

streamline

The Migrant Health News Source

Overview of Integrated Behavioral Health

Promising Practices from CommuniCare in San Antonio, TX

Martha Medrano, MD, MPH; Jennie McLaurin, MD MPH, and Jillian Hopewell, MPA, MA

Behavioral health is recognized as one of the most critical needs of patients in primary care settings. For a number of documented reasons, most patients seek help for behavioral health problems in primary care. This in part is due to patients being underinsured for behavioral health services even when they have medical coverage. Additionally there is a growing shortage of mental health providers and limited access to public mental health services for patients without major mental health conditions, particularly in rural areas. For many patients the only viable sources of care are primary care sites.

However, behavioral health problems often go undetected or untreated in the primary care setting. Until recently, most primary care residency training programs had limited educational opportunities in the area of behavioral or mental health. Recognition may be complicated when patients somatize their symptoms of depression and anxiety. Research shows that patients with chronic medical conditions like diabetes have higher rates of behavioral health problems. When done effectively, treating behavioral health problems in primary care presents opportunities for early intervention and prevention of disabling medical and behavioral health conditions.

Integrated Behavioral Health is defined as the systematic coordination of physical and behavioral health services. Integrated models may vary from integrating primary care within a community mental health center to integrating behavioral health services within a community health center. Within each model of integration, the elements of collaborative care adopted by the Chronic Care Model developed by Edward H. Wagner, MD, MPH (<http://www.improvingchronic-care.org/>) are evident. Wagner's model

includes the concepts of care management, evidence based treatment, outcome tracking and expert consultation for patients who are not improving. Care management may include patient education and empowerment, ongoing monitoring and co-management by multiple providers.

An important tool for understanding integrated behavioral health is the Four Quadrant Clinical Integration Model which conceptualizes a framework for designing integrated programs. The four quadrant model is built on the concept that the type of care people should receive depends on where that care is best delivered and the

severity of the patient's physical and behavioral health needs. This model acknowledges that patients are likely to interact with many systems of care and that these systems of care need to be coordinated and integrated. Figure 1 provides an illustration of the Four Quadrant Clinical Integration Model.

Integrated Behavioral Health in Action

CommuniCare Health Centers in San Antonio, TX is an effective example of Integrated Behavioral Health. Recognizing

continued on page 2

Figure 1 - Four Quadrant Clinical Integration Model

LOW ⇄ Behavioral Health risk/status ⇄ HIGH	Quadrant II ↑BH ↓PH	Quadrant IV ↑BH ↑PH
	<ul style="list-style-type: none"> BH Case Manager coordinates with PCP PCP (with standard screening tools and BH practice guidelines) Specialty BH Residential BH Crisis/ER Behavioral Health IP Other Community Supports 	<ul style="list-style-type: none"> PCP (with standard screening tools and BH practice guidelines) BH Case Manager coordinates with PCP and Disease Manager Care/Disease Manager Specialty medical/surgical Specialty BH Residential BH Crisis/ER BH and medical/surgical IP Other community supports
	Quadrant I ↓BH ↓PH	Quadrant III ↓BH ↑PH
	<ul style="list-style-type: none"> PCP (with standard screening tools and BH practice guidelines) PCP based BH provider 	<ul style="list-style-type: none"> PCP (with standard screening tools and BH practice guidelines) Care/Disease Manager Specialty medical/surgical PCP-based BH provider ER Medical/surgical IP SNF/home based care Other community supports

LOW ⇄ Physical Health risk/status ⇄ HIGH

BH= Behavioral health; PH= Physical Health; PCP= Primary Care Provider
ER= Emergency room; IP= Inpatient care; SNF= Skilled nursing facility

the need for behavioral health services, CommuniCare developed an integrated behavioral health model within the primary care services of a federally-qualified community health center. The CommuniCare model emphasizes the concepts of the Chronic Care Model but also the importance of creating networks of care within the community and of working within an interprofessional team of behavioral health providers. CommuniCare's program was ultimately a hybrid of many models to best address patient needs.

How It Works

CommuniCare relies on an interprofessional team to make the integrated behavioral health model work in the health center. In addition to the strengths of an integrated model, interprofessional teams provide more effective and efficient behavioral health care. The patients benefit from receiving care from professionals with various areas of expertise. Teamwork provides coordination of all aspects of patient care. Currently the integrated team at CommuniCare for behavioral health consists of a psychiatrist, social workers, a psychologist, a psychiatric nurse

practitioner, medical assistants, and a mental health technician.

Other benefits of working within an inter-professional team are the opportunities for professional growth and job satisfaction. Each team member enhances the breadth of knowledge and appreciation for skills and knowledge of other health professionals, above and beyond their roles in team work. Patient progress and problems are discussed as a team, thereby improving team knowledge, communication and continuity of care.

The team makes good use of existing tools and resources for initial screening and outcome tracking. The screening tools are used with the primary care patient population to determine if there is cause for referral to the behavioral health team located in the same primary care pod. See Box 1 for a list of the tools used by CommuniCare.

Figure 2 provides a flowchart that shows how patients are handled within the integrated behavioral health model at CommuniCare.

There are a variety of situations in which the behavioral health team has made a significant impact. These include: a woman

