National Needs Assessment of Farmworker Health Care Organizations

A Biannual National Report on Farmworker Health Outreach Programs

Second Edition

2003 Report

farmworker health services, inc.

Washington, DC

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Farmworker Health Outreach Programs

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farmworker health services, inc.

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 for 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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Foreword

Farmworkers are the men, women, and children that bring food to our tables every day.

"We are proud to release this report after thirty-five years of service to the farmworker health community..."

Farmworkers play an integral role in the U.S. agricultural economy.

The publication of the second edition of our *National Needs Assessment of Farmworker Health Care Organizations* coincides with Farmworker Health Services, Inc.'s 35th anniversary celebration. We are proud to release this report after thirty-five years of service to the farmworker health community.

Since 1970, Farmworker Health Services, Inc. (FHSI) has been the leading organization for the promotion, delivery, and enhancement of health outreach and prevention strategies for farmworkers and their families. The opportunity to once again provide a national overview and analysis of outreach program activities and outreach program and farmworker needs is even more exciting the second time around. We remain proud to be leaders of a movement that over the past three and a half decades has successfully applied models of outreach, health education, and prevention to farmworker health, and popularized these methods as legitimate and effective long before their widespread use in other health fields. Thirty-five years later, farmworker health remains one of the most unique, challenging, and innovative fields in community and public health.

We hope in this report to highlight that success and innovation and recognize the pioneering work done by migrant and community health centers and voucher programs nationwide. We also hope to present an opportunity to grow and continue to improve outreach services to farmworkers. Finally, we hope that by sharing this information with our partners and colleagues, the field of farmworker health will continue to expand and grow in its effort to improve the quality of life of our nation's farmworkers.

FHSI wishes to thank you for your continuing collaboration and support. May we build upon that collaboration in the future and continue to demonstrate how dynamic, flourishing, and rewarding it is to work with and on behalf of the men, women, and children that bring food to our nation's tables everyday.

Sincerely,

Oscar C. Gomez
Executive Director

Executive Summary

Outreach services are a critical component of providing effective and quality health care services to migrant and seasonal farmworkers (MSFW) in the United States. The provision of outreach services includes facilitating access to quality health care and social services, providing health education, bringing linguistically and culturally responsive health care to the farmworkers, aiding farmworkers in becoming equal partners in their health care, and increasing the community's awareness of farmworkers, farmworker issues, and farmworkers' important contributions to this nation.

In 2004, Farmworker Health Services, Inc. conducted its second biannual *National Needs Assessment of Farmworker Health Care Organizations*. Data were collected from 78 migrant and community health centers and migrant voucher programs on their outreach programs during calendar year 2003. Migrant and community health centers and migrant voucher programs (M/CHCs and MVPs), who receive funding under the Public Health Services Act, Section 330g, are key players in farmworker health and the provision of outreach services to farmworkers. The *2003 National Needs Assessment of Farmworker Health Care Organizations* sought to gather information from M/CHCs and MVPs about (1) the farmworkers in their service areas; (2) the outreach services offered by their organization; (3) programmatic needs in performing those services; and (4) outreach staff perceptions of farmworker health and social service needs.

The needs assessment employed three methods of data collection: a mail survey, completed by 50% (60 out of 121) of potential M/CHC and MVP respondents; a telephone survey, completed by 100% (30 out of 30) of potential M/CHC and MVP respondents; and a focus group with seven clinical providers from M/CHCs across the United States. The 2003 assessment effort improved upon the 2001 assessment by adding both the telephone survey and focus group to the methods used for data collection, and by improving the mail survey through additional questions and the provision of a Glossary of Terms for respondent reference (pg. 53). Data from 2001 and 2003 were compared where possible.

Key findings from the *2003 National Needs Assessment of Farmworker Health Care Organizations* include:

-Nationwide, mail survey respondents reported that diabetes is the most common health issue faced by farmworkers, followed by hypertension, dental health, and prenatal care.

-Transportation is the greatest barrier to accessing health care as reported by mail survey respondents nationwide. Transportation is followed by financial issues, language, and a lack of knowledge of available services.

-The top social service need for farmworkers, according to mail survey respondents, is housing assistance, followed by English language instruction, food assistance, and employment training/job assistance.

-Nationwide, the majority of telephone survey respondents (72%) reported their staff as the number one reason for the success of their outreach program.

-The average outreach dollars spent per farmworker user as reported by mail survey respondents is $42. Average dollars spent range from $71 in the Eastern stream to $34 and $26 in the Midwestern and Western streams, respectively.

-Respondent organizations reported that for each full-time outreach worker employed, there are approximately 1,782 farmworker users.

-Nationwide, outreach workers spend the most time on patient registration/eligibility, followed by health education, case management, and referrals.

-Nearly half (45%) of respondent outreach programs nationwide use a farmworker health outreach program plan in their work.

-Only one-third (32%) of respondent organizations had conducted a farmworker needs assessment in the past year.

Recommendations for farmworker health outreach programs based on findings include:

-Increase program infrastructure elements in your outreach program.

-Assess the strengths of your farmworker outreach program and build on them.

-Make full use of outreach staff as advocates for the farmworker community.

-Assess your outreach program's personnel and financial resources with respect to the farmworker population in your service area and identify goals-based programmatic needs and organizational priorities.

-If you have never done so or have not done so in the past several years, conduct a needs assessment of the farmworker population in your community.

-Outreach programs should consider multiple strategies to provide services that are in balance with the ever-changing racial, ethnic, and linguistic makeup of farmworkers in their service areas.

-There should be consistency between the health care plan and the farmworker health outreach program plan. There should be a clear quality assurance mechanism for sharing programmatic information about outreach with the Board of Directors and administration.

-Use outreach staff input in planning in order to most appropriately meet farmworker needs.

-Seek to institutionalize cultural competence, including availability of staff who speak area farmworker languages in your outreach program and throughout the larger organization.

-Clearly delineate outreach staff roles and responsibilities and share this information throughout the health organization.

-Increase formal collaboration between outreach and other health system departments.

-Outreach programs should take full advantage of partnering and networking with other area agencies in order to advocate for farmworkers, improve referral networks, and close gaps in services.

-Participate in and strengthen local farmworker coalitions through organizational membership and by encouraging the participation of other organizations and agencies.

Introduction

Farmworker Health Services, Inc.'s mission is to improve the quality of life for 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.

Farmworker Health Services, Inc.

This year, Farmworker Health Services, Inc. (FHSI) celebrates its 35th anniversary of working towards the goal of improving the quality of life of farmworker families nationwide. Over the past 35 years, FHSI estimates having collaborated with over 50 local communities to deliver health and social services to approximately 1.5 million farmworkers. Since 1970, FHSI has evolved from a small outreach operation working in five states on the East coast, to the oldest and most experienced farmworker health organization in the nation, dedicated exclusively to working with farmworker health delivery systems and providing quality programmatic support to outreach service providers. FHSI's growth and success is due in large part to collaboration and partnership with community health centers, primary care associations, and local and national farmworker leaders.

2003 National Needs Assessment of Farmworker Health Care Organizations

The *2003 National Needs Assessment of Farmworker Health Care Organizations* is the second biannual needs assessment conducted by FHSI, preceded by the *2001 Farmworker Health Outreach Needs Assessment*. Both assessments were conducted to meet a documented need in the farmworker health outreach community for national data on outreach programs, service benchmarks, outreach program needs, and farmworker health. In an effort to meet this need, the *2003 National Needs Assessment of Farmworker Health Care Organizations* sought to gather information from migrant and community health centers and migrant voucher programs about: (1) farmworkers in their service areas; (2) the outreach services offered by their organizations; (3) programmatic needs in performing those services; and (4) outreach staff perceptions of farmworker health and social service needs.

The *2003 National Needs Assessment of Farmworker Health Care Organizations* gathered information from grantees defined under section 330g of the Public Health Service Act.[1]

Agricultural Worker Definitions

Defined by Section 330g of the Public Health Service Act[2], 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 agriculture 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 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. This definition does not include aquaculture, lumbering, poultry processing, or cattle ranching.

Outreach Definitions and Models of Care

The United States Bureau of Primary Health Care (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[3]." In addition, the BPHC Uniform Data System (UDS) 2004 Reporting Instructions Manual categorizes outreach as an enabling service and defines it as "case finding, educa-

tion or other services to identify potential clients and/or facilitate access/referral of clients to available services."

FHSI supports these definitions and related descriptions, and has built upon both in an effort to further recognize the uniqueness of each outreach program and better encompass the range of services provided through outreach. The definition below and the accompanying model in Appendix A are intended to emphasize the concepts of total health, holistic service delivery, and the ultimate anticipated health and quality of life outcomes for farmworkers and their families.

FHSI defines outreach as the process of improving the quality of life for migrant and seasonal farmworkers by: facilitating access to quality health care and social services, providing health education, bringing linguistically and culturally responsive health care to farmworkers, aiding farmworkers in becoming equal partners in their health care, and increasing the community's awareness of farmworkers, farmworker issues, and farmworkers' important contributions to this nation (Appendix A).

Types of Health Delivery Systems

Migrant and community health centers (M/CHC) and migrant voucher programs (MVP) are primary care organizations that serve at-risk and underserved populations, among others. M/CHCs and MVPs are partially funded through the primary care system development programs administered by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration under the Migrant Health Center Program, Section 330g 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.

M/CHCs operate out of a health center setting. MVPs 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. MVPs contract with medical providers, make necessary referrals and provide farmworkers with a "voucher" for health care services, meaning the MVP carries the cost of services from another provider or health center. An MVP may exist in areas where the numbers and/or density of migrant and seasonal farmworkers (MSFW) cannot justify the establishment of an M/CHC based on the traditional medical delivery system model. MVPs may also serve areas where existing provider organizations cannot qualify or are unwilling to serve as grant recipients, and/or existing providers have the capacity to meet many of the primary health care needs of area MSFWs.

M/CHCs and MVPs both address the issues faced by farmworkers across the U.S., including language and cultural barriers, occupational health hazards, poverty, environmental sanitation, limited transportation, and chronic disease, among others. Both strive to fully coordinate their activities with those of public health departments, social service organizations, and other agencies in their areas that also serve MSFWs.

Migrant Streams

Historically, during the non-growing season migrant farmworkers reside 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 and summer, migrant farmworkers relocate north to "receiver communities." Traditionally, these migration patterns north from home bases are referred to as migrant streams. For the purposes of this needs assessment, M/CHC and MVP respondents identified themselves by the migrant stream in which they are located: 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. 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.

Methodology

Information Gathering Approach

Farmworker Health Services, Inc. (FHSI) sought to gather programmatic and farmworker information from M/CHCs and MVPs across the nation through a variety of mechanisms. To collect both qualitative and quantitative data, the needs assessment effort utilized a mail survey, a telephone survey, and a focus group.

Mail Survey and Telephone Surveys

The mail survey instrument was distributed to 121[4] 330g grantees across the United States, and completed by 60 of those organizations. A list of these organizations was compiled from FHSI's database and the Bureau of Primary Health Care website, BPHC Service Delivery Sites locator. The telephone survey was conducted with 30 Bureau of Primary Health Care 330g grantees across the U.S., using the list noted above. Telephone interview respondents were selected randomly from this list using systematic and cluster random sampling. Some respondent organizations may have completed either the telephone or mail survey, while others may have completed both.

Both the mail and telephone surveys were pilot tested in all three migrant streams in March 2004 and feedback from the pilots was incorporated into the final version of both surveys. The mail survey was administered between April 16 and May 26, 2004. The telephone survey was administered between April 19 and May 19, 2004.

Both surveys sought information from the person with the greatest knowledge of the respondent organization's outreach program in one of the following four positions: outreach coordinator, operations director, executive director, or medical director. 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) information on the outreach program's community relations.

Focus Group

As a qualitative component of FHSI's national needs assessment project, a focus group was held on April 30, 2004 with clinical providers from varied streams and positions[5]. The focus group was held with clinicians to address the important link between clinical and outreach services, and to gather qualitative information from a clinical perspective to support data from outreach programs. The focus group took place at the 2004 National Farmworker Health Conference. A list of 28 potential participants was generated from the conference participant registration list; participants were approached to take part based on their geographic location and diverse professional representation in an effort to gain varied participation. Seven clinicians participated in the April 30, 2004 focus group. Clinical representation included doctors, dentists, physician's assistants, nurse practitioners, and nurses.

The purpose of the focus group was to gather information from clinicians about: (1) their knowledge of outreach services at their health centers; (2) the ways they work with outreach programs at their health centers; (3) access and barriers to care for farmworkers from a clinical perspective; and (4) strategies for strengthening the link between clinical and outreach services in order to improve the quality and continuity of care for farmworker patients.

Analysis

Quantitative raw data from the survey instruments were analyzed using SPSS 11.5. 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 value based on each respondent's ranking and determined through a mean score that reflected both overall ranking and frequency of responses.

Qualitative data from the telephone survey were recorded in notations by the interviewer. Focus group data were recorded in notations by two facilitators and

supplemented by an audio tape. Readers should note that quotations from the focus group are not verbatim, but very closely reflect the statements made by participants.

Data sources are noted throughout the report. Data from the mail survey provide the basis of the majority of analyses, as the mail survey sought the greatest response and most comprehensive information. Telephone survey and focus group data were used to supplement and support data from the mail survey.

Needs Assessment Assumptions and Limitations

The *2003 National Needs Assessment for Farmworker Health Care Organizations* made several improvements upon the *2001 Farmworker Health Outreach Needs Assessment*, particularly in the area of survey development and diversity of data collection methods. Many of the improvements were based on a focus group with farmworker community leaders held following the 2001 assessment in which participants from across the U.S. provided feedback on assessment limitations. Improvements are also based on FHSI's own experience in 2001.

Improvements upon the *2001 Farmworker Health Outreach Needs Assessment*

- *To gather more complete and comprehensive data*, the *2003 National Needs Assessment of Farmworker Health Care Organizations* employed a telephone survey and focus group in addition to a mail survey.
- *To ensure the use of appropriate and clear survey instruments*, both the mail and telephone surveys were pilot tested in all three migrant streams.
- *To ensure that differences in perspective might be better controlled for*, mail and telephone surveys requested responses from the person with the most knowledge of the farmworker outreach program, from one of four positions.
- *To gather uniform data*, FHSI explicitly requested that the data received from survey respondents be data from calendar year 2003, and where appropriate, suggested a particular data source or location where the requested data might be found. Respondents were also asked to provide the source of their data.
- *To address differences in understanding among organizations regarding the meaning of certain words and processes*, FHSI provided a glossary of the terms used in the survey instruments.
- *In an attempt to capture all possible answer choices*, FHSI included "other" as a response option in nearly all multiple-choice questions. The open-ended questions allowed ample flexibility for respondents to provide their individual responses.

Limitations of the *2003 National Needs Assessment of Farmworker Health Care Organizations*

- All information gathering techniques used in the 2003 needs assessment were dependent on individuals agreeing to participate; the mail survey, telephone survey, and focus group were all self-selecting survey methods.
- Because all survey methods were self-selecting, prior knowledge of FHSI may have been a factor in individuals' and organizations' decisions to participate, thus affecting the sample distribution and assessment results.

2003 National Needs Assessment of Farmworker Health Care Organizations Report

The *2003 National Needs Assessment of Farmworker Health Care Organizations* presents data findings in several different ways. Findings are presented in each assessment topic area, followed by a brief discussion of those findings. More detailed conclusions based on findings and discussions, as well as recommendations for farmworker outreach programs nationwide, can be found in the Conclusions and Recommendations section of the report. A comprehensive table comparing major findings from the three migrant streams may be found on page 48, and additional statistical information may be found in the Appendix.

Findings

Organizational Information

This section details key characteristics about respondent organizations, their patient populations, and the services provided to those patients.

Respondents

The response rate to the mail survey was 50% (60 of 121 possible respondents), an increased response rate as compared to the 41% response rate to the *2001 Farmworker Health Outreach Needs Assessment*. Looking at response rate by stream, 63% of organizations solicited from the Eastern stream, 52% from the Western stream, and 33% from the Midwestern stream responded to the mail survey. These response rates resulted in a sample, or group of total respondents, comprised of 48% (29 of 60) Eastern stream respondents, 27% (16 of 60) Midwestern stream respondents, and 25% (15 of 60) Western stream respondents (Figure 1).

