

NATIONAL ADVISORY COUNCIL ON MIGRANT HEALTH

October 19-20, 2010
Charleston Marriott Hotel
Charleston, South Carolina

Council Members

Andrea Weathers, M.D., Dr. PH (*Chair*)
Michael DuRussel (*Vice Chair*)
Frances R. Canales
Roberto Gonzalez
Jose L. Lopez
Zettie D. Page, III, M.D., Ph.D.
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Federal Staff

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Administration

Presenters

Carolyn Davis, FNP, Beaufort-Jasper-Hampton Comprehensive Health Services, Inc.
Alice Larson, Larson Assistance Services
John Ruiz, Director, Health Systems, National Association of Community Health Centers
Lathan Woodard, Chief Executive Officer, South Carolina Primary Care Association

Visitors

Anabel Andrade, Telamon Migrant and Seasonal Head Start
Yanira Arias, Latino Commission on AIDS
Sherly Armes-Harding, Migrant Head Start
Tiffany Baker, Telamon Migrant and Seasonal Head Start
Christian Castro, Latino Commission on AIDS
Jan Cox, Head Start Knowledge and Information Management
Mark Gray, Lowcountry AIDS Services
Maria Martin, South Carolina Primary Care Association
Carlo Victoriano, South Carolina Primary Care Association

TUESDAY, OCTOBER 19

Call to Order and Welcoming Remarks

- Michael DuRussel, Co-Chair

Mr. DuRussel called the meeting to order and invited visitors, staff, and Council members to introduce themselves. Following the round of introductions, he called for a motion to approve the meeting agenda. Roberto Gonzalez moved to approve the agenda. The motion was seconded by Jose Lopez and carried unanimously.

Council members reviewed the minutes of the May 2010 meeting. Israel Garcia noted that Seth Doyle and James O'Barr, who presented the Migrant Regional Coordinators Update, should be included in the list of presenters. Zettie Page moved that the minutes be approved as corrected. Jose Lopez seconded the motion, which carried unanimously.

Welcome to South Carolina

- Lathan Woodard, Chief Executive Officer, South Carolina Primary Care Association (SCPCA)
- Carolyn Davis, FNP, Beaufort-Jasper Hampton Comprehensive Health Services, Inc.

South Carolina Primary Care Association

Ms. Woodard has worked at SCPCA for 23 years. Prior to that, she worked in maternal and child health at the South Carolina Department of Health and Environmental Control (DHEC), where she had an opportunity to work with migrant and seasonal farmworkers (MSFWs).

SCPCA is a member organization that advocates on behalf of safety net health care providers and their patients, including community health centers (CHCs), migrant health centers (MHCs), and programs for public housing residents and the homeless. SCPCA has 19 member organizations. In 2009, these programs served more than 300,000 patients.

South Carolina has three migrant health grantees, plus a statewide migrant health voucher program for which SCPCA has been the grantee since 2004. SCPCA has strengthened the voucher program by identifying areas of greatest need.

The difficulty of determining the number of MSFWs in South Carolina presents a significant challenge to identifying needs. In 2007, the Employment Security Commission reported 10,750 farmworkers in the state, indicating a 20 percent decrease since 2002. However, the data only included workers who registered with the Commission. Health centers have reported a decrease in the number of farmworkers who are accessing care, but this could be due to several factors:

- South Carolina's immigration law now requires employers to document the legal status of new employees
- Farms are closing due to the tobacco lawsuit
- Farmers are sharing workers
- Farmworkers are settling in the area and moving into other types of work
- CHCs that are not MHCs do not capture data on MSFWs who use their facilities

The lack of prenatal care for farmworker families has led to an increase in the infant mortality rate. Medicaid covers delivery, but it does not cover prenatal care. Many women in the MSFW community are reluctant to apply for Medicaid because of the documentation requirements. SCPCA is trying to find matching funds for outstation prenatal services and outreach workers who can enroll patients in Medicaid.

SCPCA received a DHEC grant to create an outreach network to promote integrated care. The quarterly meetings are well attended by staff from all health centers. Through the program, Medicaid staff train outreach workers in Medicaid application procedures, while the outreach workers inform Medicaid staff about issues in the field. Other activities include training for all health centers on the range of services that are available for MSFWs and an introductory Spanish course that provides cultural information and basic language skills. SCPCA is committed to increasing cultural competence across the network, with an emphasis on training frontline staff.

The State budget deficit has decreased funding for services provided to MSFWs. Ms. Woodard stated that the existing resources would be sufficient if health departments, health centers, and mental health centers could collaborate to eliminate duplication of services.

Medicaid portability is a significant barrier to access. South Carolina has been working on an initiative with North Carolina, Georgia, and Florida, similar to the portability model developed in Texas.

South Carolina has a shortage of primary care providers and allied health professionals, including a significant shortage of dentists in rural areas. SCPCA is trying to identify creative ways to provide dental care for MSFWs, including mobile vans.

