

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

May 17-18, 2016
Bethesda, Maryland

Council Members in Attendance

Jill Kilanowski (Chair)
Susana Castro
Alina Diaz
Rev. Christopher LaBarge
Martha Lopez
Rosa Martin
Carlos Moreno
William Morgan
Victoria Montoya
Horacio Paras
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 Policy and Program Development (OPPD)

Jennifer Joseph, MEd, PhD, Director
Matthew Kozar, Director, Strategic Initiatives and Planning Division (SIPD)
Iran Naqvi, MBA, MHS, Deputy Director, SIPD
Carole Chamberlain, Public Health Analyst, SIPD
Esther Paul, MBBS, MA, MPH, Designated Federal Official, NACMH, SIPD
Priscilla Charles, Committee Meeting Manager, NACMH, SIPD

Office of Quality Improvement (OQI), Strategic Partnerships Division (SPD)

Tracy Orloff, Director

TUESDAY, MAY 17, 2016

Call to Order

Jill Kilanowski, PhD, RN, APRN, CPNP, FAAN, Chair, NACMH

Dr. Kilanowski called the meeting to order and invited Council members, staff, and guests to introduce themselves. She noted that Council member Jeff Partyka was unable to attend the meeting.

Dr. Kilanowski called for a motion to approve the agenda as presented. The motion was made by Mr. Paras, seconded by Ms. Montoya, and carried on a voice vote.

Dr. Kilanowski reviewed the materials for the meeting, including a worksheet to assist the Council in developing recommendations. After reviewing the protocols and guidelines for a successful meeting, she noted that all Council members had a voice and encouraged them to participate actively.

Dr. Kilanowski called for a motion to approve the minutes of the January 2016 meeting. The motion was made by Rev. LaBarge, seconded by Mr. Morgan, and carried on a voice vote.

BPHC Updates

Office of Policy and Program Development (OPPD), Strategic Initiatives and Planning Division (SIPD)

Jennifer Joseph, MEd, PhD, Director

Dr. Joseph reviewed the purpose and function of the NACMH and the status of the Council's January 2016 recommendations. She also provided updates on funding and emerging issues for the health center program.

The function of the NACMH is to advise, consult with, and make recommendations to the Secretary of HHS and the HRSA Administrator regarding the organization, operation, selection, and funding of migrant health centers (MHCs) and other entities funded under section 330(g) of the Public Health Service Act. HRSA relies on the Council and other stakeholders to tell them how they can better meet their responsibilities. OPPD is committed to working with the Council to make meaningful, measurable progress over time.

BPHC has prioritized optimizing the quality and value of care for its work by improving: access to care; quality of care, health information technology (HIT), and data; and health system capacity and workforce. The recommendations that the Council submitted following the January 2016 meeting were aligned with those priorities, as follows:

- Access to care
 - Facilitate healthcare access coverage for H2A visa holders
 - Enhance access portability
 - Increase mobile service utilization.
- Quality of care, HIT, and data
 - Support technology use to improve access and continuity of care.
 - Increase and standardize data collection and screening tools across federal programs.
 - Support innovations to evaluate health center performance and patient satisfaction.
 - Better quantify and leverage the return on investment of HC enabling services.
- Health system capacity and workforce
 - Invest in training, recruiting, and retaining culturally, ethnically and linguistically competent workforce (oral and behavioral health)
 - Support health system capacity building. Provide additional support for new partnerships to reduce costs, increase access, and promote quality outcomes.

Updates and emerging issues include the following:

- BPHC is developing a Health Center Compliance Manual to clarify policy guidance for health centers and centralize the information in one location so it is easier for health centers to understand what is required to demonstrate compliance.

- HRSA provided \$5 million in supplemental funding for health centers in Puerto Rico to study the Zika virus. Findings of the study will inform how it is addressed in the continental U.S. HRSA is engaged in outreach and education, in collaboration with the Centers for Disease Control and Prevention (CDC).

Funding for health center programs in fiscal year (FY) 2016 will be awarded as follows:

- Outreach and Enrollment: \$7 million (93 awards)
- Substance Abuse Service Expansion: 94 million (271 awards)
- Health Center Controlled Networks: 33 million (~45-50 awards)
- Oral Health Service Expansion: \$150 million (~420 awards)
- Health Infrastructure Investment Program: \$265 million (~290 awards)
- Patient-Centered Medical Home (PCMH) Recognition for New Grantees: \$10 million (~290 awards)
- Delivery System Health Information Investment: \$90 million (~1,300 awards)
- Quality Improvement Awards: \$100 million (~1,300 awards)
- New Access Points: \$50 million (~75 awards).

Funding for New Access Points (NAP) is lower than in previous years. The evaluation criteria include priority points to encourage health centers to develop new delivery sites in the most underserved areas.

HRSA's budget request for FY2017 includes \$5,092 million for the health center program, which is nearly 50 percent of the total request of \$10,677 million.

HRSA is making major investments in delivery system reform (access, cost, and quality) in order to demonstrate value to patients and communities; providers, and payers. Health center investments include funding for service expansion, PCMH recognition support, quality improvement awards, and delivery system health information technology. It is also investing in training and technical assistance (TA) through funding for health center controlled networks (HCCNs), primary care associations (PCAs), and national cooperative agreements (NCAs).

Dr. Joseph noted that Dr. Kilanowski, Ms. Montoya, and Mr. Partyka would cycle off the Council following this meeting. She thanked them for their contributions to the migrant health program during their tenure on the Council.