The response rate to the telephone survey was 100% (30 out of 30 possible respondents). The telephone survey sample was comprised of 30% Eastern stream respondents, 27% Midwestern stream respondents and 43% Western stream respondents.

Of the seven focus group participants, three represented M/CHCs from the Eastern stream, three represented the Midwestern stream, and one represented the Western stream.

Type of Program

Most respondents (58%) reported their organization as a jointly designated Community Health Center (CHC) and Migrant Health Center (MHC). Relatively few organizations reported their designation as CHC only (17%) or MHC only (5%). Of the remaining organizations, 8% reported their designation as a Migrant Voucher Program/Community Health Center (MVP/CHC) and 10% as MVP only (Figure 2).

The majority of mail survey respondent organizations (82%) considered their outreach programs to be year-round, while only 7% of respondents considered their outreach programs to be seasonal.

Figure 1. Survey Respondents by Stream

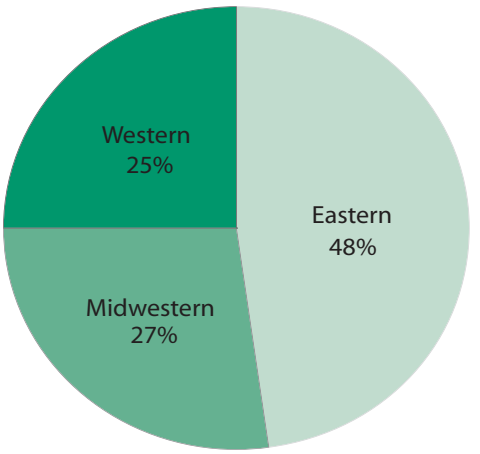
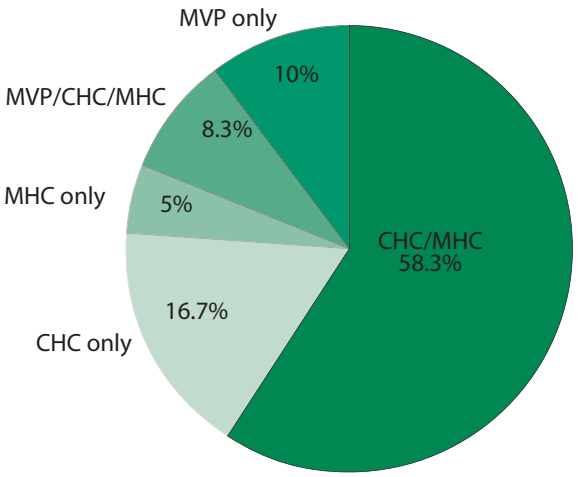


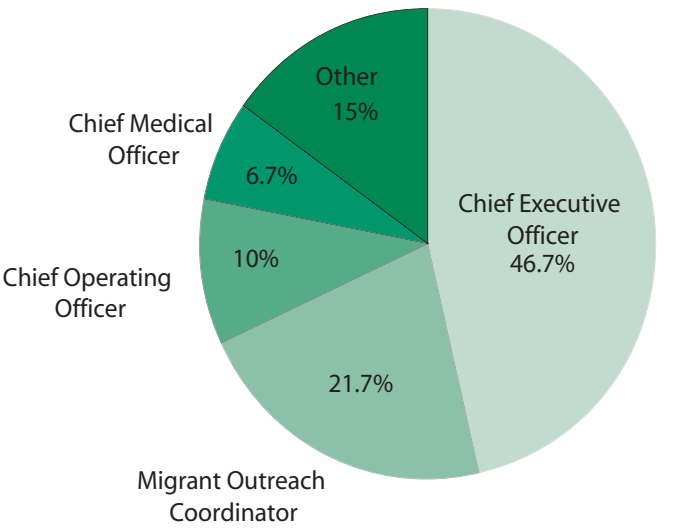
Figure 2. Respondent Organization Type



Respondent Position

Of mail survey respondents, chief executive officers (CEO) accounted for the majority (47%) of respondents. Other respondents included migrant outreach coordinators (22%), chief operating officers (10%) and chief medical officers (7%). Fifteen percent of respondents held another position within their organization (Figure 3).

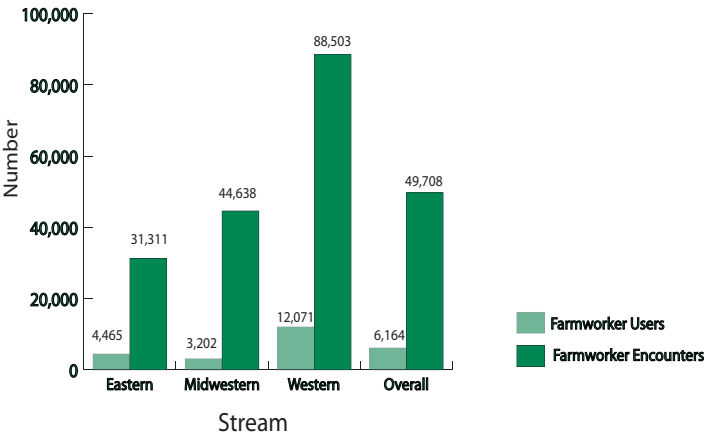
Figure 3. Respondent Position



Users/Encounters

M/CHCs and MVPs report both users and encounters[1] to the Bureau of Primary Health Care Uniform Data System on a yearly basis; mail survey respondents were asked to report these numbers for 2003. Western migrant stream respondents reported the highest average number of farmworker users per organization (12,071), followed by the Eastern (4,465) and Midwestern (3,202) streams. The Western stream also reported the highest average number of farmworker encounters per organization (88,503). The Midwestern stream (44,638) reported the second highest average number of encounters, followed by the Eastern stream (31,311). Comparing the ratio of encounters to users, the Midwestern stream reported thirteen times more encounters than users, almost twice that of the Eastern and Western streams, both of which had seven times more encounters than users (Figure 4).

Figure 4. MSFW Users and Encounters



Outreach Staff

The ratio of an organization's outreach workers to its farmworker users is one indication of how well a program is equipped to serve the area farmworker population. Nationally, the average ratio of farmworker users to outreach workers is one worker for every 1,782 farmworker users, as reported by mail survey respondents. The ratio varies across the three migrant streams. The Midwestern stream, with the lowest average number of farmworker users per M/CHC or MVP in the three streams (Figure 4), also has the lowest average number of users per outreach worker (1,143). The Eastern stream is slightly higher with 1,353 users per outreach worker, followed by the Western stream with 2,514 users per outreach worker (Table 1).

As there are usually more outreach workers than outreach coordinators, the ratio of farmworker users to outreach coordinators is higher than that of users to outreach workers. Again, the Midwestern stream has the lowest number of users per outreach coordinator

Table 1. Average Users per Staff by Migrant Stream

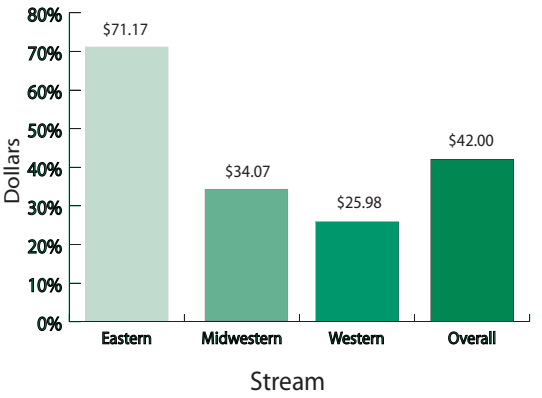
Position: Outreach Worker		
	% in stream reporting position exists at organization	Mean users/outreach worker
Stream:		
Eastern Midwestern Western	72% 81% 60%	1,353 1,143 2,514
Total	75%	1,782
Position: Outreach Coordinator		
	% in stream reporting position exists at organization	Mean users/outreach coordinator
Eastern Midwestern Western	50% 38% 80%	4,060 2,669 10,974
Total	57%	5,455

(2,669). The Midwestern is followed by the Eastern stream with 4,060 and the Western stream with 10,974 users for each outreach coordinator (see Table 1).

Outreach Cost per User

A benchmark that can be used by outreach programs to ensure that grant dollars are being used to maximize the services and care delivered to farmworker patients is the ratio of outreach dollars per farmworker user. The national average for outreach dollars spent per farmworker user is $42 according to mail survey respondents. This was calculated by dividing the average total outreach budget reported by respondents by the average total number of farmworker users reported by respondents. These figures are included in the overall budgets of the respondent organizations; the percentage of outreach budget covered by federal grant dollars is not accounted for. Within each of the three streams the outreach dollars spent per user varies considerably. In the Eastern stream the average is $71, which is the highest amount spent in the three streams. The average

Figure 5. Mean Outreach Dollars per Farmworker User



spent in the Midwestern stream is $34, and in the Western stream it is $26 (Figure 5).

Discussion

Respondents to the *2003 National Needs Assessment of Farmworker Health Care Organizations* reported widely varying organizational characteristics. The different streams reported varying average users and encounters, outreach cost per user, and staffing.

The relationship between number of users, encounters, outreach staff, and the average cost per farmworker user merits further consideration. In this assessment, Eastern stream respondent organizations reported the highest average cost per farmworker user. They also reported higher than average ratios of outreach workers and outreach coordinators to farmworker users. The Midwest reported the lowest number of users overall, but the highest number of encounters per farmworker user. They also reported the highest ratio of outreach workers and outreach coordinators to farmworker users. These data indicate that Midwestern stream organizations had the most outreach staff serving their farmworker populations as compared to the other streams. Given this higher proportion of outreach staff to users, it is of interest that Midwestern stream respondents had a lower than average cost per

farmworker user. The Western stream had the lowest ratio of outreach staff to farmworker users, an average ratio of encounters to users, and the lowest cost per user.

Outreach programs strive to achieve the right number of outreach coordinators and outreach workers necessary to serve their farmworker population without over-taxing outreach staff or over-hiring within a limited budget. Depending on program structure and need, programs may require a different number of outreach coordinators/workers in order to best meet program and community needs. These data confirm that programs need to consider a range of factors, including overall user numbers, staff to user ratios, number of encounters per user, and overall cost per user when planning for outreach programs.

Farmworker Information

Migrant health grantees receive funding to serve farmworkers in their areas in order to reduce the 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 in order to plan for the provision of farmworker health services.

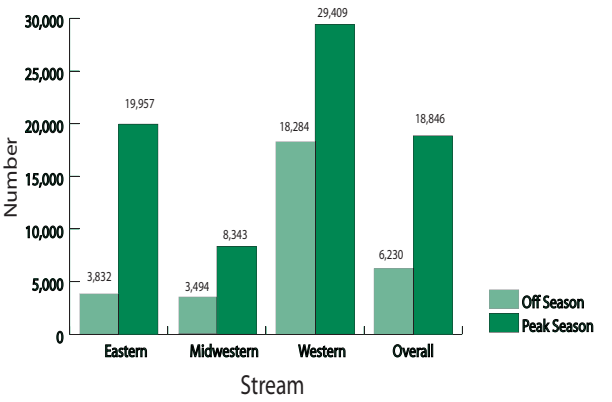
Farmworker Population

Respondents to the *2003 National Needs Assessment of Farmworker Health Care Organizations* were asked to estimate the total number of farmworkers in their organization's service area during peak harvest times as well as during the off-season. Farmworker population estimates vary greatly by season. Figure 6 shows the average number of farmworkers during peak and off-peak seasons in respondent organizations' service areas. In peak season mail survey respondent organizations nationwide reported an average of 18,846 MSFWs in their regions. Only about one-third of farmworkers – 6,230 on average – remained in these programs' service areas during off-peak season.

The most marked seasonal differences are in the Eastern stream, with an average of 19,957 farmworkers residing in respondent organizations' service areas during peak season, but only 3,382 during off-peak season. The Western stream reported the highest number of MSFWs during both the peak (29,409) and off-peak (18,284) seasons. Farmworker serving health care organizations from the Midwestern stream reported the lowest number of farmworkers in their service areas during peak (8,343) and off-peak (3,494) seasons.

"All Midwestern and Eastern stream respondents, and most Western stream respondents (93.3%), reported Spanish-speaking farmworker populations..."

Figure 6. Mean Number of Farmworkers in Service Area by Stream



Farmworker Languages

Mail survey respondents were asked to report on the languages spoken by farmworkers in their service areas. All Midwestern and Eastern stream respondents and most Western stream respondents (93%) reported Spanish-speaking farmworker populations. About 70% said that MSFWs in their area speak English. Other

farmworker languages reported by respondents included indigenous Mexican and Central American languages (51%), [Haitian] Creole (18.6%), and Asian languages (8.5%). Almost 14% of organizations reported that farmworkers in their areas speak another language, ranging from Russian to Low German. Asian languages were most commonly reported by Western stream respondents (27%), while Eastern stream respondents were most likely to report farmworkers speaking Creole (39%) and indigenous languages (71%) (Figure 7).

Farmworker Race/Ethnicity

Overall, mail survey respondents reported that 89% of their total farmworker users in 2003 were Hispanic or Latino. The next most numerous group reported was "White, not Hispanic or Latino" (5%), followed by "Black/African American, not Hispanic or Latino" (4%). White farmworker users were most common in the Midwestern and Western streams (9% and 8%, respectively). Black farmworker users were most common in the Eastern stream (8%). The Western stream reported the greatest proportion of "Asian/Pacific Islander" farmworkers, while the Eastern stream reported the highest proportion of "American Indian/Alaskan Native" farmworker users (Figure 8).

Health Issues Facing Farmworkers

In order to determine what services should be delivered, farmworker serving health care organizations need accurate information about the health issues

Figure 7. Languages Spoken by Farmworker Users by Stream

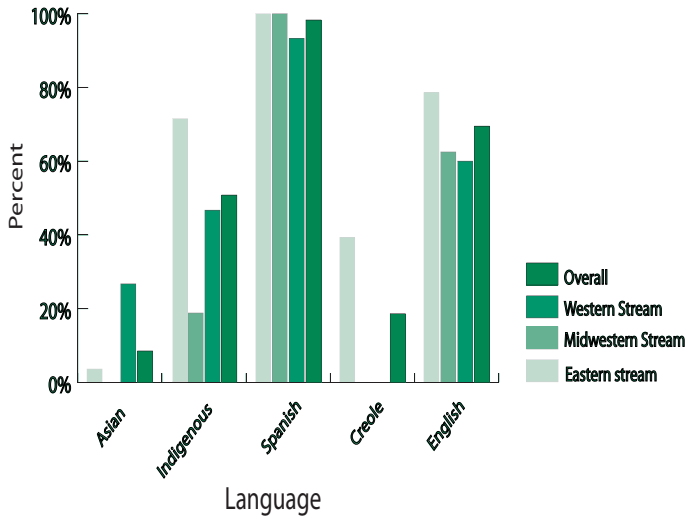
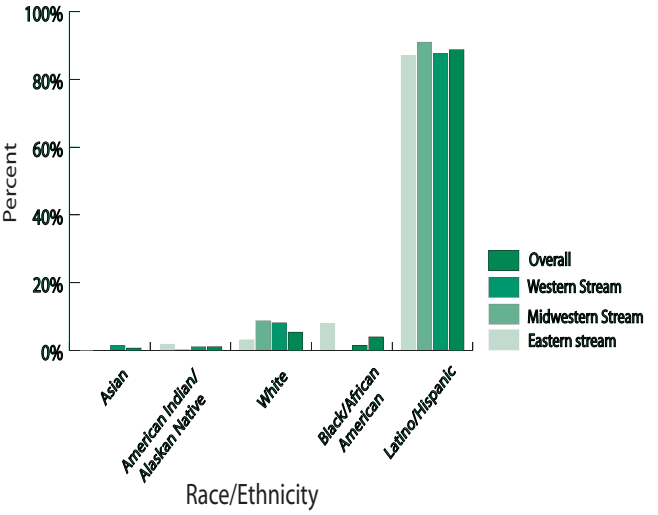


Figure 8. Farmworker Race/Ethnicity by Stream



"Mail survey respondents reported that 89% of their total farmworker users in 2003 were Hispanic or Latino. The next most numerous racial/ethnic group was White/Non-Latino, followed by Black/Non-Latino ..."

farmworkers face, the health issues that interest them, the barriers they face in accessing health care, and the social service needs that confront them.

