Access to Care for Rural People with Disabilities

Toolkit

December 2016

This toolkit was produced by the NORC Walsh Center for Rural Health Analysis in partnership with the Rural Health Information Hub.

Welcome to the Access to Care for Rural People with Disabilities Toolkit. The intent of this toolkit is to provide rural communities with the information, strategies, resources, and other important materials that could be helpful in implementing a program to improve access to care for people with disabilities.

This toolkit consists of seven modules. Each module contains specific information that communities can use to develop a program to improve access to care for people with disabilities. There are also links within each module to connect to resources and materials that can help in creating your program. There are more resources on general community health strategies available in the Rural Community Health Toolkit.

Module 1: Introduction
An overview of the needs of rural residents with disabilities.

Module 2: Program Models
Evidence-based and promising program models for improving access to care.

Module 3: Program Clearinghouse
Examples of programs that have been implemented in rural communities to improve access to care for people with disabilities.

Module 4: Implementation
Implementation strategies for programs to improve access to care for rural residents with disabilities.

Module 5: Evaluation
Evaluation considerations, frameworks, and methods for programs to improve access to care.

Module 6: Funding & Sustainability
Sustainability strategies for programs to improve access to care in rural communities.

Module 7: Dissemination
Methods for sharing the results and successes of your program to improve access to care for people with disabilities.

Module 1: Introduction to Access to Care for Rural People with Disabilities

People with disabilities face many challenges when accessing healthcare services. This module provides an overview of disabilities as well as an introduction to some of the unique healthcare needs of individuals with disabilities. This module will provide insight into important background information needed before implementing a program to improve access for people with disabilities in a rural community.

For general information on what to consider as you start your program, see Creating a Program: Where to Begin in the Rural Community Health Toolkit.

In this module:

- Defining Disabilities
- Disability in Rural Areas
- Specific Healthcare Needs of People with Disabilities
- Barriers to Accessing Care for Rural People with Disabilities
- Social Determinants of Health
- Services that May Need to be Integrated

Defining Disabilities

There are many types of disabilities and different ways that disability can be defined and categorized. The Centers for Disease Control and Prevention defines disability as:

Any condition of the body or mind that makes it more difficult for the person to do certain activities and interact with the world around them.

Disabilities can be present at birth, developmental, accident-related, or caused by a long-term illness or condition. Each disability and each individual is unique. In a 2005 Surgeon General Call to Action to Improve the Health and Wellness of People with Disabilities, the Surgeon General highlights the importance of considering that disabilities include biological, environmental, and social causes and limitations. This variety of factors impacts both how a disability affects people in their daily lives and specific healthcare needs.

Types of Functional Disabilities and disability-related conditions:

- Cognitive Disability
- Severe and Persistent Mental Illness
- Inability to Live Independently
- Vision Impairment
- Hearing Loss
- Intellectual Disability
- Difficulty with Self-care

Resources to Learn More

Centers for Disease Control and Prevention: Disability and Health
Website
Provides a more detailed overview of disabilities including data, statistics, articles, and other resources.
Organization(s): Centers for Disease Control and Prevention

Federal Statutory Definitions of Disability
Document
A collection of 67 different laws and statutes and their respective definitions of disability.
Organization(s): Interagency Committee on Disability Research
Date: 7/2003

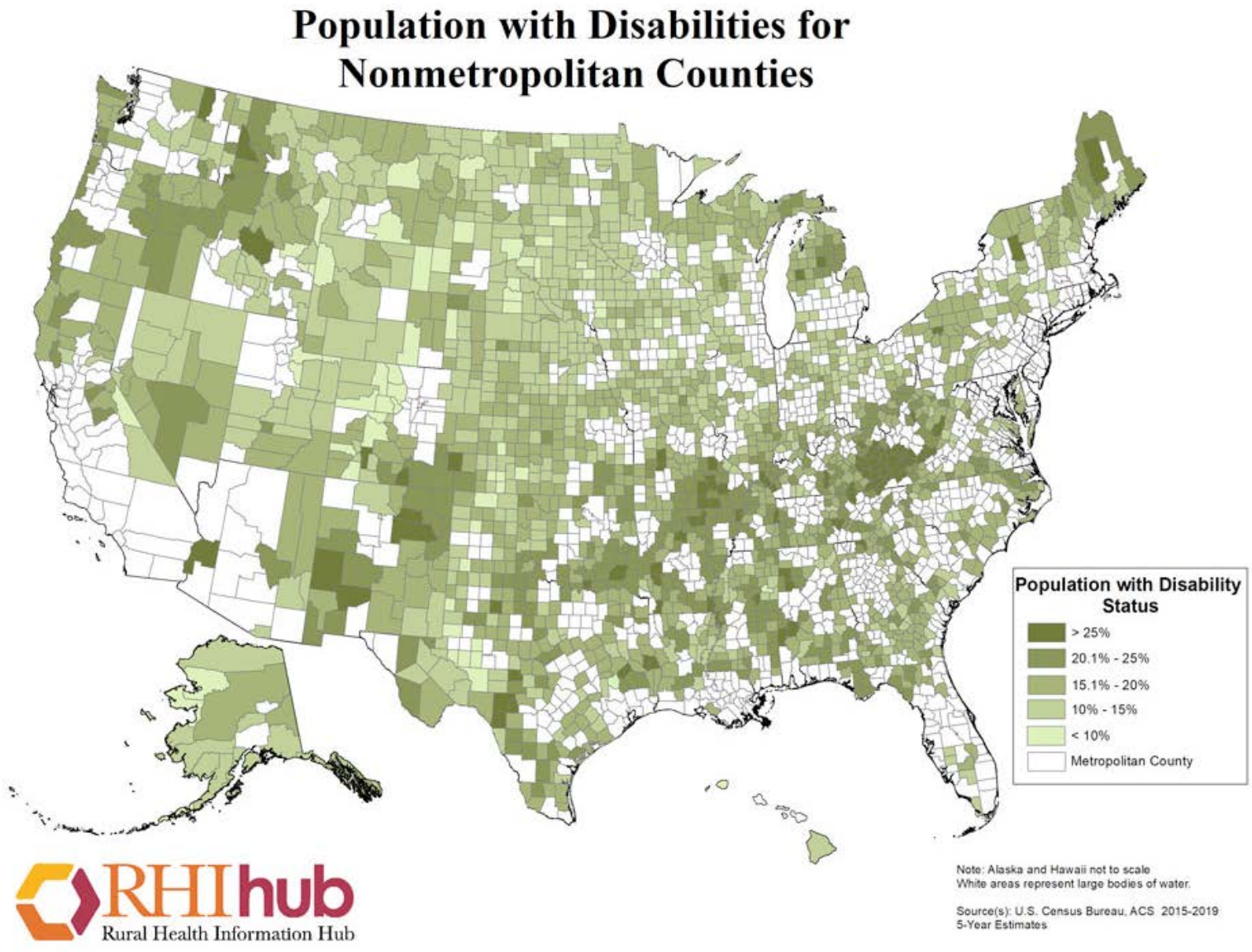
Overview of the International Classification of Functioning, Disability, and Health
Document
Explains the International Classification of Functioning (ICF), a World Health Organization framework, which provides a common language and definitions to measure disability and health.
Organization(s): Centers for Disease Control and Prevention

Research and Training Center on Disability in Rural Communities
Website
Publications and training on disabilities in rural communities.
Organization(s): University of Montana Research and Training Center on Disability in Rural Communities.

Disability in Rural Areas

According to the 2015-2019 American Community Survey five-year estimates, an estimated 9,194,108 non-institutionalized people with a disability live in a rural community. This equates to 15.0% of people living in rural areas, higher than the national average (12.6%). Across the whole United States, around 40 million people are living with some type of disability.

For both rural and non-rural areas, disability rates are higher in certain sub-groups, including adults ages 65 and older and veterans. However, because disabilities exist on a wide spectrum it can be difficult to identify an exact number of people who are living with a disability, especially in rural communities.



