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Review of State Policies for Delivering Health Care Services to Migrant Farmworkers

A Review of State Policies for Delivering Health Care Services to Migrant Farmworkers

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Jeffrey Alwang
Department of Agricultural Economics
Virginia Tech

Introduction

State governments face a number of issues in the provision of health services to migrant agricultural workers. Among these are: who will provide the services, the source of funds for reimbursement, and how to coordinate service delivery and funding sources. The funds for migrant health care come from four sources: national systems, insurance, state appropriations, and private groups. Service coordination is necessary mainly because the national system funds come in different forms from different sources.

Agricultural producers are generally exempt from any obligation to provide health insurance or health services to their workers, and migrant workers and their products move from state to state. Because of this, the federal government has maintained lead responsibility for providing for the health needs of migrants. This support comes in two broad forms: public health insurance, and national systems support.

Citizens of the U.S. may be eligible for certain services under Medicaid. Migrant citizens usually meet income guidelines needed for Medicaid eligibility. Some states are involved in an effort to coordinate reciprocal arrangements for Medicaid eligibility and reimbursement, so that payment for services can be more equitably spread among states where migrant workers are employed (see the discussion of individual state actions, especially Virginia).

National systems support for migrant health services comes through section 329 and 330 of the Public Health Service Act which provides block grants for migrant (MHCs) and community (CHCs) health centers, respectively. The Act is administered by the Bureau of Health Care Delivery and Assistance (BHCDA) of the U.S. Department of Health and Human

Services. **MHCs** and **CHCs** provide services that augment medicaid reimbursable services. In addition, the centers can provide services for non-citizens who meet certain guidelines. Both sections of the Public Health Service Act are designed to provide a broad range of services to migrants. The centers encourage migrants to apply for Medicaid, WIC, and other programs, and help facilitate the transfer of health records.

The **Migrant Health Program** funds the 389 **MHCs** found in 34 states and Puerto Rico. These **MHCs**, their locations and the services they provide are cataloged in The 1990 Migrant Health Centers Referral Directory.

State Health Departments often receive federal funds to provide support to the **MHCs** and **CHCs** for delivery of services. This support comes in the form of Cooperative Agreements with BHCDA and provides funds for things such as physician or provider recruitment, transportation services and other items.

As a part of the Immigration and Reform Act of 1986, **State Legalization Impact Assistance Grants (SLIAG)** are block grants to assist states in meeting the needs of newly legalized residents. **SLIAG** money is allocated according to the number of legalizations approved for state residents, and is destined for three broad areas: education, health, and welfare.

States with significant migrant populations generally have some funding for health services available to migrant workers. States with **MHCs** and **CHCs** often provide facilities and other state support for the centers. Many states administer pass-through federal dollars earmarked for indigent health care which reaches migrants, since they usually meet eligibility requirements.

Individual State Activities

In order to determine the policies of individual states in meeting migrant health needs, letters were sent to contact people in each state. Follow up letters were sent to individuals whose names and addresses were provided by respondents to the initial letters when necessary. A list of respondents is provided at the end of this section.

The letters asked for information on state assistance for health services for migrant workers. First, the existence of line-item state funds for migrant health care was determined. Then questions about state policies specifically designed for migrant workers were asked. Next, information about state financial or other support for MHCs or CHCs for migrant health care was requested. Finally, questions were asked about contracting mechanisms for the delivery of services to migrants.

Forty out of fifty states responded. The following sections summarize the results on a state-by-state basis.

State policies tend to augment federal programs, and vary widely. Support ranges from none, or complete reliance on the existing indigent delivery system, to coordinated auxilliary services for migrant workers. States with significant migrant populations tend to be more active in providing support for the medical needs of migrants. These states also frequently form cross-agency coordinating committees. These coordinating committees are needed since migrant funds come from different federal and private sources and are handled in the states by different agencies.

