Charting New Frontiers

in Rural Women's Health Conference

Summary Report

August 13-15, 2007
Omni Shoreham Hotel
Washington, DC

U.S. Department of Health and Human Services
Office on Women's Health

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August 13–15, 2007 • Omni Shoreham Hotel • Washington, DC

Introduction

This report summarizes the proceedings of the Charting New Frontiers in Rural Women's Health Conference. Held August 13–15, 2007, at the Omni Shoreham Hotel in Washington, DC, the conference was hosted by the Office on Women's Health (OWH) within the U.S. Department of Health and Human Services (HHS). The conference brought together approximately 300 representatives from health departments and rural health agencies, associations, academic institutions, hospitals, clinics, and other providers, in order to increase awareness and replication of best practices that address the needs of women and families living in rural and frontier areas.

Conference Goals

OWH identified several goals for the Charting New Frontiers in Rural Women's Health Conference:

- ★ Discuss the latest sex- and gender-specific research and programs to improve the health status of women, especially rural women.
- ★ Translate sex- and gender-specific research into clinical practice by sharing programs and tools that have proven effective in applying the research and addressing the social concerns of women living in rural areas.
- ★ Share strategies with national and regional change agents to enhance effective outreach to rural women and their families and increase support for women's programs and services.
- ★ Provide hands-on workshops to teach participants how to implement programs in their own communities.

Conference Features

In addition to the 4 plenary and 16 workshop sessions summarized in this report, the Rural Women's Health Conference featured a series of poster presentations. Breaks during the conference were extended to provide participants with extra time to browse the poster presentations and talk to the presenters. Topics included cancer outreach, intimate partner violence, oral health strategies, using the Internet for health care and education, ayurveda and yoga, avoiding burnout, and more. Other conference features included the opportunity to earn continuing education credits through the Centers for Disease Control and Prevention (CDC) and a photo contest.

The first round of the photo contest was held online in the months leading up to the conference. The contest featured two categories—rural health and rural life. Using the conference Web site, a panel convened by OWH voted to determine the pool of 20 finalists. These 20 photos were displayed during the first 2 days of the conference. Conference participants voted to determine the winners, who were announced on the third and final day of the conference. Photos from both the winners and finalists are featured throughout this report.

This report also includes a summary of the conference evaluation. In addition, a list of the Conference Planning Committee is included in Appendix A and the complete Conference Participant List is included in Appendix B.

Background

It is estimated that 65 million people, or approximately one-fifth of the total population, live in rural/frontier areas. Frontier counties alone comprise about 56 percent of the land area and contain 49 percent of the water area in the United States. On a daily basis, people living in these areas must deal with everything the environment brings, including droughts, floods, tornados, and fires. In addition to the environment, rural/frontier people face numerous challenges that are difficult for people from urban environments to understand. When all a person sees is pavement, it is hard to grasp that in rural/frontier America, reaching the nearest service takes much more than jumping in the car. It could involve a drive of several hours, or even a plane ride. When a person living in a rural or frontier area needs health care, it is not just about making an appointment and showing up.

Photo Contest Grand Prize Winner

"Curiosity"
Leslie Morris, Sacramento, CA

When compared to urban residents, rural and frontier residents tend to have higher poverty rates, poorer health, fewer physicians, and fewer other health resources. Rural/frontier women are also more likely to suffer from heart disease, hypertension, and cancer than urban women residents.

Over the past 20 years, HHS has taken several steps to address the health disparities and challenges faced by rural/frontier people. In 1987, HHS established the Office of Rural Health Policy (ORHP) in the Health Resources and Services Administration (HRSA). Congress charged ORHP with informing and advising HHS on matters affecting rural hospitals and health care, coordinating activities within the Department that relate to rural health care, and maintaining a national information clearinghouse.

Since 1996, OWH has provided funding for the National Centers of Excellence in Women's Health (CoEs), a program designed to improve the health status of all women across the life span. In 2000, OWH created the National Community Centers of Excellence in Women's Health (CCOEs). The CCOE program is designed to integrate, coordinate, and strengthen linkages between programs and activities that are already underway in the community to enhance services available to women and reduce fragmentation in women's health services. In addition, since 2001, OWH has provided funding for the National Rural/Frontier Women's Health Coordinating Centers (RFCCs) to address the health status of the rural/frontier population. In 2005, OWH announced the funding of 8 new RFCCs, bringing the total to 11 centers across the United States.

The Charting New Frontiers in Rural Women's Health Conference represents another significant step in OWH's commitment to improving health care for rural and frontier women.

Welcome & Greetings

Wanda K. Jones, Dr.P.H., Deputy Assistant Secretary for Health (Women's Health) and Director of the U.S. Department of Health and Human Services Office on Women's Health, opened the 2007 Charting New Frontiers in Rural Women's Health Conference and welcomed participants. She noted that many of the conference's participants represent OWH's CoEs, CCOEs, and RFCCs—from whom OWH has learned numerous strengths and lessons that are making a difference in national women's program efforts.

Dr. Jones noted that people's thinking is often restricted by the area in which they live and work. For example, in Washington, DC, thinking is often restricted by the "Beltway," or the highway that circumscribes the metropolitan area. People frequently say that you have to get outside the Beltway to understand how the rest of America lives and interacts with the services the Federal Government provides. In most of rural America, life truly is a collaborative effort—women and men work together. Although there is still a division of labor by gender, you are just as likely to see girls and women doing the heavy work as you are to see men.

Dr. Jones explained how when it seems like everything is paved from Washington, DC to Boston, it is hard for people to realize that approximately one-fifth of the U.S. population lives in a rural area. It is also hard to understand that, day in and day out, people deal not only with environmental challenges, such as drought, floods, and wildfires, but also with the fact that getting to town takes much more than just jumping in the car. It could involve a drive of several hours.

Dr. Jones shared an example of a friend of hers who went to serve the Native American population in Alaska and had to take a plane every 6 weeks to get groceries. When you need health care in a rural setting like that, you do not just make an appointment and show up. It is a challenge if you have to return in 3 days and transportation is not reliable or readily available. She noted that one of the purposes of this conference is to share some of the success stories in overcoming these challenges.

> **"In rural America, life is truly a collaborative effort—women and men work together."**
>
> **—Dr. Wanda K. Jones**

Dr. Jones concluded by thanking the numerous people and organizations who helped make the conference possible. In particular, Dr. Jones thanked Marcia Brand from ORHP; the Planning Committee; Verizon Wireless; Samuel Allende and the Marshfield Clinic; the New York CCOE at St. Barnabas Hospital; the Scitor Corporation; the University of California, San Francisco CoE; the CDC for sponsoring the conference's continuing education credits; and the staff at OWH for their ongoing dedication and hard work.

Opening Plenary

The opening plenary session included three presentations. First, **Lori Arviso Alvord**, M.D., Associate Dean of Student and Multicultural Affairs at Dartmouth-Hitchcock Medical Center, offered her perspective on rural women's health gained from her work as a Stanford University-trained surgeon and her heritage as a Navajo woman. Second, **Hilda R. Heady**, M.S.W., Associate Vice President for Rural Health at the Robert C. Byrd Health Sciences Center of West Virginia University, discussed some of the valuable lessons that can be learned from rural women and the resilience of their spirits. Third, **Marcia Brand**, Ph.D., Associate Administrator for Health Professions, and Director of the Office of Rural Health Policy at the Health Resources and Services Administration in the U.S. Department of Health and Human Services, presented a practical four-step process for addressing the issues rural communities face.

The Scalpel and the Silver Bear: A Navajo Woman Surgeon's Story

Keynote speaker **Lori Arviso Alvord**, M.D., began her presentation by discussing her interest in two disciplines, psychiatry and surgery—the life of the mind and the life of the body. She explained how, although it seems that psychiatry and surgery should be connected, the two disciplines do not speak to each other. Yet psychiatry and surgery are incredibly dependent on each other. People's mind states are very relevant to their physical well-being and vice versa. She said there is one system of medicine that has never separated the two disciplines—Navajo medicine.

Photo Contest First Prize—Rural Health

"Rural Health"
Malalai Mateen, Del Mar, CA

Dr. Alvord spoke about the roles women and elders play in Navajo culture. In her father's and grandfather's generations, there were no Navajo physicians, attorneys, or engineers. During that time, people who worked in those professions were typically white. However, even though people did not have physicians or engineers as role models, they had guidance from the strength of Navajo women. People had "the voice of the wisdom of the grandmothers." According to Dr. Alvord, "This is missing in American society. If we are lucky, we hear it once in a while in a segment on Oprah. Our women and our elders have so much to show and offer us, if we listen."

Dr. Alvord went on to discuss her experience growing up in Crownpoint, New Mexico, where books were her only access to the rest of the world. She said the term "culture clash" cannot adequately describe the stark contrast between her childhood experience in rural New Mexico and her experience attending college at Dartmouth, which was 2,500 miles from her home.

At Dartmouth, Dr. Alvord earned a double major in sociology (Native American studies) and psychology. After college, she worked in a laboratory at New Mexico University and was encouraged to apply to medical school. Ultimately, she was accepted at Stanford University. During medical school, she was advised to specialize in primary care so that she could go back to New Mexico and help her people. Her perspective changed, however, when she met a Native American surgeon and witnessed how he was able to help patients using American medicine and still honor their heritage as Navajo people. This image carried her through medical school and shaped her into the surgeon, and woman, that she is today.

RAW Spirit: Resilience and the Rural American Woman

Plenary speaker **Hilda R. Heady,** M.S.W., opened her presentation by noting that she was the 2005 President of the National Rural Health Association (NRHA), a nonprofit, non-partisan membership organization that aims to serve as the voice for rural health care. She went on to explain that one of the purposes of her work as a rural health advocate is to focus on what is right about rural America, instead of focusing on what is wrong. According to Ms. Heady, in order to address the "new frontier" in improving health care and access for rural women, people need to consider and connect with the "old frontier," and learn from the strengths and challenges of rural culture.

"Our women and elders have so much to offer us, if we listen."

—Dr. Lori Arviso Alvord

> "It is important to go into situations with rural women and expect to be taught before we expect to teach."
>
> —Hilda R. Heady

Ms. Heady outlined the three main points of her presentation:

1. Rural women's values make them and their culture special.
2. Rural women's experiences and values guide their passion in all that they do.
3. Resilience is a hallmark reflection of rural culture.

Ms. Heady then explained her points. She noted that rural women have a natural affinity for putting people first. Whether rural women are factory workers or homemakers, they put people first—in advocacy, policy, work, and service. For these reasons, rural women have a lot to offer as teachers. According to Ms. Heady, "It is important to go into situations with rural women and expect to be taught before we expect to teach."

As part of her work promoting the positive aspects of rural America, Ms. Heady coined the phrase, "Rural Beatitudes©." The idea behind the phrase is that rural people learn life skills by dealing with things. Ms. Heady presented a list of her "Rural Beatitudes©:
Blessed are the rural for …

- ★ They are collaborators and self-reliant. If they cannot solve a problem on their own, they will band with someone else to get it done.
- ★ They value their families and are friendly people.
- ★ They value individualism and are personable, independent, and modest.
- ★ They are authentic, direct, unpretentious, and honest.
- ★ They are patriotic and go to war—and allow their children to be sent to war. Ms. Heady noted that research shows rural people and minorities serve in the military at higher rates than the rest of the population. For example, she said 35.7 percent of women in the military are African-American women, a figure which is not proportional to the general population.
- ★ They serve others without being asked.
- ★ They make goods and products for everyone else.
- ★ They have a deep faith, a sense of beauty, and a sense of humor.
- ★ They all deserve high-quality health care.

In closing, Ms. Heady noted that resilience is imbedded early and must be nurtured. "We must remember our special obligation to the next generation," she said. "Our faith in the human spirit is to know that its own sense of innate health can guide us in all our endeavors. Our efforts to define community are less important than our search for common unity."

What Can You Do About Issues Rural Communities Face?

Plenary speaker **Marcia Brand**, Ph.D., began her presentation by providing an overview of HRSA ORHP, which was established in 1987. ORHP was created to address problems that arose from the implementation of the Inpatient Prospective Payment System, which led to the closure of an estimated 400 rural hospitals. Today, ORHP advises the Secretary of Health and Human Services on rural healthcare issues.

Dr. Brand outlined several reasons the country has rural healthcare issues:

1. There is limited access to primary care and specialty care. In particular, it is difficult to obtain oral health care and mental health care.
2. The healthcare system is limited by infrastructure, including hospitals and clinics, providers, and emergency medical services. For example, in Washington, DC, emergency medical services are paid positions; while in rural America, they literally hold bake sales to fund these services.
3. The country is also limited by financing. One result of this limitation is that people are challenged to create economies of scale and to co-locate businesses. An example is the "lose it/tone it/tan it" business that is a nutritional store, workout facility, and tanning salon, all in one.
4. The country is limited by the special challenges rural communities face. These limitations include geography, population (the population is older with greater health disparities), Federal funding that is population-based, and cultural and social barriers.

Dr. Brand continued by stressing that healthcare providers must try to work directly with communities for a number of reasons:

1. There are many different ways to be rural; one solution doesn't fit all of the challenges.
2. Limited financial and technical expertise makes engaging local, State, tribal, and Federal governments difficult.
3. Rural communities cannot afford to make mistakes or engage in programs that will not work for them—they must get it right the first time.
4. Often, the Government does not hear from the rural communities.

With these reasons in mind, Dr. Brand outlined four simple steps healthcare providers can take to accomplish working directly and effectively with communities.

Step 1: Have the information

Dr. Brand explained there are numerous resources available for finding the information you need. One is the Rural Assistance Center at **www.raconline.org**. A second resource is ORHP—it can be accessed through **www.hrsa.gov** by clicking on Rural Health. Another extremely important resource that ORHP encourages people to use is the appropriate State Office of Rural Health. Dr. Brand noted that you can locate each State's Office of Rural Health by accessing the ORHP site and clicking on States.

Step 2: Decide if it is a policy or resource issue and at what level

If the issue is a policy issue, Dr. Brand explained you need to determine on what level it exists—Federal, State, tribal, or local. For example, if you do not know whether your area is in a Health Professions Shortage Area (HPSA), that is a Federal policy issue. If Medicaid does not pay for dental care, that is a State policy issue. If the county is no longer providing obstetrics and gynecology services, that is a local policy issue.

