A Modified Community Oriented Primary Care Model for the Delivery of Migrant Health Care

esource ID# 5192

Modified Community Oriented Primary Care Model for the elivery of Migrant Health Care

Antonio N. Zavaleta, Ph.D.
Executive Director, COPRIMA
Associate Professor, Anthropology
The University of Texas at Brownsville
Brownsville, Texas

Jordan W. Finkelstein, M.D., M.Sc.
Professor of Biobehavioral Health
Human Development and Pediatrics
The Pennsylvania State University
University Park, Pennsylvania

Carmen D. Rocco, M.D.
Clinical Assistant Professor of Pediatrics
The University of Texas Medical Branch-Galveston
Pediatric Staff
Brownsville Community Health Center
Brownsville, Texas

More than thirty years have passed since the broadcast of *The Harvest of Shame* focused the nation's eyes on the plight of migrant and seasonal farmworkers. The investigative report documented the severity of migrant health and housing problems, poorly enforced labor standards and inadequate education for migrant children. The Kennedy administration proposed steps to implement programs which targeted this highly vulnerable population. Thirty years later, the Migrant Health Act passed in 1962 continues to serve as the backbone of the migrant health program in the United States. It is often overlooked that the implementation of Migrant health legislation pre-dates the legislation which created federally funded Community Health Clinics. Over the past thirty years, the Federal government has continued to support a variety of programs designed to impact America's most marginal population, its migrant farmworkers. Unforeseen in the early 1960s, however, was the tremendous increase in the emigrant population from Latin American and Caribbean countries that would take place during the 1970s and the 1980s. While many (perhaps most of these recent arrivals) settled in urban areas of the country, a large percentage found a niche as migrant farmworkers, greatly increasing their numbers. A number of studies have shown that the characteristics of migrant farmworker populations vary according to their principal migrant stream— east, central or west, and their country of origin. While migrant sociocultural characteristics may vary, one thing is true for all. Migrant farmworkers are poor and lack access to basic resources which could improve their overall health status.

A Modified Community Oriented Primary Care Model for the Delivery of Migrant Health Care

Particularly marginal among this population is the migrant farmworker of the lower Rio Grande valley of Texas (Valley). Dedicated students of Valley health status will recall the results of the Texas Nutritional Survey in 1968 (Poverty in Texas, 1972) and the Baylor School of Medicine-Field Foundation study of 1970 (Poverty in Texas, 1972). The Baylor study focused on the health status of migrant farmworkers and led to the alarming testimony of Drs. Lipscomb and Wheeler given before the Committee on Labor and Public Welfare of the United States Senate in 1970. Dr. Lipscomb testified that, "I doubt that any group of physicians in the past 30 years has seen, in this country, as many malnourished children assembled in one place as we saw in Hidalgo County (Poverty in Texas, 1972)." Dr. Wheeler added that, "the children we saw that day have no future in our society. Malnutrition since birth has already impaired them physically, mentally and emotionally. They do not have the capacity to engage in the sustained physical or mental effort which is necessary to succeed in school, learn a trade, or assume the full responsibilities of citizenship in a complex society such as ours (Poverty in Texas, 1972)."

This testimony led directly to major intervention and eventually to the creation of three federally funded Migrant Health Clinics and a host of other programs for the Valley's poor Mexican American population. It is not suggested that the

One Day Old

This young mother is from the Rio Grande Valley area of Texas. She had her baby in Indiana, leaving the hospital to return to the labor camp the same day the baby was born.

majority of the Valley population was involved in agricultural work in 1969. However, agriculturally related industries continued to be the principal occupational category in the Valley through the 1970s. There was never more than 30 percent of the Valley's Mexican American population involved in agricultural production during the 1960s and 1970s. It is also true that among low income persons and recent arrivals from Mexico, the agricultural industry offered the most direct and immediate avenue into the local economy. Thus any examination of Valley demographics during the years 1960 to 1990, clearly indicates the build-up of this population at the bottom of the socio-economic strata which began with the end of the bracero era in 1964. The same time period, 1960 through 1980, saw the rise of the colonia phenomenon in the Valley. Colonias would become the focal point for the Valley's health problems in the 1980s and 1990s (Maril, 1989).

