

# U.S. Department of Health and Human Services National Advisory Council on Migrant Health (NACMH)

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May 4-5, 2015  
San Antonio, TX

## Council Members in Attendance

Jill Kilanowski (Chair)  
Edelmiro Garcia (Vice Chair)  
Frances Canales  
Alina Diaz  
Gwendolyn Gould  
Martha Lopez  
Rosa Martin  
Victoria Montoya  
Carlos Moreno  
Jeffrey Partyka  
Jesus Tijerina  
Joan Tronson  
Wenceslao Vasquez

## Federal Staff

Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services

- Seiji Hayashi, MD, Chief Medical Officer and Senior Advisor for Special Populations
- CDR Jacqueline Rodrigue, MSW, Designated Federal Official for the NACMH
- Matthew Kozar, Division Director, Strategic Initiatives and Planning Division, Office of Policy and Program Development
- LCDR Vesnier Lugo, MPH, Public Health Analyst, Strategic Initiatives and Planning Division, Office of Policy and Program Development

## MONDAY, MAY 4, 2015

### CALL TO ORDER

*Jill Kilanowski, PhD, RN, APRN, CPNP, FAAN (Chair)*

Dr. Kilanowski called the meeting to order at 9:34 a.m. and welcomed Council members and staff to the meeting, with a special welcome for new members, Ms. Alina Diaz and Dr. Carlos Moreno.

Frances Canales moved to approve the agenda with no changes. The motion was seconded by Edelmiro Garcia and carried by unanimous voice vote.

Council members introduced themselves for the record.

Joan Tronson moved to approve the minutes of the previous meeting (October 22-23, 2014). The motion was seconded by Jeffrey Partyka and carried by unanimous voice vote.

## **BUREAU OF PRIMARY HEALTH CARE (BPHC) UPDATE**

*CDR Jacqueline Rodrigue, MSW, Designated Federal Official for the NACMH*

CDR Rodrigue provided an update on the BPHC. Key points were as follows:

- BPHC has been reorganized to respond to the expansion of the Community Health Center program as a result of the Affordable Care Act (ACA). The Bureau now consists of five offices that report to the Associate Administrator: Office of Policy and Program Development; Office of Quality Improvement; Office of Strategic Business Operations; Office of Northern Health Services; and Office of Southern Health Services.
  - The Strategic Initiatives and Planning Division of the Office of Policy and Program Development (OPPD) will provide strategic oversight and manage the NACMH. Matt Kozar will be the new DFO.
  - The Office of Quality Improvement (OQ), Strategic Partnerships Division will coordinate the National Cooperative Agreement (NCA) grantees, Primary Care Associations, and Health Center Controlled Networks.
- Seven new members have been proposed for the Council. Details will be provided once the new members are approved by the Secretary.
- The next Council meeting is tentatively scheduled for November 2015, with dates and location to be confirmed.
- HRSA is sponsoring a four-part webinar series on Improving Quality Health Care Access for Migratory and Seasonal Agricultural Workers (MSAWs) and their Families. All sessions are on Tuesdays from 2:00 to 3:00 p.m. ET. Webinars include:
  - Part I: Migrant and Seasonal Head Start Partnership Models (March 3, 2015)
  - Part II: Promotora Models (May 19, 2015)
  - Part III: Intake Innovation Process (July 21, 2015)
  - Part IV: National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care (September 22, 2015).

CDR Rodrigue introduced her colleagues, Matt Kozar and LCDR Vesnier Lugo. Mr. Kozar provided an overview of the OPPD. Key points were as follows:

- OPPD has three operating divisions:
  - Expansion Division: Leads and monitors the strategic development of primary care programs, including health centers, special population programs, and other health systems.
  - Policy Division: Develops new and clarifies existing policy for the health center program based on identified internal and external needs.
  - Strategic Initiatives and Planning Division: Ensures that BPHC activities and priorities are informed by health care marketplace trends/reforms and oversees grant expenditure operations and loan guarantee programs.

- Mr. Kozar is the Division Director for the Strategic Initiatives and Planning Division and looks forward to supporting the work of the NACMH going forward.

## Discussion

Council members did not have any questions for the speakers.

Dr. Kilanowski opened the floor for members to identify issues in their communities that they would like to bring to the Council's attention. Members raised the following issues:

- Many rural communities are experiencing a shortage of primary care and mental health providers. Only 11 percent of medical school graduates go into primary care, and small rural health centers cannot compete with salaries offered in the private sector.
- Mental health services can be provided via telehealth, but that method of service delivery is not reimbursable.
- There are high rates of teen pregnancy and infant mortality in Texas, which are linked to sexually transmitted diseases and family violence.
- Kentucky has a new advisory board that is looking into payment for promotoras.
- California has a new law that allows undocumented farmworkers to obtain a driver's license.
- Workman's compensation claims are challenging for migrant health centers (MHCs) and for MSAWs. Clinics do not know how to process the paperwork, which places a burden on advocates or farmworkers. Doctors are unable to serve patients when they are called to testify at court. MSAWs often choose not to file a claim because they do not know how to complete the paperwork.
- Nurse practitioners (NPs) are not approved as full-authority practitioners in all states. Without full authority, their work must be overseen by a physician. When the supervising physician retires, patients are left without a provider. NPs are an important component of the health care system, and they can participate in loan forgiveness programs by working in rural areas. Addressing this problem would help to alleviate the shortage of providers.

## WELCOME TO SAN ANTONIO

*Sonia Lara, Director of Outreach & Enrollment and PCA Special Populations Point of Contact, Texas Association of Community Health Centers (TACHC)*

*Rachel A. Gonzales-Hanson, Chief Executive Officer, Community Health Development, Inc.*

Ms. Lara provided an overview of health care services for MSAWs at the regional level. Key points were as follows:

- Overview of TACHC and members
  - Texas has 73 federally qualified health centers (FQHCs) with approximately 400 sites and 14 MHCs with about 115 sites
  - Most MHCs are concentrated in south Texas.
- Overview of South Midwest Region (Arkansas, Louisiana, Oklahoma, and Texas)
  - 17 MHCs in the region, with a total of about 148 sites (most in Texas)
  - Oklahoma has the only migrant voucher program in the region.

- MSAW population and numbers served (conservative threshold estimate, based on data collected by the Regional Minority Health Coordinator; the definition was revised in 2012 to include those who work in horticulture and with livestock):

State	Horticulture	Livestock	Total State Population	Children	Children (Percent)
Arkansas	30,044	37,476	67,480	19,676	29
Louisiana	30,771	26,988	57,759	16,166	28
Oklahoma	39,415	95,213	134,628	47,242	35
Texas	159,132	252,077	411,209	144,299	35
Total	259,362	411,714	671,076	227,383	34

