TOWARD HEALTH EQUITY

Addressing Disparities and Barriers to Care through Effective Community/ Migrant Health Services to Farmworkers in Southwest and West Michigan



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Workshop Goals

- Increase awareness of widespread unmet health needs and disparities among Hispanic migrant farmworker families wherever they work and live
- 2. Present factors that inhibit farmworker health equity
- 3. Explain how FQHCs (Federally Qualified Health Centers) exist to fulfill public policy to overcome poverty, language and cultural barriers to provide effective health care at Migrant/Community Health Centers by employing supportive and enabling services to create health equity and inclusion for farmworkers

Expected Workshop Outcomes

- 1. Identify multiple social determinants of health and resulting health disparities prevalent among MSFWs
- 2. Knowledge of at least 15 barriers that exclude MSFWs from access to healthcare and increase risk of accidents and poor health status
- 3. Understand the public policy response to meeting health needs of MSFWs and how FQHCs function as independent, community controlled health center safety nets
- 4. Explain 4 health center approaches that increase health equity and inclusion and promote more effective health care delivery to MSFWs.

FIVE SOCIAL DETERMINANTS OF HEALTH:

Manifestations Among Farmworkers in the USA

1. EMPLOYMENT AND WORKING CONDITIONS

- Long hours exposed to the elements
- Lack of fresh, clean water
- Lack of sanitation, toilets
- Continuous stoop labor, repetitive motions, heavy lifting
- Hazardous equipment ladders, machinery, pesticide applicators
- Substandard, dangerous transportation to and from work sites
- Second most dangerous U.S. occupation (mining is first) yet many agricultural exemptions in labor and worker protection laws)
- Illegal child labor, with or without grower compliance
- Chronic exposure to pesticides

Biomarkers of Farmworker Pesticide Exposure in North Carolina

Urine samples were collected by Wake Forest University School of Medicine investigators from 284 farmworkers at monthly intervals during the period of May through August 2007. A total of 939 urine samples were provided by farmworkers and analyzed for pesticide urinary metabolites by the National Center for Environmental Health, Centers for Disease Control and Prevention, Atlanta.

Organophosphorus (OP) Insecticides: The four metabolites analyzed and their associated insecticides

were APE - acephate, TCPy - chlorpyrifos, MDA - malathion, and Dmet - dimethoate.

More than 75% of the farmworkers had at least one sample that contained APE (acephate).

About 75% of the farmworkers had at least one sample that contained TCPy (chlorpyrifos).

About 16% of the farmworkers had at least one sample that contained Dmet (dimethoate).

More than 65% of the farmworkers had at least one sample that contained MDA (malathion).

Carbamate Fungicide: The metabolite ETU was analyzed; it is associated with mancozeb.

Almost 50% of the farmworkers had at lease one sample that contained ETU (mancozeb).

Pyrethroid Insecticides: Two pyrethroid urinary metabolites were analyzed. 3PBA is general pyrethroid metabolite. TCC is associated with permethrin.

About 87% of the farmworkers had at least one sample that contained 3PBA.

About 9% of the farmworkers had at least one sample that contained TCC (permethrin)

Herbicides: Three herbicide urinary metabolites were analyzed, 2,4-D, ACE which is associated

with acetochlor, and MET which is associated with metochlor.

92% of the farmworkers had at least one sample that contained 2,4-D.

72% of the farmworkers had at least one sample that contained ACE (acetochlor).

36% of the farmworkers had at least one sample that contained MET (metochlor).

Policy Brief, Center for Worker Health, Wake Forest University School of Medicine, Thomas Arcury, PhD, Director

2. INCOME/SOCIAL STATUS

- Very low, sporadic wages; no unemployment benefits
- High debt owed to, and wage cheating by, unfair labor contractors, some growers; fear of complaining
- Food insecurity, limited access to healthy, affordable food, diet high in processed foods, Coke, power drinks
- Invisible, despised, marginalized population
- Discrimination on worksite, during travels, within receiving communities; victims of hate crimes, bullying of children and adults
- Lack of drivers licenses, racial profiling
- ICE (Immigration and Customs Enforcement) activity; mixed status families, chronic fear due to immigration status problems and threat of fines, incarceration, and deportation; difficult family fragmentation, female head-of –household "single parent " families left in U.S.

