



Massachusetts League  
of Community Health Centers



**Monthly Meeting 10am – 11:45am**

**Jan. 17, 2012**

**AGENDA**

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**Introductions**

**2011 Program**

- Transportation, Outreach & Voucher bills
  - **non-billable visits** need to be sent in ASAP for 2011
- Farmworker Patient Satisfaction surveys
- Increased allocation requests needed ASAP
- Outreach contact sheet summary total and by CHC
- Medical Chart Review contacts & audit meetings
- Uniform Data System - Tables

**2012 Program**

- 2012-2016 Grant Notice of Award
  - Contract Amendments emailed out
  - Program Condition – OB services / coordination
  - Migrant representation - Advisory Board member recommendations
  - BPHC Clinical Measures – PHQ 2 review
- 2012 CRVFHP forms
- Outreach update from health centers
- Prevent Blindness America training rescheduled

**Resources**

- Northeast Region 2011 Migrant Health Profile – draft
  - 8 questions

**Next Meetings**

- Feb. 21 – CRVFHP Monthly Meeting, Conference Call (Focus – 2012 Request For Proposal)
- Mar. 21-25 – NACHC Policy & Issues Forum, Washington DC
- Apr. 17 from 9:30am-1:30pm – Prevent Blindness America training, Caring Health Center, Springfield, MA
- 2012 meeting schedule – locations TBD

**TOTAL BY MONTH - OUTREACH SUMMARY - as of 1-13-12**

**IDS Funding:**

**Migrant Funding:**

Outreach contact	January		February		March		April		May		June		July		August		September		October		November		December	
	bill	contact	bill	contact	bill	contact	bill	contact	bill	contact	bill	contact	bill	contact	bill	contact	bill	contact	bill	contact	bill	contact	bill	contact
Brightwood	1	1	1	1	1	1					1	na	1	1	1	1	1	1	1	1	1	1	1	1
CHCE											1	1	1	1	1	1	1	1	1	1	1	1	1	1
CHCFC	1	1	1	1	-	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Generations	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Holyoke	-	-	-	-	-	-	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

**Missing data**

Monthly Outreach Expenditure Reports must be submitted by the 15<sup>th</sup> of the month following the reporting month.

Monthly Outreach Contact Sheets must be submitted by the 15<sup>th</sup> of the month following the reporting month.

In addition, all Outreach Expenditure Reports and Outreach Contact Sheets from Jan. 1, 2011 through June 30, 2011 must be submitted to MLCHC no later than Aug. 15, 2011;

all Outreach Expenditure Reports and Outreach Contact Sheets from July 1, 2011 through Dec. 31, 2011 must be submitted no later than Jan. 15, 2012.

For IDS, the same 15th of each month deadline remains.



2011 MONTHLY OUTREACH CONTACT SHEET

Agency: CRVFHP Agencies

Report Dates of Service: 2011

estimated # of unduplicated contacts seen for the 1st time ever: 399 30% of primary care encounters this month: 1,261 # of primary care encounters this month: 2,316  
 estimated # of unduplicated contacts seen for the 1st time this month in 2011: 1,310 # of dental encounters this month: 1,742 # of dental encounters this month: 1,025 **3,341**

type of enabling services (case mgmt, education, outreach, transportation)	Contact Type	Location Type	Male						Female						TOTAL
			<1	1-12	13-19	20-44	44-64	65+	<1	1-12	13-19	20-44	44-64	65+	
Eligibility assistance	Registered MSFWs into CRVFHP ( <i>unduplicated</i> )		6	66	41	579	181	13	6	61	28	328	31	7	1,347
Eligibility assistance	Assistance in securing access to available health, social service, pharmacy and other assistance		4	22	22	497	138	8	4	19	21	367	38	6	1,146
Outreach	Case finding, education or other services to facilitate access / referral		3	70	37	532	144	12	4	59	25	260	49	6	1,201
Patient Health Education	Personal assistance provided to promote health and healthy behaviors (to be detailed on p2 of Contact Sheet)		1	15	11	192	56	5	2	13	8	165	19	5	492
translation/interpretation	Translation (number of times used as a translator)		1	35	54	258	135	21	8	29	74	228	75	24	942
Transportation	Transportation (each one way trip for each person)		2	36	26	402	148	4	10	40	7	332	56	10	1,073
Case Management	Health agency referral (health center, health dept, specialist, etc.)		0	6	5	311	90	3	2	12	15	321	43	3	811
Case Management	Pregnancy related referral (family planning, pregnancy test, prenatal, post natal)		0	0	0	1	1	0	0	0	2	121	2	0	127
Case Management	Referrals received from health / social service organizations		0	0	2	32	3	1	0	1	4	24	2	0	69
Case Management	Follow-up / case management		2	53	30	463	97	4	2	49	21	346	46	3	1,116
	Other (please specify):		0	0	0	4	26	0	0	0	0	3	1	1	35
<b>Total:</b>			19	303	228	3,271	1,019	71	38	283	205	2,495	362	65	8,359

<b>2011 numbers:</b>	case management	2,123	25%		<b>2007 numbers:</b>	case management	1,185	12%	
	transportation	1,073	13%			transportation	1,744	18%	
	outreach	1,201	14%			outreach	1,535	16%	
	patient education	492	6%			patient education	931	10%	
	translation/interpretation	942	11%			translation/interpretation	1,665	17%	
	eligibility assistance	2,493	30%			environmental health rr	0	0%	
	other enabling services	35	0%			eligibility assistance	2,723	28%	
		8,359	100%	-11% increase from 2010		other	9	0%	
							9,792	100%	-26% increase from 2006
<b>2010 numbers:</b>	case management	1,846	20%		<b>2006 numbers:</b>	case management	1,375	10%	
	transportation	2,450	26%			transportation	298	2%	
	outreach	708	8%			outreach	2,324	18%	
	patient education	447	5%			patient education	1,747	13%	
	translation/interpretation	1,128	12%			translation/interpretation	4,453	34%	
	eligibility assistance	2,777	30%			environmental health rr	12	0%	
	other enabling services	13	0%			eligibility assistance	2,968	23%	
		9,369	100%	-6% increase from 2009			13,177	100%	-16% increase from 2005
<b>2009 numbers:</b>	case management	1,613	16%		<b>2005 numbers:</b>	case management	1,903	12%	
	transportation	2,917	29%			patient education	3,819	24%	
	outreach	839	8%			outreach	7,084	45%	
	patient education	712	7%			transportation	2,938	19%	
	translation/interpretation	1,170	12%				15,744	100%	6% increase from 2004
	eligibility assistance	2,744	27%		<b>2004 numbers:</b>	case management	3,006	20%	
	other enabling services	2	0%			patient education	3,374	23%	
		9,997	100%	15% increase from 2004		outreach	7,097	48%	
<b>2008 numbers:</b>	case management	1,788	21%			transportation	1,372	9%	
	transportation	1,183	14%				14,849	100%	62% increase from 2003
	outreach	1,287	15%		<b>2003 numbers:</b>	case management	1,054	11%	
	patient education	936	11%			patient education	1,213	13%	
	translation/interpretation	710	8%			outreach	5,529	60%	
	eligibility assistance	2,736	32%			transportation	1,374	15%	
	other enabling services	20	0%				9,170	100%	
		8,660	100%	-12% increase from 2007					

<b>Health Center/Organization</b>	<b># of contacts</b>	<b>%</b>
Baystate Brightwood Health Center	1,565	18.7%
Community Health Center of Enfield	307	3.7%
Community Health Center of Franklin County	4,150	49.6%
Generations Family Health Center	1,879	22.5%
Holyoke Health Center	458	5.5%
	<u>8,359</u>	

## ZIP CODE

Zip Code	Patients
Other Zip Codes	
Unknown Residence	
TOTAL	

*Note: This is a representation of the form; however the actual on-line input process will look significantly different, as may the printed output from the EHB.*



Health Resources and Services Administration

**TABLE 3A: PATIENTS BY AGE AND GENDER**

<b>AGE GROUPS</b>		<b>MALE PATIENTS (a)</b>	<b>FEMALE PATIENTS (b)</b>
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25 – 29		
27	Ages 30 – 34		
28	Ages 35 – 39		
29	Ages 40 – 44		
30	Ages 45 – 49		
31	Ages 50 – 54		
32	Ages 55 – 59		
33	Ages 60 – 64		
34	Ages 65 – 69		
35	Ages 70 – 74		
36	Ages 75 – 79		
37	Ages 80 – 84		
38	Age 85 and over		
39	<b>TOTAL PATIENTS (SUM LINES 1-38)</b>		

**TABLE 3B: PATIENTS BY RACE AND HISPANIC OR LATINO ETHNICITY/PATIENTS BY LANGUAGE**

PATIENTS BY RACE		PATIENTS BY HISPANIC OR LATINO ETHNICITY			
		HISPANIC/ LATINO (a)	NOT HISPANIC/ LATINO (b)	UNREPORTED/ REFUSED TO REPORT (c)	TOTAL (d)
1.	Asian				
2a.	Native Hawaiian				
2b.	Other Pacific Islander				
2.	<b>Total Hawaiian/Pacific Islander</b> (SUM LINES 2A + 2B)				
3.	Black / African American				
4.	American Indian / Alaska Native				
5.	White				
6.	More than one race				
7.	Unreported / Refused to report				
8.	<b>TOTAL PATIENTS</b> (SUM LINES 1+2 + 3 TO 7)				

PATIENTS BY LANGUAGE		NUMBER (a)
12.	<b>PATIENTS BEST SERVED IN A LANGUAGE OTHER THAN ENGLISH</b>	

## TABLE 4: SELECTED PATIENT CHARACTERISTICS

CHARACTERISTIC		NUMBER OF PATIENTS ( a )				
<b>INCOME AS PERCENT OF POVERTY LEVEL</b>						
1.	100% and below					
2.	101 – 150%					
3.	151 – 200%					
4.	Over 200%					
5.	Unknown					
6.	<b>TOTAL (SUM LINES 1 – 5)</b>					
<b>PRINCIPAL THIRD PARTY MEDICAL INSURANCE SOURCE</b>		<b>0-19 YEARS OLD ( a )</b>		<b>20 AND OLDER ( b )</b>		
7.	<b>None/ Uninsured</b>					
8a.	Regular Medicaid (Title XIX)					
8b.	CHIP Medicaid					
8.	<b>TOTAL MEDICAID (LINE 8A + 8B)</b>					
9.	<b>MEDICARE (TITLE XVIII)</b>					
10a.	Other Public Insurance Non-CHIP (specify:)					
10b.	Other Public Insurance CHIP					
10.	<b>TOTAL PUBLIC INSURANCE (LINE 10a + 10b)</b>					
11.	<b>PRIVATE INSURANCE</b>					
12.	<b>TOTAL (SUM LINES 7 + 8 + 9 +10 +11)</b>					
<b>MANAGED CARE UTILIZATION</b>						
Payor Category		MEDICAID ( a )	MEDICARE ( b )	OTHER PUBLIC INCLUDING NON- MEDICAID CHIP ( c )	PRIVATE ( d )	TOTAL ( e )
13a.	Capitated Member months					
13b.	Fee-for-service Member months					
13c.	<b>TOTAL MEMBER MONTHS ( 13a + 13b)</b>					
<b>CHARACTERISTICS – SPECIAL POPULATIONS</b>					<b>NUMBER OF PATIENTS -- (a)</b>	
14.	Migrant (330g grantees only)					
15.	Seasonal (330g grantees only)					
16.	<b>TOTAL MIGRANT/SEASONAL AGRICULTURAL WORKER OR DEPENDENT (ALL GRANTEES REPORT THIS LINE)</b>					
17.	Homeless Shelter (330h grantees only)					
18.	Transitional (330h grantees only)					
19.	Doubling Up (330h grantees only)					
20.	Street (330h grantees only)					
21.	Other (330h grantees only)					
22.	Unknown (330h grantees only)					
23.	<b>TOTAL HOMELESS (ALL GRANTEES REPORT THIS LINE)</b>					
24.	<b>TOTAL SCHOOL BASED HEALTH CENTER PATIENTS (ALL GRANTEES REPORT THIS LINE)</b>					
25.	<b>TOTAL VETERANS (ALL GRANTEES REPORT THIS LINE)</b>					