Dr. Joseph provided a list of resources that could assist the Council in developing recommendations and noted that full details were available in the meeting materials. She closed by encouraging Council members to contact her directly.

Discussion

- Ms. Montoya requested more information on the NAP competition.
 - Dr. Joseph replied that NAP funding is for new or existing centers to add new delivery sites to increase access to services. MHCs can request funding for a seasonal site, but they must have one full-time brick and mortar site. Applications must include a plan to build the site, attract providers, and demonstrate compliance. The funding opportunity announcement was published in April; application deadlines are June 17 (Part 1) and July 15 (Part 2).

- Dr. Kilanowski expressed concern that funding for HIV/AIDS was lower in FY2017, yet significant numbers of adolescents and young adults require medication to maintain their quality of life.
 - Dr. Joseph replied that the appropriations were determined by Congress.
- Ms. Morgan stated that sexually transmitted diseases (STDs) were a significant problem in rural Pennsylvania.
 - Dr. Joseph noted that state and local public health funding for prevention and treatment of STDs had decreased over time. HRSA was funding a three-year pilot program to determine whether HIV/AIDS could be treated as a chronic disease and managed within a primary care setting.
- Dr. Moreno stated that if testing could be mandated, more cases would be identified, which in turn would justify funding for a safety net.
 - Dr. Joseph replied that the findings of the pilot study would provide important information regarding how health centers could provide the spectrum of care that is needed to manage HIV/AIDS.

Office of Quality Improvement (OQI), Strategic Partnerships Division

Tracy Orloff, Director

Ms. Orloff provided an overview of the national cooperative agreements (NCAs) that provide training and technical assistance (T/TA) to potential and existing health center program grantees and look-alikes. She noted that the grantees provide webinars, educational sessions, publications, newsletters, monographs, fact sheets, trainings at state/regional/national meetings, and other TA resources.

A complete list of the 19 NCAs was included in the meeting materials. Key grantees for migrant health are Farmworker Justice, Health Outreach Partners (HOP), MHP Salud, Migrant Clinicians Network (MCN), the National Center for Farmworker Health (NCFH), and National Association for Community Health Centers (NACHCs). Resources and programs provided by migrant NCAs include:

- MCN: Expanded the Health Network case management and patient navigation project to increase the continuity of care for migrant and seasonal agricultural workers (MSAWs) and their families
- NCFH: Developed a train-the-trainer curriculum to help front desk staff more accurately identify who is a MSAW and family member during the patient intake process, resulting in more accurate reporting in the Universal Data System (UDS)
- NACHC and NCFH: Launched the “Ag Worker 2020 Campaign” to serve two million agricultural workers through the health center program by 2020
- MHP Salud: Uses the Pasaporte de Salud (Health Passport) to equip promotores/as de salud with the skills needed to enhance community outreach and education
- HOP: Launched a transportation initiative to document the impact of transportation barriers on health care costs and strengthen patient-centered transportation solutions
- Farmworker Justice: Supports the H-2A Health Access Project to build coalitions and partnerships among primary care associations (PCAs) and CHCs in Washington, Florida, Georgia, and California to promote enrollment into health insurance marketplace coverage.

Migrant health initiatives at HRSA/BPHC include:

- A Memorandum of Understanding (MOU) with the HHS Administration for Children and Families (ACF) Migrant and Seasonal Head Start (MSHS) program to improve access for MSHS children at CHCs. Activities have included:

- Specialized training to 27 MSHS program grantees that serve more than 35,000 children
- Dual web widget, to help parents, educators, and health care providers find a health center and MSHS program ([HRSA Data Warehouse](#))
- MSHS workshops at three Migrant Health Stream Forums.
- HRSA/Department of Labor (DOL) Interagency Agreement to support the National Agricultural Workers Survey (NAWS). The new supplement developed by HRSA and NAWS will collect data on preventive care and digital access among MSAWs.

HRSA has allocated significant resources to combat the Zika virus and protect MSAWs and their families:

- HRSA awarded \$5 million in funding to enable 20 health centers in Puerto Rico to expand voluntary family planning services and hire more staff.
- OQI is facilitating meetings with health centers to support ongoing efforts to prevent the spread of the virus.
- HRSA is using the NCA with MCN to implement outreach and education strategies, including assessment of clinical information and patient education materials on the Zika virus; assessing current knowledge and need of MCN's constituents; conducting a national webinar about available resources; distributing information via email, website, and social media platforms; and an article in MCN's newsletter on recommended resources.

Discussion

- Ms. Montoya asked how her health center could improve its partnership with the local MSHS grantee.
 - Ms. Orloff stated that Gladys Cate would put Ms. Montoya in contact with staff at ACF who could provide resources on programs that are working well.
 - Mr. Gallegos of NACHC stated that the director of the MSHS collaboration office at Head Start, Guadalupe Cuesta, would be an excellent resource.
- Ms. Andrés-Paulson stated that private providers of Head Start programs need specific guidance on how to enroll migrant children.

NACHC Update

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

Mr. Gallegos provided an update on NACHC's legislative agenda, Medicaid expansion and payment reform, National Health Center Week, and the Ag Worker Access 2020 Campaign.

NACHC Legislative Agenda

The current policy environment for health centers includes bipartisan support for health centers, but major action in Congress is unlikely during an election year and with new leadership in the House. NACHC continues to educate new members of Congress.

