“Improving Quality Health Care Access for Migrant and Seasonal Agricultural Workers and their Families”

Part I: Migrant and Seasonal Head Start Partnership Models

Tuesday, March 3, 2015
2:00 – 3:00 pm, ET

Hosted by
Bureau of Primary Health Care
Office of Quality Improvement
Strategic Partnerships Division
AGENDA

• Welcome & Introductions
  – CDR Jacqueline Rodrigue, Branch Chief, BPHC
  – LT Israel Garcia, Senior Public Health Analyst, BPHC

• Bureau of Primary Health Care Priorities
  – Dr. Seiji Hayashi, Chief Medical Officer, BPHC

• Migrant and Seasonal Head Start Program Overview
  – Guadalupe Cuesta, Director, National Migrant and Seasonal Head Start Collaboration Office

• HC & MSHS Partnerships Model
  – Teri Buchanan, Sr. Vice President, Family Health Centers of Southwest Florida, Inc.
  – Susan Bauer, Executive Director, Community Health Partnership of Illinois

• Strategic Partnerships and Resources
  – Joe Gallegos, Senior Vice President, Western Operations, NACHC

• Questions and Answers
HRSA & ACF
Strategic Partnership

Major Accomplishments

• Developed an MOU between Administration for Children and Families, Office of Head Start and HRSA, Bureau of Primary Health Care, on November 29, 2012.

• Developed the Effective Partnerships Guide: Improving Oral Health for Migrant and Seasonal Head Start Children and Their Families

• Developed a dual web widget Finding a Health Center & Migrant and Seasonal Head Start Program (Posted on HRSA and ACF’s websites)

• Conducted workshops at three Migrant Health Stream Forums with over 600 participants

• Trained CEOs of Migrant and Seasonal Head Start programs

• Hosted a National Enrichment Webinar for Health Centers & Migrant and Seasonal Head Start Programs
BUREAU OF PRIMARY HEALTH CARE PRIORITIES

Seiji Hayashi, MD, MPH, FAAFP
Chief Medical Officer & Senior Advisor for Special Populations
Health Center Program
Calendar Year 2013

Program Grantees (All)

SERVED 21.7 MILLION PATIENTS
93% Below 200% poverty
73% Below 100% poverty
35% Uninsured

1,131,414 homeless individuals
861,120 agricultural workers
227,665 residents of public housing

Provided 86 MILLION PATIENTS VISITS
in 1,202 organizations across more than 9,208 service sites

Empl oyed More Than 156 THOUSAND STAFF
including 10,733 physicians, 8,156 nurse practitioners, physicians assistants, and certified nurse midwives

Migrant Health Centers

790,226 Patients Served
- 97% Below 200% Poverty
- 93% Racial/Ethnic Minorities
- 52% Uninsured

782,651 Agricultural Workers
35,479 Homeless Individuals
4,403 Veterans

Provided 3.1 Million Patient Visits
Employed Over 34,000 Staff
- 2,147 Physicians
- 1,617 NPs, PA, & CNMs
73% Spanish Speaking

- White, 16%
- Hispanic, 79%
- Other, 3%
- African American, 1%

73% Foreign Born

67%

6%
## Current Program Impact: Key National Indicators

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% of HC with EHR Implementation</td>
<td>90%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>EHRs at all sites used by all providers</td>
<td>79%</td>
<td>88%</td>
<td>82%</td>
</tr>
<tr>
<td>EHRs at some sites used by some providers</td>
<td>11%</td>
<td>8%</td>
<td>14%</td>
</tr>
</tbody>
</table>

### Patient-Centered Medical Home Recognition (44% as of March 2014)

| % of HCs Achieving PCMH Recognition                                                | 59%                 | 77%                 |

### Health Center Meeting/Exceeding Healthy People 2020 Goals

| Meet/Exceed Hypertension Control Goal of 61%                                     | 59%                 | 58%                 | 55%                 |
| Meet/Exceed Diabetes Control (HbA1c ≤9) Goal of 84%                              | 11%                 | 7%                  | 4%                  |
| Meet/Exceed Early Entry into Prenatal Care Goal of 78%                            | 37%                 | 37%                 | 35%                 |
| Meet/Exceed Low Birth Weight Goal of 7.8%                                         | 61%                 | 60%                 | 67%                 |
Primary Care: Key Strategies

