

Still Unequal Access:

Health Services Available to Migrant Farmworkers and their Families, Access Problems and Remaining Needs

Elizabeth Courtney Crane-Sherman, Summer 2005

THE HEALTH CARE SAFETY NET

While the United States has one of the most advanced health care systems in the world, the US' healthcare system is trapped within a for profit private market. High market prices limit the availability of the best health care services to those who can afford the price tags or to those who have good health insurance plans. For the million of people without health insurance in the United States, access to affordable health care is limited to a sparse group of health providers referred to as the Health Care Safety Net. The health care safety net includes hospital emergency rooms, free clinics, private physicians' offices and health centers. The safety net is financed through state, federal and local funds including Medicaid and Medicare programs. The safety net providers are individuals and agencies who are either personally committed or legally responsible to provide services regardless of a patient's ability to pay for the services.

DEVELOPMENT OF HEALTH SERVICES FOR THE POOR AND UNINSURED

The Public Health movement in the United States began in tandem with medical developments in the control of infectious diseases during the 19th century. The first free care provided by the US government was delivered by new state agencies founded during the latter part of the 19th century, state health departments. In 1869 Massachusetts was the first state to found a state health department. By 1890 every state had its own health department given the task of controlling infectious diseases and improving sanitation (Bennett & DiLorenzo 2000: 7-8). The state health departments were empowered to administer inoculations, regulate sanitary conditions and try to eradicate various diseases (trying to eliminate populations of mosquitoes and other disease causing insects). The federal government rationalized the provision of funds to these agencies for "the public good" (Bennett & DiLorenzo 2000:8). During this time the government showed an interest in the health of its population.

Public Health interventions by state health departments did appear to better the health of the United States. In 1865 the annual death rate was 25 people per 1000; in 1900, 19 people per 1000 and in, 1920 14 people per 100 (Bennett & DiLorenzo 2000: 9). Similarly, numbers of cases of infectious diseases also dropped. Bennett and DiLorenzo (2000) quote statistics. In Massachusetts, deaths from Typhoid Fever dropped from 71.5 per 100,000 people in 1869 to 5.0 per 100,000 people in 1920. Similar statistics are seen for Tuberculosis and other "preventable and postponable diseases" and other states (10).

In the 1960 under the Kennedy and Johnson administration's ideals of creating "The Great Society" and "The War against Poverty", public health was expanded from prevention to treatment. With the Migrant Health Act of 1962, Amendments to the Social Security Act of 1965 establishing Medicare for citizens older than 65, and

Amendments to the Economic Opportunity Act of 1966 establishing funding to build and manage Neighborhood Health Centers, the US Federal Government recognized that primary health care is as much a part of disease control as immunizations. With this realization the Federal government catalyzed the creation of a separate health infrastructure for poor and at risk populations.

During the Senate Subcommittee hearing on “Health Clinics for Migratory Farmworkers” 15 February 1962, the members considered a bill to amend title III of the Public Health and Service Act to provide grants for improving domestic agricultural migratory workers’ health services and conditions (H.R. 5285, H.R. 5849, H.R. 6114, H.R. 6480, and H.R. 7088) and to authorize grants for family clinics for domestic agricultural migratory workers and their families (H.R. 8882). Witness testimony and congressional sponsors indicated during the hearing that because of the nature of seasonal farm work, the demands of a mobile lifestyle with temporary housing, poor pay and lack of personal transportation, farmworkers and their families had much poorer health conditions than the rest of the American public (Health Clinics for Migrant Farmworkers, 49). Witnesses argued that the poor health conditions of the workers resulted in public health problems for the population at large (Health Clinics for Migrant Farmworkers, 22 & 47), posed possible economic risks to the United States agricultural industry in that a widespread epidemic would destroy an irreplaceable labor force (Health Clinics for Migrant Farmworkers, 56 & 68) and were an embarrassment to have people still living in such poor health conditions (Health Clinics for Migrant Farmworkers, 51). Congressman Ryan compares the health of the migrant population with that of the “general population in the year of 1900” (Health Clinics for Migrant Farmworkers, 49).

The witnesses testify that the governmental funds to increase migrant farmworkers’ access to medical services would eventually save tax payer dollars. Dr. Brumback in his prepared statement to the subcommittee wrote,

“These proposals will cost money, but this money is already being spent. It is spend for the far-advanced case of tuberculosis requiring years of care who could have been treated in months if a chest X-ray had been available. It is spend for emergency hospitalization for a mother and baby for whom no prenatal care was provided. It is spent by taxpayers, farmers, purchasers of food who mush pay for our failure to provide health services to migrant which are available to residents” (Health Clinics for Migrant Farmworkers, 54).

As such the proposal’s objectives are to lay infrastructure so that diseases can either be prevented or diagnosed before reaching advanced stages when the costs of treatment are substantial.

The ideal model presented to the senate was a junction of the services provided by the State Health Department with a family practice. The doctors requested grant money to create clinics that would combine disease eradication programs with treatment through outreach programs, which would provide public health education, vaccinations and look for health problems within the population, and transportation, which would help increase

access to needed treatment (Health Clinics for Migrant Farmworkers, 53-54). The model also served to accommodate the rise chronic disease management like diabetes and high blood pressure to reduce the numbers of hospitalizations for those chronic conditions. Clinics for migratory workers would eliminate the need for migrant workers to go to multiple service sites for primary medical needs, reducing the confusion created over where they should go for what type of service (Health Clinics for Migrant Farmworkers, 31).

This ideal model however was not to be government run but rather government funded. What the doctors requested was an expansion of services within the private sector. Rather than creating competing clinics, the governmental funds would create fully functioning private clinics with support to provide medical services at a lower charge to the migratory population. In addition the practices would retain the power of designing their practices within the frameworks of what was necessary to procure the grant money under public law 87-692 (Section 310 of the Public Health and Service Act) passed September 25, 1962.

The passing of the Economic Opportunity Act in 1964 opened the doors for the creation of a new type of health center to serve the inner city poor and underserved rural populations. Hayes (1981) observed that the vaguely worded 1964 legislation that created the Community Action Program allowed health system reformers like Dr. H Jack Geiger and Dr. Count Gibson of the Tufts University Medical School to apply for grants to open two model health centers, one in Boston and the other in Mount Bayou, MI. These health centers, called Neighborhood Health Centers, would not only provide comprehensive health care, but also would train and employ community residents and involve them in community development, fitting within the goals of the war on poverty (123). In 1966 Senator Edward Kennedy sponsored amendments to the 1964 Economic Opportunity Act to fund more “comprehensive health centers” under an office of comprehensive health service (Sandell 1988: 52).

However a the chance for a complete overhaul of the medical system was short lived as the American Medical Association as well as pharmacists and local practitioners in urban areas felt that the creation of neighborhood health centers created unwanted competition to their private practices (Sandell 1988: 60). Under pressure by the AMA, congress in 1967 amended the Economic Opportunity Act to make eligibility criteria of receiving discounted medical care from the neighborhood health centers less than the poverty level (Sardell 1988: 64). In 1969 amendments to the Economic Opportunity Act restricted the number of self-pay patients to below one fifth of total patient volume (Sardell 1988: 64). As a result Neighborhood Health Centers (a.k.a. Community Health Centers) became regulated as separate health services for the poor, not alternatives to the burgeoning private practice and hospital industry for which Dr. Geiger strove.