Dr. Brand noted there are numerous avenues for finding help with policy resources. On the Federal level, there are ORHP, the Centers for Medicare and Medicaid Services, other agencies in HHS, your Congressional delegation, and national professional organizations, to name a few. On the State level, there are the Governor, State legislature, State Office of Rural Health, and State organizations. On the local level, there are local government, local hospital boards, civic groups, and community organizations.

Photo Contest Finalist—Rural Life

"Snowy Butte"
Chris Singer, Monument Valley, UT

Dr. Brand then explained, if the issue is related to resources instead of policies, there are also several avenues communities can access to improve rural health care:

- ★ Rural Assistance Center (**www.raconline.org**) and other Web-based tools
- ★ ORHP's outreach and networking grants
- ★ Health Center expansions
- ★ National Health Service Corps, which is looking for health professionals
- ★ 3RNet—job placement service
- ★ Area Health Education Networks
- ★ Other HHS resources
- ★ U.S. Department of Agriculture, which has numerous non-agriculture resources
- ★ Foundations
- ★ State resources

Step 3: Determine who else cares about the issue

First, Dr. Brand noted, we must think beyond the healthcare sector. Educators and business people can be powerful allies. For example, if you are seeing children with unmet mental health needs, so are the schools. There are allies all around. Next, Dr. Brand stated, we must put the "good guys" out front. For example, if dental caretakers are talking about increasing access, it will be seen as a business proposition. But if you put the Parent-Teacher Association out in front, it will be seen as positive. Finally, we should not be afraid to "look up"—to both State and Federal officials.

Step 4: Set reasonable goals

Dr. Brand explained that when we are setting goals, we first must remember that rural communities have limited infrastructure. Next, we must be aware there is a "risk averse" culture of health care—rural communities simply do not take big risks. Finally, people must also think about

sustainability from the beginning—how to keep something going even if the State or Federal dollars go.

After outlining the four steps, Dr. Brand concluded her presentation by walking participants through the process using a familiar healthcare issue as an example—the lack of access to oral health care for adults and children in the community.

Dr. Brand reminded participants that step one is to have the information. For example, one-third of all adults have untreated cavities. In addition, tooth decay is the most common chronic childhood disease—it is five times as common as asthma and seven times as common as hay fever. Children miss 51 million school hours per year for dental problems and dental visits, and adults lose 164 million work hours per year. In addition, 108 million Americans lack dental coverage. For each adult without medical coverage, there are three without dental coverage; and for each child without medical coverage, there are 2.6 without dental coverage. In addition to these statistics, the scientific evidence that poor oral health has a significant impact on physical health continues to grow. In addition to this big-picture information, Dr. Brand noted that you also need to gather information on other levels. For example, you should be able to describe oral healthcare access in your State and community.

Photo Contest First Prize—Rural Life

"Old Gas Station"
Donna Dunaif, Portland, OR

After you have the information, Dr. Brand reminded participants that step two is to decide if it is a resource or policy issue. She noted that oral healthcare access is both a policy and resource issue. On the policy side, Medicare does not pay for oral health care. On the resource side, there is a lack of dental insurance, limited number of providers, and limited infrastructure.

Dr. Brand then walked participants through step three, which is to determine who else cares about the issue. In the oral health care example, potential collaborators on the local level may include employers, educators, provider groups, and especially local hospitals, considering the frequency of dental-related ER visits. On the State level, collaborators may include employers, educators, provider groups, hospital associations, the State rural health association, the State legislature, and State government. On the Federal level, collaborators may again include employers, educators, provider groups, and hospital associations, as well as the NRHA, Congress, Federal Government, American Association for Retired People, and the Children's Defense Fund, to name a few.

Finally, Dr. Brand reviewed step four, which is setting reasonable goals. She noted that this may include establishing a mobile clinic; recruiting an additional healthcare provider; getting other healthcare providers to perform some basic dental services, such as varnishes; or providing service through schools or nursing homes.

In closing, Dr. Brand stated that these are four straightforward strategies for thinking about rural health.

Workshops, Part I

Improved Quality of Life Through Weight Management

This presentation focused on an approach to helping fight obesity in the setting of a rural clinician. **Wendel J. Ellis**, D.O., Greeley County Health Services, started this informal program upon noticing that his prescriptions of diet and exercise were ineffective and that more people coming to the clinic with obesity were also suffering from depression.

Dr. Ellis opened his presentation by noting that obesity affects over 108 million Americans and greatly increases health risks for many conditions, including hypertension, type 2 diabetes, coronary heart disease, gallbladder disease, certain cancers, dyslipidemia, stroke, osteoarthritis, and sleep apnea. Obesity is defined as having a Body Mass Index (BMI) of 30, or higher. Dr. Ellis noted that in adults ages 20–74, the rate of obesity has risen from around 15 percent in 1976 to over 30 percent in 2003. As measured by the CDC's Behavioral Risk Factor Surveillance System, in 1995, no States had an obesity rate above 20 percent of the population. However, by 2000, 22 States had obesity rates over 20 percent.

Dr. Ellis explained that one of the reasons for the increase in obese adults in America is the increase in the size of servings. He then presented a series of slides, produced by the CDC, comparing the average number of calories in portions 20 years ago to the number of calories today. Due to the increase in portion sizes, Dr. Ellis noted that people ingest many more calories than 20 years ago, contributing to the increase in the number of obese Americans.

Dr. Ellis outlined the four different types of therapy for obesity: (1) diet and exercise, (2) pharmacotherapy, (3) behavioral therapy, and (4) surgery. He emphasized that the combination of a low-calorie diet, increased physical activity, and behavioral treatment is the most successful strategy for long-term weight loss and maintenance. This approach to weight loss should be attempted for at least 6 months before considering drug or surgical therapy.

Dr. Ellis then described the details of the program he has initiated in Greeley County, Kansas. After he sees a patient and diagnoses obesity, a variety of things happen. First, Dr. Ellis will work with a Registered Nurse (RN) to help educate the patient and develop a plan of action to help induce behavioral change. Dr. Ellis has taken the position that obesity is an ongoing condition, like diabetes, that cannot be addressed in one treatment cycle.

After the initial visit, the RN schedules weekly appointments with patients, providing emotional support and accountability to patients. The RN also helps patients keep food diaries, develop exercise programs, and set realistic weight-loss goals of 0.5 pounds per week.

In closing, Dr. Ellis presented testimonial letters from two of his patients who had managed to lose over 50 pounds each. Both mentioned the positive effects of a daily exercise routine and the importance of changes in lifestyle, as well as the enormous importance of the RN in helping them get through tough times in the program.

Health Experiences of Women Living in Rural/Frontier Communities

This presentation summarized the findings of a study supported and conducted by the Wyoming Health Council from 2006 to 2007 to explore the health-related experiences of women living in rural/frontier Wyoming. **Susan McCabe**, Ed.D., APRN, BC, Associate Professor, School of Nursing, University of Wyoming, and **Corinna Seely**, B.S., Contractor at the National Rural/Frontier Women's Health Coordinating Center, Wyoming Health Council, opened the presentation with an overview of the study.

Dr. McCabe and Ms. Seely noted that the researchers designed a qualitative study in which the main data collection method was focus groups. In addition, a nested study was conducted using photo-voice methodology, a process through which participants are given disposable cameras and asked to take photos of things in their communities that represent health to them. Once the photos are developed, the researchers discuss their meaning with the participants.

The major research question addressed by the study was:

- ★ What is the experience of health for a woman living in rural/frontier Wyoming?

Sub-questions included:

- ★ What are the main health concerns of women living in rural/frontier communities?
- ★ What are the supports and barriers to health?
- ★ What is the impact of the experience of living in rural/frontier communities on women's access to care?

The focus groups were conducted in six communities in Wyoming, representing various aspects of the State, including geographic region, economic base, and population diversity. Dr. McCabe and Ms. Seely noted that a "snowball" process with key informants was used to recruit women for the focus groups in each of the six communities. A total of 45 participants were recruited, ranging in age from 19 to 64, with an average age of 41 years. Ethnicity was self-reported, with approximately one-tenth reporting as Hispanic, and the remaining nine-tenths split evenly between white and Native American.

Dr. McCabe and Ms. Seely stated that the focus groups lasted between 50 and 80 minutes. Audio and video recordings were made of each session and researchers compiled field notes. In addition, participants completed health assessment surveys. The researchers also collected data from other sources, such as the chamber of commerce/visitor information center, newspapers, and phonebooks, as well as community photos. A mid-process review was conducted to determine whether changes to the protocol were necessary. As a result of the review, the researchers put more stress on the confidentiality of collected information, given the personal nature of the information discussed and the closeness of the rural communities.

The findings identified five main concerns that were consistent across all six groups:

- ★ Lack of health insurance and ability to pay for health care
- ★ Strong sense of own expertise in personal health and health-related issues
- ★ Competing needs related to the health of family members
- ★ Unavailability of quality mental health care
- ★ Difficulty of remaining healthy in a rural environment

> "Women are responsible for their own health and the health of their families—they are the glue."
>
> —Wyoming Health Council

Dr. McCabe and Ms. Seely noted that the participants identified several factors that support good health, including the rural lifestyle, which typically has less stress and is characterized by a more supportive community; meaningful personal supports, such as the church, family, animals/pets, and nature; the importance of personal independence and self-reliance; and easy access to health information, most often via the Internet. Participants also identified several barriers to good health, including the rural environment, especially the difficulties of travel (e.g., distance, time, and cost); environmental pollutants; disrespect and cultural bias on the part of providers; the fragmented nature of care (i.e., having to travel to multiple sites to obtain services); and limited care options.

The overarching findings from the study were:

- ★ Women are "straddling the line"—at any moment something could happen that could result in catastrophe.
- ★ Rural areas were perceived as both the best and the worst place to be in terms of health.
- ★ Many factors affect overall health and access to health care.
- ★ Women are responsible for their own health and the health of their families—they are the "glue."

Women's Behavioral Health Systems Building: Innovative Ideas for Local and State Collaboration

This presentation showcased an innovative women's behavioral health program from Maine. **Anne Conners**, M.A., B.A., Project Specialist at the Muskie School of Public Service, University of Southern Maine, began the presentation by noting that substance abuse and depression are growing problems in the State of Maine. Issues include prescription drug abuse and binge drinking. In addition, Ms. Conners noted that one in five Mainers report experiencing depression. To help address these issues, Maine received a Women's Behavioral Health Grant from the HRSA Maternal and Child Health Bureau's Division of Perinatal Systems and Women's Health.

Ms. Conners explained that the vision of Maine's Women's Behavioral Health initiative was to integrate screening for depression and substance abuse for women of reproductive age into the primary care setting in rural underserved areas. She went on to explain that the program targets areas from all over the State. One of the project highlights is that it aims to involve systems, not just health centers. It also emphasizes public-private organizations and the involvement of grassroots organizations. In addition, because the HRSA grant is nonrefundable, there is a large effort to build sustainability.

Ms. Conners stated that project designers selected four primary locations in four counties. Since the State of Maine is the largest of the New England States, some sites are as far as a 5- or 6-hour drive apart, and distance is a constant challenge. The program designer's methodology included three coordinating entities—the Women's Behavioral Health Grant Steering Committee, the Women's Behavioral Health Systems Initiative Advisory Group, and the Demonstration Sites Leadership Team. Each of the three entities contributed something unique to the project.

Ms. Conners noted that although the project is still in progress, they have already learned many valuable lessons. Maine has a strong sense of community—people really do pitch in and help each other. The health centers ended up sharing information and resources, rather than competing with each other. If one health center had a good idea, it would share it with another. Another thing they discovered was that women were more likely to come to an event if there was a connection to their children.

In closing, Ms. Conners stated that one of the most exciting outcomes of the program is that all four health centers plan to do universal screening. Their first step is to implement the screening for chronic disease patients. It is important to acknowledge that although the process is difficult, what helps is having support along the way. They have also achieved policy changes—their project was written into the State health plan.

Integrating Cognitive Behavioral Therapy in Primary Care Treatment of Depression and Anxiety for Rural Women

This presentation summarized a program developed by the Radford School of Nursing to educate primary care providers in cognitive behavioral therapy (CBT). It was presented by Radford School of Nursing faculty **Janet McDaniel**, Ph.D., Professor of Nursing; **Laura LaRue**, APN-BC, Instructor; and **Sarah Strauss**, Ph.D., Professor of Nursing.

Dr. McDaniel began by noting that Radford University is located in the Blue Ridge Mountains of Southwest Virginia, approximately 13 miles from Virginia Tech. There are numerous challenges to providing mental health care in the area, including a lack of insurance and a lack of providers. Many primary care providers and nurses are not trained as counselors. In addition, there is a lot of stigma associated with mental health in rural areas. Transportation is also a problem, and there are long waits for appointments. Dr. McDaniel explained that Radford University received a grant from the Virginia Health Care Foundation to educate providers in CBT. She went on to explain that CBT is a psychotherapeutic model that engages the client in a collaborative manner to examine the way she constructs and understands her world (cognitions), evaluate the process by which the individual

acts on cognitions (behaviors), and challenge targeted behaviors and cognitions to gradually change a client's way of thinking, behaving, and interacting. Dr. McDaniel noted that once you can modify the way of thinking, it results in symptom improvement.

Dr. McDaniel outlined the three program objectives:

1. Identify mental health needs of rural women
2. Discuss cognitive behavioral strategies appropriate for primary care
3. Discuss issues in providing CBT in the primary care setting

Dr. McDaniel then explained that the university developed a three-credit course that focused on preparing advance practice nurses (APN) to provide CBT. Eleven providers participated in the three-credit course. Overall, 717 women and men were screened for depression, and 480 were screened for anxiety. Of those screened, 168 were recommended for further mental health services, which was mostly CBT.

Ms. LaRue then summarized some of the issues they encountered regarding CBT in primary care. They included commitment, integration, time factors, and dealing with CBT codes and documentation. Next, Dr. Strauss walked participants through a sample screening.

