NCFH
National Center for Farmworker Health, Inc.

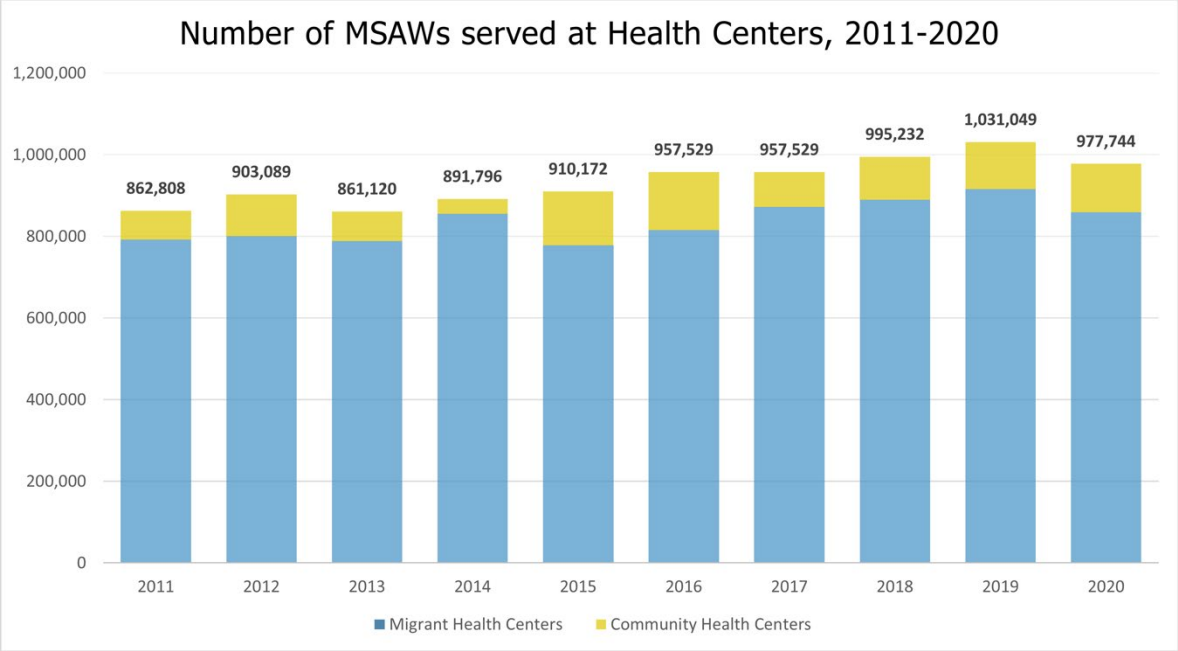
A Profile of Migrant Health

2020 Uniform Data System Analysis

Introduction

Background on the Health Center Program

The Health Resources and Services Administration (HRSA) administers the Health Center Program which provides federal grant funding to nearly 1,400 Health Centers that operate approximately 13,500 service delivery sites across the United States, Puerto Rico, the Virgin Islands, and the Pacific Basin to "ensure access to affordable, comprehensive, high-quality primary care services for patients regardless of their ability to pay," (UDS manual). Health centers are community-based organizations that reach individuals and families that often lack access to quality health care, such as those experiencing homelessness, residents of public housing, veterans, and agricultural workers (HRSA).