Innovative mechanisms for service delivery to migrant workers exist. Some state (eg., North Dakota, Virginia) do not have MHCs and contract with MHCs in neighboring states to

provide services to migrants. Other states (Pennsylvania, Kansas, etc.) contract with **MHCs** to provide services for which the entire indigent population is eligible. This contracting helps ensure delivery to the migrant portion of the targeted population.

Colorado

About 43,000 migrant and seasonal farmworkers live or work in Colorado. These workers' health care needs are largely met by the state's four **MHCs**. One of these, the **Colorado Migrant Health Program (CMHP)**, operates as a section of the Colorado Department of Health. **CMHP** services some 6,000 medical users and 3,000 dental users. The state provides office space for the **CMHP.**

State support for migrants includes the **Medically Indigent Program(MIP)**, which provides outpatient services for migrant farmworkers who are U.S. citizens or legal residents. The **MIP** (also called the **Colorado Residence Discount Program**) reimburses 23-30% of inpatient costs and is designed to pick up after Medicaid benefits have been exhausted. These benefits are available to all indigent residents; no special programs for migrants exist. Inpatient services for non-citizens may be funded through **SLIAG** grant funds.

Florida

Because such a large number of migrant farmworkers live and/or work in Florida, health care for them has been a major concern of the state government. The most recent estimate states that there are nearly 270,000 migrant farmworkers and their families traveling to and around Florida.

There are 12 **MHCs** in Florida, which received approximately $7 million in 1987-88. In 1986, these clinics served a combined total of 279,000 patients. The Florida legislature passed the **Health Care Access Act** in 1984, and $30 million has been appropriated to counties to defray parts of the cost of establishing and providing care for low-income persons. This legislation has been extended under an indigent health care law to establish primary care facilities in most counties. Migrants are eligible, in general, to use the services of these facilities.

The Governor's **Advisory Council on Farmworker Affairs** examines issues related to migrant labor and makes recommendations to the governor for improvements. In 1989, the **Health Care Subcommittee** addressed issues such as pesticide exposure, nursing shortages, shortages of funding for community health centers, and access to normal low income services. Specific concerns include: 1) the need to coordinate service better to reach migrants; 2) more basic health education programs; 3) better identification by health personnel of pesticide poisoning symptoms; 4) more extended outreach to the migrant population; 5) reimbursement for hospitals providing services for migrants.

Hospital cost reimbursements were studied by the State of Florida's **Health Care Cost Containment Board**, which issued its final report in February 1989. It estimated that in 1987, approximately $59.5 million in gross unreimbursed hospital charges were registered by migrants. The Board made recommendations on funding these services including: 1) improved documentation on use of services by migrants; 2) increased state funding for hospital reimbursement; 3) strengthening existing indigent care funding; 4) exploring the feasibility of health insurance models.

Indiana

There were approximately 7,500 migrant workers in Indiana during 1990, with the largest concentration of workers in the east-central portion of the state.

The Indiana State Board of Health provided $115,435 in 1990 for migrant health and dental care. Over $67,000 was spent on the **Migrant Camp Health Aide Program** which pays for travel expenses for 16 registered nurses to make visits to migrant labor camps. In other counties, the county Boards of Health determine the type and amount of services provided. The **Migrant Dental Program** provides screenings, instruction, prophylaxis, and other basic dental care to migrant children aged 1-19. The total cost of this program in 1990 was $48,435. The Indiana Board of Health budgeted $22,000 in salaries, and the Division of Dental Health absorbed the remaining costs.

The **Task Force on Migrant Affairs** meets monthly to advise the governor, provide information, and coordinate programs. The **Task Force** includes representatives of people from various state agencies, migrant advocates, and health center organizations.

Kansas

The number of migrant workers in the state is subject to debate, but the pattern of migrant employment changed in recent years. Prior to 1984, large numbers of migrants (10,000-12,000) were employed in the Western Kansas sugar beet industry. The beet processing plants were closed in 1984, and subsequently far fewer migrants are used in the region. The health care delivery system had to be restructured to adjust for this change.