In a study conducted in the 1980s by the city of Brownsville and the Brownsville Community Health Clinic, it was found that the persons with the poorest health status and the greatest health needs in the Brownsville urban area of southern Cameron County resided in the colonias which encircled Valley cities outside of their jurisdiction (Zavaleta et al., 1985). Similar findings have resulted from other scientific studies of the Valley. A notable example is the Government Accounting Office (GAO) study entitled, "Health Care: Availability in the Texas-Mexico Border Area" published in 1988. Quoting from the section entitled "Colonias: The Shanty Towns of the Area," the report states that, "Poverty and the scarcity of adequate, yet affordable, housing in the area have contributed to the growth of colonias. These substandard housing subdivisions in rural districts consist of small plots of land with few or no roads and polluted water and inadequate sewage facilities. Colonias are in unincorporated parts of counties adjacent to American cities and towns along the border. The land for the colonias was usually acquired by migrant workers and other low-income groups of Mexican descent (GAO/HRD, 1989)."

The report goes on to describe the inadequacy of health care delivery systems along the U.S.-Mexico Border. Today the Valley's low-income people including migrant farmworkers receive health care from federally funded migrant health clinics and community health clinics. There is no difference between the types of services and health care delivered at federally funded migrant

In 1986, indigent health care legislation in the State of Texas led to the creation of programs designed to impact upon the state's most *at-risk* populations. It was at this time both Drs. Finkelstein and Rocco of the University of Texas Medical Branch (UTMB), Department of Pediatrics, developed the Community Oriented Primary Care (COPRIMA) model, an Independent Physician Association, Health Maintenance Organization (IPA-HMO) model. Conceptualized as a demonstration project, the program targeted colonias in the Brownsville area identified by the earlier Brownsville study. As required by the Texas Department of Health Primary Care Program, Community Oriented Primary Care Association provides the qualifying colonia patient population with: 1) diagnosis and treatment, 2) emergency services for acute illness, 3) family planning services for all men and women in the child bearing ages, 4) preventative services including immunization, case detection, screening, health maintenance, and promotion, 5) health education, and 6) laboratory, radiologic, nuclear medicine and other diagnostic services. In addition, the model includes an ambitious plan for social work and health education specialities and provides for the training of Community Health Aides who function as an outreach team.

The COPRIMA program is currently in its sixth year of operation. During its first and second years, the program operated as a UTMB project. In years three through six, the program has operated as a non-profit corporation with a governing board designed after the model required of federally funded projects in which a majority of board members are "consumer" members or their representatives. From the outset of the COPRIMA program in

A Modified Community Oriented Primary Care Model for the Delivery of Migrant Health Care

1986, the migrant and seasonal farmworker subpopulation was identified and targeted as the most potentially needy in the colonia population. The migrant farmworker population represents approximately one out of every three families served (Zavaleta et al., 1989). As described above, it is not surprising that the highest percentage of Valley migrant farmworkers live in colonias. Importantly, the 1990 census of population has for the first time identified the characteristics for some of the more notorious Valley colonias, including Cameron Park where the greatest number of COPRIMA patients reside. The COPRIMA program functions by providing a broader-than-normal range of primary care *support services* to the patient. These include community Health Aides (similar to Migrant Camp Aides) and on-going health education classes. Individual patient and family cases are followed with a quality assurance model which targets specific patients and channels them to a social worker, community health aid or health educator. The process insures the continuity of care by ultimately returning patients to their private provider. The desired and documented end result is the on-going education and overall improvement of their health through an empowerment of the individual family. For example, through five completed years the COPRIMA program has reduced patient visits from an average of six per person per year to two visits per person per year (COPRIMA, Data Files). Recently, Project Hope, a world-wide organization has funded a two-year Community Health Aide training program modeled after the COPRIMA plan. These newly trained para-professionals will serve as the critical link between colonia residents and migrant farmworkers and the health care delivery system.

The efficacy of the model may be seen by comparing it with proposed plans developed at the national level. In 1990, the Office of Migrant Health of the Bureau of Health Care Delivery and Assistance, Public Health Service, commissioned the National Migrant Resource Program and the Migrant Clinician's Network in collaboration with numerous other associations to prepare a working document which would describe the "Migrant and Seasonal Farmworker Health Objectives for the Year 2000." Fifteen *migrant-specific*, objectives were identified which best represent the most critical areas of migrant health (NMRP, 1990).

