Nurse Ambassadors as a Trauma-Informed Strategy to Encourage Rural Migrant Populations' Use of Sexual Assault Victim Service

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Michelle Hughes Miller received sabbatical leave to conduct this research. Mayra Espinosa worked full-time as Nurse Ambassador and Sexual Assault Nurse Examiner at the site where this took place.

Abstract

Rural migrants are vital to rural areas in terms of their engagement in the agricultural economy and as the fastest growing population in rural areas in the United States. Yet, rural migrants do not have access to all the education, services, and resources they need, including sexual assault education and care. In this paper we consider a novel approach, a Nurse Ambassador model that integrates trauma-informed care, as a strategy to increase knowledge about and access to sexual assault services for members of a large rural migrant community. A nurse practitioner specialized in sexual assault, in the Nurse Ambassador role, can offer expertise from direct clinical care to targeted educational support. Nurse Ambassador programs have been used effectively within patient support programs to provide clinical and/or educational support to clients perceived to be at risk for treatment abandonment or medication non-adherence and to decrease overall health care costs for patients with chronic diseases. Yet there is no research on their utilization to address sexual assault. Using a case study approach grounded in a community assessment of a rural area in a southern state, we share a first-person narrative from a Nurse Ambassador working within a rape crisis center to describe how such a position might facilitate community-based knowledge-building and enhanced trauma-informed service delivery, specifically for rural migrant survivors. Our study details the responsibilities, strategies, engagements, challenges and opportunities for a Nurse Ambassador model working to educate about and provide services to address sexual assault in a rural domain.

Keywords: migrant communities, sexual assault services, Nurse Ambassadors, rural victim services

"The rural United States is sometimes viewed as a paragon of stability, but demographic change has been a constant."

Slack & Jensen (2020, p. 775)

The quote above nicely begins our discussion of rural migrant communities and the need to better serve them in this changing rural environment–particularly in terms of sexual assault services. Business-as-usual in rural America in the last several decades has meant a shift from agriculture to more diversified economies related to nearby urban areas. However, the rural increase in ethnoracial diversity is predominantly due to an increase in the non-metro Hispanic immigrant population– many of whom work within the agricultural and food production industries to which they are actively recruited (Ramos, 2016)–which is partially making up for white rural depopulation (Slack & Jensen, 2020). Indeed, people with ancestry from Latin America are now the most rapidly growing rural population in America (Crowley et al., 2015). In other words, rural migrant populations are not just vital to rural agricultural economy (Ramos, 2016), there is some suggestion that "the attraction of immigrant groups might well be a viable rural development strategy" (Slack & Jensen, 2020, p. 779; see also Lichter & Johnson, 2020). Thus, services that support and help maintain rural migrant communities and their members' well-being may be essential to the overall vitality of relevant non-metro areas and should be researched accordingly.

That is our intent in this paper. Specifically, we take on the question of how a novel approach, a Nurse Ambassador model that integrates trauma-informed care, can be used to increase knowledge about and access to sexual assault services for members of a large rural migrant community. While sexual violence is only one of a multitude of issues that affect communities, its prevalence speaks to its importance: more than ½ of women and close to ⅓ of men have experienced physical sexual violence in their lifetimes (Basile et al., 2022). The trauma that arises after sexual violence can result in physical and/or emotional or psychological health outcomes that may be chronic and can impact multiple aspects of survivors' experiences, from relationships to employment to their ability to feel comfortable in their daily lives. Thus, preventing sexual violence, or effectively providing support to survivors of sexual violence, facilitates the health of both individuals and communities.

To consider how a Nurse Ambassador model could improve awareness and access to sexual assault services amongst a rural migrant population, our case study integrates findings from before and after the opening of a new rape crisis center (RCC) near a rural migrant community. Our collaboration began in 2022 while the first author, Espinosa, was employed as a Nurse Ambassador at a non-profit RCC, which we call here the Urban Victims Center (UVC). The position was designed as a novel community engagement strategy to prepare for a second UVC site opening in a rural area of the same county. Espinosa's experiences as a Nurse Ambassador, including her intentional use of trauma-informed care, are presented in the context

of the results of a key informant community assessment conducted by the second author, Hughes Miller, on behalf of UVC.

UVC and Access to Sexual Assault Services

UVC is located in a large urban area in the southeast United States. The county within which UVC is located is one of the largest in the state, with a large urban center and a significant amount of rural and agricultural land, leading to a large concentration of rural migrant workers in the county. UVC is the only certified rape care provider in the entire county and offers resources and trauma-informed mental health services for sexual assault survivors, [1]24-hours, 7 days a week, year-round. RCCs like UVC allow for individualized and confidential care including victim advocacy to sexual assault survivors (Ullman & Townsend, 2008),and offer Sexual Assault Nurse Examiners (SANEs) who receive specialized training and enact trauma-informed care toward victims of sexual assault (Poldon et al., 2021; Thiede & Miyamoto, 2021). SANE forensic medical exams can also provide evidence to law enforcement if survivors wish to report their victimizations. In 2022, the UVC provided 338 forensic medical exams to victims of sexual assault as the only clinic offering these services in the county.[2]

Despite the services and resources provided by UVC and other RCCs nationally, many sexual assault survivors do not access sexual assault services (see e.g., Bach et al., 2021), especially if they are women of Color (Weist et al., 2014), members of the LGBTQ+ community (de Heer et al., 2023), or are undocumented migrants (Zadnik et al., 2016). Common reasons for this lack of service utilization include cost and lack of transportation to the site, fear of the exam process, lack or presence of law enforcement at the site, fear of being blamed, self-negation of the seriousness of the victimization, and being unaware of the availability of services (Logan et al., 2005; Richardson et al., 2015; Zinzow et al., 2021). Rural residents, who generally have higher rates of sexual violence than their urban or suburban counterparts (DeKeseredy, 2019), also have distinct barriers to accessing and receiving sexual assault services given gaps in service (Carter-Snell et al., 2020; Logan et al., 2005), and rural access to SANE exams may be significantly more challenging (Thiede & Miyamoto, 2021). Although limited data exists due to underreporting, studies also suggest Hispanics are more likely to experience sexual victimization (Flores et al., 2023), though an early study suggested the rates may be higher for native-born Latinas than migrant-seasonal women (Hazen & Soriano, 2007). Further, though much diversity exists within the Hispanic population, Amaya and Gray (2021) argue that there are some

[1] For purposes of this paper, we are using both victims and survivors as terms, though we are aware of the extensive feminist and practitioner debate on the topic and the variability (across time and identity) for those who have been victimized in their choice of self-label (see e.g. Boyle & Rogers, 2020). However, due to Espinosa's nursing expertise which has led to her understanding of and clinical experience working with patients (including those in crisis), the term "victim" is used when referencing someone in that capacity. Otherwise, we use the term survivor to represent those who are continuing to manage their victimization.

