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

January 13-14, 2016
Santa Clara, California

Council Members in Attendance
Jill Kilanowski (Chair)
Susana Castro
Alina Diaz
Rev. Christopher LaBarge
Martha Lopez
Rosa Martin
William Morgan
Victoria Montoya
Horacio Paras
Jeffrey Partyka
Adriana Andrés-Paulson
Amanda Phillips Martinez
Stephanie Triantafillou

Federal Staff
Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS**)**

Office of Quality Improvement (OQI), Strategic Partnerships Division
CDR Jacqueline Rodrigue, MSW, Designated Federal Official, NACMH
Gladys Cate, NACMH Committee Manager

Office of Policy and Program Development (OPPD), Strategic Initiatives and Planning Division
Iran Naqvi, MBA, MHS, Deputy Division Director
Esther Paul, MBBS, MA, MPH, Public Health Analyst

THURSDAY, JANUARY 13, 2016

CALL TO ORDER
Jill Kilanowski, PhD, RN, APRN, CPNP, FAAN, Chair, NACMH

Dr. Kilanowski called the meeting to order, welcomed new Council members, and invited new and returning members, staff, and guests to introduce themselves. She noted that NACMH Vice Chair, Edelmiro Garcia, and Carlos Moreno were unable to attend this meeting.

Dr. Kilanowski called for a motion to approve the agenda as presented. The motion was made by Rev. LaBarge and seconded by Mr. Partyka.

Dr. Kilanowski called for a motion to approve the minutes of the May 2015 meeting. The motion was made by Mr. Partyka and seconded by Ms. Montoya.

BPHC UPDATES

Office of Quality Improvement, Strategic Partnerships Division
CDR Jacqueline Rodrigue, MSW, Designated Federal Official for the NACMH
CDR Rodrigue announced that HRSA was actively working on filling the six vacancies on the Council. She urged Council members to recommend potential candidates.

BPHC launched a webinar series on Migrant Health Enrichment. Four webinars were presented in 2015 covering the following topics: Migrant and Seasonal Head Start model, the Promotoras model, a new intake process that is more culturally responsive, and the National Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards). CDR Rodrigue stated that the Bureau was planning additional webinars for 2016 and would welcome suggestions for topics.

Discussion

- Dr. Lopez asked if the webinars were on the website.
- CDR Rodrigue stated that most of the webinars had been posted. The remaining webinars were being reviewed for compliance with accessibility standards and would be posted when the review was complete.

Office of Policy and Program Development, Strategic Initiatives and Planning Division (OPPD)
Iran Naqvi, MBA, MHS, Deputy Division Director

Ms. Naqvi reviewed the purpose of the NACMH, the rationale for transitioning oversight of the Council from OQI to OPPD, and the structure of OPPD. She also provided a funding update and reviewed the BPHC mission and strategies.

The purpose of the NACMH is to develop recommendations for the Secretary of HHS on health issues that impact migratory and seasonal agricultural workers (MSAWs) and their families. The Council's recent recommendations focused on quality improvement and direct services; public policy; the Affordable Care Act (ACA) triple aim; and funding to support health equity initiatives.

OPPD handles issues related to policy, budget, and data. OPPD staff has significant expertise that can help move the agenda of the NACMH forward. NACMH has been placed within the Strategic Initiatives Program and Development Division.

HRSA made the following awards in fiscal year (FY) 2015:

- Mental Health Service Expansion-Behavioral Health Integration: $51 million, including $9 million to Migrant Health Centers (MHCs)
- Quality Improvement (QI) Awards: $36 million ($6.4 million to MHCs)
- New Access Points (NAPs): $269 million ($45 million to MHCs)
- National Cooperative Agreements: $3 million
- Quality Improvement Awards: $63 million ($10 million to MHCs)
- Expanded Services: $350 million ($56 million to MHCs)

- Base adjustments, including Patient Centered Medical Home (PCMH) recognition: $165 million ($65 million to MHCs)
- Health Infrastructure Investment Program: $150 million ($33 million to MHCs).

HRSA is waiting on final Congressional action on its appropriation for FY 2016. Key approved activities that will be awarded include Substance Abuse Service Expansion ($100 million), Health Center Controlled Networks ($33 million), and Oral Health Service Expansion ($100 million). In addition, the president's budget requested $40 million for QI and $50 million for NAPs.

The BPHC mission and strategies guide the Bureau's activities and support its focus on delivering value-based care. Outcomes and goals for the four strategies are as follows:

- Increase access to primary health care services
    - Outcomes: The number of patients served by health centers increased by 34 percent, 334 new health centers opened, and 12 million individuals were assisted with ACA Outreach and Enrollment since 2008.
    - Program goals: Continue to increase the number of individuals served, the percent of patients served in existing service areas, and the percent of low-income communities served by health centers.
    - National impact: In 2014, health centers served one in 14 people in the U.S., one in 10 children, and one in seven people living in poverty. Nearly 892,000 patients were MSAWs.
    - MHC impact: In 2014, 172 MHC grantees served 814,178 patients. Clinicians included 2,257 physicians and 1,800 nurse practitioners, physician assistants, and certified nurse midwives. Eighty-one percent of MHCs have received PCMH recognition, and 97 percent have adopted electronic health records (EHRs).
- Modernize infrastructure and delivery systems
    - Outcomes: Ninety-eight percent of health centers have adopted EHRs, 69 percent are PCMH-recognized (FY2015 goal was 50 percent), and 800 health center sites were improved through capital investments.
    - Program goals: All health centers adopt EHRs across all sites, more health centers reach Stage 2 of the Meaningful Use standards, all health centers are PCMH-recognized, and more health centers have modernized facilities.
    - PCMH recognition: PCMH is an evidence-based model that leads to improved patient satisfaction by strengthening the patient-provider relationship. PCMH recognition has been linked with improved health behavior, better health outcomes, and less use of emergency departments and hospitals. PCMH-recognized health centers do better in 11 of 15 clinical quality measures tracked by the Uniform Data System (UDS). Once a health center is PCMH-recognized, next steps are to focus on team-based integration of care and patient engagement, improve care coordination with other providers, and build community partnerships to address the social determinants of health (e.g., housing, education, and transportation).
- Improve health outcomes and health equity
    - Outcomes: Ninety percent of health centers demonstrated improvement on one or more clinical quality measures; 89 percent met or exceeded Healthy People 2020 (HP 2020) goals on at least one clinical quality measures; the 2009 Patient Survey found no disparities in access to care, patient satisfaction, cancer screening, diabetes care, or

hypertension care; and 215 health centers met or exceeded Million Hearts goals on aspirin therapy, blood pressure control and smoking/tobacco cessation.
    - Program goals: Increase the percent of health centers that a) exceed HP 2020 goals, b) improve performance on quality measures, and c) provide enabling services.
    - UDS Quality Improvement Awards (QIAs): Ninety percent of all health centers and 91 percent of MHCs received a QIA based on 2014 UDS data.

- Promote performance-driven, innovative organizations
    - Outcomes: Health centers employ multi-disciplinary teams that include more than 11,200 physicians and more than 9,000 nurse practitioners, physician assistants, and certified nurse midwives, and they provide linguistically appropriate enabling services to more than 2.2 million patients.
    - Program goals: Increase the percent of health centers that provide integrated care; increase the number of health centers utilizing team-based practice models/PCMH; and increase the use of health center data to drive program performance.
    - Data transparency: The UDS webpages within the BPHC website provide a Health Center Profile for each health center grantee, with data for both the state and the individual health center that is available to the public.

Health centers played a significant role in helping the uninsured enroll in affordable coverage and in increasing access to the full spectrum of health care for the populations they serve. From July 1, 2013, through June 30, 2015, health centers assisted more than 12 million individuals in their efforts to become insured. According to UDS data, outreach and enrollment efforts helped to increase the number of insured patients at health centers by 16 percent between 2013 and 2014.

Ms. Naqvi reiterated CDR Rodrigue's request for current Council members to encourage qualified candidates to serve on the NACMH. She closed by providing a list of resources and her contact information.