BOX 1
Tools and Resources
Used for Screening for
Behavioral Health Issues

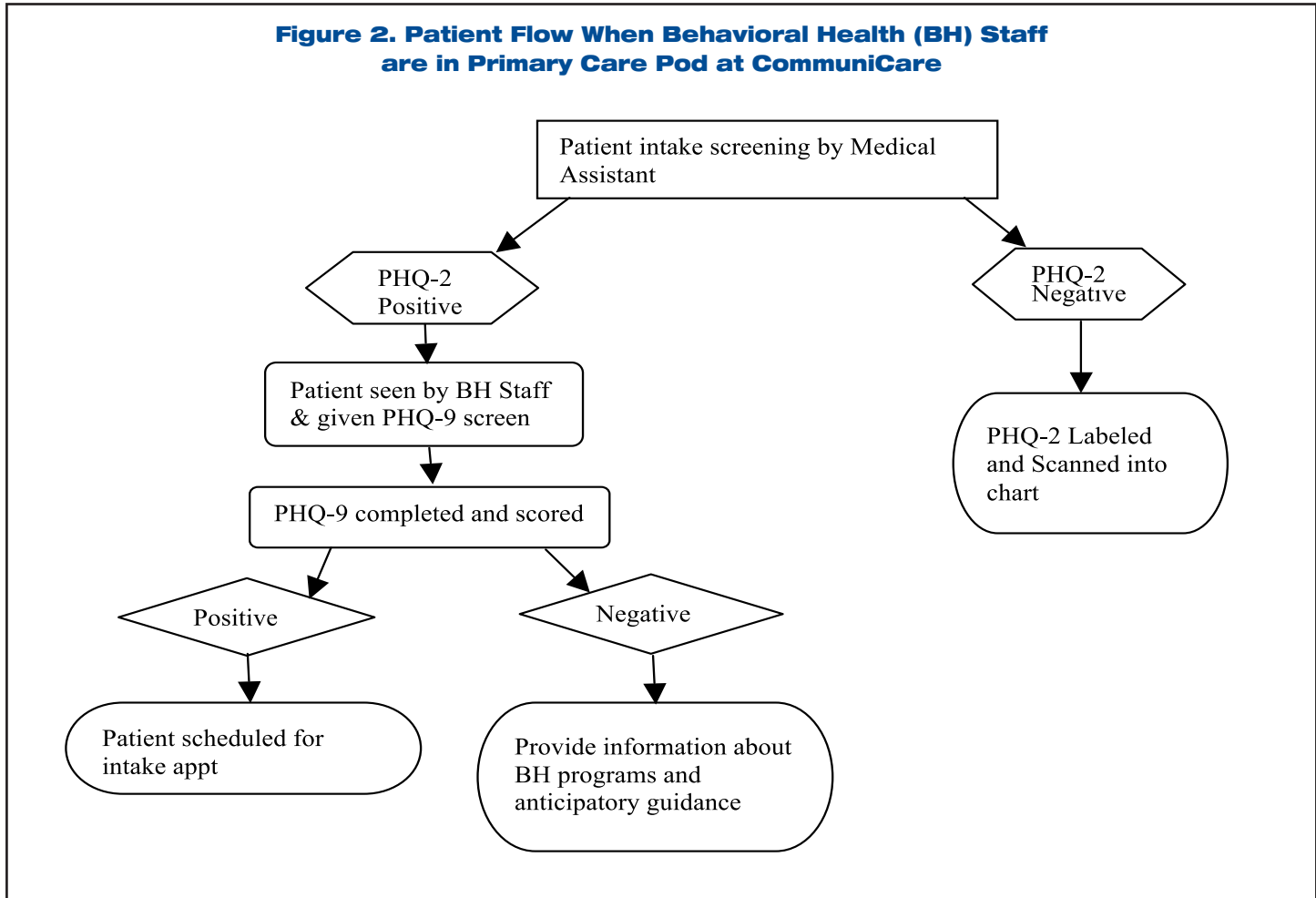
[Go to MCN's website, www.migrantclinician.org for links to these resources]

- Patient Health Questionnaire (PHQ)-2
- Patient Health Questionnaire (PHQ)- 9
- Beck Depression & Anxiety Inventory (BDI & BAI)
- Mood Disorder Questionnaire (MDQ)
- Vanderbilt Attention Deficit Hyperactivity Disorder (ADHD) Scale
- Edinburgh Post-Partum Depression Scale
- Fagerström Tobacco
- Michigan Alcohol Screening Test-Short form

presenting during a well visit asking, "Why am I not happy?"; an eight year old with ADHD on stimulant medication and with obesity; an individual who presented to the primary care clinic depressed and anxious

continued on page 6

Figure 2. Patient Flow When Behavioral Health (BH) Staff are in Primary Care Pod at CommuniCare





Mental Health Professionals Weigh in on the Intersection of Migration and Mental Health

Minden Pletsch, MA

As clinicians on the frontline are well aware, the intersection of migration and poverty creates a unique set of mental health issues that manifest themselves in diverse ways. Mental health researchers and clinical experts also understand that the migrant experience can result in a distinct set of issues for the migrant as well as their family. To better understand some of the current research on migration and mental health, MCN initiated a conversation with two mental health researchers who are also experts in the field of migration health.

Dr. Roberto Lewis-Fernández is a Professor of Clinical Psychiatry at Columbia University and Director of the New York State (NYS) Center of Excellence for Cultural Competence and the Hispanic Treatment Program at New York State Psychiatric Institute. He is also a Lecturer on Social Medicine at Harvard University. Dr. Lewis-Fernández's research focuses on developing clinical interventions and novel service-delivery approaches to help overcome disparities in the care of underserved US cultural

groups.

Dr. Cécile Rousseau is a research and clinical psychiatrist at the Montreal Children's Hospital where she directs the Transcultural Child Psychiatry Clinic. She received her training in medicine and psychiatry at the University of Sherbrooke, Université de Montréal, and currently studies at McGill University. Her clinical work is with refugee children and with torture victims. Dr. Rousseau's current research involves refugee children and adolescents from Southeast Asia, Central America and Somalia.

The following is a summary of a conversation with Drs. Rousseau and Lewis-Fernández on behavioral health in the migrant community including the changes health centers grapple with as they integrate behavioral health into primary care as well as strategies to improve access to care for migrant patients with mental health concerns.