[2] UVC offers forensic medical exams to victims 13 years and older; any victims under this age are referred to child protective services. In 2022, 62 clients reported being 13-17 years of age.

important commonalities in ideologies, perceptions, and experiences that may affect whether and how Latinas, in particular, access or respond to mental health treatment for sexual assault. These commonalities include concerns about *familismo*, traditional gender roles, and religion/spirituality. Undocumented Hispanics and Latino populations in particular face even greater challenges accessing services, including fear of deportation and language barriers (Cabral & Cuevas, 2020).

South County

To better address rural access concerns in the county, in April 2023, UVC opened a second site approximately one-hour away from its urban location, in a largely rural part of the county, which is the focus of our case study (Schoch, 2020) and which we call "South County." South County is geographically separated from the county's predominant urban area by a body of water. It has more than 50% of the total landmass of the county, yet its population is only around 30% of the total county population which is estimated to be more than 1.5 million (U.S. Census Bureau, 2023). South County's population is largely contained within several small rural communities which are projected to grow over the next several years (Economic Development Corporation, 2021) due to exurban growth (see e.g., Slack & Jensen, 2020). It also has a large rural migrant community that has a relatively high degree of stability, with members predominantly speaking Spanish as their first or only language. However, some South County migrants only speak indigenous languages from Central America, which can be a significant barrier to them accessing services or education (see, e.g., Campbell-Montalvo, 2023). Many members of the migrant community in South County have or had some relationship to the agricultural industry. The county is the 3rd largest agricultural producer in the state (Department of Agriculture and Consumer Services, 2022).

While there is an increasing call for integration of in-migrating Hispanic populations into existing rural communities so as to avoid "parallel" worlds that may invisibilize migrant lives and needs (Ramos, 2016; Ramos et al., 2017), in South County there is evidence of both significant segregation and some collaborative investments that suggest awareness of, but not necessarily full appreciation of, migrant experiences. For instance, although many organizations in the area strive to incorporate services for migrants and have bilingual workers, few migrants take part in community meetings or voice their input on governance issues, an important element of sustainable immigrant integration for rural communities (see e.g. Ramos, 2016). As the region continues to become more migrant-focused, however, a few key Hispanic community leaders have facilitated discussions to ensure relevant migrant issues are local priorities**.** At the same time, as Ramos and her colleagues (2017) note, differences among members of the rural migrant community in terms of education level, language(s) spoken, length of time in South County, and legal status can affect members' degree of integration and, if desired, acculturation.

Overall, primarily due to its rurality, lower population base, and distance to the county's

urban core, South County has long lacked many social services and attention, particularly in terms of mental health and health-related services. The addition of a local RCC in South County was believed by UVC to ensure that survivors could receive services in a timely and accessible manner, and early statistics suggest it is contributing on that front: from its opening in April 2023 to June 2024, 74 forensic exams had been completed in the South County clinic (16.6% of the total exams completed at UVC over that time period).

However, the decision to locate the second UVC facility in South County was largely driven by expressed interests of community leaders, rather than extant South County community groups.[3] There is, to-date, mixed evidence that the South County facility is increasing access to services for South County victims who would not have previously journeyed to the urban location, as the total number of exams completed across both locations has remained fairly consistent over the last few years. At the same time, the proportion of forensic medical exams completed with patients who identify as Hispanic/Latino have increased, from 18% in 2022 (prior to South County's opening) to 27% by Summer 2024. It should also be noted that the South County location would, by default, reduce transportation barriers for any South County victims, saving them time and cost while increasing their ability to choose the site most convenient for them to receive services.

To preemptively address the question whether South County residents would utilize or be encouraged to utilize their services, UVC sought to ensure that the agency and the services it intended to provide would be welcomed by a diversity of South County community stakeholders and service providers, especially from within the large, rural migrant community located near the new South County facility. They partnered with a researcher, Hughes Miller, to conduct a key informant community assessment of the South County area prior to opening to identify local attitudes toward and suggestions for the success of the new facility from community leaders.

UVC also chose to hire a Nurse Ambassador (NA; Espinosa) prior to opening their new site with the goal for that hire to engage and educate the community on sexual assault and services available. The Nurse Ambassador model allows for greater integration of community-based education around topics that are often considered "taboo," while offering greater access to trauma-informed and culturally relevant care. Below we discuss the role of the Nurse Ambassador as a novel, trauma-informed approach to community education related to sexual assault, highlighting Espinosa's development of NA strategies relevant to the specific rural migrant population in South County. Prior to introducing her reflections, we briefly discuss the results of the key informant community assessment as a backdrop.

[3] We are unaware of any concern about preventing differences between the two locations in terms of professionalization of staff, endorsement and enactment of empowerment strategies for survivors, or adherence to feminist philosophies that undergird the history of RCC, all of which have been found to be significantly lessened in rural RCC compared to their urban counterparts (Edmond et al., 2020).

Key Informant Community Assessment (KICA)

From September 2022 through February 2023 Hughes Miller interviewed 13 community stakeholders (agency directors, local politicians, law enforcement, health care professionals, and community leaders) from the communities surrounding the new South County facility in order to provide information to UVC on community attitudes toward and support of the new South County UVC site. A special effort was made to interview key informants working with/in the rural migrant community, resulting in four targeted stakeholder interviews, and the rest of the stakeholders were asked about their work with/in the migrant community. Each interview was recorded, transcribed, and then analyzed using reflexive thematic analysis (Braun & Clarke, 2022). The timing of this KICA was important, because the new facility was due to open in April 2023, and it was hoped that the results of the KICA would support the agency's goal of a successful beginning to their efforts.

The community stakeholder interviews focused on a few goals of interest to UVC:

a. Identifying local barriers to help-seeking for sexual assault victims;
b. Identifying appropriate strategies and current structures of support for sexual assault victims in the community, particularly as they relate to the populations of interest (in particular, migrant community members);
c. Continuing to build trust with the community for the South County site.