Mail survey respondents were asked to rank, from one to five, the most common health issues faced by farmworkers in their communities. When a health issue was ranked "most common," it received a score of five points. When a health issue was ranked least common, it received one point. When a health issue did not fall into the top five, and therefore was not ranked, it received zero points. The point values for each health issue, across all respondents, were then summed and averaged to obtain a mean score. The rank order of health issues presented in Table 2 is based on the mean score that each health issue received using this method. Additionally, data are presented on the percentages of respondents ranking each health issue as the number one or number two issue facing farmworkers. These percentages are presented in Figure 9.

Overall, based on mean score, diabetes was the most common health issue among farmworkers and their families, hypertension was the second, and dental health was the third most common health issue (Table 2). This rank order is identical to the order of most common health issues facing farmworkers reported in 2001. As seen in Figure 9, diabetes was ranked either the most common or second most common health issue facing farmworkers by 68% of respondents and hypertension was ranked in the top two by 47% of respondents.

In the Western and Midwestern streams, diabetes was most frequently ranked as the most common or second most common health issues facing farmworkers (93% and 71% of respondents, respectively). Eastern stream respondents most frequently ranked hypertension (62%) as the most common or second most common health issue facing farmworkers. Prenatal care and dental health were also frequently ranked as one of the top health issues. A small number of respondents in each stream ranked alcohol/substance abuse as the most

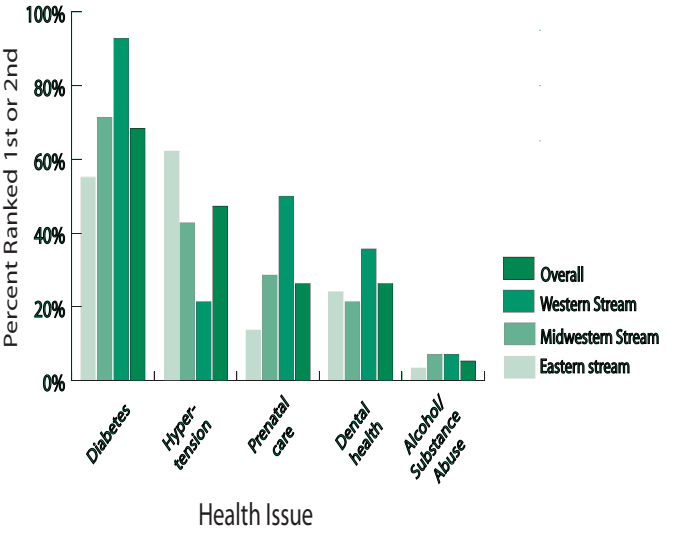
"...Diabetes was the most common health issue among farmworkers..."

Table 2. Most Common Farmworker Health Issues

Health Issue	Overall Rank*
Diabetes	1
Hypertension	2
Dental health	3
Prenatal care	4
Mental health	5
Dermatitis	6
Alcohol/substance abuse	7
Environmental/occupational health	8
HIV/AIDS/STIs	9
Eye care	10

*Overall rank based on mean score.

Figure 9. Most Common Farmworker Health Issues by Stream



common or second most common health issue facing MSFWs.

Health Topics of Interest to Farmworkers

M/CHCs and MVPs also ranked, from one to three, the health topics of greatest interest to farmworkers in their service area. Based on mean score rankings, diabetes, dental health, and hypertension were once again at the top of the list (Table 3). Figure 10 shows the percentage of respondents that ranked an issue as the topic of greatest interest to farmworkers. Thirty-four percent of M/CHCs and MVPs overall ranked diabetes as the topic of greatest interest to farmworkers, and 23% ranked dental health as the most interesting topic. Prenatal care and hypertension were ranked as the number one topic of interest by 7% and 6% of respondents, respectively. Less than 4% named alcohol/substance abuse as the topic of greatest interest.

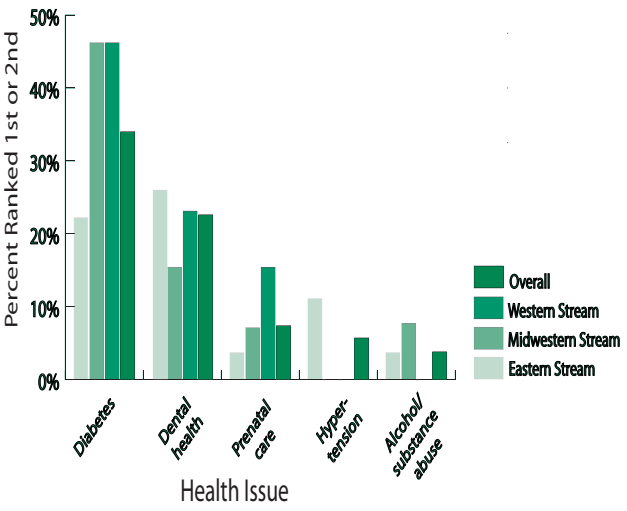
Table 3. Health Topics of Interest to Farmworkers

Health Issue	Overall Rank*
Diabetes	1
Dental Health	2
Hypertension	3
Prenatal care	4
HIV/AIDS/STIs	5
Environmental/Occupational Health	6
Eye care	7
Mental health	8
Alcohol/substance abuse	9
Dermatitis	10

*Overall rank based on mean score.

In both the Midwestern and Western streams, diabetes was cited as the health topic of greatest interest to MSFWs more than any other topic (by 46% of respondents in each stream). Eastern stream respondents (26%) most commonly named dental health as the topic of greatest interest to farmworkers. Hypertension was frequently ranked as one of the top three topics of interest, and therefore received a higher mean score (and overall ranking, see Table 3) than prenatal care. However, as seen in Figure 10, prenatal care was more frequently ranked as the number one issue of interest to farmworkers. Only Eastern stream respondents (11%) mentioned hypertension as the number one topic of

Figure 10. Health Topics of Greatest Interest to Farmworkers by Stream



"Eastern stream respondents most commonly named dental health as the health topic of greatest interest to farmworkers..."

interest. Only Eastern (4%) and Midwestern stream respondents (8%) named alcohol/substance abuse as the topic of greatest interest to farmworkers.

Barriers to Accessing Health Care

Respondents ranked transportation, pay scale/financial issues, and language/interpretation as the three greatest barriers that farmworkers face in accessing health care (Table 4). Twenty-six percent of respondents overall cited transportation as the top barrier to care, with an equal number naming pay scale/financial issues as the top barrier. Nearly 14% of respondents cited language as the most important barrier faced by MSFWs. Legal issues and lack of knowledge about available services were each noted as the largest barrier to care by 10% of respondents (Figure 11).

In the Eastern stream, transportation was most frequently ranked as the top barrier to care (45% of respondents). In the Midwestern and Western streams, respondents most often ranked pay scale/financial issues as the top barrier to care (40% and 29%, respectively). Language was considered the top issue by 10 to 20% of respondents, and lack of knowledge of available services was cited as the top issue by 7 to 14% of respondents across streams. Only respondents in the Eastern and Western streams said that legal status was the greatest barrier to accessing health care for farmworkers.

Participants in the clinicians' focus group also discussed barriers to care faced by farmworkers in their areas, in particular in relation to outreach services. Focus group participants spoke at length about some of the challenges facing outreach services and the access issues faced by farmworkers in utilizing outreach and clinical services. Clinicians highlighted some barriers not identified through the other survey methods. Outreach-specific barriers included, among others, a lack of knowledge of services available: many farmworkers do not know that they qualify for services at health centers, or do not even know that centers exist.

"For many patients, they don't know [services] are available. They don't know anyone, may not be legal, and are afraid to go somewhere they don't know about. Some of the work [of outreach] is just getting the word out about services." – Registered Nurse

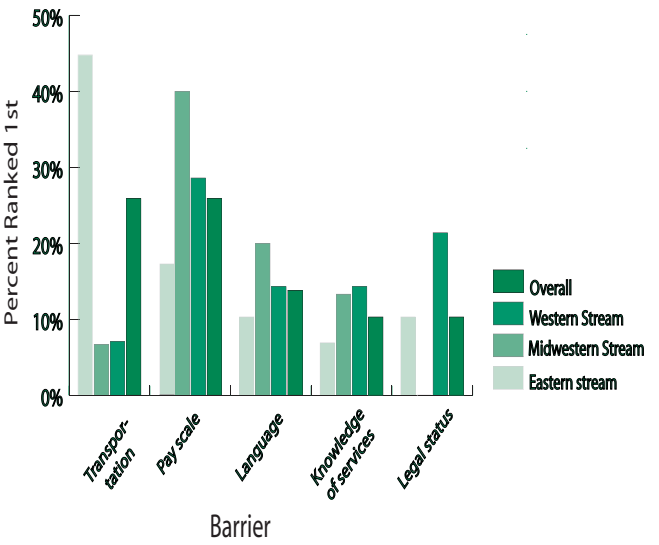
"We are trying to get the highway people to put up a sign that says *Migrant Clinic* at this exit. They won't put up signs – there are a lot of politics involved. They have the signs in

Table 4. Barriers to Care

Barrier	Overall Rank*
Transportation	1
Pay scale/financial issues	2
Language	3
Lack of knowledge of available services	4
Legal status	5
Hours of operation	6
Lack of outreach services	7
Cultural differences	8
Alternative medical beliefs	9

*Overall rank based on mean score.

Figure 11. Top Barriers to Care by Stream



[other states] and it works great, so we want the same signs in our area." – Medical Director

"Most of our [farmworker] patients live in the city, in apartments. Since they are not all in one place, it's hard to get information to them about services." – Medical Director

In addition, several clinicians mentioned that a significant amount of time is invested in developing and maintaining a working relationship with growers and crew leaders.

"Outreach works with the farmers – does the leg work. They get permission from growers to get into the camps and to provide information to [farmworkers]. It is a big issue [for us]. A lot of time goes into working with the growers to get permission to go out to the camps – it gets the message out about the services that are out there. Crew leaders aren't always aware of late night services, and won't let them out of work [to go to the center]. It's important to educate growers about services and the reason for services. The perception by growers is that they go [to the center] to get "freebies" and handouts." – Dental Director

"Me and a physician set up [outreach services] at camps for a bit, but we had problems with growers. We set up at mobile home camps. Some were successful and some weren't. We didn't start it up again." – Physician's Assistant

"A challenge is getting crew leaders to allow farmworkers to come to the center. On nice days, they are expected to be in the field." – Dental Director

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 areas. Based on the mean score generated by summing and averaging the rankings of a list of social service needs, housing assistance ranked as the most pressing social service need for MSFWs. English language instruction and food assistance ranked as the second and third most commonly observed social service needs for farmworkers, respectively (Table 5).

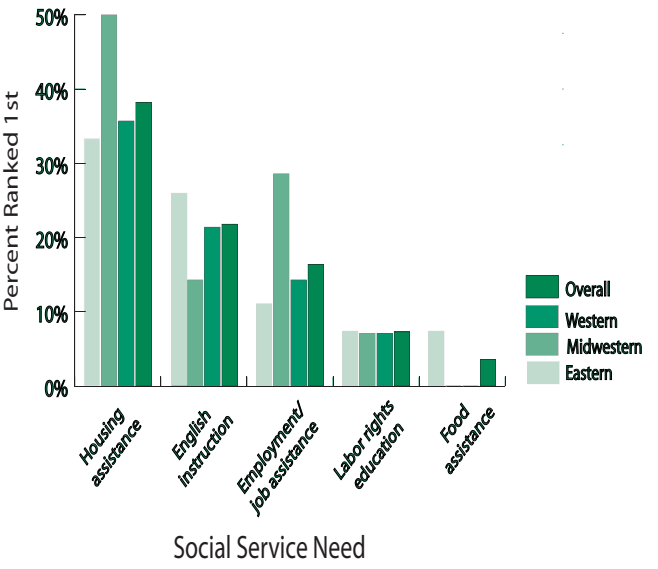
Housing assistance was most frequently cited as the top social service need of farmworker families, with nearly 40% of respondent M/CHCs and MVPs ranking it first. Over 20% of respondents cited English language assistance as the top social service need. Although many M/CHCs and MVPs listed food assistance among the top three social service needs of MSFWs,

Table 5. Farmworker Social Service Needs

Social Service Need	Overall Rank*
Housing Assistance	1
English language instruction	2
Food assistance	3
Employment training/job assistance	4
Legal services	5
Labor rights education	6
Domestic violence prevention education	7
Accessing children's education services	8
Other violence prevention education	9

*Overall rank based on mean score.

Figure 12. Farmworker Social Service Needs by Stream



few (less than 4%) listed it as the greatest need. A greater percentage (16%) ranked employment training or job assistance as the biggest social service need facing MSFWs (Figure 12).

As discussed above, M/CHCs in all streams reported housing assistance as the top social service need facing farmworker families. Fifty percent in the Midwestern stream, 36% in the Western stream, and 33% in the Eastern stream ranked housing assistance first. Nearly 30% of Midwestern respondents cited employment training/job assistance as the top social service need, while 26% in the Eastern stream and 21% in the Midwestern stream felt that English language instruction was the most pressing need. In all streams, about 7% of M/CHCs and MVPs reported labor rights education as the most important social service need.

Discussion

Given the significant differences reported in farmworker populations during peak and off-peak seasons, it is clear that a considerable percentage of farmworkers in all parts of the country are migrating to stay employed. The consequences for both farmworker health and for the M/CHCs and MVPs serving farmworkers are significant. For the individual farmworker, maintaining continuity of health care while migrating for work can seem impossible. For health organizations that serve farmworkers, changing needs in staffing levels and outreach priorities can be difficult challenges. A large seasonal population calls for a fully-staffed year-round program; a large migrant population necessitates immediate care and referrals, and can make follow-up challenging. Different combinations of migrant and seasonal populations call for a mix of services and strengths for individual outreach programs. Addressing migrant and seasonal farmworkers' continuity of care may require both seasonal and year-round program staffing solutions and strategies for year-round support and follow-up.

Linguistic and cultural characteristics of area farmworkers are also an important part of staffing decisions and solutions. The majority of respondents (98%) reported that Spanish-speaking farmworkers reside in their service areas. Respondents also reported that 89% of their farmworker patients are Hispanic or Latino. However, it is important that these figures do not mask the existence of other farmworker subpopulations. Nine percent of respondents reported the presence of farmworkers who speak Asian languages in their service areas. However, Asian farmworkers only accounted for 1% of these organizations' farmworker users. M/CHCs and MVPs need to keep pace with emerging farmworker subpopulations.

Chronic disease and prenatal care ranked as the most common health issues confronting farmworker patients, according to mail survey respondents. These same issues also ranked as the top health issues of interest to MSFWs. Western stream respondents emphasized prenatal care more frequently than Eastern or Midwestern stream respondents. This may be explained, in part, by the higher concentration of seasonal farmworker families in the Western region (see Figure 6). More seasonal (vs. migrant) farmworkers may indicate more farmworker families in a region. However, these data must be interpreted with caution. The National Association of Community Health Centers estimates that health centers only serve 15-20% of MSFWs in the U.S.[6] Existing information about farmworker health issues is based on the issues confronting farmworkers seen by health centers and other providers, meaning that over 80% of MSFWs are not represented. As a result, important health issues that exist in the population may be missed. Concerns about job security, lack of health insurance, documentation status, language differences and cultural differences are all issues which may keep a farmworker from seeking health care. Multiple data sources, including asking farmworkers themselves, should be used before drawing conclusions about health issues that affect, and that are of interest to, MSFW populations.

Data from the *2003 National Needs Assessment of Farmworker Health Care Organizations* highlight the fact that M/CHCs and MVPs must consider issues outside the general realm of health care when planning how to best serve farmworkers and their families. Transportation, financial issues, legal status, language, and knowledge of available services were cited as top barriers farmworkers face in accessing health care. Gaining access to farmworkers through growers is also a significant outreach-based challenge. Growers and crew leaders are important stakeholders in providing quality health care to farmworkers in that they often facilitate or enable outreach contact with farmworkers. Because outreach programs need to reach farmworkers as the ultimate recipients of their services, strategies for gaining

the cooperation of growers and crew leaders are important to program success.