Resources to Learn More

data.census.gov: Disability
Database
Using data from the U.S. Census Bureau you can search for disability-related data specific to a state, community or subpopulation.
Organization(s): United States Census Bureau

Behavioral Risk Factor Surveillance System (BRFSS) Annual Survey Data
Database
For more information about data and figures, the BRFSS data page can provide more details about the number of people living with disabilities in different states.
Organization(s): Centers for Disease Control and Prevention

Specific Healthcare Needs of People with Disabilities

The healthcare needs of people with disabilities include many of the same needs as people without disabilities like preventive medicine and screenings. In addition, people with disabilities usually require specialized care for their specific type of disability and they may have additional medical conditions that require attention. For example, according to the Centers for Disease Control and Prevention, obesity is more common among people with disabilities than among people without disabilities.

Additionally, people with disabilities receive less preventive care and tend to be in worse health than their counterparts without disabilities. To maintain health, people with disabilities also need to be able to engage in physical fitness and other activities. The ability to participate in different activities is important to the social and emotional health of an individual.

According to the 2005 report, The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities, meeting the healthcare needs of people with disabilities includes:

- Getting to the appointment
- Getting into the clinic building
- Checking-in for their appointment
- Maneuvering through the clinic to their exam room

Factors that become important once the patient is in the exam room, according to the Surgeon General's report and a 2007 JAMA Commentary include being able to:

- Communicate their health needs effectively with their care provider
- Receive an appropriate and thorough examination with appropriate equipment for screening, preventive, and diagnostic appointments
- Spend sufficient time with their care provider to understand the steps they will take to maintain health

After the patient leaves their healthcare appointment, there are still needs that should be met to maintain health:

- Obtaining prescriptions
- Getting to therapy or specialty care appointments
- Making and keeping follow-up appointments with the same care provider, which is important to continuity of care
- Accessing groceries and maintaining proper nutrition
- Participating in physical, social, or other community activities

Resources to Learn More

Healthy People 2020 Disability and Health
Website
The goals for improving the health of people with disabilities to be met in 2020.
Organization(s): Healthy People 2020

Surgeon General's Call to Action to Improve Health and Wellness of Persons with Disabilities
Document
This is a comprehensive document that explains challenges to health and well-being of people with disabilities as well as goals that can be used as recommendations to improve the health of people with disabilities.
Organization(s): U.S. Office of the Surgeon General; U.S. Office of Disability
Date: 2005

Barriers to Accessing Care for Rural People with Disabilities

There are many barriers that people with disabilities face when accessing healthcare. People living with disabilities in rural and urban locations face many similar barriers when trying to access care, but rural residents typically have a significant disadvantage to receiving proper healthcare services.

Some of the barriers that are specific to rural communities include geographic isolation, qualified provider shortages, and the built environment characteristics of the local health clinic.

Geographic barriers: The geographic isolation of rural communities means that there are a limited number of clinic and hospital choices within an accessible radius as well as secondary and tertiary facilities with more sophisticated treatment capabilities. This can make care coordination even more difficult, especially for younger individuals with disabilities who are dually-eligible for Medicaid and Medicare.

Transportation barriers: Geographic isolation limits the transportation options available, according to focus groups conducted by Iezzoni and colleagues, many para-transport and public transportation systems will not travel to larger cities for medical appointments.

Physical and built environment barriers:

- Inaccessible parking
- Inaccessible sidewalks or no sidewalks
- Poorly designed front desk that limits patient check-in
- Inability to maneuver through clinic effectively
- Poor exam room design and lack of appropriate equipment
- Lack of handicap accessible restrooms
- Limited resources to update clinics and fulfill other structural requirements for disabilities

Service barriers and provider shortages: In a 1996 Journal of Rural Health article, a shortage of trained medical staff, primary care physicians, and specialty care physicians, as well as poor retention of already employed physicians and little training available for medical staff, are identified as barriers to accessing primary and specialty care services. Other service barriers include a lack of TTY or hearing accessible phone services and readily available telehealth technology. There is little access to outreach and care teams or community health workers as well.

Cost barriers: Cost is a limiting factor in accessing care. Travel may be costly and many transportation options are not reimbursed by insurance. There are costs associated with obtaining regular medical care, even with health insurance. Cost is especially limiting if an individual is un- or under-employed.

Resources to Learn More

Rural Guide to Federal Health Professions Funding
Document
Addresses health provider shortages by identifying funding opportunities to encourage health professionals to work in rural communities.
Organization(s): U.S. Department of Health and Human Services Health Resources and Services Administration
Date: 5/2012

Social Determinants of Health

The social determinants of health are the

"…conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes."

These factors influence an individual's ability to stay healthy. Rural residents experience a unique set of contributing social factors that impact their health. Social determinants of health are important to determining individual well-being and quality of life. Creating partnerships with organizations to address social determinants of health is vital to the well-being of people with disabilities in rural communities.

Examples of social determinants that affect the health and well-being of a person with disabilities are:

- Employment opportunities, non-discriminatory work environments, and equal pay
- Accessibility to education and educational attainment
- Accessibility of affordable, nutritious food
- Housing that is accessible, clean, and safe
- Accessible community groups and social support
- Ability to participate in daily life
- Health literacy

Services that May Need to be Integrated

Given the many different social determinants that affect a person's health, integrating services is a key way to ensure that the complex needs of people with disabilities are met in an efficient way.

- Housing services or independent living services can help a person with a disability live independently by providing services to make sure their homes are accessible and safe.
- Meal delivery services can help provide a balanced diet to meet nutrition requirements.
- Transportation services that are disability-appropriate
- Companion care and access to social or community activities provides people with a community network. The ability to access different community-based activities is important to social and mental well-being. Insurance enrollment assistance and assistance using HealthCare.gov will ensure that rural residents with disabilities are covered with health plans that can meet their needs.

Resources to Learn More

ADA National Network
Website
Information, training, and guidance on the Americans with Disabilities Act, complete with links to regional ADA centers, fact sheets, and resources for implementing the ADA.
Organization(s): ADA National Network

Administration for Community Living (ACL)
Website
Federal agency responsible for increasing access to community supports to meet the unique needs of older Americans and people with disabilities across the lifespan Part of the U.S. Department of Health and Human Services.
Organization(s): Administration for Community Living
Date: 4/2016

Association of Programs for Rural Independent Living (APRIL)
Website
A national network of rural centers for independent living (CILs) and other organizations and individuals concerned with the unique aspects of rural independent living. APRIL is organized to promote independence and strive for full rights and benefits for individuals with disabilities living in rural environments. The site includes resources on accessing healthcare.
Organization(s): Association of Programs for Rural Independent Living

Community Health Workers Toolkit
Website
Community Health Workers can be used not only in a clinical setting but to help individual access different human services.
Organization(s): Rural Health Information Hub

Rural Services Integration Toolkit
Website
Online toolkit designed to help rural communities seeking to implement services and integration programs using evidence-based and promising models.
Organization(s): Rural Health Information Hub

U.S. Department of Labor People with Disabilities
Website
Training and employment assistance to people with disabilities.
Organization(s): United States Department of Labor

Module 2: Evidence-Based and Promising Services to Improve Access for Rural People with Disabilities

People with disabilities who live in rural communities often face barriers to accessing healthcare. There is not a single solution to solve this issue. Instead, there are many factors that contribute to inadequate access to care for people with disabilities, including individual needs, built environment and community characteristics, transportation, and methods of care delivery. Different programs can be implemented to achieve the same goal of improving access to care for individuals with disabilities. Interventions should be selected based on available community resources and needs.

To learn how identify and adapt interventions, see Developing a Rural Community Health Program in the Rural Community Health Toolkit.

This toolkit identifies six models to improve access for people with disabilities:

- Office-based Physical Accessibility
- Home Health and Home-based Services
- Care Coordination
- Community Health Workers
- Transportation
- Technology and Telehealth

Office-based Physical Accessibility

According to a 2008 study, physical accessibility of healthcare facilities, clinics, and hospitals is one of the largest barriers facing rural residents with disabilities. Many clinics in rural communities have not been updated to the same standards that are found in urban locations. In order to make a medical office accessible to people with disabilities, clinics should look at features both outside and inside the clinic.