## TABLE 5: STAFFING AND UTILIZATION

Personnel by Major Service Category		FTEs (a)	Clinic Visits (b)	Patients (c)
1	Family Physicians			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
6				
7	Other Specialty Physicians			
8	Total Physicians (Lines 1 - 7)			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	Total NP, PA, and CNMs (Lines 9a - 10)			
11	Nurses			
12	Other Medical personnel			
13	Laboratory personnel			
14	X-ray personnel			
15	Total Medical (Lines 8 + 10a through 14)			
16	Dentists			
17	Dental Hygienists			
18	Dental Assistants, Aides, Techs			
19	Total Dental Services (Lines 16 - 18)			
20a	Psychiatrists			
20a1	Licensed Clinical Psychologists			
20a2	Licensed Clinical Social Workers			
20b	Other Licensed Mental Health Providers			
20c	Other Mental Health Staff			
20	Total Mental Health (Lines 20a-c)			
21	Substance Abuse Services			
22	Other Professional Services (specify ___)			
22a	Ophthalmologist			
22b	Optometrist			
22c	Other Vision Care Staff			
22d	Total Vision Services (Lines 22a-c)			
23	Pharmacy Personnel			
24	Case Managers			
25	Patient / Community Education Specialists			
26	Outreach Workers			
27	Transportation Staff			
27a	Eligibility Assistance Workers			
27b	Interpretation Staff			
28	Other Enabling Services (specify ___)			
29	Total Enabling Services (Lines 24-28)			
29a	Other Programs / Services (specify ___)			
30a	Management and Support Staff			
30b	Fiscal and Billing Staff			
30c	IT Staff			
30	Total Administrative Staff (Lines 30a-30c)			
31	Facility Staff			
32	Patient Support Staff			
33	Total Admin & Facility (Lines 30 - 32)			
34	Grand Total Lines 15+19+20+21+22+22d+23+29+29a+33)			

**TABLE 6A: SELECTED DIAGNOSES AND SERVICES  
RENDERED**

Diagnostic Category	Applicable ICD-9-CM Code	Number of Visits by Primary Diagnosis (A)	Number of Patients with Primary Diagnosis (B)
<b>Selected Infectious and Parasitic Diseases</b>			
1-2.	Symptomatic HIV , Asymptomatic HIV	042 , 079.53, V08	
3.	Tuberculosis	010.xx – 018.xx	
4.	Syphilis and other sexually transmitted diseases	090.xx – 099.xx	
4a.	Hepatitis B	070.20, 070.22, 070.30, 070.32	
4b.	Hepatitis C	070.41, 070.44, 070.51, 070.54, 070.70, 070.71	
<b>Selected Diseases of the Respiratory System</b>			
5.	Asthma	493.xx	
6.	Chronic bronchitis and emphysema	490.xx – 492.xx	
<b>Selected Other Medical Conditions</b>			
7.	Abnormal breast findings, female	174.xx; 198.81; 233.0x; 238.3 793.8x	
8.	Abnormal cervical findings	180.xx; 198.82; 233.1x; 795.0x	
9.	Diabetes mellitus	250.xx; 648.0x; 775.1x	
10.	Heart disease (selected)	391.xx – 392.0x 410.xx – 429.xx	
11.	Hypertension	401.xx – 405.xx;	
12.	Contact dermatitis and other eczema	692.xx	
13.	Dehydration	276.5x	
14.	Exposure to heat or cold	991.xx – 992.xx	
14a.	Overweight and obesity	ICD-9 : 278.0 – 278.02 or V85.xx excluding V85.0, V85.1, V85.51 V85.52	
<b>Selected Childhood Conditions</b>			
15.	Otitis media and eustachian tube disorders	381.xx – 382.xx	
16.	Selected perinatal medical conditions	770.xx; 771.xx; 773.xx; 774.xx – 779.xx (excluding 779.3x)	

17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive)--does not include sexual or mental development; Nutritional deficiencies	260.xx – 269.xx; 779.3x; 783.3x – 783.4x;		
<b>Selected Mental Health and Substance Abuse Conditions</b>				
18.	Alcohol related disorders	291.xx, 303.xx; 305.0x 357.5x		
19.	Other substance related disorders (excluding tobacco use disorders)	292.1x – 292.8x 304.xx, 305.2x – 305.9x 357.6x, 648.3x		
19a.	Tobacco use disorder	305.1		
20a.	Depression and other mood disorders	296.xx, 300.4 301.13, 311.xx		
20b.	Anxiety disorders including PTSD	300.0x, 300.2x, 300.3, 308.3,309.81		
20c.	Attention deficit and disruptive behavior disorders	312.8x, 312.9x, 313.81, 314.xx		
20d.	Other mental disorders, excluding drug or alcohol dependence (includes mental retardation)	290.xx 293.xx – 302.xx (excluding 296.xx, 300.0x, 300.2x, 300.3, 300.4, 301.13); 306.xx - 319.xx (excluding 308.3, 309.81, 311.xx, 312.8x, 312.9x,313.81,314.xx)		

**TABLE 6A: SELECTED SERVICES RENDERED**

Service Category		Applicable ICD-9-CM or CPT-4 Code	Number of Visits (A)	Number of Patients (B)
<b>Selected Diagnostic Tests/Screening/Preventive Services</b>				
21.	HIV test	<b>CPT-4:</b> 86689; 86701-86703; 87390-87391		
21a.	Hepatitis B test	<b>CPT-4:</b> 86704, 86706, 87515-17		
21b.	Hepatitis C test	<b>CPT-4:</b> 86803-04, 87520-22		
22.	Mammogram	<b>CPT-4:</b> 77052, 77057 OR <b>ICD-9:</b> V76.11; V76.12		
23.	Pap test	<b>CPT-4:</b> 88141-88155; 88164- 88167, 88174-88175 OR <b>ICD-9:</b> V72.3; V72.31; V76.2		
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diptheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	<b>CPT-4:</b> 90633-90634, 90645 – 90648; 90670; 90696 – 90702; 90704 – 90716; 90718 - 90723; 90743 – 90744; 90748		
24a.	Seasonal Flu vaccine	<b>CPT-4:</b> 90655 - 90662		
24b.	H1N1 Flu vaccine	<b>CPT-4:</b> 90663; 90470		

Service Category		Applicable ICD-9-CM or CPT-4 Code	Number of Visits (A)	Number of Patients (B)
25.	Contraceptive management	<b>ICD-9:</b> V25.xx		
26.	Health supervision of infant or child (ages 0 through 11)	<b>CPT-4:</b> 99391-99393; 99381-99383;		
26a.	Childhood lead test screening (9 to 72 months)	<b>CPT-4:</b> 83655		
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	<b>CPT-4:</b> 99408-99409		
26c.	Smoke and tobacco use cessation counseling	<b>CPT-4:</b> 99406 and 99407; S9075		
26d.	Comprehensive and intermediate eye exams	<b>CPT-4:</b> 92002, 92004, 92012, 92014		

Service Category		Applicable ADA Code	Number of Visits (A)	Number of Patients (B)
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### Selected Dental Services

27.	I. Emergency Services	<b>ADA :</b> D9110		
28.	II. Oral Exams	<b>ADA :</b> D0120, D0140, D0145, D0150, D0160, D0170, D0180		
29.	Prophylaxis – adult or child	<b>ADA :</b> D1110, D1120,		
30.	Sealants	<b>ADA :</b> D1351		
31.	Fluoride treatment – adult or child	<b>ADA :</b> D1203, D1204, D1206		
32.	III. Restorative Services	<b>ADA :</b> D21xx – D29xx		
33.	IV. Oral Surgery (extractions and other surgical procedures)	<b>ADA :</b> D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7272, D7280		
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	<b>ADA :</b> D3xxx, D4xxx, D5xxx , D6xxx, D8xxx		

## TABLE 6B: QUALITY OF CARE INDICATORS

(NO PRENATAL CARE PROVIDED? CHECK HERE: <input type="checkbox"/> )				
SECTION A: AGE CATEGORIES FOR PRENATAL PATIENTS (GRANTEES WHO PROVIDE PRENATAL CARE ONLY)				
DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS				
AGE		NUMBER OF PATIENTS ( a )		
1	LESS THAN 15 YEARS			
2	AGES 15-19			
3	AGES 20-24			
4	AGES 25-44			
5	AGES 45 AND OVER			
6	TOTAL PATIENTS (SUM LINES 1 – 5)			
SECTION B – TRIMESTER OF ENTRY INTO PRENATAL CARE				
TRIMESTER OF FIRST KNOWN VISIT FOR WOMEN RECEIVING PRENATAL CARE DURING REPORTING YEAR		Women Having First Visit with Grantee ( a )	Women Having First Visit with Another Provider ( b )	
7	First Trimester			
8	Second Trimester			
9	Third Trimester			
SECTION C – CHILDHOOD IMMUNIZATION				
CHILDHOOD IMMUNIZATION		TOTAL NUMBER PATIENTS WITH 2 <sup>ND</sup> BIRTHDAY DURING MEASUREMENT YEAR ( a )	NUMBER CHARTS SAMPLED OR EHR TOTAL ( b )	NUMBER OF PATIENTS IMMUNIZED ( c )
10	Children who have received age appropriate vaccines who had their 2 <sup>nd</sup> birthday during measurement year (on or prior to 31 December)			
SECTION D – CERVICAL CANCER SCREENING				
PAP TESTS		TOTAL NUMBER OF FEMALE PATIENTS 24-64 YEARS OF AGE ( a )	NUMBER CHARTS SAMPLED OR EHR TOTAL ( b )	NUMBER OF PATIENTS TESTED ( c )
11	Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer			
SECTION E – WEIGHT ASSESSMENT AND COUNSELING FOR CHILDREN AND ADOLESCENTS				
CHILD AND ADOLESCENT WEIGHT ASSESSMENT AND COUNSELING		TOTAL PATIENTS AGED 3 – 17 ON DECEMBER 31 ( a )	CHARTS SAMPLED OR EHR TOTAL ( b )	NUMBER OF PATIENTS WITH COUNSELING AND BMI DOCUMENTED ( c )
12	Children and adolescents aged 3 - 17 with a BMI percentile, <b><i>and</i></b> counseling on nutrition and physical activity documented for the current year			