The top social service needs of farmworkers, as identified by mail survey respondents, are housing assistance, English language instruction and employment training/job assistance. These needs, along with the barriers to accessing health care discussed above, highlight an urgent need for M/CHCs and MVPs to develop partnerships with other community agencies that serve underserved populations. Helping farmworkers meet their basic needs will facilitate the health education and prevention strategies of M/CHCs and MVPs and strengthen the rapport and trust between farmworkers and farmworker service providers.

Outreach Program Information

The information provided in this section is intended to give the reader a general sense of the type of outreach programs in existence at farmworker-serving organizations across the nation. Data discussed here pertain specifically to outreach programs, and to the larger organizations (M/CHCs, MVPs) within which they operate.

Many of the following data regarding outreach program specifics, such as outreach staff full-time equivalents, cultural competency training, and program structure were not collected in the *2001 Farmworker Health Outreach Needs Assessment*. The data, therefore, are not comparable to data from 2001.

Number of Staff

Different outreach program 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 (camp health aides or *promotoras*), 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.

The majority of respondents (75%) have an outreach worker position in their outreach program. Of programs with outreach workers, the average number of full-time staff per program, or FTE, was 3.5. The majority of respondents' outreach programs (57%) also have an outreach coordinator position, with an average of 1.1 FTE per program. There was considerable variation in the other positions listed above. Twenty three percent of respondent programs nationwide have community health worker positions, 27% have clinical outreach worker positions, and 35% have transportation staff positions; the average number of FTE per program is 3.6, 2.7, and 1.6, respectively (see Glossary of Terms for staff position definitions).

In a regional analysis, it is interesting to note the differences in staffing and average FTE by stream among outreach positions. The majority of respondent programs in the Western stream have outreach worker positions (60%) and outreach coordinator positions (80%); nearly half (47%) have transportation staff positions. About one third of respondent programs in the Western stream have clinical outreach positions (33%) and community health worker positions (27%). In the Eastern stream, the majority of respondent programs have outreach worker positions (72%), and half have outreach coordinator positions. As with the Western stream, fewer respondent programs in the Eastern stream had transportation staff positions (38%), clinical outreach positions (25%), and community health workers (19%) than had outreach workers and coordinators. The Midwestern stream demonstrates a similar trend, with the majority of respondent programs having outreach worker positions (81%), and a smaller percentage of programs having coordinator (38%), community health worker (19%), clinical outreach (13%), and transportation (13%) positions.

In terms of FTE for respondent programs with the above staff positions, the Western stream has the highest average FTE per program for outreach workers (4.8), followed by the Eastern (3.3) and Midwestern (2.8) streams. The Western stream also has the highest aver-

> ***"The majority of respondents had an outreach worker position in their outreach program..."***

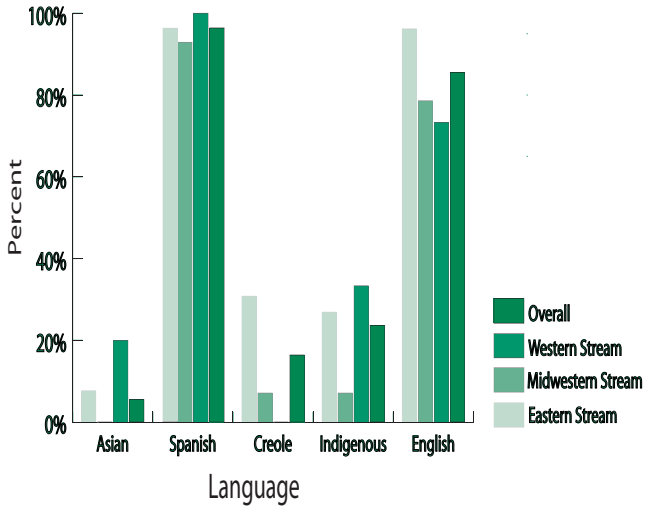
age FTE per program for clinical outreach workers (3.6) compared to the Midwestern (2.7) and the Eastern (2.0) streams. The Eastern stream has the highest average FTE per program for community health workers, 4.2 compared to 3.3 in the Western and 2.8 in the Midwestern stream. Each stream had an average of about 1.1 outreach coordinators and 1.5 transportation workers per program.

Language Spoken

The languages spoken by outreach staff can provide some insight into the languages spoken by farmworkers across the country, as outreach programs often try to match staff language abilities with farmworker needs in their area. Nationally, over 96% of mail survey respondents employ outreach staff members that speak Spanish. These data are consistent with data published in the 2002 National Agricultural Workers Survey (NAWS)[7], which reports that 77% of farmworkers in the United States are Mexican-born, and that of all farmworkers in the U.S., both U.S. and foreign born, 88% are Hispanic/Latino. Additionally, 24% of respondent organizations reported employing outreach staff that speak an indigenous Central American or Mexican language, and 16% employ outreach staff that speak Creole. Six percent of organizations employ staff that speak an Asian language (Figure 13).

When analyzed regionally, the varying language characteristics of the farmworker streams become apparent. There is relative accord among streams in terms of percentage of organizations with Spanish-speaking outreach staff members (100% in the Western, 96% in the Eastern, and nearly 93% in the Midwestern stream). In contrast, the percentage of staff speaking Central American or Mexican indigenous languages, Creole, and Asian languages does vary by stream. Western stream respondents reported the greatest percentage of staff who speak Central American or Mexican indigenous languages (33%) and Asian languages (20%) (as compared to 27% and 8% in the Eastern, and 7% and 0% Midwestern stream). Eastern stream respondents were most likely to report Creole speaking staff (31%), followed by the Midwestern (7%) and Western (0%) streams, respectively.

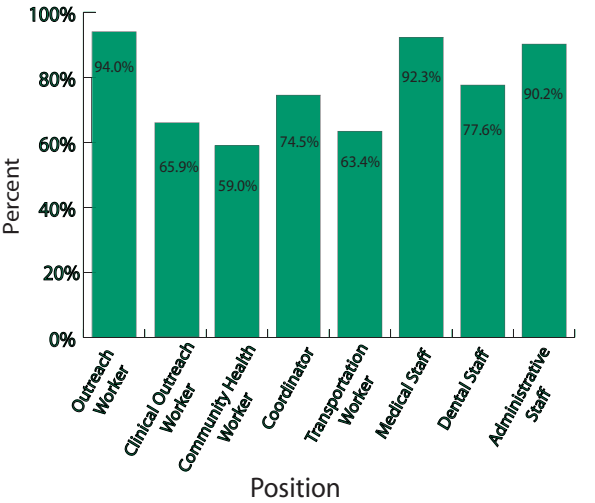
Figure 13. Languages Spoken by Outreach Staff by Stream



Cultural Competence

Culturally competent services are vital to the provision of effective health care for farmworkers;

Figure 14. Staff Receiving Cultural Competency Training

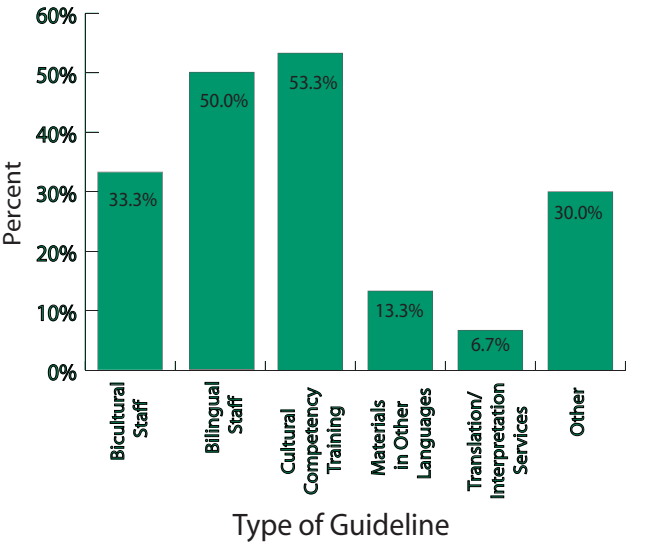


farmworker health care organizations across the U.S. employ various strategies to train and support staff in providing culturally competent care. Mail and telephone survey respondents were asked to report on outreach program and organizational policies for employee cultural competency training (Figure 14). Overall, the vast majority of mail survey respondents reported providing cultural competency training for three specific staff positions: 94% trained outreach workers, over 92% trained medical staff, and over 90% trained administrative staff. Other staff positions also received training, although to a lesser degree. Nearly 78% of dental staff, 74% of coordinators, 66% of clinical outreach staff, and 63% of transportation staff all received cultural competency training. The staff position in which employees were least likely to receive cultural competency training was community health worker (59%).

Telephone survey respondents reported slightly lower percentages of staff receiving cultural competency training. Slightly over half (53%) of the respondents stated that cultural competence or cultural sensitivity training is provided to staff members. Of those programs providing cultural competency training, slightly more than one in three (38%) indicated that the training provided to staff members is given at least on an annual basis, if not more frequently. In addition to cultural competency training, respondents gave detailed information about the specific guidelines they follow to ensure the delivery of culturally competent care to farmworkers (Figure 15). One half (50%) of respondents indicated that retention of bilingual staff members is a requirement to ensure the delivery of culturally competent care, and one in three (30%) reported that the employment of bicultural staff members is a guideline for their organization.

In addition, interview respondents also mentioned the importance of providing written materials to farmworker patients in their native languages (13%) and providing interpretation services for their patients (7%). One third of telephone survey respondents reported program policies for culturally competent care that did not fall into one of the above categories, yet are innovative and worthy of discussion. Examples of these policies include hiring staff members with a farmworker background, creating protocols for delivering culturally competent care, addressing cultural competency in the organizational mission statement, conducting an annual cultural competency review, and offering free language lessons to staff.

Figure 15. Guidelines for Culturally Competent Care



"Examples of cultural competency policies include hiring staff members with a farmworker background, creating protocols for delivering culturally competent care, addressing cultural competency in the organizational mission statement, conducting an annual cultural competency review, and offering free language lessons to staff..."

Keys to Success

Telephone survey respondents provided qualitative data on the unique characteristics of their programs that make them successful. Nearly three out of four (72%) respondents specifically referenced the staff members employed by their program as the primary element of their success. Respondents went on to highlight the particular qualities that make their staff a key to the success of their program (Figure 16). Staff commitment and dedication was most commonly cited, with two out of five (38%) respondents mentioning it as the number one reason for their program's success. The second most commonly noted key staff qualities were having a trusting relationship with and being known in the community (31%), and being bilingual (31%).

Figure 16. Outreach Program "Keys to Success"

Other staff qualities emphasized by respondent organizations were enthusiasm for going out into the community to provide services, and possessing a farmworker background. One in four respondent organizations that mentioned staff members as a key to success for their program noted that outreach staff physically going out to the community to deliver services is an important factor in their success.

Current Outreach Activities

All the mail survey respondents were asked to rank the top three activities performed by outreach staff at their organizations. As in previous sections of this report, two methods were used to determine and present the relative frequency of these activities. First, activities were ranked based on a mean score; this ranking is shown in Table 6. In addition to ranking activities by mean score, data are presented on the percentages of

Table 6. Current Outreach Activities

Outreach Activity	Overall Rank*
Patient registration/eligibility	1
Health education	2
Case management	3
Referrals	4
Follow-up	5
Appointment setting	6
Health fairs	7
Clinical outreach	8
Transportation	9

*Overall rank based on mean score.

"One in four telephone respondents noted that outreach staff physically going out to the community to deliver services is an important factor in their success ..."

respondents ranking each activity as the number one activity performed by outreach staff (see Figure 17).

Overall, patient registration/eligibility was reported as the activity most frequently performed by outreach staff. This was followed by health education and case management (Table 6). This differed from the *2001 Farmworker Health Outreach Needs Assessment* conducted by FHSI. In 2001, case management was the highest ranking activity performed by outreach staff; referral/follow-up and formal health education were the 2nd and 3rd most frequent outreach staff activities.

As seen in Figure 17, patient registration/eligibility was most frequently ranked as the top activity performed by outreach staff (29% of respondents). Case management followed, with 16% of respondents ranking it as the top activity. Respondents from the Midwestern and Eastern streams most frequently ranked patient registration/eligibility number one (42% and 22%, respectively), while in the Western stream, health education was most often cited as the top outreach activity (29%). Midwestern stream respondents were much more likely than other streams to report patient registration/eligibility and appointment setting as the top activity for outreach workers; the Midwest was less likely than other streams to cite case management, clinical outreach, follow-up, and health education as top outreach activities.

Figure 17. Current Top Outreach Activities by Stream

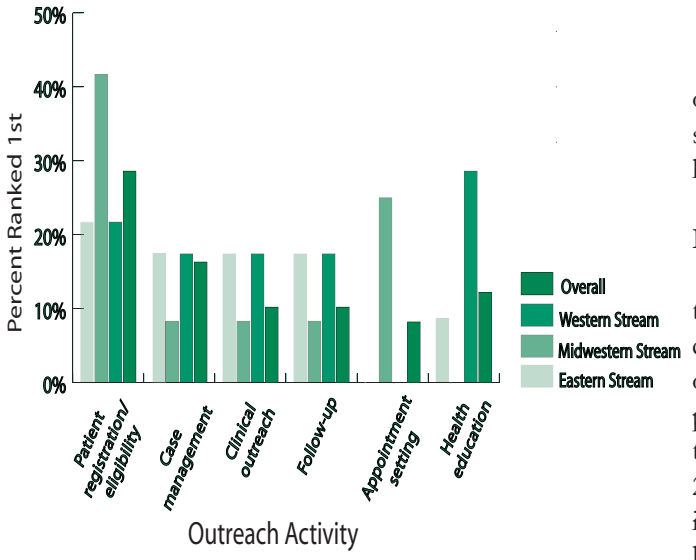


Table 7. Future Outreach Activities

Outreach Activity	Overall Rank*
Health Education	1
Case management	2
Patient registration/eligibility	3
Clinical outreach	4
Health fairs	5
Follow-up	6
Referrals	7
Appointment setting	8
Transportation	9
Data collection	10

*Overall rank based on mean score.

"Midwestern stream respondents were much more likely than other streams to report patient registration...and appointment setting as the top activity for outreach workers..."

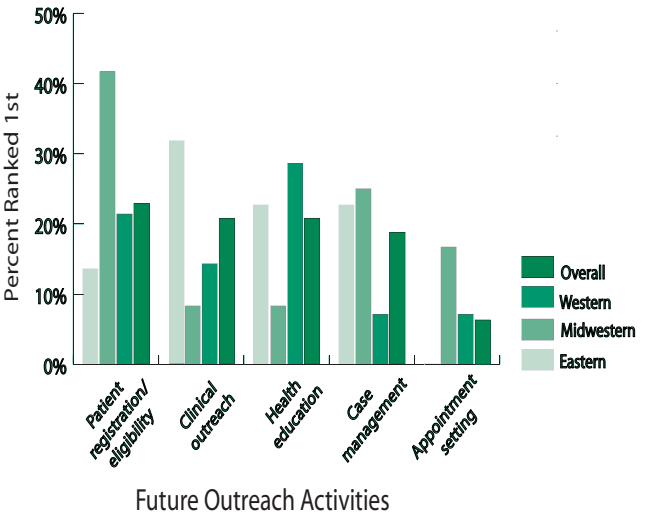
Future Outreach Activities

All respondents were also asked to rank the top three activities they would like to see outreach staff devote the most time to in the next two years. Based on the mean score, health education ranked as the top priority activity, followed by case management and patient registration/eligibility (Table 7). This differed 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.

Overall, a comparable percentage of respondents ranked patient registration/eligibility (23%), clinical outreach (21%), health education (21%), and case management (19%) as the activity they would like to see outreach staff devote the most time to over the next two years. Eastern stream respondents (32%) prioritized clinical outreach, Midwestern respondents (42%) named patient registration/eligibility, and respondents from the Western stream (29%) emphasized health education as the top desired activity for outreach workers over the next two years. Case management was cited as the top desired activity by 23% in the East and 25% in the Midwest, but only 7% of Western stream respondents felt case management should be the top activity performed by outreach staff in the next two years (Figure 18).

