

Community Health Asset Mapping Partnership Engages Hispanic/Latino Health Seekers and Providers

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BACKGROUND The Hispanic/Latino population in Forsyth County, North Carolina, is growing quickly and experiencing significant disparities in access to care and health outcomes. Assessing community perceptions and utilization of health care resources in order to improve health equity among Hispanics/Latinos at both the county and state levels is critical.

METHODS Our community engagement process was guided by the Community Health Assets Mapping Partnerships (CHAMP) approach, which helps identify gaps in health care availability and areas for immediate action to improve access to and quality of health care. Specifically, we invited and encouraged the Hispanic/Latino population to participate in 4 different workshops conducted in Spanish or English. Participants were identified as either health care providers, defined as anyone who provides health care or a related service, or health care seekers, defined as anyone who utilizes such services.

RESULTS The most commonly cited challenges to access to care were cost of health care, documentation status, lack of public transportation, racism, lack of care, lack of respect, and education/language. These data were utilized to drive continued engagement with the Hispanic community, and action steps were outlined.

LIMITATIONS While participation in the workshops was acceptable, greater representation of health care seekers and community providers is needed.

CONCLUSIONS This process is fundamental to multilevel initiatives under way to develop trust and improve relationships between the Hispanic/Latino community and local health care entities in Forsyth County. Follow-through on recommended action steps will continue to further identify disparities, close gaps in care, and potentially impact local and state policies with regard to improving the health status of the Hispanic/Latino community.

Racial disparities in North Carolina and other Southern states have resulted from a long history of biased zoning laws, policies, and distribution of resources [1], all of which significantly impact the ability of underserved populations to access and utilize health care resources. A recent study by Rhodes and colleagues [2] indicated that fear of immigration enforcement policies is generalized across North Carolina counties among Hispanics/Latinos and that interventions are needed to increase immigrant Hispanics' and Latinos' understanding of their rights and eligibility to utilize health services. Hispanic/Latina mothers in the aforementioned study also expressed a profound mistrust of health services, often avoiding such services and even sacrificing the health of their families. In order to improve health outcomes in this population, collaborative efforts with the community are crucial to eliminate barriers to high-quality health care.

This study describes a grassroots community engagement process led through asset mapping workshops that involved health care providers and seekers within the Hispanic/Latino population in a midsized urban city in North Carolina. This process resulted in early policy and practice changes aimed at improving access for this population. By focusing on cultural humility and the lifelong process of

self-reflection and self-critique, our work reflects the principles that drive exemplary community-based participatory research [3, 4], in which health and social service providers can reverse disparities and improve cross-cultural relationships with those they serve [5].

Background

In recent decades, North Carolina has seen significant growth in its Hispanic population. In the period 1990–2000, North Carolina experienced a 500% increase in its Hispanic/Latino population, which accounted for 6.3% of the state's population in 2000 [6], and a similar rate of expansion was seen in the following decade. According to the 2014 American Community Survey, persons of Hispanic/Latino background accounted for 8.9% of the North Carolina population, ranking the state 11th in the nation for this ethnic group [7].

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Among North Carolina's Hispanics/Latinos, approximately 51% are native-born US citizens, with a median age of 24 years [8]. Of the remainder, it is estimated that 42% are undocumented, and 7% are naturalized citizens [9]. The main driver of the growth of the Hispanic/Latino population, both nationally and on a state level, is births within the United States, not immigration. Similar to national population trends, the majority of Hispanics/Latinos in North Carolina are from Mexico or have Mexican heritage, with the next largest groups (including foreign and native-born) representing those from El Salvador, Honduras, Guatemala, and Costa Rica [10]. Economically, Hispanics/Latinos in North Carolina suffer from higher poverty rates and lower rates of educational attainment than their non-Hispanic white counterparts [11].