NACHC's legislative priorities for 2016 are health center funding, workforce development, and CHC innovation:

- Funding: Mandatory funding (\$3.6 billion per year from a trust fund established by HR2/MACRA) will support the health center program through FY2017, but it is essential to fight for sustainable funding and to protect the \$1.5 billion in discretionary funding. NACHC has asked Congress to:
 - Support health center funding in the FY17 appropriations process by signing the Bilirakis-Green letter in the House and the Wicker-Stabenow letter in the Senate. (The

letters were signed by 70 percent of House members and 62 senators, which is a record in both chambers.)

- Request level discretionary funding (\$1.5 billion)
- Commit to taking action well before the September 2017 deadline to make the Health Centers Fund permanent.
- Workforce development: NACHC conducted the first national CHC workforce study since 2004 to better understand current vacancies, recruitment/retention challenges, training activities, barriers, and opportunities. The study found that 95 percent of all CHCs have a current vacancy, and 70 percent have a family physician vacancy. If fully staffed, CHCs could serve two million more patients. NACHC's asks of Congress are:
 - Fully fund the National Health Services Corps at the president's budget request (\$380 million)
 - Invest in Teaching Health Centers (short- and long-term funding)
 - Pass the Family Health Care Accessibility Act to include volunteer providers under the Federal Tort Claims Act
 - Pass the CONNECT for Health Act to improve CHCs' access to telehealth technology
 - Reauthorize and fund the Nurse Practitioner Training program.
- CHC Innovation: CHCs are seen as a solution to improve health and increase access to healthcare. MHCs developed and implemented this model of care and enabled access to those services by incorporating translators and outreach workers as part of the model.
 - NACHC is urging members of Congress to join the Bipartisan Caucus on Community Health Centers.
 - NACHC invited members of Congress to visit a CHC during a district work period or during National Health Center Week (August 7-13).

Medicaid Expansion and Payment Reform

- Thirty-one states and the District of Columbia have expanded Medicaid. Six states have 1115 waivers for expansion. A number of states are actively working on expansion, and a number of expansion states are considering changes.
- There is a national movement toward payment reform, such as alternative payment models (e.g., California and Oregon), Accountable Care Organizations (e.g., Minnesota), the State Innovation Models Initiative, and Section 2703 Health Homes. More information is available at: [National Association of Community Health Centers](#)

National Health Center Week

The theme of National Health Center Week 2016 is "Celebrating America's Health Centers: Innovators in Community Health." Mr. Gallegos urged Council members to have their health centers hold an event and to invite their Congressional representatives to visit. More information is available at: [National Health Center Week](#).

Ag Worker Access 2020

The Affordable Care Act expanded coverage, but coverage is not meaningful without access to a provider. The number of MSAWs and dependents served by MHCs (891,796) is only 19.8 percent of the total estimated number in the U.S. (4.5 to 4.6 million). NACHC is working with health centers, PCAs,

MSHS, farmers and growers, and community organizations to expand access to care for MSAW populations.

Although funding for MHCs increased between 2010 and 2013, the number of users declined. Barriers to accessing care include:

- Changes in MSAW demographics
- Changes in the length of the growing season, droughts, intense heat, lack of water, increased mechanization
- Changes in type of agriculture; increased ethnic, cultural, and linguistic diversity among MSAWs
- Changes in migration patterns
- National and state immigration policy
- Lack of knowledge of services available, inconvenient hours, lack of transportation, fear and lack of trust
- Patients do not self-identify as MSAWs, making it difficult to capture data for UDS reporting
- Health center staff lack training on definitions of “migrant” and “seasonal workers”
- Lack of financial resources and cost of services
- Language and cultural differences
- Growers and farmers restrict outreach workers’ access.

NACHC and NCFH launched the Ag Worker Access 2020 Campaign to reverse that trend, with a goal of serving two million MSAWs by 2020. They are calling on every MHC grantee to increase the number of MSAWs served by 15 percent each year over the next five years.

To date, NACHC and NCFH have:

- Established the Ag Worker Access 2020 Campaign Task Force to guide the campaign
- Partnered with organizations at the local, state, and national level to create a national coalition to improve access
- Provided technical assistance to PCAs in six states and Puerto Rico
- Developed administrative tools to improve health centers’ ability to identify and verify MSAW patients
- Created a Learning Community on the NACHC website to access resources, share best practices, and announce training programs and webinars.

Mr. Gallegos urged the Council to endorse and express support for the campaign, with a goal of expanding it into a national coalition of organizations to improve access to care for MSAWs and their families. BPHC could support the campaign by comparing the ratio of medical, dental, and behavioral health visits for MSAW and non-MSAW users.

NACHC will provide periodic reports to the Council on how the campaign is impacting access to care.

Discussion

- Ms. Andrés-Paulson noted that MHCs and MSHS have different definitions of “migrant” and stressed the need for informal advocacy and education.
 - Mr. Gallegos replied that NACHC was advocating for alignment of definitions across programs.
- Dr. Moreno asked what information Council members would need to increase support in Congress for health centers.