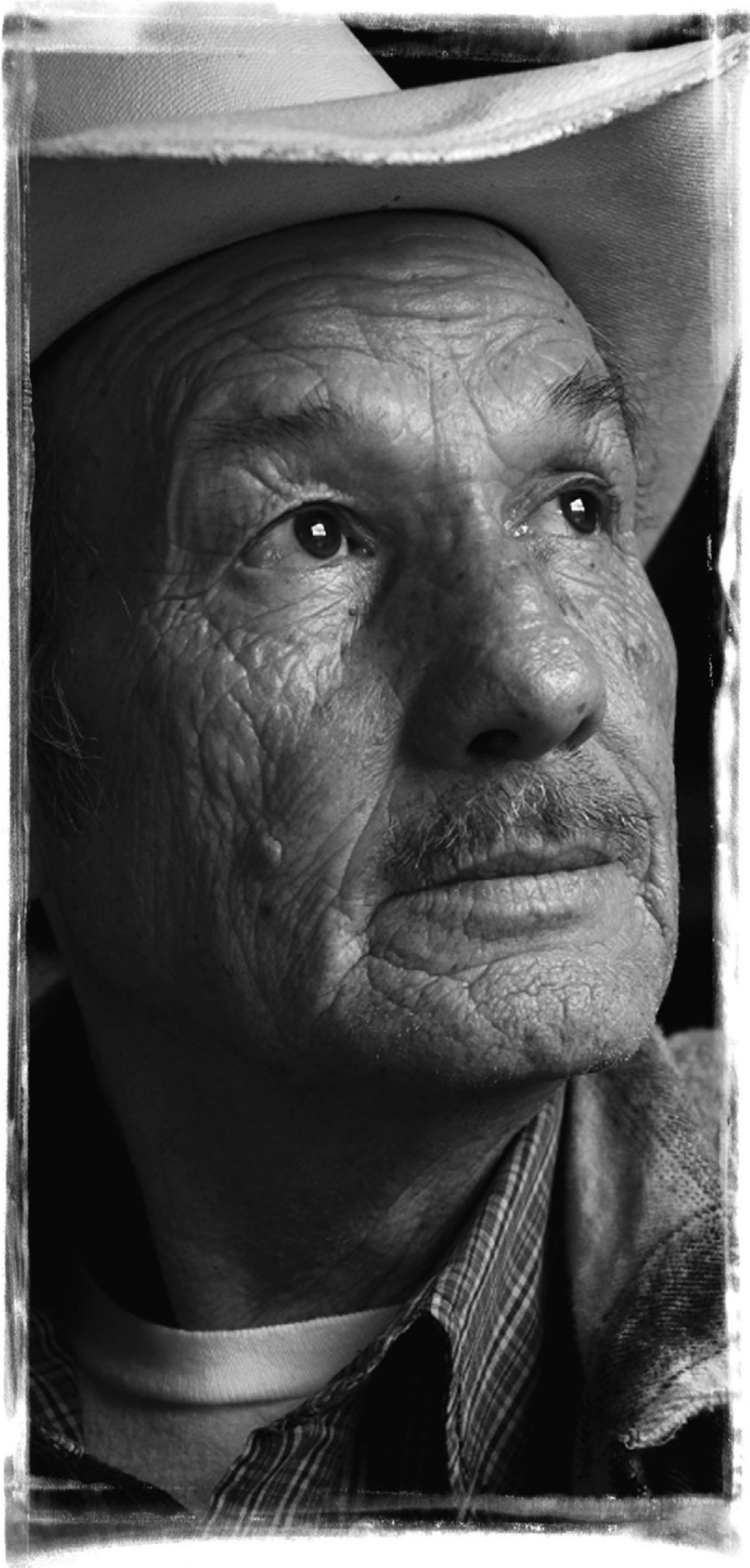
Both clinicians agreed that understanding the reasons why an individual is migrating is critical to working effectively with patients. It may also be important to understand at what

stage a patient is in their migration journey. Migration trajectory can be divided into three components: premigration, migration and postmigration. Each one of these components can have a unique set of stressors that may contribute to mental illness in this population.

"There certainly are some behavioral health issues associated with all three of those settlement times. A common stressor related to migration is that of the moving itself," stated Dr. Lewis-Fernández. "One must ask why the person is migrating." There are different pre-migration experiences [such as political turmoil] that contribute to varying degrees of mental health issues. "It is not as simple as to say that migration is really hard and that's why mental health is affected."

When asked what effects these socio-political and economic issues have directly on migrant behavioral health, Dr. Rousseau agreed that considering the reason why these people are moving is a fundamental factor in determining mental health. She stated,

continued on page 7



Integrated Care at Migrant Community Health Centers

Israel Garcia, MSSW

[Editor's Note: This article was originally published in the North Carolina Community Health Center Association Newsletter (Spring 2009, Volume XII). At that time, Mr. Garcia was a Regional Migrant Health Coordinator. Mr. Garcia is currently a Public Health Analyst at the Department of Health & Human Services, HRSA.]

As is often the case with Federally Qualified Community Health Centers, Migrant Community Health Centers (MCHCs) in North Carolina go beyond the call of duty by integrating behavioral health care to meet the current gap of mental health services in the State.

Blue Ridge CHC in Hendersonville, Roanoke Chowan CHC in Ahoskie and Piedmont Health Services in Siler City are all MCHCs hosting a behavioral health co-location pilot program. The co-location projects, which provide small grants to primary care settings to hire a part-time behavioral health provider, are coordinated by the State Office of Rural Health and Community Care of North Carolina (CCNC). These pilot projects have been well received by the community as a whole and some grantees have also been able to secure additional funding support from city councils, local hospitals and universities.

Behavioral and primary health integrated projects are vital to the general population as 80% of patients prefer to get their mental health services at a primary care setting. Integrated programs are even more crucial to minorities including the Migrant and Seasonal Farmworker (MSFW) population who battle against numerous barriers including stigma.

Mental health, which is often highly stigmatized, especially among minorities, is no longer a taboo. Mental health is serious and requires the same level of attention as primary care. It is unfortunate that mental illness prevalence among minorities appears to be higher than the general population. For example, some studies find that on average nationally, 40% of farmworkers are depressed and 30% experience anxiety.

Outreach staff at MCHCs also go beyond the call of duty and play a key role at the co-location projects. Migrant outreach personnel have a unique opportunity to identify both primary and behavioral health issues among migrant workers and their families as they see this population in

continued on page 6

National Farm Medicine Center Director Announced

Matt Keifer, MD, MPH, the Dean Emanuel Endowed Chair and Senior Research Scientist at the National Farm Medicine Center (NFMC) has been named the Director of NFMC. Dr. Keifer joined Marshfield Clinic Research Foundation (MCRF) in August 2010 from his position as associate director of the Pacific Northwest Agricultural Safety and Health Center at the University of Washington, where he conducted research and provided clinical services for Spanish-speaking farm workers.

Barb Lee, RN, PhD, will continue on as a Senior Research Scientist and Director of the National Institute for Occupational Safety and Health (NIOSH) funded Children's Center for Rural and Agricultural Health & Safety. "MCRF is grateful to Dr. Lee for serving as Director of NFMC for the past 11 years," says Richard Leer, MD, MCRF Interim Director.

Dr. Keifer is a bilingual occupational medicine physician with extensive clinical, research, and programmatic expertise in agricultural

health and safety. His professional efforts for the past 20 years have largely focused on Hispanic farmworkers, both in the United States and in Latin America. His research and practice emphasize pesticide health effects and agricultural injury. In conducting research, he is continuously involved in assessing the health and safety conditions of workplaces, the effectiveness of workplace practices, the needs of workers, the health impacts of workplace conditions and practices and the impact of health and safety policies on worker health. He currently serves as the co-director of the NIOSH-funded Upper Midwest Agricultural Safety and Health Center.