Over the years both programs were revisited in Congressional hearings to reauthorized and increase funding for the program. In 1975 under the Nixon administration the Office of Economic Opportunity was closed and the control of the Neighborhood Health Centers, which became Community and Migrant Health Centers,

was given to the Bureau of Public Health Care (Taylor 2004: 4). Community Health Centers were listed under §330 of the Public Health and Service Act. One of the biggest changes over the years was the Omnibus Budget Reconciliation Act of 1989, 1990 and 1993 that amended the Social Security Act to create a new type of facility under Medicare and Medicaid known as the Federally Qualified Health Center (FQHC). This change allowed Community Health Centers (CHC) and Migrant Health Centers (MHC) to receive reimbursement from Medicare and Medicaid. Although, Medicare has never proven itself to be an useful revenue, because Medicare's per encounter rate is capped at \$106.58 for urban FQHCs and \$91.64 for rural FQHCs (Taylor 2004: 17).

Since the change in the 1990's the "hallmark of being an FQHC has been cost-based reimbursements" by Medicaid (Taylor 2004: 14). Cost-based reimbursements by Medicaid were based on the clinics over all costs, not the costs of providing care to Medicaid patients alone. What cost-based reimbursement allowed for was that federal funding and other grant money could be used for the population without insurance. Under the cost-based system, FQHCs totaled their annual allowable costs (personal, mortgage, utilities, transportation and supplies and divided that by their total encounter with patients to get a cost-per-encounter rate). Medicaid paid the difference between the patient's visit co-pay and the cost-per-patient-encounter rate (Taylor 2004: 14).

Under pressure from those who felt that Medicaid's policy of cost-based reimbursement provided disincentives to control cost, in 1997 Congress passed a law to phase out the system and replace it with a prospective payment system (PPS). The new system is tied to the average of each FQHC's allowable cost from FY 1999 and FY 2000. The cost-per-encounter rate is then calculated from the calculated average and adjusted for inflation with the Medicare Economic Index for primary care (Taylor 2004: 14-15). This change allowed the states to better anticipate annual Medicaid expenditure but has limited revenue for the health centers. In today's competitive market for Medicaid reimbursement with private practitioners due to Medicaid managed care some health centers have lost market share as other providers began to compete for patients. Some lost patients during the paper work shuffling when Medicaid patients failed to select the health centers as their primary care providers (Bailey 2000: 7). Although Medicare and Medicaid reimbursements allowed FQHCs to stretch Federal Grant money to care for more patients without health insurance, competition for patients drove FQHCs back into the private market from which during the 1960s they were expelled.

To achieve financial stability through Medicaid and Medicare reimbursements while trying to maintain competitive with affordable prices and quality doctors, FQHCs are required to be savvy and resourceful when applying for grants. The best applications fulfilling center requirements are most likely to receive grant money. In 1996 with the Health Centers Consolidation Act, the need for resourcefulness only grew. The act, Public Law 104-299, was passed on October 11, 1996, consolidating and reauthorizing the four Federal health center programs, Migrant Health Centers (formerly section 329), Community Health Centers (formerly section 330), Healthcare for the Homeless (formerly section 340) and Healthcare for residents of Public Housing (formerly section 340b) under one authority, section 330 of the Public Health Service Act. In addition to

consolidating the health center programs, the act authorized grants to create linkages and networks between care sites to encourage the opening of more locations and creation of agreements between the centers and local hospitals so that the centers would be competitive in the managed care market. The requires grantees to demonstrate ties between their health center and area hospitals, rural health clinics and health departments for the coordination of cost effective services (Senate Report 104-186, 19). As a result clinics were given incentive to create new clinic locations rather than improve services in a specific area. Older, established clinics were even limited in using funds for the purpose of building maintenance. Grants were distributed on for the purpose of operation and the acquiring or leasing of buildings and equipment and necessary training of staff, but no longer for the purpose of capital projects so that existing clinics can modernize and expand under pressure of current health care market trends (§330 (e)(2) & (3)).

The consolidation of the health center programs under one authority replaced the categorical programs with a single program. The idea was to streamline the application process, allowing centers to apply for a number of program grants with one application to better meet the needs of the community they serve. Therefore, under the Health Centers Consolidation Act Migratory and Seasonal Agricultural workers became “a special medically underserved population” (§330 (g) (1)) for who health centers could apply for additional grants to cover services rendered, create an outreach program and provide transportation to the clinic. As a result of the consolidation, populations of migratory and seasonal farmworkers become an additional source of revenue for the clinics. When before the migrant clinic program was separate from the program that administered the community health clinic, though one organization could receive both grants, now the migrant health program became a check box on the application for federal funding. Under the current law the range of grants given to a community health center are from \$45,000 to \$8,827,000 (www.federalgrants.wire.com). Migrant programs on average receive \$800,000 but can receive as little as \$50,000 and as much as \$2,500,000 (www.educationmoney.com) seriously augmenting the yearly operating budget of a local clinic. As a result not only can clinics in areas with migratory farmworkers gain qualify for additional funds, but the presence of “the special medically underserved population” can give the application more priority. The same issue is true of the other two 330 grant programs, Healthcare for the Homeless and Healthcare for Residents of Public Housing.

On September 30, 2001 the Health Center Consolidation Act of 1996 was set to expire without reauthorization. With strong bipartisan support including the support of President Bush for the health center program, the program was reauthorized by Public Law 107-251 known as the Safety Net Amendments of 2002 on October 26, 2002. In short the amendments increased the programs funding from \$802,124,000 to \$1,340,000,000, reauthorized and increased funding for the National Health and Service Corps to increase the number of physicians available for the health center program, designated all FQHCs and FQHC look-a-likes as health professional shortage areas (HPSA) so that they are eligible to receive a NHSC doctor, changed the definition of a migrant agricultural worker to allow for workers who are employed year round to qualify for services, and created the Healthy Community Access Program (HCAP) (National Association of Community Health Centers, Fact Sheet on S. 1533).

The amendments addressed the raising number of people without health insurance or ability to pay the high cost of health care. Because FQHCs are legally required to serve anyone regardless of their inability to pay for health services, the health center program is viewed as one of the best solutions of providing primary care to the nation's uninsured. President Bush's initiative called for 645 new health centers and 555 health centers by 2006 to increase the number of patients served by about 1 million a year (Sam Shekar 2003). The goal to be achieved by increasing the health center program is "to establish health centers as the best primary care system in the US ...and to be the model for primary care in the US" (Sam Shekar 2003). Velma Lopez Hendershott in a statement before the subcommittee on Public Health said, "Health centers are one of the best health care and tax bargains anywhere ... The average total cost of health centers services amounts to less that \$350 annually—less than a dollar a day for each person served" (Hendershott 21 March 2001: 6). The community health center program argues that as numbers of uninsured increase, the only affordable solution is to increase investment in the most affordable system of primary care delivery.