- Increase access to primary health care services for underserved populations
- Modernize the primary health care safety net infrastructure and delivery system
- Promote a performance-driven and innovative internal organizational culture
- Improve health outcomes for patients
Administration for Children and Families/Migrant and Seasonal Head Start Program

Guadalupe Cuesta, Director, National Migrant and Seasonal Head Start Collaboration Office

Email: gcuesta@fhi360.org
Tel. 202.884.8594
Migrant and Seasonal Head Start Programs Located in 37 States
<table>
<thead>
<tr>
<th>Agency Types</th>
<th>Migrant and Seasonal Head Start Programs (56)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Action Agency (CAA)</td>
<td>13</td>
</tr>
<tr>
<td>Government Agency (Non-CAA)</td>
<td>2</td>
</tr>
<tr>
<td>Private/Public for profit (e.g., for-profit hospitals)</td>
<td>1</td>
</tr>
<tr>
<td>Private/Public non-profit (Non-CAA) (e.g., church or non-profit hospitals)</td>
<td>36</td>
</tr>
<tr>
<td>School System</td>
<td>4</td>
</tr>
</tbody>
</table>
1. Birth to **compulsory** school age

2. Income below federal poverty guidelines

3. 51% of income from agriculture within the last 12 months—families must meet this requirement each year

4. The *entire* family must have moved within the last 24 months in search of agricultural work
(A) with respect to services for migrant farmworkers, a Head Start program that serves families who are engaged in agricultural labor and who have changed their residence from one geographical location to another in the preceding two year period; and

(B) with respect to services for seasonal farmworkers, a Head Start program that serves families who are engaged primarily in seasonal agricultural labor and who have not changed their residence to another geographic location in the preceding two year period

Agriculture Labor: row and tree crops, (some nursery and cannery work)
Improving Access to Health Services

Steadily increased access to health services for children (infant, toddler and preschoolers).

• In 2014, 34% of MSHS children received Health Services from a Migrant Health Center

• Improved education among MSHS children on the importance of oral health care services:
  – **Prevention** (Fluoride, reducing the transmission of bacteria from the mother (or primary caregiver) to child and through education/health literacy for parents and caregivers)
  – **Early detection** (Stop/delay the onset of tooth decay in the primary teeth)
  – **Treatment** (Treating tooth decay early)
  – **Continuous care** (Preventing new and recurrent tooth decay)
SHARING COST:

- Recruitment of Families
  - 51% of MSHS return to the area for every season
  - 49% are new families in the area
- Enrollment in Medicaid/CHIP/Health Insurance Marketplace
- Transportation, Interpretation and Translation
- Case/Workload Management
- Education, Training and Technical Assistance
- Collaboration on Community Needs Assessments
Guadalupe Cuesta, Director
National MSHS Collaboration Office
202.884.8594
gcuesta@fhi360.org

For copies of ACF/HRSA MOU, Effective Partnerships Guide and the Locator/Directory:
http://bphc.hrsa.gov/technicalassistance/headstart/index.html
Community Health Partnership of Illinois, Inc.

Susan Bauer, Executive Director
Email: sbauer@chpofil.org
Tel. 312.795-0000 x 222
www.chpofil.org
COMMUNITY HEALTH PARTNERSHIP OF ILLINOIS: 3 DECADES OF COLLABORATION WITH MIGRANT AND SEASONAL HEAD START
Community Health Partnership of Illinois (CHP) is one of the “original” migrant voucher programs.

Transitioned in last decade to on-site services and expanded scope to include predominantly rural, Latino underserved communities.

Clinic sites in Aurora*, Kankakee*, Rantoul, Mendota* and Harvard (*dental and medical services).