Because of the changing pattern of migrant populations, a task force was convened which developed a statewide plan for migrant health care delivery. Under the plan, the services of Migrant Education, SRS, the two **MHCs** in the state, the Hunter Health Clinic, county public health departments and Harvest America (a non-profit organization) were combined and coordinated to deliver migrant health services statewide. The consortium mentioned above applied for a $298,000 federal (329) grant which will be supplemented by $51,000 in in-state funds. The project is expected to reach 2,200 users in its first year.

Migrant Education, Harvest America, and the local health departments will certify migrants, who can then visit 6 statewide contractors or receive vouchers for additional services. A key element of the plan is to identify the number of migrants eligible for service in order to provide improve needs documentation for subsequent years.

Maryland

Migrants are used in hand labor crops in all regions of the state, with the Eastern Shore being the major agricultural area. The Department of Health and Mental Hygiene's **Migrant Health Program** coordinates delivery of health services. The central office staff works with local health departments and other service providers. The program awards supplemental grants (5 in 1989) to counties with high migrant populations. The grants are monitored by making on-site evaluation visits to local health departments, telephone contacts, and visits to the migrant labor camps by the program chief. Migrant health services in non-grant counties are also monitored.

County health departments provided services to migrants as they were needed. Services delivered include: visits to migrant camps for health and nutrition screening, immunizations, family planning, communicable disease counseling, drug and alcohol services, maternity and prenatal care.

The state provided small amounts of financial assistance to the two **MHCs** which serve Maryland migrants: the Shenandoah Community Health Center, and Delmarva Rural Ministries.

Michigan

There are an estimated 40,000-50,000 migrant workers Michigan. There are five **MHCs** which delivered health services to approximately 25,000 migrants in 1989. The Michigan Department of Public Health contributes to these centers by funding or passing through federal funding for many services delivered by these Centers, such as WIC, a Medical Screening Program for minors, and others. In addition, the Department of Public Health funds two programs directly targeted at migrants. The **Camp Health Aid Program** trains women who live in camps to serve as health resources to camp residents, and the **Migrant Health Program** funds outreach nursing services to increase immunization levels among migrant children and dental screening and preventative treatment.

There is some state support for programs targeted at migrants or for which migrants are eligible. The **Migrant Hospitalization Program** (MHP) pays for inpatient hospital services which are medically necessary. To be eligible, the migrant family must be eligible for medicaid. The **Non-resident Hospitalization Program** supports inpatient hospitalization for migrants who do not meet the requirements of the **MHP**. It is available to non-citizens and individuals who

do not have legal alien status. The Department of Social Services reimburses counties for these services.

Minnesota

In addition to programs such as WIC and Medicaid which target all residents in need, the State of Minnesota, mostly through Migrant Health Services, Inc., an **MHC**, provides some health and social services to migrant workers. The State Department of Health provides funds for hemoglobinopathy screening and a mobile health unit (funding from the State was $108,000 in 1990). The Department of Human Services helps fund a chemical dependency education program ($28,000), and the Department of Corrections provides services for battered women ($47,350). Finally, the Department of Education provides $52,000 for health screening for migrant children. In 1987, almost 9,000 migrants in Minnesota and North Dakota received health care through Migrant Health Service, Inc.

Missouri

No state funding for migrant health services. Some state agencies do pass through federal funds to provide services to migrants. This funding is processed through three non-profit groups: the **Southeast Migrant Education Program**, the **Southwest Migrant Education Program** and **Rural Missouri, Inc.** The funds are used for eye exams, glasses, and emergency medical care for migrant children. **Rural Missouri, Inc.** uses its funds for housing, transportation and emergency medical treatment for migrants.

The state has one MHC which is exclusively funded through the federal government. It provided services to approximately 1,000 migrants in 1990, all of whom were located in southeast Missouri. This MHC is attempting to coordinate migrant health care delivery, though with little active support from the state government.