LIMITATIONS TO THE FQHC PROGRAM

Besides financial demands on CHC, the largest problem facing the effectiveness of safety-net providers is the decreasing amount of charity care offered by other healthcare providers and hospitals (Hendershott 21 March 2001: 7-8). The problem is that while FQHC are required by law to serve patients without ability to pay as are hospital emergency rooms, specialists are not required by law and can make decisions on the basis of ability of resources to fund non reimbursed treatment. The result of this problem is that while community health centers can address the primary needs of their patients, safety net providers find themselves having to beg for needed services for their patients in absence of Charity Care programs at the hospitals. John Geyman MD describes the quest of getting specialist care for the uninsured as "perpetual, frustrating, quixotic, creative and demeaning having to beg for services from others from [their] patients" (Geyman 2005: 23). Hospitals limited in ability to provide free services often refuse safety net providers referrals, denying needed advanced services to the patients. Patients in areas without access to Charity Care programs can literally "fall through the safety net", knowing the problem but being unable to get treatment.

Some states have responded to the need of low cost charity hospitals by funding public hospitals. New Jersey on the other hand does not have a public hospital system but rather has created the New Jersey Charity Care program to reimburse hospitals for services given at no cost to New Jersey residents unavailable to afford the services. This programs enables patients without any type of insurance to receive hospital services for free as long as they are New Jersey residents and their annual income is below 200% of the Federal Poverty Guideline (10:52-11.8 (b)(1)) (SEE TABLE 1 for INCOME BREAKDOWNS) or pay a percentage of service cost if their income is between 200 and 300% of US Federal Poverty Guidelines (10:52-11.8 (b)(2)) (SEE TABLE 2 for INCOME BREAKDOWNS). Reimbursement for free services and discounted services to the hospitals is given at the Medicaid rate for the service (NJ Code 10:52-11.3). Undocumented and migrant farmworkers qualify for Charity Care as long as they state

that they were living in New Jersey at the time when services were given and sign an affidavit of residence (10:52-11.7 (a)(1-3). NJ law also provides that hospitals must inform their patients about the existence of Charity Care.

TABLE 1: Charity Care Income Cut-offs for Free Medical Care by Family Size from <http://www.lsnjlaw.org/english/healthcare/charitycare.cfm>

Family Size	Maximum Yearly Income
1	\$19,140 or less
2	\$25,660 or less
3	\$32,180 or less
4	\$38,700 or less
5	\$45,220 or less
6	\$51,740 or less
7	\$58,260 or less
8	\$64,780 or less
More than 8	Add \$6520 for each additional family member

TABLE 2: Charity Care Income Cut-off for Percentage of Service Paid by Family Size from <http://www.lsnjlaw.org/english/healthcare/charitycare.cfm>

Family Size	You Pay 20% 200-225%	You Pay 40% 225-250%	You Pay 60% 250-275%	You Pay 80% 275-300%
1	\$19,141 - \$21,533	\$21,534 - 23,925	\$23,926 -26,318	\$26,319 - 28,710
2	\$25,661 - 28,868	\$28,869 - 32,075	\$32,076 - \$35,283	\$35,284 - 38,490
3	\$32,181 - 36,203	\$36,204 - 40,225	\$40,226 - \$44,248	\$44,249 - 48,270
4	\$38,701 - 45,538	\$45,539 - 48,375	\$48,376 - 53,213	\$53,214 - 58,050
5	\$45,221 - 50,873	\$50,874 - 56,525	\$56,526 - 62,178	\$62,179 - 67,830
6	\$51,741 - 58,208	\$58,209 - 64,675	\$64,676 - 71,143	\$71,144 - 77,610
7	\$58,261 - 65,543	\$65,544 - 72,825	\$72,826 - 80,108	\$80,109 - 87,390
8	\$64,781 - 72,878	\$72,879 - 80,975	\$80,976 - 89,073	\$89,074 - 97,170

Many workers indicate problems with the Charity Care program. Because hospital contact is through the emergency room, workers do not receive bills for their services immediately. They receive the bill in the mail and the amount is not scaled. Therefore the workers can receive a bill for service above a couple of thousand of dollars. What the workers do not often know, as well as other residents in New Jersey, is that they have thirty days to call the hospital and make an appointment to either set up a payment program or apply for charity care. One worker received treatment for kidney stones before returning to Mexico. He never received the bill and when he returned a year later the hospital informed him of withstanding charges. Though now his service is covered for free, he still is making payments on an \$800 bill.

Sometimes while the Charity Care says that when a person makes less that 200% of the Federal Poverty level in one year he or she are eligible to receive free care, not all services are covered. One family indicated that though the surgery and hospital stay was covered, the anesthesia was not covered. Regardless they indicated that through the program they are required to pay very little in comparison to what they would pay if they had insurance.

New Jersey has also created Rx4NJ to help New Jersey residents get free or reduced priced pharmaceuticals (<http://www.Rx4NJ.org>). Rx4NJ is an application service to apply for free prescriptions from pharmaceutical companies. Ella Murphy, a social worker at CAMcare, indicated that the program is not anything new but only what she as a social worker had been doing over the past few years, applying to the pharmaceutical companies on behalf of her patients so that they could get free medicines. The only new thing about the program is that Rx4NJ searches for the needed applications for the appropriate pharmaceutical charity program and sends the applications to the patient. Ella Murphey indicates that the application only cuts down on the initial time spent of finding the appropriate applications and filling out the patients' demographic information. With a doctor she must still finish the forms.

Pennsylvania on the other hand does not have an extensive Charity Care reimbursement program or to date a state run pharmaceutical assistance application program like New Jersey has. What the State of Pennsylvania has done is appropriate \$400,000,000 from Tobacco settlements to reimburse institutions deemed of 'purely public charity' (those that provide uncompensated goods and services equal to 3% or more of their total operating costs) (PA House Bill 1691 2001: Section 1 (5-7)). These funds are to augment already existing community access funds for some acute care centers. The major difference between the Pennsylvania Charity Care legislation and New Jersey's legislation is that New Jersey's legislation guarantees patients free medical care. Pennsylvania's legislation allows hospitals to decide who and what type of service warrants charity care coverage. Peggy Harris nurse director of Project Salud (FQHC look-a-like) in Kennett Square, Pennsylvania indicated that affordable specialized care is achievable through a referral agreement between Project Salud and area hospitals, but that provision of free or low cost services is case specific. The example she gave was of a patient receiving free heart valve replacements by a cardiologist.

FQHC GRANTEE REQUIRED SERVICES

The Public Health and Welfare Act defines a health center to be "an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements" (§330 (a)). The health centers to receive federally funding are required to provide or contract for primary health services. Primary health services are defined to be: basic health needs (health services related to family medicine, internal medicine, obstetrics or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners and nurse midwives (§330 (b)(1)(A)(I)(i)); diagnostic laboratory and radiological services (§330 (b)(1)(A)(I)(ii)); preventative health services (prenatal and perinatal services; appropriate cancer screenings; well-child services; immunization for vaccine-preventable diseases; screenings for elevated blood lead levels, communicable disease and cholesterol; pediatric eye, ear and dental screenings to determine the need for vision and hearing correction and dental care; voluntary family planning services; and preventative dental services) (§330 (b)(1)(A)(I)(iii)); emergency medical services (§330 (b)(1)(A)(I)(iv); and

center appropriate pharmaceutical services (§330 (b)(1)(A)(I)(v)). Centers are also required to provide referrals (§330 (b)(1)(A)(II)); patient case management services (§330 (b)(1)(A)(III)); services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such indications (§330 (b)(1)(A)(IV)); and education patients of the targeted communities what type of services are available (§330 (b)(1)(A)(V)). In addition of providing primary health services, FQHC can receive funds to support provision of additional health services. Additional health services are defined to be: Behavioral and Mental Health Services; Recuperative Care Services; and Dental Services (§330 (b)(2)(A-C)). The addition of these health services makes FQHC literally a “one stop shop” for primary healthcare needs.

