A Plan of Action for Improving the Health of Migrant and Seasonal Farmworkers

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This report is dedicated to our friend and colleague Manny Gonzales, former Director of the Migrant Services Division, Michigan Family Independence Agency. Manny was a tireless advocate on behalf of Michigan's migrant and seasonal farmworkers. He will be missed.

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Introduction:

Migrant and seasonal farmworkers (MSFW) face considerable barriers to maintaining their health and the health of their families. Most farmworkers travel frequently and over significant distances to secure agricultural employment, creating barriers to the continuity of care and to health care access for migrant farmworkers. Due to the seasonal nature of their work, MSFWs work long hours, often starting work before dawn and ending after sunset to ensure that crops are harvested on time. In addition to their migratory life and long work hours, many MSFWs feel akin to strangers in a strange land. English is usually not their primary language. Cultural differences abound including nutritional habits, language, family structures and practices, religion, and health seeking behaviors. These factors result in significant barriers to accessing timely, high quality primary and preventive health care.

Why should we focus our efforts toward improving the health of MSFWs? While many of the parties involved in the development of this plan of action believe health care should be available to all persons regardless of their age, race, sex, income, immigration status, or occupation, there remain at least two other very pragmatic reasons:

1. Their health is our health.
   - Infectious disease rates are much higher amongst MSFWs, including a particularly high prevalence of tuberculosis.
   - Untreated illnesses typically do not remain contained within a small collective when people of the collective access many of the same resources as a larger community. For example, seasonal farmworker children share classrooms with non-MSFW children.

2. MSFWs represent a significant economic force in Michigan.
   - MSFWs harvest over 2.1 billion dollars worth of goods (MSD/FIA, 2001).
   - MSFWs are a major source of inexpensive agricultural labor.

This paper represents the work of an interagency coalition comprised of people concerned about the health of MSFWs. Our partners include:

Community Action Agency
Family Independence Agency
Family Medical Center
Health Delivery, Inc.
InterCare Community Health Network
Michigan Department of Community Health
Migrant Health Promotion
National Center for Farmworker Health
Northwest Michigan Health Services, Inc.

The following pages describe the major health issues affecting MSFWs and available resources. The interagency coalition developed a plan of action based on this information. Coalition members have committed to working together to pursue the goals identified in our plan of action.

Who are the MSFWs?

National Overview

According to the National Center for Farmworker Health (NCFH), there are approximately 3.5 million migrant and seasonal farmworkers in the United States. The Bureau of Primary Health Care Migrant Health Branch further estimates that approximately 600,000 (16% of estimated total population) migrant and seasonal farmworkers received health care services through migrant health centers nationwide (Uniform Data System, 1999).

The annual income of most farmworker families falls below 100% of the federal poverty level, and their health status is comparable to that of a third world nation's population (Dever, 1991). In addition to the health risks associated with poverty, another risk associated with farm labor is the actual process of migration. Many farmworkers must travel frequently and over significant distances to secure agricultural employment, creating barriers to the continuity of care and to accessing timely health care services.

The March 2000 National Agricultural Workers Survey (NAWS) reports that 39% of farmworkers are classified as "shuttle migrants" meaning that they travel between farms for an approximate distance of less than 75 miles, although they may reside further than 75 miles from any or several of these jobs. An additional 17% of farmworkers are classified as "follow-the-crop migrants" meaning that they hold at least two farm jobs a year which are more than 75 miles apart and require the farmworker to set up a temporary abode. Mobility leads to gaps in the MSFWs' abilities to properly access services. Farmworkers may stay in areas for periods too short to familiarize themselves with local access points for health care or social services. Occupational and environmental conditions have been a persistent problem across the country.

The Bureau of Primary Health Care uses the following Public Health Service (PHS) definitions as stated in the Health Centers Consolidation Act of 1996, Section 330(g) (Public Law 104-299-Oct. 11, 1996):

> **Migratory Agricultural Worker** is defined as, "an individual whose principle employment is in agriculture on a seasonal basis, who has been employed within the last 24 months, and who establishes for the purpose of such employment a temporary abode."
>
> **Seasonal Agricultural Worker** is defined as, "an individual whose principle employment is in agriculture on a seasonal basis, and who is not a migratory worker agricultural worker."
>
> **Agriculture** is defined as, "farming in all its branches, including: cultivation and tillage of the soil; the production, cultivation, growing and harvesting of any commodity grown on, in, or as an adjunct to the land; and any practice performed by the farmer or on a farm incident to or in conjunction with the above stated."

Michigan Profile

The majority of migrant farmworkers originate from California, Texas, Florida and Mexico. Three migration patterns have traditionally existed. The *western stream* consists of California as

the home base with migration to the northwest and western states, especially Washington, Oregon, northern California, Arizona and New Mexico. The *midwestern stream* begins with Texas as the home base and proceeds north to the central plains region. Those who travel the *eastern stream* originate in Florida and may travel north along the east coast or travel through Georgia and Alabama to northern states. Members of the policy and health care service delivery communities have noted some variations in these traditional patterns over time. Ongoing studies of migratory patterns would assist in determining whether these traditional patterns continue to accurately describe migration flow among the transient farmworker population.

Michigan is a receiving State for both the midwestern and the eastern migrant streams. In 1994, two-thirds (67%) of Michigan's migrant farmworkers were believed to have originated in Texas and the remainder from Florida, Arkansas, Georgia, Alabama, Mississippi, Louisiana and other States (Migrant Services Division/Michigan Department of Social Services, 1994). Beginning in April of every year, MSFWs leave their home base States for Michigan. Figures from the Family Independent Agency (MSD/FIA, 2001) show that 72% of MSFWs come from Texas, 24% from Florida, and 3% from elsewhere in the United States. Almost all of Michigan's MSFWs are migratory while only a little more than 800 are seasonal (MSD/FIA, 2001). About 2/3 of all MSFWs are less than 35 years of age (U.S. Department of Labor 2000). Only about 1% of MSFW households utilize disability insurance (U.S. Department of Labor, 2000).

In Michigan, the Migrant Services Program of the Family Independence Agency (FIA) defines a migrant farmworker as a person who:

- Works or seeks work in agriculture or a related seasonal industry; and
- Moves away from their usual home to a temporary residence as a condition of employment or because the distance from their usual home is greater than 50 miles.

The Michigan FIA defines a seasonal farmworker as a person who:

- Works in agriculture or a related seasonal industry; and
- Is not required to be absent overnight from their permanent place of residence.

The federal Migrant Health Branch of the Division of Primary Care Services published State of Michigan estimates of the number of migrant and seasonal farmworkers in 1990. According to this report, there were 67,227 migrant and seasonal farmworkers in Michigan. The vast majority (89%) were migrant farmworkers. However, estimates of the number of Michigan's migrant farmworkers have varied widely, ranging from 20,000 (Michigan Commission on Spanish Speaking Affairs, 1995) to 103,241 (Larson and Plascencia, 1993).

The Migrant Services Division of the Michigan Family Independence Agency (MSD/FIA) estimates that 40,000 migrant farmworkers travel to Michigan annually (MSD/FIA, 2001; Millard, Ladia, Jefferds et. al, 2001). There has been some decline in recent years in the number of Michigan's migrant and seasonal farmworkers, largely due to a decline in the number of Michigan farms. A study of employment among Michigan's farmworkers revealed that between 1982 and 1992 the number of Michigan farms declined from 58,661 to 46,562 (Rochin, Siles, 1994). In 2001, the MSD/FIA estimated that most of Michigan's migrant workers (98%) are of Mexican descent, followed by those who are white (1%) and black (1%). The average family size among Michigan's migrant workers was 3.5 persons.

