The Agricultural Worker Health Study

Case Study No. 4: North Tulare County

A baseline report of
The Agricultural Worker Health Initiative

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Summary of Main Findings

Population and Environment

- Tulare County leads the nation in value of county agricultural production, which in the Kaweah delta and North Orange Belt consists mainly of citrus, deciduous tree fruit, and grapes. A major crop, valencia oranges, has declined in price in recent years, and consequently growers have cut back on pruning orchards, increasing the risk of injury to workers.

- A large portion of the approximately 57,000 farmworkers in Tulare County live in small towns in the north region. At the southern edge of this region there is a growing population of Oaxacans, particularly Mixteco-speaking people.

- The majority of towns in the study region demonstrate a mature, stable settlement pattern. However, Cutler and London represent prototypical newcomer farmworker towns occupied by many solo males.

- Farmworkers in the region follow a well-established pattern of migration north to Oregon and Washington for the deciduous harvest. Many legal residents also travel back and forth between Mexico and Tulare County during the year.

Living and Working Conditions

- Farmworker housing conditions in North County range from adequate to extremely substandard. In the worst cases, workers inhabit dilapidated structures and converted garages. Many residences lack heat and air conditioning. Moreover, both service providers and farmworker informants report that overcrowding is common in these communities.

- Farmworker men crowded into camps composed entirely of solo males and in apartment complexes are prone to involvement in prostitution, drinking, and violence. Their participation stems not only from their poverty but also from situational mental distress caused by separation from families left behind in Mexico.

- The lack of activities for youth, coupled with limited opportunities for parental monitoring and participation are exacerbating widespread problems of teenage pregnancy, gang violence, and alcohol and drug abuse. Farmworker youth are joining gangs for protection from retaliating gang members and to achieve social acceptance. Tulare County consistently demonstrates one of the highest teen pregnancy rates in California.

- Difficult working conditions include inadequate pesticide safety and sanitation measures on the job; mistreatment by foremen and crew bosses, including denial of payment for hours worked and being pressured to work faster; and excessive charges for transportation to work by raiteros/transportation providers. Workers most vulnerable to abuse are older workers, minors, indigenous workers, women, and the undocumented.
Major Health Care Programs for Low-Income Residents

- Tulare County has California’s highest percentage of Medi-Cal recipients; 26 percent of residents were enrolled in 2001.
- The county ranks sixth in the state for the percent of the county’s population that is enrolled in Healthy Families.
- Efforts to enroll eligible people in Medi-Cal and Health Families occur mostly in more urban areas of the county. There is little funding to reach out to uninsured individuals in the small, geographically isolated North County communities.
- Thousands of farmworkers in Tulare County are uninsured, particularly undocumented adults. Funding for Tulare County Medical Services, the county’s indigent health care program, allows coverage of only about 1,500 adults.

Characteristics of the Health Care System

- In Dinuba, Cutler-Orosi, Ivanhoe, and Woodlake, health service delivery is restricted to primary care; other North County towns offer no local services at all.
- Federally qualified health centers are the major source of primary care for agricultural workers in the region. Farmworkers also frequent a county-operated clinic and several small, private, for-profit physician practices.
- Health services such as radiology and specialty care require travel to facilities in Visalia and Reedley.
- Kaweah Delta Health Care District’s hospital serves as a provider of last resort for inpatient and emergency care for North County residents. Hospitals outside Tulare County also receive area farmworkers.
- Federally qualified health centers, particularly the large community outreach program at Family Health Care Network, and the county’s clinic and Preventive Services division provide most health education in the region.
- Private, for-profit physician practices vary in the extent to which they accept Medi-Cal and uninsured patients, generally do not offer payment options, and do not focus on preventive care. A few private physicians have established trust in the community and offer health care that is perceived by farmworkers as culturally appropriate and expedient.
- Farmworkers find that enrollment and support services for Medi-Cal, Healthy Families, and Women Infants & Children are more convenient and helpful at the county-operated clinic in Dinuba than those at often overcrowded welfare offices.
- Due to the region’s large number of low-income and uninsured adults, area providers must manage high levels of uncompensated care.
- The number of emergency room visits for non-urgent care is rising. Kaweah Delta Health Care District saw a 10 percent increase in emergency room visits between 2000 and 2001. Recruitment and retention of medical and mental health professionals who speak Spanish and understand the culture of Mexican immigrants remains a challenge in all service areas.
Outreach Activities in North Tulare County

- Both public and private entities conduct outreach activities in North County, including home visits, community presentations, and services delivered through community-based organizations, out-stationed staff, and local health fairs.

- Outreach efforts in farmworker communities address Healthy Families and Medi-Cal benefits, diabetes, prenatal care, dental care, HIV/AIDS prevention, and car seat safety.

- The majority of outreach in North County occurs through community-based organizations and school-based efforts.

- The Diabetes Community Intervention Project, a coordinated effort, provides a promotora model of outreach to farmworkers at risk for or suffering from the disease.

Inter-organizational Collaboration Efforts

- Collaborative partnerships designed to enhance access to health care for farmworkers and their families are being built in Tulare County by public, private, and nonprofit sectors.

- Significant challenges to collaboration come from the limits on participants’ time, the lack of training in collaborative skills and of people to lead the efforts, insufficient organization commitments to these long-term projects, and competition between organizations.

The Referral System

- Inefficiencies in the referral system in the study region reduce the quality of care patients receive and unnecessarily consume staff time and resources.

- Referrals are difficult to obtain for farmworkers who have no insurance and therefore have difficulty paying for expensive care and/or pay cash. Inadequate and unreliable transportation, limited English skills, and a general mistrust of U.S. institutions also impede the referral process.

- Primary care providers often suffer from staff shortages and poor patient tracking/information systems.

- Cultural insensitivity, lack of interpreters, and a shortage of bilingual providers all make it difficult for Spanish-speaking and indigenous-language patients to properly implement prescribed treatments. There are few medical clinicians who are aware of beliefs, cultural practices, and health care preferences common among farmworkers.

- Especially among adults, mental health services are sorely lacking.
Utilization of Health Services

- Most farmworkers and a significant proportion of their dependents lack adequate and/or continuous health care coverage. Few agricultural employers provide such benefits, and plans that do exist often require expensive premiums/copays and do not cover prescriptions.

- Farmworkers identify health care resources by word of mouth and social networks, including family, friends, coworkers, and mayordomos/crew bosses. Service providers also act as cultural brokers for care.

- Farmworkers continue to rely on home remedies, self-prescribed medications, and Mexican physicians. Access to health insurance does not appear to eliminate these practices. However, people who cannot afford to pay for services often neglect health care entirely.

Principal Medical Conditions

- The severe dental problems experienced by many farmworkers and their families have not been alleviated by current prevention efforts in the north region. Farmworkers suffer from poor dental hygiene habits, lack of insurance coverage, and the limited number of affordable programs and providers in the area.

- Diabetes, which disproportionately affects Latinos, is a principal medical condition within the farmworker community. Countywide, about 21,000 individuals have diabetes. Many of farmworker families do not accurately understand the disease. In addition, their work schedules, low incomes, lack of health insurance, and unreliable transportation make it difficult for them to manage the condition. Providers have responded to these challenges with a promotora model to educate farmworkers about diabetes and improve health outcomes.

- The often severe living and working conditions experienced by farmworkers and their families put them at risk for mental health problems. Stressors include extreme poverty, poor housing conditions, separation from families and friends, fear of North American institutions, frequent periods of migration over long distances and under stressful conditions, exploitation at work, lack of transportation, and inability to obtain health care. Difficulties with immigration authorities, family relationships, and alcohol and drugs are also common.

- There is a potent cultural stigma in Latino culture associated with seeking help for mental health disorders.
Introduction

The purpose of this assessment is to provide The California Endowment (TCE) with a profile of farmworkers in the North Tulare County subregion. The assessment focuses on several key dimensions and generates a menu of potential community-based approaches for improving farmworker health care. This analysis is intended to assist TCE in developing a place-based strategy of intervention in this subregion as part of its Agricultural Worker Health Initiative.

This is the fourth in a series of Agricultural Workers Health Study (AWHS) reports profiling and assessing farmworker health care delivery in several agricultural subregions of California. Each subregion roughly encompasses a commuting area in which farmworkers travel to and from their residences, work, and health service delivery areas. Within each region, there is a community of professional and volunteer health care and social service providers who know each other and the communities they serve and who share common goals. Furthermore, farmworkers in an area tend to come from a few common communities of origin in Mexico. Many farmworkers maintain contacts within their original communities and with their colleagues in other parts of California and the U.S., creating an information network that spans subregional boundaries. By working within a geographic area, we can define the farmworker community and health care delivery systems available to them in detail. This targeted analysis allows us to identify specific problems and design effective solutions. TCE has defined each subregion to comprise a relatively cohesive unit with unique health care and institutional problems.

The AWHS utilizes a case study approach. The main subject of the inquiry is barriers to and facilitators of health care delivery as utilized by this subregional population, both in and out of the immediate area. Documentary review, participatory observation, and interview techniques were used to identify barriers and facilitators and ways to improve delivery. A telephone survey of service providers in the area was conducted, as were in-person interviews with representatives of providers, the communities, and, most importantly, farmworkers. Through these methods, many sources of information were marshaled to arrive at the full story. (See Appendix B for details on methods.)
Background

Environmental Setting

The location of this study is an area we will call the North Orange Belt or North County. The study area covers the flat land north of Visalia and east of Highway 99 and the northern part of a strip of citrus orchards three miles wide and fifty miles long called the Orange Belt, which abuts the Sierra Nevada foothills. A unique microclimate there called a “thermal belt” provides milder winter weather and thus exceptional growing conditions.

The study area forms the eastern edge of the Kaweah River delta, an extraordinarily fertile growing area that for more than a hundred years has supported dry farming of small grains and some olives and grape vines. In addition, livestock and some vegetables have traditionally been grown there. Beginning in the twentieth century, farmers installed pump irrigation systems and expanded their acreage. They planted deciduous fruit and nut trees and extended the vineyard belt south from Fresno County into the flat lands.

In the early 1950s, the Central Valley Water Project constructed the Friant-Kern canal, ushering in a new era in eastside agriculture. Although small orange orchards had been planted in Tulare County as far back as the nineteenth century, the water supply provided by the canal allowed the “belt” of oranges and lemons to develop. With canal water and additional irrigation water diverted from the Kings River, growers also expanded the
number of acres of fruit trees, nut trees, and vegetable crops. Today, tomatoes and green peppers are the leading row crops. Field crops are planted along the western edge of the delta, but they are largely outside the study area.

**Demographic Patterns in the North Orange Belt**

The Migrant Enumeration Profile Project estimates that there are about 57,000 farmworkers in Tulare County, which last year ranked first among all counties in the United States in agricultural value. The precise number of these farmworkers who live and work in the North Orange Belt is not known, but they represent a substantial subset. The study area includes two small cities, Dinuba (the largest, with about 17,000 residents) and Woodlake. Scattered across the region are a number of much smaller, unincorporated towns of less than 10,000 residents each where many of the people who work the orchards and packing houses of the Orange Belt reside. They are Ivanhoe, Yettem, London, Cutler-Orosi, Seville, and Sultana. Although some of these towns are clustered together and separated by just a few miles of rural roads and open fields, residents identify with the uniqueness of their communities and recognize their boundaries. Other North County towns are more than twenty miles apart, and limited public and personal transportation restricts travel for many farmworkers. According to census figures, more than 70 percent of each town’s inhabitants are Hispanic. In Cutler, Hispanics make up more than 95 percent of the population. Given that census figures consistently undercount solo males, poorly housed people, and migrant farmworkers, the actual percentage of Hispanics in these areas is undoubtedly much higher.

The seasonal demand for labor in Tulare County means that the population of farmworkers peaks in the summer and declines in the winter. Employment data indicate that Tulare County farm employment levels vary from 27,000 in March to 41,000 in June, a ratio of 1.5. Informants confirm that the number of workers in citrus growing areas tends to vary less than does the county as a whole since the valencia and navel orange crop creates employment ten months a year for many workers.

Most immigrant workers still come from the traditional Mexican sending states of Michoacan, Guanajuato, Jalisco, and Zacatecas. There is, however, a growing Oaxacan and particularly Mixtec presence in Farmersville in central Tulare County. Our interviews confirm a traditional pattern of migration by some Tulare County farmworkers to deciduous harvests further north, including into Oregon and Washington. There are also many mostly legal migrants who travel back and forth, spending part of the year in their hometown in Mexico and part of the year in Tulare County.

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1 U.S. Census, Profile of General Demographic Characteristics, 2000.
2 California State Employment Development Department.
3 We discovered a particularly close association between Cañon de Juchipila in the state of Zacatecas and the area around Cutler-Orosi.
Census data for most of the area’s towns show fairly even percentages of men and women over eighteen, indicating a mature and stable settlement pattern. Remember that the presence of solo males throughout farmworker areas is typically understated because the census routinely undercounts this difficult-to-find population. Cutler and London, however, look more like prototypical newcomer farmworker towns, even in the census data. In Cutler, for example, only 5 percent of workers live alone, 63 percent of the households are married-couple families, 96 percent are Hispanic, 57 percent of those over eighteen are men, and only 5 percent of residents are over the age of sixty-five. Cutler and London, then, have higher proportions of solo male workers than the surrounding towns.

### Agricultural Structure

Tulare County is distinguished by its vast tracts of citrus orchards and grape vineyards, which cover 300,000 acres. One third of this area is committed to orange orchards. There are also deciduous crops such as peaches, nectarines, and plums. There are less than 7,000 acres of row crops in the county and only 2 percent of the county’s agricultural value comes from nurseries.

Table 1 describes key characteristics of the county’s agricultural industry. Farm dimensions are generally moderate, with average gross sales of $352,000. The dairy industry is also very strong, accounting for about one third of Tulare County’s $3 billion in gross agricultural sales through liquid milk products.

Dangers inherent to the area’s farmwork include the risk of falls and other injuries associated with orchard work. Harvesting in orchards involves hauling bags of fruit that sometimes weigh as much as eighty pounds up and down ladders, leading to back and other injuries. In recent years, with declines in the price of oranges, growers have been pruning orchards less, exposing workers to more risk of injury from thorns and falls.4

Another serious danger comes from agricultural chemicals. Table grapes involve especially intensive applications of chemicals and the organically-certified product sulfur.5 Farmworkers engaged in canopy management spend a great deal of time working closely

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4 Less than 0.5 percent of valencia groves are nonbearing. See Agricultural Commissioner’s Report, 2001. Information about pruning collected by Rick Mines in farmworker interviews, Tulare County, 2001.

5 The Department of Pesticide Regulation lists sulfur as the second most common substance after Adjuvant in causing pesticide poisonings. (See Fields of Poison)
in treated vines. North County’s substantial dairy industry exposes workers to injuries associated with unexpected movements by animals. Because nursery work and the stoop labor associated with row crops are not commonly needed in the area, exposures associated with these activities are less prevalent.

**County Characteristics**

Although Tulare County is the leading producer of agricultural commodities in the state, it is also one of the poorest counties overall. Nearly a quarter of the population and 32 percent of children in the county experience poverty. Moreover, small towns like Cutler-Orosi represent some of the poorest regions in California. Coupled with severe poverty is a high rate of unemployment—an annual average rate of 15.4 percent in 2001. The county also consistently ranks among the highest in California for teen birth rates. In 2000 the county’s teen birth rate was 79.6 per 1,000 females ages fifteen to nineteen, among the worst in the state for this measure. Additionally, females in this age group comprise a significant proportion of chlamydia cases, a disease on the rise in Tulare County (see chart).

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6 U.S. Census Bureau, 2000.

7 An estimated 29.9 percent of the population of Dinuba and Cutler-Orosi live below 100 percent of the poverty level. For Ivanhoe and Woodlake, these rates are estimated at 25.9 percent and 23.9 percent, respectively. Source: Claritas Corporation, 1996 Estimated Population: Totals by Medical Service Study Area, County and Region. [http://www.ruralhealth.ca.gov/demographics.htm](http://www.ruralhealth.ca.gov/demographics.htm).


9 California Maternal and Child Health Data Book, May 2002, Tulare County, California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section.
Analysis of Key Dimensions

Living Conditions and Farmworker Neighborhoods

The northern part of Tulare County lacks the large farm labor centers found in other parts of the county, such as Linnell Farm Center and Woodville Farm Center, which have nearly two hundred units each. Most North County farmworker housing consists of rented units that range from adequate to extremely substandard. Some people have been able to purchase homes, usually through government subsidized programs and programs administered by an organization called Self-Help Enterprises.

Service providers have identified conditions they consider prevalent among farmworker households, including lack of heat and air conditioning and lack of telephone service. The most common problem is overcrowding, which was confirmed by direct observations and farmworker informants. In the worst cases, farmworkers and their families occupy dilapidated apartments and trailers, converted garages, and makeshift structures. Because most towns in North County are not incorporated, housing codes often are not enforced.

A recent improvement to farmworker housing in Cutler-Orosi is Villa de Guadalupe, a complex funded by The California Endowment. It offers a playground, a community center, and a clinic. Generally, however, there is a shortage of affordable housing for farmworkers. According to a representative for a local housing organization, opportunities for creating affordable housing are limited by the number of sites adequate for multi-family rental property and new homes and the complexity of balancing “smart growth,” various models of planning, and preservation of agricultural land. In addition, many communities lack adequate sewer and water capacity, further restricting development.

The majority of farmworkers live with families, but there are concentrations of solo males scattered throughout the region in homes, trailers, and apartments. A social service provider in the region describes those housing conditions. “Some of the renters during the season . . . can put ten single men in an apartment and collect money from each one. Of course, the men don’t have their families here.”

In addition, farmworkers live in camps specifically for solo males. The number of these camps in the region is unknown. Direct observations and conversations with farmworker informants identified difficult social conditions, including heavy alcohol consumption and prostitution, at one such privately operated camp in North County (North County Camp).10 This risky behavior affects the well-being of the men who live there as well as of

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10 The actual name and location of this camp has been suppressed. For purposes of this report, the camp will be referred to as the North County Camp.
the wives and children they support back in Mexico. A resident of the camp was asked about alcohol consumption at the site and gave the following response.

Sometimes, or I think all of the time, it is very difficult for people like myself, and many more, to come [home] and just feel at ease. Many times, it’s to talk with the same people that live here or just to forget a little and not feel melancholic in thinking about the loved ones that one has in his country, or for whatever other reason. This transforms itself into a daily routine. Every day, every day it’s the same, so that sometimes one is inclined [to drink].

Although none of the informants currently living at the camp admitted to using prostitutes, most admit that prostitution takes place there. A longtime farmworker and active member of the community concurred. However, risky sexual behavior is not limited to this all-male camp. A farmworker informant from Orange Cove believes the problem is common in the larger farmworker community.

They get mixed up a lot with prostitutes. And hopefully they are the only ones that get infected. But many times, lots of men are married . . . and they get infected with some illness and they return to Mexico and they infect their poor women.

An HIV/AIDS community education specialist for the county indicates that prostitution and unprotected sex are common among male farmworkers, placing them at risk for sexually transmitted diseases. One resident of North County Camp describes why he believes farmworker men engage in high risk sexual behavior. “Lack of understanding, ignorance . . . there are people that don’t even know what a venereal disease is . . . and they don’t believe or don’t think at that moment of the risk that they are running.”

In general, North County residents complain about the presence of gangs, drugs, alcohol, and prostitution in and around their communities. Many North County farmworkers do not consider their communities safe, especially for children. Both farmworker informants and service providers report gang activity, particularly in Cutler-Orosi, Ivanhoe, and Dinuba, that often spills into neighboring towns, as described by a mother in Dinuba.

This area is very dangerous. Yes, you know certain neighbors, but it is also dangerous in the sense that there are a lot of little gangsters here. That is the problem that I have. And my worry is for my daughters. Not for us; for my daughters. Because they do their fighting here in the street.

Through a school-community-policing grant, Cutler-Orosi Joint Unified School District has been able to address some of these problems. The district has a sheriff’s officer working with the schools plus two probation officers. Although gang problems persist, a school administrator there attributes recent improvements to this added law enforcement presence. Law enforcement in general is lacking because the area’s towns are not incorporated.

Service providers and school administrators also indicate that methamphetamine is a major problem in the region. According to an administrator for youth programs, “there are meth labs out here in the rural areas because that is a way of making money.”
Recreational areas and activities are extremely limited in several North County towns. Dinuba has parks, swimming pools, and youth centers, but other communities lack such facilities. In Ivanhoe, which has a youth center, residents and service providers, including the members of two churches, would like to see a community park created. A farmworker’s spouse in Ivanhoe explains.

I was just commenting to my husband. I told him we need there to be a park here too. I told my husband why not? . . . Because it is lacking here. So that the town looks more . . . beautiful. Oh, I would like it if there could be a little place that would be a little closer for us, to go out with our kids.

For now, residents of Ivanhoe travel to Woodlake for recreation. Farmworkers who live in Yettem, a town of only a few hundred people, also have no park and travel to Cutler-Orosi.

Some farmworker informants complain about the presence of alcohol and intoxicated men in local parks. A farmworker in Yettem describes the scene. “There’s the park here in Cutler. But I don’t like to go there because in the evening there are many men there. Many men there laying around on the benches, on the ground, laying around like this.”

Additionally, both service providers and farmworkers voice concern about the lack of sidewalks and pedestrian safety in several North County communities, a problem that only exacerbates the dearth of recreational opportunities for young people, who need safe spaces where they can ride bikes, skateboard, or just walk.