To facilitate the success of the KICA and support the early efforts of the newly hired NA, Hughes Miller was paired with Espinosa to coordinate interviews and community contacts so as to avoid multiple contacts to the same community stakeholders over the same time period. A shared online spreadsheet of community contacts was developed, originally utilizing (but then expanding) a list of community agencies in the area generated by UVC. Interactions with stakeholders were recorded on the spreadsheet by both authors to coordinate contact strategies.[4] We further agreed upon a common principle: that the long-term establishment of relationships between the NA and community contacts was prioritized. This agreement was important because of the third goal, above, on building trust with the community, which was an explicit expectation of the NA role and less likely to be maintained by Hughes Miller after the study was completed. To enact this principle, we agreed that both authors would encourage community members to meet with the other, but the NA had first and priority access to any stakeholders on the shared list. Through this agreement, the close relationships the NA created with stakeholders working with/in the rural migrant community later explicitly facilitated those community assessment interviews for the study. As a final benefit of this partnership, the KICA was able to integrate elements of the NSVRC SART Readiness Assessment (2011)[5] into the interview questions to

[4] Interviews were only recorded on the shared doc after those interviewed signed consent forms and agreed to have their names/titles included in the final report to UVC.
[5] For instance, Hughes Miller noted in her field notes whether respondents felt like they "understand the social/cultural causes of sexual violence" (NSVRC, 2011).

support the NA's development of a list of potential Sexual Assault Response Team members in South County.

While a final report on the themes identified through the KICA was presented to UVC, here we only discuss those relevant to the position of the NA that were shared with Espinosa to support her work. This included four themes shared by many, and sometimes all, of the respondents:

a. Few respondents directly discussed sexual assault during their interviews (despite direct questioning), avoiding that topic explicitly in favor of violence, domestic violence, or vague euphemisms. This may be due to a discomfort with the problem of sexual assault itself and a need for the NA and agency personnel to be clear about services being provided and to educate broadly about the need for sexual assault services.
b. Respondents reported that South County agencies tend to work outside of their missions due to the sparsity of local services available. Long-standing local concerns included poverty and houselessness, both of which were perceived to be much more prevalent (and for some respondents, more pressing) concerns than sexual assault, regardless of the high prevalence of sexual assault discussed earlier. Respondents recommended that the new South County UVC facility grow to participate in that shared and whole-person support of clients in order to gain the full trust of community stakeholders, although all expressed a great willingness to partner with the agency.
c. South County was perceived to hold different value orientations and experiences than the urban center of the County (see e.g., Johnson et al., 2014; McGrath et al., 2012), making it imperative that facility staff, especially the NA, interact with "humility" and learn the ways (not just the people) of the area.
d. Respondents expressed concern about whether migrant victims of sexual assault would utilize the facility, either because of barriers such as were discussed earlier, or because of coercion to not report perceived to be coming from within the migrant community. Respondents not working with/in the migrant community also commented that it was migrant women and girls who were most at risk of sexual victimization in South County[6]– a belief not fully shared by those who directly worked with/in the migrant community. Respondents working with/in the migrant community also expressed concern about whether migrant women and girls would feel comfortable reporting sexual victimization.[7]

[6] A perception of heightened vulnerability for migrant women is not uncommon (Cuevas, Sabina, & Milloshi, 2021).
[7] Hazen & Soriano's (2007) research suggest that migrant-seasonal Latinas may be more likely to report than other immigrant women. Yet Zadnik et al. (2016) suggest reporting rates for migrant women may be affected by their undocumented status and language barriers, in addition to economic considerations.

Collectively, the KICA provided the agency and the NA early feedback from potential collaborators and stakeholders from within the South County communities, information that could benefit the NA's activities and support the Nurse Ambassador model of the agency.

NA role

We are unfamiliar with any research on the use of a Nurse Ambassador model in relation to sexual violence services– which speaks to the novel usage of this strategy by the UVC. Originally, Nurse Ambassador programs were conceived of as a peer support/mentoring strategy to improve the retention of nurses given a critical shortage of nurses nationally and internationally (see e.g., Bryon & Lane, 2002) and particularly in rural areas (Baldwin et al., 2016). But, NA programs have gone well beyond that recruitment beginning.

The responsibilities and skill sets of the NA are distinct from those of social service providers and other healthcare providers, including community health workers, by integrating those two domains. For instance, a NA trained in sexual assault care and as a certified sexual assault examiner is able to provide specialized, high-quality care to victims of sexual assault.[8] The NA is also able to provide medical care, in the capacity as a nurse practitioner, for follow-up medical services after sexual assault. At the same time the NA may also provide social services by incorporating themself into the community as an educator and outreach specialist to improve knowledge about sexual assault and sexual assault services. Thus, the NA is not a medical provider that remains in the clinic, but becomes integrated into the community as an approachable, informed, trustworthy community member and care provider.

Because of this dual focus, NA programs have been successfully integrated into Patient Support Programs (PSP) to provide clinical and/or educational support to clients perceived to be at risk for treatment abandonment (Brixner et al., 2019a), medication non-adherence (Hollier & Jennings, 2018), or to support specific health education initiatives for low health literacy patients (Naccarella et al., 2018). The educational, in addition to the clinical, elements of the role have been found to be particularly helpful for topics such as opioid use (Fendrick et al., 2021), cardiac rehabilitation (Naccarella et al., 2018), and new nurse training (Hare, 2007). For instance, Fendrick and colleagues (2021) noted that in an effort to reduce opioid use among some patients, the NA provided cognitive support as well as motivation to improve health literacy and increased awareness of their disease and treatment. NA programs have also been found to decrease health care costs for patients with chronic diseases (Brixner et al., 2019b).

Regardless of their emphasis, the NA role should be structured in a way that best fits the needs of the community population served. The Nurse Ambassador model, as a family nurse

[8] Forensic nursing, as a specialty, requires additional training and certification by the International Association of Forensic Nurses that is not otherwise provided in general nursing or nurse practitioner education. This training, however, can be provided to any nurse/provider interested in sexual assault care by a RCC through a combination of hands-on training and autodidactic training.

practitioner driven concept, was integrated by the UVC specifically to address the sexual violence healthcare and educational needs of residents, especially migrants, in the rural communities in South County. The NA, as a leader, has the flexibility and freedom to identify organizational partners and create new opportunities for collaboration and integration. The NA is also able to rely on tight-knit rural community connections to facilitate this collaboration. Especially when introducing a new service into a rural setting, identifying key partners who are established and respected is crucial, as individuals living in rural areas are more likely to already have developed trust with local organizations.