Exterior Accessibility:

- Designated, accessible parking for cars and vans
- Accessible entrances without stairs
- Ramps and appropriate sidewalk features for wheelchairs and walkers
- Sidewalks and roads clear of debris and potholes
- Door accessibility:
    - » Size
    - » Level exterior door handles for easy reach
    - » Push-button operated exterior doors

Interior Accessibility:

- Level interior door handles for easy reach
- Clear floors for safety
- Adequate space to maneuver through halls and doorways
- Wheelchair height accessible check-in desks and counters
- Restrooms with appropriately sized toilet stalls, grab bars, and sinks at wheelchair height
- TTY telephone/hearing aid compatible phones
- Wheelchair accessible scales
- Exam tables and chairs that are adjustable and allow for independent transfer
- Accessible diagnostic equipment

Program Clearinghouse Examples

- Oregon Office on Disability and Health

Resources to Learn More

2010 ADA Standards for Accessible Design
Document
This document details the regulations for new construction as well as alterations for current buildings to make them compliant with the Americans with Disabilities Act guidelines.
Organization(s): U.S. Department of Justice
Date: 2010

Access to Medical Care for Individuals with Mobility Disabilities
Document
Overview of clinic accessibility according to the Americans with Disabilities Act guidelines. Provides specific details for those with mobility disabilities and how they can use healthcare.
Organization(s): U.S. Department of Justice, U.S. Department of Health and Human Services
Date: 7/2010

Harris Family Center for Disability and Health Policy Resources
Website
This webpage contains a number of resources that can be used to assist communities and programs interested in reducing physical access barriers to healthcare services. Resources range from communication, medical equipment, and physical structures to policies and insurance coverage.
Organization(s): Harris Family Center for Disability and Health Policy

Inclusive Healthcare Facilities: Access and Accommodations Resource Toolkit
Document
A comprehensive list of resources to improve access to healthcare services for people with disabilities including webinars, national standards and guidelines.
Organization(s): Montana Disability and Health Program
Date: 2014

Readily Achievable Barrier Removal: Checklist for Existing Facilities
Document
A checklist for buildings to identify barriers as well as possible solutions that can be used to remove the barriers.
Organization(s): Institute for Human-Centered Design, ADA National Network
Date: 2010

VA Barrier Free Design Standard: A Supplement to the Architectural Barriers Act Accessibility Standards
Document
This document describes the requirements to meet barrier free guidelines that are determined by the Department of Veterans Affairs.
Organization(s): U.S. Department of Veterans Affairs
Date: 11/2018

Home Health and Home-based Services

Many people living with a disability face difficulties traveling long distances to receive healthcare in a clinical setting, which can pose particular challenges in rural areas. Home healthcare services are one way to bypass the barrier of receiving healthcare and similar services without having to travel. Home healthcare encompasses a range of services that are provided in the home to meet a variety of healthcare needs in both short-term and long-term situations.

Home health is made up of a variety of medical and social services that are provided in an individual's home. This model is especially important to individuals with disabilities who have advocated for receiving care in the community, rather than in institutional settings. For many individuals with disabilities, home health care includes assistance from a personal care attendant; it may also include a range of other services, which require care coordination to organize. The following section highlights care coordination models for rural residents with disabilities.

In addition to personal care assistants, types of caregivers that can provide home care to people with disabilities include:

- Nurse practitioners
- Registered nurses/public health nurses
- Physical therapists
- Occupational therapists
- Speech-language therapists
- Respiratory therapists
- Social workers
- Community health workers
- Care coordinators
- Family members

Program Clearinghouse Examples

- Mid-State Health Center: PATT Project

Resources to Learn More

Caregiver Self-Assessment Worksheet
Document
This worksheet can be used by a range of different types of caregivers to assess their needs and the amount of support they are able to offer their clients/patients/family members.
Organization(s): Department of Veterans Affairs
Date: 3/2014

Direct Care Worker Training for Aging Clients with Developmental Disabilities
Document
This provides an overview of how Pennsylvania Direct Care Workers were trained to meet needs of older rural residents with developmental disabilities.
Author(s): Mabry, J.B., Kemeny, M.E., & Chateau, A.
Date: 7/2010

Farm Assessment and Rehabilitation Methods (FARM) Program
Website
The FARM program delivers rural rehabilitation specialists to farmers to help them continue to operate and work on their farm operations despite disabling injuries and illnesses.
Organization(s): Rural Health Information Hub

Quality of Care Home and Community-Based Services (HCBS) Waivers
Website
The Medicaid-funded home and community-based services (HCBS) program works to provide a variety of services to Medicaid beneficiaries within their own home or community. These programs serve a targeted population groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities and programs vary by state
Organization(s): U.S. Department of Health and Human Services Medicaid

Rural Caregivers Website
Website
Resources for caregivers in rural settings, including online support groups, links to disability-related organizations, financial information, state and region-specific caregiver information, and other educational materials.
Organization(s): Purdue University and Indiana State Office of Rural Health

Care Coordination

The Agency for Healthcare Research and Quality defines care coordination as a service that:

"Involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."

Care coordination can be a useful strategy to improve the health and wellness of people with disabilities. Creating an organized care plan can reduce medical errors, coordinate appointments across different care requirements, and reduce duplication of services. People with disabilities often have complicated medical needs that require appointments with multiple providers. A care coordinator can work with the patient to make their experiences with the medical system more efficient and effective.

Coordination services can be provided by clinical or non-clinical providers. Types of care coordinators identified in the Rural Care Coordination Toolkit include:

- Health Educators
- Patient Navigators
- Care Managers
- Community Health Workers
- Registered Nurses

Coordinators can also connect rural citizens with disabilities to a number of services outside of the hospital or clinic setting, including medical equipment, home healthcare, Medicaid and medical reimbursement, and homemaker and meal delivery services.

Program Clearinghouse Examples

- County of Nevada
- Mid-State Health Center: Ignite Project
- Mid-State Health Center: PATT Project
- Ohio Department of Health

Resources to Learn More

How a Pediatric ACO Coordinates Care for Children with Disabilities
Website
This website provides a case study of a care coordination program for children with disabilities in central and southeastern Ohio. Using lessons learned from the development of an accountable care organization's pediatric care-coordination effort, key takeaways are presented to assist other organizations looking to start a care coordination program.
Organization(s): Partners for Kids

Community Health Workers

Community health workers (CHWs) are:

"Public health workers who are a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."

Community health workers serve multiple roles in their community and can improve access to care and reduce health disparities for people with disabilities in a number of ways. Some examples include:

- Providing culturally-appropriate education and information to the clients they serve
- Reducing transportation barriers by providing services in the client's home
- Ensuring that individuals with disabilities are receiving all necessary health and social services
- Conducting outreach and education activities throughout the community

Program Clearinghouse Examples

- Ohio Department of Health

Resources to Learn More

Community Health Worker Addressing High Risk Disabilities and Older Adults
Presentation Slides
Provides an example of how the community health worker model has been applied to addressing the needs of older adult and individuals with disabilities in Maine.
Author(s): DiMascio, M., Gogan, T., Jones, C., & Cole, V.
Organization(s): Spectrum Generations and Seniors Plus
Date: 6/2015

Community Health Worker Interventions to Improve Access to Health Care Services for Older Adults from Ethnic Minorities: A Systematic Review
Document
Describes how community health workers are important in improving the healthcare use and health behaviors of community members.
Author(s): Verhagen, I., Steunenberg, B., de Wit, N.J., & Ros, W.J.G.
Citation: BMC Health Services Research 2014 14:497
Date: 12/2013

Community Health Workers Toolkit
Website
Online toolkit providing information on developing a community health worker program in rural areas, including training materials and examples of program models.
Organization(s): Rural Health Information Hub

Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities
Website
Describes the many roles that community health workers can play in improving health access and outcomes and addressing health disparities.
Organization(s): American Public Health Association

Transportation

Transportation barriers are both a public safety issue and an issue that impacts individual health status. It is important to look at transportation barriers when addressing access to healthcare. A transportation barrier can lead to missed medical appointments, skipping prescription refills, and not engaging with community or recreational activities. When this happens, changes in health status can go unmonitored and cause greater health problems.

