Growing Up Healthy in Minnesota* initiative. These goals were: to increase the ability of families from communities of color to access and appropriately use child and adolescent preventive services, and to remove barriers to adolescent preventive care, especially for teens from ethnic and minority communities.

As part of *Growing Up Healthy in Minnesota*, the Blue Cross Foundation funded nine grantees in the summer of 2002. These grantees represent a diversity of project strategies, geographic scope, target population, and preventive focus.

Wilder Research was contracted to collaborate with Blue Cross Foundation staff in the design, development, implementation, and reporting of evaluation activities related to this initiative. As part of their contract with the Blue Cross Foundation, it is the responsibility of each of the grantees to have a project-level evaluation plan so that they may report on the process of implementing their project and the outcomes of their Blue Cross Foundation funded activities. While most of the nine grantees have a project-level evaluator, Wilder Research provides technical assistance to the grantees and ensures that each of the evaluation plans addresses the overall goals of *Growing Up Healthy in Minnesota.*

The purpose of this document is to provide an understanding of the goals of *Growing Up Healthy*, the related research questions, a list of evaluable project activities, data collection sources, and initiative-level evaluation activities.

Overview of the initiative-level evaluation design

There are three purposes of the evaluation design. The first goal is to document the activities and outcomes of this initiative on the individuals who participate in grant funded activities. The second goal is to examine key issues related to the implementation of program strategies. The third goal is to examine how satisfied key stakeholders (project participants, staff, partners, and Blue Cross Foundation Board and staff) are with the initiative.

In its *Growing Up Healthy* Call for Proposals document, the Blue Cross Foundation identified the following objectives to be targeted by this initiative:

- To increase the ability of families from tribal communities, populations of color and foreign-born populations to access and appropriately use child and adolescent preventive services
- To remove barriers to adolescent preventive care, especially for teens from ethnic and minority communities
- To develop partnerships between communities of color and/or recent immigrant groups, providers, counties, businesses, and other local organizations
- To create youth -friendly preventive care environments and adopt clinical practice approaches and tools that reflect the breadth of adolescent health issues
- To address barriers to preventive care through education and outreach based on an understanding of the health-related cultural beliefs of the population(s) served
- To demonstrate best practices using collaboration and sound evaluation methods
- To effect changes in clinical practice, administrative systems, and organizational policy to promote culturally and linguistically appropriate services and to foster patient-centered preventive care models

Outcome evaluation

The first component of the evaluation is an examination of initiative outcomes. It is anticipated that changes will take time to evolve; thus, the outcomes can best be measured and understood by collecting baseline information and tracking progress over the course of the grant periods. The following are some of the preliminary outcome evaluation questions that have been identified:

Questions related to direct preventive health services to the children and youth

1. Do these services result in larger numbers of children from ethnic and minority communities receiving preventive health services (well child visits)?[1]
2. Do these services result in larger numbers of children from ethnic and minority communities receiving preventive dental services?
3. Do these services result in larger numbers of teens receiving preventive health services?

Questions related to projects that provide parent and youth outreach and education

1. Do these efforts increase knowledge of preventive care?
2. How many children and/or families were referred to services? Of these, how many children were provided preventive services? What are the characteristics of children and/families who were provided care?
3. Do these efforts influence parent and youth behavior in the areas of seeking out and obtaining these services?
4. Do these efforts reduce barriers faced by children and families from ethnic and minority communities?
5. Do these efforts increase the number of families whose children are insured?

Questions related to projects that provide provider education and training

1. Are providers behaving and providing services differently?
2. Are youth satisfied and comfortable with the clinicians? Do youth perceive services as confidential?
3. Are providers more culturally competent as a result of receiving the training?
4. Are there new training materials related to increasing provider competence in adolescent care and care of children from minority and immigrant communities? Are these materials replicable?

[1] Increase is intended to be measured using baseline data. Increase will vary by project.

Process evaluation

The second component of the evaluation is a process evaluation. This component will be used to examine implementation of the initiative and each of the nine projects, to identify the influence of implementation variables on outcomes, and to measure stakeholder satisfaction.

The following preliminary process evaluation questions have been identified:

1. How many children and/or families received services from each grantee? Of these, how many children were referred for preventive services? How many received preventive services?
2. What are the characteristics of children and/or families who were served by the grantees?
3. What services and resources are most needed by participating families? What services are most often provided by the grantee organizations? What services are provided by community health workers? What are the challenges and barriers to accessing care by the populations served?
4. What are the provider capacities? To what extent are the providers bicultural or bilingual? What type of cultural competency training have the providers received?
5. How have the various models been implemented? What barriers have been encountered in implementing the models?
6. How satisfied are families with services?
7. How do families perceive the effectiveness of each of the programs?
8. How has the project contributed to a culturally competent approach to providing access to health care for persons of color or new immigrants?
9. What new tools, guides, and other written or video materials have been developed as a result of this initiative?
10. How do the projects empower the communities served? Do they take more responsibility for their health care? How do we evaluate "shifting attitudes" as a group of nine projects? *(question from June 6th meeting with grantees)*
11. How well did the community partnerships work?
12. How successful was each project in realizing the outcomes stated in each of their proposals?
13. Were there any trends or policy changes during the timeframe of the initiative that had an impact on the projects, their outcomes, and/or their futures?

14. What are the prospects for sustainability for the projects?
15. Do funded projects show enough value to be replicated? What are the necessary ingredients for the promising projects to be replicated?
16. What are the unique preventive care access contributions of the different types of organizations that were funded under this initiative? What were the unique limitations of the chosen grantees?
17. Did the Blue Cross Foundation and grantees develop a "learning network"? How helpful was this learning network?
18. How well did the Blue Cross Foundation's process of granting and oversight for this initiative work?

Summary of data collection activities

To measure these outcome, process, and satisfaction issues, the following data collection activities will be conducted.

1. The collection of baseline information for the year prior to the *Growing Up Healthy* grant period. This baseline information would include specific service use by the population targeted by the grantee.
2. The collection of descriptive information on participants from each grantee agency. This portion of the cluster initiative depends on the ability of individual grantees to implement common data collection or submit common information from each agency. The data collected would provide details on participant characteristics and services received. Wilder Research will provide a log to interested grantees that will help them track the number of persons participating in project activities and characteristics of persons served including common data elements (see the Appendix) such as: demographics, last doctor/dentist served, barriers to receiving services, etc.
3. Ongoing documentation of program activities and services provided. Wilder Research will provide a log to interested grantees.
4. For direct service programs, a description of the child and adolescent preventive health and dental services provided (based on guidelines for Child and Teen Checkups).
5. Follow-up survey of clients who are referred for health/dental services including: did the client get care; did client get preventive services (with specific definition), what was the client's perception of accessing care (including cultural sensitivity issues), and would the client go back to get care in the future? This follow-up

survey will be completed by project staff (when applicable). Wilder Research will provide a template.

6. Key informant interviews with project level collaborative partners to measure success, challenges of the project-level collaborations (2 to 4 interviews per grantee organization, up to 50 total interviews, will detail successes and challenges during the first and again in the second year of implementation).
7. Review of each project's progress report(s) and final evaluation report. This involves the examination of each evaluation report(s) prepared by grantee agencies based on their specific evaluation plans and reporting requirements specified by the Blue Cross Foundation.
8. Overall review of process of granting and oversight for Blue Cross Foundation staff.

Proposed common data elements for the initiative-level evaluation

The following are some common data elements that direct service grantees may be required to gather to measure success in reaching the intended population. Grantees may wish to ask Wilder Research to provide a form to collect this information, or grantees can collect it within their own system. Wilder Research simply needs to know how grantees are doing the data collection.

Information about participants

1. Age (collect date-of-birth) of participant. If project targets parents, collect ages of children (date-of-birth) of child/children
2. Race and/or ethnic background
3. Gender
4. At intake, does the participant have health insurance for their children?
5. At intake, does the participant have dental insurance for their children?
6. At intake, last doctor visit
7. At intake, last dental visit
8. Approximate length of time since last well baby/child visit
9. Purpose of current visit or service
10. At follow-up, did the client receive health/dental care? Did the care include preventive services (see child/teen checkups components)?
11. At follow-up, did the client enroll in health and/or dental insurance for children?
12. Description of risk factors or barriers to previous access of health care (Wilder Research will work with Blue Cross Foundation to prepare checklist that may include items such as transportation, language, distance, no insurance. One potential question is: do you need an interpreter (family member or other English speaking person) to communicate with your child's doctor or nurse?)

Wilder Research may also be interested in specific questions related to access being asked of client/participant at follow-up (if a follow-up is appropriate). These questions may include: did client get care; did client get preventive services (give specific definition); what was the client's perception of accessing care (including issues related to cultural sensitivity); and would the client go back to get care in the future.

Wilder Research is also very interested in collecting baseline information about the targeted populations use of the targeted services within the past year (or 2 years – if available). For example, (in the previous year before funding) the number of visits to Pilot City Health Center by children of Hmong or Lao background; or (in the previous year before funding) the number of adolescents who visited Affiliated Community Health Center in Willmar for a teen checkup.

Initiative-level evaluation timeline

Tasks	Timeframe
1. Schedule and initiate site visits. Assess needs for technical assistance. Assist in the preparation of logic models.	July and August, 2002
2. Develop plan for initiative-level evaluation.	July and August, 2002
3. Draft plan for initiative-level evaluation.	By September 12, 2002
4. Plan submitted and discussed to Blue Cross Foundation Board.	September 26, 2002
5. Finalize and implement initiative-level evaluation activities and data collection plans.	October – December, 2002
6. Provide technical assistance for project start-up.	October – December, 2002
7. Interim project reports due for Somali Community Health and U of M Division of Pediatrics (both 1 year projects).	December 2002 – January 2003
8. Check-in with grantees on project level evaluation implementation.	January – April, 2003
9. Key informant interviews with project leaders (2 to 4 interviews per grantee organization, up to 50 total interviews, will detail successes and challenges during the first year of implementation).	May – June, 2003
10. Review of first year evaluation progress reports from each grantee.	July – August, 2003
11. Preparation of first year progress report on the overall initiative (combines information from 1 and 2 above).	September, 2003
12. Collection of descriptive information on participants from each grantee agency. This portion of the cluster initiative depends on the ability of individual grantees to implement common data collection or submit common information from each agency. The data collected would provide details on participant characteristics and services received. (If this component of the cluster evaluation is not feasible, WRC could identify a small sample of project participants from each grantee organization and conduct phone interviews regarding service access, barriers and other project specific goals.).	Implement at the beginning of the second full year for two year grantees (May or June, 2003) and collect data until project funding has ended (May, 2004)
13. Second year key informant Interviews (conducted with 1 to 3 project leaders at each grantee site)	May – June, 2004
14. Review of each project's final evaluation report.	July – August, 2004
15. Preparation of final cluster evaluation report that would include: a) aggregate information from any common data collection or participant surveys, b) the results of the second year key informant interviews, c) summaries from the final evaluation reports from each individual project, and d) evaluator's summary and review of project challenges and successes	September, 2004

B. Evaluation tools used in the initiative

Type of data collected	Instrument used	Who developed and administered the data collection?
Descriptive information about participants	"Common Data Elements" as a guideline for project data collection[2]	Wilder Research gave each project a list of "Common Data Elements" to help shape their intake data collection process. Each project or evaluator was expected to collect this information for participants served.
Process data (collecting information from grantees about implementation issues)	Notes from grantee site visits (summer 2002)	Wilder Research staff.
	Structured notes from conference call "Check-Ins" with grantees (spring 2003)	
	Key informant interviews with Blue Cross Foundation staff at the end of Year 1 and Year 2	
	Key informant interviews with project staff and partner agency staff[3]	
	Grantee Interim and Final Reports to the Blue Cross Foundation	Each grantee was asked to describe successes and challenges in implementation in the Interim and Final reports. Some of this information was collected systematically by project evaluators.
Participant satisfaction	Parent interviews conducted with a selected sample from five of the grantees[4]	Wilder Research (interviews conducted in five languages)
	Some grantees collected participant satisfaction information	Project-level evaluators
Outcome data	Interim and Final reports and the Summary Tables requested by Wilder Research	Blue Cross Foundation and Wilder Research provided the template.
	Outcome data also collected from all sources described above.	

[2] See previous Appendix for a list of Common Data Elements.

[3] See attached for a copy of the key informant interview.

[4] Because each of the participant surveys was customized to fit the project and then translated, each parent survey is slightly different. Somali Community Resettlement's version (in English) is attached as representative of the types of questions and responses collected.

Activity Code: 70297 CASE ID #: _____

Growing Up Health in Minnesota (Blue Cross Foundation)
Key Informant Survey with Staff and Partners

INTRODUCTION:

Hi, my name is _____, and I'm calling from Wilder Research. Wilder Research is working with the Blue Cross Foundation to better understand the impact of the Growing Up Healthy grants that were funded about two years ago. We are calling staff and partner agencies of projects that were funded through Growing Up Healthy to gather input about project successes, challenges, and future plans. We are also interested in your thoughts about barriers for children and youth in communities of color to access preventive health and dental care. The survey is voluntary and confidential, and takes about 15 minutes. Would you be willing to participate? We can do it now if this is a convenient time.

IF YES, PROCEED.

IF NO, ASK IS THERE A BETTER TIME TO CALL AND RECORD DATE AND TIME ON FACESHEET.

IF REFUSED, ASK: Is there any particular reason why you would rather not participate in this survey.

_____
_____
_____

1a. We understand that you [DESCRIBE ROLE WITH PROJECT]. Is that correct?

Yes 1
No .....(GO TO Q. 2)..... 2

1b. Can you briefly describe your role with the project?

_____
_____

2. How long were you involved with [NAME OF PROJECT]?

Less than 6 months, ... 1
6 to 12 months, or 2
More than 12 months 3
Refused 7
Don't know 8

3. What do you think were some of the most effective strategies your project used to help connect children, youth, and families to preventive health or dental care?

4. What did your project do to make preventive care more accessible to children and youth of color?

5. Did [NAME OF PROJECT] use bilingual or bicultural advocates or community health workers?

Yes 1
No .....(GO TO Q. 6)..... 2
Refused 7
Don't know 8

5a. Can you tell me a bit about the role of bilingual or bicultural advocates or community health workers?

_____

_____

_____

_____

_____

_____

Did [NAME OF PROJECT] focus on building the cultural competency of providers or community organizations?

Yes 1
No .....(GO TO Q. 8)..... 2
Refused .....(GO TO Q. 8)..... 7
Don't know .....(GO TO Q. 8)..... 8

7. What do you think were some of the most effective strategies that [NAME OF PROJECT] employed to build the cultural competency of providers or community organizations?

_____

_____

_____

_____

_____

_____

_____

_____

8. What do you think were some of the biggest challenges of the [NAME OF PROJECT] model for increasing access and use of preventive health and dental care for children, youth, and families (particularly those from communities of color)? [PROBE: What made it difficult to achieve project goals?]

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

9. How did [NAME OF PROJECT] empower the communities served? Did communities take any more responsibility for their health care? Were attitudes changed?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Did your project partner with any organizations in the community?

Yes 1

No .....(GO TO Q. 13)..... 2

11. Who did you partner with?

12. How well did the project's organizational and community partnerships work?

13. Were there any trends or policy changes during the timeframe of the initiative that had an impact on the projects, their outcomes, and/or their futures?

14. Without special grants or one-time funding opportunities, what are the prospects for sustaining this kind of project in the future?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The next questions are about your involvement in the Growing Up Healthy Grantee Learning Network. Just to remind you, there are no right or wrong answers.

15A. We are gathering feedback about the Grantee Learning Network meetings that were convened by Blue Cross Foundation staff (at the Arboretum, Lao Assistance Center, and St. Mary's Hospital in Mankato). Did you participate in any of the Learning Network meetings?

Yes 1

No ..... (GO TO 18) 2

Refused ..... (GO TO 18) 7

Don't know ..... (GO TO 18) 8

15B. Comments [PROBE: Why do you say that?]:

_____

_____

_____

_____

16A. How helpful were the Learning Network meetings in helping you to learn more about other projects?

Very helpful, ... 1

Somewhat helpful, ... 2

Somewhat unhelpful, or 3

Very unhelpful? 4

Refused ..... (GO TO 17A) 7

Don't know ..... (GO TO 17A) 8

16B. Comments [PROBE: Why do you say that?]:

_____

_____

_____

_____

_____

_____

17A. How helpful were the Learning Network meetings in giving you ideas and strategies for your own projects?

Very helpful, ... 1

Somewhat helpful, ... 2

Somewhat unhelpful, or 3

Very unhelpful? 4

Refused ..... (GO TO 18) 7

Don't know ..... (GO TO 18) 8

17B. Comments [PROBE: Why do you say that?]:

_____

_____

_____

_____

18. Did you have any other contact or information sharing with any of the other grantees involved in Blue Cross Foundation funded activities?

Yes 1

No ..... (GO TO 20) 2

Refused ..... (GO TO 20) 7

Don't know ..... (GO TO 20) 8

19. What type of contact or information sharing did you have?

_____

_____

_____

_____

_____

_____

20. We are also gathering feedback about the process of granting and oversight by Blue Cross Foundation. Did you work directly with Blue Cross staff who oversaw your grant?

Yes 1
No .....(GO TO Q. 23)..... 2
Refused .....(GO TO Q. 23)..... 7
Don't know .....(GO TO Q. 23)..... 8

21A. How helpful were Blue Cross staff in answering your questions related to Growing Up Healthy's vision and goals as they impacted your program?

Very helpful, ... 1
Somewhat helpful, ... 2
Somewhat unhelpful, or 3
Very unhelpful? 4
Refused 7
Don't know 8

21B. Comments [PROBE: Why do you say that?]:

_____
_____
_____
_____

22A. How helpful were Blue Cross staff in answering your financial questions?

Very helpful, ... 1
Somewhat helpful, ... 2
Somewhat unhelpful, or 3
Very unhelpful? 4
Refused 7
Don't know 8

22B. Comments [PROBE: Why do you say that?]:

_____
_____
_____
_____

23. Can you think of any other suggestions or comments about the process of granting and oversight provided by the Blue Cross Foundation?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

24. Finally, we are interested in your perceptions barriers for children and families to access preventive health care – particularly for those families who **have** insurance. What do you think keeps children and families from accessing preventive health care?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thanks very much for taking time to do the interview. We really appreciate your feedback in helping us learn more about the impact of the Growing Up Healthy initiative.

Client ID: _____

Growing Up Healthy in Minnesota
Somali Community Resettlement Services Parent Follow-Up Survey
Organization Code: 70297

Introduction

Hi, my name is _____ and I'm calling from the Wilder Research for Somali Community Resettlement Services in Rochester. We are calling people who get services from Somali Community Resettlement Services. We are calling to ask a few questions about your experiences in learning about health and dental care for your children. Somali Community Resettlement will use this information to improve services. We are offering a $5 Target gift certificate to everyone who completes this telephone survey. This survey is voluntary and confidential. It takes about ten minutes. No one at Somali Community Resettlement Services will know who participated in this survey. Would you have a few minutes now?

IF YES: Proceed

IF NO: Would there be a better time to call? RECORD CALL BACK/APPOINTMENT INFORMATION ON FACESHEET.

IF REFUSED ASK: Is there any particular reason why do not want to take part in the survey?

RECORD REFUSAL REASON

Organization Code: 70297

Growing Up Healthy in Minnesota
Somali Community Resettlement Services Parent Follow-Up Survey

1. Do you ever watch Somali TV (cable access)?

Yes 1
No.....[GO TO Q. 6].....2
Refused .....[GO TO Q. 6].....7

2. How often do you watch Somali TV?

Every day 1
Several times a week.....2
Once a week.....3
A few times a month.....4
Once a month.....5
Less than once a month.....6
Refused 7
Don't know 8

3. Have you ever seen a health message on Somali TV?

Yes 1
No.....2
Refused 7
Don't know 8

4. Have you ever seen a health message about getting immunizations for your children on Somali TV?

Yes 1
No.....2
Refused 7
Don't know 8

5. Did you hear anything on Somali TV that encouraged you to get immunizations or other health care for your children?

Yes 1
No.....2
Refused 7
Don't know 8

6. Do you currently participate or have contact with Somali Community Resettlement Services?

Yes 1
No.....2
Refused 7
Don't know 8

7. How often have you talked with someone at Somali Community Resettlement Services? Has it been. . .

Just once,.....1
Two to five times, or.....2
More often than that?.....3
Refused 7
Don't know 8

8. Did the staff at Somali Community Resettlement Services

	Yes	No	REF	DK
a. Help you find or get dental care for your children?	1	2	7	8
b. Help you find or get dental insurance? (For whom? _____)	1	2	7	8
c. Help you find or get medical care for your children?	1	2	7	8
d. Help you find or get medical insurance? (For whom? _____)	1	2	7	8

9. Did the people at Somali Community Resettlement Services give you any information about preventive health care for your children such as immunizations, well child visits, or regular dental exams?

Yes 1

No.....[GO TO Q. 12].....2

Refused .....[GO TO Q. 12].....7

Don't know .....[GO TO Q. 12].....8

10. What kinds of information did they give you?

_____

_____

_____

_____

11. How helpful was the health or dental information?

Very helpful 1

Somewhat helpful 2

Not at all helpful 3

Refused 7

Don't know 8

12. Now, I'd like you to think about the services that you received from Somali Community Resettlement Services.

(How would you rate …)	Would you say… Very good,	Good,	OK,	Poor, or	Terrible?	REF	DK	NA
A. the staff's ability to understand your concerns or problems?	5	4	3	2	1	7	8	9
B. the usefulness of staff's suggestions and recommendations?	5	4	3	2	1	7	8	9
C. the staff's respect for you as an individual?	5	4	3	2	1	7	8	9
D. the staff's ability to relate to your ethnic or cultural background?	5	4	3	2	1	7	8	9
E. the staff's ability to refer you to community resources?	5	4	3	2	1	7	8	9
F. the results of the services you received?	5	4	3	2	1	7	8	9
G. the overall benefit of the program to you and your family?	5	4	3	2	1	7	8	9

13. Since you first had contact with SCRS have you gone to the doctor or clinic for a well-child or teen checkup or an immunization for your children?