The primary goals for the UVC NA working with rural migrant populations in South County included:

a. Forming multi-disciplinary collaborations and relationships within the rural community. The NA has the ability to collaborate with local law enforcement agencies, medical providers, and community programs which specifically serve the migrant community to increase support and service access to survivors of sexual assault.
b. Organizing a Sexual Assault Response Team, or SART, to increase collaboration and improve pathway access points. The SART will assist in increasing stakeholder trust and collaboration by incorporating their feedback as a team, improving communication, and highlighting the prevalence and need for sexual assault services.
c. The NA should be culturally competent, show cultural humility, and be aware of strategies to overcome cultural barriers for migrant survivors. The NA should be multilingual to communicate effectively with the migrant community.
d. The NA should understand the rural community structure and should be able to effectively increase awareness about sexual assault services and adapt to fit the needs of the audiences.

Further, the Nurse Ambassador model allows for greater access to trauma-informed care to the rural migrant communities. Though trauma has multiple forms (see e.g., Substance Abuse and Mental Health Services Administration (SAMHSA), 2014), as we mentioned above, trauma can arise from experiences of sexual violence and can result in physical, emotional, and/or psychological acute or chronic health outcomes that can impact multiple aspects of survivors' lives (Basile & Smith, 2011; see also Centers for Disease Control and Prevention, 2021). Trauma-informed care (TIC) has a strong history of integration into services for sexual violence (see e.g., Reeves, 2015).

TIC has been described as a "meta-framework" as opposed to a theoretical model (Mihelicova et al., 2018, p. 145). For nursing, Guest (2021) proposes this definition for TIC: "the knowledge, recognition, respect, and concern to care for victims who have experienced physical

or emotional trauma" (p. 1006). This definition largely reflects the expected principles for enacting TIC (SAMHSA, 2023):

1. Safety- in settings and interactions
2. Trustworthiness and transparency- designed to build and maintain strong relationships
3. Peer support- from those who have experienced trauma
4. Collaboration and mutuality- leveling power differences
5. Empowerment- building on individuals' strengths
6. Cultural, historic and gender issues- rejecting stereotypes and biases

The rural migrant population may have additional trauma that has to be recognized and responded to with significant respect and concern, including racial trauma/minority stress (Ranjbar et al., 2020), gender stereotypes (e.g., migrant men are not seen as potential victims of sexual assault; see e.g. Tummala-Narra, 2021a) and significant polyvictimization/revictimization for Latinas (Cuevas, Sabina, & Milloshi, 2012; Serrata et al., 2020; Tummala-Narra, 2021b).

Research on community resilience in response to such community-level traumas is well-developed within Community Psychology. Scholars discuss community resilience in terms of structural resilience, which is significantly more challenging to develop for historically marginalized communities with ongoing exogenous threats (see e.g., Meyer, 2015), or in terms of what Vaneeckhaute and her colleagues (2017) call "components-centered conceptions of resilience (e.g. communal resources and agency)" (p. 736) that factor in community members' collective actions. However, King and colleagues (2022) have argued that the field lacks a cohesive definition of community resilience. Instead, in their scoping review, they identified common definitional traits: "resilient communities promote the safety, protection, and wellbeing of residents and the ability to thrive despite risk factors" (p. 3326). Their review also highlighted themes within community resilience, such as social support, collective efficacy, spirituality, and cultural preservation as potential components of community resilience.

Cultural preservation also may affect resilience on the individual level, as migrant status is not always correlated with increased levels of psychological distress due to racial trauma, a finding that has been labeled the "immigrant paradox" (see, e.g., Cuevas et al., 2012). Such research suggests that living within ethnic enclaves (such as the rural migrant community in South County) and retaining cultural traditions may be somewhat of a protective factor for racial trauma. Yet issues related to the rural migrant communities' liminal status in the United States can contribute to racial trauma, include a growing anti-immigrant sentiment culminating in rising xenophobic and racist incidents in recent years, coupled with longer-term problems of misogyny toward Latinas, immigrant-targeted violence, and significant economic inequality (Tummala-Narra, 2021a; Tummala-Narra, 2021b).

Collectively, such intersecting forms of direct, indirect, and community forms of trauma may be experienced by rural migrants who then interpret them through diverse cultural and biographical lenses. This diversity suggests the need for practitioners to embrace the concept of "cultural humility"– or practices of mutual learning that empower those with whom one interacts (Ranjbar et al., 2020), a practice that could help avoid stereotyping. All these understandings, principles, and practices guided Espinosa's work as an NA in the rural migrant community of South County as she worked to offer and facilitate trauma-informed care at the individual and community-level.

Enacting the NA Role-Reflections on Strategies

As a child of Mexican migrant workers, I (Dr. Espinosa, DNP, APRN, FNP-BC, SANE-A)[9] understood the complex needs the Hispanic migrant community faced firsthand. I grew up in a small, rural agricultural town in Florida, with Spanish being my predominant language at home and around town. Growing up, I remember the intense fear Hispanic families and my loved ones had regarding interactions with law enforcement. Avoiding medical care was a way to prevent interactions with law enforcement; some individuals would prefer to use home-made remedies and many of the elders as their *curanderos,* or healers, instead of accessing the standard American healthcare system. The only times I would hear about topics like sexual assault would be in *novelas,* extremely dramatized soap operas. It was difficult to believe these situations actually occurred in real life. Even then, the topics were never really talked about in the household. It wasn't until my time as NA that I began discovering many experiences faced by people from my small town were injustices, including sexual assault, sexual harassment, and sex trafficking, and that no one had spoken up about these crimes. This substantiates the belief that members from migrant communities do not disclose their victimization easily. It astonished me that even though in my small rural town, where everyone seemed to know everyone and everything, these crimes were never reported. Yet in my conversations with migrants in South County in the NA role, many began disclosing past experiences they had never previously shared.[10] Some individuals shared they had not reported sexual assault for fear of being judged by people in their social circles. The dense rural networks made them believe everyone would know their business, which prevented them from accessing services. They also feared their victimization would be used against them by members of their own community. It was beneficial and important for me to be able to offer trauma-informed support when stories were disclosed. The lack of awareness and education about these topics creates vulnerabilities and subsequent susceptibility to revictimization.

[9] Certifications/Qualifications: Advanced Practice Registered Nurse (APRN); Family Nurse Practitioner Board Certified (FNP-BC)-providing healthcare services across the lifespan, Sexual Assault Nurse Examiner-Adolescents and Adults (SANE-A)

[10] Because of Espinosa's bilinguality, conversations were often in Spanish or English, and sometimes both.

When I was hired by UVC in October 2022, prior to the opening of the South County clinic, I was recruited because of my passion for serving rural migrant communities. Prior to working at UVC, I had no knowledge about the sexual assault services available, or the prevalence of it within the county. I had moved to the city for college, but despite studying four miles from the UVC during my college years, I was unaware of this great community resource. I later found out I was among many community residents who did not know of the availability of resources in their own neighborhood. Lack of exposure and awareness of the services offered at UVC limited the assistance accessed. When I started as NA and learned about the over 3,000 resources in the UVC database and their 24/7 support, I became even more excited to share this information with those living in South County. If the individuals living close to the UVC urban site did not know much about this resource, it is hard to imagine the residents 50 miles away in South County would.

