2005-2006 REPORT

National Needs Assessment of Farmworker-Serving Health Organizations

A Biannual National Report on Outreach Service Delivery at Farmworker-Serving Health Care Organizations and Head Start Agencies

FARMWORKER HEALTH SERVICES, INC. OAKLAND, CA ▪ WASHINGTON, DC

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Third Edition

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Farmworker Health Services, Inc.
Oakland, CA • Washington, DC

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Farmworker Health Services, Inc. (FHSI) is a private, not-for-profit corporation, whose mission is to improve the quality of life of our nation's farmworkers in collaboration with local communities and their existing health delivery systems, and most importantly, in partnership with the farmworkers we serve. FHSI is a Central Office Grantee of the Bureau of Primary Health Care (BPHC). FHSI has a Cooperative Agreement with the BPHC in order to provide programmatic support services and products to migrant and community health centers and migrant voucher programs for the enhancement and/or development of farmworker health outreach programs.

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List of Acronyms

BPHC	Bureau of Primary Health Care
DHHS	Department of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FHSI	Farmworker Health Services, Inc.
FQHC	Federally Qualified Health Center
FTE	Full Time Equivalent
HRSA	Health Resources and Services Administration
HSAC	Health Services Advisory Committee
M/CHC	Migrant and Community Health Center
MSFW	Migrant and Seasonal Farmworker
MSHS	Migrant and Seasonal Head Start
MVP	Migrant Voucher Program
NAWS	National Agricultural Workers Survey
PCA	Primary Care Association
PIR	Program Information Report
UDS	Uniform Data System

Foreword

An estimated 250,000 children migrate with their parents each year.

". . . many of the data and findings in this report capture and confirm very significant trends in the farmworker population . . . These data demonstrate the significant reach and potential that health outreach and enabling services have within local communities . . ."

Farmworker men, women, and children provide our nation with the fruits and vegetables we eat daily.

Farmworker Health Services, Inc. (FHSI) is proud to present and share its third edition of the *National Needs Assessment of Farmworker-Serving Health Organizations.* Since 1970, FHSI has been the leading organization for the promotion, delivery, and enhancement of health outreach and prevention strategies. We are pleased once again to have the opportunity to present an overview of data and analyses of outreach programs' services and needs nationwide.

Approximately 89% of farmworker-serving health care organizations reported providing health outreach services to farmworkers and their families. To a large extent, this figure validates the fact that health outreach, enabling services and prevention strategies increase farmworkers' access to care and directly impact their health and well-being. Interestingly enough, many of the data and findings in this report capture and confirm very significant trends in the farmworker population including shifts in labor sectors in rural areas, the impact of the immigration debate/legislation, and influxes of indigenous, non-Spanish speaking farmworkers in larger farmworker states. These data demonstrate the significant reach and potential that health outreach and enabling services have within local communities and have direct implications for the delivery of timely, effective, and culturally responsive health care.

In our efforts to obtain a broader and deeper understanding of farmworker health outreach programs and the farmworkers they serve, this third edition of our report includes data obtained from Migrant and Seasonal Head Start agencies, health departments, and a sampling of local community health centers not currently receiving migrant funding. While by and large, migrant/community health centers remain the best suited and best prepared health providers to care for farmworkers, these other local community organizations often function as initial points of access to care and/or referral points for health care for many farmworkers.

We wish to thank you once again for your continued support and collaboration in our collective efforts to improve the quality of life of our nation's farmworkers and their families.

Best Regards,

Oscar C. Gomez,
Executive Director

Executive Summary

Background

In 2005 and 2006, Farmworker Health Services, Inc. (FHSI) conducted its third biannual *National Needs Assessment of Farmworker-Serving Health Organizations.* All three assessments have responded to a documented need in the farmworker health outreach community for national data on outreach programs, service benchmarks, outreach program needs, and farmworker health. In order to address this need, the *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* sought to gather information from migrant and community health centers (M/CHCs), migrant voucher programs (MVPs), Migrant and Seasonal Head Start (MSHS) grantee and delegate agencies, farmworker-serving health departments and health centers not receiving migrant funding about four core areas: (1) the farmworkers and farmworker family members in respondents' service areas; (2) the outreach services offered by respondent organizations; (3) programmatic needs in performing those services; and, (4) staff perceptions of farmworker health and social service needs.

Methodology

The needs assessment effort utilized three primary methods – a mail survey, telephone survey and focus group discussions – enabling both qualitative and quantitative findings. The mail survey was completed by 42% (98 of 232) of potential respondents including farmworker-serving health care organizations and MSHS agencies. [For the purposes of this report, the phrase "farmworker-serving health care organizations" refers to M/CHCs, MVPs, and farmworker-serving health departments and health centers not receiving migrant funding]. In order to reach a target goal of 30 organizations, 53 M/CHCs and MSHS agencies were contacted to participate in the national telephone survey. Five focus group discussions were conducted, including three with clinical providers from farmworker-serving health centers and two with representatives from farmworker-serving health departments; a total of 38 participants provided consent to have the discussions recorded and transcribed. Qualitative data captured in open-ended questions on the mail survey, telephone survey, and focus group discussion transcripts were analyzed using MAXqda2 software. Quantitative data were analyzed using SPSS 11.5. Data from FHSI's 2001 and 2003 national needs assessments were compared to 2005-2006 findings where possible. Existing data sources are incorporated to complement FHSI findings, where appropriate.

Key Findings

Farmworker-Serving Health Care Organizations

- Nationwide M/CHCs reported an average of 5,396 users/patients and 20,777 encounters per organization as reported to the Bureau of Primary Health Care Uniform Data System, calendar year 2005.
- All (100%) farmworker-serving health care organization respondents indicated that multiple sites increase access to services; the vast majority (89%) also reported increased user/enrollment numbers.
- Health care organization mail survey respondents reported that diabetes was the most common health issue faced by farmworkers, followed by hypertension and dental health.
- Participants in the clinicians' focus group discussions and respondents to the telephone survey discussed specific changes or trends in the farmworker population; shifts out of migrant work to seasonal work and settling out were among those trends discussed in depth, illuminating the changing face of farm work in the U.S.
- The majority (92%) of health care respondents revealed that farmworkers and/or farmworker family members are also working in labor sectors other than agriculture.
- Focus group discussion participants highlighted concerns regarding the impact of the national immigration debate on the farmworker community and health centers' ability to effectively reach them.

- Farmworker-serving health care mail survey respondents reported patient registration/eligibility as the activity most frequently performed by outreach staff.
- Overall, farmworker-serving health care organizations reported grant writing/funding sources and transportation solutions as their two top outreach program needs.

Migrant and Seasonal Head Start Agencies

- According to 2004-05 Office of Head Start Program Information Report (PIR) data MSHS agencies enrolled over 33,000 children and served 24,729 farmworker families.
- Nearly all (95%) MSHS mail survey respondents indicated that multiple sites increased user/enrollment numbers while also citing increased accessibility of services (75%) and a wider scope of collaborating agencies (70%).
- Migrant and Seasonal Head Start mail survey respondents reported that dental health was the most common health issue faced by farmworker children, followed by asthma and overweight/obesity.
- Housing assistance ranked as the most pressing social service need for MSFWs, according to MSHS agencies. Transportation ranked as the second most commonly observed social service need for farmworkers.
- The majority (76%) of MSHS mail survey respondents revealed that farmworkers and/or farmworker family members are working in labor sectors other than agriculture.
- Migrant and Seasonal Head Start mail survey respondents reported patient or client registration/eligibility as the activity most frequently performed by outreach staff.
- When commenting on the specific characteristics that make their outreach services successful, many MSHS respondents focused on their individualized and family-specific outreach along with the availability of bilingual staff/bicultural staff to meet farmworker families' needs.
- Overall, MSHS mail survey respondents ranked community coalitions followed by community needs assessments as their areas of greatest programmatic need.

Recommendations

Farmworker-Serving Health Care Organizations

Managing Multiple Sites

- Standardize key outreach infrastructures across all sites while balancing the specific needs of each site and its farmworker population.

Health Issues and Health Education

- Incorporate health education goals and objectives that specifically address diabetes, hypertension and dental health into the health care plan and outreach plan.
- Explore or expand upon the current scope of clinical outreach activities to address diabetes, hypertension and dental health issues with the farmworker community.

Responsiveness to Change

- Analyze unique farmworker-specific data collected through outreach activities including newly-emerging barriers to care and prioritized health needs. Use these data to inform and direct specific activities in an organization's strategic plan, overall health care plan and farmworker outreach plan.
- Consistently evaluate outreach activities and interventions for cultural appropriateness, responsiveness to identified needs, impact and the degree to which resources are used, both human and financial, in order to make a case for and maximize organizational inputs into the outreach program.

Organizational Integration

- Build upon efforts to integrate outreach priorities into the organization's overall scope in order decrease farmworker-specific barriers to care and maximize the delivery and effectiveness of culturally-appropriate services.

Joint Recommendation for Farmworker-Serving Health Care Organizations and Head Start Agencies

Farmworker-Serving Health Care Organization and Head Start Agency Collaboration

- Formalize collaborative efforts between local farmworker-serving health care organizations and MSHS agencies in order to build on each other's strengths, pool resources and fill gaps in services to more comprehensively serve farmworkers in your geographic area.
- Convene a national panel consisting of representatives from farmworker-serving health care organizations, MSHS agencies, and technical assistance providers for these agencies. Create a set of standard guidelines for formal collaborative efforts to enhance organizational capacity for successfully reaching farmworkers and their families.

Introduction

Farmworker Health Services, Inc.

Since 1970, Farmworker Health Services, Inc. (FHSI) has been working alongside migrant and community health centers and migrant voucher programs to provide quality, cost-effective, and meaningful health services to the men, women, and children who help deliver food to our tables everyday – our nation's farmworkers. Over the past 36 years, FHSI has evolved from a small outreach operation working in five eastern states to providing programmatic support nationally to farmworker-serving health organizations including all 330(g) migrant health grantees. In addition to essential information services, including this report, the *Outreach to Farmworkers* newsletter and the *Innovative Outreach Practices Report*, FHSI provides many other technical assistance services such as on- and off-site outreach program assessments, customized consultations to address programmatic needs identified by our clients, and education and training opportunities to enhance the skills of those working in farmworker outreach at the community level. As the oldest and most experienced non-profit organization advancing farmworker health, FHSI believes that collaborating with other farmworker advocates, individual communities, and farmworkers themselves enables the organization to fulfill its mission in the best possible way.

2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations

The *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* is the third biannual needs assessment conducted by FHSI. All three assessments have responded to a documented need in the farmworker health outreach community for national data on outreach programs, service benchmarks, outreach program needs, and farmworker health. In order to address this need, the *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* sought to gather information from migrant and community health centers (M/CHCs), migrant voucher programs (MVPs), Migrant and Seasonal Head Start (MSHS) grantee and delegate agencies, and other farmworker-serving health care organizations about four core areas: (1) the farmworkers and/or farmworker family members in each respondent's service area; (2) the outreach services offered by respondent organizations; (3) programmatic needs in performing those services; and, (4) staff perceptions of farmworker health and social service needs.

The *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* gathered information from migrant health grantees as defined under section 330(g) of the Public Health Service Act as well as from non-grantee health centers and health departments that serve farmworkers. In addition, the assessment gathered information from MSHS grantee and delegate agencies as defined under Section 637 of the Head Start Act. This report's main findings focus on farmworker-serving health care organizations and MSHS agencies.

Agricultural Worker Definitions

Defined by Section 330(g) of the Public Health Service Act, a "migrant agricultural worker" is an individual whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who establishes temporary residence for the purposes of such employment. Migrant agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. The definition includes those individuals who have been so employed within the past 24 months and their dependent family members. "Seasonal agricultural workers" are defined similarly to migrant agricultural workers; however, they do not establish a temporary home for the purposes of employment but rather live permanently in one location and work seasonally.

For the purposes of MSHS agencies, "migrant farmworkers" are defined under section 637 of the Head Start Act as individuals who are engaged in agricultural

labor and have changed their residence from one geographic location to another in the preceding 2-year period. "Seasonal farmworkers" engage primarily in seasonal agriculture and have not changed their residence to another geographic location in the preceding two years.

For both categories of workers, agriculture is defined as farming of the land and all its branches, including cultivation, tillage, growing, harvesting, preparation, and on-site processing for market and storage. Aquaculture, lumber production, poultry processing, and cattle ranching are not included.

Outreach Definitions and Models of Care

With experience in both direct outreach services and programmatic support, FHSI recognizes the uniqueness of each community health outreach program. This recognition includes the understanding that outreach can encompass more than information sharing and marketing health delivery system services. FHSI therefore defines outreach from a broader perspective, including in its definition concepts of total health, open access to care, comprehensive service delivery, and an ultimate anticipated outcome of increased service use and decreased health disparities for farmworkers.

Farmworker Health Services, Inc. defines outreach as the process of improving the quality of life for migrant and seasonal farmworkers (MSFW) by: increasing access to quality health care and social services, providing health education, bringing linguistically and culturally responsive health care to farmworkers, helping farmworkers to become equal partners in their health care, and increasing the community's awareness of the presence of farmworkers and/or other underserved populations.

Outreach is the practice of providing information, clinical, and educational services to farmworkers where they live, work, and spend time. Doing outreach is often defined by physical location and the people with whom one is working. This typically means going outside of the traditional clinical setting to deliver outreach services. Therefore, outreach is an effective way to access and work with farmworkers while taking into consideration their transience and isolation. Farmworker Health Services, Inc. has developed a Community Health Outreach Model that addresses elements of both infrastructure and service delivery of the farmworker community health outreach program within the larger health delivery system and can provide a framework for understanding and implementing FHSI's unique vision of a community health outreach program (see Appendix A).

In addition to FHSI's extensive experience, the United States Bureau of Primary Health Care (BPHC) has influenced FHSI's definition of outreach. The BPHC defines outreach as, "a service or complement of services for actively reaching patients in their own environments and communities to increase access to care and result in improved health outcomes."[1]

Types of Health and Social Service Delivery Systems

Migrant and Community Health Centers and Migrant Voucher Programs

Migrant and community health centers and MVPs are primary care organizations that serve at-risk and underserved populations, among others. Migrant and community health centers and MVPs are partially funded through the primary care system development programs administered by the Bureau of Primary Health Care, Health Resources and Services Administration (HRSA) under the Migrant Health Center Program, Section 330(g) of the Public Health Service Act. These programs provide outreach to farmworkers through various methods and combinations of services. It should be noted that there is no universal model for an M/CHC or MVP that will uniformly meet the needs of farmworkers across all service areas. There are currently 134 health centers or voucher programs that receive funding specifically to meet the needs of MSFWs.

Migrant and community health centers operate out of a health center setting. Migrant voucher programs provide primary care services to the community without the traditional health center base, meaning the majority of their services are delivered through outreach and case management to the farmworker community. Migrant voucher programs contract with medical providers, make necessary referrals and provide farmworkers with a "voucher" for health care services, carrying the cost of services from another provider or health center. An MVP may exist in areas where the numbers and/or density of MSFWs cannot justify the establishment of an M/CHC based on the traditional medical delivery system model. Migrant voucher programs may also serve areas where existing provider organizations cannot qualify or are unwilling to serve as grant recipients, and/or where existing providers have the capacity to meet many of the primary care needs of area MSFWs.

Migrant and Seasonal Head Start Agencies

Migrant and Seasonal Head Start agencies, administered at the national level, are designed to provide comprehensive services to eligible farmworker families and their children, from birth to compulsory school age.[2] Funded directly through the Department of Health and Human Services (DHHS), MSHS agencies include educational, health and social services such as medical and dental screenings, disabilities, home visits, nutritious meals, parent education, mental wellness, and school readiness.[3] Although health care is not MSHS agencies' primary mission, they do have a significant health component. For the purposes of this report, the phrase "farmworker-serving health care organizations" refers to M/CHCs, MVPs and farmworker-serving health departments and health centers not receiving migrant funding. Migrant and Seasonal Head Start agencies are referred to separately.

Migrant and Seasonal Head Start services are free to eligible families and operate across the country in a total of 36 states. There are a total of 66 MSHS grantee and delegate agencies operating approximately 475 centers nationwide.[4] Those families that are engaged in agricultural labor and who have changed their residence from one geographic location to another in the preceding two year period may receive services. Migrant and Seasonal Head Start agencies are operated by non-profit organizations and sometimes by the local education agency. The agency receiving federal funds to operate the program is known as the "grantee." Grantee agencies may operate a program directly or may choose a "delegate" agency to operate part or all of the program for them. Most MSHS agencies do not provide a full year of services.

Migrant Streams

Certain findings in the *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* are presented by migrant stream. Historically, during the non-growing season migrant farmworkers have resided in "home base" communities in the U.S., such as Florida, Texas, or California, or abroad in Mexico, Central America, or the Caribbean. As the growing season progresses in the spring or summer, migrant farmworkers relocate north to "receiver communities." Traditionally, these migration patterns moving north from home bases are referred to as migrant streams. For the purposes of this needs assessment, respondents were classified into one of the three migrant streams including: 1) the Eastern migrant stream, running from Florida to New England; 2) the Midwestern migrant stream, from Texas to the Northern Plains and Great Lake states; and 3) the Western migrant stream, from California to the Pacific Northwest. Although the migration patterns of each stream are not as clearly defined as they once were, they remain a useful way of understanding farmworker migration and regional differences in outreach and medical services. Table 1 defines each of the three streams according to its respective states.[5]

Table 1. Composition of migrant streams by state

Eastern stream		Midwestern stream		Western stream
Alabama	New Jersey	Arkansas	Nebraska	Alaska
Connecticut	New York	Colorado	New Mexico	Arizona
Delaware	North Carolina	Illinois	North Dakota	California
Florida	Pennsylvania	Indiana	Ohio	Hawaii
Georgia	Puerto Rico	Iowa	Oklahoma	Idaho
Kentucky	Rhode Island	Kansas	South Dakota	Nevada
Maine	South Carolina	Louisiana	Texas	Oregon
Maryland	Tennessee	Michigan	Utah	Washington
Massachusetts	Vermont	Minnesota	Wisconsin	
Mississippi	Virginia	Montana	Wyoming	
New Hampshire	West Virginia	Missouri		

Methodology

Information Gathering Approach

Farmworker Health Services, Inc. sought to gather programmatic and farmworker information from farmworker-serving health organizations across the nation through a variety of methods. Using a mail survey, a telephone survey and focus group discussions, qualitative and quantitative data were collected from migrant and community health centers (M/CHCs), migrant voucher programs (MVPs), Migrant and Seasonal Head Start (MSHS) grantee and delegate agencies, and farmworker-serving health departments and health centers not receiving migrant funding.

Mail Survey and Telephone Survey

The mail survey was administered between March 17, 2006 and April 21, 2006. It was mailed to 232 respondents, composed of 128 330(g) grantees, 40 farmworker-serving health centers not receiving migrant funding, and 64 MSHS agencies. Ninety-eight of these organizations completed the survey, including 62 330(g) grantees, 10 farmworker-serving health centers not receiving migrant funding, and 26 MSHS agencies. A list of these organizations was compiled through consulting the following sources: FHSI's database, BPHC's list of grantees, Primary Care Association (PCA) contacts, and the Office of Head Start Program Information Report (PIR) database. The telephone survey was administered between March 24, 2006 and April 28, 2006 and conducted with 30 M/CHCs and MSHS agencies, using the list above. Telephone interview respondents were selected randomly from this same list using systematic and cluster random sampling. FHSI staff were trained in conducting telephone surveys and were observed in the interview for quality assurance purposes. Some respondent organizations may have completed either the telephone or mail survey, while others may have completed both.

In February and March 2006, telephone and mail surveys were pilot tested with a total of nine sites, located in all three migrant streams. Feedback from the pilots was incorporated into the final version of both surveys. The surveys sought information from the person with the greatest knowledge of the respondent's farmworker and/or farmworker family programs and issues at the organization. Such persons included: executive directors, Head Start directors, medical directors or outreach coordinators. While the mail survey sought to gather mostly quantitative data, the telephone interview sought qualitative responses on the same general topics. Major topic areas covered by both surveys were: 1) respondent organization information; 2) farmworker information; 3) outreach program information; and 4) organizational needs.

Focus Group Discussions

As another qualitative component of FHSI's national needs assessment project, five focus group discussions, comprised of three discussions with clinical providers from farmworker-serving health centers and two with representatives from farmworker-serving health departments, were conducted between October 2005 and May 2006. The clinicians' focus group discussions were held during the three annual migrant stream forums. Lists of potential clinical participants were generated from conference registrant information; participants were invited to take part based on their geographic location, with one representative per organization. Upon providing their consent, a total of twenty-six clinical providers participated in one of three focus group discussions facilitated at the East Coast Migrant Stream Forum (October 21, 2005), the Midwest Stream Farmworker Health Forum (November 11, 2005), and the Western Migrant Stream Forum (January 29, 2006). Clinical representation included nurse practitioners, physician assistants, nurses, physicians and dentists.

To explore the outreach activities of health departments who serve farmworkers, two focus group discussions took place via teleconference in May 2006. A list of potential health department participants was created by FHSI in consultation with PCAs and Cluster Coordinators. Candidates were invited to take part based

on their geographic location and it was requested that the person with the greatest knowledge of the respondent organization's health services for farmworkers participate. Upon providing their consent, a total of twelve representatives participated in one of two focus group discussions on May 30 and May 31, 2006. Representation across the three migrant streams included participation from nursing supervisors, directors of health services, senior eligibility review specialists, coordinators of a migrant health program, executive community health nursing directors and operations manager.

The purpose of the focus group discussions was to gather information from clinical and health department perspectives about such key topics as: (1) health care utilization; (2) trends in farmworker populations; (3) access and barriers to care for farmworkers; (4) outreach program operations and challenges; (5) organizational needs with regard to outreach [health department focus group discussions only]; and (6) strategies for strengthening the link between clinical and outreach services in order to improve the quality and continuity of care for farmworker patients [clinicians' focus group discussions only].

Analysis

Quantitative data from the survey instruments were entered, cleaned, and analyzed using SPSS 11.5. Prior to initiating data entry, a codebook was created to guide the process and a pilot test was conducted; the same two surveys were entered independently by two FHSI staff and coding results were compared. The data entry codebook was modified accordingly. Respondents who did not complete all survey questions were excluded only from analyses concerning responses to those questions that were left unanswered. Responses to ranking questions were assigned a point value based on each respondent's ranking order; answer choices not ranked by respondents received zero points. The values for each possible response, across all respondents, were then summed and averaged to obtain a mean score. The overall rank order was determined based on these mean scores for each answer choice.