- Mr. Gallegos stated that NACHC relies on those at the local level to speak with their representatives. Council members should emphasize the value proposition, showing that adequate funding for the program keeps people out of emergency rooms or specialty care. It is also helpful to put a face behind the numbers.
- Dr. Moreno asked how the number of health center visits by MSAWs was determined.
 - Mr. Gallegos replied that the number was reported by health centers that do not receive migrant health funding. The number of MSAWs that health centers are serving is underreported because they are not identified correctly and because centers that do not receive section 330g funding are not required to identify and report them.
- Ms. Triantafyllou asked for more information on the vacancies reported by health centers.
 - Mr. Gallegos stated that the vacancies were across clinical professions. The survey included all health centers, not just MHCs. It would be helpful to disaggregate the data to have a better picture of vacancies in MHCs, given the challenges of recruiting providers in rural areas.
- Rev. LaBarge suggested that NACHC should contact health centers that are located in districts of Congressional representatives who do not support CHC funding.
 - Mr. Gallegos replied that NACHC has coordinators in each state who are doing that outreach.
- Ms. Andrés-Paulson asked if incentives could be created for practitioners to serve rural areas.
 - Mr. Gallegos stated that health professionals who are trained through residency programs at health centers are three times more likely to practice in those settings. Federal loan forgiveness programs give health centers three years to work on retaining the providers. Workforce issues will continue to be a problem for rural and migrant health centers.
- Ms. Naqvi asked if there were innovative models for provider recruitment that MHCs could consider replicating.
 - Mr. Gallegos replied that professional recruitment is about matching the site to the provider. Health centers are not keeping pace with their competitors.
- Mr. Morgan noted that salaries at his health center reflect the local standard, but they cannot offer the same package of benefits. The health center loses doctors to the local hospital, although some return.
 - Mr. Gallegos added that family needs, such as schools, also factor into a practitioner's decision.
- Mr. Paras stated that board members could play a role in recruiting providers, along with the state PCA and the local Chamber of Commerce. He asked if grant applications are required to include letters of support from elected officials.
 - Gallegos – evidence that community supports the initiative are very important.

Medicaid Eligibility and Enrollment for Migrant Workers

Stephanie Bell, Deputy Director, Division of Eligibility and Enrollment, Children and Adults Health Programs Group (CAHPG), Center for Medicaid and CHIP Services (CMCS), Centers for Medicare and Medicaid Services (CMS)

Annie Hollis, Analyst, CAHPG/CMCS/CMS

Ms. Bell and Ms. Hollis provided an overview of Medicaid eligibility and enrollment, including changes to the process under the Affordable Care Act (ACA) and approaches to facilitate enrollment for migrant workers.

The ACA changed eligibility for Medicaid and the Children’s Health Insurance Program (CHIP) in a number of ways:

- Established a streamlined eligibility and enrollment process for Medicaid, CHIP and the health insurance Marketplaces, creating a seamless system of coverage
- Expanded Medicaid eligibility with additional financial support
- Simplified income and household counting rules across insurance affordability programs
- Coordinated verification policies across Medicaid, CHIP, and the Marketplaces
- Instituted renewals every 12 months for most individuals.

To be eligible for Medicaid, an individual must be a member of a specific group for which coverage is available and meet financial and non-financial eligibility requirements. Some additional requirements apply for people who are eligible based on age, blindness, or disability.

All states must provide Medicaid coverage to children under age 19 whose family income is at or below **133 percent of the federal poverty level (FPL**,mm,./,./), which is \$24,300 per year for a family of four in 2016. State-specific eligibility information is available at Medicaid.gov.

Thirty states and the District of Columbia have expanded Medicaid to cover adults (19 and over). In expansion states, adults are Medicaid eligible if they have income below 133 percent of the FPL (\$11,880 per year in 2016 for an individual). Federal statute provides for both mandatory and optional coverage for individuals with disabilities and the elderly.

States must cover pregnant women to at least 133 percent of the FPL (\$16,020 per year in 2016 for a pregnant woman expecting one child). Thirty-six states cover pregnant women above that minimum. States must also cover individuals who are a parent or caretaker relative.

Individuals must be residents of the state to be eligible for Medicaid in that state. Those who are 21 or older are residents of the state in which they live and intend to reside, or the state they have entered with a job commitment or seeking employment. Those under 21 are residents of the state where they reside, or the state of residence of the parent or caretaker. Individuals are not required to have a fixed address in order to be considered state residents.

“Qualified non-citizens” are eligible for Medicaid and CHIP, if they are otherwise eligible. “Qualified non-citizens” includes lawful permanent residents or green card holders, asylees and refugees, Cuban or Haitian entrants, parolees for more than one year, and battered non-citizens, spouses, and children. There is no federal funding to cover undocumented immigrants beyond treatment for an emergency medical condition.

The CHIP Reauthorization Act of 2009 made available a state option to cover lawfully residing children and pregnant women who are lawfully present, and otherwise eligible, without a five-year waiting period, regardless of their date of entry into the U.S. To date, 29 states, DC, and the Commonwealth of the Northern Mariana Islands have elected this option.

A description of who is considered “lawfully present” and a detailed chart showing eligibility options for non-citizens was included in the meeting materials.

The streamlined eligibility and enrollment process envisioned in the ACA includes three steps:

- Submit a single, streamlined application to the Exchange or Medicaid/CHIP
- Information is electronically verified and eligibility is determined
- Enroll in affordable coverage.

States must allow applicants to apply for all insurance affordability programs through a single, streamlined application, and they must accept applications online, by mail, by telephone, and in person. To minimize the burden of the application process, the state may only require an individual to provide the information necessary to make an eligibility determination. Applications may ask a non-applicant for certain information necessary to determine eligibility for an applicant (i.e., income, tax filing status, relationship). States are permitted to request the Social Security number of a non-applicant if providing that information is voluntary, it is used only to determine eligibility, and clear notice is provided to the individual. States may not ask for citizenship/immigration information from a non-applicant. Information about immigration status may only be used to determine eligibility for coverage; it may not be used for law enforcement.

