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Patient Navigational Tool Increase Resource Use in a Latino Population

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This Manuscript Partially Fulfills the Requirements for the Doctor of Nursing Practice Program and is Approved by:

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Patient Navigational Tool Increase Resource Use in a Latino Population

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Abstract

Practice Problem: The practice problem is a patient navigation tool in a mobile health clinic for the Latino population to help improve utilization of resources within Daviess County, Indiana, and improve overall health literacy and health of those populations?

PICOT: The PICOT question that guided this project was: In a mobile health clinic serving Latino populations (P), does a navigation tool (I) compared to current practices (C) improve utilization of services (O) within a 12-week timeframe (T)?

Evidence: The evidence that guided this project showed that patients with limited English proficiency and immigrant families have a disparity of health literacy and an increased rate of social needs while, at the same time, having a low utilization of community resources.

Intervention: The intervention will provide a navigation tool containing resource contacts for health and social needs for the community that will be translated into Spanish and Haitian Creole languages to be distributed at a mobile health clinic.

Outcome: The resources associated with food assistance and requests for education in stretching food dollars in the community showed an increase in utilization by the Latino populations in the community. The vaccines administered by the health department did not show significant improvement.

Conclusion: This DNP project can help to increase health equity and overall health in the Latino populations by offering a comprehensive list of resources in a navigational tool and an emergency list of resources on a magnet that is easily visible. This provides the population the knowledge on how to contact and find the resources, as well as the assistance those resources can provide.

Patient Navigational Tool Increase Resource Use in a Latino Population

In the rural community, there are many barriers to improving overall health. For individuals who are foreign born, these barriers can greatly impact health, socioeconomic factors, and community health as navigating a new community and culture can prove to be difficult (Bettenhausen et al., 2021; Tulimiero et al., 2021). This DNP project will utilize a patient navigation tool in a mobile health clinic for the Latino population to help improve utilization of resources within Daviess County, Indiana. The navigation tool will provide clarity of resources available for the community's growing Latino populations, often referred to as Hispanic and Haitian populations. Individuals from countries in Latin America, which include the continent of South America, Mexico, Central America, and countries in the Caribbean, are grouped together as Latino populations. In Washington, Indiana, the Latino community is primary made up of individuals from Mexico and Haiti with primary languages of Spanish and Haitian Creole (Indiana Department of Health, 2021). The navigation tool will provide information such as where people can find resources for mental health, primary health, food resources, transportation assistance, nutrition, peer recovery, immunizations, pregnancy care, and other needs. This tool is being developed as part of The Rooted Project with is a partnership between the local health department and other community service providers.

Significance of the Practice Problem

Vulnerable populations such as the local Latino population are strongly affected by social determinants that impact overall healthcare (Tulimiero et al., 2021). These social determinants of health include geographic location, age, social and cultural norms, racism, and other non-medical factors. Addressing and adjusting these social determinants will help increase health equity in vulnerable populations (CDC, 2022). Health equity is providing fair and equal access

to healthcare and thus allowing for everyone to obtain the highest possible level of health by addressing and decreasing health disparities and social determinants of health (CDC, 2022). These social determinants lead to health disparities such as economic, social, and environmental factors that create greater barriers to healthier living. These factors can include food insecurities, transportation difficulties, lack of health literacy, higher rates of uninsured or under insured for health care, and other barriers (U.S. Department of Health & Human Services, 2022). This project will measure if utilization of resources increases with a navigational tool provided in primary languages that describes what the resources in the community are and how to use them.

With the Latino population being the second-fastest growing ethnic group in the United States, they are facing many health and social disparities that impact their overall health (Flores, 2017). Not only will half of all Latinos end up developing diabetes, they also have higher instances of kidney disease, infant mortality, maternal mortality, and mental health disorders all while also having an increase of barriers to access health care (Hostetter & Klein, 2018; Shiro & Reeves, 2020).

In the city of Washington, Indiana, there is a wider general gap of poverty compared to the state and nation with Washington having a poverty level of 15.9% while the state of Indiana has a poverty level of 12.2%, and Daviess County having a poverty level of 12.7% (U.S. Census Bureau, 2022). It has been shown that individuals in higher poverty levels are at risk of uninsurance or underinsurance for health care and face greater challenges obtaining healthcare and proper nutrition (Levin & Philips, 2018). Washington is also the most diverse city in Daviess County with 76.3% of residents of Washington being White alone whereas 90.3% of the Daviess County population is White alone (U.S. Census Bureau, 2022). Additionally, the percentage of foreign born persons in Washington is 8.8%, whereas Daviess County is 3.4% and

Indiana is 5.4%, leading to show that finding resources may not be simple tasks for those who are not native to a rural area (U.S. Census Bureau, 2022). For proper health equity, there should be a proper proportion of health care providers per proportion of residents of a community. With an almost triple rate of foreign-born residents, there is also multiple language barriers with residents of Washington and health care providers.

PICOT Question

The PICOT question that guided this project was: In a mobile health clinic serving Latino populations (P), does a navigation tool (I) compared to current practices (C) improve utilization of services (O) within a 12-week timeframe (T)? The population involved in the project will be the Latino population of Washington, Indiana. The navigational tool will consist of two parts. One will be a magnet that includes the contact information for urgent resources within the community, and another will be a printed description of resources within the community with both being translated into Spanish and Haitian Creole. This evidence-based project will be evaluated by comparing the utilization of resources being used to a 12-week timeframe over Summer and Fall 2023 semesters.

Evidence-Based Practice Framework & Change Theory

This project will be utilizing the Johns Hopkins Evidence-Based Practice (JHEBP) model. This model has a three-phrase approach which is referred to as the PET process which stands for practice question, evidence, and translation (Kelly, 2023). The first phase is where a practice question is developed that identifies the patient population to be served, the interventions to be put into place, and the outcomes the project is hoping to achieve (Kelly, 2023). The second phase is the evidence phase where the evidence is evaluated for quality and strength after a literature search is conducted (Kelly, 2023). The third phase is the translation

phase where the findings of the evidence are utilized to develop recommendations for implementing an evidence-based project by using best practices (Kelly, 2023).

This project will also utilize Lewin's change management model. This model was developed by Kurt Lewin and is a three-stage model which uses an unfreeze, change, and refreeze model (Petiprin, 2023). This project benefits from this model as it allows for knowledge sharing among an interdisciplinary team. This knowledge sharing helps to bring in new ideas and obtain buy-in from the team members to inspire change (Hussain et al., 2018). This model also allows for the knowledge shared to be organized, personalized, and arranged for the project to better fit the goals of the organization (Hussain et al., 2018). Using this change model will allow for the unfreezing of the current practice; examine what resources, based on evidence-based practice, the vulnerable populations would best benefit from along with the best methods for distributing the information regarding those resources; and then freezing the new intervention to continue to evaluate, assess, and adapt as needed.

Evidence Search Strategy

When searching, the key words utilized were "Latino, health disparities, resources, mobile clinic". The University of St. Augustine's (USA) library was utilized, and EBSCOhost was searched. The search resulted in the findings of 2048 articles. Of those, 1966 were excluded by selecting only articles within the United States, Peer Reviewed, published in academic journals, and published from 2018 until present. The remaining 82 articles were further reduced to 56 by excluding articles related to the Covid-19 pandemic. Upon examining the remaining articles, further articles were eliminated that were not studies or did not include Latino populations, health disparities, or mobile clinics. This left five studies that met the requirements for the search. The PubMed database was also searched using the same keywords

with four articles returned. Of those, 3 were excluded due to being published before 2018 and the remaining article was excluded as it did not pertain to health disparities or mobile clinic. These articles were organized by utilizing the Prisma Model (see Figure 1).

Evidence Search Results

The research results provided five articles. When reviewing those articles, quality and grade were assigned utilizing the Johns Hopkins EBP model (Kelly, 2023). Of the articles, two were Level III with a quality of B (Tulimiero et al., 2021; Uwemedimo & May, 2018), one was a Level V with an A quality (Gonzalez et al., 2018), and the remaining two articles are Level III with a quality of C (Fischer et al., 2021; Malone et al., 2020). Reviews of the articles and descriptions can be found in Appendix A and B.

Themes with Practice Recommendations

The literature showed the positive impact of interventions as interventions in various forms helped those vulnerable populations in accessing resources and healthcare access within the community. The practice recommendations focused on reducing health disparities among vulnerable populations. They defined vulnerable populations in various methods such as limited English proficiency (LEP), rural populations, extreme poverty, and immigrant families (Fischer et al., 2021; Gonzalez et al., 2018; Malone et al., 2020; Tulimiero et al., 2021; Uwemedimo & May, 2018). Based on this review, the information was grouped into the following themes, which were identified in the literature as use of resources, mobile clinics, and limited English proficiency.

Use of Resources

A systematic review that was quality A demonstrated that the application of the Vulnerability model is supported (Gonzalez et al., 2018). This model shows a direct inverse

relationship between level of vulnerability and access to high quality healthcare, with patients who have access to high quality health care and low healthcare needs having a low level of vulnerability and those patients who have low access to high quality healthcare and high levels of health care needs having a high level of vulnerability (Figure 2) (Gonzalez et al., 2018). Those resources are more often utilized by those with LEP and immigrant families when explained to them in their primary language (Uwemedimo & May, 2018). There is a consensus among the articles that families who are immigrant families, LEP, or uninsured have higher incidences of health disparities and lack the ability to fully take advantage of and utilize community resources to assist with decreasing those social determinates of health.

Mobile Clinics

In one level III, quality B study, it was shown that by providing a mobile clinic to Latino communities on Saturday afternoons, the number of emergency room visits by those communities were reduced as the mobile clinics offered hours of service that allowed migrant workers to not be required to take a day off work in order to have access to health care and can be seen without an appointment (Tulimiero et al., 2021). In another level III, quality C study, mobile clinics were utilized to provide health care services to vulnerable populations including those that do not have insurance, are covered by a Medicare insurance policy, belong to a minority group, or resided in a rural area (Malone et al., 2020).

Limited English Proficiency

A level III, quality B study showed that those with LEP, as well as immigrant families, have a higher rate of social determinants of health which can cause lower utilization of resources as well as poorer health outcomes (Fischer et al., 2021). However, a level III, quality B study showed that when LEP or immigrant families have resources explained in their primary

language, they have a higher utilization of those social resources (Uwemedimo & May, 2018). Those patients are also more likely to continue with health care follow up (Uwemedimo & May, 2018). This stresses the importance of ensuring that patients have access to information in their primary language to improve health incomes and increase utilization of resources by this vulnerable population.