Except in situations of extreme medical emergency (i.e. loss of consciousness, cardiac arrest, trauma or any life-threatening emergency), FQHCs can and should be the first stop for uninsured and undocumented patients. Required by law to not turn away patients on account of ability to pay or resident status (reporting that a patient is an illegal immigrant is a violation of the health privacy act), undocumented and migrant workers are guaranteed affordable and confidential service. The health center program is designed to direct patients to the necessary of level of care according to the patients need. Health center referrals are honored at local hospitals and with the referral patients are eligible to receive discounted rates by agreements between the health centers and hospitals. In addition, FQHCs are required to provide services in the language of their patients. When center refers a patient to a specialist often one of the center’s translators will accompany the patient to the consultation. All migrant health services are required to be in the primary language of the patient.

PAYMENT FOR SERVICES AND THE SLIDING FEE SCALE

Safety net providers as a result of receiving federal reimbursement for services rendered are required by law to provide “access to services without regard for a person’s ability to pay” (PIN #98-23: 36). The purpose of the federal funding is to reimburse the health centers for the cost of services of patients who cannot pay for services. However, to ensure that federal funds go to the reimbursement of those in the most need FQHC are required to create a scale based upon percent of the Federal Poverty Guidelines. The scale known as the sliding fee scale is a schedule of discounts (usually a co-pay for service and then a percentage of additional services). What the scale creates is a dual payer system. The patient pays for part of the services based upon his or her ability and the federal government covers the rest of the bill.

The Bureau of Primary Health Care sets the upper and lower parameters for patients eligible for discounts based upon current Federal Poverty Guidelines, but health centers are able to design the patients’ individual fees within the scale. The guidelines for establishing the fees are that the fees are “adequate and competitive” (PIN #98-23: 26), meaning that the total cost of health services must be competitive with local private

practices and that discounted prices are competitive with other health center discounts as well as “designed to cover its reasonable costs of operation” (www.tachc.org/fqhc/pl_104-299.pdf). According to the BPHC, discounts must be offered to all health center patients below 200% of the Federal Poverty Level and patients above 200% of the federal poverty level are not eligible for discounts and must pay the full charge of services. Patients between 101% and 200% of the federal poverty level receive a % discount and patients below 100% are entitled to a full 100% discount though a nominal fee is charged (bphc.hrsa.gov/osnp/FeeScale.htm). The requirement of paying a nominal fee eliminates the FQHC’s appearance as a free clinic. Rather FQHC patients must still contribute to the cost of their health care. The sliding fee scale represents a subsidized health care system reinforcing that while a patient has a right to receiving healthcare regardless of how much money the patient earns that health care has a price.

All patients who use FQHC services as well as services by FQHC look-a-likes are screened by a financial counselor most will even have to meet with the financial counselor before seeing a doctor or immediately after. All sliding fee scales applications must be bilingual and the counseling sessions be in the native language of the patient. “Billing of clients without insurance, collection of co-payments and minimum fees, and screening for financial status must be done in a culturally appropriate manner to assure that these important administrative steps do not, themselves, present a barrier to care.” (PIN #98-23: 36).

The purpose of the screening is too fold: 1) to scale the patient by family size and income, and 2) to look to see if the patient qualifies for any other medical assistance program and try to enroll the patient in that program like Medicaid or Medicare or some disease specific program. Financial counselors are required to ask for patient identification, if the person has a social security number, number of household members and total household income. Types of documents that can serve as identification can be an addressed letter to the person or driver’s license, birth certificate or passport or visa. The most important thing is proof of yearly income. FQHCs want either a month’s worth of paycheck stubs or a state or federal income tax return from the previous to scale the patient. Often a letter from an employer stating patient’s residence and monthly income will suffice.

The BPHC realizes that it is unreasonable that patients on the first visit be required to bring all of the required documentation. Thus the BPHC has stated, “Patients who present without any required documentation can be given a 'grace period' to turn in documentation and qualify for a discount” without proper documentation the patient will have to pay the full cost of the visit and full cost of services (bphc.hrsa.gov/osnp/FeeScale.htm). Ella Murphy at CAMcare says that the financial officers have be very firm in stressing the need for personal information so that often the officer sounds threatening saying, “If you don’t bring us the information next time you will have to pay \$150.00”.

DEFINITIONS

Many of the problems encountered by the federal health center programs result from the lack of accessible centers within the communities. For people who live within walking distance to the clinics or have access to some form of transportation whether it is public transportation, personal vehicles or clinic provided transportation. The distance and difficulty of going to the clinic makes the workers reassess whether the ailment is severe enough to warrant a time consuming visit to the local clinic.

The phrase medically underserved population means a “population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services” (§330 (b)(3)(A)). “The Secretary may designate a medically underserved population that does not meet the criteria established under subparagraph (B) if the chief executive officer of the State in which such population is located and local officials of such state recommend the designation of such population based on unusual local conditions which are a barrier to access to or the availability of personal health services” (§330 (b)(3)(D))

As defined by §330 (g)(3)(A) a migratory agricultural worker is “an individual whose principal employment is in agriculture, who has so been employed in the last 24 months and who establishes for the purposes of such employment a temporary abode”. A seasonal agricultural worker is “an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker” (§330 (g)(3)(B)). §330 (g)(3)(C) defines agriculture to mean (i) cultivation and tillage of soil; (ii) the production, cultivation, growing and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in, or on the land; and (iii) any practice including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident.

LOCAL REALITIES: HEALTHCARE IN PRACTICE AMONG THE MIGRANT COMMUNITY

AVAILABLE SERVICES

In the area that CATA covers in Southern New Jersey and surrounding Kennett Square, Pennsylvania, there are a number of Health Care Safety Net Services available, including Community Health Centers, Migrant Health Centers, FQHC look-a-likes, free clinics, charitable private practices and hospitals with charity care services. Because each center has its own autonomy, the clinics’ internal decisions and attitudes towards the migrant population are what create the barriers to medical care. This autonomy given to the clinics under federal law creates not only a problem in evaluating the services but also in suggesting one solution to better the health of migrant workers in this area. The best that I can do is present the realities within the territories covered by the clinics. What is important to keep in mind is the discrepancy even within the territories between workers who live on camps close to the clinics and workers who live far away.

USE OF MEDICAL SERVICES BY MIGRANT FARMWORKERS

Because of the nature of migrant farm work, the continual movement of people and availability of work, initial contact with the United States' health profession is frequently on an emergency basis. Need to go to the doctor is determined by the workers based upon a scale of whether they can go to work for the day. For the most part, the workers indicated that they would go to the doctor when they could no longer work. Preventative health services like physicals, blood work and dental cleanings are not the primary means of contact with the health profession as they are in the among US citizens. Rather workers go to the doctor because a tooth hurts, they have a cold or something more serious is wrong, like pesticide exposure or heat stroke.