The major health needs of MSFWs in South Carolina include diabetes, hypertension, tuberculosis, dental care, skin disorders, substance abuse, and depression. Primary care providers often overlook depression in minority patients because they are not trained to conduct culturally competent mental health screenings.

The lack of information regarding available services and limited knowledge of how to navigate the health care system create barriers to care for all patients, not just MSFWs. Additional barriers for MSFWs include the lack of transportation, the lack of translation and interpretation services, and the lack of coverage for prenatal and specialty services. Ms. Woodard stressed the importance of developing patient-centered *health care* homes, as opposed to patient-centered *medical* homes.

Discussion

CAPT Lopez noted that many of the issues identified by Ms. Woodard were prevalent across the country, especially the impact of immigration policies and the economy. The job of the Bureau of Primary Health Care (BPHC) is to educate the public that health centers serve all patients, because disease does not recognize borders. CAPT Lopez also noted that many MSFWs are separated from their families, which can contribute to substance abuse and depression.

Mr. DuRussel asked whether South Carolina had used BPHC service expansion funds to provide dental and mental health services. Ms. Woodard replied that the grant process is very competitive, and it is difficult for South Carolina to compete with states such as California. She encouraged BPHC to ensure all CHCs are prepared to provide the full range of services needed by MSFW patients, and she stressed the importance of integrating behavioral health services with other health services.

Responding to a question from Dr. Gómez, Ms. Woodard stated that SCPCA has a strong collaborative relationship with the Migrant Head Start program.

Mr. Garcia asked whether any Medicaid eligibility workers were stationed in South Carolina. Ms. Woodard replied that South Carolina utilized this approach in the 1990s. When State funding for eligibility workers was reduced, South Carolina trained intake workers to assist patients with their applications. This approach seems to be working.

Andrea Weathers asked about trends in the distribution and demographics of farmworkers in South Carolina. Ms. Woodard's colleague, Maria Martin, stated that MSFWs have become more mobile and are staying for shorter periods. Many seasonal workers have left South Carolina due to concerns about the immigration law. Carolyn Davis noted that the number of Hispanic patients at her clinic decreased along with the decline in housing construction, but she had not seen a similar trend among the MSFW population.

Beaufort-Jasper-Hampton Comprehensive Health Services, Inc. (BJHCHS)

Ms. Davis is a Family Nurse Practitioner (FNP) at BJHCHS as well as the director of the migrant health program. BJHCHS has a long history of providing farmworker health services, starting with a summer program in the 1980s. At that time, the program's major shortcoming was its inability to provide follow-up and referral services.

BJHCHS now offers comprehensive services throughout the year and can provide any service for which a need is identified, including ophthalmology and podiatry. The migrant health clinics operate during evening hours to accommodate farmworkers' schedules, and they provide transportation during daytime and evening hours. A full-time outreach coordinator manages outreach services across nine counties. BJHCHS offers nutrition and education programs in the field, as well as dental exams and treatment. The Migrant Head Start program provides physicals for children of MSFWs.

BJHCHS participates in the Migrant Clinicians Network (MCN) record keeping system. Services are coordinated through partnerships with other local organizations, including churches and health departments. BJHCHS also provides learning opportunities for medical students and other health professionals.

Many farmworkers have settled in the area in recent years. Those who migrate come primarily from Florida, Mexico, and Haiti. Most French-Creole speaking farmworkers are employed in packing sheds. Many farmworkers come with their families, but there are also single males and females. Most have no personal transportation, no insurance, and very little money.

Over-immunization is a potential problem for MSFW patients due to incomplete record keeping. The children are up to date on their immunizations, but many adults are not. Thirty to 40 percent of the children have dental health problems, and an increasing number are overweight. The Migrant Head Start program keeps children safe, educated, and well fed, but the cumbersome enrollment procedures are a barrier.

Pesticide incidents, farm accidents, and sexually transmitted diseases (STDs) have decreased in recent years. Most pregnant women have prenatal care, but they do not have regular pap tests or breast screenings. Female patients often present with abdominal pain and fatigue due to underlying depression. Males present with musculo-skeletal issues, fatigue, and eye issues. More patients have chronic care needs, such as diabetes and hypertension. Many migrant patients have problems associated with poor nutritional habits, such as obesity and significant vitamin deficiencies. Food storage barriers, such as lack of a refrigerator, contribute to this problem.

Dental care is a significant need. Half of the migrant patients who seek dental care at BJHCHS have never seen a dentist. The clinics are screening more people, but they do not have enough dentists to treat them all. The ophthalmology clinic at BJHCHS has been very successful.

Ms. Davis agreed with Ms. Woodard that health centers should focus on creating a patient-centered health care home. Patients at CHCs have better health outcomes than those who see private physicians because health centers provide comprehensive, integrated services, education, and outreach.