In clinical practice, he attended the University of Washington Occupational Medicine Clinic and the Yakima Valley Farmworkers Clinic in Washington. He continues to practice in the Marshfield Occupational Health Department and the Farming, Agriculture and Rural Medicine Clinic (FARM). In this capacity he regularly visits agricultural worksites to assess his patients' working conditions.

Dr. Keifer currently serves on the Federal Advisory Committee Act (FACA) committee to the Office of Pesticide Programs at the US Environmental Protection Agency and has also spearheaded efforts within the American Public Health Association to adopt policy resolutions supporting the protection of agricultural workers. He recently served on an Institute of Medicine committee to strengthen occupational health in electronic health records. He served as the medical officer of an integrated pest management project in Nicaragua for two years, where he trained field staff and clinicians in the diagnosis and management of pesticide poisonings. He has trained health promoters in his work in Nicaragua and his projects in Idaho and Yakima. He has developed innovative training programs aimed at training health professionals on agricultural health and safety issues, funded by the Certification and Worker Protection Branch, Office of Pesticide Programs – US Environmental Protection Agency. ■

Spotlight on Promising Behavioral Health Practices

CommWell Health Center, North Carolina (formerly Tri-County CHC)

CommWell Health has one of the oldest and most established behavioral health programs operated by a community health center. In particular, CommWell excels at alcohol and drug addiction treatment and interventions and all of their behavioral health programs are provided in both Spanish and English. The following are included in the behavioral health services offered by CommWell:

- Harvest House is a residential treatment program for individuals recovering from the disease of alcoholism and drug addiction. The residence is located on the main campus of CommWell Health in Dunn, NC.
- The Angelic House is a transitional housing program for women. This program offers a safe and supportive environment for women who are in recovery from chemical dependencies and desire to live a healthy lifestyle.
- Substance Abuse Intensive Outpatient Program gives individuals an opportunity to interact in the real world environment while benefiting from a peer-oriented, structured therapeutic program.
- Outpatient Groups are focused on individuals who are new to recovery or are returning after a relapse.
- The Aftercare Program is the stage following discharge when the client no longer requires services at the intensity required during primary treatment.
- Building Bridges Walk-in crisis center offers Mental Health and Substance Abuse treatment services to anyone in a crisis situation.

For more information about these CommWell Health programs call 800-567-5021.

Malama I Ke Ola Health Center (formerly Community Clinic of Maui)

The Community Clinic of Maui has a fully integrated behavioral health and primary care system. At each of the clinic's three sites there are behavioral health providers who are available to the primary care clinicians to assist in a vast number of activities including "warm handoffs" for acute behavioral health crisis; substance abuse counseling in both individual and group settings; tobacco cessation counseling; chronic disease self management counseling and long term individual and family therapy. Most remarkable is the organization's emphasis on tobacco cessation counseling. They currently have a full time tobacco cessation specialist and 3 of their other behavioral health therapists have been credentialed to provide tobacco cessation counseling. For more information about the Community Clinic of Maui's integrated behavioral health program contact Dana Alonzo-Howeth at 808-872-4027.

■ Promising Practices from CommuniCare continued from page 2

with a history of uncontrolled arthritis and hypertension; and a man who presented with severe chest pain determined to be caused by panic attacks. In each of these situations the behavioral health issue was identified upon intake and the integrated behavioral health team was able to intervene and provide support, services and assistance to these individuals in the context of their immediate primary care concerns and with full collaboration of the primary care clinician.

In addition to working in the general primary care clinic, the behavioral health team has developed behavioral health initiatives for the patients and clinicians around specific issues including post partum depression, ADHD in children, smoking cessation, and alcohol abuse intervention.

Lessons Learned

In the process of developing this integrated behavioral health model, CommuniCare has learned many lessons from both the successes and challenges of implementation.

The integrated behavioral health program has benefited from effective data collection, allowing program impact to be demonstrated. In adults with depression and anxiety, most of the patients initially rated themselves in the severe range as measured by Beck Inventories. Of the of patients who completed the initial intervention and the

three month follow-up, there was an average reduction of 8 points on their aggregate Beck Depression Scale scores. For these patients, the aggregate scores went from severe to mild symptoms. Seventy percent of these patients had reductions in scores.

CommuniCare finds it is critical to have supportive leadership within the organization as well as within the departments affected by the overall concept and model of integration. Since the Chronic Care Model is integral to CommuniCare's model of behavioral health integration, it has also been essential to have an organizational environment that systematically supports and encourages chronic illness care. Components of patient self-management, decision support, delivery model redesign, information technology, organizational leadership, and community collaboration are explicitly addressed.

While internal support and systems development is critical for a successful integrated behavioral health program, external support is also essential for success. The CommuniCare model depends on partnerships with various community agencies for resources and services that are not currently provided within the program. These partnerships allow for seamless transition and or access to care to meet patient's needs. Example of community partnerships are the

Community Mental Health Authority, the County Health Care System, inpatient psychiatric facilities, United Way Agencies, homeless facilities and programs, and substance abuse programs. Funding is provided through the Methodist Health Care Ministries and the St. David's Foundation.

Future Plans

Building on the success of the integrated behavioral health program at CommuniCare there are plans for expansion and improvement. The program would like to expand capacity by bringing in pharmacists as consultants to the project. Project staff desire to expand screening and evaluation by including a good tool to screen for panic disorders. Additional behavioral health services are under consideration. Finally, the program hopes to extend community partnerships to include hospital emergency rooms.

Where to go for more information and/or resources:

Hogg Foundation for Mental Health at www.hogg.utexas.edu

Improving Mood Promoting Access to Collaborative Treatment (IMPACT) at www.impact-uw.org

Integrated Behavioral Health Project at www.ibhp.org ■

■ Integrated Care at Migrant Community Health Centers continued from page 4

their natural environment.

JoAnn Hernandez, migrant outreach worker from Roanoke Chowan MCHC speaks highly of the clinical social worker who was first hired through the co-location project at her center.

Ms. Hernandez states: *"The social worker is amazing; he has helped many of my clients cope with serious emotional issues."* More recently, Ms. Hernandez may have saved the life of a 33 year old migrant worker who was suicidal.