Synthesis

In all, the literature shows that those with LEP, immigrant families, and those that live in rural settings, do not utilize community resources as often as those that do not fall into those categories. They also experience higher levels of health disparities and social determinates of health than other groups. When those resources are presented in their primary language and explained to them, those vulnerable groups utilized the community resources as a higher level than they did before those interventions. Mobile health clinics also allowed for health care services to be provided at non-traditional times and in the community, allowing patients to access health care without taking time off work and with a shorter commute to services. By putting the community resources into the primary language of the patients, explaining what each resource can offer to the patient, and distributing the navigation aid at mobile clinics, this could increase the utilization of those resources by that vulnerable population in the community.

Setting, Stakeholders, and Systems Change

The setting for this DNP project is a rural health department in Southern Indiana. The county population this health department serves is around 30,000 people with the department also offering services to residents of neighboring counties as well. The mission statement is to improve the health in the county "by providing quality, culturally proficient, and preventative services with respect to dignity; regardless of socioeconomic status with emphasis on the

underserved" (Indiana Department of Health, 2021). The identification of need for services in this area has been ongoing since the opening of the health department. In 2014, this county had the highest infant mortality in the state with half of the infant deaths occurring in the Latino population as well as a higher than average child and maternal mortality rate (Indiana State Department of Health: Division of Maternal and Child Health, 2016). When exploring methods to decrease these mortality rates within that population, it was found there were many unmet social needs that were negatively affecting the health of the population. These health disparities include socioeconomic status, rural geographic location, Medicaid or no health insurance, limited English proficiency, food insecurities, and housing insecurities (U.S. Department of Health & Human Services, 2022). Organizational support was found on the local, district, and state level over the past several years. The local data also supports that the population within the community will accept and utilize the resources when access is presented and explained. The Covid-19 pandemic helped to bring to light the importance of funding at the county level for improved health of residents and thus the Governor's Public Health Commission was developed to help identify weaknesses at the local level and provide funding to help improve overall health (Indiana Department of Health, 2023a).

The stakeholders for this project include a variety of participants. The medical stakeholders include the employees of the health department, the partnership with the mobile health clinic, the local hospital, county medical officer, mental health services, and health care providers in the area. Interprofessional collaboration will include an education extension center, local community leadership, transportation services, health care enrollment specialist, local food bank services, and other social needs. Stakeholders will also include members of the community.

This project will create several levels of change. The micro level will allow families and individuals to find resources that are appliable to their needs to improve their health and social determinants. At the mezzo level, this project will help reduce health disparities by putting members of the group in contact with resources within the community to improve overall health of the community. At the macro level, improving health of the vulnerable population of the community will improve overall health of the county.

Implementation Plan with Timeline and Budget

This project proposed that when vulnerable population within the community has the knowledge and access to resources in the population's primary language, they will utilize those resources. This project will take about 12 weeks from start to finish (See Appendix C for timeline). This project will also utilize SMART goals which allows for goals to be set that are specific, measurable, attainable, relevant, and time bound to better evaluate success of the project (Bjerke & Renger, 2017). Those SMART goals are:

1. At least 100 magnets and packet navigational tools will be distributed at the first mobile clinic after project approval with the date to be determined along translators available at the mobile clinic to assist in explanation.
2. At least 100 magnets and packet navigational tools will be distributed at community locations such as churches, community stores, library, and other locations after project approval along with translators available at the mobile clinic to assist in explanation.
3. A portable document format (PDF) copy of the packet navigational tool along with directions will be disseminated to all the primary health care providers

practicing in the county within two weeks after project approval along with instructions on how to utilize the tool.

4. Data collected will be from the health department regarding the number of vaccines provided, from a local food bank regarding number of food boxes distributed, the number of participants with the back-to-school mobile clinic sponsored by the local health department, and the number of requests for assistance from a community partner. The data collected will compare utilization of resources from July through September for 2022 and 2023 for evaluation.

The data collection will include partnering with community providers. One data point will be vaccine rates in the area serviced by the health department for childhood and adult vaccines. Data will be collected for vaccine rates for the same 12-week timeframe in 2022 and 2023 to determine if there was an increase in vaccine rates after distribution of the navigation tool and app. Data will also be collected from a local food bank to assess the number of food boxes distributed between same 12-week timeframe in 2022 and 2023 to determine if there was an increase in food box distribution after implementation of the project. Also collected will be the number of participants in the back-to-school mobile clinic by the local health department along with requests for assistance from a community partner.

There are several potential risks for this project, however, those can be mitigated to being lesser risks. One would be mistranslation of the resources. This risk has been reduced by having it translated by government employees who have already been established as translators for not only spoken language but written as well. These translators are also involved in the population they are performing the translation for, so also serve as a resource in understanding how to correctly phrase the benefits of each resource. Another risk would be the resource information

becoming out of date. This risk will be reduced by the community resource employee of the health department maintaining the resource packet to keep resources listed up to date with addresses, phone numbers, and relevance. The community resource employee will also be able to add new resources as they present to the community as well as remove resources if they change or close. A third risk would be that the packets are misplaced or not understood. To reduce that risk, the packets will be available in a multitude and variance of locations. To reduce the risk of understanding, translators for the population's native language will be present at events and available by the health department to help explain what the packet is and how to use the packet.

The evidence-based practice model being uses is the JHEBP model previously discussed. The practice setting and evidence have been set and obtained, so this project will take place in the translation portion of the JHEBP model. The evidence shows that when the Latino population is presented with resources in their primary language, they will utilize those resources as well as local data supporting this population is receptive to assistance in finding and utilizing those resources by evidence of the improvement rate of the infant mortality from 2014 to 2021 (Fischer et al., 2021; Indiana Department of Health, 2021; Uwemedimo & May, 2018).

With the utilization of the Lewin's change management model, this project will be in the change stage where change will occur in thought, feelings, and behavior (Hussain et al., 2018). A change of thought will occur in the population, as well as the project partners, in a different method to disseminate and receive information. It will also promote a change of feeling in that trust is being built between resource partners and the population through the inclusion of that population by use of translators and written communication in their primary language. This change of feeling will be demonstrated by the population's increased use of resources to

demonstrate that the population has increasing trust in the resource partners. The behavior change will occur through the increased use of resources.

The navigational tool will consist of two parts. One will be a magnet, which includes the contact information for urgent resources within the community, see Appendix G, and other will be a printed description of resources within the community with both being translated into Spanish and Haitian Creole, see Appendix H. The translation will be performed by government county employees who are approved translators for each language. Once the project is approved, the navigational tool will be printed at the health department, and the magnet will be printed locally with a company that the health department has a contract with (See Table 1 for budget). The health department and community partners will be holding a mobile health clinic during the summer with the end of July 2023 being the target dates. At this clinic, the magnet and navigation tool will be disseminated in print form to the population. The county health officer has also requested that once approved, a PDF be sent to all primary health care providers in the county as he feels this navigation tool would be a valuable resource for their vulnerable populations. The local food bank will also include a copy of the navigation tool in food boxes distributed after project approval. Copies of the magnet and navigational tools will also be provided to community partners to disseminate in their offices. After 12 weeks from the mobile health clinic, data will be collected from community partners to compare utilization of resources from the same time in 2022 to the current time to assess if there has been an increase in utilization of resources. The project manager’s responsibility will be: building a navigation tool and magnet, consulting with graphic design and translation, obtaining approval for project, having materials printed, providing directions and oversight for dissemination, participating in the mobile clinic where dissemination will occur, providing community partners with

navigational tool, providing primary health care providers with a PDF of the navigational tool, collecting the data from community partners, and analyzing data.

Results

The data collected came from several community partners as well as the health department. This included childhood and adult vaccines given, the number of households and household members assisted with food from the local food pantry, and the number of assistance requests from a community partner in stretching food dollars during the timeframe from June 2022 through September 2022 and June 2023 through September 2023. The data also examines how many participants were at the back-to-school mobile health clinic in 2022 compared to 2023. Prior to starting the project, approval and permission to perform the project was received from both the University of St. Augustine for Health Sciences as well as from the participating facilities.

The data collected was significant to the project. The vaccination rate of the county is an important metric as increasing vaccination rates to reduce vaccine-preventable diseases is a goal of Healthy People 2030 (Indiana Department of Health, 2023b). The back-to-school mobile clinic provided an option for school-aged children to obtain a school physical from an advanced health provider, a vision exam from a licensed ophthalmologist, school-required vaccines, and other health services to promote health in children. The food and nutrition support data are significant as 53% of the people surveyed at the mobile health event in March 2023 indicated they need help with obtaining food and getting their food dollars to stretch further (Daviess County Health Department, 2023).

The data was collected in a variety of methods. The back-to-school mobile health clinic participants were counted based on how many were registered for and received services on the

day of the event by the health department. The vaccine rates are tracked in electronic medical records, and then reported to the state department of health. The number of assistance requests are tracked by a community partner based on how many people fill out a request for assistance form and met with an outreach educator, and the data is reported to the university who sources the outreach education. The food boxes distributed are counted as they are given and reported to the state department of health. The data collected for this EBP project does not contain any personal or private patient information, so patient privacy and HIPAA information will be maintained. All the data collected is maintained by the organization performing the service and reported to various state departments.

The data collected was analyzed in a few methods. The data from the vaccine rates, local food bank, and community partner was analyzed using a paired t-test through Intellectus Statistics (Intellectus Statistics [Online computer software], 2023; Razali & Wah, 2011).

The data from the back-to-school mobile clinic did not contain enough data points for a t-test to be conducted. The back-to-school mobile clinic showed an increase of participants. In 2022, the event had 55 participants and in 2023, there were 90 which is a 63% increase in participants.

The data for the other measurements were varied. The results from the t-test for the vaccine rate was not significantly different with an alpha value of 0.05 and a p value of 0.174. In looking at number of vaccines given, the number given in 2023 was less than 2022 (see Table 2 for data and Appendix D for results).

Table 2

Vaccines given by the local health department in 2022 and 2023

	2022	2023	Increase from 2022 to 2023
DTap	65	67	2
Dtap/5 pertussis antigens	8	6	-2
DTap/IPV/Hib/HepB	47	127	80
DTap/HIB/IPV	197	71	-126
DTap/IPV	161	141	-20
HPV9	145	84	-61
Hep A	240	197	-43
Hep B	180	61	-119
Hib	28	17	-11
IPV	49	74	25
Influenza	37	59	22
MMR	119	136	17
MMRV	156	132	-24
Meningococcal B	50	67	17
Pneumococcal	145	110	-35
TDap	372	349	-23
Meningococcal MCV4P	141	0	-141
Meningococcal MCV4	221	330	109
Rotavirus	51	27	-24
Varicella	19	28	9
Zoster	11	15	4
Total	2442	2098	-344

The results from the t-test for the requests for assistance stretching food dollars showed significantly difference the time frame compared from 2022 to 2023 with an increase in requests in 2023 with an alpha value of 0.05 and a p value of 0.975 (see Table 3 for data and Appendix E for results).

