

FOURTH EDITION | ISSUED APRIL 2010



BREAKING DOWN THE BARRIERS

A National Needs Assessment on Farmworker Health Outreach



Health Outreach Partners
www.outreach-partners.org

This publication is supported in part by a grant from the Health Resources and Services Administration (HRSA) to provide training and technical assistance to Health Center grantees. The content does not necessarily represent the views of HRSA or the Federal government.

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Health Outreach Partners wishes to thank the following people
and organizations for their contributions to this report:

Larson Assistance Services

Institutional Review Board at Migrant Clinicians Network

All organizations with which we piloted the data collection tools

North Carolina Community Health Center Association, National Center for Farmworker Health, and Northwest Regional Primary Care Association for hosting community forums at the Migrant Stream Forums

California Head Start Association and National Migrant and Seasonal Head Start Association for hosting focus groups at their respective conferences

U.S. Department of Labor, Employment, and Training Administration & JBS International, Inc., Aguirre Division for National Agricultural Workers Survey data

Health Outreach Partners extends a special thank you to staff at Community Health Centers who participated in the online survey, community forums, and telephone surveys who contributed critical data for this report.

Health Outreach Partners also gives a heartfelt thank you to the farmworkers who participated in focus groups, whose voices are reflected in this report.

Health Outreach Partners especialmente les agradece a los trabajadores agrícolas que participaron en los grupos de enfoque, los cuales tienen su voz en este reporte.

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EXECUTIVE SUMMARY

INTRODUCTION

Health Outreach Partners (HOP) conducted its fourth national needs assessment on farmworker health outreach. This report is the culmination of HOP's research, uncovering a wealth of compelling and useful information on the specific needs of farmworker health outreach services as well as the farmworker communities they aim to serve.

With this report, HOP intends to increase the migrant health community's understanding about how farmworkers are currently being reached, as well as what more can be accomplished to improve health access and decrease health disparities among the nearly three million migrant and seasonal farmworkers in the U.S. agricultural industry.

This report can be used as a benchmark for comparing individual outreach programs with a nationwide average. In addition, these data provide a practical resource for reports, funding proposals, and planning documents.

The following is a brief synopsis of the project, including a description of the research methodologies, key findings, and recommendations for responding to specific needs outlined in this report.

METHODOLOGY

Core Themes

HOP designed a research framework based on core themes to obtain high-quality quantitative and qualitative data for its national farmworker health outreach needs assessment project.

- Background information about Migrant/Community Health Centers
- Farmworker information
- Access to care
- Health outreach and enabling services
- Funding
- Needs assessment and evaluation data
- Cultural competency
- Community collaboration and coalition building

Data Collection Methods

HOP chose five methods to obtain information from unique audiences serving migrant and seasonal farmworkers. Health administrators, outreach managers, frontline outreach staff, as well as farmworkers themselves contributed their experiences and observations to this study.

- Three community forums, including a convenience sample of 82 outreach staff attending the migrant stream forums.
- Three focus group discussions, including a convenience sample of 34 farmworker parents participating in Migrant and Seasonal Head Start Parent Policy Councils.
- An online survey administered to migrant health grantees; 108 of 155 responded to the survey.
- Telephone survey administered to a random sample of 24 migrant health administrators.
- A review of existing data from other research studies, including the National Agricultural Workers Survey (NAWS), the 2008 Migrant and Seasonal Head Start Program Information Report (PIR), and the 2007 Community Health Center Uniform Data System (UDS).

Migrant Clinicians Network's Institutional Review Board (IRB) approved the study design, the instruments, and the corresponding informed consent documents used with each data collection method. Special considerations were used with confidentiality and protections procedures for the farmworker participants.

Of special note, the research team made a concerted effort to foster variability in respondents by geographic region as well as professional title. Steps were taken to ensure that outreach programs in the 10 Health Resources and Services Administration (HRSA) regions participated in the study.

Qualitative data from community forums, focus groups, and telephone surveys were entered and analyzed in ATLAS.ti version 5.5, a qualitative data analysis software package. Quantitative data from the online survey were analyzed in SurveyMonkey, MS Office Excel 2007, and SPSS 16.0.

FINDINGS

Data culled from HOP's research revealed numerous compelling and important key findings. These findings are organized by major topics. The topics chosen emerged from the qualitative and quantitative data. The topics include Farmworker Information, Barriers to Accessing Health Care, Fear and Discrimination, Outreach and Enabling Services Delivery, Outreach and Enabling Services Funding, Outreach and Enabling Services Staff, Data Collection and Evaluation, Cultural Competency, and Social Service Needs and Community Collaboration.

Farmworker Information

- Based on data from the National Agricultural Worker Survey (NAWS), over three-quarters (78%) of the U.S. farmworker population are male. Most farmworkers are relatively young (average age is 34) and have a seventh-grade education.
- One-third (33%) of migrant health professionals indicated the presence of emerging farmworker populations within their service area (n=100), including indigenous Mexicans from the state of Oaxaca like the Triqui, Zapotec, and Mixtec.
- Most migrant health professionals (84%) confirmed that farmworkers or their family members work in labor sectors other than agriculture (n=101). The five most common labor sectors include landscaping (71%), construction (64%), restaurant work (57%), dairy farming (48%), and greenhouses (43%) (n=84).
- The health issues of greatest concern among farmworkers and their families include diabetes (79%), followed by dental health (50%), and hypertension (42%) (n=101). These findings are consistent with previous HOP national needs assessments.

Barriers to Accessing Health Care

- Migrant health professionals identified the following top farmworker barriers to accessing health care: lack of transportation (67%), lack of knowledge of available services (58%), cost of health care services (48%), lack of insurance (35%), and lack of comfort with health care services/facilities (22%) (n=100).
- Migrant health professionals and farmworker parents reported that farmworkers experience confusion when trying to navigate health delivery systems and public insurance programs. Overall, there is a lack of information among the farmworker population about insurance eligibility requirements as well as how and where to access health services.
- Lack of reliable transportation resounded as a top barrier to care throughout the quantitative and qualitative data generated. Many farmworkers live and work in rural communities with little to no public transportation.
- Insurance eligibility is one of the biggest barriers to health care faced by farmworkers. Most farmworkers are not eligible for insurance programs due to documentation status.

Fear and Discrimination

- Fear due to immigration and discrimination plays a pivotal role in preventing farmworkers from accessing health care services. An overwhelming majority of migrant health professionals, farmworker parents, and health center administrators indicated that farmworkers and their families live in fear due to lack of legal documentation.
- Migrant health professionals and farmworker parents discussed the inequitable treatment suffered by farmworkers in the workplace. Farmworkers are frequently threatened by their employers with lost wages, loss of work, or deportation if they miss work or object to unhealthful working conditions.

Outreach and Enabling Services Delivery

- The most frequently performed outreach and enabling services include health education (50%), basic health screenings (38%), health fairs and community events (37%), and interpretation (33%) (n=100).
- Farmworker parents voiced a need for more information and education among the farmworker communities, especially on pesticide exposure, legal services, health system navigation, and managing chronic diseases.
- Migrant health professionals ranked transportation issues (39%) and lack of staff (31%) as the two most common outreach challenges faced by farmworker health outreach services (n=99).
- Migrant health professionals reported that the most common outreach locations include community events and celebrations (85%), inside the clinic (85%), and community agencies (75%) (n=100).

Outreach and Enabling Services Funding

- In 2007, each health center spent an average of \$1.3 million on enabling services. Health centers spent about \$55 per user for enabling services.
- While some health center administrators rely solely on federal funding, most accessed some combination of other funding sources, including state funding, private foundations, program income, and donations.
- Health center administrators indicated that grant opportunities for outreach programs are sporadic and have short funding periods, forcing health centers to continuously seek new funding sources.

Outreach and Enabling Services Staff

- On average, health centers employ approximately 15 enabling service staff, of which three are considered outreach staff.
- The top three characteristics contributing to the success of outreach services include relationships with the farmworker community (60%), staff dedication (47%), and administrative support (34%) (n=99).
- Staffing shortages emerged as a significant challenge for outreach and enabling services programs. Thirty-one percent of online survey respondents identified lack of staff as a key challenge that organizations face when providing outreach and enabling services.
- Migrant health professionals reported balancing competing responsibilities inside and outside the clinic setting. Although interpretation is an invaluable service, it was noted by migrant health professionals that this demand can interfere with outreach staff's ability to fulfill other essential community-based activities with the farmworker community.

Data Collection and Evaluation

- Nearly half (45%) of migrant health professionals reported that their programs had conducted a farmworker needs assessment (n=98).
- Sixty-nine percent of migrant health professionals revealed that their organization evaluates the effectiveness of their outreach and enabling services (n=97).
- When gathering data for outreach programs, the most frequent challenges experienced are lack of internal resources such as time (55%), funding (44%), and staff (42%) (n=95).
- Health centers report that an evidence base is exceedingly useful in writing quality grant applications, determining programmatic needs, and justifying continued support for outreach and enabling services.

Cultural Competency

- Health centers reported that having bilingual staff (93%), bicultural staff (75%), and extended hours (68%) are the most common techniques for providing culturally-responsive services (n=95).
- There was overwhelming desire among migrant health professionals and farmworker parents to strengthen clinic staff understanding about farmworker cultures.

- Many farmworker parents spoke about obtaining less expensive medicines from Mexico and relying on home remedies when they or their family members become ill.
- Migrant health professionals reported that there is a lack of health clinic staff that can respond to the language needs of indigenous farmworker populations who speak neither English nor Spanish. Mixtec is the third-most reported language among farmworker patients and their families (n=101).

Social Service Needs and Community Collaboration

- Four of five (81%) migrant health professionals reported that their health centers collaborate with Migrant and Seasonal Health Start agencies, whereas three of four (76%) reported coordinating with health departments. Other frequently-cited organizations include migrant and/or bilingual education programs (69%), Women, Infant, and Children (WIC) programs (68%), coalitions and collaboratives (63%), and other community organizations (63%) (n=95).
- Migrant health professionals ranked assistance with Medicaid or other social service applications as the social service of greatest concern for farmworkers (60%) (n=101).
- According to farmworker parents, there is a critical need for educating farmworkers on where and how to access social services.
- Nearly two-thirds (62%) of health centers indicated involvement in a community coalition that addresses farmworker needs (n=95).
- According to health center administrators and migrant health professionals, challenges in working with community partners include difficulties in defining distinct scopes of work, lack of language capacity, and improper or inadequate response to referrals.

RECOMMENDATIONS

This section focuses on four key themes supported by substantial needs assessment findings and well-suited for action by those involved in serving migrant and seasonal farmworkers. The recommendations are structured towards two overall audiences: Funders/Policy Makers and Farmworker Advocates. In addition, they include HOP's commitment to responding to the data outlined in this project.

Fear

Fear among farmworkers emerged as a prominent theme throughout the research findings; it stems from the lack of legal documentation and the anti-immigrant climate in many communities. Recommendations include:

- Funders and policymakers ensure that funds accommodate immigrants living and working in the United States.
- Farmworker advocates engage farmworker community members in discussions to better understand their fear and its underlying causes.
- HOP disseminate its research on fear to advocacy organizations and develop resources to help understand how fear acts as a barrier to care.

Transportation

Farmworkers ranked accessing transportation options as the number one barrier to care (67%) and the number two social service need (57%). Recommendations include:

- Funders and policymakers support a variety of transportation methods, including mobile health units, clinic vans, Telehealth, and community-wide collaborations.
- Farmworker advocates forge community-based solutions, where partner agencies can share existing transportation resources.
- HOP place special emphasis on collecting innovative practices about transportation, thereby converting local solutions to nationwide best practices.

Education and Information Sharing

Health education was identified as a top outreach priority and is the most frequently performed outreach and enabling service among health centers. Yet, farmworkers desire more education on system navigation, occupational health, and legal rights. Recommendations include:

- Funders and policymakers allocate funding to support group and collaborative health education initiatives.
- Farmworker advocates enhance their approaches to education by collaborating with other community agencies and using experiential learning or popular education methods.
- HOP develop training modules focused on effective collaboration models and partnerships.

Data

Collecting strong and reliable data is essential in order to demonstrate the value of outreach and understand the health and social service requirements of farmworker populations. Recommendations include:

- Funders and policy makers institute data collection requirements that are flexible and consistent.
- Farmworker advocates collect data that proves the value of outreach. Consider collaborating with Head Start agencies in order to collect needs data.
- HOP develop resources that will formalize outreach data collection. Informal data coupled with formal data can make a strong case for the effectiveness of outreach.



INTRODUCTION

Health Outreach Partners (HOP) is proud to present its fourth National needs assessment! HOP embarked on this in-depth project in order to fulfill the need in the migrant health community for high-quality, national data focused on farmworker outreach programs and the farmworker communities they serve. HOP has developed this report not only to be used as a benchmark for comparing your work with the general picture of farmworker outreach in the U.S., but also as a practical resource for reports, funding proposals, and planning documents. We at Health Outreach Partners hope that you will find these findings as exciting and thought provoking as we do!

This report highlights the voices of migrant health administrators, outreach managers, frontline outreach staff, as well as farmworkers themselves. The focus of this needs assessment project has been organized around the following eight core themes: 1) background information about Migrant/Community Health Centers; 2) farmworker information; 3) access to care; 4) health outreach and enabling services; 5) funding; 6) needs assessment and evaluation data; 7) cultural competency; and, 8) community collaboration and coalition building. HOP is confident that these diverse topics will provide a little something for everyone working to provide outreach and enabling services to farmworkers.

HOP has collected and synthesized this rich set of data to serve a variety of purposes, both internal and external. First, HOP will tap this information to develop customized products and services to meet those needs. These data will also be used internally for HOP's operational and strategic planning. More importantly, the information presented here will fill existing gaps in national data about farmworkers which outreach programs across the country can leverage to improve their own services and support fundraising opportunities.

How have we improved this needs assessment?

Health Outreach Partners remains deeply committed to the needs assessment process. It is something that we not only recommend to our client organizations, but something that we hold ourselves accountable to year after year. Previous needs assessments conducted in 2001, 2003, and 2006 have given HOP the experience and expertise to deliver its best and most thorough report yet. Specifically, the 2006 report highlighted the need for a closer look at outreach funding, health education, and emerging farmworker populations—all of which are explored in detail in this edition.

The integration of farmworker voices into this year's needs assessment has been one of the most exciting and rewarding new pieces of the report. HOP facilitated focus group discussions in Spanish with members of Migrant and Seasonal Head Start Farmworker Parent Policy Councils. Thanks to these focus groups, HOP is able to offer the necessary farmworker perspective around topics such as access to services, dental care, alternative care options, fear and immigration, and much more. HOP believes that in making the case for outreach and enabling services to farmworkers, nothing is more critical than hearing the powerful health realities that our nation's farmworkers face each day.

Another key change in this year's report is its methodology. As you will see in the section that follows, HOP was able to use more and varied methods in its data collection. This needs assessment was the first in which HOP used an online survey, as opposed to mail surveys used in previous years. With this online survey method, HOP achieved a 70% response rate. This was also the first time HOP conducted community forums with frontline staff as a component of its data collection—this method, along with the farmworker focus groups and telephone surveys provided a great deal of substantive qualitative data. Additionally, HOP increased its review of existing documents and data sources related to farmworker outreach and enabling services and farmworker demographic information. Finally, this needs assessment is the first in which HOP contracted with a migrant health researcher for technical advising.

How do I use this report?

This report was designed to present a large, complex set of data in a concise and easy-to-read report. "You look at one outreach program and you've seen one outreach program," is a common expression used at HOP, pointing to the incredible variety from one program to the next. Despite this variation, we believe this report provides a comprehensive snapshot of the strengths and limitations that farmworker-serving outreach programs possess nationwide.

You can use this report to get a picture of the farmworker populations targeted by outreach and enabling services programs in the U.S. This can lend an understanding of barriers to care, social service needs, and demographics of our

nation's migrant and seasonal farmworkers. HOP has also designed this report to serve as an easy reference for use in funding proposals, to supplement community needs assessments in program planning, and in positioning outreach as a priority in your organization. Most importantly, this report provides a nationwide look at what outreach does every day, as well as the need to prioritize and fund outreach and enabling services as a means of increasing access to care for farmworkers and their families.

The Methodology section of the report explains our data collection methods in depth, including response rates, respondent profiles, HOP's approach to analysis and key limitations. The Findings section presents detailed information that HOP explored in the report. Please see the Table of Contents for a complete list of topics.

Finally, the Recommendations section of the report provides HOP's culminating thoughts from the data analysis. This section explores four key themes from the findings, including outreach data, fear, transportation, and education and information sharing. First, a discussion section is presented, followed by specific recommendations for policy makers/funders, community advocates, as well as HOP.



Be on the lookout for these helpful resources!

Along with this report, HOP is distributing five corresponding Fact Sheets that explore the following topics in further depth:

- Executive Summary
- Farmworker Voices
- Fear, Discrimination, and Immigration
- Outreach Funding
- Insurance & Farmworker Eligibility

ABOUT HEALTH OUTREACH PARTNERS

Since 1970, Health Outreach Partners (HOP) has been the leading organization for the promotion, delivery, and enhancement of health outreach and enabling services to farmworkers and their families. In 2001, HOP leveraged its more than 30 years of direct-service experience and transitioned into a national training and technical assistance organization dedicated to helping community-based organizations improve their outreach and enabling services to farmworkers. In 2009, HOP changed its name from Farmworker Health Services, Inc., and expanded its scope to respond to the changing labor populations targeted by outreach.

Health Outreach Partners' mission is to build strong, effective, and sustainable grassroots health models by partnering with local community-based organizations across the country in order to improve the quality of life of low-income, vulnerable, and underserved populations.

Health Outreach Partners offers a wide range of customized services which help to enhance community-based organizations' outreach delivery. Through HOP's training, consultation, and information services, organizations can expect improvements around the following six priority areas:

- Health Outreach & Enabling Services
- Program Planning & Development
- Needs Assessment & Evaluation Data
- Health Education & Promotion
- Community Collaboration & Coalition Building
- Cultural Competency

To learn more about Health Outreach Partners please visit

www.outreach-partners.org.





METHODOLOGY

OVERVIEW

Health Outreach Partners (HOP) sought to gather national programmatic and farmworker needs information from migrant and community health centers as well as farmworker parents through five methods. The research team identified core themes, or main topics, to be examined through the needs assessment and proceeded by defining appropriate audiences and methods for addressing each one. These core themes included: 1) background information about Migrant/Community Health Centers; 2) farmworker information; 3) access to care; 4) health outreach and enabling services; 5) funding; 6) needs assessment and evaluation data; 7) cultural competency; and, 8) community collaboration and coalition building. This framework enabled the study team to plan the assessment, providing a snapshot of how each core theme would be addressed across all methods.

Data collection methods used included an online survey, telephone survey, focus group discussions, community forums, as well as references to existing data from other research studies. Tables 1 and 2 provide an at-a-glance profile of each method implemented and their corresponding response information.

DATA COLLECTION METHODS

Community Forums

In order to create a platform for documenting observations and experiences of frontline outreach staff, HOP conducted three community forums as part of the national needs assessment project. Each community forum took place at an annual migrant stream forum and was organized in two parts: a small group discussion and a large group discussion. The community forum guide was divided into four topics, each one with a few corresponding questions. The guide and forum format was piloted at the first of three migrant stream conferences, yielding minimal changes. Each small group was assigned a topic to discuss among their group. An HOP staff person took notes of the small group discussion. In the large group, each small group shared a few of their key findings and then all other participants were invited to add to or comment on their observations. The large group discussion was recorded and back-up notes were taken. The large group recording was transcribed. In total, 82 outreach staff participated across all three community forums, including piloting.

Existing Documents & Data

In order to maximize existing information sources on farmworkers, three secondary sources were identified and reviewed for relevant data. The sources selected included: 1) the National Agricultural Workers Survey (NAWS); 2) 2008 Migrant and Seasonal Head Start Program Information Report (PIR) database; and, 3) 2007 Community Health Center Uniform Data System (UDS) results.

The NAWS, performed under contract to the Department of Labor, was selected as a key source of national-level farmworker demographic, employment, and health characteristics data. Additionally, it encompasses invaluable national-level data on indigenous farmworkers. The 2008 Migrant and Seasonal Head Start PIR database showcases aggregated data about migrant and seasonal farmworker families in the program, including health-related information about migrant children and their families. Lastly, the UDS includes information on all migrant and community health centers nationwide as it is a requirement for grantees. It tracks a variety of information, including patient demographics, migrant and seasonal farmworker status (of patients), services provided, costs, and revenues. Most of the data accessed across all three sources was publically available with the exception of portions of the UDS data. The latter was accessed by way of a formal request process.

Focus Group Discussions

As a national needs assessment on the needs of outreach programs and the farmworker communities they serve, it was essential to include a method that targeted farmworker experiences and opinions of health issues and services. HOP hosted three focus group discussions with farmworker parents attending either one of two Head Start program conferences or a Migrant & Seasonal Head Start Parent Policy Council meeting. One conference was state specific while the other had a national scope. Prior to the first focus group, a guide was created and translated into Spanish. The first

focus group discussion served as the pilot group, yielding nearly no changes to the original guide. All discussions were recorded, transcribed, and translated. All informed consent documents were reviewed verbally with each group. In total, 34 persons participated in the discussions.

Online Survey

The online survey tool garnered a national, quantitative snapshot of farmworker outreach programs. In order to develop the online survey, previous HOP national needs assessment mail survey tools were referenced. The core themes (highlighted above in the Overview section) were used to guide the content areas of the online survey questions. For comparison across previous needs assessments, some questions were replicated from existing HOP surveys. However, a significant number of questions were modified or added to allow for 1) the exploration of new topics or 2) the examination of previous topics from new angles (i.e. funding, community collaboration, and emerging farmworker populations).

Three pilot sites representing each migrant stream were selected to test the online survey. Each site completed the pilot survey and provided detailed feedback on the format and content. These pilot sites also completed the final version of the online survey.

In order to effectively launch the final version, extensive efforts were taken to develop a respondent list comprised of one person per organization that had the most knowledge about the farmworker outreach program. This step along with thorough marketing initiatives, were instrumental in achieving a high response rate. Sixty-percent response goals were established for each HRSA region to ensure regional representation. These goals were used to monitor progress and informed the direction of additional marketing efforts. Also, the implementation of an online survey helped with achieving a high response rate. Respondents could start and stop the survey as often as needed to complete it, making the implementation of this method extremely user-friendly and efficient for the respondents. Lastly, participants received a \$5.00 Starbucks gift card incentive for their participation. As a result of these combined efforts, a 70% response rate overall was achieved with at least a 60% response rate for seven of the 10 HRSA regions.

Telephone Survey

In response to numerous funding-related challenges documented in previous HOP needs assessments, the telephone survey tool was designed to explore more in-depth and nuanced information about funding and staffing issues with migrant and community health center administrators. The tool was piloted with three sites, one per migrant stream. Each site completed an evaluation of the pilot telephone survey and minor revisions were made.

In order to sample a diverse selection of migrant and community health centers, 2007 UDS site-specific data was acquired by way of formal request. One hundred forty-seven grantees (6 grantees in Puerto Rico were excluded) were categorized according to three criteria: 1) percentage of the client base comprised of farmworkers; 2) percentage of enabling service staff compared to total health center staff; and, 3) percentage of financial costs attributed to enabling services. A score was then assigned to each migrant and community health center based on these combined criteria. Forty-eight health centers were randomly selected and then clustered into groups according to score values.

Of the 48 organizations identified, 44 were contacted to participate. Twenty-eight agreed to participate and 24 completed the survey for a 55% response rate. Of the 24 organizations, three were pilot sites. Since minimal changes were made to the pilot telephone survey, the pilot data was included in the analysis.

Quantitative

The quantitative data derived from the online survey yielded a number of cleaning and analysis procedures. After data collection, descriptive statistics were first tabulated in SurveyMonkey. Then, the data were imported and cleaned in MS Office Excel 2007. The data were subsequently transferred into SPSS 16.0 for another round of cleaning and running of descriptive statistics. For quality assurance purposes, the descriptive statistics in SurveyMonkey were compared with those calculated in SPSS. An additional step was conducted with cleaning the online survey qualitative data, verifying that “other” responses were true “other” responses, and when needed, “other” responses were re-categorized into existing answer choice categories. When cleaning the data, a consistent effort was made to work in pairs in order to provide quality assurance with checking each other’s cleaning and calculations work.