Yes 1

No.....[GO TO Q. 16].....2

Refused .....[GO TO Q. 16].....7

Don't know .....[GO TO Q. 16].....8

14. In thinking about your child or children's last visit, how satisfied are you with the helpfulness of the services that you got from the doctor or clinic? Would you say...

Very satisfied, ...1

Somewhat satisfied, ...2

Neutral,.....3

Dissatisfied, or 4

Very dissatisfied?.....5

Refused 7

Don't know 8

15. Would you go back to that doctor or clinic?

Yes 1
No.....2
Refused 7
Don't know 8

16. Since you first had contact with Somali Community Resettlement have your children seen the dentist to get a regular exam?

Yes 1
No.....[GO TO Q. 19].....2
Refuse .....[GO TO Q. 19].....7
Don't know .....[GO TO Q. 19].....8

17. In thinking about your child or children's last visit to the dentist, how satisfied are you with the helpfulness of the services that you got from the dentist? Would you say...

Very satisfied, ...1
Somewhat satisfied, ...2
Neutral,.....3
Dissatisfied, or 4
Very dissatisfied?..... 4
Refused 7
Don't know 8

18. Would you go back to that dental clinic?

Yes 1
No.....2
Refused 7
Don't know 8

19. In the last year, have any of the following things kept you from getting health or dental care for your children? [READ ALL RESPONSES. CIRCLE YES OR NO FOR EACH.]

	Yes	No	Refused	Don't know
A. Transportation was a problem for you?	1	2	7	8
B. The doctor or dentist schedules were not convenient for you?	1	2	7	8
C. You wanted to wait until your child was sick before you went to the doctor or dentist?	1	2	7	8
D. You felt uncomfortable with the doctor or dentist?	1	2	7	8
E. You could not communicate with the doctor or dentist or they did not speak your language?	1	2	7	8
F. Cost of care was too high or lack of insurance?	1	2	7	8
G. Other? (SPECIFY: _____ _____)	1	2	7	8

20. Did Somali Community Resettlement help you in any of these areas?

Yes 1

No.....2

Refused 7

Don't know 8

21. In what ways?

_____

_____

_____

22. Do you have any difficulty with speaking or reading English?

Yes 1

No.....[GO TO Q. 24].....2

Refused .....[GO TO Q. 24].....7

Don't know .....[GO TO Q. 24].....8

23. Did the project help you understand materials or procedures in Somali?

Yes 1

No.....2

Refused 7

Don't know 8

24. What did you like best about the services that you received from Somali Community Resettlement?

_____

_____

_____

25. If you could <u>change one thing</u> about the services you received, what would that be?

_____

_____

_____

26. Do you have any other comments about the program?

_____

_____

_____

Thank you very much. Those are all the questions we have. I would like to send you a $5 Target gift certificate to thank you for your time. What address should I send it to?

_____

_____

_____

Thank you very much. Good-bye.

C. Growing Up Healthy in Minnesota budget

Grants	$1,103,129
Grants related to Increasing Healthcare Provider Cultural Competence	$102,180
Evaluation with WRC	$107,500
Admin expenses	$60,331
Total Budget	$1,373,140

D. Grantee projects clustered by main strategy

In order to understand and compare project services and methods, Wilder Research evaluators clustered the projects into three main categories: direct preventive care (medical and dental services), education and outreach, and curriculum development.

A1. Grantee projects clustered by main strategy

Type of project	Affiliated Youth Wellness Center: Willmar	Apple Tree Dental: South-west MN	Lao Assistance Center: North Mpls	Meld: Mpls	Mpls Medical Research Fdn: HCMC	Open Door Health Center: Mankato	Red Lake Dental	Somali Community Resettlement Center: Rochester	U of M Division of Peds. Prac-titioner training
Direct preventive care									
Preventive health						X			
Preventive dental		X				X	X		
Participant education/ outreach									
Targeting parents			X	X	X	X		X	
Targeting youth	X		X					X	
Curriculum develop-ment									
For parents				X					
For health professionals									X

The table above shows that some projects fit into more than one category. For instance, Open Door Health Center in Mankato provides direct health care services as well as education and outreach through bilingual/bicultural community health workers. Meld is developing a preventive health curriculum that was tested through parent education and support groups. Nonetheless, the categories are useful for describing the major emphasis of grant activities.

Projects providing direct preventive care

The three projects that provided direct medical and dental services to participants are: Apple Tree Dental's *Head Start Smiles Project*, which provided dental screening and preventive care at Head Start locations in southwestern Minnesota; Red Lake Comprehensive Health Services' *Blue Cross Foundation School Dental Prevention Project*, which concentrated its activities at Head Start and school locations in the Red Lake Nation in northern Minnesota; and the Open Door Health Center, which provided preventive health and dental care to immigrant and refugee children in Mankato.

Projects providing education and outreach

These projects often provided multiple education, referral, and outreach services related to both medical and dental preventive care. The three projects in this category are: Affiliated Community Health Foundation, which concentrated its activities in establishing Wellness Centers in Willmar's secondary schools; Lao Assistance Center of Minnesota in partnership with Southeast Asian Community Council, which employed bilingual/ bicultural community health workers to work with Lao and Hmong families in North Minneapolis; and the Minneapolis Medical Research Foundation's *Healthy Smiles Project*, which provided bilingual/bicultural community health workers who provided dental health education to Latino families who visit Hennepin County Medical Center and connect them to preventive dental care.

Projects developing training curricula

Two projects developed curricula. Meld developed a preventive health curriculum to be used in parent support groups. The University of Minnesota Department of Pediatrics developed a curriculum that involved adolescents as actors to train medical providers regarding the skills and needs of adolescents.

E. Accomplishments and activities of projects providing direct medical and dental preventive care

Apple Tree Dental – Head Start Smiles Project

The Head Start Smiles Project was created to improve dental care access for children from low income backgrounds, particularly those from ethnic and minority communities. Apple Tree Dental provides mobile dentistry services to Western Community Action and Southwest Minnesota Opportunity Council Head Start programs. These Head Start agencies also partner with Apple Tree Dental to provide preventive dental education services to preschool Head Start children within a nine-county area in southwest Minnesota.

From September 2002 through May 2004, Apple Tree Dental provided dental education, screening, and treatment to children enrolled at the Head Start programs (serving Ghent, Redwood Falls, Pipestone, and Worthington). Dental care was provided using the staff and mobile delivery systems from Apple Tree's Twin Cities program. Five dentists and two dental hygienists from Apple Tree provided patient care.

A2. Apple Tree Dental-Head Start Smiles Project: number of people served

	Number
Number of children receiving dental screenings	362
Number of children receiving dental treatment	321
Total number of children served (all received dental health education)	420

Source: *Project's report to the Blue Cross Foundation.*

Project goals

- Access to dental preventive and treatment services will be increased for children attending the Head Start programs.
- Dental services will be provided to a diverse population.
- Parents will be satisfied with the dental services, including satisfaction with cultural competency and sensitivity.
- Parents will gain increased knowledge of preventive dental care.

Progress on goals

Access to dental preventive and treatment services will be increased for children attending the Head Start programs. Apple Tree Dental partnered with Western Community Action Agency and Southwest Minnesota Opportunity Council Head Start programs, which are located in Marshall and Worthington, respectively, and serve children in a nine-county area in southwest Minnesota. A total of 362 children received screenings and 321 received dental treatment. Classroom instruction and demonstrations of appropriate oral care was provided to all 420 students in these Head Start classrooms. Between 50 and 60 percent of all of the area's Head Start children were served by Apple Tree Dental. Of these, 40 percent had never received dental services before.

Most of the children (95%) served by the program were between the ages of 3 and 4. Three-quarters (75%) of the children who were screened or treated were covered by Medical Assistance or MinnesotaCare and only 19 percent had private insurance. The children who were not covered by dental insurance received services paid for by the Head Start Smiles Project (34% or 66 children). Twenty-one percent of children in Year 2 were reported as having difficulty in getting needed dental care.

Dental services will be provided to a diverse population. Most of the children served were Latino (44%) or White (40%). Seven percent were African American; 5 percent were Asian; 2 percent were American Indian; and 1 percent had multiracial backgrounds. This reflects a higher diversity of racial backgrounds served than found in the general population of children in the area.

Parents will be satisfied with the dental services, including satisfaction with cultural competency and sensitivity. Of the 117 parents who completed a survey in Year 2, 89 percent were very satisfied with the services their child received, 9 percent were somewhat satisfied, and 2 percent were a little satisfied. In addition, 73 percent of parents said the program staff's sensitivity to their cultural background was very good and 27 percent said it was good.

Parents will gain increased knowledge of preventive dental care. Dental health information was provided to parents in both English and Spanish in newsletters, pamphlets, and magazines. In addition, as part of regular Head Start activities, teachers work with families to increase their knowledge of preventive dental care.

Other implementation activities

Several other events and activities reported by Apple Tree in its final report demonstrate leadership and initiative on the part of project staff:

- An event was held by Apple Tree in December 2002 called "Something to smile about," which brought together community dental health leaders to present dental

access solutions, celebrate successes, and present new technologies that will help improve access.

- An oral health forum was organized by the Minnesota Head Start Association and the Minnesota Association for Community Dentistry called "Working toward better oral health for Head Start children and families."
- Meetings were held with leaders of the American Dental Hygienists Association at their national conference in New York to discuss ways to address unmet needs for preventive dental care among rural, low-income families with children (in 2003 and 2004).

Challenges and lessons learned

One of the challenges encountered was delivering services to children in a distant location. The Apple Tree Dental staff who served the Marshall and Worthington sites are based in the Twin Cities. They often faced difficult travel conditions in going to southwestern Minnesota. In addition, there were some difficulties in arranging child care for staff so that they could stay overnight on their periodic two-day site visits. This staffing arrangement is different from that outlined in Apple Tree Dental's proposal, according to the Foundation consultant who reviewed the original proposal. In addition, there was a shortage of local dentists to provide follow-up care. One reason the program cites for this is that Minnesota ranks worst of all states in declining dentist-to-population ratios.

In response to this and because of other opportunities, Apple Tree Dental has begun using teledentistry, which enables dentists to review dental history, investigate, and offer treatment solutions from a different location. Recently, Apple Tree established an office at Madelia Hospital in south-central Minnesota, in a fully equipped dental clinic that was not in use. This will become the staffing base for future dental services to southwestern Minnesota, in partnership with Minnesota State University at Mankato that will provide students as dental assistants and hygienists.

Another major challenge is the declining number of dentists in Minnesota, and the difficulty of engaging local dentists in providing care. Apple Tree is actively involved in developing a professional role of mid-level "oral health practitioner" (i.e., between a dental hygienist and a dentist) through partnerships with two dental hygiene education programs in Minnesota.

Parents' suggestions for ways to improve the program included having the results about the child's teeth sooner, resources of where to go if there is a problem after a visit to the dentist, having separate rooms for each child so that if one child is crying and scared it won't influence the others, having more check-ups, and providing more explanations about what is included in a thorough check-up for children at this age. Forty-six parents

did not give any suggestions and 21 parents said they were very happy with the services and did not have any suggestions.

Red Lake Comprehensive Health Services

The Red Lake Dental project provides dental screening and preventive services to children living on the Red Lake Nation in northern Minnesota. The project uses a dental hygienist and a bicultural community health worker to provide direct dental care to children in Head Start, elementary, and junior high schools.

A3. Red Lake Dental: number of people served

	Number
Number of children receiving dental exam/screening	1,536
Number (percent) of preschool (Head Start) children receiving three fluoride varnish applications*	149 of 189 (79%)
Number of school age children receiving sealants	332
Number of teachers/school staff receiving dental education	211
Number of community members receiving education or training regarding preventive dental care	2,249
Number of persons served	3,996

Note. *Originally, the project hoped to provide preschool dental screenings for non-Head Start 3 and 4 year-old students. It was very difficult for the project to find non-Head Start preschool families. Thirty non-Head Start children received dental screenings.*

Source: *Project's final report to the Blue Cross Foundation.*

Project goals

- Annually screen 95 percent of all children attending Head Start on the reservation; identify and annually screen 80 percent of all 3 and 4 year-old children attending Head Start; annually screen 95 percent of all children attending reservation schools in grades 1, 2, 7, and 8.
- Obtain consent from caregivers for 85 percent of all students screened.
- Annually apply fluoride varnish three times during the school year to 95 percent of participating 3 and 4 year-olds.
- Train 90 percent of Head Start staff twice a year in dental caries prevention.
- Apply dental sealant to permanent molars for 80 percent of 1st and 7th graders, and 50 percent of 2nd and 8th graders.

- Increase the percentage of children who have received permanent molar sealants within one year after tooth eruption, from 5 percent in the baseline year (2001) to 53 percent by August 2003.
- Establish the provision of clinical preventive services in the school beyond the period of the grant.

Progress on goals

Annually screen 95 percent of all children attending Head Start on the reservation; identify and annually screen 80 percent of all 3 and 4-year-old children attending Head Start; annually screen 95 percent of all children attending reservation schools in grades 1, 2, 7, and 8. In all, 93 percent of Head Start children were screened; 13 percent of non-Head Start children were screened; 82 percent of children in grades kindergarten through 2nd and 6th through 8th grades were screened. In fact, this goal was increased because the project saw a need in grades not originally targeted in the grant application. The project states that it had some difficulty accessing children during class time.

Obtain consent from caregivers for 85 percent of all students screened. About 94 percent of children screened had consents from caregivers. Project staff were pleased with the success of obtaining parental consents.

Annually apply fluoride varnish three times during the school year to 95 percent of participating 3 and 4-year-olds. Eighty-nine percent of participating 3- and 4-year-olds received one application of fluoride, 84 percent received two applications, and 79 percent received three applications.

Train 90 percent of Head Start staff twice a year in dental caries prevention. The project team made two presentations to Head Start staff in which attendance was mandatory, although information is not available on the percent of Head Start staff that were trained.

Apply dental sealant to permanent molars for 80 percent of 1st and 7th graders, and 50 percent of 2nd and 8th graders. Over 330 children received sealants (17 5-year-olds, 39 6-year-olds, 63 7-year-olds, 84 11-year-olds, 70 12-year-olds, and 59 13-year-olds). The average number of sealants per child was 3.8, for a total of 1,261 molar sealants received. No information is available on the percent of children who received sealants.

Increase the percentage of children who have received permanent molar sealants within one year after tooth eruption, from 5 percent in the baseline year (2001) to 53 percent by August 2003. For children age 5- to 7-years-old, 12 received sealants in 2001, 28 received sealants in 2002, and 8 received sealants in 2003. No information is available on the percent of children who received sealants.

Establish the provision of clinical preventive services in the school beyond the period of the grant. The development and use of third party collections brings in about $60,000 annually. In addition, two grants (in addition to the Blue Cross grant) have brought in $38,000 to the program.

Other implementation activities

The Red Lake Dental project accomplished many of its implementation objectives during the grant period including:

- The hiring of new staff, including a permanent dental assistant from the Red Lake Nation.
- Scheduling appointments for children during the summer months, mailing appointment reminders to each family, and following up with phone contacts.
- The development of data entry files for exam data that allow staff to screen and assess the dental health of children.
- Publishing of a blank parental consent form in the Red Lake Nation newspaper, for parents to clip out and complete.

During the first year, the Red Lake Dental project completed 745 exams out of a possible 865. Project staff screened: 87 percent (133) of Head Start children using portable dental equipment, 8 percent (30) of all 3 and 4 year olds not attending Head Start, and 67 percent (555) of students in Kindergarten, 1st, 2nd, 6th, 7th and 8th grades.

In addition, project staff applied fluoride varnish for 15 percent (57) of 3-and 4-year-old children and applied sealants to permanent molars for 30 percent of children. The project increased the percentage of children receiving permanent molar sealants within one year of tooth eruption from less than 10 percent to 39 percent. For children under 5 years, 65 percent had baby bottle tooth decay with one of the four upper front teeth decayed. For children under 6 years, 78 percent had untreated dental decay; 8 percent were caries-free. For children ages 6 to 14, 69 percent had untreated dental decay; 26 percent were caries-free.

During the second year, project staff screened: 93 percent (176) of Head Start children using portable dental equipment, 13 percent (30) of all 3 and 4 year olds not attending Head Start, and 82 percent (588) of students in Kindergarten, 1st, 2nd, 6th, 7th and 8th grades.

In addition, in Year 2 project staff applied fluoride varnish for 89 percent (169) of 3-and 4-year-old children and applied sealants to permanent molars for 332 children.

Challenges and lessons learned

The project has faced difficulty in completing treatments despite mailed appointment reminders and phone calls. Even with double booking, there was only a 50 percent show rate in the first year. A related problem is that parents tend to confuse the Red Lake Dental Clinic with the project activities occurring in the schools. The project team has published many instructions for parents as to the distinction between the two programs, but the confusion still exists.

The project is considering lengthening the timeline for completing the examination of all the children to two years, because of some limitations in access to children. The project also borrowed a portable dental examination unit from White Earth Reservation and set up portable equipment at two different schools to allow for more flexibility to see children during the school day.

Many of the children seen by the project team have deep cavities that will require tooth extraction if not treated immediately. The team discovered a new material (Triage) that can be used to temporarily fill and perhaps slow or arrest growth of gross cavities. The material is applied so the tooth/teeth can be saved until the child can see a dentist.

Open Door Health Center

The purpose of this project is to provide preventive care and better serve children from immigrant groups (mainly Latino and African) at the Open Door Health Center, which is a low-cost center that primarily serves uninsured or underinsured populations in South Central Minnesota.

A4. Open Door Health Center: number of people served

	Number
Children (immigrant and refugee) receiving health care	279
Children (immigrant and refugee) receiving dental care	63
Persons/parents receiving assistance to access health or dental care or insurance (case management services by social worker) December 2001 – June 2004	398
Community members contacted through group presentations, meetings, and fairs	700
Cultural competency training of staff or other professionals	38
Number of persons served	1,478

Source: *Project's final report to the Blue Cross Foundation.*

Project goals

- Serve 800 new immigrants or refugees with culturally, linguistically, and age-appropriate prevention and wellness services.
- Provide appropriate primary care to 800 immigrant and refugee children and adolescents.
- Help 300 families navigate the health care system to get needed care for their children.

Progress on goals

Serve 800 new immigrants or refugees with culturally, linguistically, and age-appropriate prevention and wellness services. The project served 342 immigrant (Latino and African) children.

Provide appropriate primary care to 800 immigrant and refugee children and adolescents. Again, the clinic served 342 immigrant children during this period. The project ensured that all children have up-to-date immunization records and are registered on a state database.

Help 300 families navigate the health care system to get needed care for their children. The case manager served 398 individuals and families. Approximately 20 families per month were provided outreach services by each of the two bilingual community health workers.

Other implementation activities

Since July 2002, Open Door Health Center has hired several bilingual staff and has staff who are fluent in either Spanish or Oromo. Qualitative data suggests that these staff have had a positive impact on how clients are served by the program. For example, one staff member related a story of how an Oromo-speaking family was assisted when their teenage child wanted to drop out of school and the Oromo-speaking staff member was able to convince him and his family of the value of staying in school. On the other hand, the results of efforts to work with youth advisory councils was not successful due to several challenges including youths' busy schedules, transportation, and scheduling barriers. Instead, the project approached the Chicano-Latino Youth Leadership Institute in Mankato, but due to funding problems this arrangement did not work out either. Involvement with community elders has been mostly informal, although efforts are being made to establish a formal structure for elder input and involvement in conjunction with the program becoming a Federally Qualified Health Center (which requires that a majority of board members are clinic users).

Between December 2002 and June 2003, the social worker and bilingual case managers together made an average of 166 monthly patient contacts, including 33 new clients per

month, on average. These staff positions were added during this period with *Growing Up Healthy* funds. This information was not available for the Year 2 evaluation.

Virtually all of the 342 new patients who were seen at Open Door Health Center had problems with underinsurance that were addressed by the social worker or case manager during their visit. While the project's evaluation does not claim that all 342 new patients are now insured, it does suggest that all 342 clients are closer to having full insurance compared to their situation at the time of their first visit.

In all, 342 immigrant and refugee children were seen at Open Door Health Center during this evaluation period, most of whom were Latino (98%). An estimated one-quarter of these office visits included immunizations; project staff maintain that 100 percent of youth seen at Open Door Health Center now have updated immunizations. (Immunization records are entered into a regional registry in which Open Door participates.)

All of the youth seen at Open Door Health Center (100%) have also received preventive dental care. On average, 23 percent of patients per month required interpreter services during their clinic visit. Open Door Health Center also worked with partner organizations to develop and promote culturally and age-appropriate health programs, including health messages during Spanish-language programming on a local radio station, participation in health fairs, and other prevention-related activities. Staff also participated in family fiesta night and other culturally-specific community events.

The first year of the *Growing Up Healthy* project coincided with a year of major growth for Open Door. The health center moved into a larger facility donated by an orthopedic clinic in Mankato. An expanded dental office is under construction. New staff and board members were added.

Challenges and lessons learned

This project experienced a significant loss at the outset of the grant period with the unexpected withdrawal of the University of Minnesota Family Practice Residency Program. A physician new to Mankato, with experience working with Latino families in Chicago, now serves as a bilingual medical director to the program. Open Door staff members also hope that the residency program will rejoin the site in the future.

Staff members identify the three primary barriers to providing preventive care to immigrant families as: communication and cultural differences, transportation, and the high cost of prescription drugs. The communication and language barriers have been addressed by using interpreters and hiring more bilingual staff. The language barrier when dealing with African immigrant communities that have multiple languages can be eased by providing the African immigrant case manager with written information in a variety of African languages. Cultural differences, including lack of experience with

scheduling appointments, has led staff to make extensive reminder and follow-up calls to clients with clear messages about expectations regarding when clients are expected to show up for their appointments. Regarding the transportation issue, Open Door Health Center staff members have been working with Saludano Salud and other area transportation providers to increase transportation reliability and options for their clients. Meeting the medication needs of patients who do not have insurance and those who do not qualify for any government assistance (e.g., undocumented workers and their families) has been an increasing challenge for the program, but they have been able to address some of these problems by providing medication assistance by using sample medications from pharmaceutical companies. Prescription cost is likely to become an increasingly large problem as eligibility for MinnesotaCare is tightened.