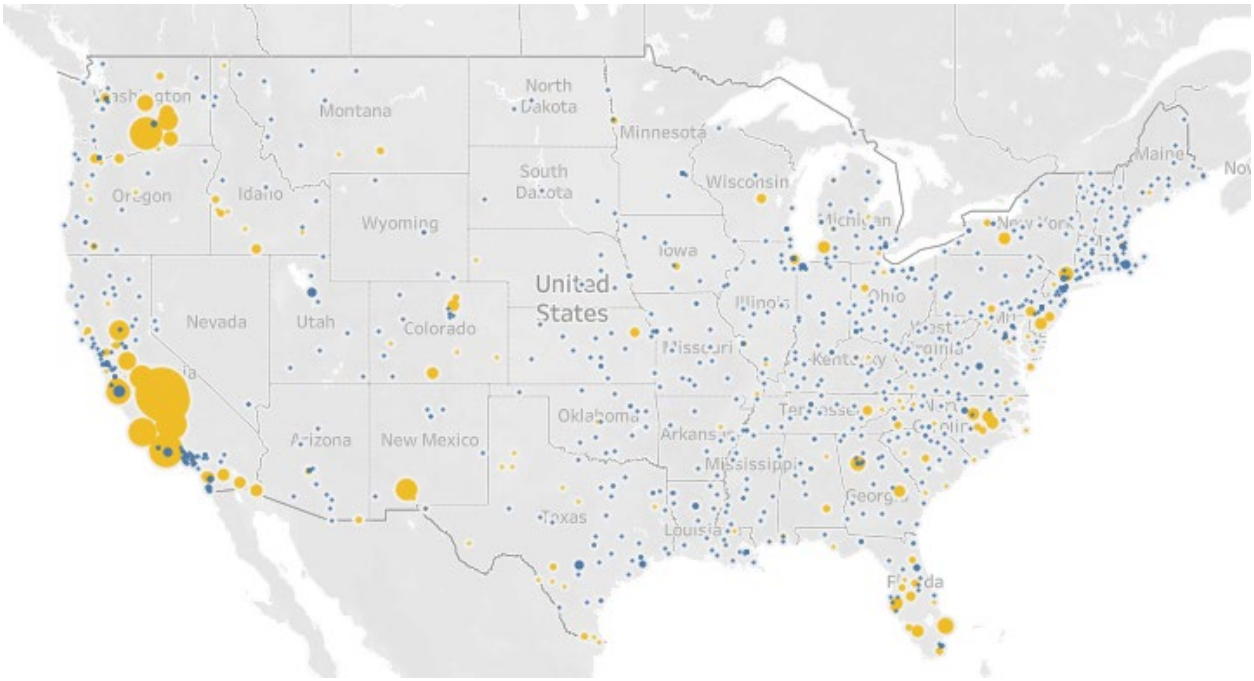


While any Health Center may serve **migratory and seasonal agricultural workers and their family members (MSAWs)**[1], Migrant Health Centers (MHCs) serve the vast majority of MSAWs. One hundred and seventy-five MHCs receive federal grant funding to specifically serve MSAWs and their families, and are required to report specific data on MSAWs through the Uniform Data System (UDS). Most of these MHCs also receive other types of funding from HRSA; however, a small number of MHCs exclusively receive Migrant Health funding. In 2020, there were 9 Migrant Health only programs, located in Maine, Massachusetts, South Carolina, North Carolina, Georgia, Minnesota, Kansas, Iowa, and Montana. Historically, these

[1] HRSA refers to migratory and seasonal agricultural workers and their family members as MSAWs. All family household members of an agricultural worker patient receive the same classification of migratory or seasonal as the worker.

programs tend to primarily serve MSAWs that are migratory and are located where agricultural worker communities are smaller and not as dense. Health centers that do not receive Migrant Health funding will be referred to as Community Health Centers (CHCs) in this report. All CHCs are required to report all special populations, including MSAWs, regardless of the type of funding they receive.

The analysis in this report is based on the Uniform Data System (UDS) reported by Health Centers. The UDS is a data set reported annually and provides information about health centers, including patient demographics, services provided, and health outcomes. It is the source of unduplicated data for the entire scope of services included in the grant or designation for the reporting year (UDS manual). HRSA's awardees are required to report in the UDS under the Health Center Program.



View the interactive map of MSAW patients by Health Center location

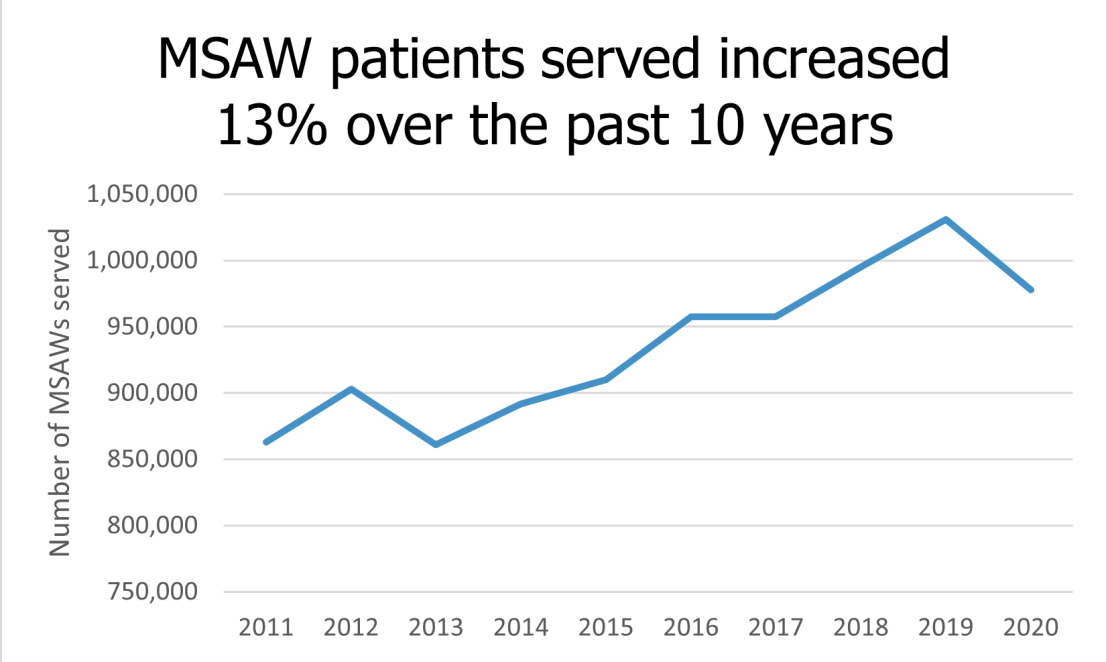
Trends in 2020 among Health Centers

Overall, Health Centers saw a 7% decrease in patient visits, and a 4% decrease in patients served from 2019 compared to 2020. For MSAW patients, there was a total decrease of about 5%, from 1.03M patients in 2019 to 0.98M patients in 2020. MSAWs represented less than 4% of all patients in both 2019 and 2020 – suggesting that the proportion of MSAWs served held relatively constant.

While there is not thorough evidence to fully understand the overall decrease, several trends provide more context to the trend. Not all services were impacted equally - for example,

mental health visits increased by 15%, while dental and vision visits decreased by 34% and 28% respectively. There was also a shift from in-person to virtual patient visits. While in-person visits decreased by 30% from 2019, virtual visits increased by nearly 6,000% (HRSA).