Critical issues include the need for better follow-up care, better record keeping to ensure continuity of care for patients with chronic disease, funding for specialty services, more dental providers, ophthalmology care, affordable medication programs that are transferable across states, certification for medical interpreters, and more primary care providers.

Ms. Davis thanked HRSA for the increased emphasis on, and funding for, outreach and new access points, which has enabled BJHCHS to provide additional services for an important and delicate population.

Discussion

Dr. Gómez informed the Council that Ms. Davis had been appointed by Secretary Sebelius as a new member of the Council and will attend the February 2011 as a new member.

Dr. Page asked how BJHCHS was able to provide interpreters for multiple languages. Ms. Davis stated that the program had included these services in its budget for many years, using base services funding.

Ms. Woodard brought up the issue of electronic medical records (EMRs) and how it impacts health care for MSFWs. CAPT Lopez indicated that EMRs would help to reduce duplication of efforts and improve follow-up care for mobile populations. An issue discussed was how to find ways to overcome mistrust of government to get patients enrolled. HRSA has funded pilot projects to develop local networks around EMR and hopes to expand this on a national basis.

Dr. Weathers asked the speakers to identify one or two top priorities. Ms. Davis cited the need for more dentists and the need for electronic health records to manage care for patients with chronic problems. Ms. Woodard cited the need for funding to improve health literacy, including accurate translation of instructions for medications, and the need for all CHCs to adopt an appropriate mindset for serving farmworkers.

Office of Special Population Health (OSPH) Update

- CAPT Henry Lopez, Jr.

CAPT Lopez thanked Council members for their excellent work on behalf of MSFWs and their families. After expressing his commitment to arrange for Secretary Sibelius to meet with the Council in February, he provided an update on the migrant health program and the Affordable Care Act (ACA) and described recent organizational changes within BPHC.

During calendar year (CY) 2009, health centers served 18.8 million patients, with 73.8 million patient visits. The goal of the ACA is to reach 40 million patients by 2015. This will require a significant increase in facilities and staff.

The Uniform Data System (UDS) reports health outcomes of CHC patients, such as the percentage of women who enter prenatal care in the first trimester, the percentage of low birth weight babies, the percentage of children who receive all recommended immunizations by their second birthday, the percent of hypertensive patients with blood pressure at or lower than 140/90, and the percent of diabetic patients with HbA1c at or lower than 9. The Council discussed the need to include health issues of special populations, including MSFWs, in these performance measures.

Funding through the American Recovery and Reinvestment Act (ARRA) enabled health centers to serve 2.7 million new patients, including more than 1.5 million new uninsured patients, and to add 10,000 health center jobs in 2009. Next steps include funding for 1,600 new or improved health center sites, 650 health centers with new equipment or health information technology (HIT) systems, and 380 health centers with new or enhanced EHR systems. BPHC recently funded an HIT network among migrant health centers in the Finger Lakes region of New York, which it hopes to roll out on a national basis.

The ACA provides \$11 billion in funding over the next five years for the operation, expansion, and construction of health centers throughout the nation, which will double the number of patients seen by health centers. Most of these funds (\$9.5 billion) are targeted to create new health center sites in medically underserved areas (MUAs) and expand preventive and primary health services at existing sites, including oral health, behavioral health, pharmacy, and/or enabling services. \$1.5 billion will support major construction and renovation projects at CHCs nationwide.

Funding opportunities for fiscal year (FY) 2011 include:

- \$250 million to continue New Access Points and Increased Demand for Services funding initiated under the ARRA
- \$250 million for Health Center New Access Points, including new health centers and satellite sites
- Funding for expanded services to enable existing health centers to serve additional patients
- \$25 million for Behavioral Health Service Expansion
- Planning grants
- National/regional/state cooperative agreements for new site development, expansion planning, development of patient-centered medical/health homes, meaningful use of EHR technology, and workforce recruitment and retention.

Detailed information about these funding opportunities is available on the BPHC website: <http://bphc.hrsa.gov/>.

Other key provisions of the ACA include:

- National Health Service Corps and workforce programs
- Teaching Health Centers that will enable health centers to establish residency programs to train their own providers
- School-based health centers
- Negotiated rulemaking for shortage
- Community-based collaborative care networks

The inclusion of community-based collaborative care networks reflects the Obama administration's commitment to collaboration. The Department of Health and Human Services (HHS) is working with the Departments of Education, Labor, and Housing and Urban Development to meet the needs of communities.

HRSA's strategic priorities for FY2011 are to: 1) improve access to quality health care and services, 2) strengthen the health care workforce, 3) build healthy communities, and 4) improve health equity. To succeed in these areas, BPHC must work together with partners such as the Council.