Upon completing cleaning procedures, a data analysis plan was created in order to determine the level of analysis for each quantitative question of the online survey. Analysis was conducted in SPSS 16.0 and consisted of three possible tiers of operations: calculated frequencies, rankings, and cross tabulations. Each question was ultimately categorized according to the core theme in which it corresponded.

Qualitative

Qualitative data from community forums, focus groups, and telephone surveys were entered and analyzed in ATLAS.ti version 5.5, a qualitative data analysis software package. Prior to analysis, community forum and focus group data were transcribed and in some cases, translated. Then, all transcripts and notes were imported into ATLAS.ti. HOP staff pilot-tested coding the data in order to establish a similar approach across multiple staff members.

Three HOP staff pairs were created in order to identify codes, i.e. recurring topics. Specifically, each HOP staff pair was assigned one of the three qualitative data methods and its corresponding dataset in ATLAS.ti. Based on review of their dataset, each individual in the pair independently created their own code list. Pairs met to compare their lists and established consensus on one combined list for their assigned method. Three code lists resulted, one for each qualitative method. The three code lists were independently reviewed and then, consolidated by HOP staff to create a master list of codes. The master code list was entered into ATLAS.ti.

Qualitative data was coded according to the master code list. Three staff assigned codes to the data, with one lead coder per dataset. A separate staff person reviewed the assigned codes for quality assurance and consistency purposes. Each code and its corresponding passages were assigned to one of the project’s core themes.

Final Stages

Quantitative and qualitative data was ultimately allocated to one of eight core themes. For example, all data related to the core theme “Farmworker Information” was analyzed together. Each core theme was assigned to two staff who reviewed all the corresponding data for emerging trends and findings. These findings were shared and discussed among all HOP staff.

KEY CONSIDERATIONS

Human Subjects Protections

Migrant Clinicians Network’s Institutional Review Board (IRB) approved the study design as well as instruments and corresponding informed consent documents used with each data collection method. Of special note, additional considerations were taken with confidentiality and protections procedures for farmworker participants. Specifically, informed consent documents were written to be low-literacy friendly and were made available in English and Spanish. Additionally, focus group facilitators reviewed the form’s content aloud. Identifying information of farmworker participants was also optional.

The purpose of an IRB is to provide an independent determination that the rights and welfare of individuals involved in medical, behavioral, and social science research are protected. It is the responsibility of the IRB to verify the appropriateness of the methods used, to secure informed consent, and to ensure that subjects are not exposed to unreasonable risk in the study or project.

HRSA Regions

In order to monitor progress with the online survey marketing procedures and response rate as well as examine the geographic distribution of telephone survey respondents, HOP used the Health Resources & Services Administration’s (HRSA) ten region breakdown (see Table 3). Since migrant and community health centers receive migrant funding from HRSA, HOP decided to maintain this regional breakdown with the national needs assessment project as well. Table 2 delineates the response rates for the online survey and telephone survey, by HRSA region.

TABLE 1 : HRSA REGIONS

No.	STATES
1	Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut
2	New York and New Jersey
3	Pennsylvania, Maryland, Delaware, Virginia, and West Virginia
4	Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Florida, Alabama, and Mississippi
5	Minnesota, Wisconsin, Illinois, Indiana, Michigan, and Ohio
6	New Mexico, Texas, Oklahoma, Arkansas, and Louisiana
7	Nebraska, Kansas, Iowa, and Missouri
8	Montana, North Dakota, South Dakota, Wyoming, Colorado, and Utah
9	Nevada, California, Arizona, and Hawaii
10	Washington, Oregon, Idaho, and Alaska

Limitations

Listed below are key limitations to *Breaking Down the Barriers: A National Needs Assessment on Farmworker Health Outreach*.

- Findings from focus groups reflect opinions and experiences of farmworker parents who have children. Although participants were encouraged to share their observations of their communities at large, experiences from other farmworker groups, like unaccompanied men, are not necessarily represented in the focus group data. This is significant implication as the NAWS indicates that only 48% of farmworkers are accompanied.¹ Additionally, 22 of the 34 focus group participants were women, introducing potential gender bias to the information.
- Community forum and focus group participants largely reflected their intended target audiences however a select number of exceptions were noted, potentially introducing bias. Although clear guidelines were included in announcements and marketing materials, there were 7 (of 82) non-health center staff that participated in the community forums and approximately 2 (of 34) non-farmworkers included in the focus group discussions. Their involvement may have biased the data to not include the intended audience perspective or may have made participants less inclined to participate.

- Different institutions, agencies, and/or individuals have varying definitions of outreach and enabling services. Although definitions were made available, individual or organizational definitions may have been biased or influenced participants' responses to outreach-specific questions.
- Telephone survey participants may have been biased toward administrators that had an existing relationship with HOP staff or programs. Although prospective participants were randomly selected, those that had an existing relationship with the organization were more inclined to participate in the study.
- Although 108 online survey participants responded, 9 of these individuals started but did not complete the survey tool. Above all, the survey length may have prohibited a complete response from these individuals. Additionally, others may not have started the online survey because they lacked access to computers, or were uncomfortable or unfamiliar with the electronic format of the survey.
- All data collection methods relied on the prompt and honest feedback (both written and verbal) from participants. All of the data generated is self-reported data, which can be susceptible to bias and participant's ability to accurately recall information.
- Community forum participants had varying levels of experience delivering outreach. Not all persons participating in the community forums may have been the most appropriate to respond on behalf of the outreach program and the farmworker community. For example some community forum members may have been new to the position or outreach may have been a small proportion of their overall role.
- Due to the seasonal nature of outreach program staffing, some seasonal outreach staff may not have had the opportunity to participate in a community forum or online survey and as such, were not included in the overall sample.
- In some situations, information about health facilities was collected without identifying information. For example, the participant may have been referring to community/migrant health center or a private clinic. When this ambiguity was evident, the health facility was referred to as a *health clinic*.

Improvements

Listed below are key improvements to *Breaking Down the Barriers: A National Needs Assessment on Farmworker Health Outreach*.

- To maximize community participation in the study design and instrument development, HOP conducted a brief online survey of 12 needs assessment stakeholders to identify their preferred content and format for receiving the project's findings.
- To ensure human subjects protection and confidentiality, HOP received approval by Migrant Clinicians Network's Institutional Review Board. All methods requiring participant involvement were initiated with appropriate informed consent explanation and paperwork.
- To be responsive to varied needs assessment aims, the study team decided to implement five methods, including a mix of qualitative and quantitative approaches. This breadth of information enabled the team to explore certain topics through numeric findings and others through rich notes and transcription.
- To maximize the quality of the study design and tool development, HOP worked with Alice C. Larson, professional consultant of Larson Assistance Services. The consultant's involvement functioned to advise and assure high-quality needs assessment study design, process, and products.
- To ensure the direct involvement of farmworkers, three focus groups were conducted with Head Start Parent Policy Council members in each migrant stream (Eastern, Midwestern, and Western). All three focus groups were facilitated in Spanish, then transcribed and translated. Relevant findings were reported back to these audiences.
- To ensure a more substantive qualitative component, three of the five methods selected for the study (community forums, focus groups, and telephone surveys) provided opportunities for respondent's open-ended opinions and experiences. This allowed for rich, in-depth information on a variety of essential needs assessment topics. Additionally, when transcripts were not available, data from notes taken during community forums or telephone surveys have been included.

Timeline

- Planning, IRB proposal, development of data collection tools (May 2008 – February 2009)
- Data collection (October 2008 – April 2009)
- Data entry, cleaning, and analysis (March – September 2009)
- Report writing and dissemination of findings (October 2009 – April 2010)

TABLE 2 : METHODS OVERVIEW

Method 1 : COMMUNITY FORUMS (CF) A facilitated large group discussion

dates administered: CF #1 : 10/24/08 | CF #2 : 11/21/08 | CF #3 : 01/24/09

target audience: Outreach staff attending one of three migrant stream forum conferences.

Outreach staff include outreach workers, outreach coordinators, clinical outreach staff, promotores/as, mobile health unit staff, and health educators.

pilot details: CF guide piloted during first forum.

sampling method: *Convenience Sample* : Target audience choosing to attend a CF session at a conference.

topics addressed:

Access to Care
Community Collaboration & Coalition Building
Cultural Competency
Farmworker Information
Outreach Service Delivery

implementation highlights:

Facilitated one CF per stream forum conference
Completed three CF total
Conducted primarily in English

data format:

Qualitative data in two formats:

- Facilitator notes
- Audio transcripts

Method 2 : EXISTING DOCUMENTS & DATA Existing information relevant to study's aims

dates administered: n/a

target audience: n/a

pilot details: n/a

sampling method: *Convenience Sample*: National data sources addressing one or more of the needs assessment's core themes.

topics addressed:

Access to Care
Farmworker Information
Outreach Service Delivery

implementation highlights:

Three sources identified:

- NAWS
- Migrant & Seasonal Head Start Agency program database
- Health Center's Uniform Data System

Relevant data extracted from each data source

data format:

Qualitative data in one format:

- Closed or structured responses to existing surveys or reporting mechanisms

Method 3 : FOCUS GROUP DISCUSSION (FGD) A facilitated small group discussion

dates administered: FGD #1 : 01/26/09 | FGD #2 : 02/4/09 | FGD #3 : 03/13/09

target audience: Farmworker parents participating in Migrant & Seasonal Head Start Parent Policy Councils & attending one of three conferences or meetings.

pilot details: FGD guide piloted during first group discussion.

sampling method: *Convenience Sample*: Target audience choosing to attend FGD at a conference or meeting.

topics addressed:	implementation highlights:	data format:
Access to Care	Conducted two FGD at two Head Start conferences	Qualitative data in one format:
Cultural Competency	Conducted one FGD at a Head Start Parent Policy Meeting	<ul style="list-style-type: none"> • Transcripts (in Spanish & English)
Farmworker Information	Completed three FGD total Facilitated in Spanish	

Method 4 : ONLINE SURVEYS (OS) A survey administered via internet

dates administered: start date 02/09/09 | end date 03/09/09

target audience: Health centers receiving federal migrant health funding. One respondent per grantee.
Respondents included the “person most knowledgeable of the outreach program” (i.e. outreach coordinators, outreach workers, program directors).

pilot details: OS piloted internally twice. | OS piloted externally with three different health centers.

sampling method: *No sampling method needed*: Entire population of Migrant Health Grantees were administered the OS.

topics addressed:	implementation highlights:	data format:
Access to Care	Conducted OS using Survey Monkey software.	Quantitative & qualitative data in two formats:
Community Collaboration & Coalition Building	Extensive marketing/follow-up procedures conducted.	<ul style="list-style-type: none"> • Open-ended and closed • structured questions in Survey Monkey
Cultural Competency	Small incentive provided to all external pilot site respondents and final OS respondents	
Farmworker Information		
infrastructure & Sustainability		
Needs Assessment & Evaluation Data		
Outreach Service Delivery		

Method 5 : TELEPHONE SURVEYS (TS) A survey administered via phone

dates administered: start date 03/09/09 | end date 04/21/09

target audience: Administrators of Migrant Health Grantees. One interviewee per grantee.
Interviewee selection criteria included “person most knowledgeable about outreach and enabling services funding challenges and concerns.”

pilot details: TS piloted externally with three Migrant Health Grantees. One grantee per migrant stream.

sampling method: *Random Sample:* Random number generator used to select sample. Sample distributed according to three key factors.

topics addressed:	implementation highlights:	data format:
Infrastructure Sustainability	Sample selection based on data from 2007 Uniform Data System, site specific findings. All Migrant Health Grantees initially categorized according to three factors: 1) % client base comprised of farmworkers; 2) % of enabling service staff; and, 3) % of costs attributed to enabling services.	Qualitative data in one format: • Interviewer notes

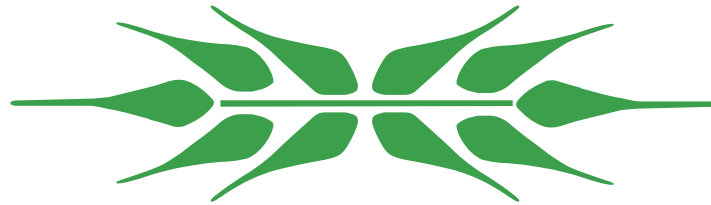


TABLE 3 : RESPONDENT PROFILE

Method 1 : COMMUNITY FORUMS (CF) A facilitated large group discussion

possible respondents: n/a

total respondents: 82 participants*

response rate: n/a

**number of participants
by organization type:**

Migrant/Community Health Centers = 43
Community Based Organizations = 15
Health Centers** = 11
Research/Universities = 4
Health Departments = 3
Government = 2
Primary Care Associations = 2
Head Start Agencies = 1
Technical Assistance Providers = 1

**number of participants
by title or gender:**

Outreach Staff/Case Managers = 39
Outreach Coordinators/Supervisors = 22
Program Directors = 9
Non-Health Center Staff = 7
Other/unknown = 3
Board Member = 1
CEO = 1

**number of participants
by geographic region:**

Eastern Stream = 34
Western Stream = 25
Midwestern Stream = 23

Method 2 : FOCUS GROUP DISCUSSION (FGD) A facilitated small group discussion

possible respondents: n/a

total respondents: 34 participants*

response rate: n/a

number of participants
by organization type:

Migrant & Seasonal Head Start Agency
Affiliated participants = 34

number of participants
by title or gender:

Women = 22
Men = 12

number of participants
by geographic region:

Midwest participants = 13
National participants = 11
California participants = 10

Method 3 : ONLINE SURVEYS (OS) A survey administered via internet

possible respondents: 155

total respondents: 24 participants*

response rate: 70%

number of participants
by organization type:

Migrant/Community Health Centers = 108

number of participants
by title or gender:

Directors = 32
Managers = 25
Outreach Coordinators = 19
Other = 17
Did not provide title = 6
CEO/ED = 5
Clinician = 3
CHOO = 1

number of participants
by geographic region:

HRSA I = 0
HRSA II = 3
HRSA III = 5
HRSA IV = 24
HRSA V = 10
HRSA VI = 9
HRSA VII = 4
HRSA VIII = 6

Method 4 : TELEPHONE SURVEYS (TS) A survey administered via phone

possible respondents: 44

total respondents: 24 participants*

response rate: 55%

number of participants
by organization type:

Migrant & Seasonal Head Start Agency
Affiliated participants = 24

number of participants
by title or gender:

CEO/ED = 14
Other = 4
CFO = 3
COO = 3

number of participants
by geographic region:

HRSA I = 0
HRSA II = 1
HRSA III = 4
HRSA IV = 4
HRSA V = 1
HRSA VI = 1
HRSA VII = 1
HRSA VIII = 4
HRSA IX = 7
HRSA X = 1

* includes pilot sites



FINDINGS

FARMWORKER INFORMATION

The following section highlights a national overview of farmworkers, including demographics, emerging populations, agricultural workforce trends, and leading health issues.

Farmworker Demographics

According to the National Agricultural Worker Survey (NAWS) data from 2002-2007, over three quarters (78%) of the U.S. farmworker population are male. Most farmworkers are relatively young (their average age is 34) and have a seventh grade education on average. Although 65% of farmworkers are married, only 48% of the total farmworkers surveyed by NAWS are accompanied by their families. A little more than half (51%) of all farmworkers are parents.²

Regarding language fluency, the majority (75%) of U.S. farmworkers primarily speak Spanish followed by English (21%), then “other” languages (4%).³ This finding is consistent with HOP’s online survey results concerning farmworker patient language preference within migrant and community health centers’ service areas; Spanish ranked number one (101 of 101 respondents), English ranked number two (34 of 101), and Mixteco ranked number three (24 of 101). Additionally, 2007 Uniform Data System results reported that 78% of farmworker patients were best served in a language other than English (n=770,402).

Based on 2007 NAWS data, Mexico is the most frequently cited country of origin for U.S. farmworkers (72%), followed by the U.S. (24%), then “other” (3%).⁴ When HOP asked the online survey respondents to respond about the ethnic/racial groups represented within migrant and community health centers’ service areas, an overwhelming majority (98%) mentioned the presence of non-indigenous Mexicans, followed by non-indigenous Central-Americans (46%), Mixtecs (35%), White (27%), and Black/African-American (24%).

It is assumed that many farmworkers living and working in the U.S. are unauthorized. According to the Pew Hispanic Center, there are approximately half a million unauthorized workers within the U.S. agricultural industry, more than any other sector in the country. This estimate is thought to be even higher due to seasonal workforce fluctuations. Moreover, the percentage of unauthorized hired crop farmworkers in the U.S. has quintupled since 1989.⁵

In 2007, the Department of Labor, the U.S. Citizenship and Immigration Services, and the Department of State, authorized and oversaw 50,791 visas under the H-2A Temporary Agricultural Worker Program.⁶

TABLE 4 :
NATIONAL FARMWORKER DEMOGRAPHICS

Male	78%	Married	65%
Average Age	34	Parent	51%
Average Highest Grade	7	Accompanied	48%
Indigenous	17%		

Source: National Agricultural Workers Survey Data (NAWS) from years 2002-2007, excluding the indigenous farmworker data, which NAWS collected from 2005-2007.

Emerging Farmworker Populations

In recent years, HOP has noticed increased anecdotal evidence concerning a surge of newly-emerging farmworker populations from specific ethnic or cultural groups. HOP investigated this trend by asking the online survey respondents if they had noticed an increased presence of emerging farmworkers within their respective service areas. One third of

respondents (33%) answered “yes,” while a little less than one quarter (22%) answered “do not know,” which suggests that the number of emerging farmworkers could be higher than reported (n=100). As indicated by online survey respondents, these populations predominantly consist of indigenous Mexicans from the state of Oaxaca like the Triqui, Zapotec, and Mixtec. Thus, it is not surprising that Mixtec is the third-most prevalent (35%) ethnic/racial group represented and third-most reported language among farmworker patients and their families, as reported by online survey respondents (n=101).

Based on 2005-2007 NAWS data, 17% of the national farmworker population is indigenous, with the majority residing within the Western and Eastern migrant streams.⁷ Tremendous linguistic diversity exists among indigenous populations. Although HOP online survey respondents indicated that Mixtec is the most common indigenous language reportedly spoken by farmworker patients and their families, there are at least 30 different Meso-American languages spoken by indigenous farmworkers.⁸

TABLE 5 :
INDIGENOUS LANGUAGES SPOKEN BY FARMWORKERS

Achi	Chinanteco	Kanjobal	Nahuatl	Tepehuano	Visayo
Aguateco	Chuj	Mam	Otomi	Tlapaneco	Zapoteco
Amuzgo	Garifuna	Maya	Popti	Triqui	
Cakchiquel	Ixil	Mazateco	Quiche	Tzeltal	
Chatino	Jacalteco	Mixteco	Tarasco	Tzotzil	

Source: National Agricultural Workers Survey Data. 1999-2007.

From 1989 to 2007, the number of farmworkers born in the Pacific South region of Mexico (Chiapas, Guerrero, and Oaxaca) tripled.⁹ From 2002-2004, 16% of the total farmworker population in the U.S. emigrated from the Pacific South region in Mexico; this figure increased to 21% for the next three year reporting period.¹⁰ Over half (53%) of the farmworkers emigrating from this region are indigenous, and most (81%) are male. The average age of farmworkers born in the Pacific South region is 29 years old and the average highest grade completed is sixth; these figures are slightly lower than the national farmworker average. However, family composition statistics are somewhat comparable to the national farmworker average as reported by the NAWS data. Fifty-one percent of farmworkers from the Pacific South region of Mexico are parents, 9% are married without children, and 40% are classified as single/other. The majority (90%) of these farmworkers are also unauthorized to work in the U.S. and 36% are recent newcomers, having been in the U.S. for less than 12 months.¹¹

Agricultural Workforce Trends

NAWS defines non-migrant farmworkers as farmworkers who reside within 75 miles of their residence and migrant farmworkers as persons who travel more than 75 miles during a 12-month period to obtain work in agriculture.¹² From 2002-2007, the number of settled versus migrant farmworkers in the U.S. slightly increased; settled farmworkers rose from 64% to 67% while migrant farmworkers decreased from 36% to 33%.¹³ More farmworkers are making their long-term home within their host communities. This trend is consistent with qualitative data generated from this needs assessment and previous HOP national needs assessments.¹⁴ According to needs assessment participants, one reason this trend may be occurring is because undocumented farmworkers have become less likely to risk deportation by following crops into anti-immigrant communities.

The participant’s state has passed laws over the past few years that have affected migration to the state and created a more unfriendly environment for undocumented workers. Over the last few years, the participant noticed a decrease in the numbers of migrant farmworkers coming into the area.

– Health Center Administrator, Telephone Survey Notes

Additionally, a few participants from HOP’s community forums and telephone surveys indicated an increased number of H-2A workers in their service areas. They believe H-2A farmworkers have unique needs due to their immigration status. H-2A farmworkers are frequently less knowledgeable about the health and social services available and more reluctant to seek health care options because they fear their employer will not ask them to return to work the following agricultural season and sponsor their visas.

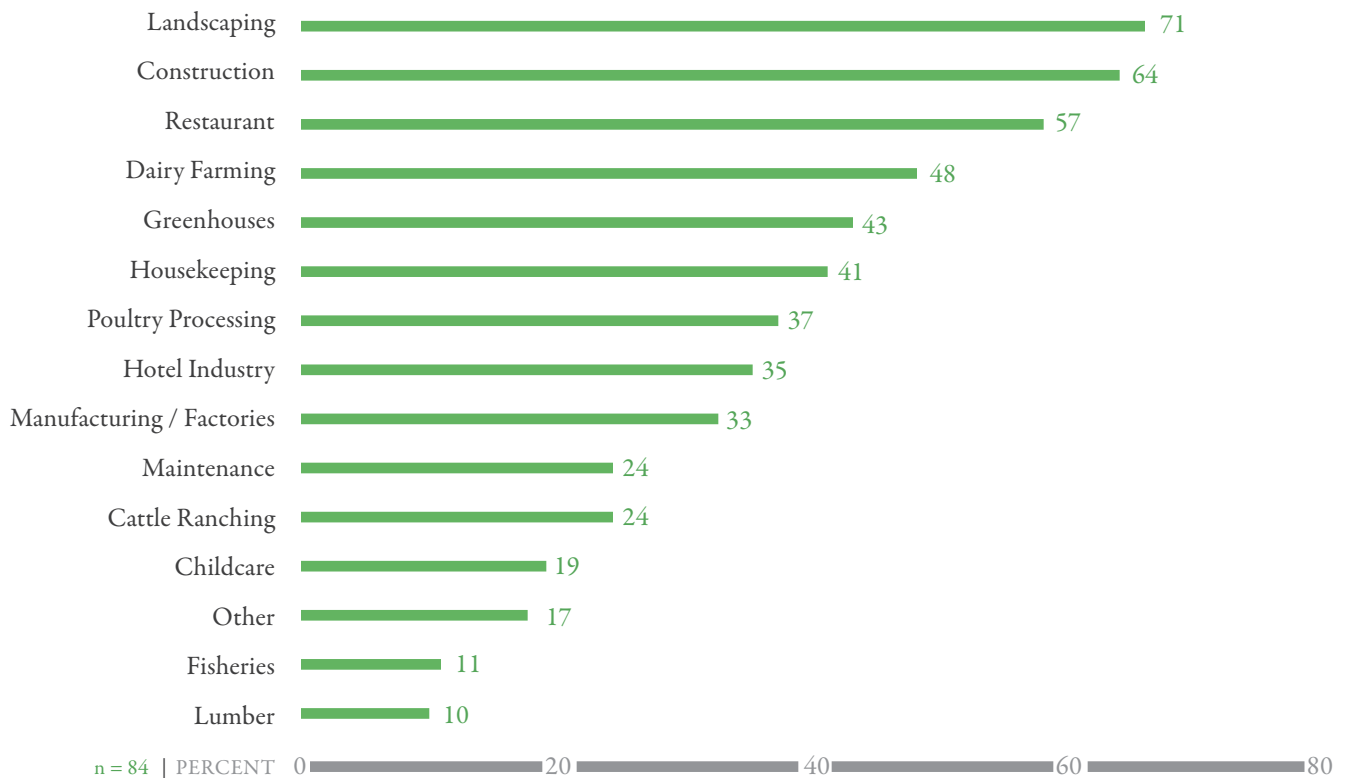
“Because of recent immigration policies, there has been an influx of H-2A farmworkers. They are a different population with different needs. We need to continue to identify H-2A workers’ needs and adapt our outreach approach to them.”