Quantitative findings are presented on two levels: nationally and by migrant stream. When migrant stream analyses are not presented, this is due to such considerations as the following: small sample sizes, minimal distinction between stream results, or response options not being conducive to stream analysis. All tables and figures presented in the Findings section correspond to mail survey results only, unless otherwise indicated. The number of respondents to a question ("n" value) is presented on the figures and tables, where feasible.

Telephone survey responses were recorded in notations by the interviewer. Focus group discussions were facilitated by one FHSI staff person while simultaneously being captured by a digital voice recorder and notations taken by a second FHSI staff member. All five focus group discussions were transcribed verbatim by FHSI staff members. Two FHSI staff independently reviewed the qualitative data for initial key themes. Then, qualitative data from the surveys and focus group discussions were entered, coded and analyzed more extensively using MAXqda2, a qualitative data analysis software package. Readers should note that the majority of quotations are verbatim; in a few cases, data from telephone and mail surveys were adapted for readability but still closely reflect the original statements. As well, the quotations are representative of the findings but are not exhaustive.

Quantitative findings from the mail survey provide the initial structure of the report with qualitative findings included throughout the report, when appropriate and salient findings emerged to support quantitative findings. In addition, some of the qualitative data have been presented on their own to illuminate interesting information not captured by the survey instruments. Overall, the report aims to maximize the strengths and contributions of each method, creating a comprehensive snapshot of farmworker demographic and health information, programmatic issues and organizational needs.

Refining the National Needs Assessment

The *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* included several improvements to the *2003 National Needs Assessment of Farmworker Health Care Organizations*, particularly in the area of survey development and qualitative data. Many of the improvements were based on feedback from 2003 respondents, 2005-2006 pilot responses, and priority areas identified by FHSI staff.

Improvements to the *2003 National Needs Assessment of Farmworker Health Care Organizations*

- *To gather more complete and comprehensive data, the 2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* expanded the sample to encompass MSHS grantee and delegate agencies, farmworker-serving health departments and health centers not receiving migrant funding along with M/CHCs and MVPs.
- *To maximize existing data resources,* findings from the 2004-05 Office of Head Start Program Information Reports (PIR), 2005 BPHC Uniform Data System (UDS) Rollup Reports and other sources are included, where appropriate.
- *To ensure that survey instruments were applicable to a broader audience,* survey questions were adapted to encompass responses regarding farmworker family members as well as farmworkers.
- *To ensure a more substantive qualitative component,* focus group discussion guides were customized for two different audiences (clinicians and health departments). All five focus group discussions were recorded and transcribed. The telephone survey tool was adapted to include more qualitative and fewer quantitative questions. Qualitative data were analyzed using MAXqda2 software. Nearly all qualitative data presented reflect verbatim quotations.
- *To ensure accurate data entry,* a pilot step was included that required FHSI staff to independently enter two of the same surveys and compare results. The mail survey codebook, used during data entry, was revised accordingly.
- *To learn more about farmworker demographics,* questions were added on indigenous farmworker languages and ethnicities, farmworker children, and participation in other labor sectors.

Limitations of the *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations*

- Findings on farmworker information, such as barriers to care or health topics of greatest interest to farmworkers, are limited insofar as they reflect the respondent's perception of farmworker issues. These are secondary sources and do not reveal findings as reported directly by farmworkers themselves.
- The response rate to the mail survey decreased slightly (from 50% to 42%) between the 2003 and 2005-2006 needs assessments. This may be attributed to such factors as: 1) a longer mail survey; 2) a wider, more diverse distribution of the mail survey to an audience that had minimal prior knowledge of FHSI; and/or 3) the timing of mail survey administration.
- Information reported only pertains to the sample of respondents and is not necessarily representative of all M/CHCs, MSHS agencies and farmworker-serving health departments and health centers nationwide.
- A regularly updated, centralized database of 330(g) grantees, farmworker-serving health departments and health centers not receiving migrant funding is currently not available. As a result, the list of health departments and health centers serving farmworkers was limited to the information obtained through alternative sources identified by FHSI. The 330(g) grantee list was based on FHSI's database, comprised of the latest accessible information.
- Respondent groups reported data from different time periods for 2005. For instance, M/CHCs were requested to report data from calendar year 2005, as this is consistent with required UDS reporting procedures. Migrant and Seasonal Head Start respondents reported according to their latest, complete programmatic year, consistent with their PIR reporting process. As a result, MSHS agency data were not limited only to the 2005 calendar year as in the case of M/CHCs.
- Different institutions, agencies and/or individuals have varying definitions of outreach. Although definitions were made available in the mail and telephone surveys, individual or organizational definitions may have biased or influenced participants' responses to outreach-specific questions.

2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations Report

The *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* report is organized according to organization or agency type. The Findings section is presented in two parts; the first part is dedicated to the findings specific to farmworker-serving health care organizations, defined here as M/CHCs, MVPs, farmworker-serving health departments and

health centers not receiving migrant funding. The second part of the Findings section addresses results specific to MSHS grantee and delegate agency respondents. Each of the two parts is organized by key assessment topic area. A Discussion and Recommendations section follows that is based on key findings. As in previous needs assessment reports, specific recommendations are presented for farmworker-serving health care organizations. In 2005-2006, as FHSI expanded the target audience to include an assessment of MSHS agencies, two additional recommendations were included that focus on possibilities for collaboration between MSHS agencies and farmworker-serving health care organizations. Comprehensive tables summarizing major findings for both audiences may be found in the Appendices section.

Findings

This section delineates key findings about respondent organizations and agencies, including information about their farmworker populations and outreach services. It is divided into two parts. Part I reports findings from farmworker-serving health care organizations, defined here as M/CHCs and MVPs as well as other farmworker-serving health centers and health departments; Part II reports findings from MSHS agency respondents. The Farmworker Population portion of Part I is the only exception because it includes some qualitative data from MSHS respondents alongside data from health care organizations. The findings were consolidated for these two organization types because the information that emerged was not specific to either audience.

Part I: *Farmworker-Serving Health Care Organizations*

The quantitative and qualitative findings presented in this section are specific to respondents from 330(g) funded migrant and community health centers (M/CHCs) and migrant voucher programs (MVPs) as well as other farmworker-serving health centers and health departments. The data were derived from four sources including the mail survey, telephone survey, focus group discussions and calendar year 2005 UDS reports. The mail survey data represent findings from a total of 72 respondents, comprised of 62 federal 330(g) grantees from across the United States and 10 farmworker-serving health centers not receiving migrant funding. The telephone survey results were the product of 15 telephone interviews with farmworker-serving health centers nationwide. The focus group data refer to three discussions with 26 clinical providers from farmworker-serving health centers and two discussions with 12 providers and administrators at farmworker-serving health departments nationwide.

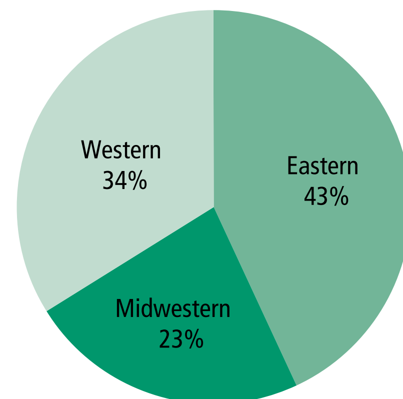
Organizational Information

This section details key characteristics about respondent organizations, MSFW user/encounter information, outreach staffing, and budget information.

Respondents

Overall, 125 individual health care organization respondents participated in the focus group discussions, mail and telephone surveys; 43% (54 of 125) were located in the Eastern stream, 34% (42 of 125) from the Western stream and 23% (29 of 125) from the Midwestern stream. Figure 1 demonstrates these findings.

Figure 1. Focus group discussion, mail and telephone respondents, by migrant stream (n=125)



The mail survey was administered to a total of 168 farmworker-serving health care organizations comprised of 128 330(g) grantees and an additional 40 health centers not receiving migrant funding. The response rate was 43% (72 of 168 possible organizations). Of the total 168 possible mail survey recipients, 46% were located in the Eastern stream, 27% in the Midwestern stream, and 27% in the Western stream. Forty-nine percent (35 of 72)

of respondents were from the Eastern stream, 31% (22 of 72) from the Western stream and 21% (15 of 72) from the Midwestern stream.

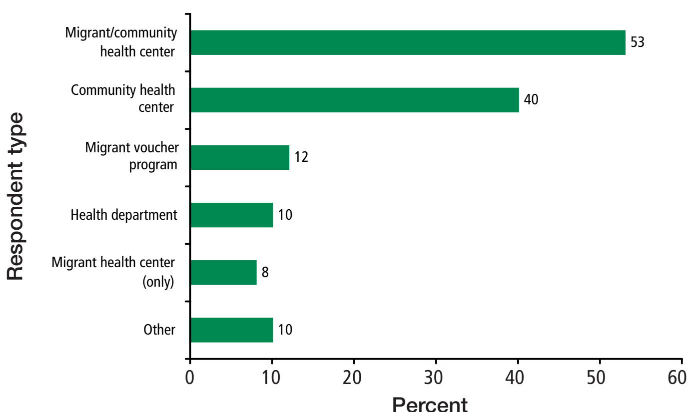
A total of 25 farmworker-serving health centers were contacted in order to reach the target goal of 15 to participate in the telephone survey. Forty percent (6 of 15) of telephone survey respondents were located in the Western stream, 33% (5 of 15) from the Eastern stream and 27% (4 of 15) in the Midwestern stream.

Of the thirty-eight focus group discussion participants, 39% (15 of 38) represented the Western stream, 37% (14 of 38) represented the Eastern stream and 24% (9 of 38) represented the Midwestern stream.

Respondent Organization Type

Respondents to the *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* were asked to classify their organizations, selecting multiple designations if necessary. The three most frequently cited respondent organization types included M/CHC (53%), community health center (40%), and MVP (12%) (Figure 2).

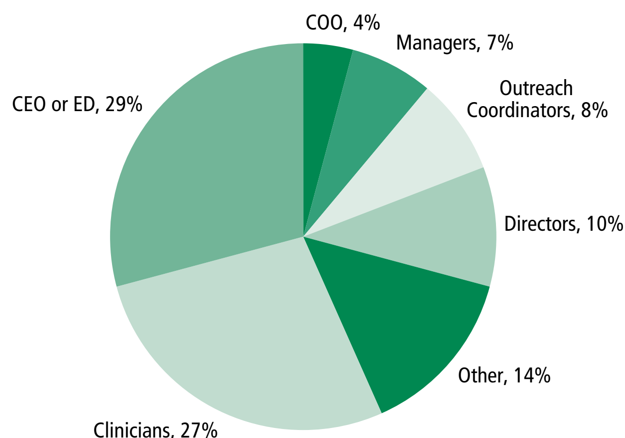
Figure 2. Focus group discussion, mail and telephone survey respondents, by organization type (n=124)



Respondent Position

Respondents were categorized according to eight general titles; one title per respondent. Chief executive officers (CEO) or executive directors (ED) accounted for nearly a third (29%) of mail, telephone and focus group participants. Other respondents included clinicians (27%), directors (non-clinical) (10%), outreach coordinators (8%) and managers (non-clinical) (7%). Fourteen percent of respondents held a different position within their organization, including health educator, corporate compliance officer and board member (Figure 3).

Figure 3. Focus group discussion, mail and telephone survey respondants, by title (n=121)



Number of Sites

In 2006, FHSI asked mail survey respondents for the first time to identify the number of sites making up their organization. Forty-four percent indicated their organizations were comprised of six or more sites, 29% had four or five sites, 17% had two or three sites, and 7% had one site only.

Respondents selected the benefits of having multiple sites. All (100%) indicated that multiple sites increase access to services. The vast majority (89%) cited increased user/enrollment numbers. Other benefits included an increased understanding of a service area and its needs (73%), more diverse clients able to access services (68%) and a wider scope of collaborating agencies (65%). About half (52%) reported that having multiple sites enables more distinct services (Figure 4.)

Mail survey respondents also provided qualitative data on challenges their organizations face in having more than one site. Overwhelmingly, the greatest challenges included fostering effective communication, assuring operational consistency, and a variety of staffing issues including supervising/managing staff, addressing staff isolation-related concerns, and securing/maintaining skilled personnel. Geographic distance and the time required for travel between sites were factors cited that exacerbate many of these challenges.

Figure 4. Percent of respondents reporting selected benefits of multiple sites (n=66)

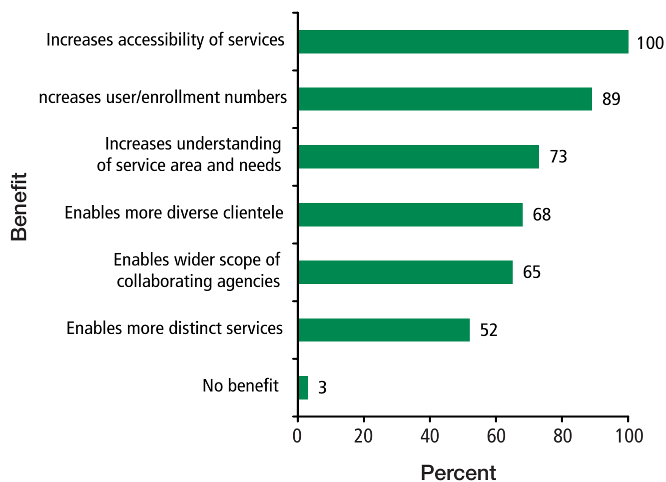
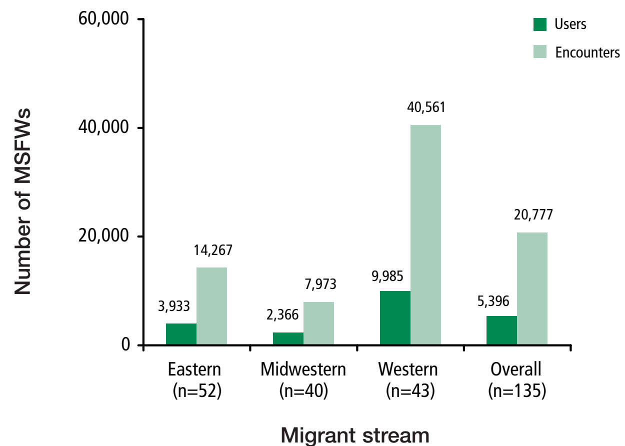


Figure 5. Average number of MSFW users and encounters per grantee, by stream



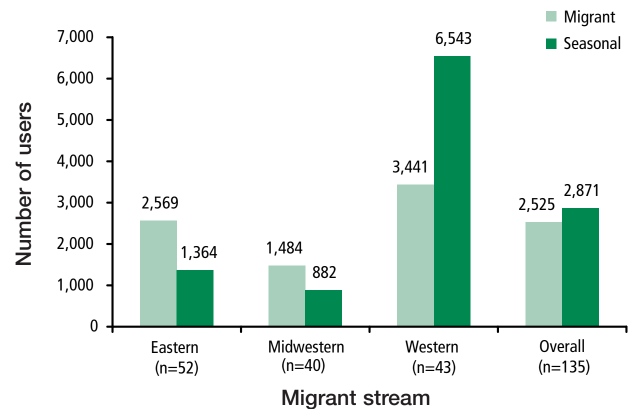
Users/Encounters

Migrant and community health centers report both users and encounters to the BPHC UDS on an annual basis. According to the UDS, a total of 776,668 MSFWs or dependent users were served in the 2005 calendar year. Based on 2005 UDS 330(g) grantee data, Western stream organizations reported the highest average number of farmworker users per grantee (9,985), followed by the Eastern (3,933) and Midwestern (2,366) streams (Figure 5).[6]

The 2005 UDS data also captured information on MSFW encounters for all migrant health grantees. The Western stream had the greatest average number of encounters per grantee (40,561), followed by the Eastern (14,267) and Midwestern (7,973) streams (Figure 5).[7] Comparing the ratio of UDS farmworker users to encounters per grantee, the Midwestern stream reported the lowest ratio, with one farmworker user per 3.4 farmworker encounters per grantee, followed by the Eastern (1 to 3.6) and Western (1 to 4.1) streams; overall, this makes for a ratio of one user to 3.9 encounters per grantee.

Migrant health grantees report the number of farmworker users by their migrant or seasonal status in the UDS. Similar to findings presented in Figure 5, in calendar year 2005 Western stream grantees reported the highest average number of migrant and seasonal farmworker users per organization, with 3,441 and 6,543 respectively. The next highest averages were among the Eastern stream grantees, followed by the Midwestern grantees (Figure 6).[8]

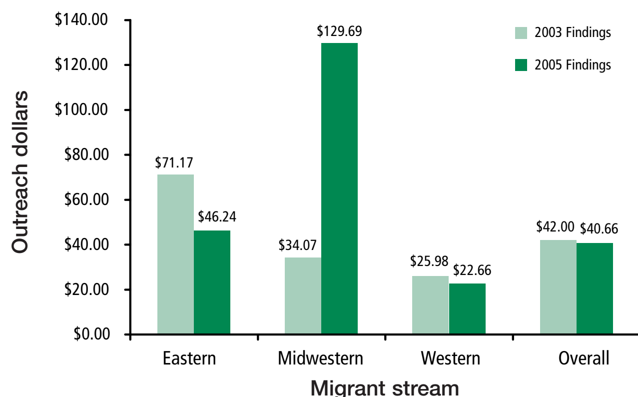
Figure 6. Average number of migrant and seasonal users per grantee, by stream



Outreach Cost per User

One benchmark that can be used by outreach programs to ensure that grant dollars are used to maximize the services and care delivered to farmworker patients is the ratio of outreach dollars per farmworker user. Nearly identical to the 2003 needs assessment findings, the national average for outreach dollars spent per farmworker user is $40.66 according to mail survey respondents. This was calculated by dividing mail survey respondents' average total outreach budget, by the average number of farmworker users per grantee in 2005 UDS data. As can be seen in Figure 7 (next page), the dollars per user varied considerably by stream from 2003 to 2005.

Figure 7. Average outreach dollars per MSFW user, by stream



Farmworker Information

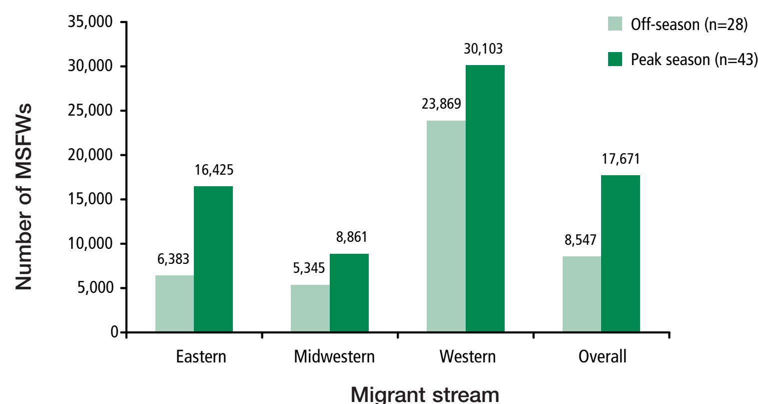
Farmworker-serving health care organizations play a critical role in the reduction of significant health disparities that exist between MSFWs and the general population. Knowledge about farmworker demographics, including population numbers, language, race/ethnicity, and health issues is essential to being responsive to the unique needs of this population.

Farmworker Population

According to the 2000 National Agricultural Workers Survey (NAWS), approximately 70% of MSFWs permanently reside in the United States.[9] Yet farmworker population estimates vary greatly by season. Mail survey respondents to the *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* were asked to estimate the total number of farmworkers and farmworker family members in their organization's service area during peak harvest times as well as during the off-season. Figure 8 shows the average number of farmworkers during peak and off-peak seasons in respondent organizations' service areas. Forty-three organizations nationwide reported an average of 17,671 farmworkers and farmworker family members in their regions during the peak season. Twenty eight organizations nationwide reported an average of 8,547 farmworkers and farmworker family members remaining in their program's service areas during the off-peak season.

Similar to findings from the *2003 National Needs Assessment of Farmworker Health Care Organizations*, the most marked seasonal difference was in the Eastern stream, with an average of 16,425 farmworkers residing in respondent organizations' service areas during peak season, but only an average of 39% (6,383) remaining during off-peak season. The Western stream reported the highest (30,103) average number of MSFWs and family members during the peak season and an average of 23,869 remaining during off-peak seasons. Respondents from the Midwestern stream reported the lowest (8,861) average number of farmworkers and family members in their service areas during the peak season and an average of 5,345 remaining during off-peak seasons (Figure 8). Comparing the ratio of UDS farmworker users to mail survey farmworker population data (during peak season), the Western stream reported the lowest ratio of one user to 3 MSFWs in the population, followed by the Midwestern (1 to 3.7) and Eastern (1 to 4.2) streams. Overall, this makes for a ratio of one user for every 3.3 farmworkers in the population during the peak season.

Figure 8. Average number of MSFWs and family members in service area, by stream



Participants in the clinicians' focus group discussions and respondents to the telephone survey were asked about changes or trends in the farmworker population that they have observed over the past couple of years. Shifts out of migrant work to seasonal work and settling out were among those trends discussed in depth, illuminating the changing face of farm work in the U.S.

Shifting out of migrant work to seasonal work

Changing migration and farmworker lifestyle patterns dominated the conversations with study respondents. It appears that locations normally used to seeing an influx of migrant farmworkers yearly are now seeing more and more farmworkers shift from migrant work to seasonal work, as farmworkers try to remain in an area long-term. There appears to be a growing desire by many farmworkers to acquire year-round work in one location and end their mobile lifestyles. In some cases, they may still do seasonal farm work for part or all of the year and work in different industries when the growing and harvesting seasons are over. In other cases, they may be attempting to move out of farm work entirely.

> *"One change is that there are less migrant farmworkers and more residential [farmworkers]. They used to come in as migrants and then leave. Now, some of our patients are here year round. They are still farmworkers, but there's an increase in the number who stay."* (Corporate Compliance Officer, Eastern stream)

> *"They are finding farmers to employ them year round. Our organization spans a several county area with cotton, rice, and milo. Many farmers can use farmworkers year round in the preparation of fields, harvesting of crops, and ginning. This leaves only a couple of months where the farmworkers aren't actively working the fields. During this time they help the farmers prepare the machinery."* (Community Partnership Specialist, Midwestern stream)

> *"Of the fifteen years that I've been [here], when I first arrived in the early 90's, there was a distinct season, from April through November. And now, the settling out that we have and other agricultural industries that have also been formed…chicken, growth of chicken, pork, and those have presented other problems too. Even if it's a rainy day they can work. I've seen some changes over the years. The true migrant now, I can't really tell."* (Dental Director, Eastern stream)

Settling out

Some clinicians' focus group discussion and telephone survey respondents mentioned a tendency toward farmworker families intentionally settling out longer-term in their host communities for the purpose of ensuring that their children can stay in school year-round.