Montana

Montana is typical of many states in that while there are a number of migrant workers and a federally funded health center, the state is mainly involved in administering the transfer of federal funds to the center. Thus, the state contributes very little resources for migrant health services. It is estimated that 7,000-7,500 migrants work in agriculture in the state.

The Montana Migrant Council, Inc., an MHC provides migrant health services in Montana and in 2 counties in western North Dakota. The state of Montana provides some funds to coordinate WIC, nursing, maternal and child health services for which migrants are eligible. Funds for these services, which are provided by the federal government, are distributed to the counties. The state also helps distribute vaccines for migrant children purchased with federal funds.

New York

New York has an estimated 26,500 migrant workers and dependents. In addition to the three MHCs and their satellite clinics, the New York State Department of Health (through the Maternal and Child Health Services Block Grant--MCHSBG) and the State Education Department specifically fund health care for migrants and their dependents. In 1986 the

MCHSBG provided $100,000 in grants for migrant health. The largest was $30,000 to fund nursing services at 20 day care centers. The remaining grants were allocated to 6 programs providing medical diagnosis and treatment programs, maternal and child health services, and dental services.

The Department of Education's **Tutorial Outreach Program** helps provide children of migratory workers with medical and dental health care. In addition, the Education Department funds the **Migrant Student Record Transfer Service** which provides information on education and health that is forwarded when the children move to new day care centers or public schools.

The Department of Education also contracts with the **Cornell Migrant Program (CMP)** to provide and subcontract for health care of migrant children. In 1986 **CMP** spent $64,457 for health care. **CMP** also administers a modified case-managed voucher program for school area youth not served by health centers. This is a unique program for migrant children who do not have access to doctors, health clinics or necessary health services. If personnel determine that a migrant child needs health care that is not available through any other source, that care can be provided through the voucher system.

The **Interagency Workgroup on Migrant Health Care** was convened in 1987 to address issues of health care specific to migrant farmworkers. They found that though numerous agencies and bureaus fund migrant health services, services remained largely uncoordinated; this lack of coordination tended to diminish the efficiency of the programs. The **workgroup** suggested that the Department of Health take leadership in coordinating the delivery of health care services. The **workgroup** identified transportation and mobile health teams as critical to

the needs of migrants. It suggested that budgets and evaluation forms among providers be standardized, and the existing health care network be strengthened.

The **workgroup** also suggested the creation of a statewide coordinator of migrant and farmworker health services, to foster interagency coordination. Providers of services were urged to designate a coordinator to deal with the various state and federal agencies.

North Carolina

North Carolina has three **MHCs** serving migrant workers. In addition, the **Migrant Health Program (MHP)**, run out of the North Carolina Department of Human Resources' Division of Adult Health, receives Section 329 funding. The State supplements the $750,000 in federal money for this program with $250,000 in state funds. These state funds pay for inpatient hospital services for migrants; the $750,000 in federal funds are for reimbursements for services provided by doctors. The state, recently streamlined its billing and payment programs; providers can now directly bill the **MHP** for services, whereas previously they had to get approval from local health centers. This streamlining has increased efficiency and helped centralize data collection needed for program reviews. The **MHP** also maintains contracts with county health departments to provide limited health services to migrants.

North Carolina has two committees to coordinate action on migrant health issues. The **North Carolina Farmworker Council** is a cabinet-level group of state agency designed to advise the governor on state policies. The **Farmworker Services Coordinating Committee** is an informal group of state and federal agency representatives, and farmworker and farmer advocacy groups which meets bimonthly to share information on funding and available

programs. A **Task Force on Migrant Health Services** will report in July 1991 on a state profile of migrant farmworkers and health care needs and services available to them.

The state also has a $120,000 **SLIAG** and is using some of these funds to subcontract with health centers to provide health services to aliens involved in the leagalization process.