The 2001 average annual income for a family of four migrant farmworkers in Michigan was $7,500 (MSD/MFIA, 2001). Between 1985 and 1994, farmworkers' real wages (i.e. inflation adjusted wages) increased from $4.66 per hour to $6.52 per hour, representing a 40% increase. As the following excerpt from a report on employment and housing indicates, most of Michigan's migrant farmworkers live in poverty:

If farmworkers were paid the average hourly wage of $6.52 . . . they could earn $261 per week or $1,044 per month. For someone working 150 days per year (8 hours a day), his or her earnings . . . would be $7,824. For a family of four, this income would fall below the poverty threshold and make them qualified for AFDC, WIC (Special Supplemental Nutrition Program for Women, Infants and Children) which is transferable across state lines, migrant education, food stamps, Earned Income Tax credits and other welfare programs (Rochin, Siles, 1994).

Primary Issues Threatening the Health of Migrant and Seasonal Farmworkers and their Families

Migrant and Seasonal Farmworkers (MSFW) face significant barriers when attempting to access preventive and primary health care services. Some of the most difficult barriers to overcome include limited proficiency in English, shortage of providers with hours that accommodate the typical MSFW workday, cultural prejudices, and payment issues. In this section, some of the most critical issues will be discussed. A number of sources contributed to this list of challenges including focus groups composed of Camp Health Aides, a series of published monographs from the National Center of Farmworker Health (NCFH), discussions by the interagency work group, and various published materials relating to MSFW health. By highlighting these issues, we hope to create awareness and a better understanding of the barriers MSFWs face. These issues are the foundation of the plan of action.

Because of the disparate and mobile nature of the population, scientific documentation of what is known anecdotally is very difficult. Even the most basic data, such as an accurate count of the population, is nearly impossible to achieve. Although anecdotal information abounds, hard data on specific health indicators is extremely limited or unavailable. Those who provide care know that the health disparities are great. The need for research into migrant health issues is evident in the dearth of literature. The lack of rigorous scientific documentation and evaluation of circumstances surrounding farmworker health have long been cited by farmworker advocates as an impediment to policy development to correct problems (Dockery, 1995).

The last published literature review of research on migrant health was published in 1990 (Rust, 1990). The studies that were cited indicated that farmworkers have the worst overall health status of any sub population in the nation in addition to facing some of the most complex and extensive barriers to accessing health care (Dever, 1991). In addition to these access barriers, migrant health centers and their service delivery sites often function in isolation from similar health delivery entities. Often, the primary care provider (PCP) that the health professionals providing care in the receiver State need to contact to provide continuity in patient care or diagnosis consultation is 2000 miles away in a home base or upstream clinic.

Access to Federal and State Programs

One of the major problems facing MSFWs today is a lack of health care insurance. Further exacerbating access to insurance is the limited awareness of and underutilization of various federal and State assistance programs that could benefit MSFWs. Although an estimated 40-60% of farmworkers are believed to be eligible for federal safety net insurance programs, such as Medicaid, Medicare, and the State Children's Health Insurance Program, less than five percent are estimated to participate in these programs (Bunnell, 2001). The annual income of most farmworker families falls below 100% of the federal poverty level (Dever, 1991). Although some MSFWs enroll in State programs such as WIC (Women Infant Child), Medicaid, and SCHIP (State Children's Health Insurance Program), they may not be able to use them once they relocate from their home States, due to the fact that such programs are not portable from State to State. Every State has a different set of eligibility criteria for Medicaid and SCHIP and due to

budget constraints and State administrative policies, most States do not cover, or have provisions for covering, qualified residents of other States. When a migrant worker comes to Michigan, they must apply for Medicaid or SCHIP offered by the State of Michigan regardless of their Medicaid status in their home-base State. "Regretfully, participation of eligible farmworkers continues to be impeded by the State-based structure of the system, by eligibility requirements which are not uniform, and by benefits which are not portable." (Losing Ground, 1995).

In designing their SCHIP programs, States had options to create a separate program, expand Medicaid or create a hybrid of the two (part separate/part Medicaid expansion). This has further compounded issues of potential reciprocity between States. The low rate of farmworker participation is attributed to health systems problems in the regulation and administration of child health insurance programs, as well as to the perceptions of issues related to Public Charge (Arendale, 2002). The Immigration and Naturalization Service (INS) defines a public charge as "an alien who has become (for deportation purposes) or is likely to become (for admission and adjustment status purposes) primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance, or institutionalization for long-term care at government expense." Despite the eligibility of many farmworkers and their dependents for coverage under the numerous Medicaid expansions, "many workers are simply not eligible for Medicaid – either because they are categorically excluded, or because they do not meet Medicaid State residency requirements" (Wright, et al., 1993).

In many States, legal immigrants are unable to receive Medicaid, SCHIP, and Food Stamps if they entered the country after August 22, 1996. Otherwise eligible persons must wait five years before they are able to receive benefits. Michigan elected to provide some coverage using State-only funds. Undocumented workers are prohibited from most services except for WIC and school lunches.

Availability of Primary Care Services

Policymakers must recognize that insurance does not equal access. If a community lacks sufficient primary care providers, mental health providers, or oral health providers, even those persons with insurance will face significant barriers to accessing timely health care. Public insurance programs can change to allow more MSFWs to maintain their coverage but there must be significant efforts to increasing the numbers of providers available and willing to serve them. In addition, to truly address the needs of MSFWs, health care providers in training must begin to be more reflective of the communities.

More than three-quarters of Michigan's counties (63 out of 83) are designated by the National Center for Health Workforce Analysis (NCHWA) as either a partial county or as a full county Medically Underserved Area/Population (MUA/P). Also 72 of 83 counties contain a Health Professional Shortage Area (HPSA) designation. NCHWA further estimates that almost a third of Michigan's population live in communities with a severe shortage of primary care physicians.

Federal law allows States the discretion to enact new State laws to provide State-only Medicaid and SCHIP services for low-income immigrants, regardless of when they arrived in the United States. Michigan is among the one-third of all States that adopted State-only coverage for Medicaid and SCHIP (called MIChild in Michigan) during the federal five-year bar period.

Michigan's "qualified" immigrants, thus, retain the right to enroll in and receive benefits from Michigan's Medicaid and MIChild programs. Texas, one of Michigan's main source States, has less liberal policies, providing State-funded prenatal care and SCHIP or Medicaid assistance to some legal immigrant children. For additional discussion of the impact of these laws on MSFWs, see California Primary Care Association, *Expanding Immigrant Access to Health Services;"* Kenesson, Mary S., *Improving Health Services Access for Medicaid-Eligible Migrant Farmworkers,* Health Policy Crossroads, prepared for the Center for Health Care Strategies, Inc., Princeton, New Jersey, September, 2000; and Rosenbaum, Sara, *Memorandum to the Migrant Work Group on Options for Expanding Publicly Financed Heath Coverage of Migrant Farmworkers and Their Families,* DRAFT, October 20, 2000.

Increased Need for Primary Care Services

A comprehensive, statewide health profile of Michigan's migrant and seasonal farmworkers has not been conducted. However, some studies on specific health issues in selected regions of Michigan are available. Additionally, some national reports have included the experiences of migrant farmworkers from the Midwestern stream, which can be used as a proxy for Michigan's experiences in the many instances where statewide data are not available.

A recent study of the nutritional patterns and needs of migrant farmworkers in Northwest Michigan found that 60% of study participants were obese and that nearly one-third of migrant men had hypertension (Kowalski, et al, 1999). Another study examined 154 medical records of patients who received services from migrant clinics located in the eastern central region of Michigan in the late 1980's. The study gathered data on clients' socio-demographic characteristics, medical histories, symptoms, diagnoses and referrals (Millard, Ladia, Jefferds, et. al, 2001). Highlights from this report include the following:

- 52% percent of patients had digestive system diseases;
- 51% suffered from respiratory system diseases;
- 40% of patients had infective and parasitic diseases present; and,
- 43% percent suffered from nervous system and sense organ disorders.

The most common referrals were for dental care (26%), radiological services (26%) and vision services (17%).

The Migrant Clinicians Network partnered with the National Migrant Resource Program (now known as the National Center for Farmworker Health (NCFH)) to commission the first and only national study of morbidity and mortality among farmworkers, *Profile of a Population with Complex Health Problems,* (Dever, 1991). This study analyzed data from nearly 7,000 medical encounters from migrant health centers in Texas, Michigan and Indiana. Highlights of health status findings include the following items.