Long-standing collaboration with Migrant and Seasonal Head Start Program (MSHS) and Migrant Education (1982).
• Work collaboratively to provide/arrange for provision of all required health screenings and follow-up - including preventive dental services and treatment - while the families are in our service area
• Provide monthly on-site nurse observations/training for infant caregivers as required by Head Start Program regulations
• Share cost of services that are not covered by Medicaid/CHIP
Evolution of CHP Collaboration with MSHSP

- 1982: CHP (part of the Illinois Migrant Council) received a state grant for a 2-chair mobile dental van
- Coordinated with MSHS Health Services Coordinator (state level) to offer services of dental van (friend of a friend: match made in heaven!)
- Created state-level agreements for medical, dental services
- CHP clinic director, MSHS center director/health services coordinator complete “Planning Grid” (See Inter-Agency Agreement)
- CHP staff serve on MSHS Health Services Committee, MSHS staff serve on CHP Board of Directors
• Assure that all Migrant and Seasonal Head Start enrollees receive all required screenings, services within 30 days of enrollment.

• Adapt service delivery to the specific need, circumstances, available resources:
  – Bring services (physical exams, preventive dental services) to the MSHS center using portable or mobile equipment
  – Established CHP seasonal site at the largest MSHS center in Illinois (Rantoul)
  – Co-located clinic/MSHS center in same building (Kankakee)
  – Contract for services with other HCs, private provider where we do not have a dental clinic (Princeville, Rantoul)
  – Coordinate with local health departments for immunization services
Outcomes of Migrant Health/Head Start Partnership: 2013*

• **Served 143 children** jointly by CHP and MSHS (down from 350+ over the last decade, due to reduced enrollment in MSHS in CHP service areas). 439 children served in Illinois by MSHS

• **Early detection and coordinated case management** for children with identified health conditions requiring follow-up

• **Parent Engagement**—While most parents are working and unable to be present when their child receives services, CHP staff is active in MSHS parent open houses, providing health screening, education, registration for CHP services for parents and other family members

*2014 data not yet complete
### Selected Clinical Outcomes Measures of Migrant Health/Head Start Partnership: 2013*

<table>
<thead>
<tr>
<th>Measure</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPSDT screenings</td>
<td>90%</td>
</tr>
<tr>
<td>BMI</td>
<td></td>
</tr>
<tr>
<td>• Normal</td>
<td>80%</td>
</tr>
<tr>
<td>• Overweight</td>
<td>8.5%</td>
</tr>
<tr>
<td>• Obese</td>
<td>8.5%</td>
</tr>
<tr>
<td>Up to date immunizations</td>
<td>85%</td>
</tr>
<tr>
<td>Dental exam</td>
<td>82%</td>
</tr>
<tr>
<td>Dental Treatment Needed</td>
<td>27%</td>
</tr>
</tbody>
</table>

* Statewide data. Includes collaboration of other FQHCs, providers
Ongoing Challenges

- **Migration**: Families arrive, depart unpredictably, which challenges scheduling providers, and completing all required services.
- **Food “Insecurity”**: Low-income families have limited access to nutritional foods, snacks, which lead to increased rates of obesity, recurring dental disease.
- **Time**: Due to competing priorities for CHP clinic and MSHS staff, there is less time for regularly scheduled communication to address issues that arise.
- **Geography**: Collaborate with all MSHS programs statewide, which can be taxing, requiring a great deal of travel and moving portable equipment.
- **Staff Turnover**: Many MSHS and clinic staff positions are seasonal, which often leads to high staff turnover.
- **Consents**: MSHS staff often struggle to get parents to sign consent forms, which may result in delays in screenings, treatment, or late cancellations.
- **Immunization Records**: Multi-state/country records are often incomplete/unreliable and challenging and time-consuming to obtain.
Successful Collaboration

#1: Build Positive Working Relationships
- Focus on common purpose
- Let go of negative assumptions based on past experience
- Support and/or participate in each other’s special events, advisory committees

#2: Create Clear, Realistic Expectations
- Use the MOU Agreement Template, Planning Grid to clarify roles/responsibilities in advance, timeframes, “Plan B”

#3: Structure time for ongoing communication
- Establish regular in-person “check-ins” with key staff from both programs

#4: Celebrate shared successes
- Assess and address what doesn’t go as planned
Family Health Centers of Southwest Florida, Inc.