The verification process has decreased reliance on paper documentation. Electronic processes can make it easier for migrant workers.

If an individual is eligible for Medicaid, it should be easy to remain in the program. Eligibility is now automatically renewed once every 12 months, unless the agency received information about a change that may affect eligibility. If available information is insufficient to determine continued eligibility, the agency must send a pre-populated form giving the individual at least 30 days to respond.

For many migrant workers, online systems are the best way to apply for or renew coverage. Others may find it easier to apply or renew over the phone, using paper forms. Non-electronic ways to prove identity are available. Application assistance is available at no cost for individuals with limited English proficiency or disabilities.

Interstate coordination of Medicaid coverage is challenging, but possible. States may establish interstate agreements to facilitate enrollment for individuals who move between states, and they can be reimbursed for providing care to beneficiaries who are enrolled in another state.

A detailed list of resources regarding eligibility and other issues was provided in the meeting materials.

Discussion

- Ms. Castro asked if the application process for interstate agreements could be started when the individual is moving.
 - Ms. Hollis replied that there is no standard agreement; it depends upon the states. State residency rules allow people to be absent temporarily without being disenrolled.
 - Ms. Bell added that the new rules make eligibility more consistent and transferrable.
- Ms. Diaz noted that people who migrate do not always receive renewal forms in time. This creates problems, because people may see a provider, but the pharmacy will not provide prescription coverage.
 - Ms. Bell stated that the application now includes an option to receive notices electronically. Children's coverage would continue regardless of re-enrollment. Individuals receive three months of retroactive coverage when they re-enroll. The mailing address does not have to be the applicant's current home, and they can designate an authorized representative to apply on their behalf.

- Ms. Philips-Martinez asked if there were any emerging practices for effective outreach that could help health centers inform MSAW patients about their eligibility.
 - Ms. Bell replied that the complex nature of Medicaid makes it difficult to develop a standard practice.
 - Ms. Charles noted that CMS conducts a monthly conference call for ACA navigators and assisters to share best practices.
- Ms. Andrés-Paulson stated that the application process is complex, which makes it difficult to communicate.
- Dr. Moreno stated that it can be difficult to document eligibility, even in a person’s home state. Interstate agreements are challenging if one of the states did not expand Medicaid.
- Rev. LaBarge noted that his health center’s electronic records system tracks patients’ eligibility. Information about renewal is given to the patient navigator, who coordinates with the individual.
 - Ms. Bell noted that navigators are helpful, but eligibility needs to be determined by a state employee. The electronic process has simplified the process.
- Ms. Triantafillou suggested that MSHS could help families maintain enrollment.
 - Ms. Andrés-Paulson described how her organization handles that process.
- Ms. Bell added that CMS regional offices can provide additional resources.

Discussion of Potential Recommendations

Council members discussed the presentations and identified potential issues for recommendations:

Identified Gap	Recommendation to Address the Gap
Inconsistent access to care for MSAWs	<ul style="list-style-type: none"> • Highlight indicators/guidelines that reference expectations around culturally competent care and the quality of care experiences for MSAWs • Actively communicate that to health centers • Create a list/matrix of different definitions of MSAW • Address lack of clinical providers and behavioral specialists
Need to identify distinct data on MHCs	<ul style="list-style-type: none"> • Analyze data to understand workforce issues of non-MHC grantees • Identify specific work force gaps in MHCs • Follow-up with Joe Gallegos to capture the number of vacancies in 330g grantees
Not enough resources to service HIV positive patients once more testing occurs for 16+	<ul style="list-style-type: none"> • Identify resources to support new UDS clinical measure to capture STDs in adolescents • Intra-agency follow-up with work group at HRSA HIV/AIDS Bureau to identify implications of this new measure

Identified Gap	Recommendation to Address the Gap
HHS/HRSA websites need widgets in Spanish, Creole, etc.	<ul style="list-style-type: none"> • Update websites with user-friendly resources for non-English speaking populations (ensure accessibility for mobile users) • Address difficulty of finding information related to MHCs
Lack of total economic gap analysis in regions	<ul style="list-style-type: none"> • Before defunding or reducing program funding, a total economic gap analysis needs to be completed

The HITEQ Center: Supporting Migrant Health Centers’ Effective Use of Health Information Technology

Susan Friedrich, John Snow Incorporated (JSI)

Lawreen Duel, Director of Operations, Finger Lakes Community Health, NY

Ms. Friedrich provided an overview of the HITEQ (Health Information Technology, Evaluation, and Quality) Center, a HRSA NCA that was funded to help health centers fully optimize their electronic health record (EHR)/health information technology (HIT) systems for continuous, data-driven quality improvement (QI). The HITEQ Center is operated by a partnership of JSI, Advocates for Human Potential, Inc. (AHP), and Westat; its advisory committee includes representatives of PCAs, HCCNs, health centers, and other HRSA NCAs.

The HITEQ team began by conducting a needs assessment that included two components:

- UDS data analysis: Assembled a data set to integrate UDS data with other data sources; analyzed data from 2011 to 2014 to understand the state of HIT across health centers
- Stakeholder input: Document current and past activities; raise awareness of the HITEQ Center as a resource; solicit input regarding the role of the **HITEQ** Center; identify best practices for dissemination.