Improving transportation resources can help increase the accessibility of medical care as well as increase access to social, vocational, and recreational activities that can improve one's quality of life.

Public (Vehicle) Transportation

Transportation can range from a personal vehicle to a bus, taxi, or train. Para-transport is a special form of public transportation reserved for people with disabilities, which typically run 'door-to-door' services. Cities with public bus routes are required to offer para-transport services that are comparable to the public transportation system and run in a timely and efficient manner.

Rural communities typically lack sufficient standard public transportation options like taxi services and public buses due to limited resources. They also rarely have para-transportation services or coordinated transportation efforts for people with disabilities. Improving transportation in rural communities can be accomplished by coordinating resources. Examples might include:

- Pool resources to serve a wider population
- Use para-transit services across multiple communities, combining routes to create wider access
- Identify funding opportunities and ways to coordinate funding sources to achieve sustainability
- Create a provider referral system to refer patients to transportation organizations. For example, the HealthTran referral system provides patients with access to affordable transportation organizations that will accommodate disabilities.
- Beyond public transportation, expand the availability of private transportation options in rural areas, such as taxis, Uber, and Lyft.

Pedestrian Transportation

Walking is a common alternative to motorized transportation, but in rural communities people cannot typically walk to the grocery store for food or to the city center for a medical appointment due to the spread out nature of the community. Lack of safe and accessible pedestrian routes can pose major transportation barriers. In rural communities the pedestrian barriers are not limited to distance between destinations but also include a lack of sidewalks and appropriate handicap accessible curbs outside of buildings.

Methods to improving pedestrian accessibility and safety include:

- Sidewalks without bumps or cracks
- Curb cuts
- Ramps
- Routes that shorten the distance from place to place

Program Clearinghouse Examples

- Mid-State Health Center: PATT Project
- Missouri Rural Health Association
- Oregon Office on Disability and Health

Resources to Learn More

The ADA & Accessible Ground Transportation
Website
This website, maintained by the ADA National Network, provides a brief overview of ground transportation requirements related to the ADA.
Organization(s): ADA National Network

ADA Guide for Rural Demand-Response Transportation Service Providers
Document
The toolkit booklets explain Americans with Disabilities requirements and regulations for vehicles, service policies, and etiquette for smaller, rural operators.
Organization(s): Easter Seals
Date: 2013

National Aging and Disability Transportation Center
Website
This website provides trainings, webinars, resources, and publications, including a Rural Transportation Topic Guide, with the goal of improving transportation for older adults, people with disabilities, and their caregivers.
Organization(s): National Aging and Disability Resource Center

National Center for Mobility Management
Website
This website provides resources designed to "support Federal Transit Administration (FTA) grantees, mobility managers, and partners in adopting proven, sustainable, and replicable transportation coordination, mobility management, and one call–one click transportation information practices."
Organization(s): National Center for Mobility Management

National Council on Disability Transportation Update
Document
Provides a national update on the status of disability-related transportation options and future recommendations.
Organization(s): National Council on Disability
Date: 5/2015

National Rural Transit Assistance Program
Website
This website is dedicated to assisting rural communities with developing public and other transit solutions by providing technical assistance, collaboration, trainings, and many resources specific to people with disabilities.
Organization(s): U.S. Department of Transportation and Federal Transit Administration

National Rural Transit Assistance Program: ADA Toolkit
Website
This toolkit goes over the American's with Disabilities Act requirements for transportation and a number of resources to assist rural communities in meeting these requirements.
Organization(s): U.S. Department of Transportation Federal Transit Administration

Transit Cooperative Research Program (TCRP) Synthesis 116: Practices for Establishing ADA Paratransit Eligibility Assessment Facilities
Document
State of implementation of ADA para-transit eligibility, various processes, facilities, equipment, and tools used by transit agencies.
Organization(s): Transit Research Board, Federal Transit Administration
Date: 2015

Transit Cooperative Research Program: Toolkit for Rural Community Coordinated Transportation Services Document

The purpose of this toolkit is to help rural communities with creating a coordinated transportation system to improve rural resident's ability to access a variety of destinations.

Organization(s): Transit Research Board, Federal Transit Administration

Date: 2004

Transportation to Support Rural Healthcare

Website

This website provides background on rural healthcare transportation, FAQs, and a list of resources to get more information about rural transportation programs.

Organization(s): Rural Health Information Hub

Technology and Telehealth

Telehealth (telemedicine) is a service delivery model defined by the Health Resources and Services Administration as:

"…the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration."

Using telehealth services to address the healthcare needs of rural residents with disabilities can overcome a number of barriers, such as travel distance and time, transportation, and limited access to specialists throughout the medical workforce. Because of the complex health needs of people with disabilities, telehealth allows patients and providers to check in more regularly. It also increases the ability of care coordinators to help with care plans and medication-management without traveling.

Telehealth in a home setting is an ideal way for people with disabilities to access service providers. In order to be implemented, telehealth requires a significant amount of technology infrastructure. In communities or households that have a limited ability to create individual telehealth sites, common, community locations for telehealth services can be effective way to make telehealth services available without the cost of individual technology equipment.

Telehealth is also beneficial for providers. Health educators, community health workers, and nurses can assist patients through long-distance coaching and provider training, which helps to increase knowledge and broaden the provider network.

Program Clearinghouse Examples

- Avera Sacred Heart
- Bay Rivers Telehealth Alliance

Resources to Learn More

Consortium of Telehealth Resource Centers
Website
Telehealth Resource Centers (TRCs) provide assistance, education, and resources to those providing or seeking to provide healthcare services to underserved populations at a distance.
Organization(s): Consortium of Telehealth Resource Center

Indiana Veterans Behavioral Health Network (IVBHN)
Website
To address the lack of mental healthcare options for rural veterans, a tele-behavioral health hub network was created to connect Community Mental Health Centers to the VA Medical Center.
Organization(s): Indiana Veterans Affairs

Tele-Health Promotion for Rural People with Disabilities: Toward a Technology Assisted Peer Support Model
Document
Documents the process of studying a well-known program for people with disabilities that was turned into an internet-based program and the resulting outcomes.
Organization(s): University of Montana Research and Training Center on Disability in Rural Communities
Date: 9/2007

Module 3: Program Clearinghouse

The HRSA Federal Office of Rural Health Policy has funded several programs in rural areas with the goal of improving access to care for people with disabilities as part of the 330A Outreach Authority program. This program focuses on expanding access to healthcare services in rural areas.

Examples of current 330A Outreach Authority grantees and other organizations that have developed promising programs designed to improve access to care for people with disabilities in a rural community are provided below. Evidence-based and promising service models for improving access to care for people with disabilities are available in Module 2.

- Avera Sacred Heart
  Project Title: South Dakota eResidential Facilities Health Care Services Access Project
  Synopsis: This program uses telehealth services to improve access to care for residents of long-term care and similar facilities.
- Bay Rivers Telehealth Alliance
  Project Title: Bridges to Care Transitions
  Synopsis: This program uses telehealth to improve access to care and access to chronic disease self management education programs to rural residents.
- County of Nevada Human Services Agency
  Project Title: Healthy Outcomes Integration Team
  Synopsis: This program provides coordinated health services to rural residents with mental health conditions at-risk for developing chronic conditions.
- Mid-State Health Center: Ignite Project
  Project Title: Ignite: Making Connections that Spark Change
  Synopsis: This program aims to provide health coaching and care management to patients with depression and a co-occurring chronic health condition.
- Mid-State Health Center: PATT Project
  Project Title: Plymouth Area Transitions Team (PATT)
  Synopsis: This program is a care transitions program designed to reduce hospital readmissions, improve quality and contain costs for patients with complex care needs.
- Missouri Rural Health Association
  Project Title: HealthTran
  Synopsis: This program coordinates non-emergency medical transportation for patients demonstrating a transportation need for routine and preventative medical care.
- Ohio Department of Health
  Project Title: Black Lung Clinics Grant Program
  Synopsis: This program provides clinical, rehabilitative, and social services to coal miners affected by Black Lung and other occupational lung-related diseases.
- Oregon Office on Disability and Health
  Project Title: Community Engagement Initiative
  Synopsis: This program engages rural communities in improving access to care for people with disabilities using a three-step, grassroots method.