Teri Buchanan, Senior Vice President, Chief Administrative Officer
TBuchanan@HCNetwork.org
Tel. 239-931-3867
http://www.fhcswf.org/
Family Health Centers

has been a federally qualified health center since 1985, and has provided uninterrupted primary health care service to the people of southwest Florida since 1964.
General Overview

• Dental Grant in partnership with Redlands Christian Migrant Association

• Strong Social Services/Outreach Department

• Disease Management Program

• One of few Medical/Dental providers that accept Medicaid
<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Dental Patients</td>
<td>31,049</td>
</tr>
<tr>
<td>Total Dental Encounters</td>
<td>102,673</td>
</tr>
<tr>
<td>Dental Providers</td>
<td>18</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>10</td>
</tr>
<tr>
<td>Dental Assistants</td>
<td>58</td>
</tr>
<tr>
<td>Head Start School Screening Program covering counties:</td>
<td>3</td>
</tr>
<tr>
<td>• Children seen in Lee County</td>
<td>500</td>
</tr>
<tr>
<td>• Children seen in Hendry County</td>
<td>200</td>
</tr>
<tr>
<td>• Children seen in Charlotte County</td>
<td>400</td>
</tr>
<tr>
<td>Migrant/Seasonal Patients</td>
<td>2,580</td>
</tr>
<tr>
<td>Migrant/Seasonal Children 0-17</td>
<td>1,615</td>
</tr>
<tr>
<td>CHIP/Medicaid Children 0-17</td>
<td>1,357</td>
</tr>
<tr>
<td>Migrant/Seasonal Dental Patients</td>
<td>1,432</td>
</tr>
<tr>
<td>Migrant/Seasonal Dental Encounters</td>
<td>5,737</td>
</tr>
<tr>
<td>Migrant/Seasonal Sites</td>
<td>25</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----</td>
</tr>
<tr>
<td>EVENTS</td>
<td></td>
</tr>
<tr>
<td>Health Fairs</td>
<td>17</td>
</tr>
<tr>
<td>Screening Events</td>
<td>33</td>
</tr>
<tr>
<td>Adult Health Education Classes</td>
<td>37</td>
</tr>
<tr>
<td>Child Health Education Classes</td>
<td>6</td>
</tr>
<tr>
<td>Donation Distribution Events</td>
<td>14</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>107</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 0-5</td>
<td>789</td>
</tr>
<tr>
<td>Age 6-16</td>
<td>383</td>
</tr>
<tr>
<td>Age 17-21</td>
<td>291</td>
</tr>
<tr>
<td>Age 22-45</td>
<td>2269</td>
</tr>
<tr>
<td>Age 46+</td>
<td>1692</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5424</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STATISTICS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Migrant</td>
<td>1035</td>
</tr>
<tr>
<td>Seasonal</td>
<td>795</td>
</tr>
<tr>
<td>Other</td>
<td>3283</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5113</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Metabolic Syndrome</td>
<td>791</td>
</tr>
<tr>
<td>Adult Weight management</td>
<td>53</td>
</tr>
<tr>
<td>Case Management</td>
<td>333</td>
</tr>
<tr>
<td>Kids Shape It Up</td>
<td>277</td>
</tr>
<tr>
<td>Quest for Kids Health</td>
<td>598</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>4</td>
</tr>
<tr>
<td>Women's Gestational Diabetes</td>
<td>299</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>2355</td>
</tr>
</tbody>
</table>
## Partnership Impact From UDS

<table>
<thead>
<tr>
<th>Access</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Users</td>
<td>63,554</td>
<td>68,601</td>
<td>66,009</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>58.57%</td>
<td>62.86%</td>
<td>70.77%</td>
</tr>
<tr>
<td>Child/Immunization</td>
<td>38.57%</td>
<td>51.43%</td>
<td>81.43%</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>0</td>
<td>71.90%</td>
<td>75.71%</td>
</tr>
<tr>
<td>Prenatal</td>
<td>54.26%</td>
<td>50.46%</td>
<td>59.61%</td>
</tr>
<tr>
<td>Child Weight</td>
<td>61.43%</td>
<td>71.41%</td>
<td>82.86%</td>
</tr>
<tr>
<td>Adult Weight</td>
<td>51.43%</td>
<td>47.53%</td>
<td>57.61%</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>81.43%</td>
<td>91.03%</td>
<td>96.47%</td>
</tr>
</tbody>
</table>
• Provide dental care in all of the schools (Head Start Program and public schools)
• Medicaid reimbursement rate (including children not covered by Medicaid).
• Established Social Service and Disease Management partnerships in the migrant community.
• Focus on benefits of Head Start partnership with CEO and CFO.
• Social Service/Outreach Department
• Disease Management Education
• Bilingual Providers
National, State & Regional Partnership Resources

Joe Gallegos, Senior Vice President
Western Operations, NACHC
Email: igallegos@nachc.com
Tel. 505-855-6964
https://www.nachc.com
It is about the mission and a shared vision!!!