Discussion

- Dr. Kilanowski asked if all health centers use the same EHR systems.
    - CDR Rodrigue stated that most health centers use one of the top five vendors. A key issue is the ability to access medical records as MSAWs travel. HRSA is working on mechanisms to increase continuity of care.
    - Ms. Naqvi acknowledged that it is a challenging process. There will be advantages once the system is up and running.
- Dr. Kilanowski asked if health centers were required to use one of the top five vendors.
    - Ms. Naqvi replied that the federal government cannot require a grantee to use a specific vendor.
    - CDR Rodrigue stated HRSA was working on improving the dialogue with each of the vendors. In addition, a new cooperative agreement partner was working with health centers to help them report data on clinical outcomes for all populations. Information would be available when the analysis was complete.
    - Ms. Paul stated that health centers are free to choose a vendor. However, BPHC has provided funding to establish health center controlled networks.
    - CDR Rodrigue stated that the Council's concerns were similar to those of other groups. She encouraged the Council to continue to raise this issue.

- Ms. Castro asked if HRSA was looking to recruit members from specific parts of the country.
    - CDR Rodrigue replied that the aim was for the Council to be a geographically diverse group, but the primary requirement is to be a consumer board member of a MHC.
- Ms. Phillips Martinez asked if there were any funding streams that would support the full PCMH model, including transportation.
    - CDR Rodrigue stated that funding for Expanded Services supports transportation. She noted that her office does cross-sector collaboration and was looking at developing new funding opportunities.
    - Ms. Naqvi added that HRSA was looking at a comprehensive perspective based on what patients need.
- Dr. Kilanowski asked if the OPPD's organizational chart was likely to change following the presidential election
    - Ms. Naqvi stated that OPPD was actively seeking to fill the positions that were currently open. She noted that the health center program had grown significantly under the ACA.
- Ms. Andrés-Paulson stated that the current immigration climate makes it difficult for those living in border communities to access health centers.
    - Ms. Naqvi stated that OPPD was looking at all barriers to care for this population, including cultural competency and transportation. She acknowledged that patient perception is significant and health centers need to understand intangibles, such as fear.
    - CDR Rodrigue encouraged the Council to bring those concerns forward. There should not be roadblocks to care.

WELCOME TO SANTA CLARA, CALIFORNIA

Carmela Castellano-Garcia, President/Chief Executive Officer, California Primary Care Association (CPCA)

Ms. Castellano-Garcia welcomed the Council to California and to her home town and noted that she had spent her career as an advocate for Latino health, first as the founder of the Latino Coalition for a Healthy California and now as the CEO of the CPCA.

The CPCA represents more than 1,100 community health center sites throughout the state, including 29 MHC grantees. In 2014, California health centers provided care to nearly six million people. More than half of all health center patients are Latino, and more than 500,000 are MSAWs. About one-third of health center patients are uninsured, and many are undocumented immigrants.

Immigrant health and access to care are important issues in California, which is home to more immigrants than any other state. Nearly half of California's immigrants are naturalized U.S. citizens. About one-quarter have some other legal status, and about one-quarter (2.6 million) are undocumented. Undocumented immigrants represent about 6.4 percent of the state's overall population, but approximately 9.4 percent of the state's labor force, primarily in the service and agricultural industries.

California produces nearly half of all U.S.-grown fruits, nuts, and vegetables, and those crops are harvested almost exclusively by MSAWs. However, farmworkers generally earn low wages and do not have employer-based health insurance, worker's compensation, or disability coverage. Exposure to environmental factors such as heat and cold weather, pesticide exposure, and extreme working conditions contribute to farmworker health. Those factors combine to make MSAWs one of the state's most vulnerable populations. Drought conditions have compounded the situation.

California has been a model for ACA implementation and was the first state to develop its own health insurance exchange (Covered California). During the first open enrollment period, California enrolled nearly three million residents into a Covered California health plan or Medi-Cal, including 1.1 million Latinos. However, nearly 70 percent of farmworkers have no health insurance, and millions of individuals cannot access coverage due to their immigration status.

A recent poll found that 58 percent of registered California voters supported extending Medi-Cal services to immigrants not currently eligible for coverage under the ACA. Currently, 47 of California's 58 counties provide some sort of coverage to undocumented residents. Highlights include the following:

- The state budget agreement for FY2016 allocated $40 million to expand Medi-Cal to undocumented children. Legislation will be introduced this year to provide similar coverage options for undocumented adults.
- Fresno County Board of Supervisors approved a deal with state legislators that committed $5.6 million to health care for the county's indigent population, including the undocumented.
- Sacramento County Board of Supervisors voted unanimously to restore health care funding that they had cut in 2009.
- The County Medical Services Program, which pools the resources of 35 rural counties to provide health services to the poor, voted to provide basic health care to the undocumented.
- Monterey County instituted a pilot insurance service that sets aside $500,000 to pay for lab tests, radiology and pharmacy services.
- Contra Costa County expanded services to undocumented adults.
- The Los Angeles County Supervisors passed a $61 million program (My Health LA) that offers primary care, chronic disease management, prescription medication, and specialty care at county facilities for undocumented individuals at or below 138 percent of the federal poverty level.

CPCA is working with the National Association of Community Health Centers (NACHC) and the National Center for Farmworker Health (NCFH) on the Ag Worker Access 2020 campaign to help California's MHCs increase the number of agricultural workers they serve by 15 percent in the next four years. To reach that goal, CPCA is working with the Central Valley Health Network to expand outreach and enrollment efforts and provide technical assistance in areas such as:

- Educating and enrolling H-2A visa workers in health insurance (in partnership with Farmworker Justice)
- Providing access to coverage for victims of domestic violence
- Resolving enrollment issues for hard-to-reach populations, including migrants, immigrants, and those eligible for Deferred Action for Childhood Arrivals
- Enrolling undocumented children into coverage as soon as possible.

CPCA is also supporting MHCs by using its Outreach and Enrollment Peer Network for communication, updates, best practices, and resource inquiries; participating in the Covered California advisory committee on Marketing, Outreach, and Enrollment Assistance, including the subcommittee for special populations; meeting with a Covered California board member who is a strong advocate for migrant families; and working with the Latino Health Alliance to create awareness that Certified Enrollment Counselors at community clinics and health centers (including MHCs) can help individuals enroll in coverage and access care.

Discussion

- Mr. Morgan commented that the farmworker population in Pennsylvania includes Central Americans, Puerto Ricans, and Dominicans. He had observed similarities between migrant and non-migrant farmworkers and across different populations.
    - Ms. Castellano-Garcia agreed that the farmworker population changes from one area to another. She noted that many MSAWs in California are Chinese.
- Ms. Triantifillou asked for an estimate of the total population of MSAWs in California.
    - Ms. Castellano-Garcia stated that she did not have that information.
- Dr. Kilanowski noted that the demographics of MSAWs vary across the country, and she emphasized that immigrants and migrant workers are different populations.

IMPROVING ACCESS TO QUALITY HEALTH CARE FOR MIGRATORY AND SEASONAL AGRICULTURAL WORKERS

Bobbi Ryder, President & CEO, National Center for Farmworker Health (NCFH), Inc.

Ms. Ryder began by noting that NCFH would celebrate its fortieth anniversary this year and was committed to supporting farmworkers and the NACMH in every way possible. Her presentation provided an overview of national and state trends in funding and users served, strategies to turn the curve and increase the penetration rate, and strategies to build capacity for growth.

Ms. Ryder noted that NCFH refers to the target population as "migratory and seasonal agricultural workers," as stated in the Section 330 legislation. The word "migrant" is used only in the title of the Migrant Health Program and is often considered derogatory. She encouraged the Council to consider making this shift in terminology.