With regard to health, significant disparities exist between Hispanics/Latinos and their non-Hispanic counterparts, with Hispanics/Latinos generally experiencing more chronic conditions and poorer health outcomes than whites. For example, Hispanics/Latinos have higher obesity rates than non-Hispanic whites, both nationally (68% versus 62%) and in North Carolina (68% versus 64%) [12, 13]. It is well known that obesity is a leading risk factor for many chronic diseases, including diabetes, heart disease, and stroke. Hispanics/Latinos also have a higher prevalence of diabetes compared with whites [14] and higher rates of cardiovascular disease risk factors and/or comorbid risk factors [15]. The increasing prevalence of these and other chronic conditions is a significant concern in the United States, particularly as the cost of care for chronic diseases comprises two-thirds of health care spending in the United States per year [16].

More than one-third of US Hispanics/Latinos were uninsured in 2010 [17]; this number is likely to drop with the implementation of the Patient Protection and Affordable Care Act (ACA), but data are not yet available regarding this potential decrease. Hispanics/Latinos in North Carolina are less likely than both non-Hispanic whites and non-Hispanic blacks to have access to health care due to lack of insurance, high cost, or not having a provider [18].

Health and social services are available to underserved and undocumented Hispanics in Forsyth County through several organizations: the Community Care Center (free clinic), Downtown Health Plaza (a clinic for underserved individuals that is subsidized by Wake Forest School of Medicine [WFSOM] and is utilized primarily for obstetric/gynecology services), Southside United Health and Wellness Center (a federally qualified health center), and Green Street United Methodist Church Clinic (a church-based free clinic that is open 1 night per week). Social services are available through the Crisis Control Ministry (which provides food, medications, and emergency utility assistance) and through numerous church-based food pantries. Winston-Salem Transit Authority and Trans-AID provide limited transportation for persons on Medicaid, and the Shepherd Center

provides limited transportation for the elderly. Most services are located in ZIP codes 27101 (downtown and parts of eastern Winston-Salem) or 27107 (Waughtown), but 3 of the aforementioned clinics are difficult to access via public transportation. Specifically, patients must take 2 buses to reach the clinic from the area where most of the new immigrant population lives.

Methods

The setting of our work, Winston-Salem, has the highest percentage of Hispanics/Latinos (14.7%) of the large cities in North Carolina. Forsyth County, where Winston-Salem is located, is also above the state average, at 12.4%, and Hispanics/Latinos accounted for 30% of Forsyth County's population growth in the period 2010–2013 [7]. Hispanics/Latinos in the Winston-Salem/Forsyth County (WS/FC) area primarily work in manual occupations such as construction, agriculture, and service industry jobs [11]. Demographic characteristics of Hispanics/Latinos in WS/FC are similar to those of Hispanics/Latinos statewide in terms of ethnicity, median age (24 years), and average time in the United States (less than 15 years among foreign-born individuals) [11]. Residentially, Hispanics/Latinos in WS/FC are concentrated in the eastern and southeastern areas of the city in census tracts that have been identified over multiple years as urban distressed tracts; one of these tracts is the 4th-most distressed urban tract in all of North Carolina [19].

Our asset-mapping model, Community Health Assets Mapping Partnerships (CHAMP), identifies community health assets and existing community partnerships for the purpose of furthering community well-being [20, 21]. Kramer and colleagues' critical review [20] highlights how asset-mapping approaches can promote the aforementioned processes—particularly by providing an effective strategy to foster participation, agency, and inclusivity—and how these approaches can reconceptualize or reframe communities as being resourceful and resilient, rather than just the source of problems. The CHAMP methodology was adapted from the research model Participatory Inquiry into Religious Health Assets, Networks, and Agency (PIRHANA), which was developed by Drs. Steve de Gruchy, Gary Gunderson, James Cochrane, and Deborah McFarland [22] of the African/International Religious Health Assets Programme (IRHAP) [23]. Community asset mapping that focuses on religious and spiritual assets has been previously utilized in communities across Africa and the United States, and the primary author of the current article (T.C.) has been an IRHAP fellow since 2009. CHAMP-Access to Care (CHAMP-AC) was further developed and refined by T.C. and team members in Memphis, Tennessee during 2007–2013.