BPHC has been reorganized to prepare for program growth, promote the integration of service delivery programs, improve the coordination of internal and external technical assistance and training activities, and provide increased administrative service and support for grantees and staff. BPHC now has four regional operating divisions (used to have only three), plus the Division of National Hansen's Disease Program continues to be part of the Bureau. The Bureau also has two new offices, the Office of Training & Technical Assistance Coordination and the office of Administrative Management.

The Office of Minority and Special Populations has been renamed the Office of Special Population Health (OSPH), which more accurately reflects its mission and focus. The staff has more than doubled, from 9 to 21 positions, including an Operations Director as of December 1. The Office now has two branches: Health Services, headed by LDCR Sonsy Fermin, and Health Systems, headed by Tiffane Smith. Israel Garcia, who previously served as the Mid-Atlantic Migrant Health Coordinator, recently joined the staff of the Health Services Branch to work on migrant health and behavioral health issues.

CAPT Lopez will continue to direct the activities of OSPH and to advocate on behalf of the Council. He urged Council members to let him know what they need and to become familiar with the information on the BPHC website. <http://bphc.hrsa.gov>.

CAPT Lopez invited Christian Castro and Yanira Arias to describe the activities of the Latino Commission on AIDS. Mr. Arias is the director of the Latinos in the Deep South project, which conducted roundtables in seven Southern states in 2007 and 2008 to identify key issues in providing services to Latinos with AIDS. The second phase of the project is working with the Office of AIDS Research at the National Institutes of Health (NIH) to develop partnerships and action plans. A forum held in November 2009 identified a pressing need for data and research.

A second forum held in June 2010 developed priorities for community-based research. The project is currently working to engage researchers and community stakeholders to address these issues. Ms. Arias described her efforts to develop community-based partnerships, develop leaders who can implement a model of collaborative leadership, and build coalition networks at the local, regional, and national levels. Mr Castro and Ms. Arias stressed their desire to learn from and collaborate with the Council. Dr. Gómez invited them to make a formal presentation at a future meeting so that both groups could identify potential partnerships.

Discussion

Dr. Weathers asked Mr. Castro how his organization would become aware of issues of farmworkers. Mr. Castro replied that a local organization in South Carolina conducted an extensive mapping exercise to identify the needs in the community. The next step is to build a coalition and to ensure that the migrant voice is represented.

Migrant Health Center Program Update

- Marcia Gómez, MD

Dr. Gómez reminded the Council that the mission of the BPHC is to improve the health of the Nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services. BPHC's primary focus remains on ensuring that health centers provide high quality, state-of-the-art services.

The reorganization into four regional operating divisions will accommodate growth, and the new structure of OSPH will enable it maximize the services it provides. It is an exciting time, with new staff and new ideas.

The most recent UDS data show that the migrant health program served 864,996 patients in CY 2009. Most of these patients were seen by the 155 migrant health grantees. The patient demographics have not changed significantly. The number of uninsured patients has increased slightly, to 53%. Eighty-three percent of the migrant health patients are under 100% of the Federal Poverty Level (FPL), and 98% are below 200% of the FPL.

There are now seven Regional Migrant Health Coordinators. In response to the Council's recommendations, an additional position was created to cover the mid-Southwest region.

Dr. Gómez announced that three new members had been approved to serve on the Council, with terms to begin in November 2010. Six members will rotate off the Council in November. OSPH has identified qualified nominees for four of those positions. Dr. Gómez urged Council members to assist in identifying potential candidates for the remaining two positions. Candidates must be consumer board members of a migrant health center.

Dr. Gómez noted the growing trend within Federal agencies to conduct virtual meetings. BPHC supports face-to-face meetings for the Council; but the Council needs to start considering this

option as a possible mean to officially meet. The Council discussed that this has been tried in the past and that virtual meetings could present barriers for some members of the Council and therefore, may be an unrealistic expectation for this Council.

Dr. Gómez distributed a table summarizing the Council's meetings, membership, recommendations, achievements, and challenges for FY 2000 through FY 2010. She noted that the Council's recommendations resulted in funding for service expansion and outreach for special populations and led to measures to ensure that the grant review panels for these programs included individuals who understand special populations.

Dr. Gómez informed the Council that the National Association of Community Health Centers (NACHC) Farmworkers Committee had invited the Council to make a presentation at the Community Health Institute this summer. Since this was not possible due to the invitation being a short notice and following Mr. Michael DuRussel (Vice-Chair) request, OSPH provided NACHC with a list of the Council's recommendations from their last meeting (May 2010).

HRSA recently convened a working group to review and revise the criteria for designation as a Medically Underserved Area (MUA) or a health professions shortage area (HPSA). To ensure that special populations would be represented, the National Center for Farmworker Health submitted an application with Dr. Alice Larson to represent Special Populations at this group; Ms. Bobbi Ryder, NCFH CEO was Dr. Larson's backup in the application. Dr. Larson and Ms. Ryder were appointed as a member (and alternate) of the workgroup and would address the Council on the second day of this meeting.