Wilder Research staff found it somewhat difficult to discern from the reports the project's progress in increasing preventive care for children and youth as defined by *Growing Up Healthy*. This project and a few others mingled resources to meet the acute care and preventive care needs of the community. At times, the emphasis on well-child preventive visits and immunizations may have been obscured by acute health needs. In Year 2, Wilder Research and Blue Cross Foundation staff encouraged the project and its evaluators to clearly distinguish between progress toward increasing child and teen checkups and the other services Open Door provides for the immigrant communities targeted in this grant. However, the Year 2 report did not describe the preventive and/or acute care services provided except to state that all children seen by the clinic are up to date on their immunizations. The fact that the project knows that these children are up to date on their immunizations is an important feat in itself – given the difficulty in locating the immunization detail and the fact that all children are now reportedly listed on a statewide immunization database. So, even if immunizations were not directly given to children, documentation has been updated due to project work.

F. Accomplishments and activities of projects providing education, referral, and outreach

Affiliated Community Health Foundation

The Affiliated Community Health Foundation developed and implemented Teen Health and Wellness Centers in the Willmar junior high school, senior high school, and alternative learning center.

A5. Affiliated Community Health Foundation: number of people served

	Number
Youth who visit/consult one-to-one with Wellness Center coordinator	**Total: 336** 228 high school 73 junior high school 37 alternative learning center
School staff who visit/consult one-to-one with Wellness Center coordinator	8
Number of individuals contacted through group presentations, meetings, and fairs	**4,562 (includes youth also counted above)**
Youth participating in education and wellness activities	Approximately 1,000
Number of persons served	**4,590**

Source: *Project's final report to the Blue Cross Foundation.*

Project goals

The objectives of the Teen Health and Wellness Centers in Willmar are to provide an environment at school where adolescents can access health education and referrals related to physical, emotional, and socio-economic needs, with an emphasis on:

- Cultural competency.
- Partnerships with local health and human services organizations.
- Addressing barriers to healthcare access, such as financial, language, service availability, and transportation.
- Understanding adolescents' needs and developing youth-friendly programs.
- Evaluating the program's impact, in terms of number of youth served, number of referrals needed, and number of supporting organizations used.

- Becoming a resource for school faculty and staff regarding adolescent health issues and offering classroom presentations.

Progress on goals

Provide an environment at school where adolescents can access health education and referrals related to physical, emotional, and socio-economic needs. In each of the three schools, a room was provided to house the Wellness Center. The coordinator, with help from student volunteers, decorated the space to ensure that it was student-friendly. The goal was to provide "a getaway" for students to hang-out while class was not in session. Hundreds of brochures were available on a variety of health topics. The coordinator was available for individual consultations, referral services, and follow-up.

Address adolescent health issues with cultural competency by hiring and educating staff that can meet the needs identified by our youth. Originally, the program had intended to hire a Spanish-speaking or bicultural coordinator, but after a search they did not have appropriate applicants. The program hired a coordinator with public health experience who was a graduate of Willmar Public Schools. The coordinator worked closely with the Hispanic retention coordinators of the Senior High and Alternative Learning Center collaborating on events including health fairs, after-school activities, and summer camps. The coordinator used events to connect with Latino and Somali students on a personal level and develop a sense of trust. The coordinator also dispersed information in Spanish and Somali, whenever possible, through newsletters, brochures, and display boards.

Other implementation activities

The grantee established partnerships with Willmar schools and community health care providers to address adolescent health issues and concerns within the school setting. The total student population includes 2,152 students between the ages of 11 and 18 who attended the senior high school, middle school, or alternative learning center in Willmar. One-fifth of these are students of color (predominantly Latino, with some Asian and Somali students). The project coordinator worked closely with school staff of various ethnic backgrounds to communicate the purpose of the program and the services available to students of color. Spanish educational materials were provided by a Latina school staff member.

Before the school year began, the program coordinator met with school administrators to select the school locations within the schools for the Wellness Centers. Students were asked to help decorate the centers. The Student Advisory Group, which was formed in summer 2002 and met regularly throughout the school year, identified pertinent health issues and developed messages of prevention and intervention for their peers.

During the school year, there were school-wide events, special gatherings such as "Lunch and Learn," and opportunities for students to seek individual information or referrals. A variety of health and human services organizations collaborated with the Wellness Centers to put on several events, including a Teen Health and Wellness Expo at the senior high, at which over 25 different community health organizations were present, attended by over 600 students. The grantee also worked closely with Kandiyohi County Public Health.

In all, the Wellness Center coordinator met individually with 218 different students in Year 1 and 98 students in Year 2 (unduplicated count).

- The Wellness Center at the senior high was visited 168 times in Year 1 and 104 times in Year 2, predominantly by White female students. Over half of the visits were for the purpose of getting general information on health topics such as weight loss, nutrition, and sexually transmitted diseases.
- The Wellness Center at the junior high school was visited 134 times by 73 students in Year 1, predominantly by White female students. Over half of these visits were for the Wellness Advisory Group, and another quarter were for general information. Nutrition (26 inquiries), exercise (25 inquiries), and weight control (10 inquiries) were the most popular topics of interest. No data is available on visits made by junior high students in Year 2 because the program focus in Year 2 was for the senior high and alternative learning center.
- The alternative learning center's Wellness Center was visited 27 times in Year 1 and 21 times in Year 2. In Year 1, 62 percent of the students who visited were White, and 38 percent were Latino. In Year 2, 62 percent of visits were from Latino students and 38 percent were by White students. In Year 1, nearly two-thirds of these visits were for the purpose of getting general information about a variety of topics and in Year 2 nearly three-quarters of visits were related to drug use.

Overall, the project had contact with over 4,400 individuals in Year 1 and 2,600 individuals in Year 2 through presentations, displays, meetings, conferences, and fairs. The topics of presentations included wellness (30 presentations), suicide prevention (10 presentations), collaboration (8 presentations), healthy eating and nutrition (13 presentations), obesity (7 presentations), and over 70 other topics. Outreach and marketing for the Wellness Centers included newspaper articles, advertisements, posters in the schools, and display boxes in the senior high and alternative learning center that featured various topics throughout the school year. The project also offered a website on health and wellness issues.

The program evaluators measured four short-term outcomes of the program activities: increased participation in preventive health and dental care; increased number of student contacts with Wellness Center staff and school nurses, social workers, counselors, and

psychologists; increased number of students served by the Wellness Center who are multi-cultural or lack adequate insurance coverage; and decreased number of absentees. In addition, the program evaluators measured three longer-term outcomes including: students will report overall better health; students will be less likely to participate in risk-taking behaviors (self-report); and students' academic performance will improve (not practical).

Satisfaction with the Wellness Centers was measured through surveys completed by 405 students who participated in 16 events. The events included: assertiveness (9 events), yoga (2 events), pre-natal care (1 event), nutrition (1 event), wellness and health promotion (1 event), Alternative Learning Center health fair (1 event), and suicide prevention and depression awareness (1 event).

Challenges and lessons learned

Several challenges to implementing this program are described in the project's evaluation report, prepared by the Minnesota Institute of Public Health. The first challenge was to integrate a new program into an existing system. Therefore, the authors caution against judging the program on its preliminary outcomes. The second challenge was that students did not use the project's services as frequently as anticipated. This was attributed mainly to the fact that students do not have much free time during the school day.

Other implementation challenges include:

- Only one coordinator to arrange services for over 2,100 students in three schools. The coordinator's schedule was changed in Year 2 to focus more time with the high school and Alternative Learning Center students.
- Limited classroom participation by the project coordinator, making it difficult for the students to get to know and trust her. The coordinator did provide information via posters and flyers so that even students who did not visit the Wellness Center were exposed to some of the messages from the program.
- Limited access to community resources due to a lack of funds and need for parental consent.
- Difficulty working with adolescent students on prevention topics, since this age group often has a hard time relating current activities to future consequences. This issue was addressed by providing monthly information by theme, including: fitness and nutrition, child and teen check-ups, pregnancy and sexually transmitted disease prevention, mental health and suicide prevention, alcohol and tobacco prevention, illicit drug prevention, and self-esteem.

Overall, this program's evaluation resulted in reasonably high levels of satisfaction of program staff, students, and school staff. The strengths of this program, according to information collected from staff and students, are:

- The project coordinator is liked and respected by students and school staff.
- A variety of materials is easily available to persons who are willing to access the Wellness Center.
- Students and staff liked the Health Expo because it created awareness about the importance of health and wellness and provided a wealth of information and resources for those attending.
- Staff and students felt that confidentiality issues were sufficiently addressed, which was an important factor for building trust and participation in the program.
- Staff members believe students are receiving accurate health information.

Furthermore, the Wellness Center program and the continuation of school-wide health promotion activities, and the integration of these activities into the long range plan of the Health and Physical education departments of the schools has impacted the students and the Affiliated Community Health Foundation. Specifically, the Foundation has developed a model of teen health prevention and education that has been proven effective. The Wellness Center activities have raised both student and faculty awareness of current health topics, and the senior high principal has indicated that a half-time teaching position has been added to the health department to enhance programming in the regular academic schedule for the 2004-05 school year and beyond.

Lao Assistance Center of Minnesota and Southeast Asian Community Council

Lao Assistance Center and the Southeast Asian Community Council worked together to provide bilingual/bicultural community health workers in order to increase access to preventive health services for children and teens from the Hmong and Lao communities in North Minneapolis.

A6. Lao Assistance Center and the Southeast Asian Community Council: number of people served

	Number
Adults receiving assistance to access health or dental care	**107**
Children receiving assistance to access health or dental care	**485**
Educating youth regarding importance of preventive care	**249**
Educating community members regarding importance of preventive care	**538**
Number of persons served	**770**

Source: *Project's final report to the Blue Cross Foundation.*

Project goals

The overall objective is to increase access to preventive medical services for children and teens while at the same time decreasing barriers. Key objectives include:

- More Lao and Hmong youth and children will access preventive health care (medical and dental).
- The Southeast Asian community will be more knowledgeable about the benefits of preventive care for children and youth.
- Health care providers will expand their awareness of Southeast Asian cultures in relationship to preventive health care needs.
- Lao Assistance Center of Minnesota and Southeast Asian Community Council will increase organizational capacity to identify children and youth needing preventive care.

Progress on goals

More Lao and Hmong youth and children will access preventive health care (medical and dental). Project staff implemented the following services to increase the rates of seeking preventive care: creating community health care worker positions within organizations trusted by the community; hiring bilingual and bicultural community health workers who are known and trusted by community members are who can help families negotiate the health and dental care systems; providing reminder calls to ensure that follow-up appointments with health care providers were kept; providing translation and interpreting services to families; and working closely with Pilot City Health Care Center to offer on-site education about preventive dental care. Project staff also addressed barriers to seeking preventive care by: working with families who previously received care through the Glenwood Lyndale Clinic to encourage them to seek services from Pilot City; helping families schedule health care appointments; providing transportation to and from health care appointments; reminding families to make sure follow-up appointments were kept; providing transportation to pick up prescriptions; immediately addressing confusions and/or frustrations with the health care system through the community health care workers; and providing one-on-one training regarding the health care system and the benefits of preventive care for children and adults.

The Southeast Asian community will be more knowledgeable about the benefits of preventive care for children and youth. Project staff provided education to families in group settings and one-on-one on topics such as kidney stones, diabetes, and mental health issues. Project staff also worked closely with staff from Pilot City to implement the Healthy Smiles project, which was designed to increase awareness of proper dental hygiene for infants and children of Southeast Asian families living in the Northside

community in Minneapolis. Part of this effort included the development of culturally appropriate materials for Hmong and Lao families that were not previously available.

Health care providers will expand their awareness of Southeast Asian cultures in relationship to preventive health care needs. Although there was no evidence to document this outcome presented in the project reports, the Pilot City Health Center Healthy Smiles coordinator indicated that there was a sharing of cultural knowledge. At a Learning Network meeting, she talked about the rapport that had been built with the Lao and Hmong communities because of the project and her own personal learnings from the bilingual/bicultural community health workers.

The Lao Assistance Center of Minnesota and the Southeast Asian Community Council will increase organizational capacity to identify children and youth needing preventive care. This outcome was not documented in the report, but Lao Assistance Center staff report that health is an increasing focus of the organization and important for the future sustainability of the program. In key informant interviews, staff report that the need for health education and access is present in the community. They feel that their organization is well-positioned to help fill gaps and reduce barriers to accessing care. Staff also talked about their own increased knowledge of the health care system and preventive care.

Other implementation activities

According to project records, 107 adults and 409 children received assistance from the Hmong and Lao bilingual/bicultural community health workers to access health or dental care services. Of these, 26 percent of the children (108 children) received preventive health care services. Fifty-four children served by the project visited the dentist. Of these, 43 children received preventive dental care services. When visiting the doctor or dentist, 91 percent of Lao families and 83 percent of Hmong families requested interpreter services.

The project reports extensive to train the Hmong and Lao community health workers. Training was provided by the project manager at Lao Assistance Center during weekly meetings with the community health workers. Topics included discussions of the objectives of the *Growing Up Healthy* initiative, and learning the roles of partners, agency staff, the Advisory Group, and other groups involved in community health. Community health workers were also encouraged to attend relevant conferences and workshops on topics such as diabetes and health disparities.

With the addition of Healthy Smiles as part of the project, new support came to the community health workers from the Pilot City Health Center project liaison. The Healthy Smiles program is a health education program funded by the Greater Twin Cities United Way to address the high incidence of tooth decay in Southeast Asian children, particularly Hmong children. Healthy Smiles began in September 2000 as a school-based

program in North Minneapolis elementary schools with the highest percentages of Hmong and Lao children. Due to movement of students among schools, the program worked with more African American students than Southeast Asian. The Healthy Smiles project's dental consultant met with the Lao and Hmong community health workers for several sessions over the course of two months to develop culturally specific curricula and provide training on dental health education. Obtaining input on cultural practices and beliefs from both communities is critical to a successful behavior change program like Healthy Smiles, whose main component is preventive education. The first classes were implemented in June 2003.

- Ten families participated for a total of 10 adults and 32 youth participants.
- Of the 32 youth participants, 22 received preventive dental care at Pilot City Health Center as part of the program.
- Preliminary results of tests given before and after participation in Healthy Smiles indicate the average score rose 6 percentage points, from 65 percent to 71 percent, showing some increase in dental health knowledge.

With respect to the partnership with Pilot City Health Care Center, progress has been made in connecting the Lao and Hmong communities to Pilot City. Sunny Sinh Chanthanouvong, executive director of the Lao Assistance Center of Minnesota, and Cha Lee, executive director of the Southeast Asian Community Council, are active members of the Pilot City Health Center Community board. Cha Lee is secretary of the board. The Pilot City Healthy Smiles project liaison has developed a working relationship with the bilingual/bicultural community health workers. She reflects, "My understanding and appreciation for the differences in Asian and American cultures has increased substantially. Every group of people has its own wisdom and worthwhile contributions."

Challenges and lessons learned

During the course of Year 1, the challenges faced by Lao Assistance Center included staff turnover. One of the Hmong community health workers left after several months on the project. The new worker had to be trained.

The project also faced challenges because of changes at local community clinics. During the first year, Glenwood Lyndale Clinic, a clinic used by many in the Southeast Asian community, was closed. In addition, some transitions occurred at Pilot City Health Center that made it challenging to implement some of the partnership activities described in the grant proposal. However, during the last half of the project year, Pilot City's Healthy Smiles project partnered with the Lao Assistance Center to provide preventive dental health education services to Lao and Hmong families.

Project staff described barriers to educating community members about preventive health, especially since traditional health care-seeking behaviors focus primarily on acute

care needs. Adopting a preventive health care perspective may take considerable time, and it is critical that recent immigrants be able to see practical benefits of preventive care. In addition, there was a lack of Lao language preventive health care materials. Project staff developed these materials to overcome this barrier.

Minneapolis Medical Research Foundation at Hennepin County Medical Center: "Una Sonrisa Saludable/A Healthy Smile"

The "Una Sonrisa Saludable/A Healthy Smile" uses bilingual/bicultural community health workers to provide dental health education and access to dental care for Latino families who visit Hennepin County Medical Center for a child or teen checkup.

A7. Minneapolis Medical Research Foundation at HCMC: number of people served

	Number
Number of families receiving dental education	226
Number of children receiving dental care through an appointment made by project staff	125
Number of families in the research control group (involved in the study through participation in surveys, but did not receive dental education)	210
Number of persons served	436

Note. *Project records show that of the 226 who received dental health education, 36 had already received dental care and 73 were under age 1 and thus too young. The remaining were in need of dental care and appropriate appointments were made with dental clinicians.*

Source: *Project's final report to the Blue Cross Foundation.*

Project goals

The "Una Sonrisa Saludable/A Healthy Smile" program seeks to develop, evaluate, implement, and replicate effective and culturally appropriate preventive dental health education and provide assistance with dental care access to Latino families when they are seen for routine pediatric care. The objective is to increase the proportion of families using developmentally appropriate preventive dental care at home and to increase the proportion of Latino children who have completed at least one visit with a dentist by age 2 or, for children age 3 or older, have seen a dentist within the past 6 to 12 months.

Hennepin County Medical Center (HCMC) has sought to build its capacity to provide dental services for the large population of Latino children served in its medical clinics by establishing the Una Sonrisa Saludable Dental Task Force. The objective of the Task Force is to decrease the average waiting time required to obtain an initial dental

appointment for Spanish-speaking pediatric patients from six weeks to three weeks in the metro clinics.

Key project goals for Latino children served by Una Sonrisa Saludable are:

- Practice age-appropriate daily preventive dental health care at home with the assistance and support of their families.
- Establish and maintain regular treatment by a dentist.

Progress on goals

Practice age-appropriate, daily preventive dental health care at home with the assistance and support of their families. The program provided dental health education and age-appropriate dental care supplies, including toothbrushes, toothpaste, floss, and washcloths, to 226 families. In addition, Spanish-speaking community health workers taught families appropriate home dental care for their children. At the time of the four month follow-up, 84 percent of children age 1 and older in the intervention group brushed their teeth once or more per day compared with 68 percent of children in the control group.

Establish and maintain regular treatment by a dentist. The program scheduled dental appointments for 125 children who were in need of dental care. At the time of the four month follow-up, 81 percent of the children in the intervention group had completed a dental visit compared with 38 percent of children in the control group.

Other implementation activities

In this project, Spanish-speaking community health workers were trained as peer dental educators. When families visited the clinic for a child or teen medical checkup, the community health workers met with them to share preventive dental health information and, if needed, to arrange appointments for dental care.

This was the only *Growing Up Healthy* project designed as a research study, with rigorous evaluation methods. The project randomly assigned Latino families who came to Hennepin County Medical Center for a child or teen checkup to either an intervention group or a comparison (control) group. Both groups were asked to complete baseline and follow-up surveys conducted by Spanish-speaking community health workers. This method was chosen to learn whether bilingual educational intervention at the health checkup had an impact on families' knowledge and behavior regarding preventive dental care.

During the evaluation period, 436 families were surveyed, 226 of whom received education/intervention and 210 of whom did not. Sixty-nine percent of families who participated in the study have children age 3 or younger, and the rest have children over age 3. Over half (56%) of the families surveyed reported that they were covered by

Medical Assistance and 5 percent were uninsured. Seven percent of participating families were covered by an unknown insurance plan and the rest were covered by Medica Choice (23%), Medicaid (7%), Assure Care (<1%), Blue Cross/Blue Shield (<1%), Preferred One (<1%), or Health Partners (<1%).

Of the children in the intervention group, 125 were in need of dental care and had an appointment made for them, 73 were under age 1 (too young for dental care), and 36 had already received dental care. The children and families in the comparison group received no additional educational or advocacy intervention by the dental community health workers (it was anticipated that after the study period these families would be offered the dental education intervention).

Project outcomes include:

- Development of age appropriate dental education scripts and survey tools.
- Development of a dental education program for Latina educators (community health workers).
- Training of three Hennepin County Medical Center community health dental educators.
- Enrollment of 436 families in the evaluation study.
- Provision of dental health education and age appropriate dental care supplies, including tooth brushes, toothpaste, floss, and washcloths to 226 families.
- Scheduled dental appointments for 125 children in need of dental care.
- Task force convened to develop strategies to upgrade current dental care, and to encourage collaboration between medical and dental care. The task force meets quarterly and the members include Hennepin County Medical Center clinic dentists, Metropolitan Health Plan's child & adolescent coordinator, Medica Health Plan regional coordinator, University of Minnesota Community-University Health Care Center executive director, Way to Grow liaison, and members of the project staff. (Both the Metropolitan Health Plan and Medica have large enrollments of Medical Assistance clients in Hennepin County; BluePlus does not currently have a Medical Assistance contract there.)

Challenges and lessons learned

One of the challenges that this project encountered early in its course was the announcement by Hennepin County Medical Center's pediatric dentistry department that they would no longer provide primary care services for all children seen by the clinic, due to severely limited resources. The program addressed this challenge by working with other community dental clinics. This challenge was completely resolved six months into

the project, when the HCMC dental clinic began reserving one morning clinic per week specifically for families enrolled in the project.

Another significant challenge was the difficulty in scheduling hospital interpreters for dental appointments due to the lack of interpreter availability at the times of appointment openings. Through the Task Force, the project learned that health plans may also provide interpreters for their participants. The dental educators now use the health plan interpreters whenever the hospital's interpreters are not available. This obstacle to access has been successfully removed.

The project has experienced on-going challenges with engaging Hennepin County Medical Center pediatric dental providers due to competing demands for their time. Although their participation in Task Force meetings was limited, they continue to voice their support for and interest in the project. In addition, the dental providers collaborated with project staff on the dental education scripts and also when problem-solving with individual families. These providers also independently referred non-enrolled Spanish-speaking families to the project for assistance in complying with dental treatment plans and to pursue needed health and dental care benefits.