SECTION F – ADULT WEIGHT SCREENING AND FOLLOWUP				
	ADULT WEIGHT SCREENING AND FOLLOWUP	TOTAL PATIENTS 18 AND OVER (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH BMI CHARTED AND FOLLOW-UP PLAN DOCUMENTED AS APPROPRIATE (c)
13	Patients aged 18 and over with (1) BMI charted <b>and</b> (2) follow-up plan documented <b>if</b> patients are overweight or underweight			
SECTION G1 – TOBACCO USE ASSESSMENT				
	TOBACCO ASSESSMENT	TOTAL PATIENTS 18 AND OVER (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS ASSESSED FOR TOBACCO USE (c)
14	Patients queried about tobacco use one or more times in the measurement year or prior year			
SECTION G2 – TOBACCO CESSATION INTERVENTION				
	TOBACCO CESSATION INTERVENTION	TOTAL PATIENTS WITH DIAGNOSED TOBACCO DEPENDENCE (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS ADVISED TO QUIT (c)
15	Tobacco users aged 18 or older who have received cessation advice or medication			
SECTION H – ASTHMA PHARMACOLOGICAL THERAPY				
	ASTHMA TREATMENT PLAN	TOTAL PATIENTS AGED 5 - 40 WITH PERSISTENT ASTHMA (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH ACCEPTABLE PLAN (c)
16	Patients aged 5 through 40 diagnosed with persistent asthma who have an acceptable pharmacological treatment plan			

**TABLE 7: HEALTH OUTCOMES AND DISPARITIES**  
**SECTION A: DELIVERIES AND BIRTH WEIGHT BY RACE AND HISPANIC/LATINO ETHNICITY**

0	HIV Positive Pregnant Women				
2	Deliveries Performed by Grantee's Providers				
Line #	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500-2499 grams (1c)	Live Births: =>2500 grams (1d)
<b>Hispanic/Latino</b>					
1a	Asian				
1b1	Native Hawaiian				
1b2	Pacific Islander				
1c	Black/African American				
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	<i>Subtotal Hispanic/Latino</i>				
<b>Non-Hispanic/Latino</b>					
2a	Asian				
2b1	Native Hawaiian				
2b2	Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	<i>Subtotal Non-Hispanic/Latino</i>				
<b>Unreported/Refused to Report Ethnicity</b>					
h	Unreported/Refused to Report Race and Ethnicity				
i	<b>Total</b>				

**SECTION B: HYPERTENSION BY RACE AND HISPANIC/LATINO ETHNICITY**

#	Race and Ethnicity	Total Hypertensive Patients (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
<b>Hispanic/Latino</b>				
1a	Asian			
1b1	Native Hawaiian			
1b2	Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	<i>Subtotal Hispanic/Latino</i>			
<b>Non-Hispanic/Latino</b>				
2a	Asian			
2b1	Native Hawaiian			
2b2	Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	<i>Subtotal Non-Hispanic/Latino</i>			
<b>Unreported/Refused to Report Ethnicity</b>				
h	Unreported/Refused to Report Race and Ethnicity			
i	<b>Total</b>			

**SECTION C: DIABETES BY RACE AND HISPANIC/LATINO ETHNICITY**

#	Race and Ethnicity	Total Patients with Diabetes (old Line 9) (3a)	Charts Sampled or EHR Total (3b)	Patients with Hba1c <7% (3c)	Patients with 7%<= Hba1c <8% (3d)	Patients with 8%<= Hba1c <=9% (3e)	Patients with Hba1c >9% Or No Test During Year (3f)
<b>Hispanic/Latino</b>							
1a	Asian						
1b1	Native Hawaiian						
1b2	Pacific Islander						
1c	Black/African American						
1d	American Indian/Alaska Native						
1e	White						
1f	More than One Race						
1g	Unreported/Refused to Report Race						
	<i>Subtotal Hispanic/Latino</i>						
<b>Non-Hispanic/Latino</b>							
2a	Asian						
2b1	Native Hawaiian						
2b2	Pacific Islander						
2c	Black/African American						
2d	American Indian/Alaska Native						
2e	White						
2f	More than One Race						
2g	Unreported/Refused to Report Race						
	<i>Subtotal Non-Hispanic/Latino</i>						
<b>Unreported/Refused to Report Ethnicity</b>							
h	Unreported/Refused to Report Race and Ethnicity						
<b>i</b>	<b>Total</b>						

## TABLE 8A: FINANCIAL COSTS

		ACCRUED COST  ( a )	ALLOCATION OF FACILITY AND ADMINISTRATION  ( b )	TOTAL COST AFTER ALLOCATION OF FACILITY AND ADMINISTRATION ( c )
<b>FINANCIAL COSTS FOR MEDICAL CARE</b>				
1.	Medical Staff			
2.	Lab and X-ray			
3.	Medical/Other Direct			
4.	<b>TOTAL MEDICAL CARE SERVICES</b> (SUM LINES 1 THROUGH 3)			
<b>FINANCIAL COSTS FOR OTHER CLINICAL SERVICES</b>				
5.	Dental			
6.	Mental Health			
7.	Substance Abuse			
8a.	Pharmacy not including pharmaceuticals			
8b.	Pharmaceuticals			
9.	Other Professional (Specify _____)			
9a.	Vision			
10.	<b>TOTAL OTHER CLINICAL SERVICES</b> (SUM LINES 5 THROUGH 9A)			
<b>FINANCIAL COSTS OF ENABLING AND OTHER PROGRAM RELATED SERVICES</b>				
11a.	Case Management			
11b.	Transportation			
11c.	Outreach			
11d.	Patient and Community Education			
11e.	Eligibility Assistance			
11 f.	Interpretation Services			
11g.	Other Enabling Services (specify: _____)			
11.	Total Enabling Services Cost (Sum lines 11a through 11g)			
12.	Other Related Services (specify: _____)			
13.	<b>TOTAL ENABLING AND OTHER SERVICES</b> (SUM LINES 11 AND 12)			
<b>OVERHEAD AND TOTALS</b>				
14.	Facility			
15.	Administration			
16.	<b>TOTAL OVERHEAD</b> (SUM LINES 14 AND 15)			
17.	<b>TOTAL ACCRUED COSTS</b> (SUM LINES 4 + 10 + 13 + 16)			
18.	Value of Donated Facilities, Services and Supplies (specify: _____)			
19.	<b>TOTAL WITH DONATIONS</b> (SUM LINES 17 AND 18)			

**TABLE 9D: PATIENT RELATED REVENUE**

PAYOR CATEGORY	FULL CHARGES THIS PERIOD (a)	AMOUNT COLLECTED THIS PERIOD (b)	RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (c)				ALLOWANCES (d)	SLIDING DISCOUNTS (e)	BAD DEBT WRITE OFF (f)
			COLLECTION OF RECONCILIATION/WRAP AROUND CURRENT YEAR (c1)	COLLECTION OF RECONCILIATION/WRAP AROUND PREVIOUS YEARS (c2)	COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/ INCENTIVE/ WITHHOLD (c3)	PENALTY/ PAYBACK (c4)			
1. Medicaid Non-Managed Care									
2a. Medicaid Managed Care (capitated)									
2b. Medicaid Managed Care (fee-for-service)									
3. TOTAL MEDICAID (LINES 1 + 2A + 2B)									
4. Medicare Non-Managed Care									
5a. Medicare Managed Care (capitated)									
5b. Medicare Managed Care (fee-for-service)									
6. TOTAL MEDICARE (LINES 4 + 5A + 5B)									
7. Other Public including Non-Medicaid CHIP (Non Managed Care)									
8a. Other Public including Non-Medicaid CHIP (Managed Care Capitated)									

PAYOR CATEGORY	FULL CHARGES THIS PERIOD (a)	AMOUNT COLLECTED THIS PERIOD (b)	RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (c)				ALLOWANCES (d)	SLIDING DISCOUNTS (e)	BAD DEBT WRITE OFF (f)
			COLLECTION OF RECONCILIATION/WRAP AROUND CURRENT YEAR (c1)	COLLECTION OF RECONCILIATION/WRAP AROUND PREVIOUS YEARS (c2)	COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/ INCENTIVE/ WITHHOLD (c3)	PENALTY/ PAYBACK (c4)			
8b. Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)									
9. <b>TOTAL OTHER PUBLIC</b> (LINES 7+ 8A +8B)									
10. Private Non-Managed Care									
11a. Private Managed Care (capitated)									
11b. Private Managed Care (fee-for-service)									
12. <b>TOTAL PRIVATE</b> (LINES 10 + 11A + 11B)									
13. Self Pay									
14. <b>TOTAL</b> (LINES 3 + 6 + 9 + 12 + 13)									

## TABLE 9E: OTHER REVENUES

	SOURCE	AMOUNT (a)
<b>BPHC GRANTS (ENTER AMOUNT DRAWN DOWN - CONSISTENT WITH PMS-272)</b>		
1a.	Migrant Health Center	
1b.	Community Health Center	
1c.	Health Care for the Homeless	
1e.	Public Housing Primary Care	
1g.	<b>TOTAL HEALTH CENTER CLUSTER</b> (SUM LINES 1A THROUGH 1E)	
1j.	Capital Improvement Program Grants (excluding ARRA and ACA)	
1k.	Capital Development Grants	
<b>1.</b>	<b>TOTAL BPHC GRANTS</b> (SUM LINES 1G + 1J + 1K)	
<b>OTHER FEDERAL GRANTS</b>		
2.	Ryan White Part C HIV Early Intervention	
3.	Other Federal Grants (specify: _____)	
3a.	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
4.	American Recovery and Reinvestment Act (ARRA) New Access Point (NAP) and Increased Demand for Services (IDS)	
4a.	American Recovery and Reinvestment Act (ARRA) Capital Improvement Project (CIP) and Facility Investment Program (FIP)	
5.	<b>TOTAL OTHER FEDERAL GRANTS</b> (SUM LINES 2 – 4A)	
<b>NON-FEDERAL GRANTS OR CONTRACTS</b>		
6.	State Government Grants and Contracts (specify: _____)	
6a.	State/Local Indigent Care Programs (specify: _____)	
7.	Local Government Grants and Contracts (specify: _____)	
8.	Foundation/Private Grants and Contracts (specify: _____)	
9.	<b>TOTAL NON-FEDERAL GRANTS AND CONTRACTS</b> (SUM LINES 6 + 6A+7+8)	
10.	Other Revenue (Non-patient related revenue not reported elsewhere) (specify: _____)	
<b>11.</b>	<b>TOTAL REVENUE</b> (LINES 1+5+9+10)	

## The Patient Health Questionnaire-2 (PHQ-2)

Patient Name \_\_\_\_\_ Date of Visit \_\_\_\_\_

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

## The Patient Health Questionnaire-2 (PHQ-2) - Overview

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is not to establish final a diagnosis or to monitor depression severity, but rather to screen for depression in a “first step” approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

### Clinical Utility

Reducing depression evaluation to two screening questions enhances routine inquiry about the most prevalent and treatable mental disorder in primary care.

### Scoring

A PHQ-2 score ranges from 0-6. The authors<sup>1</sup> identified a PHQ-2 cutoff score of 3 as the optimal cut point for screening purposes and stated that a cut point of 2 would enhance sensitivity, whereas a cut point of 4 would improve specificity.