Ohio

An estimated 8,000-11,000 migrants work in hand-labor operations, orchards, and in other specialized occupations in Ohio. The principle sources of migrant health care services in Ohio are the two **MHCs** and their corresponding satellite clinics. These centers and satellite clinics operate on a voucher nursing and medical model. Nursing visits lead to immediate treatment, the issuance of vouchers for off-site medical services, or an appointment with a clinic physician.

Though these centers are funded largely with section 329 federal dollars, the state provides some support and assistance. The state funds facility, maintenance, data collection, administration, medical director, and nursing services for many of the satellite clinics. Facilities and support for the WIC program, Medicaid invoicing, and some well-child services are also funded by the state. The Ohio Department of Health contracts with all the out-of-clinic service providers.

State level migrant policy is coordinated by the **Governor's Committee for Migrant Affairs.**

Oregon

Health services for migrants are provided through the four **MHCs** in the state. The **Ad Hoc Committee on Migrant and Seasonal Farmworkers Health Concerns**, a group of state agencies and other providers of health services to farmworkers meets monthly to discuss migrant health issues, but there are no specific state policies.

Several Divisions within the Department of Human Resources provide health services for which migrants are eligible. These services are not specifically targeted for migrant workers, but migrant residents are eligible. The Office of Alcohol and Drug Abuse Programs has SLIAG funds for alcohol treatment.

Texas

Texas is a state with a large migrant population, which is evidenced by the 14 **MHCs** in the state. Despite this, there are no line item programs in the state budget strictly for migrant workers. To avoid political opposition, migrant advocates have wrapped migrants up in the whole issue of rural and indigent health care.

State support for the 329 centers has come mostly through the **Primary Health Care Act.** In addition, the **Maternal Infant Health Improvement Act** provides state support.

Virginia

Estimates of migrant workers and their dependents in Virginia range from 8,000 to 19,000. Migrants work in vegetable crops on the Eastern Shore, tobacco and vegetables in Southside, and in fruit orchards in the Shenendoah Valley.

There are two **MHCs** and one **CHC** providing medical services to migrant workers. The state provides a $250,000 line item specifically for migrant care which goes to a hospital on the Eastern Shore as reimbursement for services provided to migrants. Two coordinating councils in the state government exist: the **Interagency Migrant Policy Committee**, and the **Migrant and Seasonal Farmworkers Board.**

The state is involved in an effort among states along the east coast migrant stream to coordinate reciprocal arrangements for medicaid reimbursement and eligibility.

Washington

Washington has five **MHCs** providing health services to migrant workers. All of these are jointly funded **CHCs** and receive Section 330 dollars. Several other **CHCs** in the state provide health services to migrants. The state supports the services these clinics provide in a number of ways. First, the Department of Health provides **Primary Health Care Program (PHCP)** grants to these centers to assist and enhance the delivery of prescribed services. **PHCP** grants allow some Health Centers to provide dental services oriented toward Spanish-speaking individuals. Mental health services are also provided in two of the Health Centers. The mental health program began in 1986 and it is expected that funding will continue into the future.

The State Office of Parent Child Health Services (PCHS) funds maternity services for migrant women. These funds are provided as grants to the **MHCs** which provide prenatal and delivery services. This program began in 1989 and is currently (1990-91 biennium) funded at $700,000 annually. The **Migrant Education Program** provides health insurance for children enrolled in school and finances health care for these students. Women who fall within 185%

of the official poverty level are eligible for special maternity care assistance through the **State First Steps** program. These services include pre- and post-natal care and other support services. The program extends Medicaid eligibility and, though not entirely geared toward serving migrants, includes a large number of migrant participants.

There is no specific state agency designated to coordinate migrant health policy, but a number of agencies and committees are actively involved in migrant affairs.