> *"…Well and settling out too for kids as well. Either deciding to stay down here and not migrate so their kids can stay in school or settling out up north so that the kids can stay in school. It used to be years and years ago that they would come up as large family groups and stay…we have a site up [in the northern part of the state] and it's potato season and they would come up in March and stay until October and go to school up there just on the ends – the end of the school year, and the beginning of the school year – and then come back down here for a few months and get back into school down here and now we're seeing those families settle out and find you know that they'll still work at the potatoes in the summertime but then work in other jobs during the wintertime and stay living [in the community]."* (Researcher, Midwestern stream)

> *"Many families wanted to get familiar with the area. Families that have been in the area for 5-6 years are becoming more aware of how moving affects the education of their children. They are thinking more about the educational system for their children. Some parents are even getting involved in the school. Some families are becoming established in the area."* (Health Specialist, Western stream)

Impact on farmworker-serving health organizations

According to both farmworker-serving health care and MSHS agency respondents, the phenomenon of settling out, whether to move into other labor sectors or to concentrate solely on seasonal farm work, has started to have an impact on the ability of these organizations to effectively serve their clients, especially MSHS agencies which are intended to serve migrant farmworker families only.

> *"…Our numbers have increased through the year—instead, you know, like before, they will be moving from New York to Florida to pick up or to go back to Mexico, now they are staying. So, now before we could plan for three months of really heavy work and that now we don't have three months, we have twelve months of really heavy work."* (Registered Nurse, Eastern stream)

> *"With regard to the labor sector, there has been a decrease in migrant fieldwork and an increase in construction. Programmatically, this has resulted in difficulties to meet enrollment needs due to this change (in the labor sector)."* (Health Services Supervisor, Western stream)

"Our settled out community is a challenge for our outreach program. We know that they are there but they are becoming more scattered around the city and we need to make sure that they are continuing to receive care." (Outreach and Enrollment Specialist, Midwestern stream)

"Farmers are requesting that families stay behind—they only want men, no women and children which hurts our program. And weather over the past three years has had an impact [up here]. With the hurricane cleanup last year, it will affect us this year. Many farmworkers didn't come last year – they stayed behind and worked in clean-up efforts which means this year when they come, they may not qualify for services." (State Family Service Coordinator, Eastern stream)

Single male farmworkers

Observations were made about the farmworker population's decreasing number of families traveling together to do farm work; it appears that the make-up of the farmworker population has shifted in some areas towards men who travel alone. Some of these men are single males but others are married male farmworkers who leave behind their settled out families while they travel for work.

"More single male workers are coming to work--they may not actually be single having left their families behind but employers are looking for these single workers who are more likely to work, work, work while they are there since they won't be distracted by the families, enrolling their kids in Head Start etc." (Executive Director, Midwestern stream)

"The biggest one [trend] we see is they no longer migrate as a family unit; there are more single men or men going alone in the migrant stream and leaving families behind." (Early Intervention Prevention Director, Midwestern stream)

A couple of respondents observed that the solo male farmworker trend has introduced new health challenges including higher incidences of sexually transmitted infections and depression.

"I've noticed there are fewer families. There are more single males and married males. That brings different issues and concerns. There's been an increase in STDs. We didn't see that when there were mostly families. There's also more violence, more drug use." (Outreach Director, Eastern stream)

"We are seeing more depressed farmworkers in the young adult population – men. It is just the general circumstances of being a farmworker away from home and so often they are clustered in camps where they are almost all men and they're lonely." (Clinical Director/Manager, Midwestern stream)

Farmworker Age and Gender

According to the UDS, in calendar year 2005, 330(g) grantees served 53,621 more female than male users, serving a total of 393,294 female and 339,673 male users.[10] Mail survey respondents reported on farmworker and farmworker family clients served by age and gender. Overall, the largest user group was males and females between 25-44 years, yielding an average of 816 males and 1129 females. The lowest average was among senior males and females between ages 65-74 with an average of 72 and 77 MSFWs per organization respectively (Table 2).

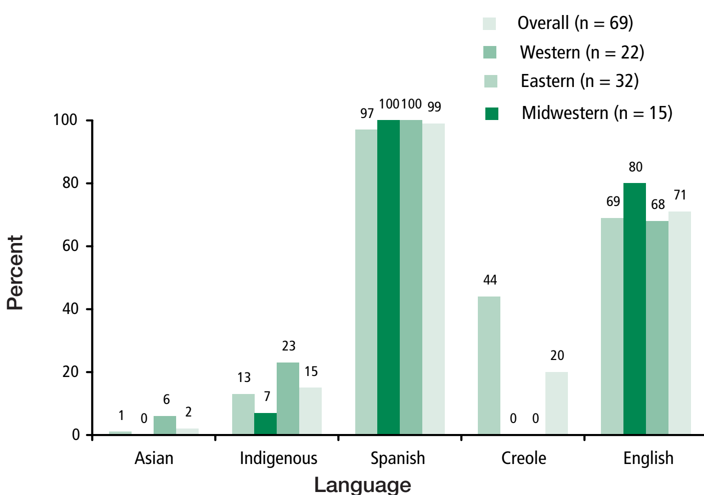
Table 2. Average number of farmworker and farmworker family users per organization, by age and gender (n=47 to 51)

Age Group	Males	Females
0-3 years	366	365
4-5 years	150	142
6-10 years	270	259
11-14 years	196	195
15-19 years	213	292
20-24 years	234	350
25-44 years	816	1129
45-64 years	420	508
65-74 years	72	77

Farmworker Languages

Mail survey respondents were asked to identify languages spoken by farmworkers and/or farmworker family members in their service areas. Nearly all respondents (99%) reported the presence of Spanish-speaking farmworkers and farmworker families in their service areas. Similar to findings in the *2003 National Needs Assessment of Farmworker Health Care Organizations,* almost three of every four (71%) respondents indicated that MSFWs in their area speak English. Haitian Creole was reported by one in five respondents (20%) whereas indigenous languages (including Kanjobal, Mixteco, Triqui and Zapotecan) were reported by 15% of respondents; of these, nearly one in three respondents (29%) reported Mixteco being spoken by farmworkers and farmworker family members. Only 2% of respondents reported farmworkers that speak Asian languages (including Thai, Tagalog and Hmong). Western stream respondents most commonly reported indigenous languages (23%) and the presence of Haitian Creole was limited to Eastern stream respondents (44%) (Figure 9).

Figure 9. Percent of respondents reporting languages spoken in local farmworker population



In discussions with various focus group and telephone survey participants, newly emerging farmworker languages were cited as a significant challenge to effectively providing services. Conducting successful outreach increasingly necessitates staff who can speak languages other than Spanish and who understand the cultural beliefs and practices of the various indigenous cultures that have become more prevalent in farmworker communities over the past few years.

> *"I work at a community health center and almost 40% of my population of my patients are indigenous speakers and before we had our outreach workers, our communication with that entire patient base was extremely minimal, um, it was whatever little bit of Spanish they spoke and if they brought their husbands they were dragged in to be the interpreters and the level of actual clinical communication was, you know, you could examine, you could talk, you could order blood tests but that doesn't mean that you've actually communicated with people."* (Clinical Coordinator/Case Manager, Western stream)

> *"…and with this community [Oaxacan community], we have learned that simply because somebody else is from your same locale, speaks your dialect, does not mean that the client is readily going to be willing to accept that person that you have as a resource as your translator. That's a huge mistake that we've made here or almost walked into before."* (Public Health Nurse, Western stream)

> *"This year we really had a real problem with a very new group of people who have arrived in our area… that are speaking Mixteco. And that has, really thrown a ringer into us because they don't speak Spanish. They really do not. So, it's a whole different dialect."* (Adult Nurse Practitioner, Eastern stream)

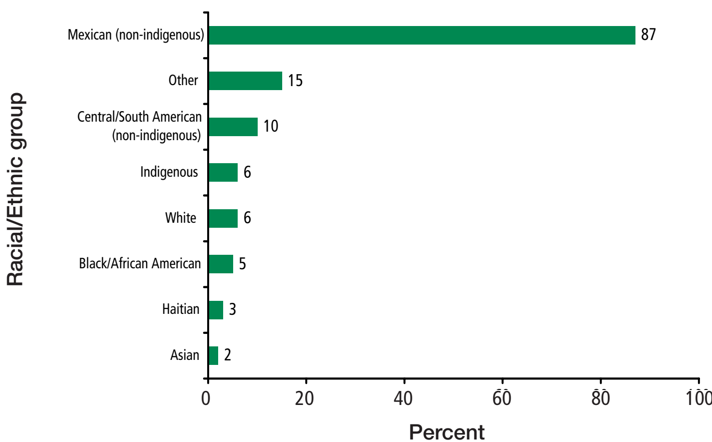
> *"What we're seeing in [our] county is primarily Mixteco-speaking population which has started migrating in the last two or three years to our county, and the lack of interpreters to provide interpretations to them. So that's a big barrier for us. We may have to go make a home visit with a Spanish-speaking interpreter who tries to speak with someone in the family who speaks both Mixteco and Spanish, who then translates to the Mixteco-speaking person. It makes for lengthy visits and I am also not really clear how much understanding there is."* (Nursing Supervisor, Western stream)

Farmworker Race/Ethnicity

Mail survey respondents were asked to identify ethnic/racial groups represented by farmworkers and farmworker family clients at their organizations; for those groups selected, respondents estimated the percentage of

the total farmworker family clients served. Mail survey respondents reported an average of 87% of their total farmworker clients were "Mexican (non-indigenous)." Respondents reported that 15% of their farmworker population were "Other" races/ethnicities. Ten percent indicated "Central American (non-indigenous)" and "South American." "Indigenous" farmworkers, including Kanjobalan, Mixtec, Trique, and Zapotecan groups made up an average of 6% of clients served, as did "White" farmworkers (Figure 10).

Figure 10. Average estimated percent of farmworker racial/ethnic groups at respondent organizations

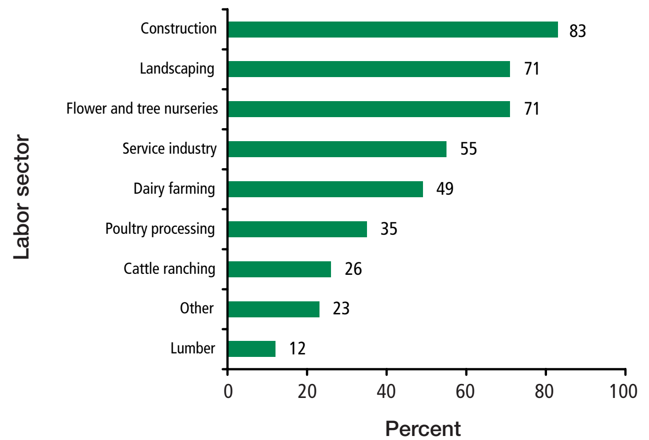


Labor Sectors

Respondents were asked to report whether farmworkers and/or farmworker family members in their service areas worked in labor sectors other than agriculture. The majority of respondents (92%) revealed that farmworkers and/or farmworker family members are working in labor sectors other than agriculture. Eighty-three percent reported that farmworkers and their family members are working in construction and nearly three of every four respondents (71%) reported landscaping, with the same percentage in the flower and nursery industry (Figure 11).

Focus group participants as well as telephone survey respondents commented on this trend toward farmworkers moving into other labor sectors. Some of the labor markets mentioned were those highlighted in Figure 11 including construction, nurseries and the poultry industry just to name a few.

Figure 11. Percent of respondents reporting farmworkers in other labor sectors (n=66)



"Farmworkers are beginning to work in other sectors like golf course maintenance, lawn maintenance, construction and yard work." (Social Services Director, Eastern stream)

"Ours are working in the boats, which is big where we are. They are in the lumber yards. We've had growers die off. People never left the area. They got into other work--construction. We're getting calls from people, 'do we know of any Hispanics looking for work?' No we don't. They're all working." (Adult Nurse Practitioner, Eastern stream)

"…especially because the population is growing by leaps and bounds down here in the valley, there's a lot more jobs, you know, usually low pay jobs, a lot more maintenance at the schools 'cause they keep growing so they need janitors, more cleaning ladies whatever. So a lot of people are starting to find full-time jobs at home." (Physician Assistant, Midwestern stream)

Health Issues Facing Farmworkers

In order to inform services and programs, farmworker-serving health care organizations need accurate information about the health issues farmworkers face, the health topics that interest them, the barriers they face in accessing health care, and the social service needs that confront them.

Overall, based on a mean score, diabetes was the most common health issue among farmworkers and their families, hypertension was second and dental health was the third most common health issue (Table 3). This rank order is identical to the order of the most common health issues facing farmworkers reported in 2003 and 2001.

Table 3. Overall ranking of most common farmworker health issues and health topics of greatest interest to farmworkers

Health Issue	Overall rank* of most common health issues	Overall rank* of health topics of greatest interest
Diabetes	1	1
Hypertension	2	2
Dental health	3	3
Prenatal care	4	4
Asthma	5	N/A
Mental health	6	9
Dermatitis	7	7
Alcohol/substance abuse	8	10
Nutrition education	9	5
HIV/STIs	10	8
Environmental/ occupational health	N/A	6

* Overall rank based on mean score.

These rankings were further supported by qualitative findings from the clinicians' focus group discussions. Participants noticed that farmworkers and their families were especially prone to developing certain chronic illnesses such hypertension, diabetes, childhood obesity (correlated with diabetes) and asthma. In some cases, it was noted that these conditions were developing at an earlier age than in the past. Some respondents suggested that better screening may account for the increased incidence of some of these illnesses.

"That's the trend that we've noticed is that these chronic diseases or illnesses or the acute onset in a younger, much younger age than before in the Hispanic population. It's an awakening because you're already dealing with full-blown diabetes in people who are 20 years old instead of when you would see them at 40 and 50. I don't know what's doing that. It must be the obesity and the change in the diet when they move here." (Clinic Manager, Western stream)

"I've only been working since April so I don't have last year to base it on but the one thing I notice is these guys wanting their blood pressure checked, being 20 years old and consistently having hypertension." (Outreach Program Coordinator, Western stream)

"I've seen a lot of the same families for years and years and I've been in migrant health for a long time and I see the children grown up and we have a lot of families and they are chubby and the girls who were thin 10 years ago are now really obese …definitely seeing more diabetes--part of it is because of the lifestyle and the obesity I think is probably the relationship there and the other thing is that we're doing a better job of picking up and looking for it." (Family Nurse Practitioner, Eastern stream)

"We are finding in our home turf right now, we're waiting - getting referrals from hospitals for migrant citizens hospitalized whether there's a larger number of hypertension and diabetes issues; so there's a great need for diabetic teaching also." (Migrant Health Program Coordinator, Eastern stream)

"I've also seen throughout the years, especially in the past three or four, three or five years, an increase in diabetes. So we have established community educational classes through the outreach, and also through the providers of the clinics to actually extend those services for the people that are in need of additional assistance whether it's teaching them how to shift from your normal way of cooking to cooking in a more healthy way and just adding all these different things to help the community farm laborers." (Senior Eligibility Review Specialist, Midwestern stream)

Health Topics of Interest to Farmworkers

Farmworker-serving health care organizations also ranked, from one to three, the health topics of greatest interest to farmworkers. Based on mean score rankings, diabetes, hypertension, and dental health were the top

three topics of interest (Table 3). These areas figured in the top three health topics of interest to MSFWs in the *2003 National Needs Assessment of Farmworker Health Care Organizations* as well.

Barriers to Accessing Health Care

Based on mean score rankings, mail survey respondents ranked transportation, pay scale/financial issues, and lack of knowledge of available resources as the three greatest barriers that farmworkers and farmworker family members face in accessing health care in their service area. The ranking order evident in 2005-2006 was nearly identical to those of 2003's findings (Table 4).

Table 4. Overall ranking of barriers to care (2003, 2005-06)

	Overall ranking*	
Barrier	2005-06	2003
Transportation	1	1
Pay scale/financial	2	2
Lack of knowledge of available services	3	4
Language/lack of interpretation services	4	3
Legal status	5	5
Hours of operation of health services	6	6
Not enough outreach services	7	7
Cultural differences	8	8
Differing medical beliefs	9	9

* Overall rank based on mean score.

Many of the qualitative responses to questions about barriers to care that were asked in the clinicians' and health department focus group discussions supported the quantitative findings above. The participants' insights below illustrate the complexities and context of some of the pre-identified barriers included in the mail survey while also highlighting additional barriers not previously addressed.

Immigration reform climate

Focus group discussion participants highlighted concerns regarding the impact of the national immigration debate on health centers' ability to effectively reach farmworkers.

The impact of the political climate around immigration has manifested in a variety of ways including an increased stress level in farmworkers and a guardedness on the part of farmworkers and crew leaders. The immigration reform climate has also impeded the provision and utilization of critical health services and created unsympathetic community environments in which to seek funding for outreach efforts.

"And I think also, I live just a few miles from the border and la miga, *[immigration] they're everywhere and people [farmworkers] are worried that they are gonna get taken away. And it was really sad, one day I was out there and there was probably over a hundred farmworkers in this chili field…and a helicopter was off in the distance and everybody ducked at the same time, and it was like, 'uh, what a way to exist.' The stress level – I can't even imagine…"* (Outreach Program Coordinator, Western stream)

"…I think that the depression and the stress is, I am seeing a lot more, a lot larger population that are going without seeing their families for long periods of time because they're afraid to cross the border again because they can't get back or I'm seeing them go and then not be able to get back to be able to be cared for, you know, to resume their position so they don't have their position, they don't have access to their meds when they're gone, they haven't articulated what it is that they're taking and so I'm seeing both sides of that too along with the border patrol issue." (Case Manager, Western stream)

"We've seen a pretty significant increase in the difficulty of access to workers that are undocumented. A sort of higher level of secrecy and guardedness on the part of both workers and their crew bosses. Which is a particular issue for us because all our clinics are mobile clinics, so, we can only see people if we can actually get into their camps." (Medical Director, Eastern stream)

"We face the challenge because we get some local funding in our communities, of some of the politics that's gotten involved, and some of the, uh, guest workers, immigrant type issues. And we're a very, very, very 'Red State' …and that's very difficult for us. We want to do the outreach, but we're always walking a very fine and political line on that." (Area Administrator, Eastern stream)

"The sole purpose of outreach is because the farmworkers are afraid of medical services because of fear of deportation. We go out to advise, build trust, to come into the clinic. There is a need to work through fears to just get the available services such as prenatal, immunization, etc." (Operations Manager, Western stream)

"We have grown continuously for the past seven years; however, given the current immigration climate, we anticipate less migrant farmworkers crossing the border as in years past. In fact we already see it now-we didn't have farmworkers in the fields like we used to and I had my part-time person start two weeks later than usual. We anticipate the drop in numbers this year but of course we don't know yet." (Outreach and Enrollment Specialist, Midwestern stream)

Payment process/challenges with coverage

As evidenced in the results from the mail survey, financial issues often serve as a barrier to farmworkers seeking health care services. However the issue is more complex than a lack of financial resources to pay for services or the reality that farmworkers are less inclined to seek care if they must sacrifice a day's worth of work to visit the clinic. Clinicians also spoke about the challenges of confronting complicated payment processes and the need to address issues related to insurance coverage that does not transfer across state lines. These factors also serve as barriers in their own right to the uptake of services. In other cases, these challenges also influence whether or not farmworkers comply with the follow-up care prescribed.

"…Just coming back to the clinic for follow up and that is a really big thing because I don't know about your situation but for us, the second visit is very different because the first visit is practically free. And then the second visit, they have to go through the paperwork to do the sliding scale . . . because we just want them to get in there and get taken care of what's wrong and then the second time they come back, they have to have gone through the paperwork so that becomes really confusing, very hard." (Outreach Director, Western stream)

"Our financial process I think is a barrier for people…We have a very extensive sliding scale and offer services at incredibly reduced costs, a $1/month payment plan, but it all requires that you sort of participate in the process and fill out a form or provide proof of your family's income and your family size. And we've even reverted to just taking people's word for it like you don't even have to bring in proof of your taxes or anything, you just have to sort of declare what your family's income is, and we've even gone to that kind of informal system but the number of people that we have that won't do it, um, won't even provide that information verbally much less with documented proof is really astonishing and unfortunate because unless they do that, we'll bill them full price." (Director of Outreach, Western stream)

"We had interstate referrals a long time ago, where people who were going back could do it. Mothers coming up right now are not changing their Medicaid. It's too complicated. They will not. So, they go under a sliding scale in the community health center, but then what happens is there's a significant problem; they cannot be referred out unless they want to go all through that, and they don't. So, we don't have interstate coverage and children in particular, who use the health center much more than adults, don't qualify for it anyway." (Adult Nurse Practitioner, Eastern stream)

Farmworkers delaying care

Several focus group participants noted that many farmworkers often only seek health care services when they are very sick; clinicians and health department providers commented on patterns related to farmworkers not readily seeking services early on and the difficulties associated with coming in for preventive care such as prenatal care. Some of the reasons that exacerbate this problem were constraints such as farmworkers not wanting or being able to afford to miss work, a lack of information about available services, as well as a lack of means of transportation – findings which are supported by the quantitative mail survey responses.

"If they're real sick, if they need their medication, and if they have transportation, then they may come." (Physician, Eastern stream)

"Under-utilization again, I think because, we normally see in our clinics more the acute very sick where they have to come in…I work in the OB clinic, and again it's because of the need for prenatal care but the need you see comes as the result of having a problem with that. Not to come in for screening or it's the right thing to receive prenatal care. The majority of our women are beginning to become moderate to high risk care also because they wait too long to access the system even though they have been here." (Clinic Manager, Western stream)

". . . when you [a farmworker] come up, you're coming up to work. If it is a nice day out, you are going to put in that 16-hour day whether or not you have medication, whether or not your blood sugar is sky high . . .but if it's a really nice day out and people are out working then we don't have the numbers and so our diabetes educators can get so frustrated 'cause they're thinking 'we do all this outreach and we want the people to come in' and yet we also understand. This is when you're making money, you're up north and you need to make that money too so my diabetes is gonna be the last thing on the plate." (Researcher, Midwestern stream)

". . .in general when you talk to folks out in the clinics most people do believe that migrant workers come into care later than other women because of the—perhaps fear but absolutely because they're just not aware that they can get their medical care covered while they're pregnant." (Coordinator of Maternal, Child and Adolescent Health, Western stream)

"We still are seeing that when we see the acute care getting taken care of maybe by inappropriately going to the ER, when had they jumped on something a few days earlier, it would have been better. But so we're seeing inappropriate use of the ER services." (Executive Community Health Nursing Director, Eastern stream)

"We don't even have really a public transportation system and so one of the things people do run into, to get rides, sometimes they have to pay people and we know that they charge outrageous rates and that's a barrier. And no, we don't have any funding and there's not anything to assist with that at this point." (County Nurse Manager, Eastern stream)

Social Service Needs

In addition to barriers to accessing health services, farmworkers face a host of other challenges that can greatly affect their health. Mail survey respondent organizations reported on the top three social service needs for farmworker patients in their service area. Based on the mean score, housing assistance ranked as the most pressing social service need for MSFWs. Transportation and English language instruction ranked as the second and third most commonly observed social service needs for farmworkers, respectively. This is comparable to data from 2003 with one notable exception. In 2003, food assistance was among the most needed social services instead of transportation which was not an answer choice on the 2003 mail survey (Table 5).