Ms. Hernandez attended a phone call from a camp resident who asked for help for his friend. Although without formal training, Ms. Hernandez did exactly what a mental health professional would have done. Ms. Hernandez stayed on the phone with the patient until he was out of suicidal risk and he had contacted to seek treatment. Although the patient refused to be taken to the hospital the same day, the patient agreed to see the co-location therapist and psychiatrist within the MCHC the next day. *"The patient has continued to comply with*

his mental health treatment and is no longer suicidal" says Ms. Hernandez.

The support from administrative and executive staff at MCHCs is also crucial to ensure that through the co-location programs clients' health is addressed from a holistic mind and body approach. Milton Butterworth, Director of Development and Community Outreach at Blue Ridge CHC states: *"Mental health services are particularly important to migrant farmworkers and their families as they deal with feelings of isolation from their roots, their culture, their language, their family, and their friends."*

Mr. Butterworth sees the importance of the co-location project at his clinic and he goes the extra mile by allowing his outreach team to be part of the behavioral health intervention: *"In order to help a patient choose healthier coping tools over tools like a twelve pack every day after work, our outreach team assists in the coordination of recreation options with a few camp residents. We settled on a soccer ball and the resulting behavior change in the patient and the other*

residents has been dramatic."

The benefits of co-location and other fully integrated behavioral and primary health care models at community health centers have been welcomed by the communities as they fill a tremendous healthcare gap. There is no argument that integrated care models improve patients' health status and reduce healthcare costs. It is only hoped that stakeholders will not be blind-sided by the short term pilot program's results. Studies demonstrate greater outcomes can only be appreciated in the long run by taking into account external benefits such as the reduction of job absenteeism and the increase of job productivity. More than ever, during this unprecedented economy, improving health and mental health systems is crucial. Governor Perdue was clear on her position paper stating that *"...it makes no sense to separate mental from physical care."* Now her support to integrate a long-time fragmented bureaucratic system that will facilitate behavioral and primary health integration is likely to be seen. ■

“There are push factors most important such as why are they moving; we must consider for example, their pre-migration dreams.” There are positive and negative factors pushing one to leave their country. Additionally important for emotional well being is how they are represented when they arrive in the host society. “If they are stigmatized and have negative mirroring for years it will result differently.”

Both clinicians agreed that contemporary cultural and economic influences, particularly in the US, have a high cost on migrants and more of a negative impact on the mental health and living conditions of second-generation migrant children than on their parents.

Dr. Lewis-Fernandez stated, “Clinicians these days are not interested in ‘why do migrants get sick?’ they want to know ‘why are migrants less sick than their children?’ Second-generation Latino groups for example, have repeatedly been shown to develop more serious mental illnesses than their parents.”

One theory of Dr. Lewis-Fernandez is that a migrant may completely understand or even expect their difficult living situation but their second-generation child is experiencing a much tougher time with mental illness than their parents. Kids are now born in the country into a much worse situation than that of their parents when it comes to contemporary US culture. “They live in poor neighborhoods, are discriminated against—these factors contribute to substance abuse, mental illness and a remarkable rise in family violence.”

Dr. Rousseau too, agreed that second-generation migrant children are more susceptible to behavioral health related problems than their parents. She stated that this could be due to a number of factors; namely that with the first generation there was an expectation of the mission to migrate. There is also the idea that parents have left their country specifically for their children. She also noted that the family structure for migrant families is more intact than the ‘western’ country. “The western world has more of a disorganized social network and different sets of collective values than migrant or refugee families.”

Dr. Rousseau explained what could be done to reduce types of major stressors, such as lack of a support network and limited access to care that ultimately leads to depression, anxiety, psychosis and other mental problems in vulnerable populations.

“We should certainly increase access to care. Clinical intervention is just the tip of the iceberg.” Rousseau said that to improve access to care for migrants is to focus on improving social services such as kindergarten, daycare facilities, access to employ-



ment, providing equitable land opportunities and provide positive representation in the media. “Mental health for migrants is first intersectorial. I believe NGOs and groups like [Migrant Clinicians Network] can help with the advocacy work.”

It has been a very important goal to have the Community and Migrant Health Centers in the US working hard to integrate behavioral health into their service delivery systems. Responding to this statement, Dr. Lewis-Fernandez stated, “The primary care physician in the C/MHC is not necessarily trained to handle the level of psychosis or anxiety-related illnesses clinicians may see in these patients.”

Dr. Lewis-Fernandez went on to say that the provider usually prefers to refer the migrant patient out for a second appointment and this can be challenging because there are so few referral resources. Limited access to healthcare relates back to basic social barriers, such as not having transportation.

Dr. Rousseau agreed and added that, as a clinician she works in a newly arrived migrant neighborhood which is 60 percent South Asian and Muslim. “People do not want to be

referred to mental health services. They are not able to attend their appointments because survival is an issue.”

Dr. Rousseau explained that she works in a shared care model at her primary care community center, Montreal Children’s Hospital. To address this and increase access to care, the idea is to go beyond the dichotomy of social health and to think of the family as a whole. To see beyond the diagnosis identified and consider priorities that may have led to a diagnosis. She said, “The migrant child may have a disorder or ADHD, but if there is nothing in the refrigerator or if the mom is suffering from PTSD; of course the child will be all over the place.”

This type of comprehensive clinical integration allows us to reach an entire migrant family. In an alliance model, social services, community organizations and the family clinician/provider are the pillars of the shared model for mental health well being.”

Dr. Lewis-Fernandez and Dr. Rousseau clarified that increasing access to health care is an important ongoing theme. The clinicians reminded us of our need to build on health-care access strategies; to go beyond the diagnosis to the heart of the migrant family. ■

How to Help the Injured Farmworker:

Why Obtaining Workers' Compensation Is Part of Clinical Care

Brent Probinski, JD

[Editor's Note: Brent L Probinski is a senior lawyer with the firm of Probinski & Associates with its main office in Sarasota, Florida. For 25 years he and members of the firm have represented injured workers and farmworkers in Florida and throughout the United States. If you have any questions or would like more information visit www.probinskiyfirm.com.]

Javier* is a Mexican-born farmworker who applied pesticides to the fields of the same central Florida orange grove for 10 years. Throughout his employment, he was repeatedly exposed to these pesticides and other toxic chemicals applied to the fields. During the past two years, Javier visited his local health clinic on several occasions to receive treatment for skin lesions and vomiting. His general practitioner established his symptoms were a result of pesticide poisonings. The physician continued to monitor Javier's condition, which continued to progress, and now the 34 year old suffers from an advanced stage of blood cancer. He requires intensive chemotherapy and radiation and it is unclear if he will survive.