Youth Issues

A significant proportion of farmworker informants in this study raised numerous concerns about the welfare of the children and adolescents growing up in these rural communities. Across North County, youth-related issues are a predominant concern among residents, service providers, and community leaders. They regularly confront teenage pregnancy, juvenile delinquency and gang violence, discipline problems, high school dropouts, alcohol and drug use, and a lack of bilingual teachers and instruction, day care options, employment opportunities for youth, mentoring, activities and programs for children and teenagers, and support for college and higher education.

Many farmworkers and service providers view the lack of programs and activities as a major contributor to youth problems. The situation is most dire during peak growing and harvesting seasons, when parents work long hours and weekends. Farmworker informants say their work schedules affect opportunities for their children to participate in activities—simple things like providing rides or even just staying informed about existing programs. Service providers believe that work demands leave too many young people unsupervised. A county nurse who has a background in mental health explains.

The kids aren’t supervised and the parents are out in the fields for a long period of time. They go to school, but when they come home, they might not be very well supervised after that. I think that causes a lot of problems at home. Even
though I do see more multi-generational living situations, I still don’t think there’s a lot of supervision for the teens.

In particular, some community members believe that teens are joining gangs because they lack positive alternatives. One mother of an ex-gang member describes the situation.

These boys, those who have access because their parents loan them cars. They get into gangs somewhere else, instead of having entertainment here, right? If there isn’t anything to entertain them here, then they go somewhere else where they find negative things to entertain themselves. . . . that is what happened to my son. My son was bored here. So if he didn’t have a car, he searched for a way to get out, even on his bicycle.

Thus, opportunities for fun represent one aspect of gang affiliation. A teenager, the son of farmworkers in Cutler-Orosi, recalls that when he was “in eighth grade, [the gangs] that was the entertainment. All of my friends that got into the gang are now in jail.”

Other factors also seem to motivate kids to join gangs, as evidenced in Cutler-Orosi Healthy Start’s Youth Survey of three different schools in 1999 (a sample of 140 students). From one quarter to one third of students considered protection an advantage to being in a gang. Among high school respondents, having fun with friends was another common response. A twenty-one-year-old farmworker youth illustrates the findings.

Oh yes, gangs. There are many. There are times that many of us get involved in those things. It’s very difficult for one to get out. Right now I have eight friends that are in jail . . . because of fighting and for hurting people. . . . Those who were born here treat us differently . . . just because we get together with one person, they confuse us with them. If I come by and talk to one guy, one that’s wearing blue, all blue, he sits with me and I talk to him and greet him. Then, those in red come by and see me, and I pass by in front of them. They are going to think that I’m with the other guy. So, even though I talk to both [groups] . . . even though I am not involved in this, they are going to get confused and there will be problems. And what do we do? We get involved in these things so that they don’t do anything to us. That way, if they do something to us, we have to do something too. . . . [We get into gangs] for protection and for drugs too. And the friends, to hang out with the friends.

Circulo de Hombres/Circle of Men, a group led by a private clinical psychologist, is working throughout the county to address the problem of gangs, alcohol, drugs, and violence by mentoring youth. A member of this mentoring program explains.

The Circulo de Hombres teaches these youth how to deal with mainstream. For example, the Circulo teaches youth how to deal with putdowns and how to deal with being profiled by police when being pulled over. We are teaching them how to deal with discrimination, but there is another aspect. How do youth deal with the barrio? How to deal with the vatos that say to them hey, we want you to join our gang. Why our gang and not that gang. And then the kid gets caught in the middle. We, as men in the Circulo, have to educate our young men on how to negotiate all that.
Educators and employment training providers also worry about the high dropout and teen pregnancy rate among farmworker youth. Teen pregnancy is particularly problematic among adolescents who have a history of poor academic achievement, limited educational aspirations, and inadequate parental monitoring. Service providers and educators believe that the lack of positive youth activities greatly contributes to the rate of teen pregnancy. A youth services provider sums up the situation.

Kids do not have anything to do around here. I know twelve-year-olds that are pregnant . . . It is not a good solution that kids have kids and right afterwards collect welfare. So, one of the solutions that we need in these communities for farmworker youth is more activities, more interaction with Health and Human Services, and correctional and probation officers. We need a building for the kids in the communities where they can be doing something other than drugs and/or getting pregnant.

Various Tulare County schools, like Cutler-Orosi Joint Unified School District, offer infant/toddler day care or teen parent child centers. In Woodlake, there is a program for pregnant or parenting teen mothers that offers education and training in life and parenting skills. The county offers case management to pregnant and parenting teens through its Family Care Services office in Dinuba through Tap-Net and a pregnancy prevention program at the only county-run clinic in North County (Dinuba). However, service providers concur that increased prevention efforts are greatly needed. A public health nurse who works directly with pregnant teens explains.

In Tulare County, for some reason, in the school system they don’t teach them. They teach them abstinence and they do teach them sex ed. And I understand why they don’t teach about birth control. But the schools are very much in denial, and the parents too are very conservative. But the girls are getting pregnant. So you’ve got to teach them . . . There are good interventions. It’s out there. The only thing is that it’s really hard to get prevention. I mean all of this is for after, after the accident. I would say over 50 percent of my teen mommies, that the dad is no longer there. But I wanted to talk to the mom because when you go as a public health nurse, you go and you just don’t talk to that family member. Everybody is affected by the pregnancy, especially the younger siblings that are fourteen and fifteen years old if the seventeen-year-old gets pregnant. They are at high risk for getting pregnant.

In general, programs for youth are in short supply in the smaller North County towns. Access often requires travel to neighboring areas, but farmworker youth often lack transportation.

The public transit system in Tulare County operates in Dinuba, Woodlake, Ivanhoe, Cutler-Orosi, London, Yettem, and Seville, and soon Traver will receive services. The smallest towns have a single stop; others reportedly have greater service and sufficient riders. In
Ivanhoe, service was cancelled one year for lack of use and then brought back the following year. Staff members of the regional planning agency, Tulare County Association of Governments, worry about the lack of riders in Ivanhoe and are not certain whether it is due to lack of awareness or demand. Lack of demand seems unlikely, however, as farmworker residents from these towns complain of inadequate transportation choices and lack of information about routes and schedules.

Community members, agencies, and organizations can present complaints at the planning agency’s annual Unmet Needs public hearing in March and throughout the year. In the past, the agency received few community comments; however, outreach efforts helped to increase the number from twelve last year to about seventy. Improvements can occur only after communities demonstrate an unmet need that can be reasonably met and a sufficient number of riders for the services requested. The transit service is required to recover 10 percent of the cost of service from bus fares. A transportation engineer explains the challenges.

So if you’re a community that’s trying to get service, I would say one of your goals is to not only attend the Unmet Needs hearing, but to try and attend the SSTAC [Social Service Transportation Advisory Council] meeting and the board meeting in the following month of June. . . . It's not just to go to the hearing and say “I need service here” period. The community of Poplar-Cotton is a good example. A couple of years ago, they wanted transit service. Well, unless that community banded together and kind of did like a grass roots effort and all joined together to really, really push and let it be known that they needed service, one person coming to the hearing asking for it probably wasn’t gonna get it. You need community effort. You need a lot of people telling the transit provider, “Hey, I did a survey. This is how many people I estimate are going to use the bus if you increase it to five days a week or if you provide us transit service.” That’s one of the things that Traver did. They did a survey. Healthy Start did a survey in the community and transit was one of their number one issues. That they didn’t have any transit to Dinuba to get groceries, to get health care, to get their kids to other events.

Farmworkers who cannot speak English, or who cannot read or write in any language, will face tremendous hurdles to participation in such community lobbying. Although farmworkers and their spouses attend parent meetings at schools, many have little if any experience interacting with other government institutions. An ex-farmworker in Cutler-Orosi explains.

Many times, also what is missing is the ability to speak English. We do not know where to direct ourselves, or with whom to direct ourselves. And then, if we know with whom to direct ourselves, we can’t go because we don’t know how to introduce ourselves. Either way, there are many services that we do not know how to take advantage of.
Working Conditions in Tulare County

The ethnographic case-study approach on which this report is based illustrates the treatment farmworkers receive as they themselves perceive it. Working conditions studied include issues of pesticides, safety, and sanitation and how people are treated in the work environment.

One can argue that working conditions are worse today than a generation ago for California’s farmworkers. Real wages, after peaking in the late 1970s, actually dropped in the early 1980s and have since remained at these lower levels. Employment Development Department data indicate that San Joaquin region all-crop wages for March 2002 were $8.32 per hour. Most importantly, farmworkers typically are employed only intermittently—statewide, the average is about 1,000 hours per year per person according to the National Agricultural Workers Survey (NAWS). The NAWS finds that this pattern of uneven employment results in very low annual earnings. Current average income for a farmworker family is $7,500 to $10,000 per year. Besides the drop in real wages, grower-sponsored housing has drastically declined. Payments required of workers for equipment, rides, and refreshments also remain high relative to their wages.

According to farmworker survey results, field sanitation may have improved and pesticide exposures declined due to stepped-up government monitoring. However, our in-depth interviews with farmworkers cast doubt on the meaning of these reported positive trends.

Pesticides

Figure 1, describing concentrations of pesticide use in Tulare County, demonstrates the large quantities of pesticides being applied in the North Orange Belt. Pesticide use is particularly intensive in the northwest corner near Fresno County and south toward Farmersville, where table and wine grapes and deciduous fruit are grown. Despite enhanced enforcement of the Environmental Protection Agency’s Worker Protection Standards (WPS),

\[\begin{align*}
\text{Average income for a farmworker family is between $7,500 and $10,000 a year.}
\end{align*}\]

\[\begin{align*}
11 \text{ http://www.calmis.ca.gov/htmlfile/subject/agric.htm#BULLETIN.}
12 \text{ Rosenberg, et al., from 1994-97 NAWS data.}
13 \text{ Binational Farmworker Health Study worker-reported findings show that in recent years there is more compliance with certifying and training workers in pesticide safety than in earlier years.}
\end{align*}\]
our study found that most farmworkers have not perceived an improvement in pesticide safety.

In the 28,000-acre table grape industry in Tulare, workers perform tasks associated with canopy management and harvesting that continually expose them to anything that is put on the leaves. They constantly tie, prune, deleaf, and thin the vineyards. One woman complains of the incessant pushing to work faster despite the dangerous conditions.

They do [pesticides do worry the worker], especially the sulfur. If it gets into your eyes, your eyes just water for like ten minutes and you can’t stop. You have to keep on working. If you get behind, then [the mayordomo] gets on your back.

California’s Department of Pesticide Regulation reports that grapes are the leading cause of pesticide poisonings and that Tulare County was first in reported poisonings among California’s counties in the 1997-2000 period.¹⁴

Sanitation and Safety

Direct accounts from farmworkers and the social service staff members who work with them provide insight into sanitation and safety issues encountered in the county’s fields, vineyards, and orchards. Adequate bathroom facilities and water are longstanding problems. In recent years, statewide survey data on bathrooms in the fields and the availability of drinking and hand washing water demonstrate improvement. In the 1995-1997 period, only 1 percent of work sites reported no toilets or drinking water and only 2 percent reported no water for hand washing.¹⁵

However, our research shows that the availability of these services can be complicated by other factors. Many farmworkers, for example, report bringing water because they do not trust the quality of employer-delivered water nor find it kept cool on hot days. Sanitary conditions are also a concern. One worker describes the problems with the water provided by the employer.

Another thing that I don’t like about the mayordoma is that she doesn’t let us have our own cups of water at the workplace. She has us pass around one single jug of water that we all have to share from, so that we don’t lose any time.

Often one hears farmworkers (especially women) complain about the lack of cleanliness in bathrooms. One worker put it this way.

The bathrooms at work are nasty. With all of the people who use the bathroom, they only wash the bathroom once a week. The last three days, it smells so bad, but if you have to go, you have to go. The bathroom hasn’t had any water for four days so we can’t wash our hands. There’s no soap. People use cold water to wash their hands. They use the cold drinking water.

¹⁴ M. Anne Katten Reeves and Martha Guzman, Fields of Poison, Californians for Pesticide Reform, 2002, San Francisco.
Another concern voiced by farmworkers is the lack of time to wash up and eat lunch in a relaxed manner. One farmworker voiced his concern about mealtime conditions.

So I think that one needs to have, for example . . . a little bit more time and a little bit more care about personal cleanliness at the time to eat . . . But there are a lot of companies or people . . . that don't care about the health of the worker.

Finally, workers complain of risks they face from employer-provided transportation to work. One farmworker reported his experience.

They stuff twenty or more people in a van and . . . go, squashed, to work. The driver will slam on the brakes so that the people will get settled and fit in their seats. He'll say, “What do you mean, you don’t fit?”

**Mistreatment in the Work Environment**

Farmwork, unlike most jobs, typically is not sought by applying directly to the owner of the operation. Instead, hiring is managed through a crew-boss system. Foremen (whether employed by farm labor contractors or growers) usually recruit, hire, and fire workers and control their paychecks. This system is fraught with opportunities for foremen to take advantage of farmworkers.

One of the most frustrating and frequent difficulties is foremen who fail to pay or who underpay for work. Often, workers and the foreman have only a verbal agreement regarding the duration of the work, the payment by hour or by piece, and other conditions of employment. Employers can avoid paying workers in numerous ways—by issuing paychecks from an account with no money in it, writing paychecks for less than a worker is owed, under-reporting hours or under-counting the units of piece work done, and including questionable or illegal deductions. One farmworker reported how he was paid less than he had earned.

Three days later, he came by to drop off my check. I didn’t even check my check when he was here. I just trusted him. We even talked. When he left, I realized that I was missing hours, but I was never able to get those hours back.

Often a misunderstanding lies at the root of nonpayment. A Tulare couple told of one agreement that ended badly. The foreman set a deal with the couple before the job started, saying that if the couple did not produce quickly enough he would pay them by the hour. Instead, when the foreman became dissatisfied with the workers’ output, he refused to pay them at all.

We were in the grapes. He said “If I see that you’re not working hard, I’m going to pay you guys by the hour. So put in some desire.” We did. There were four of us. No, it didn’t happen. We tried to finish a row and we didn’t do it. He was paying $80. We couldn’t do it, so we got out. We went to get paid and the contractor didn’t want to pay us.

Under-reporting of hours or production is common. One young worker described his experience. “I picked eight buckets worth and the mayordomo only marked that I had picked five buckets. I was mad. I argued with him and threw the ladder at him. I quit working for that man.”
Farmworkers often complain about being pressured to work faster regardless of dangerous or uncomfortable conditions. A packing house worker describes the environment. “At the packing house, they are very strict. You have to stand there and not look around. You cannot talk to anyone. All you can do is your task.” Two other workers also voiced this common complaint.

Well, my mayordoma/work supervisor was a person who wanted work done very quickly. They pressure us a lot. They want a lot of work done. It doesn’t matter to them if it is raining, or if we’re not feeling well, or anything else. They want us to finish the job just the same.
The bosses don’t let you work at a normal pace. They want you to work like donkeys (burros).

Mistreatment of workers also occurs via overcharges for rent, equipment, and utilities, a practice that is illegal but very difficult to prevent.

Workers are commonly overcharged for transportation to fields and orchards. NAWS data indicate that half of all farmworkers in California pay for rides to job sites. For 10 percent of all California farm wage workers and 16 percent of those working for farm labor contractors, the charges are obligatory, as noted by the following husband and wife from Cutler-Orosi.

Husband: Mayordomos will ask you if you have a car. If you do, they tell you there’s nothing [no work].
Wife: Now, you have to let them give you a ride. They don’t want you to take your car. They want money.”

This common practice is very exasperating for people who typically earn less than $10,000 a year. One man complained bitterly. “We are charged $25 for rides to work and then charged again for rent. And what is left for those of us who are working the fields and living in that home? Nothing but a [expletive deleted] sad life.”

Other common overcharges come from fees for drinks provided and check-cashing, as mentioned by the couple quoted above.

Husband: There were many mayordomos that would take the sodas, the beer. And if you brought your own soda from your house or if you take your coffee, they would write you down for the soda [and charge you].
Wife: Then they take the workers to cash their checks and they’ll take a cut.

Finally, farmworkers experience straightforward extortion through requests for money or favors.

Now, it’s not so much money. The workers now have to give their mayordomo a twelve- or twenty-four-pack of beer or they won’t take you to work. Every paycheck they get they have to buy them beer. The workers know this. When they

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16 NAWS data demonstrate that fully 30 percent of farmworkers in California are illegally charged for equipment. (Rosenberg, et al., p. 15).
17 Rosenberg, et al.
get their check, they also buy the beer and give it to him. If he doesn’t get the beer, then they lose their job.

**Discrimination**

Farmworkers most often and most severely mistreated fall into several groups—older and minor farmworkers, indigenous-language farmworkers, women, and, particularly, the undocumented.

The taxing nature of many farm jobs encourages discrimination against older workers. If these older workers cannot find less intensive jobs, they sometimes find it difficult to continue. One farmworker described her husband’s recent experience.

Last year he worked the grapes, but no more. One day he went [to pick raisin grapes] and came back trembling. It was like he got sun, right. He did 200 lines and he came back trembling like this. He said, “I feel really bad.” He said that he felt like vomiting. It was too hard on him.

Older workers who stay in the fields labor under the constant threat of being replaced by someone younger and faster.

If you don’t work as fast to their standard, they’ll fire you and find someone else. Also, if there’s someone who’s older, but has worked in the fields for a long time and has worked hard for them, if they slow down, they’ll get fired too. If they don’t work as well as a young person, he’ll get fired.

The type of discrimination most often mentioned relates to the undocumented status of many farmworkers. One woman described a supervisor’s efforts to intimidate people at a packing house.

I saw that they were firing people. Since I don’t have papers, and since the majority of the workers don’t have papers, that’s why we were afraid. Sometimes the mayordomos would laugh. They would say “We can call immigration, and they’ll pick you up from here.” Many of us were afraid . . . They had us very nervous with their threats. If we weren’t paying attention at work, or if we were going to the bathroom, or if we weren’t punctual at work, they would threaten to call the law on us.

Farmworkers stress that undocumented people are worked harder than those with legal status. In the mind of many, this practice creates an atmosphere of unfair competition for legal workers. An example of this sentiment was voiced by one of the farmworkers interviewed.

Well, honestly, there are a lot of people who don’t have permission to work. So, for those people to have that work, they work beyond what a person should work so that they don’t lose their job . . . So, yes, the mayordomos do give more jobs to those that give them the results that they want. I don’t think this is right. A man must work at his pace.

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18 The most recent data for California (1997) show 42 percent of farmworkers are undocumented. The percentage of workers who are undocumented has probably increased since then.
Health Care Delivery System

Farmworkers’ access to health care is influenced by a county’s policies, resources, and ability to coordinate complex systems. The northern Tulare County area does not have a local hospital, so health care access is delivered entirely through primary care operations, which are available in Dinuba, Cutler-Orosi, Ivanhoe, and Woodlake. Small communities like Yettem, Seville, London, and Sultana have no facilities.

More sophisticated levels of care and medical technology (radiology, for example) must be obtained outside of the North County community, typically in Visalia or in the Fresno County city of Reedley. However, those resources are limited by a shortage of health professionals and specialists, so gaps have developed in delivery of more intensive health care services to North County residents.

Health Care Programs for Low-Income Families

Medi-Cal and Healthy Families

Two state programs, Medi-Cal and Healthy Families, support access to health care for low-income people in Tulare County. Latinos and Spanish-speaking individuals represent the highest proportion of these Medi-Cal and Healthy Families recipients (see Table 2), indicating that these programs serve a significant proportion of area farmworkers.

According to one health plan representative in the region, immigration status precludes a significant number of farmworkers from fully participating in Medi-Cal and Healthy Families.

The biggest drawback is that in order to qualify for Healthy Families or Medi-Cal, one needs to be a U.S. citizen or resident. So, unfortunately, we leave out a huge population that is underserved. Even those that have emergency Medi-Cal and are undocumented need to pay for services out of their pocket. Many individuals would qualify . . . but because of their legal status they cannot receive services.

Medi-Cal

In 2001, 26 percent of Tulare County residents were enrolled in Medi-Cal, surpassing all other California counties. Tulare is one of twelve counties in the state that operates a two-plan model of Medi-Cal managed care. Unlike the traditional fee-for-service model, where Medi-Cal beneficiaries obtain services from any provider in the system with little coordination, managed care is more structured and comprehensive and emphasizes prevention. Clinical and administrative components are integrated into a coordinated health care system. Under the two-plan model, two health maintenance organizations (HMOs)

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20 Managed Care Annual Statistical Report, March 2002, Medical Care Statistics Section of the California Department of Health Services.
operate in a county, a locally initiated plan directed by the county and a commercial plan designated by California Department of Health Services through competitive bidding. Tulare County’s local initiative plan is with Blue Cross, and the state designated Health Net as the commercial provider. Both provide coverage through government sponsored programs (Medi-Cal, Healthy Families, and AIM [Access for Infants and Mothers]). Undocumented pregnant women with limited incomes can access prenatal care through the Presumptive Eligibility section of Medi-Cal, which qualifies them for temporary coverage.

Blue Cross outreach specialists serve as liaisons between members and their physicians. They facilitate the referral process, inform members about resources in the community, and arrange for transportation assistance, either through rides from a contracted transportation company or as reimbursements for gasoline. They also conduct home visits with patients, particularly people who are not complying with a physician’s directions and missing appointments.

**Healthy Families**

Healthy Families covers children in families who, at least temporarily, earn too much to qualify for Medi-Cal. In 2001, Tulare County ranked sixth highest in the state for the percent of the county population enrolled in Healthy Families. Under the program, parents pay a modest monthly premium to cover their children. Informants believe that accessibility to physicians under the Healthy Families program is superior to access under Medi-Cal.