Other States

State	Comments
Alaska	No policies exist.
Arizona	No line item state programs. The two **MHCs** received money from the Arizona Department of Health Services to provide dental care to migrant children. This funding ended in 1991, and the clinics now receive no support from the state. The state has begun to coordinate the delivery of health services to migrants by forming a **Migrant Coordinating Council** comprised of the two **MHCs**, social service agencies, growers, and some state agencies.
Connecticut	Few migrants in state. No state policies exist. The New England Farmworker Council (see Massachusetts) has a satellite clinic in Hartford.
Delaware	No line-items specifically for migrant services. A multi-agency group review problems and refers them to the proper state agency. Migrants are served through the one **MHC**, various **CHCs**, and State Service Centers.
Georgia	No specific programs for migrants. The Georgia **MHC** received in 1990 $377,000 in federal and $25,000 in state funds for services to an estimated 1,350 participants. The Primary Health Care Section of the Division of Public Health administers the grant.
Hawaii	No policies exist.

Idaho	State has two **MHCs**. The state provides no assistance to these clinics, nor are there state line item programs to provide health services to migrants. Some private organizations improve health delivery to migrants. The **Idaho Migrant Council** has health funds for emergency care, and also provide transportation services. **Western Idaho Community Action** operates headstart programs and has some funds for physical and dental care. Some local schools coordinate dental screening as part of their migrant education program. Finally, the **Southwest Idaho Dental Project** provides dental screenings for migrants.
Kentucky	Few migrants in State. Numbers may be growing, so there is increasing interest. No identifiable programs. No **MHCs** exist.
Louisiana	Only 2,475 migrants estimated in state. No programs or policies directed at migrants. No **MHCs** exist.
Massachusetts	No state program for migrant workers. The New England Farmworkers Council, an **MHC**, has its main office in Springfield, Ma. This center has satellite clinics around New England.
Nebraska	The Nebraska Migrant Health Project, an **MHC**, facilitates access to medical care on a fee-for-service basis through contracts with providers. There are no state policies/programs specifically for migrants in the state. There are approximately 4,000-5,000 migrants and 1,000 seasonal workers in Nebraska agriculture.
New Hampshire	No state programs exist. New England Farmworkers Council (see Massachusetts) has a satellite clinic in Manchester.
New Jersey	No programs. Two **MHCs** are found in southern New Jersey, serving approximately 4,000 users. These **MHCs** provide support for three additional satellite clinics. Migrants also have access to normal low income programs (WIC, etc.)
Nevada	No programs. No federally funded clinics exist.
North Dakota	No programs. Approximately 1,500-2,000 migrants work in sugar beet industry in western North Dakota. No **MHCs** exist. The state contracts with providers in Minnesota and Montana. In 1990, the North Dakota Department of Education provided $15,000 dollars for health screening of migrant children by the Migrant Health Service, Inc. in Minnesota.

Oklahoma

The State Department of Health formerly received a federal Migrant Health grant. This grant was discontinued in 1990, and the Migrant Health Program was discontinued. Migrants are eligible for services from county health departments. No specific state support for migrant health services exist.

Pennsylvania

No specific state programs. Pennsylvania Rural Opportunities (PARO), an **MHC**, provides health services through its numerous satellite clinics. PARO contracts with various state agencies to deliver specific services to migrants. Generally this money is part of a state-wide thrust (such as AIDS education), with PARO providing access to the migrant community.

Rhode Island

Fewer than 20 migrants. No **MHCs** exist, but the New England Farmworkers Council (see Massachusetts) has a satellite clinic in Pawtucket.

South Carolina

No line item state programs exist. The state provides personnel support for an **MHC**. This center, the South Carolina Migrant Health Project, received in 1989 an $85,000 grant from the federal government, and supported services for 1,100 users and 2,600 encounters.

South Dakota

Few migrant workers. No policies. No **MHCs** exist.