Project staff also learned that families are interested in dental education and that health care plans are willing to provide the necessary support to see that this occurs. This project also demonstrated the ability of project staff to work collaboratively and across traditional boundaries between organizations and departments. A clear message given by both families and providers was the need for more dental education activities and resources. Another important lesson learned, or rather reinforced, was that the complex health care system presents many challenges and barriers to Latino families in their desire to successfully obtain regular dental care. The barriers included interpreter availability, provider availability, lack of full or partial dental insurance, and limited dental health knowledge.

Somali Community Resettlement Services

Somali Community Resettlement Services in Rochester provides education and outreach services to the Somali communities in Olmsted and Steele counties in southeastern Minnesota. The project seeks to educate community members regarding preventive health by using Somali television, publications, and messages given by elders and religious leaders. The project also provides free transportation to child and teen checkups, provides translation and assistance with applying for health insurance, and provides interpretation at health visits.

A8. Somali Community Resettlement Services: number of people served

	Number
Number of families receiving assistance in applying for health insurance	**675**
Number of families who received direct assistance (language interpretation) in setting up health and dental services	**900**
Number of persons receiving direct assistance with setting up preventive health appointments	896*
Number of persons receiving direct assistance with setting up dental visits	789*
Number of families who received transportation from the project to a child and teen check up or immunization	**382**
Number of parents who received resources/referrals or educational materials from the program.	**1,890**
Approximate number of individuals who received education materials through Somali TV and presentations at mosques and community events	**5,770****
Number of persons served	**5,770****

Note. **Both health and dental appointments were set-up for some families. Therefore these numbers are duplicative. **All are included among those reached by local media messages. This is based on the total responses made to television program assuming that responses to other marketing was duplicative. The total number may include some duplicates.*

Source: *Project's report to the Blue Cross Foundation.*

Project goals

The goals of the Somali Community Resettlement Services project include the following:

- Increase understanding of the benefits of preventive health care among Somali families in Olmsted, Steele, and (most recently) Rice counties.
- Educate Somali community members about access to available preventive health care services.
- Remove unnecessary barriers to adolescent preventive health care services among teenagers in the Somali immigrant community.

Progress on goals

Increase understanding of the benefits of preventive health care among Somali families in Olmsted, Steele, and (most recently) Rice counties.

Educate Somali community members about access to available preventive health care services. Somali Community Resettlement provided a variety of efforts in order to educate Somali community members in this area. The following table from the August evaluation report documents the outreach strategies and the subsequent responses for a five-month period of the project.

The following information is based on a combination of data collection logs/records and estimates by staff to fill in for missing spaces. This table was provided by the evaluator, Becky Kroll, in her evaluation report and shows a snapshot of the activities provided in the early part of 2004:

Method/Month	January	February	March	April	May	Total
Television programs						
Est. Audience	35,000	29,000	37,000	37,500	37,700	NA*
Number of responses	1,750	1,700	2,001	201	118	5,770
Service/referral	250	258	351	31	9	899
Mosque Presentations						
Est. Audience	52	570	379	371	375	1,747
Number of responses	20	301	90	45	35	491
Service/referral	10	101	103	15	5	234
CTC Presentations						
Est. Audience	12	76	35	35	45	203
Number of responses	7	57	27	21	31	143
Service/referral	3	39		5		47
Other Community Events						
Est. Audience	14	90	50	47	57	258
Number of responses	8	81	11	11	13	124
Service/referral	5	59		7	3	74
Activities						
Brochures disseminated	350	350	276	253	253	1,482
Telephone Calls	27	27	27	47	43	171
Referrals made	150	10	25	10	15	210
Transportation provided	37	37	17	39	51	181

** A summary of the estimated television audience is not provided, as it is not cumulative.*

Remove unnecessary barriers to adolescent preventive health care services among teenagers in the Somali immigrant community.

As the evaluator states about youth involved in the focus groups:

> They confirmed that time in country, access to health insurance, and parents receiving information about preventative health care are factors influencing Somali teens participating in check-ups.

Other implementation activities

The Somali Community Resettlement Services project was unique among the nine projects in that the Foundation awarded a one-year planning grant to allow this small mutual assistance association to build some modest infrastructure and staffing while developing strategies to address the goals of *Growing Up Healthy*. However, Somali Community Resettlement Services wanted to move the program along quickly. In June 2003, they were awarded an additional grant of $83,000 to support the implementation of project activities that had already begun under the planning grant.

The project sought to develop a health outreach, educational, and training program to educate Somali immigrants about short and long-term benefits of preventive health care. Project activities included:

- Hiring two part-time personnel and assigning three community volunteers.
- Preparing a brochure on child immunizations and child and teen checkups with the assistance of Olmsted County Public Health Services, Mayo Clinic, and the Somali community. Distribution of 3,000 brochures took place through Somali Community Resettlement Services offices, the Community Training Center and the Rochester Islamic Center as well as local immigrant-owned businesses.
- Development of an outreach and educational program through the Rochester Local Access Somali TV. The project taped 10-minute segments on the benefits of preventive health care and aired the segments on local access television (initially in Rochester, and later in Rice and Steele counties).
- Community meetings with Somali elders, religious leaders, and mothers. Additional presentations were given on the benefits of preventive health care at the mosque and the Community Training Center, stressing the importance of immunizations and checkups.
- Religious leaders and Imams of the Rochester, Owatonna and Faribault Mosques were invited to the studios of the Rochester Somali TV to discuss Islam's stand on immunizations and child and teen checkups. The purpose of this group discussion was to dispel the mistaken belief held by any Somali resident in Minnesota that Islam prohibits immunizations. These leaders also held other presentations to support these messages.

- An educational and entertaining Somali play highlighted the benefits of the Child and Teen Checkups and Immunizations program.
- The project organized a Somali women's night at the Mayo clinic attended by about 300 women. Dr. Fozia Abrar (a Somali doctor from Region's Hospital) talked about women's and children's health issues and immunizations. In addition, there were three Somali musicians who performed a play, and a former Somali prime minister's wife spoke.
- Data collection including telephone interviews and focus groups, and records on child immunizations and the Child and Teen Checkup program.
- Interpretation, translation, transportation and referral services for people who contacted the office. The project received numerous requests for help in applying for health insurance.
- Submitting a proposal for additional funding to continue the program.

Although the project has not yet submitted data on immunization rates for the Somali community in Rochester, reports from Olmsted County Public Health indicate that immunizations and child and teen checkups among Somali immigrants have increased since the program started. However, at this point, the project evaluator notes that public health does not collect this information by ethnic group. Currently, the evaluator believes the best source of information about immunizations of Somali children is through the public schools.

Challenges and lessons learned

The project struggled initially with the best way to get out the message to the Somali community in Rochester. Project staff members report that the initial brochures were not as effective as in-person education at mosques and community meetings. Project staff also initially had some difficulty in making the message entertaining enough for television. Staff report improvements in this area. For example, staff members report a large community response to a recent television show that included health messages, a women's panel, and Somali musical entertainment.

The project identified a local challenge serving the Somali population, because of a lack of dental clinics in the Rochester area that will accept new clients of the state-funded health insurance programs. Somali Community Resettlement Services contacted 33 dental clinics in Rochester and verified that none of them accepts publicly-funded insurance programs. Somali Community Resettlement Services is currently working with other organizations to increase pressure on dental clinics to accept new MA patients.

In addition, the project faced a change in leadership staff during the first year of the project. However, the new project director embraced the goals of *Growing Up Healthy* and continued the work of his predecessor.

G. Accomplishments and activities for projects focused on curriculum development

Meld

Meld, a national organization with over 20 years of experience in parent education, used the *Growing Up Healthy* grant to develop and test a health education curriculum to be used with its parenting groups. The *Growing Up Healthy* project at Meld was an 18-month project demonstrating the effectiveness of peer-based parent education in improving health-related outcomes for children in communities of color in the Twin Cities. The project involves the development of curriculum and materials designed to increase parents' knowledge of the benefits of preventive health care for children.

A9. Meld: number of people served

	Number
Adults participating in at least three meetings that used the preventive health curriculum*	85
Organizations receiving training	15
Number of persons served	100

***Note.** 85 parents had over 250 children, but because the curriculum did not involve the children, they were not included in numbers served by the project.*

***Source:** Project's final report to the Blue Cross Foundation.*

Project goals

- Meld parent education groups will use 10 new curriculum activities related to preventive health care.
- 90 percent of the 60-70 parents participating in the program will report an increase in their knowledge of available preventive health care services.
- 25 percent of the previously uninsured parents participating in program evaluation will enroll in a health insurance plan. (During spring 2003, Meld and the foundation agreed to decrease expectations for the number of insured children because of eligibility changes in Minnesota health care programs and lower-than-expected numbers of participants in the evening parent groups during the winter season.)
- 70 percent of parents will participate in the process and outcome evaluation.

Progress on goals

Meld parent education groups will use 10 new curriculum activities related to preventive health care. Meld developed 10 new topics related to preventive health care. Five of these have been merged into Meld's basic parenting curriculum; modules on nutrition, immunizations, well-child care, health insurance, and dental care will be presented to all Twin Cities Meld parent groups as part of the new curriculum being pilot tested in 2004 and 2005. In 2006, the curriculum will be rolled out as a new curriculum available to affiliates nationally.

90 percent of the 60-70 parents participating in the program will report an increase in their knowledge of available preventive health care services. This was difficult for the project to evaluate during the time frame of implementation. Pre-tests were not given to participants, and because of difficulty with regular parent attendance at meetings, few parents participated in evaluation activities. Therefore, the evaluation was designed to take place at the end of a parent group. Parents did report that they knew how to access services at the end of the parent group.

25 percent of the previously uninsured parents participating in program evaluation will enroll in a health insurance plan. (During spring 2003, Meld and the foundation agreed to decrease expectations for the number of insured children because of eligibility changes in Minnesota health care programs and lower-than-expected numbers of participants in the evening parent groups during the winter season.) No information available to assess progress on this goal.

Other implementation activities

At the beginning of the project, Meld staff reviewed existing Meld curriculum to identify materials relating to health care. In fall 2002, staff conducted focus groups with parents from the different ethnic and cultural groups targeted for the project, in order to identify what kinds of information parents wanted and needed. They also discussed the barriers that parents were encountering in accessing health care.

Meld's *Growing Up Healthy* project coordinator and curriculum developer created a curriculum of 10 health topics. Meld developed evaluation questions for each topic area to gauge participants' knowledge afterward. Next, Meld's *Growing Up Healthy* project coordinator met individually with parent group facilitators to train them on the curriculum.

In February 2003, Meld began piloting the new curriculum with eight groups of parents: two groups of African American young mothers, one group of young fathers (mostly African American), two groups of East African immigrant parents, two groups of Hmong parents, and two groups of Latino parents. Eighty-five parents had participated in at least

3 of the 10 meetings. Attendance at the sessions was much more irregular than expected and caused difficulty in evaluating the curriculum's impact.

The following pilot sessions were evaluated using surveys at the end of that session's parent discussion:

- Introduction to healthcare
- Preventive/well-baby/well-child care
- Immunizations
- Insurance forms and resources
- Dental care

Participants completed evaluation surveys after attending meetings that addressed these preventive health topics. It is difficult to ascertain what changes in parent knowledge and behavior occurred as a result of the Meld curriculum, compared to how much was known by parents already. However, the evaluations do show that parent participants report a good understanding of preventive health care after attending.

- 101 surveys were completed by participants in Year 1, and 108 surveys were completed in Year 2. It is likely that some parents who attended multiple meetings completed more than one survey.
- Parents reported experiencing few barriers to accessing health and dental care. The one major barrier reported by East African, Latino, and Hmong parents was the need for an interpreter when visiting the doctor or dentist.
- At the start of curriculum activities, the majority of parents had health and dental insurance. Nearly all respondents had transportation to and from the doctor.
- All parents who completed the parent meeting that discussed well-baby visits reported that their children had been to the doctor. In Year 1, about half of these recent visits were for checkups; in Year 2 over three-quarters had been for check-ups.
- Nearly two-thirds of respondents at the "introduction to health care" meeting reported being satisfied with the care their child received at the doctor, and 28 to 29 percent were satisfied some of the time. Parents who completed the meeting that discussed dental care reported that fewer of their children had been to the dentist. Most dental visits were for checkups.
- The majority of parents report understanding the material presented about reasons why and when children need health and dental care.
- Most parents have a system to track their child's health checkups and immunizations, mainly through reminders sent by their health plans or primary care providers.

- In Year 1, the majority of parents said that they understand the details of their child's health insurance, including the type of insurance and where they can use it. In Year 2, just over half of the parents surveyed said that they knew where their insurance was accepted.

After collecting feedback from facilitators, Meld's curriculum specialist condensed the curriculum into five modules. There was no mention in the final report of evaluation or assessment of the impact or cultural competency of the curriculum. Perhaps, this was due to the project ending. Also, the original project plan included efforts to improve the behavior of parents. In other words, the project intended to increase the number of parents who have a medical "home" and access preventive care. These efforts to actively connect parents with health care did not happen as part of project activities. This may have been due in part to time constraints (the grant was for 18 months rather than two years) or differences in interpretation of project goals due to a change in Meld leadership during Year 1.

Challenges and lessons learned

Meld reports that the biggest barrier to effective implementation of the *Growing Up Healthy* project involved resistance of participating parents and parent group facilitators to the highly structured format of the curriculum. In addition, some participants felt the information was too simplistic – they said that they already knew the information from other resources. In the young fathers group, participants were strident in their rejection of the materials. The facilitator of the group reports that the young African American men have had negative experiences with health care and insurance and are distrustful of the system. Participants in several groups were uncomfortable talking about mental health because of some past negative experiences.

The project also struggled with irregular attendance of parents. It was impossible to evaluate the overall impact of the project on participants, because so few participants attended most or all of the health care sessions. The numbers reported by the project show that 68 persons attended three or more sessions. Staff expressed frustration at the lack of regular attendance and the impact of low attendance on testing the materials.

In addition, the pilot curriculum was available only in English, which presented some challenges for the bilingual group facilitators for whom this content was new. For the groups that were conducted in a language other than English, the group facilitator was asked to read the materials and filter it into the cultural practices of the immigrant group. In these groups, it is difficult to assess how consistently the curriculum was implemented. However, the Meld project coordinator, who is of East African origin, did facilitate one of the groups and reported a high degree of satisfaction with her ability to individualize the curriculum to meet the particular needs of the cultural group with which she met.

More can be learned about the ways that facilitator skills at cross-cultural interpretation of materials affect the success of the project.

Other lessons learned, as reported by the project, include: the need to select parent groups that are able and ready to implement program components and the need to more fully understand and address the reasons for parents' mistrust and fear of the health care system.

Finally, the project described the need to partner with agencies that provide direct health services. The project recognizes that parent education alone cannot meet the needs that immigrant families face. They felt that collaborating with agencies that provide direct services might better meet that need. This issue was also discussed at one of the original site visits with Blue Cross staff and consultants, but there may have been difficulty with implementation because of a change in staff and access to health care providers.

The project coordinator described the following anecdote in the key informant interview:

> In one of the groups, we were having a particularly difficult time with a woman who was a nurse in her home country. She was considered an expert by the community in health. She didn't believe in the health system in the US. She felt that the system would just tell her that she had something [a disease]. Because of the project, she went to a check-up. After that, she opened up and shared with the others in the group. She started sharing information about health and encouraged others in the community to access care. Because she is an expert, people believe her.

University of Minnesota Division of Pediatrics and Adolescent Health

The University of Minnesota Division of Pediatrics and Adolescent Health tailored its existing Adolescent Actors Training Project to include a cultural competency component and subsequently produced a training curriculum.

"Preventive Care for Adolescents" was designed as a training program in which adolescents themselves help teach primary care providers how to effectively screen adolescents from diverse cultural backgrounds for health risk behaviors and psychosocial problems. The project was meant to enhance the Adolescent Actors Training Program, a project already developed at the university. The grant funds were used to formalize the training guide with an added cultural competency component and pilot testing with practitioners.

A10. University of Minnesota Division of Pediatrics: number of people served

	Number
Health professionals trained in pilot project	40
Number of youth involved as teen actors	17
Total number served	57

This project has two basic premises: 1) those who provide primary care to adolescents need to focus on key behavioral risk factors during their visits in order to prevent illness or death; and 2) traditional clinical training does not adequately prepare physicians and other care providers to effectively address the health issues of greatest importance to teens, and also does not sufficiently instill cultural competence.

Project goals

- Recruit and train a multicultural company of at least 17 actors, with members from the Somali, Latino, American Indian, African American, and Hmong communities.
- Interview frontline professionals who work with youth of varying cultural backgrounds to gather information bearing on training needs and content focus.
- Interview practitioners and interpreters regarding working with language barriers in a clinical setting.
- Review recent literature on adolescent preventive care and cultural competence training.
- Conduct pilot training sessions with three groups of practitioners, and gather and analyze evaluative data from practitioners who participated in these sessions.
- Synthesize data from all of the above, combining it with the experience of the other experts, and identify key content for the training plan.
- Write the training program.
- Participate in activities of the *Growing Up Healthy* in Minnesota initiative.

Progress on goals

Other implementation activities

During the first year, the project recruited actors to enhance the multicultural scope of the Adolescent Actors Teaching Project (AATP). The AATP project was already in existence at the University. However, its representation of diversity was limited. During the grant period, the project recruited 11 youth of color. In the first year, project staff used AATP actors to assist with developing culture-appropriate training scenarios and

served as co-teachers in the pilot training sessions. In addition, the AATP company developed a 10-minute dramatic play about adolescent issues. This play was presented by the AATP company at two of three training sessions.

In developing the "Preventive Health for Adolescents" curriculum, the project:

- Developed an interview protocol to be used by practitioners with adolescents. This protocol was practiced in the pilot training sessions.
- Conducted interviews with professionals who had direct field experience working with or caring for adolescents from specific cultures.
- Conducted three pilot training sessions with different practitioners to test the training content of the curriculum.
- Conducted evaluations of the pilot training sessions.

In terms of project outcomes, the project has developed a Training Plan about adolescent preventive health issues to be used with practitioners. However, the project was unable to evaluate the plan's effectiveness within the one-year time frame of the project. Modifications to the curriculum were made after the pilot testing was done, based on feedback by participants. These modifications were made to the curriculum at the end of the grant period and were not tested.

The project anticipates the longer-term outcome to be improved preventive care for large numbers of Minnesota adolescents, and in turn the health of Minnesota adults will be positively impacted in years to come. However, at this time, the future of this project is uncertain. It is difficult for Wilder Research to ascertain which project activities were already underway by the University of Minnesota Division of Pediatrics, before the *Growing Up Healthy* funds were awarded.

Through evaluation activities, project staff found that the section of the curriculum related to cultural competence would be more effective it included more interaction among participants. In addition, feedback from participants suggested that additional information about successful strategies for working with bilingual/bicultural interpreters would be helpful. It was observed that the project may need to be more specific in strategies for working with various cultural and immigrant groups. Other feedback from the pilot phase included:

- Examples of questions to be asked of adolescent actors should be given to trainees in advance of role playing activities.
- More case studies would likely enhance the discussion of cross-cultural aspects of adolescents experiences.
- Training would likely be more effective if the cross-cultural care segment and the adolescent interview were integrated.

- More time should be devoted to youth development and related clinical applications. This material might best be integrated into role-playing scenarios, because these scenarios may make sessions more concrete and clear to trainees.
- More time is needed to discuss how to integrate information into daily practice. More practice time with adolescents will likely make the experience more effective.

Overall, the surveys from the pilot phase found that participants' confidence and skills about communicating with adolescents from different cultural backgrounds increased as a result of the training. However, the project researchers note that the survey given to clinician trainees was affected by social desirability bias. The project has updated the curriculum and training plan, based on feedback.

Challenges and lessons learned

The first challenge faced by the project was timing. It was difficult for the project to schedule the pilot training sessions to ensure participation by practitioners. In addition, the project had difficulty in finding and retaining teen actors from communities of color. However, the project did recruit 11 teens of color and American Indian teens who participated in at least one training session.

The project had intended to use a "mystery patient" – a youth to go into one of the clinics in which staff had received the training to evaluate how well the staff worked with the adolescent. However, project staff felt that this was not feasible for several reasons including the fact that the youth would have to create an identity, a non-existing health problem, and receive treatment. Project staff members have concluded that the best way to evaluate outcomes is through exit interviews with adolescents at clinic sites. This idea was initially rejected for various reasons, including timing, but seems to be the better option now.

In terms of cultural competence, project staff learned from interviews with community providers that competence across all cultural divides is operationally grounded in the same skills that permit health care providers to successfully care for adolescents. Therefore, the curriculum did not include specific cultural training, but more general awareness-building of the providers' own viewpoints and views toward others. Overall, the project learned that bridging differences based on ethnicity, age, or gender requires similar skills of respectful relating and inquiry. This general premise about cultural competency may need to be further tested and developed; some practitioners trained during the pilot phase requested more practical cultural competency training, case studies, and more practice with youth. Also, pilot testing was done with practitioners who had experience working with communities of color. Clinicians with little experience with these communities, particularly with the cultural practices of new immigrants, may benefit from more detailed training about specific cultural practices.

H. Grantees' project evaluators and logic models

As a condition of receiving a grant through the *Growing Up Healthy in Minnesota* initiative, each project agreed to develop and carry out a project evaluation, including a logic model that describes how each project activity would contribute to the immediate and long-term goals of the project.

Challenges of record-keeping and documentation

With culturally specific programs for children of immigrants, record-keeping proved to be more difficult and less familiar. Grants to these groups may benefit from more front-end technical assistance to ensure adequate record-keeping for both staff and client activities.

The value of curriculum development projects may be better judged with regard to effectiveness if the project activities not only promote follow-through with providers, but the funding period also allows time for the examination of health-seeking behaviors following exposure to the curriculum.

Some of the projects did not collect all of the common data elements asked of them. Better data collection would be helpful in documenting project activities, successes, and challenges. Strengthening the project-level evaluations can help projects effectively "tell their story" in order to demonstrate initial outcomes to current and potential funders, their communities and constituents, and others in the field.

This Appendix lists the local evaluator assisting each project and a copy of the project's logic model in its current form.