Dr. McDaniel concluded the presentation by summarizing the outcomes and findings. She noted that CBT was provided for 57 women experiencing depression and anxiety over a period of 7 months. Seventy-five percent of the clients experienced decreased depression and anxiety scores and adhered to their medications.

Dr. McDaniel stated one key finding was that those with high Beck Depression Index and Beck Anxiety Index scores could be handled in the primary care setting if there was no threat of harm to self and others. In fact, she noted that most clients rejected referral to outside settings and wanted to stay inside the primary care setting. The staff also found that clients had an improved ability to identify and use resources. Dr. McDaniel explained that the clients were better equipped to make decisions about their care. When confronted with new challenges, they self-referred themselves back to the primary care provider.

Before It Starts: Domestic Violence Prevention in Rural, Frontier, and Geographically Isolated Communities

This workshop provided an overview of the DELTA (Domestic Violence Prevention Enhancements and Leadership Through Alliances) approach to domestic violence prevention. It was presented by **Joshua Edward**, M.H.P. (in progress), DELTA Project Coordinator, Alaska Network on Domestic Violence and Sexual Assault; **Karen Lane**, M.Ed., State DELTA Project, Coordinator, Montana Coalition Against Domestic and Sexual Violence; **Janelle Moos**, M.S., DELTA Project Coordinator, North Dakota Council on Abused Women's Services; and **Jennifer Wages**, M.S.W., LCSW, Project Coordinator, Center for Rural Health.

The presenters began by explaining that the DELTA initiative is the CDC's primary domestic violence prevention effort utilizing a public health approach to address intimate partner domestic violence. The initiative includes 14 State Domestic Violence Coalitions and focuses on preventing first-time perpetration and first-time victimization.

The presenters noted that intimate partner domestic violence is defined as physical violence, sexual violence, threats of physical or sexual violence, psychological/emotional abuse, and stalking between current spouses, former spouses, current non-marital partners, and former non-marital partners. Many practitioners and researchers use the term "domestic violence" rather than the term "intimate partner violence" to refer to the same public health problem. The presenters explained that the DELTA program uses the term "intimate partner violence" to clarify that this program does not address other public health problems that are also referred to as domestic violence (e.g., child abuse and elder abuse by relatives other than an intimate partner).

DELTA is a population- and environmental-based system level of services, policies, and actions that prevent intimate partner violence from initially occurring. It uses a community level process to identify risk factors and maintain prevention implementation.

At its core, the presenters explained that the DELTA program is a collaborative community-based effort that incorporates sustainability from the very beginning of the initiative. It views sustainability not as getting funding, but as planning and supporting efforts to incorporate prevention initiatives into existing community institutions; making policy changes in the rules, regulations, and laws of the community; mobilizing community residents to own and lead prevention efforts; and finding sources of revenue to support ongoing activities of the effort. Its goal is to bring about long-term success by effecting social change.

Listen to Women: Meeting the Needs of Rural Women

This presentation highlighted approaches for providing gender-appropriate care through health provider recruitment and retention. **Jill Alliman,** M.S.N., CNM, Center Director and Nurse Midwife at the Women's Wellness and Maternity Center National Rural/Frontier Women's Health Coordinating Center, and **Julia Phillippi**, M.S.N., CNM, Lecturer at Vanderbilt University, began by explaining that "Listen to Women" is a slogan designed to remind providers to listen to the women they serve.

Ms. Alliman and Ms. Phillippi explained that two primary questions health care providers must ask are:

1. Do women have the services they need?
2. Do they feel "heard"?

Ms. Alliman and Ms. Phillippi asserted that these questions matter to women, because there is a shortage of care, and women are the gatekeepers. They often make health decisions for multiple generations. We need to provide gender-appropriate care and reduce the stigma of access to care. Ms. Alliman and Ms. Phillippi noted that the shortage of care also matters to providers. They explained that because of the shortage, there is an increased load on existing providers, in addition to the financial burden of care, the malpractice crisis, and wanting to meet the client's needs.

Ms. Alliman and Ms. Phillippi noted that the Women's Wellness and Maternity Center was established 23 years ago in response to the shortage of care in the area. It was established primarily for prenatal care and delivery services, but has added more services over the years. Through its designation as an RFCC, the Center has expanded its focus to include increased primary care, a continued

emphasis on gender-based care, a referral and tracking system, leadership development, community outreach, and research and data collection.

The presenters explained that as we look at ways to increase access, we need to look at providers' scope of care. Several national organizations have information on provider scope of care on their Web sites. They noted that providers can also turn to State organizations and boards that regulate practice. They asserted it is especially important to look at reimbursement rates and the larger regional network. Just because something does not work now, does not mean it will not work 5 years from now. They emphasized that providers must keep trying.

Ms. Alliman and Ms. Phillippi suggested that when providers look at their facilities' scope of care and what they can add, they need to think out of the box. They explained a clinic may be really busy, but it may be possible to add a nutritionist—she really only needs a desk and two chairs. They went on to suggest that providers can also look at expanding hours—many women are willing to work at the facility into the evening, when their husbands can take care of the children. The presenters explained the challenge is sustaining the model over time. Providers should be encouraged to think of their model as dynamic and to think outside of the walls of the clinic.

Photo Contest Second Prize—Rural Health

"Dr. Thompson"
Anna Day, Blanding, UT

Women Health Providers for Rural Communities: Supportive Networks to Ensure Recruitment and Retention

This presentation highlighted one center's perspective on achieving gender-appropriate provider recruitment and retention. **Barbara Levin**, M.D., M.P.H., Medical Director of the Women's Wellness and Maternity Center, began by noting that the retention and recruitment process for finding and keeping women providers in rural communities is an ongoing challenge. When Dr. Levin attended medical school, approximately 3–7 percent of students were women. Women now represent over 50 percent of students in medical school, and more women choose primary care specialties. However, Dr. Levin noted, fewer women choose rural practice than men.

Dr. Levin explained that the future impact of this issue is that more women in primary care may mean fewer providers in rural communities. Yet, she noted, documents show that very few people are dealing with the issue on a policy level. The World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) issued a resolution in 2000 stating, "Rural practice should reflect the way women experience their lives." Dr. Levin explained this issue is important, because we frequently

have to innovate. We need to think outside of the box, because in rural places, there is not a box (e.g., a dental center in a health clinic).

Dr. Levin stated that in Monroe County, Tennessee, non-physician providers include 4 dentists (2 have stayed and 2 have left), 20-plus nurse practitioners (11 are still in practice), and 14 Certified Nurse Midwives (4 are still in the county). Dr. Levin then introduced her intern, **Alana Sagin**, a second-year medical student at Jefferson Medical School in Philadelphia, PA, who conducted a pilot study of two East Tennessee counties on the issue of recruitment and retention.

Ms. Sagin presented the results of her study. She began by explaining that she developed a questionnaire, which she followed with a face-to-face interview with 20 percent of respondents. One thing she learned immediately is that reasons for coming to the county and reasons for staying were fairly similar. She noted that one of the most common issues was spouse/work opportunities. Other important issues were difficulties adapting to small-town life.

Dr. Levin then noted that nearly all women surveyed had heard about the Women's Wellness and Maternity Center. It was clear that Monroe County had become a place where you go for women's health concerns, which was due in large part to the Center's work.

Dr. Levin discussed how she started conducting Leadership Luncheons to help health care providers recognize that they are part of a larger network. She noted that nurse midwives and practitioners were more likely to participate in the luncheons than physicians and dentists, which is evidence that there is still a great need for cross-discipline interaction. Dr. Levin concluded by explaining that when you are looking for women providers, it is very important that they are embedded in the network.

Bridging Gaps in Access and Quality for Women Through Telehealth Programming in a Rural Federally Qualified Health Center

This presentation demonstrated how telehealth can be used effectively to improve health care for rural women. **Juliana Anastasoff**, M.S., Chief Project Officer at El Centro Family Health and Director of the National Rural/Frontier Women's Health Coordinating Center, began by noting that El Centro Family Health serves a 7-county region of 23,000 square miles with a population density of 0.05–12.1 percent. She explained that the region is characterized by remote mountain villages, many of which lack public infrastructure. For most of the year, road conditions are poor at best and even hazardous during certain times. In the region, 70 percent of the population is at or below 200 percent of the poverty level, and 43 percent is uninsured. Ms. Anastasoff noted that all but one of the 33 counties in the region is classified as an HPSA.

Photo Contest Second Prize—Rural Life

"Partners"
John Bice, Rhodesville, VA

Ms. Anastasoff reported that El Centro received a grant from the NRHA to fund a program that provided technical assistance for the development of telehealth capabilities. Telehealth was an attractive option to El Centro because it can be a useful tool to reduce health disparities; maximize effective utilization of resources; reduce isolation of rural clinicians; facilitate the practice of evidence-based medicine; and enable continuous quality improvement.

Ms. Anastasoff explained that the NRHA grant enabled El Centro to hire a highly qualified consultant to help them with this effort. They identified patient needs through surveys, charts, and meetings with the community, and provider needs through focus groups. El Centro also assessed its own needs by consulting middle managers, senior leadership, clinical leadership, and the Board of Directors. The final plan prioritized:

- ★ Tools to assist clinicians in making decisions
- ★ Access to specialist care
- ★ Communication between rural health providers
- ★ Improved internal communication
- ★ Improved management of patient data

Photo Contest Third Prize—Rural Health

"Wow! What Beautiful Eyes"
Alice Haenggi, Columbus, NE

Ms. Anastasoff went on to explain that the technology they identified for achieving these objectives included electronic health records, mobile computing devices, wireless Internet access, and videoconferencing. Another technology-related effort of El Centro is its Web portal targeting women and girls. Currently, it serves 1,300 users. She concluded by noting that the Web-based approach is especially good for rural teens, since many of them are very isolated.

Telehealth: Shrinking Barriers and Expanding Opportunities for Health Care

This presentation highlighted an innovative telehealth network in the State of Utah. **Deborah LaMarche**, B.S., Program Manager at the Utah Telehealth Network (UTN) began by stating that UTN's mission is to expand access to health care services and resources within Utah and the intermountain West through the innovative use of technology. UTN was initiated in 1996 and is operated by the University of Utah. The network is open to any Utah healthcare provider and there are currently over 40 members.

Ms. LaMarche explained that telehealth is defined as the use of electronic information and telecommunications technologies to support distant clinical health care, professional health-related education, public health, and health administration. Telehealth includes videoconferencing, teleradiology, telepharmacy, remote monitoring, and home health. It allows for real-time, interactive communications, is user-friendly, and is typically rated positively in patient satisfaction surveys.

Ms. LaMarche noted that while patients report telehealth is not as good as seeing a provider face-to-face, they find it much better than having to drive long distances to see a provider. In Utah, telehealth has resulted in less isolation, travel, and waiting by patients, as well as improved access, quality, value, and continuity of care.

Next, **Donna Jensen**, Women's Health Director of the Utah Navajo Health System National Rural/Frontier Women's Health Coordinating Center, stated that one example of UTN's partners is the Utah Navajo Health Association (UNHA), a federally designated 330e community health center that provides medical, dental, and behavioral health services. UNHA uses telehealth for telepharmacy, services such as retinal eye exams, echocardiograms, and x-rays. Ms. Jensen explained that an important component of UNHA's services is the use of electronic medical records, which allows providers across sites to access patients' medical records and facilitates tracking of services.

Photo Contest Third Prize—Rural Life

"Evening Light"
Alec Hartman, East Vassalboro, ME

Since initiating the system more than 10 years ago, Ms. Jensen reported that UTN has learned important lessons related to all aspects of telemedicine. She noted that there are a variety of strategies for optimizing telehealth, depending on the setting. For example, with patient care, it is important to ensure that there is written consent from the patient, and that providers introduce everyone in the room and do not allow any interruptions. Ms. Jensen concluded by stating that telehealth is also very effective in educating providers. She asserted that such techniques will make educational opportunities available to many more providers and potential providers.

Cancer Suvivorship in Rural Communities

This presentation summarized research on rural cancer survivors. **Camille T.C. Hammond**, M.D., M.P.H., a Program Director at the University of Maryland School of Medicine in the Office of Policy and Planning, began by noting that cancer survivors have been tracked as a group since 1971. She stated that in the broadest definition, anyone diagnosed with cancer is a cancer survivor from the time of diagnosis to death. Some definitions also include caregivers and family members of diagnosed cancer patients as cancer survivors.

Dr. Hammond reported that around 10.7 million Americans are cancer survivors, which is about 3.6 percent of the population. She explained that the number of cancer survivors has increased over time because of increased accuracy in detection, more effective treatments for cancer, better supportive care, and better long-term surveillance. Cancer has become more of a chronic illness, rather than a death sentence, that is addressed within the community (not as many trips to out-of-town specialists).

Dr. Hammond explained that rural cancer survivors have increased risks for poor outcomes, such as second

primary cancers, late physical and psychological effects of cancer and its treatment, unemployment following cancer diagnosis, and dealing with role adjustment (especially rural women, who feel being a patient interferes with nurturing social roles). Oftentimes, rural cancer survivors deal with senses of helplessness, hopelessness, post-traumatic stress disorder, lack of emotional support, and the physical distance from adequate care and information.

Dr. Hammond noted that rural caregivers (the informal support provided by family and friends) also need help due to limited access to healthcare services, transportation problems, and geographic/social isolation. They need clear and consistent messages about treatment goals and better coordination between healthcare services.

Dr. Hammond said that healthcare providers noted the need for training in treating cancer survivors. Many primary care doctors are unaware of the possible side effects and long-term health issues associated with specific cancer treatments. She reported that providers also suggested a "care plan" be given to patients following cancer treatment, so they are always aware of the treatments used, type of cancer treated, possible late side effects, and additional information that would be useful for other doctors to know before treating the cancer survivors.

Dr. Hammond concluded by stating that survivors want to know how to reduce the effects of cancer, how to decrease their risk of developing new cancers, and where they can find doctors familiar with late-term cancer effects. In the future, we need interventions to improve quality of life for underserved cancer survivors, provide support for informal caregivers, and train doctors to increase awareness about evidence-based followup care.