– Migrant Health Professional, Community Forum Transcripts

“Foreign-born newcomers,” defined by NAWWS as “persons who were in the U.S. for the first time and who had been in the U.S. for less than a year,” continue to be more prominent in the agricultural workforce. Among migrant farmworkers, 43% were foreign-born newcomers during 2005-2007, a staggering 200% increase from 1989-1992, when only 13% were foreign-born newcomers.¹⁵

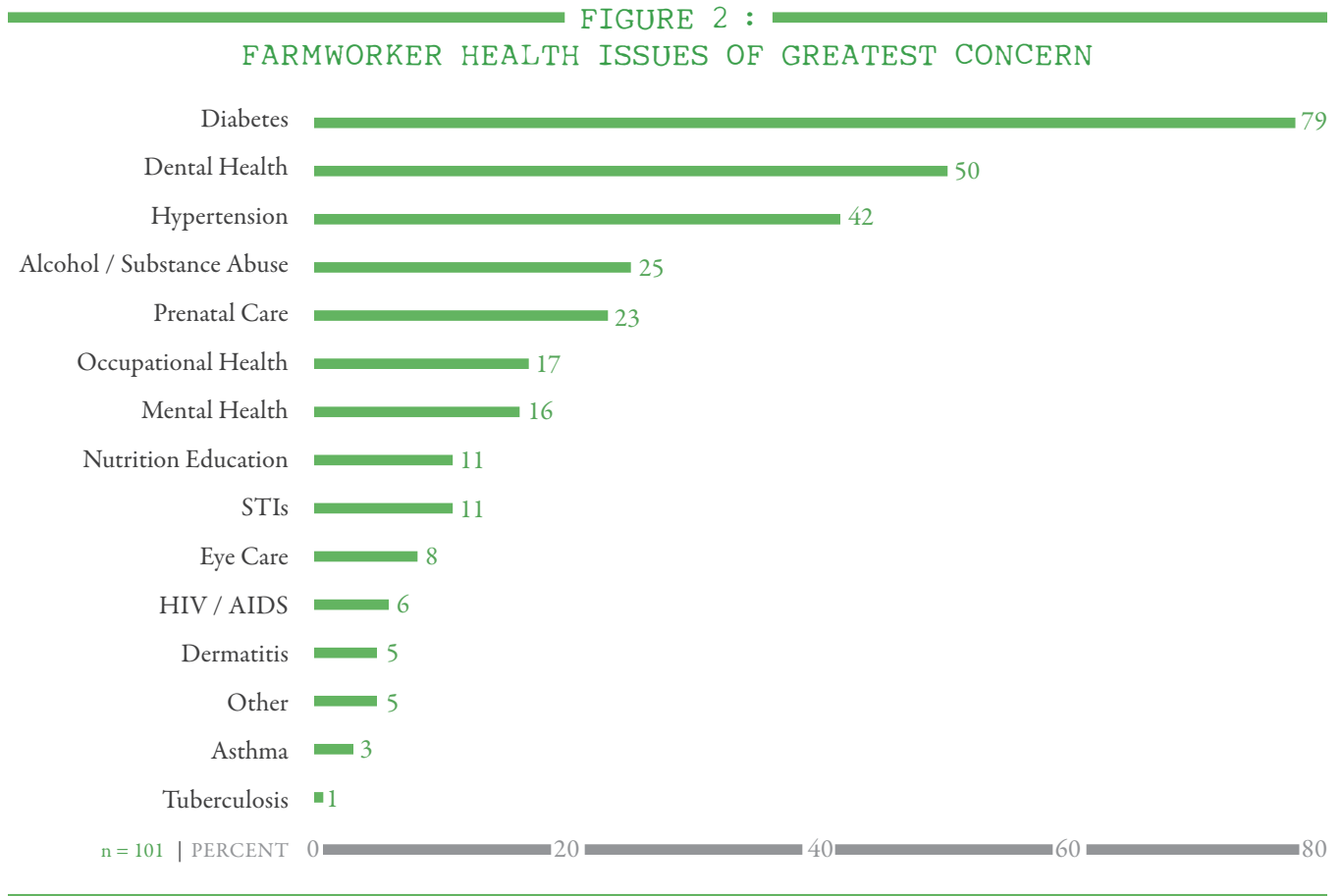
Most online survey respondents (84%) confirmed that farmworkers or farmworker family members in their service area work in labor sectors other than agriculture (n=101). The five most common labor sectors were, in order of greatest to least, landscaping (71%), construction (64%), restaurant industry (57%), dairy farming (48%), and greenhouses (43%). All labor sectors are delineated in Figure 1.

**FIGURE 1 :
OTHER LABOR SECTORS EMPLOYING FARMWORKERS**



Farmworker Health Issues

Online survey respondents were asked to report the three health issues of greatest concern among farmworkers and their families (Figure 2). Diabetes was the most frequently reported concern (79%), followed by dental health (50%), and hypertension (42%). These findings are consistent with HOP's 2003-2004 and 2005-2006 *National Needs Assessment of Farmworker-Serving Health Organizations*.¹⁶



These rankings are further supported by qualitative data from community forums and focus groups, where some participants indicated that lack of adherence to a diabetic regimen was a top farmworker health concern. It was noted that some farmworkers have elevated blood glucose levels, do not follow prescription regimens, and sometimes ignore their condition due to specific barriers to care that they encounter in attempting to seek treatment. Other community forum respondents believe that there should be health programs focused on lifestyle habits and advocacy efforts for creating local social support systems for diabetic farmworker patients.

A participant told a story about how a diabetic male farmworker with an elevated sugar level of over 400 could not make it to his appointment at the health clinic. Another participant shared a story about a diabetic farmworker who was off medication that would help control blood glucose levels, but was reluctant to miss a day of work to refill his prescription.

– Migrant Health Professionals, Community Forum Notes

After immunizations, health supervision of children and oral exams, diabetes and hypertension were the fourth and fifth top diagnoses (as measured by number of encounters) reported by migrant and community health centers.¹⁷ These figures reflect only those farmworkers that accessed care at migrant/community health centers for their conditions and most likely do not adequately represent the true need surrounding these issues in farmworker communities throughout

the U.S. Nonetheless, these diagnoses make a compelling case for why diabetes and hypertension are consistently reported as top health issues among farmworkers and their family members by online survey respondents.

“Chronic diseases play a big role in the population. We have a lot of data collection about people with diabetes... and also with high blood pressure.”

– Migrant Health Professional, Community Forum Transcripts

Since 2001, dental health is consistently ranked within the top three most common farmworker health issues.^{18, 19} As evidenced by data garnered from the online survey, community forums, and focus groups, dental health continues to be a top health priority among farmworkers. Many focus group and community forum participants reported that farmworkers do not receive dental health services due to high costs and lack of insurance.

“...Our children do have health coverage, and there is a dental program, and they receive check-ups, they have many privileges that we do not have. I have not received these [dental] services in nine years. I do not have the privilege of a dental cleaning.”

– Head Start Parent or Advocate, Focus Group Transcripts

“Buying Tylenol, buying anything is still easier... going to the dentist is a horror. No, correction... going to the dentist is a luxury. And if you are low income, [you] can't have the luxury of going to the dentist... even though my molar hurts I have to ignore the pain.”

– Head Start Parent or Advocate, Focus Group Transcripts

Dental hygiene and tooth decay were also mentioned as top priorities often neglected by farmworker families due to the aforementioned barriers. Based on data from the 2007-2008 Migrant and Seasonal Head Start Program Information Report (PIR), a little less than one quarter (23%) of farmworker children enrolled in the Migrant and Seasonal Head Start program did not receive preventative dental care treatment.²⁰ Furthermore, 2007 UDS data results indicate that oral exams, dental prophylaxis, and restorative services were the top dental diagnosis rendered to patients seeking dental services.²¹

Another top health issue emerging from the focus groups and community forums is pesticide exposure. Many participants believe that employers do not provide enough training to farmworkers about how to prevent pesticide exposure or illness. Some focus group participants shared personal stories about their exposure to pesticides, indicating that many farmworkers contend with allergies, asthma, skin conditions, and cancer. Moreover, other participants expressed genuine concern about the possibility of contaminating their homes and exposing their children to pesticides.

“I have seen many parents with their clothes covered with the chemicals ...they hug their three-year-old child, and wrap them in their arms and contaminate them.”

– Head Start Parent or Advocate, Focus Group Transcripts

“...We need more information about hygiene, what we need to do when we come back from spraying the chemicals, and all the hazards we are in contact with.”

– Head Start Parent or Advocate, Focus Group Transcripts

In addition, mental health surfaced as a prominent trend within the qualitative data. Participants expressed concern about the mental health of farmworkers, often linking farmworkers' poor mental health status to racism, inequality, difficult work situations, family separation, fear, depression, stress, and anxiety resulting from their immigration status.

“She was from Oaxaca. And she died of heat stroke; they didn’t give her water. How is it possible that in this country a pregnant girl died and because there is not water? It is an unbelievable thing. But it happens.”

– Head Start Parent or Advocate, Focus Group Transcripts

“The fact that you go out and you do not know if you are coming back home, because of the raids, what if they catch you or what if you don’t have anything to eat tomorrow or you do not have a job. All of these things affect you and make you feel depressed. There is anxiety in your life... the children see how they have to move from one place to the next because there aren’t any safe places; those [realities] are affecting the family’s mental health. I do not see mental health services for farmworkers, [services] are focused on the physical health... on diabetes, on obesity but we are forgetting that our mental health is being affected.”

– Head Start Parent or Advocate, Focus Group Transcripts

HOP’s community forums, telephone surveys, and focus groups revealed other emerging farmworker health trends. Participants discussed some pressing health needs common among farmworker women such as prenatal care, sexual and physical assault, and breast cancer prevention. Other occupational illnesses and hazards such as heat stroke and exposure to non-pesticide toxic substances were also discussed as priority health issues.

Summary

Identifying trends in agriculture and farmworker demographics is a fundamental challenge to the migrant health community. Though migrant health lacks some important data, several resources exist that shed some light on this vulnerable population. Spanish continues to be the most prevalent language spoken by farmworkers (75%), though indigenous languages, such as Mixteco, are rising. One-third (35%) of health centers report that Mixteco is spoken in their service area. In addition, more and more farmworkers are choosing to settle out in communities across the country; approximately one-third of farmworkers migrate. When farmworkers are not engaging in farm work, 84% of health center respondents say that farmworkers work in other labor sectors. With regard to health status, diabetes, hypertension, and dental health continue to be the top health issues faced by U.S. farmworkers.

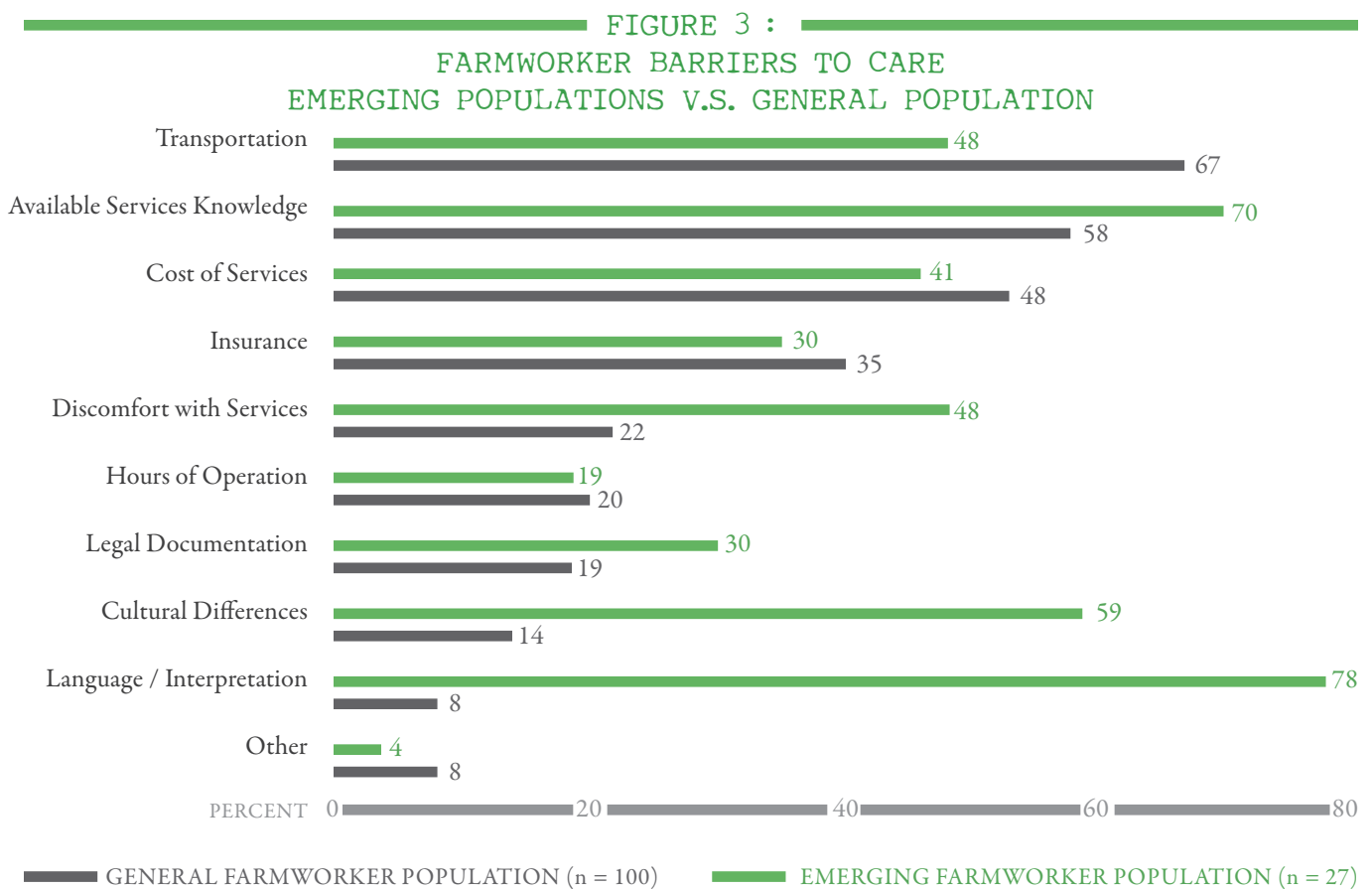
BARRIERS TO ACCESSING HEALTH CARE

There are numerous barriers to health care that continue to prevent farmworkers from receiving the services needed to live healthy and fruitful lives. The following section is a national perspective on these top health care barriers.

Top Barriers to Care

Since 2001, Health Outreach Partners (HOP) has strived to understand the barriers to care experienced by U.S. farmworkers. In HOP's 2003-2004 and 2005-2006 *National Needs Assessment of Farmworker-Serving Health Organizations*, written survey respondents identified the following top five barriers to care: transportation, pay scale/financial, lack of knowledge of available services, language/lack of interpretation services, and legal status.^{22, 23}

The findings in this needs assessment are consistent with previous findings. Once again lack of transportation (67%) ranked first, followed by lack of knowledge of available services (58%), cost of health care services (48%), lack of insurance (35%), and lack of comfort with health care services/facilities (22%) (Figure 3).



Emerging farmworker populations cope with their own set of barriers to accessing health care services. Respondents of the online survey ranked language/lack of interpretation services as the number one barrier to care (78%), followed by lack of knowledge about available services (70%), cultural differences (59%), lack of comfort with health care services/facilities (48%), lack of transportation (48%), and cost of health care services (41%). In total, over a quarter (27%) of online survey respondents believe that barriers to care are worse for emerging farmworkers than for established farmworker populations (n=100). As the number of emerging farmworker populations increases throughout the country, it is important to note that these unique barriers can impact health centers' approach for providing responsive outreach and enabling services.

One farmworker barrier to care surfacing in this study is lack of comfort with health care services and facilities; this barrier may be related to a number of other significant barriers such as staff's lack of cultural competency or fear of immigration. However, this relationship warrants additional research to fully understand why farmworkers do not feel comfortable with accessing health care services and facilities. For more information please see Fear and Discrimination, page 43, and Cultural Competency, page 67, respectively.

The 2007 National Agricultural Workers Survey (NAWS) data portrays similar barriers to care; however, the ranking order differs from those established by HOP's online survey. Most farmworkers reported that cost of care was prohibitive (81%), believing that health services are too expensive. Language was the second most reported barrier to care (20%), followed by lack of knowledge about where to access services (9%), other unspecified barriers to care (10%), and documentation status (7%). Transportation (4%) ranked the sixth most reported barrier to care, followed by farmworkers not feeling welcomed and understood (3%).²⁴

Transportation

As reported in HOP's last three consecutive national needs assessments, transportation continues to rank as the number one farmworker barrier to accessing health care. Many farmworkers live and work in rural communities without accessible public transportation services. Oftentimes, farmworkers drive long distances to reach the nearest migrant and community health center or social service agency. It is no surprise that online survey respondents also considered transportation to be the second highest social service need. Furthermore, a lack of reliable transportation resounded throughout the qualitative data generated in this needs assessment project, particularly in the data collected from outreach staff participating in community forums.

“It is a major difficulty getting people into the clinic from rural areas ...It takes an hour and a half for some people to get to the clinic.”

– Migrant Health Professional, Community Forum Transcripts

“One of our most important goals is to purchase vehicles to transport migrant farmworkers. The migrant labor camps are widespread and are long distances from the health center. Farmworkers would not obtain needed care if we didn't bring them to the health center.”

– Migrant Health Professional, Community Forum Transcripts

Aside from living in rural and isolated areas, other complex environmental factors exacerbate the lack of transportation options for farmworkers. The current immigration climate deters farmworkers from accessing the few transportation options available in rural communities. Some community forum participants noted an increase in the frequency of raids and roadblocks initiated by law enforcement agencies. These instances cause farmworkers to question their security if they use transportation options provided by health centers and other social service agencies; they fear health center vehicles will not offer protection against immigration officials. Additionally, some states have introduced legislation that denies undocumented immigrants the right to obtain a valid driver's license. Even in cases where farmworkers know how to drive and have the means to purchase a vehicle, they are forbidden to drive since they lack legal documentation.

“The health center had to resort to providing transportation services from several times a week to one time a week (only Thursday night) because fewer farmworkers were using the transportation services. Many farmworkers feared that the health center van could not guarantee their safety in the case of being pulled over by immigration officials.”

– Migrant Health Professional, Community Forum Transcripts

“There are a lot of bills being passed. The SB529 is the one that has really impacted our outreach outcomes, it’s the driver’s license bill... now a person is not able to get a driver’s license without proper identification, and if you are found to be driving ...without a driver’s license, they will seize your vehicle. So now, even though our outreach efforts are there, and we are getting them registered and we are getting referrals to the physicians, the clients aren’t going to the appointments.”

– Migrant Health Professional, Community Forum Transcripts

Many health centers are unable to provide transportation services because of issues related to liability and lack of funding. Exorbitant insurance rates are forcing some health centers to cutback or eliminate existing transportation programs or not consider implementing new programs. Some administrators also indicated that the high costs associated with allocating staff time to provide transportation has forced them to cut back on this service. Other participants indicated that their staff hours are already fully maximized, which means they simply cannot fulfill community transportation needs.

“...To insure vans cost \$9,000 per van, and it was no longer feasible so we had to discontinue the transportation program in our area ...”

– Migrant Health Professional, Community Forum Transcripts

“Our program addresses the transportation challenge by enlisting the support of promotores to provide transportation services to farmworker patients. The health center avoids liability issues but takes responsibility for the promotores mile reimbursement.”

– Migrant Health Professional, Community Forum Transcripts

One issue that the participant’s health center ran into was transportation, specifically staff using their personal vehicles and personal liability coverage.

– Health Center Administrator, Telephone Survey Notes

Lack of Information and Knowledge

As mentioned above, the online survey respondents reported that farmworkers’ lack of information and knowledge about available services was the second-most reported barrier to care. It was also the second most reported barrier to care among emerging farmworker populations (see Figure 3, page 37). Many farmworkers and outreach staff expressed concern about farmworkers not knowing where and how to access health care services.

“Some people are not aware of what services are offered or which services are provided in the area ...they lack information such as how to use these services.”

– Migrant Health Professional, Community Forum Transcripts

Community forum and focus group participants indicated that farmworkers experience confusion when trying to navigate health delivery systems. A number of participants believe farmworkers need education on topics that would help them improve their experience while accessing care at health centers. Many farmworkers are simply unfamiliar with U.S. health care systems. Many participants cited farmworkers’ need for easy-to-understand information about topics such as purchasing medications, local transportation options, applying for insurance programs, and scheduling appointments. Moreover, some participants also suggested that language barriers also contribute to farmworkers’ lack of information and knowledge about services, noting that information is not always available in preferred farmworker languages.

In addition, numerous outreach staff indicated the variation between health care systems across states adds to farmworker confusion. This is particularly problematic for migrant farmworkers as they are required to continually invest time and effort re-educating themselves about available health and social services with each new community.

Moreover, health center administrators also mentioned that health care programs are often restructured, downsized, or eliminated because of program funding fluctuations and Medicaid cuts. Again, this poses a significant challenge for farmworkers who must understand current health insurance programs.

Insurance Eligibility

Based on the 2007 Uniform Data Systems (UDS), the majority (56%) of farmworker patients served by migrant and community health centers were uninsured (n=744,809). The remaining 44% received coverage via Medicaid, Medicare, State Children's Health Insurance Program (SCHIP), or other public or private insurance. Thirty percent of all farmworkers received regular Medicaid, while 2% received Medicare and less than 1% received SCHIP. Data generated from the NAWS portray a more distressing reality of farmworkers' health insurance status; 74% of farmworkers surveyed reported not having any form of health insurance.²⁵

Recent data about farmworker spouses and children's health insurance status provides a more optimistic outlook for farmworker family members. According to NAWS data, 33% of farmworker spouses are insured while 47% of farmworker children are insured.²⁶ The data retrieved from the 2008 *Migrant and Seasonal Head Start Program Information Report* (PIR) indicates that 85% of children enrolled in Migrant and Seasonal Head Starts have insurance (n=36,271).²⁷ The percentage of children with insurance may be higher among Migrant and Seasonal Head Start children than the general farmworker children population due to the additional support and social services offered by Migrant and Seasonal Head Start programs.

One of the biggest barriers to health care faced by farmworkers is insurance eligibility. Data resulting from the community forums, focus groups, and telephone surveys suggests that many farmworkers do not qualify for state and federal insurance programs or public and private insurance options. Many farmworkers are not eligible for insurance programs due to documentation status.

Additionally, some believe farmworkers' true socio-economic status and ability to cover medical expenses is misrepresented due to unreasonable income requirements. Farmworkers are frustrated by this experience and confused by the eligibility requirements. These situations can be especially troublesome for farmworkers migrating to states where eligibility requirements vary. Consequently, many farmworkers opt to forgo care to avoid medical expenses provided by a system they do not understand.

“My wife and I applied [for Medicaid] because she was having problems with her back and required an expensive surgery, but [at the clinic] they told us that we made a lot of money. The reality is that we don't. It seems like [at the clinic, they think that] everyone makes a lot of money, and they do not want to help anyone. This affects you a lot; they said we made a lot of money and did not want to help us.”

– Head Start Parent or Advocate, Focus Group Transcripts

“A very strong need at the health center is medical coverage ...we are farmworkers, they are taking money from our checks, but we do not have any access to medical coverage... it doesn't matter if we are Russian or Mexican, we are human beings that deserve to be seen.”

– Head Start Parent or Advocate, Focus Group Transcripts

“I go to Michigan and over there in Michigan there is assistance available for health, they charge you \$25 per treatment. But then in Florida they charge \$100 and up, \$150 or \$160 per treatment. That means that there are some places in which assistance is available for immigrants and some others where it is not.”

– Head Start Parent or Advocate, Focus Group Transcripts

Their challenge is not outreach; they can find the patients and help bring them to the health center. The problem is that the patients are uninsured; they are not legal, and not eligible for service covered by Medicaid.

– Health Center Administrator, Telephone Survey Notes

Alternative Care Options

With a myriad of barriers preventing farmworkers from accessing health care services, farmworkers sometimes seek alternative care options. Some alternative health care preferences emerged from the focus group data, emphasizing differing ways in which farmworkers address health conditions. Some focus group participants cited the important role of *compadrismo*, a cultural practice in which strong bonds and camaraderie are forged among Latino community members. According to participants, it plays an important role in creating a social support system wherein farmworkers rely upon neighbors, friends, and family for home remedy advice and recommendations. Further, many participants indicate that farmworkers are known to use herbal or natural remedies to alleviate certain ailments.

“[We go] with a *compadre* that knows ...or with the *comadrona*. The Latinos can regularly go 10, 11 years without visiting the doctor because they use home remedies that people tell them to use. They take any herb that the *compadre* tells them to use.”