My first goal as NA was to become acquainted with the resources available. Once I understood those services, my goal was to understand South County. Community alliances, especially in rural regions, are significant for developing trust. My overall goal was to establish a relationship with the South County community and to bring awareness, engagement, and education to the members of this somewhat ignored part of the county. There was no checklist to follow, or any instructions provided on how to accomplish this. And, because I could find no discussion of a Nurse Ambassador model for sexual assault services in the literature, I felt somewhat on my own. So, to begin, I performed a community map. I drove around to understand how people in South County live and how this impacts their access to services. After the map was complete, I stopped in different places to meet the people and leaders at ground level. I stopped at local food pantries, day care centers, libraries, stores, local churches, any and every social services location I could identify. Common themes encountered from all these people and organizations with whom I spoke: a passion for the community.

The KICA results provided by Hughes Miller put into perspective how to use my own personal experiences and background to integrate into this new community. This assessment vocalized the community concerns I had to consider. As Hughes Miller mentions, stakeholders in this rural community did not want intrusion into their territory but, rather, they stated the new organization should, “learn the ways not just the people of the area.” As the NA I was the “face of the organization;” I had to take into consideration this belief. I knew I could not arrive bringing these avoided topics into every conversation so directly. I had to be strategic, sensitive, and most importantly trauma-informed both on an individual one-on-one level, and on a community level. From the KICA, I knew the community's perceived prevalence and need for services was low, and several respondents did not view these topics as priorities or problems.

Bringing up the topic of sexual violence effectively to prevent avoidance or dismissal required building trust.

One strategy I used to develop this trust was the simplest, yet most complex way to be introduced: connecting and getting to know the community and the community partners. Some of my initial community connections were with partners that have been in the community for 40 or more years. It is important to understand that because of the history, services, and support these organizations have offered migrant workers in the past, most victims of sexual assault would be more willing to disclose to someone at these organizations. Relying on existing, trusted organizations and leaders would facilitate the exposure of this topic, and community buy-in for the South County UVC site.

During my first "community visit" I identified an "Opportunity Center" close to several Mexican stores and childcare centers. I stopped in to introduce myself and to learn more about this center. During this visit, I met the center's community engagement specialist whose purpose was to provide opportunities to community members, especially women from low-income, migrant, agricultural backgrounds. I could not have stopped at any better place than this! During my visit, I sat down with staff, sharing stories over *cafecito,* simply getting to know the staff and sharing about my own background, with no plan other than to get to know them. This informal sharing, along with my personal storytelling, demonstrated my rejection of stereotypes about members of the rural migrant community. With no time constraints, I was able to also share my role and contact information. My adaptability allowed me to identify the best strategy based on my personality and past experiences, invoking the principles of transparency and mutuality in the process. Two hours later, I was walking out of that center with a greater understanding of the community, how its rurality and community traditions impacted acceptance of change, several new key community contacts, and trust of the staff. After these early interactions I quickly realized the impact sexual victimization has on rural migrant communities and the need for Spanish-speaking SANEs in this region; it was then I realized the need for me to train as a SANE to be better equipped as an educator and service provider. As the only Spanish-speaking SANE for the South County UVC, this demonstrated the need to recruit bilingual staff to meet the needs of the rural migrant community; a new goal to staff the South County UVC with 50% Spanish-speaking providers was discussed.

Shortly after my visit to the Opportunity Center and their sharing of my presence and contact information with other organizations in the area, I was invited to a rural health fair to table with UVC materials. At the health fair, I introduced myself to the other guest participants and left with many business cards and contacts. This simple networking contributed to the successful integration of my role and organization into this rural community. During the subsequent weeks and months, I would complete more "community visits" like this and stop at gas stations, food pantries, thrift stores, churches, any place to introduce myself, have personal conversations getting to know the community, and offer more information– seeking to demonstrate "knowledge, recognition, respect, and concern" in all encounters. As a result, many service groups welcomed me into their monthly meetings and events. Again, because of the flexibility in my schedule, I was able to show up to any event or meeting I was invited to. I

continued to participate as a member of the community at several community service meetings. I attribute most of my successful trust-building to this: even after educating the groups about UVC and services offered, I continued to participate in other meetings unrelated to my services or expertise. Being an active participant in the community opened the doors to connections and trust-building.

Another strategy to facilitate my integration and inclusion into this rural migrant community was to become personally involved. A local, rural community engagement association invited me to their monthly family-friendly events, and I would attend frequently with my parents and siblings. I attended as a participant, not as NA, but rather to simply interact with the migrant families over games and dinner. These events increased my visibility within the migrant community and consequently trust among them. Because of the rurality of the area and the denseness of the social ties within the rural migrant community, I quickly became recognized as someone committed to the area and their community.

At the opening of the clinic in April 2023, tours were hosted for the community, most of whom were contacts I had made during my community engagement. By April 2024, many community partners and community neighbors had heard of and toured the South County UVC facility, which facilitated their appreciation for the space as one of safety. This was important due to the increased awareness of services and the goal of increasing exams being performed in the South County location. Other community organization partners also started calling me directly for assistance related to other situations they encountered– proof trust-building was successful.

These requests reiterated the KICA finding regarding the need for additional support services in the community, apart from sexual assault services. I communicated these direct requests to UVC leadership, who then continued to identify areas of expansion. A mental health counselor position, for example, was discussed and approved to begin by late 2025 for the South County UVC clinic.

My role as a medical professional and as a SANE facilitated engagement and education of community members on effective prevention and intervention strategies from a healthcare perspective, with an explicit consideration for rural living. Educating about sexual assault as health care services allowed for an even greater understanding of the medical management required. Educating on the medical importance of seeking care after sexual assault put into perspective seeking care as a patient, rather than a “victim.” During my time as NA, I was also becoming more involved in identifying areas for improvement within sexual assault care. My Doctor of Nursing Practice [DNP] project, which overlapped with my goals as NA, focused on continuity of care after sexual assault. The awareness of a lack of follow-up medical services led to the focus of my quality improvement project on increasing continuity of care after the initial forensic exam. My DNP project became the framework for increasing medical services at UVC,

including offering subsequent HIV (Human Immunodeficiency Virus) testing and laboratory follow-up months after the initial SANE exam. This was important, as many survivors of sexual assault usually had no medical care access before or after receiving SANE services.