Some workers indicated that they prefer to self-medicate before going to the doctor. They define the process of self-medication as rest and when transportation is available they go to local pharmacies to buy over-the-counter medication. Sometimes they even call home to get known remedies or in the case of many of the mushroom workers return to Mexico to visit a naturalist or a Mexican doctor. The most extreme case that I encountered on the camps was a worker who had called home to Puerto Rico to send his cousin to a local doctor to get his usual prescription to control his flaring Gouty Arthritis and have the medicine sent from Puerto Rico to the farm. Some workers even try to tolerate the condition till they can return home to receive medical care in their own countries. One Puerto Rican worker in Vineland said that he once went to the clinic in Vineland for a toothache. He said that he only went to the clinic because he still had two more months to go on the season and realized that the pain was so strong that he could not wait for the end of the season to return to Puerto Rico. Therefore reluctantly he went to the clinic. He like many other workers decided to go to the doctor in the moment when the worker can no longer tolerate the condition or local remedies no longer suffice.

Use of the clinics preventative health services, like dental services and physicals, is more frequent among the permanent members of the communities and their children, who grew up in the United States. Of the workers who live in the migrant communities in Bridgeton, Vineland and Salem, not only are many familiar with the clinics' services but attend the vision screenings and dental screenings offered at the lower prices. Children who grow up in the communities and attend schools often have Medicaid and see doctors on a regular basis because of the required physicals for school. These children as a result of Medicaid coverage of services receive extensive medical care for expensive chronic conditions like asthma. Because of familiarity with preventative services, those children, who grow up in the US, are more likely to continue use of preventative services. One 20 year old indicated that he still goes to the dentist for cleanings every year.

There are differences between camps of workers who recently have arrived for work and camps with workers who have worked for years. The new workers report that they are healthy and that they do not have any need to see a doctor. They say they are here and able to work. However, on camps with older workers, there are problems with diabetes, high blood pressure, kidney stones and other health ailments. At these camps it

is possible to find of workers complaining about muscle aches and not feeling well, many having coughs or developing neurological problems.

It appears that workers come to the United States healthy ready to work, but leave the United States in worse physical condition due to their migratory and demanding lifestyle. This phenomenon is often referred to as the “healthy worker effect”. Lea et al. (1999) describes the components of the “healthy worker effect” as a “healthy hire effect,” meaning that the initial selection process for work self-selects for those who can perform the labor thereby suggesting that with time in that particular industry the increase of mortality increases, an association between exposure and mortality and the “healthy worker survivor effect” the continuous self selection problem in that those who can no longer continue to work leave and those who can work and are healthy remain employed (1099-1106). The problem created by this phenomenon is a lack of experience within the camps in dealing with the health industry. Often there are many camps without any worker who has had need to go to the clinic. In the case of an emergency there is a lack of information within the community of workers.

The lack of information regarding use of the clinics is not necessarily a lack of information about healthcare or health needs. The majority of the farmworkers are familiar with some type of medical system either in Puerto Rico, México or Guatemala. Among the workers there is a consensus that if a person is sick or injured, he or she needs to go to the doctor. In addition going to the doctor can help maintain a healthy body. On the Puerto Rican camps many of the workers indicated that as they got older they would go to the doctor for check-ups during the winter. Many of these workers are managing chronic conditions. Some workers during return visits to Mexico will consult a doctor or naturalist. Others are state familiarity with going to a doctor or pharmacy back in their country, but state confusion due to too many choices of over the counter remedies.

Because of the infrequent use of the clinics, when there is need to go to the clinics often the workers are lost and without information. In addition the perceived seriousness of the condition compounds the sense of urgency of the need to be seen by a doctor. Any barriers or hassles encountered in trying to go to the clinic such as a lack of transportation, busy phone lines, documentation requirements, or waiting time adds to the sense of urgency and often results in sentiment of confusion, helplessness and being scared. The emergency need to see a doctor can best be described as being thrown into an ocean fully clothed and being told to swim to shore. The worker knows how to swim because of familiarity with medicine at home but does not know where the shore is and is wearing bulky clothes making the swim to shore difficult.

THE HEALTHCARE ENVIRONMENT IN SOUTHERN NEW JERSEY

The Health Care Safety Net in New Jersey is strong due to strong support and dedication by state officials, specifically Assemblyman Lou Greenwald (budget chair), Senator Vitale (Chair of Health Committee), Senator Wayne Brayant (Chair of Senate Appropriations), Senator Bonnie Watson Coleman, Assemblyman Loretta Wienberg (Health Chair) and Governor Codey. As a state New Jersey is dedicated to alleviated

health disparities between minority populations and funds a state department of Minority and Multicultural Health of which Linda Holmes is the direction. Due to strong support by state officials and deeming the health of New Jersey residents a priority, New Jersey officials dedicate time and resources to increasing access to health resources. Through the Charity Care program, FQHC sites, Medicare and Medicaid, New Jersey is slowly trying to provide health care to all residents. Since 1993 New Jersey has increased the number of FQHCs from seven operating 32 sites to 20 agencies operating about 76 sites (Interview with Katherine Grant-Davis NJPCA 19-7-05). In 2003, according to BPHC statistics New Jersey FQHCs had 829,764 patient visits, averaging a cost of \$122 per patient visit (www.bphc.hrsa.gov/uds/data.htm).

Success in increasing the amount of FQHC funding for New Jersey has been partly due to the executives like Katherine Grant-Davis working for the New Jersey Primary Care Association (NJPCA). The NJPCA works with the New Jersey State Office of Rural Health (NJSORH) to manage the FQHC program. The NJPCA serves as a link between the Community Health Centers (CHCs) and both federal and state offices of Public Health. In addition the NJPCA is constantly looking for new and expanded revenue sources for the delivery of primary care to promote equitable reimbursement mechanisms for CHCs (<http://www.njpca.org/about/default.aspx>). Recently CAMcare an FQHC in CAMden was about to build a new 45 room site due to a capital raising campaign by Capital Link, a capital raising organization in Boston (Grant-Davis). In addition the NJPCA has received \$1.2 million for the centers to mount a marketing campaign to increase number of patients served to reduce the number of patients coming to the ERs for primary medical needs (Grant-Davis).

In the southern counties of New Jersey, specifically Atlantic, Camden, Cumberland, Gloucester and Salem there are three FQHCs: CAMcare, a Community Health Center that operates in inner city Camden; Southern Jersey Family Medical Center (SJFMC), a FQHC with special funding for a migrant farmworker outreach program for migrant farmworkers working in Atlantic, Burlington, Camden, Gloucester, and Salem counties; and Community Health Care, a FQHC with specific funding for a migrant program in Cumberland County. In addition because migrant farmworker camps can be considered temporary housing, migrant workers can qualify for health care services by healthcare for the homeless programs. The only federally funding healthcare for the homeless is called AlantiCare Mission Health Care and is located in Atlantic City. Currently only migrant programs receive funding to offer outreach and transportation services to the migrant populations, while all centers have bilingual capabilities, including bilingual social workers and financial counselors to help navigate the workers through their treatment.