**Tulare County Health and Human Services’ Enrollment Efforts**

Tulare County Health and Humans Service’s (HHSA’s) Human Services division is responsible for TulareWORKs, the county’s suite of Medi-Cal and financial assistance programs. Every County clinic employs a full-time Medi-Cal eligibility worker, there is a full-time Tulare County Medical Services eligibility worker assigned to Kaweah hospital, and Medi-Cal workers rotate though private clinics and organizations. Workers go to Family Health Care Network clinics once a week and visit the Woodlake Family Resource Center twice a week.

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**Table 2. Medi-Cal & Healthy Families Data for Tulare County for January 2001**

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<tbody>
<tr>
<td>Total Medi-Cal recipients</td>
<td>102,094</td>
</tr>
<tr>
<td>Total Healthy Families recipients</td>
<td>7,040</td>
</tr>
<tr>
<td>Medi-Cal recipients, percent Latino</td>
<td>65.5%</td>
</tr>
<tr>
<td>Healthy Families recipients, percent Latino</td>
<td>80.0%</td>
</tr>
<tr>
<td>Percent of Medi-Cal recipients under managed care plan</td>
<td>38.5%</td>
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Some farmworkers characterize the local TulareWORKs office in Dinuba as not helpful to clients. They report that it is difficult to get assistance in filling out forms and that they often must wait a long time, which discourages them from going back. A former longtime county employee explains how the excessive demand on eligibility workers impacts the quality of services provided.

When I worked in the welfare [TulareWORKs] office, there’s a lot of people that actually were eligible for the help and they wanted you to help them. But you couldn’t spend a lot of time on them because . . . there’s no incentive for you to spend time with anybody to help them. Their incentive is . . . numbers, numbers, numbers. You have to process this many cases; don’t get behind. If you spend too much time with one family, you get behind on the other ones.

With workers trying to manage such large caseloads, clients sometimes must schedule an appointment to return to the agency a second time to complete applications. The eligibility workers stationed at the clinics are not burdened with these caseloads and usually can provide more personal and comprehensive assistance without a long wait. An eligibility worker describes the less intimidating services farmworkers at one such site. “When they come in here, I put together my own stuff, so I only give them what they’re requesting.” They can more often take time to fill out the forms with clients as well. However, once individuals are enrolled in Medi-Cal, a “continuing” worker at the HHSA office handles their cases. Clinic intake workers usually assist only in the one-time application process unless benefits discontinue or are terminated and a client must re-apply.

According to Woodlake Family Resource Center’s program coordinator, the demand for Medi-Cal enrollment assistance is high.

She comes a half hour after we are open and leaves a half hour before we are closed, but she is booked solid all day. When we first had Medi-Cal, they agreed to come out here for half a day per week, only if the people did not have transportation. So, people that had transportation drove to Lindsey and the other people that did not have transportation came here. It has grown now to two full days.

Adjacent to the Dinuba county clinic is an office for a full-time, bilingual Medi-Cal eligibility worker. This worker mainly handles intakes, accepting applications and determining eligibility for Medi-Cal and Tulare County Medical Services. Assistance in connecting with programs such as food stamps, cash aid, and Child Health and Disability Prevention (CHDP) is also available. The majority of patients served by this office in Dinuba are women, approximately 95 percent are Latino, many cannot read or write, and nearly all come from farmworker families. According to the eligibility worker, about half of them are recent arrivals from Mexico. “They are like seven, eight months pregnant. They are starting their prenatal care here, now.” The rest of the women come from settled families. Most enroll in pregnancy-related Medi-Cal programs, so care is limited to that condition. After their children are born, they and their newborns can sometimes qualify for other aspects of Medi-Cal, depending on their incomes and immigration status. Clients who
failed to qualify for available health programs at this clinic typically failed to turn in necessary verifications within the time allowed.

**HMO Enrollment Efforts**

In Tulare County, the two major health plans, Health Net and Blue Cross, collaborate for Healthy Families enrollment events. These events take place throughout the county, primarily in the larger urban areas of Visalia, Tulare, and Porterville. A Health Net representative describes the efforts this way.

We’ve laid everything aside, let it out the door . . . I’ve been working with Blue Cross and Blue Shield representatives, and even Delta Dental . . . we all sponsored, put money in, and we divided and budgeted out to do enrollment for Healthy Families.

Medi-Cal representatives from the county were present to assist those who did not qualify for Healthy Families.

Both Blue Cross and Health Net participate in health fairs sponsored by Family Health Care Network, a large clinic system in the region. They also offer information about Medi-Cal and Healthy Families at community events and flea markets and to schools, clinics, Woodlake Family Resource Center, Cutler-Orosi Healthy Start, Villa de Guadalupe, Home-Base Head Start, and church groups. These HMOs promote their respective member benefits and services through their outreach efforts.

**Challenges Associated with Increasing Enrollment**

Line staff for the area’s health care providers—mainly Health Net, Blue Cross, Family Health Care Network, and HHSA—support expanded outreach to identify and enroll people who are eligible for Medi-Cal and Healthy Families. Remote towns in the North County are particularly in need. A hospital administrator elaborates.

I think that some of the Proposition 10 dollars are now being used to promote the enrollment of families and children into the Healthy Families program. I think that part of the solution is having outreach efforts, such as flyers, that talk about health insurance enrollment fairs where people can go to sign up. Of course, we can complain bitterly about uninsured populations, but unless we go out and enroll them . . . we are not complaining very effectively.

Unfortunately, funding for such outreach and promotion activities is dwindling. The state recently failed to fund HHSA’s existing enrollment program for the current fiscal year, eliminating support for their efforts to connect with people through schools and community-based organizations. Without the funding, HHSA now concentrates its efforts on assigning eligibility workers to public and private health care facilities and participating in health fairs. In addition, HHSA is working with a statewide group on a legislative effort to streamline enrollment for programs, including CHDP, and to support a case-management component to increase retention.
The structure within which people must apply also discourages enrollment. To qualify, farmworkers must provide verification of their incomes, employment, assets, immigration status, and housing. According to an eligibility worker, failing to provide this verification is the most common reason clients do not qualify. “It’s mainly not returning information that we request. That’s the biggest thing.” As a result, some service providers argue for follow-up or case management services to get and keep people enrolled. Moreover, farmworker informants perceive enrollment requirements as deeply intrusive and the process burdensome.

Farmworkers also fail to qualify because they lack the reliable transportation necessary to follow through with verification requests and because their inability to read and write makes filling out forms difficult. In some cases, people have just recently arrived or are living in makeshift quarters so they cannot provide rent statements or utility bills as proof, as one woman explained.

And like a battle, I had to go various times [to the county welfare office]. Because I had to take [something] or something was missing. Since I came here and was staying in a house with my sister-in-law, she [the eligibility worker] wanted my address. They wanted to know how much I pay rent, and that one comes to a home. How am I going to show a receipt if I don’t have anything? And that was the problem. You don’t know anything here. You don’t have bills. You don’t have anything, so there isn’t anything.

Her experience highlights the barriers inherent in people’s impressions and fears. Medi-Cal does have a process for resolving her concern. Individuals who cannot furnish a rent receipt are given a form for the person who is responsible for paying the rent to sign. But many people don’t stick with the process long enough to find this out, and even those who do sometimes do not want to involve others. The situation is similar for employment verification.

A lot of times the client is afraid to ask them [employers] to fill it out. I tell them it’s not going to affect them. I’m only requesting this just to determine if you’re eligible for the program. I don’t look into your boss and why is he paying you cash.”

Public Charge Provisions related to Medi-Cal and Healthy Families

Both public and private entities that promote Medi-Cal and Healthy Families in the study region are aware of concerns among farmworkers about possible government reprisals for using public benefits because of their immigration status. Service providers concur that this fear of being labeled a “public charge” inhibits farmworkers from seeking health care and other programs for which they qualify, such as WIC. Consequently, organizations that promote Medi-Cal and Healthy Families offer written and/or verbal information regarding Immigration and Naturalization Services policies in this matter. HHSA, for example, offers this information at its clinics, plus outreach workers and public health

Service providers are trying to allay people’s fears about being a “public charge” if they accept benefits such as Medi-Cal.

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22 See INS information at www.cbpp.org/1-7-00imm.htm.
nurses inform clients. Health Net and Blue Cross provide public charge information in their promotion efforts, and Family Health Care Network provides flyers in both Spanish and English for patients.

Tulare County Medical Services

Tulare County Medical Services (TCMS) is the county program that pays for safety-net health services to medically indigent county residents, specifically those ages twenty-one through sixty-four who fail to meet Medi-Cal eligibility requirements and have no other source of health coverage. The program offers financial assistance but only pays for services provided at county clinics and county contracted hospitals. TCMS also pays some of the cost of specialty services and emergency hospital care, but emergency room visits for non-emergency care are not covered. Like Medi-Cal, TCMS requires a treatment authorization for some medications and services. The county determines eligibility criteria for TCMS, and the program uses the same application form that is used for Medi-Cal.

To receive TCMS benefits, recipients must sign a real property lien as a payment guarantee. The liens apply to any property a recipient currently owns and to property he or she purchases in the future. The benefits must be repaid when property is bought or sold. According to a county eligibility worker, the liens do not discourage residents from applying since most of them do not own any property. However, people who do or may eventually own property may hesitate to apply.

TCMS offers restricted and unrestricted full-scope benefits to those with legal status. Undocumented immigrants are not eligible for full-scope benefits; they receive emergency services only. Clients receive a TCMS card that is color coded to identify their level of benefits (restricted, emergency only, or unrestricted). In June of 2002, an administrator for HHSA estimated that approximately 1,500 TCMS patients were enrolled in the county, mostly as eligible for unrestricted care. Since probably half of the adult farmworkers in Tulare County are undocumented, thousands of farmworkers in Tulare County apparently do not benefit from this care.

Health and social service providers in North County are critical of the county’s indigent care program and its financing. Despite the fact that TCMS fills a gap left by Medi-Cal and is an essential program for the poor, health care providers believe that the program fails to meet the particular needs of farmworkers. Inadequate funding contributes to this problem. A health care administrator explains some of the issues.

We have a TCMS program which is intended to be the county’s funding vehicle but it is modestly funded and currently there are only 1,700 designated indi-

23 Income guidelines for TCMS are between 135 percent and 275 percent of the federal poverty level (FPL) with a share of cost. Those above 275 percent FPL are not eligible under income guidelines. The documented unemployed and those below 135 percent FPL are eligible for TCMS without a share of cost. But undocumented individuals must be at or below 100 percent FPL.

24 Statewide estimates were that 42 percent were undocumented in 1997. See Rosenberg, et al., Who Works on California Farms, Department of Labor Office of Policy, Washington, D.C., 1999.
gent patients. The TCMS program is not really entirely relevant to the real needs of the farmworker population.

Another health administrator agrees with others that TCMS’s eligibility criteria are a major problem. “Their criteria is too stringent. It’s established by the county, and it’s much more stringent than most other counties.” Health providers in both public and private sectors support the development of health programs that would qualify underserved populations, particularly undocumented individuals. Such measures would require policy changes at local, state, and federal levels. Local surgeons and organizations such as Health Care for All are backing efforts to change the allocation of Proposition 10 dollars to fund health care services for the poor, but this effort faces strong opposition from the county board of supervisors.

**Child Health and Disability Prevention Program**

In Tulare County, the state’s Child Health and Disability Prevention (CHDP) program is crucial to the health of farmworker children, particularly the undocumented. CHDP funds a broad range of services, and children diagnosed with conditions receive referrals for additional treatment. Through the program’s health assessments, children receive physical examinations, nutrition assessments, immunizations, health education, some laboratory tests, and vision, hearing and lead screening. Children age three and above can receive annual preventive dental care. In Ivanhoe, there is only one CHDP participating primary care provider, Family Health Care Network. In Cutler-Orosi and Woodlake, a few providers participate in the program, including a private, for-profit physician, while Dinuba has several providers using the program.

Case managers facilitate families’ access to diagnostic and treatment services, arrange transportation, and assist with scheduling appointments. In north Tulare County, families are linked to CHDP through the local welfare department, clinics, family resource centers, and school nurses.

Funding constraints limit the ability of CHDP to provide case management and outreach such as home visits. According to a county administrator, despite a growing population, funding for CHDP has not kept up with demands on the program. She describes the severity of CHDP’s current situation.

That means more expenses and less money . . . We have had to cut a nurse [position] and now we have one nurse to cover the whole county on following up on these physicals. We also had to cut a community health technician [position]. We had three and now we have two.

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25 In 1998, Proposition 10 was passed, establishing the California Children and Families First Program to fund programs in early childhood development through taxes on tobacco products.

26 Laboratory tests include TB, hematocrit or hemoglobin, urinalysis, blood lead level, gonorrhea culture, pap smear, chlamydia test, sickle cell test, ova/parasites test.

27 Based on a listing provided by HHSA.
Limited funds also make it difficult to provide dental care and the follow-up services recommended in a CHDP assessment. The children most affected are the uninsured, those not enrolled in Medi-Cal or Healthy Families, so CHDP endeavors to help families enroll in those programs.

**California Children’s Services**

California Children’s Services (CCS) is a state program that serves low-income children and youth who have physical limitations and/or serious chronic medical conditions such as congenital heart disease, cancer, sickle cell anemia, endocrine disease, HIV infection, and disorders of the gastrointestinal, nervous, and musculoskeletal system. In Tulare County, the same funding constraints that affect CHDP also apply to CCS, creating a gap in services. A program administrator explains the result.

> For our program to send these children to a specialist after a CHDP physical has been conducted, in order to get diagnostic testing, is where the hole is. That is where we could use some money . . . to see if the children do have those conditions which are eligible under CCS. CCS does pay for some diagnostic testing, but not for all.

**Other Programs**

**Vision Service Plan**

Vision Plan Service sponsors a national program called Sight for Students that addresses the vision care needs of low-income, uninsured children. In Tulare County, health providers use this program to provide free eye care and eyewear to the uninsured. To qualify, families must meet low-income guidelines, and their children may not be receiving Medi-Cal or vision insurance, must be under eighteen years of age, must have documented status, and cannot have accessed the program in the preceding twelve months.

**Women's Health Screenings**

Two programs in Tulare County offer free health screenings and diagnostic services to adult women, California’s Department of Health Services Breast Cancer and Early Detection Program and the federal Breast and Cervical Cancer Control Program. Both serve low-income, uninsured, and underinsured women. The services are available through county clinics and nonprofit community and rural health centers.

**California Kids**

California Kids is a nonprofit organization that offers low-cost health care to uninsured children through partnerships with businesses, foundations, providers, community-based organizations, and individuals. Representatives for local health plans mention California Kids as a safety-net program for undocumented children who are not eligible for other low-cost health services. Unfortunately, because of the large number of undocumented
children in Tulare County, the program’s funds for the county were rapidly depleted for the year and there are reportedly many children on a waiting list.

**Current Budget Issue**

The budgets of all of the state programs previously described are being sharply scrutinized as California grapples with a looming multi-billion-dollar deficit.

**Inventory of Providers in North Tulare County**

**Health Care**

The health care providers described in this section represent key access points to primary and higher levels of care. In addition to the clinics and hospitals mentioned, other health care facilities in the region provide services to the farmworker community. These clinics include private for-profit physician groups and community-based nonprofit clinics. Their facilities are distributed throughout Tulare and Fresno Counties, in towns that include Hanford, Tulare, Exeter, Farmersville, Reedley, and Orange Cove.

Primary care clinics operating at the front lines of service delivery to farmworkers face a challenging health care environment because of the area’s high proportion of underserved, low-income, and uninsured people. The extent to which these clinics successfully serve the farmworker community and earn its acceptance varies from facility to facility.

**Family Health Care Network**

**Facilities and Staffing**

A federally qualified health center since 1989, Family Health Care Network (FHCN) is North County’s major private nonprofit provider of primary care to low-income and uninsured individuals, particularly farmworkers and their dependents. The network consists of seven clinic sites, with three in the north region in Ivanhoe, Woodlake, and Cutler-Orosi. All offer family medicine, obstetrics/gynecology, health education, nutrition counseling, and psychosocial counseling via medical providers who rotate weekly. In addition, the Ivanhoe clinic provides ultrasound services, and both Woodlake and Cutler-Orosi offer dental care. Since many patients lack transportation, clinic vans link patients with additional services within the network, such as radiology available at the Visalia clinic. (Visalia is about twenty-five minutes from Woodlake or Cutler-Orosi by car).

The Cutler-Orosi clinic, FHCN’s newest North County site, was established under the Agricultural Worker Health and Housing Program (AWHHP) administered by Rural California Assistance Corporation with funds from The California Endowment. This successful collaboration between FHCN, Self-Help Enterprises, community leaders, and organizers associated with the Catholic community brought together FHCN’s health care services and affordable housing for farmworkers in a single complex called Villa de Guadalupe.
Currently, FHCN clinics serve approximately 42,000 farmworkers and their dependents.\footnote{Based on the most recent reporting period for Office of Statewide Health Planning and Development’s Annual Utilization Report of Primary Care Clinics (Calendar Year 2001), FHCN reported 41,917 farmworker patients or dependents of farmworkers for its seven clinic sites.} The center’s longstanding presence in the community has earned its clinics a high level of trust among these families; several staff members are longtime community residents who are well regarded by both workers and service providers. A representative from HHSA notes the qualities of their services.

FHCN is very public health care minded, and because they are larger, they are able to get better providers. They have everything there. They have good teaching, nutritionists, dentists. And in other rural clinics, they cannot afford all that.

One thing FHCN does not provide is direct specialty services. Most health and social service providers in the county, public and private, are concerned about the lack of specialists in the region. Health professionals believe that integrating specialty care into primary care would increase the overall quality and efficacy of medical treatment. A hospital administrator ascribes this role to clinics like FHCN.

So we believe that if there is one thing that can be done that would improve these rural health clinics or federally qualified health clinics [it] would be to engage specialists on a paid basis as a part of what primary care offers. So the expansion of primary care to the very natural follow-up that is needed for specialty care is essential.

County eligibility workers process Medi-Cal and Healthy Families applications at various FHCN sites, and there is also an FHCN enrollment and referral representative who connects patients with needed health care services, including difficult-to-access specialty care.

According a network representative, about 60 to 65 percent of FHCN patients have Medi-Cal or some type of coverage. As a federally qualified center, FHCN must offer a sliding fee scale based on income to uninsured patients.

**Bilingual Staffing**

The majority of FHCN clinic staff members are bilingual, and a significant number come from farmworker families.

**Good News Medical Clinic**

**Facilities and Staffing**

Good News Medical Clinic was established in 1992 by Kaweah Delta Health Care District (Kaweah) and Good News Center, a Catholic charity organization. The clinic, which is located in Visalia, represents the only free clinic in Tulare County. The clinic’s goal is to reduce people’s use of hospital emergency rooms for non-emergency care. According to the clinic’s director, Good News is “a help to the hospital and so they’ve always been a great help to us.” A major source of support for the clinic is the Daughters of Charity
Foundation, whose mission is to care for the poor. Grants and both monetary and in-kind donations also provide funding.

Good News Medical Clinic offers four examination rooms, a dental room, and a pharmacy that are operated by fifty volunteers, including pediatricians, obstetricians and gynecologists, podiatrists, and dentists. One day each week, the clinic offers the following services: medical surgery on Tuesdays, pediatric care on Wednesdays, obstetrics and gynecology on Thursdays, and dental services on Fridays. Podiatry services are offered once every two weeks, and pap smears are available thanks to federal support for cancer prevention.

Good News draws patients, many of them farmworkers, from surrounding communities. The clinic accepts walk-ins, but patients with appointments are seen first. Last year, the clinic completed more than 5,000 patient encounters and currently sees more than 1,100 active patients, about 95 percent of whom speak Spanish. A representative of the clinic notes that it is “a place with a real high comfort zone to them . . . They don’t feel they’re going to be reported or they’re going to be deported.”

Because diabetes is so common among the Hispanic population, patients are routinely tested for it and diabetes education is provided onsite. The clinic checks patients’ blood sugar levels every three months and monitors their progress. In addition, promotoras from Diabetes Community Intervention Project, a coordinated effort described later in more detail, provide education and support for diabetics at the clinic twice a week. The clinic director attributes a 50 percent improvement in regimen compliance among diabetic patients to the program’s health education classes.

Sustaining a free clinic is an intricate balancing act. Currently, Good News faces a shortage of volunteer clinicians as some veteran volunteers are retiring. The clinic does rotate its volunteer specialists in an effort to avoid overburdening them. Medications are the most costly line item in the clinic’s budget. Good News purchases medications and gives them to qualified patients free of charge, but it also supplies free medications to patients from other clinics. A clinic representative describes the pressure faced by Good News.

“A lot of them come over here asking them to fill their prescriptions because they can’t afford the medicines. So we’re doing that too. Supplying medicines to them and to patients in the emergency rooms.

Direct service providers often characterize Good News Medical Clinic as a provider of last resort for patients. Good News is particularly well respected for providing care at no cost and accepting poor, uninsured patients, including ones with serious medical conditions. Nurses who work in the region rely on the clinic and refer their uninsured patients there. Others claim that the clinic accepts cases where the county refused to provide care, undoubtedly a contentious issue. Some health professionals allege that the county has even referred patients to Good News. In response to these claims, a county staff member focused attention on the actual number of patients served by the free clinic. “They contrib-
Alta Family Health Clinic is a federally qualified health center “look-alike” that deals with a high rate of uncompensated care.

Although the extent to which Good News is responsible for providing indigent care is a matter of disagreement in the county, the clinic’s commitment to care for the poor is without question.