Dr. Gómez urged Council members to remain informed of announcements issued by BPHC that could affect MSFWs, including rules, regulations, and funding opportunities. She offered to assist the Council in convening subcommittee meetings if necessary to address specific issues that may arise.

Noting the emphasis on collaborative efforts, Dr. Gómez encouraged the Council that when discussing recommendations to the Secretary, to think about how ways they could recommend the Secretary to collaborate with other Departments of the Federal government to improve health care for MSFWs.

Issues for Discussion with the Secretary

Meeting as a committee of the whole, the Council discussed potential issues for a meeting with the Secretary. Council members identified a wide range of concerns, including: the impact of the ACA on employers; Medicaid portability; continuity of care; workforce development; affordable medications; voucher programs; work-related injuries and workmen's compensation; HIT; integrated services at all MHCs, including oral health, behavioral health, substance abuse counseling, and ophthalmology services; accountability; the aging farmworker population; occupational safety hazards for youth; grant writing challenges and the review process for grant applications; funding for additional MHCs; collaboration/partnerships to

improve delivery of migrant health services; public charge guidance; and hospitalization coverage for MSFWs.

Dr. Gómez noted that the current New Access Point grant competition would award 10 points for programs that provide services to special populations, including MSFWs. Dr. Page stated that this created an important incentive for health centers to serve these populations.

After further discussion, the Council narrowed the topics down to two priority issues: Medicaid portability and continuity of care (including hospitalization coverage, and collaboration/partnerships).

Dr. Weathers, Mr. DuRussel, Dr. Page, Ms. Sanchez, and Ms. Canales agreed to prepare a letter to invite the Secretary that would include a summary of the key issues related to the priority topics and the Council's recommendations in these areas. Dr. Gómez offered to make a conference line available and to participate in the call if requested.

Mr. Garcia noted that the regional coordinators were a valuable resource for the Council. Dr. Gómez offered to ask the coordinators to provide a list of issues and recommendations related to their priority topics.

Next Meeting Dates

The Council agreed to meet on February 8-9, 2011 in Washington, DC. The meeting will be held at the Humphrey Building or a hotel in downtown Washington, DC to facilitate a meeting with the Secretary.

The Council agreed to hold its spring meeting on May 14-15, 2011 in Delray Beach, Florida, immediately following the NACHC National Farmworker Health Conference. The agenda for this meeting will include a session of testimonies.

Dr. Page proposed two potential topics for presentations: models for collaboration, and the impact of the new CHC residency opportunities on the migrant health program. Dr. Gómez suggested that the Administration of Children and Families (ACF), which administers the Migrant Head Start Program and the Department of Education could address collaboration models, and she could invite a speaker from HRSA to discuss new initiatives. The Council should let her know which speakers they would like to invite.

Recap for Next Day

Mr. DuRussel summarized the presentations and discussions of the first day and adjourned the meeting at 4:35 p.m.

WEDNESDAY, OCTOBER 20

Review Agenda for Second Day

- Andrea Weathers, Chair

Dr. Weathers began her tenure as chair by calling the meeting to order and reviewing the agenda for the second day of the meeting. She then called for a discussion of issues for recommendations, moderated by Mr. DuRussel.

Council Discussion

- Michael DuRussel, Co-Chair

Council members reviewed a table summarizing the Council's recommendations from 2000-2010. Dr. Weathers asked if there were any key issues from previous years that could inform the new recommendations. Dr. Gómez noted that several new initiatives were a direct response to the previous set of recommendations, such as incentives in the current round of New Access Point grants for programs that address the health needs of special populations. CAPT. Lopez urged Council members to encourage health centers in their home areas to apply for these grants.

Council members discussed potential recommendations related to ACA funding. One suggestion was to incorporate incentive points for special populations in all grant programs, including Service Expansion, Expanded Medical Capacity, and Planning Grants. Another suggestion was to require grant applications to include specific, measurable outcomes for special populations and to provide examples of effective collaborations.

Council members discussed a potential recommendation regarding training and orientation for MSFWs on environmental health hazards, such as pesticide use. Roberto Gonzalez stated that prevention is less expensive than treating health problems resulting from pesticide exposure. Council members suggested delivering the training could be delivered through a webinar series or train-the-trainer programs for outreach workers. They noted the importance of creating awareness on all levels—including MSFWs, outreach workers, and providers—because environmental health affects the continuum of care. Council members also suggested linking environmental health with clinical performance measures. Dr. Gómez informed the Council that HRSA was working with the Environmental Protection Agency (EPA) and the Department of Labor to incorporate questions on environmental health into the National Agricultural Worker Survey (NAWS). Migrant Clinicians Network (MCN) and Farmworker Justice are also involved in the effort of T/TA to providers around how to best diagnosed issues with pesticide exposure/prevention. Dr. Weathers suggested that this issue could guide the Council's thinking regarding collaboration.