The purposes of the CHAMP-AC workshops are to make visible, align, and leverage community health, particularly faith-based assets (a subset of community health assets); better understand the gaps in health care; improve com-

munication between health seekers and health providers; engage community members; build trust; and begin a process of creating a health care system that includes more grassroots actors. Workshop participants become educators and researchers during the process, and results are shared transparently with the participants and community for use in future planning activities. CHAMP is unique in that it highlights both tangible community health assets (eg, safety-net clinics) and intangible assets (eg, how respectfully care is delivered at a given clinic site). CHAMP-AC methodology focuses further on the 4 domains of health care access: affordability, physical accessibility, acceptability, and adequacy of supply [24]. Similar processes were undertaken in Memphis, Tennessee from 2007-2012 through the Congregational Health Network [25], resulting in improved health care utilization for community and congregational members who participated in this participatory process [26]. A full review of asset mapping methodology, including CHAMP's limitations and strengths as a tool for community engagement, can be found in the review by Kramer and colleagues [21].

In July 2014, Wake Forest Baptist Medical Center (WFBMC) staff—including FaithHealth staff, chaplains, translation services personnel, and WFSOM faculty—and medical school, divinity school, and health policy students worked in conjunction with pre-existing community and faith-based partners to host 4 CHAMP-AC workshops. One workshop was held for providers (employees and volunteers from organizations that offer health care, social services, and ministries), and 3 workshops were held for seekers (community members who seek health and social services) within the Hispanic community of Winston-Salem, an urban center with a population of approximately 250,000 people. Our work was led by FaithHealth staff members, and we relied heavily on prior relationships with those in safety-net clinics, social service agencies, faith communities, and ministries to recruit subjects and to bring the most appropriate

participants to both the providers' and seekers' workshops. Hence, we feel that a focus on faith-based assets was critical to the process.

Preparation for the workshops included several different activities. First, background research and training workshops for facilitators and staff were conducted; training components included cultural competency, cultural humility, local historical trauma, and trust issues. Second, 6 meetings were held with the mapping team and with key Hispanic/Latino community partners and leaders 2 months prior to the workshops; the goal of these meeting was to plan the workshops and to enlist help with recruitment. Third, driving and walking tours of the neighborhoods were conducted. Last, we collected data, generated a geographic information system (GIS) map, and prepared workshop logistics and materials.

Recruitment efforts (4-6 weeks prior to the workshops) and venue procurement included distribution of flyers in churches and businesses; e-mail distribution to community agencies, networks, and partners; personal visits to key social nodes in target neighborhoods; phone calls; and word of mouth.

One asset workshop was held for providers and 3 workshops were held for seekers within the Hispanic community of Winston-Salem. The providers' workshop was conducted in English and lasted approximately 4 hours; the 3 seeker workshops were conducted in Spanish and also lasted 4 hours each. Providers were included if they served some Hispanic/Latino persons through their organization; seekers were required to be of Hispanic/Latino ethnicity. While the CHAMP methodology was used in all workshops, adherence to the formal CHAMP protocol varied in the health seekers' workshops, based on the number and comfort level of participants with regard to the exercises conducted (see Table 1). Informed consent was obtained from all participants at each workshop site, and participants from all workshops were invited to attend a follow-up meeting where consolidated findings were transparently presented to workshop partici-

TABLE 1.
Health Care Provider and Seeker CHAMP Workshop Exercises

Health Care Provider Workshop ^a	Health Care Seeker Workshops ^b
1. Community mapping: Participants verify and add new entities to a large map of the community.	1. Community mapping: Participants draw maps of the assets in their community. (Old Town)
2. Health service matrix: Participants identify the ways that local entities contribute to health.	2. Health and well-being index: Participants identify the most important factors contributing toward and working against health in the community. (All sites)
3. Health and well-being index: Participants rank community health assets in regards to access to care.	3. Facility/health ranking: Participants rank community organizations on how well they support factors contributing to health. (East Winston and Old Town)
4. Collaboration contribution grid: Participants identify existing and potential collaborative partnerships and shared resources.	4. Local action: Participants discuss where to go from here. (East Winston and Old Town)
5. Social capital and networking: Participants describe the connections and relationships between community entities.	
6. Local action: Participants discuss where we go from here.	