In 2020, a total of **977,744 migratory and seasonal agricultural workers and their family members** were served by Health Centers. Although there was a decrease in MSAWs served in 2020 from an all-time high the previous year, the MSAW patients served still reflect an overall increase of 13% over the past decade.



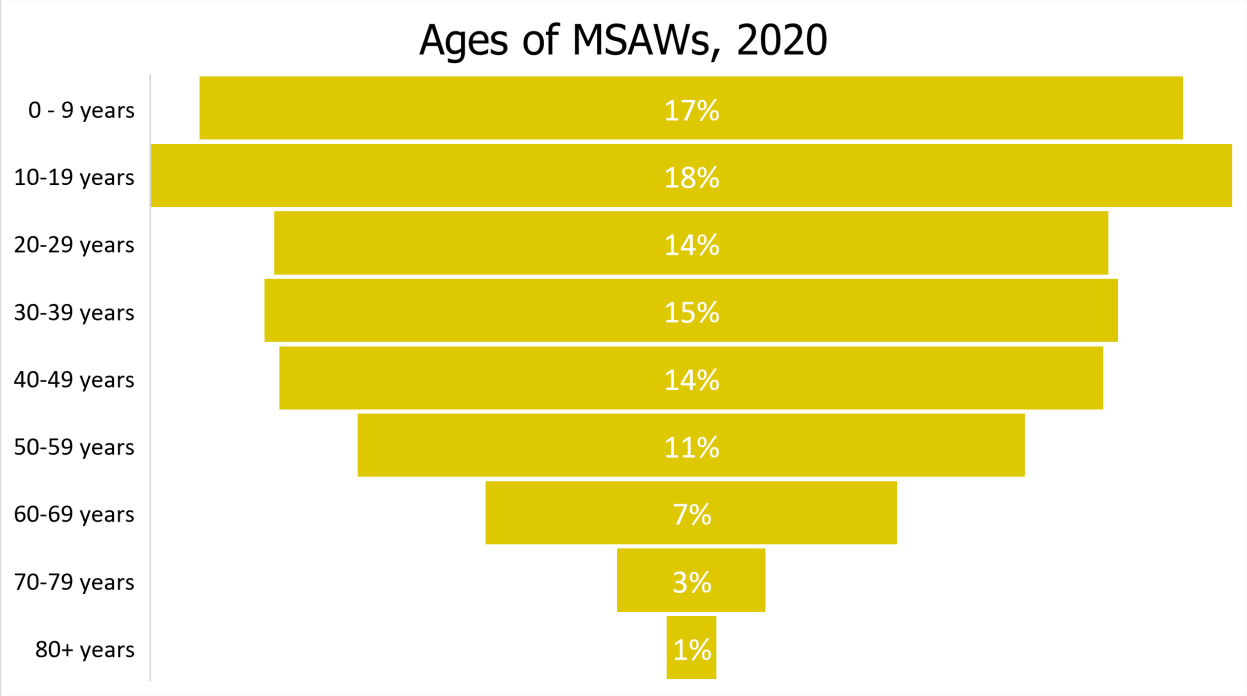
This report summarizes data about MSAW patients of Migrant Health Centers[2] in 2020, trends in MSAW patient populations from 2011 to 2020, and new metrics reported with the outbreak of COVID-19.

[2] This report excludes the data of one "Migrant Health Only" program, Community Health Services, because MSAWs were less than half (42%) of the patients served by this Health Center.

MSAW Characteristics & Trends

Age Distribution

The largest age group of MSAW patients and their families served by MHCs are children, with 32% under the age of 18. More than half (53%) of MSAW patients are working age adults (18-59), and 10% are of retirement age (60+ years).



Race/Ethnicity & Language

87% of MSAW patients are Hispanic/Latino/a
62% are best served in a language other than English

The vast majority of MSAWs served by MHCs are ethnically Hispanic (87%) and speak languages other than English (62%).[3]

Of non-Hispanic MSAW patients, 8% are White, and Black and Asian patients each represent 1%. Less than 1% are American Indian/Alaskan Native, and less than 1% are Native Hawaiian/Pacific Islander. Less than 1% of MSAW patients indicated they identified with more than one race (the category of more than one race does not capture the multiple races selected).