Funding for Section 330g MHCs increased from $180 million in 2010 to $438 million in 2015, while the number of MSAWs served declined from 804,000 in 2010 to 790,000 in 2013. Community health centers (CHCs) that do not receive Section 330g funding serve an additional 74,000 MSAWs each year, on average. In 2014, the number of MSAWs served by MHCs increased to 814,000, and data from 2015 are likely to show an additional increase. The challenge is to find a way to sustain that growth.

NCFH estimates that the number of MSAWs who are currently served by C/MHCs represents about 17 percent of the total estimated MSAW population of 4.5 million. To turn the curve and increase the penetration rate, C/MHCs must identify and report all current MSAW users. This would assure: the future funding of the program; accountability for funding (both local and national); the strength of the C/MHC program as a whole; and meaningful use of EHR and UDS data. It would also assure that MSAWs receive the kind of care that they need.

In FY2015, NCFH conducted a study using the Wall of Wonder (WOW) large-scale focus group methodology. Data were collected through interactive plenary sessions at the Midwestern Migrant Stream Forum in November 2014 and the Western Migrant Stream Forum and the East Coast Migrant Stream Forum in 2015. Participants responded to the following questions:

1. What changes have you seen in your local farmworker community?
2. How have these changes impacted the utilization of services at your health center?
3. What ideas/suggestions do you have that could result in an increase in the number of farmworkers served at your health center?

Responses to these questions identified the following challenges:

- Stigma of self-identifying as "migrant"

- Lack of cultural sensitivity in the "ask"
- Self-registration versus one-on-one interviews at intake
- Limited use of "self-declaration"
- Competing demands on health center staff
- Misperception that "Special Population" status is an insurance category
- Limited new Access Points to open new centers
- Decrease in MSAW patients as a percent of the CHC whole
- Limited availability of bilingual staff
- Emphasis on "outreach and ACA enrollment" versus "MSAW outreach and case management"
- Confusing interpretations of definitions and terminology
    - "Preparation, processing and delivery"
    - "Aged and/or Disabled former Migratory Workers and families"
    - Casual use of language (i.e., "families" versus "dependents")
    - Habit of classifying family members as "Other"
    - HRSA's 12.1.12 UDS clarification of the definition of "agriculture"
- The priority on EHR adoption adds to the confusion. There are no standard fields for Occupation across the industry; there is no system of checks and balances between registration and electronic health history forms; some software rewrites patient demographics on each visit; and some software severs adult children's records from their MSAW parent.

Ms. Ryder offered potential solutions to address the challenges identified through the study:

- Strengthen health centers' ability to evaluate and modify systems
- Review and develop policies and standard operating procedures for accurately capturing and maintain occupational data
- Provide training for staff on an on-going basis
- Analyze penetration rates (estimated number of MSAWs compared to number of users by county), for an accurate needs assessment
- Train staff to ask the right questions in the right way, with sensitivity to political climate, literacy levels, and culture
- Clarify federal policies and guidance.
- Provide training to boards to strengthen their oversight role in assuring access for the MSAW population
- Adopt a C/MHC Financial Performance measure regarding sustaining and increasing the numbers of MSAWs reached
- Adopt C/MHC Clinical Performance measures regarding identification of patients engaged in high-risk occupations, migration, or other factors that have implications for treatment protocols
- Enforce expectation that all Section 330 grantees will ask, document, and track special population status regardless of funding sources
- Establish mandatory requirements that EHR software vendors include standardized fields for documentation of occupation in order to become certified.

Ms. Ryder emphasized that turning the curve requires C/MHCs to open doors and increase access by:

- Revitalizing the "Causa" to serve the MSAW population
- Reaching out to unserved population pockets
- Defining "outreach and enabling" as different from "outreach and enrollment"
- Institutionalizing and integrating "outreach and enabling"
- Identifying and articulating the value proposition to CHCs as potential MHCs.

Ms. Ryder proposed that C/MHCs ask themselves the following questions:

- Are we identifying all MSAWs and their families currently served at our health center sites?
- Are we serving all MSAWs and their families in close proximity to our "Service Area"?
- Are there other MSAWs and their families that are currently not receiving services, and how can we reach them?
- Have we unintentionally created barriers for MSAWs and their families?
- Do Consumer Board Members have the tools to be effective?
- Are board members fully engaged?
- Who are our key partners to assist in increasing the number of MSAW patients?

NCFH is in an ongoing dialogue with HRSA and BPHC regarding strategies to sustain and fund growth of the Migrant Health Program. They have recommended changes to bring the UDS into alignment with the statute and regulations; funding that recognizes growth where it occurs; and new funding mechanisms that are sensitive to the needs of the uninsured MSAW population.

Ms. Ryder announced that NCFH is partnering with NACHC on a new initiative, "Ag Worker Access 2020," with a goal of reaching two million MSAWs by 2020. The initiative has three strategies: ensure accurate identification and reporting; increase access to quality care; and build capacity to sustain growth.

NCFH and NACMH were in the process of finalizing the initiative, appointing a task force and steering committee, and building a network of supporters. Ms. Ryder invited Council members to become partners in this effort. Resources are available at the NCFH website (NCFH Website) and NACHC's My Learning Community (NACHC's My Learning Community).

Ms. Ryder presented three recommendations for the Council's consideration that were aligned with the Ag Worker 2020 initiative:

1. Identify concentrations of unserved and underserved agricultural workers
2. Expand access to quality care
3. Expand health center capacity to serve MSAWs.

Ms. Ryder invited Council members to provide feedback regarding the proposed strategies and approaches.

Discussion

- Rev. LaBarge asked if migratory workers who fall outside the definition of agriculture could benefit from the migrant health program.
    - Ms. Ryder stated that migratory workers who are not involved in agriculture were not eligible for migrant health services, but they could be seen at CHCs.
- Ms. Andrés-Paulson supported the need for more concerted efforts to train front desk staff at M/CHCs.
- Ms. Diaz stated that MSAWs are concerned that their privacy is not respected, especially in small clinics, and they are reluctant to complete evaluations due to fear of retaliation.
    - Ms. Ryder offered to address this issue directly with Ms. Diaz.
- Ms. Phillips Martinez asked for clarification of what is included in "enabling services."
    - Ms. Ryder stated that BPHC and HRSA define them as services that enable patients to access a health center.

PERINATAL ORAL HEALTH

Francisco Ramos-Gomez, DDH, MS, MPH, Professor, Division of Pediatric Dentistry, and Director, Pediatric Dentistry Preceptorship Program, University of California, Los Angeles School of Dentistry

Dr. Ramos-Gomez discussed issues related to perinatal oral health. He noted that pregnant women are at higher risk for tooth erosion and periodontal disease. Untreated maternal tooth decay increases the risk of dental caries in their children, and untreated oral infections can further complicate pregnancy, especially for those with chronic conditions such as diabetes.

Pregnant women often do not seek oral health care or they are referred for care by their doctors. Many health care and dental providers have limited knowledge of the safety and benefits of perinatal oral care, and dentists often delay or withhold treatment for pregnant women due to fear of potential harm to the mother or fetus or concerns about liability.

The California Dental Association issued a consensus statement on perinatal oral health in 2010 which stated that, "Prevention, diagnosis and treatment of oral diseases, including needed dental radiographs and use of local anesthesia, are highly beneficial and can be undertaken during pregnancy with no additional fetal or maternal risk when compared to the risk of not providing care. Good oral health and control of oral disease protects a woman's health and quality of life and has the potential to reduce the transmission of pathogenic bacteria from mothers to their children." (CDA Foundation).

Cavities are contagious, and what happens during pregnancy will be mirrored during infancy. Bacteria that cause tooth decay can be passed to the newborn by anyone who spends eight hours or more per day with the baby.

Early childhood caries (ECC) includes any tooth decay, including extractions and fillings from previous decay, in the primary dentition. It is more prevalent among families with lower socio-economic status, in certain ethnic and cultural groups, such as Hispanics and Native Americans, and among children with disabilities and other special needs.