3. SOCIAL SUPPORT AND CONNECTEDNESS

- Migratory lifestyle; costly, perilous desert crossing; human trafficking
- Long-term family separations, single men and unaccompanied minors with family in Mexico
- Large, very closely bonded families and extended families; short intervals between deliveries and next pregnancies; often inadequate prenatal care
- Children's frequent school changes, highest U.S. school dropout rate
- Isolation from familiar cultural norms, high acculturative stress
- Infidelity (transnational polygamy)
- In-camp female sex worker activity, MSM, increased risk for sexually transmitted diseases
- Lack of access to shopping, laundry, recreation, churches
- Reliance on alcohol and drugs as self-medication, escapism, especially among men
- Fear, anxiety, depression, family dysfunction, hopelessness, fatalistic outlook
- Lack of knowledge of support services, including health care, available and earmarked for migrant farm workers
- Language barriers

4. ENVIRONMENT AND HOUSING

- Transient lifestyle, stress of unsafe traveling, often to unfamiliar places, frequent vehicle breakdowns
- Substandard living conditions, very few personal possessions (vermin, rodents; poor food storage facilities; communal kitchens; hazardous wiring; contaminated well water, lack of plumbing, indoor showers and toilets; inadequate garbage disposal and pickup; lack of laundry facilities; few, if any inspections, even in states with licensed migrant housing laws)
- Hidden away and nearly inaccessible housing; isolation
- Forced overcrowding which violate privacy needs and can lead to sexual abuse and domestic violence
- Lack of recreation areas, playgrounds and equipment, children exposed to hazards in fields and in camps; adult and childhood obesity

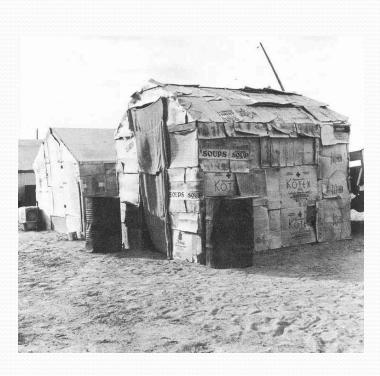
Migrant labor housing

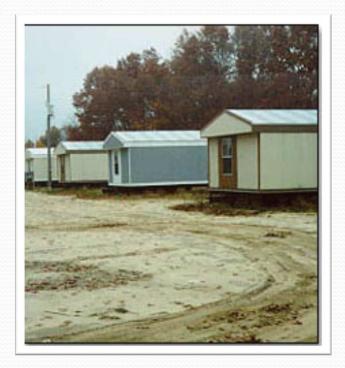














5. ACCESS TO HEALTH CARE AND HEALTH LITERACY

- Communication barriers Monolingual Spanish, some with monolingual indigenous language skills only, Low English Proficiency (LEP); reliance on children, relatives, friends, strangers as Spanish/English interpreters, despite civil rights laws
- Discrimination by health care providers (attitudes, quality and types of services offered and provided, disregard for patient understanding, etc.)
- Only 154 migrant farm worker health centers (some with multiple sites) in 42 states accessed by approx.
 800,000 farm workers of an estimated 3-5 mil in this country (16-26% served by federally funded migrant or migrant/community health centers)

(CONTINUED) ACCESS TO HEALTH CARE AND HEALTH LITERACY

- Lack of inclusion in community environmental disaster preparedness plans; lack of knowledge of safety practices and procedures
- Limited access to available health care lack of knowledge about available health care and Sliding Fee Discount; ineligibility for health insurance or lack of knowledge of existing eligibility; lack of transportation to get to appointments, long work hours that do not fit clinic schedules; inability to obtain appointment when needed or permission from grower to leave work (threat of being fired, loss of housing); difficulty accessing and affording specialty care; unmet dental needs; lack of mental health, substance abuse, and social services resources
- Lack of familiarity with U.S. health care delivery system and insufficient means to execute care plan
- Prevalence of co-seeking indigenous medical practitioners (spiritual healers, herbalists, drug injection specialists, etc.), increased risk for contraindications or disregard for medical care plan; fatalistic view towards sickness and suffering.
- Inability to understand health handouts, teaching, leading to "noncompliance"
- Late access to, or no prenatal care; restrictions by spouses for women's health care

(CONTINUED) ACCESS TO HEALTH CARE AND HEALTH LITERACY

- Never had or infrequent physical exams, especially males
- Never had or behind in adult immunizations
- Little or no preventative care, advanced progress of untreated illnesses and injuries, poor prognoses
- Tendency to seek acute care only when condition becomes extreme and prevents ability to work

Unmet Health Needs and Health Disparities Among Migrant and Seasonal Farmworkers

WORKING ADOLESCENT AND ADULT FARM WORKERS

- Cancer
- Chemical- and pesticide- related illnesses (often undiagnosed)
- Dental and oral health diseases
- Dermatitis
- Diabetes
- Eye diseases and preventable blindness
- Headaches
- Heat-related illnesses
- Hypertension
- Infectious diseases (bacterial, spirochetal, viral, fungal, parasitical)
- Malnutrition and obesity
- Mental health problems (anxiety, depression, stressrelated, post traumatic stress disorder
- Musculoskeletal disorders
- Reproductive health problems
- Respiratory conditions, Tuberculosis
- Sexually transmitted illnesses
- Social disorders (domestic abuse, substance abuse, child endangerment and neglect)
- Traumatic injuries
- Urinary tract infections
- Vehicular accident injuries and fatalities