Affiliated Community Health Foundation: Logic model

Project evaluator: Becky Sechrist, Minnesota Institute of Public Health

Willmar Teen Wellness Center

LOGIC MODEL

Background:

1) Cultural, financial and social barriers exist for adolescents seeking health care services.
2) Health care staff is available in the school, but time to provide preventive health care service is limited.
3) The teenage years are a time when lifelong habits are developed.
4) The teenage years are a time of risk-taking.

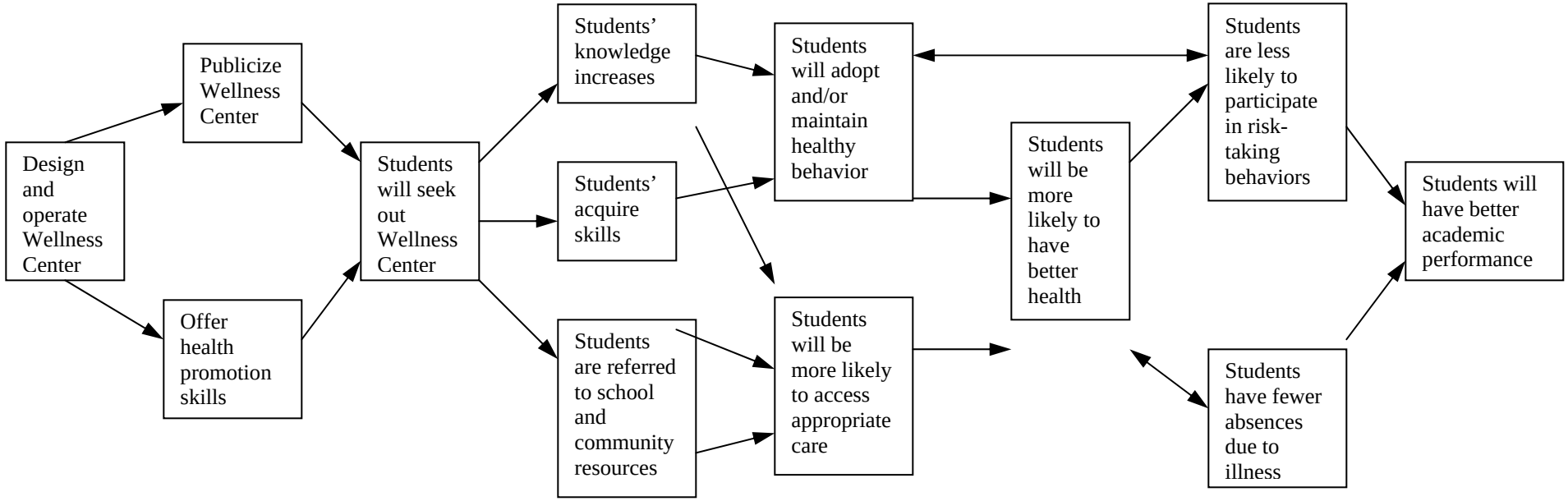
Services/activities:	**Frequency/duration of activities:**	**Target group:**	**Documentation of activities:**
Provide health education information (books, videos, activity ideas, etc.).	Ongoing	Students in the Junior High, Senior High and Alternative Learning Center (ALC).	Track number of materials distributed.
Conduct individual and group consultations with students that include health behavior goals.	Ongoing	Students in the Junior High, Senior High and ALC seeking information on health issues.	Document number and nature of contacts with Wellness Center staff.
Listen, assess and refer students for health care needs.	Ongoing	Students in the Junior High, Senior High and ALC seeking information on health issues.	Document number and nature of referrals.
Raise awareness regarding a specific health issue each month. (center promotion and student recruitment)	Monthly	Students in the Junior High, Senior High and ALC.	Document methods used to cover issue and students' reception to the ideas.
Conduct classroom presentations. (center promotion and student recruitment)	As requested and using proactive methods	Classrooms in the Junior High, Senior High and ALC.	Track presentations, the number of participants and participant satisfaction.

Services/activities:	Frequency/duration of activities:	Target group:	Documentation of activities:
Conduct school-wide health promotion activities. (center promotion and student recruitment)	Monthly (new topic each month)	Students in the Junior High, Senior High and ALC.	Document activities, student involvement and student satisfaction.
Conduct community presentations? (center promotion and student recruitment)	As requested and using proactive methods	Community members, organizations and parents.	Track presentations, the number of participants and participant satisfaction.
Involve health/dental care providers from the community in the implementation of the Wellness Center. (provider group will be developed and used for gaining insight)	Ongoing	Community health care providers.	Document contacts and nature of involvement.

Theory of change:

- If a friendly youth-oriented environment is designed and operated for students to receive wellness education and counseling, then the center can be publicized as a place where students will be offered skills to promote health.
- If the center is publicized as a place where students will be offered skills to promote health, then students will seek out the center.
- If students seek out the center, then they will receive services that are likely to increase knowledge, acquire skills and be referred to school or community resources when necessary.
- If students receive knowledge, acquire skills and are referred to resources, then they will be more likely to access appropriate care.
- If students access appropriate care, then they are more likely to have better health.
- If students have better health, then they will have fewer absences due to illness and be less likely to participate in risk-taking behaviors.
- If students are absent less and chose not to participate in risk-taking behaviors, then they will have better academic performance.

Theory of Change (continued):



Short-term Outcomes:

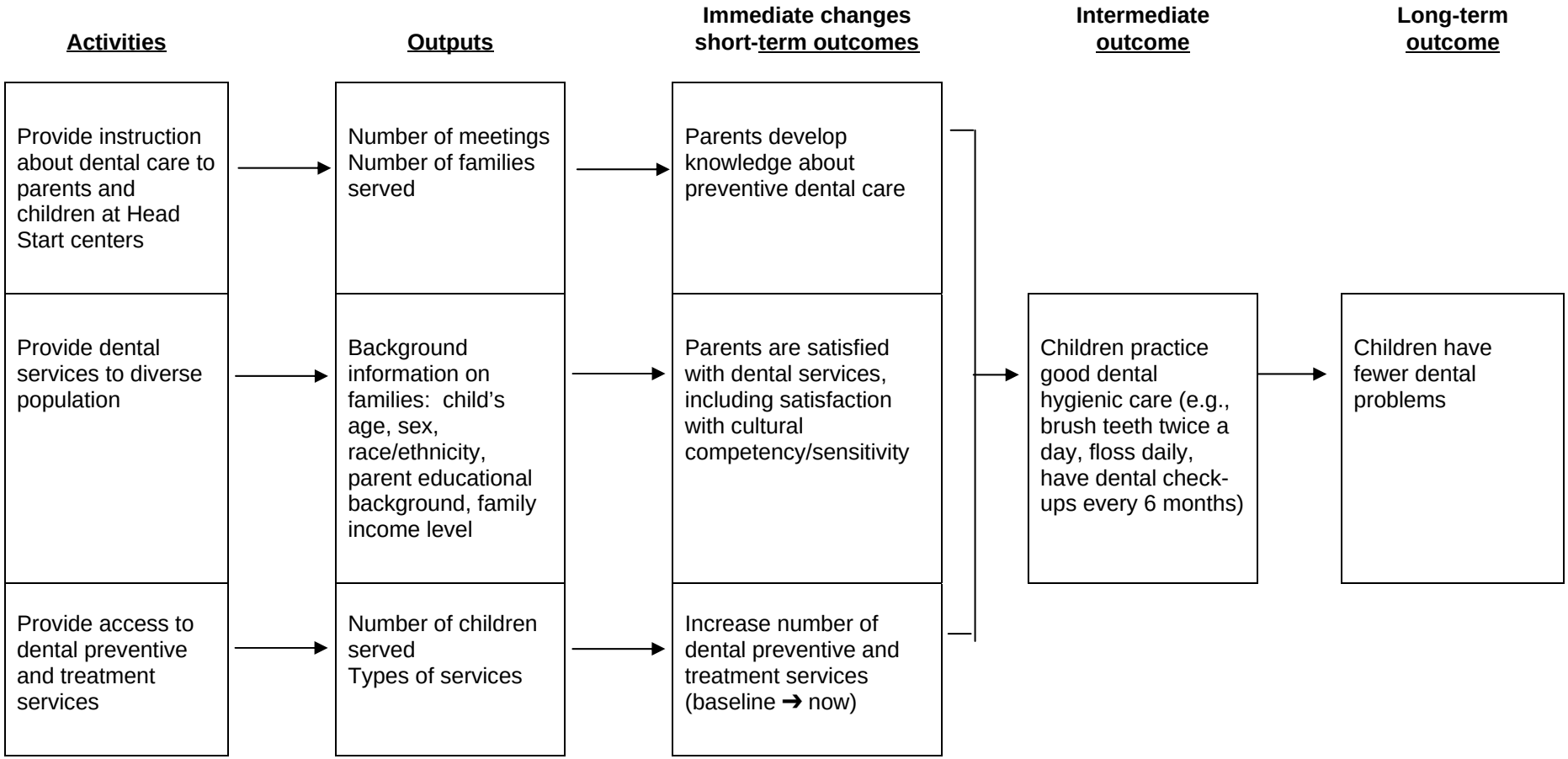
1) Increased participation in preventive health and dental care.
2) Increased number of student contacts with Wellness Center staff and school nurses, social workers, counselors and psychologists.
3) Increased number of students served by the Wellness Center who are multi-cultural or lack adequate insurance coverage.
4) Decreased number of absentees.

Long-term Outcome:

1) Students will report overall better health.
2) Students will be less likely to participate in risk taking-behaviors (self-report).
3) Students' academic performance will improve (not practical).

Apple Tree Dental: Logic model

Project evaluator: Edith Gozali-Lee, Wilder Research



Lao Assistance Center of Minnesota: Logic model

Project evaluator: Christa Treichel, consultant

Children Avoid Preventable Disease			
Program	**Long Term Outcome**	**Intermediate Outcome**	**Short Term Outcome**
Lao American Families	Children grow up healthy	Parents demonstrate knowledge of the preventive health care children need.	Parents understand the importance of preventive health care for children.
		Parents demonstrate knowledge of the preventative dental care children need.	Parents understand the importance of preventive health care for children.
		Parents (who are not insured) get healthy care coverage for their family.	Parents understand how health insurance coverage can help their family.
		Parents report success at using health insurance.	Parents understand how and where they can use health insurance.
		Children receive preventative health and preventative dental care.	

Meld: Logic model

Project evaluator: Christa Treichel, consultant

Long-term indicators - child outcomes	Intermediate indicators	Short-term indicators	Specific curriculum Strategies leading to outcomes	Evaluation questions for parents	Statements able to be made
Children live free of maltreatment.	Parents use positive discipline strategies.	Parents learn about a variety of positive disciplinary strategies.	Discipline	1. I use the following ways to manage my child's behavior: ▪ ___ time outs ▪ ___ praising good behavior ▪ ___ spanking ▪ ___ redirecting behavior	--% of Meld parents use positive discipline strategies with their children.
	Parents develop support networks.	Parents learn about the importance of developing support networks.	Support networks	2. I have a trustworthy adult in my life who: ____ can provide childcare for me ___ I can count on in an emergency ___ can listen to me when I have a problem	--% of Meld parents are connected to other supportive adults
	Parents respond quickly to children's needs.	Parents understand children's needs and know how to respond appropriately. Parents understand how to show empathy and emotional support for child.	Developing empathy and providing emotional support for child. Responding to children's needs.	3. I respond quickly when my child needs me (for example, when my baby cries or my toddler is hurt).	Parents respond quickly to children's needs.
	Parents manage stress in safe and healthy ways.	Parents learn about the importance of managing stress.	Stress management	4. I am able to deal with the stress in my life.	--% are coping with the stress in their life.

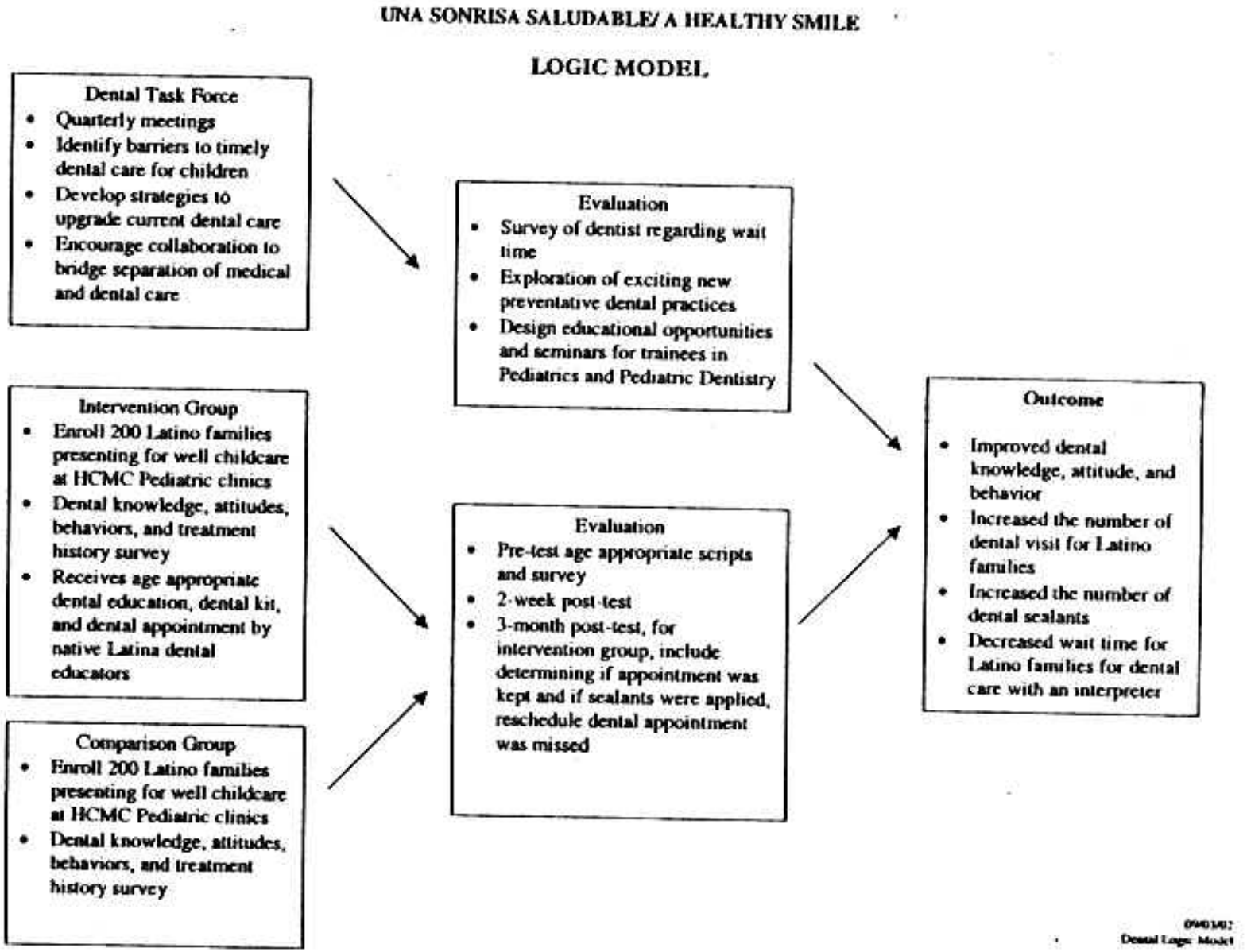
Long-term indicators - Child Outcomes	Intermediate Indicators	Short-term Indicators	Specific Curriculum Strategies Leading to Outcomes	Evaluation Questions for Parents	Statements able to be made
Children are on-track socially and emotionally and are ready to learn.	Parents use community resources.	Parents learn about the importance of accessing community resources,	Community resources	5. I use community resources when I need help for my family.	Children's needs are met through parents accessing community resources.
	Parents celebrate culture and family traditions.	Parents understand the importance of developing an appreciation for culture and heritage in their children.	Celebrating culture; culturally specific curricula; Meeting plans draw on parents' experiences.	6. Our family celebrates our culture and heritage through community events or family traditions.	Children view themselves, their family, culture, and heritage in a positive way because their family celebrates culture and/or family traditions.
	Parents anticipate and meet the developmental needs of their children.	Parents understand the developmental implications of play with their children.	basic child development Play	I play with my child every day.	Children learn by playing with their parents (reported by --% of parents).
		Parents understand the social foundations of learning.	Social development of children	7. My child and I do an activity or engage with others once a week (like playing with another child, going to the park, or visiting the library).	Children participate in learning opportunities that help him or her grow socially.
				8. My child participates in an organized social activity (like preschool, Sunday school, day care, Head Start, etc.)	Children are in social learning environments (reported by --% of parents).
	Parents help to develop learning skills in their children.	Parents understand how to develop literacy and learning skills in their children.	Reading to a child; literacy development	9. Most days, someone looks at a book with my child (like me or another adult).	Children are developing literacy skills (--% of parents report regularly looking at a book with their child and --% of parents report that their child has access to books)
		Parents understand the benefits of communication with their child.	Communication skills	I talk with my child every day.	Children are developing vocabulary skills (through parent-child conversation as reported by --% of parents)

Long-term indicators - Child Outcomes	Intermediate Indicators	Short-term Indicators	Specific Curriculum Strategies Leading to Outcomes	Evaluation Questions for Parents	Statements able to be made
Children's basic needs are met.	Parents take steps toward self-sufficiency, such as holding a job or continuing their education.	Parents identify basic needs and self-sufficiency goals (e.g., education or employment).	Parent development; Decision-making and goal-setting	10. I am currently continuing my education. 11. I am currently holding a job at least 20 hours a week. 12. If I am not employed, I am looking for work.	Children are supported by parents who are becoming self-sufficient, as indicated by ___% who are continuing their education and by __% who are employed or looking for work ___ %.
	Parents speak up or take action in order to ensure their child's needs are met.	I understand my role in representing my child's interests.	Advocacy	13. I am confident that I can speak up for my child's needs with professionals who are responsible for my child's care.	Children's best interests and needs are represented adequately by parents.
	Non-custodial parents are taking steps to provide for their children. OR parents are seeking support from the child's other parent for their children.	Parents understand the advantages of children being supported by 2 parents.	Co-parenting	14. I am taking steps to provide for my children (if I don't have custody of my child) or I am seeking support from my child's other parent for my children.	Children are beginning to be supported by 2 or more adults.
	Parents have delayed subsequent pregnancies and are maintaining at least a 2 year spacing between births when possible.	Parents understand the advantages to their child of delaying subsequent pregnancies and are aware of the advantages for their family of spacing between births, when possible.	Subsequent pregnancies and birth spacing. Decision-making	15. My decision to have another child is based on what is best for my existing children.	Parents make decisions about having another child is based on information about what is best for my children.

Long-term indicators - Child Outcomes	Intermediate Indicators	Short-term Indicators	Specific Curriculum Strategies Leading to Outcomes	Evaluation Questions for Parents	Statements able to be made
Children avoid preventable childhood diseases.	Parents provide nutritious meals for their children,	Parents understand what good nutrition is for their child.	Child development. Nutrition	16. I provide for my child a variety of nutritious foods, including fruits and vegetables, every day.	Children are eating healthy foods.
	Parents provide opportunities for their children to play physically every day.	Parents understand the need for their children to have exercise/ movement daily.	Daily exercise. Play.	17. My child plays physically for at least 30 minutes some time throughout the day.	Children are getting physical exercise on a daily basis.
	Children receive preventive health care and treatment.	Parents understand the benefits of regular dental care.	Dental care.	18. My child brushes his or her teeth at least twice a day (or I clean his or her gums and teeth daily if he or she is an infant). 19. My child has been to the dentist at least once (if he or she is 2 or older).	Children are getting appropriate dental care.
		Parents understand the importance of immunizations for their children.	Immunizations	20. My child has received immunizations that are recommended for his or her age.	Children are up-to-date on immunizations.
		Parents understand the importance of regular health exams.	Well-child care.	21. My child visits the health clinic regularly for well-child check-ups, (even when he or she is not sick).	Children are getting preventive care (i.e., well-baby visits) (reported by --% of parents)
		Parents understand the benefits to their family of obtaining and using health insurance.	Health insurance.	22. My child has health insurance.	Children are covered by health insurance (reported by --% of parents)
		Parents are able to recognize when their children need to see a health care provider.	Helping an ill child.	23. I know when I need to call or visit my health care provider when my child is sick.	Parents have a good understanding of when to call or visit their health care provider.
	Children are kept safe from preventable accidents.	Parents learn about ways to keep their children safe.	Safety and accident prevention	24. My home is safe for my child (stairs have gates, electrical sockets covered, medicines are locked away).	Children are living in childproofed homes (reported by --% of parents).

Minneapolis Medical Research Foundation: Logic model

Project evaluator: Joni Geppert, Minneapolis Medical Research Foundation



Open Door Health Center: Logic model

Project evaluator: Laura Bloomberg, consultant

Open Door Health Center: Blue Cross/Blue Shield Foundation Grant: Growing Up Healthy In Minnesota
Logic Model and Evaluation Plan

PROGRAM INPUTS
Funding, Adequate clinic space, Materials and supplies, Trained staff and volunteers,
Community partnerships with Saludando Salud, Community Assistance for Refugees, Blue Earth County Public Health,

OBJECTIVE ONE	**ACTIVITIES** *What do we do?*	**OUTPUTS** *How do we quantify the scope of our work?*	**IMMEDIATE OUTCOME INDICATORS** *From the outset, how do we know we are moving toward our long term outcomes?*	**INTERMEDIATE OUTCOME INDICATORS** *Over time, how will we know we're continuing to move toward our long term outcomes?*	**LONG_TERM OUTCOMES** *What do we hope will ultimately be different for program participants?*
To provide culturally, linguistically, and age appropriate prevention and wellness services to 800 new immigrants or refugees	Create/manage immigrant and refugee child and adolescent services at the clinic and in community. Provide immunization clinics (20 hr/month). Work with partner organizations to develop culturally and age appropriate health promotion programs. Develop two (Somali and Latino) culturally appropriate well child and teen checkup programs. Work with community elders on community outreach. Create a Youth Advisory committee to assist in program planning and evaluation.	Number of programs created/service hours provided Number of children immunized/clinic hours Number of health promotion initiatives/service hours Number of children/youth seen in well child checkup programs Number of elders who participate in decision making Number of participants on youth advisory board	Members of new immigrant/ refugee community actively participating in and advising program development. Increased number of families seeking prevention services for children/youth.	Increasing number of clients report that services received are culturally respectful and of high quality. 100% immunization rate of youth seen at ODHC 100% of youth seen at ODHC receive preventative dental care. Reduced number of new immigrant/ refugee youth who do not fully participate in school or co-curricular activities due to health or wellness concerns.	All new immigrant/ refugee children in the region receive up to date immunizations. All new immigrant/ refugee children in the community receive preventive dental care. All new immigrant/ refugee children and youth in the region receive regular well child/teen checkups.