^aThe provider workshop was held at Wake Forest Biotech Place.

^bFor health care seeker workshops, text in parentheses indicates the workshop location. All health care seeker workshops were primarily discussion-based. Note. CHAMP, Community Health Assets Mapping Partnerships.

pants and other interested community members.

Two Hispanic/Latino chaplains co-facilitated the 4 workshops, all of which were held in July 2014. Two of the seeker workshops were held at 2 local churches in underserved areas, and 1 seeker workshop was held in a plaza located in the area with the highest concentration of Hispanic/Latino residents in Forsyth County; the latter location was also used for the follow-up meeting. The provider workshop was held at the Wake Forest Biotech Place at WFBMC. Other staff served as greeters, scribes, and photographers.

Workshop data from each session, which were primarily qualitative in nature, were captured through multiple researchers' notetaking. Analyses included a composite analysis of community and provider workshop maps; a qualitative thematic content analysis of community members' views about local health services; mapping of services provided in the local community; spidergrams to map relationships between service providers; and brainstorming lists outlining suggested actions, both from community members and service providers. Specific findings that drove our subsequent engagement with the Hispanic community are highlighted in this article, and full mapping reports of workshops are available at www.faithhealthnc.org.

Results

The provider workshop included 18 participants, including traditional health care providers (eg, a pediatrician, a dermatologist, nurse practitioners, nurses, and health educators) as well as social service agency, ministry, and public health practitioners (eg, clergy and those offering services for homeless individuals). Seeker workshops included 24 participants, all of whom were Hispanic. The first workshop included 8 seekers; the second workshop included 15 participants; and the third workshop included only 1 person, a man who worked at the plaza where the workshop was held. No sex differences were noted in the results, although women were more heavily represented. Thirteen additional community members attended the follow-up meeting that was held in August 2014, for a total of 55 persons. Attendees at the follow-up meeting included 8 providers and 2 seekers from the previous workshops, as well as 3 community seekers who had not participated in prior sessions. Table 2 provides sex and ethnic breakdowns of all meeting participants.

Participants in the provider workshop brainstormed the factors they personally felt were most important to the health and well-being of those who need better access to care, as well as those factors their organizations felt were most important. Personal factors were education (how to find resources); access to resources (medicine, insurance, and transportation); trust, compassion, respect, and cultural sensitivity; and affordability. Organizational responses were similar but were ranked in a different order, with the most important factor being access to care (affordability, location, and documentation status); followed by trust, compassion, respect, and cultural sensitivity; education (how to find

TABLE 2.
Participant Sex and Ethnicity for Mapping Workshops and Follow-Up Meeting

Workshop	Sex		Ethnicity		
	Male	Female	Hispanic	Non-Hispanic white	Non-Hispanic black
Provider workshop	8	10	13	4	1
Seeker workshop #1	3	5	8	0	0
Seeker workshop #2	0	15	15	0	0
Seeker workshop #3	1	0	1	0	0
Follow-up session	2	11	5	6	2
Total	14	41	42	10	3

resources); and transportation.

Participants in the 3 seeker workshops discussed the challenges that can hinder access to health care. The challenges most frequently mentioned among all groups clustered into 5 areas: cost of health care; documentation status (and its relationship to access to pharmacy, insurance, and transportation); lack of public transportation; racism, lack of care, and respect; and education (more Spanish literature).