1. Reduce Alcohol and Other Drug Abuse
2. Improve Nutrition
3. Improve Mental Health and Prevent Mental Illness
4. Reduce Environmental Health Hazards
5. Improve Occupational Safety and Health
6. Prevent and Control Unintentional Injuries
7. Reduce Violent and Abusive Behavior
8. Prevent and Control HIV Infection and AIDS
9. Immunize Against and Control Infectious Diseases
10. Improve Maternal and Infant Health
11. Improve Oral Health
12. Reduce Adolescent Pregnancy and Improve Reproductive Health
13. Prevent, Detect and Control Chronic Diseases and Disorders
14. Improve Health Education and Access to Preventive Health Services
15. Improve Surveillance and Data Systems

It is clear that the migrant farmworker's pattern of seasonal movement and the nature of agricultural work produces a population which has different and more complex health problems than the general clinic populations in the Valley or anywhere else. The recent migrant health status study conducted by Alan Dever for the Migrant Clinician's Network, accurately examines these *different and complex* problems and the resulting inadequate health status of our nation's migrant farmworkers (Dever, 1991).* Because migrant and seasonal farmworkers have multiple residences

* Alan Dever's Study, Migrant Health Status: Profile of a Population with Complex Health Problems is in this journal pages 6-27

throughout the year, access and continuity of care is virtually impossible. Thus, migrant farmworkers suffer from more ailments than the general population, and they suffer longer. An examination of the medical files for 15 migrant families drawn at random from the COPRIMA patient population and compared to the characteristics of the total COPRIMA patient population exactly matched the results of the Dever study.* That is, migrant families are sick more often for longer periods of time. Migrant farmworkers make more clinic visits, and do not usually receive any care for chronic heath problems such as diabetes. Once migrant farmworkers leave the *homebase* area, there is no continuity of care and *up-stream* providers are not usually able to access homebase medical records (COPRIMA Medical Records).

While away from their homebases, migrant farmworkers move often and frequently. Therefore, illnesses are not properly managed. Medications are not purchased and are not taken for the recommended duration. This results in the children of migrant families enduring chronic infections during the spring and summer months. They return to the COPRIMA patient load in the winter with severe chronic infections. Adults with chronic illnesses such as diabetes have typically not been treated and return to the primary care provider in much worse shape than the year before. Examinations of the migrant family records also indicate that life in the colonias produces a much higher rate of injury from accident than in the general population. For migrant farmworkers, the rates of illness and accident are even higher than those of the general colonia population. For example, the periodic abandonment of non-functional vehicles around the house leads to less than desirable home environment conditions which promote illness and injury, especially in children.

Examination of Dever's table entitled the "Most Common Principal Diagnoses in Migrant Health Clinics by Sex and Age" presents a list which is virtually identical to the COPRIMA "homebase" migrant population. The top five diagnosis expressed as an overall percentage for both sexes and all ages are: 1) Diabetes Mellitus, 2) Health Supervision of Infant or Child, 3) Otitis Media, 4) Normal Pregnancy (COPRIMA does not provide pregnancy services) 5) Acute Upper Respiratory Infection (Dever, 1991). Tracking the COPRIMA colonia population over five years, Health Supervision of Infant or Child, Otitis Media, Acute Upper Respiratory Infection, and Hypertension are the top diagnoses. The results for the COPRIMA migrant population are largely the same as what Dever found, with injury being added. Once again, the major difference between the permanent colonia population and the migrant colonia population is that the migrant population is sick more often and, as a result, realize more doctor visits for the same problem or condition over time. Medical cases from the COPRIMA population indicate that migrant farmworker families have specific health problems that continue year after year with little or no treatment.

The National Advisory Council on Migrant Health is acutely attuned to the "Farmworker Health for the Year 2000," plan described above. The Migrant Health Council's 1992 recommendations to Dr. Sullivan, the Secretary of Health and Human Services, includes eight areas (NACMH, 1992). Four of these areas deal with important health issues which fall outside of direct delivery of care. They are Housing, Appropriations, Health Professions, and Research, which are obviously important components of the overall health care picture for migrant farmworkers. However, four recommendations categories fall squarely within the primary health care delivery model. The first area is *outreach*. The 1992 Migrant Health Council Recommendations cite that the difficulty that migrant farmworkers have had in attempting to access health care has necessitated the development of outreach programs specifically designed to locate the migrant population and to eliminate linguistic and cultural barriers to care which might exist. Outreach programs connect the migrant family with the health services which best fulfill the five "A's"—availability, accessibility, acceptability, appropriateness and affordability. Of particular im-