- Migrant farmworkers suffer more frequently from infectious diseases than the general population.

- Farmworkers have more clinic visits than the population in general for diabetes, medical supervision of infants and children, pregnancy, hypertension, and contact dermatitis and eczema.
- Clinic visits for general medical exams account for only 1.4% of all visits to migrant health clinics, 39% below the national average.
- Multiple and complex health problems exist among over 40% of all farmworkers who visit migrant health clinics.
- In the 30-44 age group, two of the top three problems for both males and females are diabetes and hypertension.
- Nearly half of all clinic visits for men and women in the 45-64 age group are for diabetes, hypertension, or arthropathies.
- Among the elderly, over 60 percent of clinic visits by males and 80 percent by females are for diabetes and hypertension.

Reduced utilization of primary care services stem from a variety of factors including fear of deportation, high cost of services, lack of insurance, and confusion regarding eligibility. Focus groups conducted with Camp Health Aides in 2001 found that there is confusion regarding eligibility to programs such as Medicaid, SCHIP, and WIC amongst the MSFW community. MSFWs sometimes receive incorrect information regarding eligibility from a friend or relative. There is also a general lack of awareness of programs that will assist in covering the cost of providing health care. As a result, MSFWs sometimes do not seek preventive and primary care services.

Limited proficiency in English and cultural differences are barriers to accessing preventive and primary health care services. Health and human service agencies and organizations regularly report a severe shortage of bilingual staff. Many MSFWs believe that townspeople perceive them as asking for handouts if they receive subsidized programs and services. Some say that they fear their citizenship applications would be denied if they were found to be receiving government assistance. MSFWs also report that they regularly face impolite and unhelpful staff at some human service agencies and health care organizations.

Insufficient Outreach and Recruitment Efforts

Outreach programs are used to inform MSFWs of resources available to them and their families such as local federally qualified health centers, immunizations, prenatal care, and government assistance programs. One effective method that has improved outreach to MSFWs is the Camp Health Aide Program. Camp Health Aides are typically MSFWs who receive formal training to provide health education, advocacy and outreach to farmworker families. Camp Health Aides assist MSFWs by making appointments, completing necessary paperwork, directing them to available resources, providing first aid and health education, and translating. State funding availability limits how many Camp Health Aides are trained each year.

Camp Health Aides also work full time as farmworkers, only have a limited amount of time to serve MSFWs, and must limit the time spent on additional outreach efforts. Additional State funding is needed to significantly increase access to the Camp Health Aide program.

Michigan's FQHCs have the potential to greatly increase the amount of outreach and enrollment activities taking place today. The Michigan Primary Care Association (MPCA) has successfully negotiated with the Michigan Department of Community Health for adequate payment for Medicaid outreach and eligibility activities performed by Federally Qualified Health Centers (FQHC) and FQHC 'look-alikes.' Significant work will take place by MPCA staff to ensure that FQHCs are maximizing their abilities to outreach to special populations including MSFWs.

Children's Health

MSFW children are at risk for many types of illnesses and injuries, resulting primarily from their status as members of MSFW families. According to the Bureau of Primary Health Care (BPHC), 66% of all farmworker parents have their children with them (BPHC, 1997). These children have limited access to culturally and linguistically appropriate educational services and the developmental, health, and social services needed to achieve optimal health and well-being. Farm-related accidents and injuries among adolescent farmworkers is also a growing concern. A study comparing the health status of migrant children to non-migrant children found that migrant children had a higher proportion of acute medical conditions over a three-month period (114 per 1,000) than non-migrant children (95 per 1,000) (Ruducha, 1994). The American Academy of Pediatrics has documented that migrant children have a higher-than-average risk for respiratory and ear infections, bacterial and viral gastroenteritis, intestinal parasites, skin infections, scabies, head lice, pesticide exposure, tuberculosis, poor nutrition, anemia, short stature, undiagnosed congenital anomalies, undiagnosed delayed development, accidents, and teenage pregnancy (American Academy of Pediatrics, 1997).

A National Conference on Health Strategies for Adolescent Farmworkers was held in 1991. Adolescent farmworkers, migrant health service providers, farmworker advocates and migrant educators assessed health needs, identified barriers to addressing these needs, identified areas of greatest concern and priorities for action, and drafted recommendations to health care institutions, community-based organizations and the federal government (National Coalition of Advocates for Students, 1994). Areas of greatest concern included substance abuse, sexuality, mental health, physical health and occupational health. Youth participants indicated that illegal drugs use was a top priority concern and emphasized the easy access they have to them. Lack of sex education, teen pregnancy and double standards between teen boys and girls were also discussed. Mental health issues important to teens include stress, low self esteem, family issues, bad relationships with friends, child abuse, lack of love and assertiveness, the need to feel included in the mainstream, vulnerability, isolation and the desire to feel accepted. The top two physical health issues identified were nutrition and dental health. Child labor, field sanitation and safety and pesticides were the primary occupational health issues discussed. Researchers have found that MSFW children have an increased risk of exposure to pesticides. Listed below are some of their findings:

- 48% of children have worked in fields still wet with pesticides;
- 36% had been sprayed directly or indirectly by drift; and,
- 34% of the children's homes had been sprayed in the process of spraying nearby fields (BPHC, 1997).

There is also growing concern over the long-term affects of pesticide exposure. The Environmental Protection Agency (EPA) estimated that there are 300,000 acute illnesses attributed to pesticides.

Exposure to pesticides is only one problem facing migrant children. The American Academy of Pediatrics (AAP) conducted a study in 1997 that showed that immigrant children might harbor infectious diseases that American pediatricians may be inexperienced in diagnosing and treating. Most children born outside of the country are not necessarily screened at birth. The AAP recommends the screening for diseases such as tuberculosis should be considered in any unusual clinical presentation of a foreign-born child or a child whose family travels between the United States and their country of origin.

Immunization coverage levels have long been used as a measurement of health for a specific population. Few studies have been done on coverage levels of migrant children. Immunization assessments in Michigan show that only 50.7% of migrant two-year-old children are up-to-date for recommended vaccinations. Problems include maintaining immunization records for migrant children, inability to locate records of previous immunizations a child has had, differences in vaccines that are available in the United States and other countries, and record translation difficulties.

Migrant children also suffer from disproportionately high rates of tooth decay and permanent tooth loss and have less access to dental care than non-migrant children (Koday, 1990). Periodontal disease in children can be painful, create financial burden on families, can increase school absenteeism and cause a loss of days from work for parents (Good, 1992). A study of migrant children in northwest Michigan found that a high percentage of children have decayed teeth, a low percentage have had these teeth filled, and that neglect in oral hygiene was widespread (Woolfolk, Hamard, Bagramian; 1984). There was a large disparity in dental decay between the migrant children studied and the decay rate for all children living in the United States. The percentage of teeth with decayed surfaces among the migrant children was 65 percent compared to 17 percent for all American children. Additionally, the percentage of decayed teeth that had been filled was 29% for migrant children compared to 76% for all American school children (Woolfolk, Hamard, Bagranian; 1984).

Some of the occupational hazards children are exposed to include farm machinery, exposure to pesticides, poor field sanitation, unsafe transportation, fatigue from long periods of physically demanding work, and substandard or nonexistent housing (Wilk, 1993). The National Committee for Childhood Agricultural Injury Prevention (NCCAIP) estimates that 100,000 children suffer a preventable injury each year from working in agriculture (NCCAIP, 1996). The Committee indicates that the primary causes of fatal and nonfatal injuries to children working on farms include tractors, farm machinery, livestock, building structures and falls.