Given Javier's work history (he worked on the same farm for 10 years), the nature of his injury and his physician's diagnosis, attorneys working on his behalf were able to successfully obtain workers' compensation benefits for Javier. His employer's workers' compensation carrier will be required to pay for his medical treatment.

As this case illustrates, when an injured farmworker shows up at your clinic with a broken shoulder after falling from a picking ladder or with serious respiratory distress from exposure to pesticides, the workers' compensation system can be a viable option to obtain coverage for the injured worker. For clinicians, having a basic understanding of workers' compensation law will go a long way toward getting the necessary medical care and lost wages the worker so desperately needs.

The purpose of workers' compensation is to provide immediate medical care and lost wages to an injured worker without consideration of who may be at fault in causing the accident. Under workers' compensation it does not matter who was at fault — the worker, a co-worker, the employer — or if it

was merely an accident; it is a "no fault" system and if the injury happened "in the course of the work," it is compensable. There are exceptions such as when a worker is injured while "going to or coming from" work or if the accident happened during a break such as lunch. Those injuries will not be compensated. However, if an injury occurs while the worker is being transported to and from work by the employer in his bus it is compensable.

Most US states have workers' compensation laws that provide benefits for "on the job" injuries, including for agricultural workers. Sixteen states do not require workers' compensation benefits for farmworkers: Alabama, Arkansas, Delaware, Georgia, Indiana, Kansas, Kentucky, Mississippi, Missouri, Nebraska, Nevada, New Mexico, North Dakota, South Carolina, Tennessee and Texas. Some other states require employers to provide workers' compensation benefits only if certain conditions are met, such as having a minimum number of workers, a specified minimum sum for employee salaries paid by the employer each season or establishing that the worker is documented. Employers who hire agricultural workers under the H-2A visa program are required to provide workers' compensation insurance or an equivalent.

What Does Workers' Compensation Cover?

Workers' compensation generally covers 66% of the salary of the injured worker. If the worker is seasonal, the previous season's wages may be considered in making the calculation. The insurance carrier's objective will be to minimize the amount of compensation paid, whether it is for medical care and treatment or lost wages.

A worker who suffers from a "pre-existing" injury or medical condition will be compensated for a new injury that exacerbated the previous one if the worker can show that the new injury is a "major contributing cause" (more than fifty percent) of the new injury. A worker who suffers "repetitive trauma" from constant and continuous bending and twisting such as when planting or harvesting field crops, over a period of months or years will be entitled to compensation if a serious injury results. Heat stroke or heart attack will be compensated if the worker can show that

Check the MCN website
http://www.migrantclinician.org/files/OverviewOfWorkersCompensationTool_FJ.pdf
 for the Farmworker
 Justice/MCN listing of
 workers' compensation
 requirements for each state.

by virtue of working outside he or she is exposed to hazards materially greater than other workers in the same vicinity. Injuries from "acts of nature" such as lightning strikes may also be paid if the nature of the work enhanced the risk.

In exchange for purchasing workers' compensation insurance for its employees, the employer is immune from a lawsuit by the injured worker. In Javier's case, his employer is immune from penalties and is protected under workers' compensation immunity provisions. There are, however, exceptions to the immunity an employer enjoys from workers' compensation insurance. When the employer or a co-worker commits an intentional act causing injury, such as battery or sexual assault, or when the employer's acts, though not intentional, are "virtually certain" to cause injury or death the employer can be held directly liable for the worker's injury. An employer can also be directly liable for a worker's injuries if the employer violates the EPA's Worker Protection Standard for Agricultural Pesticides (WPS). In Javier's case, his employer can be held liable for his injuries, the costs of his medical treatment and lost wages if it is established the employer violated WPS provisions. The WPS is a federal law requiring employers to take specific measures to mitigate workers' risk of pesticide exposure including worker protection during pesticide applications, restricted-entry intervals, providing personal protective equipment to workers, decontamination supplies for pesticide handlers and workers and emergency assistance and transportation to a medical care facility in the event of an exposure. (For

* Not his real name

continued on next page



Attorney Brent Probinsky with workers in the field

more information on the WPS visit <http://www.epa.gov/agriculture/twor.html>).

Key Considerations for Clinicians

The clinician is vital in helping to secure workers' compensation benefits for which the injured worker is eligible. If a clinician suspects that a patient's injuries are work related, it is important that the clinician notify the employer, document the injury and gather additional information from the patient about their work history. Providing "notice" to – or notifying – the employer as soon as possible preserves an injured farmworker's compensation claim. This can be done by telephone, e-mail, fax or regular mail. An employer is required to inform the workers' compensation insurance carrier on notice of the injury. Notice of the injury should be made within thirty days and a claim must be brought in some states within two years of the injury. After notice, a representative of the insurance carrier will communicate with the injured worker or his representative, monitor the worker's condition and hopefully approve medical care and lost wages.

There are a number of strategies a clinician utilizes to document a worker's injury and/ or

overexposure to pesticides. Photographing the injury (burns, lesions, redness of the skin or eyes), reporting the injury to the proper surveillance agencies and preserving the worker's clothing can aid in securing benefits for the worker. The clinician can also ask the worker to provide names of witnesses to their exposure or injury, to photograph pesticide labels and to preserve any clothing or shoes worn which may contain pesticide residue. The following information is also helpful in securing workers' compensation benefits:

- Name of farmer(s) or labor contractor(s)
- Which pesticides/ herbicides used or handled
- Dates of spray or pesticide application
- Work history (dates of employment and/or number of seasons at each farm)
- Occupational duties
- Crops farmed

As in the case of Javier, obtaining the information related to these questions played an important role in helping to obtain workers' compensation benefits.

Clinicians working with patients who may be undocumented should know that an undocu-

mented worker is normally entitled to workers' compensation benefits even if the worker or the employer used a false social security number or a false name when the worker originally obtained employment. However, it is important to note that using a false social security number or false name after an injury occurs in attempt to obtain workers' compensation benefits, will be considered a fraudulent claim and will result in a bar to any benefits. Children who work in the fields are also entitled to workers' compensation benefits even if they are working in violation of federal labor laws.

What is the Role of a Workers' Compensation Attorney?