Key findings from the UDS data analysis were as follows:

- Reporting using EHR rather than a sample increased from 22 percent to 56 percent
- Average performance increased
- Compliance results reported through EHR were slightly lower than those reported using a sample
- Health centers that participate in HCCNs were nearly twice as likely to report using EHR and had higher compliance results regardless of reporting method.

Stakeholders provided the following recommendations regarding the role of the HITEQ Center:

- Provide the “glue to bring silos together”
- Identify and disseminate best practices from across stakeholder groups
- Operate as an independent, objective broker to link grantees to available resources
- Assemble and facilitate access to relevant, timely, and high-quality resources.

Based on the findings of the needs assessment, HITEQ will focus its services on:

- Developing a searchable and adaptable web-based HIT clearinghouse
- Conducting workshops and webinars on Health Information Technology (HIT) and data-driven quality improvement topics

- Providing TA (Recommend clarifying abbreviations) and responsive teams of experts to work with small groups of health centers experiencing specific challenges or needs.

The content of HITEQ's services will focus on:

- Data-driven QI
- QI/HIT workforce development
- Health Information Exchange (HIE)
- EHR selection and implementation
- Privacy and security
- Emerging technologies
- Electronic patient engagement
- Updated UDS EHR form and instructions to provide accurate reporting.

HITEQ solutions that would improve access and quality of care for MSAWs include:

- Special population status identification and health history (EHR implementation)
- Mobility resulting in incomplete health record for Health Information Exchange (HIE)
- Treatments that recognize unique circumstances (data-driven QI).

Ms. Duel described lessons learned by Finger Lakes Community Health (FLCH) in using EHR to collect and report UDS data. She noted that FLCH is a federally qualified CHC/MHC program with 10 health center sites in rural New York state. They have a migrant voucher program in 42 counties and also offer mobile medical and dental programs.

Challenges have included determining how to collect the data; obtaining accurate data on patient demographics, characteristics, and race/ethnicity; and continuity of care. To address those challenges, FLCH devoted resources to developing forms and training staff to use them accurately.

Continuous QI processes at FLCH include reviewing data on a monthly basis; developing quality of care indicators; using data to identify under-utilization of care; and reviewing data metrics.

Tips for successful reporting include flexibility (i.e., have more than one system), a team-based approach, methods to validate data, and dedicated time for all steps in the process.

Discussion

- Mr. Morgan stated that the "Latino" ethnic category is meaningless because the categories are not sufficient to capture all of the possible realities.
- Rev. LaBarge noted that many MSAWs are indigenous and not Latino.
- Dr. Moreno asked if the new funding was available in addition to grants to achieve meaningful use.
 - Ms. Friedrich said that a small amount of funding was available.
- Dr. Moreno noted that his health center was an early adopter of EHR, but they had no one with whom to communicate and the community infrastructure and regional support (T1 lines, Fiberoptics and mobile towers) did not exist or expand for effective usage.
- Ms. Naqvi asked what HRSA's top priority should be in terms of reporting.
 - Ms. Friedrich stressed the importance of validation; support and decision-making; and training providers to use the system.

- Dr. Kilanowski asked how health centers select which charts will be used for reporting and if there were any privacy issues.
 - Ms. Friedrich replied that charts are chosen randomly. Health centers are prohibited from utilizing individual data.
- Dr. Moreno asked what lessons could be taken from CHCs that are performing well.
 - Ms. Friedrich replied that the top 10 percent have a robust system in place for utilization of EHRs and access to data.
- Ms. Diaz asked how long it takes to train physicians to use EHR.
 - Ms. Friedrich replied that it depends on the individual.
 - Ms. Duel stated that data entry is time consuming, but doing it manually was worse.

Discussion of Potential Recommendations (continued)

Council members discussed the presentations and identified potential issues for recommendations:

Identified Gap	Recommendation to Address the Gap
Medicaid renewal forms are complicated and must be approved by a state or county employee	<ul style="list-style-type: none"> • Address lack of knowledge of interstate agreements • Foster the development of interstate agreements
Lack of alignment across HRSA regarding models and resources that impact MHCs Smaller CHCs/MHCs have a tendency to outsource data and lose control of data without additional costs	<ul style="list-style-type: none"> • Make data warehouses economical • Implement limitations/restrictions on HIT funds (e.g., reduce outsourcing) • Find affordable data management tools • Future resources to house data sets • Insufficient internal capacity to handle data (e.g., paying vendors during UDS reporting)
EHR systems are not being utilized to their full potential	<ul style="list-style-type: none"> • Cross-collaboration on data • Increasing capacity for data analysis
Educate migrant workers and defuse negative association of being labeled “migrant”	<ul style="list-style-type: none"> • Growers play a pivotal role in encouraging workers • Increase outreach in the community • Increase collaboration with associations that already serve this population
Low penetration rate of migrant workers utilizing MHCs (19.8%)	<ul style="list-style-type: none"> • Increase awareness of MHCs among migrant workers. • Address migrant perceptions that might serve as barriers to accessing care • Collaborate with DOL to support the AG Workers Access 2020 campaign

Monitoring the Terms and Conditions of Agricultural Employment and Assessing the Conditions of Farm Workers

Susan Gabbard, PhD, Vice President, JBS International, Inc.

Jennifer Amore, Policy Analyst, Wage and Hour Division, Office of Policy, U.S. Department of Labor (DOL)

Dr. Gabbard provided an updated on the status of the National Agricultural Worker Survey (NAWS). She noted that the proposed questionnaire was undergoing final review by the Office of Management and Budget. Data collection is expected to begin by the end of the year.