THE REALITIES FOR THE WORKERS

While CAMcare and AlantiCare offer health services to the population of migrant farmworkers in New Southern New Jersey, the migrant population is not familiar with these agencies. CAMcare has capabilities of daily managing HIV/ AIDs treatment in conjunction with an infectious disease specialist at Cooper University Hospital. Thereby

reducing the everyday cost of disease management using the clinics lower cost services in place of the hospitals. However, because of their locations within a city and not near the camps of workers, these two agencies while potentially useful are underutilized due to need for transportation. Moreover patient campaigns do not reach the fairly isolated workers on the camps and those in the communities in Penns Grove, Vineland and Bridgeton because they are outside of the radius of these two agencies. Both agencies indicated through conversation that the limited outreach done in the communities is to bring patients back to the clinics for follow-ups and initial visits, but rarely admit to going outside of the city limits to look for patients. Both agencies did indicate their willingness to share information with CATA so that we could recommend or inform our membership about their services. However for the meantime the membership base is most familiar with the services of Community Health Care and SJFMC.

SJFMC...

SJFMC operates four clinics: one in Burlington, one in Pleasantville, one in Hammonton and one in Salem. Migrant outreach programs operate from the clinics in Burlington, Salem and Hammonton. SJFMC migrant program's coordinator is Cherie Stauffer and she works from the Hammonton office. She coordinates a staff of outreach workers, a van driver, specific migrant clinic hours during the evening and various health fairs including a Farmworker Festival in Hammonton to celebrate the end of the Blueberry harvest in July and a health fair in August. She also coordinates specific health events at each clinic including free dental and vision screenings for the workers and their families.

Each SJFMC outreach team is responsible to cover a certain area. According to Julia Harris an outreach worker from the Salem clinic during a phone interview on the 9th of June, she and her partner Erica are responsible for visiting 60 camps in Salem county and Gloucester county during the summer. Throughout the summer she and her partner try to visit each camp three times, making outreach visits four nights a week. On migrant clinic nights they stay at the clinic to help translate. During the visits to the camps, they will check the workers' blood pressures and blood glucose levels. They also ask if anyone has a headache or has been feeling sick and ask if anyone would like an appointment to see a doctor or dentist. She and her partner are trained to provide certain health education programs to provide the workers on disease prevention and management such as sun safety, STD prevention and diabetes awareness. These programs are presented due to expressed interest by the workers.

The Salem outreach team is new this year as both workers were hired before the summer season. Julia indicated that the workers had been "receptive and welcoming" to both her and her partner. She felt fairly satisfied with the amount of information about SJFMC on the camps. Most camps still had people who remembered the names of their old outreach workers and almost all still had the SJFMC fliers posted. However during my visits to the camps in Salem and Gloucester, while some of the older workers remembered past outreach workers, many referring to the workers as friends, most did not remember the names of their new workers. The problem with this turnover of workers means that many of the workers do not have a consistent outreach team.

Without familiarity and trust of their clinic's team the workers may not feel entitled to ask for specific health education programs or feel comfortable asking for assistance.

In visits to the camps with CATA personal, while it was evident that outreach workers had come to the camps (there were new fliers and posters posted on the walls of the dining room and some of the blueberry workers mistook CATA's van for the SJFMC outreach van asking for us to help schedule dental visits), the outreach program was functioning only to bring patients to the clinic. Rather than perform health educational programs, the outreach workers perhaps due to the large number of workers on the camps and also the need to visit a large number of camps throughout the year, the outreach workers were only doing the blood pressure and blood glucose screenings for hypertension and diabetes and arranging appointments and transportation to the clinic. At the Farmworker Festival on July 10, 2005 the clinic's staff did not use the opportunity to pass out health information but rather only provided health screenings and back massages. Thus rather than using the outreach program as a preventative health measure the program is geared to promoting the image and name of the clinic within the worker population to increase patient volume. As a result opportunities of teaching workers fist aid or basic health and safety techniques are being lost to the desire of increasing patient numbers.

Perhaps SJFMC greatest asset to the farmworker population is that it offers transportation for its patients to medical services at the clinics. However, due to age requirements for people to drive the van only the Hammonton clinic has a full time van driver. Some outreach workers will take turns picking up the patients but mostly the one van driver is responsible for the transportation of all of the workers in Atlantic Burlington, Camden, Gloucester and Salem counties. As a result the transportation service is in high demand during even clinic hours when the workers are able to go. However, during the day migrant workers can usually find a next day appointment. One Puerto Rican worker at Leoni indicated that he prefers to go to the clinic during the day for his monthly blood work for his diabetes. "I don't mind missing work," he says, "Each month I get a social security check. Therefore I don't really have to work if I don't want to." As for the transportation service offered by the clinic he indicated that "it is great! I make an appointment. The van picks me up here and after the appointment it brings me back."

For workers who are trying to manage their conditions within their work schedules trips to the clinics becomes inconvenient and often difficult to arrange. A group of workers at Zee Orchards, after waiting for a week for transportation, finally resorted to arranging their own means of transportation. In consensus the workers described the service as "slow" and "not dependable". When the outreach workers made appointments for them, they waited for the transportation and it never came. They ended up waiting for a week. One of the workers, who has been treated for kidney stones, expressed frustration in the lack of transportation. Because he needs to return for follow-up visits and financial meetings with the hospitals to cover his lab expenses, he must return multiple times to the clinic and often is forced to miss work, losing out on more money.

Except for workers who are willing to miss work for doctor's appointments due to grave need or flexibility with financial situations, one of the greatest frustrations for workers is trying to schedule an appointment. Because summer hours spent in the fields often are till eight o'clock at night, many workers are unable to call and schedule an appointment during the clinic's operating hours. They end up leaving a message that is not returnable or having to miss a day of work to call the clinic and then try to schedule an appointment for the next day. The result of this problem is that many workers have started to call CATA's organizers to help them get an appointment. One of the Puerto Rican workers at Leoni, suffering from being unable to walk to a flaring case of Gouty Arthritis in his knee, called asking for assistance in making an appointment. He had indicated that he could not get through to anyone who could schedule an appointment for him. The appointment with the aid of CATA's organizer finally succeeded in getting him an appointment for the next day. The worker had missed a full week of work.

SJFMC's outreach program rather than fostering a self-sustaining patient self help capacity is facilitating a dependence upon the outreach workers or others to schedule medical consultations and transportation. What is occurring is that workers are still reliant upon others to take action for their own healthcare. They expect the clinic to follow-up with them about test results rather than schedule another appointment themselves at their convenience. As a result some workers wait for weeks for test results as their conditions persist. They feel neglected by the clinic whereas it is there responsibility to be proactive. The result of this is a miscommunication of the role of the outreach program and the role of the clinic. Both are enabling services to maintain good health and manage chronic conditions but not, but neither can the outreach program nor the clinic assume a truly proactive role in the management of the patient's condition.

Community Health Care...

Community Health Care is Cumberland County's FQHC with specific funding for a migrant outreach program. It operates three clinics: one in Vineland, one in Bridgeton and one in Millville. The clinics in Vineland and Bridgeton each have a migrant outreach worker and specific hours for evening migrant clinics. Nelva Ancona and Filemon Matias are Community Health Care's bilingual outreach workers, acting as liaisons between the clinics and camps and within the local communities. According to Community Health Care's website they provide education counseling on various topics including: "benefits of preventative healthcare; proper personnel hygiene, vision screening; diabetic teaching; asthma education; immunization programs; dental care; high blood pressure screening and foot care services" at both the camps and also at health fairs (www.sjhs.com/communityservices/outreach.htm).