- Uniform Data System data on MSAWs served from 2007 to 2013 indicate that only 2.3 percent of MSAWs were served by MHCs.
- Texas Migrant Care Network (TMCN)
  - Addressing gaps in coverage for MSAWs has been a priority for TACHC for more than two decades. They developed the TMCN in collaboration with the Texas Medicaid agency to provide portability of benefits. Other models of care that were studied required a third-party administrator to run the network.
  - Key elements include continuous enrollment, waiver of prior authorization, and honoring the Medicaid Prospective Payment System (PPS) encounter rate.
  - No legislation or special waivers were required. They only needed other states to enroll in the program.
  - Medicaid portability was launched in 2008, which allowed Texas MSAWs to use their Medicaid coverage outside of Texas. At its peak, 21 FQHCs with 52 sites were part of the network that included 15 states.
  - The Supreme Court decision that made Medicaid expansion optional and the shift to managed care in March 2012 made it difficult for other states to enroll in Texas Medicaid. Those developments and other complications led to a decision to stop advertising the program. Participation has declined since then. The network currently has only six participating FQHCs.
- Support for MSAWs
  - NCAs, including Migrant Clinicians Network and Health Outreach Partners
  - National Association of Community Health Centers (NACHC)
  - TACHC departments that provide support for special populations (Community Development, Clinical, and Outreach and Enrollment).
- Outreach and enrollment in Texas
  - Approximately 421 Certified Application Counselors (CACs) in about 200 community health center (CHC) sites statewide assisted patients and consumers through more than 478,000 encounters from July 2013 to December 2014. Approximately 147,037 applications were submitted and 83,481 people enrolled in the federal health exchange as a result of this effort.
  - Best practices included a special enrollment period for MSAWs.

Ms. Gonzales-Hanson provided an update on issues facing migrant health centers (MHCs) in the Winter Garden area. Key points were as follows:

- An ongoing drought and recent hailstorms have affected MSAWs, growers, and ranchers.
- Many growers struggle to find workers; the problem is exacerbated by the current immigration climate.
- Recruiting providers is a major challenge for the health center. Two part-time physicians currently share the responsibilities of a Medical Director for the health centers in Winter Garden. The board of directors has agreed to fill two of its three vacancies with mid-level providers and have them focus on improving clinical outcomes, while the more senior physicians provide higher level case management. Case Care Coordinators will work with health care professionals within the system to help patients learn how to manage their conditions. The salary for the vacancy that is not filled can be used to increase salaries for the other providers.
- Texas did not participate in the Medicaid expansion. There is significant competition for primary care providers, and health centers need to find creative ways to offer a competitive salary. Providers with the “corazon” that is required to work with MSAWs are few and far between.
- The health centers can no longer offer same-day appointments due to the shortage of providers. Patients now wait four days to three weeks for an appointment, depending on the provider.
- The health center offers extended hours to accommodate the needs of MSAWs and makes creative arrangements with providers to provide coverage.

Ms. Gonzales-Hanson provided an update on the NACHC Farmworker Health Committee, which she chairs. Key points were as follows:

- The committee is focused on two issues this year: increasing access to health care for farmworkers, and building relationships with growers to achieve the mutual goal of a healthy workforce.
- The committee developed policy recommendations related to HRSA funding policy to increase access to health care for farmworkers. The full text of draft recommendations was distributed to Council members. Highlights include:
  - Modify the current New Access Point (NAP) requirement for a minimum of 3,000 new patients and consider awards to serve smaller population groups to address the need in geographic areas where the concentration of MSAWs is highly seasonal and limited in numbers.
  - Restore flexibility of funding requirements to support unique service delivery models that address specific needs of the MSAW population, such as mobile units.
  - Modify and/or eliminate the requirement that NAPs be placed in medically underserved areas where the low-income population is less than 50 percent.
- The new definition of MSAWs, which now includes those who work in horticulture and with livestock, has led to inconsistencies in identifying individuals who qualify for migrant health services. The National Center for Farmworker Health has developed an effective training program for front-line staff at MHCs to address that issue. NACHC is shifting its terminology.
- During the National Farmworker Conference, NACHC will launch a campaign to increase access to care for MSAWs. The campaign will focus on the policy recommendations to HRSA and will include strategies for health centers, PCAs, and Farmworker Health Network (FHN) members.

## Discussion

- Dr. Moreno asked if the gas and oil boom had any impact on the MSAW workforce.
  - Ms. Lara stated that some farmworkers left to work in the oil and gas sector, but lower prices have led to layoffs. Some of those individuals might return to farm work.
- Ms. Canales noted that young male farmworkers often take care of their own injuries rather than going to a clinic, where they will have to pay for care.
  - Ms. Gonzales-Hanson expressed concern that health centers are reluctant to take workers compensation cases for any patients due to the shortage of providers.
- Dr. Moreno asked to what extent the Council should focus on issues of funding for MHCs.
  - Ms. Gonzales-Hanson replied that health centers need to increase the number of patients and maintain the required percentage of MSAW patients in order to justify funding. In her opinion, most of the decline in MSAW patients is due to the fact that patients were not identified correctly.
- Dr. Moreno stated that mobile units would increase access and would help increase credibility and sustainability for MHCs.
- Dr. Moreno noted that he has seen major demographic changes in the patient population at his health center. An area that was mostly African American is now predominantly Hispanic, but those who are from Central America are reluctant to seek services due to concerns about their immigration status.
  - Ms. Gonzales-Hanson agreed about the importance of this issue. She also cautioned against equating immigrants with MSAWs.

## ENVIRONMENTAL HEALTH OF MIGRANT FARMWORKERS: THREATS TO HEALTH IN THE RESIDENTIAL AND WORK ENVIRONMENTS

*Sara A. Quandt, PhD, Professor, Department of Epidemiology and Prevention, Division of Public Health Sciences, Wake Forest School of Medicine*

Dr. Quandt discussed threats to health in the residential and work environments of MSAWs. Key points were as follows:

- Environmental health recognizes that health is related to where people live and work. MSAWs work in unfamiliar environments where their previous experiences may not be sufficient to understand and protect against environmental health threats. Healthcare providers and policy makers should be well-informed about these threats in order to develop practices and policies to protect the health of migrant farmworkers.
- Threats to health in the residential environment:
  - Policies regulating migrant farmworker housing
    - Occupational Safety and Health Administration (OSHA) standards for temporary labor camps are dated, and standards are often rudimentary and vague (e.g., 50 square feet per person in sleeping rooms, “adequate” storage space).
    - OSHA regulations do not include provisions for privacy or lead exposure.
  - Variability in housing stock and housing tenure; exemplary housing is not the norm.

- Dr. Quandt’s study of farmworker housing at 170 migrant camps in North Carolina found housing code violations in all areas (sleeping rooms, bathrooms, kitchens, safety and security, heat levels).
- Health threats in housing
  - Food- and water-borne illnesses related to sanitation, water quality, and refrigeration
  - Respiratory and allergic symptoms; asthma
  - Heat illness
  - Injury/safety
  - Mental health
  - Residential pesticide exposure.
- There is very little research on health outcomes from low-quality housing.
- Threats to health in the work environment
  - Pesticides: Contain neurotoxicants, endocrine disruptors, and carcinogens. Immediate health effects of high-level exposure include rash, coma, and death. Long-term health effects include neurodegenerative disease, reproductive problems, and cancer.
  - Heat exposure: Heat stroke is the leading cause of death in farmworkers. Workers are often left alone in fields and are not given time to acclimate to local conditions.
  - Tobacco: Exposure to the plant causes “green tobacco sickness” (GTS). GTS is synergistic with heat. The impact on children of exposure to high levels of nicotine is an emerging concern.
- Current regulations
  - Pesticides: U.S. Environmental Protection Agency (EPA) Worker Protection Standard
  - Field sanitation: U.S. Department of Labor Field Sanitation Standard
  - Heat: Only three states have heat-related provisions in their occupational safety standards (California, Oregon, and Washington).
- Dr. Quandt’s study of North Carolina farmworkers
  - Farmworkers reported inadequate enforcement of regulations for pesticide safety, field sanitation, and heat.
  - Pesticide exposure: Farmworkers had an average of seven different pesticides in their urine.
  - GTS: One in four workers get GTS, and workers are sick four days per 100 days they pick tobacco. Risk factors include harvesting and topping tobacco, working in wet clothing, and limited work experience.
- Organization of work vs. prevention of exposures
  - Demands : Place of work, hours, physical exertion
  - Control: Decision latitude on hours and tasks
  - Work safety climate: How much management stresses safety
  - Crop work has high demands, low control, and a poor safety climate.
- Recommendations: Residential environment
  - Enforce existing housing regulations.
  - Strengthen housing regulations by 1) adding greater specificity to bathroom provisions to ensure usability of facilities in light of privacy concerns; 2) requiring inspections during occupancy; and 3) including provisions to control heat index within housing.