Council members identified a number of other issues for potential recommendations, including chronic illness, collaborations at the Federal level, clinical performance measures that reflect the needs of MSFWs, mechanisms to track referrals (links to continuity of care, chronic illness),

and mechanisms to correctly identify MSFWs who receive services at CHCs that are not migrant health grantees.

CAPT Lopez informed the Council that Dr. Gómez and HRSA's Chief Medical Officer, Dr. Hayashi, were working on linking health outcome measures to performance measures. The fact that clinical outcome data are not disaggregated makes it difficult to determine specific outcomes for MSFWs. Moreover, some patients do not want to identify themselves as MSFWs.

A representative of Migrant Head Start noted that their program tracks health data on migrant children and reports the data to the national office. Dr. Gómez suggested that this could be a potential area for collaboration, and CAPT Lopez stated that a Memorandum of Agreement between HRSA and Head Start was being finalized. Dr. Weathers noted that identifying MSFWs and tracking their health outcomes was related to the issue of accountability. Mr. Garcia noted that capturing MSFWs in UDS data is the only way to document the need for migrant health services.

At the Council's request, Dr. Gómez reviewed the budget request for the ACA and noted that BPHC was preparing for exponential growth once the budget is approved. It will be important for the Council to assess the potential impact of this funding for MSFWs.

Future Directions of the Council

- Dr. Andrea Weathers, Chair

Meetings

The Council agreed that the current schedule of meetings works well. The schedule includes three face-to-face meetings per fiscal year, two of which are generally held in conjunction with larger meetings such as the National Farmworker Health Conference. The Council can also meet by conference call as needed; but keep in mind that the attendance to these meetings may be a much smaller percentage since many members may not have access to phones and/or may not be able to stay on the line for the period of time required by a meeting.

Testimony Sessions

Dr. Weathers noted that in May 2010 the Council agreed to obtain future testimonies in a closed session, with minutes generated. The Council debated whether the minutes from the testimony portion of the meeting should be part of the public record. It was agreed that the testimony minutes would be available from OSPH upon request, but they would not be posted on the Council website.

The Council requested a summary of the issues that were identified in recent testimonies. Dr. Gómez agreed to prepare a summary for the February 2011 meeting.

Dr. Gómez provided an overview of how the questions were developed for the two previous round of testimonies. The Council agreed to identify key issues and some potential questions for the next round of testimonies.

The Council noted that a closed session would have to be facilitated by a Council member or BPHC staff. Dr. Gómez will investigate if records for closed sections of meetings could be maintained confidential.

Speakers for Future Meetings

The Council agreed to issue a standing invitation to John Ruiz of NACHC.

In addition to a possible meeting with the Secretary, the Council proposed the following speakers for February 2011:

- HRSA/BPHC staff, including Jim Macrae and Seiji Hayashi
- HRSA Office of Health Information Technology
- John Ruiz (NACHC)
- Roger Rosenthal (Migrant Legal Action Program)
- Bobbi Ryder (National Center for Farmworker Health)
- Regional Coordinator for Texas or Jana Blasi (update on Medicaid portability)
- Regional Coordinators for the East Coast
- Christian Castro and/or Yanira Arias (Latino Commission on AIDS)

The Council proposed the following speakers for May 2011:

- Representative of the Florida Primary Care Association
- Representative of a local CHC
- John Ruiz (NACHC)
- Migrant Clinicians Network
- Farmworker Justice
- Chair of the Farmworker Health Network

The Council agreed that its first meeting for FY 2012 would be held in November 2011, in conjunction with the Midwest Stream Forum. The Council will identify speakers at a later date.

Nominations for Council Positions

The Council discussed strategies to recruit candidates for the Council who are both MSFWs and board members of a CHC. Council members suggested publicizing the positions through State Primary Care Associations, State Offices of Rural Health, and NACHC. Announcements should specify the qualifications for the positions and should include a nomination form. Council members noted that most MSFWs have limited experience serving on advisory boards, and many do not have Internet access.

Negotiated Rulemaking Committee Process

- Dr. Alice Larson

Dr. Larson described the negotiated rulemaking committee process that was recently launched to review and revise regulations for the designation of Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs).

The HPSA designation is based on the ratio of providers to the population and is one factor that is used to determine eligibility for programs that improve access to health care. An organization must have a HPSA designation in order to start a CHC. The MUA/MUP designations are used as a basis for awarding grants to CHCs.

Current regulations regarding the HPSA designation were drafted in the 1970s and are reviewed every 3-4 years. The MUA/MUP designations were drafted in the 1980s and have never been reviewed. Previous attempts to revise them met with significant negative comments. The negotiated rulemaking process is an attempt to revise these designations with stakeholder input.