While neither Nelva nor Filemon returned numerous phone calls to elaborate on their outreach work in the community, in correspondence with one of the clinics directors Robert Moran, it was indicated that the nature of the outreach program has been slowly changing over the last couple of years. In regards to a question about whether Community Health Care offered transportation services for the migrant workers from the camps to the clinics and back, Robert Moran answered, "We currently do not offer transportation. We have in the past with miserable results. We would schedule 10-15

each night for pick up, but when we arrived to pick them up maybe 1 person would use this service” (6/9/05). Keith Talbot, a lawyer working for South Jersey Legal Services, again voiced a sentiment that Community Health Care’s priorities toward the migrant population was changing. Keith Talbot’s wife Lori Talbot had been the former director of the Migrant Program. Recently within the last few years he said that she had been fired and her job replaced by a minorities program coordinator. Dr. Talbot left Community Health Care and continues a free migrant clinic as well as outreach to camps in the Bridgeton area.

Whether Community Health Care outwardly admits that the migrant program is being reprioritized or not, the outreach program seems to have been discontinued this year. In visits to camps surrounding the Vineland and Bridgeton area, not only were workers saying that no one from the clinics has come to visit them this year but also Community Health Care did not host or run a health fair this summer to promote not only the clinic’s services, locations and hours, but also to promote and educate the workers on means of preventative medicine and good health. Among the Puerto Rican workers in Vineland they indicated that many years before Nelva used to visit the camps to take blood pressure and schedule both medical and dental appointments for the workers. Now, workers only encounter Filemon and Nelva during clinical visits that they have arranged on their own. Usually after an office visit the workers will meet with Nelva or Filemon about the next stage of their treatment. Many of the workers during these meetings are given the either Nelva or Filemon’s cell phone numbers.

As a result of the discontinuation of outreach services to the camps, information about the clinic’s services is slowly becoming centralized. Only the older workers or those who are in charge of the camps have the information. When a worker becomes ill, they go to the person in charge to ask where to go. Usually they are given a direction and maybe a telephone number of either the clinic in Bridgeton or Vineland and then expected to arrange their own transportation or walk. For workers living on camps like Sunny Slope that are close to the clinics workers can walk to the clinics without transportation assistance but on camps further from the clinics, like Campo de los Flores, without transportation workers are unable to arrive at the clinic and thus even the information is useless.

One of the permanent camps at Shepard Farms served to contract to the health care knowledge of the rest of the workers. Because the families had small children born in the United States receiving Medicaid benefits to cover healthcare, the women were incredible familiar with the inner workings of health profession. One family had a young child with serious asthma. As a result they were very familiar with the local hospitals. As a result, though the parents did not qualify for any medical benefits they used the complete services of community healthcare: dental, vision and medical for physicals. What the women expressed was that “I should not worry about them, but rather about the single men living by themselves on the camps.” “They don’t have cars or any one to tell them to go to the doctor.”

While the permanent families are thriving by learning to take care of themselves via the healthcare granted to their children, the single men are hopelessly lost. I spent one evening at Sunny Slope trying to point the workers in the right direction of getting adequate health care. At that camp I met one worker, who had just been re-prescribed the same medicine for the same condition he was already taking, another who was in a holding pattern in his medical treatment unsure of what to do with his doctor's order to go to the hospital for lab work strongly contemplating just returning to the clinic to see the doctor without the lab results and finally one worker unable to contact Filemon to be taken for very specific tests. This last worker who was trying to contact Filemon had in desperation walked the 30 minute distance to the clinic only to find the clinic closed when he got there. Each one of these problems was caused by a lack of communication between the clinic and the workers.

However to frustrate these workers more when they all went to the clinic, Community Health Care, unlike SJFMC, required workers in Cumberland County to get a signed form from their bosses to prove that the workers live on a camp and not within the community to qualify for the reduced scale. In having to perform this task, one worker was scared that his bosses would not sign the paper and they would have to pay \$150 instead of \$20. To add to the inconvenience the workers had to immediately return to the clinics with the forms or they would be charged the full price for services anyhow. Families forced to use Community Health Care's services say that the financial screening process is arduous. They must prove incomes of all people living in the residence as well as produce statement about how much they pay in rent and utilities to receive the reduced fee.

Pesticide Treatment Capabilities

FQHC are equipped to be only ambulatory clinics. While they are supposed to offer diagnostic and radiologic services, most have contracted the service with local hospitals. Both SJFMC and Community Health Care indicated quite ambiguously that they have "some" capabilities of dealing with pesticide exposure. In serious cases they refer patients to the emergency room for treatment. They also cite the state as a potential reference when needed in treated a patient that presents with pesticide exposure. Local emergency rooms are most likely the places where farmworkers will receive treatment for pesticide poisoning. In correspondence with nurse directors at local emergency departments, they nurses indicated that emergency department policy is to call poison control with the name of the chemical for the specific guidelines for treatment. All state emergency departments are equipped with special showers to decontaminate the body and initiate treatment. However, emergency departments stated that they cannot remember a case of pesticide exposure in recent years.

What these answers and policies represent is known cases of pesticide exposure. They depend on a couple of factors. The worker know when he or she was exposed, how they were exposed, and to what they were exposed. Most workers do not even know when certain fields had been sprayed let alone what type of pesticide was used. Many farms use the pesticide plaques not to inform the workers but rather as if they were "NO TRESPASSING" or "KEEP OUT" signs. As a result many workers may go to the doctor

for pesticide exposure not knowing they were exposed and thereby receiving treatment for the flu or simply dismissed without any treatment. A few of the workers at Zee Orchard went to SJFMC's clinic in Salem, reporting not feeling well. A few workers had burning eyes; others felt "off" like they were having hard times focusing and concentrating. However the doctor sent them home without any diagnosis saying that they were only "drunk".

THE HEALTHCARE ENVIRONMENT IN KENNETT SQUARE, PA FOR THE MUSHROOM WORKERS

In contrast to its neighbor state across the Delaware, Pennsylvania is not a progressive public health state. Health disparities have been growing over the past few years without much state directed corrective action. For example while New Jersey has a Department of Minority Health and Welfare, Pennsylvania is still one of the few states without an office of minority health. This lack of dedication towards improving state welfare and the need to have a proactive state to help apply for federal funds, only complicate the already existing problem of acquiring low cost health care for the population of mushroom workers in the Kennett Square area. In short the problem facing the mushroom workers is that while they do not make much money, the rest of the county does. From the State of PA counties published in 2002, Chester County is ranked among one of the most affluent counties in the whole state of Pennsylvania (Pierce 2002). Unfortunately this means for the mushroom worker communities in Avondale, Toughkenamon and Kennett Square that access to federal health programs would be extremely limited. Not only can Chester County Pennsylvania not qualify as an underserved area but it also cannot qualify as a rural area in need of a rural clinic nor because of the permanent quality to mushroom work can the workers qualify for migrant program funds. Westside Health Clinic indicated that they had applied for FQHC grant money to open a clinic in Kennett Square but had been rejected because Kennett Square did not meet the definitions of a Medically Underserved Area or a Medically Underserved Population.