- Recommendations: Work environment
  - Pesticides: Enforce existing pesticide and field sanitation regulations. Monitor pesticide exposure in field workers (non-applicators).
  - Heat: Establish and enforce national heat standards.
  - Tobacco: Establish a minimum age of 18 for work in tobacco. Mandate health and safety education for workers.

## Discussion

- Dr. Moreno asked how the level of pesticides in the urine of farmworkers in Dr. Quandt's study compared to the non-farmworker population.
  - Dr. Quandt replied that the National Health and Nutrition Examination Survey (NHANES) published some data on indicators for pesticide exposure. The pesticides found in the farmworker population were different from the set of pesticides that can be found throughout the U.S. population due to residues in non-organic food.
- Dr. Moreno asked Dr. Quandt if comparative data on pesticide residues were available from farmworkers in the location with better housing.
  - Dr. Quandt replied that the researchers looked at housing variables and found no difference in pesticide levels in farmworkers.
  - Dr. Moreno noted that washing machines are a key variable, due to the cumulative effect of pesticide residues on clothing.
  - Dr. Quandt stated that her study found wide variations in the washing machines that were available in migrant housing. She noted that the re-entry interval in the pesticide regulations is set to prevent acute pesticide poisoning, but that interval does not prevent exposure to pesticide residue. Growers can be in compliance with the regulations, but workers are still exposed to pesticides.
- Dr. Moreno asked if the study looked at availability of portable toilets.
  - Dr. Quandt stated that growers are required to have a toilet within a quarter mile. However, in many cases they are not moved, and workers often report that they are dirty. Women reported that they did not feel safe using them.
- Rosa Martin said she had seen the same issues time after time and asked what could be done to require growers to meet the standards.
  - Dr. Quandt stated that one purpose of her research was to provide information for policy makers and advocates. Growers are caught in the middle. Tobacco and pesticides are marketed by large, multinational corporations, and workers are often blamed.
  - Gwendolyn Gould stated that advocacy is important, and educating local communities can help to create pressure.
- Ms. Canales noted that conditions have improved in Texas, where her teenage son took a 10-hour course from OSHA. The migrant camp where she works in Minnesota provides excellent housing, and local Boy Scouts installed smoke detectors and carbon monoxide detectors.
  - Dr. Quandt stated that growers who have large camps are most likely to follow the regulations.

## POLICY UPDATE

*Joseph Gallegos, MBA, Senior Vice President for Western Operations, NACHC*

Mr. Gallegos provided an update on the policy environment for health centers. Key points were as follows:

- There is bi-partisan support for the health centers' mission as the program celebrates its fiftieth anniversary. Both sides are looking for solutions to looming health care costs. Health centers are central to the conversation.
- Access to primary care is vital for the cost savings and improved health outcomes anticipated under the ACA. Sixty-two million Americans are still without primary care. There will be increased demand among the newly insured, the remaining insured, and the underinsured.
- Federal support, through Section 330 grants and Medicaid payments, are crucial to sustain the model of care. Lawmakers need to be educated about the critical role that health centers play in decreasing costs and reducing health disparities.
- Health center funding streams include discretionary funding (currently \$1.5 billion), and mandatory funding through a special five-year Trust Fund created by the ACA to boost health center capacity (currently \$3.6 billion). The mandatory funds that were scheduled to expire as of September 30, 2015 have been extended through Fiscal Year 2017. That extension set an important precedent for future funding.
- NACHC's goals in 2014 were to fully fund the last year of the Health Center Fund (accomplished), and to find a long-term solution to the funding cliff (accomplished in part).
- Funding for the National Health Service Corps (NHSC) and Teaching Health Centers (THC) graduate medical education programs was extended until 2017.
- Medicaid
  - States that are participating in the Medicaid expansion are looking at a number of options to structure their programs and should be granted flexibility.
  - The House and Senate budget resolutions for fiscal year 2016 (FY16) call for block-granting Medicaid. This would cap federal payments to states, allowing only small annual increases regardless of case-load changes or actual cost increases. Per-capita caps are not much better. In either case, the FQHC benefit and PPS payment system could be eliminated.
  - NACHC will monitor these developments closely.
- HRSA funding for FY15
  - The \$5.1 billion allocated for FY15 is HRSA's largest budget ever.
  - HRSA will spend this on NAP and Expanded Services grants (\$350 million), base grant adjustments (\$165 million), construction and capital improvements (\$150 million), outreach and enrollment (\$150 million), behavioral health integration (\$51 million), and clinical quality awards (\$36 million)
  - NACHC is monitoring the 340B program, which covers pharmacy services. Congress is concerned about the rapid growth of contract pharmacies. Health centers need to ensure and document compliance.

- Federal Torts Claims Act (FTCA)
  - The FTCA Program Requirements Manual was scheduled to be released in Spring 2015.
  - Issues include the number and complexity of program requirements, detailed guidance to meet requirements, better coordination between FTCA site visits and operational site visits, and detailed guidance on preparing for FTCA site visits.
- Centers for Medicare and Medicaid Services (CMS) Policy
  - Medicaid PPS started in October 2014 and is being phased in through September 2015.
  - Health center outreach and enrollment staff members are even more important as other funding streams dry up.
- Health Insurance Marketplace for 2016
  - The rules for qualified health plans to participate in the Marketplace in 2016 have been finalized.
  - NACHC is advocating for no changes around network adequacy, payments to FQHCs, and requirements to contract with one FQHC per county.
- Veterans Choice
  - In November 2014, the Veterans Administration (VA) issued a regulation that allows veterans to access health care outside of the VA system.
  - There is a need to clarify whether providers are being enrolled in Veterans Choice or PC3; streamline the authorizations and contracting process, and increase coordination between third-party administrators.
- August 9-15, 2015 is National Health Center Week. This year marks the fiftieth anniversary of the community health center program. Council members are encouraged to promote this event in their health centers.

## Discussion

- Victoria Montoya said that her son, who is in the Navy, wanted to go to a clinic near his home. He was told that he would have to receive his primary care at the VA clinic.
  - Mr. Gallegos replied that if a veteran goes to a health center that is not a contracted provider for the VA; the health center will not be reimbursed for their services.
  - Dr. Moreno stated that if a veteran is approved to seek care outside the VA, the VA still needs to approve the treatment methodology.
  - Mr. Gallegos stated that the referral and payment system still needs work, and there is a need for more integration between the VA and health centers. NACHC is working with the VA to resolve those issues.