### Psychometric Properties<sup>1</sup>

Major Depressive Disorder (7% prevalence)				Any Depressive Disorder (18% prevalence)			
PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)	PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)
1	97.6	59.2	15.4	1	90.6	65.4	36.9
2	92.7	73.7	21.1	2	82.1	80.4	48.3
<b>3</b>	<b>82.9</b>	<b>90.0</b>	<b>38.4</b>	<b>3</b>	<b>62.3</b>	<b>95.4</b>	<b>75.0</b>
4	73.2	93.3	45.5	4	50.9	97.9	81.2
5	53.7	96.8	56.4	5	31.1	98.7	84.6
6	26.8	99.4	78.6	6	12.3	99.8	92.9

\* Because the PPV varies with the prevalence of depression, the PPV will be higher in settings with a higher prevalence of depression and lower in settings with a lower prevalence.

1. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. *Medical Care* 2003, (41) 1284-1294.

**NORTHEAST REGION**  
**2011 MIGRANT HEALTH PROFILE**



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## EXECUTIVE SUMMARY

This report provides an assessment of the demographic, ethnographic, migratory, work, health, and health care service use patterns of migrant and seasonal farmworkers in the states of the Northeast Region: Maine, Massachusetts, Connecticut, New York, New Jersey, and Pennsylvania. As requested by the Bureau of Primary Health Care's Office of Special Populations Health, the Migrant Health Profile is the first coordinated region-wide assessment to be done, covering the 30 states and seven regions served by the HRSA-funded Regional Migrant Health Coordinators based in areas of the country where seasonal hired farm labor is employed in production agriculture. The information and statistical data is drawn from sources ranging from Migrant Health, Community Health Center, and Primary Care Association staff, to State and Federal agencies, to farmworker advocacy and service organizations. The ultimate purpose of the Profile is to give a current account of the health status and access to health care services of the migrant and seasonal farmworker population, and the conditions and context in which they live and work. It is intended that the information thus gleaned will serve as a basis for future program planning and development, at the regional and national levels, and will provide a common ground for the efforts of Regional Coordinators and their colleagues in State Primary Care Associations and in the Bureau of Primary Health Care.

The importance of providing a *current* assessment of conditions, needs, resources, and available services for migrant and seasonal farmworkers cannot be overstated. As this report illustrates, the number of variables at play in the lives of agricultural workers—seasonal employment, mobility, lack of legal status, immigration policy, immigration politics, to name a few—means that instability and unpredictability are givens. So too with production agriculture, dependent as it is on weather, water supply, pest and microbial infestations, local, national, and global economies and market conditions, production costs, government policies, government subsidies, regulatory oversight, etc. Thus, a study of agricultural production and farm labor in any given season or year can at best be little more than a snapshot of conditions rarely if ever to be repeated. For that reason, regular assessments of farmworker health needs, use patterns, and resources, such as this Regional Migrant Health Coordinator Profile, should be seen as a basic tool in HRSA's continuing efforts to improve the planning and implementation of health care programs for this very vulnerable, hard to reach, yet essential workforce.

## Introduction

Agricultural production has long been important to the lives and livelihoods of the people and the economies of the U.S. Northeast. Since the late 19<sup>th</sup> century, when migratory farm workers began to replace family and locally hired help at harvest time, farms in the states of Maine, Massachusetts, Connecticut, New York, New Jersey, and Pennsylvania have made use of various cohorts of seasonal workers, including Native Americans, unemployed coal miners and displaced sharecroppers during the Depression, high school students, and Jamaican and Bahamian workers and prisoners of war during WW II. When the war ended, African Americans from the South became the major source of the Region's migratory labor, and the six states served as the northern terminus of what came to be called the East Coast Migratory Stream. Originating in Florida, the East Coast Stream eventually brought workers north each spring after seasonal labor in the Sunshine State's rapidly expanding fruit and vegetable industries, following the harvests as they occurred in the states east of the Appalachians until finally reaching the Northeast in the summer and fall, before returning home to start the cycle again.<sup>1</sup>

With the replacement of African Americans by Mexicans, other Latinos, and workers from the Caribbean over the past thirty years, the Stream no longer serves as the principle conduit of migrants to the Northeast. And while, for reasons to be addressed later in this report, the numbers of workers who harvest the region's crops cannot be definitively stated, the numbers of dollars their labor produces for the six states' economies are carefully and regularly tabulated. The Economic Research Service of the U.S. Department of Agriculture reports that in 2009, the total value of receipts for all agricultural commodities in the Northeast Region was more than 11 billion dollars, half of which came from livestock, and half from crops. This represented 4% of the cash value of agricultural production in the U.S. in 2009, with net farm income of over 2 billion dollars representing 3.5% of the U.S. total.<sup>2</sup>

When the first Migrant Health Act funding was allocated by Congress and distributed by the Public Health Service in 1963 and for several years after, much of it went to local and county health department programs. In 1970, new program guidelines allowed for the funding of migrant projects that used the Neighborhood (later Community) Health Center model of comprehensive primary care and consumer involvement in program governance.<sup>3</sup> The current Migrant Health providers in the Northeast Region—Maine Migrant Health, Connecticut River Valley Farmworker Health, Oak Orchard Community Health, Finger Lakes Community Health, Hudson River HealthCare, Southern Jersey Family Medical Centers, CompleteCare Health Network, and Keystone Health—are all descendents of those projects, and all are FQHC 330g funded programs.

## Agricultural Commodities in the Northeast Region

The farms of the Northeast Region are relatively small in size, ranging from an average of 193 acres in New York to 71 acres in New Jersey, for a regional average of 87 acres. Most of the crop production requiring hand labor has traditionally been fresh market and processed fruits and vegetables, but in recent years nursery and greenhouse revenues have outstripped every commodity except dairy.<sup>4</sup> And even though the highest value receipts from the Northeast's top five agricultural commodities, as shown in Table I, are for livestock and their products (milk, eggs, aquaculture, etc.), fruit and vegetable crops, including apples, peaches, cranberries, grapes, blueberries, sweet corn, cabbage, mushrooms, onions, and potatoes, continue to be important produce for the domestic market and for export.

**Table I**

### **Estimated Revenue, Top Five Agricultural Commodities, Northeast Region**

<b>State</b>	<b>Value of Receipts</b>	<b>Percent of Total Farm Receipts</b>	<b>Percent of U.S. Value</b>	<b>Number of Farms</b>
<b>Maine</b>	396,954,000	68.7%	10.2%	8100
<b>Massachusetts</b>	324,644,000	67.5%	28.6%	7700
<b>Connecticut</b>	395,313,000	73.9%	6.2%	4900
<b>New York</b>	2,654,778,000	72.4%	21.4%	36,000
<b>New Jersey</b>	579,263,000	57.9%	29.1%	10,300
<b>Pennsylvania</b>	3,075,806,000	63.8%	13.9%	63,200
<i>USDA Census of Agriculture, 2009</i>				

While the total value of agricultural production in the Northeast states in 2009 (\$11.25 billion) was almost evenly divided between crop and livestock commodities, the only livestock operations that employ large numbers of workers drawn from the same demographic as those who qualify for federally-funded health care services, are dairy and poultry. Qualified or not, these workers have many of the same living and working conditions, poor wages, morbidity rates, and barriers to care as those who harvest the field, orchard, and other crops and commodities that make them eligible for coverage under the Migrant Health Act.<sup>5</sup>

**Table II**

### **Top Five Agricultural Commodities Requiring Intensive Hand Labor**

<b>State</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Maine</b>	Potatoes	Dairy	Greenhse/Nursery	Blueberries	Apples
<b>Massachusetts</b>	Greenhse/Nursery	Cranberries	Dairy	Apples	Sweet Corn
<b>Connecticut</b>	Greenhse/Nursery	Dairy	Tobacco	Sweet Corn	Apples
<b>New York</b>	Dairy	Greenhse/Nursery	Apples	Potatoes	Cabbage
<b>New Jersey</b>	Greenhse/Nursery	Blueberries	Tomatoes	Peaches	Green Peppers
<b>Pennsylvania</b>	Dairy	Mushrooms	Greenhse/Nursery	Apples	Peaches
<i>USDA Census of Agriculture, 2009</i>					

## MSFW Demographics in the Northeast Region

Since the *Atlas of State Profiles* was published by the Migrant Health Branch of the Public Health Service in 1990<sup>6</sup>, there have been ongoing attempts to count farmworkers—ongoing in part because of the constantly changing dynamics of agricultural production, the transience of migrant workers, and the endless dangers, threats, and uncertainties that must be negotiated by those who do seasonal agricultural labor. All of which is to say that, just how many migrant and seasonal farmworkers there are in the Northeast Region, as in the United States as a whole, is a vexed question. Especially with the change of the MSFW population from largely African American and H2A Jamaican workers in the Northeast to largely undocumented Mexicans, efforts at enumerating the seasonal farmworker population have been exercises in what the Undercount Behavioral Research Group of the Bureau of the Census has called “counting the uncountable.”<sup>7</sup> The most recent effort to make a dependably accurate, state by state estimate of the current (2011) farmworker population has come from the National Center for Farmworker Health (NCFH).<sup>8</sup> The NCFH estimate is offered as a “threshold estimate only,” with further research required on a county by county basis, and a number of variables needing to be considered, to arrive at a “validated and complete estimate...which could increase the total estimate of potential migratory and seasonal worker users in the state.” Until then, for the purposes of this report, we will use the NCFH numbers estimate for the Northeast Region.

**Table III**

### **Estimated Number of Farmworkers and Their Families in the Northeast Region**

#### **Horticulture**

State	Workers			Dependents		Total/Horticulture
	Migrant	Seasonal	Total	Children	Spouse	
<b>Maine</b>	4233	8056	12,289	5876	3977	22,142
<b>Massachusetts</b>	3909	7440	11,349	5428	3673	20,450
<b>Connecticut</b>	3858	7343	11,201	5357	3625	20,183
<b>New York</b>	14,070	26,778	40,848	19,534	13,220	73,602
<b>New Jersey</b>	8180	15,569	23,749	11,357	7686	42,792
<b>Pennsylvania</b>	13,112	24,955	38,067	18,204	12,320	68,591
<b>Total</b>	47,362	90,141	137,503	65,756	44,501	244,760

(NCFH, 2011)

The operational definition of “migrant and seasonal agricultural worker” accepted by HRSA for use in enumeration studies has expressly excluded those working with livestock, poultry, and in fisheries.<sup>9</sup> However, as noted earlier, people employed in those farming operations, especially dairy and poultry, are increasingly drawn from the same population as those deemed qualified for services funded by Migrant Health monies, with the same marginalization and the same need for remediation that was the original purpose of the Migrant Health Act. In any case, the NCFH estimate includes livestock workers (Table IV, below). This is particularly relevant to agricultural production in the Northeast, where *fifteen* of the twenty-five “top agricultural commodities” from the Region’s five states are livestock products (including aquaculture, which did not exist as an industrial scale in this country when the Migrant Health Act became law almost fifty years ago).

**Table IV**

**Estimated Number of Farmworkers and Their Families in the Northeast Region**

**Livestock**

State	Workers	Dependents		Total Livestock	Total, Hort/Livestock
		Children	Spouse		
<b>Maine</b>	2409	1156	771	4336	26,478
<b>Massachusetts</b>	2892	1388	925	5205	25,655
<b>Connecticut</b>	2682	1287	858	4827	25,010
<b>New York</b>	21,792	10460	6973	39225	112,827
<b>New Jersey</b>	1728	829	553	3110	45,902
<b>Pennsylvania</b>	25,654	12,314	8209	46,177	114,768
<b>Estimated Total, Horticulture and Livestock, Northeast Region, 2011</b>					<b>350,640</b>

*(NCFH, 2011)*

The growing season in the Northeast states, as it affects the movement of workers through the region, is a function of both the major crops/or commodities produced, and the weather. This means that the season proper begins when the ground can be worked, and ends when the last crop, usually apples, is harvested. For the Region as a whole, the growing season is seven to eight months, and the peak season for farmworkers, about six months.