Avera Sacred Heart

Project Title: South Dakota eResidential Facilities Health Care Services Access Project
Grant Period: 05/01/2012-04/30/2015
Program Representative Interviewed: Anthony Erickson, Project Director
Location: Yankton, South Dakota
Program Overview: The Avera Health System is known for providing electronic care services in the hospital setting. The South Dakota eResidential Facilities Health Care Services Access Project aims to expand on preexisting e-care services to residents in long-term care, assisted living and rehabilitation facilities. The goal of this program is to improve access to care for residents by looking at their care and monitoring changes in conditions. The eCare services are staffed 24/7 with advanced practitioners who provide both urgent care and specialty consult services to 6,000 residents across 40 facilities.

Read about the eResidential Facilities Health Care Services Access Project in RHIhub's Rural Health Models and Innovations.

Models represented by this program:
Telehealth

Bay Rivers Telehealth Alliance

Project Title: Bridges to Care Transitions
Grant Period: 05/01/2015-04/30/2018
Program Representative Interviewed: Donna Dittman Hale, Executive Director
Location: Tappahannock, Virginia
Program Overview: The Bay Rivers Telehealth Alliance is a network of providers and community-based organizations working to improve access to care for patients in rural areas and bring in additional programming to reduce hospital readmission rates using telehealth. The goal of the project is to use remote patient monitoring to supplement care transitions coaching for patients who are discharged from the hospital with conditions associated with high rates of readmission and to provide access to chronic-disease self-management services.

Models represented by this program:
Telehealth

County of Nevada Human Services Agency

Project Title: Healthy Outcomes Integration Team (HOIT)
Grant Period: 05/01/2012-04/30/2015
Program Representative Interviewed: Rebecca Slade, Behavioral Health Director
Location: Nevada County, California
Program Overview: The Healthy Outcomes Integration Team (HOIT), run by the Nevada County Behavioral Health Department, is made up of a group of varied providers from different sectors of healthcare, community, and family. A registered nurse and service coordinators work together to connect clients who have a serious mental illness and have, or are at-risk for, a chronic condition to primary care, mental health, behavioral health, and substance use treatment services. Additionally, program staff work with clients on their core health indicators and help clients set and meet health goals. HOIT uses care coordination across different organizations and clinics to help facilitate these service needs. The program is modeled after the evidence-based, IMPACT model, which is an intervention for adult patients with depression and a chronic disease or other major health condition.

Read about the Healthy Outcomes Integration Team (HOIT) Program in RHIhub's Rural Health Models and Innovations.

Models represented by this program:
Care Coordination

Mid-State Health Center: Ignite Project

Project Title: Ignite: Making Connections that Spark Change
Grant Period: 05/01/2015-04/30/2018
Program Representative Interviewed: Sharon Beaty, CEO
Location: New Plymouth, New Hampshire
Program Overview: Ignite: Making Connections that Spark Change, housed in the Mid-State Health Center, works with clients with depression and diabetes or high blood pressure using care coordination frameworks based on the evidence-based program, the IMPACT model. Using a referral system from primary care providers, behavioral health providers, or self-referral – patients can participate in the program where they will receive 12 weeks of telephone-based monitoring for health indicators for diabetes and hypertension. During the telephone call, the Ignite team member will also use behavioral activation techniques to help treat depression. Following the initial 12-week period, patients select the type of continued follow-up they would like. A nurse case manager oversees the implementation of the program, engages patients and families, and helps to train staff to better accommodate patients and to adapt the IMPACT model to better fit the needs of the community.

Models represented by this program:
Care Coordination
Telehealth

Mid-State Health Center: PATT Project

Project Title: Plymouth Area Transitions Team (PATT)
Grant Period: 05/01/2012-04/30/2015
Program Representative Interviewed: Sharon Beaty, CEO
Location: New Plymouth, New Hampshire
Program Overview: The goal of this program, run by the Mid-State Health Center, is to address care transitions and reduce hospital readmissions for patients with complex health needs, as well as to improve quality and reduce costs of care. PATT is modeled off of three transition of care program models – Project BOOST, Care Transitions Intervention, and the Transitional Care Model. A transitional care manager is used to work with the patient and caregiver on education and developing an appropriate care plan. The transition manager will also follow up with the patient both at-home following discharge and then weekly by telephone for 30 days. During this time, the transition manager also provides assessments, patient and family education and continued support. In addition, this program provides coordinating inter-agency services to identify potential problems, partnerships with home health agencies and transportation services to continue to reduce barriers faced in rural New Hampshire.

Models represented by this program:
Care Coordination
Transportation
Home Health

Missouri Rural Health Association

Project Title: HealthTran
Program Representative Interviewed: Doris Boeckman, MRHA Rides to Wellness Director
Location: Missouri
Program Overview: HealthTran provides non-emergency medical transportation for rural Missouri residents who otherwise would have difficulty finding a ride to their appointments. The program, which is administered by the Missouri Rural Health Association, began in 2013 with a three-year grant from the Missouri Foundation of Health, along with additional funding from the Missouri Department of Transportation and the National Center for Mobility Management. The first step of the program was to hold a panel discussion at the Missouri Public Transit Association's strategic planning session. In this discussion, it became clear that there was a need to coordinate between healthcare and transportation providers.

Today, HealthTran coordinates rides for residents of 10 rural Missouri counties, coordinating between numerous transportation and healthcare providers. The program is targeted toward individuals who are unable to access safe, reliable, and affordable transportation through other means, such as Medicaid non-emergency transportation or veterans' transportation assistance.

Patients without transportation for appointments can be referred by their healthcare provider to HealthTran. Once that happens, a HealthTran Coordinator contacts the patient to complete a needs assessment and to schedule the trip. HealthTran can be used for one-time or reoccurring visits at no cost to the patient.

Since its inception, HealthTran has served hundreds of patients, more than half of whom had a self-reported disability. This transportation has led to fewer missed appointments, which benefits both patients and providers.

Read about HealthTran in RHIhub's Rural Health Models and Innovations.

Models represented by this program:
Transportation

Ohio Department of Health

Project Title: Black Lung Clinics Program
Grant Period: 07/01/2014-06/30/2015
Program Representative Interviewed: Phillip Styer, Project Director/Program Manager
Location: Ohio
Program Overview: The Ohio Black Lung Clinics Program is one example from the larger Black Lung Clinics Program funded by the Health Resources Services Administration. The Ohio Black Lung Clinics Program targets uninsured coal workers with black lung disease and other occupational-related lung diseases who live in rural Appalachia. The program has been funded since 1979, working to connect coal miners with services related to lung disease. These services include diagnosis, treatment, rehabilitation, prescription, case management, and social services, such as help with enrollment in public benefit programs and transportation. Providing these services to participating coal miners and their families will reduce emergency room and hospital visits as well as improving overall health outcomes and ability to perform activities of daily living.

Models represented by this program:
Care Coordination
Community Health Workers

Oregon Office on Disability and Health

Project Title: Community Engagement Initiative
Program Representative Interviewed: Angela Weaver, Project Coordinator
Location: Oregon
Program Overview: The Community Engagement Initiative (CEI), led by the Oregon Office on Disability and Health, is a grassroots model in which rural communities identify and address priorities for improving access to care for people with disabilities in three main areas: transportation; facility access and services; and provider knowledge, attitude, and communication.