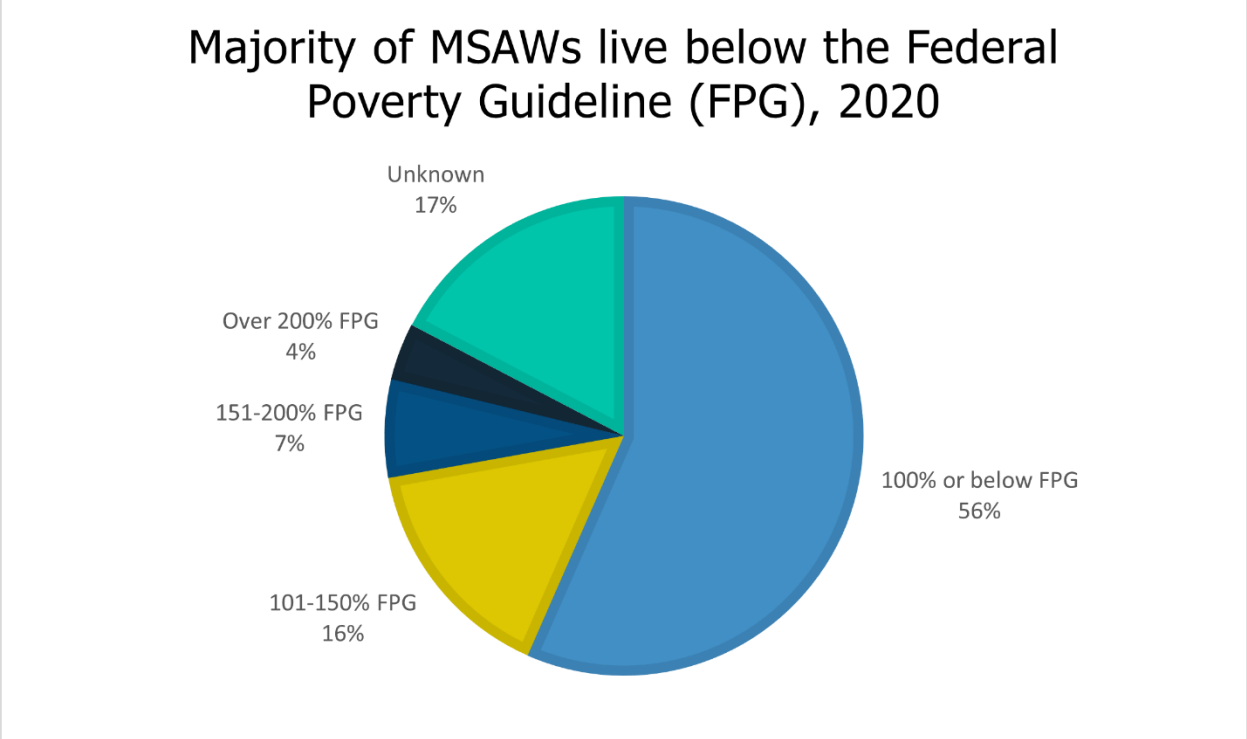
[3] Languages other than English, includes those best served in sign language, those served by a bilingual provider, and those who brought their own interpreter. The data, however, does not specify which languages are represented.

Countries of Origin
Patients included in the Hispanic category represent persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, including those who were born in the United States.

Poverty Level

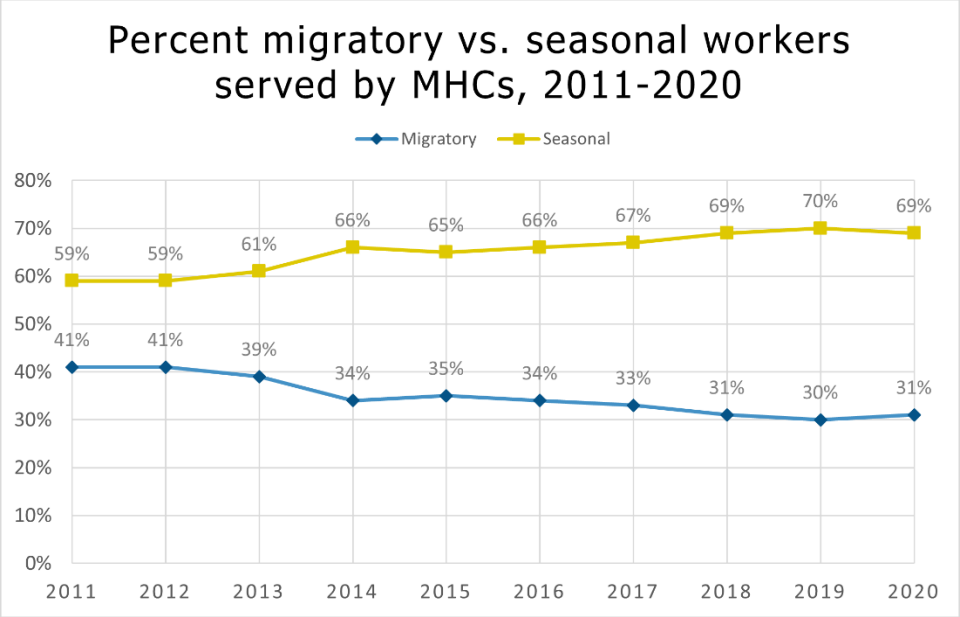
In 2020, the national federal poverty guideline (FPG) for a family of four was $26,200, and $12,760 for a single person. The majority (56%) of MSAW patients served by MHCs in 2020 had family incomes at or below the FPG. Households up to twice the FPG are still considered low-income families (NCCP).

Nearly one-fourth (23%) have incomes between 101-200% of FPG and 4% have incomes over 200% of FPG. MHCs were unable to document income level for 17% of MSAW patients.



Migratory & Seasonal

All MHCs must classify agricultural worker patients as either migratory or seasonal. Migratory workers & families must find new, temporary housing in order to work in agriculture, while seasonal workers do not, but may experience a change in their tasks, hours, or income at work (HRSA definitions). In 2020, **31%** of MSAW patients were migratory workers, and **69%** of MSAW patients were seasonal workers.



The percentage of MSAW patients who are classified as migratory has been gradually declining over the past decade. This could be because agricultural workers are moving away from migratory employment patterns, migratory workers are not seeking care at MHCs, or MHCs have become better at identifying seasonal agricultural workers in their communities (thus decreasing the total percentage of MSAW patients who are classified as migratory). It is likely that some combination of all three causes is contributing to the decline in migratory worker patients. Additionally, there has been an increase in H-2A workers who migrate to the U.S. to work temporarily across thousands of farms, and these workers face many obstacles to accessing health care.