## HIV AND SEXUALLY TRANSMITTED DISEASES RISK AMONG MIGRANT AND SEASONAL AGRICULTURAL WORKERS

*Yolanda Rodriguez-Escobar, PhD, LMSW, Assistant Professor of Social Work, BSW Program Director, Our Lady of the Lake University's Worden School of Social Service*

Dr. Rodriguez-Escobar shared highlights from her research on HIV and sexually transmitted diseases (STDs) among Latinas and MSAWs. Key points were as follows:

- Issues identified through a literature review
  - Up to 70 percent of migrant populations come from Mexico.
  - Migrant workers represent an important source of economic development for the USA.
  - Migrant workers do not seek medical attention, given that only nine percent have health insurance.
  - The exact prevalence rate of HIV in the migrant population is unknown.
  - HIV testing and diagnosis are difficult, given the constant mobility of migrant workers and barriers to testing.
  - Research has linked migration to increased HIV incidence and vulnerability in a variety of contexts, especially among unaccompanied minors.
- There is a dearth of research on Latina migrant workers with HIV/AIDS and their needs, and there are few culturally and linguistically appropriate interventions that address the unique needs of Latina MSAWs with HIV. The few studies that do exist focus on Latino migrant workers, in general, and tend to focus on HIV transmission and risk factors; they do not focus on the psycho-social issues and lived experiences of Latina MSAWs with HIV.
- Risk factors
  - Latina migrant workers risk rape and sexual abuse when traveling through border towns.
  - They may turn to prostitution for economic survival and may be hired as commercial sex workers, and many perform sex without the use of a condom.
  - They may use and share non-sterile syringes to inject vitamins and antibiotics.
  - Latina migrant workers may have limited education and knowledge and may have misconceptions about HIV.
  - Due to cultural stigmas, Latino men are less likely to disclose bisexual behaviors or HIV-positive status to their female sexual partners. This places their partners at a high risk for acquiring HIV and other STDs.
  - Latina migrant workers may simply be at risk for having sex with their husbands who have engaged in unprotected sex with both men and women.
- Access and barriers to health care
  - Latina migrant workers are not eligible for Medicaid assistance due to immigration status and fear of deportation when utilizing medical care at hospitals and clinics.
  - Stigma in the Latino culture is a major barrier to accessing medical care.
  - Medical clinics may not be culturally and linguistically equipped to provide services.
  - Latina migrant women often report late to care.
  - Continuity of care can be challenging due to constant mobility.
- Many women and children are fleeing countries in the Northern Triangle (Honduras, Guatemala, and El Salvador) due to violence, fragile and corrupt governments, inadequate post-war disarmament, and proximity to the North American drug market.

Dr. Rodriguez-Escobar offered the following recommendations:

- Fund more qualitative research to better understand the needs of this marginalized group.
- Fund more culturally and linguistically appropriate intervention approaches in migrant communities, with a focus on sub-groups and sub-populations.
- Sponsor proper educational programs and campaigns to fight stigma and possibly increase the number of migrants who get tested.

- Utilize Spanish media and produce popular educational messages via television, radio, and low-literacy printed materials.
- Utilize the promotora model and train from within migrant communities to decrease HIV infections.
- Consider utilizing home-grown interventions and share them with other communities.
- Initiate further research to examine social and cultural factors specific to Latina migrant women.
- Fund more research studies to examine current migration trends, to include other Latin American countries from the Northern Triangle.
- Examine the incident rate of human trafficking and commercial sexual exploitation placed on the undocumented female migrant workers along the U.S.-Mexican border.

## Discussion

- Dr. Kilanowski asked Council members who work in MHCs about the prevalence of HIV among MSAWs.
  - Ms. Montoya said the director of her clinic thought that men were more likely to have HIV, but the number would be too small to detect.
  - Dr. Moreno said the HIV testing program at the clinic where he previously worked was de-funded because they did not find enough cases. He noted that people from a small, rural community may go to a larger city to get tested due to concerns about confidentiality.
  - Ms. Martin said her clinic has an HIV program, with funding for community outreach using promotoras. She noted that Latina women are reluctant to get tested.
- Dr. Moreno asked what resources are available to ensure continuity of care for HIV-positive MSAWs as they travel to.
  - Dr. Rodriguez-Escobar said that the difficulty of ensuring continuity of care for MSAWs is a major challenge, especially when they move without giving notice.
  - Ms. Martin suggested that the network that was created to track MSAWs with tuberculosis could be used for HIV.
- Ms. Diaz stated that her clinic has a very aggressive approach to HIV because they have a large population of dairy farmworkers. Prostitution is high because dairy farmers do not allow families. MSAWs may be willing to get tested, but follow-up with treatment is very difficult. She felt that HIV testing should be offered in a more private setting.
  - Dr. Rodriguez-Escobar noted that one event in Georgia was billed as a health fair. HIV information was provided at one of the tables.
  - Ms. Martin said that her clinic holds a health fair and a three-day “Festival Latino” each year. Last year, they tested about 45 people.
- Dr. Kilanowski noted that many of the Council’s recommendations have addressed the need to improve continuity of care for patients with chronic conditions.

## INTEGRATING MEDICAL-LEGAL APPROACHES TO IMPROVE HEALTH CARE FOR MIGRATORY AND SEASONAL AGRICULTURAL WORKERS

*Susan Schoppa, Esq., Supervising Attorney, Medical-Legal Partnership for Children|Dallas, Legal Aid of NorthWest Texas, Children's Medical Center*

Ms. Schoppa introduced the Medical-Legal partnership (MLP) model. Key points were as follows:

- The National Center for Medical-Legal Partnership (NCMLP) was awarded a National Cooperative Agreement in 2014 to promote the development of civil legal aid access in health centers.
- An MLP is a healthcare team that can identify, treat, and prevent health-harming legal needs for patients, clinics, and populations. Integrating legal services within the team improves coordination of resources to address social determinants of health that create legal problems.

<b>Common Legal Problem</b>	<b>Social Determinant of Health</b>
Families wrongfully denied food supports or housing subsidies	Lack of basic resources
Children living in housing with mold or rodents, in violation of housing laws	Physical environment
Seniors wrongfully denied long-term care coverage	Lack of access to insurance

- Rationale for MLPs for farmworker communities:
  - Increase knowledge of health-harming legal needs of farmworkers to provide effective intervention and prevention
  - Promote interprofessional training to increase coordination and leveraging of resources
  - Integrate legal care as a component of health care to empower farmworkers to improve their living and working conditions and their health
  - Address systemic problems that lead to poor health outcomes to improve the health of the community.
- Civil legal aid resources include: Federal legal aid (Legal Services Corporation); state and local legal aid (National Legal Aid & Defender Association); private pro bono resources (American Bar Association); and academic law school clinics (Association of American Law Schools).
- Current legal aid resources cannot meet the need without changing how legal care is provided. Nationwide, there is one civil legal aid attorneys in the U.S. for every 62 potential clients. They are able to meet less than 20 percent of the need each year, and unfair, unhealthy systems go unchanged.
- The MLP approach has four components:
  - Train healthcare providers and lawyers and identify needs
  - Treat patients
  - Transform clinic practice
  - Improve population health.