Poverty and Community Food Resources as Determinants of Insufficient Household Food Resources Among Rural Women

This presentation summarized the findings of studies on rural women's nutrition. **Joseph Sharkey**, Ph.D., M.P.H., RD, Associate Professor at the School of Rural Public Health, Texas A&M Health Science Center, Social and Behavioral Health Department, opened the session by noting that rural women have many challenges to a healthy lifestyle, including high levels of chronic conditions, low levels of available health support, poorer housing, limited transportation, and limited access to resources and programs.

Dr. Sharkey explained that healthful eating training is focused on the individual choice level, without taking into account issues of adequate resources, food environment, and food security/food sufficiency. He went on to explain that connecting the Brazos Valley Health Status Assessment (BVHSA) and the Brazos Valley Food Environment Project (BVFEP) allows a snapshot of rural women's health to be studied in the context of physical surroundings.

Dr. Sharkey stated that the BVHSA surveyed over 2,000 individuals, of which over 60 percent were rural inhabitants. Of rural participants, 73 percent were women. Many households had children, and many also had nutrition-related conditions, like diabetes, obesity, heart issues, and hypertension. He noted that the survey found that rural women had higher percentages of food insecurity (ran out of food, no money for more); unbalanced meals based on cost (too expensive to eat healthy); and skipping meals to spread out food supplies. Rural women also reported a much higher feeling of dissatisfaction with the variety of choices available, number of stores nearby, and food cost.

Dr. Sharkey explained that the BVFEP mapped all of the food stores available in the area by satellite and allowed researchers to see where respondents lived in relation to store locations. Forty-one (41) percent of rural women lived 10 or more miles one way from the nearest supermarket, whereas most lived closer to a convenience or small grocery store. Because the area has no public transportation, access to different types of food supplies severely limits food choices for many. Since supermarkets are hard to access, rural women face higher food costs, less healthy food choices, less fresh food, and increased risk of inappropriate food choices. Rural women also are at a higher risk for increasing levels of insufficient household food resources due to limited financial resources, children at home, and limited community food resources.

Dr. Sharkey concluded by stating that the findings of these studies suggest that there needs to be an increased focus on rural areas and rural women. He noted that they also suggest the importance of comprehensive community health assessments that include the context in which people live, including households, neighborhoods, and communities.

Promoting Heart Health in Rural Women: The Halfway Perspective of an Intervention Study

This presentation summarized the preliminary findings of a study being conducted on rural women's heart health. It was presented by **Pamela Stewart Fahs**, D.S.N., Associate Professor, Endowed Decker Chair of Rural Nursing and Health at the Decker School of Nursing, and **Margaret Pribulick**, RN, a student in the Rural Nursing Ph.D. Program, both of Binghamton University. Dr. Fahs and Ms. Pribulick began by stating that the New York Women's Health Care Partnership, based at Binghamton University, and a research team at the University of Virginia are conducting an intervention study to determine whether rural women receiving Stage Matched Nursing & Community Intervention (SMNCI) have greater lifestyle behavior changes to support heart health than women who receive only Community Intervention (CI).

Dr. Fahs and Ms. Pribulick explained that the study is looking for measurable differences in SMNCI vs. CI in dietary, smoking, and physical activity of rural women in Orange County, VA, and Delaware County, NY. The presenters noted that the outcomes to be measured include:

- ★ Stage of change (SOC) for each behavior—diet, smoking, and physical activity
- ★ Movement in SOC over time
- ★ Change in modifiable physiologic and cardiovascular risks (BP, BMI, Lipids, C-Reactive Protein, Framingham Coronary Heart Disease Risk Score)

Dr. Fahs and Ms. Pribulick noted that many of the women participating in the study felt they were already in the action or maintenance stage in one or more behaviors. Seventy-six (76) women self-reported action in diet (eating 5 or more fruits and vegetables per day), while 24 women said they had stopped smoking more than 6 months ago (maintenance) and 44 reported they had 30 minutes of physical activity on 3 or more days of the week.

Dr. Fahs and Ms. Pribulick explained that enrollment in the intervention study is three-quarters complete, and researchers are just receiving the 7-month questionnaires for the first enrollees. Before any speculation about changes or results can be reported, the next 7-month

questionnaires are needed. The presenters went on to explain that what the study does present is that the women enrolled are overweight, have one or more behavioral issues, show beginning level risk factors, and have more abnormal electrocardiograms (ECGs) than expected. They concluded by noting that while there is currently not enough data to indicate that there are stage changes for any of the behaviors or changes in the physiologic outcomes that are normally associated with cardiovascular risk, what can be said is that the women have increased their healthy behaviors just by being part of the study.

Going Red in Rural West Virginia

This presentation summarized the findings of a pilot project on women's heart health. It was presented by **Elaine Bowen**, Ed.D., West Virginia University Extension Specialist–Health Promotion at the Extension Service National Center of Excellence in Women's Health, and **Sharon Brinkman-Windle**, M.P.A., M.A., West Virginia University Mary Babb Randolph Cancer Center. Dr. Bowen and Ms. Brinkman-Windle began by explaining that the West Virginia Women Wear Red for Heart Health Pilot Project uses an aggressive, yet personal, woman-to-woman approach to bring culturally appropriate heart health information to rural women through a variety of communication channels

Dr. Bowen and Ms. Brinkman-Windle reported that the first step of the project was to create a community advisory board, consisting of community stakeholders such as CEOs, university stakeholders, local opinion leaders, and local health entities—to explore what women would want in an education program. The group then conducted various focus groups to learn from women in the community their experiences with heart health messages and care, explore what they thought a successful heart health education event would look like in their community, and what they thought was important to know about heart health.

Dr. Bowen and Ms. Brinkman-Windle stated that from this information, the project organizers developed four main events:

- ★ A Heart of the Mountain video that presented stories of West Virginia women who were heart disease survivors
- ★ Heart Health is Fashionable—a health education lunch and fashion show
- ★ Training events for extension personnel on how to hold "Love Your Heart Talks" for heart health education
- ★ Media outreach timed to correspond with the American Heart Association Go Red campaign

Dr. Bowen and Ms. Brinkman-Windle reported that the response to all methods of community communication was overwhelmingly positive. Women indicated they liked the focus groups as an opportunity to shape the events. Women connected with the stories in the Heart of the Mountain video and could identify with the survivors. The video was featured at American Heart Association media events and distributed to 173 public libraries.

The pre- and post-tests from the Heart Health Is Fashionable events showed significant changes on all metrics used and was replicated to reach a total of 401 women. The training in Love Your Heart Talks reached 12 women in Wood County, and 16 community organizers were trained at statewide training, who will then train women in their communities.

The presenters concluded by reporting that the program has ongoing support from the American Heart Association and additional community trainings are scheduled. In addition, the results of the pilot will be published in scholarly journals and the State Medical Journal.

Plenary Session

Native American Medicine: A Model for Creating Healing Environments

Keynote speaker **Lori Arviso Alvord**, M.D., Associate Dean of Student and Multicultural Affairs at Dartmouth-Hitchcock Medical Center, opened her presentation by reading a passage from the book she co-authored titled, *Native American Medicine: Ancient Wisdom for Modern Times*. The passage was from the chapter called "Ceremony Medicine." It is the story of a woman with breast cancer whom Dr. Alvord tried to convince to have a Native-American ceremony before trying surgery. The ceremony is called the Night Chant.

Photo Contest Finalist—Rural Life

"Shawls and Backpacks"
Deborah Scott, Houston, TX

Dr. Alvord continued by explaining that to talk about Navajo healing, we need to consider work at the Massachusetts Institute of Technology on "systems thinking," which is a way of understanding complex systems. She went on to explain that "systems thinking" is useful when thinking about large systems like ecosystems or healthcare systems. Some of the components of the system are almost invisible until you point them out.

Dr. Alvord went on to explain that a systems approach to illness and wellness would look at all levels of a human being's environment. She stated that body, mind, and spirit are part of a family; which, in turn, is part of a work environment. The work environment is part of a community, which, in turn, is part of a global environment. Dr. Alvord noted that illness can occur at any of these levels—body, mind, spirit, family, work environment, community, or global environment. Navajo Diné (people) say illness can occur at any point in life, and when it occurs, it is because of a lack of balance. Illness affects the body and the mind, as well as relationships with other human beings and animals.

Dr. Alvord then explained more about Navajo ceremonies. She said it is hard to describe a Navajo ceremony and do it justice in a limited amount of time, but if there is one concept that is at the heart of the ceremony, it is "hózho."

Dr. Alvord said that hózho is defined as a mixture of beauty, harmony, balance, and peace. It is a state of being and a way of being. It is a part of a larger phrase, "Sa'a Naghai Bike'e Hózho," that translates to "moving along the life path with spiritual balance and harmony." She explained that hózho is similar to yin and yang. It is the name of the force in the universe that created all things. The concept is that the creator created all things and is also in all things. As a result, she said, separateness is an

illusion. In contrast, it is hard to think of the American concept of the individual. If you believe that everything and everyone around you are part of you, then you want everything and everyone to be well, and to do well, too. It is like a prism. She said that in ceremony, the word "energy" is the closest word that can be used to describe the concept.

Dr. Alvord explained that Navajo ceremonies teach people to think. Words have great power—Navajo Diné believe that it is possible to speak or think something into existence. She said there is evidence of this concept in American culture, too. Research has shown that athletes who envision success often perform better. They are thinking something into existence. She noted that corporations do the same thing through mission statements and strategic planning.

Photo Contest Finalist—Rural Life

"Morning Breath"
Tammy Donaldson, Tellico Plains, TN

Dr. Alvord went on to explain that in American medicine, psychoneuroimmunology is a blossoming field. She reported that Dr. Herbert Benson, Emeritus of the Benson-Henry Institute for Mind-Body Medicine and Assistant Professor at Harvard Medical School, has found that various mind states do influence the body, including the body's ability to fight infection and cancer. However, the majority of systems have not yet adopted this way of thinking.

Dr. Alvord noted that there is, however, a movement called guided imagery, which is used to calm a person before a surgical procedure. It has been shown to significantly reduce anxiety, pain, and the narcotic requirements of surgery, and to increase patient satisfaction. In Navajo culture, ceremonies, sand paintings, and dancing are elaborate forms of guided imagery. It is, therefore, ironic that the Navajo concepts have been called primitive, while guided imagery is considered progressive. Dr. Alvord also noted that when considering the concept of guided imagery, it is important to consider the reverse—how images that people are receiving from the news, television, and video games can have negative effects.

Dr. Alvord explained how in traditional Navajo culture, if you wanted to survive, you had to do it yourself. If you wanted to eat, you had to hunt or grow your food, or make something that could be traded. She noted it was a very vigorous physical lifestyle, but it was a lifestyle that ensured bodies were active and strong. She said issues like osteoporosis were nonexistent. She went on to explain that human beings were meant to use their bodies. Modern machines, such as lawnmowers, microwaves, and cars, promote not using the body. She noted that obesity is now one of the top medical issues in our country today. Obesity affects almost every other illness. Becoming a couch potato culture promotes illness.

Dr. Alvord stated that traditional Navajo diets were based on grains, vegetables, fish, and meat, and were high in fiber. She said this diet is better suited to a healthy lifestyle, and asserted that simply returning to traditional diets,

to what we used to eat, may reduce health disparities, including obesity.

Dr. Alvord then explained that Navajo Diné believe that human beings are part of all things in the universe, including the winds. Our breath is part of this wind. Health is the well-being of all things in the universe. The universe has a consciousness, and we are a part of that. Spirituality, as practiced through ceremony, strengthens the bonds between human beings, families, communities, animals, and the environment. She explained how Navajo's view the natural world as sacred and refer to it as a family. The earth is a mother, the sky is a father, and the bear is a brother. The things that we seek to protect are those that we consider family. By assigning this value to the animal world and natural world, we become protective of them. She went on to explain that this is a concept of interconnectivity. She noted that we are seeing the effects of not thinking this way—toxic water, toxic earth, and global warming. Change is needed quickly.

Photo Contest Finalist—Rural Health

"Rural Hospital Transfer"
Clare Wilmot, Littleton, NH

Dr. Alvord reported that America represents 5 percent of the world's population, but it consumes more than 25 percent of the world's resources. For some reason, she said, there is no dialogue about living in balance and drawing too much from our natural world. Dr. Alvord asserted that what we need is a systems approach—if we want to be healthy as human beings, we need clean air, clean water, and a clean earth.

Dr. Alvord explained how through ceremonies, people develop mental wellness, which helps promote physical wellness. Spiritual wellness influences family, community, and planetary wellness. She noted that ceremonies also are said to energize the healers, which is something not built into modern medicine.

Dr. Alvord then discussed how these concepts can help us form a new way of thinking about health care. She said if you consider a systems approach, if mind-states matter, if you can influence the minds of patients, you may be able to influence their care. She noted that one important part of this concept is using the power of all of the senses to promote healing. She said there have been numerous studies on this concept. There was the study on guided imagery. There was also a study on the power of touch—babies who were not held did not survive. She suggested the same may go for elders. Yet another study showed the power of music therapy in getting patients off ventilators by listening to music.