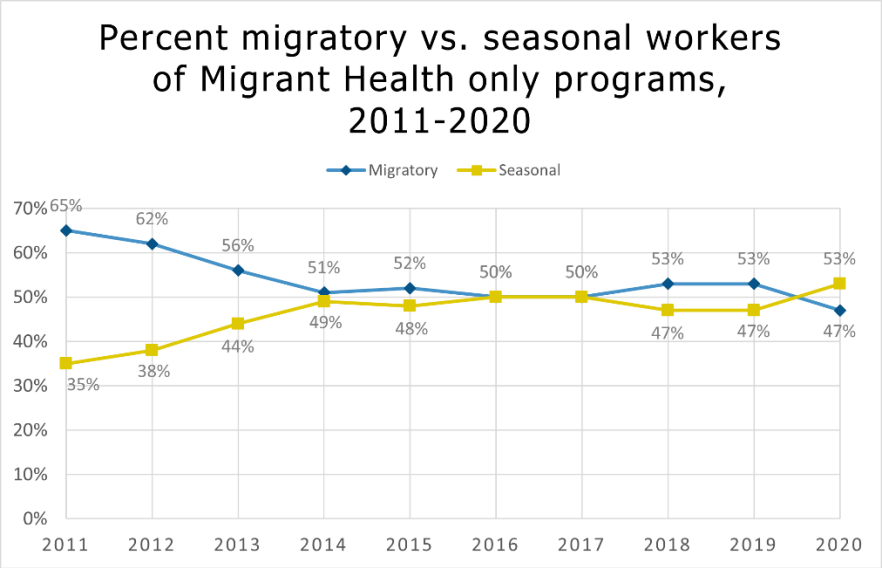
H-2A Program
The H-2A temporary guest worker program is a complex and rapidly-expanding program that in FY 2020 brought nearly 300,000 individuals to the U.S. to work on thousands of farms. Five states (CA, WA, NC, FL and

GA) accounted for over half of these H-2A workers.[4] The majority of H-2A workers are young men traveling without their families from Mexico, many of whom work on the same farm every season.[5]

H-2A workers often face a variety of social determinants of health that adversely impact their access to health care, including:

- Shared transportation and/or lack of reliable transportation[6]
- Extremely demanding work schedules
- Overcrowded employer provided housing
- Living in remote, rural areas with few social or family support networks[7]
- Lack of information about U.S. health care in Spanish, indigenous, or other languages

A small number of MHCs exclusively receive Migrant Health funding. Historically, these Migrant Health only programs primarily serve MSAWs that are migratory. However, Migrant Health only programs have seen a decline in the proportion of their MSAW patients that are classified as migratory since 2011. Still, a greater percentage of their patients are migratory compared to all Migrant Health Centers.



[4] U.S. Department of Labor. (2020). H-2A Temporary Agricultural Program – Selected Statistics, Fiscal Year (FY) 2020 EOY. Retrieved from https://www.dol.gov/sites/dolgov/files/ETA/oflc/pdfs/H-2A_Selected_Statistics_FY2020.pdf

[5] U.S. Department of Homeland Security. (2021). Nonimmigrant admissions to the United States 2019 data tables. Retrieved from https://www.dhs.gov/immigration-statistics/nonimmigrant

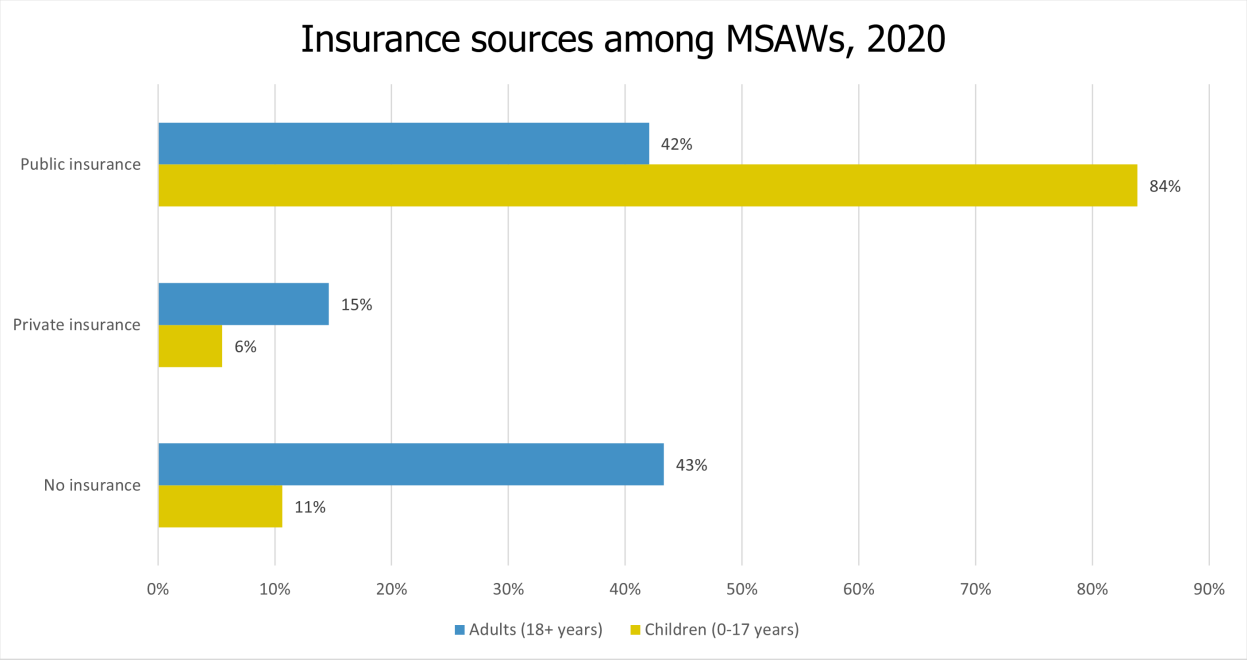
[6] Farmworker Justice. (n.d.). No way to treat a guest: Why the H-2A agricultural visa program fails U.S. and foreign workers. Retrieved from https://www.farmworkerjustice.org/resource/no-way-to-treat-a-guest-why-the-h-2a-agricultural-visa-program-fails-u-s-and-foreign-workers/