Comprehensive health care services including subsequent HIV testing and mental health follow-up are also limited in rural regions (Carter-Snell et al., 2020). Given that not all the needed services may be found close to rural communities, it was important to ensure that the South County UVC facility had the opportunity to fulfill these follow-up healthcare needs.

Although outside my role as NA, my DNP project involved incorporating knowledge of quality sexual assault care and identifying and decreasing disparities, all of which strengthened my role as NA.

As NA, I was able to connect with the migrant residents on a level most healthcare professionals are not able to. With no patient load and complete autonomy, I was able to use my time to form connections and prioritize education. I was able to tailor my presentations to fit the audience as I deemed appropriate. Most of the time, my presentations were adjusted before any discussion, to provide population-specific examples. For example, when speaking to farmworkers and migrant families, my presentations had multiple examples involving farm-work settings and familial resources. This also allowed for discussion of these topics in a way the migrant families could best understand and process.

For example, I presented at a migrant parent meeting to discuss sexual assault services and sex trafficking for parents of teenagers, but because of the favorable parent interest and discussion, the one-hour meeting extended to two and a half hours. Parents began expressing their concerns, asking questions, and I was able to facilitate these discussions and dismantle common misconceptions about services for victims. One participant believed anyone receiving a sexual assault exam would have their fingerprints taken and would be subsequently deported. Many others in the room also agreed this was a concern for them. After I discussed reporting and non-reporting options and explained the forensic exam process, many individuals agreed they would seek services if it did not put them at risk of deportation. After educating the group about victimization– that a victim of sexual assault is a victim and not to blame for their Victimization-- many participants acknowledged the benefit of seeking assistance and supporting the victim.

Because of my family background I understood the struggles and fear of accessing healthcare and the lack of trust with law enforcement within the migrant community. This awareness created a need to reach out to migrant families and be seen as a community member rather than just a healthcare provider or organization representative. Adjusting my educational sessions to fit the needs of the other members of the community also involved providing elderly-specific resources and situational examples when speaking to staff at local assisted living facilities, for example. After every session I provided, evaluations and de-briefing

opportunities were encouraged to facilitate community participation and to adjust future presentations– thus empowering the community to help design the content of future presentations. Empowerment of community members was also facilitated by exhibiting "cultural humility" and acknowledging I had much to learn from the South County rural migrant community. While I was there to share information, they shared so much of their lives and experiences with me also. Though sexual assault awareness and intervention was the goal, learning about their experiences and what they needed made me a better NA and improved services at the South County UVC location.

Opportunities and Challenges for the NA role in Rural Migrant Communities

Being aware of the opportunities and challenges of the Nurse Ambassador model will allow an RCC interested in adopting this model to fully benefit from helpful strategies, while preparing to best manage possible challenges. Here we will discuss some of the opportunities and challenges of the NA role in rural migrant communities.

Integration of social and medical support through Nurse Practitioners as NA

The Nurse Ambassador Model for sexual assault education is a beneficial role for community settings and worked well within the unique challenges of our case study. Initial integration of this model required a general community assessment of risk factors and existing service capabilities to understand the needs and structure of the community. We do not see this model used widely (if at all) by RCCs, given the absence of research on the topic, but we believe RCCs elsewhere could benefit from this model, especially if a nurse practitioner (NP) fills that role. Technically, such a health education ambassador position can be filled by any community service provider, such as a social worker or other community-based worker. The NA role being filled by a family nurse practitioner, however, allows for the social services, education, and outreach portion of social work to be achieved, while allowing for the integration of medical knowledge to these services for all members of families– children and adults– as well. A nurse practitioner trained in sexual assault services and sex trafficking is better equipped to navigate social and health concerns that arise from these situations.

Trust building in rural communities involves improving communication between health care providers (Gu et al., 2022) and between health care providers and community members. As part of person-centered care (Pratt et al., 2020), the NA authentically enters the community and learns about the residents and their specific educational and health service needs in relation to sexual violence. The ability to provide medical services *and* education in remote locations makes the NA a link to the continuation and access to care. As part of trust building, it is important that the outreach provider be able to balance medical care provided with the integration of community education and engagement. To do this, the NA must have autonomy to structure schedules accordingly. The community does not function solely from 8am to 5pm, Monday through Friday; the NA must have flexibility to allow for additional community

engagement in the evenings and on weekends. For instance, there could be structured clinic days, along with community engagement days, in the NA's work schedule.

Multi-level trauma-informed community education

The NA role also brings in new opportunities for trauma-informed community education by incorporating a medical provider who can offer medical services in addition to education. The NA, being out in the community, may encounter different situations or conversations that are not appearing at the RCC. Further, when preparing for training sessions within the community the NA is able to take into consideration the audience– for example, parents' meetings versus church groups, multilingual or monolingual– and best learning methods for the audiences. Recognizing the multiple levels at which trauma can operate is also important, necessitating that the NA work toward community resilience as they strive toward individual support and resources in trauma-informed ways.

For rural migrant communities, the NA should understand English literacy levels may be low (and should be assessed during the community assessment), so reading materials may not be the best tool to use. If the NA opts to create a presentation, the presentation should be easy to understand and avoid medical jargon or elaborative vocabulary. The NA should also consider providing materials that are multi-purpose; examples include a hot/ice pack, little flashlight, pen, or stress ball with the organization's hotline. These may be more likely to be used or accepted by members of the migrant community and can facilitate agency awareness more than a pamphlet in English can. Education about these services in a way that attendees best understand and communicate, allows the NA to directly address community trauma. As trust builds, community members will hopefully be more open to disclose personal or known experiences of victimization, at which point the NA's expertise can both support victims medically and educate them about their choices and available services.

Increased multi-organizational collaboration leading to expanded service access

Collaborating agencies and key stakeholders play an important role in increasing access to sexual assault services for migrant communities. Agencies that offer resources and/or education to migrants should know the needs of the migrant community and have generated trust through their own support services. Survivors of sexual assault would then be more likely to disclose or ask for assistance from these established agencies. The NA enhances pathways for rural migrant survivors into victim and correlated services through these connections with agencies who may come to view the NA as a trusted contact at the RCC. Especially in rural communities, this "word of mouth" or "trust referral" pathway can lead to increased access to services for rural migrant survivors of sexual assault. An opportunity for new pathways is created at each encounter with key stakeholders and agencies.