One successful example of this model being implemented was in Pendleton, OR. The Pendleton Project's primary goal was to increase access to healthcare for people with disabilities through the three-step CEI process. The first step in addressing access barriers was to bring together the community in a town hall style meeting, which allowed community members to voice concerns and identify specific problems that people with disabilities face. The second step was to bring together key community infrastructure representatives to discuss the identified barriers, identify resources, and create an action plan to address the healthcare barriers. The third and final step was community mobilization and implementation.

It was during the third phase that specific physical access barriers were identified using a newly-designed ADA accessibility checklist for medical clinics and facilities. Physical access improvements were made to clinic design, paths of travel, and medical equipment. During this process, an accessible bus route was also added alongside medical centers to address barriers to transportation.

Models represented by this program:
Physical Access
Transportation

Module 4: Implementation Strategies for Programs to Improve Access to Care for Rural Residents with Disabilities

Each rural health program designed to improve access to care for people with disabilities is unique, and there is no one-size-fits-all implementation strategy. Successful programs identify existing resources and best practices, and tailor them to address their community's needs. This module identifies key concepts to consider when implementing a program to improve access to care for people with disabilities.

For a broad overview of rural program implementation, see Implementing a Rural Community Health Program in the Rural Community Health Toolkit.

In this module:

- Implementation Challenges
- Implementation Considerations

Implementation Challenges

There are many possible challenges that can arise when implementing a program to improve access to care for people with disabilities in a rural community. Challenges will be specific to each program. Broad challenges that may be encountered include:

Acceptance of a new program or strategy requires community, provider, and staff buy-in. If providers, healthcare staff, community members, and the target population are not accepting of the program's goals and vision, the long-term sustainability of the program will be limited. Cultural barriers, social issues, languages, and program objectives can affect acceptance.

Possible Solutions: Partnership, Staff

Funding or financial sustainability leads to both short-term and long-term advancement of program goals. Having adequate financial resources can help with long-term sustainability. Funding and financial resources are necessary for space, supplies, staff salaries, and outreach and engagement activities. Other funding challenges include:

- Cost of renovation and construction to implement accessible building features
- Cost of disability-appropriate medical equipment
- Cost of travel for program participants and program staff
- Reimbursement for transportation, home care, care coordination and other services; flexibility in obtaining reimbursement for non-standard care

Possible Solutions: Partnerships, Financial Resources

Provider shortages include shortages of primary care physicians and specialty providers. These shortages can also reduce provider ability to network and keep up-to-date on standards of care. Provider shortages are not limited to physicians; people with disabilities often require complex care from multiple types of providers that are less readily available in rural communities such as:

- Physical, occupational, or speech therapists
- Specialized physicians and advanced practitioners
- Nurses, nurse practitioners, and nurse case managers
- Dietitians and nutritionists
- Community health workers
- Rehabilitation specialists
- Mental health and behavioral health providers

Possible Solutions: Partnerships, Staff

Technology is a common challenge in rural communities. Barriers to implementing and using technology to improve access to care stem from financial constraints and limited availability of technology infrastructure such as broadband, high-speed internet, and Wi-Fi. These barriers exist in individual households as well as in larger healthcare settings, which limit the flexibility to use telehealth technology and provider ability to share patient information across clinics.

Possible Solutions: Technology Infrastructure, Financial Resources

Implementation Considerations

There are many factors to consider to successfully implement a program. While each program is unique in its implementation considerations, this module identifies five broad considerations that are important to implementing a program to improve access to care for rural residents with disabilities.

In this section:

- Staff
- Partnerships
- Financial Resources
- Technology

Staff

Staff are critical to the implementation of any program. It is helpful to have staff with education, skills, or qualities that are specific to the program and target population needs. For example, an organization may recruit volunteers to conduct outreach activities, hire a certified professional to deliver screening services, or work with retired providers or students. If a staff member is going to be working directly with the community, hiring a community member to fill this role could help generate community buy-in.

Training is the one of the first opportunities that an organization has to create a strong, positive staff environment. Training for clinical staff, physicians, nurses and other healthcare workers that see people with disabilities in clinic or home care settings can include seminars about:

- Communicating with and about people with disabilities
- Communicating with patients about their needs
- Helping patients with realistic goal setting for health improvement
- Demonstrating cultural competency
- Addressing social determinants of health

Resources to Learn More

Access to Medical Care DVD Set & Training Curriculum
Tutorial/Training
This training curriculum is intended to inform providers about the barriers in accessing clinical care. This training can be used to improve access to quality care in a variety of clinical settings.
Organization(s): World Institute on Disability
Date: 1/2016

Disability and Health Information for Health Care Providers
Website
Recommendations for healthcare providers on meeting the needs of people with disabilities as well as additional training resources.
Organization(s): Centers for Disease Control and Prevention

Partnerships

Partnerships are important to pooling resources and combining efforts when implementing a new program. It is important to include possible partners from the beginning of the planning process in order to develop mutual goals and shared involvement in the project. Partnerships are important in rural communities for sharing scarce resources, both human and capital.

Possible partners that would benefit a rural program for people with disabilities include:

- Clinics
- Larger hospital systems
- Academic centers/universities
- University/county extension services
- Public transportation, or state transit authority
- Local, county, state health departments
- Urban planning organizations or architectural companies
- Health plans
- Government organizations
- Multicultural alliances and associations
- Community organizations
- Home care organizations
- Organizations that could bring in disability-specific provider trainings

Possible partners that would benefit a rural program for people with disabilities include:

- Leaders can help generate community buy-in.
- Leaders can help reach partners and fortify commitment.
- Leaders can create a network to help combine community resources across communities.
- Leadership is important for overall sustainability.
- Leadership involvement can lead to sustainability and better long-term outcomes.

Financial Resources

Having sufficient funds will help further program sustainability. Paying attention to funding sources, such as grants, can provide short-term financial resources for programs. Financial resources can come from a wide variety of sources such as foundations, community or organizational partnerships, and reimbursement.

Sharing and disseminating program successes can be a useful strategy to garner support, especially when approaching potential funders. More information on funding programs can be found in Rural Health Information Hub's Rural Funding & Opportunities section.

Technology

Implementing a program that requires technology also requires a certain level of infrastructure such as:

- Funding to pay for the technology
- Appropriate routers and receivers that can handle video and voice conferencing or other technological needs
- Space to put the equipment or the ability to move the equipment to the patient

Technology infrastructure is not limited to physical infrastructure that enables connectivity. It also requires:

- Information technology staff capable of implementing and troubleshooting the technology needed for program activities.
- Training for providers and staff who will use technology services to connect with their patients.
- Education for patients to understand how the technology services can help them connect with their providers.

Resources to Learn More

Telehealth Resource Centers
Website
A program designed to assist healthcare organizations, networks, and providers in implementing telehealth programs that serve rural and medically-underserved areas.
Organization(s): Office for the Advancement of Telehealth, Health Resources and Services Administration

Module 5: Evaluation Considerations for Programs to Improve Access for Rural Residents with Disabilities

Evaluation is a tool for measuring a program's impact and providing information on where to make improvements. Careful evaluation of programs designed to improve access to care for rural residents with disabilities is critical to ensuring that the programs are achieving their goal.

Just as there are many ways that communities might reduce barriers for individuals with disabilities, there are various strategies that could be used to evaluate programs. This module will provide methods and considerations for conducting evaluations of programs designed to improve access to care for people with disabilities.

For a detailed overview of program evaluation, see Evaluating Rural Programs in the Rural Community Health Toolkit.

In this module:

- Evaluation Frameworks
- Evaluation Data Sources
- Evaluation Objectives
- Evaluation Measures

Evaluation Frameworks

There are multiple types of evaluations that can be done to assess how effectively a program is improving access to care for rural residents with disabilities. Several frameworks for approaching evaluation of programs are listed below.