[7] Schmalzbauer L. (2015). Temporary and transnational: gender and emotion in the lives of Mexican guest worker fathers, Ethnic and Racial Studies, 38:2, 211-226, DOI: 10.1080/01419870.2013.857033

Insurance Status

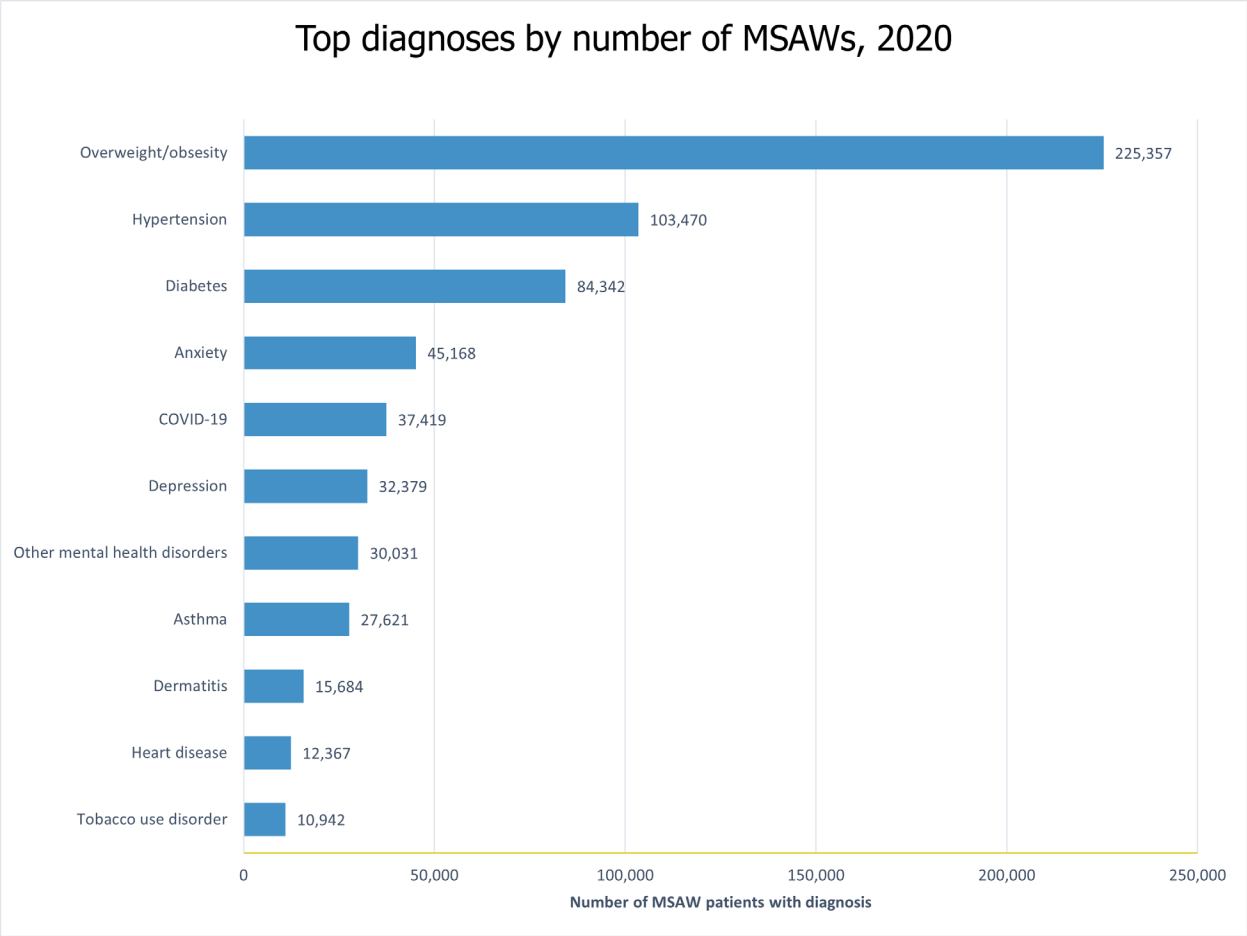
Insurance status for MSAW patients varies significantly for children and adults. Among children under the age of 18, 85% had a public form of insurance, which includes Medicaid, Medicare, Children's Health Insurance Program (CHIP), or another state- or locally-funded health insurance. One in ten (11%) children had no insurance, and just 6% of children were covered through a private insurance source.