– Head Start Parent or Advocate, Focus Group Transcripts

A large majority of focus group participants report that farmworkers rely on obtaining medicines from Mexico since they are far less expensive and prescriptions are not required. Farmworkers can easily access medications and frequently place orders for prescriptions with people traveling to and from Mexico. Additionally, some focus group participants reported that medications are oftentimes obtained from Mexican grocery stores in the U.S.

“When I need medicine, my father and mother-in-law go to Mexico in July and bring more medicine when they come back.”

– Head Start Parent or Advocate, Focus Group Transcripts

“We had to bring penicillin, which is what you mostly bring. We had to bring Sufatiasol because the person injured his foot. My *compadre* told me ‘Can you go to Tijuana?’ And I tell him ‘Yes.’ He tells me, ‘Listen why don’t you bring me all of these [medications]?’ We brought it for him and then I told him, ‘What is it that you have?’ It was pitiful to see the condition of his foot. And he continued to go to work with an injured foot.”

– Head Start Parent or Advocate, Focus Group Transcripts

Without insurance and the financial means to access health care services, farmworkers frequently resort to other forms of self-treatment. Focus group participants mentioned that farmworkers either handle health conditions themselves or completely ignore the condition. The general sentiment among focus group participants suggested that farmworkers do not have a choice and must resort to these alternative self-care options that could potentially aggravate existing health conditions.

“Do you know what happens when there is no medical support? You resort to brutality. A while ago I had a problem with a [toe] nail and I ended up removing it myself. A vacuum cleaner fell on me. My nail turned black and I said, ‘What am I going to do?’ There is a little infection there. Okay, I have to remove my nail. I have to take it out. You turn into an animal, sadly ...There comes a time when you say, ‘Ok, I will tolerate my pain and deal with the problem because this will turn into a severe problem.”

– Head Start Parent or Advocate, Focus Group Transcripts

Summary

The findings in this needs assessment are consistent with previous findings. Once again lack of transportation (67%) ranked first, followed by lack of knowledge of available services (58%), and cost of health care services (48%). However, emerging populations experience a unique set of barriers including language/lack of interpretation services (78%), lack of knowledge about available services (70%), and cultural differences (59%). Transportation emerged as a significant barrier to both farmworkers and health centers, as managing the costs and logistics can be equally burdensome. The qualitative data exposed that farmworkers lack information about health services and that farmworkers often use alternative care options due to existing barriers to care. Lastly, insurance eligibility was also a significant barrier; 74% of farmworkers reported that they do not have any form of health insurance.

The following section presents findings about how fears associated with health conditions, health clinics, immigration status, and discrimination are significant barriers that discourage farmworkers from accessing health care services.

Fear of Health Conditions

Based on qualitative data from farmworkers and outreach staff, farmworkers experience fear on many different levels, one of which is knowing about their true health status. Though farmworkers admittedly may be battling an illness, they are simply afraid to face the ramifications for their medical conditions. According to some participants, this fear is further intensified by farmworkers' perceptions concerning the financial, emotional, and physical costs associated with treating a condition. At times, the fear is all consuming, appearing to be easier for participants to deny their conditions and continue life as usual.

“Farmworkers don’t want to recognize that they may be ill. Fear of knowing that they have a chronic disease or infection is fearsome for some individuals.”

– Migrant Health Professional, Community Forum Transcripts

“They don’t want to face their health issues due to costs or because of their fear.”

– Migrant Health Professional, Community Forum Transcripts

Fear of Health Clinics

Qualitative data also revealed that farmworkers' fear is generated from health clinic personnel. The term, “health clinic” used here refers to any number of health institutions that a farmworker may visit, such as hospitals, health centers, and other public clinics. Some data from community forum participants indicate that farmworkers believe that health clinic staff has ulterior motives for reaching out to the community. This lack of trust can become so extreme that it turns into fear. It was repeatedly reported that some farmworkers are skeptical and cautious when interacting with outreach staff.

“Sometimes farmworkers don’t want to participate because they are wondering what we [outreach staff] are doing there, they think ...are they doing an investigation, a study on me? Is everything that they ask ...lies? They [outreach staff] are not sincere.”

– Migrant Health Professional, Community Forum Transcripts

Other community forum and focus group participants reported that farmworkers fear being mistreated by health clinic staff. Participants repeatedly mentioned concern over farmworkers' experiences with front desk staff from health clinics, citing their insensitivity.

One participant felt that the fear in many farmworkers minds was that the health clinic would not hire the right staff that will treat them appropriately. – Migrant Health Professional, Community Forum Notes

Fear and Immigration Status

A significant number of community forum, focus group, and telephone survey participants described situations where farmworkers and their families live in fear due to their lack of legal documentation. In other words, farmworkers fear breaking the law, which could lead to losing their jobs and deportation. According to participants, farmworkers find themselves in extremely vulnerable positions if they do not have proper legal documentation; they are oftentimes perceived as powerless and become targets for abuse and maltreatment. Moreover, many needs assessment participants commented that undocumented farmworkers rarely trust anyone and find themselves questioning their safety and security at all times. Because of this fear, they often resort to living in the shadows of society not wanting to be discovered, even by health clinic personnel.

“You see when you’re talking to farmworkers, they’re kind of scared. They’re listening to you, but maybe don’t believe you. Their arms are crossed; they’re looking around – maybe thinking immigration is coming or something.”

– Migrant Health Professional, Community Forum Transcripts

One participant commented that fear and public charge concerns are difficulties. Many in the group agreed. Some farmworkers don’t open up unless they really feel trust.

– Migrant Health Professional, Community Forum Notes

As previously mentioned in this report, the current immigration climate is pervading throughout many agricultural communities in the U.S. Some states have even promoted policies that have negatively impacted the health of immigrant farmworkers and their families. Several community forum and focus group participants reported that in some states, farmworkers were unable to apply for a driver’s license without proof of legal documentation status. While this contributes to transportation as a barrier to care, it also is a factor in creating fear and insecurity among the farmworker population.

According to a few focus group, community forum, and telephone survey participants, the message sent to the farmworker community is that they are void of basic rights, regardless of how much they contribute to the agricultural economy. This finding was further reinforced by focus group participants who frequently reported a need for legal rights education.

“It could be good to give them information, a brochure or something about their [farmworkers] rights, with and without legal documentation. It is important for them to learn about their rights, that way people would not feel afraid to defend their rights.”

– Head Start Parent or Advocate, Focus Group Transcripts

Additionally, several needs assessment participants also iterated that law enforcement officials are being trained by immigration officials and given the authority to ask farmworkers for documentation in some regions of the U.S. Moreover, many farmworker communities have witnessed an increase in raids. Undocumented farmworkers must face the possibility of being deported back to their countries of origin and separated from family and loved ones in the U.S. Moreover, many farmworkers must also bear the loss of their livelihood as well as the numerous emotional, physical, and financial costs associated with re-entering the U.S. Not knowing when or where these raids will occur, farmworkers are reported to be hyper-vigilant, oftentimes demonstrating a reluctance to trust people they do not know; this tactic helps farmworkers manage feelings of fear and uncertainty about being deported.

“The problem is that everyone is afraid because of what happened; ...they have taken people, immigration has taken people; so there are many illegal people without health services.”

– Migrant Health Parent or Advocate, Focus Group Transcripts

“...A lot of the police departments and sheriff’s departments are having deputies and police officers trained by ICE, and they have been given the authority to ask an individual for documentation, so they [the farmworkers] are hit with a double whammy when they are stopped. They don’t have a driver’s license, then if they don’t have legal status in the United States, they are detained and ICE is called.”

– Migrant Health Professional, Community Forum Transcripts

Recent immigration policies have had a chilling effect on migrant workers ...There have been raids on farms and meat packing production plants. The general sentiment in the state is that the population is not wanted. As a result the health center has seen decreases in [clinic] numbers over the years.

– Health Center Administrator, Telephone Survey Notes

Many participants talked about how some states prohibit undocumented people from accessing public health and social services. More health clinics are facing stringent state and county funding restrictions that deny or limit the provision of health care services to undocumented workers.

In the last few years, restrictions have been instituted on funding; no public dollars can be used with undocumented workers. This extends into county-level funding as well; the administrator’s health center can’t use county dollars for farmworker programs. This has been a restrictive factor over the last several years. Nevertheless, this has not prevented them from funding the farmworker program with federal dollars and program income.

– Health Center Administrator, Telephone Survey Notes

A couple of community forum participants commented that one law is so extreme that it penalizes providers with jail time if they are found providing services to undocumented persons. A few focus group participants believe that in some states service providers are required by law to report undocumented persons seeking health care services. This poses a significant challenge to farmworker outreach personnel who must help farmworkers distinguish between facts and myths associated with accessing to care. This is no easy task with so many farmworker community members disseminating information, which is sometimes incorrect, about potential raids and risky situations.

“... The anti-immigrant laws are very strong... At the hospital, even when they receive federal and state funds; they are denying the service [to undocumented people.]”

– Head Start Parent or Advocate, Focus Group Transcripts

Discrimination

Focus group and community forum participants also discussed the inequitable treatment suffered by farmworkers in the workplace. Farmworkers living in the United States can experience discrimination, racism, and intimidation by their employers. According to many focus group and community forum participants, farmworkers are frequently threatened by their employers with lost wages, loss of work, or deportation if they miss work or object to unhealthy working conditions. As a result, many farmworkers are fearful to protest and advocate for themselves. Instead, participants believe that farmworkers will endure inhumane working conditions, abuse, and poor treatment because they do not see any other choice.

“Like they said, we do not have many benefits ...It is because of the fear of immigration. Where I am working, there is a foreman there, and he scolds us. He says it does not matter if people go to Legal Aid. They intimidate you so you do not speak up for yourself. For this reason, farmworkers just back off.”

– Head Start Parent or Advocate, Focus Group Transcripts

“Farmworker are afraid of being deported and unwilling to take a chance and will forgo appointments.”

– Head Start Parent or Advocate, Community Forum Transcripts

Some focus group participants discussed situations where employers provided little to no pesticide education to farmworkers. In these situations, if farmworkers had insisted on improved pesticide trainings, employers may have denied their request or worse, they may have fired the farmworkers for raising the issue. Additionally, one focus group participant described a situation in which a grower refused to assume financial responsibility for a hospital bill resulting from the death of a farmworker who was struck by lightning on the job.

“My cousin was struck by lightning in the fields and died ...and then there was the bill ...they asked us [the family] to pay for it ...we were told that the farmer was going to pay for it but no, that did not happen. Just this past week, I received a letter letting me know that they were going to send the bill to the credit service. They are charging us almost \$11,000 for my cousin who died.”

– Head Start Parent or Advocate, Focus Group Transcripts

“And it’s because they saw that they were spraying the fields and everyone started to feel bad. And they told the foreman. And the foreman ignored them ...and I said to the farmworker, ‘why don’t you do something?’ and he said ...‘No, they don’t pay us any mind or if we say something, they are going to fire us.’”

– Migrant Health Professional, Community Forum Transcripts

Additionally, focus group and community forum participants discussed situations where farmworkers actually had legal documentation but still did not receive proper treatment from employers and other members within a community, including health clinic personnel. In particular, focus group participants discussed personal stories of mistreatment and abuse in seeking health care services, explaining situations where they were ignored or treated poorly during medical encounters. Many believe this treatment is the result of discrimination and racism, often believing that if they were not immigrants they would be treated better.

“Even crossing legally, I didn’t know the rights that we have in this country when I arrived. But now I do and it doesn’t matter. You are not treated adequately, whether you are legal or not legal. There is a lot of discrimination, a lot of racism.”

– Head Start Parent or Advocate, Focus Group Transcripts

“I left in tears just from seeing how they treat you. And I said, ‘Where are the rights in this country?’ I arrived less than two months earlier and I worked in a hospital in Tijuana and I was never treated like that. And you come here hoping that your life expectations improve and that they treat you like a human being. And to see the doctor behave as he did, as if what you are saying does not interest him. He’s going to give me what he wants to give me. I left in tears.”

– Head Start Parent or Advocate, Focus Group Transcripts

Summary

As evidenced by the qualitative data, it is clear that fear, fear due to immigration, and discrimination play a pivotal role in preventing farmworkers from accessing health care services. Farmworkers fear knowing their true health status because of existing barriers to care. Farmworkers sometimes also fear the health delivery system or health care providers, possibly feeling discrimination or lacking trust. Fear of immigration came up over and over in the qualitative data. Head Start parents and advocates discussed the fear of being undocumented; migrant health professionals discussed the challenges of serving undocumented farmworkers; and, health center administrators stated how very little funding exists for undocumented patients.

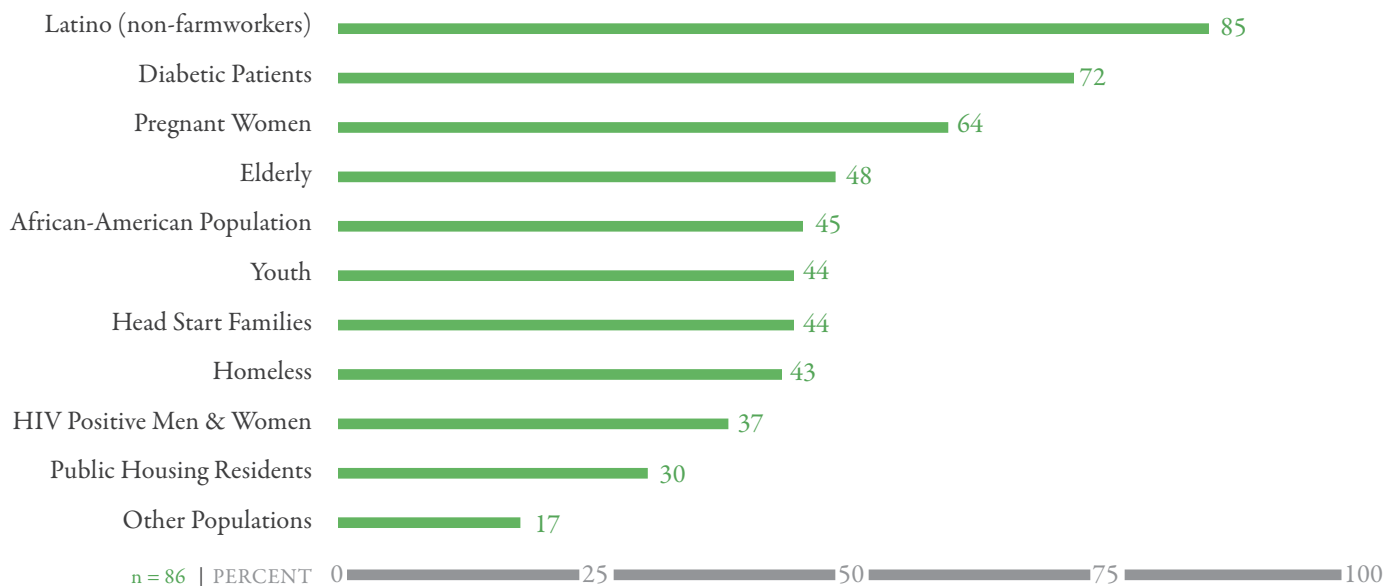
OUTREACH AND ENABLING SERVICES DELIVERY

The quantitative and qualitative findings presented in this section provides a snapshot of outreach and enabling services implemented by migrant and community health centers nationwide. Specifically, this section includes information about target populations, duration, locations, activities, current challenges, and future priorities for the delivery of outreach and enabling services.

Populations Served & Outreach Settings

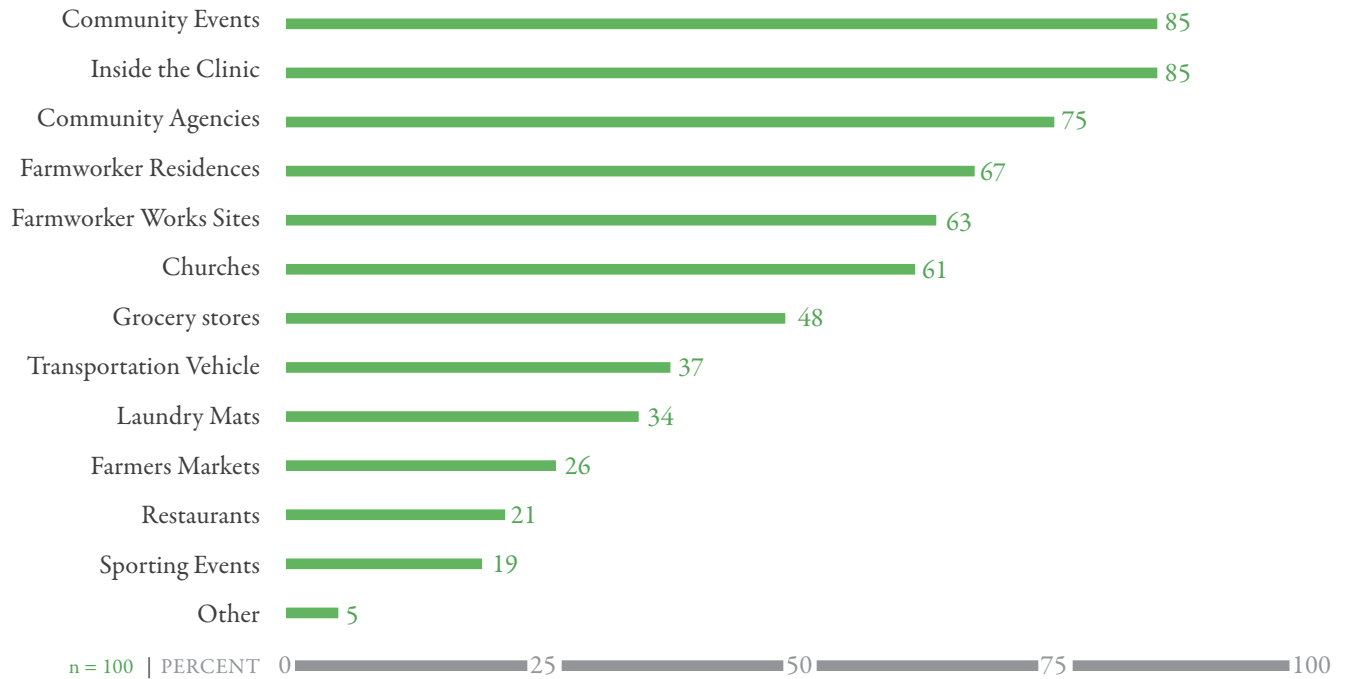
Nearly all (99%) online survey respondents provide outreach and enabling services to farmworkers and their families (n=102). However, serving the farmworker population is only part of the picture; numerous other populations benefit from these services as well. Figure 4 demonstrates the breadth of outreach and enabling services beneficiaries including other Hispanic/Latino populations (non-farmworkers), pregnant women, and public housing residents, amongst others. Since respondents could select multiple answer choices, the populations delineated in Figure 4 are not necessarily mutually exclusive.

FIGURE 4 : OTHER POPULATIONS SERVED BY OUTREACH & ENABLING SERVICES



Despite serving multiple populations, health centers maintain a consistent commitment to farmworkers and their families throughout the year. Four of five (82%) online survey participants offer outreach and enabling services year-round to farmworkers and their families (n=100). Figure 5 reveals that these services are offered at a variety of locations; the most commonly selected included community events and celebrations (85%), inside the clinic (85%), and community agencies (75%) (Figure 5).

FIGURE 5 :
LOCATIONS FOR PROVIDING OUTREACH & ENABLING SERVICES



Uniform Data System (UDS) results indicate that enabling service encounters comprise of 11% of all encounters nationwide (n=2,837,910); this figure includes encounters for case managers and patient/community education specialists only. Outreach workers, transportation staff, eligibility assistance workers, or other enabling services professionals are not included in this definition.²⁸

Most Frequently Performed Outreach Activities

In order to gain a snapshot of the current composition of outreach and enabling services, online survey participants were asked to select their three most frequently performed services (Table 6). Health education was most commonly selected (50%), followed by basic health screenings (38%), health fairs and community events (37%), and interpretation (33%). Table 6 demonstrates the full range of activities including case management, referrals, transportation, language services, and appointment setting.

TABLE 6 :
MOST FREQUENTLY PERFORMED OUTREACH ACTIVITIES & OUTREACH ACTIVITIES OF HIGHEST PRIORITY IN THE NEXT TWO YEARS

Activity	Most Frequently Performed Outreach Activities (n=100)		Outreach Activities of Highest Priority in the Next Two Years (n=99)	
	Rank	Percentage (%)	Rank	Percentage (%)
Health education	1	50	1	50
Basic health screenings	2	38	2	39
Health fairs / community events	3	37	5	22
Language services / interpretation	4	33	6	19
Registration/eligibility	5	23	4	27
Case management	5	23	3	29
Clinical outreach	5	23	2	39
Referrals	6	21	8	14
Transportation	7	17	7	16
Appointment setting	8	15	9	12
Follow-up	9	7	10	10
Health system orientation	10	6	7	16
Paperwork orientation	11	4	11	4
Other	12	3	12	1

Qualitative findings also reflected a wide breadth of outreach activities and approaches. Numerous participants mentioned additional activities such as providing information, screening events, transportation services, home or worksite visits, health education, and health fairs.

“We go out and knock on doors to inform farmworkers about the services available.”

– Migrant Health Professional, Community Forum Transcripts

“Someone goes out every Wednesday to look for new camps (or old camps with new workers). They describe our services, give an orientation to the health center, what we’re there for, etc. and give education on immunizations, chronic disease, etc. Then they set up an appointment for a provider to go out the following week ...”

– Migrant Health Professional, Community Forum Transcripts

“We do screenings (high blood pressure, glucose, etc.). We go inside the companies. We have super access. Also we are well known in the community and can go in the radio station any time.”

– Migrant Health Professional, Community Forum Transcripts

“...That way besides all the help we can give them, including medication, transportation, we help them apply for any of those programs so that if they have to see a specialist, we network with specialists that will take [state health insurance program] or free-care.”

– Migrant Health Professional, Community Forum Transcripts

“Organizing health fairs is one way to build relationships.”

– Migrant Health Professional, Community Forum Transcripts

Future Priorities of Outreach

When asked to select the three highest priorities for outreach and enabling services in the next two years, the most frequently cited responses by online survey participants were remarkably similar to the top three current outreach and enabling services (Table 6). Health education, basic health screenings, and clinical outreach were ranked the top three respectively (Table 6).

Telephone survey respondents were also asked to comment on one or two of their long-range goals for their organization’s outreach and enabling services. A few themes surfaced including implementing lay health worker programs, integrated outreach services, hiring more outreach staff, and expanding specific outreach services like transportation and case management services.

The administrator wants to make the lay health program a year-round program.

– Health Center Administrator, Telephone Survey Notes

The administrator intends to apply for funding for the *promotora* program.

– Health Center Administrator, Telephone Survey Notes

The administrator mentioned that instead of having an outreach program separated by special populations, they would like to integrate the program. “I’d like to cross train all outreach personnel so that they can serve all the different types of special populations.” The administrator feels the competencies for all outreach personnel are similar. “The populations may have different health care needs, situations, and barriers, but the types of persons needed for the job and strategies tend to be similar.”

– Health Center Administrator, Telephone Survey Notes

The administrator would like to have enabling service staff at each health center. S/he would like to have an outreach team at each site. S/he also expressed a strong wish to continue to have teams that don’t stay at the health center but rather are working in the community.

– Health Center Administrator, Telephone Survey Notes

The administrator commented that there is a need for more than one outreach worker; their current staffing is not enough and as such, at least one more is needed.

– Health Center Administrator, Telephone Survey Notes

The administrator commented that s/he would like their health center to add more case management services. Their health center defines case management as part of their outreach functions. The administrator feels that it is really important to follow-through with patients in

order to be compliant with medical and treatment plans.

