

June 10, 2014

The Honorable Secretary Sylvia Burwell  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, DC 20201

Dear Secretary Burwell:

This letter is offered on behalf of the National Advisory Council on Migrant Health (Council) that met April 8-9, 2014 in Rockville, MD. The purpose of this meeting was to formulate recommendations to assist in improving health services to migratory and seasonal agricultural workers (MSAWs) and their families, ultimately enhancing their health status. The meeting agenda included presentations from James Macrae, Associate Administrator, Bureau of Primary Health Care, Health Resources and Services Administration, on the expansion of health services to MSAWs. The Office of National Assistance and Special Populations provided updates on future program planning and evolving issues. In addition, agencies that affect or focus on migrant health presented information on the Affordable Care Act (ACA), agricultural protection standards, Head Start Programs, the Uniform Data System, the status of immigration reform, and the National Health Service Corps. As previously acknowledged in the letter dated March 2014, the recommendations offered may be influenced by the ACA and current immigration policy.

We would like to commend your decision to appropriate funding for vision services, and to increase funding for oral health, mental health and pharmacy services in Community and Migrant Health Centers (CHC/MHC). These measures will make important contributions to improving the health care available to MSAWs. Based on the Council members' unique experiences working with the migrant population and health issues, presentations made to the Council over the past year, and the testimonies from MSAWs, the Council has identified three major issues and offer recommendations for action. They are: (1) the evolution of the Affordable Care Act, (2) promotion of the Patient Centered Medical Home concept including patient self-participation in health management and, (3) access to specialty care services.

#### **Evolution of the Affordable Care Act**

- It has been brought to our attention that MSAWs need education on insurance literacy in order to take advantage of the benefits of the ACA. Insurance literacy is defined as the ability to understand what is insurance, how it operates, what it may cover, how to enroll, fees and services, and how to access health care when needed.

We recommend that the National Migrant Cooperative Agreement agencies develop a program to close this knowledge gap on insurance literacy. This may be in the form of brochures, flyers, posters, and public service announcements. These should be written from the patient prospective and be culturally and linguistically appropriate, and with consideration of patient language reading levels. In addition, the materials should be clear and concise and written for a grower audience.

- The ACA was designed to offer access to quality, affordable health care for all Americans. With their geographical diffusion, most MSAWs cannot take their present insurance across state lines. The current structure of the ACA is not realistic for a mobile population with multiple barriers to health care access.

We suggest that the Department of Health and Human Services (HHS) uses its influence to recommend to insurance companies the formation of a preferred provider organization network for CHC/MHCs. In addition, we recommend that the administrators of CHCs/MHCs be encouraged to petition insurance companies to be part of their medical home marketplace and promoted as an option for mobile populations.

### **Efficient and Effective Management of Patient Health Care Information**

- Duplication of Services  
There is sometimes duplication of care services and diagnostic testing when a MSAW travels to different work locations. There is no central method for timely communication with a health care provider and a patient from a mobile population. This situation is not cost effective or efficient. It certainly delays the formulation of appropriate treatment plans for patients.

Until electronic medical record systems can interface with each other, we suggest a workaround that is already utilized by some health centers. We recommend that patients be given copies of their medical records, including progress notes and diagnostic test results to hand carry to the next work location for the new healthcare provider. A previously distributed portable health card did not demonstrate usefulness or transfer accurate information. A copy machine is the best method for now.

### **Promotion of Efficient Scheduling Practices**

- Restrictive Scheduling Policies  
We have been informed that CHC/MHCs are often unable to schedule multiple health appointments on the same day. For example, if a woman requests a clinic appointment for a chief complaint of back pain, but also has a need for a gynecology appointment she cannot have both scheduled on the same day. This frequently encountered policy may originate in the fact that insurance does not pay for two professional visits in one day.

Since the rules for CHC/MHCs and Medicaid fall under the jurisdiction of the HHS, we suggest that the current policy and reimbursement guidelines be re-evaluated to allow multiple visits on the same day. This change will not only impact MSAWs, but will also positively affect rural populations and overall health care delivery. Health prevention visits and resulting episodic events scheduled on the same day will prevent restrictive access to patients. We also suggest encouraging flexibility in decision-making in scheduling practices and service delivery that will consider barriers to care originating from real life dilemmas that include transportation, distance to CHC/MHCs, lost wages, language differences and difficulty of pursuing follow-up care.

**Access to Specialty Care Still Remains a Barrier to Quality Health Outcomes**

- Each CHC/MHC cannot feasibly afford to have a multitude of unique health care specialists on staff.

We recommend that a specialty care referral and treatment program be adapted and modeled after the current Migrant Health Voucher Programs. Individual health centers would seek funding for this service, administer the program, and maintain the accountability for being the primary care providers thus maintaining the Patient Centered Medical Home philosophy and status. This would serve as a cost effective solution to meet the unique needs of these patients, as well as being considerate of patients' time and travel resources. Most importantly the patient would receive the specialty care that is needed.

We are honored to serve on the National Advisory Council on Migrant Health. It is with this honor and respect for those we represent that we offer these recommendations to you on behalf of the entire Council. We thank you for the opportunity to serve.

Sincerely,

Carolyn S. Davis, MN, RNC, APRN, FNP  
Chair

cc: Dr. Mary Wakefield  
Mr. James Macrae  
Ms. Tracey Orloff  
CDR M. Sonsy Fermin