Table 5. Overall ranking of social service needs (2003, 2005-2006)

	Overall ranking*	
Social Service Need	2005-06	2003
Housing assistance	1	1
Transportation	2	N/A
English language instruction	3	2
Employment training/ job assistance	4	4
Day care	5	N/A
Legal services	6	5
Labor rights education	7	6
Children's education services	8	8
Food assistance	9	3
Domestic violence prevention education	N/A	7
Other violence prevention education	N/A	9

* Overall rank based on mean score.

Outreach Services Information

According to the Kaiser Commission on Medicaid and the Uninsured, only 20% of farmworkers access care at health centers.[11] Therefore, outreach staff are often the only link to the 80% of farmworkers who do not access formal health care services. Outreach is a critical function of health centers that serve farmworkers and one that distinguishes organizations that serve them from other primary care providers. This section is intended to give the reader a general sense of the structure of outreach services among respondents across the nation. Data discussed here pertain specifically to outreach services, and to the larger organizations within which they operate.

In addition to qualitative data sources, this section presents information from sixty-three farmworker-serving health care mail survey respondents who indicated that their organization provides outreach services to farmworker families. Most of these centers (87%) reported that their services are provided year-round whereas 13% reported seasonal services only.

Purpose of Outreach

During the clinicians' focus group discussions, providers were asked to share their views on the purpose of outreach. Clinicians reflected on the various ways that outreach has been critical to their success in interacting with farmworker patients. Some of the themes below were also reflected in mail and telephone survey responses.

Link to and extension of health care services

Across migrant streams, clinicians and health department representatives agreed that outreach activities allow health care organizations to make the critical link between the farmworker community and health services. Additionally, outreach services allow health care organizations to expand their ability to provide services to farmworkers.

> *"A bridge. They [outreach workers] are like a bridge between the clinic and the communities. Without that bridge you cannot go anywhere."* (Registered Nurse, Eastern stream)

> *"I see outreach as an extension of the primary care setting and it's the extra hands and feet that the providers don't have and they just help so greatly with access and follow up and case finding…"* (Clinical Director/Manager, Midwestern stream)

> *"Well the main thing I guess is we are the segue, the thoroughfare to the clinic if they need it and like I mentioned earlier, we do have a mobile medical unit that's staffed with a doctor and the back up staff that goes out to a very third world community and they go there twice a month. And so that's a nice central point where people feel less threatened rather than going into the clinic and they can get prenatal care and anything…basically we're just keeping the lines open for medical care."* (Outreach Program Coordinator, Western stream)

> *"I would agree with everyone as far as what we do for outreach but also I think maybe adding the word linkage there because there's times when we do outreach that we're linking clients to services that they need as well, if it seems opportune, if we have the information, if they need something, we may make the phone call for them at that time and also providing things."* (Nursing Supervisor, Western stream)

Outreach workers create trust

When addressing the purpose of outreach, one central theme that emerged among focus group discussion, mail and telephone survey respondents regarded outreach workers' ability to create trust between the clinic and its farmworker patients. Clinicians spoke about the significance of outreach workers' capacity to build trust and foster good relationships, an instrumental component to facilitating farmworkers' access to health services.

> *"I think also because they have very good relationships with the community, the outreach worker, it's not only—you know, sometimes we fail, to communicate with our patient, because we just talk to them about health issues. An outreach person goes to visit this person, they don't say, you know, 'here, you are sick,' or 'you have, you know…' they will talk about family issues and something else. …They are able actually to talk and bring these patients—so this outreach piece is so important in our communities because it's already a relationship with the community, they are not only members of the clinic, but they are friends… So, that*

outreach piece is so important, without that, I think we could not do as many things as we are able to do with them." (Registered Nurse, Eastern stream)

"…You know if you are going to have a relationship between the clinic and the farmworkers, somebody has to initiate that relationship and with everything else on their plate, for them to initiate that relationship is quite a burden." (Family Physician, Western stream)

"The [outreach workers] go out, they bond, they gain the trust, then the people come in and gain trust of clinic and doctors. The [outreach workers] are caring – if we do not have the patient's trust, we do not have the patient." (Operations Manager, Western stream)

Voices of the farmworker community

Several clinicians described how outreach workers serve as two-way conduits of information between the health center and the farmworker population. In addition to communicating valuable outreach-specific information to farmworkers, outreach workers also bring back critical information about farmworker needs to health center staff.

"To me, the outreach worker…you said outreach is a bridge…to me, that bridge goes both directions, not only do they go out to the camps but they're the ones that I think are crucial to come back and say, 'You gave this guy this medicine to take four times a day. Do you know where he is all day long?! And you want him to get water and take that medicine, in the middle of the day. …Can't you do something different?' …I think the outreach worker should have a very big role in saying, you know, 'This place is different…this guy has this and this won't work, you'll have to do it a different way.'" (Physician, Eastern stream)

"…We try and remember that our outreach workers, our promotoras are two-way conduits that yes, they could be valuable for taking health information out to people but that we need to make concerted efforts to listen to what they say—so we've invited them to provider meetings. We have clinicians' meetings in the clinics and we invite them to give feedback on what they're hearing and what common concerns are and to make sure that it is a two-way source of information and not just a one-way." (Family Physician, Western stream)

"One of things I've done…was to include both promotoras and outreach workers in all the clinical meetings. So that when the doctors and nurses are sitting and problem solving, they are also at the table as important resources." (Medical Director, Eastern stream)

Number of Staff

Different outreach services structures and regional needs call for different staff mixes and varied positions. Mail survey respondents reported on their programs' number of staff full-time equivalents (FTE) for several common outreach positions, including outreach workers, community health workers *(promotor/a)*, clinical outreach workers, outreach coordinators and transportation workers. Not all respondent organizations have each of the above positions; the average FTE for each position is based on respondent organizations that do have each position. The data below do not account for fluctuations in staff FTE during peak farmworker season, but rather represent average staff FTE for the entire year.

Among respondents providing outreach services, two of three respondents (68%) reported having an outreach worker in their organization. Of programs with outreach workers, the average number of full-time staff per program, or FTE, was 3.4. This represents only a minor decrease (0.1) from 2003 findings. The majority of respondent organizations (63%) have an outreach coordinator position, with an average of 1.1 FTE per position. Of those respondents providing outreach services, nearly a third (32%) have clinical outreach worker positions, 42% have community health worker/promotor(a) positions, and 32% have transportation worker positions; the average number of FTE per organization is 2.4, 3.3, and 1.7 respectively.

Languages Spoken by Staff

The languages spoken by outreach staff can provide some insight into the languages spoken by farmworkers across the country, as outreach services often try to match staff language abilities with farmworker needs in their area. Mail survey respondents were asked to indicate the languages spoken by staff serving farmworkers and farmworker family clients. Nationally, almost all mail survey respondents (97%) employ Spanish-speaking staff. These data are nearly identical to 2003 findings, when over 96% of mail survey respondents reported employing outreach staff members that speak Spanish. Additionally, 17% of respondent organizations reported employing

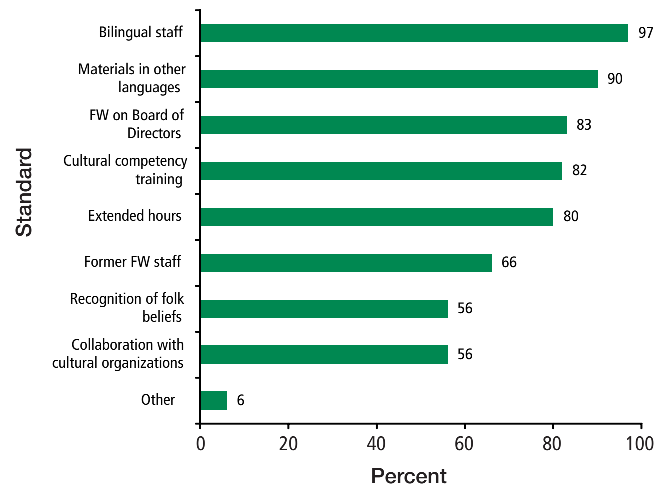
staff that speak Creole and 4% employ outreach staff that speak an indigenous Mexican or Central American language (including Mixteco, Kanjobal and Zapotecan). Three percent of organizations employ staff that speak the Asian languages of Hmong or Tagalog. Thirteen percent of respondents indicated that staff speak "Other" languages including Hindi, Russian, and French.

Cultural Competence

Farmworkers have very unique lifestyles and socio-economic factors that are important to understand and address in the provision of health care services making culturally competent services vital to the provision of effective health care for farmworkers. Farmworker-serving health care organizations across the U.S. employ various strategies to train and support staff in providing culturally competent care. The Department of Health and Human Services' Standards for Culturally and Linguistically Appropriate Health Care Services include a set of core guidelines for providing culturally and linguistically appropriate care.[12] As reflected in the Standards, mail survey respondents were asked to identify how their organization provides culturally appropriate services to farmworkers and/or farmworker family members. The most frequently reported culturally competent practices mentioned included bilingual staff (97%), providing materials in other languages (90%), and recruiting former or current farmworkers to serve on the Board of Directors (83%). Four of five respondents (82%) indicated that their organization provides cultural competency training and approximately the same number (80%) have extended hours (Figure 12). The most frequently reported culturally competent practices mentioned in 2003 included cultural competency training (53%), bilingual staff (50%) and bicultural staff (33%).

To delve further into the practice of cultural competency training, mail survey respondents were asked to identify staff positions that participate in this type of training at their organization. Two out of every three respondents (68%) reported that all of their staff receive cultural competency training. Over half (58%) indicated that their outreach workers participated in cultural competency training, followed by nearly that many (57%) reporting the participation of outreach coordinators as well. Other staff also received cultural competency training: community health workers (41%), clinical outreach workers (38%), and transportation staff/drivers (28%). When compared to the *2003 National Needs Assessment of Farmworker Health Care Organizations* findings, 2005-2006 results indicated a general decrease in the number of respondents reporting that various staff had participated in cultural competency training. For example, a decrease of 36% is evident in the portion of respondents reporting this year that outreach workers had received this type of training. In 2003, other frequently mentioned staff included medical (92%), administrative (90%) and dental (78%) personnel.

Figure 12. Percent of respondents practicing selected standards for culturally and linguistically appropriate care (n=71)



Not providing cultural competency training consistently to all staff can have an impact on the ability of health care organizations to effectively serve farmworkers as evidenced by some of the insightful qualitative data that emerged in the clinicians' focus group discussions. Two clinicians discussed the detriments of front desk staff ill-equipped to recognize the severe challenges of getting farmworkers into the health clinic and more importantly, the importance of creating a welcoming environment. By default, farmworker-serving health care organizations can create their own access barriers to care when staff who have not been properly trained to provide culturally competent services, come into contact with farmworkers throughout a clinic visit. It is not only up to outreach workers to provide culturally competent care—it is a responsibility of all staff at the various points in the system where farmworkers access services.

"…they'll [farmworkers] walk in in the middle of the day and they'll [staff] say 'come back at nighttime' you know for night clinic instead of—you know, we see people by appointments now where a long time ago we used to just see people who would walk in the community health center so when a farmworker comes in the daytime from out in the field and they want to be seen, they don't have an appointment. So they say 'come back at nighttime.' You know, we really should triage a patient and a lot of time we're working with that and they [staff] do sometimes but sometimes it's just real easy to just say 'come back at nighttime.' And they might not come back at nighttime." (Outreach Director, Western stream)

"I think that there's a lot of, as we were just saying earlier, so many different populations that, and a lot of times what I see is our staff trying to assert themselves—with the clients! And [the clinic is] saying 'we're here to serve' and they're trying to put a barrier between them and the clients. 'I'm up here and you're on the other side of there and I am your access' so I think some kind of training around that would be helpful for front line staff." (Family Nurse Practitioner, Eastern stream)

Keys to Success

Mail and telephone survey respondents provided qualitative data on the specific characteristics that make their outreach programs successful. Several core themes surfaced repeatedly. Specifically, programs highlighted the availability of bilingual staff, including staff with bicultural and farmworker backgrounds, which lends itself to a high level of cultural competency and sensitivity in outreach efforts. Many respondents also noted the commitment and enthusiasm of outreach staff, strong community collaborations for serving the spectrum of farmworker needs, and the provision of services directly where farmworkers live, work and congregate - a basic tenet of outreach.

"…What also makes it successful is that we go out to the patients. And we have bilingual staff. The programs are designed for one-on-one or to work with groups. Our organization is 'one-stop shopping.' We not only provide health services, but also on-site pharmacy, we do our own labs, we have an asthma clinic - when farmworkers come in, they get everything under one roof. Having bilingual staff from providers on down is what really is an asset for us." (Corporate Compliance Officer, Eastern stream)

"…We also know every loaf and jug [convenience store] in the area where the farmworkers get dropped off every morning for any of their needs for the day before they go into the fields. The part-time person will be there every morning to meet with them before they go into the fields. It's not romantic but it's got teeth." (Outreach and Enrollment Specialist, Midwestern stream)

Current Outreach Activities

Mail survey respondents were asked to rank the top three activities performed by outreach staff at their organizations. Overall, patient registration/eligibility was reported as the activity most frequently performed by outreach staff. This was followed by health education and health fairs or community events (Table 6). In 2003, patient registration/eligibility also ranked as the most

Table 6. Overall ranking* of most frequently performed outreach activities and most desired future outreach activities

Activity	Most frequently performed outreach activities	Most desired future outreach activities
Patient registration/ eligibility	1	3
Health education	2	1
Health fairs or community events	3	5
Case management	4	2
Clinical outreach	5	4
Transportation	6	N/A
Language services	7	N/A
Referrals	8	6**
Follow-up	9	6**
Data collection	10	6**

* Overall rank based on mean score.

**Identical rankings

frequently performed outreach activity. In 2003 and 2001 health education figured in the top three outreach activities performed as well.

Promotoras(es)

One popular model for delivering these outreach services includes the use of lay health promoters or promotoras(es). Their role in reaching farmworkers with health services appeared in many of the focus group discussions. Clinicians described the various ways they used their promotoras(es) to help them effectively reach their farmworker patients.

> *"We have the promotoras program-that's really helped out a lot. It's great. You get an abnormal lab or you get something significant and you have no idea where this camp is, where they live and then our nurse who does the promotora program is like 'oh yeah, they live right next to this area, next to so and so...' They know exactly and then they'll go find them and track them down and take them their medicine or tell them to come in or something."* (Migrant Medical Director, Midwestern stream)

> *"…most of our promotora outreach is actually done IN the clinic—all of the introductory steps of you know-making sure they're registered and what it means to be here, and what's going to go on in an exam room 'cause many, many people-this is their first medical visit ever. I could see that type of patient for an OB-HMP, probably one, I could probably see 5 patients a day if I had to do every step of that myself whereas I can see 25 patients a day-well not very well but-I can see 25 patients a day because of them."* (Clinical Coordinator/Case Manager, Western stream)

Future Outreach Activities

Mail survey respondents provided rankings of the top three activities they would like to see outreach staff devote the most time to in the next two years. Based on a mean score, health education ranked as the top priority activity, followed by case management and patient registration/eligibility (Table 6). These activities and their respective rankings are identical to the 2003 findings. These findings differ from 2001, when case management was reported as the priority activity for outreach staff. Clinical outreach and health education were the second and third activities respectively, that respondents wanted to see the most outreach time devoted to in 2001.

Clinical outreach or including clinicians in outreach activities ranked as fourth in 2005-2006 and 2003 and was among the top three desired activities in 2001. The clinicians' focus group discussions provided a few models of how clinicians are currently involved with outreach activities.

> *"I reach out to the population through health fairs, also through home visits…we also have an outside clinic that we have a PA that goes out there once a month and provides consultations, specifically in the labor camps."* (Farmworker Outreach Coordinator, Western stream)

> *"For our agency we have—each site has a clinic director who is an RN, so for all of our outreach efforts, the RN, I go to every outreach effort so I am there as a clinician and I screen every single person."* (Registered Nurse, Midwestern stream)

> *"I think also that—outreach bring the patients to the clinics, to the clinicians—to also make a connection, the clinician needs to go with outreach to the camps, to work with them and see what they're doing, who they are serving, you know, truly."* (Registered Nurse, Eastern stream)

Challenges to Providing Outreach Services

Farmworker-serving health care organizations confront various challenges in providing outreach services. Mail survey respondents were asked to rank the top three challenges facing their outreach component. Lack of staff clearly ranked as the greatest challenge followed by grant writing/securing funding and measuring performance/effectiveness (Table 7, next page).

Participants in the clinicians' focus group discussions and telephone surveys were also asked to identify the challenges faced by their outreach programs. Key challenges around funding were particularly salient. Many centers cited a lack of programmatic funding or an inability to serve uninsured and undocumented workers, who generally make up the majority of their patients. In one case, a participant astutely conveyed that he was able to find programmatic funding to support services to uninsured, low income patients; nevertheless, he also indicated that this funding may not be a steady source of income and so his ability to provide consistent or comprehensive care is compromised as a result.

Table 7. Overall ranking of greatest challenges facing outreach programs

Challenge	Overall Rank*
Lack of staff	1
Grant writing/ securing funding	2
Measuring performance/ effectiveness	3
Transportation issues	4
Conducting community needs assessments	5
Penetrating new service areas	6
Developing new services	7
Issues with data collection	8

* Overall rank based on mean score.

"Financial, financial, financial . . . . Our [farmworkers'] sliding fees start at $20 a head and we may not be able to charge this for all the kids also. There is no insurance for these individuals and other clinics with sliding fees start at $50 per head -so they come to our clinic because they can not afford to pay more than $20. So the clinic has to make money on Medicare and other programs to cover the expenses of providing services to those without funds. We had a grant for services to 500 optical and 500 medical patients which was great …however, these grants come for short periods of time, and when they end there are no funds to support the continuing care for these people." (Operations Manager, Western stream)

"I think one thing probably that is different for farmworkers is many of them are undocumented, and they don't have insurance in our state if they are undocumented. So it seems like we spend maybe more time trying to hook them into services in other ways if they don't have medical insurance which is a big issue for many of our farmworkers." (Nursing Supervisor, Western stream)

Staffing was also a critical challenge voiced by some clinician and health department focus group discussion participants as well as telephone survey respondents. One of the key issues raised was a manpower shortage, as many respondents simply listed the need for more staff. However, there were other staffing issues identified as well. Specifically, the challenge of finding bilingual staff or qualified staff willing to work for short periods of time were highlighted by some participants. Other challenges mentioned included:

- experiencing frustration around training and re-training part-time staff each year;
- staff burn-out due to the long hours spent in the community; and
- managing and supervising outreach staff who spend much of their time working away from the health center where job duties are typically more well-defined and verifiable.

"Staff recruitment: It is difficult to find bi-lingual providers who are willing to work when we need them. And staff burnout: Things are exciting but they can wear heavily on staff, i.e., working night after night and late into the night or people are on vacation during the migrant season and we just try to see as many people as possible with the staff that we have." (Executive Director, Midwestern stream)

"We have a managerial need for a person or two skilled enough to coordinate our outreach program. We have our health educator who organizes our mobile unit but when she is doing that in the summer, she can't do health education at the clinic. We have a manpower shortage. It will be difficult to find bilingual skilled staff who understand farmworkers' needs like those of us who have been doing migrant health for a long time…It is difficult to manage part-time workers every year even though it is necessary because of the on-going training hassle. You have to constantly train and retrain." (Executive Director, Midwestern stream)

"We take an interpreter with us when we go, none of us, none of the nurses in our agency are Spanish-speaking or bicultural which I think is unfortunate so we always take interpreters. Sometimes securing an interpreter to work in the evening is difficult; not all of our staff is available in the evening so trying to get in odd hours is sometimes difficult to get our outreach program the way that we want to have it run." (Nursing Supervisor, Western stream)

Programmatic Needs

Of those respondents providing outreach services, the majority received federal funding (88%) for their outreach services; other sources of funding included state funding (38%), private funding (32%) and other sources (28%) such as grants, program income, and donations.

These respondents were also asked to rank the two greatest financial challenges for their respective organizations' outreach programs, based on a list of possible answers. Overall, respondents ranked lack of reimbursable services as the greatest financial challenge for their outreach component (Table 8). That is, the number one challenge for respondent organizations is to find a way to compensate their program for the outreach services rendered to farmworker patients. The findings represented in Table 8 parallel the findings from 2003 which indicates a troubling trend challenging the sustainability of critically-needed outreach services.

Table 8. Overall ranking of greatest financial challenges for outreach programs

Challenge	Overall Rank*
Lack of reimbursable services	1
Securing federal funding	2
Securing private funding	3
Securing state funding	4

* Overall rank based on mean score.

Farmworker-serving health care organizations were also asked in the mail survey what are the five most needed additional resources that would benefit their organization in improving outreach services. Of a list of 13 programmatic support needs from which to chose, respondents ranked their responses from one to five. Table 9 shows the ranking of resources based on a mean score. Two of the top three ranked programmatic needs were shared with those from 2003; assistance with grant writing/funding sources ranked as the top programmatic need in both studies whereas assistance with community needs assessments ranked as second in 2003 and third in 2005-2006.

Table 9. Overall ranking of areas of greatest programmatic need

Programmatic need	Overall Rank*
Grant writing/funding sources	1
Transportation solutions	2
Community needs assessments	3
Program planning	4
Patient education materials/resources	5
Data issues/performance measures	6
Best practices/models that work	7
New service development	8
New service area penetration	9**
Community coalitions	9**

* Overall rank based on mean score.
**Identical rankings

Both the telephone survey and the health department focus group discussions were asked to identify their programmatic assistance needs. The desire for more funding was a topic mentioned frequently; this directly correlates with some of the top challenges discussed earlier in the report. More often than not, farmworker-serving health care organizations wanted to use this funding to either provide more services to their farmworker clientele or hire more staff to enable them to expand their reach to farmworker patients.

Respondents also mentioned training and programmatic assistance on a variety of topics. The topics most often identified included data tracking and management and cultural sensitivity and competency.