Table 3

Number of households (HH) and household members (HHM) provided with food boxes

	Households	Household Members
June 2022	326	973
July 2022	318	914
August 2022	304	846
September 2022	306	818
June 2023	370	1118
July 202	382	1158
August 2023	436	1228
September 2023	377	1087

The results for the t-test for food boxes distributed also showed a significant difference in number households assisted and number of household members assisted with an increase in food boxes distributed in 2023 over 2022 with alpha values of 0.05 for both and a p value of 0.26 for total households and a p value of 0.013 for total household members (see Table 4 for data and Appendix F for results).

Table 4

Number of assistances requests between 2022 and 2023

Requests for assistance	2022	2023
June	1	6
July	3	28
August	2	18
September	4	16

Impact

When examining the practice problem, this project helped to alter practices and impact the population. This can be seen in several areas of the data collection. The navigational tools were distributed via the food bank in the June and July distributions. Following these

distributions, the food bank saw an increase in food distributions in August. Also improved was the back-to-school mobile clinic participation in August as well as the requests for education for assistance with stretching food dollar education in August and following.

The vaccine rate did not improve and found that few vaccines were given over the same time in 2023 when compared to 2022. This could be due to a few reasons. For example, this community has a significant Amish population that makes up about a fourth of the population and can cause fluctuation with the vaccine rate due to religious beliefs (Indiana Department of Health, 2023a).

Medical providers in the community, as well as community partners, were also positively receptive to the project. The majority were pleased with having a list of resources that were also translated to share with patients and clients to help with needs. Several had voiced knowing patients and clients had needs but were unsure of how to help or were to direct patients and clients for assistance. In all, over 900 packets and 250 magnets were printed and handed out by the project.

There were several limitations for the project. Not all community partners or members of the community were receptive to a list of resources being provided as they had different criteria and thoughts in determining who should and should not receive services. This is a common barrier in services in this area per the health department and community partners. Also, the short time frame was a limitation as it may take time for people to reach out to services needed and see a positive impact in resources utilized in the community. The impact of the Covid-19 pandemic could also be impacting utilization of resources as well as the economic challenges of inflation causing more people to seek assistance.

Sustainability is something that has been discussed with the local health department. The community liaison employee has been active in the project and will be taking over the maintenance of the navigational tool. That job position will have an added job responsibility to ensure that it is kept up to date with phone numbers, addresses, and hours if applicable. When the project was being implemented, contacts were obtained from community partners including contact name, phone number, and email to email out a copy of the navigational tool. This will also serve to assist the community liaison employee in maintaining contacting with community partners to update the navigational tool. Mobile clinics will also continue to occur with navigational packets and magnets being distributed.

Dissemination Plan

There will be several parts to the dissemination plan of the project. The health department, the county health officer, and the mobile health committee will then be invited to discuss and demonstrate the data analysis and findings. They will also be provided a copy of the project manuscript for their records. An oral poster will also be presented at the university describing the project and results. This poster can also be presented at the Alpha Alpha Alpha Chapter of Sigma Theta Tau at the next DNP Scholarly Project Symposium as well as at the Indiana Rural Health Association Annual Conference. As this project will focus on a vulnerable population within a rural setting in Indiana, as well as focusing on improving health equity, making this conference appropriate for project submission. The project manuscript will also be published through the university's SOAR@USA repository.

Conclusion

The goal of this project was to present resources to a vulnerable population within the community in their primary language at a mobile health clinic. This can help improve social

determinants of health and increase health equity to individuals who are isolated, either due to lack of transportation or language, are unsure what services are offered, or do not know where to find services that are offered (Attipoe-Dorcoo et al., 2020; Malone et al., 2020). By providing both a comprehensive list of resources in a navigational tool and an emergency list of resources on a magnet that is easily visible, the population then has the knowledge on the assistance those resources can provide as well as how to contact and find the resources.

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Table 1

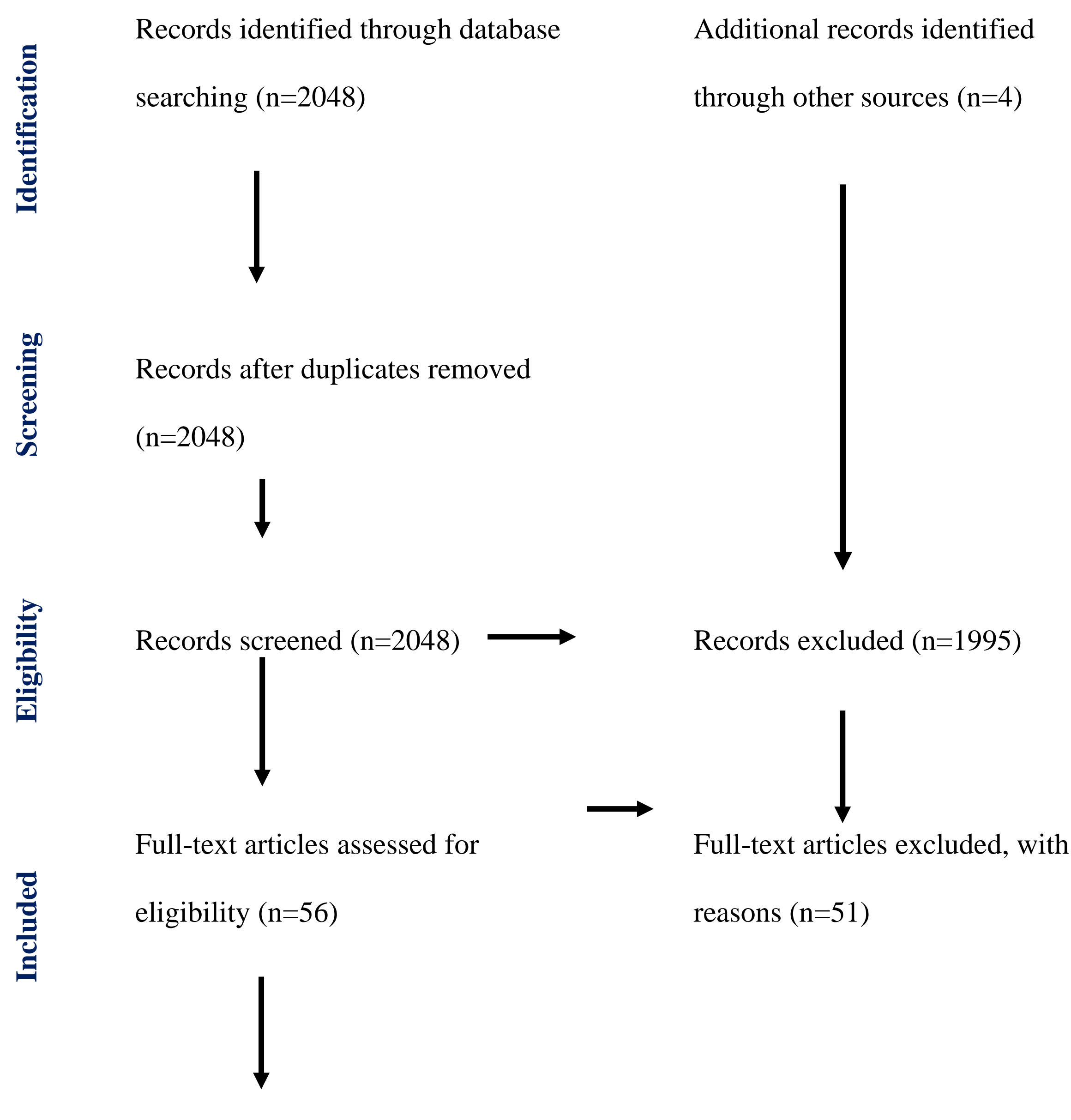
Implementation EBP Project Budget

Expenses		Revenue	
Indirect- Included in regular operating costs	est. $	Billing (no billing will occur)	$0
Salary and benefits x 2 hour for translation	$25/hr x 2 staff	Grants	3000
Overhead	$0		
Printing 250 navigation tools/magnets	$525		
Printing 900 packets	$2000		
Estimate Total Expenses	$2625	Estimate Total Revenue	$3000
Net Balance			$375

Note: All budget entries are estimates. Expenses are based on means. Revenue estimates do not include potential cost avoidance due to realized outcomes. All costs associated to salary and benefits, printing supplies, and overhead are fixed indirect expenses not associated with this project.

Figure 1

PRISMA Flowchart



Note. Prisma flow chart diagram from "Preferred Reporting Items for Systematic Reviews and Meta-analyses: The PRISMA Statement," by D. Moher, A. Liberati, J. Tetzlaff, & D.G. Altman, 2009, Annals of Internal Medicine, 151(4), p.267 (http://dx.doi.org/10.7326/0003-4819-151-4-200908180-00135). Copyright 2009 by The American College of Physicians.

Figure 2

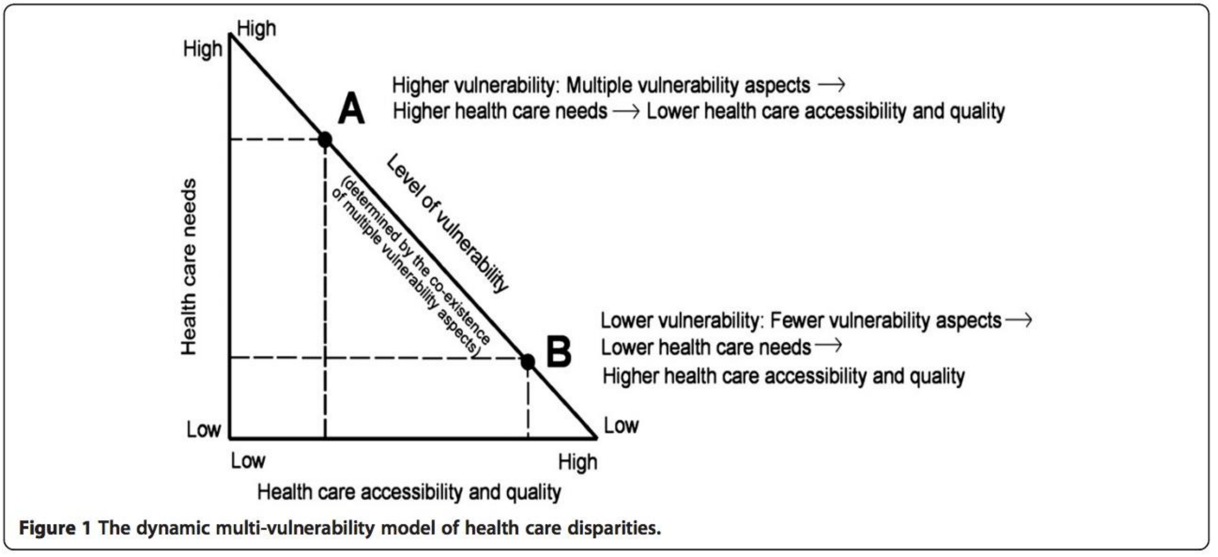


Figure 1 **The dynamic multi-vulnerability model of health care disparities.**

Reproduced from Gonzalez, K. M., Shaughnessy, M. J., Kabigting, E.-N. R., Tomasulo West, D., Callari Robinson, J., Qimin Chen, & Stewart Fahs, P. (2018). The healthcare of vulnerable populations within rural societies: A systematic review. *Online Journal of Rural Nursing & Health Care*, *18*(1), 112–147. https://doi.org/10.14574/ojrnhc.v18i1.507