As a result the closest FQHC to Kennett Square are in Coatesville (ChesPenn Health Services and Community Dental) and in Wilmington, DE (Westside Health Clinic and the Henrietta Johnson Medical Center). Though they are only about 15-20 miles away from downtown Kennett Square, the distance must be traveled by private transportation for there is not any public transportation that can transport workers from Kennett Square to the clinics. Therefore these clinics are underutilized by the mushroom worker population, though the services are available. Health options in Kennett Square are Dr. Roy Farias private family practice, Community Volunteers in Medicine in West Chester and Project Salud in Kennett Square. These other services are the more fragile components of the US' healthcare safety net.

Dr. Roy Farias' Practice...

Dr. Farias' office is popular among the mushroom worker community not only for his ability to speak Spanish but also because of the office's convenience to the workers. Workers during Concilio meeting expressed that he runs a good practice and that he is an

honest man. He has crafted his hours around the workdays at most of the mushroom farms, having morning hours and late evening hours to be accessible to his patients. He refuses to accept private insurance and rather requires each patient to pay a co-pay of \$30.00 to cover the cost of the visit. However to keep cost down, often Dr. Farias refers patients to other local public health services like planned parenthood for more expensive diagnostic tests. While he cannot help the patients with free medicine, he only prescribes affordable generics to patients. In a telephone conversation, Dr. Farias expressed that he “is not looking for anymore patients because [his] practice is more than full”.

Community Volunteers in Medicine...

Community Volunteers in Medicine (CVM) is a free clinic for working residents of Chester County. CVM relies upon the charity of local practitioners and community members to offer their services and expertise to the working poor of Chester County. The clinic has some donated pharmaceuticals. Laboratory Services are contracted out or given for free as well as many of the doctors agree to see CVM patients for free within their own practice. This partnership often reduces the cost of hospital services.

To qualify for the free services the patient cannot have any type of medical insurance, or government medical benefits like Medicaid, Medicare or veterans benefits and must earn less than 200% of the federal poverty guideline. For dental service the clinic charges a co-pay of \$5.00 for a visit. The catch to the service is that unlike an FQHC that sets the co-pay for an entire year, every patient must meet with a financial screener every ninety days to re demonstrate the need to remain a patient of the clinic. As a result of the focus on pre-qualifying for services, a patient must pre-register to determine eligible before there is need to use the clinic’s medical services and continue to register till the clinic’s services is no longer needed. The financial screening process is not convenient. The screeners are only at the clinic for two hours a day Monday through Thursday alternating morning and afternoon hours. Because transportation is not offered and there is no public transportation running between West Chester and Kennett Square \, CVM is not a convenient service for those without access to a car or within a vicinity to walk.

Project Salud

Project Salud is the clinical arm of La Comunidad Hispana, a social support organization for Kennett Square’s Hispanic population, providing not only low cost medical care but also clothing and shelter assistance. Project Salud is considered a FQHC look-a-like, meaning that it offers the same type of discounted primary medical services (except for dental) as a FQHC offers but does not directly receive federal funding. Therefore Project Salud cannot be classified as either a Migrant Health Center or a Community Health Center. However, because of the small numbers of migrant workers working in the mushroom houses, Project Salud is reimbursed by a Keystone Rural Health, a migrant health center, for the cost of medical care for the workers who live on the mushroom camps. Project Salud is subcontracted to serve the health needs of the migrant mushroom workers by Keystone Rural Health. The subcontract only covers the cost of the workers consultation and lab work. Project Salud does not have operating money for migrant outreach program nor transportation assistance.

The only time the clinical staff from Project Salud is funded to go to the mushroom camps is during the fall to distribute the flu vaccine and with an anti-tobacco outreach program. Peggy Harris the chief licensed nurse practitioner of the clinic states that during the flu vaccination program she and her nursing staff utilize the time with the migrant workers during the waiting period of vaccine administration till dismissal to tell the workers a little bit about the clinic. But this type of outreach is not health screening or providing preventative education talks, nor is this a program that enables the workers to seek health from the clinics. Rather it is what it appears to be, a public health vaccination initiative. Without transportation even with the clinics information workers have difficult arriving at the clinic. The only other group currently visiting the camps is the Chester County Health department. Salvador Villacana is incharge of administering free oral HIV tests with the workers. However, currently Project Salud is not capable of handling HIV cases or processing the tests if a worker was to ask for one.

Project Salud like the local FQHC does offer a sliding fee scale. Based upon yearly income levels the patient is required to pay a portion of their health services. Unlike the FQHC which scale of the cost of services to a percentage, Project Salud is unable to scale the cost of services. Without the federal funding and dependence on charitable organization for funding the cost of the clinical visit is based upon how much Project Salud paid for the equipment. The complaint within the community in Kennett Square is that ten years ago the cost of a consultation at Project Salud has been affordable, however recently many workers say a basic visit is requiring a co-pay of \$40.00.

LOOKING TOWARD SOLUTIONS: Concilio's Sentiments and Moving Forward

In presentations with both the Kennett Square Conilio on August 10, 2005 and the New Jersey Concilio on August 11, 2005, the current primary health care options were presented and discussed with the present Concilio members. During both meetings the consensus that arose was the need for more information. But information was not just the names of the clinics and the services offered but how to use the clinics' services. What the presentation of the types of services available incited was a plethora of stories surrounding mistakes the concilio members or their family members had made in contact with the health profession. Many of these problems were quantified with an introductory statement that "In Mexico we...". Each story in one way or another qualified the problem of translating one medical systems' nuances into another medical systems' nuances.

SUGGESTIONS FOR CHANGE from the Kennett Square and New Jersey Concilios

- A bi-monthly/ monthly class with community members as well as workers living on the mushroom camps to discuss types of services available, patient's rights at the doctors office, necessary documentation and other useful tips to help the workers learn how to use the medical services available... Kennett Square

- Assistance in selecting/ making sense of the health insurance plans offered by the mushroom companies, perhaps pressuring companies for better insurance plans ... Kennett Square
- Mobilizing the community to help with transportation for medical visits ... Kennett Square
- Increased communication about needs, assuming roles on the health clinic's advisory councils ... New Jersey
- Increasing community communication regarding health experiences and helping out neighbors ... New Jersey
- Contact Cards with the clinic's contact number, address and other services numbers. This should also have CATA's information on it as well as a line for the worker to write the farm's address and pesticides used... New Jersey

CONCLUSION

The 1962 legislation creating health clinics for migratory workers to address access to healthcare issues has only had minor success. The current problem encountered by the workers is the institutional expectation that all a worker needs is a telephone number, an address and a \$20.00 co-pay to receive adequate services. The reality is that the workers need much more: translation, transportation, and familiarization with the certain clinical expectations of them. Specifically a worker needs to understand why the clinic is going to ask for income documentation and some type of personal identification and what documents will fulfill the clinic's need. Also, workers need to be introduced to clinical protocol, what clinical etiquette is expected. Similarly the clinics should be conscious of the different health care etiquettes followed by the migrants. Outreach programs are some of the best means of communication with the workers. So asking for a restructuring of outreach programs to return back to the public health and preventative agenda rather could be one of the best solutions.