Dr. Alvord noted that pet therapy and art therapy are also powerful healing tools. Animals can often reach people when others cannot. They have been used with people with mental illness and children with autism. She said animal contact results in decreased loneliness, improved

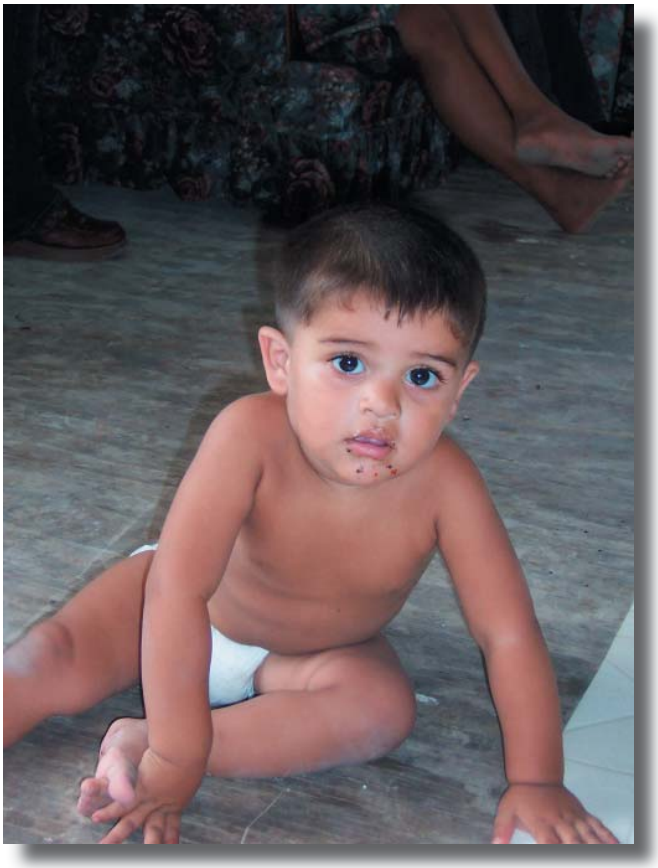
morale, and increased social interaction. Animals can produce higher levels of relaxation among patients and can play a role in promoting optimal holistic health. She explained that art may also help the mind become relaxed, energized, or happy. It may reduce stress, and therefore, augment the immune system to help fight disease. She noted that art is woven throughout Native culture and medicine and used extensively in Navajo ceremonies.

Dr. Alvord then described how another powerful healing tool can be the beauty of the environment. She said that in health care, the environment around us should be beautiful too—we should be surrounded by things that calm patients. She emphasized that it is important to think about things from the patient's perspective. We should use art, color, and lighting to create patient spaces whenever we can.

Dr. Alvord went on to describe how the model goes beyond patients to medical teams. In order to provide good medical care, medical staff must be happy. She said the system should reward teams that practice this. Mistakes happen when teams have low morale. It is a domino effect. Sleep deprivation is part of this, as is family. Work must include family, too. She explained that people function best in their work environments when they are able to take family considerations into account. She suggested that some approaches might include onsite daycare, flexible work schedules, and including families in events.

Dr. Alvord concluded by stating, "The ideal hospital would not smell like a hospital—nor would it necessarily look like a hospital. Perhaps it would have adobe walls and natural smells. It would be filled with light and warm, with generous and comfortable seating for relatives. The windows would not be square and chrome but rather round or arched. There would be porches, flowers, and gardens. In addition to state-of-the-art operating rooms and equipment, there would be a ceremonial space for use by anyone who felt the need for it. Most important, when patients entered, they would feel that every person they encountered was committed to their comfort and participating in their healing process."

Photo Contest **Finalist—Rural Life**



"Barefoot Baby"
Julie St. John, McAllen, TX

Workshops, Part II

Identifying and Addressing Depression During and After Pregnancy Among Rural Georgia Women

This presentation summarized the findings of a study on depression in expecting and new mothers. **Sandra Pittman**, Ph.D., Director of the Perinatal Center at the Medical College of Georgia, began by noting that the study was conducted through the Enterprise Community Healthy Start program in rural Georgia. The learning objectives included:

- ★ Understand process components of identifying depression during and after pregnancy
- ★ Consider the incidence of positive depression scores pre- and post-natally among a population of rural women
- ★ Describe other considerations necessary when women screen positive for depression
- ★ List implications and strategies for practice in addressing perinatal depression
- ★ List implications and strategies for community education in addressing perinatal depression
- ★ Discuss implications for research in addressing perinatal depression

Dr. Pittman explained that the program uses the Beck Depression Index and the Edinburgh Postnatal Depression Scale for depression screening. In many cases, they cannot contact women by phone but can mail a letter with information on the program and perinatal depression. She noted that face-to-face screening is more effective because the tool can be scored right away and discussed with the client. With mail screening, there are always concerns about literacy level.

Dr. Pittman also noted that with scoring face-to-face, one issue is how to follow-up with the client. She said they look for all types of intervention possibilities. She noted that oftentimes, the client does not want to go into care or into counseling, but sometimes, a support group is okay. She said they have numerous spaces arranged for counseling to help with the issue of stigma.

Dr. Pittman reported that the results of screening included enrolling 397 clients between 2004 and 2006. There were 111 clients in the program 3 months postpartum who had a positive depression screen pre-natally. She said of those clients, 18 women accepted the intervention, and 66.7 percent became negative for depression. She noted that what you see is what you expect—the earlier you identify depression and the earlier the woman accepts services, the greater the number that will move from a positive to a negative depression score.

Dr. Pittman described how Enterprise Community Healthy Start has learned several lessons from this study. She reported that one important fact is that depression screening helps identify women who have severe mental illness. Another conclusion is that group and individual strategies may be helpful in meeting the needs of women resistant to appointment keeping. In addition, enlisting other community agencies will broaden community awareness. She concluded by stating that additional strategies for overcoming barriers to access to mental health services must be sought and evaluated.

Using Videoconferencing Technology to Effectively Train Remotely Located Community Health Promotion Staff

This presentation highlighted a health training program that is conducted via videoconferencing. **Litia Garrison**, B.S., Health Educator for the WISEWOMAN and WISE At Every Size programs at the Southeast Alaska Regional Health Consortium (SEARHC), began by explaining that SEARHC is a health organization governed by representatives from 18 communities. She reported that the clinics serve 12,500 Native people and another 6,000 non-Natives in rural areas with minimal access to health services. She said the service communities are spread throughout the southeastern Alaska panhandle over a distance of approximately 350 miles from the north to the south end. She noted that most communities are not connected by roads. Instead, transportation is mostly by boats and planes.

Ms. Garrison explained that SEARHC uses videoconferencing for business meetings, telemedicine, telepharmacy, telebehavioral encounters, continuing education credits, staff training, lab procedure training, and family visits. She also noted that when people in tightly knit communities come to Sitka for a hospital stay, videoconferencing allows them to connect with their families.

Ms. Garrison went on to explain that in order to enhance their usage of the media, SEARHC sponsored a 4-day videoconferencing training session. She said staff learned numerous things during the training, including the benefits of using a document camera to share information right on the screen that they typically would have had to send in some other way to the remote sites. Like with theater, Ms. Garrison explained, creating an optimum set is a key to success. Good eye contact, clear sight lines, good lighting, access to tools and materials, good backdrops, and the presenter's appearance all need to be considered.

Ms. Garrison said the group also learned about differences between live videoconferencing and traditional classrooms. Live videoconferencing is similar to live TV and very different from classroom instruction. Coordinating the teaching of those onsite and at remote locations takes practice and planning. She said they learned about the importance of developing involvement objectives, like knowing how often you will include your learners, how you will do that, when you will do it, and how many times they will interact. The minimum standard to strive for is 30 percent interaction time during a live videoconferencing event. Even better, you should strive to engage learners among remote sites, not just from the near side to the far side.

Ms. Garrison concluded by noting that while there are limitations, videoconferencing allows for a near hands-on experience and helps connect people across great distances. She said in Sitka, they could not plan a training session on any single day and expect that people from all of the State's remote communities would be able to make it on that day. However, videoconferencing enables them to schedule regular trainings and connect with people on a consistent basis.

Improving Migrant Women's Access to Early Detection Services Through Effective Partnerships in a Frontier State

This presentation highlighted a program that uses partnerships to improve the health of rural and migrant women, including increasing early detection for breast

cancer. It was presented by **Carol Peterson**, M.S., RN, National Rural/Frontier Women's Health Coordinating Center Director and Health Promotion/Disease Prevention Specialist, Wyoming Health Council; **Cathy Florian**, Director, Wyoming Migrant Health Program; and **Mandy Hobbs**, RN, Women's Wellness Coordinator, Wyoming Migrant Health Program.

Ms. Peterson opened the session by describing how providing health services in a large, rural State like Wyoming presents multiple challenges. With 515,000 residents, Wyoming is very sparsely populated. Seventeen (17) of the State's 23 counties are classified as frontier. It is also fairly homogeneous—91 percent of the population is white.

Ms. Peterson, Ms. Florian, and Ms. Hobbs explained that the Wyoming Health Council (WHC) works to address the health-related needs of low-income residents. Formed in 1990, WHC is the coordinating agency for the State's Title X Family Planning Program. Partnering with other organizations is a critical part of providing services in rural areas because it can reduce duplication of services. They went on to explain that since WHC is a nonprofit organization, as opposed to a public entity, it is not weighed down by bureaucratic issues. This allows for more rapid implementation of programs and the ability to respond quickly to changing priorities. Another important aspect of partnering is that programs can pool resources and complement strengths and weaknesses.

The presenters described how the Wyoming Migrant Health Program (WMHP) serves the Big Horn Basin area, which includes four counties—Park, Big Horn, Washakie, and Fremont. They stated that the goal of the program is to improve the health status of migrant and seasonal farm workers and their families through the assurance of high-quality primary and preventive care. WMHP also administers the Women's Wellness program. This program provides navigation for wellness services for women who are uninsured or cannot afford to pay for annual breast and cervical cancer screening. The program also provides education on self breast exams, either on an individual or a group basis.

The presenters explained how the program grew significantly during the first 2 years in terms of both staff and clients. A secretary was added to take care of paperwork, schedule appointments, make reminder calls, and communicate with the State Health Department. An outreach worker was also hired. They concluded by noting that in year 2, the program conducted 559 educational encounters and 264 clinical breast exams, of which 18 were abnormal. Thay also provided 199 mammograms, of which 14 were abnormal.

A Survey of Rural Women's Health Literacy and Sources of Health Information

This workshop offered strategies for improving community health literacy. **Barbara Disckind**, Senior Writer at the U.S. Department of Health and Human Services Office on Women's Health, began the session with a definition of health literacy—the ability to obtain, process, and understand health and medical information. She noted that it is different from regular literacy. Many highly literate people have low health literacy. Health literacy is affected by culture, knowledge, and the clarity with which health information is communicated.

Ms. Disckind went on to note the importance of health literacy, which can directly effect people's medical treatment. Many underserved people (e.g., elderly, poor, low education, minority, and limited English speakers)

may have their health care suffer in quality due to health literacy issues. In 2003, the National Assessment of Adult Health Literacy found that 90 million Americans had either basic or below-basic levels of health literacy.

Ms. Disckind then offered several strategies for improving health literacy, including the use of plain language and the teach-back method. She explained that the teach-back method is a non-judgmental way of having patients repeat instructions to make sure they understand the health information given to them. She explained that plain language is a tool to remove jargon from health information. It is not "dumbing down" the information or an insult to patients, but a helpful tool in improving health literacy.

Next, **Jennifer Peters**, Coordinator for Community Health Promotion at the University of Arizona, Mel and Enid Zuckerman College of Public Health, Rural Health Office, outlined four practical strategies to improve health literacy. First, improve the usability of health information, making sure the contents are appropriate and easily understood. Second, improve the usability of health services like forms and instructions. Third, improve the accessibility of healthcare environments through clear signs and directions. Lastly, improve accessibility to quality health information and educators.

Ms. Peters went on to explain how health literacy issues lead to low social empowerment, low self-efficacy, poor health outcomes, and an increase in money spent. She said health literacy should be viewed as a learned behavior. Improving health literacy in a community involves improving the environment and resources to assist community members in supporting and helping each other.

Ms. Peters outlined four types of literacy—fundamental, scientific, civic, and cultural. She explained that civic literacy is the ability to recognize, process, and understand media sources and quality; where to access media; and how to advocate for causes. The media often sends mixed health messages. A person with low civic literacy would have trouble interpreting the data, which leads to low health literacy. She concluded by stating that because of the high prevalence of TV as a health information source, we need to increase people's ability to discern quality information.

Gender-Specific, Culturally Competent Recovery Services for Rural Women

This presentation highlighted an innovative program that offers gender-appropriate services for substance abuse treatment and recovery. **Niki Miller**, M.S., CPS, Executive Director of the New Hampshire Taskforce on Women & Recovery and Adjunct Faculty at the Springfield College School of Human Services, began by noting that 92 percent of women in need of alcohol or drug treatment do not receive it. Ms. Miller said that you cannot send someone away for 30 days and then expect them to come back and be cured. For example, you would not send someone with diabetes away for 30 days and expect them to be healed. She explained that women heal within the context of relationships, communities, and families.

Ms. Miller then described the New Hampshire Taskforce on Women & Recovery, which is a small, nonprofit organization dedicated to improving the lives of at-risk and recovering women, families, and girls through collaboration, education, empowerment, and advocacy. It was formed by a group who conducted a statewide needs assessment and made a report to policymakers. She noted that instead of just walking away from the report, the group formed an advocacy taskforce.

Ms. Miller discussed some of the findings from the needs assessment. One finding was that women who had experienced more than five treatments were told they were treatment resistant. She explained that the treatment system is failing women and that there is also an incredibly high rate of trauma among women in treatment. She noted one alarming study by Feletti and Anda, which found that 78 percent of female IV drug users experienced 4 or more types of childhood trauma, whereas only 0.5 percent of non-traumatized women use IV drugs. Ms. Miller explained there is a clear cycle of sexual and violent victimization and addiction.

Ms. Miller stated that the New Hampshire Taskforce on Women & Recovery developed five types of services:

1. **Corrections services**—workers go into the prison system and deliver interventions. Ms. Miller noted there is a skyrocketing rate of incarceration of women that is driven by substance abuse.
2. **Telephone "warmline" and linkage services**—both providers and women can call for help and information. Ms. Miller noted that the majority of these services are provided by volunteers.
3. **Professional and public education**
4. **Women's Leadership Training Initiative (WLTI)**—an initiative that spans mental health, substance abuse, and domestic violence. Ms. Miller noted WLTI is funded by the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services and Center for Substance Abuse Treatment.
5. **Ensuring the voice of recovering women and families is at every table**

In closing, Ms. Miller noted that through this effort, the New Hampshire taskforce has learned several things that they did not know 5 years ago. In the past, women have been labeled treatment resistant, but the reality is that the treatment was woman resistant. She explained that the treatment did not address child care, history of trauma, and other important issues. No system is capable of healing every recovering woman, but every recovering woman has a role in healing the system.