"We need staff development. Not just taking staff off-site for a day of training, but actually working one-on-one with them [staff] to improve their cultural competency and work with Spanish-speaking populations. We still have the problem of staff not being well-equipped to effectively communicate and anticipate the needs of the patient. It's not just a language issue . . . We could also use technical assistance on data collection with a transient population." (Director of Program Management, Eastern stream)

"I meet with new employees to teach them about the farmworker community and cultural sensitivity. I could benefit from learning more so I could teach new employees. When we had an outreach team, we had a system of reporting. Now we don't have a system of logging. …we need a data collection system in place. I just log things in my own personal calendar. I need technical assistance on a system for logging encounters." (Outreach Director, Eastern stream)

"Anytime you can do cultural awareness and sensitivity training and teach people about their population, this is always needed." (Executive Director, Midwestern stream)

"I would like to know how to effectively evaluate the work of outreach; we are trying to measure it but it's very hard." (Health Education/Outreach Coordinator, Western stream)

"Yes, I would have to agree that we need more interpreters, especially with like I said, the Oaxacan community and all their dialects. But I also wanted to say that cultural sensitivity training, that's a must." (Health Education Clinic Assistant, Western stream)

"I think [assistance with] tracking would be very helpful. Again, that would prevent us from duplicating services that may have been recently provided." (Area Administrator, Eastern stream)

Farmworker Outreach Plan

A farmworker outreach plan refers to a written plan that outlines an organization's farmworker community outreach activities and services, separate from one's overall organizational health care plan. This plan is an essential tool for documenting program goals and objectives as well as planning how these goals will be actualized and measured. At least one of every two mail survey respondents (55%) indicated that their organization has a written farmworker outreach plan. Thirty-nine percent did not have one and 5% identified having another type of plan including business and health care plans.

Mail survey respondents with a farmworker outreach plan reported on uses of their plan within their organization. Of those that have a plan, almost all respondents (97%) indicated their plan is used to guide activities whereas nearly two-thirds (62%) utilize it to orient new staff. Other uses included reporting to funders (56%), communicating between departments (53%) and other uses (6%) like "measuring team effectiveness and progress to meeting outreach goals."

Telephone survey respondents were asked to elaborate on how they plan their outreach activities. A few themes emerged. A few health centers noted that the process for planning outreach is less deliberate and more "automatic" given their long history of working with the farmworker community. Many health center respondents rely on their experience and strong community partners to inform and execute outreach efforts. In some cases, respondents commented on pre-season internal planning meetings, incorporating direct input from clinicians and outreach staff. Others noted that outreach is planned by request. At least two health centers commented on an organizational shift towards more planning for a better use of outreach resources.

"We have been working in the state since 1979 and we're well situated in knowing where migrants come from/to, the growers, crew chiefs and the various agencies that serve the migrant community. In the spring prior to the migrant season, we contact our contacts to see when the migrants are coming and we also try to be aware of new areas of migrants or of new growers who might be using migrants for the first time." (Executive Director, Midwestern stream)

"Yearly, we do an accessibility and outreach plan to define our goals for the upcoming year. We assess where we've done outreach in the past, where to find the farmworkers and whether we were successful or not. We have just been doing this so long that we are good at what we do and don't generally have to modify our outreach services much–we know where to find our farmworkers." (Outreach and Enrollment Specialist, Midwestern stream)

"We have done the program for many years. We have strong partnerships, and many invitations to attend outreach events. We create a calendar with partners to coordinate and maximize opportunities for health outreach." (Health Research and Grant Management Director, Western stream)

"We have meetings to go over where our mobile unit coordinator is in the process of setting things up. This is a pre-season get-together that will involve myself, a Board member and the medical director as well. By this meeting, we have already identified our temporary summer workers that we have recruited on college campuses. It works for them because we are meeting their language learning needs. I giggle that you talk about planning because we have been doing this for so long that the process is almost automatic! But with the expanded medical capacity grant, we have been talking a lot about making changes to the way we do things." (Executive Director, Midwestern stream)

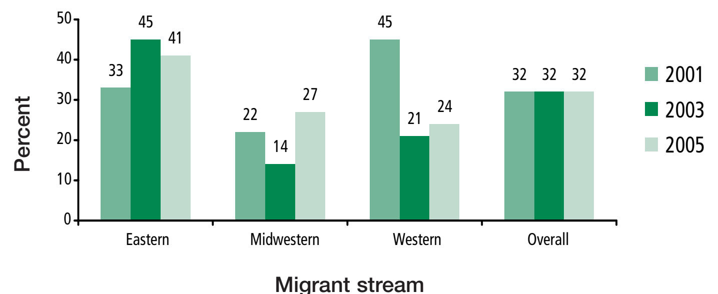
"We have team meetings to discuss outreach. Before, events were planned on request but now we have a more analytical planning process in place based on reaching people, maximizing resources, and doing smarter work." (Health Education and Outreach Coordinator, Western stream)

Needs Assessments

An accurate assessment of community needs is an invaluable resource for planning the direction of programs and service provision, as well as for gaining funding that will appropriately meet patient needs and result in positive outcomes. Knowing where different farmworker populations are living and working and understanding the major heath concerns that they identify is essential to conducting effective outreach—outreach that will meet true needs and encourage patients to enter the health system.

Farmworker needs assessments were conducted in 2005 by nearly one-third (32%) of mail survey respondents. These data are identical to 2003 and 2001 findings: where one-third (32%) of respondents had conducted a needs assessment in the prior 18 months. In 2005, Eastern stream respondents were most likely to have conducted a farmworker needs assessment, with 41% completing assessments. About one in four Midwestern (27%) and Western (24%) stream respondents reported conducting a farmworker needs assessment in 2005. Regionally, data collected from 2005 and 2003 are more similar than different whereas there is greater variance with the 2001 results (Figure 13).

Figure 13. Percent of respondents that have conducted a farmworker community needs assessment, by stream and year



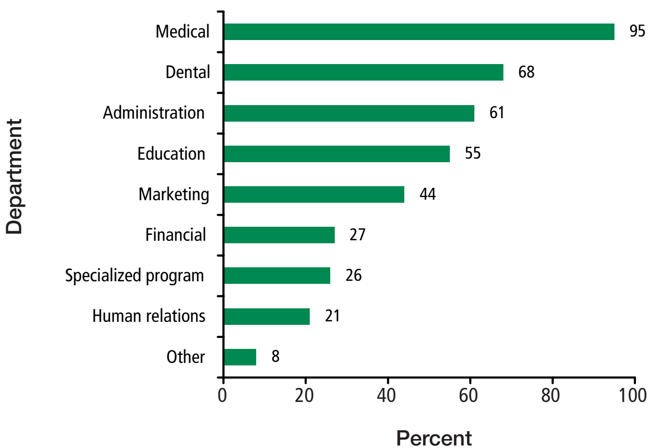
Mail survey respondents were specifically asked about the type of information collected, methods used, and application of findings. Of note in the needs assessments of 2005, nearly all respondents (97%) collected demographic information and two of three (68%) collected farmworker health status information; over half collected information on social service needs (59%), migrant and seasonal status (59%), and health education topics (55%). Other topics included but were not limited to barriers to care, benefits information, education level, and patient satisfaction.

When asked to report methods utilized for their community needs assessments, individual interviews were cited most frequently (86%), followed by community forums (41%), focus group discussions (27%), and telephone surveys (18%). Nearly half of respondents (46%) also indicated other techniques including working with community leaders, literature review, and health statistics from patients served and community data. Four of five respondents (82%) used farmworker needs assessment data to establish organizational priorities and to conduct program planning. Nearly three of four (73%) used the needs assessment data to inform strategic planning efforts and one of two (50%) used them to supplement a grant application.

Organizational Integration

Collaboration, communication and information-sharing between an outreach program and other departments in a health center are important components of the program's infrastructure. Nationally, mail survey respondents reported a high degree (95%) of collaboration between the outreach program and the medical department in their respective organizations. Respondent organizations also reported relatively high rates of collaboration with both dental departments (68%) and administration departments (61%). Lower rates of collaboration were evident with financial departments (27%), specialized programs (26%), and human relations departments (21%) (Figure 14). Findings from the *2003 National Needs Assessment of Farmworker Health Care Organizations* similarly revealed high levels of collaboration with the medical department (96%) as well as relatively high levels with administration (70%) and dental departments (69%).

Figure 14. Percent of respondents indicating outreach program collaboration with the following departments (n=62)

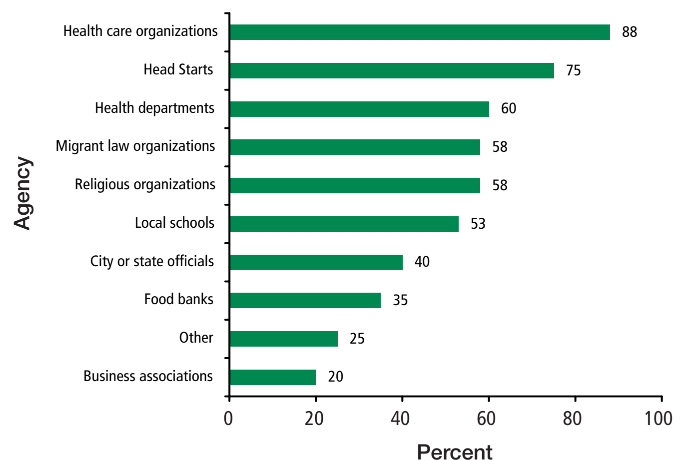


Farmworker Coalitions

Consistent with findings from 2003 and 2001, the *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* aimed to gather information about how farmworker-serving health care organizations collaborate with community groups and agencies in their service area. Respondents were asked if there was a farmworker coalition or other formal group of organizations that addresses farmworker family needs in their organization's community. Overall, 58% (40 of 68) of organizations surveyed reported the presence of a farmworker coalition in their communities; 29% reported no farmworker coalition in their community and 13% of respondent organizations did not know if there was a coalition established in their community. The percentage of respondents indicating farmworker coalitions in their community has steadily declined since 2001. In 2001 and 2003, 73% and 67% of respondents reported the existence of a farmworker coalition in contrast to only 58% in 2005.

Of the forty-one organizations who reported the existence of a coalition in 2005, nearly one of every two (49%) participate in their local farmworker coalition as members, whereas almost a third (29%) were lead members, and nearly one out of five (17%) served as advisory members. Respondents also indicated the agencies that participate in their local farmworker coalitions. The three most frequently cited agencies included health care organizations (88%), Head Starts (75%), and health departments (60%). One in four respondents (25%) indicated that other agencies participated in their coalition; these included growers, housing assistance groups, universities and migrant education organizations (Figure 15).

Figure 15. Percent of respondents indicating the following agencies' participation in their farmworker coalition (n=40)



Mail survey respondents were asked to share the benefits experienced from participating in a local farmworker coalition. Many respondents noted that their

farmworker coalition provided opportunities for networking and collaboration as well as chances to learn more about the needs of the farmworker populations they serve. Coalitions provide opportunities to keep abreast of current issues, share best practices, and new approaches.

"We learn the concerns [social and health] farmworker families have. We find out how to leverage resources within the community, helping share information between farmworker families and other agencies. This allows the coalition to help empower farmworker families." (Program Manager, Western stream)

"The farmworker coalition creates opportunities for collaboration, maximizing resources, expanding services and building support for farmworker issues." (Executive Director, Midwestern stream)

"The network of partners allows for increased contacts to farmworker communities to bring awareness of services." (Program Coordinator, Midwestern stream)

Though no questions were asked in this study regarding specific collaborative efforts between M/CHCs and MSHS agencies, two clinicians in one of the focus groups remarked how MSHS agencies have helped to increase their user numbers by facilitating access of farmworkers and their families to health center services. These comments suggest a natural fit for more systematic collaboration between M/CHCs and MSHS agencies that would take advantage of existing synergies which result from the way in which each organization is able to uniquely respond to the health needs of farmworkers and their families.

"We have several Migrant Head Start programs in and around our health centers and because of their enforcing of all of the requirements, those families at least bring the children in and that gets the family involved with the health center." (Clinical Director/Manager, Midwestern stream)

"I think those that get the best care are those enrolled in the head start program 'cause we have one near us and it's a state law that they have to have physicals, all their shots-everything-within a couple of days if they enroll in two or three days. Well, we have a bus now that goes up to the school. Before we went ourselves and just did the physicals on table tops and just did them in mass with whoever was there but now we have the mobile unit we can just go there one night every week and now we can see their parents too-the whole family now. Those kids probably get the best care because it's mandated. They have to be seen." (Migrant Medical Director, Midwestern stream)

Part II:
Migrant and Seasonal Head Start Agencies

The findings presented in this section are specific to Migrant and Seasonal Head Start (MSHS) agencies and were derived from three sources: the mail survey, telephone survey and the Office of Head Start Program Information Reports (PIR). The mail survey data represent findings from 26 MSHS grantee and delegate agency respondents. The telephone survey results came from 15 telephone interviews with MSHS agencies. Data from 2004-05 Office of Head Start PIR - an annual report required of grantee and delegate agencies - were included to supplement the mail and telephone surveys where appropriate.

Organizational Information

This section details key characteristics about MSHS respondent organizations, enrollment and families served, staffing and budget information.

Respondents

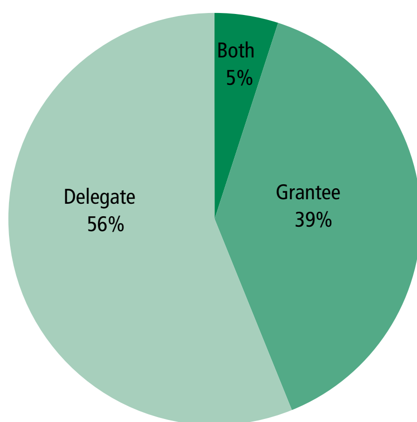
In total, 41 MSHS respondents participated in the mail and telephone surveys.

The mail survey was administered to all 64 MSHS grantee and delegate agencies; the response rate was 41% (26 of 64 possible respondents). For the telephone survey, a total of 28 MSHS agencies were contacted in order to reach the target goal of 15 participants.

Types of Agencies

Mail and telephone survey respondents were asked to classify their organization by type. In total, of the 41 mail and telephone survey respondents, over half (56%) were delegate agencies, over a third (39%) were grantee agencies and the remaining agencies (5%) were of both grantee and delegate status (Figure 16). The majority (73%) of telephone survey respondents identified as a delegate agency while the remaining quarter (27%) were grantees. Mail survey respondents were equally distributed between grantee and delegate agencies, each group constituting 46% of the total. The remaining 8% were of both grantee and delegate status.

Figure 16. MSHS mail and telephone survey respondents, by agency type (n=41)

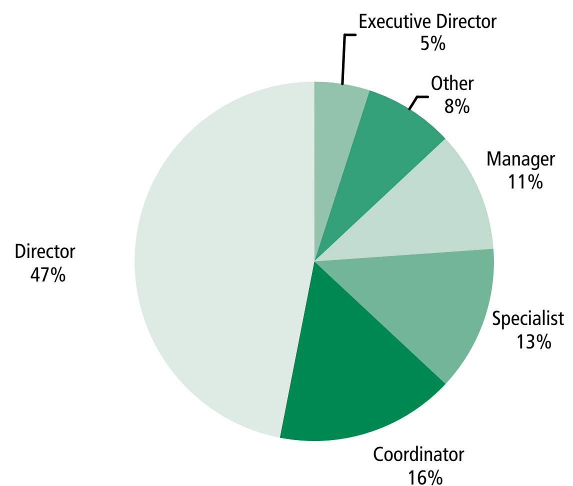


Migrant and Seasonal Head Start grantee and delegate agencies operate programs through a variety of agencies. According to PIR data on all 64 agencies, over half (53%) classified their agency as a private/public non-profit, followed by 23% community action agencies, 9% school system (public/private), 9% private/public for profit agencies, and 5% government agencies.[13]

Respondent Position

Directors (i.e., program directors, Head Start directors) accounted for the majority (47%) of MSHS mail and telephone survey respondents. Other respondents included health and migrant program coordinators (16%), education, community partnership and migrant family specialists (13%), health/nutrition managers (11%) and executive directors (5%). Eight percent of respondents held a different position within their organization, including for example, health services supervisors (Figure 17).

Figure 17. MSHS mail and telephone survey respondents, by title (n=38)



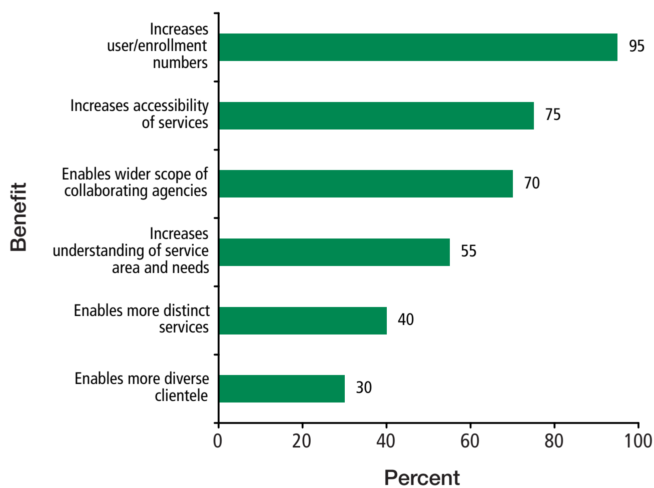
Number of Sites (Centers)

Migrant and Seasonal Head Start mail survey respondents were asked to identify the number of sites in their organization. Almost half of all respondents (46%) indicated their organizations were comprised of six or more sites, 12% had four or five sites, 19% had two or three sites, and 23% had one site only.

Respondents were asked to identify the benefits of having multiple sites (or centers). Nearly all (95%) indicated that multiple sites increase user/enrollment numbers. The majority also cited an increase in the accessibility of services (75%) and a wider scope of collaborating agencies (70%). Other benefits of having multiple sites included an increase in the understanding of the service area and its needs (55%) and being able to offer more distinct services (40%) (Figure 18).

Mail survey respondents also were asked to list the top three challenges their organizations face in having more than one site. For MSHS agencies, geographic distance and the travel time between sites presented the greatest challenge followed by monitoring activities, and staffing issues such as finding qualified staff for short time periods.

Figure 18. Percent of MSHS respondents reporting selected benefits of multiple centers (n=20)



Enrollment and Families Served

Migrant and Seasonal Head Start grantee and delegate agencies report the number of migrant children (0-5 years) enrolled in their respective programs as well as farmworker families served in their PIRs. For the 2004-05 program year, a total of 24,729 farmworker families and 33,058 migrant children were served nationwide.[14]

Staffing

Health services managers facilitate the health services component of MSHS agencies including tracking records, planning screening events, and organizing community events. According to PIR data, all three streams reported a high percentage of health services managers across delegates and/or grantees agencies, with 54 (of 64) agencies reporting the presence of this position. Other positions present included child development/education managers and family/community partnerships managers, of which 55 and 57 organizations reported these positions respectively.[15]

Outreach Finances

Migrant and Seasonal Head Start mail survey respondents were asked to share their approximate annual budget for outreach services in 2005. Thirty-one percent (8 of 26) responded, indicating an average annual budget of $120,399 for outreach services. Overall, of seven responses, an average of 3% of their annual budgets were allocated for outreach services. Ninety-four percent (17 of 18) indicated that some part of their 2005 outreach budget was earmarked specifically for farmworkers and/or farmworker family members.

Farmworker Information

Migrant and Seasonal Head Start agencies' (MSHS) comprehensive services – including child development, social, and health services – are essential to increasing access to health services for migrant children (0-5 years) and their families. At regional and national levels, knowledge about farmworker demographics, including population numbers, language, race/ethnicity, and health issues is essential to being responsive to a highly mobile and transitory population.

Farmworker Population

Farmworker population estimates vary greatly by season. Mail survey respondents to the *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* were asked to estimate the total number of farmworkers and farmworker family members, including infants and young children, in their organization's service area during peak harvest times as well as during the off-season. Migrant and Seasonal Head Start respondents reported an average of 5,823 farmworkers and farmworker family members in their service areas during peak harvest times. Less than half (42%) provided an estimate of the number of farmworkers and family members in their organization's service area during off-peak season. On average, 1,992 farmworkers and family members remained in these programs' service areas during off-peak season. (See also the Farmworker Population portion in Part I. of the Findings section. Qualitative data from both farmworker-serving health care organizations and MSHS agencies are presented collectively).

Farmworker Languages

Mail survey respondents were asked to identify languages spoken by farmworkers and/or farmworker family members in their service areas. All MSHS respondents (100%) reported Spanish-speaking farmworkers and farmworker family populations and over half (54%) reported English. Nearly one in three (31%) respondents indicated that farmworkers and farmworker family members were Mixteco-speakers, an indigenous language principally from Mexico. None of

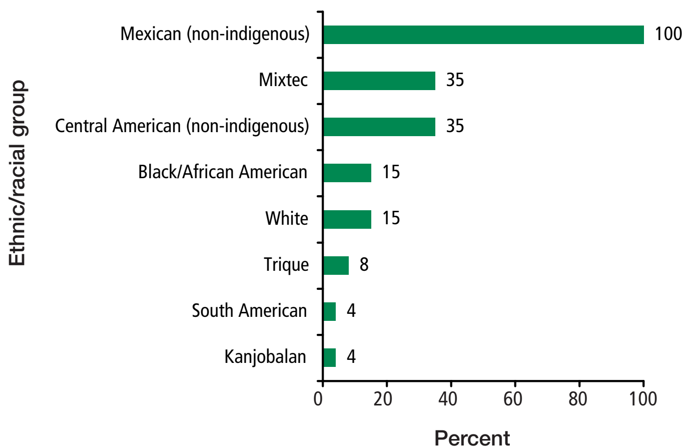
the Asian language choices (Hmong, Tagalog and Thai) nor Haitian Creole were selected.

According to 2004-05 PIR data on all 64 grantees/delegates, the primary language of the majority of MSHS clients is Spanish (86%), followed by English (10%), Native Central American, South American and Mexican languages (3%), and Caribbean languages (0.5%).[16]

Farmworker Race/Ethnicity

Migrant and Seasonal Head Start mail survey respondents were asked to report racial/ethnic groups represented by farmworker family clients at their organization. "Mexican (non-indigenous)" was the most frequently cited group reported by all respondents (100%). Respondents also reported "Mixtec" (35%), "Central American (non-indigenous)" (35%), "Black/African American" (15%), and "White" (15%). "Other groups" (19%) included bi-racial, Cora, Kikapoo, Tarasco, and Jamaican (Figure 19).