Figure 18. Future Top Outreach Activities by Stream



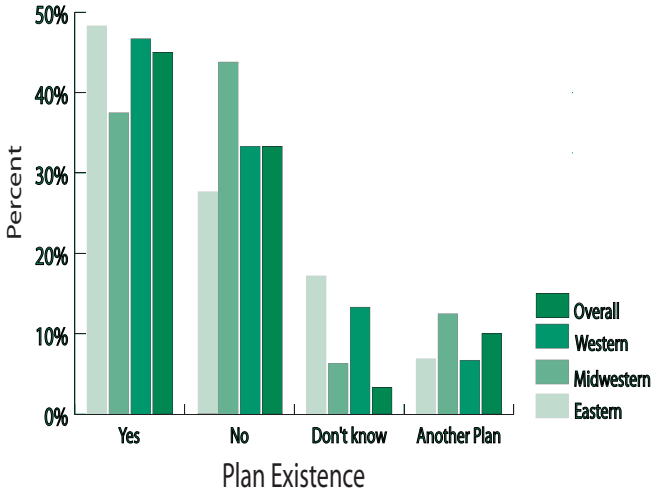
Program Infrastructure

Program infrastructure refers to the non-staff program elements that provide an organized framework for farmworker health outreach programs, including planning documents, policies and procedures, scheduling and referral mechanisms, job descriptions, collaboration with other departments, and avenues of communication. Program infrastructure mechanisms are vital to the functioning of outreach programs.

One key element, and often the building block for other infrastructure mechanisms, is the outreach program plan. Forty-five percent of respondents overall reported having a written farmworker outreach plan and 10% responded that they used another type of document or method for planning purposes. Fully one third

"Program infrastructure mechanisms are vital to the functioning of outreach programs..."

Figure 19. Presence of Outreach Plan by Stream



(33%) of respondents reported not using any type of plan (Figure 19). These data are consistent with the data gathered in 2001, which also indicated that one third (33%) of outreach programs did not use a farmworker outreach plan in conducting outreach activities.

The use of a plan differed by stream in both 2001 and 2003, with some differences between years. In 2003, programs in the Eastern stream (48%) were most likely to use plan, closely followed by the Western (47%), and then Midwestern stream (38%). In 2001, the Midwestern stream had the highest percentage of programs using a farmworker outreach plan (71%) as compared to the Western (68%) and Eastern (67%) streams.

Another important component of program infrastructure is having job descriptions for the various staff that make up the outreach program (Figure 20). Most programs reported having job descriptions for outreach workers (85%) and outreach coordinators (70%). By comparison, in 2001 three in four respondents (75%) had job descriptions for outreach workers and slightly over half (56%) had job descriptions for outreach coordinators.

The 2003 data show some variation in the existence of written job descriptions by stream. The Eastern stream reported the highest percentage of programs with job descriptions for both outreach workers (92%) and outreach coordinators (83%), followed in both cases by the Western stream (79% and 79%, respectively) and Midwestern stream (79% and 33%, respectively). In 2001, the Western stream had the highest percentage of programs with an outreach worker job description (89%) followed by the Eastern stream (78%) and the Midwestern (61%) stream. In 2001 the Eastern stream had the highest percentage of programs with an outreach coordinator job description (67%) followed by the Western (45%) and Midwestern (45%) streams.

In 2003, respondents reported on the existence of job descriptions for a number of other positions. Nationwide, 30% of outreach programs have a job description for clinical outreach workers, 42% for community health workers, and 50% for transportation staff.

Collaboration and mechanisms of communication and information sharing between the outreach program and other departments in a health center is an important part of the infrastructure of a program. Nationally, mail survey respondents reported a high degree of collaboration (96%) between the outreach program and the medical department in their respective organizations. Respondent organizations also reported relatively high rates of collaboration with both the administrative de-

Figure 20. Presence of Job Descriptions by Stream

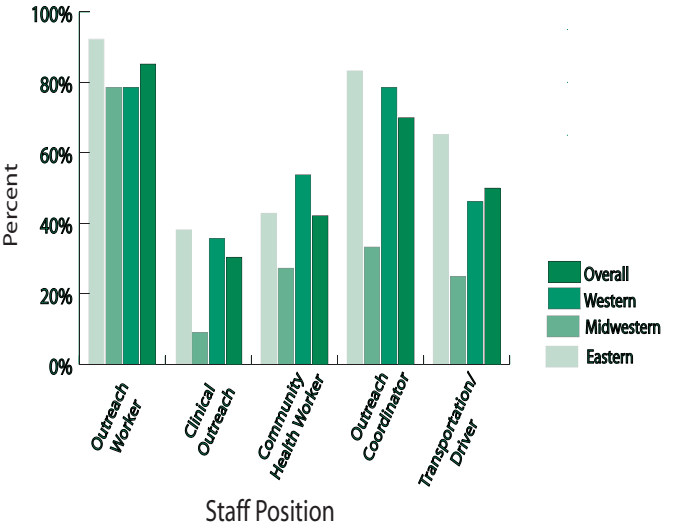
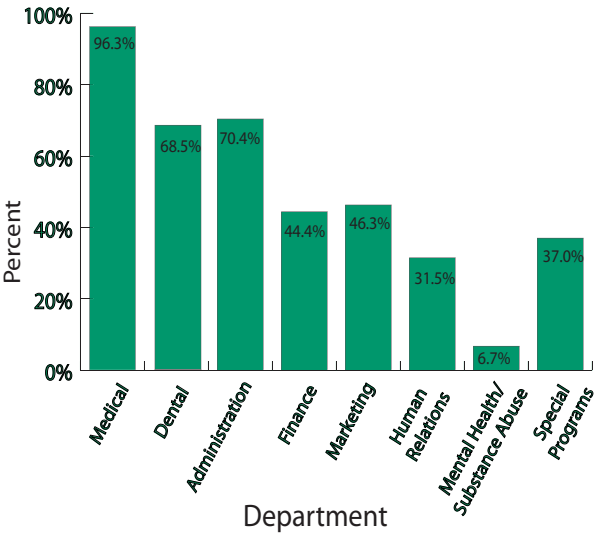


Figure 21. Outreach Program Collaboration within Organization



partment (70%) and the dental department (69%). Overall, the lowest rates of collaboration with the outreach program are demonstrated by human relations (32%), finance (44%), and marketing (46%) departments (Figure 21). In a regional analysis, both Western and Eastern stream respondents' outreach programs have comparably higher rates of collaboration with other departments across the board. The Midwestern region organizations reported a lower percentage of collaboration between their outreach programs and all other departments.

Telephone survey respondents were asked to elaborate on how the outreach program collaborated with other departments in their organization. One in three respondents (35%) mentioned regular meetings as a way for the outreach program to collaborate with other departments, with most respondents reporting that meetings were the primary mechanism for collaboration and communication. Over 10% of respondents specifically mentioned communication as an ongoing means of collaborating. In addition, over 10% of respondent organizations described their outreach program collaborations with other departments as a "team effort."

Clinicians' focus group participants also discussed the importance of collaboration, in particular between outreach and clinical programs, and noted several of the challenges and needs faced by clinical providers, outreach staff, and farmworkers in making that collaboration successful.

The clinicians emphasized the importance of education in improving collaboration, and highlighted having clinical staff who are well-educated about farmworker lifestyle and culture.

"Outreach can and should educate providers about living and cultural issues for farmworkers. For example, that [farmworkers] often don't have a refrigerator to store medications." –Medical Director

Clinicians also noted the importance of collaboration between outreach and clinical programs in improving patient compliance with clinical care. Again, outreach services played an important role in increasing compliance through education and through following-up with individual patients outside the health center. Several participants noted the importance of outreach staff educating farmworkers about the long-term effects of diseases, especially for those patients needing follow-up care for a specific illness. One medical director also noted the key role outreach staff play in tracking and finding high-risk patients who need to come back into the health center for follow-up care. A physician's assistant reported the use of a patient management system that automatically triggered outreach if a high-risk patient had not been back into the center in over three months.

Clinicians also spoke at length about strategies they or their health centers had employed to increase interdepartmental collaboration between outreach and clinical programs. There were a variety of strategies employed by both clinical and outreach programs to better link and integrate their services in order to improve patient care. Among others, strategies included improved communication and the direct integration of services.

Similar to telephone survey respondents, three clinicians mentioned regular meetings with outreach staff as an important mechanism of communication. Meetings were often for all staff and were used to discuss particular cases and to be sure follow-up was being conducted through outreach. The majority of participants agreed that more could be done to facilitate direct communication between outreach and clinical services.

"We meet regularly with the [outreach] director. The outreach coordinator is a nurse and she goes to the camps, and we also have *promotoras* that work with the nurse." –Medical Director

" At various times we have had monthly meetings with all staff – medical, dental, and nursing." –Dental Director

"Outreach staff are present at our regular staff meetings, but we don't have any special meetings with them." –Physician's Assistant

"I wish I could say we had something like that [to share information between clinical and outreach services]." –Physician's Assistant

"The case manager facilitates. We take one patient and share what is going on with them – all their needs. We talk about how they are progressing… It's a very important component. If a person is "missing" they are brought up and outreach goes out to try to find them." –Dental Director

"[Outreach staff] communicate the pulse of the community to us. Depending on the weather and the crops, *promotoras* tell us what is happening in the community. They communicate individual patient need, if a patient has a specific need. They help get information to the right people; they share information. Outreach staff are present at the

migrant clinics – they directly communicate with us. The migrant director knows ahead of time that someone needs a service and will be ready on-site." –Medical Director

Another strategy mentioned by focus group participants for linking outreach and clinical services was to directly integrate services, or for clinical providers to perform clinical work in an outreach setting. Four participants' centers were directly integrating services. The clinicians agreed that such direct integration could be a very effective way of linking services and combining the strength and efficacy of outreach services in the field with on-location clinical care.

"We are working on getting the mobile van to take out to the farms – farmworkers could come for screenings right there. Time away from the fields would be minimal and they wouldn't need to travel…Sort of a "one-stop-shop." That would be a way that wouldn't have an economic impact on [farmworkers], so they would be more willing to use it." –Registered Nurse

"We have migrant services at all of our permanent sites, but most services occur at sites we set up during the peak season. We work with the health department at night – we have a bus that provides dental care. People will come to the bus for dental services, but not as much for medical. But we do medical screenings at the dental bus as a side effort." –Medical Director

A final aspect of program infrastructure included in the 2003 needs assessment is the existence of protocols for conducting outreach activities, and in particular referral procedures. Sixty-five percent of respondents nationwide had written protocols for the delivery of outreach. There was variation in these data by stream: in the Eastern stream, 89% of programs had written protocols for delivery of outreach, followed by 53% in the Western and 36% in the Midwestern streams (Figure 22).

In terms of protocols for referral procedures, the majority of respondents had established written protocols for making in-house (70%) and outside referrals

Figure 22. Presence of Outreach Protocols by Stream

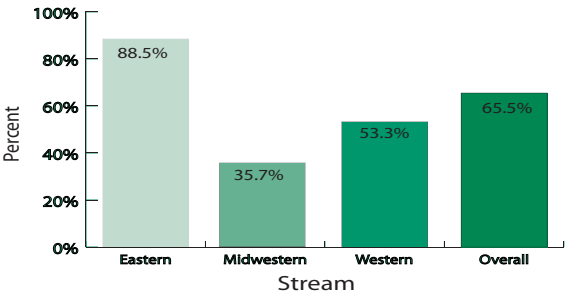


Table 8. Financial Challenges for Outreach Programs

Financial 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.

"Sixty-five percent of respondents nationwide had written protocols for the delivery of outreach..."

(59%). The majority of respondents also had protocols for filling out referral forms (68%) and entering referral data (58%), as well as for tracking patient referrals (75%).

Programmatic Needs

Based on the current cycle of increased federal funds available to M/CHCs and MVPs due to the Presidential Initiative, the *2003 National Needs Assessment of Farmworker Health Care Organizations* asked about the two greatest financial challenges for respondent organizations' outreach programs. The question asked respondents to rank the top two greatest financial challenges for farmworker outreach programs, based on a list of possible answers (Table 8). Overall, respondents ranked lack of reimbursable services as the greatest financial challenge for their outreach programs. Figure 23 shows that over half (56%) of respondent organizations reported that the lack of reimbursable services is the top financial challenge for their farmworker outreach program. That is, the number one self-reported challenge for respondent organizations is to find a way to compensate their program for the outreach services rendered to farmworker patients. Eastern stream respondents were even more concerned about this issue, with 65% citing lack of reimbursable services as the top challenge. Securing private funding was cited by 14% of respondents as the top financial challenge, with 31% in the Western stream prioritizing securing private funding.

Farmworker-serving organizations were also asked what would be the top five additional resources that would most benefit their organization in improving outreach services. Respondents were given a list of 13 programmatic support needs from which to choose, and asked to rank their responses from one to five. In order to analyze the results of this question, responses were given a mean score based on the frequency with which

"The number one financial challenge for respondent organizations is to find a way to compensate their program for the outreach services rendered to farmworker patients..."

Figure 23. Outreach Program Financial Challenges by Stream

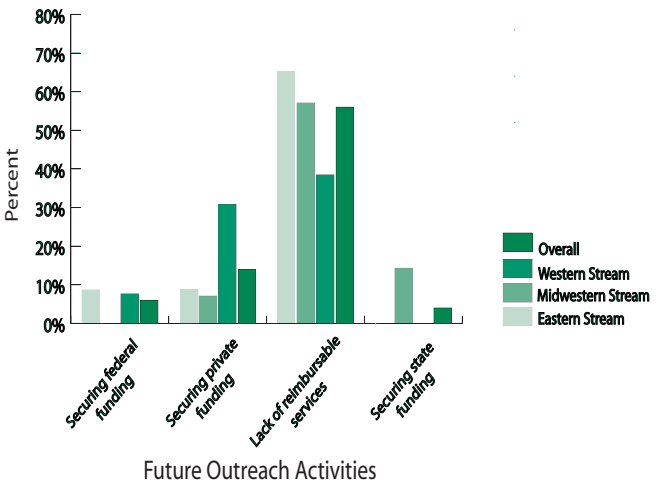


Table 9. Areas of Need for Programmatic Support

Programmatic Need	Overall Rank*
Grant writing/funding sources	1
Needs assessments	2
Program planning	3
Best practices/models that work	4
Data issues/performance measures	5
Transportation solutions	6
New service area penetration	7
Patient education materials	8
Staff training	9
Infrastructure for interdepartmental cooperation	10
New service development	11
Strengthening community coalitions	12
Interpretation services	13

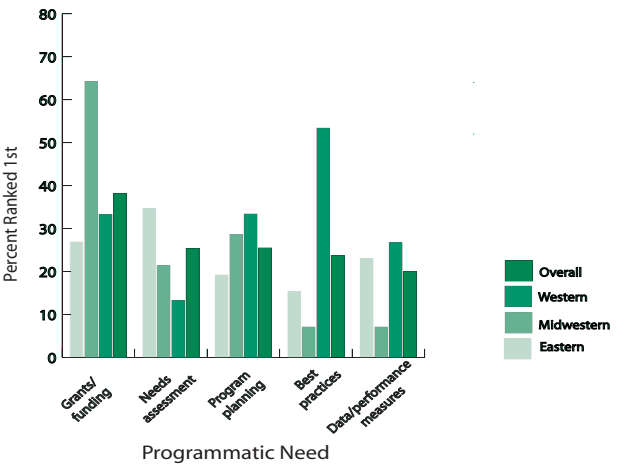
*Overall rank based on mean score.

each need was ranked. Table 9 shows the ranking of resources based on mean score. Figure 24 represents the sum of the percentage of times respondents ranked each need either most or second most needed.

Respondent organizations reported assistance with grant writing/funding sources as the top programmatic need for their organization, ranking it either 1st or 2nd most needed 38% of the time. Assistance with program planning was ranked 1st or 2nd most needed by respondents 26% of the time, while assistance with community needs assessments was ranked among the top two needs 25% of the time. Support for best practices/models that work was ranked as the greatest or second greatest programmatic support need by 24% of respondents. Twenty percent ranked support with data issues/performance measures as one of the top two programmatic support needs (Figure 24).