Dental caries is 100 percent preventable. A simple risk assessment looks at the following factors:

- Family history of dental decay
- Bottle with other fluid (i.e., not water or milk)
- Frequent between-meal snacks (more than three times/day)
- Child sleeps with bottle or breastfeeds
- Saliva-reducing factors (e.g., medications, radiation/systemic)
- Low socio-economic status.

A risk assessment form for young children is available at Caries Risk Assessment Form (Ages 0-6).

ECC can be prevented through an approach that includes both the mother and the baby. Mothers should obtain necessary dental treatment before delivery, if possible; chew or dissolve sugarless or xylitol-containing gum or lozenges after eating; avoid smoking or use of tobacco products; and avoid sharing saliva between family members. Infants and children should learn good oral hygiene and behaviors from birth, including regular dental visits beginning no later than their first birthday, brushing twice daily with fluoride toothpaste, limiting sweets and starches, avoiding frequent snacking, and weaning by age one.

Fluoride is important for the formation of healthy teeth and to prevent tooth decay. It is important to address concerns that many immigrants have about public water sources. Tap water can be boiled or filtered without reducing the benefits of fluoridation and should be used to make baby formula. All children should use fluoridated toothpaste, which should be the last thing that touches a child's teeth.

Parent education is important. Tooth brushing should be seen as part of the bonding experience with the child and should be part of the everyday routine. The "Two Minutes, Twice a Day" campaign was developed to educate families and children about proper tooth brushing. Videos in English, Spanish, Chinese, and other languages are available at 2min2x.org.

Dr. Ramos-Gomez provided examples of educational tools for parents and caregivers, including a chart with self-management goals, general oral health tips, oral health tips for infants and toddlers, and a graphic showing the amount of sugar in various types of beverages.

Dr. Ramos-Gomez closed by emphasizing that oral health is an issue of social justice and human rights.

Discussion

- Ms. Naqvi expressed concern that the recommendation to wean by age one could be controversial, because it is a personal decision that is influenced by culture and economic factors. She asked how that recommendation was received.
    - Dr. Ramos-Gomez replied that the focus had shifted to recommend controlled breastfeeding, beginning at age one, and to clean the teeth and gums after feeding to eliminate residual milk in the mouth.
- Ms. Andrés-Paulson asked how to help families when a child has cavities. She noted that dentists do not want to treat children unless they are cooperative, and many appointments are in the morning, when parents have to work.
    - Dr. Ramos-Gomez stressed the importance of prevention and education. New mechanisms for protective restoration can arrest infection, but it is important to teach parents about prevention so the problem does not recur.

THE CHANGING LANDSCAPE IN EARLY CHILDHOOD EDUCATION

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

Ms. Cuesta provided an overview of the Migrant and Seasonal Head Start (MSHS) program, which provides services for children from birth to mandatory school age. She noted that most families in the program have two parents, and more than 90 percent are from Mexico. Slightly more than half of the children are infants and toddlers.

MSHS has a strict definition of what constitutes agriculture (i.e., row crops or tree crops).

The number of children in MSHS programs has dwindled in recent years. Factors include the cost to provide services for infants and children and the political climate regarding immigration.

Most children enrolled in MSHS have coverage through Medicaid and/or the Children's Health Insurance Program (CHIP), and a small number have other insurance. Fewer than 10 percent have private health insurance.

Children in MSHS get health care and oral health care while they are enrolled in the program. MSHS and HRSA have begun to work together to ensure that children receive health care services at health centers when they are not enrolled in Head Start.

Head Start is mandated to ensure that 100 percent of children receive a professional dental exam. However, it is difficult for MSHS to achieve that goal due to the seasonal nature of the program. Challenges in providing oral health services include finding pediatric dental providers who accept Medicaid within the service area, lack of Medicaid reciprocity in migrant streams, difficulty accessing complete medical and dental records for children who migrate, and lack of parent education materials in Spanish.

HRSA and MSHS recently developed a more direct and detailed memorandum of understanding (MOU) for their collaboration. The first stage of the collaboration was to promote the MOU at the state and national level. Stage II will focus on impact at the program level. It includes direct assistance to MSHS grantees, a MSHS Health Manager's Network that will utilize social media for educational purposes, and a series of leadership training programs for grantee staff provided by Farmworker Justice.

MSHS also established a partnership with NACHC to promote collaboration between federally qualified health centers (FQHCs) and MSHS programs, with a focus on oral health.

Discussion

- Dr. Kilanowski noted that her dissertation focused on pediatric oral health. She found that children who were enrolled in MSHS had more access to health care and better oral health.
    - Ms. Cuesta stated that MSHS takes responsibility for taking children to health and oral health services during the months that children are enrolled in the program. Parents tend to withdraw from those services once the child begins to attend school.
- Dr. Lopez asked if Head Start has parent education materials on oral health.
    - Ms. Cuesta replied that Head Start has education materials for parents, as well as curricula to train staff to discuss oral health with parents. The Collaboration Office has conducted webinars for Head Start staff on that topic. The Head Start has extensive resources ((ACF OHS Early Childhood Learning & Knowledge Center).
- Mr. Paras asked if Ms. Cuesta had examples of best practices of collaboration between MSHS programs and FQHCs.
    - Ms. Cuesta stated that in addition to the MOU, MSHS and HRSA developed a partnership guide to help MSHS and FQHCs work together and to ensure that children benefit from those relationships. They also developed a "widget" that parents can use to find the nearest MSHS programs and health centers as they travel across the country. They hope to develop an app that would help parents locate migrant education, child care, and health services.
- Ms. Andrés-Paulson asked what efforts were being made to ensure that the collaboration outlined in the MOU is implemented at the local level.
    - Ms. Cuesta replied that HRSA and MSHS are working on building relationships at the local level to support the collaboration. Shortly after this meeting, they would meet with a grantee that covers 12 states to ensure that all of their sites are working with health centers. In California, Ms. Cuesta is working with the CPCA to connect CHCs with the MSHS programs that have the greatest need for oral health services.

PRENATAL EXPOSURES IMPACTING THE HEALTH OF MIGRANT CHILDREN

Kenneth Lyons Jones, MD, Chief, Division of Dsymorphology/Teratology, Department of Pediatrics, University of California, San Diego School of Medicine, and Medical Director, MotherToBaby

Dr. Jones described the impact of exposure to a teratogen, which is a drug, chemical, or environmental agent that when taken by a woman during her pregnancy can have an adverse effect on her unborn baby. He noted that little is known about the health status of female migrant farmworkers. However, many of the known occupational risks that they face (e.g. substance abuse, pesticide exposure, hypothermia, overexertion, under-nutrition, lack of sanitary washing facilities in the fields, and domestic violence) can impact the health of a fetus.

A teratogen registry was formed in San Diego in 1979 to provide information and alleviate public concerns. The registry is now known as "MotherToBaby" (MTB) and is operated as a service of the non-profit Organization of Teratology Information Specialists (OTIS) (MothertoBaby).

OTIS/MTB provides information to pregnant women and women contemplating pregnancy about the risk of drugs chemicals, and environmental agents to the developing fetus and conducts research. They also conduct research to gain new information about the effects of agents for which little or no information is presently available.

Alcohol is the most serious teratogen to which female farmworkers are exposed. Fetal alcohol syndrome is associated with prenatal and postnatal growth deficiencies, developmental delay, fine motor dysfunction, and facial malformation. More than minimal exposure to alcohol during gestation—including the weeks before a woman knows she is pregnant—has a greater impact on fetal development than any other illicit drug, including marijuana and cocaine.

Little is known about alcohol consumption among female farmworkers. Dr. Jones presented findings from a number of studies on alcohol use among Latino migrant workers, average number of drinks per week by country/nation of origin, binge drinking by country of origin; and frequency of alcohol use by gender. Extrapolating from those findings, he speculated that approximately 100 infants are born with FAS each year to female farmworkers.

It can be difficult to prove that prenatal pesticide exposure causes adverse pregnancy outcomes. Research on pesticide exposure is based primarily on animal studies. Most studies can only estimate the amount absorbed. Often only recent exposure can be determined, and it is difficult to identify a population that has not been exposed. Actual exposure is often not specified; and exposure to pesticide is often determined by job title, without interviewing the worker.