- FQHCs and MSHS programs have a common mission and common constituent.
- Both were created as part of the *War on Poverty*, are community-based; sister agencies.
- FQHCs are funded to serve migratory and seasonal agricultural workers and their families.
- FQHC Mission - to provide access to care for low-income medically underserved communities and populations.
- MSHS Mission – to provide health, nutrition, early childhood education and parent involvement services to low income farmworker children and their families.
It is about a shared vision!!

- Ensure Health Outcomes are met for MSHS children & their families — assure quality, culturally competent, comprehensive primary care services for MSHS children & their families.

- FQHCs strive to provide “one-stop shop/care” model that is convenient for children/families as well as for the provider. “Refer down the hall vs. refer down the road”

- FQHCs goal is to provide a “health care home” so everyone has a regular source of care over their life cycle.
Challenges

• Lack of awareness of each other’s role and responsibility.
• Lack of understanding the organizational climate in which each agency operates.
• Some FQHCs are at full capacity and unable to serve additional patients. High Staff Turnover.
• Recruitment and retention of health professionals, especially in rural areas is a challenge.
• Need for leadership of each agency to come together to understand each others culture, resource availability and understand each others limitations.
• Scheduling and timeline for service delivery dates.
Initiating the Partnership

Key to effective partnering is---Planning, Planning and more Planning

• Get the right people to the table—Key management staff and Program staff from FQHC and MSHS grantees to develop an MOU/MOA/Contract. MOU is an expression of commitment.

• The purpose of the MOU is to develop a joint strategy for ongoing planning, service delivery and evaluation. A tool for managing expectations

• MOU outlines need for collaboration, need for services, payment provisions, identify responsibilities for transportation, translation, and case management. Identify areas of collaboration and mutual benefits: Shared staffing, training, community needs assessment, patient education, clinical outcomes.

• Face-to-face meeting is critical to building trust and confidence between the partners.

• Begin planning at least six months prior to anticipated need for services.
• Increased access to culturally competent comprehensive primary health care and enabling services, such as interpretation, translation, transportation and case management for MSHS children and their families

• Maximization of local resources for both agencies – (community needs assessments, staff training, technical assistance, shared staffing, patient education)

• Achieve improved health outcomes for MSHS children and their families.

• It is about the mission, it is about vision and It is the right thing to do!!!
State Primary Care Association Offices (PCAs)

- State or regional nonprofit organizations that provide training and technical assistance to safety-net providers.
- Designated staff person who serves as the Point of Contact for Special Populations.

Resources:

National Center for Farmworker Health – Models of Collaboration: Fostering Partnerships between Migrant Education and Migrant Health
Migrant National Cooperative Agreements

Farmworker Justice  
http://www.farmworkerjustice.org

Health Outreach Partners  
http://www.outreach-partners.org

MHP Salud  
http://www.mhpsalud.org

Migrant Clinicians Network  
http://www.migrantclinician.org

National Association of Community Health Centers  
https://www.nachc.com

National Center for Farmworker Health  
http://www.ncfh.org
Improving Quality Health Care Access for MSAWs and their Families:

- **Part I: Migrant and Seasonal Head Start Partnership Models**
  - Tuesday, March 3, 2015, 2:00 – 3:00 pm ET

- **Part II: Promotora Models**
  - Tuesday, May 19, 2015, 2:00 – 3:00 pm ET

- **Part III: Intake Innovation Process**
  - Tuesday, July 21, 2015, 2:00 – 3:00 pm ET

- **Part IV: National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care**
  - Tuesday, September 22, 2015, 2:00 – 3:00 pm ET