> **"In the past, women have been labeled treatment resistant, but the reality is that the treatment was woman resistant."**
>
> **—Nikki Miller**

Substance Abuse Treatment for Women in Rural Indiana: A Costly Gender Gap

This presentation summarized the findings of a study on the gender gap between substance abuse treatment services for men versus services for women in rural Indiana. **Ruth Case**, B.S., Performance Improvement Coordinator at the Affiliated Service Providers of Indiana (ASPIN), began by providing an overview of ASPIN, which is located in Indiana. ASPIN is a network of 13 community mental health centers and addiction providers that deliver services to 74 of Indiana's 92 counties. Ms. Case noted that there are 45 federally designated rural counties in Indiana, and many other counties are very rural, although they have not officially received that designation.

Photo Contest Finalist—Rural Health

"Dental Fun"
Anna Day, Blanding, UT

Ms. Case explained that ASPIN conducted a needs assessment and identified that women in need of addiction treatment were a significantly underserved population. She said one of the first things ASPIN did was look at the data and analyze the differences between women and men in substance abuse treatment. They found that women represented only 35 percent of those served, despite data indicating that addiction is an equal opportunity disease. Yet, the total cost of serving women was 47 percent of the total overall cost for substance abuse services. They also found that women in treatment have a lower average annual household income than men in treatment, yet women have a higher average number of dependents in their households. Of individuals desiring employment, the unemployment rate for women was much higher. Ms. Case explained that this information means that women who need treatment typically need more services at higher costs, yet they have less money to pay for them.

Ms. Case then discussed the numerous barriers to treatment for women. She noted that the financial barrier is tremendous. If you only have enough money to buy groceries for your children, you are going to spend the money on that, not on a weekly treatment session. Transportation and child care are also significant barriers. She went on to explain that there are also barriers to treatment in the legal system. In many cases, women are more likely to be sent to jail than to be referred to a court ordered treatment diversion program.

Ms. Case concluded the session by outlining several strategies ASPIN identified to effect change. She said the first key is to reduce barriers to treatment. A number of providers who work directly with the courts showed them that the number of referrals were higher for men than for women. Ms. Case noted that this information was an eye-opener to the courts. Ms. Case then described additional strategies that included securing funding for childcare, developing women-only treatment groups, offering combined treatment, and providing supplemental educational programs. She said securing financial support is also a key strategy. One solution is to look at how current funding can be adjusted to target women. Ms. Case said ASPIN also did a lot of work with the court system to talk about the cost of incarcerating

women versus putting them in a treatment program. She explained that another way to consider the financial burden involved is to look at costs now versus hidden costs down the road that will be incurred if women do not receive treatment. She went on to explain the hidden costs of not providing treatment—which include judicial costs, incarceration, child welfare, and child treatment costs. For example, each child afflicted with Fetal Alcohol Syndrome will cost $1.4 million over his or her lifetime in institutional and medical costs.

Taking Control: Women and Their Options in Treating Premenstrual Syndrome and Menopause

This presentation offered a summary of options for dealing with menopause. **Carol Roberts**, M.D., President and Medical Director of Wellness Works, began by noting that menopause occurs in stages. In their 40s, most women experience perimenopause, during which ovulation is intermittent. Dr. Roberts explained that menopause occurs when menses cease, which for most women is in their 50s. As women enter their 60s, the process continues with a decline in the production of all hormones. There are a range of symptoms associated with the various stages of menopause, many of which overlap. These include insomnia, mood swings, poor concentration, and memory loss. In particular, during menopause a rise in cholesterol, weight gain, and bone loss can occur. She noted the greatest bone loss occurs in the first 5 years of menopause.

Dr. Roberts questioned, if menopause is a natural process, why is it necessary to treat it? She said over the centuries, there have been various approaches to addressing the symptoms of menopause. These have included committing women to insane asylums, divorce, and herbal treatments. She said in 1950, Premarin, the first form of estrogen replacement therapy (ERT), also known as hormone replacement therapy (HRT), was introduced.

Dr. Roberts noted that following the introduction of ERT, the incidence of endometrial, uterine, and breast cancer increased significantly. In the 1970s, progestins were invented and used to prevent uterine cancer, when combined with Premarin. She said in 2002, questions were raised about the safety of HRT (progestins and Premarin). However, it was also reported that HRT can prevent heart disease. Currently, many women are unsure of what is the best approach for treatment of the symptoms of menopause.

Photo Contest Finalist—Rural Health

"Rural Health Transportation"
Clare Wilmot, Littleton, NH

Dr. Roberts concluded by noting that bioidentical hormones are an alternative to HRT for the treatment of menopausal symptoms. In addition, she noted that they are available over-the-counter, which is an indication of their safety.

Women's Bone Health: Issues Through the Lifespan

This workshop included presentations on three topics: (1) secondary osteoporosis, (2) the female athlete triad, and (3) fracture care.

Secondary Osteoporosis

Kimberly Templeton, M.D., Associate Professor of Orthopaedic Surgery and Health Policy and Management at the University of Kansas Medical Center, began her presentation on the first topic by noting that peak bone mass occurs in females between 11 and 14 years of age. She said bone mass is relatively constant until mid-life, after which, women undergo two phases of involutional bone loss. Dr. Templeton explained that while bone density is used to define osteoporosis, bone quality is also an issue. In fact, she said, there are multiple issues involved in bone health. These include genetic influences, exposure to hormones, and lifestyle (e.g., diet, exercise, smoking, and alcohol consumption). Dr. Templeton went on to explain that there are also various medical conditions and medications that can increase the risk of osteoporosis. Medical conditions include insulin-dependent diabetes, malabsorption syndromes, hyperparathyroidism, hypogonadism, rheumatoid arthritis, and inflammatory bowel disease. Various medications associated with reduced bone mass in adults include anticonvulsants, cytotoxic drugs, glucocorticoids and adrenocorticotropin, gonadotropin, and immunosuppressants.

Dr. Templeton noted that oral contraceptives have also been associated with loss of bone mass. However, there is conflicting data and many variables including differing strength. She explained that there have been many studies done relating to this topic. While the findings are mixed, it is most likely that use of oral contraceptives has an impact on bone mass. She said breast cancer also is a proposed risk factor for osteoporosis, which can be related to premature ovarian failure, direct effects of chemotherapeutic agents, direct effects of breast cancer, or the effect of anti-estrogen hormonal agents.

Dr. Templeton concluded the first part of the presentation by noting that there are many additional factors that affect bone health. These include lifestyle and other conditions and/or their treatment. She said these conditions effect bones either through impact on sex hormones or other mechanisms.

The Female Athlete Triad

Sharon Hame, M.D., Associate Clinical Professor at the University of California, Los Angeles, Department of Orthopaedic Surgery, began by explaining that the Female Athlete Triad (FAT) is made up of three conditions: (1) disordered eating, (2) amenorrhea, and (3) osteoporosis. She said these three components do not need to occur simultaneously. She went on to explain that while the prevalence of FAT is unknown, major variables are age, sport, and ethnicity. She also noted important factors include striving for low body weight and participation in an activity where appearance is judged.

Dr. Hame explained that eating disorders are a wide spectrum of harmful and often ineffective eating behaviors used in attempts to lose weight or achieve a lean appearance. Behaviors associated with disordered eating include binging, purging, caloric restriction, excessive exercise, and use of diuretics, laxatives, and diet pills. Dr. Hame reported that an estimated 3 percent of young women suffer from disordered eating—10 to 62 percent of females athletes suffer from it. With female athletes, the risk factors include the perception that thinness can

improve performance, as well as pressure from coaches, parents, and judges.

Dr. Hame went on to explain that inadequate nutrition accompanied by excessive exercise can result in the ovaries decreasing production of estrogen, leading to amenorrhea, which can lead to bone loss. Amenorrhea is defined as the lack of menses for 3 or more consecutive months after menarche begins. Dr. Hame reported that amenorrhea occurs in 2 to 5 percent of the general female population and in 15 to 66 percent of female athletes.

Dr. Hame concluded the second part of the presentation by stating that FAT is treatable. Key aspects of treatment include athletic participation, positive energy balance, healthy weight goals, frequent visits with health care professionals, and written contracts. She emphasized that in order to treat disordered eating, a multidisciplinary team approach is often used including a physician, psychologist, nutritionist, athletic trainer, coaches, and parents.

Breaking Tradition: A New Look at Fracture Care

Laura Tosi, M.D., from the Division of Pediatric Orthopaedic Surgery at the Children's National Medical Center in Washington, DC, began the third part of the presentation by asserting that too much focus and public attention has been directed toward osteoporosis. She explained that while osteoporosis is a serious condition, fracture risk is a much more comprehensive way of assessing an individual's bone health and determining the liklihood of future fractures.

Dr. Tosi reported that each year in the United States there are 1.5 million fractures. Fractures can have significant consequences. For patients with hip fractures, 6.3 percent die while in the hospital. Of the 93.7 percent that survive, up to one-third dies within a year. Of those who live beyond a year, half of those returning home need help with daily activities. She noted that the estimated annual cost of treating fragility fractures is $12–$18 billion.

Dr. Tosi stated that traditionally, calculations on fracture risk have been based on the World Health Organization's (WHO) definition of osteoporosis. However, this has been revised and the new approach considers age, previous history of fracture over age 45, bone mass density (BMD), low body mass index (BMI), family history of hip fracture, current cigarette smoking, high alcohol intake, and previous steroid exposure. This new approach is based on evidence that prior fractures are a risk factor for future fractures—the risk increases 1.5–9.5-fold following the initial fracture. She noted that a history of fragility fracture is more predictive of future fracture than bone density.

Dr. Tosi concluded by stating that other important considerations with fracture risk are the rapidly expanding population of individuals with secondary osteoporosis and the fact that the majority of Americans are not receiving adequate levels of Vitamin D, which plays a critical role in calcium absorption. According to the Third National Health and Nutrition Survey, over 70 percent of women ages 51–70 were estimated to not be meeting adequate intake guidelines for Vitamin D based on daily intake from diet and supplements.

New Leaf Choices for Healthy Living

This workshop highlighted a weight loss and healthy living behavior change program for rural women in Alabama. **Jessica Hardy**, M.P.H., B.S.N., Director of the Alabama Office of Women's Health and Emergency Preparedness

and Nurse Coordinator at the Alabama Department of Public Health, began by reporting that Alabama ranks second-highest in the United States for obesity, with 26–30 percent of the population defined as obese. Ms. Hardy explained that when her office started project planning in 2004, the Alabama Department of Public Health found that 57 percent of women in Alabama were overweight or obese, including 66 percent of women ages 45–54, 73 percent of black women, and over half of white women. She noted, however, that this was self-reported data, and in 2006, some of these data shifted.

Ms. Hardy explained that New Leaf is a lifestyle initiative with a structured nutrition and physical activity program and two assessment components developed by the University of North Carolina (UNC) at Chapel Hill. The initiative focuses on chronic disease risk reduction through weight reduction with an emphasis on cardiovascular health.

She went on to explain that in an effort to conduct community outreach cost-effectively, the Alabama Office of Women's Health used a pre-existing network of community health advisors from the University of Alabama that do outreach for breast cancer survivors. They trained these advisors in the New Leaf curriculum to conduct weight loss and healthy behavior change programs in women ages 40–65.

Ms. Hardy stated that the program was implemented at five sites in three counties, with one alternate county. Based on meetings and focus groups, the curriculum was modified to fit community health advisors' schedules and training from the UNC nutritionist. Ms. Hardy noted that they found the program needed to be long enough to bring about change, but not too long to burden volunteers. The result was a 6-month program. Each participant received a manual and participated in 14, one-hour sessions. They also met weekly for the first 8 weeks to get people into a pattern of desired behavior changes. After that, they met biweekly for 2 months and then met monthly for the last 2 months.

In closing, Ms. Hardy noted that one of the biggest lessons learned is that communities are very eager for participatory programs. She said if we can find ways to help them take part in program planning from the beginning, they are more open to the programs and will try to find ways to sustain them.

Utilizing Community Health Workers to Engage Colonia Residents to Improve Health Through Resident-Led Community Partnerships

This workshop highlighted an innovative community program for increasing access to care and improving health outcomes for rural people in South Texas. **Julie St. John**, M.A., M.P.H., South Texas Regional Director at the Center for Community Health Development, began by explaining that community health development is a process by which a community identifies its needs, develops goals, and plans and implements activities. She went on to explain that the Center for Community Health Development focuses on broader determinants of health, social, psychological, physical, and emotional well-being. Its work is population-focused, not individual-based. The center pools resources as much as possible to improve community health status.

Ms. St. John stated that the center received funding from HRSA and the Robert Wood Johnson Foundation to

create an Integrated Health Outreach System (IHOS). The goal of the project was to create a model to improve health status and access to care in two clusters of colonias in Hidalgo County, Texas. The population of 655,202 in Hidalgo County is 90 percent Hispanic. There is a 13.4 percent unemployment rate, and 36 percent of residents live below the Federal poverty level. Sixty (60) percent are uninsured and more than 20 percent, or 150,000–200,000, live in colonias. Colonias are unregulated residential areas lacking basic services like water, electricity, mail, and trash pick up.

Ms. St. John explained that the idea behind the project was to get health providers to come together to serve residents. The area had a network of agencies, including Planned Parenthood, a Federal clinic, and a university program that provided transportation. They also had promotoras and community health workers—lay people from the community who live in colonias and have some training. In addition, HRSA funded a federally qualified health center to open two satellite clinics with full-time doctors, covering about 80,000 of the residents.

Ms. St. John noted that the project centered on a partnership approach. Project planners assessed needs and conducted several key informant interviews and focus groups led by the promotoras. From this work, they identified a range of issues to address. Promotoras then led the residents in prioritizing these issues, so they could start seeing an impact as soon as possible. Residents decided to form three task groups to focus on environmental issues, health, and transportation.

In closing, Ms. St. John stated that there were numerous successes. Her team held health fairs and walkathons; developed a bilingual resource directory of services; created a network of health providers called the Colonia Health Improvement Network (CHIN); established trash collection once a week in each area; and revised the IHOS transportation service to be more user-friendly. In the last 3 months, they have made close to 1,000 transports to appointments.

"Communities are very eager for participatory programs ... if we can find ways to help them take part in program planning from the beginning ... [they] will try to find ways to sustain them."