Of greatest interest is the diversity in the top programmatic need identified in each region by respondent organizations. Figure 24 shows that respondent organizations in the Eastern stream on average identified needs assessments as an area of greatest need for their program success. Midwestern organizations overwhelmingly indicated that grant writing and fundraising were the areas of greatest need for programmatic support. Western stream respondent organizations highlighted the identification of best practices/models that work as their area of greatest programmatic need. Figure 24 illustrates some of the differences in resources needed between the three farmworker streams.

Figure 24. Programmatic Needs by Stream



Discussion

Outreach programs across the United States, while sharing some general programmatic elements such as Spanish-speaking staff, cultural competency training, and dedicated staff, differ considerably in terms of staffing, program infrastructure, and program needs, particularly by stream. Some of the characteristics of outreach programs across the three streams may also provide information about the farmworkers living and working in those areas. Indeed, higher percentages of Asian language- and Creole-speaking outreach staff in the Western and Eastern streams correspond to the respective Asian and Haitian farmworker populations in these two streams. The high percentage of Central American/Mexican indigenous language speaking staff in the Western stream may point to challenges in recruiting staff with Central American/Mexican indigenous language skills in the other two streams.

The majority of outreach staff, as well as medical and administrative staff employed at respondent organizations, receive cultural competency training in order to provide appropriate care to the farmworkers. Respondents reported that medical and dental providers, outreach workers, outreach coordinators, and administrative staff are very likely to receive cultural competency training. The exception to the high levels of cultural competency training is community health workers. Community health workers most often come from the farmworker community or a farmworker background, and speak a farmworker language. Community health workers may not be receiving cultural competency training for several reasons. It may be because they come from the farmworker community themselves and that there is a perception that they are already culturally competent. It may also be that they are not receiving training because they are part-time staff or because they are not proficient in English, making training difficult. Whatever the reason, it is important for all staff to receive uniform training in cultural competency, regardless of background. In general, however, the fact that farmworker-serving organizations reported such a high percentage of cultural competency training across posi-

tions is encouraging. It is evidence of the commitment of these organizations to providing culturally appropriate and quality care to their farmworker patients.

Despite regional differences and variation in program structure, outreach programs across the nation value their staff as the number one reason for their success. Outreach programs place a great deal of responsibility on outreach staff; they rely on them to make successful connections with area farmworkers in order to bring them into the health care system, to educate, and to promote health and healthy lifestyles. The staff characteristics mentioned by respondents that made their outreach programs successful were not formed overnight, but rather over time through staff experience in the community and the delivery of culturally competent and appropriate care. These findings suggest the importance of staff retention and of institutionalizing cultural competency and knowledge of the farmworker community throughout farmworker health care organizations.

Health education, case management, and patient registration/eligibility ranked as the top three activities where respondents felt outreach workers should be spending most of their time. It is encouraging that, when asked about the most frequent activities that outreach workers currently engage in, these same activities were among the top three. Within the migrant streams, however, programs necessarily adjust the emphasis on each activity based on their own unique needs. For example, Western stream respondents spend the most time on health education. Given the high number of farmworkers in the West, this is a good strategy for reaching a maximum number of farmworkers, and educating on specific illnesses while encouraging preventive and necessary care. In contrast, Midwestern respondents noted that their outreach workers spend the most time on patient registration and eligibility. Since the Midwestern stream has the smallest number of farmworkers, it stands to reason that outreach workers in this region would concentrate more on bringing farmworkers into the health delivery system. It should be noted, however, that case management ranked as the top activity in the Midwest in 2001. While this could reflect sampling differences in the two surveys, it is interesting to consider whether changes in funding or another issue is responsible for this shift.

The majority of respondent outreach programs have one or more infrastructure mechanisms in place, and nationally there was an increase from 2001 in both the existence of a farmworker outreach program plan and job descriptions for outreach workers and coordinators. Both telephone interview respondents and participants in the clinicians focus group emphasized the importance of communication and regular meetings, and clinicians hoped to increase means of regular communication in the future. These data point to an effort on the part of outreach programs nationwide, at least in the past two years, if not longer, to increase the infrastructure mechanisms in place in their programs.

Regionally, there remain differences between streams as to the extent of infrastructure present in outreach programs, as well as a large change in the Midwestern stream from 2001 to 2003. Midwestern respondents consistently reported having fewer infrastructure mechanisms in 2003 than was reported in 2001. Some of the changes from 2001 to 2003 may be due to sampling differences or to the provision of specific definitions for infrastructure components to mail and telephone survey respondents in 2003 that were not included in 2001 (see Glossary of Terms). Differences could also be partially accounted for by the fact that the Midwestern stream had slightly more migrant voucher program respondents in 2003 than the Eastern or Western streams. In some instances, MVPs' central offices have outreach staff only (i.e. no clinical staff), significantly decreasing the availability of departments with which to collaborate. These data could, however, also signal an actual change in the past two years. This infrastructure disparity merits further investigation, especially given the importance of program infrastructure in providing consistent and comprehensive health care services for farmworkers.

Lack of reimbursable services was cited by respondents as the top financial challenge to their outreach programs. The prevailing thought is that the majority of services provided by farmworker outreach programs are considered enabling services, and thus not reimbursable by federal or state programs like Medicaid, 330g grants, or state insurance programs. Many programs are forced to supplement M/CHC and MVP (330g) funding with other funding sources in order to provide the outreach services needed to farmworkers and their families. Interestingly, Western stream respondents placed less emphasis than other streams on lack of reimbursable services and more emphasis on securing private funding (see Figure 23).

The challenge of securing funding for outreach programs is reinforced by the fact that respondents cited

assistance with grant writing/fund raising as the top resource needed to improve these programs. Community needs assessments, program planning, sharing of best practices/models, and data issues were also frequently mentioned. The identification of these disparate programmatic needs suggests the direction in which farmworker outreach programs are headed in each region, and gives insight into where their strengths and needs may lie. Such data support the migrant stream paradigm in the apparent differences between the three streams' needs.

Community Relations

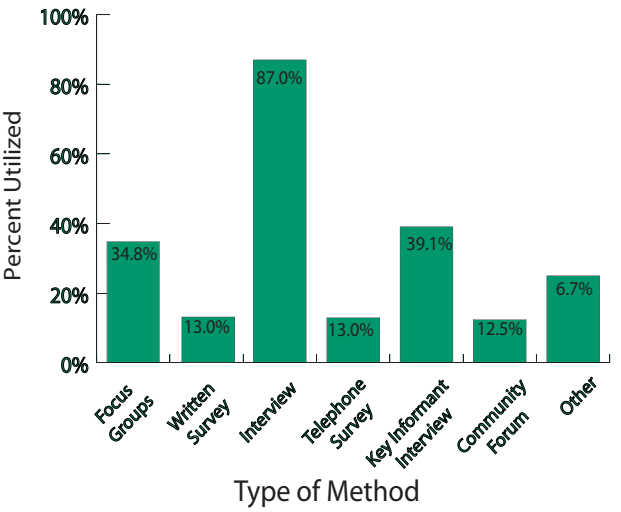
An outreach program's relationship with the farmworker and larger community in its service area is vital to the success of the program. There are a number of ways to foster good community relations. The *2003 National Needs Assessment of Farmworker Health Care Organizations* asked both mail and telephone survey respondents about two methods, needs assessment and community coalitions.

Needs Assessment

Farmworker needs assessments were conducted in 2003 by nearly one third (32%) of mail survey respondent organizations nationwide. These data are nearly identical to 2001 data: in 2001 one-third (32%) of respondents had conducted a needs assessment in the prior 18 months. In 2003, Eastern stream respondents were most likely to have conducted a farmworker needs assessment in the past year, with nearly half (45%) completing assessments. One in five (21%) Western respondent organizations and one in seven (14%) Midwestern stream respondents reported conducting a farmworker needs assessment in 2003. Regionally, data from 2003 differs from data collected in 2001, in which respondents in the Western stream were most likely to have conducted a needs assessment (45%), followed by Eastern (33%) and Midwestern stream respondents (22%).

Recognizing the lack of detailed data regarding needs assessments and farmworker serving organizations' mechanisms for gathering information about their farmworker patients, the *2003 National Needs Assessment of Farmworker Health Care Organizations* sought to collect more information from organizations that completed a needs assessment, specifically about what types of assessment methods were used, and how the information gathered was utilized. Of note in the needs assessments conducted in 2003 is the high usage across the board of interview methods, and relatively low usage of written and telephone survey methods in assessing farmworker needs (Figure 25). Nearly all mail survey respondent organizations (96%) used farmworker needs assessment data to plan their outreach program. Others

Figure 25. Farmworker Needs Assessment Methods



"Of note in the [farmworker] needs assessments conducted in 2003 is the high usage across the board of interview methods, and relatively low usage of written and telephone survey methods in assessing farmworker needs..."

used the information to expand services (61%), for a grant application (48%), to start a new program (48%), or to prioritize their services (48%).

Community Coalition

Consistent with the *2001 Farmworker Health Outreach Needs Assessment*, the 2003 needs assessment aimed to gather information about how farmworker-serving 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 address farmworker needs in their organization's community. Overall, 67% of organizations surveyed reported the presence of a farmworker coalition in their community; 19% reported no farmworker coalition, and nearly 14% of respondent organizations did not know if there was a coalition established in their community. In 2001, 73% of respondent organizations reported an existing farmworker coalition or other formal group of organizations addressing farmworker needs in the community, and nearly all of the organizations with a coalition participated in some capacity.

Overall, Eastern stream respondent organizations reported the greatest number of community farmworker coalitions (76%), and the Midwestern stream the least (57%). Western stream respondent organizations reported the highest percentage of uncertainty regarding the presence of farmworker coalitions in their communities (27%). Figure 26 details the specifics of how those organizations who reported the existence of a coalition in 2003 actually participate in that coalition. Overall, one in four (24%) respondent organizations reported carrying the role of leader in the farmworker coalition. Nearly half reported participating in the coalition as a member, while one in five reported acting in the capacity of an advisory member of the coalition.

Western stream organizations reporting farmworker coalitions in their communities had the highest rate of participation in the capacity of member and leader, 60% and 30%, respectively. However, no Western organizations reported functioning as an advisory member in their farmworker coalition, and Western organizations also had the highest percentage of non-participation among streams (10%). Eastern and Midwestern organizations reporting participation in the farmworker coalition had comparable participation in the various capacities (leader, member, advisory member), with the exception that the Midwestern organizations had zero non-participation.

Figure 26. Participation in Farmworker Coalitions

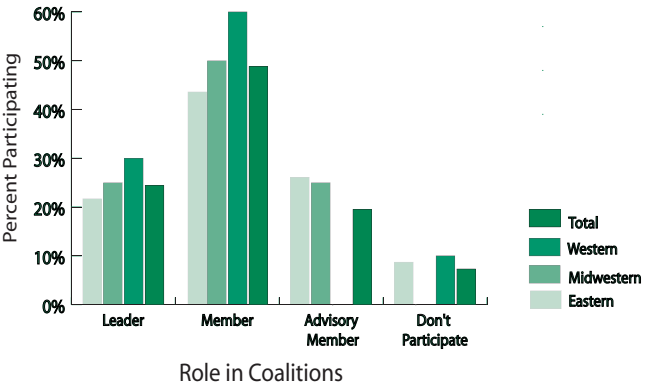


Figure 27. Agency Participation in Farmworker Coalitions

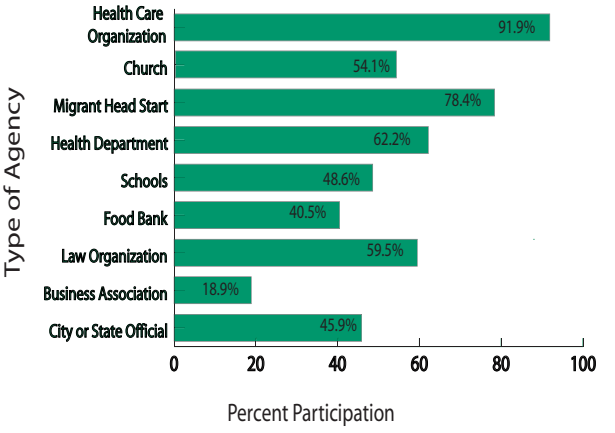


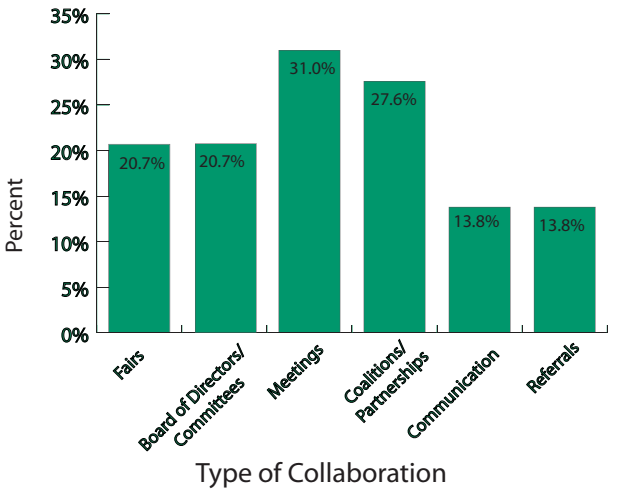
Figure 27 illustrates the general makeup of farmworker community coalitions according to those

respondent organizations reporting the presence of a coalition in their community. The greatest agency participation in farmworker coalitions, at nearly 92%, was from health care organizations, followed by Migrant Head Start at 78%. Health departments participated in 62% of farmworker coalitions, while legal agencies or organizations were members in nearly 60%, and local religious organizations participated in 54% of coalitions. The least amount of participation was seen on the part of business associations, which only participated in 19% of farmworker coalitions.

In addition to the questions surrounding farmworker community coalitions, the *2003 National Needs Assessment of Farmworker Health Care Organizations* gathered information from telephone surveys about how respondent organizations' outreach programs collaborate with other agencies or organizations in their service area. Figure 28 below shows the primary mechanism for achieving community collaboration, as reported by respondent organizations. Nearly one-third (31%) of telephone survey respondents indicated that outreach staff attendance at community meetings was a key way to maintain community collaboration and communication. Nearly one third (28%) also noted their organization's participation in either community coalitions or partnerships as a means of sustaining good community collaboration. Other ways of keeping up community collaboration mentioned by respondent organizations were participation in community and health fairs, participation on local boards of directors or community committees, establishing a referral system with other community agencies, and increasing communication with other community agencies.

Participants in the clinicians' focus group also discussed the importance of community collaboration. Participants were working with local health departments, schools, and law firms, as well as with other area providers.

Figure 28. Outreach Program Community Collaboration



"One thing we have used…is working in collaboration with school migrant liaisons. [The liaison] is a person grounded in the community that works with the school too…We use them to push families to us and to get information to them. They are usually a former farmworker, bilingual, and they know the families and where they live." –Registered Nurse

"We have a partnership with area churches and two buses equipped to provide dental and medical services. We work with churches in the area. In the future [the churches] will work with outreach workers to advertise for health fairs." –Dental Director

"We have two lawyers come…to provide immigration law. We want to set up a health booth at that event." –Medical Doctor

"We are talking about getting someone to come in [from outside] to do diabetic eye exams." –Physician's Assistant

Discussion

These data highlight both the importance put upon the relationship between the outreach program and the community, as well as the barriers faced by programs working to improve and increase community relations. Needs assessments can be costly and time consuming, and organizing outreach participation in a community coalition demands staff commitment, time, and energy. That the data show little increase in needs assessments or participation in community coalitions highlights these challenges. It should be noted, however, that needs assessment data from 2001 to 2003 do not account for

those organizations that had conducted an assessment in 2001; those organizations may not have conducted a needs assessment again in 2003, thus accounting in part for the low needs assessment numbers in 2003.

It should also be noted that those organizations that did conduct a needs assessment in 2003 did so using methods appropriate for farmworkers – specifically face-to-face interview methods. These methods are most appropriate given the fact that farmworkers rarely have access to telephones and have varying literacy levels.

The data above also point to the emphasis placed on relationships with other local agencies and organizations through community coalitions. The telephone interviews and clinicians' focus group in particular highlighted the importance to outreach programs and health centers of these relationships. Outreach programs across the country are working to improve community relations as an important way of reaching out to the farmworker community, improving services, expanding the resources available to outreach programs, and increasing patient numbers. It should be noted, however, that nationally, participation in community coalitions did not increase from 2001 to 2003. Low participation may be due in part to a lack of knowledge about community coalitions, and in part to a lack of community coalitions in M/CHC and MVP service areas.