Long working hours can be fatal to children, can pose a risk to their health and safety and can interfere with school performance (Pollack et al, 1990). A survey of 614 farm owners and operators in central Washington revealed that almost all (98%) employed minors work in the fields. Of the 2,500 children they employed, 73% were younger than 16 years old and most (80%) worked a 40-hour week (Polack et al, 1990). In 2001, the American Academy of

Pediatrics (AAP) released a policy statement that calls for more probing by physicians into farm residence, the provision of more information to parents about the risks of agricultural injury and effective preventive measures, promoting better understanding of the developmental risks to children working on farms, and the need for manufacturers of farm equipment and farm chemicals to invest in research to decrease the number of agricultural injuries and poisonings.

The AAP lists several reasons why MSFW children often do not seek health care. The barriers they found include cost, language, cultural barriers, and fear of apprehension by immigration authorities. It is often up to the children to translate health information which they do not fully understand to their parents. Another complicating factor for providing care to immigrant families is the possibility that different family members may have different immigration status. When one family member is in the country illegally, the whole family may forgo medical care for fear that they might trigger an investigation (AAP, 1997). Due to MSFW children having inaccessibility to health care, the use of primary and preventive care services is episodic and too often occurs in emergency rooms.

Environmental and Occupational Safety

Second to mining, the most dangerous occupation in the United States is agriculture (National Advisory Council on Migrant Health, 1995). Farmworkers are exposed to sun, rain, dust, pollen, freezing temperatures and chemicals. They often work in fields that lack toilets, potable water, and hand washing facilities. Safety has always been a concern in regards to the overall health of MSFW. Increasingly, the underutilization of disability insurance is becoming a major health issue for MSFW. The U.S. Department of Labor (DOL) released a survey entitled the *National Agricultural Workers Survey: 1997-1998.* The survey shows that only about 1% of farmworkers were collecting disability. One possible explanation is that in the same survey 52% of all surveyed were unauthorized to work in the United States. One of the prime concerns regarding workers' safety has to do with environmental factors that can cause ailments such as skin cancer, and dermatitis.

In some instances, MSFWs may be eligible for workers' compensation. Workers' compensation laws provide medical and cash benefits to employees or their dependents that incurred a work-related injury or illness through no fault of their own, and relieve employers of liability from lawsuits involving negligence. No data is available to demonstrate exactly how many MSFWs use workers' compensation, although most advocacy organizations believe that far less than those eligible actually take advantage of the program. Fear of retaliation from an employer seems to be the leading reason cited for why MSFWs do not seek damages.

Pesticide exposure is also a growing concern with cancer rates amongst farmworkers far greater than that of the general population (Baca, 2002). Farmworkers frequently endure stomach ailments, headaches, rashes, burns, and other pesticide-related problems (Cunningham, 1994). The Environmental Protection Agency (EPA) has estimated that 300,000 farmworkers suffer acute illnesses and injuries as a result of exposure to pesticides (National Advisory Council on Migrant Health, 1995). The World Resources Institute's estimate of 313,000 farmworkers suffering from pesticide-related illnesses is consistent with this estimate (Perfecto, Velasquez, 1992). The World Resources Institute also estimates that 800 to 1,000 farmworkers die each year from pesticide exposure. Little has been written on the types and prevalence of workplace

hazards experienced by Michigan's migrant and seasonal farmworkers. A 1996 paper written by Lisa Gold on pesticide laws and Michigan's migrant farmworkers argues that pesticide exposure is underreported in Michigan (Gold, 1996). The Michigan Department of Agriculture received 282 complaints in 1994. Of these, 82 were found to be violations of the Pesticide Control Act. Only 12 of the 282 complaints took place in field crops, four were for vegetable crops and none for fruit crops. None of the 12 field crop complaints was found to violate the law.

Another recurring problem amongst MSFWs has been from respiratory illness, which is caused by constant exposure to respiratory irritants, including pesticides, dust, plant pollen, and molds. In many instances, the workers who are most at risk typically tend to work in nursery or greenhouse operations, which happen to be enclosed places with poor ventilation (Von Essen, 1993). Dermatitis is also a common ailment; the cause is often by plants that scratch the skin, by allergic reaction, by exposure to chemicals, or by other causes related to agricultural production (Hogan & Lane, 1986; O'Malley, 1997). In 2000, the Bureau of Labor Statistics (BLS) found that nearly half of all occupational illnesses are associated with skin disease and disorders (BLS, 2000). Problems associated with the eye are also common. Typically, eye irritants are dust, pollen, and chemicals, just as with the other conditions. Eye problems can lead to vision impairment and possibly blindness.

Particularly in cases where pesticides are concerned, most farmworkers are unaware of the potential risk of cancer or other pesticide related illnesses. Clinicians receive little training in recognition and treatment of pesticide-related illness (Mobed et al. 1992). With dermatitis, many physicians are not trained to treat agriculturally related dermatitis and have little experience identifying the cause of problems. Workers are hesitant to seek medical help for these conditions until they reach extreme levels (Larson, 2000). In many instances, optical problems will go untreated due to the fact that most health care organizations accessible to MSFWs do not have an ophthalmologist on staff, and therefore may face many difficulties referring patients to qualified treatment centers.

Housing and Sanitation

Due to the difficulty associated with finding affordable housing, poor living conditions in association with inadequate sanitation lead to poor general health in MSFW populations. Overcrowding is the biggest problem associated with migrant housing. The number of housing units provided by growers is very limited, which leads to overcrowding. Also, due to their limited incomes and rising cost of housing, many families and individuals share living space. The number of people that might live in a MSFWs house or apartment varies from three to 15 or more depending on the source you are citing. One survey, however, shows that 51% of those polled live with 4-6 other persons, while 30% said 7-9, and 11% said they live with 10 or more (Power, 1998). In a study released in 2001 by the Housing Assistance Council (HAC), almost 52% of the living units were crowded and 74% of the crowded units had children living there.

Crowded conditions can increase the risk of infectious disease such as tuberculosis and influenza. Improper sanitary facilities can lead to the contraction of hepatitis and other conditions. Such conditions can also expose food preparation surfaces to pesticides and fertilizers (InterAmerica Research Associates, 1978). Although there are some programs

available to growers to improve housing, little is being done because of potential cost and government regulations.

In Michigan, there are 900 licensed housing sites including 4,500 living units with a capacity of 25,000 persons (Michigan Department of Agriculture, 2002). Part 124 of Act 368, Public Acts of 1978, as amended, requires annual licensing of sites occupied or used as living quarters for five or more migratory laborers engaged in agricultural activities, including related food processing. The migrant labor housing licensing program requires a minimum of two inspections per year for each licensed camp. Some advocates believe that not all of the 900 camps receive their required inspections.

Between July and November 2002, 8,060 State employees will take advantage of an early retirement program designed to reduce State general fund expenditures. The State of Michigan has indicated their intention to replace only 1 in 4 employees or about 2,000 positions. Currently, the State employs five people to inspect migrant housing facilities. Four of the inspectors are expected to retire. Advocates fear that this will further reduce the number of inspections conducted annually.

Mental Health and Substance Abuse

MSFWs face serious stressors daily including but not limited to language barriers, the unpredictable nature of finding work, poverty, difficult physical work, and health related concerns. Though stress is a natural occurrence, too much can be harmful and have a detrimental affect on overall health. Continued stress can lead to major health problems such as heart disease and ulcers. Sleeplessness, headaches, and poor digestion are other less acute conditions resulting from stress (National Agricultural Safety Database, 2002). Stress may also make migrant farmworkers susceptible to mental health problems such as depression, anxiety, substance abuse, and suicide. Currently, there has not been much research conducted on the prevalence of depression and anxiety within the MSFWs population. However there was a survey of FQHC clinicians that shows that one out of two patients are estimated to have a behavioral or emotional problem. An estimated one out of five patients is currently receiving services from a mental health professional. Nearly one-third of all providers' direct patient contact hours are spent addressing behavioral or emotional concerns. If you would like more information on this study, please contact the Michigan Primary Care Association. Chronic anxiety can lead to negative health consequences such as suppression of immune system functioning, which increases the chance of infectious diseases, and increased risk for high blood pressure and heart disease (Comer, 2001).