The Section 330 legislation stipulates that health centers that serve MSFWs do not need a separate MUP designation to apply for funding through the migrant health program. However, there is no guarantee that the Section 330 program will still exist in 20 to 30 years. This makes it critical to ensure that MSFWs are specifically included in the MUP designation criteria.

The legislation establishing the negotiated rulemaking committee stipulates that the criteria must be “simple.” The committee will develop interim final regulations that will go into effect following a 30-day comment period. The Committee consists of 28 members who represent various constituencies, such as NACHC and the Rural Health Association, as well as researchers and other informed individuals. HRSA will publish any regulations upon, which consensus is achieved.

Dr. Larson represents three special populations: MSFWs, Individuals experiencing Homelessness, and Public Housing Residents. Bobbi Ryder is Dr. Larson’s alternate at these meetings. John Snow, Inc. is serving as a technical consultant to the committee and has provided a suggested methodology for calculating need. Many committee members would like to have a national database, but this would not work for special populations.

The Committee is addressing a number of issues:

- Whether the HPSA/MUA designations should be separate, or combined
- How to define the population
- How to count providers
- How to include mid-level providers
- How to reflect health status issues
- Which health care access barriers will be included in the criteria
- How to determine the threshold level for the physician/population ratio

- Whether to include a scoring system to prioritize grant applications

Health access barriers are a major factor in the designation criteria. Access barriers for MSFWs include transportation, language, clinic hours, and health conditions. Committee members representing the Native American and Asian communities are also concerned about language barriers.

A number of other groups are seeking designation as special populations, including persons with disabilities, lesbian/gay/bisexual/transgender individuals. The November meeting will be devoted to a discussion of the MUP designation.

Background documents and minutes are available on the official website:

<http://www.hrsa.gov/advisorycommittees/shortage/index.html>

Discussion

Mr. DuRussel noted that funding is available at the Federal level, but State and local governments are facing budget shortfalls. Dr. Larson replied that the core concepts of health care reform would not go away. Given the fact that baby boomers will be eligible for Medicare beginning next year.

John Ruiz observed that a MUP designation is conferred by statute when an organization receives MHC funding, and he expressed concern that establishing a separate designation would make it more complicated to establish MHCs. He also noted that it is nearly impossible to establish a MHC without having an existing CHC, which requires an organization to have HPSA or MUA designation beforehand.

Dr. Larson stated that the definition could go many ways. Many Federal programs use the HPSA and MUA designations. It is very likely that the MUA/MUP designations will be reviewed on regular basis going forward. The point system that is currently used for MUAs could work well for MUPs.

Carolyn Davis cautioned against including too many mid-level practitioners in the HPSA designation, because State laws vary dramatically. Dr. Larson agreed and noted nurse practitioners and physician assistants are not considered as primary care providers in every state.

Dr. Page asked how the HPSA designation accounts for primary care providers who still hold a professional license but are no longer in practice. Dr. Larson replied that the burden is on State agencies. The system to review existing HPSAs uses the list of licensed providers as a starting point for a survey. This system could be adopted for determining the need for a new HPSA designation.

Dr. Larson requested the Council's assistance in obtaining input from those in the field for the November meeting.

NACHC Update

- John Ruiz

Mr. Ruiz met with a visitor from Mongolia to discuss the challenges of providing health care in rural areas. The MHP is successful due to entrepreneurship, but if one part fails the system could collapse.

The government is currently operating under a continuing resolution until December, with flat funding. Final budget decisions will be made by the lame duck Congress. Legislation has already been proposed to cut the ACA funding by \$6 billion. It is critical to encourage the patient population to be informed and to participate in the democratic process.

NACHC is working on obtaining Federal Tort Claims Act (FTCA) coverage for volunteers.

Obtaining ACA funding for MHCs is a challenge. Grantwriters are charging \$40,000-\$45,000 for their services, making it difficult for small programs to compete. The application guidance is complicated, especially in the area of data requirements.

NACHC recently held a conference call with Jim Macrae that addressed issues in five areas:

- Community development: Reviewers for MHC grants should have relevant experience with these programs.
- Expansion: HRSA has an unprecedented opportunity to create a model MHC program that provides integrated services, including oral and behavioral health. Priority should be given to existing centers that have a demonstrated ability to serve MSFWs.
- Meaningful use: Data collection impacts continuity of care. The Council should be concerned about identifying and integrating health-center controlled networks for data collection.
- Patient centered medical home: The models that have been proposed to date do not address continuity of services for MSFWs. Portability is an important element of continuity of care for MSFWs and must be included in the model that is adopted. NACHC would welcome the Council's assistance in moving this issue forward.
- Workforce expansion: It is difficult to obtain bilingual staff at all levels. MHCs should be at the top of the list. Workforce development must include community health workers. They are a key element of a medical home and should be trained and compensated accordingly.