OBJECTIVE TWO	ACTIVITIES *What do we do?*	OUTPUTS *How do we quantify the scope of our work?*	IMMEDIATE OUTCOME INDICATORS *From the outset, how do we know we are moving toward our long term outcomes?*	INTERMEDIATE OUTCOME INDICATORS *Over time, how will we know we're continuing to move toward our long term outcomes?*	LONG_TERM OUTCOMES *What do we hope will ultimately be different for program participants?*
To provide culturally and linguistically appropriate primary care to 800 immigrant and refugee children and adolescents.	Co-locate medical and dental staff (physicians, residents, dentists, hygienists, nurse practitioners) at ODHC Work with Nurse Practitioner to address complex pediatric needs of immigrant and refugee youth. Train staff and residents in medical Spanish. Provide cultural competency training to all staff, volunteers, and residents. Provide trained medical interpreters at ODHC	Number of co-located health care practitioners. Number of hours health care services are provided. Number of children/youth treated. Number of Medical Spanish trainees; number of training hours provided. Number of clients requiring interpreter services. Number of interpreter hours provided.	Increasing number of clients report that services received are culturally respectful. Increasing number of clients believe that the services received are having a positive impact on their overall health.	Decreasing number of new immigrant/ refugee youth who report they would use ER, Urgent Care or not receive care at all if they didn't access ODHC.	Improved overall health and wellness for new immigrant/ refugee youth in the region.

OBJECTIVE THREE	ACTIVITIES *What do we do?*	OUTPUTS *How do we quantify the scope of our work?*	IMMEDIATE OUTCOME INDICATORS *From the outset, how do we know we are moving toward our long term outcomes?*	INTERMEDIATE OUTCOME INDICATORS *Over time, how will we know we're continuing to move toward our long term outcomes?*	LONG_TERM OUTCOMES *What do we hope will ultimately be different for program participants?*
Help 300 families navigate the health care system to get needed care for their children.	Work with families on case management and related health needs (eg, referrals, transportation, etc) [role of social worker] Assist families in gaining health insurance coverage. Assist families in accessing medications through the Medication Assistance Program. Assist families in accessing dental care through ODHC dental services	Number of referrals made. Number of clients who successfully become insured. Number of clients served through the Medication Assistance Program. Number of ODHC clients receiving dental care. Number of dental service hours provided.	Increasing number of clients report that services received are culturally respectful and of high quality.	Increasing number of clients report fewer problems accessing primary care and dental services. Increasing number of new immigrant/ refugee children and families moved into public or private insurance systems.	Improved overall health and wellness for new immigrant/ refugee youth in the region.

Red Lake Comprehensive Health Services: Logic model

Project evaluator: John Robinson, Red Lake Dental

RED LAKE
COMPREHENSIVE HEALTH SERVICES
P.O. BOX 249
RED LAKE, MINNESOTA 56671
PHONE (218) 679-3316
FAX (218) 679-3990

Red Lake Nation-Blue Cross School Dental Prevention Project Logic Model

ACTIVITIES	OUTCOMES
Screen students in school using portable dental equipment Mail consents to caregivers Process incoming consents and re-mail as needed Begin prevention treatment Service data processing Share progress at periodic meetings with the Advisory Committee Publish results in tribal newsletter and health newsletter Promote program for addition to the strategic plan of the hospital	Knowledge of caries rates in age groups Knowledge of percent target population served Knowledge of number of services and type by child Calculations of total services, total services per participating child, number of children with 2 preventive visits Permanent funding with increase for health service inflation
Schedule and conduct screening using portable dental equipment in schools Submit encounter forms Enter treatment data onto IHS computer Calculate the number of children screened	The number of children screened will attain the goal of about 1225
Track receipt of consents mailed Re-mail consent if reply not received within two weeks Ask Community Health Nurses to follow-up with 2 or more failures to respond	85% of consents will be returned for participation
Apply fluoride varnish to the teeth of Head Start children three times during the year. Each application will be separated by a minimum of one month	Fluoride varnish will be provided to participants 3 times during year
Obtain a roster of full and part-time Head Start staff Schedule and provide training on at least two occasions	81 full and part-time staff will each have attended two dental health education sessions
Apply fluoride varnish and sealants to children with consents in grades 1,2,7 & 8	80% of participants will have sealants placed on permanent molars

Somali Community Resettlement Services: Logic model

Project evaluator: Becky Swanson Kroll, Calabash

CLIENT AND SYSTEM CONDITIONS	MAJOR PROGRAM COMPONENTS	PROGRAM ACTIVITIES	OUTCOMES
1. Over 300 Somali immigrant families resettle in Olmsted and Steele Counties annually. More than 47% of the Somali immigrants are under 17 years old. 2. The Somali culture does not advocate preventive health care for children. 3. A majority of new Somali immigrants do not know how to access health insurance plans. 4. There is a language barrier preventing Somali parents from learning about medical and dental preventive care.	1. Education 2. Training 3. Partnerships	1. (1)Translation of health information pamphlets into Somali. 2. (1)Educational programs on Somali television focused on health information. 3. (1)Information provided by phone and in person in the office (location of health clinics, health insurance information, etc.). 4. (1)Health care information to participants of the Community Training Center. 5. (1) Workshops and conferences. 6. (2)Training of individuals in the community who will spread information to their neighbors. 7. (3)Partnerships with service providers and other resettlement agencies to increase cultural sensitivity and enhance services for Somali residents.	**Immediate Outcomes** 1. Somali residents will have increased awareness of the importance and benefits of immunization and well child visits. 2. Eligible Somali residents will have public funded health coverage. **Long Term Outcomes** 1. Somali residents will have up to date immunization and well child visits.

University of Minnesota Division of Pediatrics and Adolescent Health: Logic model

Project evaluator: Clea McNeely, University of Minnesota Division of Pediatrics

Logic Model for *Preventive Care for Adolescents*

Program Processes	Intermediate Outcomes	Longer-term Outcomes
Create curriculum and training manual for the *Preventive Care for Adolescents* program. 36 clinicians receive 2-day training in preventive care for adolescents. 75% of these clinicians also participate in at least one seminar in the Division of General Pediatrics and Adolescent Health.	Increase adolescent health care providers' self-perceived *skill* and *confidence* in interviewing and counseling adolescent patients about their psychosocial health, substance use and sexual behaviors, as recommended by Guidelines for Adolescent Preventive Screening. Increase adolescent health care providers' intercultural communication skills and confidence applying and adapting the Guidelines for Adolescent Preventive Screening to youth from diverse cultural contexts.	Increase the number of age-appropriate health risks screened for by adolescent health providers who receive training.

I. Overview of grantees' partnerships and collaborations in Growing Up Healthy

A11. Community partners or collaborations involved in *Growing Up Healthy*

Grantee agency	New or existing; partnership or collaboration*	Name of community partner or collaborating agency
Affiliated Community Health Foundation (Willmar)	▪ New partnerships →	▪ Willmar Public Schools: to establish a Wellness Center in the junior high school, senior high school, and alternative learning center ▪ Kandiyohi County Public Health: to provide health education to community members
	▪ New collaboration →	▪ Latino school retention specialist (who works with Latino students to prevent drop-out): for outreach to Latino community ▪ 25 other health and human service agencies: to conduct several events including a Teen Health and Wellness Expo at the senior high school
Apple Tree Dental	▪ New partnerships →	▪ Western Community Action Agency and the Southwest Minnesota Opportunity Council Head Start programs: serving nine counties in Southwestern Minnesota. Head Start staff obtained parent consent, provided parent education, and coordinated dental visit schedules on site. Because of the project, a new partnership was formed with: ▪ Minnesota State University at Mankato Dental Hygiene Department: to provide student hygienists at the Madelia site ▪ Madelia Hospital to provide on-site dental chairs and teledentistry that Apple Tree Dentists will staff.
Lao Assistance Center	▪ Existing partnership → ▪ ▪ New partnership →	▪ Southeast Asian Community Council: to work with Hmong and Lao families in North Minneapolis ▪ Pilot City Health Center: to connect families to medical provider/home. This led to a new dental component for the project as families served were connected to the "Healthy Smiles" project.
Meld	▪ Existing collaboration →	The following agencies piloted the Meld curriculum as part of their parenting groups with immigrants: ▪ Association for the Advancement of Hmong Women ▪ Centro Cultural Chicano ▪ Hennepin County Home School ▪ House of Prayer Lutheran Church ▪ Pilot City Health Clinic ▪ Merrick OIC ▪ Brian Coyle Community Center ▪ Reuben Lindh Community Center

A11. Community partners or collaborations involved in *Growing Up Healthy* (continued)

Grantee agency	New or existing; partnership or collaboration*	Name of community partner or collaborating agency
Minneapolis Medical Research Foundation	▪ Existing partnership → ▪ New and existing collaborations →	▪ Hennepin County Medical Center Task Force; Met quarterly to develop strategies to upgrade current dental care and to encourage collaboration to overcome separation of medical and dental care. Members included project staff and: ▪ Hennepin County Medical Center clinic dentist ▪ Metropolitan Health Plan's child & adolescent coordinator ▪ Medica regional coordinator ▪ University of Minnesota Community-University Health Care Center executive director ▪ Way to Grow liaison
Open Door Health Center	▪ New collaborations →	Other health-related programs: ▪ Rural AIDS Action Network ▪ Saludando Salud ▪ Migrant Health Services Culturally specific support programs: ▪ La Mano, Centro Campesino, Community Assistance for Refugees, CLUES, Southern Minnesota Sudanese Community Organizations providing services for low-income families: ▪ Lions Club, Minnesota Valley Action Council, Volunteer Interfaith Network Effort, United Way, and Blue Earth County Human services
Red Lake	▪ New collaborations → ▪ Existing collaborations →	▪ Schools ▪ Red Lake Indian Health Services

A11. Community partners or collaborations involved in *Growing Up Healthy*, by project (continued)

Grantee agency	New or existing; partnership or collaboration*	Name of community partner or collaborating agency
Somali Community Resettlement Services	▪ New collaborations →	Partnerships for implementation included: ▪ Rochester Somali TV ▪ The Community Training Center ▪ Rochester Islamic Center Collaboration with: ▪ Olmsted County Public Health: to develop health education materials for Somali families ▪ The Mayo Clinic ▪ Rice County Public Health Department The agency has also worked with the following agencies to increase access for Somali families around immunizations and medical checkups: ▪ the Multicultural Health Care Alliance ▪ Olmsted Medical Center ▪ Salvation Army Clinic Somali Community Resettlement Services convened a community meeting with local dentists and public health representatives to address the serious shortage of access to dental care for Somali families.
University of Minnesota Division of Pediatric and Adolescent Health	▪ New and existing collaborations →	Partners involved in evaluating the training module: ▪ TAMS (Teenage Medical Services) ▪ Community University Health Care Center ▪ North Memorial Family Practice residency program In addition, agencies that were interviewed as part of the curriculum development process and are thus considered collaborators were: ▪ Hmong American Partnership ▪ Youth Link ▪ La Clinica

***Note.** "Partnership" here denotes that the organization was critical to project implementation; "collaboration" here denotes that the organization provided helpful support, but was not necessary for project implementation.*

J. Summary of responses from interviews with project staff and partners

In Year 2, Wilder Research conducted key informant interviews with several staff from each of the grantee agencies as well as selected partner organizations. Efforts were made to gather input from staff and partners who had a variety of roles in the project to ensure that there was a broad range of perspectives and feedback. In all, 40 project and partner agency staff participated in key informant interviews about their perceptions of the project, its impact, the collaborations formed, and overall views of the *Growing Up Healthy* initiative. These interviews were conducted at the end of the funding period in summer 2004.

Wilder Research asked participants about their roles in the project in order to better understand and generalize their responses. Sixty percent of respondents interviewed were planners or managers providing oversight of project activities, 25 percent of respondents were evaluators, 23 percent of respondents were line staff, and 18 percent were healthcare providers. Some respondents had multiple roles (e.g. six of the seven health care providers were also planners or managers; four of the evaluators were also planners or managers). The majority of participants in the interviews had been involved with the project for more than 12 months (see figure below).

A12. Length of project involvement by project and partner agency staff who participated in key informant interviews

N=40	Number	Percent
Less than 6 months	2	5%
6 to 12 months	6	15%
More than 12 months	32	80%

These key informant interviews were conducted before a decision was made by the Blue Cross Foundation Board in September 2004 about funding of sustainability efforts of grantees.

A13. Staff and partner ratings of the helpfulness of the Learning Network meetings

Helpfulness of the Learning Network meetings in...	Very helpful		Somewhat helpful		Somewhat unhelpful		Very unhelpful	
Helping project staff learn more about other projects (N=25)	20	80%	5	20%	0	-	0	-
Giving ideas and strategies to use in their own projects (N=26)	16	62%	8	31%	2	8%	0	-

One example of information-sharing among the grantees occurred around changes in rules regarding dentists and hygienists. The Red Lake dental hygienist had been asked to speak at a state conference and was soliciting input from the other grantees about needs for these services around the state, so that she could share these at the conference. The following is a copy of an email message that was sent from the Red Lake dental hygienist to the grantee group.

> I am contacting each of the other grantees to ask whether they are still experiencing difficulties finding dental care for their clients. Minnesota is the second state to legalize collaborative working agreements between dentists and hygienists. This agreement between a dentist and a hygienist would allow the hygienist to perform their preventive services outside of the private dental office without dentist supervision. This is designed to meet needs of the underserved in our state. Work in currently underway to inform hygienists of this new practice mode. Hygienists may apply for their own MA provider number and bill DHS for services to MA eligible clients. While a hygienist may not perform complete restorative work, they can screen and refer. Their primary function in a public health setting would be to educate and deliver services to slow or prevent dental diseases.

A14. Staff and partner perspectives on the most helpful aspects of the Learning Network meetings

Meeting people/networking – benefits pragmatic (helps program) (includes in-between meetings for direct service staff)	Apple Tree, Lao Assistance Center, Open Door, Meld, Red Lake, Somali Community Resettlement
Learning about other projects' challenges and how they faced them	Apple Tree, Lao Assistance Center, Open Door, Mpls. Medical Research, Red Lake, University of MN Division of Pediatrics
It was interesting but not useful; limited interest/applicability because we're different	Affiliated Willmar Wellness, Apple Tree, Mpls. Medical Research, Meld, Red Lake
Meeting people/networking – benefits social or not specified	Affiliated Willmar Wellness, Apple Tree, Lao Assistance Center, Open Door, Mpls. Medical Research
See what others did that we could do	Lao Assistance Center, Mpls. Medical Research, Red Lake, Somali Community Resettlement
Specific (positive) mention of the Sustainability Workshop	Apple Tree, Red Lake, University of MN Division of Pediatrics
Learn about Blue Cross Blue Shield Foundation	Apple Tree, Lao Assistance Center
Appreciate the (non-grantee) experts they brought in	Red Lake, University of MN Division of Pediatrics
Learned what was expected of/how to do the evaluations	Lao Assistance Center, University of MN Division of Pediatrics
Feel validated (personal or project); gain motivation and energy	Lao Assistance Center, Red Lake
There was not enough time (to get the most out of them)	University of MN Division of Pediatrics

A15. Staff and partner perspectives about helpful aspects of services provided by Blue Cross staff

Questions relating to financial issues or vision and goals:	
Accessible and prompt	8 of 9 projects
Not accessible/prompt	1 of 9 projects
Always had an answer; helpful; complete; good information	Affiliated Willmar Wellness, Apple Tree, Lao Assistance Center, Open Door, Mpls. Medical Research, Red Lake, Somali Community Resettlement
Consistent message; helped us in sticking to/focusing on/modifying goals	Affiliated Willmar Wellness, Lao, Open Door, Mpls. Medical Research, Meld, Red Lake
Not consistent	1 of 9 projects
Thorough/clear about what we have to do; they were right to hold our feet to the fire on documentation and evaluation	Lao Assistance Center, Open Door, Mpls. Medical Research, Somali Community Resettlement, University of Minnesota Division of Pediatrics
Friendly and nice	Lao Assistance Center
Site visits helpful	Affiliated Willmar Wellness, Apple Tree, Open Door, Mpls. Medical Research, Red Lake
Helped with evaluation/contract	Open Door, Mpls. Medical Research
Flexible and realistic/gave us time to do what we had to do/let us make it fit in our own community	Lao Assistance Center, Mpls. Medical Research, Red Lake
Report due before end of fiscal year	1 project
Culturally competent with American Indians/had materials in Lao	Lao Assistance Center, Red Lake
Facilitated us in doing our project; questions helped us think through; were a helpful partner in project	Open Door, Red Lake, University of Minnesota Division of Pediatrics
Email is a good way to communicate with us	Apple Tree, Open Door

In a closing question, respondents were given an opportunity to voice any other comments they might have about the grant award and management process. Other than comments that repeated those already summarized above, grantees took this opportunity to express appreciation for the funding (and wish for more), commend the staff for their management of the initiative, and mention a few specific ways in which things could have gone more smoothly.

A16. Other comments about granting and oversight done by Blue Cross Foundation

They do an excellent job/it went very smoothly	Lao Assistance Center, Open Door, Mpls. Medical Research, Red Lake, Somali Community Resettlement
Appreciate the learning experiences/meetings (but please make them shorter and more convenient)	Apple Tree, Meld
Criteria /guidelines were not clear (e.g., for sustainability fund, for June report, for use of reduced grant amount, for baseline data)	Affiliated Willmar Wellness, Lao, Meld
Liked the Wilder evaluation – clear, organized	Lao Assistance Center
Questions for Blue Cross duplicate those for Wilder	Meld
Would like a copy of the final overall evaluation report/feedback from Foundation at conclusion	Mpls. Medical Research, University of Minnesota Division of Pediatrics
Thanks for the funding; keep on funding this; needed more than we got	Apple Tree, Lao Assistance Center, Red Lake, Somali Community Resettlement

Blue Cross Foundation staff members observed that the process of granting and oversight has been positive:

> It has been a fantastic learning experience and professional opportunity to be involved in this project and work with Blue Cross government programs, the advisory committee, and consultants.
>
> The site visits took a lot of time, but they were so important... and worth the time. We developed nine new relationships. As a result [of the site visits], we have very good relationships with grantees. All nine grantees know that they can call us and talk about issues.
>
> The Learning Network has been an exciting aspect of the project. [Grantees] seemed animated and involved in the meetings as well. The feedback from the evaluation forms has been positive. The additional effort on our part to schedule and coordinate these meetings has had a good payoff. It has built a different kind of relationship which is one that is important to have over these multiyear projects. They see us as more than a funder.

Blue Cross Foundation staff members also noted limitations on the level of their involvement with grantees, because of other project demands including the launching of a new Foundation strategic direction focusing on systemic issues that influence health, such as education, income, housing, and social capital.

Effectiveness of partnerships

The partnerships worked very well. I think strong relationships were built, including the school administration, and that will help to sustain the program. The health care organizations now are familiar with the school situation and have contacts to call. The school is more familiar with resources to call should students need help.

The partnerships worked very well. We were very fortunate to have much networking between health and human services organizations and to keep them very active for two years. It was very instrumental that we had a Steering Committee and the Student Advisory Committee, because they were the go-to groups. We had those two core groups. The Steering Committee was made up of doctors and the school nurse. I think that was it, there were about ten of us. The Student Advisory Committee had about 12 members; the second year was a little smaller. To have champions in the community is very essential. We are very fortunate to have the superintendent of schools very actively involved and the president of the clinic. So, to have those leaders join us once a month at the wellness center, you couldn't ask for anything better.

To my understanding, they worked well, because they were able to get the support form the other community organizations and funders.

Very good – just that all you have to do is look at how the project was formed, the planning group and steering committee was made up of 12 different community groups.

They worked very well. We worked closely with the Head Start staff and the health coordinator to get the program up and running. And we had a lot of input as to how the project was to be run.

I think they worked very well. We certainly felt like we got the support we needed from Head Start, and they got support from us. Translating this into a global effort to work with Head Start statewide is in large part due to [the support]. The enthusiasm of the partners [was also effective]. Certainly Cynthia Maxwell was the chief person in Head Start who wanted to make this work. I think the dentists in the southwest part of the state were willing to find out what we were trying to do, and try to help however they could. In some communities we've gone into, for whatever reason, dentists have felt threatened by someone trying something new. [Another value of the partnership is] the fact that we've been working together to expand to provide teledentistry through Head Start programs. The federal Head Start Innovations grant is designed to see how teledentistry fits within Apple Tree's mobile clinic. Teledentistry is basically an internet connection that allows the hygienist to download digital images (x-rays, etc). And if you have a high-speed connection, it allows the dentist and hygienist to communicate live. Since we have a small number of dentists and a 37 percent increase in hygienists, it makes sense to figure out new ways to use hygienists.

It worked well overall. The net summary from all of the agencies was that it was very positive. Pilot City got entry into the Lao and Hmong communities. SEACC got to respond to some of the health care needs of its communities, both parents and kids. For us, it changed our direction completely. Because of the response of community to the education endeavors, we are looking at restructuring to become a resource center for information for elders, families, everyone; instead of focusing on citizenship or employment services. Those are important as well, but we got such a huge response from the community about the education resources. Either people will exit or participate in these types of organizations and programs. When they participate, you know you have something they want. Lao Assistance Center and SEACC partner in different ways; right now we have 5 different partnerships with them. Pilot City was the new one. The reason it worked well was the liaison staff at Pilot City. The first member was Elsa, and she was Filipina, so she had some understanding of Southeast Asian cultures, and she knew the project inside out; she laid a good foundation. She left and Carla came to Pilot City. Carla empowered the workers, inculcated herself in culturally meaningful ways. She developed a culturally relevant, but personal, relationship with the CHWs. It was something to see these two Southeast Asian women become empowered, and overcome their own cultural concerns about whether they could do this.