Similarities and differences were found in seeker and provider data. Seekers were most concerned with physical and legal access to health resources, and they lamented how the lack of insurance for undocumented parents ultimately impairs the health of their insured, US-born children. Seekers also believed that more Spanish literature on prescriptions and brochures was needed. In contrast, providers felt that education about resources was the most prominent challenge to the Hispanic community. Both groups felt that compassionate care and respect were a crucial aspect to good health care, and seekers discussed many instances in which systematic and organizational racism had affected their ability to obtain high-quality care. For instance, one female seeker critiqued a local safety-net clinic by saying, "Just because a provider speaks Spanish doesn't mean they provide respectful, quality care."

Table 3 presents quotes selected from both seekers and providers that illustrate the 5 clustered domains with regard to access to care in Winston-Salem. Many seekers and providers acknowledged that these issues are widespread and extend beyond Hispanics/Latinos to also affect other populations. A local business owner at the provider workshop commented, "Many of these problems are not specific to the Hispanic community, they are abundant in the community overall." Health care seekers shared their views on the strengths and weaknesses of local safety-net clinics and other health care organizations. As is often the case among underserved individuals, respondents sought care from these organizations due to lack of other options. Those responses are presented in Table 4.

TABLE 3.
Health Care Seeker and Provider Responses

Domain	Quotes
Cost of health care	"Mothers think it's better to spend money taking care of your kids than your own health. But then the problem gets bad and you have to go to the ER. That's when the bills really add up." Seeker participant at El Buen Pastor
	"The [Community Care Clinic] says that I have too much money to qualify. They don't consider that we are sending money home to our countries and relatives there, they think we can't possibly send that much." Seeker participant at St. Benedict Church workshop
	"When my dad was dying, I wanted to go to Mexico to be with him. He told me, no, that I needed to support my family, I needed to pay for his funeral. Even to die is expensive." Seeker participant at St. Benedict Church workshop
	"We always seek help with doctors first, and then we turn to home remedies. We know doctors look down on us for this, but we need to work, and can't spend hours in the hospital when they may not help us anyway." Seeker participant at St. Benedict Church workshop
Documentation status (access to pharmacy, insurance, and transportation)	"The health of the children depends on the health of the mothers." Seeker participant at St. Benedict Church workshop
	"Sometimes, they want to see your bills for proof of address. But the owner of the apartment I rent has his name on the address, not mine. So, I end up not having any proof of address." Seeker participant at St. Benedict Church workshop
	"When I tried to pick up medicine for my wife I needed a driver's license. I didn't have one so I couldn't get the medicine. Sometimes I need to ask a friend to get the medicine for me, but who do I ask when everyone's working?" Seeker participant at St. Benedict Church workshop
Lack of public transportation	"Because they are born in the US, the door is open for children, but it is slammed in the parents' faces." Provider workshop participant
	"Say my child is sick and I need to go to the [Southside] clinic, because it's the only one I can afford. It takes me four hours and 3 buses to get there. What happens when it's an emergency?" Seeker participant at El Buen Pastor workshop
	"Although it is for our community, we can't use LatinoTaxi because it's too expensive." Seeker participant at St. Benedict Church workshop
Racism, lack of care, lack of respect	"Transportation takes a lot of time, and there's not a lot of it." Provider workshop participant
	[Referring to one of the major health clinics in the city] "They don't treat us well... they think we're not educated. Even some of the Spanish-speaking staff look down on us." Seeker participant at El Buen Pastor workshop
	[Referring to the workshop] "There is no guarantee that this information will be used for our good, or against us." Seeker participant at El Buen Pastor workshop
Education (more Spanish literature)	[When discussing medical terminology] "We don't understand them, even when they're speaking our own language." Seeker participant at El Buen Pastor workshop
	"Even when there is someone to explain the directions to me [at the pharmacy], all of the directions are still in English." Seeker participant at St. Benedict Church workshop