Figure 19. Percent of MSHS respondents reporting the following farmworker ethnic/racial groups (n=26)

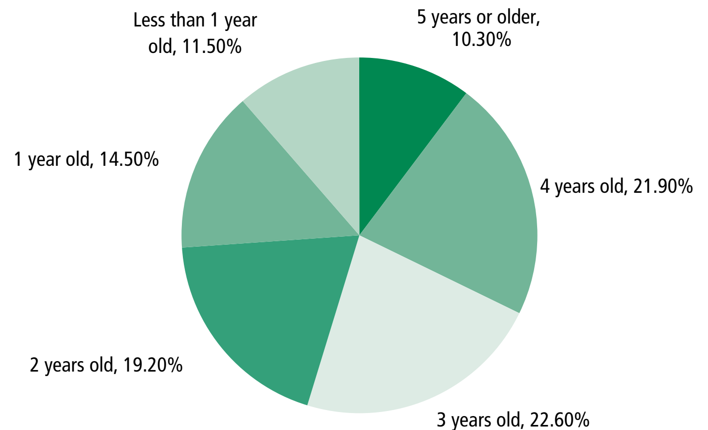


Head Start PIR data (2004-05) indicated that nearly all MSHS enrollees (98%) in the 2004-05 programmatic year were of "Hispanic or Latino Origin." Race data revealed that the majority (63%) were of an "Unspecified Race," followed by "White" (30%), "American Indian or Alaskan" (4%), "Bi-racial or Multi-racial" (2%), "Black/African American" (0.9%), "Other races" (0.3%), and "Asian" (0.02%).[17]

Ages of Enrolled Farmworker Children

Migrant and Seasonal Head Start agencies serve migrant children 0-5 years old as well farmworker families. According to 2004-05 PIR data, grantee and delegate agencies' three largest age groups were 3-year olds (22.6%), 4-year olds (21.9%) and 2-year olds (19.2%) (Figure 20).[18]

Figure 20. Enrollment of children in MSHS agencies, by age, as reported by 2004-05 PIR data (n=64)



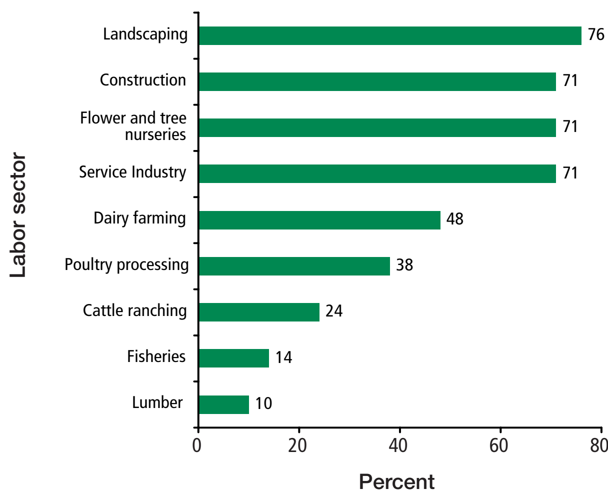
Labor Sectors

Mail survey respondents also reported on whether farmworkers and/or farmworker family members in their service areas worked in labor sectors other than agriculture. Seventy-six percent of MSHS respondent agencies indicated that farmworkers and farmworker family members were working in landscaping followed by other sectors like construction (71%), dairy farming (48%), and poultry processing (38%) (Figure 21).

Health Issues Facing Adult Farmworkers

In order to inform services and programs, farmworker-serving health organizations need accurate information about the health issues farmworkers face, the health issues that interest them, the barriers they face in accessing health care, and the social service needs that confront them. Overall, based on a mean score of MSHS mail survey respondents, dental health was the most common health issue among farmworkers and their families. Nutrition education was second, prenatal care was the third most common health issue followed by asthma and diabetes as fourth and fifth, respectively (Table 10).

Figure 21. Percent of MSHS respondents reporting other farmworker labor sectors (n=21)



Health Issues Facing Farmworker Children

In addition to the health issues of the general farmworker client population, MSHS respondent agencies were asked to rank, from one to five, the most common health issues facing farmworker children in their service areas. Based on mean score rankings, dental health, asthma, and overweight/obesity were the most commonly observed health issues or needs of farmworker children followed by upper respiratory tract infections and anemia (Table 11).

Table 10. Overall ranking of most common farmworker health issues

Health Issue	Overall Rank*
Dental health	1
Nutrition education	2
Prenatal care	3
Asthma	4
Diabetes	5
Mental health	6
Alcohol/substance abuse	7
Hypertension	8
Eye care	9**
Dermatitis	9**

*Overall rank is based on mean score.
** Identical rankings

Health Topics of Interest to Farmworkers

Migrant and Seasonal Head Start agencies also ranked, from one to three, the perceived health topics of greatest interest to farmworkers in their service area. Based on mean score rankings, nutrition, dental health, and prenatal care were the top three topics of interest (Table 12, next page).

Table 11. Overall ranking of most common health issues facing farmworker children

Health Issue	Overall Rank*
Dental health	1
Asthma	2
Overweight or obesity	3
Upper respiratory tract infections	4
Anemia	5
Hearing difficulties	6
Diabetes	7
High lead levels	8**
Vision problems	8**
Domestic violence	8**

* Overall rank is based on mean score.
** Identical rankings

Barriers to Accessing Health Care

Migrant and seasonal farmworkers and their families confront numerous barriers to accessing health care stemming from the nature of their work, extreme poverty and mobility, transitioning to a new cultural and linguistic context, and different living and working arrangements. Based on mean score rankings, mail survey respondents ranked language/lack of interpretation services, transportation, and hours of operation of health services as the three greatest barriers that farmworkers and their family members face in accessing health care at their service area (Table 13, next page).

Table 12. Overall ranking of health topics of greatest interest to farmworkers

Health Topic	Overall Rank*
Nutrition education	1
Dental health	2
Prenatal care	3
Violence/domestic violence	4
Mental health	5
Environmental/ occupational health	6
Asthma	7

* Overall rank based on mean score.

Table 13. Overall ranking of barriers to accessing health care

Barrier	Overall Rank*
Language/lack of interpretation services	1
Transportation	2
Hours of operation of health services	3
Lack of knowledge of available services	4
Legal status	5
Pay scale/financial	6
Cultural differences	7
Differing medical beliefs	8

* Overall rank based on mean score.

Social Service Needs

In addition to barriers to accessing health services, farmworkers face a host of other challenges that can greatly affect their health. Migrant and Seasonal Head Start mail survey respondents reported on the top three social service needs for farmworker clients in their service area. Based on the mean score generated by summing and averaging the rankings from a list of social service needs, housing assistance ranked as the most pressing social service need for MSFWs. Day care and transportation equally ranked as the second most commonly observed social service needs for farmworkers, followed by English language instruction (Table 14).

Table 14. Overall ranking of most needed social services for farmworkers and farmworker families

Social service need	Overall Rank*
Housing assistance	1
Transportation	2**
Day care	2**
English language instruction	3
Children's education services	4
Legal services	5
Food assistance	6
Labor rights education	7
Employment training/job assistance	8

* Overall rank based on mean score.
** Identical ranking

Head Start 2004-05 PIR data also captured findings regarding the number of MSHS families receiving social services through the Head Start program. Over a third (37%) of MSFW families received parenting education classes and nearly that many (34%) participated in health education activities. Other social services provided but not limited to were transportation assistance (21%), emergency/crisis interventions (20%), English as a Second Language training (19%), adult education (11%), mental health services (9%), and housing assistance (5%).[19]

Outreach Services Information

Farmworkers experience significant health disparities when compared to the general population. Despite the existence of a health care safety net designed to serve them, many farmworkers and their children do not or cannot access health services due to linguistic, cultural, structural and other types of barriers to care. Moreover, farmworkers have complex needs that go beyond physical health. Migrant and Seasonal Head Start (MSHS) agencies offer a holistic approach to working with farmworker families, providing health, education, and social services including referrals, community outreach, and crisis support. This section is intended to give the reader a general sense of the structure of outreach activities at MSHS agencies, as derived from FHSI findings and where appropriate, PIR results.

The majority (89%) of MSHS respondent agencies indicated that they provide outreach services; over half (57%) revealed that their outreach services are seasonal, whereas 43% reported year-round services.

Type of Staff

Different outreach services structures and regional needs call for different staff mixes and varied positions. Mail survey respondents reported on their programs' number of staff full time equivalents (FTE) for several common positions engaged in outreach activities, including transportation/drivers, education/child development managers, facilities managers, family service workers, community service workers, health specialists, and disabilities specialists. Not all respondent organizations have each of the above positions; the average FTE for each position is based on respondent organizations that do have each position. The data below do not account for fluctuations in staff FTE during peak farmworker season, but rather represent average staff FTE for the entire year.

Among respondents providing outreach services, the majority (91%) reported having at least one health specialist in their organization. Eighty-seven percent of respondent organizations reported having a disabilities specialist, with the same percentage reporting family service workers. Nearly that many (83%) have an education/child development manager and three of every four respondents (78%) reported teacher positions who do outreach. Sixty-five percent of respondents reported transportation/drivers.

Languages spoken by Staff

In an effort to provide culturally and linguistically appropriate services, farmworker-serving organizations often hire bilingual staff (see also "Cultural Competency" section below). Mail survey respondents were asked to indicate the languages spoken by staff serving farmworkers and farmworker family clients. Nationally, nearly all MSHS mail survey respondents (96%) employ Spanish-speaking staff. Additionally, respondent organizations reported employing staff that speak Mixteco (15%), Triqui (4%), and Hmong (4%). Twelve percent of organizations employ staff that speak other languages including American Sign Language, Laotian, and Kickapoo. None of the 26 respondents reported having staff who speak Tagalog, Thai, Haitian Creole, Kanjobal, or Zapotecan.

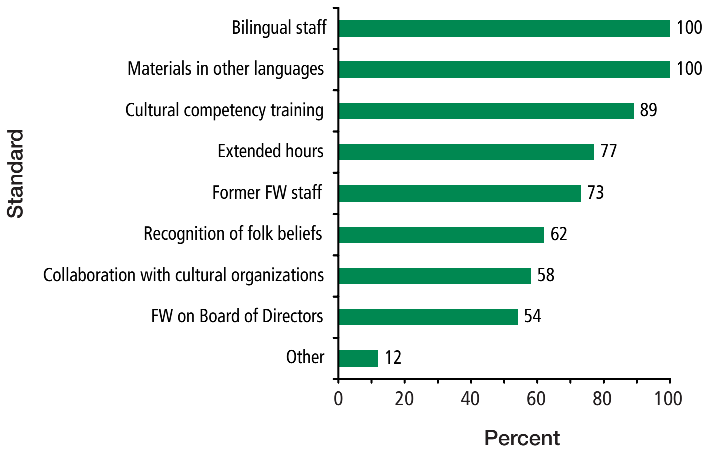
Cultural Competence

Head Start services are family-centered, following the tenets that children develop in the context of their family and culture and that parents are respected as the primary educators and nurturers of their children. Culturally and linguistically competent services are vital to the provision of effective health and social services for farmworker families; farmworker-serving organizations across the U.S. employ various strategies to train and support staff in providing culturally competent care. The Department of Health and Human Services' (DHHS) Standards for Culturally and Linguistically Appropriate Health Care Services include a set of core guidelines for providing culturally and linguistically appropriate care.[20] As reflected in the Standards, mail survey respondents were asked to identify how their organizations provide culturally appropriate services to farmworkers and/or farmworker family members. The most frequently reported culturally competent practices mentioned included employing bilingual staff (100%), providing materials in other languages (100%), and providing staff cultural competency training (89%). Three of four respondents (77%) indicated that their organizations provides extended hours and nearly that many (73%) have former farmworker staff (Figure 22, next page).

Mail survey respondents were asked to identify staff positions that participate in cultural competency training at their organization. Nearly three of every four (72%) MSHS respondent agencies reported that all their staff receive cultural competency training. Education and child development managers were cited most frequently (96%)

as participants in cultural competency training, followed by teachers (88%), family service workers (88%), disability specialists (84%) and health specialists (84%).

Figure 22. Percent of MSHS respondents practicing selected standards for culturally and linguistically appropriate care (n=26)



Keys to Success

Mail and telephone survey respondents provided qualitative data on the specific characteristics that make their outreach programs successful. Many MSHS respondents focused on their individualized and family-specific outreach along with the availability of bilingual staff/bicultural staff to meet farmworker families' needs.

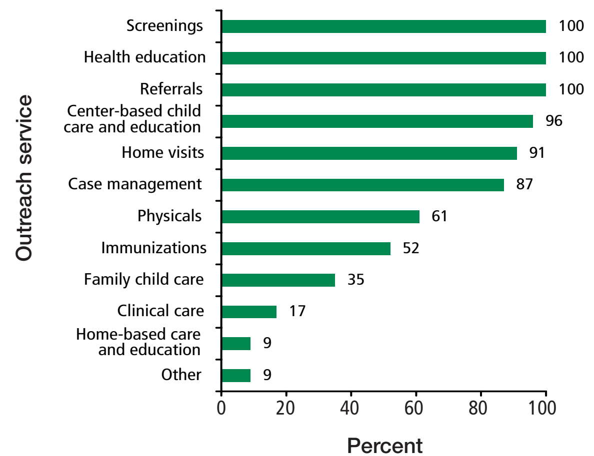
> *"We build the program around the needs and timing of families while they are here. We do our outreach in the evening hours or weekends when families are working 12-14 hours a day. We ask parents what they need and follow up on referrals. We get constant input from the parents. Often farmworkers don't like to complain; we've learned the hard way that if they don't say anything that doesn't mean everything is ok."* (Head Start Director, Midwestern stream)

> *"Although only the family advocates and specialists are charged with this responsibility, staff/everyone is very involved in recruitment and outreach. It is 'like a habit' where staff carry business cards or flyers with them all the time. For example, if a staff person sees a potential family at the store, they talk to them about services. Everyone does this – staff are very sensitive and they want to provide these services to the families. Also, there are many former farmworkers on staff. They understand the needs of their families."* (Health Specialist, Western stream)

Current Outreach Services for Farmworker Children

Migrant and Seasonal Head Start agencies offer child-focused programs, and have the overall goal of increasing the social competence of young children in low-income families. "Social competence" refers to the child's everyday effectiveness in dealing with his or her present environment and later responsibilities in school and life. Social competence takes into account the interrelatedness of social, emotional, cognitive, and physical development.[21] In order to respond to this goal, MSHS agencies offer a package of different services, of which outreach and health services are a part. Mail survey respondents were asked to identify what services are provided to or for farmworker children (0-5 years) at their organizations. Screenings, health education, and referrals were reported by all respondents (100%). The majority of respondents also selected center-based child care and education (96%), home visits (91%), case management (87%), physicals (61%), and immunizations (52%) (Figure 23).

Figure 23. Percent of MSHS respondents reporting outreach services provided to or for migrant children (n=23)



Current Outreach Services

Mail survey respondents were asked to rank the top three outreach activities performed by staff at their organizations. Based on a mean score, client registration/eligibility was reported as the outreach activity most frequently performed by staff. This was followed by case management, referrals, and language services (Table 15).

Table 15. Overall ranking of most frequently performed outreach activities

Activity	Overall Rank*
Patient registration/eligilbility	1
Case management	2
Referrals	3
Language services	4
Follow-up	5

* Overall rank is based on a mean score.

Case management is a critical component to outreach services. Case management-related services provided to MSFW families were documented in the 2004-05 PIR data. For example, 5% of MSFW families in the MSHS agency received housing assistance (subsidies, utilities, repairs, etc.) and 19% participated in English as a Second language training. Other services included but were not limited to health education (34%), domestic violence services (5%), and substance abuse prevention or treatment (6%).

While not ranked among the top three activities, transportation is an important service offered by many MSHS agencies. According to 2004-05 PIR data, one of four (24%) MSHS agencies contract with a transportation provider to transport some or all enrolled children. Additionally, transportation assistance (subsidizing public transportation, etc.) was received by 21% (5,246 of 24,729) of MSFW families during the one year operating period during 2004-05.[22]

Mail survey respondents were also asked to share the benefits of outreach services at their respective sites. MSHS respondents noted that outreach helps their program to fill program slots, meet funded enrollment levels, and maintain attendance. Outreach also helps MSHS agencies reach those families most in need with the critical services available to them.

Challenges to Providing Outreach Services

Qualitative findings revealed that much like the obstacles experienced by farmworker-serving health care organizations, MSHS agencies faced similar ones in conducting outreach. Challenges cited included a lack of transportation and programmatic funding as well as farmworkers' work schedules which can prohibit some outreach efforts. Various issues around staffing also presented many challenges including a lack of bilingual staff and staff specifically designated to do outreach and enrollment. A high staff turnover, attributed to the inability to pay competitive wages, was also mentioned.

Another top challenge identified in focus group discussions and telephone surveys was the immigration status of farmworker families, often disqualifying them for services. In some cases, MSHS agencies may be able to qualify children for certain services but may not be able to locate resources to benefit their adult family members. These problems were exacerbated by the fact that many families are in the service area for a short period of time. The programs often cannot find appropriate resources in the short window of time afforded by the mobile lifestyles of the farmworker families they serve.

Programmatic Needs

Of programs with outreach services, the majority indicated that they receive federal funding (83%) for their outreach services. Other sources of funding were less common such as private funding (4%), state funding (9%) and other sources (22%) such as tobacco funds.

Migrant and Seasonal Head Start mail survey respondents were asked to rank the two greatest financial challenges for their organizations' outreach services, based on a list of possible answers. Based on a mean score, MSHS respondents ranked securing federal funding as the greatest financial challenge for their outreach component, followed by securing private funding (Table 16, next page). Other challenges mentioned included allocating funds and not having enough recruitment days.

Migrant and Seasonal Head Start agencies were also asked to name the five resources that would benefit their organization most in improving outreach services. Of a list of 13 programmatic support needs from which to chose, respondents ranked their choices from one to five. Table 17 (next page) shows the ranking of resources based on a mean score: strengthening of community coalitions ranked first, followed by assistance with community needs

Table 16. Overall ranking of greatest financial challenges for outreach components

Challenge	Overall Rank*
Securing federal funding	1
Securing private funding	2
Other challenges	3
Lack of reimburseable services	4

*Overall rank based on a mean score.

assessments, and assistance with grant writing/funding sources as well as client education materials/resources and best practices/models that work (Table 17).

Table 17. Overall ranking of areas of greatest programmatic needs

Programmatic Need	Overall Rank*
Community coalitions	1
Community needs assessments	2
Grant writing/funding sources	3
Education materials/resources	4
Best practices/models that work	5
Program planning	6
New service development	7
New service area penetration	8**
Training	8**
Transportation solutions	9

*Overall rank based on mean score.
** Identical rankings

The telephone survey also asked MSHS respondents to discuss the types of resources and programmatic assistance needs that would most benefit their organizations. Funding was the most cited resource followed by a desire for more staff members. Migrant and Seasonal Head Start agencies also desire more training and professional development. Respondents identified their desire to learn about topics such as: networking, setting up a comprehensive outreach program, communicating effectively with parents to create trust, conducting needs assessments, maximizing community resources, and effectively promoting their services in the community.

Community Needs Assessments

An accurate assessment of community needs is an invaluable resource for planning the direction of programs and service provision, as well as for gaining funding that will appropriately meet client needs and result in positive outcomes. Community assessments are completed every three years and updated annually in MSHS agencies. Farmworker needs assessments were conducted in 2005 by 89% (23 of 26) of the MSHS mail survey respondents. These respondents were specifically asked about the type of information collected, methods used, and application of findings. Nearly all (96%) collected demographic information and information on social service needs. Four of five (83%) collected migrant and seasonal status information and three of four (78%) respondents collected information on children with disabilities. Over half (57%) of respondents reported collecting information about health knowledge, status and health education topics while only a quarter (26%) reported information on health practices.

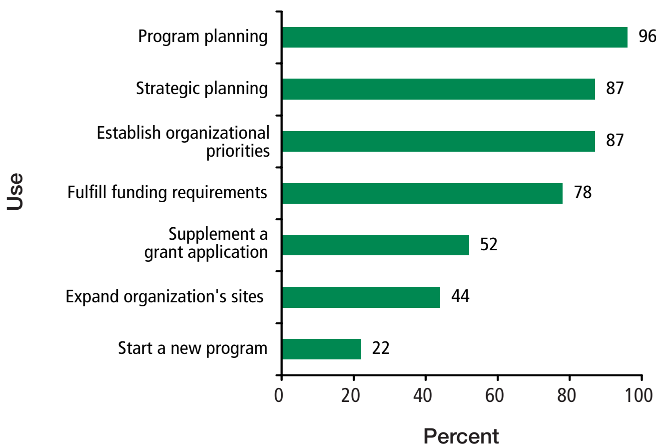
When asked to report methods utilized for their community needs assessments, individual interviews were cited most frequently (87%), followed by telephone surveys (65%), mail surveys (57%), and community forums (44%). Thirty-nine percent of MSHS respondents indicated other methods including utilizing other agencies' reports, census data and parent surveys. When examining uses for the data, the three most common applications included program planning (96%), strategic planning (87%) and establishing organizational priorities (87%) (Figure 24).

Farmworker Outreach Plan

A farmworker outreach plan refers to a written plan that outlines farmworker-focused outreach objectives and activities, separate from one's overall organizational health care plan. Migrant and Seasonal Head Start agencies use enrollment and recruitment plans. These

plans are essential tools for documenting program goals and objectives as well as planning how these goals will be actualized and measured. About half of mail survey respondents (48%) indicated that their organization uses a written farmworker outreach plan of some kind.

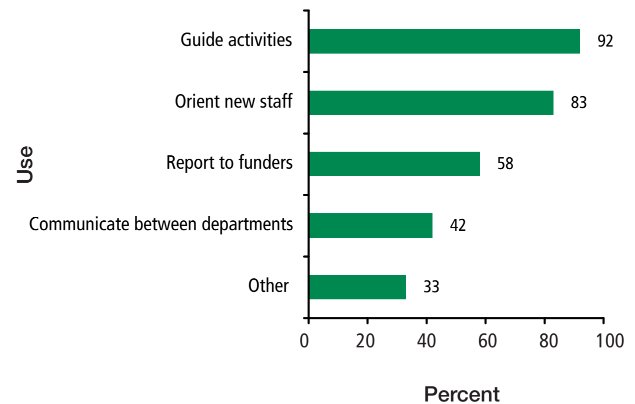
Figure 24. Percent of MSHS respondents reporting uses for farmworker community needs assessment findings (n=23)



Mail survey respondents with a farmworker outreach plan reported on uses of their plan within their organization. Of those that have a plan, nearly all respondents (92%) indicated their plan is used to guide activities, and four of five respondents (83%) utilize it to orient new staff. Other uses included reporting to funders (58%), communicating between departments (42%) and other uses (33%) like community collaborations, developing budgets and grant reports (Figure 25).

Telephone survey respondents were asked to elaborate on how their MSHS agency plans outreach activities and two main methods emerged. Community needs assessments and individual family needs assessments guide planning for several of the programs interviewed. The information collected in the needs assessments, sometimes done in conjunction with community partners, provides critical information on such topics as where clients are coming from, gaps in services, and the distribution of insurance coverage among clientele in the past year.