Payment Arrangements

To qualify for free services, individuals must be uninsured and ineligible for low-cost health programs, although no verification is required. Until last year, Kaweah provided radiology services and hospitalization at no cost to the clinic’s patients. Currently, patients referred to Kaweah hospital meet with a financial counselor who determines each patient’s cost based on a sliding fee scale.

Alta Family Health Clinic

Facilities and Staffing

Alta Family Health Clinic (Alta) in Dinuba is a federally qualified health center “look-alike.” Alta converted to its look-alike status shortly after its inception in 1994 as a hospital-based rural health clinic governed by Alta District Hospital, which recently closed after filing bankruptcy. The majority of Alta patients are farmworkers. Clinic billing records show that 86 percent of the clinic’s patients come from Dinuba; the rest come mostly from Cutler-Orosi, Visalia, Porterville, Kingsburg, and Parlier. As a federally qualified look-alike, the clinic must treat patients regardless of ability to pay, and Alta is a critical point of access to primary care for uninsured and indigent people in the Dinuba area. Table 1 shows that 60 percent of the clinic’s patients fall below 100 percent of the poverty line. About 20 percent of the clinic’s patients pay with cash.

According to a clinic representative, Alta experiences a high rate of uncompensated care. A staff member who has worked at the clinic since its inception comments about the rising rate of uncompensated care. “That’s a lot. I’ve never seen it that high, and they’re mostly new patients.” Alta’s costs for those visits may not be covered under the state health department’s Expanded Access to Primary Care program because the funds allocated to Alta were quickly depleted.

After some disagreements with the hospital, the clinic moved to its current quarters and is in the midst of constructing a larger facility. The new clinic headquarters will provide room for more examination rooms and health classes, a radiology laboratory, and a pharmacy. Currently, patients in need of radiology must travel to Reedley for this costly service.

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29 FHCN is a federally qualified health center while the Dinuba clinic is a look-alike. Both get full cost reimbursement for some of the uninsured patients they serve. For a qualified center, reimbursement comes from a Bureau of Primary Care grant; for look-alikes, it is from Medicaid funds from California Department of Health Services.
Medical professionals at Alta include two full-time pediatricians, a part-time general practitioner, and an obstetrician. The clinic is reportedly recruiting specialists in dermatology, cardiology, ophthalmology, and ear/nose/throat care. A majority of its staff members speak Spanish.

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Table 3. Selected Utilization and Demographic Data for Community and Rural Health Centers in North Tulare County

<table>
<thead>
<tr>
<th>Total Patients</th>
<th>Hispanic Patients as % of Total</th>
<th>Seasonal &amp; Migratory Ag Workers Patients</th>
<th>Poverty Level – Patients Below 100%</th>
<th>Poverty Level – Patients 100%-200%</th>
<th>Primary Care Provider FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHCN – Woodlake (FQHC)</td>
<td>3,047 88.97</td>
<td>2,742 8,812</td>
<td>73.38</td>
<td>2.86%</td>
<td>3.27</td>
</tr>
<tr>
<td>Woodlake Family Health Center (Rural Health Clinic, 95-210)</td>
<td>2,857 70.28</td>
<td>1,951 6,587</td>
<td>46.10</td>
<td>39.10%</td>
<td>2.60</td>
</tr>
<tr>
<td>FHCN – Ivanhoe (FQHC)</td>
<td>3,014 86.93</td>
<td>2,561 8,761</td>
<td>56.97</td>
<td>1.99%</td>
<td>2.80</td>
</tr>
<tr>
<td>FHCN – Orosi (FQHC)</td>
<td>1,831 97.54</td>
<td>1,560 3,203</td>
<td>91.81</td>
<td>1.69%</td>
<td>1.45</td>
</tr>
<tr>
<td>Orosi Family Medical Care (Rural Health Clinic, 95-210)</td>
<td>2,888 95.26</td>
<td>0 0</td>
<td>52.01</td>
<td>24.03%</td>
<td>2.35</td>
</tr>
<tr>
<td>Alta Family Health Clinic (FQHC look-alike)*</td>
<td>5,246 75.01</td>
<td>3,409 12,784</td>
<td>59.99</td>
<td>20.00%</td>
<td>11.70</td>
</tr>
<tr>
<td>United Health Centers of San Joaquin Valley – Orange Cove, Fresno Co. (FQHC)</td>
<td>6,346 96.14</td>
<td>4,569 16,724</td>
<td>88.09</td>
<td>10.45%</td>
<td>8.93</td>
</tr>
</tbody>
</table>

Report Period 1/01/01-12/31/01.

Source: Office of Statewide Health Planning and Development 2001 Primary Care Clinic Annual Utilization Report. 30

*Nearly 40 percent of primary care FTEs at Alta are contract personnel rather than salaried. Almost all primary care FTE figures in Table 1 correspond to salaried personnel.

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Medical professionals at Alta include two full-time pediatricians, a part-time general practitioner, and an obstetrician. The clinic is reportedly recruiting specialists in dermatology, cardiology, ophthalmology, and ear/nose/throat care. A majority of its staff members speak Spanish.

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30 Utilization data represents licensed primary care clinics in California (community clinics). Seasonal migratory and agricultural workers include farmworkers and their dependents. Total FTEs for primary care providers include physicians, physician assistants, family nurse practitioners, certified nurse midwives, dentists, registered dental hygienists and assistants, psychiatrists, clinical psychologists, licensed clinical social workers, marriage family and child counselors, registered nurses, licensed vocational nurses, and unlicensed patient education staff. Primary care FTEs reflect the total of salaried, contract, and volunteer FTEs.
The clinic provides a range of primary care services, including well baby care, health education, and dental services. The clinic also offers podiatry services on a part-time basis, and employs a licensed clinical social worker. Transportation assistance is available through financial aid.

Alta runs a diabetes management program that includes diet and health training while taking aspects of traditional Mexican diets into account. This program follows guidelines adopted by the American Diabetes Association. The program started with 450 diabetics. After eighteen months in the program, these patients’ average blood sugar levels had dropped by more than 40 percent.

Tulare County HHSA Primary Care Services

Tulare County HHSA, whose assignment is to maintain the health and well-being of county residents, operates in a difficult environment. While working with a disproportionately large number of poor, indigent patients relative to other California counties, the agency also faces budget cuts and staffing shortages. Low state and federal reimbursement rates for programs such as Medi-Cal and Medicare continue to strain all providers of medical care, both public and private. Despite these considerable constraints, HHSA is working to improve coordination of services.

The county’s primary care services consist of six clinics, with one in the north region in Dinuba. That facility, which is located along a main thoroughfare, provides comprehensive primary care, prenatal services, WIC services, breast and pelvic examinations, treatment for sexually transmitted diseases, testing for HIV/AIDS, tuberculosis control, care for occupational injuries, and laboratory and pharmacy services. Children receive well-child exams, no-cost physical exams, and immunizations through CHDP, and special needs children are treated through CCS. TeenSMART, a program aimed at preventing unwanted pregnancy and reducing sexually transmitted diseases, is also available there. Patients at the HHSA clinic can take advantage of several payment options.

Waiting times at many of the region’s clinics, including the private community health centers, tend to be long, but providers of health and social services note this problem most frequently at the county facilities and at offices of specialists under contract with the county. Farmworkers who have sought care at a county clinic complain of overcrowding, long waits, and that the clinics charge more than they can afford.

Private For-Profit Clinics

Although private physicians are mentioned less frequently, farmworkers do seek health care from private practitioners. The structure, function, and mandates of these clinics differ significantly from their nonprofit and community-based counterparts. For example,
they generally do not offer a sliding fee scale. Farmworkers treated at private clinics report fees of $80 and more for a single clinic visit. For-profit clinics also vary in the payment schedules and policies they offer. For example, one private clinic in Dinuba does not accept payment plans for adult patients, but will consider this option for pediatric patients previously treated at the clinic. A clinic in Visalia will initially care for a patient unable to make full payment but will then request that the patient pay up front for subsequent visits; otherwise, the patient is referred to the county. Also, private for-profit providers vary in the extent to which they serve Medi-Cal patients. Some of these practices employ bilingual Spanish-speaking staff, including medical assistants and office personnel.

Private practices offer little if any formal health education. A health program administrator in the region notes that many of the small for-profit clinics lack health education departments and staff, “where they could go pull stuff out or . . . going to sit with somebody.” Patients clearly find less orientation toward preventive care at the for-profit clinics. According to a family practice physician in Visalia, Medi-Cal patients are served providing they are sick. “If they are not sick, then we don’t want them. Well, what we can offer is medical service and if they don’t need it and are not sick, then we don’t want them.”

In addition, the accessibility of particular health programs may be more limited at some private practices. For example, private for-profit clinics offer CHDP, which provides free physical exams and immunizations for children, but access can be inconsistent, as a county staff member notes. “If they go to a private doctor, it’s really up to the receptionist worker to offer it [CHDP] to them. Often, if they go to a private doctor, they probably won’t know that program is available to them.”

In a few instances, private doctors have been able to cultivate trust in the farmworker community and provide medical treatment that is affordable, expedient, and culturally appropriate. Farmworkers describe the practice of a Visalia physician, for example, who speaks English and Spanish. He treats patients very quickly and is well regarded among farmworkers. One of his previous patients, a longtime resident of Yettem, learned about him when she first arrived in town. She related that at the time “everyone from here, from this ranch [in Yettem], would go to doctor X.” A staff member of a local clinic describes this doctor’s care. “Dr. X gives shots easily and asks for payment up front. It is faster to go to him since he minimizes paper work. He prescribes what you ask for. “Receta lo que uno pide.” Currently, residents of Yettem also seek health care from other sources, including the newly established FHCN facility in Cutler-Orosi, FHCN’s clinic in Visalia, and clinics in Dinuba.

31 In accordance with state and federal regulatory requirements, federally qualified health centers (including look-alikes) and nonprofit rural health centers must provide a sliding fee scale discount.
32 Unlike federally designated clinics, these clinics do not receive cost-based reimbursement for Medicaid/Medicare patients.
Tulare County Hospitals

Hospitals in Tulare County, like most rural hospitals, suffer from low Medicare and Medicaid reimbursements. A number of small Tulare hospitals failed, and only three remain: Kaweah Delta Health Care District’s hospital, Tulare District Hospital, and Sierra View District Hospital. Tulare County no longer runs a hospital; instead, the county contracts with existing hospitals like Kaweah for treatment of its TCMS indigent patients.

Kaweah

For North County residents, Kaweah’s facility in Visalia is the nearest hospital and emergency medical facility. Kaweah is a nonprofit, community-owned hospital supplying 450 beds for general acute care and offering basic emergency medical services. The hospital district has numerous outpatient clinics offering specialties and operates inpatient rehabilitation and transitional care centers. Additionally, the hospital provides comprehensive rehabilitation and neonatal intensive care, a cardiac surgery center, a cancer care center, and accredited magnetic resonance imaging and ultrasound services.

In 1997, when there were seven hospitals in the county, Kaweah experienced the highest percentage of admissions of indigent uninsured patients at 79 percent. Medicare comprises the largest share of Kaweah’s net revenue, followed by other third party payers, and Medi-Cal.

Now that so many of the county’s hospitals have closed, Kaweah may find it difficult to manage demand. The emergency room has been overwhelmed for some time. In the last hospital report period of 2001, emergency room visits at Kaweah totaled 64,866, a 10 percent increase from the previous reporting period. Representatives of the hospital believe that primary care providers in the region must help solve this problem. While emergency room use for non-emergency care is not limited to Kaweah or Tulare County, a hospital representative notes the heavy non-emergency use Kaweah sees.

Statistically, 80 percent of the time patients that come to the emergency room do not need emergency or urgent care. Granted, some of those 80 percent are here because they don’t know what they have, such as heartburn, go home, take Tums, and you’ll be fine. But there are others who may actually be here for real problems, such as cardiac reasons, that need treatment. On the other hand, there are many that come here for lack of access and they come to the most expensive site for care and receive episodic care as opposed to longitudinal care. The clinics do have to step to the plate to better serve patients. Rural health clinics, federally qualified health clinics, private health clinics, and county clinics.

34 Office of Statewide Health Planning and Development, Hospital Annual Financial Data Profile, 2001, Report period 1/01/01-12/31/01.
35 Ibid.
Furthermore, in order to retain physicians who deal with uncompensated care in the emergency room, the hospital has increased compensation to physicians who take call. According to an administrator of Kaweah, “In terms of the orthopedic surgeon, general surgery, cardiology, and intensivist, we now pay $1,000 a day for their services . . . This comes out to a cost of $1.5 million a year.”

Kaweah recently closed San Juan Health Center and discontinued skilled nursing inpatient services at Memorial Hospital, both in Exeter. Other services, including the mobile clinic that was funded by The California Endowment, were also discontinued. Hospital administrators say the cuts were made in an effort to offset financial shortfalls and that the cost of meeting state seismic safety requirements strains Kaweah’s finances.

Due to this, the hospital is short with beds. If we want to remain a hospital in the community, Kaweah Delta needs to take care of earthquake safety measures . . . and it is an expensive cost. We have already cut back in beds, recruitment of doctors, and nurses. These are all expenses that nobody in the community really sees.

Staff members at Good News Clinic are subsidized by Kaweah, which continues to support the free clinic through its services and staff. According to an administrator, the hospital is also pursuing a program to enhance linguistic and cultural competence of Kaweah staff and services.

Other Hospitals

Kaweah is the primary hospital facility serving the north Tulare region, but farmworkers also use several nonprofit general acute care hospitals in neighboring Fresno and Madera Counties. They resort to these resources typically for emergency services and for serious medical conditions, including terminal illnesses. In some rare instances, providers have referred cases outside the county to Fresno’s University Medical Center, which is a teaching hospital, and to St. Agnes Medical Center in Fresno. The number of Tulare residents who cross county lines for care is not known.

Additionally, Valley Children’s Hospital, a pediatric facility in Madera, serves a significant number of Tulare County children. The hospital is a nonprofit general acute care facility. According to a hospital staff member, Tulare County represents the second largest region served, accounting for approximately 18 percent of patients.36 Valley Children’s Hospital is the only children’s hospital in the region, serving a multi-county area that extends as far south as Kern, to the central coast region to the west, and north to Stanislaus County.

Valley Children’s Hospital offers emergency services, neonatal and pediatric intensive care units, and a large array of specialties, including endocrinology, oncology, and psychiatry. Pediatric surgical services include cardiovascular, neurological, orthopedic, and

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36 Fresno County patients account for approximately 50 percent of patients treated at Valley Children’s Hospital.
Like so many areas of California, North County suffers from a lack of affordable dental care services.

Dental Care

Dental health services are particularly limited in this region, and services beyond routine and preventive care are not available in some North County towns. Without private coverage or Medi-Cal, most adult farmworkers cannot afford care and go without. Additional resources are available to serve children, but even those services present a patchwork of care, especially for those not enrolled in Medi-Cal or Healthy Families.

Federally Qualified Health Centers

Basic and preventive dental services are available at FHCN sites in Woodlake and Cutler-Orosi. The Alta clinic in Dinuba also provides comparable dental care. Both organizations offer sliding fees.

Kaweah

Kaweah offers dental care to children from underserved, low-income families in the small communities around Visalia through a partnership with a mobile clinic operated by University of Southern California. Only children who are eligible for Medi-Cal can be treated.

Tulare County HHSA

HHSA collaborates with Tulare-Kings Dental Society to provide the Adopt-A-Child dental program to children who lack other forms of coverage through the CHDP program. The program was established nine years ago by a county staff member with a background in dentistry who identified a serious need for dental care among children. Eighteen dentists currently participate in this small but vital program and new dentists are recruited annually. An administrator for Adopt-A-Child describes the process.

What we do with the program is we have volunteer dentists throughout the county and we work together with the Tulare-Kings Dental Society and each dentist volunteers to see between five to twelve children a year for cleanings, fillings, sealants, and extractions. This is at no cost. The requirement is that we
Many individuals in the farmworker community suffer from situational mental health problems, but there are very few resources available to address those problems.

In 2001, the program provided no-cost dental care to nearly one hundred children. Some of Adopt-a-Child’s participating dentists also gave free dental care to another fifty children at a one-day event during dental health month in February. The event helped them to identify children with urgent needs. HHSA staff offered families some assistance arranging transportation to the dental offices.

Adopt-A-Child serves a limited number of children, and health care providers agree that additional dental programs for uninsured children are needed. The same administrator for the program describes one of the agency’s efforts to sustain this important service.

We only have about eighteen dentists and this year we had an instillation [event] where we gave out awards and plaques. I think that by us giving the dentists awards, which made them feel good and also might encourage them to do more.

Migrant Education

Migrant Education is working with private business in order to better serve their students by negotiating reduced rates with a local dentist and optometrist.

Mental Health Services

Mental health care is unevenly distributed in this region, with few resources available to address more common, situational conditions. Service providers in North County describe programs as constrained by lack of funding, service restrictions, and eligibility requirements. Less threatening, situational issues such as mild depression, alcohol and drug abuse, adjustment problems, work-related stress, family relationship issues, and domestic problems are prevalent in the farmworker community, but few resources for adults are available to address them. The case is similar for undocumented children since they are not eligible for Medi-Cal.

Woodlake Family Resource Center

Woodlake Family Resource Center, part of Woodlake Union School District, is a one-stop counseling, resource, and referral center. The center is primarily funded by The California Endowment and Proposition 10 and serves low-income people regardless of their immigration status. Woodlake is known for bilingual, culturally competent mental health care. It provides comprehensive case management services and home visits to farmworkers and their families. Reportedly, farmworkers comprise about 90 percent of those served by Woodlake, and more than 50 percent of its clients are undocumented. They come not only from the community of Woodlake, but also from surrounding areas. However,
Woodlake Family Resource Center is known for its bilingual, culturally competent mental health care services, which it provides to low-income people regardless of their immigration status.

Woodlake schools are a primary source of referrals to the agency. The center also works with local law enforcement to intervene with counseling services for first-time youth offenders. Woodlake Family Resource Center employs a mental health therapist, four home visitors/case managers, and a public health nurse and contracts with another agency for licensed clinical social workers. More than half the staff members speak Spanish. Bilingual counseling services include individual and family counseling and alcohol and drug support groups. A representative for the center explains case management services.

The case manager goes out to talk to the family and addresses what basic needs they need or provides the family information as to why the referral was submitted. Many times, when the case manager visits the home, the case managers see other problems that need to be addressed, like domestic violence or sexual abuse. We get referrals from the school and the referral is assigned to a case manager. The case manager makes contact with the family to address the referral, and most times the referral comes to us with the knowledge of the family. We are considered by the public as a good thing. We are not looked at like a child welfare agency or probation. We are here to provide assistance and the mothers and fathers know this.

The center also offers nutrition and health education, in addition to referrals for primary care, immunizations, tuberculosis testing, CHDP services, and vision, hearing, and dental care. Parenting classes, including ones for teen parents, are also available. Clients receive assistance with Medi-Cal and Healthy Families enrollment and access to job training services, food, clothing, and other basic needs. Case managers who conduct home visits serve as liaisons between clients and physicians and coordinate care.

FHCN

FHCN has sought to encourage farmworkers to take advantage of mental health services by integrating them into the primary care setting in a culturally appropriate manner in order to combat the stigma associated mental health. The clinic system received a grant from the federal Health Resources and Services Administration to develop this model of care and plans to hire three psychologists.

Tulare County HHSA

The county’s mental health efforts fall under the Primary Care Services Branch, which provides some services to both youth and adults for serious, medically diagnosed mental health conditions, including cases identified through the criminal justice system. Dinuba Mental Health Clinic is the only one of the county’s six adult mental health facilities in North County. It operates Monday through Friday from 8:00 a.m. to 6:00 p.m., with crisis services available after hours. The agency employs a part-time psychologist, seven mental health therapists, seven case managers, and two licensed clinical social workers. Most staff members are bilingual, except the psychologist. The clinic accepts payment from Medi-Cal and Medicare and on a sliding fee scale based on income.
There are just five county psychologists and only one speaks Spanish. The bilingual psychologist, whose clients are about 80 percent monolingual Spanish speakers, says, “We have so many people who need services in their language and we just don’t have enough professionals to do it.”

Family Care is a home-visit program that involves case management and short-term interventions for mental health problems. The Dinuba office serves the North County region. Family Care Services employs mostly bilingual staff members, the public health nurse being the exception. Families receiving cash aid are eligible for a range of free services provided by clinical social workers: anger management education, grief sessions, sexual abuse and domestic/family violence counseling, and education about family relationship issues. An alcohol and drug specialist offers substance abuse counseling. Among the resources to which social services workers can link clients are medical care, food, clothing, legal services, WIC, nutrition education, housing, and shelter. A public health nurse teaches teenage pregnancy prevention, offers follow-up care and health education, and links uninsured patients with health resources. The agency also serves adolescents who are not receiving cash aid through its Adolescent Family Life Program.

Kaweah

Hospital systems such as Kaweah also experience problems in maintaining an adequate number of mental health providers, as one administrator explains.

We are in dire need of psychiatrists that can speak any language. In other words, the very viability of our psychiatric program hinges on our ability to obtain psychiatrists who then can admit patients. Both acute and rehabilitation demands are more than we can accommodate, but psychiatric availability is the key issue. So, we need any psychiatrists, bilingual or monolingual, because we may not have anything at all.

Children and Youth Services

In general, children and youth experience greater access to mental health interventions, including school-based interventions; however, the providers of care primarily treat Medi-Cal enrollees. The county contracts with Turning Point, a private nonprofit organization, to provide substance abuse services for youth. Counseling services are limited to substance abuse cases and are available at two North County sites, twice a week in Dinuba, and once a week in Woodlake. Tulare Youth Services Bureau is another private, nonprofit organization that contracts with the county to provide school-based therapists and children’s mental health care, but the organization services primarily the south county, except for cases of sexual abuse.
Community Health Services and Outreach

This section describes only those community and outreach efforts currently identified that operate in north Tulare County and reach farmworkers and their families. The majority of outreach in this region operates through community-based organizations and school-based efforts. The smaller communities of Seville, Yettem, and London are rarely if ever mentioned in descriptions of outreach efforts.