The NAWS health supplement planned for June 2016 will provide critical data on preventive health; access to and quality of preventive health services for the farmworker and his/her family; health status, including mental health; access to digital media for employment and health issues.

NAWS health research addresses information gaps and yields interventions that improve farmworker health and safety. Abstracts of papers using data from previous supplements were included in the meeting materials.

NAWS data tables are available at the NAWS website ([National Agricultural Workers Survey](#)). The website is being redesigned to improve the user interface and make the data more accessible.

Ms. Amore provided an overview of the work of the Wage and Hour Division (WHD) at the Department of Labor. WHD enforces several laws that protect MSAWs, including the Fair Labor Standards Act (FLSA), the Migrant and Seasonal Agricultural Worker Protection Act (MSPA), the Field Sanitation Standards and Temporary Labor Camp Provisions of the Occupational Safety and Health Act, and the H-2A Temporary Worker program.

WHD conducts investigations in response to complaints as well as directed investigations. The reason for the investigation is not disclosed, and all complaints are confidential. After explaining the process to the employer, WHD investigators review records and interview employees. When the investigation is complete, they inform the employer of any violations and seek assurance of future compliance.

In FY2015, WHD conducted more than 1,300 investigations in agriculture and held more than 200 outreach events. The investigations resulted in payment of more than \$4.3 million in back wages for more than 10,000 workers and more than \$5 million in civil penalties.

The basic requirements of the MSPA are: registration for farm labor contractors (FLCs) (including authorization to house and transport workers); disclosure of terms and conditions of employment; payment of the disclosed or promised wage; housing safety and health standards; transportation safety standards, including driver licensing and insurance; and recordkeeping and pay statements.

WHD maintains a list of registered FLCs, which is updated quarterly. A separate list of ineligible contractors is updated monthly.

A new WHD Administrator's Interpretation issued January 20, 2016 clarified joint employment under the Fair Labor Standards Act (FLSA) and MSPA. The interpretation states that if an individual works for two or more employers and those businesses are related, the hours worked are combined to determine eligibility for overtime pay. Employers are jointly and severally liable for any fines.

Factors governing joint employment under H-2A are not the same as FLSA/MSPA. Employers must demonstrate that they cannot find sufficient "able, willing, and qualified U.S. workers" to perform temporary and seasonal agricultural employment and that employment of H-2A workers will not adversely affect the wages and working conditions of U.S. workers who are similarly employed.

Basic requirements of H-2A program include: no layoff, displacement, or unlawful rejection of U.S. workers; no preferential treatment of H-2A workers; disclosure of terms and conditions; payment of the required wage and guarantee of hours; recordkeeping and pay statements; free housing that meets safety standards; inbound and outbound transportation; employer-provided transportation that meets safety standards; and no recruitment charges to the worker.

The definition of “employer” varies across different statutes and/or enforcement agencies. WHD defines “employer” as a person that has a place of business in the U.S. and has an employment relationship with H-2A workers and workers in corresponding employment.

WHD ensures housing safety and health protections under MSPA and H-2A, including enforcement of standards related to water, electricity, ventilation, lighting, heat, waste disposal, bathrooms, safety measures, and other areas. WHD conducts a pre-registration inspection, and the contractor must maintain the housing at that level.

WHD enforces field sanitation standards, including drinking water for the entire work period; toilet and hand washing facilities when working more than three hours, including travel time; and employee notification requirements. Facilities must be provided at no charge.

A list of online resources was provided in the meeting materials.

Discussion

- Mr. Paras asked who conducts housing inspections.
 - Ms. Amore stated that WHD regional offices conduct inspections as part of the registration process.
- Dr. Lopez asked how farmworkers are informed of their rights.
 - Ms. Amore replied that employers must display a poster that outlines employee rights under the MSPA.
- Ms. Diaz stated that it is important to educate workers that lost wages can be recovered. She asked if housing violations must be reported by the worker, or if they can be reported by a third party.
 - Ms. Amore stated that anyone can report a violation to WHD.
- Ms. Diaz asked what could be done to prevent contractors from selling their registration to others.
 - Ms. Amore stated that WHD does not have the resources to enforce compliance by all FLCs.
- Rev. LaBarge asked how long it takes to conduct an investigation into owed wages.
 - Ms. Amore replied that if the complaint was serious, an investigation would begin immediately, although it might not be resolved until the following growing season.

Improving the Health and Welfare of Migrant and Seasonal Agricultural Workers, Including H-2A Workers

Frank Gasperini, Jr., Executive Vice President/Chief Executive Officer, National Council of Agricultural Employers (NCAE)

Mr. Gasperini provided an overview of labor policy and compliance issues from the employers’ standpoint. He noted that NCAE is a trade association whose members are labor-intensive growers,

associations, and others whose business is dependent on domestic labor-intensive agriculture. They represent approximately three-quarters of U.S. agricultural production employers.

NCAE's top priorities in 2015-2016 are: labor availability; worker eligibility, immigration status, and guest worker programs; employer health, safety, and liability issues; health care implementation and mitigation; the H-2A process, administration, legal challenges, and "special procedures;" and advocacy for real immigration reform.

Labor is a continuing limiting factor for agriculture. Mechanization, computerization, and better practices have extended the productivity of agricultural workers, but many crops are not readily mechanized.

Housing is a limiting factor for many growers, particularly in some regions and for some crops. Growers are not required to provide housing for domestic workers (local or migrant), but they must provide housing for H2-A workers. There is no federal requirement to provide family housing.