—Jessica Hardy

Conducting a Community-Based Needs Assessment

This workshop highlighted the findings from an assessment of the needs of a rural New Hampshire community. **Karen Horsch**, M.A., Evaluation Consultant, and **Martha Hill**, M.A., Director of the North Country Health Consortium (NCHC), New Hampshire National Rural/Frontier Women's Health Coordinating Center, began by explaining that the assessment was a partnership between the RFCC and the NCHC. The presenters noted that it was a big step for the RFCC to determine the needs of the community, because up to that point, little to no data had been collected and organized about the area. Through the assessment, the RFCC planned to learn about the concerns of women and identify the services in the North Country, help the services meet the needs of women, and identify the role of the RFCC in meeting the needs of women and care providers.

Ms. Hill noted that the project team developed a three-pronged strategy to collect data. They used focus groups of women, interviews with providers, and an anonymous survey distributed at women's health fairs.

Ms. Horsch reported that the findings from the focus groups and survey revealed that the lack of specialists, lack of providers, transportation barriers, and lack of parenting programs for new moms were perceived as the biggest challenges facing women in receiving health care. Many women lamented the "dehumanization" of health care, especially older women. Ms. Horsch reported that women also found it hard to form relationships with doctors because the doctors often left the area within one or two years. She said women also did not seek out Nurse Practitioners and almost exclusively wanted to see their doctors. Also, the focus groups found that women expected a prescription at the end of the visit, because they equated a prescription with a solution.

The presenters noted that the providers interviewed believed that health resources are inadequate for everyone, not just women. The lack of training on women's health was seen as a problem exacerbated by lack of funding and the expense and time it takes to travel to training courses. The providers also cited the difficulty in recruiting and maintaining staff, mirroring the frustration the women expressed. The interviews suggested that the RFCC could help with training, community education, and connecting resources for service work.

Photo Contest Finalist—Rural Health

"No Cavities"
Alice Haenggi, Columbus, NE

Closing Plenary

The closing plenary session featured three presentations. First, **Linda Chamberlain**, Ph.D., M.P.H., Founding Director of the Alaska Family Violence Prevention Project, presented information on domestic violence in rural Alaska. Second, **America Bracho**, M.P.H., CDE, Executive Director of Latino Health Access, discussed several women's health issues and offered solutions for change. Third, **Marcia Brand**, Ph.D., Associate Administrator for Health Professions and Director, Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services, closed the conference with a summary of the key themes and lessons learned.

Domestic Violence: Trends, Best Practices, and Rural Challenges

Linda Chamberlain, Ph.D., M.P.H., opened her presentation by noting that in Alaska, rates of sexual assault, abuse, and violence are extremely high. However, she noted that the exact numbers are difficult to report, because the majority of Alaska's communities are small and tightly knit, which makes the stigma around the issue very high.

Dr. Chamberlain went on to note that when she started this project, it was called the Domestic Violence Training Project. However, when she started talking about domestic violence, Dr. Chamberlain received questions about whether she would talk about child abuse and elder abuse, too. Dr. Chamberlain explained that this proves family violence is a continuing cycle.

Dr. Chamberlain explained that another part of family violence is animal abuse. She said animal abuse is an indicator of other problems. In fact, she noted, the numbers are overwhelming.

Dr. Chamberlain then explained that the discussion cannot be isolated with domestic violence. Instead, the issue needs to be discussed within the context of lifetime exposure. For example, Dr. Chamberlain met one woman who had been abused, but within the context of what the woman had experienced growing up, she did not believe the abuse she suffered was that severe—because she did not have broken bones like her mother. Dr. Chamberlain stated that this example illustrates why the issue of domestic violence must be addressed in terms of lifetime exposure to violence.

Dr. Chamberlain went on to explain that the issue of domestic violence must also be considered in the context of rural culture. She noted that in rural culture, building trust is a big issue. For example, it took Dr. Chamberlain eight visits to meet with one Eskimo community before they would let her talk to the community members. Dr. Chamberlain described how there is also a code language of abuse. For example, "acting funny" is often equated with abuse. She noted that communities and cultures, especially those that are rural, develop their own languages.

Dr. Chamberlain described several rural challenges that have a significant impact on the issue of family violence. She stated that some of these challenges include confidentiality and isolation. In addition, she said people must deal with a high prevalence of firearms and a rollout of violent offenders from other communities. She explained that people from Montana and other States often flee to Alaska when the law enforcement in their town finally comes calling. Dr. Chamberlain noted that one additional challenge is the remoteness of rural communities.

Dr. Chamberlain described strategies for overcoming some of the challenges associated with addressing domestic violence in rural communities. She noted that traditional domestic violence training pushes the provider to ask direct questions. In contrast, in Alaska, Dr. Chamberlain noted they often have to use less direct questions, such as, "If you knew someone," and incorporating code words such as "acting funny." She explained that when everyone gets more comfortable, it often opens the door to discuss current victimization. She also noted that depression and substance abuse can be a part of victimization. Screening for domestic violence does not capture sexual abuse. She emphasized that scripted screening is also important. She explained that turnover of care providers is high, and so it is important to script all questions, including sexual assault questions, physical abuse, etc.

Dr. Chamberlain then explained that using integrated locations is very important. She explained it is hard to hide a domestic violence shelter in a remote location. She said one effective strategy is integrating services to the point that no one can be sure why a woman is walking through the door.

Dr. Chamberlain also noted that the Association of Maternal and Child Health Programs has been looking at domestic violence as a perinatal disparity. She said this perspective—looking at domestic violence as a health disparity—is breakthrough thinking.

In closing, Dr. Chamberlain emphasized that the solution to dealing with the cycle of family violence is to create a community safety net. To illustrate her point, Dr. Chamberlain showed a picture of a traditional blanket toss—the more people you have around the blanket, the safer it is. She explained that for family violence, we need to work together to see the answer. In the final analysis, what that takes is a team. You can go much further with a team than you can go alone.

Women's Health Issues

America Bracho, M.P.H., CDE, began her presentation by noting that she recently attended a California Healthcare Leadership Training, where she learned about a book called Leadership on the Line, published by the Harvard Business School Press. The book is about being a leader and dealing with issues without becoming the issue.

Dr. Bracho stated that when we consider an issue, we need to think collaboratively. She illustrated her point with the issue of HIV in the Bronx, where there is a high rate of infection among Latina and black women, higher than the combined infection rate of 45 other States. People say the issue is sex. But the truth is that the issue is connected with issues of substance abuse, literacy, and economics. Because the system ignores those issues, we are left to deal with survivor issues.

Photo Contest Finalist—Rural Health

"Sim Man"
Pam Brister, Madisonville, KY

Dr. Bracho went on to explain that we have a system of services in which we tell people what to do. People are disposable. The solution is to bring people into leadership roles. She noted that it is not just about having a CPA in the office—it is about having the people that are infected. It is about training the people so that when the money goes away, the help does not. The passion, the activism, the combination, the world perspective is the way out. It has to go beyond just telling someone to stop with domestic violence. It has to go further.

Dr. Bracho stated that when women learn something, communities improve. Investing in women is investing in community health. Women continue the culture. No matter how poor they are, they will continue giving to the community. Disparity does not mean difference. It is not a difference between one ethnic group and another. It is a disparity when it has to do with cause.

Dr. Bracho noted that in rural women, there are higher rates of poverty and lower rates of insurance. Poverty is an indicator for a lot of other issues. Poverty does not mean that you are bad, but it does mean that you will not have the same opportunity—the same access. From the adaptive point of view, you will deal with poverty; you will deal with the lack of an education; and so on. Every article talks about poverty, but how many articles talk about economic development for women?

Photo Contest Finalist—Rural Life

"South Texas Colonia Children"
Julie St. John, McAllen, TX

Dr. Bracho stated that we need comprehensive interventions. These are problematic for people to design, emulate, and measure. One illustration that comprehensive interventions can happen is to think of a single mother with three children. She explained that a mother never just thinks about one thing, such as, "my son is not taking his medication." Instead, the mother thinks about a number of issues intertwined. Problems are connected; solutions are connected. Nutrition in the school is connected to an unsafe neighborhood, and they are both connected to obesity.

Dr. Bracho emphasized that we need to go the extra mile. She said, "We need to get to the adaptive side. We have it in our hearts and minds. We need to deal with our own egos and our own inability to cooperate. We need rural women at the center of this strategy."

Dr. Bracho also noted that we need to transform rural women into community workers. The "compañeras," which means "friends" in Spanish, will do the rest. She explained that people may think they want a doctor to do it all, but at the end of the day, they will depend on that person. For example, if a neighbor named Sabina begins exercising and improving her health, other women may say, "If Sabina can do it, so can I." That is not true with the doctor. People will not say, "If the doctor can do it, so can I."

"When women learn something, communities improve. Investing in women is investing in community health."

—Dr. America Bracho

Dr. Bracho discussed how when providers are looking at how to train lay people to be community health workers (building capacity), there is a model to follow. She noted that to really train the community, the workers need to be trained in every area. She explained that the most important aspect of this training is communication. When Dr. Bracho's program works with promotoras, they work with the community twice. She explained that the women they hire live in the community, so they are dealing with the same issues. These women offer a perspective that no one else can.

Dr. Bracho noted that a parallel is the story of Dell Computers. Michael Dell says that the reason they are successful is that the sales force tells the engineers what consumers are saying—the sales force and the engineers communicate with each other. Dr. Bracho noted that in Harvard's strategy, the concept is called "crafting strategy." In the healthcare world, it is called improvising. The promotoras work in all areas—everything is intertwined. The women learn how to cook their parents' food. They learn how to use medication. She also noted that it is also extremely important that volunteers receive payment for their work.

Dr. Bracho went on to explain that the data that is collected from the community needs to go back to the community—not just to inform them but to create change.

Dr. Bracho illustrated this point with the story of a woman with diabetes who was unable to afford preventive treatment, and ended up losing her sight. She asked the promotoras if they had to pay a large amount of money to avoid blindness, would they? She received a range of responses. One woman said she would sell her furniture, or whatever it took. Then one woman said she would do it even if she had to sell tamales. In Mexico, this phrase is equivalent to Americans saying they would sell apple pies.

The thought stuck. Dr. Bracho's group decided they needed a healthcare community, even if they had to sell tamales, so they started selling tamales to raise money for eyesight screenings. They worked together to develop a master recipe (and a healthy recipe), and they ended up receiving national press.

Since then, Dr. Bracho's group has also created a children's initiative—they have a group of over 100 child promotoras. She noted that children are an example of "the extra mile." She explained that women are more likely to take their children into a healthcare clinic than themselves. When the woman brings her child to a clinic, this is a perfect opportunity to talk to her about her health as well. That is going the extra mile.

Photo Contest Finalist—Rural Life

"Peaceful Pasture"
Alec Hartman, East Vassalboro, ME

In closing Dr. Bracho noted that the key message is to follow the path that the people show you. She said you may start working with diabetes … then you follow the path to housing … and so on. The solution is in the collaboration.

Next Steps: Where Do We Go From Here?

Marcia Brand, Ph.D., Associate Administrator for Health Professions and Director, Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services, was the final presenter.

In closing, Dr. Brand reflected on why people come to conferences. There are four primary reasons:

1. Reaffirmation—to learn whether they are on the right track and up to date
2. A new way—to find new strategies and techniques
3. A takeaway—to have something to take home and share with coworkers
4. Inspiration—to reflect and re-energize

As evidenced by this report, the HHS OWH Charting New Frontiers in Rural Women's Health Conference provided all four of these opportunities for participants—and much more. Participants heard success stories and lessons learned from rural women all over the country.

From California, participants learned the importance of going the extra mile. And from Alaska, they heard the story of one woman who did just that by making eight

> "Rural women will lead the way."
>
> —Dr. Marcia Brand

separate trips to a community to build trust in order to address domestic violence.

From Wyoming, participants learned that women multitask and are the glue that holds things together. And from Texas, they heard the story of promotoras who banded together to bring access to care and other services to two rural colonias.

From New Hampshire, participants learned that women aren't substance abuse treatment-resistant—treatment is women-resistant. And from Georgia, Indiana, Virginia, Maine, and more, they learned new strategies for overcoming rural barriers and providing gender-appropriate substance abuse treatment and care.

Finally, from a story that spanned the desert mesas of New Mexico to the tree-capped mountains of New Hampshire, participants learned about the interconnectedness of health. Body, mind, and spirit are part of a family; which, in turn, is part of a work environment; which, in turn, is part of a community; which, in turn, is part of a global environment. Illness can occur on any of these levels, and health care must consider all of them.

From all of these success stories and lessons learned, the key takeaway message was that rural communities can lead. Rural communities are a manageable size. In Philadelphia, PA, it might be hard but in a Philadelphia in another state—it is possible. And in this effort, Dr. Brand stated, "Rural women will lead the way."