A longitudinal birth cohort study (CHAMACOS study) examined chemicals and other factors in the environment and children's health in the Salinas Valley in California. The study found no evidence of an adverse relationship between fetal growth and any measure of in utero organophosphate pesticide exposure. However, it did find a decrease in pregnancy duration, especially with increasing exposure levels during the latter part of pregnancy.

OTIS/MTB conducted a study to identify barriers to access and utilization of OTIS/MTB among Latinas in San Diego and to measure the effectiveness of a Spanish-language media campaign and health education outreach in the Hispanic community. The study found that health education outreach was a necessary activity to raise awareness regarding teratogens and the benefits of teratogen counseling; a

multi-media effort is productive, given appropriate funding; and face-to-face health education efforts are more productive than telephone-based information for many Hispanic women.

Dr. Jones offered the following recommendations to develop collaboration between OTIS/MTB and the migrant health program:

1. In farmworker clinics and MHCs, designate an established individual who is linked to a designated counselor at one of the MTB services to whom the clinic worker or pregnant woman can speak on a regular basis
2. Collaborate with other types of screening programs (e.g., cervical cancer, dental, etc.)
3. Provide a health fair focused on prenatal environmental exposure
4. Participate in a quarterly screening day on a regional level
5. Connect with schools and send information home with students when they do vision and hearing screenings
6. Participate in the Ag Worker Access 2020 campaign
7. List information on OTIS/MTB about the free lunch program information that is sent to schools and sent home with every child
8. Provide Spanish-language educational materials at MHCs and other health centers.

Discussion

- Dr. Lopez noted that the MTB website did not include a link for information in Spanish.
    - Dr. Jones stated that a Spanish-language website had been developed with funding from HRSA and would be uploaded in the near future.
- Ms. Naqvi noted that female farmworkers often have little control over their working conditions.
    - Dr. Jones agreed, but he suggested that they could contact OTIS/MTB to learn about the risks of pesticides to which they may be exposed and the risk of alcohol exposure during pregnancy.
- Ms. Andrés-Paulson stated that female farmworkers would never speak up against their employer because of fear of retaliation.
    - Dr. Jones stated that OTIS/MTB was not asking women to speak out against their employers. They are providing education regarding their pregnancy and risks to which they may be exposed.
- Ms. Triantifillou stated that she worked with women who were involved in the AgMart case that Dr. Jones cited. She noted that even if pregnant women were not directly exposed during pesticide application, they were exposed to pesticide residues on plants. The courts found a plausible relationship between working in the field and birth defects. However, the company did not have records showing when individual workers were in the field, and there was not enough evidence to hold the company accountable for the exposure. AgMart was levied one of the highest fines in the history of North Carolina agriculture, but they ended up paying a fraction of that amount while the families suffered the lifelong consequences of the exposure.
    - Dr. Jones stated that a number of things could be done to improve the situation, including additional research and education.
- Dr. Kilanowski noted that Migrant Clinicians Network developed a comic book in Spanish to inform women about pesticide exposure.

ENVIRONMENTAL INFLUENCES IMPACTING THE HEALTH OF MIGRANT CHILDREN

Dorina M. Espinosa, PhD, Youth, Families, and Communities Advisor, University of California Cooperative Extension, Humboldt/Del Norte/Mendocino/Lake Counties

Dr. Espinosa provided an overview of food insecurity and its implications for nutrition and health in migrant families. She began by reviewing the history of this issue:

- 1984: The President's Task Force on Food Assistance cited evidence of hunger in the U.S., but was unable to estimate the extent of the problem.
- 1990: The National Nutrition Monitoring and Related Research Act recommended a standardized mechanism and instrument to measure food insecurity, and the American Institute of Nutrition published definitions of food security, food insecurity, and hunger.
- 1994: National Conference on Food Security Measurement and Research
- 1995: First federal food security survey is administered through the U.S. Census Current Population Survey.
- 2006: USDA introduced new language to describe the range and severity of food insecurity (e.g., "low food security" and "very low food security").
- 2011: Food security questions were added to the National Health Interview Survey.
- 2015: The USDA Economic Research Service released 20th year of annual Food Security Survey data.

Dr. Espinoza noted that only poverty-linked food insecurity and hunger are captured by research instruments. She defined key terms as follows:

- Food security: Access by all members at all times to enough food for an active, healthy life. It includes at a minimum: (1) ready availability of nutritionally adequate and safe foods and (2) assured ability to acquire acceptable foods in socially acceptable ways (without resorting to emergency food supplies, scavenging, stealing, or other coping strategies).
- Hunger: An individual physiological condition that may result from prolonged, involuntary lack of food that goes beyond the usual sensation.
- Food insecurity: A household whose members are uncertain of having, or unable to acquire, enough food to meet the needs of all members because they have insufficient money or other resources for food.
- Low food security: Household members obtain enough food to avoid substantially disrupting their eating patterns or reducing food intake by a variety of coping strategies, such as eating less varied diets, participating in federal food assistance programs, and/or participating in community food pantries.
- Very low food security: One or more household members experience disrupted normal eating patterns and reduced food intake because of insufficient money or other resources.

It is important to monitor food insecurity because poverty and income measures do not account for local differences in housing and food costs. Recent changes in the household (e.g., divorce, illness) affect food insecurity but are not reflected in yearly income.

Levels of low food security and very low food security spiked at the onset of the Great Recession (2007-2008) and have not returned to their pre-recession level. In 2014, 14 percent of U.S. households were food insecure (8.4 percent with low food security, and 5.6 percent with very low food insecurity), compared to 12 percent prior to the depression and 16 percent during the depression. The level of food insecurity was higher in households with children.

Average annual spending on food increases along with income, while the percent of income spent on food decreases. Households in the lowest income quintile spend approximately 11 percent of their income on food, while those in the highest quintile spend approximately eight percent of their income on food.

External mediators (e.g., food and nutritional policy, social norms, agro-economic conditions, equity) and internal mediators (e.g., changes in income, chronic disease, lack of coping strategies, etc.) have an impact on the nutrition and health outcomes of food insecurity.

Dr. Espinoza reviewed the findings of several studies connecting food insecurity with health outcomes:

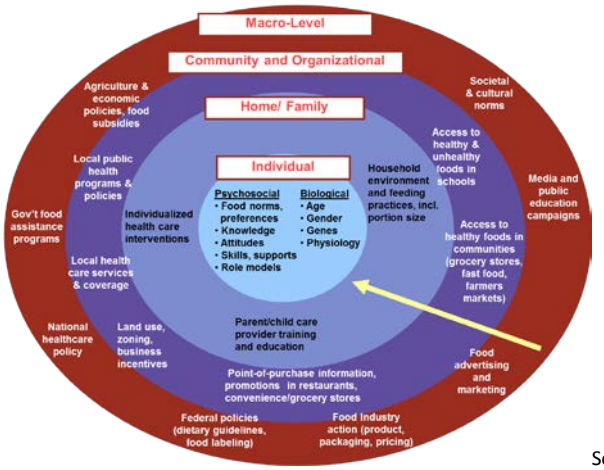
- Food insecurity was associated with depression that impacted physical health among parents as well as parenting practices such as infant feeding that impact health outcomes for children.
- Food insecurity was associated with lower nutrient intakes and lower dietary quality, especially in adult women; disordered eating patterns in women; self-report of "poor or fair" health; poor mental health/depressive symptoms; and obesity in adults, especially women.
- Latino households were significantly more likely to be food insecure than white households.
- Household food insecurity was associated with low educational attainment, low household income, lack of health insurance, and tobacco use.
- Among youth, food insecurity was associated with poor health, colds, and headache; lower bone mineral content in boys; anemia in young children and teens; insecure attachment and delayed mental proficiency in toddlers; anxiety, depression, withdrawal, and other behavior problems; lower math and reading skills; and suicidal symptoms in teens.
- Lower household supplies of food and vegetables were associated with lower intake of those foods in children
- Food insecurity was associated with higher intake of fat, saturated fat, sweets, and fried snacks among immigrant children.