Endnotes

[1] 330g grantees are those grantees receiving migrant funding from the Bureau of Primary Health Care either as a Migrant Health Center or Migrant Voucher Program. Both funding streams may be combined with other federal funding programs.

[2] Public Health Service Act. U.S. Department of Health and Human Services, Health Resources and Services Administration.

[3] Bureau of Primary Health Care, 2004; See http://bphc.hrsa.gov/ for details.

[4] At the time of the 2003 National Needs Assessment of Farmworker Health Care Organizations, the BPHC reported the existence of 121 330g grantees. At time of publication of this report, there are 128 330g grantees. Visit http://bphc.hrsa.gov/ for updated information.

[5] The Uniform Data System 2003 definitions for clinical providers were used in selecting focus group participants.

[6] "A Perspective on America's Farmworkers and the Migrant Health Center Program", National Association of Community Health Centers, 2003. Based on data from the 2002 Uniform Data System Reports.

[7] Findings from the National Agricultural Workers Survey. U.S. Department of Labor, Office of the Assistant Secretary for Policy, Office of Program Economics, 2003.

Migrant Stream Comparison Table

Organizational Information	Overall
Number of MSFW users	6,164
Number of MSFW encounters	49,708
Ratio of outreach workers to farmworker users	1 to 1,782
Ratio of outreach coordinators to farmworker users	1 to 5,455
Mean dollars spent per farmworker user	$42.00
Farmworker Information	**Overall**
Number of MSFWs in service area, peak season	18,846
Number of MSFWs in service area, off-season	6,230
Most common health issues facing MSFWs (rank order based on mean score)	1. Diabetes 2. Hypertension 3. Dental health
Health topics of greatest interest to MSFWs	1. Diabetes 2. Dental health 3. Hypertension
Greatest barriers to accessing health care for MSFWs (rank order based on mean score)	1. Transportation 2. Pay scale/financial 3. Language/interpretation
Greatest social service needs of MSFWs (rank order based on mean score)	1. Housing assistance 2. English language instruction 3. Food assistance
Outreach Program Information	**Overall**
Staff receive cultural competency training	93.1%
Current top outreach activities	1. Patient registration/eligibility 2. Health education 3. Case management
Desired future outreach activities	1. Health education 2. Case management 3. Patient registration/eligibility
Percentage of organizations using a written farmworker outreach plan	45%
Percentage of organization with established written protocols for delivery of outreach services	65.5%
Lack of reimbursable services is greatest financial challenge for outreach program	56%
Top programmatic need to improve outreach services	Assistance with grant writing/funding sources
Community Relations	**Overall**
Percentage of organizations that conducted a farmworker community needs assessment in 2003	31.6%
Percentage of organizations that participate in a community farmworker coalition	80.5%

Migrant Stream Comparison Table, continued

Eastern Stream	Midwestern Stream	Western Stream
4,465	3,202	12,071
31,311	44,638	88,503
31 to 1,353	1 to 1,143	1 to 2,514
1 to 4,060	1 to 2,669	1 to 10,974
$71.17	$34.07	$25.98
Eastern Stream	**Midwestern Stream**	**Western Stream**
19,957	8,343	29,409
3,832	3,494	18,284
1. Diabetes 2. Hypertension 3. Dental health	1. Diabetes 2. Hypertension 3. Dental health	1. Diabetes 2. Hypertension 3. Prenatal care
1. Dental health 2. Diabetes 3. HIV/AIDS/STIs	1. Diabetes 2. Prenatal care 3. Hypertension	1. Diabetes 2. Dental health 3. Prenatal care
1. Transportation 2. Language/interpretation 3. Pay scale/financial	1. Pay scale/financial 2. Language/interpretation 3. Lack of knowledge of available services; transportation	1. Transportation 2. Pay scale/financial 3. Legal status
1. Housing assistance 2. English language instruction 3. Labor rights education, food assistance	1. Housing assistance 2. Food assistance 3. English language instruction	1. Housing assistance 2. Employment/job training assistance 3. Food assistance
Eastern Stream	**Midwestern Stream**	**Western Stream**
96.6%	85.7%	93.3%
1. Case management 2. Health education 3. Patient registration/eligibility	1. Patient registration/eligibility 2. Appointment setting 3. Referrals	1. Health education 2. Patient registration/eligibility 3. Health fairs
1. Health education 2. Case management 3. Clinical outreach	1. Patient registration/eligibility 2. Case management 3. Health education	1. Health education 2. Patient registration/eligibility 3. Case management
48.3%	37.5%	46.7%
88.5%	35.7%	53.3%
62.5%	57.1%	38.5%
Assistance with community needs assessments	Assistance with grant writing/funding sources	Support for best practices/models that work
Eastern Stream	**Midwestern Stream**	**Western Stream**
44.8%	14.3%	21.4%
73.9%	75%	90%

Conclusions and Recommendations

Organizational Information

Conclusion One:

Mail survey respondents reported on a number of issues that may be used to determine the efficiency and effectiveness of outreach services. Specifically, respondents reported the following data: 1) total number of farmworker users and encounters; 2) seasonal fluctuations in farmworker populations; 3) the ratio of outreach workers and outreach coordinators to farmworker users; and 4) the average outreach cost per farmworker user. There were substantial variations by stream in each of these areas. The Western stream had the highest number of farmworker users, the lowest ratio of outreach workers to users, and the lowest cost per farmworker user overall. However, this region had the least difference in farmworker population numbers between the peak and off-peak seasons. The Eastern stream had the highest increase in farmworker population numbers from the off-peak to peak season (81%) and also reported the highest expenditure per farmworker user. The Midwestern stream reported the lowest number of users, the highest ratio of outreach workers to users, and a cost per farmworker user lower than the national average [as determined by this assessment]. Ultimately, these data do not suggest one "best" model for incorporating all of these elements and merit further investigation.

Recommendations:

Assess your outreach program's personnel and financial resources with respect to the farmworker population in your service area and identify goals-based programmatic needs and organizational priorities. As discussed in the Organizational Information section of this report, each program has its own unique characteristics and needs. Currently, many outreach programs hire part-time workers to meet increased outreach needs during peak season. Some programs are not able to operate during the winter months, with the result being that seasonal workers (who remain in the service area) do not receive outreach services during this time. Set realistic goals about the number of users you hope to serve and the optimal ratio of encounters to users, outreach workers to users, and overall cost per farmworker for your stream and service area. The realities of your program, as well as your organization's mission and culture, will be important factors driving this process. Where current funding sources do not meet the goals of your outreach program, consider seeking small grants or other private funding to supplement your outreach budget.

Farmworker Information

Conclusion One:

Ninety-eight percent of respondents reported Spanish-speaking farmworkers in their service areas. However, Spanish was not the only non-English language reported in significant numbers in farmworker communities. Fifty-one percent of respondents reported that area farmworkers speak indigenous Central American or Mexican languages, 19% reported Creole, 9% reported Asian languages, and 14% reported other non-English languages in their farmworker communities. These data suggest an increasingly diverse farmworker population across the U.S., with regional differences by stream. Depending on the size of populations of farmworkers speaking languages other than Spanish, these data may suggest that newly emerging farmworker racial/ethnic groups are not being reached by M/CHCs and MVPs. Indeed, the percentage of respondent organizations reporting staff that speak indegenous Central American or Mexican languages, Asian languages, and Creole are lower than the percentage of respondent organizations reporting farmworkers that speak those languages (see Outreach Program Information, Conclusion One for more information).

Recommendations:

Outreach programs should consider multiple strategies to provide services that are in balance with the ever-changing racial, ethnic, and linguistic makeup of farmworkers in their service

areas. Outreach programs should first conduct a farmworker needs assessment which includes information about farmworker language and race/ethnicity. Outreach staff are an invaluable information resource concerning farmworkers outside of the program, as they can report firsthand on trends such as increasing numbers of certain population groups in a farmworker community. Following the needs assessment, there are short-term and longer-term steps that can be taken in order for outreach programs to improve their responsiveness to the diversity of farmworker populations. In the short-term, programs can assess their health education materials to determine which materials are relevant and which are not appropriate for their current farmworker populations. Longer-term, a number of steps can be taken by individual programs, as well as by local and regional groups: 1) outreach programs should identify farmworker leaders in the community who could serve as potential interpreters, outreach staff, or clinic staff; 2) farmworker-serving organizations should collaborate to determine the needs of particular sub-populations in the community; 3) state or regional primary care associations should collect information about regional farmworker population trends in order to document need and plan for resources on a regional level. Given the shifting nature of farmworker migration patterns, these strategies should be considered as ongoing activities, not one-time solutions.

Conclusion Two:

According to mail survey respondents, diabetes, dental health, hypertension, and prenatal care are the most common health issues facing farmworkers as well as the health topics of greatest interest to farmworkers. However, emphasis on specific health issues varied by stream: Eastern stream respondents were much more likely than respondents from other streams to name hypertension as one of the most common health issues facing farmworkers, while Western stream respondents were more likely to name prenatal care as a top issue. Outreach programs can best plan relevant, effective health promotion and prevention activities when they have accurate data concerning the specific health concerns of farmworkers in their service area. It is important that these data come from multiple sources, including farmworkers themselves, and that they go beyond the health issues observed in farmworkers presenting for care.

Recommendations:

There should be consistency between the health care plan and the farmworker health outreach program plan. There should be a clear quality assurance mechanism for sharing programmatic information about outreach with the Board of Directors and administration. The outreach program's farmworker needs assessment should include methods for identifying the health issues facing, and of interest to, area farmworkers. Once this information is available, health centers should reexamine their health care plans in order to ensure that the health issues identified are being addressed. If there is a discrepancy between what is being observed by outreach workers in the field and what is prioritized in the health care plan, or if new trends are emerging, this information should be shared with senior staff and board members. Health care plans and outreach plans should be regularly reviewed and revised as necessary to ensure consistency between the two.

Conclusion Three:

Transportation, financial issues, and language issues are the top barriers to accessing health care that face MSFWs, according to mail survey respondents. Respondents cited housing assistance, English language instruction, and food assistance as the top social service needs facing farmworkers. Employment/job training assistance and legal issues were also identified as key needs in farmworker communities. These issues generally fall outside the realm of health care services. While outreach programs can certainly play a key role in linking farmworkers to needed services and resources, the data point to a clear need for collaborating with other organizations in order to address these needs as completely and efficiently as possible.

Recommendations:

Outreach programs should take full advantage of partnering and networking with other area agencies in order to advocate for farmworkers, improve referral networks, and close gaps in services. Outreach programs should take the lead in facilitating access to needed social services for their MSFW populations beyond primary health care needs. Strive to increase collaboration and information sharing with other farmworker serving organizations in your community or consider establishing a referral network in your community or developing a resource book for staff or farmworkers. Outreach staff should regularly attend farmworker coalition meetings and actively participate in these coalitions in order to increase awareness about social services and resources available to farmworkers.

Helping farmworkers to address their social service needs and barriers to care by facilitating collaboration and referrals will improve access to care and quality of life, increasing the likelihood that farmworkers will access health care when needed. Collaborating with other agencies to provide social services will allow health centers to stay focused on the primary health care needs of their farmworker patients.

Outreach Program Information

Conclusion One:

The majority of mail survey respondents reported cultural competency training within their organizations. Outreach workers, medical staff, and administrative staff were most likely to be trained. Some programs offered training on an annual basis, while others offered it throughout the year. Respondents also recognized the importance of hiring bilingual staff and most reported outreach staff that speak the languages of farmworkers in their service areas. However, some farmworker subpopulations may not be adequately served. In the Midwest, all respondents noted Creole-speaking farmworkers in their service areas, but only 31% had outreach staff who speak Creole. In the Eastern stream, 71% of respondents reported that area farmworkers speak indigenous languages from Mexico or Central America, but only 27% have outreach staff that speak indigenous languages. These data indicate that many organizations do not have staff that speak the languages of emerging farmworker populations (see Farmworker Information, Conclusion One for more information).

Recommendations:

Seek to institutionalize cultural competence, including availability of staff who speak area farmworker languages, in your outreach program and throughout the larger organization. As noted in the Farmworker Information section, changing farmworker demographics can increase the challenge of providing high quality health care to an already vulnerable population. Cultural competence is a necessary but difficult goal; it is an ongoing process. The cultural competence of an organization is measured by the degree to which it responds to the needs of its various patient populations at any given point in time. In the short-term, outreach programs should assess their current resources to identify gaps or discrepancies with existing populations and update materials or processes as necessary. Organizations should seek to institutionalize cultural competence by including a cultural competence component in staff trainings, written job descriptions, and organizational and outreach program protocols. This can begin immediately but should be continued long-term. Providing cultural competency training to all staff is an important step which will be most effective if done on an ongoing basis. For programs serving a farmworker population that speaks a language other than Spanish where: a) the farmworker population is not large enough to justify hiring staff that speak that language, or b) potential staff who speak that language are not available for hire, partner with other area organizations who may have capacity in that language, seek farmworkers willing to work as part-time interpreters in that language, or actively research other resources.

Conclusion Two:

Over 70% of telephone survey respondents noted their staff as the primary key to the success of their farmworker outreach programs. More specifically, respondents mentioned their staff's commitment and dedication, experience and training, and community presence and rapport with the farmworker community as the characteristics that made their staff, and in turn, their program successful. Having a bicultural, bilingual, or former farmworker staff was also mentioned as very important in fostering relationships and having success in the farmworker community. Indeed, having a community connection is vital to an outreach program's ability to effectively inform, educate, provide services, and bring farmworkers into health delivery systems.

Recommendations:

Assess the strengths of your farmworker outreach program and build on them. It is common to evaluate the performance of an outreach program if that program is not performing or functioning as intended; it is less common to do so if an outreach program is performing and functioning well, however it is no less important. There is always room to improve or grow your program, strengthen ties with the community, or recognize staff for what they have accomplished. Take stock of the elements of your farmworker outreach program that make it successful, either as a group or individual exercise, and brainstorm ways to build upon those strengths. For example, if one of your program's major strengths is your outreach staff's rapport with the farmworker community, think of ways to further strengthen that re-

lationship and expand good relations to include staff working inside the health center or area providers.

Make full use of outreach staff as advocates for the farmworker community. Outreach staff have a unique relationship with the community and are familiar with farmworker lifestyle, culture, and needs. This relationship and familiarity place outreach staff in an ideal position to negotiate collaboration with other community agencies, advocate for farmworkers, and serve as liaisons between farmworkers, the health system, and the greater community. For example, outreach staff can use their unique perspective and knowledge of the farmworker community to negotiate discount rates with pharmacies or specialists, or to build collaborative relationships with local social service organizations, charities, and religious groups.

Use outreach staff input in planning in order to most appropriately meet farmworker needs. Outreach staff's relationship with and knowledge of the farmworker community in your area is a very valuable tool in designing effective initiatives and successful efforts. For example, involve outreach staff in creating the health care plan or farmworker health outreach plan, in designing a needs assessment, or in creating marketing strategies for your services.

Conclusion Three:

By nature, many outreach programs operate with little program infrastructure in place. Indeed, fully one-third of respondent programs do not use any type of program plan for conducting outreach, and over one-third do not have written protocols for the delivery of outreach. These numbers have changed very little since 2001, indicating a continued need for improving infrastructure mechanisms in outreach programs nationwide.

Recommendations:

Increase program infrastructure elements in your outreach program. Having program infrastructure mechanisms in place improves the functioning of an outreach program by providing uniform knowledge of program function, goals, and objectives to all staff, and by institutionalizing outreach knowledge in the outreach program and entire organization. Infrastructure mechanisms will also serve as quality assurance mechanisms, making it easier to evaluate program performance and outcomes.

Develop an outreach program plan that is specific to outreach services; having a plan that is specific to outreach allows for the documentation of detailed objectives that may not otherwise be included in an organizational or health care plan. You may want to build on the health care plan for the entire organization, but make your plan specific to outreach. Be sure the two are consistent with each other and well-integrated. Consider networking with other farmworker health care organizations to get ideas, templates, or sample outreach plans, and be willing to share planning documents you have with other organizations.