A Modified Community Oriented Primary Care Model for the Delivery of Migrant Health Care

portance is the Migrant Health Councils' attention to the need for the development and implementation of more Lay Health Advisor or Community Health Aide programs. The colonia based Community Health Aide program is, of course, one of the most important features of the COPRIMA program. Two other recommended areas for 1992 may be consolidated under the heading of Family and Mental Health Issues. Many of the domestic issues listed in the "Migrant Health Objectives for the Year 2000" directly address this recommendation. These include substance abuse, mental health, violent and abusive behavior, sexually transmitted diseases, and health education—just to mention a few of the most critical. Almost every study of migrant health status that has appeared in recent years has emphasized the socio-economic marginality migrant families must endure, especially when they are away from home—up-stream. Testimony given before the National Advisory Council on Migrant Health has called for the development of family and mental health care delivery systems specifically designed to meet migrant farmworker's unique needs. These delivery systems could easily be operated by the existing network of migrant and community health clinics. The final issue is that of Medicaid eligibility. Because migrant farmworkers cross state lines and because they move frequently and often, migrant and seasonal farmworkers find that they have tremendous difficulty accessing the Medicaid system. The delivery of quality health care to all Americans in this highly mobile society begs for a system which can be easily accessed across state lines. For migrant farmworkers, this is of the highest priority. The Migrant Health Council recommendations point out that the federal government allows individual states discretionary power which differs from state to state, and that states are allowed 45 days in which to process Medicaid applications. In the case of migrant farmworkers who have followed the harvest and are several states away by the time their Medicaid application is approved, there is never any access to health care.

It may be concluded that migrant and seasonal farmworkers are a unique and highly at-risk population of Americans. Their economic marginality and poor health status is notorious. Studies have shown that health care delivery models exist which directly impact the migrant farmworker population at both ends of the migrant stream. In addition, the National Advisory Council on Migrant Health has submitted recommendations for 1992 which suggest the implementation and amplification of existing models which *reach out* to families who fall through the health care delivery net. The COPRIMA program in Brownsville, Texas is a Texas Department of Health primary care program which has operated a system which specifically targets low-income colonia populations where migrant and seasonal farmworkers have been shown to often live. Now in its sixth year of operation, the Community Oriented Primary Care (COPRIMA) in the Valley is worthy of study as one of the numerous models which positively improve migrant and seasonal farmworker health status in a highly cost effective manner.

References

Community Oriented Primary Care Association (COPRIMA). (1986). *Patient Medical Records*. Brownsville, Texas.

Dever, G.E.A. (1991). Migrant Health Status: Profile of a population with Complex Health Problems. *Migrant Clinicians Network Monograph Series*. Austin, Texas: National Migrant Resource Program.

Maril, R.L. (1989). *Poorest of American: The Mexican Americans of the Lower Rio Grande Valley of Texas*. Notre Dame, Indiana: University of Notre Dame Press.

National Advisory Council on Migrant Health. (1992). *Farmworker Health for the Year 2000: 1992 Recommendations of the National Advisory Council on Migrant Health*. Austin, Texas: National Migrant Resource Program.

A Modified Con
Migrant Health

National Migrant Re
Migrant and Se
Objectives for t
Texas: National
Office of Economic
Poverty in Texa
Economic Oppo
United States Gener
(1988). *Health*
Texas-Mexico E
89-12). Washin
Zavaleta, A.N., Cor
(1985). *Browns*
assessment sur
community case
Brownsville, Te
Zavaleta, A.N., Fink
Rocco, C. (198
Health Status in
Brownsville, Te

National Migrant Resource Program. (1990). *Migrant and Seasonal Farmworker Health Objectives for the Year 2000*. Austin, Texas: National Migrant Resource Program.

Office of Economic Opportunity. (1972). *Poverty in Texas*. Austin, Texas: Office of Economic Opportunity

United States General Accounting Office. (1988). *Health Care Availability in the Texas-Mexico Border Area*. (GAO/HRD-89-12). Washington, D.C.

Zavaleta, A.N., Coray, G. & Rubinstein, C. (1985). *Brownsville health needs assessment survey: A U.S. Mexico border community case study 1984-1985*. Brownsville, Texas: City of Brownsville

Zavaleta, A.N., Finkelstein, J., Rubinstein, C. & Rocco, C. (1989). *Mexican American Health Status in a South Texas Colonia*. Brownsville, Texas: COPRIMA