BPHC recently issued a Program Assistance Letter (PAL) stating that the definition of agriculture would be replaced with the statutory definition. NACHC recommended that grantees utilize the North American Industry Classification System (NAICS) includes two subcategories for agriculture: crop production and animal production. BPHC and HRSA will determine whether to utilize it, and what categories will be included.

Agriculture has changed since the MHP was created in 1962, but there is still a need to create mechanisms to provide health services for migrating individuals. Coverage mandated by the ACA does not include undocumented individuals. Health centers must maintain programs to provide health care for patients regardless of their legal status.

Mr. Ruiz noted that the closing plenary session of the National Farmworker Health Conference in May will focus on the needs and concerns of MHP grantees. He invited the Council to participate in that session.

Mr. Ruiz proposed a special populations summit to identify needs and set priorities accordingly. The summit would address questions such as: Where are we going with the program? What are our long-term plans? How should the ACA funds be allocated?

Discussion

Dr. Gómez noted that NACHC and other constituents provided input regarding the special populations' designation.

Formulation of Recommendations

Dr. Weathers reviewed the shortlist of topics developed during the previous day and asked if there were any additional topics.

Dr. Page stated that the presentations during the second day underscored the importance of the program guidance and the review process for grant programs.

Mr. DuRussel noted that workforce development is crucial to care for an expanded patient population. He expressed concern that migrant health issues could get lost during the rapid expansion.

Council members discussed the relationship between hospitals and MHCs. Dr. Gómez noted that hospitals often work in partnership with MHCs, but they cannot establish their own MHC due to Section 330 requirements regarding non-profit status and board composition. The Council agreed that a working collaboration with a community hospital facilitates continuity of care for MHC patients.

Dr. Page suggested that the letter should emphasize the impact of the ACA on access to services for MSFWs and the importance of continuity of care within CHC program. Grant applications should be required to specify expected outcomes, and the UDS should provide data on continuity of care for MSFWs, including clinical outcomes and tracking of referrals.

The Council discussed the issue of portability and agreed to recommend that Medicaid should be accepted across State lines to decrease dependence on Section 330 funds.

The Council discussed the medical home concept. Dr. Gómez noted that MHCs have served as medical homes for MSFWs for many years, and this was now becoming a national expectation. A good definition of this concept is available at: www.ncqa.org.

Dr. Page offered to prepare the first draft of the letter and send it to Dr. Weathers, Mr. DuRussel, and Mr. Lopez by October 29, with a copy to Dr. Gómez. The group would submit comments to Dr. Page by November 4, and he would submit a draft to Dr. Gómez by November 8.

Remarks from Departing Members

Dr. Gómez reminded the Council that Frances Canales, Michael DuRussel, Roberto Gonzalez, Diana Sanchez, Enedelia Cisneros, and Christina Ramos would be retiring from the Council in November. She invited the departing members to share some remarks.

Ms. Sanchez recalled that she felt lost when she first started, but she eventually realized that she knew the issues. She was honored to work with the Council members and staff, and it was a special honor to have been re-appointed for a second term. She stressed that it was important for the community to be aware of the Council's work.

Mr. DuRussel said he had worked with MSFWs for most of his life, and they had become like his extended family. He was honored to have the Council visit his farm and see what they were trying to do for their workers, and he expressed his commitment to doing more to ensure that all farmworkers have access to medical care.

Ms. Canales said she was blessed and honored to serve on the Council. It was a rare and moving experience to be surrounded by people who really care about MSFWs. The Council must keep doing this work.

Mr. Gonzalez had a wonderful experience and was very happy to have served on the Council. He urged the Council to continue to provide good advice to the Secretary to address the needs of farmworkers. He expressed appreciation for the staff and his fellow Council members, and he hoped that another representative of Clinical del Norte would participate on the Council.

Dr. Gómez thanked the departing members for their passion and commitment. This group made a difference for MSFWs. Farmworker members keep the Council grounded and mindful of its mission, and it was especially helpful to have growers represented on the Council.

CAPT Lopez expressed appreciation that the Council accepted him on his first day in his new position. He promised that as long as he is in that position, he would do everything possible to advocate on behalf of the Council. He assured Council members that he would welcome their input, even after their terms have ended.

Logistical Information

- Gladys Cate

Ms. Cate thanked the Council for their dedication. She noted that she prepares a report to Federal Advisory Committee each year, and she is always proud of the Council's outstanding accomplishments.

Ms. Cate reviewed the logistical information for expense reimbursements, honorarium, and per diem allowance. Following her presentation, Dr. Weathers asked for a motion to adjourn. Dr. Page made the motion, which was seconded by Mr. Lopez and passed unanimously.

Dr. Weathers adjourned the meeting at 5:48 p.m.

ACTION ITEMS

- Dr. Gómez will ask the regional coordinators to provide a list of issues and recommendations related to the Council's priority topics.
- Dr. Gómez will prepare a summary of issues identified in recent testimonies for the February 2011 meeting.