My knowledge is limited. Their work with Carla at Pilot City around the Healthy Smiles project was very effective.

Well, for the three partners, Pilot City, Lao Assistance, and SEACC, we help each other out a lot. We work with each others' capacities and assets. We teach each other a lot. We know that it's a learning process for all of us, especially a community health worker. They need to learn a lot of the western health medicine and oral health. That's one of the things that Pilot City teaches us, at the same time we teach Pilot City about our values and traditions. We take clients to Pilot City and vice versa. They come and talk at community meetings and they come and talk about health.

We work closely together and know each other pretty well and for the Lao and Hmong people, we work closely together with the community and the agency.

We bring lots of resources to the table in terms of supporting this particular strategy. We have a training component so it enhances the effectiveness of their organization and it complements their work, helps them achieve their outcome.

I know we're still working with those groups, even though the projects over, so it must have been going well, but generally I'm not involved with the project's partnerships. But they must have been working well.

Very well. People came to the dental task force meetings and worked to improve access for children. Partnerships occurred through the dental task force primarily. Metro Health Plan did donate $5,000 worth of dental health education materials. Everyone was concerned about the large number of Spanish-speaking children who had never been to the dentists and the large numbers of Spanish-speaking children who needed dental surgery.

One of the biggest challenges was the collaboration with the dental providers and interpreters – schedules etc. Like before not easy to combine the schedules of very busy/desired people. But we were pretty successful.

I think they worked fairly well. I haven't been around it as much in the last three months. From the people I worked with, they were very supportive and it was a good working relationship. We'd have every-other-week meetings, so we'd stay focused on it, and what our role was in it.

They worked very well – excellent.

Well, for the most part. Partnership development is time consuming. To the extent that people had time to nurture the relationship they were successful.

It's had a long history, at least 5 years. It came about as a result of a Robert Wood Johnson Foundation grant, and it has always had a focus on the underserved, underinsured, and building key assets, community, and youth. If you are going to have a partnership, you have to have a common focus and money has to flow into a neutral agency. Our fiscal agent was Region 9, and that was a neutral agent that we could gather around because there were payers and providers and the county and the state.

Not very well with Saludando Salud but excellent with Centro Campesino and Rural AIDS Action Network.

I think they worked very well, the relationship between the teachers and administration at the school and the project team were excellent, they really had good rapport.

Very well, I think. There was no refusal on the part of any of the partners to participate. I think all parties involved recognized the need of the project to improve the health of their children.

I think it worked really well. I think if we didn't meet our goals 100 percent, we were pretty close to where our goals were. Mainly because we really had to keep our shoulder to the wheel, our nose to the grindstone – follow-up! It's not like we can depend on them to come to us, we have to be very proactive. There's a big need, a huge demand for this.

Excellent – because it was needed and when we do something here, we have a long history of providing good services to the community. Also we have good working relationships with our partners.

Worked very well. This group (Multicultural Health Care Alliance) provided speakers to speak on dental programs, diabetes – and the audience were people from the community. We provided bilingual translators. Broadcast topics in both English and Somali after these presentations.

I think they worked very well. I think that we haven't yet seen the results for example of the work to make dental work more accessible, but everyone that is connected to these groups sees Somali Resettlement as a positive thing and is working to make things better for the Somali community.

I think that communication, talking about concerns, the needs, and the barriers and also having the community members. All that helped the partnerships work well.

Very good – these people educate us and we educate the community. They give us messages in English and we give it to the community.

I think they worked very well. We did numerous interviews with practitioners there (also interpreters). These 2 organizations were a critical part of our success with the project and especially helpful because we were able to do pilot trainings with clinic staff as well as interviewing people at both sites.

They were essential. The partners were heavily involved in all steps of the process. The training design came from the two hour informational interviews, exhaustive in nature. As a result, community partnerships were superb.

Difficult implementing in the dad's group because these were non custodial dads-too difficult a stretch. Felt powerless.

I was glad they went to the community to ask. [The collaboration for this project was a] brief interaction – not an ongoing relationship.

Again my knowledge is limited, but based on how [project] used to operate, I don't think the current folks responsible for making the community partnerships work have a clue. This is a tremendous loss for the community they used to work so effectively with to help children and families.

We work really well together.

Collaborate very well. We partner with SEACC. Pilot City provides location and we provide information. We understand each others role. We have same goal, mission: to help the community. We know each other well.

K. Summary of responses from following-up interviews with parents served by grantees conducted by Wilder Research

A17. Frequency of contact between parent and *Growing Up Healthy* project

	Just once		Two to five times		More than that	
***Growing Up Healthy* project**	**N**	**Percent**	**N**	**Percent**	**N**	**Percent**
Lao Assistance Center (N=25)	1	4%	4	16%	20	80%
Southeast Asian Community Council (N=18)	4	22%	12	67%	2	11%
Open Door Health Center (N=17)	2	12%	9	53%	6	35%
Somali Community Resettlement Services (N=31)	2	6%	11	35%	18	58%
Red Lake (N=65)	8	12%	49	75%	8	12%
Meld (N=8)	0	-	1	13%	7	88%
Total (N=164)	**15**	**9%**	**86**	**52%**	**61**	**37%**

A18. Number and percent of parents surveyed who received help finding or getting medical care for their children

***Growing Up Healthy* project**	**Number**	**Percent**
Lao Assistance Center (N=25)	9	38%
Southeast Asian Community Council (N=20)	12	60%
Open Door Health Center (N=16)	14	88%
Somali Community Resettlement Services (N=32)	17	53%
Meld (N=8)	1	13%
Total (N=101)	**53**	**52%**

A19. Number and percent of parents surveyed who received help in finding or getting dental care for their children

***Growing Up Healthy* project**	**Number**	**Percent**
Lao Assistance Center (N=25)	15	60%
Southeast Asian Community Council (N=20)	18	90%
Open Door Health Center (N=16)	10	63%
Somali Community Resettlement Services (N=32)	15	47%
Meld (N=8)	1	13%
Total (N=101)	**59**	**58%**

A20. Number and percent of parents surveyed who received help finding or getting medical insurance for their children

Growing Up Healthy project	Number	Percent
Lao Assistance Center (N=24)	8	33%
Southeast Asian Community Council (N=18)	8	44%
Open Door Health Center (N=17)	3	18%
Somali Community Resettlement Services (N=32)	11	34%
Meld (N=8)	2	25%
Total (N=99)	**32**	**32%**

A21. Number and percent of parents surveyed who received help in finding or getting dental insurance

Growing Up Healthy project	Number	Percent
Lao Assistance Center (N=25)	12	48%
Southeast Asian Community Council (N=18)	9	50%
Open Door Health Center (N=17)	3	18%
Somali Community Resettlement Services (N=32)	11	34%
Meld (N=8)	1	14%
Total (N=100)	**36**	**36%**

A22. Number and percent of parents surveyed who report that their child has had a well-child visit, teen checkup or immunization since receiving services from project

Growing Up Healthy project	Number	Percent
Lao Assistance Center (N=25)	10	40%
Southeast Asian Community Council (N=20)	13	65%
Open Door Health Center* (N=16)	8	50%
Somali Community Resettlement Services (N=31)	19	61%
Meld (N=8)	6	75%
Total (N=100)	**56**	**56%**

** Received service from Open Door Health Center.*

A23. Of those who had a well-child visit, the number and percent of parents surveyed who would go back to the doctor or clinic

Growing Up Healthy project	Number	Percent
Lao Assistance Center (N=10)	10	100%
Southeast Asian Community Council (N=13)	12	92%
Open Door Health Center (N=17)	17	100%
Somali Community Resettlement Services (N=19)	19	100%
Meld (N=6)	5	83%
Total (N=65)	**63**	**97%**

A24. Number and percent of parents surveyed who report that their child has had a preventive dental exam since receiving services from project

Growing Up Healthy project	Number	Percent
Lao Assistance Center (N=23)	11	48%
Southeast Asian Community Council (N=20)	13	65%
Open Door Health Center (N=17)	3	18%
Somali Community Resettlement Services (N=31)	20	65%
Meld (N=8)	2	25%
Total (N=99)	**49**	**49%**

A25. Of those who had a child's dental visit, the number and percent of parents surveyed who would go back to the dentist

Growing Up Healthy project	Number	Percent
Lao Assistance Center (N=11)	10	91%
Southeast Asian Community Council (N=13)	12	92%
Open Door Health Center (N=3)	3	100%
Somali Community Resettlement Services (N=20)	19	95%
Meld (N=2)	2	100%
Total (N=49)	**46**	**94%**

A26. Summary of open-ended feedback about best aspects of the services

	Lao Assistance/ Southeast Asian Community Council N=45	Somali Community Resettlement Services N=32	Open Door Health Center N=17	Meld N=8	Total N=102	Percent %
Like everything	20	3	2	-	25	25%
Translation/interpretation	3	9	5	-	17	17%
Transportation provided	1	11	-	-	12	12%
They speak the same language	-	10	-	-	10	10%
Clinic staff were attentive/caring	-	-	9	-	9	9%
Helped with paperwork	7	-	-	1	8	8%
Encourage me to get immunizations for my children	-	7	-	-	7	7%
Doctor was attentive	-	-	7	-	7	7%
Take care of my children/teach them respect	4	-	-	2	6	6%
Respect me	-	6	-	-	6	6%
Fun activities provided	1	2	-	2	5	5%
Help with accessing basic needs/ resources (housing, filling out taxes)	1	4	-	-	5	5%
Education about health	4	-	-	1	5	5%
Low cost of services	-	-	5	-	5	5%
Teach me about dental	1	1	-	2	4	4%
Set up appointments	3	1	-	-	4	4%
Dentist was kind/caring	-	-	3	-	3	3%
Taught me about eating healthy	-	-	-	3	3	3%
Takes my child to doctor/dentist	2	-	-	-	2	2%
Free medication	-	-	2	-	2	2%
Reminded me about appointments	-	-	2	-	2	2%
Built friendships	-	-	-	2	2	2%
Gave information about living in this country	-	-	-	2	2	2%
Helped explain health care billing	1	-	-	-	1	1%
Emergency ID card	1	-	-	-	1	1%
Teach my children to take care of teeth	1	-	-	-	1	1%
Help me get medical insurance	-	1	-	-	1	1%
Taught me about annual doctor visits	-	-	1	-	1	1%

Note. *Respondents could give more than one answer. Up to three items were categorized for each respondent.*

Open-ended responses

The following are verbatim responses to open-ended questions of parent participants in Wilder Research interviews.

Lao Assistance Center/Southeast Asian Community Council: Parent Follow-up Survey (interviews conducted in Hmong and Lao and responses translated to English)

What kinds of information did they give you?

Health and dentist.

Helped about dentist.

Hospital, dentist and health care.

Health care.

Taking care of children's teeth (3 responses).

Information about paperwork.

Helped with paperwork (2 responses).

Dentist for grandchildren.

Many things.

About paperwork and house.

About stop smoking.

About how to take care of health.

Child care.

Help fill form about Social Security.

Can't remember.

How to take care of my grandchildren's teeth and they told my grandchildren how often they should brush their teeth.

They teach me how to treat my children's teeth, but not doctor yet. SEACC also tell me that if I need insurance they will be.

SEACC teaches me how to take care of kids and make appointments with doctor or dentist.

SEACC teaches me how to go see dentist and how to teach my children to clean their teeth.

SEACC teaches me to come, attend the doctor and dentist sessions.

SEACC teach me about children's health and clean yourself.

SEACC teaches me about how to prepare myself for cleaning children's teeth and also what kind of toothpaste for children's teeth. How to brush.

Type of shots children need and how to clean teeth.

SEACC teaches about treating children, taking care of their teeth by making appointments with dentist.

I have a short memory so when taught, I forget most of them.

SEACC teaches me how to prepare my children to see doctors and dentist.

SEACC calls police and doctor to teach us about cleaning children teeth.

They showed a movie about how to care for teeth to my children.

In what ways?

Helped with paperwork (8 responses).

Helped with health care, finances and paperwork.

Helped with the appointment and paperwork.

Helped with medical, paperwork and health care.

Helped with dentist and paperwork.

Helped with paperwork, financial situation.

Helped with job, phone and paperwork.

Helped with appointment with doctor.

About paperwork and took client to some place.

Helped with paperwork from INS and bill from the hospital.

Helped with income tax and health care.

Helped with the appointment with the doctor.

How to take care of the children.

Helped with family.

Client lost his Social Security card a couple months ago and Lao Assistance helped him to get a Social Security card.

About paperwork, court and income tax.

SEACC helped me find doctor and dentist for my family. They also assist me with the kind of needs I need.

SEACC help me take care of everything when I ask them for help.

SEACC help me a lot, but can't explain how. Everything they done for me and my family, I am grateful for.

If I don't know anything, I ask them, and they help me. SEACC help me fill out papers and take kids to hospital for doctor appointments.

They help me find someone to translate and fill out papers.

They help me translate and help fill out papers.

SEACC helps me fill out paper and sign paper.

They help me fill out papers and pick up my children for doctor or dentist appointments.

Sometimes SEACC calls me and set up time to meet dentist.

They help me with how to teach my children to behave, teach me how to make appointments.

They (SEACC) help me with translating and pick up my children.

SEACC assists me with anything I need.

SEACC take children to see dentist.

SEACC help me with translator and writing. Thanks for helping my kids, take care my children for me when need to go to library, for example.

If I ask SEACC to help me fill out papers and take kids to see doctors, then they will do that for me.

They help me fill out papers that I don't understand and other appointments.

What did you like best about the services that you received from Lao Assistance Center/Southeast Asian Community Council (SEACC)?

I like the services that help client about the paperwork and documents that client didn't understand.

Everything (18 responses)

All the help (2 responses).

I like that sometimes they helped explain about the bill from the hospital.

About hospital.

I liked when we went on a picnic.

I want them (SEACC) to help me translate and fill out paper.

SEACC support the needs I need for my family and help fill out papers.

I really like the new card that the program provides for us (folks who cannot speak English). This card is designed to help parents access to hospital or receive the needs they need. For example, if I get in accident or injured, I show/give the person the ID card, then that person will get me fast to the hospital. It's an emergency card.

I don't because I was too stressed and had headache so sometimes I wish SEACC provides more days of meeting.

I really like when they help me with my paperwork.

I'm glad that SEACC help me fill out form/paper.

I don't know, but SEACC does help me the best they can.

I really like people who help me translate and take my children to see doctor or dentist.

SEACC helps explain everything to me and picks me up for appointments, doctor and dentist.

They help me with meeting schedule and set up time to meet other staff.

I received help from Hmong translators and they take good care of my children.

Everything SEACC taught me is useful for me.

It's helpful that there is a program to help me with anything.

I need help making appointments for my young children to see doctor.

SEACC teaches my kids to behave and respect me. Also, teach them to be good children among others.

I'm glad SEACC help me with taking care my children; for example, take kids to appointments since I can't drive.

I am really glad that SEACC helps me to fill out papers and takes my children out to see doctors or play.

They filed my income taxes. They helped me call electricity bill, phone bill and other bills when I have problem reading or understanding it.

I don't really know. I only took my children to the program only one time to watch a movie: how to care for teeth.

If you could change one thing about the services you received, what would that be?

Everything still good and nothing has to be changed.

If client would be able to change one thing, client said, "The services should be able to help more."

Client wants employee at Lao Assistance to have more responsibility.

Client wants Lao Assistance help more people and should be fair for all people.

Help more elder people.

I don't know anything or know how to drive, but I was hoping if they can teach me that, provide class for that.

I want SEACC to spend more time with my family and get my children involved with others as well as helping me with translation.

They had helped me with everything that I asked so far, so I don't have anything that need to be added.

I don't know. I haven't need them much. As I heard from my relatives and friends they did very good in every kind of help, so nothing that need to be improved or changed.

Do you have any other comments about the program?

Client thought Lao Assistance Center should be more helpful and able to help other people, too.

"Everything good." (6 responses)

Everything good. Client said, "Thank you so much for the services that have been helping client."

Client said if Lao Assistance Center wanted to help Lao people, they should help from their heart and should be fair for all people, isn't only for rich people.

Client said Lao Assistance Center should have more employees.

Client wants Lao Assistance Center to have more people.

Client says that this program helped a lot even though it is only one visit a month. In questions 3B and C, SEACC find a doctor and dentist for her children, but not insurance because she has that covered by Medicare. Also, she says that SEACC also help care and wrong for her children needs, that is taking care of teeth and health. She's glad.

I want SEACC to help any elders as they can, but not judgmental.

I'm glad and happy there is a program like SEACC to help me and my family.

I want young people and the SEACC to come pick me – older people – up to travel.

I'm happy that there is a program like SEACC to help serve my family.

Ask them to help with other needs, fill out paper and take kids to doctor's appointment.

I wanted them to continue helping me and other families who need help in the future.

What kinds of information did they give you?

They help older people a lot, and also help people with TB and Hepatitis. They encouraged me to get immunizations for my children.

An immunization and dentist and teen child check-up and Hepatitis, smoking, HIV or AIDS, and a lot of information about health.

Hepatitis, TB, immunizations, dentist. They encouraged me to get immunizations for my children.

Immunization, general check up, dental information, teen/child check up. They encouraged me to get immunization for my children. They told us about TB, hepatitis, AIDS/HIV, etc.

They bring health doctors to meet with us so they can talk about immunizations and dentists, and they had programs that talk about health on the Somali TV.

Dental information, smoking is not good near children. Immunization, TB, Hepatitis B. They encouraged me to get immunization for my children.

They gave me information about immunization, well child visit, dental exams, and they also encouraged me to get immunization for my children.

Immunization is very important. They encouraged me to get immunizations for my children.

Immunization and a lot of information about my health and my family. They encouraged me to get immunizations for my children.

Immunization on the TV and play some kind of program talking about immunization and health. A lot of information about the health and flyers.

Immunization, clinic, phone numbers, health insurance. They talk about hepatitis, TB, AIDS/HIV. They encouraged me to get immunization for children and they also encouraged me to keep the appointment with dentist.

Immunization, teen child check up. They told us immunization is very important and it help kid to grow.

They encouraged me to get immunization for my children. They talk about health information such as AIDS/HIV, hepatitis A or B or C, TB, and a lot of health information.

Immunization, dentist, and general information about health.

They told me to keep my appointment, dental information, health information like TB, hepatitis, smoking, immunization, and teen/child checkup.

They had play on the TV, talking about immunization and dentist. They encouraged me to get immunization for my children. They told information about TB, hepatitis.

They told me where the dentist office located, kids should brush their teeth at night before they go to bed, kids should not eat a lot of sweet food. They encouraged me immunize my children.

Immunization, health information. If you want your child to go to school, they (need) to have shots. TB, hepatitis (don't know which one) information. Dentist and play they had on the TV that was talking about health.

Immunization or shots, dental information for my children. They told me if my children don't get their shots, they will get sick.

Immunization, dentist. Immunization is good for school and a lot of information about health, and they had this program on the TV. Kind like a play talking about the dentist and immunization.

I saw a play on Somali TV. Information about immunization, health and how to care child's health. They encouraged me to get immunization for my children.

Immunization, teen/child checkup and a lot of health information.

Dentist, immunization, dental information, well-child visits. I like the play they had on the TV about health. They encouraged me to get immunization for my children.

Immunizations, well-child visit, dental. They encouraged me to get immunization for my children. They had programs on TV that was talking about TB, hepatitis A or B or C, etc.

Immunization, smoking, not to smoke near children or inside house, and dentist. And they encouraged me to get my children for immunization.

A lot of information about my health and my children's such as immunization, school, TB, hepatitis, AIDS.

In what ways?

They told me where to find a dentist office. They gave me a ride to doctor's office and community offices or the hospital.

Transportation, translation, interpretation, medical insurance, and also they gave me rides to the doctor's office.

They help people, but never I need them before.

Transportation to go to doctor's office or work. They took me to work and doctor's office.

Transportation, interpretation. They give me a ride to the doctor office and bring back home.

Transportation. And they help me with appointment and interpretation.

They help me with transportation, job, interpretation, child care.

They help me any way they can and with respect. Gave me ride to the doctor's office.

Transportation, language (translation), appointment schedule, dentist.

They encouraged me to take care of my health, and eat good, healthy food, and they help me with interpretation.

Interpretation and translation. They translated for me at doctor's office and gave me ride at the doctor's office.

Transportation, translator, interpreting. They even gave me ride to the store.

Transportation, interpretation, even when I need to go anywhere, they gave me ride.

Transportation, interpretation. They gave me rides to the doctor's office and hospital, and they interpreted for me at the doctor's office.

They help me with transportation, interpretation.

Translating and interpreting, transportation. They gave ride to the doctor office. They translated or interpreted at the doctor's office and county.

Transportation, interpreter, translation. They gave me a ride to the doctor's office, and they interpreted for me anywhere I want.

They told me where the dentist office located. They interpreted and gave me ride to the clinic this year.

Immunization, dentist, housing (Section 8). They help me with the immunization, dentist office and gave me ride to the doctor's office and the community office.

Transportation and interpretation. They gave me ride to the doctor's office; they interpreted for us at the doctor office.

Transportation, interpretation. They gave me ride to dentist office and doctor office.

Nothing at this time. They can help me but if I need I would call them or contact them.

Transportation to doctor office.

They helped me with interpretation, transportation. They told me where dentist office located.

I don't know yet, but I will find out when I go there.

What did you like best about the services that you received from the Somali Community Resettlement Services?

I get a lot of resources from them like "Section 8" and they connect us with government.

They help me to get my medical insurance, transportation, housing or Section 8, general health, interpretation. They encouraged me to be healthy all of the time.

They never helped me before, like I said. They would help me if I ask them I am sure, but they help other people who need them.

We speak same language and they gave me a lot of resources or refer me to other offices.

A lot of information about health like child and adult, and they help me to get an appointment.

Over TV they told us when is the shots, transportation, what I need. They helped me with transportation.

I like how they talk about the immunization, general health, how they organize soccer games, meetings about health, TV programs talking about cultural things.

They help me with everything I need and that is why I like to go there all the time.