Having an experienced advocate is essential to protect the legal rights of an injured worker. Even if the injured worker is receiving medical care and lost wages, a skilled workers' compensation attorney will monitor the claim to be sure that wage benefits have been correctly calculated. The attorney will also communicate with the treating clinicians about their assessment of the worker's need for further care and rehabilitation and whether the injured worker is physically fit to

continued on page 11

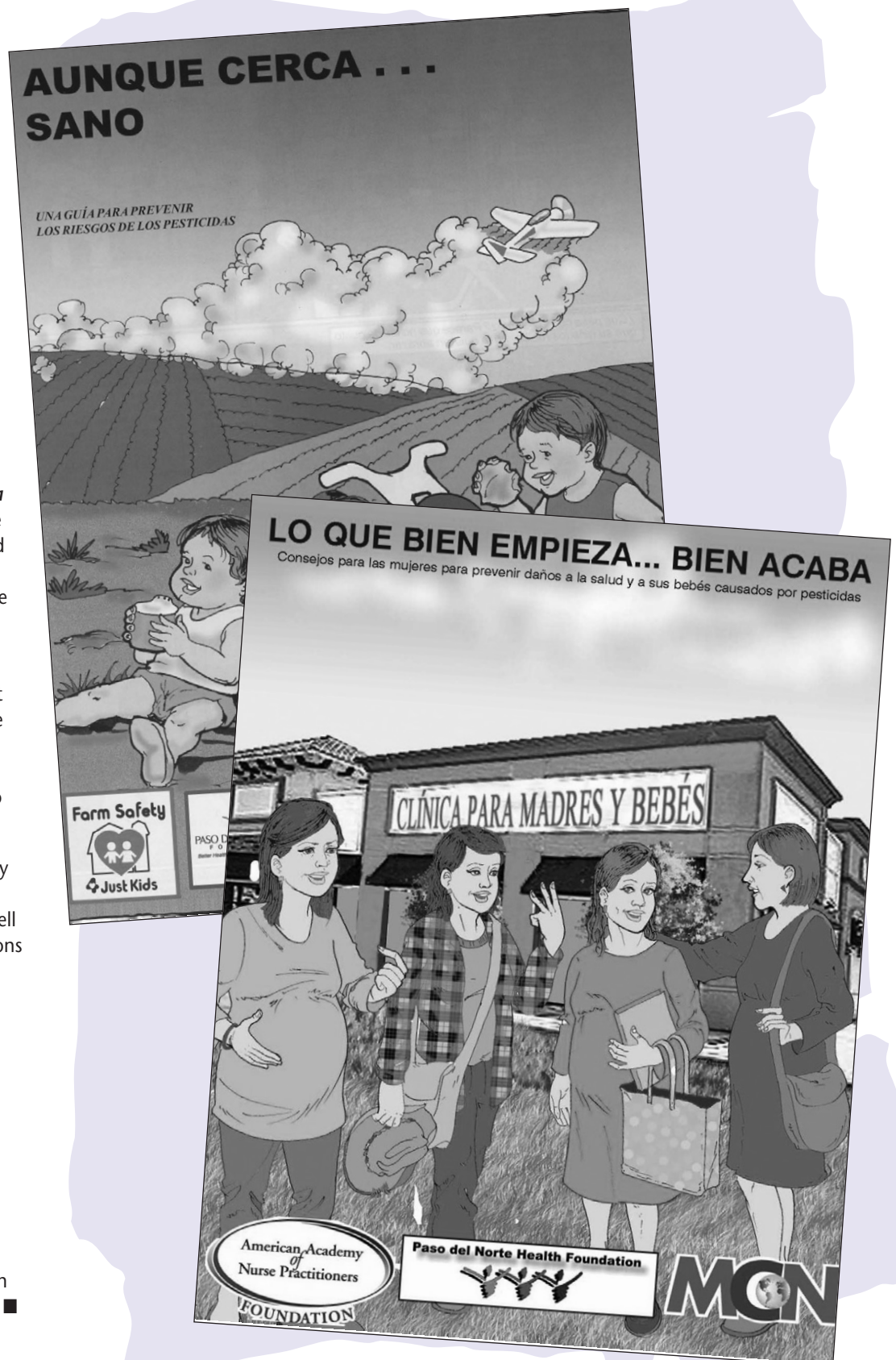
Patient Education Resources Now Available for a Limited Time!

The Migrant Clinicians Network (MCN) and the National Association of State Departments of Agriculture (NASDA) Research Foundation announce the availability of three pesticide educational comic books in Spanish. These full color publications are available free of charge and can be ordered via <http://www.migrantclinician.org/services/initiatives/occupational-health.html>. The comics include:

1. *Aunque Cerca...Sano* educates parents about children's risks to pesticide exposure and ways to minimize these risks.
2. *Lo Que Bien Empieza...Bien Acaba* helps women of reproductive age and pregnant women in rural and urban areas understand the risks associated with pesticide exposure and ways to minimize exposure.
3. *Poco Veneno...¿No Mata?* offers family-based information on what pesticides are, why one should be concerned about pesticide exposures, how to minimize pesticide exposures and how to respond to a pesticide poisoning.

The comic books were developed by MCN and partners to help educate farmworkers and their families as well as other Spanish speaking populations about pesticides and ways to minimize exposures. They offer protective concepts through illustration and conversation-style text and are an effective way to disseminate health information to populations with limited formal education.

The comic books are printed and distributed by the NASDA Research Foundation under Cooperative Agreement X8-83456201, awarded by the U.S. Environmental Protection Agency. ■



MCN Teams up with the *Journal of Agromedicine*

MCN and the *Journal of Agromedicine* are working together to increase access to relevant information for clinicians working with migrants and other agricultural workers. MCN will highlight articles of particular relevance in *Streamline*. Additionally, the *Journal of Agromedicine* is offering a special discount to anyone who currently receives *Streamline*.

Persons affiliated with Migrant Clinicians Network are entitled to the Journal's society discount subscription rate of \$52 per year. Simply contact customerservice@taylorandfrancis.com or call toll free 1-800-354-1420, press "4," and identify yourself as being with MCN. Promotional code is RH07209S.

Journal of Agromedicine: recent migrant-specific articles

Three articles in the most recent edition of the *Journal of Agromedicine* (Volume 17, Issue 1) are specific to the migrant population. Abstracts can be accessed at <http://www.tandfonline.com/toc/wagr20/current>.

The Migrant Clinicians Network: Connecting Practice to Need and Patients to Care — The authors examine the migrant population in the United States, a brief history of clinicians working in migrant health, and the scope of current Migrant Clinicians Network activities, including occupational and environmental health. (Deliana Garcia, MA; Jillian Hopewell, MPA, MA; Amy K. Liebman, MPA, MA; and Karen Mountain, MBA, MSN, RN.)