MSFW children are at greater risk for mental health and substance abuse conditions than non-migrant children. A study done by Kupersmidt and Martin (1997) found that 59% of MSFW children revealed one or more psychiatric disorders. The most common being anxiety related disorders such as phobia and separation anxiety. The day-to-day stress of migrant life can also exacerbate child maltreatment and domestic abuse. Some data has shown that migrant children were significantly more at risk for maltreatment than other children. The overall maltreatment definition was 27.7 incidents per 1000 children, which is approximately three times the rate of

maltreatment found in the general population of the five States included in the study, New York, New Jersey, Pennsylvania, Florida, and Texas (Larson et.al., 1990).

Primarily the barriers in treating the various forms of mental health and their side effects has to do with cultural prejudices or indifference and the limited amount of research that has been done on this subject. Many providers are not aware of the prevalence, so little has been done to confront this problem.

Health Programs and Services for which Migrant and Seasonal Farmworkers May be Eligible

Many migrant and seasonal farmworkers are eligible for a range of programs and services in Michigan. The following few pages highlight key programs. Additional information on these programs can be found at the sources identified throughout this section.

Programs specifically designed for the Farmworker population

- *The FQHC Programs* provide primary care services to migrant workers and their dependents regardless of their income, insurance coverage, or immigration status. Services are offered through Migrant Health Centers (MHC) and Community/Migrant Health Centers (C/MHC). Four of 26 such organizations currently in operation in Michigan received funds specifically for the care of MSFWs. Michigan's C/MHCs include the following:

  1. Family Medical Center of Michigan, Inc., which has clinics in Temperance and Carleton;
  2. Health Delivery, Inc., which has clinics in the Saginaw/Bay City area and one migrant clinic in Imlay City; and
  3. InterCare Community Health Network, Inc., which operates several clinics in Allegan, Berrien, Kent, Ottawa, and Van Buren Counties.
  4. The Northwest Michigan Health Services, Inc., based in Traverse City, operates three MHC clinics in Traverse City, Bear Lake, and Shelby and is the only Federally Qualified Health Center in Michigan focused solely on MSFWs

  For more information on services available at Michigan's C/MHCs, see the Directory of Services, 2000-2001, prepared by the Michigan Primary Care Association, www.mpca.net

  C/MHCs are required to provide a core of primary care services and preventive services (including prenatal, well-child, and family planning services), preventive dental services, and diagnostic laboratory and radiological services. MHCs also are required to provide infectious and parasitic disease screening, control services and accident prevention programs, depending on community need. C/MHCs also provide on-site or referral services for mental health, substance abuse, dental, pharmacy, health education/promotion, translation and transportation needs. The Migrant Health Program does not cover expenses related to hospitalization, nor does it cover many specialty services.

- The *Migrant Hospitalization* program was developed to assist eligible MSFWs in covering the expenses of urgent or emergency hospitalizations. Enrollees must be (1) non-residents of Michigan who move from place to place to work in agriculture or a related industry such as canning; (2) be part of a family with a child under age 21 who is living with, or during the past six months has lived with, a "specified relative" (parent, grandparent, etc.); (3) not be eligible for Medicaid. (Refer to the Family Independence Agency for additional details on eligibility requirements.) The Migrant Hospitalization program provides inpatient hospital

services and limited outpatient services during one 30-day period in 12 months. Covered services include inpatient hospital services, outpatient services that are follow-up to inpatient services and performed within 30 days of the hospital admission, or for services that are normally performed as inpatient services, but which the attending physician and the client have decided to perform on an outpatient basis. The program does not cover services outside of in the Medicaid benefits plan, elective hospitalization, ambulance service, and any inpatient or outpatient services performed outside the 30-day service eligibility period.

- *Some community-based organizations* also offer services tailored to the needs of MSFWs. An example is Cristo Rey Community Center of Lansing, funded by the Catholic Diocese and the United Way, which operates a health clinic and provides substance abuse counseling with services targeted to MSFWs. A map and listing of clinics that have targeted services for MSFWs is available at: http://www.michaglabor.org/migrant_health/migrant_health.jsp See also the Migrant Service Division's Hispanic Human Services Agency Directory (from the Michigan Family Independency Agency) and Local Regional Migrant Resource Council's individual Agency Directories, which list migrant service providers in a specific geographical area, usually multi-county region, and their respective programs, services staff and other pertinent information. The Directory is produced by the eleven Michigan Migrant Resource Councils (MRC), MRCs are regional coalitions of local representatives from public and private migrant service agencies, growers, farmworkers, and others who meet to "exchange program information, coordinate services and identify unmet needs." The MRCs also produce an *Annual Agency Resource Guide*, a brief listing of the major migrant service providers and in some cases the services they offer. For more information on MRCs, see: http://www.michigan.gov/fia/1,1607,7-124-5452_7124_7205---,00.html.

- *The Camp Health Aide Program* (CHAP), initiated in 1985, provides outreach, education, advocacy, and health promotion services for MSFWs. MSFWs are trained as lay health promoters to increase MSFWs access to health care, and help them manage obstacles related to language, culture, poverty, and geographic isolation, and to provide health information. Aides act as liaisons to public and private programs and provide links between underserved communities and local health providers. The Aides also help inform health care providers on issues related to the culture and lifestyle of migrant farmworkers. The training curriculum covers issues pertinent to farmworkers' health, including nutrition, first aid, prenatal care, well-child care, environmental concerns, diabetes, hypertension, sexually transmitted diseases, HIV/AIDS, and mental health. Program adaptations of the Camp Health Aide Program have also been implemented. The *Salud Para Todos* Farmworker Family and Community Health Program trains and supports Aides to address mental health, substance abuse, stress, and violence in their communities. *Informate* for Farmworker Teen Health provides peer based health education to adolescents and children using theater, games, and healthy activities. The State of Michigan's Maternal and Child Health Block Grant has historically provided the funds for Michigan's Camp Health Aide Program. As a result, its clients have primarily included women and their dependent children. For more information on the Camp Health Aide Program, see *State of Michigan Prenatal Care Outreach and Advocacy: Camp Health Aide Program*, Annual Report 2001, published by Migrant Health Promotion they can be contacted at 224 W. Michigan Ave. Saline, MI 48176 or by phone at (734) 944-0244, and their email is migranthealth@voyager.net

- Public Health Programs Designed for Low-income Populations for Which MSFWs May be Eligible

  Many MSFWs, whose wages tend to be below the federal poverty line, are eligible for a range of publicly funded programs, as identified below. Before describing these programs, however, it is important to note several recent changes in federal welfare and immigration policy that have had a significant effect on some MSFWs access to these programs.

  Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the Illegal Immigration Reform and Immigrant Responsibility Act of 1996. With the passage of these laws, States were granted the right to deny legal or "qualified" immigrants who entered the U.S. on or after August 22, 1996 access to "federal means-tested public benefits" for a five-year period following their entry to the U.S. These benefits were deemed by the U.S. Department of Health and Human Services to include non-emergency Medicaid services and services from the State Children's Health Insurance Program (SCHIP). Several subgroups of immigrants were affected by these changes, including lawful permanent residents; conditional entrants; parolees admitted for at least one year; refugees; persons seeking asylum; persons who have had their deportation withheld; and certain battered immigrant women and immigrant parents of battered children. Groups that are exempt from this five-year bar include "qualified aliens" who (1) are admitted for humanitarian reasons; (2) veterans, immigrants on active duty in the Armed Forces, their spouses and unmarried dependent children; and (3) lawful permanent residents who can be credited with 40 qualifying quarters of work and who did not receive any "federal means-tested benefits" during any of those quarters after December 31, 1996.

  With the exception of the Supplemental Nutrition Program for Women, Infants, and Children (WIC), undocumented workers, or "Not Qualified" immigrants, whose numbers are steadily increasing in Michigan, remain ineligible to enroll in the programs listed below. Undocumented workers' access to health-related services in Michigan is generally limited to services provided at C/MHCs and some disaster relief services, hospital ERs, treatment for communicable diseases, immunizations, nutritional services for children and WIC services for persons otherwise eligible for the program (as discussed further below). Undocumented workers also are eligible to receive Medicaid coverage for life-threatening emergency services if they are otherwise eligible for Medicaid.