The way they welcome me and my family and respect they gave me, and also they encouraged me to get immunization for my children.

A lot of resources, transportation, respect, and they also encouraged me to get immunization for my children. And they do good services for the community.

Because we speak same language (Somali) and they are willing to help me and my family any way they can.

We speak same language that make everything so easy and I can say whatever I want to say.

They always help me. Everything I need from them. They gave ride to the doctor's office, stores, and festivals. They translated for me at the clinics, Section 8, county.

I never been that community (RCRS). Only I know there are two communities, but I saw everything on the Somali TV.

How much respect they have or give me or the people they serve. Today I have a doctor's appointment and I am waiting there now and they will be here to give ride to the doctor office because I am sick.

They made me feel comfortable to talk and welcome me very good. And also they encouraged me to get immunization for my children.

We speak the same language and they help me a lot; for example, with language and transportation.

They help me with language (interpretation).

Because we speak same language. I am comfortable going and asking them help, and they respected me. They are doing good job.

They help me with English language, transportation. They help me to get housing or fill out the Section 8 application, and gave me ride to the doctor's office.

Translation, interpretation, transportation dentist office. Staff respect me, gave me a lot of resources when I needed most at that time.

They speak Somali language.

They speak Somali language, interpretation, transportation and all the resources they gave me.

When I came to Rochester, I did not know anyone. I call them to help me and they did. Whenever I needed, wherever I wanted to go. They are good people.

As a Somali Community Services, they did what they could do to help me – housing, transportation. They gave me a car (1994).

Interpretation, TV, transportation.

We speak same language. We have same culture. SCRS staff understands my concerns and they always respect me and gave me a lot of resources.

Health; a lot of information about health like dentist for my children. We speak same language. They are my people.

They encouraged me to get immunization for my children and we also speak same language and they help me anyway they can to help me.

Is good for me. They help me to anywhere I want to go and they interpreting for me if I want to go to Minneapolis. They drive for me.

An immunization, general health, TV programs, cultural events, sports (soccer), health events. They encouraged me to get immunization for my children.

If you could change one thing about the services you received, what would that be?

Nothing, they doing good job.

They need more staff so they can do more services.

Everything is good. They doing good job.

They doing good job.

There are two communities, I wish they would unite.

They need their own (or company) car. Transportation or company car. Community vehicle.

Nothing, but they need more time on the TV so people can get more information.

I am very satisfied with their work.

On the TV, they show too many songs. They need to show more cultural information and health.

We need more communication about the schools and teachers. Kids today are becoming Americanized and sometime they don't speak Somali language with us or me.

Do you have any other comments about the program?

Need transportation to go see doctor, appointments, dentist cover.

I would like to thank the doctors and Somali community.

Somali Community in Rochester is doing good job and I like the information they have on the TV or programs.

Somali Community in Rochester is doing a good job and they have good staff that are there whenever we need them.

We (I) need dentist that is not far from my city, Rochester. We have to drive 20 minutes to see dentist.

Oh yes, we need more transportation and interpretation.

Open Door Health Center: Parent Follow-up Survey (interviews conducted in Spanish and responses translated to English)

What kinds of information did they give you?

> How to eat, what to feed my children. The dentist told me about that. Also they told me how to care for our teeth. How to brush and things like that. That's all they told me.
>
> Well, when I go, they chat with me and tell me more about the physicals (exams/visits). They check and make sure my kids have had their shots. Once they gave me an evaluation sheet that asked if everything they were doing was alright or if I had any suggestions for how they could better their services.
>
> Well, they just told me to keep going to the clinic. They spoke with me about my daughter's allergies, how to use the medicine and explained everything about allergies.
>
> They just told us to keep visiting, to bring the kids to the doctor and dentist periodically. That's all the information I received from them.
>
> Answered my questions about medicines, shots, certain sicknesses, etc. They gave us pamphlets, and spoke with me in person. In the first place, I have allergies, so they talked to me about my diet, how important it is to take my medicine, show up at appointments, etc.
>
> They gave me pamphlets about the different illnesses children get.
>
> When I need other types of services around health care and my family's needs, they offered me a lot.
>
> The nurse explained to me how to use floss, explained how my daughter should brush her teeth, to do it twice a day (at least), not to eat many candies, and to go to the dentist 2 times a year for cleanings. They helped me a lot with this, because I didn't know anything.
>
> Well, they talked about medical and dental visits every year, to go in for a dental cleaning. So I wanted to take my daughter in for a visit. They explained how to make appointments and there are interpreters. They also helped me by offering me information and advice for a diet for my daughter who is overweight.
>
> One of my children has asthma, so the doctor gave me information about asthma. Later he gave us pills/medicine for the asthma.
>
> Not much because when I went, I only went because of a sickness I had with my hand and they helped me with it, but so far I haven't actually received much information.

In what ways?

> They put me in communication with a doctor who speaks Spanish and we're talking about how I can pay for the bills. We're making a plan for me to pay little by little.

They told me about MA [Medical Assistance] or said that they'll be accepting it pretty soon, so I think soon they'll be able to help me. And my mom also wants to go in now with MA, too.

I would have liked it if they arranged transportation to and from the clinic for me, but I don't know if they do that. They haven't helped me with transportation yet.

They helped simply by being affordable. Because I don't have insurance, this is the only way I can attend to my family's health, for little money.

The only problems have been lack of insurance and difficulties paying bills, however client explained that she will not ask for insurance help because she is not a citizen, does not want to be seen as a burden on the government, and does not want to jeopardize her chances at citizenship. She underscored that the personnel at ODHC are great and that they have done everything she believes they should do, but she refuses to bring up insurance issues.

They didn't help me with transportation, but I don't believe it's their responsibility to handle or worry about that. It's my responsibility to find transportation.

Sometimes I don't understand something completely and they explain it and make everything easier.

They helped me so much. Often they paid so much attention to what would help me with my children and myself.

Marcia explained to me everything related to payment. Everything I needed to know, how other groups like the hospital will help pay, what to do when the bill comes, who can help me pay, etc. She said, "Don't worry, we aren't going to leave it all up to you." They explained my options.

I don't know. I don't know if they could help people get medical insurance or not. I don't know.

They explain anything if I ever have a question. They help out very much.

They found a lady who, when I have an appointment, picks me up and brings me home.

They spoke with a lady to arrange for her to pick me up, wait with me and then bring me home. It's for people who don't have transportation. And she always makes sure I'm on time to my appointment.

They oriented me to how everything works there, got me an interpreter, and told me what sort of care I needed to give my teeth, what to do after the tooth extraction and other dental information.

There were no problems. For me, everything went well.

What did you like best about the services you received from Open Door?

Everything. It was great. Just that the dentist was really kind and he made it as fast and painless as possible when he was pulling out my son's teeth. I liked everything very much.

What I liked best was that the doctors were really caring and paid attention to what the illness was. Also, when I went to get services done, I was lacking money to pay for them and they said they'd give me a chance to pay it back later. They also gave me medicines for free (prescription meds) that I wouldn't have been able to pay for otherwise.

They treated my son really well at the dentist. They let me go in the room with him, sit next to him and they interpreted to him as well as myself, so that I always knew what was going on. It's very clean, all the tools are clean.

The personnel is very friendly. They are always alert and call me to remind me of my appointments. They ask if I'm comfortable, and they care about the health of my children. For example, my daughter had had a problem with her throat that got very bad and she needed surgery. I had problems making arrangements with other places, but Open Door was very fast to help and to make us an operation appointment.

Their kindness (of the staff), the attention we received from the doctor. They responded to and answered all of our questions. And they helped us understand how to use the medicine. They even (the non-Spanish speakers) try to speak a little Spanish to us. We can tell they care about us.

I like the treatment that my family has received and the people in charge of interpretation. They are very friendly people that make you feel you can trust them. The doctors, too. And the low cost of the services, because I've been to normal clinics where it's expensive and I couldn't afford it, but this is very reasonable.

Up until now, I have liked absolutely everything. They have been better than other places I've been, and have attended to me more than other places. In the first place, they're not very expensive. Second, they attend to you faster. Third, they give me the medicine I need. They almost always have what I need on hand and since I don't work and have children, it's wonderful that they can provide these things.

The attention from the doctors and the person who translated was what I liked the best.

The attention and the patience the staff gave me was the best. They always worked to accommodate my schedule and they answered my questions.

The people there. The interpreters are really good people. I have a lot of trust in Maria. The confidentiality and privacy with staff is great. The doctor treats me very well, too. You know you're going to get help; they give you confidence and make you feel comfortable. Even if you don't have money, they'll still help you.

Well, everything was fine. The attention was good, and the doctors, everything. When I saw the doctor for the exam, the doctor attended to me well. Her treatment of me. I don't know how to tell you more. There are interpreters. And the forms are in Spanish. It isn't expensive. Everything is good. That's all.

The cost. It's very helpful for people without insurance. Also, the people are very able and ready to help you with any need. All I can tell you beyond that is that it has always worked really well.

They treat me well. They are friendly. They help me.

That they are attentive to my appointments. They always call me to alert me of my appointment. When we arrive, they treat us well. They say hello to us. They take good care of us. In every way they are good.

They treated me very well. I didn't even have an appointment. I just dropped in because I had a molar that was causing me a lot of pain and they took care of me on the spot. Both the receptionist and the dentist were very good with me in pulling the molar out.

The friendliness of the personnel and the way of helping of the doctors and personnel. For example, I had some bad headaches. I went to another clinic and they said it's just a headache, go home and take a nap. Then I went to this clinic and they really helped me. They got me medicine, listened to me and had me take a test to learn more about my headaches.

For me, everything was great. They had an interpreter. Everything. The doctor was a good person. She checked out my situation very carefully. Everything was good.

If you could change one thing about the services you received, what would that be?

I just wish it could cost less money because it's hard for us to pay these bills. Just the money.

Maybe just not to leave me out in the lobby for such a long time. Maybe that's because they're lacking people. But there was a long waiting time.

I wouldn't change anything and I will keep going there.

More information about their services. More information about payment. I would like to know who pays. What I pay for and what the hospital will cover, because I didn't understand that last time with my daughter's surgery, and a big bill came I was not expecting. So I would like to better understand the payment.

No. I wouldn't change anything, personally.

Just that they have even more personnel. So many people don't have the resources to go to the expensive clinics, and they are helping us a lot there (at Open Door); but they need more people, because it's tough to get in since so many people are always needing services.

Nothing. The attention is very kind and friendly and the dentist is great, too. They have enough staff.

Nothing, she did not want anything to change.

Nothing, I would not change one thing; it is perfect.

Well, I think everything is good how it is.

No. Up until now everything has been good.

For the time being, nothing. I've only been there once.

Do you have any other comments about the program or the staff?

> The employees are very helpful and are very good at paying attention to what Latino families' needs are. Everyone was great.
>
> I really just hope they continue to do everything as well as they have been for a long time.
>
> Everything was good. The personnel were good.
>
> No. They attended to me well.
>
> No, just that everything was really good.
>
> Just that they are very good and they helped me a lot.

What kinds of information did [NAME OF STAFF] give you?

> Things like we should not take pop, because it has so much sugar. How to feed our children and what food they need. She would try to find help for women who want to go to school to learn. (Amharic)
>
> To take children for vaccination; to get annual checkups; that it is good to get a checkup even if you are not sick; they told us about lead and many other things. (Amharic)
>
> They gave me information about immunization, nutrition, diet, dental care, and about how to find out how he is doing in school. (Amharic)
>
> She taught or gave me medical and dental care information for my children. (Hmong)
>
> They taught me that I need to take my kids to a regular medical and dental exams. These regular exams will keep my children healthy. (Hmong)
>
> They taught us how to look after our children and communicate with them. They also taught us about keeping children healthy. (Hmong)
>
> General information. What time to play. What time to eat, what time to sleep, things like that. Everything age by age, what you need by this age. What time to get shots, when they need them. (Amharic)
>
> They gave medical information, but not dental. Just told us Minnesota Care will cover medical care. (Amharic)

In what ways did the MELD group help you?

> They taught us about eating healthy. They told us about yearly checkups. They told us about children's health. (Hmong)
>
> It helped for information and to get out to be with other people. They taught me not to eat too much fried food like McDonalds and not too much soda, too much fat. (Amharic)

What was the most positive aspect of the services you received from the MELD group? (PROBE: What did you like best about it?)

> Getting together and finding friends. I want to know many things, like if I need a lawyer. And I have seen things like Como Park and the Mall of America, because of MELD. (Amharic)
>
> We discuss our problems, our families, our jobs. We found solution. They helped us fill out applications. They helped us find ideas to solve our problems. (Amharic)
>
> We shared experience. And they helped me to have information to live in this civilized country. They shared experiences and information that helped me live in this country. And I got more friends. It is a great thing to get friends. (Amharic)

I went to the group only three times so I don't remember much. Plus I am 64 years-old. (Hmong)

They gave me a lot of information about dental care and how to care for my children's teeth. (Hmong)

The information about communication with children and children's health. (Hmong)

They wanted me to try different kinds of food. They taught me about different kinds of food. Different kinds of food I can get in store. (Amharic)

I liked that they took little kids on picnics. They did not help economic situation of her family. (Amharic)

If you could change one thing about the services you received, what would that be?

It was good. (Amharic)

At the moment, everything is okay. (Amharic)

I would not change anything. (Amharic)

I would like help with my problems. Every week, information, is boring. I would like if they would talk about problems and get help in the group. (Amharic)

Do you have any other comments about the program?

It is a good help. I like it. I never miss the meeting. I like it. (Amharic)

We are doing good now. I don't have community. I like to be with them once a week for two hours. I feel like I am back in Ethiopia. It is good to have a social life. (Amharic)

I am happy that I had taken the course because there were many things that I had learned from the group. (Hmong)

If they do it in the future, it will help many depressed people. It solves problems that they deal with, like family problems. (Hmong)

This is a small group. It is good for communication and for relationships. You can help each other with problems. The children are very happy. They have lots of things to do. (Amharic)

L. Minnesota Child and Teen Checkups (C&TC) summary of guidelines

Note: the following information was obtained from the Minnesota Department of Health to give basic information about Child and Teen Checkups in Minnesota. This information was obtained January 11, 2005 from: http://www.health.state.mn.us/divs/fh/mch/candtc.html

Child and Teen Checkups (C&TC)

Minnesota's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

What is C&TC?

The Child and Teen Checkup (C&TC) program is Minnesota's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. It is a preventative health care program for children under 21 years of age who are enrolled in Medical Assistance or MinnesotaCare.

The Federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program was established in 1967 as a preventive component of the Medicaid Program. EPSDT provides for the coverage of comprehensive and periodic evaluation of health, developmental and nutritional status, in addition to vision, hearing, and dental screening services to all Medicaid enrolled children from birth to 21 years of age. The program's primary goal is to prevent disease and detect treatable conditions early to avoid further serious health problems and more costly health services.

Minnesota's EPSDT program is called the Child and Teen Checkups (C&TC) Program and is the responsibility of the Department of Human Services (DHS). About 375,000 Minnesota children are eligible to receive Child and Teen Checkups through Medical Assistance or Minnesota Care.

The recommended C&TC periodicity schedule is based on a public health model which promotes wellness for a population (Medicaid-eligible children) with the goal of optimal benefit to the individual and community. This public health model sometimes differs from specific clinical approaches which focus mainly on individual clients in the general population.

In addition, the C&TC periodicity schedule has been established for a population of children that are at higher risk than the general pediatric population. According to the C&TC periodicity schedule, screening visits must include: a comprehensive health and developmental history, including assessment of physical and mental health development; a comprehensive unclothed physical examination; assessment of hearing, vision, and dental health; age appropriate immunizations; laboratory tests including blood lead assessment appropriate for age and risk factors; and, health education. These requirements are based on Minnesota State Rules and the Centers for Medicare and Medicaid Services (CMS) requirements for EPSDT.

Schedule of Age-Related Screening Standards

Components	Infancy						Early Childhood					Late Childhood						Adolescence			
	0-1 mo.	2 mo.	4 mo.	6 mo.	9 mo.	12 mo.	15 mo.	18 mo.	24 mo.	3 yrs	4 yrs	5 yrs	6 yrs	8 yrs	10 yrs	12 yrs	14 yrs	16 yrs	18 yrs	20 yrs
Anticipatory Guidance & Health Education	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Measurement – height & weights	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
▪ head circumference	✓	✓	✓	✓	✓	✓	✓	✓	✓											
▪ blood pressure										✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health History including – mental health, nutrition, chemical use	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Developmental/ Behavioral	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physical – including sexual development, oral exam	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Immunizations/ Review	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Laboratory Tests																				
▪ Blood lead						✓			✓	← (if never tested) →										
▪ Newborn Metabolic (if indicated)																				
▪ Urinalysis										← (optional) →						← →				
▪ Hemoglobin/ hematocrit				← →												← (menstruating adolescents) →				
▪ Other: Cholesterol, STD, TB (as indicated)																				
Vision	*S	S	S	S	S	S	S	S	S	**0	0	0	0	0	0	0	0	0	0	S
Hearing	***0/S	S	S	S	S	S	S	S	S	***0/S	0	0	0	0	0	0	0	0	0	S
Dental Checkups – verbal referral						← →				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

*S = subjective, by history. **0 = objective, by appropriate standard testing method. ***0/S = either at this age

← → Indicates range to provide service one time.

Additional screening services and/or specific screening components may be provided at other intervals as indicated.

M. Reports and other deliverables produced by Wilder Research for the Blue Cross and Blue Shield of Minnesota Foundation

Reports

Critical learning: bicultural community health workers' views on prospective training opportunities; Results of qualitative research for the Blue Cross and Blue Shield of Minnesota Foundation. March 2004. 28 pages. By Michelle Decker Gerrard.

Increasing children's access to and use of preventive care; Year 1 progress report on Growing Up Healthy in Minnesota, an initiative of the Blue Cross and Blue Shield of Minnesota Foundation. December 2003. 91 pages. By Greg Owen, Michelle Decker Gerrard, and Nicole Martin.

Growing Up Healthy Voices of Youth; Results of discussion groups with youth for the Blue Cross and Blue Shield of Minnesota Foundation (draft). March 2002. 40 pages. By Michelle Decker Gerrard and Shelly Hendricks.

Growing Up Healthy in Minnesota: Overview of evaluation design (draft). September 2002. 13 pages. By Greg Owen and Michelle Decker Gerrard.

Growing Up Healthy in Minnesota: Voices of Youth; Results of discussion groups with youth for Blue Cross and Blue Shield of Minnesota Foundation (summary). March 2002. 4 pages. By Michelle Decker Gerrard.

Presentations

Board overview. Growing Up Healthy in Minnesota. A presentation to the Blue Cross Foundation Board. September 2004. Greg Owen and Michelle Decker Gerrard.

Progress report: Growing Up Healthy in Minnesota. A presentation to Growing Up Healthy grantees. June 2004. Greg Owen and Michelle Decker Gerrard.

Year 1 progress report: Growing Up Healthy in Minnesota. A presentation to the Blue Cross Foundation Board. December 2003. Greg Owen and Michelle Decker Gerrard.

Evaluation framework: Growing Up Healthy in Minnesota. A presentation to the Blue Cross Foundation Board. November 2002. Greg Owen and Michelle Decker Gerrard.

Evaluation expectations. A presentation to Growing Up Healthy grantees. September 2002. Greg Owen and Michelle Decker Gerrard.

Evaluation components of the Growing Up Healthy application. A presentation to projects submitting proposals to the Blue Cross and Blue Shield of Minnesota Foundation. November 2001. Greg Owen and Michelle Decker Gerrard.

N. New tools, guides and other materials developed through *Growing Up Healthy*

The following is a summary of tools developed through the *Growing Up Healthy* initiative:

Affiliated Community Health Foundation developed educational presentations and a collection of information materials in English and Spanish on preventive health topics. The project developed a health and wellness web site for students (operational only during the grant period).

Lao Assistance Center developed a needs assessment survey and administered it to Lao and Hmong families.

Meld developed a 10-unit health curriculum to be used in its parenting groups across the country. The curriculum has been condensed into five units for publication as a part of a new curriculum. This curriculum is in its last year of pilot-testing and will be printed in 2006, and made available for national dissemination.

Minneapolis Medical Research Foundation developed brief dental education scripts for bilingual/bicultural community health workers and other health providers to use during preventive well-child clinic visits. Age-appropriate scripts were developed for parents of infants (age 0-1), toddlers (age 1-3), preschoolers (age 3-5), and schoolchildren (age 5 and older).

Open Door bilingual case managers presented health information monthly during Spanish language programming on KMSU radio. They also taped community service messages for local televisions stations.

Somali Community Resettlement Services, in collaboration with public health agency staff, prepared a Somali brochure on child immunizations and child and teen checkups and produced 15-minute Somali television segments about the benefits of preventive health care that were aired throughout Minnesota.

The University of Minnesota Division of Pediatrics developed and tested "Preventive Care for Adolescents," a 38 page training guide for primary care providers.

O. Learning Network meeting dates, locations, and agendas

Timeline of Learning Network meetings

June 2002:	Funding was awarded to nine organizations. Blue Cross Foundation and Wilder Research staff began providing consultation and technical assistance to grantees via phone and email.
	First Learning Network meeting (at Minnesota Landscape Arboretum) included discussion of expectations of Blue Cross Foundation, project plans, developing a learning network, and evaluation.
November 2002:	Learning Network meeting (at Lao Assistance Center in North Minneapolis) included project updates, discussion of role of bilingual/bicultural community health workers, and evaluation.
June 2003:	Learning Network meeting (at Hennepin County Medical Center) included grantees presenting in clusters, a speaker discussing implications of statewide budget cuts for projects, and an evaluation update and discussion.
October 2003:	Learning Network meeting (at Immanuel-Saint Joseph's Mayo Health Center in Mankato) included panel discussions, presentations of preventive health and dental guidelines, discussions of policy and systems change, and evaluation update.
June 2004:	Final Learning Network meeting (at Cragun's in Brainerd) included sharing project stories and lessons learned; sustainability workshop; presentation in working from a strength-based perspective; and research presentations and discussion of outcomes.

Growing Up Healthy in Minnesota: final convening of the "Learning Network" – June 2004