

SERVICE DELIVERY MODELS

PHS Act Section 330 requires health centers to provide comprehensive primary care and enabling services; however, as private organizations, health centers design their service delivery model that best meets the needs of the communities they serve. Therefore, each organization is unique in its size, number of access points, location, hours of operation, staffing patterns, services provided, service charges, etc. There are 166 health center grantees that receive partial funding to provide services to the migratory and seasonal agricultural worker population (PHS 330g). All but nine of those are also funded to serve community residents (PHS 330e). Those jointly funded grantees are known as Community/Migrant Health Centers (C/MHC). Collectively, the 166 health centers operate more than 800 service delivery sites, forming a national loosely-knit network of independent organizations serving America's migrant and seasonal agricultural workers and their families.

Although the majority of these grantees deliver their services from fixed sites, there are some who serve migratory and seasonal agricultural workers and people experiencing homelessness by utilizing mobile units and/or voucher programs to meet the needs of their target populations.

Fixed-Site Health Centers are permanent structures located in strategic places where patients can access health services. The majority of those health centers are community-based organizations (CBOs); very few are operated by state or local health departments. Many health centers are multi-million dollar operations with several satellite clinics and offer all required services in the same location. Others may focus on one service in each location, such as dental care, behavioral health service, pediatrics, or women's health. The majority operates year-round and only few operate seasonally, depending on the population they serve. For example, a health center serving migratory workers may operate only during the agricultural season.

Searching existing health centers by city or ZIP code can be done by visiting the following HRSA link: <http://www.hrsa.gov/index.html>.

Mobile clinics - as the name indicates, mobile clinics are motorized units traveling throughout a service area to bring services to populations unable to travel to fixed sites or unable to access care during traditional business hours. Mobile units usually rotate sites on a fixed schedule. Although there is no searchable directory of mobile units, this link <http://www.hrsa.gov/index.html> allows you to search for health centers by city or ZIP code.



Voucher Programs- a small number of organizations, primarily serving migratory and seasonal agricultural workers, function as voucher programs. Voucher programs, like any other PHS section 330 grantee, are required to provide comprehensive primary and preventive health services and comply with all health center program requirements. The primary difference between voucher programs and health centers is the service delivery structure. While health centers generally offer limited or no outreach services, voucher programs usually have comprehensive outreach services. Outreach workers seek out farmworkers in the fields, in farmworker housing locations, and other areas where workers are concentrated. Once farmworkers are reached, their health needs are assessed and their access to care is facilitated by the provision of enabling services such as transportation, interpretation/translation, health education, screening, and referral, etc. Although some voucher programs employ their own providers to provide primary care services at mobile units or evening clinics, health care services are generally provided by contracted private providers already established in farmworker communities. PHS Section 330g programs may be structured as voucher programs under the following circumstances:

- a. The number of farmworkers requiring care is dispersed over a large geographic area;
- b. These geographic areas are characterized by limited agribusiness or short harvesting periods;
- c. Existing provider organizations are unqualified or unwilling to be migrant grant recipients; and
- d. Existing providers have the capacity to meet the primary care needs of the farmworker population.

(See <http://bphc.hrsa.gov/policiesregulations/policies/pin199407.html>).

Voucher programs range in size from small to very large programs. The smallest programs are located in frontier and rural areas serving small groups of farmworkers that are in the area for periods as short as 6 weeks. Larger programs are often jointly funded Community and Migrant Health Centers and are located in high migrant-impact areas and serve thousands of farmworkers. To access the voucher program directory please click here: <http://www.ncfh.org/index.php?pid=65>.