Appendix A

Summary of Primary Research Evidence

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Tulimiero, M., Garcia, M., Rodriguez, M., & Cheney, A. M. (2021). Overcoming barriers to health care access in rural Latino communities: An innovative model in the eastern coachella valley. *The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association*, *37*(3), 635–644. https://doi.org/10.1111/jrh.12483	Level III Quality B	15 participants that were Latino immigrants in California Coachella Valley and were selected using convenience and snowball sampling from 1 of 4 communities.	Free mobile health clinics were implemented after in home focus group discussions to identify community health priorities and health care barriers. Comparison was with the in-home interviews before and after clinic implementation	Not specified	Outcome was to improve health care access and reduce health care barriers for rural Latino communities within the Coachella Valley area.	Key findings were that having bilingual providers and staff improved communication between patients and staff. Also offering Saturday afternoon hours better allowed those that worked through the week to seek and receive care. Having the units be mobile allowed for less travel time for patients vs brick and

						mortar facilities.
Uwemedimo, O. T., & May, H. (2018). Disparities in utilization of social determinants of health referrals among children in immigrant families. *Frontiers in Pediatrics*, *6*, 207. https://doi.org/10.3389/fped.2018.00207	Level III Quality B	148 caregivers who indicated a need on the FAMNEEDS tool and accepted assistance	A bilingual resource navigator who was trained in resources available, called caregivers to identify needs and offer referrals to resources. The navigator then followed up every two weeks for eight weeks and again at three months to assess if resources were utilized and follow up support.	Not specified	Outcome showed that caregivers who were undocumented or immigrant status or had limited English proficiency utilized resources at a higher rate than U.S. Citizens or those caregivers that were English-proficient.	Engaging caregivers and patients that have limited English proficiency or non-U.S. citizens can help prevent those patients from being lost to follow up and increase their utilization of community resources.
Gonzalez, K. M., Shaughnessy, M. J., Kabigting, E.-N. R., Tomasulo West, D., Callari Robinson, J., Qimin Chen, & Stewart Fahs, P. (2018). The healthcare of vulnerable populations within rural societies: A systematic review. *Online Journal of Rural Nursing & Health Care*, *18*(1), 112–147. https://doi.org/10.14574/ojrnhc.v18i1.507	Level V Quality A	46 articles that were published in the last 5 years that focused on vulnerability within rural populations	No intervention was performed as this was a literature review	Not specified	Some of the most vulnerable populations reside in rural communities in the U.S. thus leading to health	The application of the Vulnerability model for rural health research is supported by this literature review.

		of the U.S. and U.S. territories			disparities in these rural populations and have increased health needs with increased healthcare disparities.	
Malone, N. C., Williams, M. M., Smith Fawzi, M. C., Bennet, J., Hill, C., Katz, J. N., & Oriol, N. E. (2020). Mobile health clinics in the United States. *International Journal for Equity in Health*, *19*(1), 40. https://doi.org/10.1186/s12939-020-1135-7	Level III Quality C	811 clinics that participated in Mobile Health map between 2007 and 2017	No intervention was performed. Data was collected from the mobile clinics regarding client demographics, populations served, affiliations and funding sources, geographic distribution, and services offered.	Not specified	Mobile clinics provide a range of services to vulnerable populations given that these clinics served a majority of minorities and those that lack access to healthcare.	59% of patients served were racial/ethnic minorities Of the clinics that report insurance, 41% of patients had no insurance and 44% had public insurance The majority of services offered were primary care (41%) and prevention care (47%)
Fischer, A., Conigliaro, J., Allicock, S., & Kim, E. J. (2021). Examination of social determinants of health among patients with limited English proficiency. *BMC Research Notes*, *14*, 299. https://doi.org/10.1186/s13104-021-05720-7	Level III Quality C	92,958 individuals with 83,445 patients who are English proficient	No intervention was performed as this was data collection based on social	Not specified	LEP and patients with a primary language of Spanish had an increase in	Language barriers can perpetuate cultural barriers and thus impede

		and 9,513 who have LEP that were screened for SDH at inpatient acute-care hospitals in the Northwell health system.	needs screening for inpatients that included patient demographics		social needs such as employment, health insurance, health literacy, medical care, utility bill assistance, poor housing quality, food insecurity, material need, medical-legal assistance, and public benefit, when compared to those patients who were English proficient	provider's ability to detect social needs. A screening tool can assist with identifying those needs to better assist patients.

Legend: Social Determinates of Health (SDH), limited English proficiency (LEP)

Appendix B

Summary of Systematic Reviews (SR)

Citation	**Quality Grade**	**Question**	**Search Strategy**	**Inclusion/ Exclusion Criteria**	**Data Extraction and Analysis**	**Key Findings**	**Usefulness/ Recommendation/ Implications**
Tulimiero, M., Garcia, M., Rodriguez, M., & Cheney, A. M. (2021). Overcoming barriers to health care access in rural Latino communities: An innovative model in the eastern coachella	Level III Quality B	Would providing a mobile clinic help reduce health care barriers for the Rural Latino Community in Coachella Valley area of California?	**Databases included:** EBSCOhost and PubMed English only 2018 through present Search terms: Latino, health disparities, resources, mobile clinic	Inclusion criteria: Latino, health disparities, resources, mobile clinic Exclusion criteria: Not actual study, COVID-19, did not include Latino populations, health disparities, or mobile clinics	Individuals interviewed stated they used the mobile clinic more frequently than free standing clinics and reduced patient's need to go to the emergency room or hospital for care. Also stated was they were better able to communicate with providers and staff as they were bilingual. Saturday hours offered more flexibility for those that worked through the week, 55and patients were pleased with wait times, even when they exceeded an hour.	Key findings were that having bilingual providers and staff improved communication between patients and staff. Also offering Saturday afternoon hours better allowed those that worked through the week to seek and receive care. Having the units be mobile allowed for less travel time for patients vs brick and mortar facilities.	Utilize bilingual providers and staff Offer Saturday afternoon hours Mobile units provide less travel time than brick and mortar facilities

valley. *The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association*, *37*(3), 635–644. https://doi.org/10.1111/jrh.12483							
Uwemedimo, O. T., & May, H. (2018).	Level III Quality B	Would integrating a routine social	**Databases included:**	Inclusion criteria: Latino, health disparities,	The FAMNEEDS tool was used for screening social	Engaging caregivers and patients that	Utilizing a screening tool to identify caregivers or patients

Disparities in utilization of social determinants of health referrals among children in immigrant families. *Frontiers in Pediatrics*, *6*, 207. https://doi.org/10.3389/fped.2018.00207		determinants of health screening aligned with bilingual resource navigation services with follow-up within a hospital pediatric practice increase utilization of resources?	EBSCOhost and PubMed English only 2018 through present Search terms: Latino, health disparities, resources, mobile clinic	resources, mobile clinic Exclusion criteria: Not actual study, COVID-19, did not include Latino populations, health disparities, or mobile clinics	determinates of health among families with a hospital based pediatric practice. Families that indicated a need and accepted assistance were included in the study. Those families were provided a bilingual resource navigator and called initially, every two weeks for 8 weeks, and a final follow up call at 3 months to obtain self-reporting of utilization of resources provided.	have limited English proficiency or non-U.S. citizens can help prevent those patients from being lost to follow up and increase their utilization of community resources.	with social needs can help identify those patients while use of a resource navigator can assist caregivers and patients to finding resources. When engaged, those with limited English proficiency and non-U.S. citizens will utilize resources thus reducing social needs and health disparities.
Gonzalez, K. M., Shaughnessy, M. J., Kabigting, E.-N. R., Tomasulo West, D., Callari Robinson, J., Qimin Chen, & Stewart Fahs, P. (2018). The	Level V Quality A	What are the findings of research for vulnerable populations in rural areas in the U.S. for the past five years and how do they present in the Dynamic Multi-Vulnerability	**Databases included:** EBSCOhost and PubMed English only 2018 through present Search terms: Latino, health disparities,	Inclusion criteria: Latino, health disparities, resources, mobile clinic Exclusion criteria: Not actual study, COVID-19, did not include Latino populations, health disparities, or mobile clinics	There does need to be a clearer definition of vulnerability and rural as only in 1/3 of the articles is there a clear definition of rural and vulnerability is seldomly defined.	Some of the most vulnerable populations reside in rural communities in the U.S. thus leading to health disparities in these rural populations and have increased	The application of the Vulnerability model for rural health research is supported by this literature review. There is a need to perform research for rural health where interventions and measurements of SDH to better understand how to decrease SDH and

healthcare of vulnerable populations within rural societies: A systematic review. *Online Journal of Rural Nursing & Health Care*, *18*(1), 112–147. https://doi.org/10.14574/ojrnhc.v18i1.507		Health Care Disparities model?	resources, mobile clinic			health needs with increased healthcare disparities.	improve health disparities.
Malone, N. C., Williams, M. M., Smith Fawzi, M. C., Bennet, J., Hill, C., Katz, J. N., & Oriol, N. E. (2020). Mobile health clinics in the United States. *International Journal for Equity in Health*, *19*(1), 40. https://doi.org/10.1186/s12939-020-1135-7	Level III Quality C	What is the description of mobile health clinics that participate in the Mobile Health Map between 2007 to 2017?	**Databases included:** EBSCOhost and PubMed English only 2018 through present Search terms: Latino, health disparities, resources, mobile clinic	Inclusion criteria: Latino, health disparities, resources, mobile clinic Exclusion criteria: Not actual study, COVID-19, did not include Latino populations, health disparities, or mobile clinics	59% of patients served were racial/ethnic minorities Of the clinics that report insurance, 41% of patients had no insurance and 44% had public insurance The majority of services offered were primary care (41%) and prevention care (47%)	Mobile clinics provide a range of services to vulnerable populations given that these clinics served a majority of minorities and those that lack access to healthcare.	Expanding mobile health clinics to reach those populations who live in resource limited areas could improve health in those areas.