- *Supplemental Nutrition Program for Women, Infants and Children (WIC).* WIC is a federal grant program designed to safeguard the health of low-income women, infants, and children up to age five who are at nutritional risk. Services include supplemental foods, nutrition education and counseling at WIC clinics, and screening and referrals to other health, welfare and social services. To be eligible, applicants' gross income must fall at or below 185 percent of the federal poverty guidelines. Applicants must also be interviewed to determine the presence of nutritional risk. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) restricts participation in most food assistance programs based on citizenship and alien status. WIC is specifically exempted from these restrictions. Michigan WIC follows this policy and does not limit participation, beyond the federal program regulations that require specific income limits and the presence of nutritional

risk in pregnant women, breastfeeding, or non-lactating women and children less than five years of age.

For more information about WIC, see http://www.fns.usda.gov/wic/. For information about eligibility for WIC, see http://www.fns.usda.gov/wic/PDF%20files/WICRegulations.pdf. For information about Michigan's program, see http://www.mdch.state.mi.us/dch/clcf/wic.asp.

- *Medicaid*, jointly funded by the federal and state governments, provides health insurance for low-income persons who also meet one of Michigan's 25 eligible categories. These categories can generally be subcategorized into the following groups: participants in the Family Independence Program (Michigan's former Aide to Families with Dependent Children program); Supplemental Security Income recipients; infants and pregnant women who meet income thresholds; children older than one year but younger than 16 in families below 150% of the Federal Poverty line). For purposes of determining eligibility, federal regulations deem farmworkers to be residents of a State in which they come to work. Although FIA has 45 days to determine eligibility, FIA officials indicate that applications of MSFWs are given priority and are expedited, often being processed within a one-week period. From the time of determination of Medicaid eligibility, benefits are covered retroactively for 90 days. See http://www.mdch.state.mi.us/msa/mdch_msa/msahome.HTM and http://www.house.state.mi.us/hfa/medcost.htm for more information.

  In addition to providing a fairly comprehensive package of preventive, primary care, and specialty services, Medicaid benefits also include access to the *Early and Periodic Screening, Diagnosis, and Treatment* (EPSDT) program, a preventive and remedial health services package that provides an extensive set of services for young children. Medicaid also administers the *Healthy Kids* program (Michigan's Medical Assistance program), a Medicaid expansion program for children ages 16-18 and women during and just after pregnancy with family incomes less than or equal to 150% of the federal poverty level (FPL). For more information about Healthy Kids, see http://wash.k12.mi.us/~perform/healthy_kids.htm.

  MIChild, Michigan's State Children's Health Insurance Program, provides health care insurance for children up to age 18 who are not eligible for other insurance coverage, including Medicaid up to 200% of poverty. Eligibility for services is determined and begins within 10 days following the receipt by the Michigan FIA of the application. U.S citizens, legal non-citizens, those who live in Michigan and intend to work here, and migrant farmworkers are eligible for services. Benefits are comprehensive and include inpatient and outpatient mental health services provided through the community mental health services program, dental services, and inpatient and outpatient substance abuse treatment services. Federal SCHIP provisions require that States allocate a portion of their SCHIP funds to outreach and enrollment efforts. For more information, see http://www.michigan.gov/mdch/1,1607,7-132-2943_4845_4931---,00.html

- *Food Stamps.* The federal Food Stamp Program provides coupons or electronic benefits on debit cards to eligible low-income people to buy approved food from authorized retail food stores. A person must meet relevant poverty thresholds and be a U.S. citizen or an eligible non-citizen to qualify for Food Stamps. Persons legally admitted for permanent residence may be eligible if they have 40 qualifying quarters of Social Security work coverage or they

have a U.S. military service record. Refugees, persons seeking asylum, Cubans, Haitians, Amerasians, persons whose deportation has been withheld, parolees, persons legally admitted for permanent residence and battered aliens may be eligible if they were legally living in the U.S. on 8/22/96 and they were 65 on that date or are now receiving disability payments or are under the age of 18. Native Americans who cross the Canadian or Mexican borders also may be eligible, as may certain Hmong and Highland Laotians and their spouses and children. Even if some members of the household are not eligible, those who are may be able to get food stamps. For more details on food stamp eligibility for immigrants, see the attachment at the end of this brief. See http://www.fns.usda.gov/fsp for more information on Food Stamps in general.

- *Title X Family Planning Services.* The National Family Planning Program was created in 1970 as Title X of the Public Health Service Act. The mission of Title X is to provide individuals with the information and means to plan the number and spacing of their children. Grants made under this section provide funding for comprehensive family planning and preventive reproductive health services. In addition to contraceptive services, Title X clinics provide basic reproductive health care such as screening for breast and cervical cancer; screening for sexually transmitted diseases, including HIV; certain infertility services; and general health education, counseling and referrals. The majority of Title X clients are uninsured, do not qualify for Medicaid (although Medicaid recipients are eligible to receive Title X services), and rely on Title X clinics as their only source of family planning services. Services are provided on a sliding fee scale. Title X has no durational residency or immigration status requirements for receipt of services. Recently HB 4655 was enacted into law, which amends Title X by giving funding priority to organizations that do not perform or promote abortions. As a result well-known organizations such as Planned Parenthood will be last in line to receive State funding. For more information, go to http://opa.osophs.dhhs.gov/titlex/ofp.html or http://www.michigan.gov/mdch/1,1607,7-132-2942_4911-4912-12562--,00.html

- *The Community Mental Health Services Program (CMHSP)* provides diagnostically driven community-based care for adults with severe mental disorders and for severely emotionally disturbed children. Relatively small amounts of these dollars are spent on prevention or on children aged birth to six years of age. CMHSP clinics are funded through a federal block grant and are designed and administered by the States. They also are responsible for providing care to the Medicaid population. Because of the focus on severe and persistent mental illness and the geographic inaccessibility of CMHSP services to MSFWs, this program is rarely used by MSFWs. For more information, see http://www.michigan.gov/mdch/1,1607,7-132-2941_4868---,00.html . For a description of Michigan's Home-based Mental Health Services, see http://www.michigan.gov/eMI/CDA/eMI_CDA_Frame/1,1307,,00.html?frameURL=http://www.mdch.state.mi.us/dch/clcf/mhs_11.asp

- Title V Children's Special Health Services. This program provides specialty services for children through age 20 who have a chronic condition or other special health need, regardless of their income. Children who have one of over 2,700 diagnoses are eligible to apply, as are persons 21 and older with cystic fibrosis or certain blood coagulation disorders. If qualifying clinical criteria are met, persons who are working in or looking for a job in Michigan are eligible for program services, as are children born in the US For children not born in the US,

the parents or legal guardian(s) must be a citizen of the US or be an alien lawfully admitted for permanent residence. For more information, see http://www.mdch.state.mi.us/msa/mdch_msa/cshcs.htm.

- *Programs for high-risk pregnant women, infants and young children (e.g. Maternal and Infant Support Services, Maternal and Infant Support Services, Maternal and Infant Health Advocacy Program, Maternity Outpatient Medical Services program, the Prenatal Smoking Cessation Program).* These programs, funded through state and federal sources, seek to reduce infant mortality and improve maternal health and birth outcomes.
  - The Maternity Outpatient Medical Services program (MOMS) provides basic prenatal care services to women whose incomes are at or below 185% of poverty who have applied for Medicaid or are eligible for Emergency Services Only (ESO) Medicaid. The program covers the provide fee for prenatal care and delivery, pregnancy related medications, laboratory tests, and laboratory procedures. Hospitalization is not covered. Family planning services following delivery are included for the two months postpartum.
  - Maternal Support and Infant Support Services (MSS/ISS) provides nursing, social work and nutrition professional services as well as transportation services to women and infants in need. Childbirth education classes are also covered under the MSS program.
  - Prenatal Smoking Cessation is designed to help pregnant women quit smoking.
  - Maternal and Infant Health Advocacy Services are designed to reach out to pregnant women and infants and enroll them into care and assure that health services are maintained. Services may be provided to the pregnant woman for up to two months postpartum and to the infant for the first year of life. Services are provided by trained paraprofessionals.