FHCN

FHCN is at the forefront of health education, outreach, and collaboration efforts in Tulare County, including public-private collaborations.

FHCN’s health promotion program consists of thirteen staff members who serve the consortium throughout the county. Two are health educators/nutritionists who have earned bachelor degrees. The rest are health promotion instructors with experience as medical assistants or nurse’s aides. Recruiting additional health educators/nutritionists to work at FHCN presents a challenge, as one nutritionist indicates. “We need Spanish speakers and we are having a heck of a time finding Spanish-speaking people with at least a bachelor’s degree or higher in nutrition.” The health educators/nutritionists rotate through FHCN clinic sites and offer nutrition counseling to individuals and in group sessions on a wide range of topics, including childhood obesity, high blood pressure, and high cholesterol. Health education efforts target diabetes, asthma, prenatal care, child care, and prevention of sexually transmitted diseases and pregnancy.

Seven bilingual community outreach workers make up the community service program. They conduct home visits, present health information, and educate members about FHCN’s services. These workers are trained and certified to enroll individuals in the Healthy Families program. They also promote Medi-Cal and other programs in the community by visiting schools, work sites, Healthy Start centers, and other agencies. Working one on one with farmworkers, they serve as liaisons to address individual medical needs through available health systems. These workers clearly understand the farmworker population, as evidenced by their outreach strategies. For example, outreach workers attend local swap meets, at which farmworkers frequently gather, in their efforts to seek out farmworkers in general and “hombres solos/solo males” in particular.

Although FHCN’s community services continue to expand in size and scope, coordinating and sustaining this outreach effort is a constant challenge. The department suffers from a high rate of staff turnover, cycling through about two new staff members each year.
Kaweah

Despite financial challenges, many of Kaweah hospital’s community programs continue to operate. In 2000, the hospital received the Foster G. McGaw Prize for Excellence in Community Service. Some of Kaweah’s community services have changed in the past two years, but efforts continue in areas such as diabetes and dental health. Thanks to a major grant from The California Endowment, the hospital district was able to partner with FHCN to create and operate a promotora model of culturally appropriate diabetes education. This program, called the Diabetes Community Intervention Project (DCIP), adheres to standards set by the American Diabetes Association. DCIP targets the underserved Latino population, particularly those who are uninsured or outside the health care system, throughout Tulare County, reaching the North County communities of Cutler-Orosi, Ivanhoe, and Woodlake. Promotoras provide services at various clinical sites, including Good News Clinic in Visalia and Villa de Guadalupe Resource Center in Cutler-Orosi. However, most of their services are provided in people’s homes. According to the outreach program manager, 98 percent of DCIP’s patients are uninsured farmworkers who pay on a sliding fee scale. Patients are identified through clinics such as FHCN, presentations, health fairs, and community venues such as local swap meets. Type II diabetics identified through the program’s screening process are referred to one of several collaborating clinics, and participants receive home-based education, blood sugar monitoring, and discounts on prescription medications.

Three outreach promotoras, all Latino immigrants who themselves have diabetes, provide support, information, and education through eight sessions that cover diabetes management, health consequences of diabetes, nutrition, medication, disease prevention, and exercise. This program involves family members as caregivers. The efficacy of the program has not yet been measured, but the program manager refers to patients’ levels of compliance with the regimen and appointments and stabilizing blood sugar levels as indications that it is working.

Tulare County HHSA Community Services

HHSA’s Community Services section administers the county’s prevention programs and therefore represents its main outreach component.

Prevention Services

Prevention efforts include AIDS education and prevention programs, alcohol and drug services, dental health education, emergency medical services, family violence prevention programs, an independent living program, lead poisoning prevention, parenting education, teen pregnancy prevention (TeenSMART), car seat safety, and tobacco control. The majority of these programs are grant-funded, requiring formal needs assessments for the populations being served. Outreach occurs at various community sites,
including child care centers, clinics, health fairs, schools, adult English classes, and churches and through collaboration with other community-based organizations and agencies.

A few years ago, preventive services staff members were scattered throughout the county, but the unit now is housed in one building, which facilitates internal coordination. For example, when the unit offered education on sexually transmitted diseases at Orosi High School, staff members from TeenSMART, HIV/AIDS, and Chlamydia Awareness Prevention joined in a cooperative presentation. Increasing internal collaboration is an ongoing goal, along with enhanced inter-agency and countywide collaboration. However, representatives from other agencies and organizations already recognize the unit for its collaborative and community-oriented approach.

Prevention Services operates a program of education on oral hygiene via community education specialists who teach at schools and Head Start home-based facilities. Tulare County's “Whiter Biters” dental disease prevention program offers dental health education and services to children in grades kindergarten through six in eligible schools. 37

A bilingual health education assistant provides free car seats to parents who attend the county's class on car seat safety. This class is presented at child care centers, clinics, schools, and community centers such as Villa de Guadalupe Community Center. Farmworkers comprise roughly 65 percent of the population served by this program, with attendance higher in small communities such as Cutler-Orosi.

The county's HIV/AIDS Prevention Program provides education to farmworkers throughout the county in collaboration with the justice system, alcohol and recovery programs, clinics, schools, classes, churches, and other community sites where farmworkers gather. A bilingual community education specialist conducts presentations and works through a variety of organizations and programs. In addition, AIDS education is taken to the fields in an effort to enhance delivery to farmworkers. Approximately 65 percent of the people served by this program are Latino and farmworkers. The HIV/AIDS Prevention Program also offers assistance for testing for sexually transmitted diseases. An educator can either refer clients for testing or arrange the appointments. Transportation assistance for testing is also offered. Those who test positive for HIV may be eligible for no-cost medical services.

The county's Student Intervention program allows the agency to receive mental health realignment dollars, which fund the majority of its health education efforts. Student Intervention is primarily a case-management/mentoring program for children at risk of entering the juvenile justice or mental health system.

37 Eligibility is based on percentage of children in the school who qualify for the free lunch program.
Public Health

Tulare County employs two public health nurses who mainly provide prenatal care and guidance to pregnant women throughout the county.38 Both speak Spanish. The nurses maintain contacts with obstetricians/gynecologists throughout the county and take referrals from physicians. Their care covers a broad range of activities, including home visits, referrals to early prenatal care to decrease the number of high-risk pregnancies, referrals for social services such as domestic violence shelters and food pantries, and transportation assistance (restricted to documented pregnant women). Public health nurses and community health technicians conduct outreach for early prenatal care. One public health nurse noted that these efforts include mediums such as Radio Bilingue and Radio Campesina. A staff member at the Dinuba county clinic works with the prenatal department, conducts home visits, and attends the swap meet in Visalia.

The public health section administers free Immunization Action Plan clinics for children to eighteen years of age with no appointment required. These clinics rotate through schools, Healthy Start programs, churches, and child care facilities, including those in farm labor camps, across the county monthly.

HHSA actively participates in FHCN’s annual health fairs. Agency representatives from Human Services promote Medi-Cal, and Children’s Medical Services, a unit within Public Health, provides information in both Spanish and English about the CHDP and CCS programs directly to parents. Bilingual community health technicians from Children’s Medical Services give parents information about dental health one on one to resolve language and literacy barriers. Printed materials are also available, in Spanish, English, and, most recently, Southeast Asian languages. In addition, these technicians visit sites such as Head Start programs and inform eligibility workers and social workers about CHDP.

Other Agencies/Organizations Serving Farmworker Families

Other agencies and organizations in north Tulare County offer crucial points of contact linking farmworkers and their dependents to health care and social services. Rather than offering direct medical services, they provide essential referrals that depend on both formal and informal connections with the region’s providers. These connections facilitate entry into the health system for people who previously remained largely outside of it. In addition, farmworkers receive social services and access to safety-net programs from trusted organizations.

38 The entire Tulare Health and Human Services Agency has roughly 50 public health nurses who work in various capacities; reportedly, less than half speak Spanish.
Tulare County Office of Education Migrant Education Program

The federally funded Migrant Education Program offers supplemental health and social services to children of migrant farmworkers. Tulare and Kings Counties comprise Region VIII. In Tulare County, there are six nurses who serve fifty-four school districts. According to one of the program’s nurses, the majority of families served are undocumented and uninsured. Furthermore, funding for services in north Tulare County is very limited according to a Migrant Education representative. In the North County region, one of the program’s bilingual county nurses serves children and youth in nine school districts.

Migrant education nurses work with support aides, school nurses, teachers, school administrative staff, and parents to administer the health services component, which includes home visits, case management, and referrals for health, dental, and vision care. According to the region’s Migrant Education nurse, most of the health care problems identified in children in the program are related to dental needs. However, program funding restricts services to only the most urgent cases, leaving many children with untreated cavities that eventually develop into urgent problems.

Nurses intervene in cases where school nurses cannot meet the needs of a migrant child. They also assist families with social services, such as acquiring financial assistance for transportation and providing food vouchers. Through Migrant Education’s Even Start program, parents receive education on dental care and on the health coverage available through Medi-Cal and Healthy Families.

Cutler-Orosi Joint Unified School District/Healthy Start

Cutler-Orosi Joint Unified School District offers a broad range of programs and services to farmworker families. These programs include teenage parenting education, child care (infants to toddlers), adult classes, English as a second language classes, after-school programs, mentoring programs for youth, and family literacy education. Farmworker informants indicate that their children’s schools inform community members about health care options, such as free immunization clinics, the Healthy Families program, eye care programs, and dental services. At Villa de Guadalupe, the district also provides a program that teaches parents how to create quality time with their children. Cutler-Orosi’s Healthy Start program helps connect children with needed services through case management, information, referrals, and direct assistance. Employees help parents complete applications for Medi-Cal and Healthy Families and provide information about low-cost/no-cost immunizations. The center also provides families with food assistance, clothing, and other basic needs. Additionally, the district school nurse works closely with clinics in the community and assists families in obtaining physical examinations and vision screening for their children.
Villa de Guadalupe Community Center

Villa de Guadalupe provides Community Center facilities for Cutler-Orosi Joint Unified School District’s adult education and parenting classes. Transportation assistance is provided to parents who attend. Unfortunately, staffing constraints keep this service from reaching parents in some surrounding communities such as Seville.

Other programs available at Villa de Guadalupe Community Center include Head Start’s home-based program,39 after-school programs, and a diabetes support group under DCIP. Other agencies, such as HHSAs preventive services, also conduct health-related presentations to parents at the center.

Cutler-Orosi Senior Nutrition Center

The Senior Nutrition Center in Cutler-Orosi provides seniors age sixty and above with hot lunches daily, a place to socialize, and information about programs and services available in the community and in surrounding areas.

Catholic Social Services/Good News Center

Catholic Social Services/Good News Center operates a thrift shop, a family shelter, and a kitchen that provides free meals. Families may use the shelter for up to ninety days. Good News Center also assists these families with employment. The center is located in Visalia, adjacent to Good News Clinic.

Woodlake Union School District

Woodlake Union School District administers the Teenage Pregnancy Prevention Program, which operates from a Presbyterian church in Woodlake and teaches parenting skills, child development, and computer skills, as well as individual education in core subject areas of math, history, and English. Child care services are available for students in the program. The large majority of young women enrolled in this program originate from farmworker families. Other agencies and organizations offer services to participating mothers. A nurse from Woodlake Family Resource Center conducts health presentations once a week and county agencies provide support for violence, drug, and alcohol prevention. Each semester, a representative from University of California Cooperative Extension offers nutrition education.

Open Gate Ministries

Open Gate Ministries is a private, nonprofit, faith-based organization located in Dinuba. The organization operates a thrift shop, offers a thirty-bed family shelter, provides food

39 The Tulare County Child Care Education Program administers the Head Start home-based program, which promotes healthy child development for low-income families with children three to five years of age.
and clothing to individuals in need, and offers employment services and utility assistance. In addition, Open Gate Ministries distributes food in Cutler-Orosi, particularly to the farmworker community. According to the executive director, Open Gate provides shelter to approximately 300 individuals annually and feeds about 5,000 people. The majority of staff members are bilingual. Open Gate provides case management and refers people in need for an array of services, including medical care and mental health counseling. Health care referrals are to Alta or the Dinuba county clinic.

Proteus

Proteus is a regional private nonprofit organization that assists low-income groups in general and farmworkers in particular. Its funding streams include federal, state, local, and private money. Services are free, but programs have specific eligibility requirements, such as income limits, that clients must meet. Latinos comprise 95 percent of Proteus clients; farmworkers make up 25 percent. Proteus has offices in Cutler-Orosi, Woodlake, and Dinuba and a youth center in London. A representative for Proteus describes their efforts in London.

The town is probably 99 percent Latino and probably 99 percent farmworker and largely undocumented. We have a community outreach program and a substance abuse program out there. That was an interesting thing out there. The land belonged to the Tulare County Housing Authority and the housing authority gave us a twenty-two year lease on the land and we built a little community center. We put a mobile unit out there and we provide services out there.

Programs and services available through Proteus include child care, foster family placement, education through accredited schools, computer classes, domestic violence awareness programs, energy assistance, and emergency aid. Through a collaboration with AmeriCorps volunteers, Proteus supports pesticide safety education among farmworkers, and its National Farmworker Jobs Program teaches vocational skills and provides on-the-job training, placement, and retention services to farmworkers. For youth in the community, Proteus offers programs aimed at keeping farmworker children in school. These efforts involve support services, stipends, and a dropout recovery program through Migrant Education. Proteus’ youth development specialists serve as case managers and mentors for youth, assisting them with job placements and work experience. They also conduct outreach to young people through various community venues.

Proteus does not provide direct medical services. Instead, farmworkers who cannot afford to pay for care are offered cash assistance for dental and medical fees. The organization is currently purchasing two mobile units that, once operational, will deliver health education and screenings by collaborative providers to the small towns in North County.
United Way/Primera Llamada

United Way of Tulare County promotes efforts to improve the well-being of children and youth in the region by supporting numerous agencies that in turn offer basic and emergency services. United Way also administers an information and referral service, Primera Llamada, or First Call, which links individuals to providers of food, clothing, education, rent and utility assistance, legal services, health care, housing, counseling, and child care. In collaboration with HHSA, United Way develops and distributes the Tulare County Community Resource Directory, a guide to individuals, agencies, and organizations providing health and social services in the county. United Way also funds Basic Emergency Services Technology, BEST. This cooperative effort connects basic and emergency aid organizations to an electronic network, streamlining intakes and information exchanges, and they have developed a single shared intake form to reduce duplication of effort. Not all area agencies are connected at this time, but those participating include Foodlink for Tulare County, Tulare Emergency Aid, Open Gate Ministries, and Woodlake Family Resource Center.

Collaborative Activities in North Tulare County

In Tulare County various agencies and organizations are beginning to work together to improve the health and well-being of the farmworker community. Service providers have taken on various levels of collaboration—information sharing, coordination of services and activities, and true partnerships, including public-private sector arrangements. Collaborative partnerships entail an intensive process. They require established trust among members, sharing of resources, and careful divisions of service areas. Information sharing and service coordination are more easily accomplished. Community-based organizations, health plans, health care providers, and county agencies in Tulare County demonstrate an extensive coordination of service delivery, particularly in connection with outreach. Some agencies and organizations have established formal memorandums of understanding; others share informal arrangements. Since their efforts have not eliminated duplication, they continue to work toward greater collaboration.

Some of the activities described in this section also benefit communities outside North County, and these groups' efforts are not limited to those described here. Examples in this section corroborate examples of collaboration mentioned elsewhere in this report and demonstrate the capacity and readiness among some organizations in this region to work together for mutual benefit. This section also discusses barriers to successful collaboration efforts from the perspective of local individuals.

FHCN Health Fairs

One of the most prominent outreach efforts in Tulare County is the annual health fairs that FHCN sponsors at each of its clinics. These fairs bring together all of the various
providers, public and private, who make up the county’s health care network and effectively reach large numbers of people. This year, they drew approximately 800 people to Cutler-Orosi, 500 to Ivanhoe, and 700 to Woodlake. The spouse of a farmworker in Ivanhoe describes the scene at a recent fair. “Well the place fills up. It’s done outside the clinic; there are a lot, a lot of people. They play music . . . and they have a small raffle.” The fairs offer a variety of activities, including critical opportunities for screening for diabetes, anemia, and dental and vision problems.

**HHSA Efforts**

Currently, HHSA’s prevention division is undertaking a strategic planning process to identify health priorities for the county and to address the agency’s internal collaboration. An HHSA administrator describes the county’s vision of its responsibility.

> Our role as the county is working well with communities, at a community level, instead of working with individuals one on one. Doing more capacity-building to be able to empower communities to take on the roles of prevention. And not just the schools, but the schools and the parents and the churches and the businesses to all come together around the issues that affect the community.

During the past year, Prevention Services has worked with various entities, including Blue Cross, Health Net, FHCN, and Kaweah, in an attempt to form a collaborative. The effort began as an ad hoc committee to plan activities around Public Health Week and Women’s Health Week. It has since changed from being event-driven according to the division administrator. “We decided not to be event-based anymore. We decided to be issue-based. That’s what this committee really wants to do, is look at innovative ways to reach and actually effect change.”

Prevention Services funds the collaborative and other members dedicate resources. As of June, 2002, the collaborative was developing its mission statement.

**The FREE Collaborative**

The FREE Collaborative, Family Referral Education and Empowerment, seeks to improve the health of children and families through parent education, training, support, information, and referrals. Funded by the Tulare County Children and Family Commission, FREE is comprised of fifty-seven service providers, both county and community-based organizations that include health care providers, educators, and family resource centers. An administrator for the collaborative describes its objectives.

> The FREE Collaborative was formed by a group of people with shared interests in providing services to children and families that started to come together with the understanding that we had a lot to learn and share from one another and possibly some advantage could be gained if we were a collective rather than a set of individual programs. The hope was to try to step out of the isolation and fragmentation that is often the case in the social services. In our third year now of meeting, we are definitely moving in that direction.
One of the services provided by the FREE Collaborative is parenting education. A program trainer sums up the program’s goals.

The way we see it is, if there is healthy parenting, then there will be healthy kids. If there are healthy kids, then we have healthy families, which equals healthy communities. That is the whole philosophy of our parenting program.

Parenting classes are offered through collaborating agencies in Spanish and English using Soledad Enrichment Action, Inc. (SEA) curriculum. The program also identifies parents for training as community parenting educators who then go out and guide other parents. A program trainer describes the advantages of this internal framework.

It could be Doña Maria that has been in Ivanhoe for thirty years and everybody knows that lady and the parents in the classes are going to want to listen to her . . . Farmworker parents do not want to go to a strange building and say that they have problems with their kids. That is an uncomfortable feeling for the farmworker parents. But if the farmworker parents have someone from their own community that speaks the same language and has been there and done it, I think that more people will open up.

The program also offers this parenting component and the SEA certification to staff from other agencies in the county who are interested in providing parenting education.

Other Efforts in Tulare County

Other collaborative efforts under way in the county include Tulare County Youth Coalition, San Joaquin Valley Mental Health Collaborative, 40 and Cutler-Orosi Network for Needs of Education and Community Teamwork (CONNECT). CONNECT is an example of a successful ongoing effort to gather a diverse group of providers from health services, education, employment and training, mental health, and other areas together to share information in order to better coordinate services.

Barriers and Challenges to Collaboration

Competing Responsibilities

Time constraints are frequently mentioned by service providers as a barrier to effective collaboration efforts.

Education program coordinator: Everyone’s plate is so full that it is really hard for them to coordinate and collaborate.

Education support aide: I am sure that service providers want to work together, but they are pulled in so many directions that [it] is really hard for them to make a commitment.

Primary care provider: I admit it. I’m only trying to solve the problems of the patients I saw today . . . just to keep this place going.

Social service provider serving on five collaboratives: Collaboration takes an awful lot of time and most people don’t have enough time. It’s a full-time job just to be

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40 The California Endowment grant for this collaborative was awarded to Kaweah Delta Health Care District to establish a model of outpatient mental health care targeting Latinos.
involved in collaboratives. And I can’t get my regular work done, and my schedule is relatively flexible. When you impose that on people that have to live on time constraints, it’s really difficult to be involved in enough collaboratives to make everything happen.

**Sustainability**

Collaborative efforts can be difficult to sustain. A service agency administrator describes one challenge to the ability of such groups to endure.

When the word sustainability is used, it all depends on the power structure at the Health and Human Services level in that county. If foundations do not understand the county structures and the power dynamics at play, or their regional community people that they send out to communities do not, then sustainability is not achieved.

Sustainability is also a function of funding and long-term commitments. For example, United Way began three years ago to unite child and youth organizations, basic and emergency services, and adult education through a two-year project that struggles to continue. According to a representative for the local foundation, “It probably would have been more successful if there had been a longer term commitment to that project. A lot of these organizations continue to meet on an ongoing basis.”

**Multiplicty/Duplication of Efforts**

There are numerous collaborative efforts under way in Tulare County, many of which appear to target similar groups and share participants. A county staff member describes the situation.

The biggest constraint in my mind would be time. Because we probably have 10,000 collaboratives in the county right now . . . you see the same people at the same meetings over and over. Especially our unit manager. She probably sits on twenty different collaboratives where she’s seeing the same people over and over. You just have to choose where you’re going to divide your time. People are just getting tired of going to meetings, I think. So that’s what the biggest challenge would be in terms of forming new collaboratives.