- MLPs help patients with “I-HELP” issues: Income supports and insurance, Housing and utilities, Employment and education, Legal status, and Personal and family stability.
- MLP programs are in different stages of development and impact (referral network, partially integrated MLP, fully integrated MLP). Every MLP program can advance along the continuum.
- Farmworker Justice (FJ) and Health Outreach Partners (HOP) developed a *Medical-Legal Partnership Resource Guide for Farmworker-Serving Health Centers and Legal Services Organizations*. They will launch a Learning Network in the near future.
- A fully-integrated farmworker MLP would include referrals, cross-training on health and legal issues of farmworkers, policy advocacy, and board participation.
- A Legal Aid Interagency Roundtable (LAIR) co-led by the White House Domestic Policy Council and the U.S. Department of Justice made this work possible. Participation by HHS led to policy strategies to link civil legal aid with HRSA activities, including the recent clarification of enabling services language.

Ms. Schoppa presented the following recommendation on behalf of NCMLP:

- Ensure the continued development and strengthening of farmworker MLPs that can demonstrate impact by supporting (1) training and technical assistance in the field; (2) strategies for cross-sector workforce training and collaboration; and (3) opportunities to collect data across key MLP practice sites.

## Discussion

- Martha Lopez noted that in nearly every school district with a high population of Latino children, the majority of students in special education programs are Latino and many are native Spanish speakers. However, the special education staff rarely includes Spanish speakers.
  - Ms. Schoppa stated that integrating legal care could help in those situations. It is important to build a relationship between the health center and the school district. Funding structures differ from state to state. Students who are eligible for special education services may not get an adequate education unless the funding follows them.
- Dr. Kilanowski asked if the recommendation regarding strategies for cross-sector workforce training and collaboration was referring to interdisciplinary care.
  - Ms. Schoppa replied that the recommendation was for increased training and collaboration across health care profession as well as between health care and the legal profession.
- Dr. Kilanowski asked what type of data they would like to collect.
  - Ms. Schoppa stated that NCMLP was currently looking at basic metrics, such as types of cases and number of patients served. They would eventually like to collect data on health outcomes. Data collection will help in developing verified questions for screening to identify the need for legal services.

Dr. Kilanowski adjourned the meeting for the day at 5:05 p.m.

**TUESDAY, MAY 5, 2015**

Dr. Kilanowski called the meeting to order at 8:31 a.m.

## **RECAP FROM DAY ONE**

*Edelmiro Garcia, Vice Chair*

Mr. Garcia highlighted key issues that emerged during the presentations on Day One.

Dr. Kilanowski noted that the speakers provided recommendations for consideration by the Council.

## **Discussion**

- Jesus Tijerina asked if the data on sexual violence included women migrating within the U.S.
  - Dr. Kilanowski stated that the documentary film, “Rape in the Fields,” deals with migrant women who faced pressure to have sex with foremen.

## **ADDRESSING VIOLENCE AGAINST MIGRATORY AND SEASONAL AGRICULTURAL WORKERS**

*CDR Tarsha Cavanaugh, PhD, MSW, LGSW, Senior Public Health Analyst, Office of Women's Health, HRSA*  
*Deliana Garcia, MA, Director of International Projects, Research, and Development, Migrant Clinicians Network*

CDR Cavanaugh described violence prevention programs of HRSA’s Office of Women’s Health (OWH). Key points were as follows:

- HRSA’s vision for violence prevention includes a Violence in the Workplace policy to assist all employees, including contractors, who are impacted by violence.
- Violence prevention is a Tier 1 priority for OWH. Activities include:
  - ACA outreach and enrollment around intimate partner violence (IPV) screening and counseling preventive service
  - Pilot project on IPV Screening and Counseling at HRSA-funded health centers
  - Maternal Infant and Early Childhood Home Visiting Program domestic violence benchmark
  - Training on Trauma Informed Care for HRSA staff.
- IPV is a critical public health issue and a social determinant of health. It includes physical, sexual, or psychological harm by an intimate partner or spouse. Women are more likely to suffer violence. Three women a day are murdered by their husband or boyfriend, and three-quarters of those who commit gender violence are male.
- OWH uses a socio-ecological model of intimate partner violence developed by the Centers for Disease Control and Prevention (CDC). The model looks at four levels (Individual/relationship/community/society). Factors at one level impact those at other levels.
- A study of 295 MSAW women at health centers in North San Diego County found that 33.9 percent had experienced physical violence; 20.9 percent experienced sexual violence and coercion; and 82.5 percent experienced psychological violence. Those with substance-abusing partners were more likely to experience violence. There was a strong association between adult partner violence and childhood sexual abuse.

- A pilot project on IPV screening and counseling in health centers will take place in eight sites; OWH hopes to add six additional sites in 2016. The goal is for all health centers to add this screening to improve health outcomes for women.
- OWH is training HRSA Bureau and Office staff on Trauma-Informed Care. Expected results include enhanced understanding of the relationship among trauma and health outcomes; increased awareness and understanding of the definition of trauma-informed care; and increased understanding of how to integrate trauma-informed approaches into systems of care.
- Cross-agency/Departmental accomplishments
  - White House Intersection on HIV/AIDS, Gender-Related Health Disparities, and IPV
  - Federal Strategic Action Plan on Services for Victims of Human Trafficking in the U.S.
  - HHS “Stop. Observe. Act. Respond” (SOAR) health and wellness training.
- Opportunities for OWH
  - Collaborate with health professionals to integrate routine screening and counseling for interpersonal and domestic violence in primary care settings. Recent policy brief noted no studies done on impact of IPV on migrant women.
  - Support SOAR training and trauma-informed care training for migrant health clinicians
  - Develop resources to increase awareness of the problem of IPV among migrant and immigrant women and the impact on health outcomes.

Ms. Garcia discussed trauma assessment with MSAWs. Key points were as follows:

- A bad economic situation may induce a person to agree to a contractual work arrangement. The resulting entrapment leaves the individual with few options.
- Trauma has many levels. Trauma in transit can begin with loss of separation from family and community, continue through the trafficking experience, and culminate in deportation.
- Young, low-income men tend to present in clinics only with acute illness or injury. If the client’s condition permits, young men and women should be screened for traumatic events, even if they present with unrelated illnesses or injuries.
- Stigma is a major concern. Training should be provided to help staff at all levels recognize their personal biases.
- Trauma can be acute (e.g., serious injuries, acts of violence, physical or sexual abuse, life-threatening experiences) or chronic (e.g., repeated physical or sexual abuse over time, surviving amidst violence in the family/community, life-threatening neglect).
- Children in circumstances where adults are trying to create a safe environment can be traumatized by the changing surroundings as much as a single or acute traumatic event.
- Effects of trauma
  - Behavior may appear impulsive and/or inconsistent with what is going on in the environment because the individual is reacting to internal stimuli.
  - A history of trauma can make it difficult to cope with stresses of everyday life; trust others; benefit from relationships; maintain memory, attention, and thinking; regulate behavior; or control expression of emotions.
  - Trauma can also impact the ability to perceive and interpret information; lower academic and work performance; result in mental health challenges; lead to bodily discomforts; and affect adult functioning.