– Health Center Administrator, Telephone Survey Notes

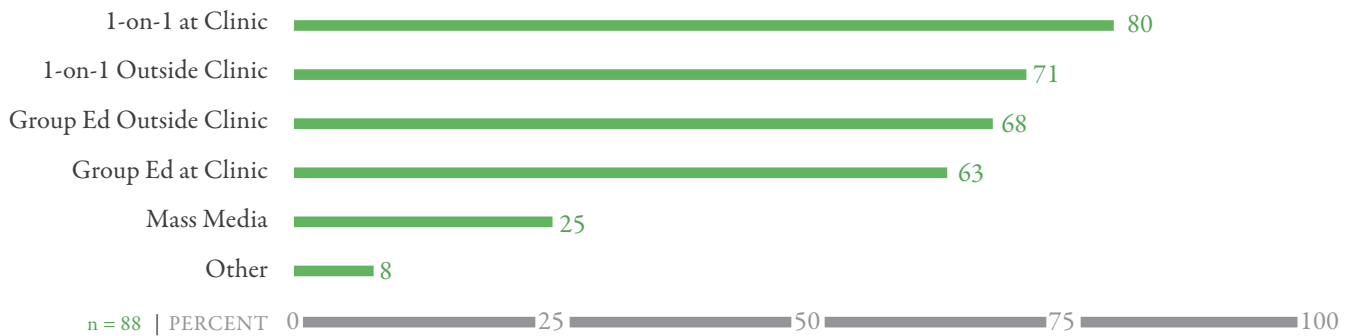
The administrator reported that one of their most important goals is to purchase vehicles to transport migrant farmworkers. The migrant labor camps are widespread and are long distances from the health center. The interviewee mentioned, “farmworkers would not obtain the care they need if they don’t bring the farmworkers to the health center.”

– Health Center Administrator, Telephone Survey Notes

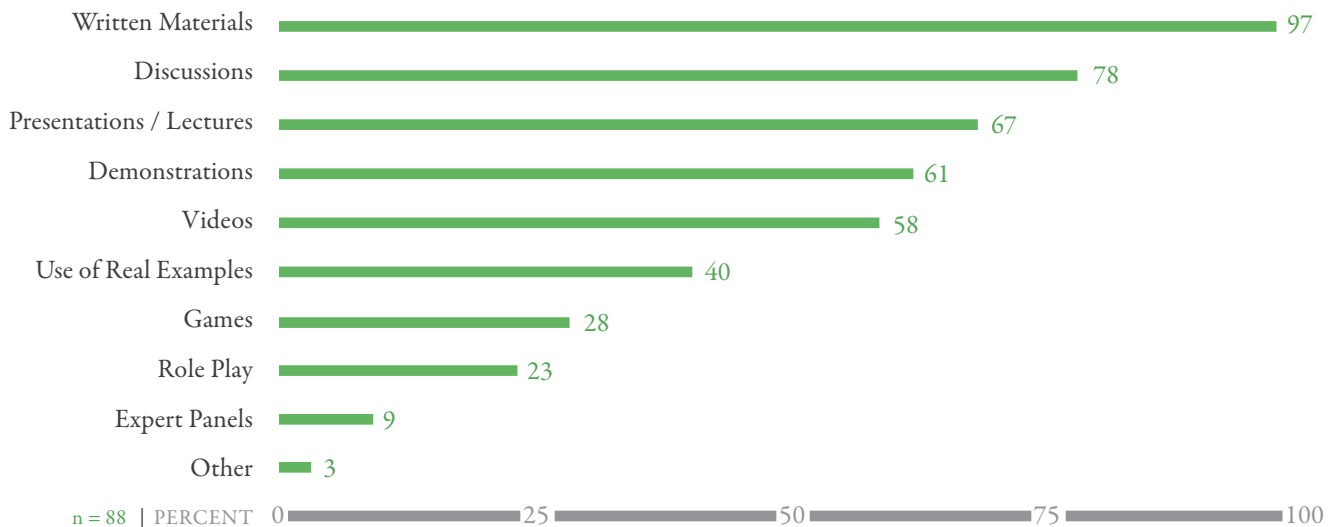
Health Education

Health education was the most frequently cited outreach and enabling service by online survey respondents. Specifically, 88% of respondents conduct health education activities with farmworkers and their families (n=100). Numerous formats and techniques are used to deliver these activities (Figures 6 and 7). One-on-one health education at the organization was the most frequently-cited format (80%), while mass media was mentioned least frequently (25%) (Figure 6). Online survey respondents reported using various health education techniques with written materials (97%), discussions (78%), and presentations/lectures (67%) among the top three approaches (Figure 7).

**FIGURE 6 :
FORMATS USED TO DELIVER HEALTH EDUCATION**



**FIGURE 7 :
HEALTH EDUCATION TECHNIQUES USED**



Despite these efforts, numerous focus group participants indicated a need for more health-related information and education, especially on pesticides.

“[Referring to health education] Because if not, we are never going to get out of the same old thing... it is important that people know... [what] happens with pesticides, what the symptoms [are]... and everything they can take so that they protect themselves a little and take precautions.”

– Head Start Parent or Advocate, Focus Group Transcripts

“...Give more information to the farmworkers. Pesticide workshops about how, when they get home, not to enter with dirty clothes. Or take into account that they have children and children can get sick simply by touching them or smelling them. They get contaminated. That is, it would be very good to give farmworkers workshops about all this.”

– Head Start Parent or Advocate, Focus Group Transcripts

“I have seen many [farmworker] parents with their clothes covered with chemicals; you can even notice the chemicals. Then if they hug their 3-month old child, and wrap them with their arms, then they are contaminating them. Then this is a lack of responsibility as a parent, and it is lack of motivation also.”

– Head Start Parent or Advocate, Focus Group Transcripts

One participant highlighted a connection between health education as a means for addressing potential cultural barriers or differences.

“We also found that education on different health issues that affect your target population is very important ...So just letting them see that you care and educating them about their particular circumstances, helps bridge the gap that there may be between cultural barriers.”

– Migrant Health Professional, Community Forum Transcripts

Another participant highlighted the critical role of health education directed at chronic disease and prevention efforts.

“...Not just health care is being provided, but health education and prevention, you know, which is very important, especially for those that are diabetics and those that have chronic diseases that can be taken care of in a preventive manner.”

– Migrant Health Professional, Community Forum Transcripts

Approaches & Challenges to Delivering Outreach

Community forum, telephone survey, and focus group participants also suggested that a program’s approach to providing outreach and enabling services is absolutely critical to how they are received by community members. Participants highlighted the importance of persistence, trusting relationships, working outside the clinic setting, and partnerships. These comments reflect the need for dependable, field-based outreach and enabling services.

“We believe we have to keep going, and go back, and go back, and go back.”

– Migrant Health Professional, Community Forum Transcripts

“I think that this needs to be very constant. Whatever is done, whatever is there, has to be constant. Not go some months and not other months. It has to be something permanent ...so that it can give security to the worker ...”

– Head Start Parent or Advocate, Focus Group Transcripts

The administrator commented that they will forever and always need to get to outlying areas and that there is no way they can do that without getting out of the clinic.

– Health Center Administrator, Telephone Survey Notes

“I think the main thing is we have to try to find more ways or visit them more often so we can make the way of trust. So they’re going to believe what you say, that you aren’t going to hurt them.”

– Migrant Health Professional, Community Forum Transcripts

“It’s very important to follow through! If you don’t, they won’t trust you. Set promises you can keep.”

– Migrant Health Professional, Community Forum Transcripts

“...It is important to build a trust and the reputation of your program in the community. If they respect your program, you will get the information that you need, and that happened to us.”

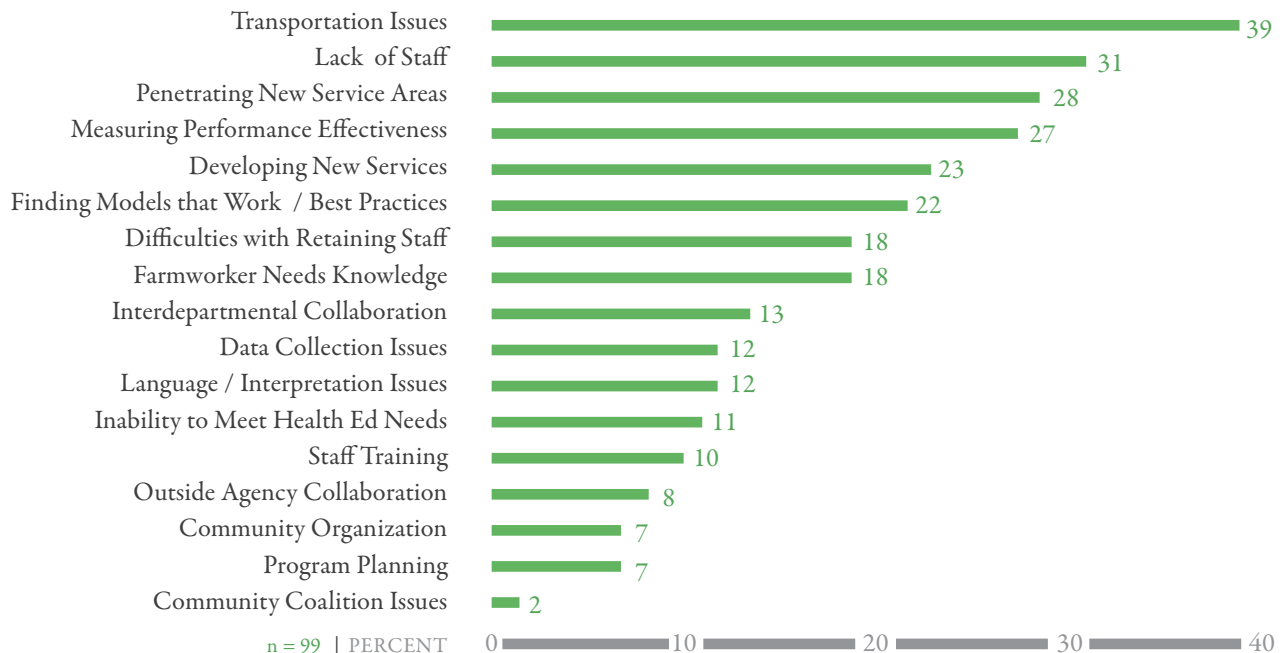
– Migrant Health Professional, Community Forum Transcripts

“If screenings are high or have abnormal results, they not only make follow-up appointments, but [we] try hard to make them comfortable by providing for the emotional part, not just the physical.”

– Migrant Health Professional, Community Forum Transcripts

Skillfully providing a range of outreach and enabling services inherently involves addressing various challenges. Online survey respondents were asked to identify the three most common challenges, aside from securing funding, their organizations confront in providing outreach and enabling services (Figure 8). Transportation issues (39%) and lack of staff (31%) ranked as first and second most common challenges respectively. Interestingly, challenges related to transportation and staffing were cited across multiple needs assessment participants and methods. For more information on transportation please see the Barriers to Care section, page 37; for other staffing capacity issues see the Staffing section, page 58.

FIGURE 8 : CHALLENGES WITH PROVIDING OUTREACH & ENABLING SERVICES



Participants repeatedly commented on their concerns with addressing barriers to care, particularly confronting farmworker fears.

“The most significant challenge now is, how do we access the migrant community, where do we access them, and how do we approach them once we DO find them without scaring them or offending them?”

– Migrant Health Professional, Community Forum Transcripts

Summary

Qualitative and quantitative data alike reflect the diversity of current approaches to outreach and enabling services as well as their respective challenges and future directions. The findings reveal that farmworkers need and desire more accurate information on topics such as legal rights, public benefit options, and managing chronic diseases. Additionally, there is an essential need for services to be delivered by programs that invest in building trusting, consistent relationships with the community. Outreach is performed in a variety of locations; the top two include inside the clinic (85%) and at community events and celebrations (85%). Health education ranked number one for both current outreach activity and most desired future outreach activity.

OUTREACH AND ENABLING SERVICES FUNDING

The following section describes findings on specific financial data, funding landscape for outreach, and funding challenges. The majority of these data come from the Uniform Data System (UDS) and telephone surveys with health center administrators.

Outreach Costs and Funding Sources

The 2007 Uniform Data System (UDS) indicated there were a total of 1,249 delivery sites averaging, 8.5 sites per health center. Services were delivered to 739,790 migrant and seasonal farmworkers and their dependents across the United States; comprising of 21% of the entire patient population.²⁹

The average cost for providing outreach and enabling services to all users in 2007 was 1.3 million dollars per health center. This figure includes services provided to farmworker users as well as all other users accessing care at Migrant and Community Health Centers. On average it cost each health center a total of \$55.00 per user to provide outreach and enabling services. This figure should be interpreted with caution as it applies to all users and does not account for whether or not each individual user received enabling services.³⁰

Of the 24 participants completing the telephone survey, 22 indicated federal funds as a primary funding source for outreach and enabling services. Other funding sources identified included state funding, private foundations, program income, and donations. While some health centers reportedly rely solely on federal funding, most utilized some combination of the aforementioned funding sources to cover the costs of outreach and enabling services.

Funding Challenges

One of the most consistent themes that emerged related to funding challenges was the time-limited nature of funding opportunities. Health centers often need to find additional means of support beyond federal funding to adequately finance outreach and enabling services. Because most of these services are non-reimbursable, health centers often absorb additional costs or seek grants to meet the financial needs. The grant opportunities available are reportedly episodic, only covering short periods of time such as one to two years. This forces health centers to continuously seek new funding sources, submit multiple grant applications, and struggle to sustain or expand their outreach and enabling service programs.

The administrator shared that their health center has to continue to reapply; if they lose funding for a year, they do not have money to pay that staff person.

– Health Center Administrator, Telephone Survey Notes

“Funding ending leaves everyone hanging.”

– Migrant Health Professional, Community Forum Transcripts

... Not too many people fund outreach and enabling services. These services are only funded for a year or two. There is no source of ongoing funding for education and outreach. Funding is very episodic.

– Health Center Administrator, Telephone Survey Notes

Continually seeking new funding requires considerable staff time to identify potential funders and prepare applications. The availability of grant opportunities, funding restrictions, general competitiveness, immigration climate, and the economy all influence a health center's ability to secure additional funding to support outreach and enabling services for farmworkers. To read more about the components of a successful grant application, please see Data Collection and Evaluation, page 61.

As a result of the political climate and anti-immigrant policies, the health center has decided not to rely on state funds for supporting their migrant and seasonal farmworker program.

– Health Center Administrator, Telephone Survey Notes

If funding is based on population figures, it’s always a challenge for the health center to secure those grants because the region is less populated, even though the need is just as great.

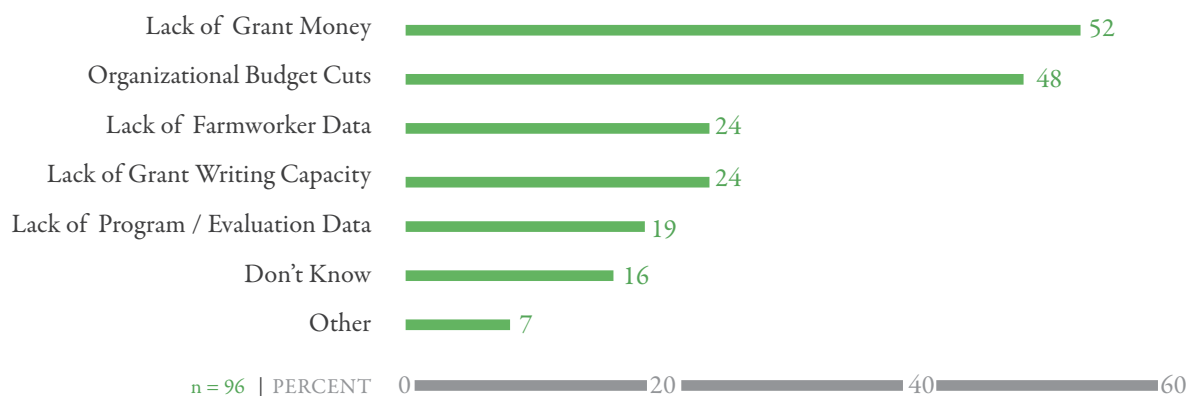
– Health Center Administrator, Telephone Survey Notes

The challenge is that the economy is bad. There is one funding entity that annually raised \$10-\$15 million to distribute out to community agencies but this year they only raised \$5 million. The economy affects the health center because it affects the donors.

– Health Center Administrator, Telephone Survey Notes

Because outreach and enabling services tend to be non-reimbursable, the consequence is that these services are often grant dependent. The health center’s ability to fund outreach and enabling services relies on their ability to identify relevant grants, receive grant awards, and use health center resources to cover costs. According to online survey respondents, the top two challenges that organizations confront in outreach and enabling services funding are the lack of grant money available for outreach (52%) and organizational budget cuts that affect the outreach program (48%) (Figure 9). Without grant funding, outreach and enabling services are more vulnerable to budget cuts. Given these circumstances, sustaining outreach and enabling services is particularly challenging.

**FIGURE 9 :
CHALLENGES WITH FUNDING OUTREACH & ENABLING SERVICES**



There is always a risk of grants running out. The outreach and enabling services are 98% grant funded through government grants. But, there is always a chance that funding will be stopped, especially with ups and downs in the economy.

– Health Center Administrator, Telephone Survey Notes

If the programs are not supported by grant funding then they will be eliminated. “This is a challenge as it’s difficult to sustain an outreach and enabling services program in this way.”

– Health Center Administrator, Telephone Survey Notes

There is no way to get reimbursed for providing these services. FQHC funding is based on cost of providing direct services and anything not directly associated with a medical visit is not reimbursed. There is no way to keep outreach staff on without grant funding and this is one of the major challenges.

– Health Center Administrator, Telephone Survey Notes

Outreach and Enabling Service Capacity

Many administrators interviewed during the telephone survey assert that outreach and enabling services are necessary and important functions of their respective health centers. There is a real commitment to maintain the level of services that are offered. Beyond sustaining services, many telephone survey participants highlighted the need to expand existing outreach and enabling services. While the interest clearly exists to increase the capacity of these services, lack of consistent funding sources restrict programs' ability to grow.

The health center could have as many as two times or three times the workers and have plenty for them to do. The health center can't provide the services at full capacity ...they can barely keep up with what they have.

– Health Center Administrator, Telephone Survey Notes

The scale of what the health center is doing needs to be expanded. The difficulty is not being able to secure funds for a needed activity but rather the scale of what the health center is currently doing is not at full capacity.

– Health Center Administrator, Telephone Survey Notes

The administrator commented that the real question is, "Have we received adequate funding?" The health center can never serve all the people that they need to serve. These kinds of services require resources like time and transportation and you can't just squeeze another appointment out like you could in the clinic.

– Health Center Administrator, Telephone Survey Notes

There are data to suggest that the migrant and seasonal farmworker population is growing by 12% in the health center's service area every year. Nothing else is being done to catch up with that. It would be nice to have expanded staff capacity but the administrator is not seeing funding opportunities available.

– Health Center Administrator, Telephone Survey Notes

Summary

On average, each health center spent about 1.3 million dollars total on enabling services and about 55 dollars per user in 2007. Federal monies made available in early 2009 were specifically mentioned by several administrators as positive opportunities for outreach and enabling services. Despite these critical strides, findings demonstrate that outreach and enabling services funding tends to be precarious and vulnerable to short-stint funding streams, limited number of opportunities, and changes in politics or the economy.

OUTREACH AND ENABLING SERVICES STAFF

The following section includes information on outreach and enabling services staff capacity, organizational culture, and outreach staffing challenges.

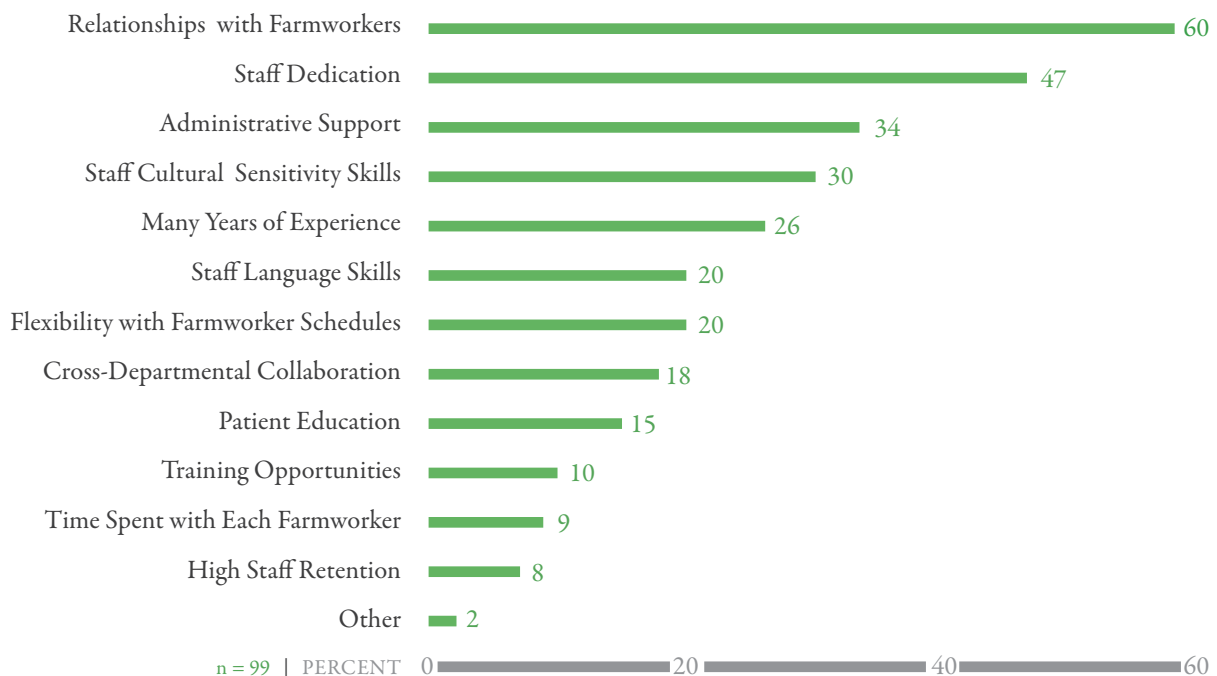
Staff Capacity

Uniform Data System (UDS) for continental U.S. reported approximately 2,147 Full Time Equivalent (FTE) enabling service staff in 2007. FTE staff totals were reported for all health center users, including farmworkers. Each health center employed an average of 15 FTE enabling services staff, of which three FTE were identified as outreach staff. In addition to outreach staff, enabling service staff also included case managers, patient/community education specialists, transportation staff, eligibility assistance workers, and other enabling service professionals.³¹

Organizational Culture

Qualitative findings and online survey results suggested that quality staff and administrative support are key factors in the success of any outreach and enabling service program. The top three characteristics that reportedly contribute the most to the success of outreach services include relationships with the farmworker community (60%), staff dedication (47%), and administrative support (34%) (Figure 10). Committed outreach staff, dedicated administration, and supportive board members were also frequently recognized among telephone survey and community forum participants. Various characteristics are attributed to an organizational culture where outreach and enabling services are valued. Specific qualities that were highlighted include allocating funds for the provision of outreach and enabling services, hiring/training staff, and providing internal training about farmworkers as well as the purpose of outreach

FIGURE 10 :
CHARACTERISTICS CONTRIBUTING TO THE SUCCESS OF OUTREACH & ENABLING SERVICES



“Together everyone achieves more, because we are there for them ...that it’s not just a number for us.”

– Migrant Health Professional, Community Forum Transcripts

“We wouldn’t be able to do what we do without a staff that’s committed to the mission, from the doctors to administration to outreach—they all have a helping hand to ensure we manage our grant and follow-through with our obligations.”

– Health Center Administrator, Telephone Survey Notes

“It’s just a question of priorities.” As the leader of the organization, the Chief Executive Officer makes recommendations about how money is spent and the CEO pushes to make outreach a priority. Outreach is what makes a program great.

– Health Center Administrator, Telephone Survey Notes

Staffing Challenges

Similar to the findings from HOP’s *2005-2006 National Needs Assessment of Farmworker Serving Health Care Organizations*, staffing shortages emerged as a significant challenge for outreach and enabling services programs. Thirty-one percent of online survey respondents identified lack of staff as a key challenge that organizations face when providing outreach and enabling services (see Figure 8, page 53). Lack of staffing resources was also referenced as a challenge to collecting primary source information in needs assessments (52%) and in gathering information needed for outreach programming (42%). More staff time (56%) was also identified as the top need in better evaluating the effectiveness of outreach and enabling services. For more information, please see Data Collection and Evaluation, page 61.

Community forum participants repeatedly expressed difficulty in attaining and maintaining adequately trained staff, specifically in regard to the outreach department and bilingual employees.

One participant worked as the Outreach Coordinator and also as the Transportation Director at his organization and, therefore, did not have the time to do both jobs. The participant indicated more time was needed with the farmworker community. Resources were needed to hire a full time outreach coordinator.

– Migrant Health Professional, Community Forum Notes

“In terms of challenges, we talked about staffing quite a bit, the problem with finding staff, of finding trained staff, or finding bilingual staff and then training them, and the high staff changeover rate.”