**Lack of Collaborating Skills/Training**

Some service providers concur that existing groups often lack the skills needed to effectively collaborate. A program administrator describes the problem.

There is not yet a climate that is conducive to a culture of capacity-building. How can we do that? The resources are limited in Tulare County and there is a huge need for capacity-building. We just had a conference and an interest survey was done where real solid results came out from that. People from agencies indicated that it is not that they are not willing to collaborate. It is just that people do not know how to collaborate. People do not have the skills. There is a suggestion on the table of the FREE Collaborative Steering Committee, because there are a series of other fairly large collaboratives in the county such as
the Youth Coalition and the Safe from the Start group. Each of those collaboratives probably have the same capacity-building needs . . . Hence the interest survey and the notion that all these collaboratives will sit together and look at how can we build collaborative capacity.

Lack of Defined Leadership

Adequate leadership is an essential but missing element for successful collaboration efforts, as noted by a county staff member.

In terms of the teen pregnancy collaborative . . . we tried to build a collaborative. Kaweah Delta, Office of Education . . . it’s a challenge if you don’t have somebody who is dedicated to bringing those folks together and coordinating that group. Because what you have is you have each agency has its own interest and you come to the table with your own interest in mind.

Competition, Turf Conflicts, and Communication/Perception Issues

Competition and conflicts over turf pose significant challenges to collaboration practices. For example, when FHCN established its clinic in Cutler-Orosi under AWHHP at Villa de Guadalupe, a representative for FHCN admits that “all ___ broke loose” with United Health Centers in Orange Cove (Fresno County), which claimed that FHCN was taking patients. Community members, including farmworkers, concur that United Health Centers in Orange Cove is a major source of health care for many North County residents. A representative for another organization has encountered other turf-related barriers when increasing service coordination and collaboration between the county and community-based organizations.

I think it is money and territorial. I do not think the county wants to release their funding to the education system that has programs such as these. They are totally different cultures, but the one nice thing with this office is that we try to bridge that gap . . . I can get the ground level staff to see it, but not the administration. The ground people at the county would love to come out here and provide services. It is just that they are so constrained in what they can and cannot do.

Past experiences and lack of communication among members of various agencies and organizations inhibits trust and hence their ability to work together. Some providers do not seem to be familiar with the other agencies that share similar goals and target populations. Despite efforts by county staff to reach and serve farmworkers, for example, various providers in the area believe that HHSA is not concerned about farmworkers’ health care needs or about the needs of uninsured individuals in general. In fact, some informants feel that HHSA is out of touch with issues associated with farmworker health. Also, some service providers describe their relationship with the county as competitive or adversarial. For example, despite FHCN’s well-established outreach department, HHSA did not contract with FHCN for outreach to children for Healthy Families and Medi-Cal for its previous funding period. A primary care provider who has been unwilling to part-
Fundamental to high quality, continuous health care for farmworkers is uninterrupted affordable insurance coverage.

A fundamental concern among both farmworker informants and service providers is the lack of adequate health care coverage for farmworker families. Often, workers either do not receive employer-based coverage or they suffer lapses in coverage because of the seasonal nature of their employment. The few farmworker informants who report having

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employer-based health plans complain of high premiums, expensive copays, and lack of medication coverage. For many, immigration status and income guidelines restrict their participation in low-cost health programs to emergency services only. Although federally qualified health centers offer a sliding fee discount, providers perceive that services remain out of reach for many farmworkers in the region. An administrator for a diabetes program reports a typical experience.

We identified several patients that did not know that they were diabetic, but when they did the test, their levels were high. We asked them if they had a doctor, and pretty much they did not have the financial means to afford a doctor. Many of them do not go to the clinic because they still have to pay a fee. Even if it is only $20 per visit, they still cannot afford that. That is the main problem that we have.

Within these communities, lack of affordable health care results in people relying on home remedies, self-medication, and care in Mexico. In general, farmworkers frequently mention dental care and prescription drugs as prohibitively costly on this side of the border. Uninsured farmworker informants report delaying care for existing health conditions such as arthritis, chronic back pain, diabetes, and dental problems. A service provider in Woodlake explains the outcome for these individuals. “Farmworkers cannot pay for medical health care, so they jump from one doctor to another and another and they do not receive consistent health care.”

Lack of coverage through programs such as Medi-Cal also inhibits access to mental health services for many farmworkers and their children. Informants concur that the mental health system does not provide for uninsured adults and that uninsured children at best receive delayed care. A school nurse explains.

My concern is that we also don’t have access to mental health. Dinuba Children’s Services . . . they are kind of the ones who’ve been helping our students out for the most part. But their funding has been cut. So if a child doesn’t have health insurance, they’re put on the waiting list . . . in the meantime, these mental health issues are not being addressed.

Public health nurses in North County face difficulties related to the emergency coverage many farmworker families rely on.

This is what happens with my postpartum women. They get restrictive Medi-Cal and it’s only good until six weeks after their postpartum period. If a year later we decide that they’re going through postpartum depression, it’s very hard to get any services for them because they don’t have any Medi-Cal or any health insurance.

Dinuba Family Care Services provides short-term interventions for three to six months. However, as a result of state budget cuts in 2002, Family Care has recently begun limiting its services to clients who receive cash aid.

Though program restrictions reduce agencies’ caseloads, allowing them to assist only the small subset of people who have Medi-Cal or some other form of insurance or who have severe mental illnesses, backlogs persist. A mental health therapist describes the prob-
Specialists are in high demand and short supply. Low Medi-Cal reimbursement rates and lack of insurance make it especially difficult for farmworkers and their families to receive specialty care.

Lack of Medical Primary and Specialty Providers

Gaps in the health care delivery system prevent services from being continuous, comprehensive, and responsive to the needs of farmworker families and individuals. Such deficiencies in Tulare County have been officially recognized; several regions of the county are designated as Medically Underserved Areas, with medically underserved groups that include low-income and migrant farmworker populations. Portions of the county are also federally designated as Health Professional Shortage Areas for primary care, dental care, and mental health based on the distribution of these practitioners.

A shortage of specialists in the county affects both insured and uninsured patients, but it hits those enrolled in government programs such as TCMS and Medi-Cal particularly hard. For example, the largest clinic system in the region, FHCN, has not been able to employ a specialist in urology. A clinic referral specialist notes that they “do refer clients to the county clinics, but oftentimes the waiting period can be so long, even up to six months.” A representative for HHSA concurs that specialists for uninsured and Medi-Cal patients are difficult to obtain, and that these patients in the county system may encounter long delays for all but emergency inpatient care.

According to this same county administrator, inefficiencies in the system exist in part because “it’s all voluntary.” Specialists are independent and not obligated to take any patient. Health care providers report that low Medi-Cal reimbursement rates and the risk of lack of payment altogether from uninsured patients cause specialists to shy away from serving these groups. Some primary care sector observers believe that there are specialists who discriminate against low-income patients. A family practice physician explains how low-income patients are given inferior service by these doctors.

The same Dr. XYZ specialist will not see them in their offices. They will see them – the same Dr. XYZ – only in a different location, in a county office. That bothers me. That surprised me. A lot of them do not want to go and see patients in their offices, but they see them in the county. When they call, they are asked to make an appointment with the county. I said to them, “Well this patient needs him.” They respond, “Well, they will see them there.” And I say to them, “So what you’re saying is this Dr. XYZ goes to the county and sees our referral over there?” They say, “Yes doctor.” I ask, “What’s wrong with seeing them in the office?” She says, “I don’t know. The doctor will see them in the county.”

Dental services are in particularly short supply in North County communities. Medi-Cal coverage opens some doors, but many providers do not accept it or must limit their services. The CEO of a federally qualified health center explains how Medi-Cal reimbursement rates affect the services offered there.

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41 She is referring to specialty referrals in general.
In our dental suite, we are only able to take care of preventive stuff. We get $122. Now that’s the new rate. Before, you used to get less than that for patient visits. Medi-Cal. But what if a patient needs a crown? What if a patient needs more than that? It costs $400 to do a crown, and I get paid only $122. So we have to have a pot whereby I can once in a while afford to do those $400.42

Most existing programs are designed to help children. Uninsured adults experience the greatest difficulty accessing affordable dental care. No programs are available to indigent adults.

_Inefficient Referral Systems_

Service providers in the region describe a number of inefficiencies in the county’s referral system that result in breakdowns in care as patients cross service domains, such as a referral from primary to specialty care or from a public to a private provider. Analysis of the referral system demonstrates that patients, providers, and politics all influence how effectively patients navigate their way through the maze of services in operation.

Barriers inherent to the farmworker population include limited incomes and lack of health insurance, language and literacy problems, and inadequate transportation resources. On the provider side, the system’s efficiency is hampered by staff shortages, inadequate patient tracking/information systems, and limited availability of interpreters. The referral process is also influenced by broad policy factors such as reimbursement rates set for Medi-Cal, restrictions on public health programs, and the shortage of providers, particularly specialists who will accept referrals for poor patients.

The referral process begins when a provider determines that a patient needs more care than the facility can offer and notifies the patient. Immediately, the system is at risk of breaking down, since referrals are much more difficult to secure for patients who are uninsured, indigent, and/or paying cash. Health personnel describe these cases as labor intensive, consuming inordinate amounts of staff time and resources. An enrollment and referral specialist for a federally qualified health center explains this extended process, which begins with “looking through all your databases in your computer to see who will take this patient at the lowest cost, especially if it’s a private pay patient.” The referral specialist may also contact a likely provider and try to negotiate a fee reduction, to which physicians are reported to “sometimes” agree. Various providers experience difficulty arranging referrals for Medi-Cal and TCMS patients, particularly for specialty care.

Once a referral is finally identified, providers sometimes have difficulty contacting the patient because farmworkers tend to move frequently and lack telephones. Good News Clinic’s director attributes such cases to poverty among her patients. “You know, they can’t pay their rent so they move in with a relative or something. It’s really a sad situation here.”

42 The clinic offers oral exams, dental cleanings, fillings, and sealants.
Delays also occur because people do not understand that there are resources available when a problem is identified. Letters from school informing parents that their children failed a hearing test, for example, go unanswered. A bilingual school district nurse who deals with this problem recognizes that some parents do not know what steps to take, but she remains frustrated that these parents do not request assistance. “They need to know that all they need to do is ask. We’ll guide you and tell you everything you need to know—just ask!” Intensive follow-up with telephone calls and home visits is required to prevent the referral process from faltering.

Many farmworkers are reluctant to make appointments because they do not speak English. A patient care associate for FHCN is often asked to assist families with this task.

Sometimes they need to schedule an appointment. The school will send the child to go get an eye check. And maybe it’s all free, but maybe they missed the appointment. They need to reschedule it. They’ll come [saying] can you help me? Because they only speak English. I need to reschedule. This is the number.

Once a referral appointment has been successfully made, limited finances and lack of transportation can prevent a farmworker from keeping the appointment. A staff member from Alta describes the difficulty financial problems introduce.

We offer a sliding fee, but it ends here because they need lab work. They need outside services. That next time they come back for the follow-up work [we say] didn’t you get your lab done? Well, I don’t have the money. Where are your medicines? I didn’t have the money.

North County does not offer radiology and specialty care services, requiring patients to travel to Visalia, Reedley, even as far away as Madera to Valley Children’s Hospital, for care. Often, farmworkers and their spouses must arrange a ride with a family member or pay for a ride plus miss work days. Consequently, some community members prefer to access care directly from facilities in the larger towns and avoid the referral step, as the wife of a farmworker in Dinuba explains.

Yes, this has happened to many people. Because you go to a clinic and they tell you you need this and that, but I don’t have it. You have to go all the way to Reedley or Visalia. It’s easier to go to Reedley or Visalia, where there are big hospitals instead of the little clinics.

The complexities of the referral process make patient tracking essential, particularly for uninsured farmworkers who lack transportation and experience navigating the system. At least two of the area’s clinics that serve the farmworker community rely on manual patient tracking systems. One is developing a computerized system for this purpose. Still, reliable patient tracking systems alone do not assure that referrals are effectively carried out. As a county administrator explains, adequate staffing is also required.

Because we are so short-staffed, most of the work is to go to the first step. The first step is to call the client and help them get the appointment. We do not have time to follow through on the second step, which is to see if the client actually made the appointment.
It is not unusual for a patient to complete one referral, only to be referred again for additional care. Tracking such cases is a challenge and requires a considerable degree of coordination among service providers. A nurse in Woodlake demonstrates the importance of such care coordination, after referring a young patient to a clinic that in turn referred the client to a specialist.

The cardiologist had ordered a heart monitor, but no one had bothered to arrange payment for it or contact California Children’s Services in order to pay for it. So the family gets a telephone call telling them they need to pay $400 up front to have the heart monitor. Well, the child did not get the monitor. You think that when the doctor’s office sees someone and they see that the family has a limited income, they are non-English speaking, and do not know how to ask for help or services, the doctor’s office would do what they could to find a program for payment.43

Care coordination is crucial if health care delivery is to be seamless, and some providers employ case managers to keep the process on track. Even then, challenges remain, as a Valley Children’s Hospital staff member explains.

What we have is the case management system where we have nurse case managers that primarily ensure the coordination and facilitation of the appointments once the patient is discharged from here. Now the thing is that we don’t necessarily know if the patient actually made it to the clinic, unless they’re still using our clinics and they’re consulting back. That’s the only way. So if, for example, they’re using clinics there and using them here, the only way we would know is that we have staff within the clinics that would coordinate the care between the two different locations. So part of our routine and follow-up is to see if they are making appointments.

Employers and Working Conditions

Farmworker informants identify working conditions as barriers to adequate and timely health care. Workers injured on the job may not report incidents for fear of reprisal. Young workers are particularly vulnerable, as demonstrated during a focus group discussion that involved young farmworkers unaccompanied by their parents. An eighteen-year-old worker from Jalisco explains the barriers.

The boss tells you that because you’re under age you can’t work. When you start work, the mayordomo tells you if you fall off of the ladder or something I’m going to have lots of problems because you’re under age. So the mayordomo tells you that if you get hurt at work, he won’t be on your side. He tells us that we’re responsible for taking care of ourselves if we get hurt.

The inability to speak English and lack of familiarity with workers’ compensation procedures also block access to care for adults who suffer a work injury. Thus, farmworker informants injured on the job describe inadequate care and difficulties settling with employers and insurance companies. A thirty-four-year-old worker from Guadalajara describes the case of his father. "But honestly, they didn’t do much for him. They were just doing

43 The nurse subsequently contacted California Children’s Services and the patient qualified for the heart monitor under CCS.
Physicians tend to underestimate how significantly the language barrier impedes a Spanish-speaking patient’s ability to understand his or her diagnosis and accurately follow instructions.

Language and Literacy

Language barriers make it extremely difficult for Spanish-speaking people to receive, understand, and follow medical advice. Informants repeatedly note that physicians are far less likely to speak Spanish than are other clinic or hospital staff members such as medical assistants, nurses, and receptionists. An ex-farmworker in Yettem describes her frustration, experienced at different levels of care.

The doctor that I have does not speak Spanish. And then he sends me to the doctor here in Exeter. He is a very good doctor, right? A very good doctor. But the bad thing is that we cannot reach a good understanding. He doesn’t understand me, and I don’t understand him either. Because he doesn’t speak Spanish at all and I don’t speak English, right? And he sends me to a specialist, a neurologist in Tulare. And he ended up like the others. That doctor doesn’t speak Spanish. And I tell them I won’t go anymore, because every time I go, the doctor doesn’t even turn around to look at me. All he does is stand there and write and write.

Mid-level providers and other staff members usually provide interpretation, the quality of which is often questionable, and farmworkers believe that more bilingual physicians would improve the quality of care. “When the doctor speaks Spanish and knows how to explain things, they go. And if it is good medicine. And when it isn’t, they lose them [patients].” Such communication breakdowns are exacerbated for central county immigrants from the Oaxaca area of Mexico. There are no providers and almost no staff members who speak their indigenous languages.

Language barriers are further compounded by farmworkers’ lack of literacy and providers’ insensitivity to this problem. Some providers fall short of coupling treatment with respect for and consideration of this fact, as a packing house worker from Dinuba explains.

I don’t know how to write, or read, or anything. And I suffer a lot because I’m going to the doctor every three days, and they have me write my name and I have to tell them how difficult it is for me. They ask so many questions, and I have to be answering them. There they help me fill out the forms. And yes, I feel embarrassed because no, I don’t know. Because where my parents lived, they lived in an isolated village.

In addition to obstructing medical care, language barriers compromise mental health care, a service area that is in desperate need of Spanish-speaking clinicians. An educator gives the schools’ perspective.

There are doctors, psychologists, and therapists in the schools, but there are not many Spanish-speaking professionals that can communicate with parents. There are a few but not enough. So, one of the issues for parents is that parents
think that their children are crazy because they do not understand what is going on. Parents are not able to comprehend what is meant by ADD or ADHD.

**Lack of Cultural Competency**

Despite the efforts of north area providers to be culturally sensitive, medical facilities still do not adequately cope with language and cultural differences, health conditions that are culturally defined (and often not recognized by U.S. medical practitioners), and the lack of literacy among farmworker families.

Comprehensive cultural competence requires resources. For example, HHSA currently maintains health education materials in Spanish, Hmong, and other languages, but a representative notes that the agency lacks skilled health educators to review and implement the material. A nutritionist for a federally qualified health center clinic echoes this sentiment.

Basically, what I'm really having a real difficulty in finding is good materials, good education material written in Spanish. I'm talking about a decent level of Spanish. I'm basically saying that most of our patients are very low literate or illiterate. So, we need to focus on education materials that are geared for that patient. Again, I’d even love to give [information] to people . . . that cannot read or write in any language. Some information that says okay, you’re diabetic. Let me show you through illustrations what some of the foods are that you can eat. This is what we’re really seeing that we don’t have enough of. But what we really need is people who are really knowledgeable about producing these types of materials.

Farmworkers commonly report that health care practitioners do not understand or accept their cultural differences. Cultural gaps that affect health care delivery involve not only health beliefs and practices brought here from Mexico, but also medical conditions identified by immigrants that are not known by U.S. medical practitioners. An ex-farmworker and the spouse of a worker offer their perspectives.

**Ex-farmworker:** No, because they don’t know. They don’t know about *empacho*, *mollera caida*/sunken fontanel, that you sometimes see in the children who can’t eat. They don’t know. How are they going to do anything if they don’t know?

**Farmworker’s wife:** Well, I think they don’t even believe in that. Because my daughter told him that. She told him “Hey, could it be *mollera caida*/sunken fontanel?” [The doctor responded sarcastically] Where did it fall?

Farmworkers who are not literate in their own language face hurdles not only in accessing available health services, but also in enrolling in programs. An outreach representative for Medi-Cal programs explains the problem.

Having somebody that knows how to read and write is a big factor in the poorer families. That’s a big challenge because a lot can’t read or write. And even if you explain it to them, sometimes they have a hard time understanding how it works. They can’t understand how a program works.

Farmworker informants relate experiencing ill manners and discrimination within the medical establishment, public and private, directed toward Hispanics, those who cannot
Farmworkers report experiencing a fair amount of discrimination and insensitivity when they interact with health care providers. They speak English, and the poor. One farmworker and father of two explained his experiences. “Many are rude to Hispanic people. Many doctors are very rude, very discriminating in that sense.”

Clinic Conditions

Farmworkers describe the conditions of health care facilities in general as crowded and frequently involving many hours spent waiting for attention. Such conditions, coupled with rude behavior on the part of some front-office staff members, discourage individuals from seeking care. Informants, including those seeking care for emergency situations, express great displeasure with the amount of time spent waiting.

Program Eligibility Requirements and Immigration Status

As previously discussed, most low-cost health programs are restricted to legal immigrants.

Transportation

Lack of transportation resources among the area’s farmworkers limits their access to clinics, hospitals, and other service providers. A large proportion of them have no personal transportation, and public transportation opportunities are limited. Many rely on family members, friends, and coworkers for rides, and sometimes these raiteros/transportation providers charge excessively. Wives typically depend on their husbands for transportation, as this spouse in Ivanhoe explains. “He had to lose work to take me all the way there [to a hospital in Fresno].” In Cutler-Orosi, farmworker informants were not able to purchase their particular prescriptions from the local pharmacy, requiring them travel to Dinuba. Although federally qualified health clinics provide some transportation assistance to patients, the services are usually restricted to rides within that particular clinic system, not to outside services. A health program administrator offers an assessment of this problem.

Transportation is a big problem for a lot of our clients. All we can do is assist them with ideas of getting a neighbor to help them or a friend to take them to the clinics. Maybe Dial-a-Ride or bus routes, but there is really no one out there to transport people. A lot of families cannot access care because they do not have the transportation. That has been an ongoing thing that is talked about every year.

Facilitators to Care

Cultural Brokering

The Community

Word of mouth plays a central role in farmworkers’ awareness of health and social services. Particularly for newcomers to an area, information about health care resources
comes from family, friends, neighbors, and coworkers. A forty-four-year-old farmworker in Yettem learned about health care programs “through friends. You know that’s the first thing they tell someone. Medi-Cal and this. They talk about those things.” Family members are often cited as providers of rides to medical visits and translation.

Mayordomos

Mayordomos or crew bosses can both obstruct and facilitate their workers’ access to health care. In some instances, mayordomos provide a critical link between farmworkers and health services. For example, some farmworker informants explain that mayordomos attend to injured workers by physically taking them to a place of care. In addition, they serve as an important source of health and safety information at work. A twenty-one-year-old ex-farmworker from Zacatecas describes his crew bosses. “They say when the water runs out let’s go. Because there is no water, and the sun will cause us harm.”