**Table V**

**Northeast Region Peak Season Migration Flow**

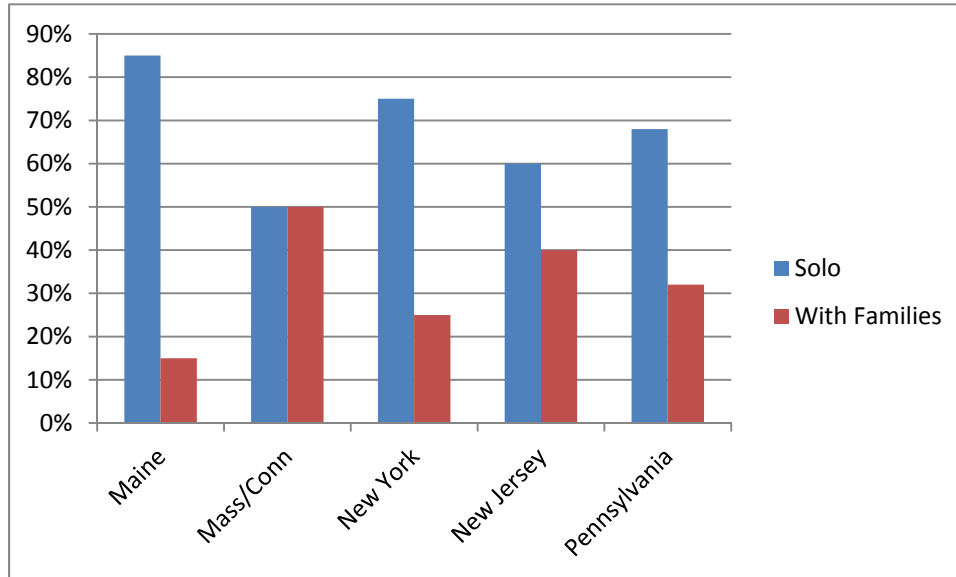
State	Peak Months	Traveling From	Traveling To
<b>Maine</b>	May thru September	Florida, Texas, California, New York, Maine, Canada	New York, Florida, home base
<b>Mass/Conn</b>	May thru September	Mexico, Jamaica, Puerto Rico	Mexico, Jamaica, Puerto Rico
<b>New York</b>	April thru October	Mexico, Jamaica, Haiti, Guatemala, Honduras, Texas, Florida	Maine, Connecticut, Texas, Mexico, Florida, Jamaica
<b>New Jersey</b>	May thru September	Florida, North Carolina, Texas, Mexico	Florida, North Carolina, New Orleans, Mexico
<b>Pennsylvania</b>	May thru October	Florida, Texas, Georgia, New Jersey	Florida, Texas, Georgia, New York, Connecticut, Virginia

*(RMHC Population Assessment, 2011)*

As indicated in Table VI, the incidence of migrant farmworkers traveling alone or with family members varies from state to state in the Northeast Region, averaging close to 70% solo and 30% with families. “Family” can mean nuclear or extended, relatives farther removed—uncles and aunts, cousins, nieces, nephews—or friends.

**Table VI**

**Proportion of Northeast Farmworkers Traveling Solo & with Families**



*(RMHC Population Assessment, 2011)*

Men, women, teenagers, and children work in production agriculture. Currently, the vast majority of farmworkers are young men (two-thirds younger than 35), a trend that has intensified in recent years.<sup>10</sup> Another trend has been the decline in the number of women to about 20% of the total nationally,<sup>11</sup> but the percentage is higher in the Northeast, as will be noted in Table VII. While some families continue to migrate together, a growing number of younger workers travel independently.

**Table VII**

**Farmworker Gender and Age Percentage Estimates, Northeast Region**

State	Male	Female	Children (0-12)	Adolescents 13-18
<b>Maine</b>	78%	22%	4%	4%
<b>Massachusetts</b>	80%	20%	5%	6%
<b>Connecticut</b>	80%	20%	5%	6%
<b>New York</b>	73%	27%	6%	4%
<b>New Jersey</b>	70%	30%	8%	6%
<b>Pennsylvania</b>	65%	35%	11%	2%
<i>Region's Summary</i>	74%	26%	7%	5%

*(RMHC Population Assessment, 2011)*

Obviously, where there are women and children, there will be an array of needs very different from those of most “single” males in terms of housing, health care, educational services, childcare, and so forth. Fortunately, the Northeast Region has well-established Migrant Head Start and Migrant Education programs, and Table IX shows the enrollment in each State. Nationally, about 7% of farmworkers are between the ages of 14 and 17 years, and as many as half this number is de-facto emancipated minors.<sup>12</sup> According to Migrant Education staff in New York, many of their students fit this especially vulnerable profile: adolescent boys, living on their own or with acquaintances or distant relatives, and doing full-time farm work<sup>13</sup>.

**Table IX**

**Children Enrolled in Migrant Head Start & Migrant Education Programs, 2010**

State	Ages 0 to 5 Migrant Head Start	Ages 3 to 21 Migrant Education	Total Enrolled Migrant Head Start, Migrant Ed	Total Migrant Users Served Ages 0 to 21
Maine	0	322	322	181
Massachusetts	131	403	534	251
Connecticut	N/A	N/A	N/A	N/A
New York	615	5364	5979	3819
New Jersey	191	1864	2055	3614
Pennsylvania	426	5076	5502	409
<b>Totals 2010</b>	1363	13,029	14392	8274

*(MSHS, 2011; USDOE ME, 2011)*

**Ethnicity**

Since 1989, when 40% of hired crop farmworkers were born in the United States or Puerto Rico,<sup>14</sup> there has been a dramatic shift in the countries of origin. Now, close to 75% of the national farmworker population was born in Mexico, and that figure is even higher in the Northeast, with a regional average of 79%. This has had many ramifications, not least of which is the predominance of Spanish as the mother tongue of a majority of the workers—in the case of the Eastern Stream, it is the primary language of 64% of farmworkers, with 58% speaking little or no English. More recently, as a result of the push effects of the increasingly depressed economy of rural Mexico, the numbers of indigenous migrants from the south of the country have tripled, accounting for 19% of the farmworkers in the Eastern Stream regions. In addition to bringing with them a unique set of cultural values and traditions, they may also come speaking Mixteco, Triqui, Zapoteco, or one of the many other indigenous languages from the newer sending regions of Mexico. While all of the Northeast Region farmworker health programs are replete with Spanish-speaking staff, the indigenous tongues are from completely different language families. Though some indigenous are bilingual (i.e. Nahuatl/Spanish), some have little or no Spanish, posing yet another language barrier that Migrant Health staff must address in doing outreach and providing care.<sup>15</sup>

In any case, the ethnic mix of the current farmworker population in the Northeast Region is dominated by Latinos, mostly from Mexico, as shown in Table X. And, as has been historically the case, it is made up almost entirely of people of color who are poor, marginalized, and/or displaced. A new development, occurring over the past ten years, is the fact that farmworkers are being drawn from even more vulnerable populations than previously, into a U.S. economy that is in a long-term recession with high levels of unemployment, and a toxic, anti-immigrant political environment.

**Table X****Ethnicity of Farmworkers in the Northeast Region**

State	Latino/Hispanic Mexican, and also Puerto Rican, Central American, Mexican-American	Jamaican	African American, Haitian	Other: American Indian Mexico Indigenous White Anglo, etc.
Maine	64%	0%	22%	14%
Massachusetts Connecticut	78%	13%	1%	8%
New York	80%	12%	5%	3%
New Jersey	85%	0%	10%	5%
Pennsylvania	83%	8%	7%	2%
Region Summary	79%	7%	9%	5%

*(RMHC Population Assessment, 2011; UDS, 2010)***Income and Poverty Levels**

Over the past decade, with the American economy increasingly in free-fall, the indices of farmworker poverty have grown worse, their unemployment doubling between 2007 and 2010 to 17.7%. During this same period, co-residency with other unemployed people rose from 2.7 to 4.5<sup>16</sup>. The farmworker average hourly wage rate in the Eastern Stream, according to the NAWS in 2007, was \$7.98 (see Table XL, below), with 33 weeks spent in farmwork and two weeks doing other work. The Farm Labor Survey (FLS) of the National Agricultural Statistics Service (NASS) in 2010 gave the wage rate as \$10.22, “about the same as maids and housekeepers.” Whatever the real rate at any given point in time, very few of the farmworker users in the Northeast Region in 2010 had earnings at or above the federal poverty level and fewer had health insurance. The NAWS found that “too expensive” was cited as the overwhelming barrier to accessing health care for farmworkers, even for the small number with insurance.<sup>17</sup>

**Table XI****Farmworker Income and Poverty Levels**

State	U.S.DOL Farmworker Hourly Wage	NAWS Farmworker Avg. Weeks Worked	NAWS Farmworker Average Wage	NCFH Average Annual Income	NAWS Average Annual Income
Maine	\$8.15/hr.	Eastern Stream  33 Farm 2 Other 35 Total	Eastern Stream  \$7.98/hr per hour	National  <u>Individual</u> \$10,000 to \$12,499  <u>Household</u> \$15,000 to \$17,499	Eastern Stream  <u>Individual</u> <\$20,000 65% >\$20,000 21%  <u>Household</u> <\$20,000 53% >\$20,000 32%
Massachusetts	\$8.51/hr.				
Connecticut	\$8.60/hr.				
New York	\$7.59/hr.				
New Jersey	\$8.03/hr.				
Pennsylvania	\$8.01/hr.				

*(UDS 2010, NAWS 2009, NCFH 2009, ERS 2010, USDOL)*

It should also be said that the federal poverty level measures poverty by a standard developed in the 1960's using data from the 1950's that indicated families spent about one-third of their income on food, and multiplying food costs times three. Since then, the figure has been updated annually for inflation but the methodology has otherwise remained unchanged. While the official measure has long been derided as having no real-world relationship to the experience of economic deprivation, it still determines the guidelines that govern qualification for safety-net programs.<sup>18</sup> In the case of farmworkers, the principal function of the official poverty status of the majority would be to enable them to qualify for Medicaid and food stamps if they have working papers, and to make use of the sliding scale fees of Migrant and Community Health Centers if they do not.

### Off-Season Employment

The impact of the recent US financial crisis and the so-called jobless recovery has had a variety of consequences for both migrant and settled-out undocumented farmworkers. There have been reports in some places of persons returning to farmwork after having lost preferable jobs, and reports elsewhere that such a shift had not occurred as anticipated since many people are simply no longer willing to do such hard and low-paying work. Whereas only ten years ago many workers had been able to stop migrating to other states, possibly settle out, and otherwise get by during the off-season by finding construction jobs and other work, the multiple effects of the 9/11 attacks and the melt-down of the American economy—widespread anti-immigrant bias, political and media fear-mongering as regards undocumented immigrants, the militarization of the US/Mexico border, round-ups of suspected undocumented workers by the Department of Homeland Security's Immigration and Customs Enforcement (ICE) agents, and by State and local police, and a shrunken job market, even for low wage work—has resulted both in farmworkers returning to Mexico and remaining there rather than resuming migration, and in workers from Mexico remaining in the United States, in part because crossing the border (in either direction) has become even more expensive and dangerous. So, the off-season employment reported by Northeast Region farmworker health programs reported in Table XII, is more a record of work that has been done pre-financial crisis and 9/11 attacks, than a current accounting of workers' employment during the off-season.