- People who have experienced trauma can and do bounce back. Trauma-informed and culturally competent services and care can help people develop resilience.
- The four Rs of trauma-informed care:
  - Realize that trauma is widespread
  - Recognize the signs and symptoms
  - Respond by fully integrating knowledge into policies, procedures, and practices
  - Resist re-traumatizing the individual.
- Key messages of Migrant Clinician Network (MCN) training on trauma assessment
  - A person with trauma can look like any other member of the community
  - The same experience can affect two people differently
  - Clinicians have to be able to provide same level of care to all patients
  - The need to migrate may supersede the person's help-seeking behavior.
- Recommendations for effective trauma assessment with adults
  - Medical history questions that look at factors that can be associated with trauma
  - Structural vulnerability domains and potential sample questions (e.g., financial status, residence, risk environments, food access, social network, legal status, education, discrimination, presumed worthiness)
- Migrant clinicians can learn from refugee health services, where clinicians begin with the assumption that the person has experienced trauma. The Refugee Health Screener-15 and Distress Thermometer are excellent assessment tools.
- Systems of support can make a significant difference in the lives of MSAWs. MCN's Health Network is a virtual case management/patient navigation system that provides continuity of care for MSAWs with chronic conditions. The completion rate for tuberculosis is 83 percent, compared to the national average of 87 percent.

## Discussion

- Ms. Canales said she had seen an increase in domestic violence with men as victims and women as abusers, primarily among undocumented men living with women who are citizens. Those men do not report the abuse.
  - Mr. Garcia cited factors such as fear of deportation, a "machismo" culture, and law enforcement's tendency to believe the woman. It is important to increase awareness.
- Dr. Moreno stated that his clinic works closely with Family Violence Prevention Services to provide primary care services at the San Antonio shelter, which is the fifth largest in the country. He noted that most centers are already at capacity and asked how that affects MSAWs.
  - Ms. Garcia said it is important to recognize that anyone with power over someone else can exercise that power in a negative way. MSAWs, whether men or women, almost always live in circumstances where the power dynamics are not in their favor. Community services are oversubscribed. Migrant women do not have a standing in the community and may not be familiar with the services that are available; they may also have concerns about immigration. For many years, women's shelters required women to be willing to end the relationship in order to receive services.
- Ms. Diaz said that it is important to make the workplace safe for women. She suggested that grants to study violence in the workplace should include funding for in-depth site visits to clearly understand the nature of the problem.

- Dr. Kilanowski asked if Council members had seen cases of domestic violence in their clinics.
  - Ms. Martin said she had seen cases of young girls being brought to the U.S.
  - Dr. Moreno said that his health center works with universities that come onsite to offer training in office skills so girls and women do not have to do manual labor and can become self-sufficient. Engaging community partners provides more options.
- Dr. Kilanowski asked if there was any difference in quality between intake using tablets as opposed to paper and pencil.
  - Ms. Garcia said that if assessment is done orally, the response depends on who is asking the question. The critical issue is to ask the questions.
- Ms. Canales said she had noticed more questions related to abuse or trauma when she went to the physician.
  - Ms. Garcia said that HRSA has made significant progress. CDC now has a violence prevention workshop for men. The attrition rate is less than two percent, which indicates that men are hungry for the opportunity to look at their lives.
- Ms. Montoya asked how a small clinic with few resources could get training.
  - Ms. Garcia replied that MCN and the other NCA grantees have resources to provide training and technical assistance for clinics. It is important to address violence at all levels of the CDC model.
  - Gayle Lawn-Day noted that the Farmworker Health Network, which includes all of the NCA grantees, is designed to provide resources. Any of the member organizations can identify the appropriate partner for the type of support that is needed.
- Dr. Moreno asked what programs have been most successful.
  - Ms. Garcia noted that a clinic in upstate New York was looking at mental health impact on workers at Saratoga race track.
- Dr. Kilanowski asked how small, rural health centers can learn about resources.
  - CDR Rodrigue stated that BPHC sends a weekly newsletter Primary Health Care Digest with information on resources for health centers and stakeholders, and the BPHC website has information on the NCA grantees.
  - Ms. Garcia noted that many MHCs operate on a seasonal basis, with new staff each year.
- Ms. Diaz stated that New York has taken human trafficking seriously. Her health center holds monthly meetings with law enforcement and invited them to talk with workers in the field to reduce fears of deportation. Their efforts resulted in the first successful prosecution of human trafficking of MSAWs.
  - Ms. Garcia stated that American Airlines recently launched a new program, recognizing that they are in a unique position to notice potential trafficking situations.
- Dr. Kilanowski asked if there were any programs to identify child abuse in camps.
  - Ms. Garcia replied that laws about reporting child abuse have been in place for many years. There is less stigma about victims deserving the abuse or being able to avoid it.
  - CDR Rodrigue stated that Migrant Head Start has many resources on their website.
- Dr. Kilanowski asked if the speakers wanted to propose any recommendations.
  - CDR Cavanaugh emphasized the importance of adequate training and resources for clinicians so they do not re-traumatize those who come in for services and can provide the help they need.

- Ms. Garcia recommended that health centers should provide support that is more horizontal and less vertical, integrating resources across staff. They should also address the concentric circles of abuse and violence.

## **STRENGTHENING THE HEALTHCARE WORKFORCE: INTEGRATION OF PROMOTORES/COMMUNITY HEALTH WORKERS**

*Patria Alguila, Program Coordinator/Promotoras de Salud, MHP Salud*

*Evelyn Delgado, Assistant Commissioner for Family and Community Health Services, Texas Department of State Health Services*

*Venus Ginés, M.A. P/CHWI, CEO/Founder, Dia de la Mujer Latina, Inc.*

*Gayle Lawn-Day, PhD, Chief Executive Officer, MHP Salud*

Ms. Delgado described training and certification of community health workers (CHWs) in Texas. Key points were as follows:

- Texas was the first state to pass legislation creating a statewide training and certification program for CHWs. Placing this program within the Division of Family and Community Health Services of the Department of State Health Services (DSHS) made it possible to leverage Title V funding for maternal and child health. Staff members at the state level are paid through Title V funding.
- Promotores/CHWs serve as liaisons and are trusted members of the community. They have a close understanding of the ethnicity, language, socio-economic status, and life experiences of the community they serve, and they assist people in gaining access to needed services.
- Leadership structures for CHWs include the National Promotora Steering Committee and CHW networks and associations (Community Health Worker Training and Certification Program (<http://www.dshs.state.tx.us/mch/chw.shtm>)).
- The primary role of the DSHS is certification of CHWs, trainers, and training sites. Certification requires completion of an approved 160-hour competency-based training program or at least 1,000 cumulative hours of CHW services within the most recent six years. There is no cost for initial or renewed certification.
- The number of certified CHWs in Texas has increased significantly since 2009. Currently, there are more than 3,200 certified CHWs in approximately 130 counties.
- Training includes a standardized framework with eight core competencies: communication; interpersonal; service coordination; capacity building; advocacy; teaching; organizational skills; and knowledge base (specific health issues).
- Training providers may design a program to meet the competencies that is culturally relevant for their communities. Training and education sources include community colleges, health science centers, CHW associations, Area Health Education Centers (AHECs), community-based organizations, and FQHCs.
- Employment opportunities for CHWs include Medicaid Section 1115 (transformation waiver) projects, expanded primary care contractors, health plans, Medicaid outreach/information, ACA navigators and CACs, and other settings.