Agricultural working conditions present significant challenges for workers who suffer from chronic health problems such as diabetes. However, well-informed mayordomos can facilitate workers’ adherence to dietary or other medical recommendations. One fifty-two-year-old diabetic worker described his request for accommodations by his foreman. “What happens is that we don’t get breaks. I told him that my doctor told me that I had to eat three small meals, but I had to eat. So since there were no breaks, what was I going to do?” His foreman allowed him to take the necessary breaks.

Provider Best Practices

Service providers in North County also act as intermediaries between farmworkers and the health care system. As part of an extensive network, these providers are in a position to broker health care services for farmworkers by negotiating lower fees, advocating on behalf of farmworkers, and intervening in other ways [see Referrals in the Barriers section.] This section highlights just some of the best support practices of providers.

Facilitating Patient Compliance

Farmworkers who cannot read or write encounter significant obstacles adhering to doctor recommendations. Providers can play a crucial role in ensuring patient compliance, as noted by the following provider.

I can think of one family where the mother could not read and she was not giving the medication orally to the child. At first it appeared as if she was noncompliant or resistant. Basically, she didn’t know how to read the label and didn’t know how much to give. So basically we were able to identify that that was the source of the problem. We just gave her a little flask that measures on the little line exactly how much medication to give. After we did that, she was very compliant from that point on.

44 In agriculture, unlike most other industries, crew bosses or foremen rather than personnel managers or owners are the principal point of hire and dismissal for farmworkers.
Employing the Promotora Model

The promotora model of outreach and health education employs peer educators who build helpful relationships with community members. Kaweah and FHCN’s diabetes project, DCIP, is one such promotora program in North County (see Community Health Services and Outreach for more detail). Promotoras in the program are diabetics themselves, and they impart health information and guide patients through treatment in a linguistically and culturally appropriate manner. At times, promotoras provide services in a clinical setting, but most of such services are delivered in homes. A program representative summed up the services.

The majority of the time is at the patients’ homes. They bring the services to the patient at their homes. Many times the patient does not have transportation or does not have the time to go out to the clinic. So, it is basically up to us to make it easier for the patients to have better control of diabetes. We go to their homes and bring the services to them. In the old model, we expected patients to come to the clinic for services. We have discovered that many times patients do not show up because of different issues, such as lack of day care, lack of transportation, or lack of time.

Offering Culturally Appropriate Mental Health Services

Despite the shortage of bilingual mental health clinicians and programs available for farmworkers, some mental health providers in the region have made great strides in serving the farmworker community. The following is an account by a mental health therapist in Woodlake.

Your traditional therapist would have said set up an appointment to bring him in. If he does not come, well, we are sorry but we are closing the case because he needs to be responsible and come in. I take a different approach. I go to the home a little before he comes out of work at 5:00 o’clock. I plan it so that I can be there when he comes because he probably would not show up if it were scheduled. I say to him, “Señor, how did it go today at work? How many boxes did you do today?” I need to talk to him in a way that I can connect with him, in a way that is culturally sensitive. That does not happen enough.

Continuous Health Care Coverage

The ability to maintain continuous health care coverage as people move from one county to another is a critical need among farmworkers. Although many farmworker families settled in North County years ago, some newcomers resided in other parts of California before coming to the Central Valley. Others regularly travel to Mexico and elsewhere in the United States. Medi-Cal inter-county transfers allow cases to remain active for thirty days while clients reapply in the receiving county. Providers and eligibility workers, however, need to inform farmworkers about this service so that they can request the transfer. The spouse of a farmworker in Dinuba describes this process as she and her family moved from Los Angeles County four years ago.
Then, when I came [to Dinuba], I already brought with me a piece of paper from her [the Los Angeles County eligibility worker] and it was easy for me. Because if I hadn’t, I think that I would have been battling more . . . She gave me the address and all of the phone numbers. She told me everything more or less. She told me very well about where to go because you know that when you get here, you don’t know which way to go.

**Ethnospecific Health Practices**

Farmworkers in North County use home remedies and self-medication to maintain their health and treat illnesses that are unfamiliar to U.S. medical practitioners. Use of these measures varies, but access to health insurance does not appear to be a determining factor as insured and uninsured individuals alike rely on them. Women tend to resort to home remedies more often than men and share the remedies with each other.

Farmworkers report that prescription medications commonly found in Mexican pharmacies are also sold at North County flea markets and swap meets and are delivered to the U.S. by family and friends. Medications reportedly purchased from Mexico include treatments for high cholesterol and asthma, an injected form of birth control, and penicillin. It is not clear whether people’s preference for Mexican prescription medicines is based on a perception that they are more effective or due to easy access and affordability. However, a general complaint among farmworkers about the U.S. health care system is that patients are not cured immediately. Rather, they receive a weak medication and are told to “come back so we can see how you are doing.”

Accounts by farmworkers also demonstrate a range of perceptions about ethnospecific conditions. For example, *nervios*/anxiousness is commonly reported in this community, followed by *empachos*/digestive conditions such as constipation. But some farmworker informants do not believe in other reported conditions, such as *mollera caída*/sunken fontanel. In addition, some individuals prefer to try a home remedy before seeking a doctor’s care for such ethnospecific ailments. An ex-packinghouse worker from Michoacan reveals her reasons for using home remedies.

> They [doctors] want to cure people with nothing but medicine. And sometimes one knows what is happening to them. Like someone that has lived in the village and one doesn’t have the money to take them to get cured . . . but one knows that with a little *sobadas* [folk therapeutic massage] there, it can be controlled.

Increasing health care providers’ ability to recognize ethnospecific diseases and their awareness of locally popular home remedies and medications is important to ensure

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45 Farmworker informant born in Merced, California, who spent twenty years in Michoacan.

46 The worker reported data from the Binational Farmworker Health Survey showing that the majority of the incidents of ethnospecific diseases are *nervios*. *Aires*, *Susto*, *empacho*, and *mollera caída* are also frequent problems for farmworkers according to this survey. (R. Mines, N. Mullenax, and L. Saca, The Binational Farmworker Health Survey, CIRS, 2001, p. V-20.)
quality health care for the farmworker community. In fact, there are providers in the region who do recognize these alternative modes of treatment, as demonstrated by an outreach specialist.

We do know that people who do not have access to health care will find different alternatives. Again, breaking through the cultural beliefs and stereotypes of going to a sobadora [one who practices folk therapeutic massage] for health care and not fully understanding a certain diagnosis, such as diabetes, can cause them more harm . . . We know that people go to the remate/flea market and they buy self-prescribed medication or they call their relatives in Mexico to send over prescriptions.

**Principal Medical Conditions**

**Dental Disease**

Despite provider efforts to meet the dental needs of North County residents (prevention efforts, mobile units, and sliding fee scales), dental disease remains common among farmworkers and their families. Primary contributors to poor dental health among farmworkers are lack of hygiene practices, lack of insurance coverage, inability to pay for care, unreliable transportation, and the limited number of providers in some areas. Farmworker informants with existing conditions complain of toothaches lasting for months, broken teeth, loose teeth, difficulty eating, decay, and cavities. A staff member at a health center describes conditions she has seen among pediatric patients.

In young kids we see a lot of extractions where it’s cheaper just to extract them than to save the tooth. Because the dentist, of course, is going to want to save it, but they go without the service because it’s costly. A root canal is expensive. And they’ll be back in a couple of months and they’ll just have it pulled . . . and we’re talking young kids . . . we’re talking, oh gosh, twelve-year-olds, fifteen-year-olds, are coming to have dental extractions. And it’s too bad because that’s something that’s a necessity for them. When they get older, they’re going to have problems.

Service providers support continuing dental health education and prevention efforts while increasing access to affordable services for uninsured children and adults. They are particularly concerned about neglect among farmworker children. For example, in one school district, the nurse identified severe conditions, including one child suffering from six abscessed teeth. According to this nurse and a local dentist in the county’s school-based dental program, even children with Medi-Cal are not utilizing the program appropriately. One thirty-four-year-old farmworker from Jalisco receives Medi-Cal for her family, but some of her children have never seen a dentist. “My son, I’ve never taken him. The oldest one, yes. I took him, but never the middle one [twelve years old], and much less the little one [four years old].”

Among children covered by Medi-Cal, interruptions in coverage due to their parents’ seasonal employment contribute to the problem, leaving farmworkers confused about when they can seek care for their families.
But when we work, like during this season, you see that we work more. That’s when they cut off everything. Medi-Cal, everything . . . during this time, it’s better that I don’t use it. I use it most in the winter, the Medi-Cal. But right now I don’t use it. Because I don’t know how I am with Medi-Cal. Because last year I worked at a nursery and I earned a lot of money . . . that time I took my son or I went to the doctor, and they are charging me money for what I used from Medi-Cal during that time.

Parents rarely seek Medi-Cal and other programs for themselves and their children for preventive care. An eligibility worker explains this approach.

What I’ve noticed with the people in this area is they . . . don’t really think of preventative care. They come in once they’re sick. And so that’s when they’ll go on them. But just to come in and apply just to know that they have coverage in the event that something happens? No, I barely see that.

**Diabetes**

Tulare County has a high incidence of diabetes, a disease that disproportionately affects Hispanics in general. Among farmworker informants, diabetes is the most common medical condition affecting them and their family members. A representative for HHSA indicates that approximately 21,000 people in the county have diabetes, demonstrating a significant disparity with regard to Healthy People 2010 objectives. A media release by Kaweah describes the magnitude of the problem.

Tulare County has the highest percentage of people on dialysis [of] any county in California, and local clinics indicate that nearly 40 percent of its Latino patients are diabetic. Moreover, approximately 22 percent of Kaweah Delta District Hospital patients are diabetic compared to the 7 percent average in hospitals nationwide.47

Thus, diabetes represents a concern among providers in North County, particularly for the largely uninsured farmworker population. Access to a regular source of care is strongly correlated to taking advantage of prevention programs.48 Service providers identify an overall lack of preventive practices in the community, as farmworkers tend to take a symptomatic approach to health and seek care only after an illness has already developed. Moreover, accounts by farmworkers demonstrate that this group often neglects conditions. Among farmworker informants suffering from diabetes, hospitalization and severe complications such as vision loss prompted their initial diagnosis. One farmworker recounts the day he was diagnosed in a Dinuba clinic. “The machine could not detect it [the blood sugar level], I had it so high. So high that I went over the highest [value] on the machine.”

Farmworker informants also communicate myths about diabetes, demonstrating a lack of community awareness about the disease. Some attribute diabetes to emotional stress,
People new to the U.S. often know nothing about diabetes’ cause and symptoms, and consequently they do not request screening for this very common condition until prompted by providers’ outreach efforts.

sadness, or anger. One ex-farmworker describes how she believes her brother, a farm labor contractor, developed diabetes.

He had to fulfill his obligation with the people. And he even became sick. He has diabetes. Many people think that the contractors are out to get rich. Now he even got sick. The diabetes developed from the worry because the rancher didn’t pay him.

Among diabetics in the farmworker community, there seems to be some awareness about proper diet and nutrition, but that awareness does not necessarily lead to changes in behavior. Awareness about the importance of exercise is often lacking, as some diabetic farmworkers consider working in the fields sufficient activity. A bilingual nutritionist whose caseload is approximately 60 percent diabetics explains the challenges of changing health behavior.

Basically, like if they come in and they’re just diagnosed with diabetes or cholesterol, they’re like, “Well, why do I have to be on a diet? Can’t you just give me a pill?” Like in Mexico, if you just take a pill, you’re fine. They have that understanding that if you just go to the doctor, get a pill, then everything will be okay. They don’t understand that they are in control. That if they just make some modifications in their diet and exercise and change their lifestyle a little bit, then they can truly avoid or at least control the amount of medication that they are taking to control this disease.

For many farmworkers, job schedules, limited incomes, lack of health coverage, and unreliable transportation make it difficult to manage a chronic health condition. In fact, for many, particularly those who are not insured, the cost of medications and treatments is too great. Some providers recognize the financial challenges associated with diabetes, including purchasing supplies and medications and receiving vision care. The following represent two providers’ approaches to these challenges.

The only thing, in order to solve the problem, we are telling them instead of checking your sugar levels three or four times a day, check it in the morning and in the evening before you go to bed. At this point, we are helping save some strips and stretch them a bit.

Medication is an issue. Many people cannot buy medication. Right now, we have a PIC program . . . But this is only a two-year program. So this is the last year we’re going to have that. So especially diabetic medication, different medication. We provide it here for them if they cannot afford it.

In order to address the high incidence of diabetes in the county, and increase awareness about diabetes and prevention, HHSA, in partnership with United Way, created a diabetes forum. Local agencies and organizations also participate, and the forum is open to the public. DCIP, run by Kaweah and FHCN, is one crucial promotora-based strategy for maintaining the health of those with diabetes. However, a representative for Alta Family Health Clinic, which operates a separate diabetes program, believes additional efforts are needed in Dinuba, which is outside the range of current promotora programs.

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49 This forum was funded by The California Endowment.
Mental Health

The daily stresses inherent to the working and living conditions of farmworkers expose them to risks for various mental health conditions. These stresses include extreme poverty, poor housing conditions, separation for extended periods from friends and family, fear of North American institutions, frequent periods of migration for long distances under difficult conditions, exploitation at work, workplace hazards, lack of transportation, and lack of health care coverage. The limited resources in North County have created a shortage of bilingual and bicultural mental health care and case management services. And in many cases, farmworkers don’t qualify for the care that is available due to legal status or income requirements.

According to mental health providers in the region, farmworker attitudes also play a role. Farmworkers do not use mental health services in part because considerable stigma is attached to seeking help for mental illness in their communities. A county nurse in the mental health division explains this attitude, which she considers prevalent.

A lot of people do not want to admit to having mental disorders. Being crazy, so to speak. And they’re in denial a lot because people don’t have a real concept of mental illness like they do physical illness. I think too that’s why we’re trying to do more education in mental health. That’s one area that we need to get rid of the stigma.

Social Isolation and Feelings of Nostalgia

Farmworkers suffer from social isolation and nostalgia for their homes. Their separation from their nuclear and extended families and from networks of friends leads to feelings of depression for many, particularly unaccompanied males. Underage boys not accompanied by parents particularly suffer from the loss.

Undocumented immigrants, who make up perhaps half of all farmworkers, face the longest periods of separation. A farmworker from Dinuba explains how immigration status shapes cross-border movement. “Those that have papers, well yes, they come and go every season. And those that don’t have [papers] don’t return for two or three years. Because it’s very difficult to cross.”

The process of migrating to the United States exposes farmworkers to considerable emotional and physical risks. And obviously coming to an unfamiliar place is quite unsettling. Moreover, since many male farmworkers come to the United States several years before their families arrive, the wives and children they leave behind risk losing touch with the head of the family. Reunification years later can result in extreme adjustment problems. Wives who join their husbands here risk losing their established support systems back in Mexico. An Ivanhoe farmworker’s spouse describes her experience six years ago when she was reunited with her husband.

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50 NAWS data show a clear pattern of prior migration by males.
In the beginning, when I came here I was a little bit, very timid . . . you know, I come from a village. Here it’s, well, a town. But I didn’t know anything. He was going to work and I felt sad here in the house.

Thus, even when family members are reunited, farmworker lifestyles on this side of the border can lead to feelings of isolation and loneliness, and it can take several years to develop social connections. The spouse of an ex-farmworker in Cutler-Orosi describes her experience.

And before, we didn’t know anything about anything. I didn’t leave my house. We never knew about programs about anything. In the first place, he worked all of the time, and me, I just stayed here . . . but when he was working, I didn’t even know who my neighbors were . . . I didn’t have anyone, no friends . . . I was alone all the time.

Other farmworker informants confront social isolation through relationships with co-workers, participation in church groups, and recreational and sports activities when they are available.

Fear of Immigration Authorities

Throughout North County communities, farmworker informants report that anxiety connected with immigration authorities affects their daily lives. The undocumented spouse of a dairy worker expressed her fears. “What causes me stress here is that we don’t have freedom. We don’t have the freedom to travel freely, or to give opinions.” Even those free from such fears believe that concerns are widespread in the community. Some longstanding residents recall massive roundups in and around North County that occurred years ago. An ex-farmworker recounts an incident that took place on a winter morning in 1976 when local authorities, not federal immigration officers, stormed into town, detaining most of the parents and leaving their children behind.

They removed almost all of the people . . . because all of their parents, well, they took them all. They cleaned out the houses, kicking down doors . . . we come here with that. Exposing ourselves to getting thrown out.

Although authorities no longer conduct these massive arrests, fear of separation from family, especially children, remains. In addition to these worries, some informants still perceive immigration authorities as menacing in Visalia and surrounding areas. As a result, community leaders and organizations recently formed the Tulare County Immigrant Support Task Force to address community-wide concerns.

Family Relationship Issues

Problems with family conflict are the most frequently mentioned emotional issue among farmworkers and their spouses. Common parenting challenges include disciplining children and youths and shielding young people from a socialization process that exposes them to sex, alcohol, and violence. Often, a lack of communication between spouses and

I would get so nervous because I felt . . . like he didn’t love me anymore . . . But that is what happens. That sometimes there is no communication with the husband, the children. Or that I could have a moment to speak openly with my husband, and my children could also talk this way. It was something that was missing here, here in my home.

Although this young mother received counseling, a mental health therapist notes that many families in similar situations do not receive therapy, leading to progressively more destructive circumstances.

Basically, the snowball gets bigger until it is out of control. Later, the child gets out of control and soon enters the juvenile hall or is on probation. Or mom is so depressed and isolates herself and does not interact or get involved with her children so the kids do not produce in school.

Domestic Violence

A few farmworker informants shared their personal stories of domestic violence. The spouse of one farmworker did not admit to living in an abusive relationship, but her friend identified her as a victim. This situation is common, as a licensed clinical social worker at Valley Children’s Hospital describes.

We find a lot of Hispanic women, that it is very difficult. They’ve been acculturated to just accept and so it’s very difficult to get them out . . . We find that when they finally decide to do something, the domestic violence is now descending down to being abusive towards their children. . . . Typically there’s a strong correlation with domestic violence and child abuse. So we always screen for child abuse when there is domestic violence in the home.

Mental health providers indicate that domestic violence leads to depression and anxiety problems among women. As a county psychologist explains, undocumented women are a particularly vulnerable group that is not likely to report abuse.

Sometimes we have couples that he’s legally here and she’s not and they [the undocumented women] don’t know . . . that they have rights under the VAWA, the domestic violence act . . . They don’t know that they really have rights whether they’re documented here or not.

Alcohol and Drug Abuse

Farmworker informants offer conflicting accounts regarding the extent of alcohol and drug abuse problems in the community. Women indicate that alcohol and drug abuse is prevalent among male farmworkers, including their spouses. Women also express feelings of anxiety and depression as a result. Their accounts range from daily alcohol consumption (usually after work) to social drinking on weekends. In addition, some informants tell of alcohol consumption on the job and describe people using illicit drugs to increase their stamina at work. Among unaccompanied male workers, alcohol consump-
tion helps suppress feelings of nostalgia, isolation, and loneliness and createsopportunities for social interaction. Farmworkers also perceive that financial stressors and anxiety lead men to drink heavily.

Although some workers receive therapy through drug and alcohol rehabilitation programs, others refuse to recognize the problem or seek treatment. Even family members have difficulty recognizing signs of alcoholism. An ex-farmworker highlights this problem. “I have a son-in-law that drinks a lot, but I don’t think... well, I don’t know. Is it alcoholism?”

Health and social service providers, however, do recognize both alcohol and drug abuse as major problems in the farmworker community. The environment in which farmworkers live and their individual health beliefs present significant challenges to providers such as this nutritionist.

If I tell a man whose liver panel function is elevated, and they drink and the mayordomos and the people in the field actually give them alcohol to drink because it’s so hot, [they’re] doing a great disservice. They’re drinking and they come home and they drink all day, and I say “You know we’re starting to see problems with your liver.” And they say “Well, what is one, two, three, four, or five drinks doing for me? It’s not going to do anything for me. Why can’t I drink? I deserve it. I work hard in the fields.

Other Risk Factors

Physical or medical conditions among farmworkers and their children often lead to feelings of anxiety and depression. Farmworker informants also perceive that workers injured on the job are particularly vulnerable to depression because their incomes are greatly reduced and they worry about being fired. In general, the financial strain experienced by many farmworker families affects their emotional well-being.
Summary of Community Assets and Liabilities

Main Assets

An Established Network of Care – There is a well-established network of care in North County that extensively coordinates health and social services, not without some duplication of efforts in some areas. The service providers that comprise this network are both public and private, and they operate through nonprofit community-based clinics, the major hospital, schools, education and training centers, churches, county prevention programs, and family resource centers.

Capacity for Increased Collaboration – Existing service provider efforts reveal openness and readiness on the part of local players to increase collaboration around farmworker health issues. Current areas of collaboration in North County include children’s dental health, parenting, and education. Additionally, coordinated efforts address diabetes education and management.

Growing Support for Programs Targeting the Uninsured – Both public and private service providers recognize the importance of health care coverage in achieving better health outcomes among farmworkers. In particular, they voice concern about the large proportion of uninsured farmworkers. Dissatisfied with current programs for the indigent, a group of health providers and others have pushed the topic into public discourse. There is already community-wide support for reallocating local funding to expand health coverage for the uninsured. The county’s local initiative under its two-plan model of Medi-Cal managed care represents an important administrative asset in these health coverage expansion efforts.