Tennessee

Tennessee has two **MHCs**. In addition, several **CHCs** also provide significant health services to migrants (eg., **Rural Community Health Services, Inc.** a **CHC** provided health services to 1100 migrants in 1990). There are no state programs designated strictly for migrant workers, though the state agencies work closely with the **MHCs** and **CHCs** to ensure that state services are made available to migrant workers. There is a state **Interagency Networking Committee**, made up of state agencies and migrant advocates that addresses local migrant needs.

Utah

One **MHC** exists. There are no state line-items. The Health Department has a cooperative agreement with BHCDA to provide some support for the 329/330 Centers. Health service delivery to migrants is coordinated by the **Migrant Farmworkers Coordinating Council**. The Council is developing a strategic plan for health service delivery to migrant and seasonal farmworkers.

Vermont

No programs. No **MHCs** exist.

Wisconsin

One **MHC** exists. Migrants are eligible for health care services funded by the State **Maternal and Child Health Block Grants**, but no state programs specifically targeted for migrant health care exist.

Wyoming	No specific programs. Two MHCs with associated satellite clinics are found in the state.

Resources

The 1990 Migrant Health Centers Referral Directory

This directory contains a list of nationwide migrant health facilities and a brief overview of the types of services each facility provides. The facilities listed are funded by the Migrant Health Program of the U.S. Department of Health and Human Services. In addition to the facilities, complete with maps and locations of satellite clinics, the directory contains: names, addresses, and phone numbers of federal and regional Migrant Health Program officials, of Migrant Health Program grantees, of state and regional primary care associations, state health departments, members of the National Advisory Council on Migrant Health, and members of the National Association of Community Health Centers' Migrant Health Subcommittee.

Respondents

Arizona
Blane Bandi
Executive Director
Clinica Adelante, Inc.
12217 Grand Avenue
P. O. Box 760
El Mirage, AZ 85335

Colorado
Bart Givens
Community Health Division
Colorado Department of Health
4210 East 11th
Denver, CO 80220

Delaware
Amos Burke, Director
Bureau of Health Planning
Delaware Health & Social Services
Jesse S. Cooper Building
Federal Street
Dover, DE 19903

Florida
Phil F. Williams
Legislative Analyst
The Florida Senate
Committee on Health Care
402 Senate Office Building
Tallahassee, FL 32399-1100

Georgia
Brook Dixon, Director
Migrant Health Program
Primary Health Care Section
878 Peachtree St., N.E.
Atlanta, GA 30309

Idaho
Royalynn Case
Executive Director
Valley Family Health Care
1441 N.E. 10th Avenue
Payette, ID 83661

Indiana
Sue Percifield
Chief Nurse Consultant
Division of Local Support Services
Indiana State Board of Health
1330 West Michigan Street
P. O. Box 1964
Indianapolis, IN 46206-1964

Iowa
Lloyd Doane
Iowa Department of Public Health
Lucas State Office Building
Des Moines, IA 50319-0075

Kansas
Garth Hulse
Office of Local & Rural Health Systems
Dept. of Health & Environment
Division of Health
Landon State Office Building
Topeka, KS 66612-1290

Kentucky
Don Coffey
Office of the Commissioner
Cabinet for Human Resources
Frankfort, KY 40621-0001

Louisiana

Marcia L. Daigle, Director
CA on Primary Care
1201 Capitol Access Road
P. O. Box 1349
Baton Rouge, LA 70821-1349

Maryland

Jolie H. Matthews
Department of Legislative Reference
General Assembly of Maryland
Legislative Services Building
90 State Circle
Annapolis, MD 21401-1991

Michigan

Shirley H. Harding, Consultant
Western Regional Division
Department of Public Health
3423 N. Logan/Martin L. King Blvd.
P. O. Box 30195
Lansing, MI 48909

Minnesota

Joan A. Altenbernd
Executive Director
Migrant Health Service, Inc.
Townsite Centre
810 4th Ave. S.
Moorhead, MN 56560

Missouri

Stephen Renfro, Executive Director
New Madrid County Group Practices, Inc.
409 Mott St., P. O. Box 400
New Madrid, MO 63869