– Migrant Health Professional, Community Forum Transcripts

The administrator indicated a lack of specific funding for outreach has led their center to only being able to have one staff person devoted to outreach. This person is stretched to the limit.

– Health Center Administrator, Telephone Survey Notes

Staff Utilization

Available outreach and enabling staff are tasked with increasing access to care for their community’s farmworker population. Frequently, outreach staff members are the face and voice of the health center. According to the telephone survey and the community forum respondents, community health workers and volunteers are often recruited by health centers to venture into the community to provide transportation, teach health education lessons, offer language or interpretation services, and establish trust among the farmworker community. Their ability to connect with the farmworker community and their flexibility are the greatest benefits of utilizing community health workers.

A consistent theme that surfaced among migrant health professionals was the difficulty encountered with balancing competing responsibilities inside and outside of the clinic setting. This tension can become particularly strained when there are significant interpretation demands inside the clinic. This theme was reinforced by online survey findings, indicating that the most common locations for conducting outreach were both inside the clinic (85%) as well as at community events/celebrations (85%). In addition, a third (33%) of respondents cited that language services/interpretation was a frequently performed outreach and enabling service. Although language services/interpretation is an invaluable service, the qualitative data suggests that this demand can interfere with outreach staff's ability to fulfill other essential community-based activities with the farmworker community. For more information, please see the Outreach Service Delivery section, page 47.

“I think one of the challenges is that you hire outreach workers, but because they are bilingual, the organizations start using them in the center as the translator, and you translate for the Medicaid person, you translate for the doctors, and then you're caught up in the office and they don't let your staff do the work they were originally hired for. That's a big challenge.”

– Migrant Health Professional, Community Forum Transcripts

“We get caught up in the clinic environment, and it takes away from my time doing what I'm supposed to do, which is being out in the field with the migrant and seasonal workers, and it's a big problem.”

– Migrant Health Professional, Community Forum Transcripts

“My phone is always ringing off the hook; the health center needs my assistance [with interpretation].”

– Migrant Health Professional, Community Forum Transcripts

“Everybody needs translation, so how do you help everybody? ...You have 200 people that don't speak English...”

– Migrant Health Professional, Community Forum Transcripts

Summary

On average, health centers employ approximately 15 enabling service staff, of which three are considered outreach staff. Staff play an important role for outreach, as the top three characteristics that contribute most to the success of outreach include relationships with the farmworker community (60%), staff dedication (47%), and administrative support (34%). Even in such an atmosphere, however, it can be difficult, if not impossible, to meet the full demand for these services. Adequate staffing levels, mis-utilization, and finding bilingual, trained staff all arose as challenges for outreach programs.

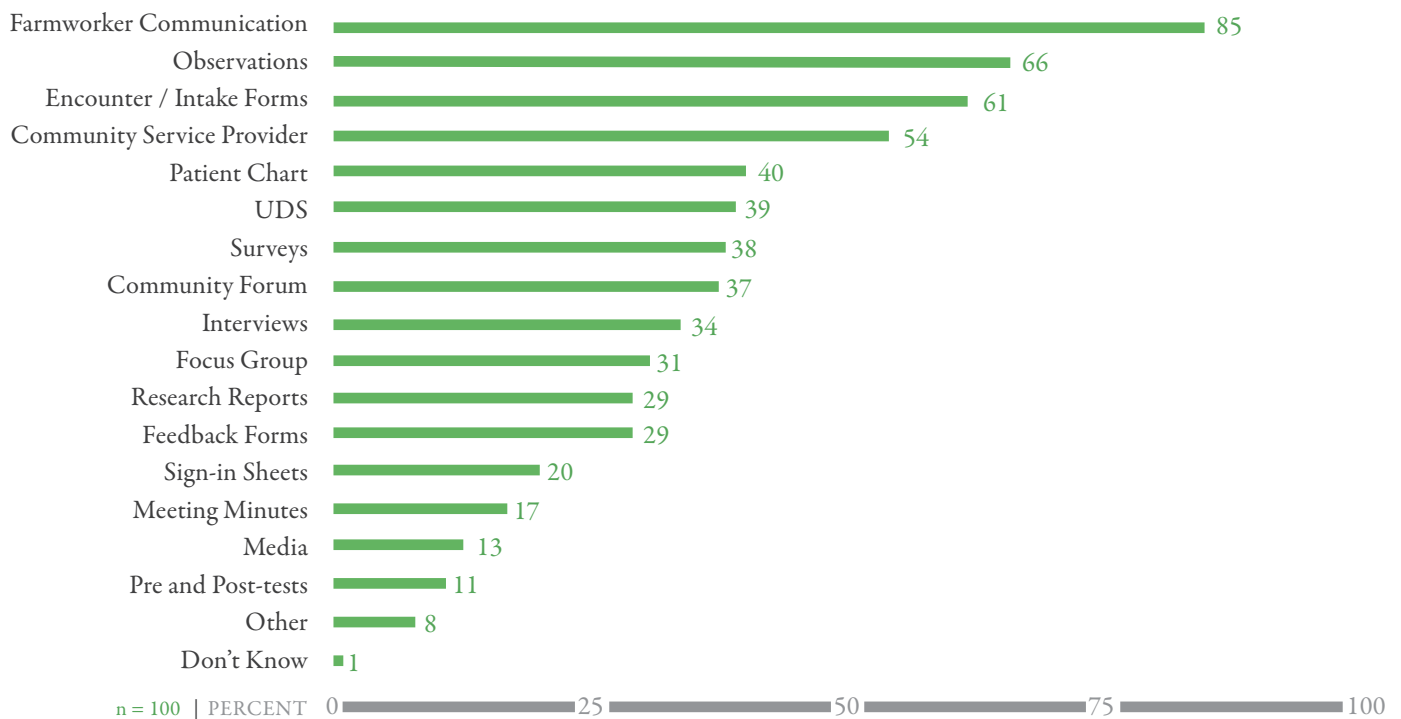
DATA COLLECTION AND EVALUATION

The following section provides findings about health centers' current data collection practices, including needs assessment, program evaluation, and data collection challenges.

Data Collection

Although health centers approach data collection in a variety of ways, most programs have some means of tracking their outreach and enabling services and the farmworkers that access them. The five most frequently cited data collection methods include communication with farmworkers, encounter forms, observations, communication with service providers, and patient charts (Figure 11).

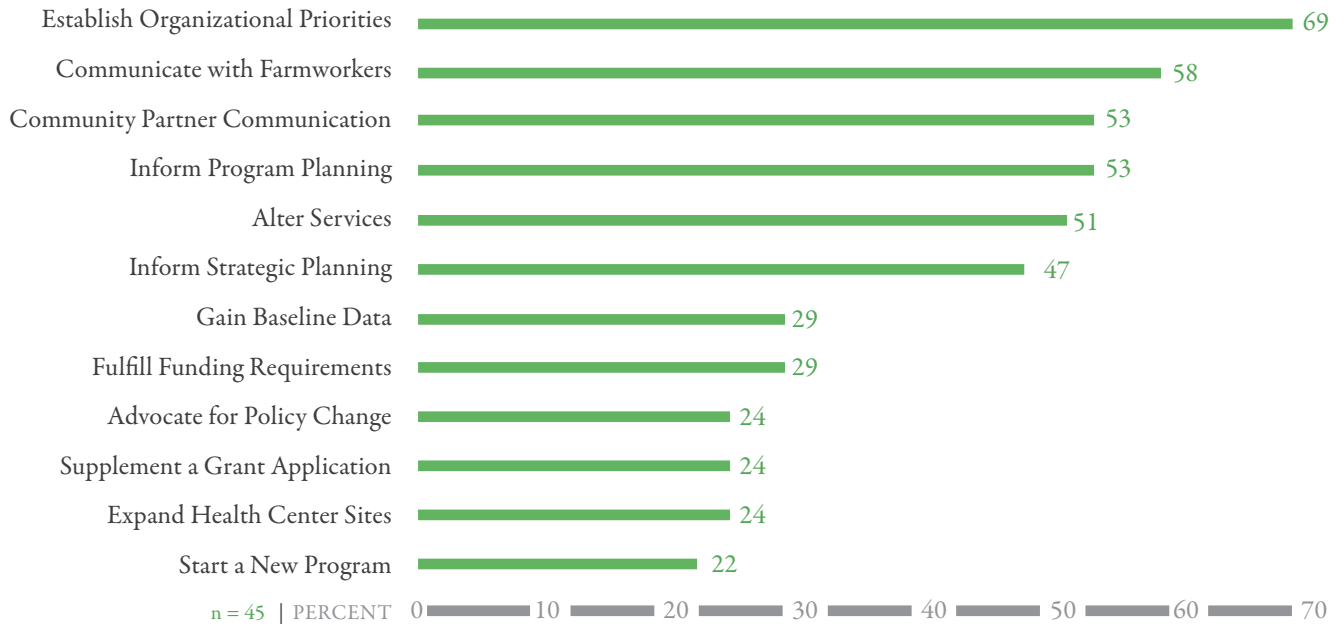
FIGURE 11 :
DATA COLLECTION METHODS USED FOR DETERMINING NEEDS & EVALUATING OUTREACH



Needs Assessment

The majority of online survey participants believed their current approach to understanding farmworker needs accomplished their intended aims. Specifically, over half (64%) of respondents revealed that their approach was effective or very effective (n=97). Approximately half (45%) of online survey participants reported that their respective programs had conducted a farmworker needs assessment, whereas nearly the same percentage (46%) had not done a farmworker needs assessment (n=98). Participants shared that the primary uses of the information collected in their needs assessments included establishing organizational priorities (69%) and communicating with the farmworker population (58%) (Figure 12).

**FIGURE 12 :
USES FOR FARMWORKER NEEDS ASSESSMENT DATA**



The information collected shows the needs of the community. Another participant added it helps determine the types of programs to focus on.

– Migrant Health Professional, Community Forum Notes

From an administrator’s perspective, establishing the needs of the community is one key aspect of a successful grant application. Having the ability to demonstrate needs based on data is integral to a health center’s ability to secure funding. Once needs are clearly demonstrated then programs and services can be developed or adjusted appropriately.

In grant applications, the health center was able to effectively make a case for the high level of need in the community that wasn’t being met.

– Health Center Administrator, Telephone Survey Notes

The health center has been successful with grants for the following two reasons: 1) writing good quality applications that are based on data, and 2) doing a good job with grant management.

– Health Center Administrator, Telephone Survey Notes

The health center has had success in grant writing because they perform good assessments of what the community needs. Then, the health center is able to deliver services based on those identified needs once the grant funding has been received. The health center’s success is because the organization develops programs based on what the community actually needs.

– Health Center Administrator, Telephone Survey Notes

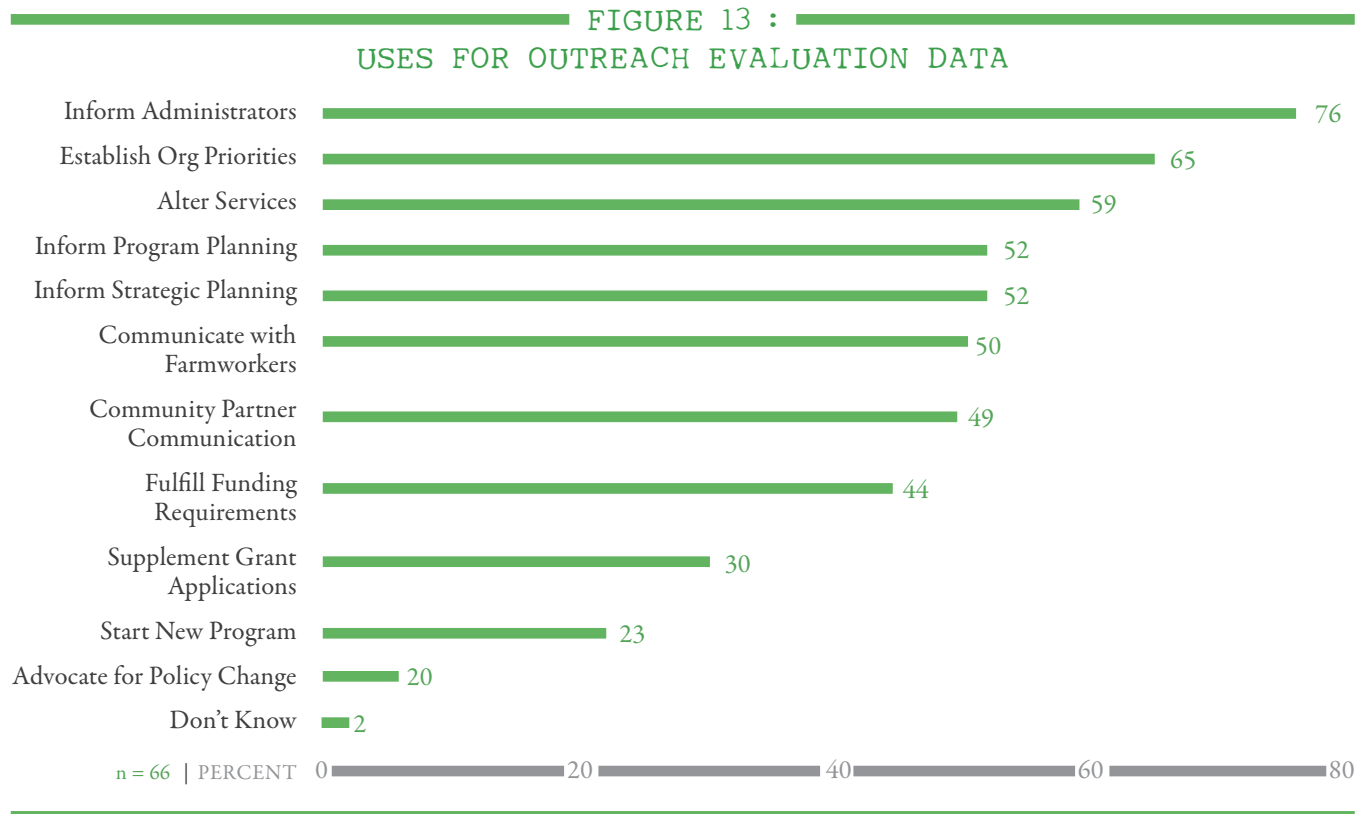
The health center wants their outreach program to be relevant to the communities they serve. They conduct an annual needs assessment and define what their goals are going to be. Then the health center sets up their objectives and works very hard to accomplish those objectives.

– Health Center Administrator, Telephone Survey Notes

Program Evaluation

A strong majority (69%) of online survey respondents revealed that their organizations evaluate the effectiveness of their outreach and enabling services (n=97). On the other hand, nearly one third (31%) either did not evaluate or did not know whether their organization evaluated their outreach and enabling services.

According to those that evaluate their programs, the most frequent uses for evaluation data included keeping administrators informed of the program (76%), establishing organizational priorities (65%), and altering services (59%) (Figure 13).



Evaluating the effectiveness of outreach and enabling services was found to be a strong component of successfully securing financial resources according to telephone survey participants. As demonstrated in Figure 13, the most common use of evaluation data was keeping administrators informed. Administrators repeatedly mentioned that they use this data to make key decisions about programs and incorporate this information into funding applications.

Telling the health center’s story and showing results has assisted the health center with securing funding. Implementing the program and then having the program evaluated was important.

– Health Center Administrator, Telephone Survey Notes

“We always meet the goals that we set for out for ourselves.” Through the health center’s evaluation practices, they’ve been able to make a case for the continued allocation of funds to support the program.

– Health Center Administrator, Telephone Survey Notes

The health center creates realistic evaluation measures and this has proved to be very important to securing funding. “If you can’t measure what you’re doing, you have no idea if your program is going to be good or bad or whether or not its meeting its objectives.”

– Health Center Administrator, Telephone Survey Notes

One reason cited by telephone survey participants for including evaluation findings in funding requests was to help establish the organization’s ability to produce positive outcomes by demonstrating previous successes. Doing so lends credibility to the program and provides an evidence base for the program’s accomplishments.

The organization has also built on the successes of prior programs. Their outreach program is adept at documenting work accomplished to demonstrate to funders successes with reaching special populations.

– Health Center Administrator, Telephone Survey Notes

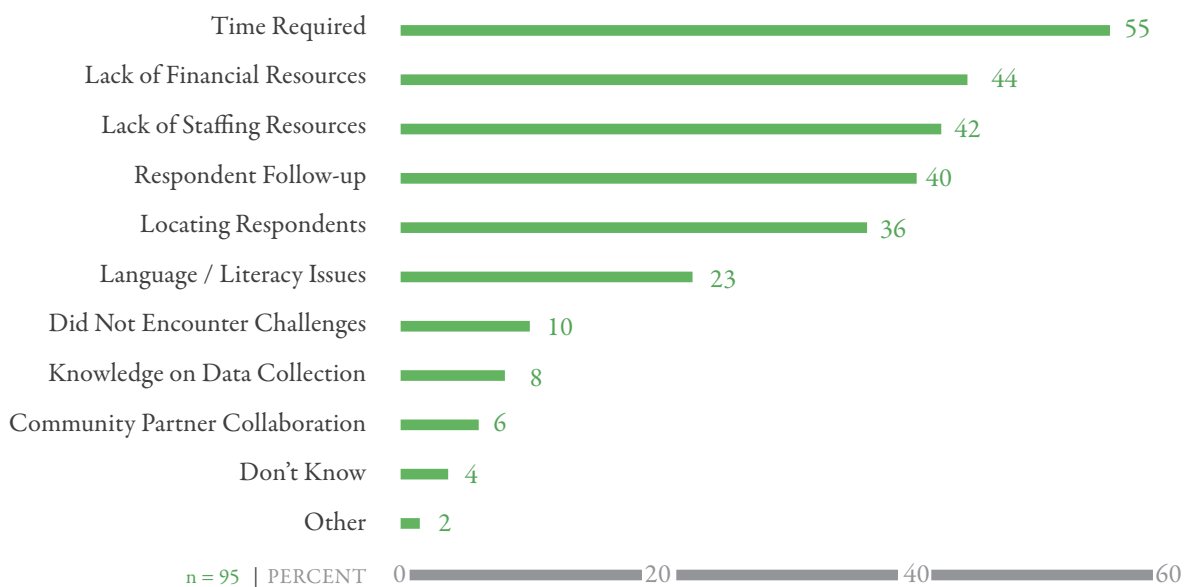
The health center is performing good services; it has a great reputation for delivering good services to farmworkers. With the good reputation, funding sources follow.

– Health Center Administrator, Telephone Survey Notes

Data Collection and Evaluation Challenges

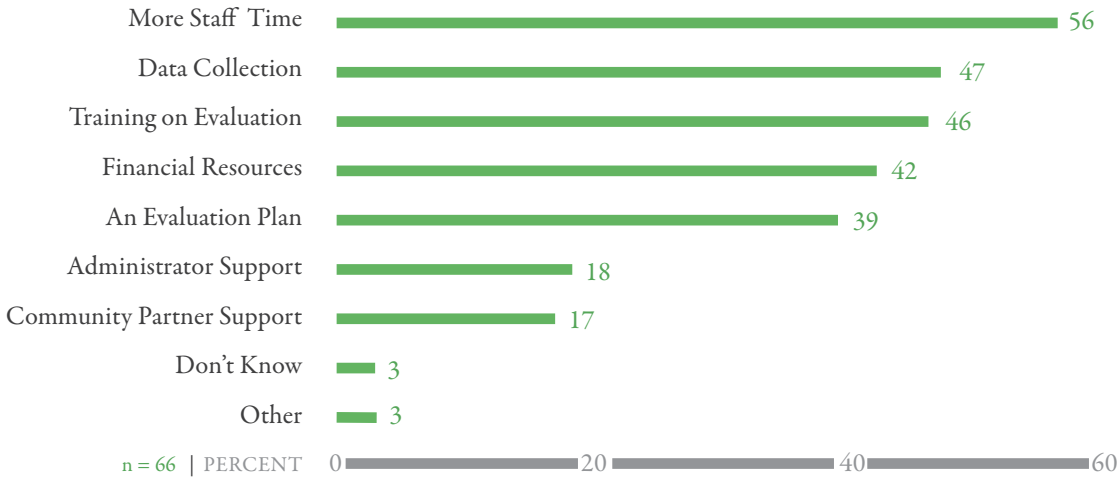
Collecting outreach program data is not a simple process. There are various considerations including identifying what data to collect, from whom, in what format, what frequency, as well as training staff in collecting this data and deciding how to enter and aggregate it. Online survey participants suggested the most frequent challenges to gathering information needed to support farmworker outreach programs were the lack of internal resources, such as time (55%), funding (44%), and staff (42%) (Figure 14).

FIGURE 14 : CHALLENGES WITH GATHERING DATA TO SUPPORT OUTREACH



Resources, especially staff time, appear to be a significant barrier to collecting data. Online survey respondents were asked what challenges they faced when collecting needs assessment data. The two most frequently identified challenges include lack of staffing resources (52%) and lack of time (52%) (n=23). Similarly, when online survey participants were asked what was needed to better evaluate the effectiveness of outreach and enabling services, the most frequently cited need identified was staff time (56%) followed by data collection/analysis (47%), training on evaluation techniques (46%), and financial resources (42%) (Figure 15). For more information, please see Staffing page 58.

FIGURE 15 :
NEEDS FOR EVALUATING OUTREACH & ENABLING SERVICES



Several telephone survey participants also noted difficulties in demonstrating the effectiveness of outreach and enabling services through data. Being able to make this link is increasingly more important in light of the fact that reporting program outcomes to funders is now considered a standard practice.

The administrator indicated that one of the biggest challenges they have is securing baseline data to demonstrate the effectiveness of outreach when s/he stated, “It is difficult to solicit funding if you can’t demonstrate that you’ve had successes.”

– Health Center Administrator, Telephone Survey Notes

Another challenge is proving the efficacy of their outreach services. The administrator summarized this challenge, stating, “Can they be sure that ‘X’ number of people will find a primary health care home because of ‘Y’ outreach efforts?”

– Health Center Administrator, Telephone Survey Notes

One administrator noted that outcome measurement requirements are getting more stringent.

– Health Center Administrator, Telephone Survey Notes

Summary

Although health centers approach data collection in a variety of ways, most programs have some means of tracking their outreach and enabling services and the farmworkers that access them. The five most frequently cited data collection methods include communication with farmworkers, encounter forms, observations, communication with service providers, and patient charts. Forty-five percent of respondents had conducted a needs assessment and 69% evaluate their outreach services. However, health centers report significant challenges with data collection, most notably staffing limitations and funding. That being said, health centers report that the benefits of investing in an evidence base are numerous, proving to be exceedingly useful in writing quality grant applications, determining programmatic needs, and justifying continued support for outreach and enabling services.