- **Process Evaluation:** Process evaluation is a systematic, focused plan for collecting data to determine whether the program model is implemented as originally intended and, if not, how operations differ from those initially planned. It seeks to answer the question, "What services are actually being delivered and to whom?" This framework also gathers information on perceptions of the program. Process evaluation assesses how a program is developed and implemented, and may investigate a program's operations, and structure.
  Example: Was the program implemented as planned? Why or why not?
- **Outcome Evaluation:** Outcome evaluation examines how well a project achieved the outcomes it set at the beginning. It is generally a summative evaluation of the program, which can be used to make recommendations for future program improvements. Outcome evaluations investigate whether changes occur in a particular program, and, if they do, the extent to which changes can be attributed to the program.
  Example: Reduction in barriers to care reported by participants
- **Impact Evaluation:** Impact evaluations review the effect that a program had on participants and stakeholders of the project. It measures the outcomes, but also the changes that resulted from those outcomes.
  Example: Increased use of preventive care measures by rural residents with disabilities
- **Performance Monitoring:** Performance monitoring is on-going evaluation of the program to have data at the baseline and at key milestones in the work plan. This provides continuous, real-time feedback on program progress so that changes to the program can be made to better align with the program objectives and goals.
  Example: Ongoing count of rural residents with disabilities accessing care
- **Cost-benefit Evaluation:** Cost-benefit evaluations study the cost-effectiveness of the program by reviewing the relationship between the project costs and the outcomes (or benefits) from the program. Data collected is used to determine whether the program outcomes were worth the investment in program development and operation.
  Example: Savings from reduced preventable hospital admissions as a result of increased primary care and preventive care access.

Resources to Learn More

ACL Data and Research
Website
Gives information on data and statistics available for information evaluation of disability-related programs. Organizations might use this information to get statistics on the prevalence of disability in their community, and the rate of health insurance among individuals with disabilities.
Organization(s): Administration for Community Living

Evaluating the Effects of Telemedicine on Quality, Access, and Cost
Document
Offers guidelines for evaluating telemedicine programs and their impact on quality, access, and cost of care. This guide includes a list of evaluation questions to consider, including a section on questions and considerations specific to access to care.
Organization(s): Institute of Medicine
Date: 1996

Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide
Tutorial/Training
Provides a self-guided training for how to plan and implement public health evaluation geared toward staff and administrators at community health agencies.
Organization(s): Centers for Disease Control and Prevention
Date: 10/2011

KTDRR Logic Models
Website
Explains how logic models can be used to decide on the most important measures for evaluation purposes.

Participatory and Inclusive Approaches to Disability Program Evaluation
Document
Examines the inclusivity of disability program evaluations and provides recommendations for how to include the voices of individuals with disabilities.
Author(s): Robinson, S., Fisher, K.R., & Strike, R.
Citation: Australian Social Work, 67(4), 495-508
Date: 6/2014

Evaluation Data Sources

In order to evaluate the success of a program to improve access to care for rural residents with disabilities, it is necessary to have reliable and appropriate data. This data may take several forms and can be used to inform all types of evaluation. Examples of relevant data include:

- **Surveys and questionnaires:** These can be used to collect information on patients' experiences accessing care. They might include closed-ended questions such as rankings, yes/no questions, or multiple choice, as well as open-ended questions that provide qualitative data on patients' experiences accessing care.
- **Focus groups and interviews:** Patients could be interviewed alone or as part of a focus group to describe their experience accessing care and any barriers they encountered in the program.
- **Observations:** Evaluators might observe patients entering a clinic and describe any barriers they perceive. This type of data collection would be especially useful for describing difficulties that individuals with physical disabilities have with a healthcare facility's physical environment.
- **Electronic health record data and/or provider data:** This could be used to demonstrate an increase in visits by patients with disabilities or to document changes in health status and use of care by rural patients with disabilities.

Resources to Learn More

Data Collection for Program Evaluation
Document
Toolkit providing information and templates to assist with evaluating a public health program, including best practices for different types of data.
Organization(s): Northwest Center for Public Health Practice

Data Collection Methods for Program Evaluation: Observation
Provides a brief overview of how and when to use observation for public health program evaluation.
Organization(s): Centers for Disease Control and Prevention
Date: 12/2008

Evaluation Objectives

Evaluations of programs to improve access to care for rural residents with disabilities should have questions that closely align with the evaluation objectives. Those objectives should be SMART:

- **S**pecific – Detecting changes in the program.
- **M**easureable – Collecting data that are complete and accurate.
- **A**ctionable – Showing performance over time to identify when or where action should be taken.
- **R**elevant – Focusing on only the relevant indicators.
- **T**imely – Capturing data in the period it is needed, if not real time.

Evaluation Measures

Rural programs often collect data to track how well the program is working and to demonstrate any changes as a result of the program. This data may include baseline data such as characteristics of the population before the program is implemented, data collected at certain intervals during the program, and data collected at the conclusion of a program.

For example, a program aiming to reduce barriers to care for rural residents with disabilities might survey the target population about perceived barriers before implementing the program, then survey them again during the program implementation and at the conclusion of the program to see if barriers to care have been reduced. Such data are crucial to evaluating a program's success.

It is important to consider how data collected will be used in program evaluation to measure changes. Because the goal of an evaluation is to demonstrate change as a result of the program, data should be collected over time. There are different kinds of changes that can be tracked, including:

- **Affective change:** Change in attitudes or feelings toward specific behavior.
  Example: Feeling more included in clinical settings and care decisions.
- **Behavior change:** Adoption of new behaviors.
  Example: Adopting preventive care behaviors due to improved access to services.
- **Learning change:** New knowledge and awareness is acquired.
  Example: Increased knowledge about self-management behaviors as a result of access to care.
- **Environmental conditions:** Reduced barriers to accessing healthcare.
  Example: Transportation or clinic interior and exterior accessibility.
- **Status change:** Improved health outcomes or indicators.
  E*xample: Improvement in health status as a result of improved access to care.*

When identifying evaluation measures for programs designed to improve access to care for rural residents with disabilities, it is important to consider the program's focus, the needs of the audience or funders, and the time frame and training available for meeting program goals. Common measures used to evaluate public health programs include:

Information on programs and potential participants, such as:

- Rate and prevalence of disability in a community
- Potential participants' age, gender, socio-economic status, language spoken
- Potential participants' baseline use of health services and access to transportation
- Documented and perceived barriers to care for rural residents with disabilities at baseline
- Number and type of programs in the area providing telehealth, home health, care coordination, or accessible transportation services
- Program resources (financial and staff) devoted to improving access to care for individuals with disabilities
- Program payer mix and funding sources

Program process measures, such as:

- Number of rural residents with disabilities who are served or impacted by the program
- Number of practices that participate in the program to improve access to care
- Number of new patients with disabilities seen by a healthcare provider
- Number of individuals with disabilities who receive and follow up with referrals
- Number and types of educational materials produced for the program

- Number of key stakeholders involved in the program
- Number of people aware of program messaging and how many intend to take action
- Number of policies developed
- Types of program activities and settings
- Number and characteristics of staff offering the program
- Extent to which activities are implemented according to the program plan
- Types of resources and contributions provided by stakeholder groups
- Cost to complete program-related activities

Outcome/impact measures, such as:

- Increase in health services use by rural residents with disabilities
- Change in health status among rural residents with disabilities
- Increase in physically-accessible transportation options and clinic spaces
- Increase in provision of telehealth, care coordination, and home health
- Change in provider knowledge about the unique needs and concerns of individuals with disabilities accessing care
- Presence of a sustainability plan to maintain improved access to care
- Policies and funding to support the program going forward

Resources to Learn More

Community Health Assessment for Population Health Improvement: Resources of Most Frequently Recommended Health Outcomes and Determinants
Document
Identifies appropriate measures to use when evaluating a population-based health intervention in order to assess its effectiveness.
Organization(s): Centers for Disease Control and Prevention
Date: 2013

Educators' Guide to Service-Learning Program Evaluation Guide
Document
Provides guidance on how to conduct a program evaluation, including information on types of evaluation measures.
Organization(s): RMC Research Corporation

Research Library: Evaluation
Website
Ongoing list of variety of fact sheets and presentations with information about how best to conduct program evaluation.
Organization(s): Amherst H. Wilder Foundation

Module 6: Funding and Sustainability Considerations for Programs to Improve Access to Care

Sustainability is continued services, relationships, and values of the project over an extended period of time. In order for a program to be successful, it should make plans for sustainability beyond its initial funding period. To do so, sustainability should be addressed early in the planning and implementation stages. For programs improving access to care for individuals with disabilities, sustainability may also come in the form of lasting accessibility of a facility's physical environment or of permanent changes to infrastructure, such as transportation and technology.