Both health care seekers and providers were asked to name tangible and intangible recommendations for improving the health care system; these local action steps stemmed from the findings and discussion at the workshops. Seeker responses included the following recommendations: create a way to give undocumented residents a form of identification (for pharmacy and driving purposes); add more bilingual directions on medications; add more bus routes in low-income areas that travel directly to health care centers; train more culturally competent and respectful health care providers; create more information on preventive care; improve access to dental services; and increase trust in health care providers and organizations. Provider responses included the following recommendations: create a general directory of resources regarding what is available and the requirements for accessing them, specifically for undocumented people; engage transit authorities to increase the number of routes on the city bus system; become more coordinated as a group of Hispanic providers; build trust, especially with those who are undocumented; focus on continuity of care

for those being served (eg, follow up with patients who test positive for diabetes at health fairs); and teach immigrant children about their heritage as a way to foster cultural pride and reduce depression and mental illness rates among Hispanic youth.

At the follow-up meeting, several additional issues were raised. First, some expressed frustration with the barriers that Hispanic immigrants face in qualifying for medical services at safety-net clinics. Second, participants noted that lack of identification is a reoccurring and detrimental barrier to care. Third, there is need for medical professionals and traditional healers to have more dialogue and to build trust in order to prevent the health crises that can stem from risky traditional treatment options or self-prescribed medicines. Fourth, there is need to create a process that will allow undocumented people to get identification cards; this could be modeled on Greensboro's Faith Action International House, which provides undocumented people with identification cards that allow them to pick up prescriptions and qualify for medical services. Fifth, there is need to share

TABLE 4.
Strengths and Weaknesses of Local Health Care Facilities, Rated by Health Care Seekers

	Strengths	Weaknesses
Community Care Center	■ Low cost ■ Free or low-cost medicines ■ Continuity of care with the same doctor ■ Free mammograms for patients who qualify for service ■ Serves the undocumented population ■ Generally the best option for care (Old Town)	■ Requires proof of income, which disqualifies many families ■ Lots of paperwork and rules ■ Patients need some form of identification
Southside United Health Clinic	■ Serves undocumented and low-income people	■ Far away from Old Town
Downtown Health Plaza	■ The best place for prenatal services	■ Service feels rushed ■ Sometimes clinicians lack compassion and respect ■ Lack of interpreters ■ Different treatment for documented versus undocumented Latinas
Forsyth Medical Center (Novant)	■ Payment plans are available ■ Provides free cancer education services (Old Town)	■ Expensive; only used in emergencies or for delivery
Wake Forest Baptist Health	■ Brenner Families in Training (FIT) offers free nutrition classes at El Buen Pastor Latino Community Services (Old Town) ■ Patients feel respected and well attended to	■ Long wait time for interpreters ■ Interpreter terminology is sometimes difficult to understand
Urgent Care Facilities	■ Usually less expensive than the hospital	■ No payment plans; all payments must be made up front

information generously. Finally, Spanish-language flyers about the various health resources available to the Hispanic community should be posted in hospital elevators and throughout communities.

Discussion

Distrust in the medical system was repeatedly named as a barrier to access to care. Anecdotal information suggests that Hispanic persons have experienced disrespect and poor-quality health care in Forsyth County; however, with the exception of the Rhodes work cited earlier [2], few formal studies have documented this phenomenon, even at the state level. Despite lack of data, we believe that the historical treatment of other vulnerable and marginalized populations—such as low-income non-Hispanic blacks and whites in North Carolina who experienced the eugenics program [27] many decades before widespread Hispanic/Latino immigration—remains germane to current distrust among the vulnerable Hispanic population (particularly undocumented persons). Given our academic medical center’s historical participation in programs that destroyed trust among underserved and marginalized populations—the North Carolina eugenics program of involuntary sterilization was based at Wake Forest until 1974 [27]—many community members were skeptical that Wake Forest staff were authentically reaching out to the community versus simply recruiting minority subjects for research. The workshops offered a platform for frank truth-telling about these historical traumas with participants who were long-term residents of these communities, which is an essential first step in building trust. In recruiting participants and during workshops, we emphasized that our efforts were separate from efforts to recruit subjects for clinical research trials, and we highlighted that these workshops were designed to build trust among the community.