Create job descriptions for all positions and include information on program infrastructure, such as the program plan and goals and objectives, as part of your new staff orientation process. Providing job descriptions makes all staff aware of the scope of their responsibilities, assists in the prioritization of tasks, and improves supervisor-staff relations by providing uniform information to each employee and his/her supervisor. Job descriptions also function to improve quality assurance by clearly defining responsibilities and expectations.

Draft protocols for the delivery of outreach services and make them available to all staff that work directly or collaborate with the outreach program. Documenting protocols for making referrals, providing transportation, delivering health education, or other outreach activities ensures uniform service delivery by all staff and may increase outreach program credibility througout the organization, making collaborative efforts more successful. Protocols should outline the involvement of staff from other departments, where applicable. For example, if referrals are made through the front desk or with clinical providers, include in the protocol each staff's role in the process, and share that protocol with all staff involved. Creating protocols in collaboration with other departments or programs and providing outreach protocols to staff that work closely with outreach increases continuity of care and further improves interdepartmental collaboration.

Conclusion Four:

While the majority of outreach programs collaborate with their organizations' medical and dental departments, as well as with administration, telephone survey respondents and participants in the clinicians' focus group highlighted the importance of further improving this collaboration, and increasing collaboration with other organizational components. Both telephone survey respondents and focus group participants emphasized the importance of communication and regular meetings between outreach staff and other departments. Focus group

participants in particular emphasized that while there was collaboration between medical and outreach departments, there was a need to increase the frequency and quality of collaboration, especially through communication and regular meetings.

Recommendations:

Increase formal collaboration between outreach and other departments. Integrating and creating formal collaboration between outreach and other departments greatly improves continuity of care for farmworker patients and safeguards against patients falling through the cracks, or not receiving needed care. Setting up formal mechanisms of communication, such as regularly scheduled meetings, file sharing, or direct integration of services (i.e. clinical providers going out with outreach to provide medical services) will increase the visibility of the outreach program and collaborative efforts with other departments, ultimately delivering improved care to patients. Consider setting up a program by which non-outreach staff can have the opportunity to "shadow" or work with outreach workers in the field, thus increasing understanding and exposure to farmworkers and outreach services and procedures.

Conclusion Five:

Respondent organizations noted that outreach workers overall are focused on patient registration, case management, and health education, however, many also spend a great deal of time on appointment setting and referrals. While it may be the case that some organizations wish to use their outreach programs primarily for patient registration, appointment setting, and referrals, as is the case for Midwestern respondents, many programs, especially in the Eastern and Western streams, want outreach efforts to focus on case management and health education in the next two years. These data support the notion that many organizations rely on outreach staff to take on almost any responsibilities that have to do with farmworker patients. This often occurs because providers, financial administrators, and even front-line administrative staff may feel unfamiliar with farmworker culture and language and therefore unequipped to deal with their needs. As a result outreach staff may be taken away from other outreach specific tasks, like health education, in order to support work with farmworkers in other positions.

Recommendations:

Clearly delineate outreach staff roles and responsibilities and share this information throughout the organization. To streamline outreach roles, assess whether you are using your outreach workers in a way that effectively meets your goals and objectives as set out in your health care and/or outreach plan. Look at your plan and determine where outreach staff can best fit in to make the most impact and maximize the effectiveness of both outreach and other staff. Outreach staff may very well be most effective in areas other than patient registration and appointment setting; registration and appointment setting in turn, can be effectively completed by front line administrative staff, referral specialists, or other employees who are already performing those functions with other non-farmworker patients. Outreach activities should be mainly oriented toward primary care such as health screenings, health education, and case management. Cultural competency and farmworker sensitivity training for all staff can help integrate farmworkers into the patient system as smoothly as possible. Health care for farmworkers is most effective and comprehensive when cultural competency and knowledge of farmworkers runs through all staff positions, not just outreach. In the end, intra-agency communication and cultural competency training for all staff will help to maximize the effectiveness of outreach staff.

Community Relations

Conclusion One:

Two-thirds of M/CHCs and MVPs had not conducted a farmworker needs assessment within the past year in 2003; the same percentage had not done so within the past 18 months in 2001. Conducting a needs assessment of farmworkers in your service area allows you to identify and verify farmworker health, social service, and other needs, connects your organization with the farmworker and larger community, and can serve to validate your services and justify funding.

Recommendations:

If you have never done so or have not done so in the past several years, conduct a needs assessment of the farmworker population in your community. Involve other community organizations, agencies, and collaborators, and be sure to work with farmworkers themselves in gathering information. By pooling resources with other organizations, you can share the cost and time needed to complete an

assessment. Recognize that an assessment does not have to go above and beyond what you are capable of. By working with other agencies and focusing on assessment areas you are most proficient at, you will maximize output while using available program resources in the most efficient way possible. Different organizations or agencies may also employ new perspectives or different approaches to assessing need that will enhance the results of the assessment for everyone involved.

It is important to conduct your assessment beyond your patient base – look to the community and non-patients where possible to get a more accurate picture of needs. Keep in mind that the needs expressed by farmworkers coming into the health center or being contacted through outreach services represent a small percentage of the farmworker population; on average M/CHCs and MVPs are seeing only 15-20% of the total farmworker population nationally or in a given area.

Recognize the ways you are already collecting data on patient needs. Very often, you can tap into data you already have, such as a patient satisfaction survey, data on farmworkers' migrant versus seasonal status, or farmworkers' state or country of origin, as a component of your farmworker needs assessment. You may also want to consider simple ways you can gather more needs information by modifying some of your other data collection tools. For example, adding one or two questions to an outreach encounter or intake form can provide a lot of valuable information.

Share the results of your assessment with all staff at your organization. Doing so will further increase farmworker awareness and institutionalize knowledge about farmworkers. The results can be used in cultural competency training as well as in setting goals and objectives and evaluating program performance. Also share the results of your assessment with farmworkers and the larger community, and in particular with those that helped you conduct the assessment. This will serve to connect your organization and your services with farmworkers in the community, as well as educate other community members about farmworkers in their area.

Conclusion Two:

Sixty-seven percent of respondents reported the existence of a farmworker community coalition in their area in 2003; in 2001 73% reported the existence of such a coalition. This represents a slight decrease in respondents reporting the existence of a community coalition in their area. Of respondents reporting the existence of a coalition in 2003, the majority participated in the coalition in some capacity. Farmworker community coalitions are vital to providing farmworker patients with a network of services and support through referrals and joint collaboration efforts. The fact that the top barrier to care and social service need of farmworkers in 2003, transportation and housing services, are not directly related to health services, makes the need for strong community coalitions all the more important in meeting farmworker needs.

Recommendations:

Participate in and strengthen local farmworker community coalitions through organizational membership and by encouraging the participation of other organizations and agencies. Broaden the scope of work done by your local coalition – oftentimes coalitions play a more ceremonial than active role in the community, as it can be hard to coordinate action by so many players. Coalitions can address this challenge by creating goals and objectives for the coalition and by prioritizing those objectives. Setting up a timeframe within which the coalition would like to meet objectives can also increase a coalition's productivity.

Work to ensure that each member of the coalition is playing a role based on their organization or agency's strengths. Making an effort to tap into the strengths and resources of particular members will greatly improve the coalition's productivity and effectiveness.

Glossary of Terms

This Glossary of Terms was provided to mail and telephone survey respondents to aid in answering questions and to standardize responses.

Case Management—when a healthcare staff person, or case manager, coordinates available health resources so that a patient can receive optimum care and achieve whole-body health.

Community Health Services or Outreach Coordinator—the person who oversees the activities, programs, and services you use to reach farmworkers in the community.

Community Health Worker—Also knows as Camp Health Aides or *Promotoras*.

Community Needs Assessment—a *farmworker community needs assessment* is the process of determining the true needs of the community that you serve, in this case farmworkers.

Farmworkers— defined by Section 330g 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. The definition includes those individuals who have been so employed within the past 24 months and their dependent family members.
> "Seasonal Agriculture Workers" are defined the same as a migrant agricultural worker except they do not establish a temporary home for the purposes of employment.

Farmworker Outreach Plan—a written plan that outlines your farmworker community outreach activities and services, separate from your overall organizational health care plan.

FQHC—a federally qualified health center that meets the requirements of and recieives funding from Public Service Act Section 330.

FQHC Look-Alike—a federally qualified health center that meets the requirements of Public Service Act Section 330 but does not receive federal funding.

Health Care Organizations—an organization that provides health and health-related services to the community and underserved populations (including farmworkers).

In-house Referrals—made by a member of your organization's staff to receive care within your organization.

Migrant Stream—Historically, migrant farmworkers reside during winter in "home base" communities in Florida, Texas, and California, or in Central American 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.

Organizational Health Care Plan—a written plan that outlines all the activities and services you provide at your organization.

Outreach Program—any activities, services, or programs that your organization uses to reach farmworkers.

Outreach Services—any service you take out to or use to reach farmworkers in your community.

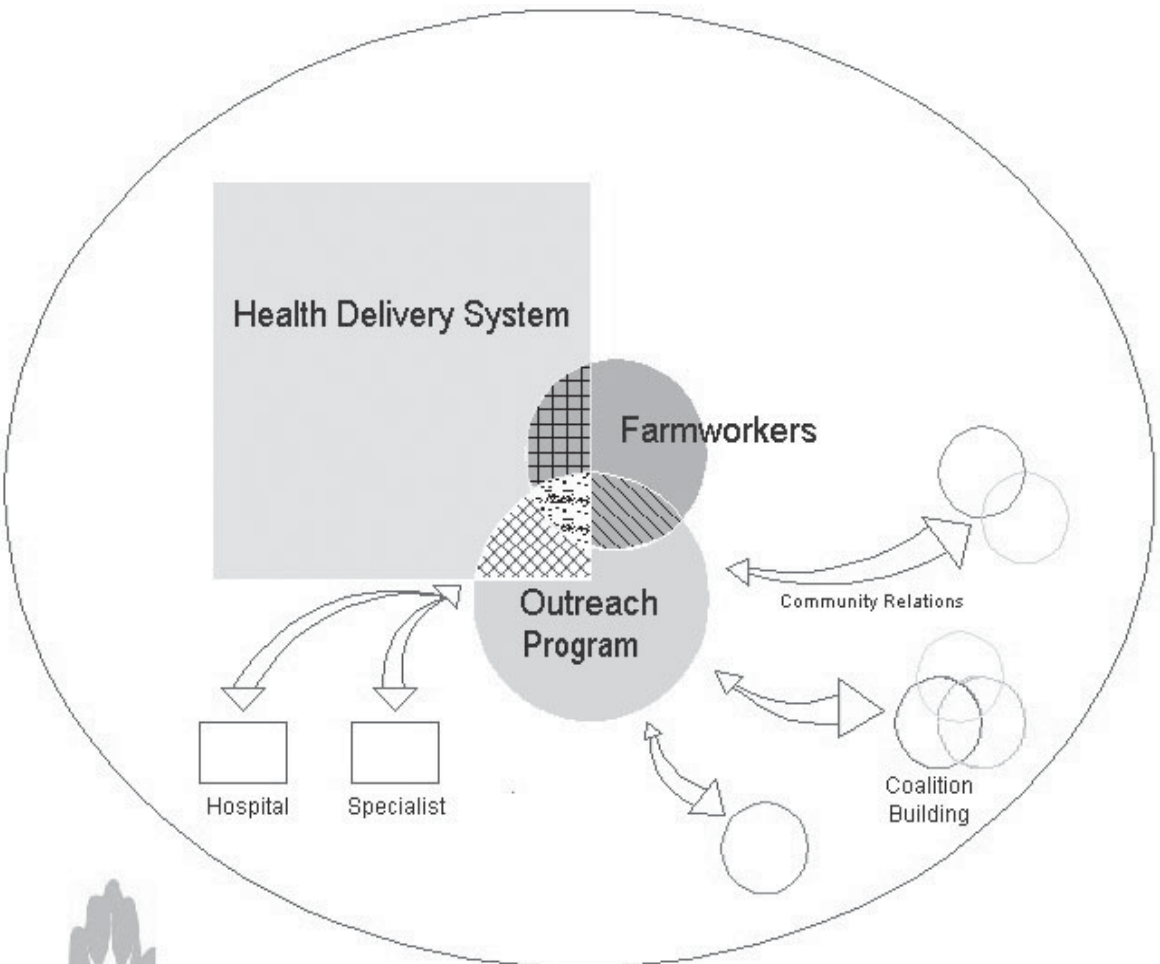
Outside Referrals—made by a member of your staff for a patient to receive care at another organization outside of your own.

Respondents—all of the individuals that will be reading and responding to this national survey.

Appendix

A.

Farmworker Health Services, Inc. Community Health Outreach Model



Community Health Outreach Model

B.

Additional Statistics on Ranked Responses to Mail Survey

Most Common Farmworker Health Issues

Health Issue	Mean Score	Std. Dev.
Diabetes	3.86	1.47
Hypertension	2.84	1.79
Dental health	1.96	1.80
Prenatal care	1.53	2.03
Mental health	1.14	1.51
Dermatitis	1.00	1.44
Alcohol/Substance Abuse	0.88	1.38
Environmental/Occupational Health	0.58	1.40
HIV/AIDS/STIs	0.30	0.87
Eye care	0.12	0.50

Health Topics of Interest to Farmworkers

Topic of Interest	Mean Score	Std. Dev.
Diabetes	1.49	1.27
Dental health	1.09	1.26
Hypertension	0.75	1.00
Prenatal care	0.67	0.99
HIV/AIDS/STIs	0.47	0.97
Environmental/Occupational Health	0.34	0.88
Eye care	0.25	0.62
Mental health	0.23	0.61
Alcohol/Substance Abuse	0.21	0.69
Dermatitis	0.15	0.53
Violence/domestic violence	0.13	0.44

Barriers to Care

Barrier	Mean Score	Std. Dev.
Transportation	1.52	1.2
Pay scale/financial issues	1.05	1.3
Language	0.88	1.11
Lack of knowledge of available services	0.67	1.03
Legal status	0.55	1.01
Hours of operation	0.47	0.88
Lack of outreach services	0.22	0.59
Cultural differences	0.19	0.51
Alternative medical beliefs	0.12	0.532

Farmworker Social Service Needs

Social Service Needs	Mean Score	Std. Dev.
Housing Assistance	1.51	1.32
English language instruction	0.93	1.23
Food assistance	0.75	1.00
Employment training/job assistance	0.67	1.12
Legal services	0.56	0.81
Labor rights education	0.47	0.96
Domestic violence prevention education	0.44	0.90
Accessing children's education services	0.36	0.78
Other violence prevention education	0.11	0.42

Current Outreach Activities

Outreach Activity	Mean Score	Std. Dev.
Patient registration/eligibility	1.02	1.38
Health education	0.98	1.13
Case management	0.92	1.19
Referrals	0.51	0.92
Follow-up	0.51	0.98
Appointment setting	0.49	0.98
Health fairs	0.47	0.82
Clinical outreach	0.41	0.93
Transportation	0.39	0.84

Future Outreach Activities

Outreach Activity	Mean Score	Std. Dev.
Health education	1.35	1.21
Case management	1.13	1.21
Patient registration/eligibility	0.94	1.29
Clinical outreach	0.83	1.23
Health fairs	0.48	0.77
Follow-up	0.38	0.76
Referrals	0.31	0.72
Appointment setting	0.27	0.79
Transportation	0.17	0.56
Data collection	0.10	0.37

Financial Challenges for Outreach Programs

Challenge	Mean Score	Std. Dev.
Lack of reimbursable resources	1.26	0.9
Gaining federal funding	0.38	0.6
Gaining private funding	0.38	0.73
Gaining state funding	0.24	0.52

Areas of Need for Programmatic Support

Program Need	Mean Score	Std. Dev.
Grants/funding	2.33	2.19
Needs assessment	1.69	1.94
Program planning	1.45	2.06
Best practices	1.38	1.86
Data/performance measures	1.25	1.77
Transportation	1.02	1.65
New service area penetration	0.95	1.66
Patient education materials	0.78	1.37
Interdepartmental cooperation	0.58	1.29
Staff training	0.67	1.39
New service development	0.53	1.12
Community coalitions	0.53	1.14
Interpretation	0.36	1.06

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