June 20, 2016

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

Dear Secretary Burwell:

On behalf of the National Advisory Council on Migrant Health (Council) that met May 17-18, 2016 and in accordance with the charge given to the Council, we submit the following recommendations for your consideration. The Council is charged to advise, consult, and make recommendations to the Secretary of the Department of Health and Human Services (HHS) in support of her role as authorized under section 330(g) of the Public Health Services Act, as amended, 42 USC 254(b) to improve health services and conditions for migratory and seasonal agricultural workers (MSAWs) and their families.

During this meeting, we received updates from the Health Resources and Services Administration (HRSA) and the National Association of Community Health Centers (NACHC). Additionally, the Council received presentations from:

- Centers for Medicare and Medicaid Services (CMS) on available services for MSAWs,
- Health Information Technology, Evaluation, and Quality (HITEQ) Center on supporting Migrant Health Centers' effective use of health information technology,
- Department of Labor (DoL) and JBS International, Inc., on monitoring the terms and conditions of agricultural employment and assessing the conditions of agricultural workers,
- National Council of Agricultural Employers on improving the health and welfare of MSAWs, including H-2A workers,
- Farmworker Justice on the New Wage-Hour Guidance on "Joint Employment" and the H-2A program,
- Environmental Protection Agency (EPA) on the Agricultural Worker Protection Standard Revisions, and
- Migrant Clinicians Network and Community Health Centers from New York and Illinois on best practices for team-based/continuity of care.

The Council prioritized the recommendations and hereby presents the following recommendations for the Secretary's consideration.

A. The penetration rate of migrant and seasonal agricultural workers (MSAWs) utilizing Migrant Health Centers (MHCs) is only 19.8 percent. The Council proposes the following efforts to increase the number of MSAWs served:

1. Support the Ag Worker Access 2020 Campaign, organized by the National Associations of Community Health Centers (NACHC), with appropriate resources, and by ensuring health centers fulfill their role and mission to conduct outreach in order to identify pockets of

agricultural workers overlooked due to agricultural industry changes. The Secretary could encourage health centers to conduct outreach in partnership with the Bureau of Primary Health Care's National Cooperative Agreements, community advocacy organizations, Migrant Head Start and Migrant Education, churches, and food banks. Migrant Health Centers (MHCs) may also find expertise in their neighboring community health centers (CHC) to help them build capacity to serve agricultural workers.

2. Equip MHC and CHC grantees to better identify MSAWs already served, by implementing mandatory in-service training programs to enable staff to identify MSAWs accurately, and by ensuring the Health Center Program Compliance Manual includes information that would enable health centers to identify MSAWs accurately. In-service programs must ensure that:
    a. Identifying MSAW status is independent of sliding fee scale eligibility determination and/or verification of insurance coverage.
    b. The term "families" used in the Health Center Program Statute may not be limited to legal dependents and should include extended family members those in domestic partnerships and common law relationships.
3. HRSA collaborate with the Department of Labor to promote the utilization of health care services available to MSAWs and H-2A workers through the Affordable Care Act and MHCs, and to demonstrate how efficient health care services enhance both the lives and productivity of agricultural workers.
4. HRSA follow-up with NACHC on the number of health care provider vacancies in 330g grantees and the number of MSAWs served through non-section 330g locations.
5. HRSA review the many definitions of the term "MSAW" and articulate a standard and more inclusive definition to ensure consistent data collection across departments and cooperative agreement agencies. The 2015 Uniform Data System Manual definition of the term "agriculture" includes farming in all of its branches, as defined by the North American Industry Classification System, a program of the Office of Management and Budget that standardizes tasks for use by Federal statistical agencies in developing data related to the US business economy. HRSA must ensure the definition of agricultural workers includes employment identified as "cultivation" to ensure workers employed in industries such as fishing and hunting, or processing harvested food are identified as MSAWs.
6. The HHS/HRSA website provides consumer information and resources, particularly for migrant populations searching for resources such as Head Start Child Care and health center locations. The Council recommends that for non-English speaking consumers the HRSA home page provide access to these websites in Spanish, Creole, and other languages commonly spoken by MSAWs.

B. Due to the rural nature of agricultural work, MHCs and CHCs that serve MSAWs continue to face challenges with technology available to society as a whole, due to lack of access to affordable and effective solutions.

1. Encourage Federal cross-agency collaboration between entities such as Federal Communications Commission (FCC), United States Department of Agriculture, and the Department of the Interior to assess the current levels of broadband expansion in order to assist rural health clinics. Broadband access is crucial for community health, especially for highly mobile MSAWs requiring mobile health records and needing care coordination across county and state lines. Funding has already been received for the extension of broadband to more rural areas through the Wireline Competition Bureau of the Federal Communications

Commission (FCC), but contractors have not necessarily completed the work. Hence, many rural and frontier communities currently lack access to affordable and effective broadband.

2. HHS and HRSA expand investment in programs that support smaller community health centers to:
    a. Collaborate in technology agreements to achieve economies of scale, and
    b. Encourage maintenance of health center ownership and control of data to enable more effective use of electronic health records data for analysis of health needs and outcomes.

HHS and HRSA have significantly invested in expanding the Health Information Technology (HIT) capacity infrastructure and utility in rural and frontier communities through programs like Health Center Controlled Networks, the Office of Health Information Technology, and the Federal Office of Rural Health Policy's HIT Network grant programs. However, MHCs and CHCs serving this highly mobile and underserved population continue to face multiple challenges in realizing the full potential of HIT to provide better quality and better coordinated care.

In closing, we thank the Secretary for her consideration of our recommendations on behalf of those we serve. The MSAW population is an important contributor to the overall health and economic well-being of our nation and we are duly honored to serve on the National Advisory Council on Migrant Health.

Sincerely,

Edelmiro Moreno Garcia
Acting-Chair

cc: Mr. James Macrae
Ms. Tonya Bowers
Ms. Jennifer Joseph
Ms. Esther Paul