A Cross-Sectional Exploration of Excessive Daytime Sleepiness, Depression, and Musculoskeletal Pain among Migrant Farmworkers — In this study, authors from the Wake Forest University School of Medicine estimated the prevalence of elevated daytime sleepiness, depressive symptoms, and musculoskeletal pain among Latino migrant farmworkers, and examined the relationship among these symptoms. Data are from a cross-sectional survey of migrant farmworkers (N=300) conducted in eastern North Carolina in 2009. Eleven percent of

Latino farmworkers reported elevated levels of daytime sleepiness, 28% reported elevated levels of depressive symptoms, and 5% reported moderate to severe musculoskeletal pain on a daily or weekly basis. Depressive symptoms and daytime sleepiness were positively associated. Depression and daytime sleepiness may increase risk of injury; further research regarding sleep issues is warranted. (Joanne C. Sandberg, PhD, et al.)

Occupational Eye Injuries Experienced by Migrant Farmworkers — Migrant farmworkers in North Carolina (n=300) reported eye injuries, circumstances of injuries, and outcomes during lifetime agriculture work. Seventeen injuries were reported by 15 farmworkers; five resulted in lost work time. Most reported injuries were penetrating or open wounds, often caused by branches or other foreign objects. Injuries were seldom reported to employers; and treatment at clinics, when received, was often delayed. (Sara A Quandt, PhD, et al., Wake Forest University School of Medicine.) ■

■ **Why Obtaining Workers' Compensation Is Part of Clinical Care** continued from page 9

return to full or part time work.

An effective attorney should represent the worker's interests by negotiating with the insurance company or if that fails, file a petition with a workers' compensation judge who will decide the matter at a hearing. Often the insurance company, not the worker, will pay the fees of the worker's lawyer who prevails in such a petition for benefits.

After the worker reaches "maximum medical improvement," which can take months or years, the attorney can negotiate a cash settlement known as a "wash out" with the insurance carrier. The attorney must be sure that the worker will require no further medical treatment when the settlement is made as the "wash out" will preclude any future payments for lost wages or medical care for the worker.

An attorney who understands the culture and language of a farmworker and his family, particularly the fear and mistrust the injured worker may have for the legal system, will be the most effective in advocating rights of the worker and his family. A lawyer should be willing to visit the worker in the rural setting including at the clinic and be available to freely provide legal advice and guidance to the worker and clinicians when asked.

In some cases a lawyer who represents injured workers must also be prepared to make

claims that fall outside of the workers' compensation system in order to maximize financial recovery for the injured worker and his or her family. This writer recently represented "Socorro," a 15 year old undocumented plant nursery worker from Guatemala who was bitten on her hand by a spider while weeding plants in a green house. She was transported by co-workers to the emergency room of a nearby rural hospital. Delay in her treatment and failure to properly and timely open her air passages after she lost consciousness, resulted in hypoxia and severe, permanent, brain damage. She requires around the clock care for all of her needs in a residential treatment center. Her workers' compensation claim was settled for several million dollars. In addition, a medical malpractice claim against the hospital resulted in a payment of an additional millions of dollars. This combined sum will be adequate for her proper and humane care for the rest of her life.

Another unique case involved five steel workers from Mexico who were building a bridge in Florida's coastal area. They worked for a sub-contractor that assembled and erected the bridge's steel columns. A 50 foot steel column collapsed while the men were working on it. They were all catastrophically injured, including the traumatic amputation of limbs. The general contractor who built the

bridge failed to provide the proper forming around the column to keep it from falling. The workers' employer, the sub-contractor, paid workers' compensation benefits that were limited to the necessary medical care and lost wages. The general contractor, the company who build the bridge and hired the sub-contractor, enjoyed the same workers' compensation immunity as the sub-contractor. The general contractor cannot be sued for negligence. But here, the bridge was built over a navigable body of water and the injured men worked from barges on the river. They could be considered "maritime workers" under federal admiralty law and this writer filed a suit against the general contractor on that basis that resulted in a multi-million dollar settlement for the men and their families. All of the men returned to Mexico where they have the resources to care for themselves and their families.

The workers' compensation system will provide essential lost wages and costs of medical care for the injured farm worker. In order for this system to work it is critical that the clinician and social worker be cognizant of the injuries that may be compensable. Having a good working relationship with qualified lawyers in one's area will go a long way to protect the rights of an injured worker and his family. ■



Migrant Clinicians Network
P.O. Box 164285 • Austin, TX 78716

Non Profit Org.
U.S. Postage
PAID
PERMIT NO. 2625
Austin, TX



Acknowledgment: *Streamline* is published by the MCN and is made possible in part through grant number U30CS09742-02-00 from HRSA/Bureau of Primary Health Care. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA / BPHC. This publication may be reproduced, with credit to MCN. Subscription information and submission of articles should be directed to the Migrant Clinicians Network, P.O. Box 164285, Austin, Texas, 78716. Phone: (512) 327-2017, Fax (512) 327-0719. E-mail: jhopewell@migrantclinician.org

Marie Napolitano, PhD, RN
Chair, MCN Board of Directors

Karen Mountain, MBA, MSN, RN
Chief Executive Officer

Jillian Hopewell, MPA, MA
Director of Education, Editor

Editorial Board — Marco Alberts, DMD, DeSoto County Health Department, Arcadia, FL; Matthew Keifer, MD, MPH, National Farm Medicine Center (NFMC), Marshfield Clinic Research Foundation, Marshfield, WI; Kim L. Larson, PhD, RN, MPH, East Carolina University, Greenville, North Carolina

calendar

Integration of Primary Care and Behavioral Health

National Webinar
March 14, 2012 12-1pm Central Time
www.migrantclinician.org

The Nuts and Bolts of Cholinesterase Monitoring for Farmers, Ranchers and Agricultural Workers

National Webinar
March 28, 12-1 pm Central Time
www.migrantclinician.org

National Health Promotion Summit

April 10-11, 2012
Washington, DC
<http://www.aptrweb.org/2012summit.html>

GHIC 2012: Global Health and Innovation Conference

April 21-22, 2012
New Haven, CT
<http://www.uniteforsight.org/conference/>

MAFO's 2012 National Farmworker Conference

April 22-25, 2012
San Antonio, TX
Lalo Zavala at 320-251-1711 or via e-mail at lalo.zavala@umos.org

2012 National Farmworker Health Conference

May 9-11, 2012
Denver, CO
<http://meetings.nachc.com>