Fischer, A., Conigliaro, J., Allicock, S., & Kim, E. J. (2021). Examination of social determinants of health among patients with limited English proficiency. *BMC Research Notes*, *14*, 299. https://doi.org/10.1186/s13104-021-05720-7	Level III Quality C	Do people with LEP have a higher prevalence of social needs than those patients who are English proficient?	**Databases included:** EBSCOhost and PubMed English only 2018 through present Search terms: Latino, health disparities, resources, mobile clinic	Inclusion criteria: Latino, health disparities, resources, mobile clinic Exclusion criteria: Not actual study, COVID-19, did not include Latino populations, health disparities, or mobile clinics	This was data collection based on social needs screening for inpatients that included patient demographics. Of the patients who had LEP, 40.8% were Hispanic and 26.8% had Medicare vs those who were English proficient had an 8.7% Hispanic population and 10.4% had Medicare.	LEP and patients with a primary language of Spanish had an increase in social needs such as employment, health insurance, health literacy, medical care, utility bill assistance, poor housing quality, food insecurity, material need, medical-legal assistance, and public benefit, when compared to those patients who were English proficient	Language barriers can perpetuate cultural barriers and thus impede provider's ability to detect social needs. A screening tool can assist with identifying those needs to better assist patients.

Legend: Social Determinates of Health (SDH), limited English proficiency (LEP)

Appendix C

Project Schedule

	NUR7801								NUR7802								NUR7803							
Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15
Meet with preceptor/mentor																								
Project approval with preceptor/mentor /faculty																								
Prepare project proposal																								
Construct PICOT question																								
Identify key stakeholders																								
Evaluate literature search and EBP																								
Gain University approval for project																								
Gain health department approval for project																								
Meet with mobile clinic committee to																								

	NUR7801								NUR7802								NUR7803							
Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15
review and plan for project implementation																								
Develop Navigational tool																								
Meet with graphic design for navigational tool/magnet																								
Send navigational tool/magnet for translation																								
Have tool/magnet printed																								
Meet with mobile clinic committee to discuss dissemination of tool/magnet																								
Participate in mobile clinic to disseminate tool/magnet																								
Providing community																								

	NUR7801								NUR7802								NUR7803							
Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15
partners with navigational tool																								
Providing primary health care providers with a PDF of the tool																								
Collect data from community partners																								
Analyze data																								
Write project report																								
Disseminate results to stakeholders																								

Appendix D

Adult and childhood vaccines given in 2022 and 2023 by the health department

Table 5

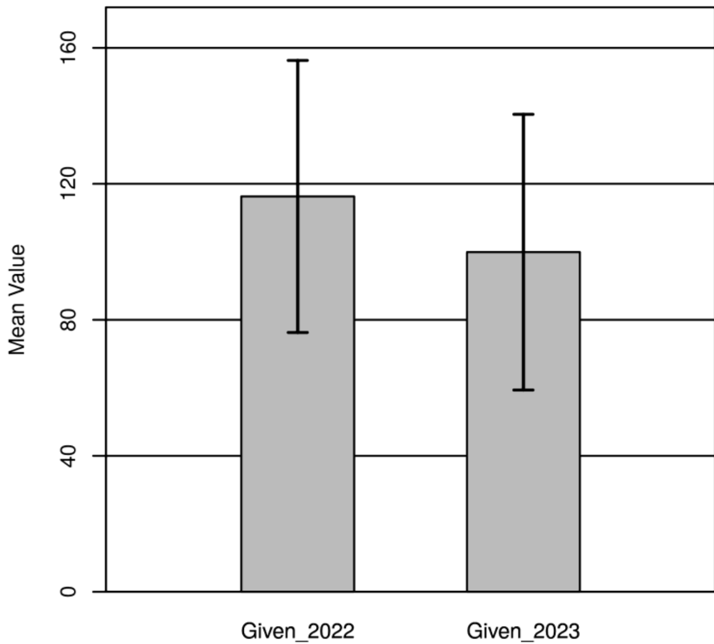
Two-Tailed Paired Samples t-Test for the Difference Between Given_2022 and Given_2023

Given_2022		Given_2023				
M	*SD*	*M*	*SD*	*t*	*p*	*d*
116.29	93.55	99.90	94.80	1.24	.229	0.27

Note. N = 21. Degrees of Freedom for the *t*-statistic = 20. *d* represents Cohen's *d.*

Figure 3

The means of Given_2022 and Given_2023 with 95.00% CI Error Bars



Appendix E

Number of assistance requests from a community partner in food education and stretching food dollars

Table 6

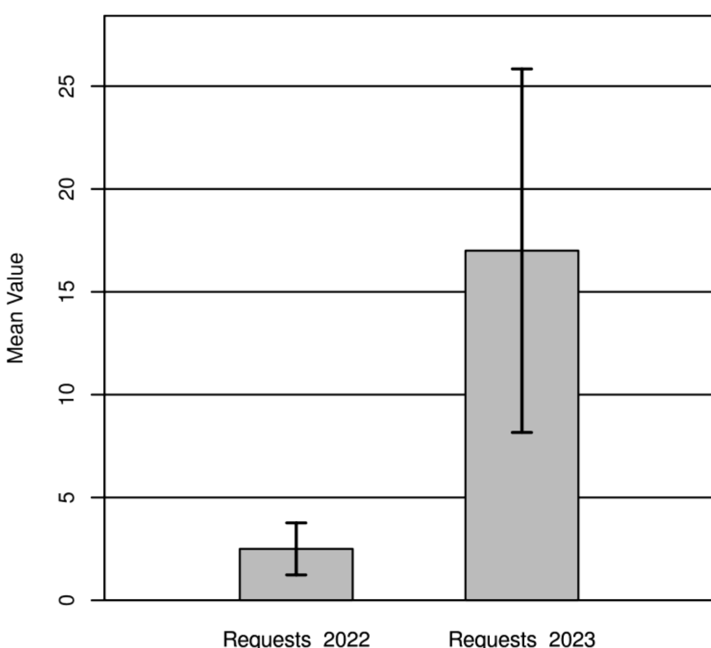
Two-Tailed Paired Samples t-Test for the Difference Between Requests_2022 and Requests_2023

Requests_2022		Requests_2023				
M	*SD*	*M*	*SD*	*t*	*p*	*d*
2.50	1.29	17.00	9.02	-3.47	.040	1.74

Note. N = 4. Degrees of Freedom for the *t*-statistic = 3. *d* represents Cohen's *d*.

Figure 4

The means of Requests_2022 and Requests_2023 with 95.00% CI Error Bars



Appendix F

Number of households and household members provided with food boxes by local food pantry

Table 7

Two-Tailed Paired Samples t-Test for the Difference Between Total_HH_2022 and Total_HH_2023

Total_HH_2022		Total_HH_2023				
M	*SD*	*M*	*SD*	*t*	*p*	*d*
313.50	10.38	391.25	30.24	-4.10	.026	2.05

Note. N = 4. Degrees of Freedom for the *t*-statistic = 3. *d* represents Cohen's *d.*

Figure 5

The means of Total_HH_2022 and Total_HH_2023 with 95.00% CI Error Bars

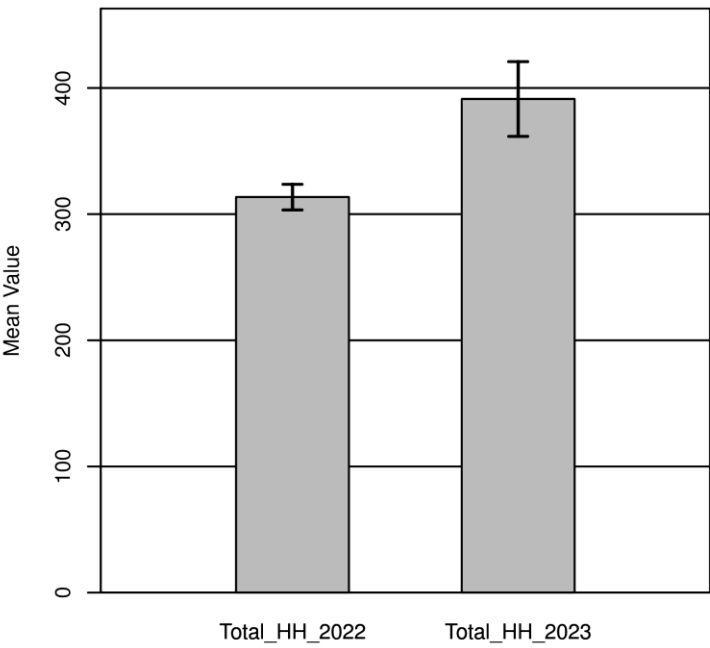


Table 8

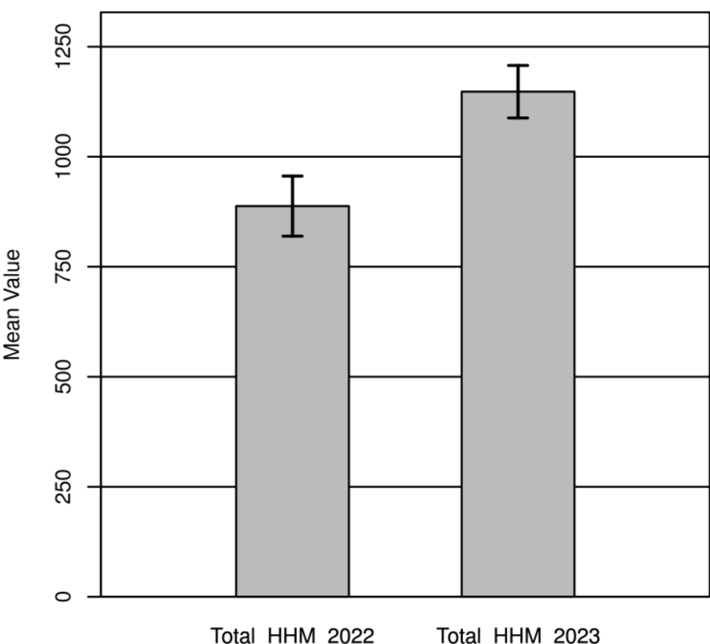
Two-Tailed Paired Samples t-Test for the Difference Between Total_HHM_2022 and Total_HHM_2023

Total_HHM_2022		Total_HHM_2023				
M	*SD*	*M*	*SD*	*t*	*p*	*d*
887.75	69.68	1,147.75	60.88	-5.34	.013	2.67

Note. N = 4. Degrees of Freedom for the *t*-statistic = 3. *d* represents Cohen's *d.*

Figure 6

The means of Total_HHM_2022 and Total_HHM_2023 with 95.00% CI Error Bars



Appendix G

Resource magnet developed for the project 4 inches by 8 inches.