For more information and other relative programs, contact the Michigan Department of Community Health, Bureau of Children and Families, http://www.michigan.gov/mdch .

- *School-based/ School-linked health education and services.* School-based/ school-linked health services seek to prevent and control communicable disease and other health problems, provide emergency care for illness or injury, foster appropriate use of primary health care services, and improve students' mental, emotional, and social health. Psychosocial services often include individual and group assessments, interventions, and referrals. School-based/ school-linked health education programs seek to address a range of health issues facing children and adolescents, including strategies for avoiding risky behaviors. Currently, the State of Michigan is providing funding to 19 school-based/school-linked health centers and health behavior/ health education programs. Because of the tremendous budget issues facing the State, continued funding of this program will largely be decided annually. For more information, see http://www.cdc.gov/nccdphp/dash/ataglanc.htm.

- *Substance Abuse Service Programs* offer a continuum of service for those who need care or treatment for abuse or dependence on alcohol or other drugs. Services are available throughout the State, with special programming available for those whose primary language is Spanish. Substance abuse services are accessed through regional Access, Assessment and Referral centers (AARs) who screen and refer clients according to their treatment need. If a customer/ applicant has Limited English Proficiency, interpretation services and written

materials in the appropriate language are provided at no cost to the customer. For further information, see the Michigan Department of Community Health web page, at http://www/michigan.gov/mdch and click on the hot button for Mental Health & Substance Abuse. For a referral to the appropriate AAR in various geographic areas of the State, call the Michigan Resource Center, toll free, at (800) 626-4636

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Goal A. Increase Access to Health Care

Work Group: Carol (Chair), Elizabeth, and Kim

Objective:	*Activities:*	*Desired Outcomes*	*Expected Start Date*
Work to increase access to primary, mental and oral healthcare services for Migrant and Seasonal Farmworkers (MSFW).	1. Support and assist the development of Federally Qualified Health Centers (FQHC) delivery sites and if appropriate, new FQHC organizations. 2. Support and assist existing FQHC organizations in the expansion of services and further development of outreach and eligibility services. 3. Educate providers on existing state and federal programs such as FQHC, State Loan Repayment Program (SLRP), and National Health Services Corp (NHSC).	MSFWs are able to access primary, mental and oral healthcare services.	July 2002
Assist health centers in managing their growth so that the greatest number of MSFWs receive the highest quality of care.	1. Assist in the identification and verification of need. 2. Provide training and technical assistance for board development. 3. Work to increase availability of clinicians and administrative staff for services to MSFWs. 4. Increase capital development opportunities for health centers. 5. Encourage health centers to participate fully in clinical and management programs. 6. Advocate for additional outreach services for the MSFW populations.	Health centers provide the greatest number of people with the highest quality of care.	July 2002

Goal B. Increase Access to Publicly Funded Health Insurance Programs

Work Group: Elizabeth (Chair), Carol, and Ann

Objective:	*Activities:*	*Desired Outcomes*	*Expected Start Date*
Encourage Michigan providers to participate in the Texas Migrant Care Network (MCN) Pilot.	1. Develop partnership between Michigan Primary Care Association (MPCA), Migrant and Seasonal Farmworkers (MSFW) Workgroup, and Texas Association of Community Health Centers (TACHC). 2. Assist in the recruitment of Michigan migrant and community health providers to participate in the Migrant Clinicians Network (MCN). 3. Work with Family Independence Agency (FIA) in the identification of Texas migrants under the age of 19. 4. Have TACHC staff present the MCN program to migrant and community health center representatives at the annual MPCA Meeting. 5. Assist TACHC in marketing the MCN pilot to both providers and migrants: ▪ Press release ▪ Newsletters ▪ Presentations ▪ Training camp health aides	Texas Medicaid coverage for Texas migrants in order to reduce Michigan costs.	November 2002

Goal B. Increase Access to Publicly Funded Health Insurance Programs

Work Group: Elizabeth (Chair), Carol, and Ann

Objective:	*Activities:*	*Desired Outcomes*	*Expected Start Date*
Advocate for presumptive eligibility of migrant farmworkers in Medicaid, MIChild, and MIFamily.	1. Research current migrant farmworker participation in these programs in Michigan. 2. Identify partners in this effort and develop coalition. 3. Work with National Center for Farmworker Health (NCFH), TACHC, and coalition to conduct a cost analysis. 4. Identify and contact a legislator to champion the piece of legislation. 5. Write the piece of legislation with the assistance of NCFH and the National Association of Community Health Centers (NACHC). 6. Work the proposal legislation with coalition and national partners. 7. When successful, celebrate and inform providers, migrants, and the public using: ▪ Press release ▪ Newsletters ▪ Presentations	Simplified enrollment and access to all Medicaid, MIChild, and MIFamily eligible migrant farmworkers that come to Michigan.	November 2002
Promote migrant farmworker enrollment in Medicaid, MIChild, and MIFamily.	1. Work closely with FIA to ensure training of eligibility workers on the MCN and/or presumptive eligibility of migrant farmworkers in the State of Michigan. 2. Increase outreach and education by Federally Qualified Health Centers (FQHC) or MCN and/or presumptive eligibility. 3. Work with the Outreach sub-committee of the MSFW Workgroup to increase the outreach and education services provided to migrant farmworkers in Michigan. 4. Monitor impact of outreach efforts.	Increase migrant farmworker enrollment to Medicaid, MIChild, and MIFamily in Michigan.	TBD

Goal B. Increase Access to Publicly Funded Health Insurance Programs

Work Group: Elizabeth (Chair), Carol, and Ann

Objective:	*Activities:*	*Desired Outcomes*	*Expected Start Date*
Advocate for modifying existing Medicaid policy to carve-out migrants from the managed care program.	1. Meet with Michigan Department of Community Health (MDCH) officials to discuss the current Medicaid policy on migrants and managed care. 2. Begin efforts to educate legislators and managed care partners of why managed care is ineffective for migrant and seasonal farmworkers. 3. Identify and incorporate other partners during the process.	MSFWs are no longer enrolled in Medicaid Managed Care.	July 2002

Goal C. Address Continuity of Care

Work Group: Ann (Chair), Carolee, Bobby, and Elizabeth

Objective:	*Activities:*	*Desired Outcomes*	*Expected Start Date*
Create a statewide network of service providers.	1. Develop a concept, and write a paper, on a provider network designed to increase access to services for migrant farmworkers. 2. Work with the Call for Health Program on strategies to establish a provider network not only with providers but with pharmacies, eye care services, dental services, etc. 3. Engage the Migrant Clinician's Network in discussions on how we could use their clinician's network to increase access and promote continuity of care. 4. Develop an outreach strategy for provider recruitment into the network.	Increase the number of providers willing to provide services to migrant and seasonal farmworkers.	April 2003
Identify State resources for covering the cost of health care for migrant and seasonal farmworkers.	1. Identify an influential partner to champion the provision of health care services to migrant and seasonal farmworkers. 2. Challenge agencies throughout the state of Michigan to share the resources (financial or services) they have available for the provision of health care to migrant and seasonal farmworkers. 3. Publish resources to ensure that health care providers and farmworkers alike can access them. 4. Include identified resource agencies as part of a statewide network of service providers.	Identify all state resources than can be brought to bear on behalf of migrant and seasonal farmworkers in the State of Michigan.	April 2003
Inform migrant farmworkers of programs that will assist in covering the cost of health care.	1. Create a bilingual list (or pamphlet) of programs available in Michigan and make that list available to migrants through migrant/community health centers, Camp Health Aides, FIA, etc. 2. Partner with the NCFH Call for Health Program for case management and referral services. 3. Provide a training, to be provided by Call For Health, on accessing community resources.	Increased access to primary care, dental, and pharmacy services for migrant and seasonal farmworkers.	February 2003