Accident-related fatalities

- Anemia
- Chemical- and pesticide- related illnesses

CHILDREN OF FARM WORKERS

- Dental diseases
- Dermatitis
- Infectious diseases (bacterial, spirochetal, viral, fungal, parasitical) otitis media, chronic sinusitis, pneumonia
- Leukemia and tumors
- Malnutrition and obesity (Metabolic Syndrome)
 Pre-diabetes
- Social disorders (domestic abuse, substance abuse, child endangerment and neglect), anxiety, depression
- Traumatic injuries
- Upper respiratory infections and asthma
- Vehicular accident injuries and fatalities

1. ACCESS ENHANCEMENT

- Anyone can receive care at a Community/Migrant Health Center. Everyone chooses own primary care provider.
- Telephone Call Center; Open Access Scheduling same or next day scheduled appointments; Increased same day slots in each providers' daily schedules; longer clinic hours
- Free transportation services via minibus, passenger van, employees' vehicles; collaboration with labor contractors to allow MSFWs to have time off for health services
- Mobile medical and dental vans to see patients in camps, at migrant head start centers, summer migrant education programs in schools

2. AFFORDABILITY THROUGH ELIGIBILITY

- Sliding Fee Scale Discount based on (1) lack of, or insufficient insurance, (2) income as related to federal poverty level, and (3) family size. Not restricted by immigration status or state residency requirements. Farmworkers can claim dependents who do not travel with them. Payment plans are offered when needed. No one turned away because of lack of money to pay for care.
- Information about and assistance applying for eligible benefits
- Voucher Program Northern Kent, Southern Newaygo, Western Montcalm, and Eastern Muskegon Counties where there are too few farm workers to sustain a Federally Qualified Health Center. InterCare screens and enrolls qualified migrant and seasonal farm workers and issues vouchers to pay all but nominal co-pays for medical visits and limited lab work at a local clinic in Sparta, operated by a Grand Rapids hospital.

3. ASSISTANCE (ENABLING SERVICES)

- Spanish language interpretation and translation services throughout the agency-bilingual, bicultural staff at most levels, several bilingual providers; one indigenous, Mixteco speaking seasonal employee thus far; agency subscription to Language Line telephone interpretation services
- Low literacy, language appropriate health information handouts and education
- Outreach program in migrant camps Seasonal Outreach Nurses and Outreach Workers provide health access information, health education, case finding, health assessments and health care, referrals to clinic, WIC, social services; follow-up of patients seen in clinic; "branding" with IC logo on materials, employees with royal blue polo shirts, t-shirts, lanyards, name badges, car signs, give away items

4. ABILITY AND EXPERTISE

- Medically and culturally competent medical providers and staff- Board certified, meet all federal and state standards and requirements; Joint Commission accredited; pending National Committee for Quality Assurance (NCQA) recognition
- Farmworker representation on Board of Directors
- Electronic Medical and Dental Records; innovative state-of-the art tools
- Adherence to health care reform mandates, e.g., Patient Centered Medical Home (application in progress) patient selected Primary Care Providers; whole-person care with patient at the center of the health care team; population management of patients with chronic diseases through Nursing Care Management; continuity of care for mobile patients through collaboration with providers in other areas; measurement and improvement of quality of care.
- Technical Assistance from Health Resources and Services Administration (HRSA), National Association of Community Health Centers (NACHC), National Center for Farmworker Health (NCFH), Migrant Clinicians Network (MCN), Michigan Primary Care Association (MPCA), Michigan Department of Community Health (MDCH) to achieve and sustain compliance with clinical measures and state of the art knowledge and skills in health care delivery to MSFWs.
- Collaboration with other organizations providing health and social services to MSFWs.

TOWARD HEALTH EQUITY? YES

Community/Migrant Health Centers are continually working to meet the challenges of providing care to America's migrant and seasonal farmworkers.

- Participation in the public debate about needed health care reform and advocacy for more FQHC access points for the 74-84% of farmworkers who lack continuity of care through continuous availability of quality health care services
- Agency-wide increasing of respect for and knowledge about the cultural beliefs, preferences, and practices of all of our patient populations through continuing education; appreciation for and acknowledgement of the strengths present in MSFW families; advocacy of educational and training opportunities, and recruitment of health care professionals who reflect the cultures served at FQHCs
- Dedication to empowering MSFWs with knowledge to self-manage their health needs through prevention practices, and active participation in planning and executing their own patient health care plans
- Active collaboration locally, nationally, and transnationally to develop and implement effective strategies for meeting health needs of MSFWs
- Continuous Quality Improvement through self-assessment of outcome measures and adherence to industry verified evidence-based practices; recognition of best practices by credentialing and funding sources

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