Appendix H

Resource packet that was distributed.

ROOTED

The Rooted Project: Growing Healthy Communities

COMMUNITY RESOURCE GUIDE
GUÍA DE RECURSOS DE LA COMUNIDAD
GID RESOUS KOMINOTÈ

DAVIESS COUNTY COMMUNITY RESOURCE GUIDE 2023

The Rooted Project: Growing Healthy Communities

The Daviess County Health Department and Purdue Extension Office are pleased to serve as your resource specialists. We offer one-on-one case management and assistance.

El Daviess County Health Department y el Purdue Extension Office se complacen en servir como sus especialistas en recursos. Ofrecemos asistencia y gestión de casos individual.

Depatman Sante Davies ak Biwo Ekstansyon pou sèvi kòm espesyalis resous ou. Nou ofri jesyon yon sèl-a-yon sèl ka ak asistans.

Contact Us/ Contáctenos/ Kontakte nou:
WhatsApp/Google Voice
(812) 610-1481

Health Resources

- Daviess County Health Department
  - 812-254-8666 Option 1. 300 E Hefron St, Washington, IN 47501
  - Vaccines
  - Free crib for baby
  - Safe sleep education
  - Baby & Me Tobacco Free Program
  - Tuberculosis testing
  - STD testing and treatment
  - CPR training
  - Birth Certificates
  - Death Certificates
  - Food safety
  - Septic system
  - Lead Testing
  - Free Narcan
- Daviess Community Hospital
  - 812-254-2760. 1314 E Walnut St, Washington, IN 47501
  - 24-hour Emergency medical treatment
  - Free car seat for baby
  - Pregnancy care
  - Breastfeeding support
- Daviess Community Hospital Quick Care
  - 812-254-7845. 1805 IN-57, Washington, IN 47501 (by Walmart)
  - Non-life threatening health care
- Fast Pace Health Urgent Care
  - 812-674-5372 1301 E National Highway, Washington, IN 47501
  - Non-life-threatening health care
  - School/Sports/DOT physicals
- Indiana Poison Center
  - 800-222-1222
  - Suspected poisoning help
  - Poison prevention
- Indiana Rural Health
  - 317-281-0095. 201 E. Main St Suite 415, Washington, IN 47501
  - Health insurance for qualified adults
- Family Health Center

- 812-254-1558. 2007 State St, Washington, IN 47501
- Mental health services for depression, anxiety, family therapy, eating disorders, substance abuse, and domestic violence for all ages

- Suicide Prevention Hotline
  - 988, 800-552-3106 or 800-273-8255
  - Mental health and addiction assistance 24/7

Social Resources

- Purdue Cooperative Extension Center
  - 812-254-8668. 300 E Hefron St, Washington, IN 47501
  - Education to provide:
    - Food and nutrition
    - Food safety
    - Personal and family management
    - 4-H program for kids kindergarten through high school
    - Food security/stretching food dollars
- Connections
  - 812-257-2650
  - Contact Police Department after hours or weekends 812-254-4410
  - Can help find resources to help with various needs
- Salvation Army
  - 812-257-2650. 211 E. Main St, Washington, IN 47501
  - Must have referral from Connections
  - Assistance with medicines, utilities, rent, and other crisis needs
- Feed My Sheep
  - 812-254-5429. 601 W Oak St. Washington, IN 47501
  - Free box of food every third Saturday from 9am to 1pm and the fourth Thursday from 6pm to 7pm (Limit one box per month)
  - Free box of produce every Monday and Friday at 1pm (Limit one box per week)
- First Baptist Church Food Bank
  - 812-254-2556. 100 E Walnut St, Washington, IN 47501
  - Free box of food Mondays and Thursdays, but must call the day before by 11:00 am to receive food box. Limit one box per month
- Heaven`s Kitchen
  - 1614 W. Walnut St, Washington, IN 47501

  - Free hot meal Monday through Friday 5pm-6pm
  - Free bread Monday through Friday 5pm-6pm
- Daviess County Division of Family Resources
  - 800-403-0864. 900 W National Hwy Suite 9, Washington, IN 47501
  - Apply for supplemental nutrition assistance program, temporary assistance for needy families, Medicaid, Hoosier Health, and Healthy Indiana Plan
- PACE Community Action Agency
  - 812-882-7927. 2 NE 21st St, Washington, IN 47501
  - Energy assistance 812-257-2132
    - Offers energy assistance to low-income households with bill assistance, fans, or air conditioning
  - Health Connection 812-254-6936
    - Family planning
    - HIV testing
    - Reproductive health services
  - Head Start 812-254-6098 ext 203
    - Preschool for 3–5-year-old children
    - Early Head Start for children birth to 3 years old
  - Women, Infants, and Children (WIC) 812-254-0002
    - Supplemental food program for women, infant, and children
- Senior & Family Services
  - 812-254-1881. 211 E. Main St, Washington, IN 47501
  - Meals on Wheels serves a hot meal Mondays, Wednesdays, and Fridays at the center
  - Adult Day Services and help finding in home services
  - Senior activities
  - Medical transportation—Please call 48 hours in advance. Wheelchair vans and cars are available
  - Women only fitness Monday through Friday 6:30am to 4pm for $20 a month
- St. Vincent DePaul
  - 812-254-6678. 815 E Main St, Washington, IN 47501
  - Preowned clothing, furniture, and house supplies
  - Urgent financial assistance for rent, utilities, prescriptions, groceries, and other needs
  - Loan medical equipment for free

- Generations
  - 812-888-5880. 1019 N 4th St, Vincennes, IN 47591
  - Case management for individuals with disabilities
  - Assistance in assessing and find services
  - Medicare insurance counseling and assistance

Community Resources

- Hope's Voice
  - 812-642-4426 or 812-886-4470. 200 W. Main St, Washington, IN 47501 (in Harvest Church)
  - Domestic violence shelter (24 hour hotline is 812-899-4673)
  - Counseling
  - Legal and Financial assistance
  - Housing and transportation support
- Recovery Cafe
  - 812-642-5007. 10 W VanTrees St, Washington, IN 47501
  - Counseling, recovery groups, and treatment programs
  - Legal Aid
- United Way
  - 812-254-1038. 1001 E Main St, Washington, IN 47501
  - Early education assistance
- RSVP
  - 812-254-1996. Eastside Park in the Community Building, Washington, IN 47501
  - Volunteer placement for ages 55 and up
  - Education on food security, early education, and senior isolation
  - Free food box for low income seniors on the 4th Monday of the month. Must apply in person
- First Choice Solutions/Pregnancy Care Center
  - 812-257-1041. 714 W. Walnut St, Washington, IN 47501
  - Pregnancy tests
  - STI treatment
- Ride Solutions
  - 812-254-3225. 1001 E Main St, Washington, IN 47501
  - Public transportation—must call 24 hours in advance
- Daviess County Court House
  - 200 E Walnut St, Washington, IN 47501

    - Marriage licenses
- Washington City Hall
    - 101 NE 3rd St Washington, IN 47501
    - Washington Police Department
    - Utility office—Pay water, sewer, trash, electric bills
- Daviess County Treasurer's Office
    - 812-254-1091. 300 E Hefron St, Washington, IN 47501
    - Pay Property Taxes
- Washington Housing Authority
    - 812-254-1596. 520 SE 2nd St, Washington, IN 47501
    - Income based housing for families, seniors, and those with disabilities
- Washington Street Department
    - 812-254-4564
    - Recycling, street maintenance, trash and limb pick up
- Sisters of St. Benedict Latino Outreach
    - 812-367-1411 Ext 2102
    - Immigration assistance
- Catholic Charities of Evansville
    - 812-423-5456
    - Immigration assistance
    - Rent or utilities financial assistance
    - Medical travel assistance for children under 18
- Goodwill
    - 812-254-1971. 301 E Highland Ave, Washington, IN 47501
    - Preowned clothing, furniture, and house supplies
- Helping Hands Ministry
    - 812-254-4443. 110 NE Second St., Washington, IN 47501
    - Free basic items such as clothing, shoes, kitchenware, linens, and household items
    - Third Saturday of the month from 10am to 2pm
- Indiana Migrant Education Program
    - 812-482-6641. 1102 Tree Lane Drive, Jasper, IN 47546
    - Education support for migratory children
- Carnegie Public Library
    - 812-254-4586. 300 West Main St, Washington, IN 47501

  - Check out books, audio books, and DVDs
  - Free WiFi
  - Adult literacy program
  - Reading programs for teens and children
- Premier Staffing Solutions
  - 812-254-2140. 308 W. National Hwy, Washington, IN 47501
  - Assistance in finding employment
- Unemployment Insurance
  - 800-891-6499
  - Benefits for those that have been fired or laid off from full time job
- USDA Rural Development
  - 812-482-1171. 1484 Executive Blvd, Jasper, IN 47546
  - Financial assistance in purchasing or repairing homes
- Indiana Legal Services
  - 866-964-2138
  - Immigration assistance
- Vincennes University Adult Basic Education
  - Vicmary Jimenez-Bene jimenez.vicmary@gmail.com
  - English as a second language (ESL) classes for Spanish and Haitian Creole speaking students
- East Coast Migrant Head Start Project
  - 812-297-5018
  - Early Education and transportation for migrant families working in agriculture
- Washington Transit System
  - 812-254-8233
  - Free bus service Monday-Friday 7 a.m. to 4 p.m.
  - Call for service
- Surge Staffing
  - 812-642-9603. 900 W. National Hwy, Washington, IN 47501
  - Assistance in finding employment
  - Services in English, Spanish, and Haitian Creole

Recursos de salud

- Departamento de Salud del Condado de Daviess
  (Daviess County Health Department)
  - 812-254-8666 Opción 1. 300 E Hefron St, Washington, IN 47501
  - Vacunas
  - Cuna gratis para bebé
  - Educación sobre el sueño seguro
  - Programa "Baby & Me" Libre de Tabaco
  - Pruebas de tuberculosis
  - Pruebas y tratamiento de ETS
  - Entrenamiento de Resucitación Cardio Pulmonar (CPR en inglés)
  - Certificados de nacimiento
  - Certificados de defunción (muerte)
  - Seguridad alimentaria
  - Sistemas sépticos
  - Pruebas de plomo
  - Narcan gratis
- Daviess Community Hospital
  - 812-254-2760. 1314 E Walnut St, Washington, IN 47501
  - Tratamiento médico de emergencia las 24 horas
  - Silla de coche gratuita para bebé
  - Atención del embarazo
  - Apoyo a la lactancia materna
- Daviess Community Hospital Quick Care- Clínica de Cuidado Urgente
  - 812-254-7845. 1805 IN-57, Washington, IN 47501 (por Walmart)
  - Atención médica no de emergencia
- Fast Pace Health – Clínica de Cuidado Urgente
  - 812-674-5372 1301 E National Highway, Washington, IN 47501
  - Atención médica que no pone en peligro la vida
  - Exámenes físicos escolares/deportivos

