CONTINUITY OF CARE FOR AMERICA'S FARMWORKERS

Report by Stream Coordinators

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(Table of Contents)

		Page
I.	**PROBLEM STATEMENT**	1
II.	**PROGRAM MODELS**	
	• Disease or Population-Specific model	2
	• Outreach model	2
	• Medical / Health Information and Data Transfer model	3
	• Portable Records and Toll-Free Numbers	4
III.	**ADDITIONAL RESOURCES**	4 - 5
IV.	**RECOMMENDATIONS**	
	• Develop a Broad Based Plan to Improve Continuity of Care Activities	5
	• Maintain the Focus on the Community and Individual	5
	• Build Capacity and Strengthen Infrastructure	6
	• Encourage Networking and Stream Wide Communications	6
	• Consider New Technologies for Data Transfer	6

PROBLEM STATEMENT

This report focuses services that assure continuity of care to farmworkers living and working in the United States The report based on the observations and expertise of the three Stream Coordinators, advisory committees, migrant health clinicians and other service providers.

The provision of health care to migrant farmworkers as they move from place to place is one of the most challenging and unique aspects of health service delivery to migrant farmworkers. Assuring continuity of care remains at the forefront of the planning and implementation of all programs and projects that seek to provide quality migrant health care services.

orm pl exist at national vel for pr viding continuum of care for farmworkers as they move. Continuity of care activities are usually practiced on case by case, health center by health center basis. This leaves the 20 independently operating migrant health programs to create their own system without niform outcomes processes and data collection and transfer methods, to act as guidepost for coordinating activities. Also missing is infrastructure that links each organization for collecting and transmitting treatment information or point of contact for farmworker entry and re-entry into the system.

CONTINUITY OF CARE FOR MIGRANT FARMWORKERS: MODELS FOR IMPROVED SERVICE DELIVERY

Despite thi lack of formal planning migrant health centers regularly engage in continuity of care activities. In general, models tend to fall into two broad types of categories:

- models that attempt to addres medical or health information transfer and
- models that attempt to address or overcome barriers to accessing care.

PROGRAM MODELS

1 Disease or population-specific model

Programs that adopt this model attempt to follow patients with a specific health problem, such as tuberculosis or focus on a narrowly defined patient population such as pregnant women. Programs in this category are more likely to be able to demonstrate success perhaps due to the short duration of time required for the treatment or follow-up (usually no more than 1 year), the relatively low numbers of patients that require referral, and because success can more easily be measured (i.e.successful completion of therapy, number of prenatal visits or successful birth outcome). In the case of tuberculosis or other communicable diseases, communicable disease laws and state reporting requirements provide an additional incentive for providers to make the appropriate referrals.

Current examples of these projects include: the Farmworker Interstate Tuberculosis Treatment and Follow-up Project (funded by the Robert Woods Johnson Foundation to the FL Putnam Co. Public Health Unit, Palatka, FL), Bi-National Data Transfer Project funded by the Centers for Disease Control to the Migrant Clinicians Network, Vida y Salud Prenatal Outreach Project (funded by the Kellog Foundation to the Valley Health Center in Somerton, AZ,).

2. Outreach model

These types of programs target barriers to health care experienced by migrant farmworkers such as language, transportation, and / or lack of knowledge of available local resources. By addressing these barriers, farmworkers who may not seek services are identified and appropriately referred to local health centers or health departments. Programs may utilize a variety of models from along the outreach continuum. A program may utilize the more formal professional or paraprofessional outreach workers that work as paid staff members of the health center or agency, the semi-formal, para-professional camp health aides that receive a small stipend for their services but continue to work as farmworkers or the less formal, volunteer lay health advisors who receive additional

training but receive no stipend or compensation for their services and have no formal ties to the health center or agency. Health centers may provide outreach services themselves or may utilize the services of another regional agency. Some programs have successfully utilized VISTA or AMERICORPS volunteers or student interns in these capacities.

Examples of these current programs include: the Lay Health Advisor Program of the National Center for Farmworker Health in Austin, TX; the East Coast Migrant Health Project in Washington, DC; the Midwest Migrant Health Information Office / Camp Health Aide Program in Monroe, MI; the Student Action with Farmworkers in Durham, NC.; and the Promotora Project of Su Clinica de Familiar in Anthony, N.M.