Autonomy and Flexibility can be facilitative of success in the NA role

On one occasion, during a community-wide tabling event, I met a young migrant mother who approached for a stamp on her health fair ticket. I gave her a brief, general introduction to UVC services, but she seemed uneasy. I told her she was welcome to reach out if she or someone she knew ever needed assistance. Later that day, she returned to the table without her children wanting to discuss more about her situation and I was able to provide trauma–informed information and resources. This story suggests that if the NA is able to personally engage with community members in a variety of settings, including county meetings, lectures, and in common gathering areas, in addition to medical settings, there will be greater opportunities to provide trauma-informed care. Opportunities for migrant and migrant service engagements include engaging in local activities being sponsored specifically for migrant communities and families. Once trust is gained, education about sexual assault can be introduced. Strategies for engaging conversations among the migrant community might include, as it did in this narrative, separating adults and children. Because of the sensitivity of the topic discussed, parents may be more likely to avoid discussion and conversations if their children are present.

Challenges/Limitations

Language Barriers

An individual in the NA role should be able to associate or relate to the community authentically. A NA that is able to connect to individuals in their own language will be able to gain trust easier than someone needing to use a translator. This is not to say that individuals using a translator could not gain trust, but it would take much longer to occur as migrants, in particular, may not disclose their victimization easily. For instance, in a training manual for gender-based violence (GBV) service providers, multiple barriers to disclosure were identified amongst migrant and refugee women and girls (and deaf survivors) internationally, many of which would be compounded by language barriers. The need for a translator could make the situation even more challenging:

> It is very difficult for most victims of [GBV] to talk about their experience, and the presence of a third person can make it even harder. Furthermore, there can be issues if the interpreter is from their own community; the person might find it difficult to trust what they say will remain confidential and might fear they will be blamed and shunned if their family or community find out. If the interpreter is from a different ethnic or political group, the victim might not trust them, and this too can lead to barriers to disclosure (Cabeza Pereiro et al., 2023, p. 16).

Integration and acceptance may take time in rural migrant communities

It is also important to recognize that the community response to the NA's sexual assault education may not be easily accepted at first. Hiring agencies must understand that community members may minimize rates of victimization and/or stereotype demographics of sexual assault survivors– both of which could lead to inaccurate perceptions of prevalence or need for services. To address this, the NA will need time to develop connections and trust both with the community and across community partners. This may involve focusing on goals that seem unrelated to those of the organization itself (i.e., not specifically addressing issues related to sexual violence). The NA should have the autonomy to structure their schedule to best fit this purpose.

Nurse Practitioners may be uncomfortable in this community-centric role

One possible limitation for this model includes not having a nurse practitioner to fill the role, or a nurse practitioner who prefers solely direct patient care. The NA role requires less patient care and more community engagement compared to other APRN positions; thus, some nurse practitioners may not be willing to take on the community engagement tasks as recertifications and relicensing require direct patient care hours. To overcome this possible limitation, a nurse practitioner hired for the NA role must be offered the opportunity to focus on quality improvement projects to apply research findings to clinical practice, provide SANE exams, train other nurses and nurse practitioners to prepare future healthcare providers for caring for the rural migrant community, and provide continuing education approved workshops and presentations. The NA may also provide the recommended follow-up medical services to patients seen after SANE exams. After a sexual assault, medical recommendation for follow-up testing on HIV and other STDs are recommended, including repeat laboratory testing (Espinosa, 2023). The NA, in the capacity as an APRN, can provide these services.

Limited Resources across Multiple Service Domains in Rural Areas

One of the main limitations to expanding the NA role and services provided by RCC is insufficient funding. Non-profits, like the RCC where this project took place, have limited funding from governmental or donor funds. While it is advised RCC continue to apply for grants and funding opportunities, we suggest RCC build sustaining partnerships with other providers in the communities served. In South County, many individuals receive medical services at a well-known medical clinic in the community. Instead of "competing" against this medical clinic, the RCC can form partnerships to allow for follow-up services or additional medical care the NA may not be able to provide. For instance, the NA may encounter situations where a patient who received SANE exam services may need diabetic management, and while the NA has knowledge about this, they do not have the funding to provide primary care services. By forming a partnership with the local medical clinic, the NA can provide a closed-loop referral for additional care. In close-knit rural communities, it is best to rely on

partnerships as many organizations that have provided resources or assistance prior to the RCC have already gained trust from community members, and by working together the RCC would be perceived as a member of the community network. Because a long-term commitment is needed to build trust within rural communities, partnership building will allow for sustainable and prudent use of limited resources.

NA may be asked to serve on local governmental advisory boards because they understand the community on a "ground-level" and are able to speak on real issues encountered. By becoming an active participant in local governmental leadership discussions, the NA will be able to engage with, and provide input about, the needs of the community to policy makers. Indeed, NA's expertise could be shared on local, state, and federal levels to engage policy makers in appropriate decision-making. This is also a continuation of the NA's role in engagement with leaders to enhance services provided to rural communities. During Espinosa's time as NA at the RCC, she served on the County's Commission on Human Trafficking, adding into discussions the medical needs of some victims of human trafficking. This experience highlighted the importance of bringing to the table the ground-level work and stories of victims she had encountered to local governmental leaders who have no medical background. These governmental leaders then took into consideration expert opinions for framing new policies and services to provide to victims of violence in the county. Having a special lens into the lives of community members, and the trust from those community members generated through direct engagement, makes the NA position a powerful force for change. For example, in rural Victoria, Australia, local primary health nurses, designated as NAs, worked closely with regional general practice nurses to develop and initiate individualized care plans for their rural cardiovascular patients, thus effectively serving as local educators, bridges to clinical care, and ultimately change agents across the entire rural domain (Hollier & Jennings, 2018).

Structural barriers and Sustainability

Given the relative lack of sexual violence services (Carter-Snell et al., 2020; Thiede & Miyamoto, 2021), including the scarcity of law enforcement officers and overall significant resource limitations in rural regions, the viability of the Nurse Ambassador model in other rural domains is an open question. As discussed earlier, members of the rural migrant community face a number of potential barriers to receive sexual assault services (Cabral & Cuevas, 2020), some of which relate explicitly to the rurality of their location. Indeed, rurality has historically been associated with fewer services overall (Logan et al., 2005), especially mental health services that can address the enhanced stigma and shame experienced by rural sexual violence survivors (Jones et al., 2023). Rurality also creates a perceived lack of anonymity that negatively affects local service access and creates the need for longer, more expensive travel to distant services perceived to be safer (Thomas et al., 2022). This has led to creative efforts to integrate, virtually, available urban services within rural areas, such as the piloting of tele-

SANE exams in rural Pennsylvania. These exams link expert "TeleSANEs" located in urban domains with clinicians at local rural hospitals who do the physical exam under the quality assurance work of the watching TeleSANEs (Miyamoto et al., 2021). Such a strategy could address some of the issues with geographic dispersion of already too-few healthcare facilities and personnel in rural domains (Maganty et al., 2023).