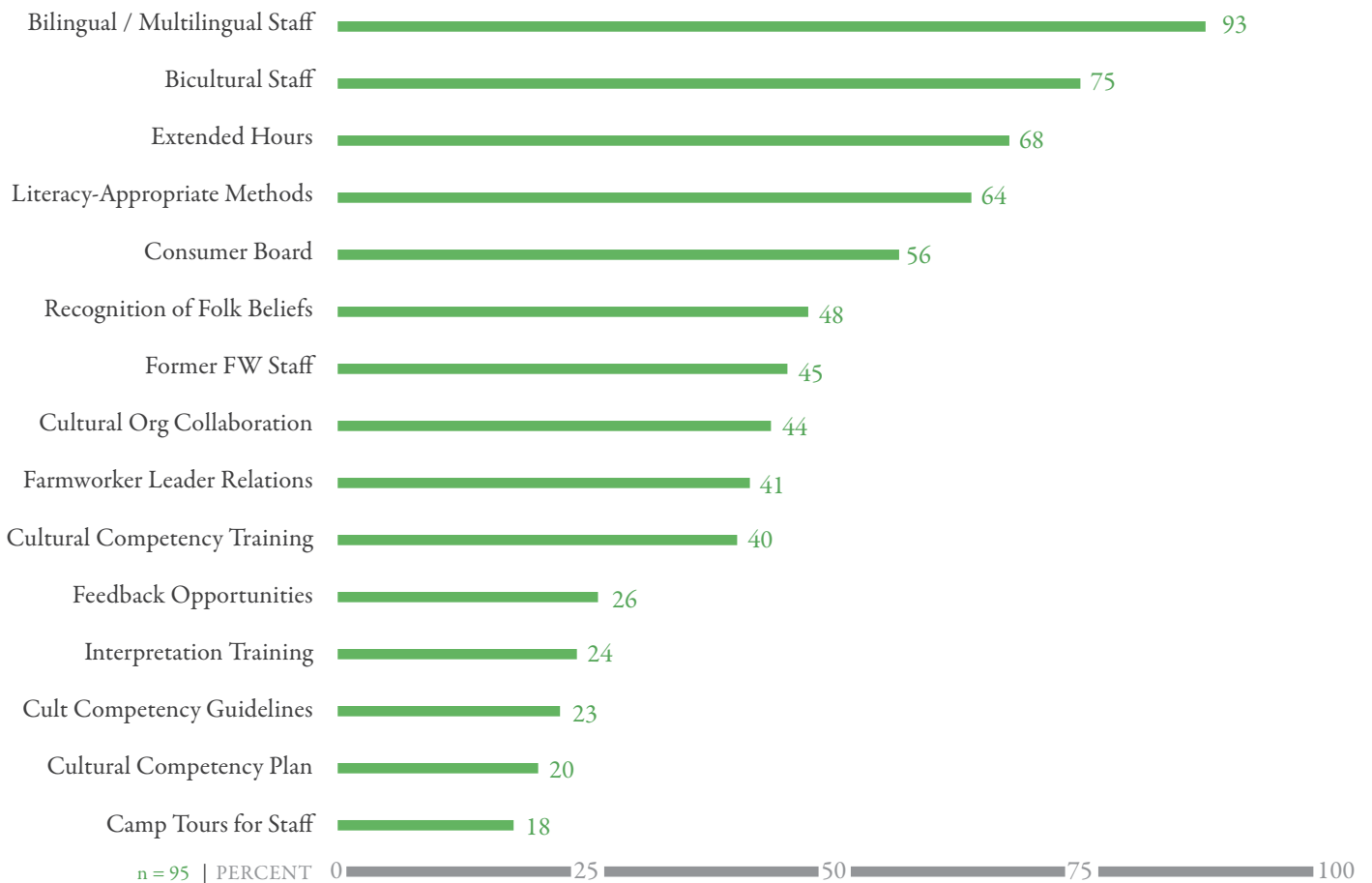
CULTURAL COMPETENCY

The findings presented in this section provide an overview of cultural competency including information about language considerations, alternative approaches to seeking medical care, and barriers to care among emerging farmworker populations.

Characteristics & Challenges

Culturally competent health centers value the unique characteristics of diverse communities in their service areas and consistently aim to ensure quality health care that is both respectful and responsive. Online survey respondents were asked to score their organization’s effectiveness of providing culturally responsive care. Over half (61%) of respondents ranked their organization as delivering a highly effective level of culturally competent care whereas nearly a third (32%) indicated an intermediate ability to do so (n=95). As Figure 16 demonstrates, having bilingual/multilingual staff (93%), bicultural staff (75%), and extended hours (68%) were among the most common techniques cited for providing culturally responsive services.

FIGURE 16 :
TECHNIQUES USED FOR PROVIDING CULTURALLY RESPONSIVE SERVICES TO FARMWORKERS



Cultural competency techniques were discussed among community forum participants as well. While some health centers do not provide cultural sensitivity trainings, many participants affirmed that their organizations have instituted these staff trainings. Other community forum participants indicated that their health centers have taken proactive steps, such as developing a cultural competency curriculum, hosting monthly cultural competency meetings, and attending farmworker community cultural events.

One participant took it upon herself to develop a cultural competency curriculum for the health center and added, “People don’t understand that there are cultural differences among farmworkers and between farmworkers and staff.”

– Migrant Health Professional, Community Forum Notes

“Trainings are not enough; there is a need to integrate cultural competence into our daily life.” The participant commented that their health center facilitates monthly meetings focused on the topic, ‘What it means to be a migrant?’ These meetings provide an opportunity for the participant to showcase their work and share their understanding about the farmworker population.

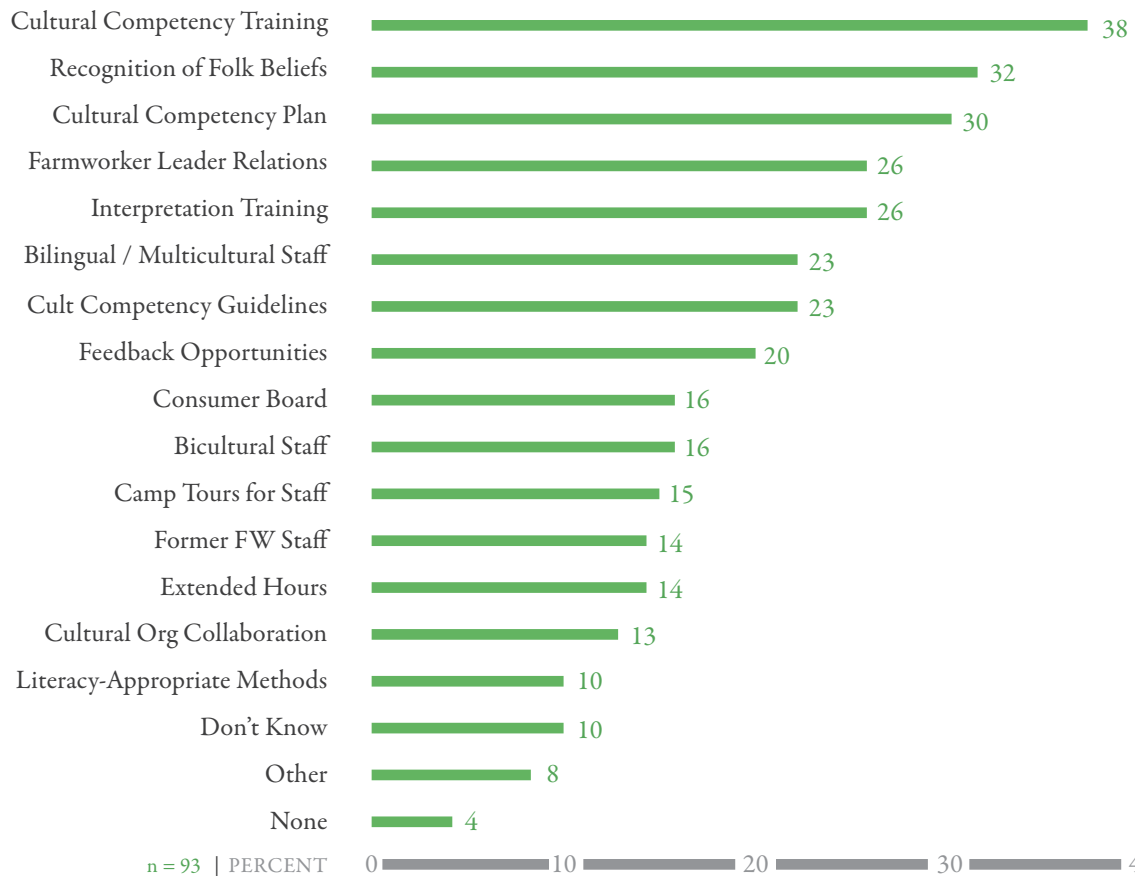
– Migrant Health Professional, Community Forum Notes

One participant mentioned attempting to attend cultural events to gain exposure to the community and foster opportunities for building strong relationships with farmworkers. She indicated, “I try to do anything that can combine us with them.”

– Migrant Health Professional, Community Forum Notes

Online survey participants were asked to share strategies needed in order to strengthen their organization’s approach toward providing culturally and linguistically responsive care to farmworkers and their families. Thirty-eight percent requested occasional cultural competency trainings and 32% cited a need for improved awareness and recognition of folk beliefs. Figure 17 demonstrates the range of cultural and linguistic competency needs highlighted by online survey respondents.

FIGURE 17 : NEEDS FOR STRENGTHENING CULTURAL & LINGUISTIC COMPETENCY



Other cultural competency-specific needs were raised among community forum participants. Specifically, numerous participants commented on the lack of cultural sensitivity among front desk personnel at health centers. There was also mention of a need for improving hiring practices of front desk staff, as these staff persons are not always community- or service-oriented individuals.

“ ...Reception is not necessarily always community oriented, service oriented, in the sense that outreach staff is more social services oriented, and so I think it has to do with hiring practices and maybe how jobs are presented and [how] the community ...served [is presented] when someone actually applies for a position at a Community Health Center.”

– Migrant Health Professional, Community Forum Transcripts

The problem facing many participants at their health centers was the front desk staff. One participant felt that the fear in many farmworkers’ minds was that the health center will not hire the right staff to treat them appropriately. Many participants indicated that their front desk staff often lacked cultural sensitivity training.

– Migrant Health Professional, Community Forum Notes

One participant stressed that it was important for the health center to orient the front desk staff to the farmworker community because the front desk staff behavior can lead to fewer farmworkers coming back to the health center.

– Migrant Health Professional, Community Forum Notes

There was overwhelming interest among focus group and community forum participants to strengthen health clinic staff’s understanding of farmworker cultures. Some participants indicated a desire for outreach staff to provide cultural sensitivity training to front desk staff and clinical providers that need additional education on how best to serve the farmworker population. Hiring staff with a farmworker background was also mentioned as a strategy for developing sensitivity to farmworker cultures.

“[It is important] to provide education and do like what they called in-reach earlier in terms of trying to train the front office and do a cultural competency training for the people of the organization...”

– Migrant Health Professional, Community Forum Transcripts

One participant indicated that upon their return to the health center, s/he would work towards getting a cultural sensitivity training for their front desk staff because she believed that they represented the first impression of a health center’s services to farmworkers.

– Migrant Health Professional, Community Forum Notes

One participant believed strongly in hiring staff that have some experience with the farmworker community and also in orienting new staff to the camps and the farmworker community as key to gaining farmworker trust.

– Migrant Health Professional, Community Forum Notes

For one participant, scheduling a monthly meeting with the front desk staff and outreach department is an important strategy to enable front desk staff to get oriented to the outreach department.

– Migrant Health Professional, Community Forum Notes

Language Differences & Considerations

From professional interpretation to appropriate signage and written materials, language access is critical to providing comprehensive, culturally-responsive health care services to farmworkers and their families. At migrant and community health centers, 78% of farmworker patients are best served in a language other than English (n=770,402).³² Thus, there is a significant need for language services among the patient population as well as among those that are prospective patients outside of the clinic setting.

Online survey findings consistently revealed favorable findings on the critical role of linguistic competency at their health centers. For example, 75% of online survey respondents indicated that their organization has the capacity to provide services to farmworkers in their preferred language “all of the time” whereas 25% have this capacity “sometimes” (n=93). The majority of online survey respondents (89%) shared that they were satisfied with their health center’s abilities to provide linguistically appropriate care to farmworkers (n=94). This result is reinforced by the additional finding that hiring bilingual/multilingual staff was the most commonly cited technique for providing culturally responsive care (see Figure 16, page 67).

Despite these positive findings, the qualitative findings revealed more complexities with providing language-accessible services. Specifically, some community forum participants commented on the overall shortages of bilingual staff at health centers, highlighting the difficulties associated with finding qualified interpreters and translators.

Many community forum participants spoke of how outreach staff are used to fulfill interpretation needs on a regular basis, pulling them away from primary job duties such as conducting outreach in the community. For more information, please see the Outreach and Enabling Services Funding, page 55 or Outreach and Enabling Services Staff, page 58.

Focus group participants spoke of challenges associated with minimal or no language capacities at health clinics. One focus group participant commented on their experience with a language line when a certified interpreter was not available. Another participant recalled difficulties experienced with having their children conduct medical interpretation.

“...If not for fear of language too. Because we have to know that there are clinics where you go and ask them, ‘Do you speak Spanish?’ ‘Oh no, one moment please.’ And they leave you waiting there a ton of time. Or if not, they put you with a machine. A machine! Even though there is a person on the other end of the line, you don’t feel the same *confianza* [trust] as when there is a translator in front of you.”

– Head Start Parent or Advocate, Focus Group Transcripts

“I think that language is one of the most common issues, there may be many people that speak English as their second language, but medical terminology is very difficult and sometimes we can make mistakes when talking about it. Then, we need to think about it, it may be a mistake to bring the children to interpret for us. Sometimes [the children] look puzzled, because they do not understand what [the doctor is talking about].”

– Head Start Parent or Advocate, Focus Group Transcripts

Three critical issues also surfaced regarding bilingual staff. Some community forum participants noted that even when bilingual staff are available for interpretation services, many do not have formal training in medical interpretation and thereby increasing the likelihood of mistakes. While formal interpretation services are needed, a few community forum participants also commented on the need to keep medical explanations simple so that farmworkers with low-literacy and educational levels can comprehend what is being communicated to them in their preferred language. Regardless of the level of interpretation training, a few participants also mentioned how bilingual language capacities do not necessarily indicate well-developed culturally sensitivity skills.

The participant pointed out that being bilingual does not necessarily make a person qualified due to medical vocabulary needed to interpret.

– Migrant Health Professional, Community Forum Notes

“There are translations and interpretations that are not appropriate. Many times, because someone speaks Spanish, it doesn’t mean that someone can do an interpretation or translation, so it is a job for a person that is certified and can do this type of work.”

– Migrant Health Professional, Community Forum Transcripts

“You have to be culturally sensitive. You can’t use big medical words or else they won’t understand. You can’t say ‘hemoglobin A1C’ or they’ll say, ‘What is that?’”

– Migrant Health Professional, Community Forum Transcripts

“We could lower the literacy levels of our materials. More pictures.” Everyone in the small group nodded.

– Migrant Health Professional, Community Forum Notes

Alternative Approaches to Seeking Medical Care

Part of cultural competency is respecting how different groups conceptualize health and illness, including how individuals naturally respond to these concepts. Focus group participants were asked to discuss where they go when they or their family members get sick. Numerous participants spoke of obtaining medicines from Mexico, seeking familiar medicines at reasonable prices. At times, participants discussed entrusting a close friend or family member with the task when traveling to Mexico.

Participant 1: “I call my mom, and she sends me medicine she buys in Mexico. That is what I do.”

Participant 2: “I do the same, I call one of my aunts and she sends me the medicine.”

Participant 3: “I do the same, when I need medicine, my father and mother-in-law go [to Mexico] in July and bring more medicine when they come back. Because they only work for the season and then they go back; they work two or three weeks and go back again, and they bring medicines.”

– Head Start Parents or Advocates, Focus Group Transcripts

“We have dental problems. We have respiratory problems. We have skin problems. I tell you this because I bring medication from Tijuana. I bring the medicine...”

– Head Start Parent or Advocate, Focus Group Transcripts

In addition to seeking pharmaceutical medicines, focus group participants mentioned using various home remedies or seeking the support of a *comadre/compadre* – a trusted friend or acquaintance. Some examples cited include use of different herbs or applying over-the-counter medicines in a particular way. These techniques may be influenced by culture, life skills, and creativity in addressing barriers to care.

“Yes, again we come back to education. From the time we arrive here, we come with our Alkaseltzer, we come with our Mejoralito, that is what cures us. And if we no longer have our Mejoralito and our Alkaseltzer, what is it that cures us? We grab a clove for a tooth ache, which is the most common.”

– Head Start Parent or Advocate, Focus Group Transcripts

“He got it [an infection] at work. But what can I say? I can’t say anything. That is, I know I have my rights. But with what right am I going to demand, if the person is going to send me to a clinic where they are not going to see me? Because that is what happened. They told him, ‘You have your Tylenol, and come back in 8 hours.’ He says, ‘I went back in 8 hours but in those 8

hours my infection was very big.’ So, he put on his Sufatiasol because that is his belief... I put on that salve. And with that he was cured.”

– Head Start Parent or Advocate, Focus Group Transcripts

“If I get sick with the flu... then I drink tea or something, and still go to work... Because I am going to miss one, two, or three or a week, then to pay the bills, the rent, electricity, everything, right?”

– Head Start Parent or Advocate, Focus Group Transcripts

Despite the alternative approaches to healing, a few focus group participants indicated that simply dealing with a pain or an ailment was their only option. For more information, please see the Barriers to Care Section, page 37.

Emerging Farmworker Populations

Qualitative and quantitative findings indicated that there are new cultures among the established farmworker population including indigenous and Asian farmworker groups. Many indigenous farmworkers are considered “emerging farmworkers” or groups of farmworkers from a specific ethnic or cultural group that have a recent history (as opposed to a long-standing history) of working in U.S. agriculture. Online survey respondents were asked to comment on their impressions of how emerging farmworkers are experiencing barriers to care. Lack of language services (78%), lack of knowledge about available services (70%), and cultural differences (59%) were the top three respectively (See Figure 3, page 37).

Challenges associated with providing health care services in appropriate indigenous languages also arose in the qualitative findings. Overall, there was a lack of health clinic staff that can respond to the language needs of indigenous farmworker populations. There were frequent references to farmworkers that speak neither English or Spanish.

“There are migrant farmworkers that do not speak Spanish. That is something that I feel really passionate about. There are migrant farmworkers that first speak indigenous languages and they are on the rise in this country, and more so, there is a huge Asian population that is being virtually ignored, and we really need to pay attention to that population and to offer them equal access and equal services in our health centers.”

– Migrant Health Professional, Community Forum Transcripts

“We have farmworkers that speak Mixteco... Their Spanish is short and we can’t communicate very well.”

– Migrant Health Professional, Community Forum Transcripts

Language was discussed in this group. Sometimes it’s not just English as the barrier but also other indigenous dialects, people that don’t know English or Spanish. So that is another barrier that makes it difficult to get the information. – Migrant Health Professional, Community Forum Notes

Summary

Overall, health centers are pleased with their ability to provide culturally-competent care. Over half (61%) of respondents ranked their organization as delivering highly effective, culturally-competent care. Having bilingual/multilingual staff (93%), bicultural staff (75%), and extended hours (68%) were among the most common techniques cited for providing culturally-responsive services. Nonetheless, outreach staff and farmworkers cite varying experiences with cultural competence, including issues with the front desk and dissatisfaction with interpretation services. With regard to alternative care, numerous focus group participants spoke of obtaining medicines from Mexico and relying on home remedies.

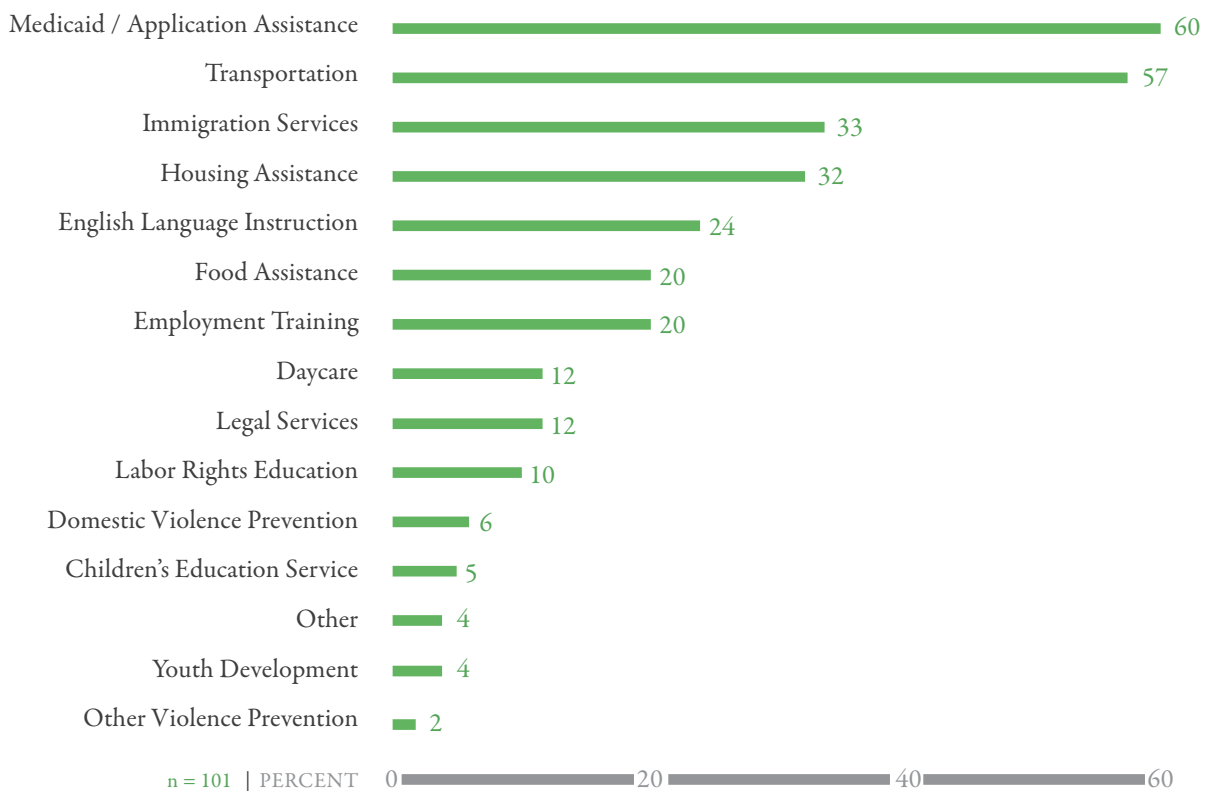
SOCIAL SERVICE NEEDS AND COMMUNITY COLLABORATION

The following section highlights qualitative and quantitative findings about the social service needs of farmworkers as well as community partnerships created and maintained to provide a safety net to the farmworker population.

Social Service Needs

Multiple factors contribute to the overall health and wellbeing of farmworkers, including affordable and accessible social services. Attending to social service needs can have direct implications on farmworker’s ability to maintain their physical health. In order to explore these issues further, online survey participants were asked to report the most critical social service needs among farmworkers in their service area. Online survey participants ranked assistance with Medicaid or other social service applications as the social service of greatest concern among farmworkers (60%), followed closely by transportation needs (57%). Significantly lower percentages of online survey respondents selected immigration services (33%) and housing assistance (32%) as social service needs (Figure 18). Community forum and focus group participants also noted numerous social service needs common among farmworkers in their respective areas. Among them were English language instruction, food security, domestic violence prevention and interventions, as well as education on worker’s rights.

FIGURE 18 :
SOCIAL SERVICE NEEDS OF FARMWORKERS AND THEIR FAMILIES



As referenced in the Barriers to Care section (page 37), the lack of information on how to obtain services compromises farmworkers’ ability to access care and highlights a critical social service need. According to several focus group participants, being educated on where and how to access social services is a critical issue.

“One of the needs is that there are many people that do not have enough information on where to get assistance. Sometimes it is better to have more information because not everyone knows where to go for help, or what kind of help they can get, or when they could get help. It is very important to have papers with more information about where to go...”

– Head Start Parent or Advocate, Focus Group Transcripts

“We need a social worker in the center. Because a social worker can focus you... and can help you a little more, too. Well, orient you in that way. What to do if you need a house. What to do if you need food. What to do if you need health services.”

– Head Start Parent or Advocate, Focus Group Transcripts

“..There should be a main emphasis on education. But I also think that there needs to be a social worker to be involved in this. So that the social worker [can] direct them...”

– Head Start Parent or Advocate, Focus Group Transcripts

According to numerous focus group participants, many who are farmworker parents themselves, child care was another predominant social service need. This need was echoed by a few community forum participants as well. It was noted that minimal or no childcare options affect the ability of farmworkers to access needed medical care.

“To me, my concern is that I have children of diverse ages, and both my wife and I work... and there is not a place close to work in which to the children could be taken care of. We have to leave them, all of them, the oldest one taking care of the younger ones.”

– Head Start Parent or Advocate, Focus Group Transcripts

“We first harvest the asparagus, and the asparagus does not have a schedule, you could start at six in the morning and end up until six at night, or keep going until the next day. It all depends on how it grows. Then, what we need is for everyone to work well... as child care is the most important thing.”

– Head Start Parent or Advocate, Focus Group Transcripts

“The lack of child care complicates the situation of farmworker families trying to obtain health services.”

– Migrant Health Professional, Community Forum Transcripts

Community Collaboration

In order to maximize efforts to serve both the medical and social service needs of migrant and seasonal farmworkers, health center staff reported working with a variety of community-based organizations and agencies. Qualitative findings from community forums and telephone surveys showed that many respondents understand the benefits of creating and maintaining partnerships within the community. Benefits of collaboration included creating a continuum of care, strengthening existing services, and collectively providing a more comprehensive set of services.

One agency cannot provide all of the services needed by farmworkers. Therefore, outreach and enabling service workers often serve as a link to other community agencies, providing services outside the scope of the health center. As frontline staff members are often the first contact with farmworkers, they are in a unique position to educate on available resources and provide referrals to a variety of partnering agencies.

“We, of course have to establish the confidence of our programs in the community and with all the agencies that we work with, domestic violence, sexual assault, the health department, ...so that they know that you’re the go-to people in town or in the county...”