- Centro de Envenenamiento de Indiana
  - 800-222-1222
  - Ayuda por sospecha de intoxicación
  - Prevención de envenenamientos
- Salud Rural de Indiana
  - 317-281-0095. 201 E. Main St Suite 415, Washington, IN 47501
  - Seguro médico para adultos calificados
- Centro de Salud Familiar
  - 812-254-1558. 2007 State St, Washington, IN 47501
  - Servicios de salud mental para depresión, ansiedad, terapia familiar, trastornos alimentarios, abuso de sustancias y violencia doméstica para todas las edades
- Línea directa de Prevención del Suicidio
  - 988, 800-552-3106, or 800-273-8255
  - Asistencia de salud mental y adicciones 24/7

Recursos Sociales

- Servicio de Extensión Cooperativo de Purdue University (Purdue Extension)
  - 812-254-8668. 300 E Hefron St, Washington, IN 47501
  - Programas Educativos sobre:
    - Alimentación y nutrición
    - Seguridad alimentaria
    - Gestión personal y familiar
    - Programa 4-H para niños desde Kinder al grado 12
    - Seguridad alimentaria/estiramiento de los dólares de los alimentos
- Daviess County CONNECTIONS
  - 812-257-2650
  - Comuníquese con el Departamento de Policía después del horario de atención o los fines de semana 812-254-4410
  - Puede ayudar a encontrar recursos para ayudar con diversas necesidades
- Ejército de Salvación (Salvation Army)
  - 812-257-2650. 211 E. Main St, Washington, IN 47501
  - Debe tener referencia de CONNECTIONS
  - Asistencia con medicamentos, servicios públicos, alquiler y otras necesidades de crisis

- Feed My Sheep (Banco de Alimentos)
    - 812-254-5429. 601 W Oak St. Washington, IN 47501
    - Caja de comida gratis cada tercer sábado de 9am a 1pm y el cuarto jueves de 6pm a 7pm (Límite de una caja por mes)
    - Caja gratuita de productos todos los lunes y viernes a la 1pm (Límite de una caja por semana)
- Heaven`s Kitchen
    - 1614 W. Walnut St, Washington, IN 47501
    - Comida caliente gratis de lunes a viernes de 5pm-6pm
    - Pan gratis de lunes a viernes 5pm-6pm
- Banco de Alimentos de la Primera Iglesia Bautista
    - 812-254-2556. 100 E Walnut St, Washington, IN 47501
    - Caja gratis de comida los lunes y jueves, pero debe llamar el día anterior antes de las 11:00 am para recibir la caja de comida
    - Límite de una caja por mes
- División de Recursos Familiares del Condado de Daviess (Family and Social Services Administration)
    - 800-403-0864. 900 W National Hwy Suite 9, Washington, IN 47501
    - Solicite el programa de Asistencia Nutricional Suplementaria, Asistencia Temporal para Familias Necesitadas, Medicaid, Hoosier Health y Health Indiana Plan
- Agencia de Acción Comunitaria PACE
    - 812-882-7927. 2 NE 21st St, Washington, IN 47501
    - Asistencia energética 812-257-2132
        - Ofrece asistencia energética a hogares de bajos ingresos con asistencia con facturas, ventiladores o aire acondicionado
    - Conexión de salud 812-254-6936
        - Planificación familiar
        - Pruebas de VIH
        - Servicios de salud reproductiva
    - Head Start 812-254-6098 ext 203
        - Preescolar para niños de 3 a 5 años
        - Early Head Start para niños desde el nacimiento hasta los 3 años de edad
    - Mujeres, Infantes y Niños (WIC) 812-254-0002
        - Programa de alimentos suplementarios para mujeres, bebés y niños

- Senior & Family Services
  - 812-254-1881. 211 E. Main St, Washington, IN 47501
  - Meals on Wheels sirve una comida caliente los lunes, miércoles y viernes en el centro
  - Servicios diurnos para adultos y ayuda para encontrar servicios en el hogar
  - Actividades para personas mayores
  - Transporte médico: llame con 48 horas de anticipación. Furgonetas para sillas de ruedas y coches están disponibles
  - Fitness solo para mujeres de lunes a viernes de 6:30 a.m. a 4 p.m. por $ 20 al mes
- St. Vincent DePaul
  - 812-254-6678. 815 E Main St, Washington, IN 47501
  - Ropa, muebles y artículos para el hogar usados
  - Asistencia financiera urgente para alquiler, servicios públicos, medicamentos recetados, comestibles y otras necesidades
  - Préstamo de equipos médicos de forma gratuita
- Generations
  - 812-888-5880. 1019 N 4th St, Vincennes, IN 47591
  - Administración de casos para personas con discapacidades
  - Asistencia para evaluar y encontrar servicios
  - Asesoramiento y asistencia para seguros de Medicare

Recursos comunitarios

- Ride Solutions
  - 812-254-3225. 1001 E Main St, Washington, IN 47501
  - Transporte público: debe llamar con 24 horas de anticipación
- Corte del Condado de Daviess (Courthouse)
  - 200 E Walnut St, Washington, IN 47501
  - Licencias de matrimonio
- Washington City Hall
  - 101 NE 3rd St Washington, IN 47501
  - Departamento de Policía de Washington
  - Oficina de servicios públicos: pague las facturas de agua, alcantarillado, basura y electricidad
  - Oficina del tesorero: pague los impuestos a la propiedad
- Oficina del Tesorero del Condado de Daviess
  - 812-254-1091. 300 E Hefron St, Washington, IN 47501

    - Pagar impuestos a la propiedad
- Autoridad de Vivienda de Washington (Washington Housing Authority)
    - 812-254-1596. 520 SE 2nd St, Washington, IN 47501
    - Vivienda basada en los ingresos para familias, personas mayores y personas con discapacidades
- Departamento de Saneamiento Washington (Washington Street Department)
    - 812-254-4564
    - Reciclaje, mantenimiento de calles, recolección de basura
- Hope`s Voice
    - 812-642-4426 or 812-886-4470. 200 W. Main St, Washington, IN 47501 (en Harvest Church)
    - Refugio de violencia doméstica (la línea directa las 24 horas es 812-899-4673)
    - Asesoramiento
    - Asistencia legal y financiera
    - Apoyo a la vivienda y el transporte
- Recovery Cafe
    - 812-642-5007. 10 W VanTrees St, Washington, IN 47501
    - Asesoramiento, grupos de recuperación, entrenamiento de recuperación y programas de tratamiento
    - Asistencia jurídica gratuita
- United Way
    - 812-254-1038. 1001 E Main St, Washington, IN 47501
    - Asistencia para la educación temprana
- RSVP
    - 812-254-1996. Eastside Park en el Edificio de la Comunidad, Washington, IN 47501
    - Colocación de voluntarios para mayores de 55 años
    - Educación sobre seguridad alimentaria, educación temprana y aislamiento de personas mayores
    - Caja de comida gratis para personas mayores de bajos ingresos el4° lunes del mes. Debe presentar su solicitud en persona
- First Choice Solutions/Pregnancy Care Center
    - 812-257-1041. 714 W. Walnut St, Washington, IN 47501
    - Pruebas de embarazo
    - Tratamiento de las ITS
- Sisters of St. Benedict Latino Outreach

- 812-367-1411 Ext 2102
- Asistencia con servicios de inmigración

- Caridades Católicas de Evansville (Catholic Charities)
  - 812-423-5456
  - Asistencia de inmigración
  - Asistencia financiera para alquiler o servicios públicos
  - Asistencia médica en viaje para niños menores de 18 años
- Tienda Goodwill
  - 812-254-1971. 301 E Highland Ave, Washington, IN 47501
  - Ropa, muebles y artículos para el hogar usados
- Helping Hands
  - 812-254-4443. 110 NE Second St., Washington, IN 47501
  - Artículos básicos gratuitos como ropa, zapatos, utensilios de cocina, ropa de cama y artículos para el hogar
  - Tercer sábado del mes de 10h a 14h
- Programa de Educación para Migrantes de Indiana
  - 812-482-6641. 1102 Tree Lane Drive, Jasper, IN 47546
  - Apoyo a la educación de los niños migrantes
- Biblioteca Pública
  - 812-254-4586. 300 West Main St, Washington, IN 47501
  - Echa un vistazo a libros, audiolibros y DVD
  - WiFi gratuito
  - Programa de alfabetización de adultos
  - Programas de lectura para adolescentes y niños
- Premier Staffing Solutions
  - 812-254-2140. 308 W. National Hwy, Washington, IN 47501
  - Asistencia en la búsqueda de empleo
- Seguro de desempleo
  - 800-891-6499
  - Beneficios para aquellos que han sido despedidos o despedidos de un trabajo de tiempo completo
- Desarrollo Rural del USDA
  - 812-482-1171. 1484 Executive Blvd, Jasper, IN 47546
  - Asistencia financiera en la compra o reparación de viviendas
- Servicios Legales de Indiana
  - 866-964-2138
  - Asistencia de inmigración

- Educación Básica de Adultos de la Universidad de Vincennes
  - Vicmary Jiménez-Bene jimenez.vicmary@gmail.com
  - Clases de inglés como segundo idioma (ESL) para estudiantes de habla hispana y criolla haitiana
- Proyecto Head Start para migrantes de la costa este
  - 812-297-5018
  - Educación temprana y transporte para familias migrantes que trabajan en la agricultura
- Sistema de Tránsito de Washington
  - 812-254-8233
  - Servicio de autobús gratuito de lunes a viernes de 7 a.m. a 4 p.m.
  - Llamar al servicio
- Aumento de personal
  - 812-642-9603. 900 W. National Hwy, Washington, IN 47501
  - Asistencia en la búsqueda de empleo
  - Servicios en inglés, español y criollo haitiano