The largest proportion of adult MSAWs (42%) also had some form of public insurance, while nearly the same amount (43%) had no insurance. Fifteen percent had private insurance, obtained through their employer, a spouse's employer, or on their own.



Health Conditions

The most common diagnoses in MSAWs reflect a burden of mental health and chronic diseases. The chronic diseases of overweight/obesity, hypertension, and diabetes were the top three most common diagnoses, followed by anxiety, depression, and other mental health disorders. The number of COVID-19 diagnoses also reflect the toll of the pandemic on MSAWs and their families in 2020.



COVID-19

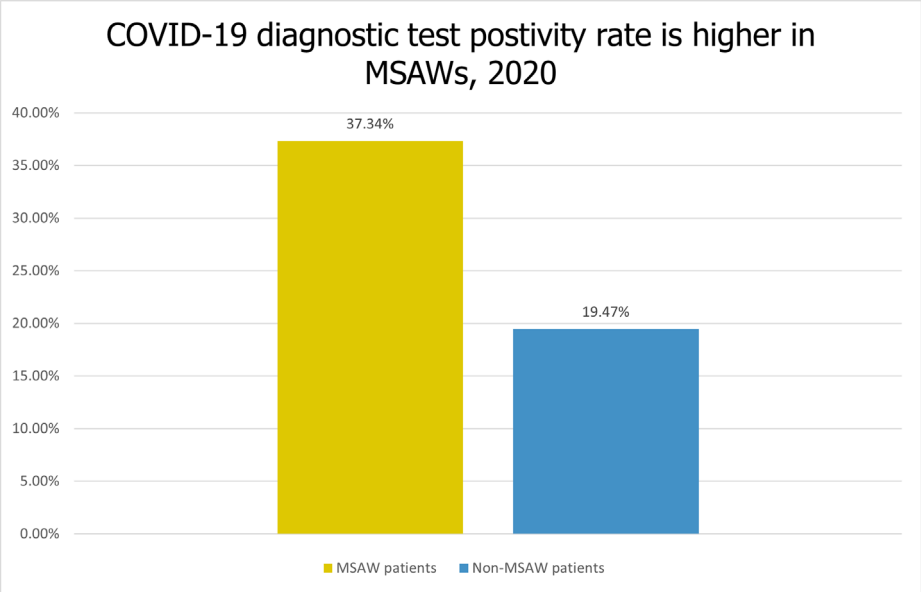
The essential nature of the work of America's agricultural workers has become more prominent during the global pandemic, but their working conditions have not improved. Agricultural workers have been facing repeated exposures to COVID-19 in unsafe workplaces and in crowded housing units with little social support. While researchers at Purdue University estimate that nearly 729,300 agricultural workers have contracted COVID-19 as

of March 2021,[8] UDS reports that 37,419 MSAWs were diagnosed with COVID-19 at Health Centers.

Number of MSAW patients who received COVID-19 diagnostic test: **100,218**
Number of MSAW patients who received COVID-19 antibody test: **2,740**
Number of MSAW patients diagnosed with COVID-19: **37,419**
Number of MSAW patients diagnosed with acute respiratory illness due to COVID-19: **2,224**

	Number of MSAW patients	Number of non-MSAW patients	Proportion of all MSAW patients	Proportion of all non-MSAW patients
Diagnosed with COVID-19	37,419	707,175	3.83%	2.56%
Acute respiratory illness due to COVID-19	2,224	68,262	0.23%	0.25%

Approximately 4% of all MSAW patients were diagnosed with COVID-19, and similarly about 3% of all non-MSAW patients were diagnosed with COVID-19. Of MSAWs diagnosed with COVID-19, about 6% of patients were diagnosed with acute respiratory illness. On the other hand, of all non-MSAW patients diagnosed with COVID-19, nearly 10% were diagnosed with acute respiratory illness.



Among MSAWs, the COVID-19 diagnostic test positivity rate was 37%, while non-MSAWs had a lower rate at about 19%, as seen in the figure above. The difference between the positivity rates between these two groups could reflect MSAW patterns in Health Center