- Many expanded primary care contractors are utilizing CHWs for the first time. Several health plans were already using promotoras to work with their Medicaid patients. They are asking Medicaid to reimburse managed care organizations for their work, rather than including them in the fixed funding for administrative services. A key issue is ensuring that CHWs do not duplicate services for which Medicaid is already providing payment.
- Key issues for the future of CHWs include:
  - Integration as professionals in mainstream health care and social service systems
  - Varying job classifications and pay levels
  - Sustainable funding/reimbursement mechanisms
  - Training/professional development
  - Recruitment
  - Supervision.
- Next steps for DSHS include
  - Continue collaboration and sharing
  - Share successes and lessons learned with other states
  - Continue to explore reimbursement mechanisms
  - Increase awareness of CHWs for supervisors and employers
  - Encourage MHCs and CHCs to increase paid employment of promotoras or CHWs to improve outreach and build relationships with migrant farmworker families
  - Reach out to those who may be reluctant to seek healthcare services.

Ms. Ginés described the activities of Dia de la Mujer Latina, Inc. (DML). Key points were as follows:

- DML trains promotoras/community health workers (P/CHWs) who serve Latina women. Their training program includes a detailed approach for each of the eight core competencies. Examples include:
  - The Communication module develops promotoras' communication skills, with an emphasis on listening.
  - The Capacity Building module incorporates FEMA training for emergency preparedness.
  - The Knowledge Base module provides detailed information on specific diseases (e.g., breast cancer, etc.) DML received an award from the CDC for its diabetes prevention training.
- P/CHWs can help reduce the three main barriers to health care (accessibility, affordability, and accountability).
- P/CHW core competencies can be incorporated into training for other professions, such as paramedics.

Ms. Alguila and Dr. Lawn-Day described how multi-tiered models and technology can expand the impact of CHWs. Key points are as follows:

- MHP Salud implements CHW programs to empower underserved Latino communities and promotes the CHW model nationally as a culturally appropriate strategy to improve health. They have been in operation for 32 years, with offices in Michigan, Texas, Florida, Ohio, and Washington. MHP Salud serves between 6,500 and 11,000 people in direct services every year. Detailed information on their history and resources is available at MHP Salud CHW Programs (<http://mhpsalud.org/>).

- CHWs are outcomes-driven, experienced, and innovative. They bridge the gap between the community and health and social services. They work with the whole person, the whole family, and the whole community, providing services that are tailored to meet the specific needs of each individual.
- Three key words apply to all CHWs: holistic, balance, and profession. Their work is about duties and orientation, not specific job titles.
- CHWs maximize impact, utility, and outcomes. MHP Salud is presently conducting studies with FQHCs to document the return on investment (ROI) for CHW services.
- Multi-tiered systems can increase the power of the CHW model because they are more effective and efficient.
  - CHWs within the same organization have different job descriptions, multiple job classes, different expectations, and different purposes. Tier I CHWs are volunteers; Tier II CHWs are contractors; and Tier III CHWs are employees.
  - Each tier has a purpose and specific outcomes.
  - All tiers work collaboratively toward a larger programmatic outcome.
  - Compensation is driven by differences in duties, expectations, and orientation.
- Combining technology with the multi-tiered model enables CHWs to provide more direct client service. (CHWs + multi-level approach + technology = POWER)
  - Promotores Connect Project: CHWs at two FQHCs used smart phones and mobile apps to collect and upload data (e.g., CommCare, Epi info, Salesforce).
  - MHP Salud CHWs also use Cloud-based services, two-in-one laptop/tablets, and portable scanners.

## Discussion

- LCDR Lugo asked if there was any national certification for CHWs.
  - Dr. Lawn-Day stated that requirements vary by state, as for other professions. The American Public Health Association comes closest to developing national standards.
- Ms. Canales noted that she had never seen a promotora in Uvalde or Minnesota.
  - Ms. Ginés stated that the primary barrier is the lack of funding or job opportunities once CHWs are trained. It is important to integrate CHWs into health departments and clinics.
- Dr. Moreno asked how much time a CHW spends with a patient.
  - Dr. Lawn-Day replied that many aspects defy quantification, but there are ways to gather the information. Protocols are specific to the program. She is developing tools and resources to help health centers compute their own ROI and demonstrate the effectiveness of CHWs.
- Dr. Moreno noted the difficulty of collecting data when individuals constantly migrate.
  - Dr. Lawn-Day stated that MCN's mobile health network can help provide data. Extrapolation from multiple points and multiple indicators is essential.

## HRSA/BPHC UPDATES

*Seiji Hayashi, MD, Chief Medical Officer and Senior Advisor for Special Populations, Bureau of Primary Health Care, HRSA*

Dr. Hayashi provided updates on BPHC. Key points were as follows:

- BPHC’s mission is to improve the health of the nation’s vulnerable populations. Federal funding for the health center program began in 1965. Key health center requirements include governance by a community board composed of a patient majority.
- The health center program addresses the root causes of health outcomes. All health centers are mandated to provide enabling services. CMS is beginning to realize that if they extend their funding beyond direct services, costs for health care will decrease.
- HHS and HRSA leadership understand the mission and challenges of the health center program. Former HRSA Administrator, Mary Wakefield, is the new Deputy Secretary of HHS, and former BPHC Director, Jim Macrae, is now the HRSA Acting Administrator.
- HRSA has four key strategies for primary care:
  - Increase access to primary care services for underserved populations
  - Modernize the primary health care safety net infrastructure and delivery system
  - Improve health outcomes for patients
  - Promote a performance-driven and innovative organizational culture.
- The new BPHC structure was driven by the expansion of the health center program. The reorganization created a Special Populations Executive Council, which includes the Chief Medical Officer (Dr. Hayashi) and the directors of all five offices. The council will meet once a month and will invite stakeholders from each special population to learn about issues that impact them. They are currently creating a 24-month calendar that will allow each stakeholder group to provide input on a quarterly basis.
- Secretary Burwell just announced funding awards for 164 New Access Points (NAPs) in 33 states and two U.S. Territories. Eleven of the 164 NAPs requested funding to serve migratory and seasonal agricultural workers as well as other populations. HRSA will also fund additional Expanded Services grants (behavioral health, oral health, pharmacy services, and enabling services). They want to allocate 20 percent of that funding to enabling services. Much of that work is done by CHWs, and HRSA is in conversation with CMS regarding payment for those services. They hope to announce funding for health infrastructure improvement program in coming months.
- HRSA would welcome input from the Council regarding:
  - Strategies to increase the number of MSAWs served by health centers
  - Incentives to encourage partnerships in areas where health centers do not exist (e.g., voucher program providers)
  - Mechanisms to help small, rural communities obtain funding and insights regarding barriers to the use of innovative strategies.

## Discussion

- Dr. Kilanowski thanked Dr. Hayashi for supporting the Council.
- Dr. Moreno noted that many health centers have state-of-the-art technology, but the local infrastructure in medically underserved rural communities does not support it.
- Ms. Diaz commented that the map of NAP grantees did not show any MHCs in North Dakota. She noted that many farmworkers migrated to that area due to oil and gas industry.