**Table XII**

#### **Northeast Region Farmworkers' Principle Off-Season Employment**

<b>State</b>	1	2	3	4	5
<b>Maine</b>	Fisheries	Seasonal craft work (wreaths etc.)	Packing houses	Landscaping	
<b>Mass/Conn</b>	Most migrate	Day labor	Construction	Landscaping	Service industry
<b>New York</b>	Day labor	Construction	Packing houses	Dairy	Factory
<b>New Jersey</b>	Packing houses	Day labor	Construction	Landscaping	
<b>Pennsylvania</b>	Packing houses	Meat packing, poultry work	Construction	Domestic labor	Orchard pruning

*(RMHC Population Assessment, 2011)*

## Migrant Health in the Northeast Region

Of the eight Migrant Health providers in the Northeast Region, two (Maine Migrant Health, Connecticut River Valley Farmworker Health in Massachusetts and Connecticut) are Voucher programs, two (Finger Lakes Community Health and Hudson River HealthCare in New York) are combined M/CHC and Voucher programs, three (Oak Orchard Community Health in New York, Southern Jersey Family Medical Centers and CompleteCare Health Network in New Jersey) are M/CHCs, and one (Keystone Health in Pennsylvania) is a statewide M/CHC Migrant Health provider. The number of farmworkers and family members seen by these providers in 2010, 34,192, is approximately 14% of the 244,760 workers and dependents estimated by NCFH to be in the Northeast Region (see Table III). Interestingly, when farmworkers in the 15 northernmost Eastern Stream states were asked in the most recent NAWS interviews “Where did you go for U.S. health care in the last two years?” only 3% said “Migrant Health Clinic.” 3% is also the national figure for “Migrant Health Clinic” visits, and 48% had *no* U.S. provider visit, a reminder that, while the penetration rate of the Northeast Region farmworker health programs is far higher than either the Eastern Stream or National averages, there is still much to be done in terms of reaching out and bringing farmworkers in to the culturally competent, patient-centered health care that our programs provide.

**Table XIII**

### **Farmworker and Family FQHC Users in the Northeast Region**

<b>State</b>	<b>MSFWs Served by 330g MHCs</b>	<b>MSFWs Served by 330 CHCs</b>	<b>Total MSFWs Served</b>	<b>Total FQHC Patients Served</b>
<b>Maine</b>	1209	551	1760	175,180
<b>Massachusetts</b>	1600	802	2402	588,064
<b>Connecticut</b>	0	1309	1309	298,268
<b>New York</b>	16,863	783	17,546	1,417,414
<b>New Jersey</b>	12,923	956	13,879	432,328
<b>Pennsylvania</b>	2755	679	3456	617,646
<b>TOTAL, 2010</b>	<b>35,350</b>	<b>5080</b>	<b>40,430</b>	<b>3,528,900</b>

(UDS, 2010)

**Table XIV**

**Migrant Health Users and Encounters in the Northeast Region**

<b>Migrant Health Provider</b>	<b>Total Patients Served</b>	<b>Total Encounters</b>
Maine Migrant Health	1209	4288
Connecticut River Valley Farmworker Health	1600	4611
Oak Orchard Community Health	1312	4947
Finger Lakes Community Health	8149	30,292
Hudson River HealthCare	7402	23,800
Southern Jersey Family Medical Centers	5665	14,331
CompleteCare Health Network	7258	21,337
Keystone Migrant Health	2755	4254
<b>Totals 2010</b>	<b>35,350</b>	<b>107,860</b>

*(UDS, 2010)*

**Most Frequent Diagnoses and Barriers to Care**

The poverty, lack of employment benefits and legal protections, poor living and working conditions, and the egregiously high morbidity and mortality rates of migrant farmworkers after WW II led to the advocacy that culminated in the signing into law of the Migrant Health Act in 1962.<sup>19</sup> In the almost 50 years since then, much has changed, yet much, alas, has remained the same. For the purposes of this report, it is enough to say that farmworkers continue to experience the health consequences of poverty, base living conditions, migrancy, and the language, cultural, and numerous other barriers to accessing health care. As for working conditions, agriculture is one of the most hazardous occupations in the United States. Farm labor is intense, and especially during harvest, requires working long hours in all weather conditions, including extreme heat, cold, rain, and bright sun. It also means doing stoop labor, working with soil and/or heavy machinery, climbing, and carrying heavy loads.

The health problems of farmworkers in the Northeast Region are exactly what one would expect of people doing such work, in such conditions, and in such a problematic context: musculo-skeletal complaints, occupational injuries, contact dermatitis, allergies, to name some of the most benign complaints treated. Two of the diagnostic categories, mental health problems and late entry to pre-natal care, are worth commenting upon. Farmworkers, especially those who migrate, have always faced numerous sources of stress, which has only increased exponentially over the past decade as discussed earlier. Fortunately, during this same period there has been an increased focus by BPHC on the integration of behavioral health services with primary care, and this is reflected in the staffing and program offerings of the Region's farmworker health providers.

*Late entry into pregnancy* reminds us again that there are women and children living the farmworker life, with 26% of the Region population being female, and 12% ranging in age from newborn to 18 (see Table VII). Women and children, in addition to being vulnerable to many of the same ills as men, face their own unique health hazards. Farmworker women “do nearly every kind of farm labor on every kind of farm.”<sup>20</sup> In addition to routinely earning less money than men for doing the same work, many face sexual harassment and the threat of rape at work, and domestic violence at home. ( Farmworker Justice, Inc.) And whether they work in the fields or at home, farmworker women, most of them of childbearing age, have reproductive health issues that demand attention. Children, because of the agricultural exemption of the Fair Labor Standards Act, are allowed to do certain kinds of hired farm labor as young as 12 years of age. They are particularly vulnerable to respiratory and communicable diseases, and children who have been exposed to pesticides have been shown to be at higher relative risks than adults for developing many cancers. If they do not receive dental care, children are at increased risk of developing severe periodontal disease as adults.<sup>21</sup>

**Table XV**

**Farmworker Health Most Frequent Diagnoses, Northeast Region, 2011**

<b>STATE</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Maine</b>	Hypertension	Diabetes II	Back Pain	GERD/Reflux	URI
<b>Massachusetts Connecticut</b>	Dental Problems	Occupational Injuries	Diabetes	Hypertension	Depression
<b>New York</b>	Diabetes	Hypertension	Mental Health Problems	Dental Problems	Occupational Injuries
<b>New Jersey</b>	Hypertension	Mental Health Problems	Diabetes	Late Entry to Prenatal Care	Dental Problems
<b>Pennsylvania</b>	Musculo-skeletal Complaints	Non-Specific Abdominal Complaints	Dental Problems	Contact Dermatitis	Depression

*(RMHC Population Assessment, 2011)*

**Farmworker and Provider Barriers to Care**

The Regional Coordinators’ population assessment asked farmworker health providers to choose from a list and rank in order of importance “the main barriers to accessing healthcare” for the farmworkers they serve. Providers were also asked to choose and rank “the main issues affecting the provision of healthcare to farmworkers”—in other words, barriers to care from the providers’ perspective. One respondent commented on the interconnection of the various barriers, saying “The economy is affecting State policies, reducing care/resources for the uninsured. National politics influences immigration issues.” Another said, “Farmworkers are here to make money and don’t get sick days, so they only come in if there is an emergency. That’s why I put Finances #1.”

**Table XVI**

**Barriers to Accessing and Providing Care**

<b>State</b>	<b>Barriers to Accessing Care</b>	<b>Barriers to Providing Care</b>
<b>Maine</b>	Fear, Finances, Transportation, HRSA Policies	Immigration Issues, Economy, State Politics
<b>Massachusetts Connecticut</b>	Transportation, Fear, Language, Finances	Economy, Immigration, State/National Politics
<b>New York</b>	Fear, Transportation, Finances, Language	Immigration, Economy, National Politics
<b>New Jersey</b>	Transportation, Finances, Fear	Economy, National Politics, Immigration
<b>Pennsylvania</b>	Fear, Finances, Transportation, Lack of Knowledge	Immigration, Economy, State Politics, National Politics, HRSA definition of “farmworker”

*(RMHC Population Assessment, 2011)*

Most of the items on these two lists are representative of the forces bearing down on farmworkers at this point in time, not only in terms of accessing and being provided healthcare services, but also in terms of being allowed the freedom to do anything in the U.S. that is not subject to threat and sanction, including the work of growing, harvesting, and processing the American food supply. Although HRSA and Health Centers’ policies were cited in the assessment, they were given relatively low rankings as problematic. In any case, where policies support the mission, history, and best practices of the Migrant Health movement, they serve to overcome the barriers to care that are built and maintained by ignorance and fear.

**Technical Assistance and Training Needs**

The farmworker health programs of the Northeast Region are all long-time Migrant Health movement participants. Leaders in each state are movement veterans, and active ones at that. And what is true of the providers is true of the PCA’s, as far as the knowledge of and sensitivity to Migrant Health issues are concerned. There is much experience, accomplishment, and a high level of professionalism in the M/CHC’s and Migrant Health programs of the Northeast Region. Where technical assistance and training needs are concerned, they are knowledgeable about resources and how to access them, whether offered by HRSA, PCA’s, or other TA/Training providers. In particular, because of their active involvement with the larger farmworker health community, they cite the Farmworker Health Network organizations and the Northeast Coordinator as their most regularly accessed resources in the Regional Coordinators’ Population Assessment.

**Table XVII**

**Principle TA and Training Needs, Northeast Region**

<b>STATE</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Maine</b>	Governance	Customer Service	FW ID and Eligibility	Health Literacy	Migrant Health 101
<b>Massachusetts Connecticut</b>	Outreach	FW ID and Eligibility	Clinical Issues	Governance	Cultural Competence
<b>New York</b>	Health Literacy	Customer Service	Clinical Issues	Cultural Competence	Governance
<b>New Jersey</b>	Health Literacy	FW ID and Eligibility	Clinical Issues	Cultural Competence	Customer Service
<b>Pennsylvania</b>	Clinical Issues	Electronic Medical Records	Transportation	FW ID and Eligibility	Health Literacy

*(RMHC Population Assessment)*

**HRSA-Supported Training and Technical Assistance for M/CHCs**

This is not to say that there is no need for TA and training in the Northeast Region, as indicated in Table XVII, only to highlight the fact that Region’s providers of health care services to migrant and seasonal farmworkers have made the best uses possible of the abundance of technical support and assistance funded through HRSA (Table XIII). However, when MSFWs are present and the work is under way, providing outreach, case finding and case management, direct care, referral and support services, often over great distances and at all hours, Migrant Health programs and staff are often stretched thin. All the more reason to emphasize that technical support is critical, planning for it is essential, and the role played by the Farmworker Health Network organizations and the Regional Migrant Health Coordinators (see Table XVIII) in providing that support is vital.