– Migrant Health Professional, Community Forum Transcripts

“Teamwork! Not one organization can do everything. Communicate with other groups, tell them what you’re doing. Conduct presentations to each other. Together everyone achieves more.”

– Migrant Health Professional, Community Forum Transcripts

“Work with other organizations to meet health needs, networking, build relationships, bring services to them, work together to fill the cracks. It’s really important that we collaborate and we network with other organizations so that whatever this organization doesn’t offer, other organizations do, and we can go ahead and give them a whole complete [set] of services.”

– Migrant Health Professional, Community Forum Transcripts

[The health center] tries to collaborate with other agencies to ensure that they are using community resources wisely and effectively to help support outreach objectives. “We try to fit in the continuum of care within our community.”

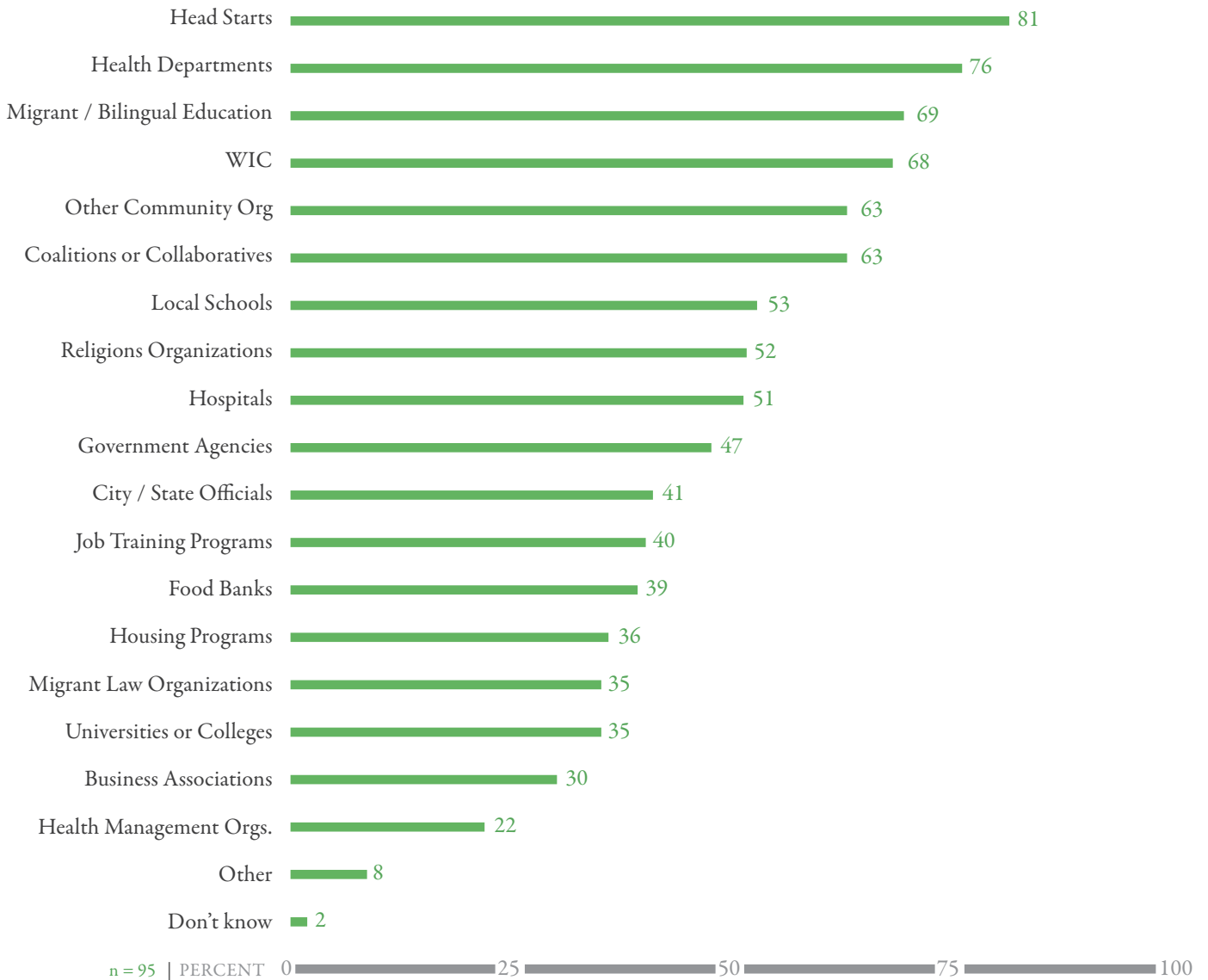
– Health Center Administrator, Telephone Survey Notes

“When agencies find people in need of primary health services, they refer them to the health center. The community works together very well to get people into care.” This is a direct result of 25 years of partnership building.

– Health Center Administrator, Telephone Survey Notes

Health centers collaborate with numerous organizations in order to serve farmworkers and their families. Four of five (81%) online survey respondents collaborate with Migrant and Seasonal Head Start agencies whereas three of four (76%) respondents reported coordinating with health departments (Figure 19). Other frequently-cited organizations included migrant and/or bilingual education programs (69%), Women, Infant, and Children (WIC) program (68%), coalitions or collaboratives (63%), and other community organizations (63%). A variety of additional agencies were specifically mentioned by community forum participants including local businesses, Catholic Charities, the Mexican Consulate, migrant education, police departments, churches, and universities. In regard to coalitions specifically, nearly two of three (62%) online survey respondents indicated involvement in a community coalition that addresses farmworker needs (n=95).

FIGURE 19 :
 ORGANIZATIONS PARTNERING WITH HEALTH CENTERS



“All of us work with different other agencies, and all of us work with growers, health centers, child migrant services. We work with voucher programs and the Mexican Consulate ...those are the agencies that really strengthen our services.”

– Migrant Health Professional, Community Forum Transcripts

Media outlets were also identified by multiple participants as valuable partners. Radio, television, and print media are well positioned to reach the farmworker population at large and to educate the community on relevant farmworker issues.

“..We are doing a lot of Latino radio, and the media is really important to tap into. Even the Spanish newspapers, you know, writing articles. That really helps...”

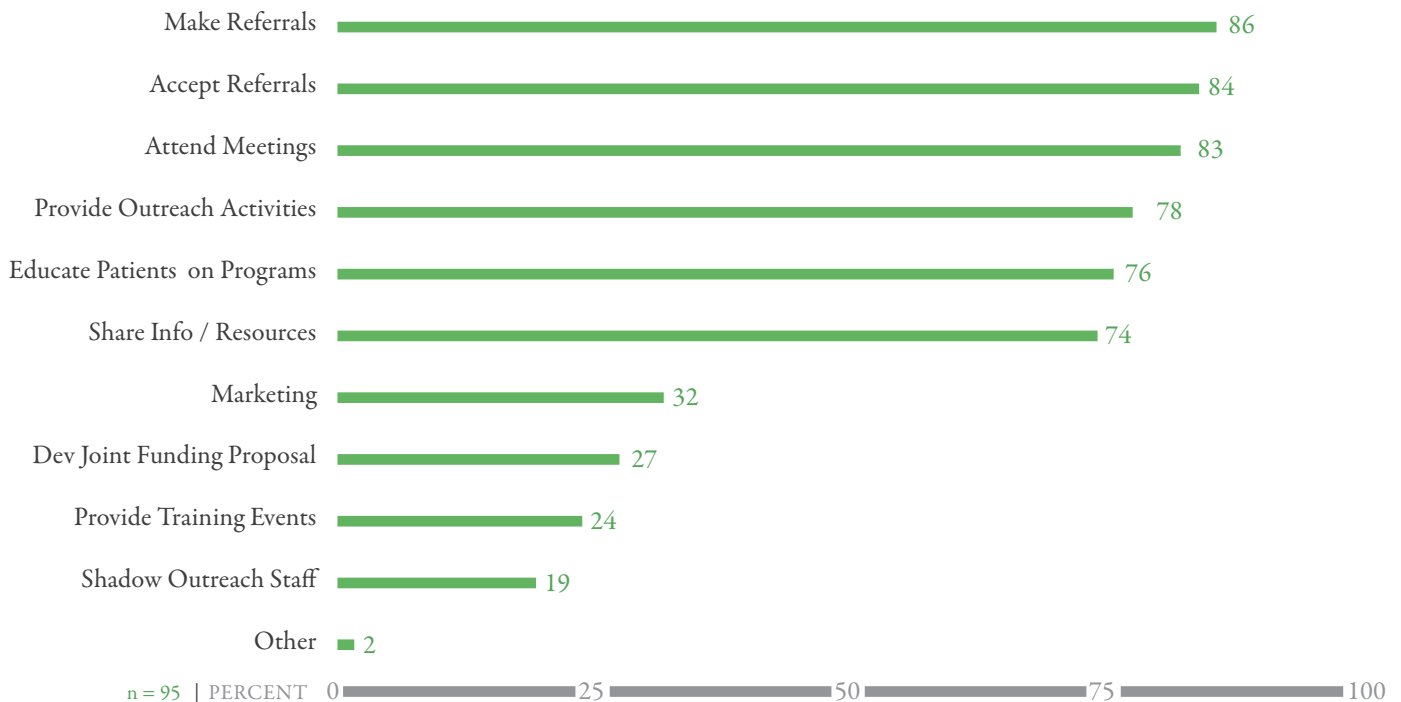
– Migrant Health Professional, Community Forum Transcripts

“We do call [our local newspaper] sometimes or they call us and request information if we have any... stories or any benefits or anything that is happening, any news that is happening in the community that is... health related.”

– Migrant Health Professional, Community Forum Transcripts

The most frequently noted method for collaborating with community partners by community forum participants was special events such as health fairs or screenings. On the other hand, online survey respondents indicated that the most frequently cited collaborative activities included making referrals (86%), accepting referrals (84%), attending meetings (83%), providing outreach activities (78%), and educating patients about their programs (76%) (Figure 20).

**FIGURE 20 :
COLLABORATION METHODS USED BY HEALTH CENTERS**



Challenges to Building Partnerships

Working with outside agencies can be challenging at times. Participants were asked to specify the challenges they have experienced or observed. Specifically, a few community forum and telephone survey participants noted that other community agencies or potential partners may have competing interests or territorial issues. For instance, agencies may be contending for the same funding as the health center. Participants also indicated that partnering agencies may not have adequate language capacities to properly serve farmworkers. Community forum participants further highlighted the frustration experienced when a referral is insufficiently or improperly handled by a community partner. Lack of proper follow through by a community agency was reported to have a potentially damaging effect on the relationship between the farmworker and the health center.

“My community faces a lot of turf issues. My job versus your job.”

– Migrant Health Professional, Community Forum Transcripts

Many organizations fall short of the right to provide translation and many try to take advantage of the health center's translation services as they are the only such resource in the area... but the health center doesn't have the staff or funding to do that.

– Health Center Administrator, Telephone Survey Notes

“We collaborate with other agencies but many of them don't follow through. Then the farmworker blames you.”

– Migrant Health Professional, Community Forum Transcripts

Unique challenges were also reported to arise when working with community coalitions or a group of organizations with a common interest, who agree to work together toward a common goal. The three greatest challenges experienced among online survey respondents include: 1) difficulties with acquiring enough participation of coalition members (32%); 2) securing funding among coalition members (27%); and 3) lacking focus or direction in the coalition's purpose (27%) (n=56). On the other hand, approximately a quarter of respondents (23%) reportedly did not confront any challenges with the coalition.

Community forum and focus group participants identified the need for a stronger internal support system within the farmworker community. For instance, there can be many different cultures represented among local farmworker communities that may prevent or hinder cohesiveness. Farmworkers creating their own system of support in their community was recognized as an asset when it existed and a challenge to establish at other times.

“We talked about different cultures, and one of the things that happens is when you have people from different areas they tend, since they don't feel like they're among their own people, they tend to isolate themselves.”

– Migrant Health Professional, Community Forum Transcripts

“Also I think that we, as Latinos and Hispanics, should unite more and help each other... and that is what I think we should do. Do like a group... give information to those who don't know. Support them.”

– Head Start Parent or Advocate, Focus Group Transcripts

“And you newly arrive here, and if you get here and the other one is here saying, ‘Come on, *compadre* and let's go.’ That is why in our society *compadre*-ism exists, because we help each other.”

– Head Start Parent or Advocate, Focus Group Transcripts

Summary

By and large, nearly every health center collaborates with other safety-net organizations in its service area. The most frequently-cited collaborative activities included making referrals (86%), accepting referrals (84%), attending meetings (83%), providing outreach activities (78%), and educating patients about their programs (76%). The most common collaborating agencies include Migrant and Seasonal Head Start (81%) and health departments (76%). However, these partnerships come with challenges, including turf issues, lack of follow through, and lack of cultural competency. Lastly, participants ranked assistance with Medicaid and other enrollment forms as the greatest social service need among farmworkers (60%), followed closely by transportat



RECOMMENDATIONS

RECOMMENDATIONS

The Recommendations provide Health Outreach Partners' (HOP) culminating thoughts based on the findings shared in this report. This section focuses on four key themes that are supported by substantial needs assessment findings and are well-suited for action by those involved in serving migrant and seasonal farmworkers.

The findings included in this report impact a variety of stakeholders, including community safety-net systems, funders, and policy makers. For this reason, the recommendations are structured towards two overall audiences: Funders/Policy Makers and Farmworker Advocates. In addition, the recommendations include HOP's commitment to responding to the data outlined in this project.

FEAR

Discussion

The impact of farmworkers' immigration status emerged as a key theme in this study. While Head Start parents and advocates discussed the fear of being exposed as undocumented, migrant health professionals highlighted the challenges of serving undocumented farmworkers. Additionally, health center administrators reported some of the struggles they experience because so few funding options are available to serve undocumented patients.

The U.S. Department of Agriculture estimates that approximately half a million unauthorized workers are currently employed within the U.S. agricultural industry, more than any other sector in the country. Some communities throughout the United States have ardently opposed the influx of undocumented immigrants, creating a resounding national backlash. On some occasions, this anger has prompted strong political stances towards undocumented farmworker communities. Immigration prosecutions now comprise over half (54%) of all federal filings, for an all-time high of 91,899 cases in 2009 (TRAC Reports 2009).

These actions create a pervasive climate of fear among undocumented farmworkers, which continually forces them deeper into the shadows of our society. Farmworkers live with the constant fear and anxiety of losing their jobs and being deported back to their country of origin. Many farmworkers endure emotional, physical, and financial hardships in order to start a better life in the U.S. These farmworkers frequently live with the psychological burden of managing the daily risk of deportation. Moreover, they are often discriminated against or become victims of employer abuse due to lack of legal documentation. Even documented farmworkers face discrimination, sometimes with employers and health care workers. With this fear affecting farmworkers, it comes as no surprise that many may find it difficult to trust health centers and social service organizations.

Funder/Policy Maker Recommendation

Ensure funding initiatives include services for immigrant populations. The overall financial viability of the health care safety net is in jeopardy as little funding is available for immigrant health care. An opportunity exists for funders and policy makers to ensure that funding accommodates both documented and undocumented immigrants. Particularly, public insurance eligibility can be expanded to be more inclusive of all immigrants.

Farmworker Advocate Recommendation

Know the nuances of the fears farmworkers face. Issues related to discrimination and abuse are likely to continue regardless of immigration reform; individual communities can and must help to alleviate them. Migrant health professionals stated that building trust and being persistent are critical to overcoming access barriers. Outreach workers are known and trusted in their communities and can build a lasting bond between farmworker communities and organizations wanting to help them. Additionally, community members can initiate discussions with farmworkers concerning their fear and anxiety issues via group discussions and informal one-on-one interviews. These conversations help health centers understand the consequences of fear on farmworker health as well as serve as a safe outlet for

farmworker patients to express their feelings. Information garnered can later be shared with others in the community, like growers, social service agencies, and other health center staff.

HOP Response

Share needs assessment data with advocacy organizations. To respond to this pressing need, HOP will share its qualitative and quantitative data generated from this needs assessment with advocacy organizations, exposing them to the nuances of fear experienced by farmworkers around the country. Additionally, HOP will develop resources to help health centers understand this fear more thoroughly. The more aware health centers are about farmworker fear, the more likely they will help address this issue head-on. Likewise, these resources will include effective approaches that make farmworkers feel safe and secure within their local health center system as well as their communities.

TRANSPORTATION

Discussion

Farmworkers and health centers alike face significant challenges with transportation. For farmworkers, accessing transportation options was ranked the number one barrier to care (67%) and the number two social service need (57%). These rankings are consistent with HOP's last three needs assessments. Similarly, health center respondents cited transportation as the most significant challenge in providing outreach and enabling services (39%). Clearly, both service providers and farmworker patients experience noteworthy challenges with transportation.

Most farmworkers work and live in rural communities that have little to no public transportation options. Beyond this, state driver's license restrictions prevent many undocumented farmworkers from purchasing a car, obtaining insurance, and safely traveling from one place to another. Even with 67% of health centers reporting that transportation is a tremendous need, many farmworkers are still hesitant to accessing clinic-provided transportation. Participants cited immigration roadblocks and cultural competence of transportation staff as deterrents to using transportation services.

Health centers encounter many challenges when trying to transport farmworkers to and from primary care. Most notable are high costs for staff, vehicles, fuel, and insurance. One participant mentioned that insurance for clinic vans is \$9,000, while another cited placing the liability risk on promotores. Some health center administrators referred to the Enabling Services for Special Populations funding opportunity as a useful mechanism for overcoming the financial challenge of providing patient transportation.

Funder/Policy Maker Recommendation

Increase funding opportunities that address transportation as a barrier to care. In many cases, transportation is not considered a reimbursable service by Medicaid or other public insurance programs even though transportation may be necessary to ensure utilization of health services. In order to overcome the financial burdens encountered by health centers, more funding opportunities that address transportation as a barrier to care would positively impact access and lessen health disparities. Funding could support a variety of approaches, including mobile health units, clinic vans, Telehealth, or community-wide collaborations. Funding models could be structured as continuous from year to year, or perhaps a reimbursable model that would encourage communities to transport as many patients as possible.

Farmworker Advocate Recommendation

Identify community-based solutions. Various agencies are struggling with providing transportation in their local communities, including schools, Head Start programs, health departments, legal rights groups, employers and other care providers. A number of these groups have some means of transportation already, thus an opportunity exists to share resources. By problem-solving with others, groups can identify community-based solutions to this seemingly omnipresent issue.

Employ a variety of transportation solutions. Health centers have been utilizing a blend of strategies to overcome the transportation barrier. Beyond clinic vans, health centers take advantage of mobile health units and Telehealth technology to make services more accessible. These combined outreach and clinical models have a lot of potential, especially when funding for these becomes more available.

HOP Response

Identify best practices on transportation. Every year, HOP collects innovative outreach practices from outreach programs across the country and publishes them in a report. To respond to the transportation need, HOP will put a special emphasis on collecting innovative practices on transportation, transforming local solutions into nationwide best practices.

EDUCATION AND INFORMATION SHARING

Discussion

Health education emerged as a top activity and priority among migrant health professionals. Eighty-eight percent of migrant health professionals reported that their organizations conduct health education activities with farmworkers and their families. Similarly, health education was reported to be the overall most frequently performed outreach activity (50%). Migrant and Seasonal Head Start programs also confirmed that education, health education, and mental health services are the top three services they provide to farmworker families.

Overall, there is an opportunity to enhance tactics and approaches to health education efforts for farmworkers. Migrant health professionals cited one-on-one education to be the most frequently used format for providing health education (80%). While one-on-one education enables health centers to offer targeted, individualized educational services, oftentimes it is not the most effective way to reach the broader farmworker population. Additionally, according to migrant health professionals, most one-on-one education occurs within the clinic setting and not out in the community where farmworkers live, work, and congregate. One can infer that the majority of educational services are reaching only those farmworkers that are already accessing care and not those that are unfamiliar with the health center system. Moreover, the top health education technique used by health centers was providing written materials, such as brochures, pamphlets, and novellas. While these resources are critical for relaying important health information, their dissemination does not encourage experiential learning or facilitate behavior change.

The findings of this needs assessment highlight that fact that farmworkers continue to need more health education, especially on topics such as diabetes, mental health, and women's health. Moreover, migrant health professionals and farmworkers identified an array of other needed educational topics, including pesticide safety, non-pesticide occupational health, legal rights, public insurance options, health systems navigation, and English language skills. These varied and complex topics demonstrate that a more all-encompassing approach to health education should be explored, addressing the physical, emotional, and social wellbeing of farmworkers.

Funder/Policy Maker Recommendation

Expand initiatives that focus on group education. Currently, public insurance restricts reimbursement to only one-on-one health education, as opposed to group education. Furthermore, grants available for group education are typically aimed at research or new product development. Various methods of education are needed to meet the needs of farmworkers, including group, one-on-one, and peer education. Funders can improve education by remaining flexible and allowing outreach programs to focus on the needs identified by farmworkers themselves. Legislators have a key opportunity to support outreach-centered group education as a valid form of increasing access to care and preventing health disparities.

Farmworker Advocate Recommendation

Collaborate to meet the diverse information gaps. Various health education tactics can be useful with the farmworker community, particularly popular education and experiential learning. In order to successfully address the breadth of farmworkers' educational needs, health centers and the broader social service community can look to each other for support. Funding tends to be disjointed. For example, a health center may receive funding to address diabetes and a labor center may get funding to address occupational health, even if both are serving the same community in similar ways. An opportunity exists for these community agencies to join forces and be more effective and more efficient. Additionally, in order to successfully address the information gap, community-based organizations should collaborate with non-traditional partners, like employers, small businesses, and lawyers.

HOP Response

HOP intends to learn more about the nuances of how safety-net organizations collaborate with each other to be more effective in their communities. There will be an emphasis on highlighting success stories from innovative collaborations. Furthermore, HOP plans to develop a module for its outreach-centered health education curriculum that is focused on creating mutually-beneficial collaborations with community partners.

DATA

Providing quality health care with limited resources requires that services address an established need and are proven to be effective. Data creates an evidence base which influences internal decisions about allocating resources and improves the ability to leverage additional resources. Health center administrators report that collecting quality needs and evaluation data is necessary for overall program sustainability.

According to the findings, collecting data to support outreach and enabling services is impacted by limitations in staffing resources. Frequently, there is not enough time to fulfill clinic responsibilities, conduct community outreach, and collect data on outreach activities. Not only are there competing responsibilities, but there may be a disconnect between outreach and administration regarding the rationale for collecting data. Administrators indicate needs and evaluation data is a key component of successful grant applications, while 76% of outreach programs report the primary purpose for collecting data is to keep administrators informed. Even though outreach staff are vital to the data collection process, they may not fully recognize the meaning or importance of what they are being asked to do.

Establishing the true impact of outreach and enabling services can also be challenging. Currently, there are few shared standards for collecting and using outreach data. Each health center is responsible for creating its own methods. While 69% of programs indicated that they evaluate their outreach and enabling services, the most common data collection methods are informal, such as farmworker communication (85%) and observations (66%). Until there is a nationally-accepted standard for outreach evaluation data, enabling services may not receive the priority they deserve when allocating resources.

Funder/Policy Maker Recommendation

Establish uniform standards for outreach data collection that are flexible enough to accommodate a variety of populations. Health center administrators stated frustrations with the vast array of reporting requirements from private and public funders. Consistent data collection and reporting allow health centers to spend less time on information gathering and ultimately have more useful data that can be aggregated.

Farmworker Advocate Recommendation

Collaborate with Head Start agencies to conduct a needs assessment. Administrators state that being able to cite community need is important to gaining funding, yet only half of health center respondents conduct needs assessments. Most health center respondents say that staff time is the biggest challenge to conducting a needs assessment. Head Start

agencies are required to conduct a detailed needs assessment every three years with annual updates. Collaborating with Head Start agencies will help to alleviate staff time needed to collect needs data and ensure that health centers have up-to-date data for patients in their service area.

Collect outreach and enabling services data consistently and thoroughly. The majority of health center administrators said that proving outreach program effectiveness is essential to securing additional funding. Collecting strong data are necessary to demonstrate the value of outreach. Most health centers track and report clinical services consistently, but not outreach services. Report outreach data to staff, board, and funders in order to improve services and increase funding.

HOP Response

Develop resources that will formalize outreach data collection. Data collection in general arose as a significant challenge for outreach programs. While nearly all programs collect data, the mechanisms most often used are informal, such as observations and communication with farmworkers. Informal data is valuable and can yield meaningful results but when coupled with formal data collection, a much stronger case can be made for the effectiveness of outreach and enabling services.



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