Goal C. Address Continuity of Care

Work Group: Ann (Chair), Carolee, Bobby, and Elizabeth

Objective:	*Activities:*	*Desired Outcomes*	*Expected Start Date*
Increase continuity of care through electronic health records that can be accessed by all states.	1. Educate providers and Migrant and Seasonal Farmworkers (MSFW) on existing electronic health information management resources such as Diabetic Track 2, Heartfax, and TBNet. 2. Research available systems including the E-Health Connector electronic record system. 3. Conduct a feasibility study for implementation. 4. Conduct a cost benefit analysis. 5. Explore funding and federal match opportunities through Medicaid.	Electronic health records for all migrant farmworkers accessing services through Michigan migrant and community health centers.	January 2003
Increase continuity of care through sharing of health records between the US and Mexico.	1. Explore current mechanisms for sharing of medical records between the US and Mexico. 2. Educate providers and MSFWs about current system. 3. Advocate for changes that would improve providers' abilities to access patient medical records.	MSFWs receive higher quality of care as a result of comprehensive health histories.	November 2002

Goal D. Develop a Cultural & Linguistic Responsiveness Improvement Strategy

Work Group: Judy (Chair), Carolee, and Kim

Objective:	*Activities:*	*Desired Outcomes*	*Expected Start Date*
Establish partnerships with health professions training programs.	1. Identify health professions training programs with large numbers of Spanish speaking students across the country. 2. Initiate discussions with selected programs and Michigan programs to begin relationship development. 3. Partner with Bureau of Primary Health Care (BPHC) and Bureau of Health Professions (BHPr), to increase participation in federal programs. 4. Explore possibility of developing a Migrant Health Job bank for health professionals interested in working with Migrant and Seasonal Farmworkers (MSFW). 5. Work to develop relationships with other likely partners such as Association of Hispanic Nurses and Physicians. 6. Educate provider organizations about current resources such as Medical Opportunities of Michigan (MOMs).	Increased numbers of Hispanic and Spanish speaking health care providers available to the MSFWs.	January 2003
Increase cultural responsiveness training opportunities.	1. Research what types of cultural responsiveness training programs currently exist. 2. Evaluate programs to determine responsiveness for MSFW providers. 3. If no satisfactory program exists, identify potential partners to assist with developing a cultural responsiveness clinician training program. 4. Work with MPCA to offer training opportunities.	Cultural responsiveness training is available to health care providers.	January 2003
Educate private providers and other community organizations on importance of linguistic and cultural responsiveness	1. Educate providers and MSFWs that children are not appropriate translators. 2. Educate providers of the importance of providing health care in a manner culturally acceptable and with access to translation services if needed. 3. Work with community organizations to increase availability of other health and human services assistance in Spanish.	MSFWs have greater access to culturally and linguistically responsive health and human services.	May 2003

Goal E. Decrease Adverse Health Outcomes from Environmental & Occupational Causes

Work Group: Monica (Chair), Jill, Carol, and Lorri

Objective:	*Activities:*	*Desired Outcomes*	*Expected Start Date*
Recognize and promote environmental health objectives regarding work elements/factors of migratory labor.	1. Promote recognition and importance of public health education objectives in protecting the overall health, safety, and welfare of migrant and seasonal farm workers. 2. Annually provide in-service training/refresher to all parties involved with migrant and seasonal farm worker safety. 3. Explore potential for partnerships between growers/farmers who employ migratory laborers and other public and private agencies concerned with health and safety issues in the migrant and seasonal farm worker occupation. 4. Collect and disseminate information regarding environmental health education activities and research relative to migrant and seasonal farm workers. 5. Partner with Michigan State University (MSU) Extension and Michigan Department of Agriculture (MDA) to provide annual grower training.	Increase awareness/education in safety issues relative to migrant and seasonal farm workers.	November 2002

Goal E. Decrease Adverse Health Outcomes from Environmental & Occupational Causes

Work Group: Monica (Chair), Jill, Carol, and Lorri

Objective:	*Activities:*	*Desired Outcomes*	*Expected Start Date*
Recognize and promote occupational health objectives regarding work elements/factors of migratory labor.	1. Encourage collaborative efforts of Federally Qualified Health Centers (FQHC), local health departments, and community to enhance awareness of health objectives 2. Encourage and support implementation of training and awareness of the workplace environment. 3. Annually provide in-service training/refresher to all parties involved with migrant and seasonal farm worker occupational health. 4. Promote awareness to health care providers of various health effects from occupational exposure to the migrant and seasonal farm worker population. 5. Promote compliance with Occupational Disease Reporting requirements through distribution of information and training. 6. Collect and disseminate information regarding occupational health education activities and research relative to migrant and seasonal farm workers.	Increase awareness/education in health issues relative to migrant and seasonal farm workers. Increase awareness and implementation of occupational reporting requirements regarding seasonal and farm worker occupations.	November 2002

Goal F. Develop a Comprehensive Approach to Outreach & Eligibility Services

Work Group: Alethia (Chair), Kathy, Tori, Manny, and Judy

Objective:	*Activities:*	*Desired Outcomes*	*Expected Start Date*
Expand outreach services provided statewide.	1. Educate Federally Qualified Health Center (FQHC) on current opportunities to increase outreach services. 2. Maintain support for existing state programs targeting Migrant and Seasonal Farmworkers (MSFW), Camp Health Aide Program (CHAP), Migrant Outreach and immunization program, prenatal enrollment and coordination grant. 3. Advocate for delivery of health and human services to migrants in more culturally responsive locations. a. camps b. McDonalds, shopping sites c. Schools, churches d. Migrant Head Start, Migrant Summer Education. 4. Advocate for expanded state funding for peer health educators targeting MSFW population. 5. Educate adolescent farmworkers of existing programs such as 4-H, Future Farmers of America, and the Boys and Girls Clubs.	Increased number of outreach and eligibility services to MSFWs.	September 2002
Assist community partners in increasing collaboration and coordination of support services available to MSFWs.	1. Partner with the Migrant Resource Council (MRC) to: a. Identify existing agencies; and b. Provide training to enhance linguistic and culturally appropriate services to non-member agencies and communities with MSFWs. 2. Explore ways to increase resources to MRCs to support expanded activities. 3. Explore AmeriCorps/ Vista support for MSFW issues.	Better coordination among community support services providers.	February 2003

Goal G. Elevating Status of MSFWs in Policy Discussions and Program Development

Work Group: Carol (Chair), Elizabeth, and Kim

Objective:	*Activities:*	*Desired Outcomes*	*Expected Start Date*
Outreach to Provider Community and other state level partners.	1. Encourage research in Migrant Health Issues 2. Work to encourage participation in the research track at Stream forums. 3. Explore opportunities with Michigan researchers to develop Michigan specific data. 4. Promote availability of NCFH as a clearinghouse to state partners and providers. 5. Increase interaction with Julian Samora Institute at MSU. 6. Request position on Governor's Interagency Migrant Services Committee. 7. Raise awareness of MPCA and Migrant and Seasonal Farmworkers (MSFW) issues by participating in events such as Annual Grower Meeting and Farmworker Appreciation Month activities. 8. Partner with MSU Extension and MDA to provide annual grower training.	Better coordination and partnership between state level partners and the provider community.	November 2002
Educate policymakers regarding the unique needs of MSFWs.	1. Develop easy to read and understand materials describing the unique needs of MSFWs. 2. Meet with state and federal policymakers to discuss issues of concern for MSFWs and the providers who care for them. 3. Regularly distribute items of interest on MSFWs to the public and policymakers.	Policy makers understand and are responsive to the needs of the MSFW.	September 2002
Continue the MSFW workgroup.	1. Schedule meetings of the MSFW work group at least quarterly. 2. Work to achieve the desired outcomes on behalf of MSFWs. 3. Regularly report to the FQHCs, state partners, NCFH, NACHC, and policymakers the results of our efforts.	Better health for the MSFWs.	July 2002