## Table XVIII

### HRSA-Supported Training and Technical Assistance for M/CHCs

Training/TA Provider	Relevant TA Expertise	Telephone	Website/E-Mail
<b>Regional Migrant Health Coordinator</b>			
James O'Barr Hudson River HealthCare Peekskill, NY	Program planning and development, Migrant Health 101, cultural competency, Board training, outreach, etc.	(914) 744-8615 (914) 584-2822 cell	<a href="mailto:jobarr@hrhcare.org">jobarr@hrhcare.org</a>
<b>Primary Care Associations</b>			
Maine PCA	Board governance, outreach, integration of Behavioral Health	(207) 621-0677	<a href="http://www.mainechc.org">www.mainechc.org</a>
Massachusetts League of CHC's	Health Information Technology (HIT), Quality Improvement	(617) 426-2225	<a href="http://www.massleague.org">www.massleague.org</a>
Community Health Care Association of New York State	Clinical QI, grants TA, HIT, workforce development	(212) 279-9686	<a href="http://www.chcanys.org">www.chcanys.org</a>
New Jersey Primary Care Association	Data Management and County Profiles, Rural Health, Community Outreach	(609) 689-9930	<a href="http://www.njpca.org">www.njpca.org</a>
PA Association of Community Health Centers	Partnering and Networking in Rural Health, QI, HIT	(717) 761-6443	<a href="http://www.pachc.com">www.pachc.com</a>
<b>Farmworker Health Network</b>			
Farmworker Justice	Occupational and environmental health, health care access, HIV/AIDS, etc.	(202) 293-5427	<a href="http://www.farmworkerjustice.org">www.farmworkerjustice.org</a>
Health Outreach Partners	Outreach and enabling services, program planning and development, cultural competency, etc.	(510) 268-0091	<a href="http://www.outreach-partners.org">www.outreach-partners.org</a>
Migrant Clinicians Network	Clinic systems, protocols, and procedures, clinical education, program development and evaluation, etc.	(512) 327-2017	<a href="http://www.migrantclinician.org">www.migrantclinician.org</a>
Migrant Health Promotion	Promotora and Camp Health Aide programs	(956) 968-3600	<a href="http://www.migranthealth.org">www.migranthealth.org</a>
National Association of Community Health Centers	HRSA program and funding initiatives, M/CHC governance, HIT, finance, workforce	(301) 347-0400	<a href="http://www.nachc.com">www.nachc.com</a>
National Center for Farmworker Health	Capacity building, health education materials, health promotion programs, leveraging of resources , etc.	(512) 312-2700	<a href="http://www.ncfh.org">www.ncfh.org</a>

### New Access Points

Migrant Health funding was awarded to two Northeast Region applicants in 2011: Finger Lakes Community Health, to serve farmworkers and the communities of Central New York's Seneca and Schuyler Counties, and Zufall Health Center in Dover, northwestern New Jersey. The Northeast MHC works closely with Finger Lakes M/CHC, and has been invited to do a presentation on Migrant Health to the Zufall Board of Directors.

## Limitations of Available Data

It is a curiosity that while there are reams of statistics, whole libraries of books, and warehouses full of studies, reports, and documentary films about farmworkers in the United States, there is to this day no certainty about the numbers of people who do the work, only estimates, usually given with a large margin of error (i.e. “between three and five million,” “over three million”). So too the morbidity and mortality data, which is used with more confidence as an advocacy tool than as a public health metric. This is not for want of trying. The Atlas of State Profiles was an ambitious effort to count workers and families by the Migrant Health Branch in the late 1980’s, followed in the 1990’s and 2000’s by Dr. Alice Larsen’s pioneering enumeration studies. In the early 1990’s the Census Bureau tried its hand, commissioning both a study on the “Causes of the Undercount of Farmworkers in the Northeastern United States in the 1990 Census and Strategies to Increase Coverage for Census 2000,” and an alternative enumeration project entitled, appropriately enough, “Counting the Uncountable,” under the auspices of the Bureau’s Undercount Behavioral Research Group. Apparently none of this worked, because, as reported in February of 2010, “Officials from the U.S. Census Bureau gathered to hear from community advocates in Sacramento on January 19, in an effort to improve their outreach to migrant and seasonal farm workers in California, as they prepare for the 2010 decennial census. The Bureau hopes to avoid a repeat of what some here describe as a “mega undercount” of farm workers in 2000, the last time the census was conducted.”<sup>22</sup> There are many reasons offered for the failure to accurately count, and account for, the people who grow, harvest, and process America’s food: their mobility, their ethnicity and home country (Mexico), their lack of work authorization, their poverty, their desire not to be counted, the desire of their employers not to have them counted, immigration politics and policy, the failure to properly identify them when they register for health care at a Community Health Center, their reluctance to identify themselves to anyone, etc. etc. etc. All of the above is undoubtedly true, and each reason proffered undoubtedly represents a piece of the puzzle. But there is perhaps a larger truth, one that was sketched briefly in the in the Executive Summary, which has to do with the American system of industrial agricultural production and it’s many variables, including one not mentioned: the use of a low wage, relatively invisible and disposable labor supply.

Does this mean that farmworkers will never be truly countable? Obviously efforts continue to be exerted (see Census Bureau, above, and NAWS, etc.), not least of which is the enumeration work that has been going on at the National Center for Farmworker Health for a number of years, and made use of in this report. Whether or not the NCFH methodology, still only an estimate, will succeed in “counting the uncountable,” is not clear. But perhaps, in its decision to support ongoing current assessments of the farmworker population like this one, done by the Regional Coordinators in collaboration with those who outreach to and serve farmworkers and their families, HRSA will tangentially be bringing more light to the shadow world where the people who produce our food live.

## Conclusions

As noted earlier, the information and statistics in this Migrant Health Profile, drawn from sources extending from the present moment to various times over the past two decades, presents an imperfect picture of farmworker numbers, demographics, health issues, access to health care, and the system of production agriculture in which they work. While imperfect, given the number of variables operating at any given time for both workers and their employers, it must be considered “good enough” for its intended purpose, or at least a good enough start to the longer term project of refining the Profile and perfecting the information and data to the degree possible. The intended purpose, “to have an accessible general picture about the needs and resources by region....for future program planning and development,” allowing for better coordination in the Regional Migrant Health Coordinators’ work with State Primary Care Associations and with BPHC, speaks to what seems to be another step forward in the 50-year march of the Migrant Health movement. The only thing missing in that statement is the recognition that any picture of agricultural production and of the workforce as it is currently configured can only be temporary, and tenuous, and must be regularly refined and redrawn, if program planning and development are to be freshly informed and fully effective.

One phenomenon that was remarked upon by several Migrant program people in the course of the survey was the dramatic increase in the numbers of Latinos (Mexican, Guatemalan) who are employed in the dairy industry. There are also large numbers of Latinos working with poultry and eggs. While these farmworkers do not qualify for healthcare under the Migrant Health Act definition as currently interpreted, they present with most if not all of the same barriers to care and need for services rendered with linguistic and cultural competence. Many of the social service and health care organizations in the Northeast Region have been trying to address the unmet needs of this population, and Migrant Health providers feel they have the means and the tools to do so, but not the authorization.

The fact that this seems to matter as much as it does to Migrant Health providers speaks more to their quality of caring than any amount of charts and numbers can reveal. The Migrant and Community Health Centers and Voucher Programs of the Northeast Region are all exemplary in their professionalism, their use of best practices and their willingness to innovate, and above all, in their deep commitment to the health and well-being of farmworkers and the communities they serve. That’s the good news of this report. The not-good news, to borrow the words of Dr. Martin Luther King, Jr., is that the long arc of farmworkers’ history in the U.S., at least in the present moment, is not bending irrevocably towards justice, nor do the statistics point to a better, healthier life for them. Some of the reasons—the economy, immigration policy, for example— are hopefully passing phenomena. But some things, like the model of industrial agriculture that predominates, impoverishing both farmworkers and small farmers, and the racism that continues to bedevil American culture, show no sign of being willingly laid to rest any time soon.

In his testimony before the House Immigration Subcommittee on September 24, 2010, after he’d spent a day harvesting sweet corn in New York’s Hudson Valley, Stephen Colbert, of TV’s *Colbert Report*, said the following: “It seems like the least powerful people in the United States are migrant workers, who come here to do our work, but don’t have any rights as a result. And yet, we still invite them to come here, and at the same time, ask them to leave. That’s an interesting

contradiction to me. And, you know, ‘Whatsoever you do for the least of my brothers...’ And these seem to be the least of our brothers right now...migrant workers suffer, and have no rights.” With all due respect to Mr. Colbert, migrant and seasonal farmworkers do have at least one right, and that is the right to a medical home, and to receive culturally competent health care provided by the Migrant and Community Health Centers and Voucher Programs of the Northeast Region, and throughout the country.

## Recommendations

The primary recommendation of this report is that the support for Migrant Health by HRSA—for providers, the organizations of the Farmworker Health Network/National Cooperative Agreements, the Regional Migrant Health Coordinators, and not least, for the BPHC Office of Special Populations Health—will continue and grow in this difficult time. Beyond that, the following recommendations are based on both the twenty-two years of experience of the Northeast Regional Coordinator, and the Profile findings reported here:

- With only 15% of the estimated population of horticultural workers and family members in the Northeast Region currently being served by the Migrant and Community Health Centers and Voucher Programs, support for outreach, promoter/promoter programs, training for Health Center staff in identifying farmworkers and family members who qualify for care, and for the efforts of the Farmworker Health Network agencies to provide technical assistance and training in identifying, reaching out to, and serving MSFW’s is essential.
- The Migrant Health Act definition of qualifying hired farm labor, interpreted for the most part to mean crop agriculture, continues to be problematic for many farmworker health providers, both within the Northeast Region and beyond. HRSA has made some efforts to address this long-standing issue, and it is important that direction on treating the question of definition be clearly communicated.
- To bring a greater focus on farmworker health issues to HRSA site visits, Regional Coordinators should be invited to participate in visits to organizations receiving 330g funding, and should be the recommended contact person for any necessary programmatic technical assistance.
- RFP’s for the funding of farmworker health programs and services should require collaboration with and necessary technical support from Regional Coordinators. In addition, grant notification letters should remind funding recipients to avail themselves of assistance from Coordinators.
- HRSA should require training in “Migrant Health 101” and best practices for Project Officers and staff with oversight of Migrant Health Centers and Voucher Programs.
- Collaboration and communication between the various federally funded programs serving farmworkers (Migrant Health, Migrant Education, Migrant Head Start, etc.) should be encouraged, facilitated, and supported by HRSA.

- Oral health and mental health services for farmworkers should have a high priority.
- Farmworkers should have continuing education regarding their right of access to care at FQHC's regardless of immigration status and ability to pay, both at health centers and clinics, and especially by way of outreach workers and promotoras/promoters.
- The Migrant Health Profiles should be revised on an annual or bi-annual basis by the Regional Coordinators, so that the assessment of the population dynamics, living and working conditions, and of morbidity statistics and health care services use patterns of migrant and seasonal farmworkers and their families can remain current and functional for effective program planning and development.
- To ensure that all of the states with significant farmworker populations have a Regional Migrant Health Coordinator to serve as a resource person for program support and technical assistance and training, and as a field link to the Office of Special Populations Health, Midwest Regional Coordinator positions should be funded by HRSA.

## Acknowledgements

The Northeast Region 2011 Migrant Health Profile was made possible by the collaboration of numerous individuals, agencies, and organizations both near and far that serve and support migrant and seasonal farmworkers and their families. Foremost among these are the Migrant and Community Health Centers and Voucher Programs of the Northeast states, whose staff not only completed the Regional Migrant Health Coordinators Population Assessment, but provided documentation and answered numerous questions seeking details and clarifications.