The relationship between food insecurity and obesity is not clear. A 2006 study found that child food insecurity increased the odds of obesity, but a 2009 study found no relationship. A study of food insecurity and obesity among farmworkers in the rural Central Valley of California found that 46 percent had low or very low food security, and 51 percent of the children were overweight or obese. A 2010 study of migrant and seasonal farmworker families found that 64 percent were food insecure, and 32 percent of the pre-school children were food insecure. Obesity was prevalent, although causation was not shown.

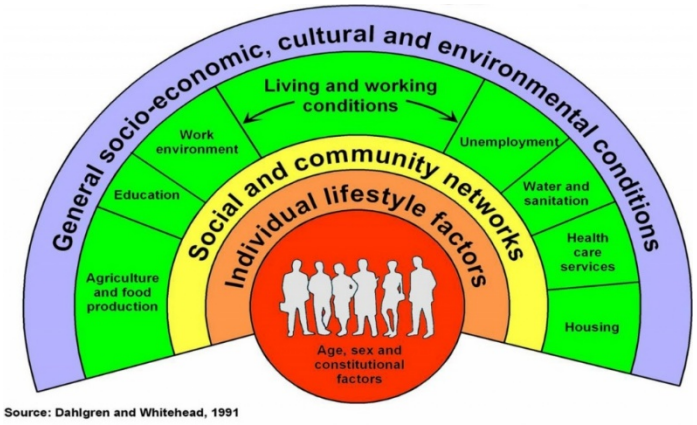
Approximately 60 percent of MSFWs live below the poverty level, but only 10 percent make use of the food assistance that is available to them.

A 2014 study found that migrant farmworker children had a higher prevalence of obesity. Children aged six to 12 had a higher prevalence of elevated blood pressure, and older children had a higher prevalence of anemia.

Dr. Espinoza presented two graphics showing the impact of multiple factors on health outcomes:



Source: US DHHS NIH, 2014



Source: Dahlgren and Whitehead, 1991

Dr. Espinoza emphasized the importance of nutrition education and food assistance programs. Participation in the Supplemental Nutrition Assistance Program (SNAP) increased significantly following the 2009 Stimulus Package, which increased benefits and expanded eligibility. Children in new-entrant SNAP households were 38 percent less likely to be food insecure six months after enrollment in the program. Early enrollment in the Women, Infants, and Children (WIC) program during pregnancy produced the greatest improvement among women from food insecure households, and longer participation in WIC produced the greatest improvement in children.

The USDA's online tool, "What's Cooking?" (USDA FNS What's Cooking?) has a searchable database of healthy recipes using foods from the SNAP Thrifty Food Plan to help with healthy meal planning, cooking, and grocery shopping.

Dr. Espinoza presented a graph from a study of nutritional strategies to reduce childhood obesity among farmworker families. The strategies included promoting mobile produce markets to farmworker camps; promoting gardens and distributing tools and inputs; providing information on healthy eating at low-cost restaurants; providing parent education on non-food treats for children; assisting eligible families to register for SNAP benefits; encouraging food pantries to establish healthy food standards; and encouraging service providers to target food distribution to family food-insecure periods.

Discussion

- Ms. Phillips Martinez asked if a family that was using only one coping strategy, such as participating in a food assistance program, would be considered to have low food security.
    - Dr. Espinoza replied that the defining feature of low food security is that eating patterns are disrupted.
- Ms. Montoya requested more information regarding the study associated with the strategies to reduce childhood obesity.
    - Dr. Espinoza replied that it was a five-year study conducted in the Central Valley of California. The use of promotoras to train the community was a key to the success of the project.
- Dr. Kilanowski described her research on food insecurity among migrant populations in Michigan and Ohio.
- Ms. Triantifillou noted that some school systems were revising their school lunch programs. She asked if MSHS had made any changes to their nutritional programs.
    - CDR Rodrigue stated that some Head Start programs in Washington, DC had begun to incorporate gardens and food preparation into their programs.
    - Dr. Lopez stated that some MSHS grantees had begun to involve families, and all grantees are required to meet nutritional standards. Key factors in school nutrition are food preparation and the amount of time that students are given to eat.

FRIDAY, JANUARY 14, 2016

RECAP FROM DAY ONE

Jill Kilanowski, PhD, RN, APRN, CPNP, FAAN, Chair, NACMH
Martha Lopez, EdD

Dr. Kilanowski called the meeting to order, noted that Dr. Lopez would provide the summary of the first day of the meeting, and called for a motion to modify the agenda to reflect that change. The motion was made by Ms. Andrés-Paulson and seconded by Rev. LaBarge.

Dr. Lopez summarized the first day of the meeting and highlighted key points.

Council members shared observations regarding educational materials:

- Dr. Ramos-Gomez presented an easy-to-remember recommendation for tooth brushing ("Two minutes, twice a day").
- Dr. Ramos-Gomez emphasized the importance of oral health prevention and education for pregnant women. He also noted that economic barriers might prevent pregnant women from accessing oral health care.
- It would be helpful to have information on resources for farmworkers from indigenous communities that do not speak Spanish.
- Education programs need to respect ingrained culture and beliefs.
- Animated videos and infographics are excellent tools.
- CDR Rodrigue noted that BPHC is moving toward developing infographics and videos, rather than brochures. Dr. Kilanowski offered to share an article on levels of health literacy.

Ms. Diaz noted that the agenda for this meeting was focused on issues related to women and children. The presentations were excellent, but she would like to see the Council address other issues as well. Dr.

Kilanowski noted that the decision to focus on maternal and child health was made at the previous meeting. At the end of this meeting, the Council would determine the focus for the next meeting.

Ms. Phillips Martinez suggested that future meetings might include site visits to farms or clinics.

Collaborations and Partnerships

Daniel Carroll, Employment and Training Administration (ETA), Office of Policy Development and Research, U.S. Department of Labor
Susan Gabbard, PhD, Vice President, JBS International, Inc.
Jorge Nakamoto, PhD, Senior Research Associate, JBS International, Inc.

Mr. Carroll, Dr. Gabbard, and Dr. Nakamoto provided an overview of the National Agricultural Worker Survey (NAWS), which is considered the gold standard for health information on the farmworker population. It is an annual random sample survey of 1,500 to 3,000 crop workers that started in fiscal year 1989.

The NAWS is a reliable source of information on crop worker demographics. However, it has limited regional coverage and does not provide local data. H-2A workers are excluded from the survey.

Collaboration among federal partners is vital to the continuation of the survey. Partner agencies sponsor questionnaire supplements and collaborate on population estimates, analysis, and reporting. The NAWS has had an ongoing collaboration with HHS since FY1999 through work with HRSA, MSHS, and the National Institute on Occupational Safety and Health. The current HRSA/NAWS partnership began in FY2008; it has included development and updating of health tables on the web and development of a new health supplement that will be fielded in 2016. MSHS has had an ongoing supplement since 2008 examining knowledge of and barriers to participating in MSHS in response to a congressional mandate. One report is published and a second forthcoming.

The NAWS collects information on the farmworker first, followed by questions about dependents. The questionnaire has been designed to streamline data collection and reduce the burden on the respondent. All changes to the tool must be announced through the *Federal Register* in order to obtain public comment. Interviewers are trained to ensure that the respondent understands each question.

Preliminary NAWS data from 2013-2014, data from the 2012 USDA Census of Agriculture, and research findings identified the following significant trends:

- Recent changes in agriculture affecting crop labor include increased fruit and vegetable consumption and changing grain use; new production practices; competition from abroad; and competition from other industries.
- The Western Stream was the only area where crop acreage increased between 2007 and 2012; it also represented half of the total agricultural wage expenditures in 2012. The Midwest and Eastern streams saw declines in acreage.
- The supply of farmworkers has been impacted by increased difficulty of crossing the U.S.-Mexico border, reduced incentives for Mexicans to emigrate to the U.S., and a change in the legal status of farmworkers in 1986.
- The number of weeks spent by U.S. crop workers in farm work and non-farm work expanded between 2000 and 2014, while the number of weeks spent out of country decreased significantly. This results in an increase in the number of weeks that farmworkers are unemployed.