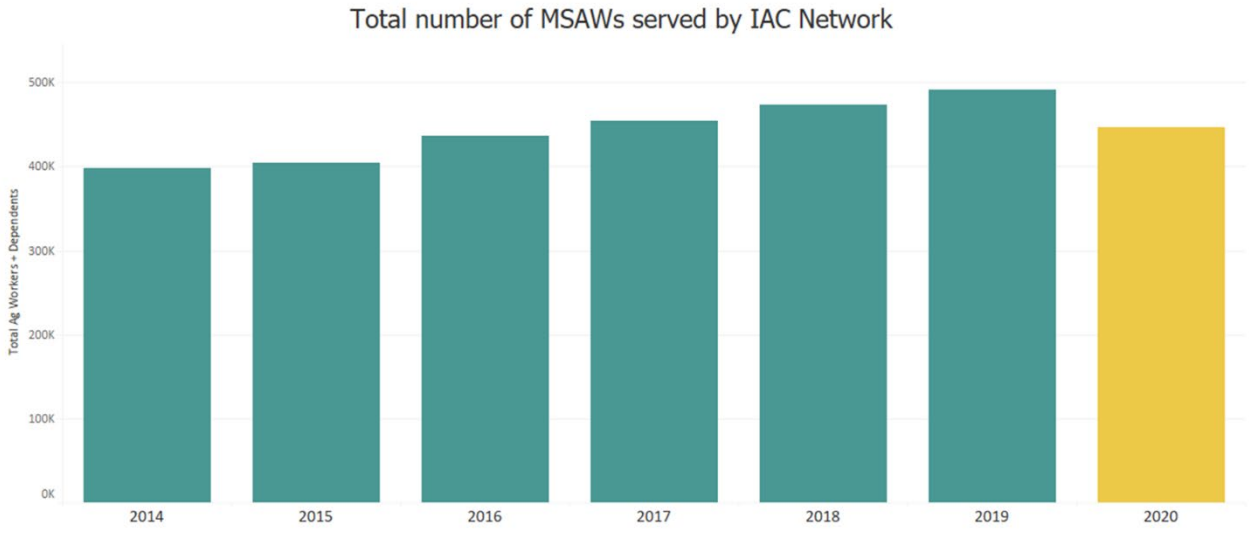
[8] Lusk JL, Chandra R (2021). Farmer and farm worker illnesses and deaths from COVID-19 and impacts on agricultural output. PLOS ONE 16(4): e0250621. https://doi.org/10.1371/journal.pone.0250621

visits (for example, only seeking health care when sick), or a higher burden of COVID-19 among MSAWs than the general population; however, further research is needed.

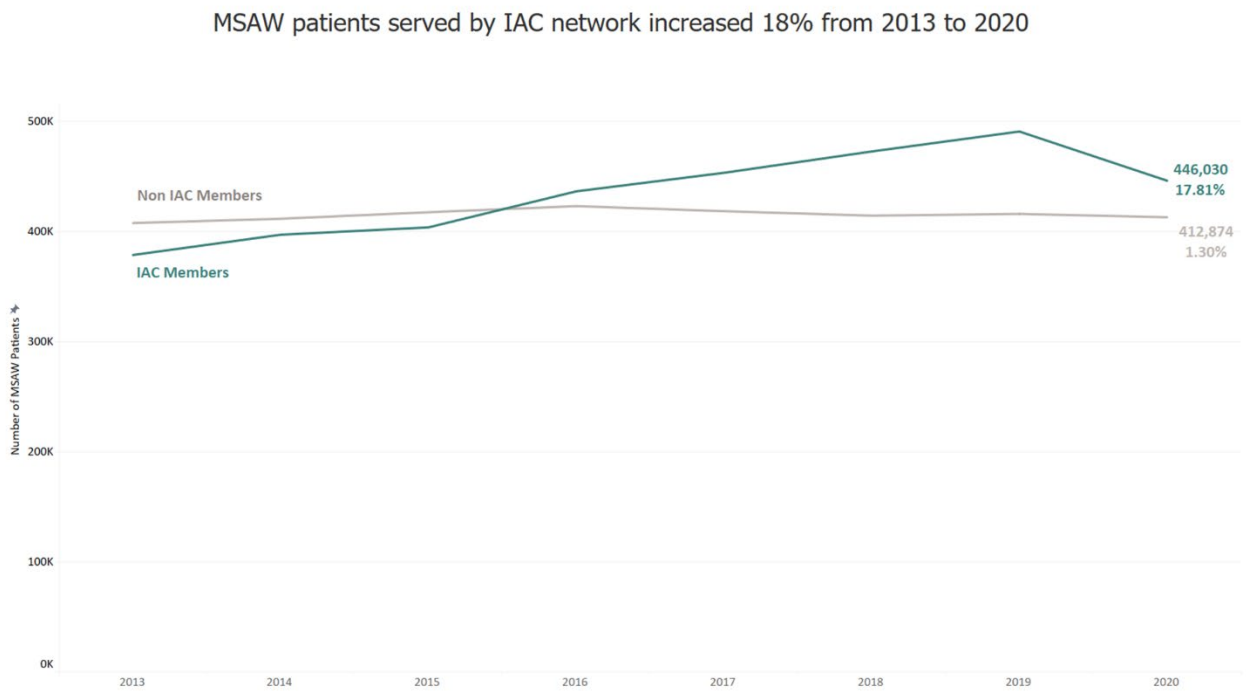
Learn more about NCFH's COVID response.

Increase Access to Care Network

The NCFH, Increase Access to Care (IAC) Network Program was designed to assist Health Centers in accurately identifying, classifying, and reporting their patients. Through this program, consisting of workforce training, learning collaborative activities, and technical assistance support, NCFH has been able to help Health Centers modify their current systems and registration processes to demonstrate their effectiveness. As a result, participating Heath Center patient registration teams are implementing the steps necessary to identify and accurately report MSAWs when they register and are participating in Migrant Health Program Action Planning to reach their increase access goals. There are currently 36 Health Centers that participate in the IAC network.



The figure above shows the number of MSAWs served by Health Centers in the IAC network between 2014 and 2020. Although the number of MSAWs served by the IAC network decreased slightly from 2019, the overall trend reflects an increase over the years. The decrease between 2020 and 2019 is similar to the decrease reported by MHCs overall.



Further, IAC members have seen a higher increase in the number of MSAWs served compared to non-IAC members over the past decade. MHCs that participated in the IAC network experienced an 18% increase in MSAW patients served from 2013 to 2020, whereas MHCs that did not participate experienced only a 1% increase.

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,916,466 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.