For an overview of the types of sustainability strategies that all types of programs might consider, see Planning for Funding and Sustainability in the Rural Community Health Toolkit.

This module discusses the key issues in planning for sustainability of programs to improve access to care for people with disabilities in rural communities.

In this module:

- Importance of Sustainability Planning
- Sustainability Strategies

Importance of Sustainability Planning

All programs should include a sustainability plan, defined as a roadmap for achieving long-term goals, which documents strategies to continue the program, activities, and partnerships. Creating a sustainability plan for programs to improve access to care for people with disabilities requires the input of program participants as well as the staff, partners, and program leadership to work together.

Important considerations when planning for sustainability in programs to improve access to care for people with disabilities include:

- Developing a shared understanding between the community and program staff
- Maintaining a qualified workforce
- Continuing engagement with community partners
- Identifying funding and resources such as grants from foundations or other organizations
- Defining goals and objectives for reimbursement or grant-funding opportunities
- Monitoring updates in Medicaid/Medicare or insurance payment policy

The Rural Health Information Hub hosts a collection of resources from the Georgia Health Policy Center to help rural organizations plan for sustainability.

Resources to Learn More

Community Health Inclusion Sustainability Planning Guide: An Addendum to a Sustainability Planning Guide for Healthy Communities
Document
This guide builds on A Sustainability Planning Guide for Healthy Communities by providing additional resources to help public and community health professionals develop a sustainability plan for programs that address the unique needs of people with disabilities.
Organization(s): The National Center on Health, Physical Activity and Disability (NCHPAD), The Center for Disease Control and Prevention (CDC), National Center on Birth Defects and Developmental Disabilities

Sustaining the Work or Initiative
Website
This toolkit supports planning for using different tactics to sustain an organization or community initiative. Example 2 provides insight into sustaining a fitness center for people with disabilities, showing sustainability strategies that can be adapted to programs to improve access to care for people with disabilities.
Organization(s): Work Group for Community Health and Development at the University of Kansas

Sustainability Strategies

Rural health programs to improve the access to care for people with disabilities can sustain program funding through:

- Contributions from partner organizations
- Funding from grants and contracts
- Reimbursement for services, including from Medicaid waiver programs
- Regular reviews of project performance
- Analysis of costs and benefits
- Tax incentives
- Communication of the value of the program to members and other stakeholders
- Analysis of return on investment and/or assessment of the monetary benefits of the program
- Continuity of strong leadership for the program
- Broadcasting successes to key entities and audiences. See Module 7 on dissemination.

Some community programs may seek reimbursement for certain activities. For more information, see the Reimbursement for Services section of the Care Coordination Toolkit and the Funding and Sustainability Module of the Community Health Workers Toolkit.

Sometimes, the organization that is leading program implementation may decide to absorb the costs of the program in order to sustain it. For example, one program in Nevada County, CA was able to move their program to improve health outcomes for people with disabilities and the program costs into the behavioral health department, creating a more sustainable model for continuing program activities.

Resources to Learn More

Medicaid Issues for People with Disabilities
Website
This page gives a snapshot of current Medicaid reimbursement policies related to disabilities, each of which may impact organizations providing services to Medicaid-eligible individuals with disabilities.
Organization(s): The Arc

Tax Incentives for Businesses
Website
This page provides an overview of the tax incentives that can help cover the costs of implementing necessary changes to make a building accessible to people with a disability.
Organization(s): U.S. Department of Justice

Module 7: Dissemination of Disability Access to Care Program Best Practices

Once a program to improve access to healthcare for rural residents with disabilities is underway, it is important to disseminate program results. Doing so is important for building relationships with potential program partners and funders, for increasing program visibility, for sharing best practices with other rural communities, and for demonstrating success in order to secure future funding.

There are numerous ways to disseminate programs improving access to healthcare to rural residents with disabilities. Often, the best starting place is to share program results with the program's board (if applicable) and project partners. However, it is also important to share program results more broadly with rural communities and stakeholders interested in access to care for people with disabilities.

For more on how to share your program's results, see Disseminating Best Practices in the Rural Community Health Toolkit.

In this module:

- Making a Plan for Sharing Successes
- Dissemination Methods and Audiences

Making a Plan for Sharing Successes

Disseminating a program's results is important for several reasons. First, it helps to validate and celebrate the work being done by program staff and participants. Second, it may help community and organizational stakeholders make decisions about the program's future and their own involvement in it. Third, it may interest other rural communities and organizations interested in improving access to care for people with disabilities.

Various dissemination methods and modes may be used to share the successes of community health programs. Programs disseminate project findings at the local, state and national levels in order to reach as many people as possible. More information about what and how to share about a program's success can be found in the Rural Health Information Hub's Rural Community Health Toolkit.

In addition to sharing success stories, when implementing a community-based program to improve access to care for rural residents with disabilities, it is important to share with the community what lessons were learned and what impact the effort had on the community. This may include sharing challenges that needed to be overcome. For example, a telehealth program may need to improve its broadband access and technology infrastructure in order to operate effectively. Programs should disseminate lessons learned at the local, state and national levels in order to reach as many people as possible.

Dissemination Methods and Audiences

Dissemination can happen at the local, state, and national level. The type of message and media used will differ, depending on the audience, and programs should plan to address multiple audiences through different means. Once the dissemination objectives and the audiences are identified, there are a variety of ways to share the developed content.

Key audiences may include:

- Current and potential program participants
- Caregiver groups
- Healthcare providers/centers
- Community groups
- Schools
- Faith-based organizations
- Local human services agencies
- Local government
- State associations of county and city health officials
- State Offices of Rural Health (SORH)
- State and county extension offices
- Hospital associations
- Public health associations
- Rural health associations
- Universities and charitable foundations
- Disability advocacy groups
- Federal agencies

There are various methods for dissemination, depending on the target audience. For specific examples, see Methods of Dissemination in the Rural Community Health Toolkit.

Resources to Learn More

American Association on Health and Disability
Website
This site is where program findings from the Disability Research and Dissemination Center are housed. It disseminates current best practices and programs in disability accessibility issues and research on disability.
Organization(s): American Association on Health and Disability

Disability and Health Journal
Journal/Newsletter
This is the official journal of the American Association on Health and Disability and is an outlet for publishing program findings related to disability and access to care.
Organization(s): American Association on Health and Disability

Best Practices: The Johnson & Johnson — Dartmouth Community Mental Health Program: Disseminating Evidence-Based Practice
Document
This article lists dissemination strategies for a program focused on assisting individuals with psychiatric disabilities. The dissemination strategies outlined in the paper may be applicable to other disability programs.Author(s): Drake, R.E., Becker, D.R., Goldman, H.H., & Martinez, R.A.
Citation: Psychiatric Services, 57(3), 302-4

About this Toolkit

Toolkit Development

The Access to Care for Rural People with Disabilities Toolkit was first published on 12/13/2016.

Toolkits are developed based on a review of FORHP grantees' applications, foundation-funded projects, and an extensive literature review, to identify evidence-based and promising models. Programs featured in the toolkit are interviewed to provide insights about their work and guidance for other rural communities interested in undertaking a similar project.

Credits
This toolkit was produced by the NORC Walsh Center for Rural Health Analysis, in partnership with the University of Minnesota's Rural Health Research Center, and in collaboration with the Rural Health Information Hub (RHIhub).

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- RHIhub at 1-800-230-1898 or info@ruralhealthinfo.org

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RHIhub
Rural Health Information Hub

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