- The share of farmworkers born outside the U.S. declined from 83 percent in 2000 to 72 percent in 2014. The number of crop workers identified as indigenous declined from 15 percent in 2006 to five percent in 2014.
- Migrant workers represented 49 percent of farmworkers in 2000 but only 16 percent in 2014.
- The average age of farmworkers, the number of female farmworkers, and the average years of education are all increasing.
- More farmworkers have families, but many live away from their families when they are working. Only one-quarter of the farm labor force is single.
- Forty percent of farmworkers live below the poverty level, but two-thirds do not use government service programs.

Health care findings from the 2014 NAWS include:

- Thirty-six percent of farmworkers, 46 percent of farmworkers' spouses, and 81 percent of farmworkers' children have health insurance coverage. Government programs are the primary source of coverage, especially for spouses and children.
- Fourteen percent of employers of crop workers offer insurance; 11 percent of workers enroll in coverage.
- Almost two-thirds of farmworkers visited a health care provider within the past two years. Those with insurance coverage were more likely to seek health care than uninsured workers.
- CHCs and MHCs are important sources of health care for crop workers, especially those without insurance. Only one percent of respondents said their last visit was to the emergency room.
- Cost of health care or lack of insurance is the main barrier to utilizing health care. A small percentage cited language barriers, immigration status, or lack of transportation.
- The prevalence of diabetes, high blood pressure, and other chronic conditions increased from 2000 to 2014. It is unknown whether this was due to new diagnoses or increased access to health care.

NAWS health data has been expanded to:

- Capture information about farmworkers' dependents' use of health services, including migrant and community health centers;
- Distinguish between preventive/routine care and care for an illness or emergency;
- Collect data on access to dental care;
- Include questions on use of preventive health services, such as blood pressure and cholesterol tests; and
- Capture information about quality of care.

A new NAWS supplement will obtain data on access to and quality of preventive health services for the farmworker and his or her family, and access to digital media for issues related to health. Another new supplement will capture data on education and training.

Discussion

- Mr. Paras asked if the survey included questions about transportation.
    - Dr. Gabbard replied that the new supplement includes separate questions on preventive care, illness, and injury as well as questions on transportation. All data from 2010 are available on the internet. The collaboration with HRSA will make health data from 2011-2014 available.

- Dr. Lopez asked how the NAWS defines a farmworker household.
    - Dr. Gabbard stated that the household is defined as the economic unit, independent of where people reside.
- Ms. Triantafillou asked what languages are used for the survey.
    - Dr. Gabbard replied that interviewers are fluent in English and Spanish. Translators are used for other languages.
- Ms. Diaz asked what types of farm work are included in the survey.
    - Dr. Gabbard stated that the NAWS is limited to crop workers.
- Ms. Triantafillou asked when data from the digital supplement would be available.
    - Dr. Nakamoto replied that data collection might begin in February, once the instrument is cleared by the Office of Management and Budget. It would take about two years to complete the process of data collection and analysis.
- Council members discussed the issue of health insurance for H-2A visa holders. They noted that contracts require employers to provide housing and transportation, but not health care. Visa holders are eligible for coverage under the ACA, but they are only here for six months and the marketplace only offers plans for one year.

PUBLIC HEARINGS

Four migrant farmworkers from the Salinas Valley provided testimonies regarding their experiences accessing health care services. Questions and key responses were as follows:

- What is working well at the clinic where you receive health services, and what do you feel needs improvement?
    - The services are good, but we have to pay out of pocket for dentists or vision care.
    - I have trouble getting to the clinic, but they treat me well so I am able to work and give my children what they need. Sometimes insurance doesn't cover the cost, and sometimes our income is not enough to cover the expenses at a private clinic.
    - The CHC had a long waiting time and wasn't able to help me. The private clinic had all of the services I needed.
    - Some people are not patient enough to wait. The problem is that some of the CHCs do not have enough doctors.
    - Sometimes they look at us differently because we are Hispanic. People who speak English do not have to wait as long. The difference is noticeable.
    - We need to get permission from our employers to miss a day of work. That makes it difficult to make an appointment.
- Do the CHCs have staff that can help you in your native language (speaking, information, materials)?
    - They brought information to my house, but I wasn't able to access services at the health center because of communication problems and the staff.
    - We don't visit the clinics that often. When we do go, they look at us as Hispanic and many of us don't have insurance and don't have much money.
- Do you have promotoras who visit your community?
    - No. Many migrants move from one county to another. They provide information on schools, but not about clinics.
- What are the greatest problems for health care for those who have children?
    - My children do not have insurance.
- How can we facilitate health care for men? What would make you want to go?

    - If we don't feel bad, we don't go to the doctor. When we go, it's at the last minute. We don't want to miss a day of work, and our employer does not offer insurance. The insurance we have does not cover much, so we end up paying out of pocket. It does not cover dental or eye care. Our children do go to the doctor.
    - People have to make less than $1300 a month to qualify for financial help. Why should we go, if we don't qualify? Thank goodness I have never needed to see a doctor. Two years ago I had anxiety—I couldn't exercise or run. When I went to the hospital, they told me I didn't have anything but they sent me to a cardiologist. He prescribed some pills, but I couldn't afford to pay for them. I went to a doctor in Mexicali. I had to pay out of pocket, but it was cheaper. When I got home, I didn't follow up because I already had a bill with the hospital. Why would I get into debt again?
- Have you gotten coverage through the ACA?
    - I got it, but it doesn't cover very much. It would be nice to have more coverage through insurance at work so we could see doctors.
    - Medi-Cal costs $300 a month, which is too much for me.
    - I have insurance through my work, but I still have to pay something. People with families also have insurance. Every worker should have insurance. We have to earn less to get coverage. The insurance doesn't cover my daughter-in-law, and it doesn't cover problems with my teeth.
- How much is your deductible?
    - We have to pay $500 to $600 before we can use the insurance. Sometimes we do not have that in our pocket.
- How many of you go to a CHC?
    - I do not visit the clinic because I do not have the coverage. There are two clinics in the area. They have people who can help you if you do not speak English. It's just for the children, not for myself. I haven't experienced discrimination.
- Were you aware that clinics can provide transportation?
    - Most of the farmworkers said they were not aware of that.
- Are appointments available for the days when you don't work?
    - We have to make an appointment two to three months in advance.
- Does the clinic have evening hours?
    - Yes
- Are women who work in the fields aware of the dangers of pesticides to which they might be exposed?
    - They know they are exposed. When they are applying pesticides, they stop work and tell us to come back later.
    - Sometimes the bosses allow pregnant women to work for six months. Some employers do not provide time off. Some people are afraid to stop working.
    - It would be helpful to have more time off when the babies are born.
- Are mothers able to continue nursing their babies?
    - Yes, for a time. But it is not possible to nurse at the work place—it is prohibited to take babies to the field because of the pesticides. Women are in pain because they cannot nurse their babies at the right time.
- Where do workers leave their children when they are working?
    - They take them to a family member. Those who don't have family take them to a program at the school. But the program ends at 5:30, and sometimes we have to work later than that.

- Are working hours changed when the weather is hot?
    - Sometimes they stop us from working when it is too hot.
    - Sometimes we have to work early in the morning in order to take our children to the doctor in the afternoon.
    - We have to work all the time. But we cannot do everything they ask, because it is hot and we are very tired. The employer is obligated to give us a 15-minute break, but they don't always follow the rules. Workers do not complain, because they don't want to lose their jobs.
- How many of you got flu shots this year?
    - My mother got one, I will get mine soon.
- Are your healthcare experiences the same, no matter where you go?
    - The service is the same.
- Have you noticed if female farmworkers have any bad experiences with supervisors or bosses?
    - I only work with men.
    - There has been training that everyone should be respected in the workplace and it is not right to be harassed.
    - A woman from my home town had to leave work because the bosses were harassing her. She was afraid to report it.
- What is your hope or dream for your family?
    - Clinics need to provide more information about health and the services that are available.
    - We need more information and opportunities to get help regarding health.
    - We need more information and more rules to protect workers. The rules should be the same for all companies, but each company has their own rules. Some companies offer paid leave, but others do not provide any time off.
- Are you able to eat what you need to live a healthy life?
    - Sometimes.