Information and statistical data for the Profile were obtained from, among others, the following sources: Northeast Region PCA's; Farmworker Health Network member organizations (especially the National Center for Farmworker Health); local, State, and national farmworker service organizations (e.g. Migrant Head Start, Migrant Education, State Monitor Advocates), State and Federal Departments of Labor; State Departments of Health and Offices of Rural Health; and the Inventory of Farmworker Issues and Protections in the United States. Data sets consulted included those of the Uniform Data System (UDS), the U.S. Department of Agriculture's Economic Research Service and Census of Agriculture, State Departments of Agriculture, the U.S. Department of Labor's National Agricultural Workers Survey (USDOL NAWS); USDOL State Occupation Profiles, and the RMHC Population Assessment.

Finally, this Regional Migrant Health Profile could not have been done without the impetus, encouragement, and support of colleagues at the BPHC's Office of Special Populations Health, the National Center for Farmworker Health, and the Regional Coordinators throughout the country. While the Profile was done by the HRSA-funded Migrant Health Coordinator for the Northeast Region, its contents are solely the responsibility of the author, and do not necessarily represent the official views of the Health Resources Services Administration.

## Notes

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STATE	NAME
1. Has there been an increase or decrease in the number of farmworkers in your area? What percent?	
2. What, if any, demographic changes are taking place in the farmworker population in your area?	
3. Has there been, or do you anticipate, a change in the number of H2A workers in your state?	
4. What industries, other than agriculture, do farmworkers in your area work in during the "off season"?	
5. What, if any, changes have you seen in the migration patterns of farmworkers in your area?	
6. How have new state immigration laws impacted the farmworker population in your area?	
7. What are your organization's most critical migrant health training needs?	
8. Are there any other recent trends or issues that are impacting farmworks in your area?	

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What are your organization's most critical migrant health training needs?	
Are there any other recent trends or issues that are impacting farmworks in your area?	



Submission date: \_\_\_ / \_\_\_ / \_\_\_

<b>Health Center/Agency Information</b>	
Contact Name: _____	Title: _____
Health Center/Agency _____	
Mailing Address: _____	
Phone / Fax: _____	E-mail: _____
Number of Service Sites: _____	Number of Employees: _____
Agency Type: <input type="checkbox"/> Migrant Health Center <input type="checkbox"/> Community/Migrant Health Center <input type="checkbox"/> Voucher Program	
<input type="checkbox"/> Other, please indicate: _____	

This application has two categories:  
 1) *Training Description/ Needs/Requests*  
 2) *Technical Assistance/Consultation Needs*  
**Please fill in the Category of greatest need.** NCFH will determine which services will be offered free or discounted.

**CATEGORY 1 - Training Description/Needs/Requests** *(All trainings can be tailored to fit organizational needs.)*  
**Please choose 3 training priorities and rank in order from 1 to 3, where 1 is highest priority and 3 being the least.**

- |   |  |
|---|--|
| <p><input type="checkbox"/> <u>Back to the Basics: Migrant Health 101</u></p> <ul style="list-style-type: none"> <li>Back to the Basics provides participants with an in-depth orientation to migrant health that includes farmworker history and demographics. This training also serves as a refresher training for health center staff.</li> </ul> <p><input type="checkbox"/> <u>Farmworker Eligibility &amp; Verification</u></p> <ul style="list-style-type: none"> <li>In this training, session participants will discuss the importance of determining eligibility, the skills and the tools needed to properly identify migrant health patients and a mechanism for documenting and reporting the status of their farmworker users.</li> </ul> <p><input type="checkbox"/> <u>Customer Service and Hospitality</u></p> <ul style="list-style-type: none"> <li>This training helps participants to define an environment of service and to create an organizational vision. In addition, this training provides a review of customer service standards, basic communication skills, handling difficult situations, and creating the WOW factor within the health center.</li> </ul> <p><input type="checkbox"/> <u>Cultural Competency Skills Building</u></p> <ul style="list-style-type: none"> <li>This training provides participants with the practical skills to incorporate cultural competency practices within the health center. Participants will also identify cultural competency basics required to effectively practice the "culturally and linguistically appropriate services" (CLAS) standards.</li> </ul> | <p><input type="checkbox"/> <u>Governing Board Leadership Training</u></p> <ul style="list-style-type: none"> <li>This training provides participants with a thorough overview of the roles and responsibilities of board members. Additionally, the training outlines the requirements and expectations for Migrant Health Centers set forth by the Bureau of Primary Health Care.</li> </ul> <p><input type="checkbox"/> <u>Strategic Planning</u> <i>(does not qualify as a free service)</i></p> <ul style="list-style-type: none"> <li>This facilitative session instructs participants in the development of an organizational strategic plan. NCFH uses the Leadership Effectiveness and New Strategies method (LENS) to guide the health center through the strategic planning process.</li> </ul> <p><input type="checkbox"/> <u>Communication Skills</u></p> <ul style="list-style-type: none"> <li>Participants in this training will focus on the methods to build optimal skills in internal and external communication. Participants will leave with tools that can be implemented throughout the organization.</li> </ul> <p><input type="checkbox"/> <u>Health Literacy</u></p> <ul style="list-style-type: none"> <li>This training provides health center staff with an overview of key health literacy issues in the U.S. and the health implications of low literacy. In addition, key risk factors for low literacy are discussed and potential solutions are provided. Materials can also be assessed during training for literacy appropriateness.</li> </ul> |
|---|--|

Situational Leadership®: Team Training for Effective Supervision, Delegation and Program Management

- Situational Leadership is an organizational training method that provides your leadership staff with effective and appropriate delegation skills. In addition, leaders are trained to identify the readiness of the staff and adjust leadership styles to improve productivity.

Group Facilitation Skills: Conducting Effective and Productive Meetings

- This training aims to help your management team acquire skills and tools to facilitate small groups, conduct effective meetings, create action plans, and implement actions to obtain long-term results.

Promotor/es Program Development  
(check the following areas):

- Breast and Cervical Cancer Program Development
- Hombres Preparados: HIV/AIDS Program Development
- Healthy Smiles: Oral Health Program Development
- Comprehensive Cancer
- Arthritis

Other (please indicate)

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**Training Delivery:**

- On-site training                       Regional training                       Virtual (Webinar or Video Conference)

**Length of time you are willing to commit to this training request:**

- On-site:**    ½ day                                       1 day                                       2 days  
**Virtual:**    1 hour                                       1.5 hours                                       2 hours

**Desired Month/Date** \_\_\_\_\_ **Approximate Number of Participants** \_\_\_\_\_

**CATEGORY 2 - Technical Assistance/Consultation Requests**

(Note: Technical assistance can be provided virtually via webinar or video conference as well as on-site.)

**Please choose 3 priorities and rank in order from 1 to 3, where 1 is highest priority and 3 being the least.**

- Translation of Health Education material
  - Development of Culturally and Linguistically Appropriate Educational Materials
  - TA on Grant Writing Application Process
  - Preparing for Your Next NAP Application Process
    - Documentation of Needs for Assistance Worksheet
    - Development of Health Care Plan
    - Development of Business Plan
  - Program Development/Improvement to Enhance Services to Farmworkers, eg. Patient flow, billing and collections, eligibility, etc.
  - Service Area Farmworker Population Estimation
  - Health Center Policy & Procedure Development
  - Other TA (please indicate)
-

Please describe your **immediate need** (priority #1 as indicated in Category 1 or 2) for training or technical assistance: \_\_\_\_\_

- Why a priority? \_\_\_\_\_
- Concerns/issues? \_\_\_\_\_

What other trainings have you received on this topic in the past? *Please describe.*

What outcomes would you like to achieve as a result of having received this training or technical assistance service? \_\_\_\_\_

***Please submit completed application by mail, email or fax to:***

Alicia Gonzales  
NCFH, Inc.  
1770 FM 967  
Buda, Texas 78610  
Phone (512)312-2700 ext. 5469 / Fax (512)312-2600  
gonzales@ncfh.org



# Massachusetts League of Community Health Centers



Date	Comment	Location
Jan. 17, 2012	<b>CRVFHP Update Meeting: 10-11:45 am</b> Advisory Board mtg: 12-2pm	Caring HC, Springfield, MA
Feb. 15, 2012	Uniform Data System (UDS) Initial Submission Deadline	--
Feb. 17, 2012	RFP Released – 3 weeks to complete; MCR to be started shortly	--
<b>Feb. 21, 2012</b>	<b>CRVFHP Update / RFP Conference Call: 10am-12pm</b>	<b>Conference call</b>
Mar. 9, 2012	RFP Due	--
<b>Mar. 20, 2012</b>	<b>CRVFHP Update Meeting: 10am-12pm</b>	<b>TBD</b>
Mar. 21-25, 2012	NACHC Policy & Issues Forum	Washington, DC
Mar. 30, 2012	UDS Final Submission Deadline; RFP Awards Announced	--
<b>Apr. 17, 2012</b>	<b>CRVFHP Update Meeting: 9:30am-1:30pm</b> Advisory Board mtg: 12-2pm – TO BE RESCHEDULED	<b>Caring HC, Springfield, MA</b>
May 9-11, 2012	MA League of CHCs Community Health Institute; National Farmworker Health Conference	Hyannis, MA Denver, CO
<b>May 15, 2012</b>	<b>CRVFHP MSFW Eligibility Training: 10-11am</b> <b>CRVFHP Update Meeting: 11am-12pm</b>	<b>TBD</b>
<b>June 19, 2012</b> <i>[tentative date]</i>	<b>CRVFHP Update Meeting: 11:45am-12:45pm</b> - to correlate with UConn Symposium from 8:30am-2:30pm	<b>UConn Medical School, Farmington, CT</b>
<b>July 17, 2012</b>	<b>CRVFHP Update Meeting: 10-11:45 am</b> Advisory Board mtg: 12-2pm	<b>Caring HC, Springfield, MA</b>
<b>Aug. 21, 2012</b>	<b>CRVFHP Update Meeting: 10am-12pm</b>	<b>TBD</b>
Sept. 7-11, 2012	NACHC Community Health Institute & Expo	Orlando, FL
<b>Sept. 18, 2012</b>	<b>CRVFHP Update Meeting: 10am-12pm</b>	<b>TBD</b>
<b>Oct. 16, 2012</b>	<b>CRVFHP Update Meeting: 10-11:45 am</b> Advisory Board mtg: 12-2pm	<b>Caring HC, Springfield, MA</b>
<b>Oct 16, 2012</b> <i>[tentative date]</i>	<b>CRVFHP Farmworker Focus Group</b>	<b>TBD</b>
Oct., 18-20, 2012 <i>[tentative date]</i>	East Coast Migrant Stream Forum	TBD
Oct., 25-26, 2012 <i>[tentative date]</i>	New England Rural Health RoundTable Symposium	TBD
<b>Nov. 20, 2012</b>	<b>CRVFHP Update Meeting: 10am-12pm</b>	<b>TBD</b>
<b>Dec. 18, 2012</b>	<b>CRVFHP Update Meeting: 10am-12pm</b>	<b>East Hartford CHC, East Hartford CT</b>
2013 CRVFHP Monthly Meetings: TO BE DETERMINED		

Also, check [www.massleague.org](http://www.massleague.org) and Click on 'Calendar of Events' for any changes to meeting schedule.