- Dr. Hayashi replied that HRSA would welcome ideas about alternative strategies to provide services in those communities. HRSA can fund new clinics for three years.
- Mr. Tijerina reported that his health center cannot meet the salaries for primary care physicians.
  - Dr. Hayashi stated that funding for the NHSC is critical. Fifteen percent of all health center clinicians are recipients of loan forgiveness or scholarships through NHSC. However, loan forgiveness is not the only incentive for clinicians to serve in those communities. Staff turnover at some rural health centers is only two percent.
- Ms. Canales reported that providers do not give consistent instructions regarding medications. That presents a challenge for MSAWs, who see different providers when they migrate.
  - Dr. Hayashi noted that there are many issues related to recruitment and retention of clinicians, including the need to develop physicians and nurses who can provide high quality care and the need to increase the diversity of the workforce.
- Dr. Lawn-Day asked if healthcare funding overlaps with funding for economic development.
  - Dr. Moreno stated that the funding does overlap, but rural communities are at the bottom of the list for installation of fiber-optic cables. Two years ago, NHSC funding was expanded to include hospitals, which increases competition for primary care physicians.
  - Dr. Hayashi noted that the Council's recommendations are submitted to the Secretary, who can reach out to other federal departments. He encouraged the Council to think broadly about what is needed in order to improve health for MSAWs.

## **SUBCOMMITTEE MEETINGS**

The Council broke into subcommittees, as follows:

- Migrant Health Services: Frances Canales (Chair), Edelmiro Garcia, Carlos Moreno, Jesus Tijerina
- Access, Resources, and Funding: Wenceslao Vasquez (Chair), Jill Kilanowski, Martha Lopez, Rosa Martin, Jeffrey Partyka
- Public Policy and Advocacy: Alina Diaz, Gwendolyn Gould, Victoria Montoya, Joan Tronson

### **Report Out**

The subcommittees presented the issues they identified during their meetings. The Council consolidated overlapping issues and agreed on priorities and issues for recommendations, as follows:

#### Migrant Health Services

- Continuity of care/specialty services to improve health outcomes before they lead to chronic conditions (dental, vision, geriatric, mental health, podiatry)
- Training for providers (including intake staff) and education for clients
  - Family violence, trafficking, and prostitution
  - New definition of MSAWs
  - Using National Cooperative Agreements
  - Procedures for workers compensation
  - Reimbursement for CHWs/promotores.

#### Public Policy and Advocacy

- Root cause: Poor/hazardous working environment
  - Social determinants beyond HRSA’s scope lead to poor health.
  - Recommendation: Continue to serve as the voice for MSAWs at the federal level through dialogue with other federal agencies to address the social determinants and improve health outcomes.
    - Create nationwide, uniform regulations for housing, pesticides, minimum age for working with tobacco
    - Enforce codes through unannounced inspections
    - Create incentives to provide safe, equitable housing (e.g., loans with favorable interest rates, tax incentives, surplus federal emergency housing, etc.)
    - Prioritize rural communities for installation of fiber optic infrastructure that has already been funded.
- ACA triple aim (Access/Quality/Outcomes)
  - Key issue: Transportation
  - Recommendations:
    - Fund mobile units in small rural communities – data on patient use of services can support the need for a permanent clinic.
    - Fair and equitable reimbursement for telemedicine services.
    - Encourage hospitals to partner with FQHCs. Possible mechanisms include: a) incentives to release patients to a health center for post-operative care (e.g., share cost savings, reduce post-operative infection period to 20 days), and b) FQHC office next to the emergency room entrance.

#### Access, Resources, and Funding

- Access
  - Continued challenges related to recruitment and retention of primary care providers
  - Support expanding full practice authority to include all healthcare professionals
  - Medical-legal partnerships
  - Specialty care.
- Resources
  - Providers
  - Education
  - Specialty care
  - Housing regulations
  - Training
- Funding
  - Need a vision
  - Design Funding Opportunity Announcements with two tiers
  - Continue to fund enabling services (promotores, outreach workers, navigators, etc.)
  - Fund additional cultural competency training, mobile units, training,
  - HPSA designation for NHSC funding.

#### **Recommendations Letter**

Ms. Tronson, Ms. Alina, and Dr. Moreno volunteered to develop the recommendations letter. The Council agreed on the following schedule:

- Ms. Tronson will develop a draft and send it to Ms. Alina and Dr. Moreno by May 15.

- Ms. Tronson will incorporate comments and send a revised draft to Dr. Kilanowski by May 22.
- Dr. Kilanowski will send a final draft to CDR Rodrigue by May 29.
- All Council members will review the final draft during the first week of June.
- The signed letter will be delivered to the Secretary by mid-June.

## **COUNCIL DISCUSSION**

### **Membership**

Ms. Lopez identified the need to increase awareness of the Council. She urged HRSA to make public announcements about membership on the Council. Members could help by informing local media about their participation on a national advisory board or by visiting a HRSA-funded clinic in their community.

CDR Rodrigue noted that letters announcing new members are sent to a listserv that includes all HCs. Going forward, those letters could include the names of existing Council members.

### **Meetings**

Dr. Moreno suggested that the Council should consider meeting after, rather than before, the national farmworkers conference so they could incorporate issues that emerge during the conference.

Council members discussed the possibility of meeting in a different location from the migrant stream conference or in locations the Council has not visited so that members could gain an understanding of issues facing MSAWs in different regions.

Council members suggested topics for the next meeting:

- Farmworker testimonies
- Provider perspectives
- Changing face of MSAW populations
- Perspectives of federal agencies outside of HHS (e.g., Labor, EPA, Housing and Urban Development)
- Outreach and education on HIV
- Children's issues (e.g., Head Start, children with disabilities)
- Behavioral health
- Overview of health centers, ACA, and other key issues to orient new members
- Introduction of new members
- Health issues and services for aging/retired farmworkers.

## **CLOSING/WRAP UP**

Dr. Kilanowski and CDR Rodrigue expressed appreciation for the members who were retiring from the Council and thanked them for their commitment, passion, and service.

CDR Rodrigue assured the Council that they have the full support of the HRSA Administrator and the Secretary. She encouraged retiring members to continue to be advocates in their community and provide the Council with insights that can inform recommendations.

## LOGISTICAL INFORMATION

*CDR Jacqueline Rodrigue, MSW, Designated Federal Official for the NACMH*

CDR Rodrigue reviewed the procedures and deadline for submission of travel vouchers.

CDR Rodrigue noted that the dates and location for the next meeting would be finalized and announced as soon as possible. HRSA will consider Council members' suggestions regarding the location.

Dr. Kilanowski called for a motion to adjourn. The motion was made by Ms. Canales, seconded by Ms. Montoya, and carried by unanimous voice vote. The meeting was adjourned at 4:45 p.m.

<b>TIMELINE FOR RECOMMENDATIONS LETTER</b>		
<b>WHAT</b>	<b>WHO</b>	<b>WHEN</b>
First draft to Ms. Diaz and Dr. Moreno	Ms. Tronson	May 15
Revised draft to Dr. Kilanowski	Ms. Tronson	May 22
Final draft to CDR Rodrigue	Dr. Kilanowski	May 29
Approved draft to Chair and Vice Chair	CDR Rodrigue	First week of June
Final letter submitted to the Secretary, with Chair and Vice Chair signatures	Dr. Kilanowski and Mr. Garcia	Mid-June

## ADDITIONAL ACTION ITEM

- CDR Rodrigue will ensure that announcements of new Council members include the names of existing members.