Council members thanked the farmworkers for sharing information about their experiences and encouraged them to consider serving on the consumer board of their local CHC.

Council members debriefed the testimonies and made the following suggestions:

- Have a more consistent process for interpretation and a more controlled environment
- Have more structure and more specific questions so the Council can obtain the information it needs to support its recommendations
- Consider having the Council travel to the farmworkers
- Work with health centers closest to the meeting site
- Correct misinformation when it is presented.

COMMITTEE MEETINGS

Dr. Kilanowski reviewed the committee assignments for the coming year:

- Executive Committee: Jill Kilanowski (Chair), Edelmiro Garcia (Vice Chair), Jacqueline Rodrigue (DFO), Bill Morgan
- Migrant Health Services: Edelmiro Garcia, Carlos Moreno, Bill Morgan, Horacio Paras, Stephanie Triantafillou

- Access, Resources, and Funding: Jill Kilanowski, Martha Lopez, Jeffrey Partyka, Amanda Phillips Martinez, Adriana Andrés-Paulson
- Public Policy and Advocacy: Susana Castro, Alina Diaz, Rev. Charles LaBarge, Victoria Montoya

Committees met to discuss issues for potential recommendations to the Secretary (with the exception of the Executive Committee).

REPORT BACK FROM COMMITTEES

Committee representatives presented the key issues that emerged in their discussions, as follows:

Migrant Health Services

- Identify eligible farmworker patients for care
- Increase access to care for migrant workers—identify and address barriers
- Extended clinic hours/urgent care
- Enabling services (transportation, outreach, interpreters)
    - Clarify expectations for services
    - Determine whether there will be sufficient funding to serve two million by 2020
- Continuity/portability/reciprocity
    - Benefits, medication, access
- Workforce
    - Culturally competent intake process that meets the needs of this population
    - Education of staff
- Patient engagement regarding health and decision-making
    - Patient satisfaction surveys
    - Recruiting farmworkers for board positions.

Access, Resources, and Funding

- MHCs need to be more accountable to the populations they serve
- Needs assessment to determine where workers are and what services are needed
    - Data from NAWS and NCFH
- Funding for mobile units
- Provider workforce capacity (number and type)
    - Diversity
    - Pipeline development
    - Issues raised in previous recommendation and letter of 3/21/14
- HRSA through NAWS communication of value
- Widely distribute the "widget" described by CDR Rodrigue (e.g., through Amazon and Apple Store)
- Funding to incorporate digital technology for direct services and education (Gayle Lawn Day/MHP Salud)
- Digital intake
- Portable EHR
- Interagency support for pesticides (labor records and health implications)
- Formal communication channels to ensure effective transfer of institutional memory and clear and consistent communication between OQI and OPPD
- Open windows for H-2A coverage, including length of time and portability
- Fund expanded education for counseling and education staff to enroll target population

- Improve patient-provider communication (e.g., how providers describe themselves when they first talk to the patient)
- Patient level
    - Oral health risk assessment
    - Pesticide exposure
    - Screenings for substance abuse, health literacy, food insecurity, homelessness
    - Standardize forms for health data collection that feeds UDS.

Policy

- Define who we serve (i.e., "migrant and seasonal farmworkers" or "migrant and seasonal agricultural workers")
- Institutionalize funding for outreach and enabling services
- Less than one-year enrollment in ACA coverage for H2A visa holders
- Transportability of insurance coverage
- Refine and clarify the definition of "migrant" versus "migratory"
- Require employers using the H2A visa program to provide health care coverage
- Clarify how PCMH includes outreach and enabling services
- Provide fluoride information at CHC/MHC/county health and prenatal programs
- Lack of available fluoride for non-tap water sites.

FORMULATION OF RECOMMENDATIONS TO THE SECRETARY OF HHS

Council members distilled overlapping issues and identified themes for recommendations, as follows:

A. Increased use of digital technology
    1. Widely disseminate the widget that HRSA developed (e.g., through Amazon and iTunes)
    2. Incorporate digital technology for patient services and education (e.g., EMRs on flash drive, digital cards)
    3. Expand the use of technology for continuity of care
    4. Encourage interagency support for labor records regarding health implications of pesticides
        a. Work with existing agencies (e.g., Association of Clinicians for the Underserved)
    5. Expand digital assessment to identify unmet needs and assist in expansion of programming
        a. Standardized forms
        b. Screens for substance abuse, health literacy, food insecurity, homelessness, depression
        c. Oral health risk assessment
    6. Increase annual funding for the NAWS and develop multi-year, interagency agreements with the Department of Labor to coordinate information collection.

B. Increased accountability of MHCs/CHCs
    1. Invest in innovations to evaluate performance and patient satisfaction
    2. Fund studies of return on investment of enabling services
    3. Establish quality measures for enabling services.

C. Effective transition of NACMH
    1. Establish formal communication channels between OQI and OPPD to ensure that institutional memory is transferred effectively and to facilitate two-way communication between the Council and national cooperative agreement grantees.

D. Access to healthcare coverage for H2A visa holders
    1. Address issues such as enrollment period, service time, and cost
    2. Use the North Carolina public-private partnership to enroll H2A visa holders as a model.

E. Capacity building/workforce development
    1. Invest in outreach, enrollment assistance, and benefits counseling for MSAWs
    2. Support increased diversity in the pipeline of healthcare professionals, especially in oral health and behavioral health
    3. Support training for intake staff, including cultural competence and ability to properly identify MSAWs
    4. Support utilization of mobile services by MHCs to reach MSAWs in remote locations.

F. Reciprocity of coverage
    1. Consider funding a pilot study to assess how Health Center Controlled Networks can work with the Office of the National Coordinator for Health Information Technology to increase reciprocity of coverage and continuity of benefits, medications, and access.

CLOSING AND WRAP UP

Ms. Triantafillou, Rev. LaBarge, and Ms. Phillips Martinez volunteered to develop the first draft of the recommendations letter. Council members agreed on a timeline to develop and submit the letter:

TIMELINE FOR RECOMMENDATIONS LETTER

Writing team sends first draft to the Chair, Vice Chair, and Mr. Partyka	Monday, January 25
Chair sends revised draft to HRSA staff	Friday, January 29
HRSA sends draft with comments to Chair	Tuesday, February 2
Chair sends revised draft to full Council	Tuesday, February 2
Council members submit comments	Thursday, February 4
Chair sends final draft to HRSA	Friday, February 5

HRSA staff and Council members agreed to hold the next meeting in Rockville, Maryland, most likely in May, 2016. Council members proposed the following topics and potential speakers:

- NACHC update
- Best practices in mental health integration (speakers from the Substance Abuse and Mental Health Services Administration)
- Retention of health care professionals
- Farmworker rights (H-2A visa, paid leave) (speakers from the Department of Labor, Farmworker Justice)
- 340b prescription program (speakers from HRSA)
- Best practices for team-based care (Ms. Andrés-Paulson will provide contact information for a potential speaker)
- Services for farmworkers with disabilities (speaker from the HHS Administration for Community Living).

LOGISTICAL INFORMATION

Gladys Cate, NACMH Committee Manager

Ms. Cate reviewed the reimbursement policy and procedures and urged Council members to submit their vouchers and original receipts as soon as possible.

ADJOURNMENT

Dr. Kilanowski called for a motion to adjourn. The motion was made by Mr. Paras and seconded by Mr. Morgan.

The meeting was adjourned at 4:18 p.m.