Montana

Maria Stevens
Montana Migrant Council
1148 First Avenue North
Billings, MT 59101

Nebraska

David Palm
Office of Rural Health
Division of Health Policy and Planning
301 Centennial Mall South
P. O. Box 95007
Lincoln, NE 68509-5007

Nevada

Dana R. Bennet
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

New Jersey

Andrew D. Miller, Director
Local Health Development Services
Department of Health
CN 360
Trenton, NJ 08625-0360

New York

Paul G. Fitzpatrick
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

North Carolina

Susan Sparrow
North Carolina Primary Health Care Association
975 Walnut Street, Suite 355
Cary, NC 27511

North Dakota

Daron Olson
Center for Rural Health
501 Columbia Road
Grand Forks, ND 58203

Ohio

Jamie Young, Chief of Staff
Office of the Director
Ohio Department of Health
P. O. Box 118
246 N. High Street
Columbus, OH 43266-0118

Oklahoma

Mrs. Jimmie J. Ewing
Jackson County Health Department
201 South Lee
Altus, OK 73521

Oregon

Charlene E. Degener
Primary Care Coordinator
Office of Health Policy
1174 Chemeketa St., N.E.
Salem, OR 97310

Pennsylvania

Kay Brown
Pennsylvania Rural Opportunities
2331 Market Street
Camp Hill, PA 17011

Rhode Island

Sharon Cagen
Health Manpower Planner
Department of Health
Cannon Building
Three Capitol Hill
Providence, RI 02908-5097

South Carolina

Tom McGee
SC Migrant Health Project
2600 Bull Street
Columbia, SC 29201

South Dakota

Bernie Osburg
South Dakota Department of Health
Center for Health Policy & Statistics
533 East Capitol
Pierre, SD 57501

Tennessee

Rosie Maldonado-Freeman
Migrant Program Coordinator
Rural Community Health Services, Inc.
P. O. Box 99
Parrottsville, TN 37843

Texas

Jose Camancho
Texas Association of Community Health Centers
4214 Medical Parkway, Suite 201
Austin, TX 78756

Utah

Denise Basse
Rural Health Field Coordinator
Office of Local & Rural Health Systems
288 North 1460 West
P. O. Box 16700
Salt Lake City, UT 84116-0700

Vermont

Stan Lane
Health Planning Specialist
Vermont Department of Health
P. O. Box 70
Burlington, VT 05402

Virginia

Bruce Behringer, Executive Director
VA Primary Care Association, Inc.
1606 Santa Rosa Rd, Suite 254
Richmond, VA 23229

Wyoming

Paul Schueler, Deputy Administrator
Department of Health
Cheyenne, WY 82002

Washington

Scott Plack, Research Analyst
Washington State Senate
Health & Long-term Care Committee
101 John A. Cherbery Building
Olympia, WA 98504

References

Colorado Migrant Health Program, "The Colorado Migrant Health Program--1990." Mimeo, Denver, 1990.

Gibbens, Brad, "The National Rural Health Policy Network Directory." Mimeo, University of North Dakota Rural Health Research Center, 1989.

Indiana State Board of Health, "State Health Plan, 1991-1996." Mimeo, Nov. 2, 1990.

Midwest Migrant Health Information Office, "1990 Migrant Health Services Directory." Detroit, MI. National Migrant Worker Council, Inc., 1990.

National Migrant Resource Program, Inc., "1990 Migrant Health Centers Referral Directory." Austin, TX: National Migrant Resource Program, 1990.

Staff of the Florida State Committee on Governmental Operations, "A Pilot Program Addressing a Comprehensive Self-help Approach to the Needs of Low-income Farmworkers in Florida." Tallahassee, Mimeo, 1988.

State of Ohio, Migrant Agricultural Ombudsman, "Migrant Farmworkers Directory." Mimeo, Columbus, 1989.