Resous Sante

- Depatman Sante Konte Daviess
  - 812-254-8666 Opsyon 1. 300 Hefron St, Washington, IN 47501
  - Vaksen
  - Bèso gratis pou ti bebe
  - edikasyon dòmi san danje
  - Ti bebe - Mwen Tabak gratis pwogram gratis
  - Tès tibèkiloz
  - Tès STD ak tretman
  - fòmasyon CPR
  - Batistè
  - Sètifika lanmò
  - Sekirite alimantè
  - Sistèm septik
  - Tès plon
  - Gratis Natè
- Lopital Kominote Davies
  - 812-254-2760. 1314 E Walnut St, Washington, IN 47501
  - 24 èdtan tretman medikal ijans
  - Chèz machin gratis pou tibebe
  - Swen pou gwosès
  - Bay tete sipò
- Daviess Lopital Kominote Swen Ijan
  - 812-254-7845. 1805 IN-57, Washington, IN 47501 (pa Walmart)
  - Swen sante ki pa menase lavi
- Swen sante ijan pou sante
  - 812-674-5372 1301 E National Highway, Washington, IN 47501
  - Swen sante ki pa menase lavi
  - Fizik lekòl/ espò
- Sant Indiana pwazon
  - 800-222-1222
  - Sispèk èd anpwazonnen
  - Pwazon
- Sante riral Indiana
  - 317-281-0095. 201 E. Main St Suite 415, Washington, IN 47501
  - Asirans sante pou granmoaj ki kalifye yo

- Sant Sante Fanmi
  - 812-254-1558. 2007 State St, Washington, IN 47501
  - Sèvis sante mantal pou depresyon, enkyetid, terapi fanmi, maladi manje, abi sibstans, ak vyolans domestik pou tout laj
- Liy dirèk pou prevansyon swisid
  - 988, 800-552-3106, or 800-273-8255
  - Sante mantal ak asistans dejwe 24/7

Resous Sosyal

- Sant Ekstansyon Koperativ
  - 812-254-8668. 300 Hefron St, Washington, IN 47501
  - Edikasyon pou bay:
    - Manje ak nitrisyon
    - Sekirite alimantè
    - Jesyon pèsonèl ak fanmi
    - Pwogram 4-H pou timoun kindergarten atravè lekòl segondè
    - Sekirite Manje / detire dola manje
- Koneksyon
  - 812-257-2650
  - Kontakte Depatman Lapolis apre èdtan oswa wikenn 812-254-4410
  - Ka ede jwenn resous pou ede ak divès bezwen
- Lame delivrans
  - 812-257-2650. 211 E. Main St, Washington, IN 47501
  - Dwe gen rekòmandasyon nan koneksyon
  - Asistans avèk medikaman, sèvis piblik, lwaye, ak lòt bezwen kriz
- Nouri mouton m yo
  - 812-254-5429. 601 W Oak St. Washington, IN 47501
  - Bwat manje gratis chak twazyèm Samdi soti nan 9am a 1pm ak katriyèm jedi soti nan 6pm a 7pm (Limit yon bwat pou chak mwa)
  - Bwat gratis nan pwodwi chak Lendi ak Vandredi nan 1pm (Limit yon bwat pou chak semèn)
- Premye bank legliz manje
  - 812-254-2556. 100 E Walnut St, Washington, IN 47501
  - Bwat manje gratis nan Lendi ak Jedi, men yo dwe rele jou a anvan 11:00 am pou resevwa bwat manje
  - Limite yon bwat pa mwa

- Divizyon Resous Fanmi (Davies Divizyon Pou Fanmi Resous Fanmi)
  - 800-403-0864. 900 W National Hwy Suite 9, Washington, IN 47501
  - Aplike pou pwogram asistans nitrisyon siplemantè, asistans tanporè pou fanmi ki nan bezwen, Medicaid, Hoosier Health, ak Plan Sante Indiana
- Ajans Ajans Kominotè POU KOminotè
  - 812-882-7927. 2 NE 21st , Washington, IN 47501
  - Asistans enèji 812-257-2132
    - Ofri asistans enèji nan kay ki pa gen anpil revni ak asistans bòdwo, fanatik, oswa èkondisyone
  - Koneksyon Sante 812-254-6936
    - Planin familyal
    - Tès pou VIH
    - Sèvis sante repwodiktif
  - Head Kòmanse 812-254-6098 ext 203
    - Timoun ki gen 3 - 5 lane
    - Kòmanse bonè kòmanse pou timoun yo fè timoun a 3 zan
  - Fanm, Tibebe, ak Timoun (WIC) 812-254-0002
    - Pwogram manje siplemantè pou fanm, tibebe, ak timoun
- Heaven`s Kitchen
  - 1614 W. Walnut St, Washington, IN 47501
  - Gratis manje cho lendi jiska Vandredi 5pm-6pm
  - Pen gratis Lendi jiska Vandredi 5pm-6pm
- Senior & Family Services
  - 812-254-1881. 211 E. Main St, Washington, IN 47501
  - Manje sou Wou yo sèvi yon repa cho Lendi, Mèkredi, ak Vandredi nan sant la
  - Sèvis Jou Pou Granmoin ak ede jwenn nan sèvis lakay
  - Aktivite granmoaj
  - Transpò medikal-Tanpri rele 48 èdtan davans. Chèz chèz ak machin ki disponib
  - Fanm sèlman kondisyon fizik Lendi jiska Vandredi 6:30am a 4pm pou $ 20 yon mwa
- St. Vincent DePaul
  - 812-254-6678. 815 E Main St, Washington, IN 47501
  - Rad ki prepare, mèb, ak founiti kay
  - Asistans finansye ijan pou lwaye, sèvis piblik, preskripsyon, pwovizyon, ak lòt bezwen

  - Ekipman medikal prè pou gratis
- Generations
  - 812-888-5880. 1019 N4th St, Vincennes, IN 47591
  - Jesyon Ka pou moun ki gen andikap
  - Asistans nan evalye ak jwenn sèvis
  - Konsèy asirans medicare ak asistans

Resous Kominotè

- Solisyon monte
  - 812-254-3225. 1001 E Main St, Washington, IN 47501
  - Transpò piblik- dwe rele 24 èdtan davans
- Davies County Tribinal Konte
  - 200 E Walnut St, Washington, IN 47501
  - Lisans maryaj
- Washington City Hall
  - 101 NE 3rd St Washington, IN 47501
  - Depatman polis Washington
  - Biwo sèvis piblik-Peye dlo, egou, fatra, bòdwo elektrik
  - Trezorye biwo-Peye Taks sou Pwopriyete
- Otorite lojman Washington
  - 812-254-1596. 520 SE 2nd St, Washington, IN 47501
  - Revni ki baze sou lojman pou fanmi, granmoaj aje, ak moun ki gen andikap
- Biwo Konte Daviess Konte Trezorye
  - 812-254-1091. 300 Hefron St, Washington, IN 47501
  - Peye Taks sou Pwopriyete
- Depatman lari Washington
  - 812-254-4564
  - Resiklaj, antretyen lari, fatra ak manm ranmase
- Sè Sen Benedict Latino
  - 812-367-1411 Ext 2102
  - Asistans imigrasyon
- Charite katolik nan Evansville
  - 812-423-5456
  - Asistans imigrasyon
  - Lwaye oswa sèvis piblik asistans finansye
  - Asistans medikal pou timoun ki poko gen 18 an

- Bòn tèren
  - 812-254-1971. 301 E Highland Ave, Washington, IN 47501
  - Rad ki prepare, mèb, ak founiti kay
- Ede Ministè men
  - 812-254-4443. 110 NE Second St., Washington, IN 47501
  - Atik debaz gratis tankou rad, soulye, kwizin, lens, ak atik nan kay la
  - Twazyèm Samdi nan mwa a soti nan 10am a 2pm
- Pwogram Edikasyon Migran Indiana Migrant Edikasyon
  - 812-482-6641. 1102 Tree Lane Drive, Jasper, IN 47546
  - Sipò pou edikasyon pou timoun migratè
- Bibliyotèk piblik carnegie
  - 812-254-4586. 300 West St, Washington, IN 47501
  - Tcheke liv, liv odyo, ak DVD
  - fil gratis
  - Pwogram alfabèt pou granmomod
  - Pwogram lekti pou adolesan ak timoun
- Jaspen
  - 463-224-1414. 520 E. VanTrees St, Washington, IN 47501
  - Asistans nan jwenn travay
- Premier solisyon anplwaye
  - 812-254-2140. 308 W. National HWY, Washington, NAN 47501
  - Asistans nan jwenn travay
- Asirans Chomaj
  - 800-891-6499
  - Benefis pou moun ki te revoke oswa revoke nan travay a plen tan
- Devlopman riral Usda
  - 812-482-1171. 1484 Blvd, Jasper, IN 47546
  - Asistans finansye nan achte oswa repare kay
- Hope`s Voice
  - 812-642-4426 or 812-886-4470. 200 W. Main St, Washington, IN 47501 (nan Legliz Rekòt)
  - Abri vyolans domestik (24 èdtan liy telefòn dirèk se 812-899-4673)
  - Konsèy
  - Asistans legal ak finansye
  - Lojman ak sipò transpò
- Rekiperasyon Kafe (Recovery Café)

- 812-642-5007. 10 W VanTrees St, Washington, IN 47501
- Konsèy, gwoup rekiperasyon, antrenè rekiperasyon, ak pwogram tretman
- Èd Legal

- United Way
  - 812-254-1038. 1001 E Main St, Washington, IN 47501
  - Asistans edikasyon bonè
- RSVP
  - 812-254-1996. Eastside Park in the Community Building,
  - Plasman volontè pou laj 55 ak moute
  - Edikasyon sou sekirite manje, edikasyon bonè, ak izolasyon granmoun aje
  - Bwat manje gratis pou granmotan aje ki pa gen anpil revni nan 4th Lendi nan mwa a. Dwe aplike an pèsòn
- First Choice Solutions/Pregnancy Care Center
  - 812-257-1041. 714 Walnut St, Washington, IN 47501
  - Tès gwosès
  - Tretman responsab
- Sèvis Legal Indiana
  - 866-964-2138
  - Asistans imigrasyon
- Vincennes Inivèsite pou granmoin Edikasyon debaz
  - Vicmary Jimenez-Bene jimenez.vicmary@gmail.com
  - Klas Anglè kòm dezyèm lang (English as a Second), klas pou panyòl ak kreyòl ayisyen pale
- Kòt Lès Migran Head Kòmanse pwojè
  - 812-297-5018
  - Edikasyon bonè ak transpò pou fanmi imigran k ap travay nan agrikilti
- Sistèm Transpò Washington
  - 812-254-8233
  - Sèvis otobis gratis Lendi-Vandredi 7 a.m. jiska 4 p.m.
  - Rele pou sèvis
- Anplwaye ogmante
  - 812-642-9603. 900 W. Nasyonal Hyw, Washington, NAN 47501
  - Asistans nan jwenn travay
  - Sèvis nan lang angle, panyòl, ak kreyòl ayisyen