The TeleSANE example also demonstrates the ongoing recognition by professionals that sexual violence is a health issue and, importantly, a community health problem. This framing is not new but it does reinforce a strategy to support the sustainability of NA programs within rural domains: the development of collaborative relationships between healthcare and sexual violence facilities. To ensure sustainability of the RCC's services, the NA must form community partnerships and collaborations with established organizations, particularly health organizations, within the community. The NA's medical expertise and connection-building mandate can lead to medical clinic integration and collaboration with other organizations offering medical support.

Similarly, to address long-term staffing, it is important to recognize that collaborative services may benefit from collaborative educational cross-trainings. We suggest that as community healthcare and rural victim services continue their endeavors to meet the needs of their rural clients, the bridging of these systems through cross-training of personnel will facilitate the knowledge of sexual assault among other healthcare providers. Concurrently, shared knowledge can better ensure the health and safety needs of victims both medically and educationally. Rural communities would benefit from further education and development of staff, like Espinosa, who are able to work within both domains as Nurse Ambassadors to provide services to rural survivors of sexual violence.

Further, the NA may assist in forming partnerships with local colleges and universities to provide education on sexual violence and SANE efforts to professionals early in their educational experiences. RCC could also prioritize increasing collaborative efforts with other organizations that will help provide nursing students and criminology students opportunities for engagement. This association with medical, nursing, public health, and criminology majors in educational programs will increase interprofessional education and collaboration for increased awareness on community public health issues, including sexual violence, and the long-term development of student awareness of the benefits of the NA role. Such partnerships can contribute to the sustainability of services offered by the RCC and also potentially address issues of scale. According to available research, to-date larger-scale NA programs appear to have been either superimposed upon existing nursing staffing (e.g. Hollier & Jennings, 2018) or have been funded by organizations (such as pharmaceutical companies; Yang & Mason, 2021) to ensure adherence with treatment protocols. To develop a large-scale NA program in a rural domain, however, neither may be available. Thus, the development of collaborative partnerships, cross-trainings, and education of students prior to their entry into the workforce

may facilitate a sharing of labor, geography, and knowledge in ways that facilitate meeting the educational and health needs of survivors of sexual violence– assuming funding follows these goals.

Recommendations on scaling up community health programs internationally include similar strategies while also suggesting that specialization and professionalism play an important role in ensuring the quality of larger programs (Schleiff et al., 2021). To achieve this larger scale and greater impact on communities, the NA role should be supported by other specialties and educational institutions as an interprofessional engagement opportunity. The NA specialization is a unique approach to addressing community health needs that will best benefit from broad and continuous community support. Gaining support of business stakeholders, for example, will facilitate the business operations needed to provide such services. As specialized and well-trained community integrated healthcare providers, NAs are well prepared for such challenges and collaborations.

Conclusion

The Nurse Ambassador Model as a family nurse practitioner-driven concept potentially has the ability to fit the sexual violence healthcare and educational needs of rural migrant communities. As Espinosa's narrative suggests, there are many ways to work within communities to generate trust, educational opportunities, and to facilitate increased access to services for minority populations using this model. Academic scholarship already suggests that the Nurse Ambassador model has substantial potential benefit to other communities (Fendrick et al., 2021), including the broader rural community within which sometimes immigrant groups reside. That said, there is to-date no research on the use of NA on the topic of sexual violence, creating an opportunity for organizations and researchers to explore the possibility for such expansion of the Nurse Ambassador Model.

More importantly, the ready integration of trauma-informed care into nursing training makes the type of services provided by NAs who are nurse practitioners reflect the normative expectations of this type of care. As previously discussed, trauma-informed care includes understanding trauma affects a survivor on multiple levels including emotionally, physically, socially, and even spiritually. Key trauma-informed strategies include:

1. Safety and Trust: providing a safe space for victims to discuss their experiences;
2. Empowerment: finding ways to allow victims to gain control over their situation; presenting all options for reporting, non-reporting, or preceding with a forensic exam and allowing the victim to make informed, autonomous decisions;
3. Survivor-centered approach: survivors of sexual assault should feel supported; this may include wrap-around services provided, and thorough follow-up services including mental health care, and compassionate providers;

4. Remaining non-judgmental: offering support and avoiding stereotypes (Ranjbar et al., 2020).

The NA's trauma-informed care can also work toward ameliorating community trauma. Thus, the NA role may impact individuals and communities as a multi-layered, transformational type of care, affecting how individuals and communities view sexual violence and accessing sexual assault services. Seeking help for sexual assault services in rural migrant communities has been perceived as a deeply rooted cultural taboo. By breaking taboo barriers, which can be interpreted as in part related to integrated educational barriers and trust concerns, the NA has the opportunity to empower migrant communities while supporting and assisting survivors of sexual assault within their inner circles. The NA role also has the potential to generate increased community awareness to help deter related crime, decrease obstacles for survivors of sexual assault--regardless of gender, race/ethnicity, social class, or educational level– and increase compassionate services/support through trust-building, collaborative strategies.

That said, our case study only hints at some of these potential outcomes for the integration and expansion of the Nurse Ambassador model into sexual violence services beyond the rural migrant community we discussed here which is a significant limitation of our paper. Given the paucity of research on such models, we recommend that more targeted case studies be conducted so as to better address questions of sustainability, efficacy, and feasibility of the Nurse Ambassador model within rural domains and across other communities and health disparity issues. From our experience in incorporating the NA role in community health, its emphasis on sexual assault facilitated discussions that would otherwise be limited in the rural community served. The implementation of the Nurse Ambassador model, in practice, requires well-prepared professionals interested in immersion into communities so as to better provide local, specialized, health education and medical care. This innovative approach has already been shown to improve health outcomes and reduce health care costs (Brixner et al., 2019a; Brixner et al., 2019b; Fendrick et al., 2021; Hollier & Jennings, 2018; Naccarella et al., 2018); we hope it can also be used to decrease healthcare disparities and improve access to community-based education in other marginalized locales. To reiterate a point made earlier, rural migrant populations are important to the future thrival of rural domains (Slack & Jensen, 2020). As a dominant source of population growth for non-metro areas there should be an increased incentive to adequately and appropriately meet the needs of this specific economic and cultural force. Those needs include quality, available, sexual assault services, as well as healthcare access and education overall.

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