3. Medical / Health Information and Data Transfer model

Programs of this nature focus primarily on the electronic transfer of medical or health information from one provider to another. Several small scale demonstration or pilot projects are underway around the country. Most projects limit the number of participating providers or limit the types of information being collected and transferred. Large scale implementation is hampered by health centers lack of sufficient hardware and lack of sufficient resources to hire staff to maintain the information systems. Other barriers that must be overcome include YAN - syndrome or health center staff resistance or unwillingness to add "yet - another" data collection system, timely entry of data and patient authorization to transfer medical records. Another less expensive, but somewhat cumbersome possibility is the use of a fax - on - demand system. Studies by MITRETEK Systems and MIS contractor Migrant Health Program conclude that there seems to be little acceptance or support by migrant clinicians for a centralized automated database system.

Examples of these types of projects include electronic data transfer being developed at DELMARVA Rural Ministries with the assistance of the Office of Migrant Health and the MITRETEK Systems and the PA Dept. of Health / Guanajuato, Mexico TB / STD Data Exchange Project and the Migrant Clinician's Network Bi-National Data Transfer Project funded by the Centers for Disease Control and Prevention and the now defunct Migrant Student Record Transfer System (MSRTS) funded by the US Dept. of Education.

4. Portable Records and Toll-free numbers.

Portable medical records are a vital aspect of assuring continuity of care. Though reactions as to their efficacy are mixed, portable records are an important component of health care for migrant farmworkers and should not be overlooked. Portable records give farmworker patients control and responsibility over their own health care and are fairly low cost. As migrant workers travel, they may receive health care from a variety of providers other than migrant health centers including local health departments, emergency rooms, urgent care facilities, private providers or free clinics. Skeptics of portable records cite the fact that farmworkers often lose their records and providers are reluctant or unwilling to fill out "yet-another" chart.

Toll-free numbers are another method for giving farmworker greater control and responsibility over accessing their own care. Two toll-free numbers are attempting to provide 24 hour information and referral: the "Call for Health Hotline" operated by the National Center for Farmworker Health and the 800 # funded by US Dept. of Education / Migrant Education Program. The two programs have begun collaborating with one another in the last several months. Though not operated expressly for the purposes of accessing health services, other agencies such as legal services and farmworker opportunities programs (402 - grantees) also operate toll-free numbers and may often refer clients for health care services. Several states also have bilingual toll free numbers that provide information and referral services to the general public.

ADDITIONAL RESOURCES

Additional resources for improving continuity of care are the Stream Coordinators and the Stream Forums. The three stream coordinators positions were established in 1994 as a cooperative effort between the BPHC / Migrant Health Branch, the NC Primary Health Care Association, the National Center for Farmworker Health and the Northwest Regional Primary Care Association to increase the coordination of health and social services provided to farmworkers. Responsibilities include the development of expanded inter-

agency networks and the on-going assessment of trends in each stream. Stream Coordinators are increasingly called on by service provider agencies to assist them in linking patients and clients with upstream or downstream services. Though not providing direct services to farmworkers or participating in continuity of care activities in the traditional sense of the concept, stream coordinators are a vital addition to assuring access and continuity of services.

The three Stream Forums began as an opportunity for migrant health providers to get together on a stream basis to meet one another and to share program ideas and successes. Participation has grown annually since the first Stream Forum was held on the East Coast in 1988 and interest in multi-state and multi-site projects has also increased. The Stream Forums provide the opportunity to put a face with a name and give one an enhanced sense of being part of a larger network of concerned providers. Provider staff state that they are more likely to go the extra "referral" mile and call an upstream or downstream provider when they know the other person on the other end.

RECOMMENDATIONS

1) Develop a broad based plan to improve continuity of care activities.

Such a plan would include the input from all stakeholders especially clinicians and define universal outcome(s), objective(s), and goal(s).

2) Maintain the focus on the Community and Individual.

Continue supporting community based programs like lay health advisors by providing ongoing training on health promotion and the important role they play in providing continuity of care services. Equally important, address transportation issues especially in rural communities where there is no public transportation, and make available necessary medical records for farmworkers to take with them as they migrate.

3) Build Capacity and Strengthen Infrastructure.

Require that all BPHC Section 329 funded programs designate staff to serve as points of contact for farmworkers to access services as they move along the migrant stream and continue capacity building efforts to develop a uniform database. This could include adding a section in the medical record that tracks anticipated next migration point and identifies the most appropriate MHC / CMC at their next work site.

4) Encourage Networking and Stream Wide Communications.

Utilize the Stream Forums and National Migrant Health Conference to educate and train individuals, particularly continuity of care liaisons and lay health advisors about continuity of care. Stream Coordinators are an essential element in stream wide communications.

5) Consider New Technologies for Data Transfer.