Figure 25. Reported uses for farmworker outreach plan (n=12)



"We have a person designated as the 'Hub Coordinator.' This person is in charge of bringing community organizations or community information into the Head Start center. This way the families do not have to go out and seek this information from individual organizations. Families complete a needs assessment and family goals information. Information from the needs assessment is tallied. Tallies are used to inform what topics will be presented on at the center. Additionally, there are some pre-defined or scripted topics." (Health and Nutrition Coordinator, Western stream)

"A community assessment is documented annually. We collect data (such as dental or who has health insurance) from previous years. We do a training plan that we look at and revise each year. We use national data from organizations like yours. The community assessment involves contacting growers and we have a community partnership that meets each month. We get a lot of feedback about gaps in services." (Executive Director, Eastern stream)

Organizational Integration

Communication and information-sharing between staff engaged in outreach activities and those in other departments is an important part of the infrastructure of an MSHS agency. Nationally, mail survey respondents reported a high degree (91%) of collaboration between the outreach component and health services in their respective organizations. Respondent organizations also

reported relatively high rates of collaboration with the medical (78%), dental (74%) and education (70%) service areas. Lower rates of collaboration were evident with specialized programs (26%), financial (17%), and other programs (13%) (Figure 26).

Figure 26. Percent of MSHS respondents indicating outreach program collaboration with the following service areas (n=23)

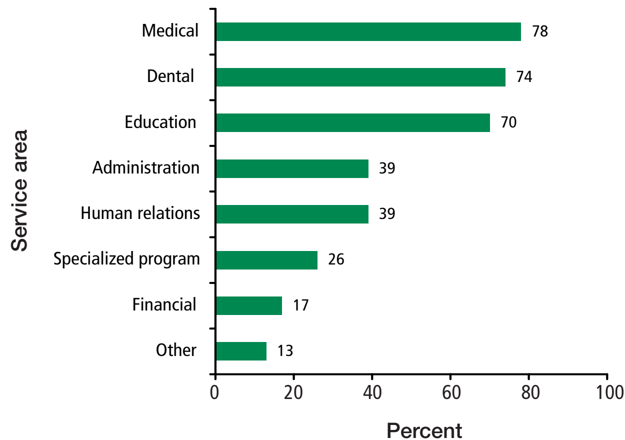
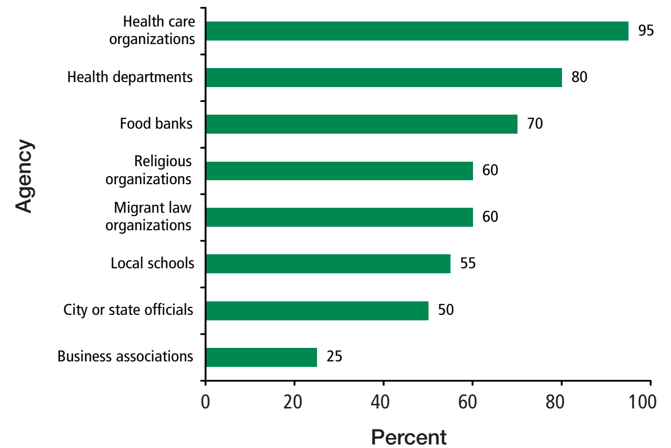


Figure 27. Percent of MSHS respondents indicating the following agencies' participation in their farmworker coalition (n=20)



Community Coalitions

Migrant and Seasonal Head Start respondents were asked if there was a farmworker coalition or other formal group of organizations that addresses farmworker family needs in their organization's community. Overall, 76% of organizations surveyed reported the presence of a farmworker coalition in their communities. Of those who reported the existence of a coalition in 2005, nearly two of every three (60%) participated in their local farmworker coalition as members, a quarter (25%) participated as advisory members, and one in ten (10%) served as lead members. Respondents also indicated the other agencies that participate in their local farmworker coalitions. The three most frequently cited agencies included health care organizations (95%), health departments (80%), and food banks (70%) (Figure 27).

Mail survey respondents were asked to share the benefits of having a local farmworker coalition. Many MSHS respondents noted that the coalition provides opportunities for networking and collaboration as well as an opportunity to share current information about the farmworker population.

Future Outreach Activities

Mail survey respondents provided rankings of the top three activities they would like to see outreach staff devote the most time to in the next two years. Based on a mean score, client registration/eligibility ranked as the top priority activity, followed by case management. Health education was ranked as the third most desired activity (Table 18).

Table 18. Overall ranking of most desired future outreach activities

Activity	Overall Rank*
Patient registration/eligibility	1
Case management	2
Health education	3
Follow-up	4**
Referrals	4**
Language services	5

*Overall rank is based on mean score.
** Identical ranking

Discussion and Recommendations

Key findings from the *2005-2006 Needs Assessment of Farmworker-Serving Health Organizations* guided the discussion and recommendations presented below. As in previous needs assessment reports, specific recommendations are presented for farmworker-serving health care organizations (Part I). In 2005-2006, as FHSI expanded the target audience to include an assessment of MSHS agencies, two additional recommendations were included that focus on possibilities for collaboration between MSHS agencies and farmworker-serving health care organizations (Part II).

PART I: *Farmworker-Serving Health Care Organizations*

Managing Multiple Sites

Discussion

Establishing multiple sites is a key strategy used by farmworker-serving health centers to increase access to care for MSFWs. Health center expansion aimed at increasing access to services for vulnerable populations, including MSFWs, has occurred in different ways, including funding new migrant health grantees (New Starts) or creating new satellites for existing grantees. The majority (90%) of health center mail survey respondents reported having two or more sites and 44% reported having six or more sites. Multiple benefits were reported by health centers that extended beyond increased access to services. The majority of respondents highlighted such positive impacts as increased user/enrollment numbers (89%), an increased understanding of the service area and its needs (73%), enabling more diverse clientele (68%), and a wider scope of collaborating agencies (65%). Over half (52%) reported that having multiple sites enables more distinct services.

Mail survey respondents also provided qualitative data on challenges their organizations face in having more than one site. Overwhelmingly, the greatest challenges included fostering effective communication, assuring operational consistency, and a variety of staffing issues including supervision/management of staff, addressing concerns related to staff isolation, and securing/maintaining skilled personnel. Geographic distance and the time required for travel between sites were factors cited that exacerbate many of these challenges.

Operating or establishing multiple sites can expand access to primary health care for farmworkers. However, determining whether to address farmworker access through additional sites, and maximizing the effectiveness of these sites, requires a solid understanding of the local farmworker population and a commitment to creating an organizational structure and service delivery model that is responsive to the target population yet accountable to organizational requirements.

Recommendation

Standardize key outreach infrastructures across all sites while balancing the specific needs of each site and its farmworker population.

A structured outreach services model creates a self-standing, sustainable program, independent of any one person or group of people. The broader and longer-term key priority areas for farmworker-serving health centers with multiple sites involve: 1) effectively managing and coordinating multiple sites; 2) implementing quality assurance standards at newer site(s); and 3) balancing the need to standardize procedures across sites while customizing outreach activities to be responsive to the MSFW population in a specific service area. A variety of core structures are essential to being responsive to these priority areas. These core structures, including an outreach plan, standardized protocols and staffing information such as job descriptions and supervisory roles can be consolidated and made available across sites in an Outreach Reference Manual.

An organized outreach plan provides a format for farmworker-serving health care organizations to think strategically across sites about the direction of outreach activities and funding. It provides a structure to actualize program priorities while being flexible enough to delineate topic areas that reflect the specific needs of MSFW populations in each service area.

Standardized outreach protocols and procedures across all sites are integral to effective management and coordination while also serving as a core quality assurance mechanism. Protocols formalize programmatic procedures at an organizational level and reinforce a consistent level of services across sites that staff are expected to follow. Outreach, clinical, and other relevant staff can provide input on these standardized protocols and policies including addendums when necessary to meet program or local population needs. Consider revisiting them on a periodic basis to ensure their relevance to the ever-changing health center and farmworker population needs.

Additionally, job descriptions and supervisory roles should be updated and standardized at the organizational level. Consider creating and/or updating standardized job descriptions for outreach staff and coordinators across all sites to clarify roles and responsibilities for staff members that reflect the goals and objectives of outreach services. Clarify responsibility and accountability for both supervisors and their staff.

Overall, it is likely that the objectives of a new satellite site will be different from those of existing centers. In addition to establishing the new physical site and coordinating new clinical services, new sites must direct their efforts towards further understanding their farmworker population, marketing efforts, and sharing information about their services. Existing sites are at a different developmental stage and can prioritize maintaining and refining high quality programmatic and clinical services. Core structures like an outreach plan and standardized protocols are flexible enough to account for these organizational differences while formalizing a consistent quality of care across sites. These tools lend themselves to more programmatic credibility, integrity and continuity; ultimately, they are critical to the long-term viability of self-sufficient operations across multiple sites.

Health Issues and Health Education

Discussion

Diabetes, hypertension, and dental health ranked as the three most common health issues among farmworkers, according to health centers participating in the 2001, 2003 and 2005-2006 needs assessment mail surveys. These same issues also ranked as the top health issues of interest to MSFWs, as reported by health center respondents in 2003 and 2005-2006. The calendar year 2005 UDS 330(g) grantee Rollup Report further supports these findings, revealing high encounter numbers relative to other diagnoses; specifically, 125,643 diabetes-related encounters, 93,159 hypertension-related and 75,720 oral exam encounters were documented nationwide.[23] A 1999 NAWS study revealed that poor dental health outcomes persist among farmworkers.xxiv Nearly half of farmworker males (49.5%) and females (44.4%) surveyed reported never going to dentist.

These health issues clearly do not exist in a vacuum but rather are compounded by the complexities of farmworker lifestyle issues including migration, language barriers, cultural differences, financial obstacles, limited transportation and demanding work hours. Outreach staff play a critical role in navigating these lifestyle issues while addressing the realities of farmworker health needs. Fortunately, chronic diseases like diabetes and hypertension are typically preventable and treatable with appropriate health behavior modifications.

Health information and education is an essential component of providing comprehensive outreach services to farmworkers and their families. Now more than ever there is a tremendous opportunity to address dental health and chronic diseases like diabetes and hypertension through the provision of health education efforts that take into consideration MSFW cultural, educational, linguistic and literacy factors. These efforts will be most effective when prioritized at an organizational level and operationalized through internal health care plans.

Recommendation

Incorporate health education goals and objectives that specifically address diabetes, hypertension and dental health into the health care plan and outreach plan.

Critical trends in chronic diseases like diabetes and hypertension, along with dental health issues, strongly

reaffirm the ongoing need for health education efforts in an outreach setting. Raising the level of awareness around topics of prevention, treatment and control is an important opportunity to engage farmworkers and their families in becoming equal partners in their health care provision and health maintenance.

In order to have a true impact on farmworkers' health status, it is crucial that farmworker-serving health care organizations strategize ways to address these issues at an organizational level. Health care organizations already incorporate measurable goals and objectives around certain health issues into their overall health care plans. It is critical that outreach staff know the connection between the health care and outreach plan's goals and their specific role in addressing diabetes, hypertension and dental health. When outreach plans flow from the expectations outlined in the overall health care plan, outreach workers are better able to prioritize and devote the time necessary to deliver health education on these key topics with farmworkers because the priority exists at an institutional level. These goals can be coupled with measurable health education objectives that provide a framework for outreach staff to structure their activities and time. Outreach staff reporting mechanisms can be designed to include progress updates on diabetes, hypertension and dental health-related health education objectives. Outreach staff meetings present an opportunity to revisit the outreach plan and debrief on successes and challenges in providing health education on these topics.

There are health education activities that could be incorporated into the outreach plan's objectives for addressing diabetes, hypertension and dental health in a culturally-appropriate fashion. Consider developing or identifying existing farmworker-friendly health education lesson plans that are specific to diabetes, hypertension or dental health (including patient education materials, popular education activities, etc.) and delivering them in appropriate outreach settings. Plan a health education fair or a regular radio show that is dedicated to addressing all three topics and solicit participation from local farmworker leaders. Additionally, consider incorporating an objective that includes partnering with local social service organizations to conduct diabetes, hypertension or dental health education activities. Outreach-centered health education is an important vehicle for reaching farmworkers with messages that promote positive health outcomes.

Recommendation

Explore or expand upon the current scope of clinical outreach activities to address diabetes, hypertension and dental health-related issues with the farmworker community.

Clinical outreach, or including clinicians in outreach activities, ranked as the fourth most desired outreach activity in 2003 and in 2005-2006 and was among the top three in 2001. One focus group discussion highlighted a different approach to basic clinical participation, entailing the development of outreach staff capacities. Some of the clinicians in the Western stream felt that it could be beneficial for outreach workers to be trained to provide some basic clinical services. Outreach staff could be trained in basic clinical skills like blood pressure and blood sugar checks. Regardless of how an organization chooses to approach clinical outreach, it is important to review liability issues. Including a clinical component to outreach, delivered by clinicians and outreach staff, can be invaluable in determining and addressing a variety farmworker health issues if deemed feasible. A farmworker-serving health care organization can make an institutional level commitment to clinical participation in outreach by delineating specific goals and objectives for both the outreach and clinical departments regarding this service.

When exploring a clinical component to outreach objectives, consider such specific activities as an in-service training on diabetes, hypertension and dental health that would be provided by members of the health center's clinical staff. There is also an opportunity for clinical staff to review health education lesson plans to be implemented by outreach staff in the field. These could be reviewed and discussed during periodic (quarterly) meetings between outreach and clinic staff on farmworker health issues including diabetes, hypertension and dental health. Having providers accompany outreach staff to the field can also increase their cultural competence and awareness of farmworkers' many challenges and foster an appreciation of outreach services. Such internal collaborative efforts have the potential to maximize organizational effectiveness while ultimately improving critical health outcomes on diabetes, hypertension and dental health for farmworkers and their families.

Responsiveness to Change

Discussion

The *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* report explored recent demographic and health status changes and trends in respondents' farmworker populations. Respondents identified and described a variety of trends impacting their outreach efforts including:

- an influx of farmworkers whose primary language is an indigenous language, who may not speak Spanish and as such, cannot be served effectively with current interpretation services;
- the settling out of farmworkers including both those transitioning from doing predominantly migrant work to more seasonal work and those who are moving out of farm work entirely to take advantage of new, more permanent labor sector opportunities;
- an observed shift in some areas from farmworker families traveling together towards single or married males traveling unaccompanied—a trend which presents a new set of health challenges around both mental and sexual health; and
- the negative impact of the current immigration climate, a newly emerging barrier to care which has hindered some outreach programs' efforts to serve farmworkers who have become more fearful and mistrustful in recent months.

The need for farmworker-serving health care organizations to understand the complexities surrounding their farmworker populations has never been greater. Traditional outreach strategies and approaches may need to be modified in order to effectively reach farmworker clients with critically-needed services.

Recommendation

Analyze unique farmworker-specific data collected through outreach activities including newly-emerging barriers to care and prioritized health needs. Use these data to inform and direct specific activities in an organization's strategic plan, overall health care plan and farmworker outreach plan.

In light of the changing trends identified in this report, it is more critical than ever that farmworker-serving health care organizations and their respective outreach programs reflect upon and assess their farmworker populations in order to be truly responsive in the coming months and years. In order to remain vital to the mission of migrant health, it is necessary for organizations to make a commitment to understanding the needs and challenges of farmworker patients, as well as the needs and challenges of farmworkers who do not present for care. The appearance of some of the changes and trends in this report draw attention to the need for a renewed commitment to a planning and programming process that is flexible, innovative, and introspective.

Only 50% of respondents to the *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* reported using a written farmworker outreach plan. The qualitative data lent support to these findings as several respondents explained that the direction of their outreach efforts depends more heavily on the level of understanding that their organization and individual staff members have developed through the years in serving farmworkers. The role of direct, long-term farmworker-serving experience, coupled with well-cultivated community connections, cannot be downplayed in executing effective outreach; however, these qualities of a program and its staff can be built upon further instead of serving as the predominant organizing technique for planning outreach activities. Farmworker-serving health care organizations, if not already doing so, should embark upon a consistent, objective and targeted approach to outreach planning. The broad knowledge and experience of staff provide the necessary context to ensure that planning is pragmatic.

Planning outreach and clinical services in accordance with outreach-derived data will enhance health care organizations' readiness to respond to the dynamic changes taking place in their farmworker populations. A thorough outreach planning process ideally involves a consistently-executed planning cycle repeated annually. It begins with identifying and prioritizing the specific needs of the community of farmworkers to be served (community needs assessment), assessing the internal capacity of the health care organization to effectively serve their farmworker clients, as well as taking an inventory of external resources available to complement the health care organization's outreach endeavors. The next step involves designing and implementing outreach activities that will address farmworker needs, capitalizing on the health care organization's strengths while also effectively leveraging other readily available resources in

the community. The planning cycle also involves a monitoring and evaluation component in order to make decisions about future outreach activities.

Recommendation

Consistently evaluate outreach activities and interventions for cultural appropriateness, responsiveness to identified needs, impact and the degree to which resources are used, both human and financial, in order to make a case for and maximize organizational inputs into the outreach program.

As alluded to above, the outreach planning cycle comes full circle when farmworker-serving health care organizations put into place mechanisms for evaluating the extent to which their outreach efforts are serving the needs of their farmworkers previously identified during the community needs assessment process. Needs assessments are particularly well-suited to influence the design and prioritization of outreach activities. In the same vein, program evaluations are well-placed to measure whether or not the activities an organization has implemented have met the needs they were designed to meet. Needs assessments can justify the why of a particular program in addition to providing some needed parameters to focus efforts in implementation. Evaluation can clarify the "how much/how many" of a particular outreach program: how many farmworkers have been served with needed services; how much impact has a program had in terms of assuring access and quality; and how many resources do individual outreach activities require to be carried out effectively? If needs assessments provide the justification for services to farmworkers, evaluation provides the evidence for making strategic decisions and further refining outreach efforts in the future.

Outreach program evaluation, whether conducted internally or externally, is crucial to maintaining the vitality of farmworker-serving health care organizations. The process of evaluation can create a reflective, improvement-oriented mindset in staff and cultivate an open environment for receiving and critically reflecting on feedback. For example, evaluation can allow a program to determine whether and how to use different outreach strategies for reaching migrant farmworkers in camp settings versus seasonal farmworkers who have settled out, may be more widely dispersed in the community and more difficult to locate. An evaluation of internal resources and skills (including language abilities and cultural competency) can help an organization determine how well-equipped it is to deal with an influx of indigenous language populations. Many opportunities exist for review and modification of an outreach program depending on the question or concern at hand.

Evaluation findings that are captured regularly, disseminated consistently throughout the organization and utilized systematically, can pave the way for a more efficient use of limited resources. They can influence and promote more effective decision-making at all levels and serve as a future advocacy tool when health care organizations make their case for future funding. Utilization-focused planning and evaluation can maximize the health care organization's ability to recognize and seize upon exciting opportunities to implement evidence-based outreach and clinical service delivery practices that will have a lasting impact on the health and well-being of their farmworker populations.

Organizational Integration

Discussion

The *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations'* findings illustrated certain core strengths evident in farmworker-serving health care organizations nationwide. Interdepartmental collaboration and the critical role outreach plays in an organization surfaced as two key components. The majority of health center mail survey respondents revealed outreach component collaboration between their medical (91%) and dental (69%) departments. Similarly, clinical staff in focus group discussions praised outreach in its critical role in linking health care organizations and area farmworkers that would not necessarily access services at the organization on their own. They described the purpose of outreach as a "bridge," an "extension of the health care setting," "the extra hands and feet that the providers don't have" and the "thoroughfare to the clinic."

Health care organization leadership build upon these identified organizational strengths to address the challenging realities of providing services to farmworkers and their families. This year's findings elucidated both recurring and new trends in barriers to care. In keeping with findings from 2003, 2005-2006 mail survey respondents reported transportation and pay scale/financial issues as the first and second greatest barriers farmworkers face in accessing care in their service

areas. Mail survey respondents ranked transportation as one of their greatest social service needs. Both transportation and financial issues surfaced in the qualitative findings as well; in regards to complicated payment processes, clinicians' elaborated on their implications for farmworkers who may choose not to pursue follow-up care. Numerous telephone survey respondents spoke of transportation issues when describing outreach-related challenges in their interviews.

Qualitative findings also revealed emerging barriers to care, in particular, the political climate around immigration. Focus group discussion participants and FHSI clients alike highlighted the impact of U.S. immigration reform efforts on the overall farmworker community, crew leaders and growers. Increased fear and guardedness has hampered outreach workers' ability to connect with farmworkers. In many cases, the hostile immigration reform climate has also exacerbated some of the barriers to care that challenged outreach workers well before the immigration debate came to the forefront in American politics in early 2006–including the tendency of many farmworkers to delay seeking health care until the moment when a health problem is no longer manageable.

Outreach staff are often expected to shoulder the burden of attending to these barriers because of their unflagging dedication, keen understanding of and close interactions with their farmworker clients. This reliance on outreach staff implicitly acknowledges their importance and the value of the overall outreach program in helping health centers to meet their service delivery objectives.

Too often, however, "outreach" becomes the catch-all for almost any farmworker-related activity. Outreach workers are sometimes the only health care organization staff providing the critical functions that facilitate farmworker access to care such as transportation, interpretation, and assistance navigating the health care system. Though many outreach workers carry out these tasks willingly, it is important that health care organization's identify ways to build upon and take advantage of their unique perspectives, expertise and knowledge rather than overwhelming them with duties that do not maximize the particular skills that they have to offer. Outreach workers are uniquely suited to establish trusting relationships with farmworkers, create linkages between farmworkers and needed services, and serve as a sounding board for health centers considering new policies, procedures and services that will impact farmworkers. They generally have good standing in the community and have established strong relationships with growers, crew leaders and community organizations such as churches and schools. As such, it is important to include them in organizational planning efforts and create opportunities for them to share their knowledge, observations and expertise with all health care organization staff who come into contact with farmworkers.

This year's findings regarding current and future outreach activities were supported by similar results from 2003 and indicate that the most common current outreach activity is patient registration and eligibility-related tasks with farmworkers. Looking ahead, health care organization respondents reported that they want outreach staff to continue to prioritize this activity into the future—patient registration and eligibility ranked as the third most desired outreach activity. However, a desire for more health education and case management rounded out the top three.

It is not surprising that farmworker-serving health care organizations continue to place a high premium on patient registration and eligibility. Most outreach services are not reimbursable, but patient registration and eligibility is the one outreach activity that has a direct correlation with sustaining the financial viability of the organization's ability to provide needed health services to farmworkers. However, as this year's data show, farmworker user numbers are not easy to achieve—for every one farmworker who becomes a user nationwide, it takes approximately four encounters to make this a reality. Outreach is essential for creating the trust and relationships needed to bring farmworkers in for care.