Conference Evaluation

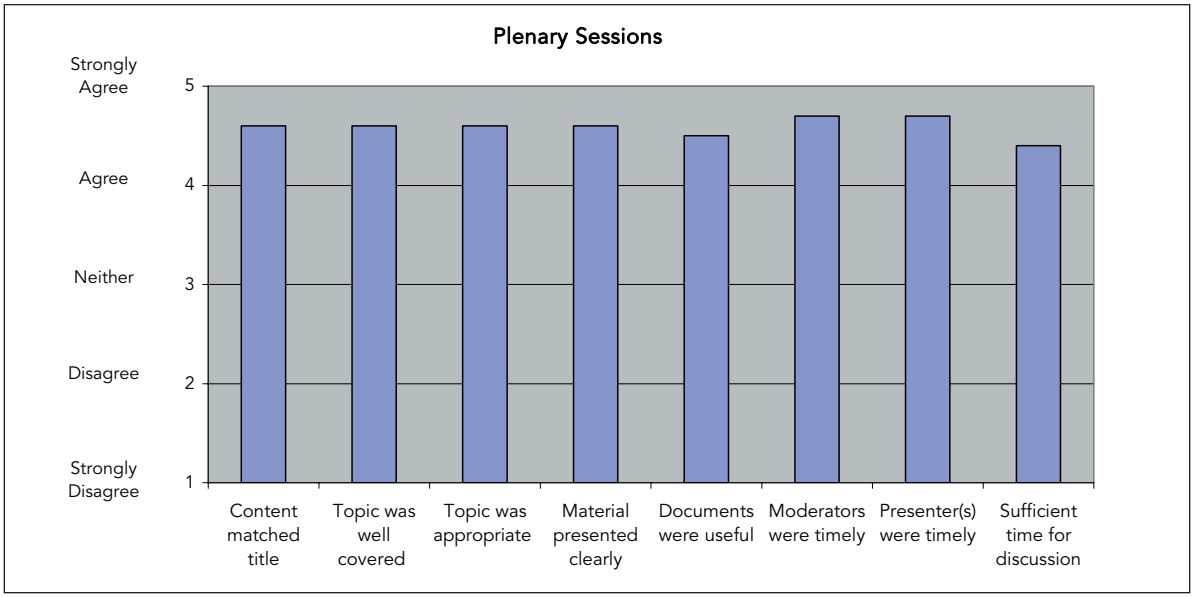
Participant feedback was a critical component of the 2007 Charting New Frontiers in Rural Women's Health Conference. At the end of each plenary and breakout session, participants were invited to fill out an evaluation summarizing their feedback for that session. Additionally, on the third and final day of the conference, participants were asked to fill out an evaluation providing their opinions on the entire conference experience, including the overall conference content and the hotel services and logistical arrangements. Each evaluation form used a mix of Likert scale response questions and open-ended questions to capture valuable participant feedback. The responses are summarized below, revealing what the participants learned and what could be added to future sessions to increase the value of a conference like this.

Plenary Sessions

Conference participants were asked to rate the following aspects of each plenary session on a scale of 1-5, with 1 meaning strongly disagree and 5 meaning strongly agree. The average response to each item is provided in Figure 1.

- ★ The content matched title/expectations
- ★ The topic was well covered and informative
- ★ The topic was appropriate for the session
- ★ Material was presented in a clear and understandable manner
- ★ Documents/handouts were useful
- ★ Moderators started and ended session on time
- ★ Presenter(s) respected the time allotted for their presentation
- ★ There was sufficient time for discussion

Figure 1: Plenary Session Evaluation Results



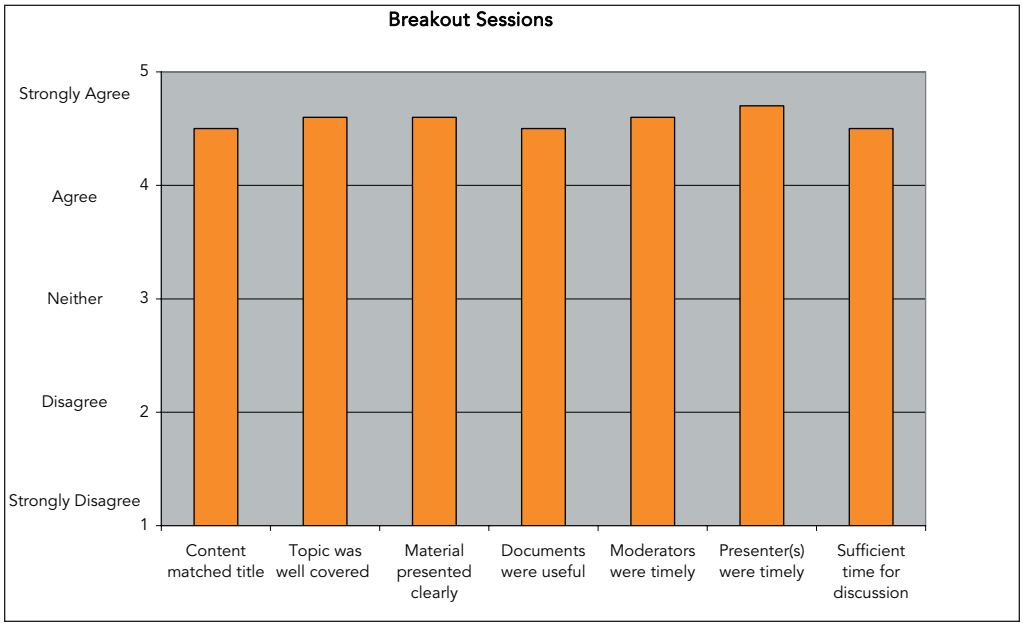
Each plenary session evaluation form also asked participants to provide feedback on their overall impression of the session. Participants made a variety of positive remarks about each of the plenary speakers. Many commented that they felt inspired and motivated by the speakers' messages. Participants also noted that they appreciated the various approaches used by the speakers, which kept the audience energized. Many stated that they were armed with valuable strategies to carry out in their own programs. Several noted that they felt encouraged to return to their communities to implement new approaches for eliminating the problems they face in rural women's health.

Breakout Sessions

Conference participants were asked to rate the following aspects of each breakout session on a scale of 1–5, with 1 meaning strongly disagree and 5 meaning strongly agree. The average response to each item is provided in Figure 2.

- ★ The content matched title/expectations
- ★ The topic was well covered and informative
- ★ Material was presented in a clear and understandable manner
- ★ Documents/handouts were useful
- ★ Moderators started and ended session on time
- ★ Presenter(s) respected the time allotted for their presentation
- ★ There was sufficient time for discussion

Figure 2: Breakout Session Evaluation Results



Each breakout session evaluation form also asked participants to provide feedback on their overall impression of the session. Participants offered a variety of positive feedback about the presentations and noted that they learned a lot from the sessions. According to participants, the breakout sessions featured several excellent speakers and sessions. Many participants

stated that they were intrigued by some of the strategies that were shared. Several participants observed that the speakers were very knowledgeable in their fields and were, therefore, able to provide extremely effective presentations.
Some of the participants remarked that they enjoyed seeing innovative ways to teach cutting-edge issues pertaining to rural women's health. Participants also made several comments about the high quality of handouts and presentations throughout the sessions. Respondents expressed appreciation about the level of speaker enthusiasm. They noted that they appreciated the valuable dialogue that developed during the breakout sessions, as well as the networking opportunities that the conference provided.

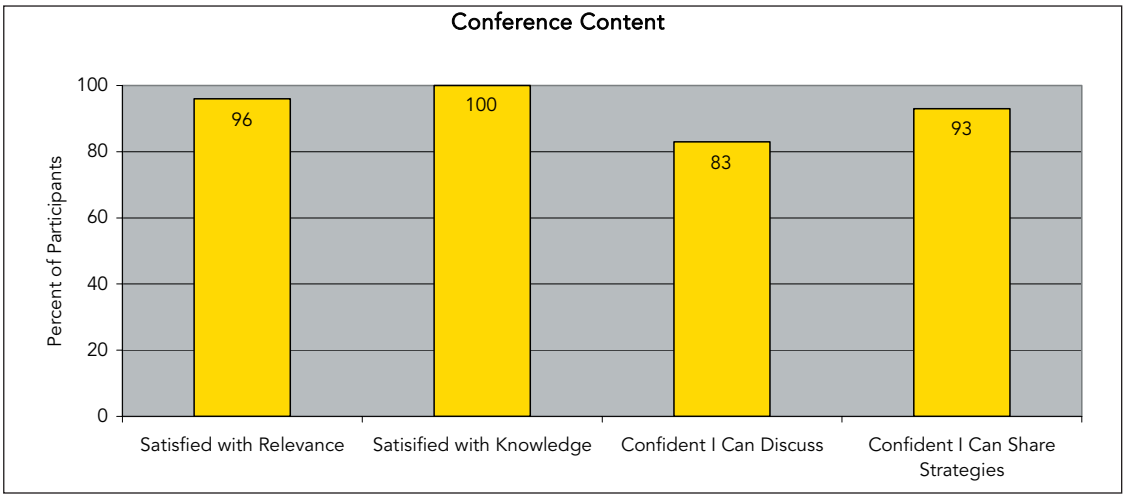
Breakout session participants also noted the value of the information they obtained from the speakers. They commented that they were excited to share information with their co-workers and their communities. Many were eager to replicate studies in their communities that they learned were successful in other parts of the country. The overwhelming majority of participants were impressed by the level of knowledge of the presenters and found the information provided to be extremely useful.

Overall Conference Content

On the third and final day of the conference, participants were asked to rate their responses to four specific statements on a scale of 1–5, with 1 meaning strongly disagree and 5 meaning strongly agree. The percent of participants who responded positively to each item is illustrated in Figure 3.

- ★ I was satisfied with the overall relevance of the conference
- ★ I was satisfied with the overall knowledge of conference presenters
- ★ I am confident I can discuss the latest sex- and gender-specific research and programs to improve the health status of women, especially rural women
- ★ I am confident I can share strategies with national and regional change agents to enhance effective outreach to rural women and their families and increase support for women's programs and services

Figure 3: Overall Conference Content Evaluation Results



The overall conference evaluation form also asked participants to note some of the most significant things they learned during the conference. Some explained that they found the resources and information provided throughout the conference to be extremely valuable. Others stated that they learned the extent to which there is a need for improvements in the field of rural health, as well as the value of communities in creating solutions to health needs.

In addition, several participants noted a recurring theme—to be diligent in the field and keep pressing to find solutions to problems that they encounter. Participants expressed the need to engage themselves in their communities as a team to get things accomplished.

Many participants also noted they felt empowered by the messages they heard and realized how much power women have, as well as how much women have to contribute to the rural health issues that were discussed. Other participants noted they felt an increased level of confidence after attending the conference and were able to learn creative ways to solve the problems that they are experiencing.

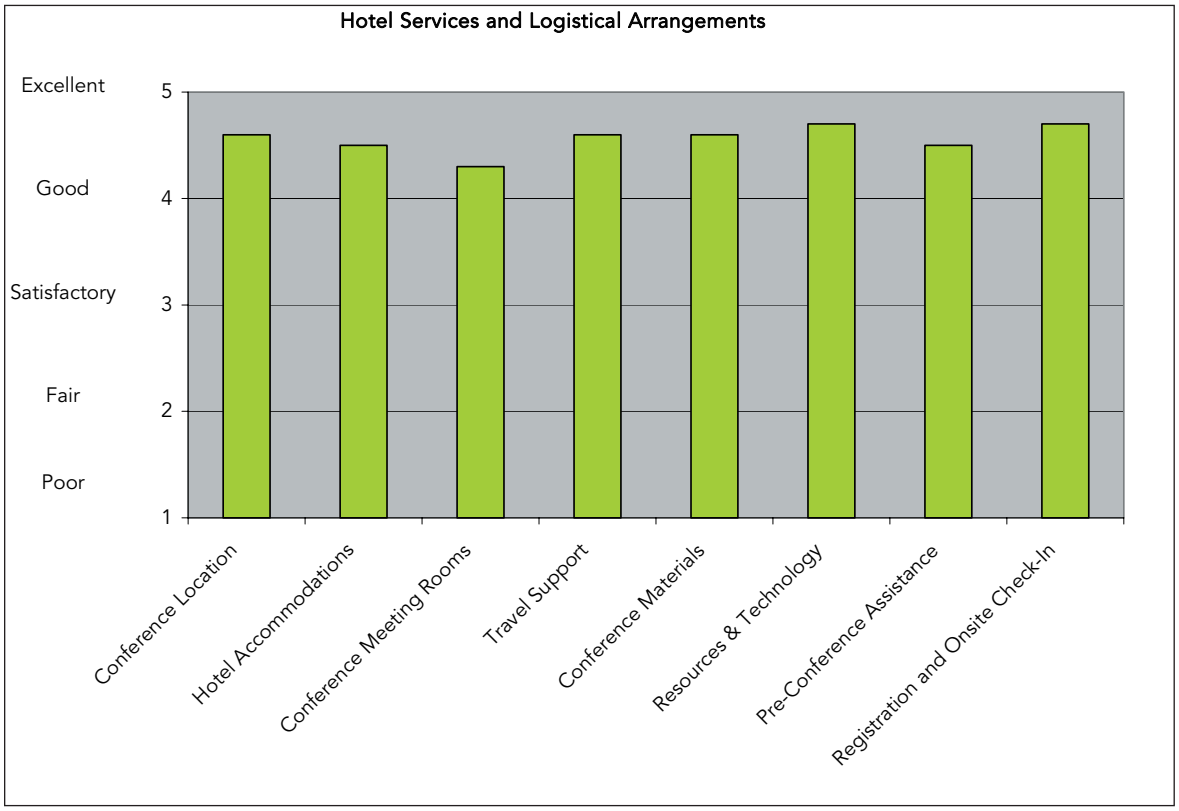
In order to determine which sessions were found to be valuable and instructive, participants were asked which sessions were most useful to them. Overall, the responses varied, but there was a largely positive response to all plenary and breakout sessions. Specifically, many of the respondents expressed appreciation for the plenary speakers and noted that they found them to be motivating, inspirational, and educational. Conference participants also noted that they were able to gain a significant amount of knowledge from the breakout sessions.

Participants also articulated what they would like to see at future conferences. Some stated they would like to see more sessions focused on translating research into practice, while others expressed the need for examples of community resources in rural America. It was also noted that highlighting the health issues of girls, and not just women, would be appreciated. Additional issues that participants would like to learn more about in the future include women and nutrition, sustainability, dental/oral health, the politics of women's health, and topics related to the aging of women.

Hotel Services and Logistical Arrangements

On the final day of the conference, participants were also asked to rate several aspects of the hotel services and logistical arrangements on a scale of 1–5, with 1 meaning poor and 5 meaning excellent. The topics that were rated ranged from the conference location to registration and onsite check-in. The average response to each item is provided in Figure 4.

Figure 4: Hotel and Logistical Evaluation Results



Participants were also asked to provide additional comments on the level of services they received while attending the conference. Many participants felt that the hotel and conference staff were extremely helpful. Others noted the usefulness of the conference Web site. Many also said they appreciated the convenient location of the hotel, which was a short distance from several restaurants and other activities. Overall, most participants said the conference was well-organized and the logistical arrangements were exemplary.

Additional comments made about the overall conference were: (1) the quality of the sessions was so high, it was difficult to choose which session to attend; (2) to encourage more people to participate in the conference, invite a local high school or women's clubs and organizations; and (3) some participants noted that they were surprised and overwhelmed by the level of interest and participation at the conference.

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Appendix A

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