Clearly, the generalizability of these findings is limited due to the relatively small number of workshop participants, all of whom lived in a single North Carolina county, and due to the qualitative nature of the data generated. To obtain more diverse responses, future community engagement efforts could sample more persons within smaller neighborhoods in our target ZIP codes. However, our grassroots engagement of Hispanic health care seekers did give representation to a consumer “voice” that is often ignored in health systems. Plus, our efforts have mobilized the local action steps described below.

As previously discussed, the workshops yielded some distinct findings and engaged staff and community members in local action steps. During the 12 months that have transpired since the workshops, we have engaged in the following work to impact policy and to improve the quality of life for Hispanics/Latinos in Forsyth County.

Photo identification cards. Our team is helping to establish photo identification (ID) cards for undocumented immigrants and other persons without access to state-issued forms of ID. We have established a working group, which has met 6 times, and we have created a white paper outlining our initiative. The group consists of representatives from the Forsyth County Health Department, county and city government, Novant Health, and WFBMC. Both health systems (Novant and WFBMC) have agreed to honor this ID for patient admittance. Members shared our findings in March 2015 in a community conference hosted by FaithAction International House in Greensboro, and team members from that group presented to Forsyth County team members, criminal justice, clergy, city council, political, and grassroots leaders on June 18, 2015. The findings of our mapping workshop allowed us to understand the importance of health seekers’ having an ID card to facilitate health care access, adding their voice to a conversation that has otherwise

focused exclusively on ID cards and law enforcement.

BIC program. We continue to work with the Winston-Salem Human Relations Department, and we are a stakeholder in the Building Integrated Communities (BIC) program. Staff members of the Latino Migration Project at the University of North Carolina at Chapel Hill serve as consultants on the BIC project and (with our permission) will use the results of our asset mapping events as a cornerstone of the report being prepared for the city of Winston-Salem.

Mapping findings. We shared mapping findings with executives and medical directors of 3 local agencies and safety-net clinics, so that they might consider altering their policies. For example, we asked directors of safety-net clinics to acknowledge that applicants often have family members in other countries who rely on remittances from the United States and to consider such financial obligations when these organizations calculate eligibility and sliding-scale charges for health care. Clinic directors were open to this change, so long as applicants documented proof of remitting funds to family members out of the country. Additionally, to improve care delivery, one safety-net clinic director agreed to participate in a follow-up dialogue with community members who had experienced less than high-quality care from the provider at his clinic.

We have also shared our findings with the Forsyth County Health Department; they will incorporate these findings with their Mobilizing for Action through Planning and Partnerships (MAPP) methodology and with the county's next community health needs assessment (CHNA). We plan to conduct specialty mapping workshops (eg, food access and security, mental health), and we have received grant funding for our food pathways work.

Wellness and chronic care management clinic. In partnership with a key Hispanic/Latino ministry, we have begun planning for the establishment of a wellness and chronic care management clinic at one of the mapping sites. We will train 15 women at that ministry as community health workers so that they can extend care to more residents in that underserved neighborhood.

Building partnerships. Lastly and most importantly, our community engagement approach has helped us begin to build trusted relationships with our community members and mapping team allies—across medical centers, businesses, coalitions, clergy, and city partners—with whom we plan to continue this work. By consulting community members and leaders, then sharing and integrating those findings into future efforts, providers gain valuable assets to help remove the barriers to care and build true partnerships with those who seek care. Our hope is that we ultimately will improve the health and well-being of all who seek and provide health care in Winston-Salem, particularly our Hispanic/Latino community members. **NCMJ**

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