Existing Outreach Efforts – Outreach is crucial to extending access to the often difficult to reach farmworker community in North County. Local outreach efforts have overcome some of the cultural, linguistic, and geographic barriers faced by farmworkers. FHCN offers a broad range of community health education and support services. Their efforts, along with HHSA’s Prevention Services and others, are essential for raising community awareness about healthy behavior and for linking farmworkers and their families to local programs. Additionally, farmworkers have access to a promotora model for diabetes management through DCIP.

A Workforce with a Farmworker Background – Across the region, various agencies and organizations employ farmworkers, ex-farmworkers, and family members. The familiarity of these individuals with farmworker life facilitates culturally appropriate service. A few work as administrators, but many more serve in the front lines of delivery as receptionists, patient care associates, outreach workers, promotoras, case managers, and marriage and family counselors. As these individuals interact with medical practitioners, they
often raise sensitivity among providers to farmworker beliefs and attitudes toward health care.

**Involved Community of Farmworkers** – In communities across North County, farmworkers, ex-farmworkers, and their spouses have overcome language barriers, transportation hurdles, and time constraints to advocate for better conditions. Even undocumented individuals, especially parents, have demonstrated an interest in bettering their communities. Undocumented parents attend school meetings, volunteer for clean-up efforts at schools, and even campaign for local politicians.

**Main Liabilities**

**Shortage of Health Professionals** – Recruiting and retaining health care personnel, particularly bilingual clinicians, remains a significant challenge in the study region. The county’s disproportionate share of poor and uninsured people further exacerbates the problem, as health practitioners feel overburdened and under-compensated.

**Major Gaps in Services** – Federal designations of Tulare County as a shortage area for service delivery underscore the serious gaps in health care in the region. Service providers identified specific breakdowns in specialty care, dental care, and mental health, resulting in delays and in lack of treatment. These service gaps disproportionately affect farmworkers and their dependents because they lack health insurance. Farmworkers also identified deficits in cultural competency among physicians and the lack of Spanish-speaking clinicians.

**Inefficient Referral Systems** – Major gaps in services exacerbate existing inefficiencies in the referral process. These inefficiencies compromise the quality and continuity of patient care and consume excessive amounts of staff time and resources. Lack of insurance makes referrals difficult to secure. Also, among farmworkers, lack of personal transportation and English skills hinder the process. Among providers, shortages of staff in general and of bilingual staff in particular and poor tracking/information systems lead to breakdowns in the process.

**Lack of Outreach for Medi-Cal/Healthy Families** – There is a lack of sustainable funding for promoting enrollment in Medi-Cal and Healthy Families and for retaining people once enrolled. FHCN, Blue Cross, and Health Net continue to promote these low-cost programs across the region, and HHSA has stationed eligibility workers at various health facilities. But efforts within farmworker communities are limited, leaving many eligible people unenrolled. Moreover, many of the farmworkers and their dependents who are enrolled are not aware of the programs’ benefits and procedures. As a consequence, they use the programs ineffectively and only intermittently.
Lack of Funding for Indigent Care for the Uninsured. TCMS is not meeting the health care needs of farmworkers in this region. According to service providers, this shortfall comes from a lack of funding for indigent care and the county’s design of the program. In addition to a high rate of poverty, Tulare County has one of the highest rates of uninsured residents in the state. About 26 percent of the more than 360,000 county residents have no insurance.\footnote{E. Rick Brown, Ninez Ponce, and Thomas Rice, The State of Health Insurance in California: Recent Trends, Future Prospects, Los Angeles: Regents of the University of California, 2001.}

**Lack of Activities for Youth** – Recreational areas are in short supply in some North County towns, which also lack facilities for pedestrian safety, such as sufficient lighting, pedestrian crossings, and sidewalks. Unlike Dinuba, which has youth recreational centers and playgrounds, other towns in the region have few if any places where children and adults can engage in healthy recreational activities, both social and physical. In general, local informants believe these deficiencies are further intensifying the high rate of juvenile delinquency and teen pregnancy.

**Lack of Service Coordination with County Clinics** – HHSA has shown some success in increasing internal coordination of services, but coordination of primary care clinics with prevention and other departments remains inadequate.
Menu of Community-based Options

The options presented below were chosen by the North County community based on the firsthand experience of people who deliver services, receive services, and observe the system and its function. They combine the perspectives of highly diverse groups – policymakers, providers, farmworkers, and other residents – all of whom have a stake in improving farmworker health. Naturally, not everyone agrees on what is best. This report highlights the areas in which stakeholders have achieved a degree of consensus regarding efforts that can benefit the farmworker community in the region.

Launch Health Care Initiatives for the Uninsured

There is broad support in North County for expanding options for health care coverage for farmworker families and for incorporating specialty care in primary care settings to resolve gaps in access to more sophisticated services. A significant proportion of farmworkers and their dependents do not qualify for existing programs, and TCMS, the county’s indigent care program, cannot keep up with demand. As a consequence, many farmworkers and their families receive episodic access to care at best and find it almost impossible to obtain specialty care, mental health treatment, and dental services.

To address blocked access and the high level of uncompensated care in the region, local surgeons and a group called Health Care for All are looking for ways to fund expanded, comprehensive health care services for people without insurance. They have proposed reallocating tobacco settlement dollars to fund a health care initiative and are raising awareness about the issue. Additional options for leveraging funding are also being considered.

Six California counties have already established expansion programs that provide coverage to indigent and uninsured adults or to children, regardless of their immigration status, who do not qualify for Medi-Cal or Healthy Families. Some of these programs are subsidized and administered by the counties’ local initiative HMOs, with supplemental funding from combinations of tobacco settlement dollars, Proposition 10 funds, foundation grants, and state and local assistance. Preliminary data collected by two adult insurance programs have demonstrated lower inpatient and emergency room visits among participating adults. Hence, these existing efforts have served as a model in developing the following components, which would be key to such an expansion in Tulare County.

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53 Ibid.
Important Components for Children’s Health Coverage

- Offer health benefits that are comparable to coverage provided by the Healthy Families program (comprehensive medical, dental, vision, and mental health care; affordable premiums; and cost-sharing).
- Include a retention component.
- Include an outreach component to identify and enroll eligible children and to further identify children and their families who are eligible for existing programs such as Medi-Cal and Healthy Families.
- Include subsidized premiums.
- Include simple application forms.

Important Components for Adult Health Coverage

- Expand access for uninsured adults, either by increasing the capacity of the county’s indigent program or through a new program that targets uninsured parents of children receiving Medi-Cal or Healthy Families benefits.
- Shift funding received under the county indigent program, with state approval, so it can be redesigned to create a new program for low-income individuals who lack insurance.
- Implement a program of managed care for indigent adults.
- Use the local initiative HMO provider’s reserve funds to subsidize additional coverage, including subsidized premiums.
- Include benefits for comprehensive medical care.
- Establish premiums that are determined on a sliding scale discount and adjusted for age.
- Arrange to shift some adults who initially participate in the new program to the Healthy Families program upon the approval of a Healthy Families waiver.

Specialty Care Access

There is widespread agreement among service providers that uninsured and publicly insured farmworker families have great difficulty gaining access to specialty care. Some providers in the region favor subsidizing the cost of placing specialists in nonprofit community-based clinics where many farmworkers obtain primary care. Others favor subsidizing increased coordination between clinics, specialists under contract to the county, and specialists in private hospitals such as Kaweah. Service providers should explore these and other options to extend the reach of specialty care.54

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54 “Operation Access,” a public-private partnership, is one such option. This tax-exempt organization, funded by private donations and grants, was established in northern California with a large network of clinics, hospitals, and volunteer medical practitioners. The program serves Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Sonoma Counties. Indigent, uninsured children and adults receive access to outpatient surgeries and specialty consultations at no cost.
Expand Outreach for Medi-Cal and Healthy Families

While Tulare County has a relatively high rate of enrollment for Medi-Cal and Healthy Families, there remains a significant number of eligible farmworkers who are not enrolled, particularly in small rural communities. Despite a lack of sustained funding, limited outreach efforts continue. A few years ago, for example, HHSA subcontracted with Proteus and Medical Billing Technologies and enrolled several thousand children under the state contract for Healthy Families/Medi-Cal for Children Outreach.55 Providers want to expand programs that promote enrollment in Medi-Cal and Healthy Families to the farmworker community through school events and community-based organizations, building on prior work in the area by way of collaborations between organizations who already engage in outreach.

Outreach programs also should focus on ways to retain families once they enroll. For many farmworkers, health care coverage is sporadic, stopping and starting with variations in their income and ability to keep up with the paperwork required.

Additionally, participating organizations should continue to educate farmworkers and help reduce their anxiety about being held responsible for health care costs through public charge.

Restructure Health Care Referral/Patient Tracking Systems

Inefficiencies in North County referral systems disrupt continuity of care, compromise the quality of care, and consume inordinate amounts of staff time and resources. An integrated referral system could improve the process, making it more responsive to both farmworkers and providers by coordinating care across settings and taking characteristics common to farmworkers into account. Some health care providers in the region favor exploring options to restructure the referral system to better accommodate both patients’ and providers’ needs and to include case management or follow-up functions to track the process from beginning to end.

Recruit and Retain Spanish-speaking Health Care Personnel

Programs to recruit and retain Spanish-speaking health care personnel are essential for quality health care for farmworkers, many of whom speak only Spanish. Spanish-speaking clinicians are in particularly short supply. Providers in North County have identified low compensation and the demands of serving numerous uninsured clients as significant impediments to both recruiting and keeping personnel despite designations as a Health Professional Shortage Area. Informants believe that development of programs focused on identifying and attracting Spanish-speaking health care personnel is fundamental to maintaining quality of care for farmworkers in the area.

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55 This enrollment figure varies from 3,000 to 5,000 children.
Increase Cultural Competency

Both public and private service providers recognize the importance of culturally appropriate services. They have endeavored to employ staff members who come from farmworker families in positions as outreach workers, case managers, health promoters, receptionists, and patient care staff. Thus, many providers in north Tulare County have the capacity to be sensitive to the culture of the farmworker population and show respect for their values and traditions. Still, farmworker informants have identified deficiencies in cultural competence within the medical establishment. Programs to increase cultural competency among local physicians would enhance health care delivery to farmworkers and promote use of services by the community. Such programs should teach providers about demographic, income, and living conditions characteristic of the community and about typical health beliefs, cultural values, and practices.

Provide Technical Assistance to Collaborative Partnerships

Improved collaboration could address many of the obstacles to health care access. An ideal collaboration allows organizations to work together in a manner that increases the capacity of each and simultaneously achieves a common goal. Some problems can only be addressed by joint endeavors. Various groups in the North County region are participating in collaborative efforts to improve farmworker health, demonstrating their interest and capacity. But effective collaboration requires unique sets of skills associated with establishing trust, negotiating territory, and sharing resources—skills which many of the participating providers do not currently have. Training by an outside organization with expertise in capacity building could offer local providers a leg up in their efforts. Some of the skills and training that would be helpful include:

- Specific knowledge about the farmworkers who comprise the target population, which would facilitate more effective planning and program design. This information is particularly important in collaborative efforts where farmworkers overlap with other target populations, but are not specifically the target.
- Understanding that encompasses the cultural values, attitudes, practices, and beliefs common among farmworkers around particular issues.
- Techniques for developing a clearly defined mission and specific objectives based on community-determined goals.
- Forums for communication and understanding between collaboration members that help identify mutual goals and acquaint members with each other.
- Conflict management and resolution skills to maintain a climate of cooperation.
- Skills for program planning, design, and implementation.

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Links to outside groups with common goals or interests to expand both financial and informational resources.

Skills for program evaluation to ensure inter-organizational accountability, measure, outcomes, and identify lessons learned for future endeavors.

**Implement Programs and Activities for Youth**

Community members believe that programs and activities for youth can help divert them from the gangs, violence, drugs, and risky sexual activity prevalent in their communities. Currently, programs are few and they lack resources with which to engage farmworker parents and their children. Better coordination of youth services already operating in some areas could increase access to other parts of North County where such avenues are lacking. Cutler-Orosi, for example, no longer has its county-run youth center, and residents of Yettem favor locally-based activities for children and youth, both educational and recreational. Informants have identified violence prevention, mentoring, leadership skills, tutoring, access to information technology and sports, and teen pregnancy prevention as important issues to address. Programs also should address the barriers that prevent farmworker families from participating, such transportation conflicts and the need to promote programs in the community.

**Build Capacity in the Farmworker Community**

Leaders within the farmworker community make a key contribution to improving the health and well-being of themselves and their neighbors. In North County, these individuals include farmworkers and ex-farmworkers, their spouses and children, documented and undocumented immigrants, and both recent arrivals and longstanding members of the community. They volunteer at their children’s schools, serve meals at the local senior citizen center, mentor youth, advocate on behalf of other workers, and participate in local political campaign efforts. Concerns identified by this study include deficiencies in the public transit system, lack of town beautification efforts, pedestrian safety, youth violence, drugs and alcohol, and the scarcity of parks and recreation activities for both adults and youth.

Building the capacity of people to help themselves increases members’ ability to effectively confront such a wide range of concern. Farmworkers and their families often feel powerless due to their inability to speak English and lack of experience interacting with local government institutions. Others are unfamiliar with formal meeting procedures, bureaucratic processes, and means by which local resources can be leveraged to better their community. Through capacity-building programs, members of the farmworker community can gain the skills and experience they need to interact with local agencies and community organizations to effectively address problems.
Appendix A
Health System Characteristics

Health Program Characteristics

Medi-Cal and Healthy Families

Those eligible for Medi-Cal include: individuals receiving public assistance benefits or who meet some requirements of these programs; the aged, blind and disabled; families with children experiencing a specified category of deprivation, such as living at or below 100% of the federal poverty level; children and pregnant women regardless of deprivation; and individuals in need of special health services such as dialysis. Individuals who exceed income and asset limits may still qualify for Medi-Cal, but they incur a share of the cost of services. Medi-Cal covers a range services, including primary care, inpatient and outpatient hospital services, nursing home care, prescribed medications, and dental services. Farmworkers and their dependents with undocumented status are only eligible for emergency services under Medi-Cal.

Child Health and Disability Prevention (CHDP)

The Child Health and Disability Prevention (CHDP) Program is administered by California’s Department of Health Services’ Children’s Medical Services branch and is primarily state funded. CHDP providers may also receive Medi-Cal reimbursements. CHDP provides essential preventive health services to California’s low-income children and youth regardless of immigration status. In California, CHDP fulfills federal requirements under the Medicaid’s Early and Periodic Screening Diagnosis and Treatment. Approximately half of the 2.2 million children in California served through CHDP are uninsured. Qualifications for CHDP for those not enrolled in Medi-Cal include being nineteen years or younger and having a family income below 200 percent of the federal poverty level. Youths who are enrolled in Medi-Cal qualify for CHDP to twenty-one years of age. Neither immigration status nor income verification is required. Additionally, children enrolled in Head Start or state preschool programs qualify for health assessments under CHDP.

California Children’s Medical Services (CCS)

The Children’s Medical Services branch of the California Department of Health Services administers California Children’s Medical Services (CCS). CCS funding comes from state, county, and federal tax dollars. Parents of eligible children may also pay part of the costs. Under CCS, children receive special medical services and/or equipment. The program offers eligible children a range of coverages that include physician services, surgical care, physical therapy, laboratory tests, and radiology. The program also offers case management and referrals. To qualify, children must be less than twenty-one years of age and
residents of California, be diagnosed with a CCS-eligible condition, and meet income guidelines. In some cases, CCS covers children regardless of income. These cases include (but are not limited to) children who are enrolled in Medi-Cal or Healthy Families and those who require diagnostic services to diagnose a medical condition covered by CCS.

**Characteristics of the Health Care System**

**Family Health Care Network**

Under Family Health Care Network’s (FHCN’s) sliding fee scale, the minimum cost incurred is $20 per visit.

The Ivanhoe site operates on Mondays from 8:00 a.m. to 9:00 p.m. and Tuesdays through Fridays from 8:00 a.m. to 5:00 p.m. The medical staff rotates weekly and includes one family practice physician, one family nurse practitioner/certified nurse midwife, and one physician assistant.

Woodlake site hours are Mondays, Wednesdays, and Fridays from 8:00 a.m. to 5:00 p.m. and Tuesdays and Thursdays from 8:00 a.m. to 7:00 p.m. One family practice physician, one physician assistant, and one dentist comprise the medical personnel at Woodlake. In addition, there is an obstetrician/gynecologist, a physician assistant, and a family nurse practitioner who rotate through the clinic weekly.

Cutler-Orosi operates Mondays and Wednesdays from 8:00 a.m. to 9:00 p.m. and Tuesdays, Thursdays, and Fridays from 8:00 a.m. to 5:00 p.m. The health professionals reported at this location include one family practice physician, one pediatrician, one family nurse practitioner, and one dentist.

Nutritionists rotate through the clinics and provide health education. Diabetics, for example, receive health education aimed at preventing complications and other co-morbidities associated with the disease. They are taught to conduct finger prick tests and receive nutritional information. Programs available at FHCN include CHDP, Breast Cancer and Early Detection Program, and a program that provides free vision care for children through Vision Service Plan.

**Tulare County Health and Human Services Agency**

Hours of operation at the Dinuba Health Care Center are Mondays, Wednesdays, Thursdays, and Fridays from 8:00 a.m. to 5:00 p.m. and Tuesdays from 8:00 a.m. to 8:00 p.m.
Appendix B
Methods Used for North Tulare County

Community-based Content

The report summarizes opinions and facts given by communities of farmworkers, of people in charge of delivering services to farmworkers, and of other observers concerned with farmworker problems. The purpose is to describe the community through its own eyes. These recommendations and observations reflect a consensus in the community as mediated by the researchers.

Methodological Steps

The approach of this study is open-ended questioning of subjects with an emphasis on collecting details on the particular problems and issues important to the respondent, while balancing this with a systematic collection of information across sites.

The first step was to organize a telephone survey of the provider and service community. Separate protocols were designed for medical providers, social workers, and outreach workers. This survey was conducted in September of 2001. It allowed identification of the main North County neighborhoods where farmworkers live and descriptions in some detail of the main programs that provide services to them. The telephone inquiry, which involved conversations with nearly twenty people, did not allow for an understanding of the strengths and weaknesses of the service resources available to farmworkers. And, of course, it did not allow for input from farmworkers identifying their major health concerns and describing the primary barriers they face in obtaining services.

Next, the team implemented one protocol for farmworkers and another for providers and others in the community. Four interviewers—Marisol Ayala, Marcus Clarke, Victor Manuel Perez, and Lisette Saca—carried out eighty-nine interviews and one focus group and attended a series of community meetings and events under the guidance of Rick Mines in April, May, and June of 2002. The sampling process endeavored to capture major networks of individuals. This proved difficult given the expansive geographic area that makes up the North County region and the effort to include farmworker informants in each North County town. As a result, the sampling of individual farmworkers focused less on network sampling and more on obtaining interviews with a representative sample, ensuring geographic representivity. Also, the sample intentionally included people of different ages, men and women, and people separated from and with their families. Indigenous-language speakers are concentrated in the central portion of the county, and only one Mixteco-speaking family was captured in this study. Interviewers intentionally followed up on issues that the community (from all sectors) identified as crucial to farmworker health. As a result, they spoke to community organizers, educators, commu-
nity leaders, and outreach workers of various kinds. In addition, they were careful to sample all types of health care providers, such as nurses, mental health professionals, intake workers, administrators, doctors, and patient care associates. The interviewers were successful in obtaining interviews with some individuals in each of the organizations considered to be front line groups delivering services to farmworkers.

The next step was to import the field notes (in Microsoft Word) to a qualitative text analysis software package (Atlas.ti). This process necessitated revision and editing of the notes, which may not be edited once they are in Atlas. This task created the opportunity to also review notes and extract contacts and leads for subsequent field work in the subregion. Standards on the format of written notes were established.

The AWHS team revised the codes used for previous community-based studies to make them more relevant to Tulare County. This helped in systematic analysis of field notes (by means of Atlas software). Codes are concepts that are represented in the interview data. Each code was defined to ensure inter-coder reliability. The code list in its categorized form is also useful for conceptualization of the model to be used to explain how to improve outreach to farmworkers. The code lists were further refined by piloting the coding, as described below. The creation of new codes arising from the data was not inhibited, but procedures were set up to guide their creation. In other words, codes were added during the coding process.

The AWHS team held a two-day training program for the field work staff before returning to the field. Protocols were re-examined and possible coding schemes were reviewed. The examination of the field notes is serving to facilitate the iterative refinement of the protocols and research design.

Coding

The interview data were placed in “text with carriage returns” format. These are called primary documents (each interview = primary document) and are considered the data source. A set of primary documents comprises a hermeneutic unit. Within a hermeneutic unit, subsets of primary documents can be grouped into families. The families in the farmworker subset include sex, age, farmworker insurance status, documentation status, health condition diabetes, place of origin, and household composition (family versus solo male). The families for health providers and others include sex, age, bilingual ability, organizational type (public versus private), administrator, health care personnel, and outreach worker.

Three hermeneutic (analysis) units were created—one for farmworkers, one for health care providers/outreach workers, and one for all other respondents. The primary documents were coded using the code lists. Coding consisted of selecting a phrase, sentence, paragraph, or group of paragraphs that represented a concept. The selected texts are
called quotes. Multiple coding was allowed and has served to facilitate analysis of the data.

Analysis

After coding was completed, data queries of codes were generated showing the quoted text for each corresponding code. Quotes associated with the codes were printed to identify themes, patterns/relationships, and dimensions of phenomena (valence) and to provide contextual understanding. Analysis of families allowed for a richer comparison of concepts by varying categories of respondents, such as public versus private health providers and insured versus uninsured farmworkers. These data queries on codes and their corresponding quotes were used to structure the report. Feedback on these analyses was given to current field researchers so they could further revise protocols and sampling.