However, farmworker-serving health care organizations must be cautious in assuming that farmworker needs should be addressed purely on an outreach level. It is imperative that these organizations build upon existing internal collaborative relations and create sustainable buy-in by other staff members for the mission of serving farmworkers. This investment should manifest as increased substantive input from other organizational staff into the design and delivery of farmworker-targeted activities, both clinical and non-clinical. By having more staff organization-wide involved in access-expanding efforts such as patient registration and eligibility and clinical outreach, outreach workers can more fully concentrate on building relationships with the farmworker community, conducting health education, and providing needed case management services.

Recommendation

Build upon efforts to integrate outreach priorities into the organization's overall scope in order to decrease farmworker-specific barriers to care and maximize the delivery and effectiveness of culturally-appropriate services.

Identifying and addressing barriers to care is as essential to farmworker health care access as providing the actual services to farmworkers and their families. As mentioned earlier, outreach staff play a critical role in navigating barriers to care through a variety of outreach activities and services that take into account a host of cultural, educational, linguistic, and social factors. Outreach staff mitigate these barriers as they arise; for example, they may provide transportation, conduct patient registration activities or interpret for a provider. Yet these efforts are short-sighted and frequently come at the cost of their own ability to reach more farmworkers. They are not able to maximize their comparative advantage: to create trust, by making home visits or attending community-wide events. Outreach workers can provide transportation and interpretation services but these enabling services, while necessary, may not constitute the best use of their time and skills.

In order to maximize outreach staff time and expertise and increase farmworker access to services in the long-term, it is important to think strategically about how the overall organization can more comprehensively address barriers to care, and provide the array of enabling services necessary to facilitate farmworker access. Consider some of the following strategies:

– Offer an annual all-staff cultural competency training in order to ensure that farmworkers patient referrals to the health organization are appropriately received by courteous and culturally-sensitive staff.
– Seek other sources of funding that support hiring a full-time clinical interpreter or a driver so that outreach workers can concentrate their time and effort on finding and building trusting relationships with future farmworker patients.
– Encourage the financial department to implement a "fast track" farmworker-friendly payment process that is easy to understand and requires the minimum amount of documentation while still appropriately meeting all requirements.
– Include key outreach staff in periodic organizational planning meetings as they will have much insight to offer regarding how the organization can better meet the needs of farmworkers.

Though much of the work that outreach staff does is in the field away from the health center, as the mail survey revealed, they do not work in a vacuum but rather rely on the strengths of interdepartmental collaboration. The more a farmworker-serving health care organization creates an enabling environment for the outreach worker to flourish, the more tangible benefits the health organization can expect to see in the long-run with farmworker user numbers.

PART II:
Joint Recommendations for Farmworker-Serving Health Care Organizations and Head Start Agencies

Farmworker-Serving Health Care Organization and Head Start Agency Collaboration

Discussion

Collaboration with community partners is a strategy that both farmworker-serving health care and MSHS agencies employ in order to increase access to health services. In the *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations,* all participants were asked whether they collaborated with other farmworker-serving community organizations. Overwhelmingly, respondents indicated that they make a concerted effort to use their community networks of local churches, food banks, health departments, schools and advocacy organizations, among others, to meet the multitude of health and social service needs of farmworkers and their families. Many farmworker-serving health care (58%) and MSHS agency (76%) respondents reported participating in farmworker coalitions. Moreover, 95% percent of MSHS agencies reported that health care organizations participated in their farmworker coalitions while 75% of farmworker-serving health care organization respondents reported the presence of Head Start programs in their local farmworker coalitions.

Data from the *2005-2006 National Needs Assessment of Farmworker-Serving Health Organizations* highlight concrete ways in which farmworker-serving health care organizations and MSHS agencies can collaborate to meet the needs of farmworker families. In the clinicians' focus group discussions, it was noted that the various requirements in place for children to enroll in MSHS agencies necessitate that farmworker families interact more frequently with health centers, in turn providing more opportunities for health centers to encourage other family members to seek health care services. Synergies do exist and farmworker-serving health care organizations and MSHS agencies should be encouraged to take advantage of these.

In regards to community needs assessments, the 2001, 2003 and 2005-2006 needs assessment data for farmworker-serving health care organizations indicate that only 32% of these organizations conducted a community needs assessment in the previous year. However, MSHS agencies are required to conduct a needs assessment every three years and update this assessment annually. Needs assessment information is most useful when systematically shared with all organizations involved in addressing farmworkers' many needs. A real opportunity exists for farmworker-serving health care organizations to glean crucial information about their area farmworker populations from their MSHS agency peers.

In addition, the data from this assessment suggest concrete areas where both MSHS agencies and health care organizations can constructively address farmworker access to health and social services. When it came to farmworker barriers to accessing health care, there was a marked difference in how both audiences ranked "hours of operation of health services." As in 2003, health care respondents ranked this 6th, whereas MSHS agency mail survey respondents ranked it as farmworkers' third most challenging barrier to accessing health care. This difference suggests that a significant number of MSHS agencies are encountering farmworkers who are not able to access health services due to hours of operation. This represents a larger opportunity for MSHS agencies and farmworker-serving health care organizations to further communicate about the needs of their shared farmworker client base. It is critical that each organization exchange information in order to foster increased responsiveness to local farmworker population needs. Data such as these highlight exciting opportunities for collaboration and, ultimately, more responsive health care and services.

Recommendation

Formalize collaborative efforts between local farmworker-serving health care organizations and MSHS agencies in order to build on each other's strengths, pool resources and fill gaps in services to more comprehensively serve farmworkers in your geographic area.

Farmworker-serving health care organizations and Migrant and Seasonal Head Start agencies both work collaboratively with community-based partners to meet the needs of farmworkers and their families. For instance, health care organizations and MSHS agencies already have certain activities that they execute jointly—such as conducting a battery of screenings for children before they enroll in an MSHS program. The data collected in this study show that the majority of farmworker coalitions include the participation of both health care organizations and MSHS agencies; therefore, it is clear that some form of collaboration is already taking place between these organizations and agencies.

However, there is room to maximize the natural partnerships that exist between health care organizations and MSHS agencies, to think creatively about how to improve upon collaborative efforts to ensure that resources are maximized, that efforts are not duplicated, that health center user numbers are increased and ultimately, that farmworker and farmworker family needs are effectively met. According to 2004-05 Office of Head Start's PIR data, only 32% of 33,058 migrant children participating in MSHS programs currently have an M/CHC serving as their medical home. Uniform Data System results from calendar year 2005 also reflect low numbers of children accessing services at M/CHCs; in 2005, only 16.9% of the farmworker users at federally-funded migrant health centers were children from the ages of 0-5.[25]

Migrant and Seasonal Head Start agencies frequently serve as their enrollees' medical homes in the states where they serve children in terms of providing health services which meet Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) Standards. However, MSHS agencies are intended to serve as a health care safety net for enrollees only when services via other health agencies are not available or when these resources have been exhausted. An opportunity exists for farmworker-

serving health care organizations and MSHS agencies to devise collaborative strategies that go beyond meeting these standards to also ensuring that the majority of MSHS program enrollees have an M/CHC as their medical home. These and other possibilities should be systematically explored further.

There are already structures in place that could facilitate collaboration and information sharing between farmworker-serving health care organizations and MSHS agencies. Each MSHS agency has a Health Services Advisory Committee (HSAC) that meets regularly to review policies and procedures, children's needs, and other issues. Migrant and Seasonal Head Start agencies should ensure that they include one or more health center representatives on their HSAC, allowing for consistent communication, coordination and problem-solving between the two organizations. In addition, farmworker-serving health care organizations could consider having an MSHS agency representative serve on their Board of Directors to ensure that this perspective is present when the health care organization is making strategic decisions about the future of services to farmworkers and their families-especially to children. Interagency representation on HSACs, Boards of Directors, or other structures, would give MSHS agencies and farmworker-serving health care organizations that cover similar geographic areas an opportunity to collectively address their most pressing concerns with respect to farmworker patients or clients.

In order to institutionalize collaborations, farmworker-serving health care organizations and Migrant and Seasonal Head Start agencies could develop, implement and periodically evaluate a joint outreach work plan that accurately reflects each organization's strengths and capabilities, including a measurable and realistic mechanism for fostering accountability to each other. Each organization would need to determine the time and resources, both human and financial, that they would be willing to commit to the collaboration, in keeping with their own respective mandates and limitations.

Recommendation

Convene a national panel consisting of representatives from farmworker-serving health care organizations, MSHS agencies, and technical assistance providers for these agencies. Create a set of standard guidelines for formal collaborative efforts to enhance organizational capacity for successfully reaching farmworkers and their families.

Given that farmworker-serving health care organizations and MSHS agencies nationwide are working in a parallel fashion to serve many of the same clients in their respective service areas, an opportunity exists to think more broadly and strategically about how they can collaborate more efficiently to increase impact. For systematic, consistent collaboration to occur nationwide, concrete, realistic strategies and evidenced-based guidelines should be developed.

According to the Migrant and Seasonal Head Start Technical Assistance Center, MSHS agencies "feel that the most urgent health concern they have for families involves access to medical and dental services, including paying for services/insurance concerns, lack of preventative care, continuity of care, and lack of culturally sensitive providers."[26] Grantees in some states also noted that they have difficulty meeting the EPSDT Standards due to providers ignoring regulations or the difficulty of accessing screening services in remote rural areas.[27] A specific concern to MSHS agencies was the inability to secure hearing and dental screenings for children; according to the Migrant and Seasonal Head Start Technical Assistance Center "dental care services continue to be difficult to access mainly due to lack of children's dental providers in remote areas and reluctance of general dental providers to treat young children."[28] As cited earlier, only 1/3 of the 33,058 enrolled MSHS children accessed services through a migrant health center in the 2004-05 program year [29] and UDS data further revealed that less than one in five farmworker users at migrant health centers were children from the age 0-5.[30] These data illustrate the real challenges faced by MSHS agencies in effectively meeting the health needs of their farmworker children, and suggest that more efforts need to be made to increase MSHS enrollees' access to health care services via farmworker-serving health care organizations.

In August 2006, Farmworker Health Services, Inc., and the Migrant and Seasonal Head Start Technical Assistance Center met to discuss the report's findings and possible implications for collaboration. It was agreed that a national panel that includes a representative cross section of farmworker-serving health care organizations, MSHS agencies as well as technical assistance providers for these organizations, should be convened to address some of these programmatic issues and explore possibilities for partnerships on a larger scale. Panel members would be encouraged to identify specific areas

where the two organizations could maximize resources in order to more effectively meet the comprehensive needs of farmworkers and their families. Based on these discussions and panel recommendations, a set of standard guidelines could be created for formalizing collaborative efforts among farmworker-serving health care organizations and MSHS agencies in order to enhance and potentially expand individual organizational capacities to meet the needs of farmworkers and their families. These guidelines should be informed by local organizations as they are invaluable sources of information regarding collaborative and realistic models that can work on the ground. Technical assistance providers are in a unique position to collect, synthesize and disseminate this information as a set of best practices for collaboration that truly represent the voice and experience of the health care organizations and MSHS agencies that serve farmworkers and their families.

Conclusion

In 2005-2006, Farmworker Health Services, Inc. (FHSI) conducted its third biannual national needs assessment in order to document farmworker needs, document the status of outreach programs and services, and serve as a much-needed resource for data on farmworkers and the services available to them. It also provides evidence on a national scale of organizational strengths and advocates for building on these strengths to increase our collective capacities for being responsive to identified needs. Timely, effective, and culturally responsive health outreach and enabling services ultimately depend on maximizing this intersection between organizational strengths, resources and farmworker needs. We hope this report provides a national context for those efforts and stimulates continued dialogue and growth towards our shared vision of providing accessible health and social services to farmworkers and their families.

Endnotes

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[8] Bureau of Primary Health Care, Section 330 Grantee Uniform Data System (UDS) Calendar Year 2005 data, Migrant Health grantee data.

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[10] Bureau of Primary Health Care, Section 330 Grantee Uniform Data System (UDS) Calendar Year 2005 data, Migrant Health grantee data.

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[12] Standards for Culturally and Linguistically Appropriate Health Care Services, DHHS, OMH, http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15.

[13] Office of Head Start Program Information Reports, Head Start Bureau, Program Year 2004-05, Summary Report, Region XII.

[14] ibid

[15] ibid

[16] ibid

[17] ibid

[18] ibid

[19] ibid

[20] Standards for Culturally and Linguistically Appropriate Health Care Services, DHHS, OMH, http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15.

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[22] Office of Head Start Program Information Reports, Head Start Bureau, Program Year 2004-05, Region XII

[23] Bureau of Primary Health Care, CY 2005 Migrant Health center Rollup Report. Table 6.

[24] National Agricultural Workers Survey, Department of Labor, 1999.

[25] Bureau of Primary Health Care Section 330 Grantees Uniform Data System, Calendar Year 2005 Data, Migrant Health Centers Rollup Report.

[26] Migrant & Seasonal Head Start TAC-12, Academy for Educational Development, Migrant & Seasonal Head Start, PowerPoint presentation.

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[28] ibid

[29] Head Start Program Information Report for Calendar Year 2004-5, prepared for Region 12 (migrant branch) on August 15, 2006.

[30] Bureau of Primary Health Care Section 330 Grantees Uniform Data System, Calendar Year 2005 Data, Migrant Health Centers Rollup Report.

[31] Bureau of Primary Health Care, Section 330 Grantee Uniform Data System (UDS) Calendar Year 2005 Data, Migrant Health grantee data

Glossary of Terms

Agriculture: farming of the land and all its branches, including cultivation, tillage, growing, harvesting, preparation and on-site processing for market or storage.

Case management: when a health care staff person or case manager coordinates available health and social service resources so that a patient can receive comprehensive, quality care.

Community Health Services or Outreach Coordinator: the person who oversees the activities, programs, and services used to reach farmworkers and/or farmworker family members.

Community Health Worker: also known as *Promotores(as)*, Camp Health Aides, Lay Health Advisors/Promoters etc. and are responsible for providing outreach services to farmworkers and/or farmworker family members.

Community needs assessment: the process of determining the true needs of the community that you serve, in this case farmworker and/or farmworker family members.

Encounter: documented, face-to-face contact between a user/patient and a provider who exercises independent judgment in the provision of services to the individual. This definition is typically used in connection with Migrant and Community Health centers for reporting purposes.

Family Services Worker/Manager: within Migrant and Seasonal Head Start agencies, the person who manages farmworker family case work.

Farmworkers: defined by Section 330(g) of the Public Health Service Act.

Migrant farmworker: an individual whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who establishes temporary residence for the purposes of such employment. The definition includes those individuals who have been so employed within the past 24 months and their dependent family members.

Seasonal farmworker: defined the same as migrant agricultural worker except that they do not establish a temporary home for the purpose of employment.

Farmworker and/or farmworker family client/patient: refers to an individual farmworker and/or farmworker family member that has received an organization's services.

Farmworker and/or farmworker family member: refers to an individual farmworker and/or farmworker family member including one's spouse, child, sibling, parent or extended family member.

Farmworker outreach plan: a written plan that outlines an organization's farmworker community outreach activities and services, separate from the overall organizational health care plan.

Farmworker-serving health organizations: For the purpose of this report, farmworker-serving health organizations refers to migrant and community health centers (M/CHCs), migrant voucher programs (MVPs), farmworker-serving health departments and health centers not receiving migrant funding as well as Migrant and Seasonal Head Start (MSHS) agencies.

Farmworker-serving health care organizations: For the purpose of this report, farmworker-serving health care organizations includes all the organizations included in the definition of farmworker-serving health organizations, except Migrant and Seasonal Head Start (MSHS) agencies.

Farmworker-serving Head Start agencies: refers to Migrant and Seasonal Head Start agencies.

Migrant stream: Historically, migrant farmworkers reside during winter in "home base" communities in Florida, Texas, and California or in Central America and Caribbean nations. As the growing season progresses in the spring and summer, migrant farmworkers relocate north to "receiver communities." Traditionally, these migration patterns north from home bases are referred to as migrant streams; the Eastern migrant stream, running from Florida to New England, the Midwestern stream, from Texas to the Northern Plains and Great Lakes states, and the Western stream from California to the Pacific Northwest.

Outreach: The Bureau of Primary Health Care defines outreach as "a service or complement of services for actively reaching patients in their own environments and communities to increase access to care and result in improved health outcomes." *See also* ***"Outreach Definitions and Models of Care" section of the Introduction segment.***

Outreach component: a broad term referring to any outreach activities, services, or programs that your organization uses to reach farmworkers and/or farmworker family members.

Site: the place(s) where services are formally offered.

Uniform Data System: system used to collect data from health centers supported by HRSA Bureau of Primary Health Care grants.

User: an individual or patient receiving at least one encounter for service.

Appendices

APPENDIX A. FHSI Community Health Outreach Model

Organizational Integration

Farmworker Access Point

Coalition Building

Health Delivery System

Farmworkers

Coalition Building

Outreach Program

Community Relations

Community Health Outreach Component

Community Relations

Community Health Outreach Model

APPENDIX B. Migrant Stream Comparison Table

Farmworker-Serving Health Care Organizations

Organizational Information	Overall	Eastern Stream	Midwestern Stream	Western Stream
Average number of MSFW users per grantee[31]	5,396	3,933	2,366	9,985
Average number of MSFW encounters per grantee[32]	20,777	14,267	7,973	40,561
Ratio users to encounters[33]	1: 3.9	1 : 3.6	1 : 3.4	1 : 4.1
Average outreach dollars per farmworker user	$40.66	$46.24	$129.69	$22.66
Farmworker Information	**Overall**	**Eastern Stream**	**Midwestern Stream**	**Western Stream**
Average number of MSFWs in service area per organization, peak season	17,671	16,425	8,861	30,103
Average number of MSFWs in service area per organization, off –season	8,547	6,383	5,345	23,869
Ratio of mean users to the mean farmworker population (peak season)	1 : 3.3	1 : 4.2	1: 3.7	1 : 3.0
Overall ranking of most common health issues facing MSFWs	1. Diabetes 2. Hypertension 3. Dental health	1. Diabetes 2. Hypertension 3. Dental health	1. Diabetes 2. Hypertension 3. Dental health	1. Diabetes 2. Hypertension 3. Dental health
Overall ranking of health topics of greatest interest to MSFWs	1. Diabetes 2. Hypertension 3. Dental health	1. Diabetes 2. Hypertension 3. Dental health	1. Diabetes 2. Dental health 3. Hypertension	1. Diabetes 2. Hypertension 3. Prenatal care
Overall ranking of greatest barriers to accessing health care for MSFWs	1. Transportation 2. Pay scale/financial 3. Lack of knowledge of available resources	1. Transportation 2. Language/lack of interpretation services 3. Lack of knowledge of available resources	1. Lack of knowledge of available resources 2. Pay scale/financial 3. Transportation	1. Pay scale/financial 2. Transportation 3. Lack of knowledge of available resources
Overall ranking of greatest social service needs of MSFWs	1. Housing assistance 2. Transportation 3. English language instruction	1. Transportation 2. Housing assistance 3. English language instruction	1. Housing assistance 2. Transportation 3. Employment training/job assistance	1. Housing assistance 2. Transportation 3. Employment training/job assistance

APPENDIX B. Migrant Stream Comparison Table (continued)

Farmworker-Serving Health Care Organizations

Outreach Services Information	Overall	Eastern Stream	Midwestern Stream	Western Stream
Percent of organizations reporting the provision of cultural competency training	82% (58 of 71)	82% (28 of 34)	80% (12 of 15)	82% (18 of 22)
Overall ranking of most frequently performed outreach activities	1. Patient registration/eligibility 2. Health education 3. Health fairs or community events	1. Case management 2. Health education 3. Transportation	1. Patient registration/eligibility 2. Health fairs or community events 3. Health education	1. Health education 2. Health fairs or community events 3. Patient registration/eligibility
Overall ranking of desired future outreach activities	1. Health education 2. Case management 3. Patient registration/eligibility	1. Case management 2. Health education 3. Clinical outreach	1. Health education 2. Patient registration/eligibility 3. Clinical outreach	1. Health education 2. Patient registration/eligibility 3. Case management
Percent of organizations using a written farmworker outreach plan	55% (34 of 61)	64% (18 of 28)	54% (7 of 13)	45% (9 of 20)
Percent ranking lack of reimbursable services as the greatest financial challenge for outreach program	64% (30 of 47)	52% (12 of 23)	78% (7 of 9)	73% (11 of 15)
Overall ranking of areas of greatest programmatic need to improve outreach services	1. Grant writing/funding sources 2. Transportation solutions 3. Community needs assessments	1. Transportation 2. Grant writing/funding sources 3. Support with data issues/performance measures	1. Community needs assessments 2. Grant writing/funding sources 3. Program planning	1. Program planning 2. Grant writing/funding sources 3. Community needs assessments
Percent of organizations that conducted a farmworker community needs assessment in 2005	32% (22 of 68)	41% (13 of 32)	27% (4 of 15)	24% (5 of 21)
Percent of organizations that reported the presence of a farmworker coalition in their community	58% (40 of 69)	69% (22 of 32)	53% (8 of 15)	45% (10 of 22)

APPENDIX C. Summary Table

Migrant and Seasonal Head Start Agencies

Organizational Information	Overall
Number of MSFW children (0-5 years) enrolled[34]	33,058
Number of MSFW families served[35]	24,729
Farmworker Information	**Overall**
Average number of MSFWs in service area, peak season	5,823
Average number of MSFWs in service area, off –season	1,992
Overall ranking of most common health issues facing MSFWs	1. Dental health 2. Nutrition education 3. Prenatal care
Overall ranking of most common health issues facing MSFW children	1. Dental health 2. Asthma 3. Overweight or obesity
Overall ranking of health topics of greatest interest to MSFWs	1. Nutrition education 2. Dental health 3. Prenatal care
Overall ranking of greatest barriers to accessing health care for MSFWs	1. Language/lack of interpretation 2. Transportation 3. Hours of operation of health services
Overall ranking of greatest social service needs of MSFWs	1. Housing assistance 2. Transportation 3. Day care

Outreach Services Information	Overall
Percent of organizations reporting the provision of cultural competency training	89% (23 of 26)
Overall ranking of most frequently performed outreach activities	1. Client registration/eligibility 2. Case management 3. Referrals
Overall ranking of most frequently reported outreach services provided to or for farmworker children	• Screenings • Health education • Referrals
Overall ranking of most desired future outreach activities	1. Client registration/eligibility 2. Case management 3. Health education
Percent of organizations using a written farmworker outreach plan	48% (11 of 23)
Percent reporting securing federal funding as their greatest financial challenge	53% (9 of 17)
Overall ranking of areas of greatest programmatic need to improve outreach services	1. Community coalitions 2. Community needs assessments 3. Grant writing/funding sources
Percent of organizations that conducted a farmworker community needs assessment in 2005	89% (23 of 26)
Percent of organizations that reported the presence of a farmworker coalition in their community	76% (19 of 25)

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