Growers face a number of housing issues, including:

- Overlap with different federal, state, and local standards
- Capital investment disadvantages for small/beginning growers
- Housing built with USDA 514 loans is not available to H-2A workers
- Increasingly onerous local zoning/permitting restrictions and "not in my back yard" (NIMBY) attitudes
- State and local occupancy/landlord requirements
- Safety/security
- Proposed shift to Occupational Safety and Health Administration (OSHA) standards from Employment and Training Administration (ETA) standards, which may reduce the housing stock "allowance"
- Housing allowance.

Future trends include:

- Decline in traditional grower-provided housing, except in more remote rural areas
- Increase in on/near farm housing for specialty producers (e.g., dairy and other year-around operations)
- Housing for active employees only
- Continuing impact of the shift to H-2A workers
- More "non-traditional" housing (e.g., hotels, local apartments, etc.)
- More local zoning, permitting, and NIMBY issues.

Discussion

- Ms. Philips-Martinez asked how MHCs can build productive relationships with growers to increase access for MSAWs.
 - Mr. Gasperini suggested that it would be helpful they to invite growers to visit the clinic and demonstrate an understanding of the issues that they face. He also suggested that clinics align their hours with shopping hours, since employers must provide transportation for H-2A workers to do grocery shopping.
- Dr. Moreno requested more information about USDA housing loans.

- Mr. Gasperini replied that the Section 514 loan program was created to finance construction or renovation of affordable rental housing for farmworkers. Much of that housing is now vacant, but it cannot be converted into housing for H-2A workers.
- Dr. Lopez asked how many growers are using farm labor contractors
 - Mr. Gasperini stated that nearly half of the growers in California are using them, and about one-third of growers in Florida. This has an impact on migrant labor.
- Mr. Paras asked what position NCAE members take on the ACA.
 - Mr. Gasperini replied that most NCAE members support the ACA. His role is to ensure that his members understand their obligations and options under the employer mandate. He noted that H-2A workers are subject to both the employer mandate and the individual mandate.
- Dr. Lopez asked how the H-2A program compares to policies in Canada.
 - Mr. Gasperini stated that Canada has a guest worker program that is smaller than the H-2A program. They also have agreements with Commonwealth countries that allow people to work in exchange for room and board.

Discussion of Potential Recommendations (continued)

Council members discussed the presentations and identified potential issues for recommendations:

Gap	Recommendation to Address the Gap
1) Declining migration (i.e., decreasing migrant stream) and decline in available housing make it difficult to employ H-2A workers 2) Quality of housing for H-2A workers does not meet standards 3) Growers are only required to provide housing for H-2A workers, not migrants	<ul style="list-style-type: none"> • Promote interagency collaboration with DOL, NCS, USDA, and others to address health implications • Recommend an interagency partnership between HHS and DOL to examine H-2A worker data on productivity levels and access/use of health services, per ACA guidelines/requirements

WEDNESDAY, MAY 18, 2016

Recap from Previous Day

Dr. Kilanowski called the meeting to order at 8:00 a.m.

Mr. Garcia provided a recap of the previous day, highlighting key issues presented by the speaker.

Ensuring Continuity of Care for Migrant Agricultural Workers

MCN Health Network

Deliana Garcia, MA, Director, International Projects, Research, and Development, MCN

Ms. Garcia provided an overview of the MCN Health Network. She noted that real-time, accurate health data is a medical necessity, especially for migrant patients who are often lost to follow-up.

A case study of a migrant enrolled in Health Network illustrated the value of networks. Over the course of 10 years, the farmworker had 124 patient contacts at 46 clinics; his medical records were transferred nine times to six different clinics. Health Network ensured that his records transferred with him. The

farmworker's diabetes was managed successfully when he was enrolled in the network, but it spiked when he lost contact.

MCN designed the Health Network system to meet the needs of migrant patients, after studying the most prevalent diagnoses and health conditions. The initial system, TBNet, was designed as a cost-effective approach to treatment for tuberculosis (TB).

MCN has a contract with U.S. Immigration and Customs Enforcement, which guarantees that individuals with active TB receive sufficient treatment to cure the disease before they are deported. Completion rates have been documented for 83 percent of patients.

Health Network has been used for cohort management in a research project in Arizona. MCN hopes to work with other universities to include migrants in their research.

Innovations in communication make it easier to maintain contact with patients. Appointment reminders and other information can be sent by text so patients do not need to interrupt their work to take a call.

MCN wants to take the system to scale now that its effectiveness has been demonstrated. The Health Network case management team is the key to the success of the system. MCN is working to determine what factors are essential in order to replicate the model.

MCN Health Network received a Premier Cares Award in recognition of this innovation.

Discussion

- Ms. Andrés-Paulson asked if the Health Network system is used exclusively for health care.
 - Ms. Garcia replied that services are not limited to primary care. Once a patient is engaged, the caseworker can refer him or her to education, housing, transportation, and legal services. The network can take a comprehensive approach because the case manager knows all of the patient's needs.
- Dr. Moreno asked how this type of tracking compares with HIT.
 - Ms. Garcia stated that the Health Network's centralized approach makes it possible to make a warm hand-off to specialists or new providers. An anchor contact (i.e., someone who always knows how to reach the patient) and a case manager who has an investment in the patient are essential. The quality of the team is essential, and MCN is trying to understand the intangibles behind this approach.
- Ms. Triantafillou asked how MCN ensures that text messages are secure.
 - Ms. Garcia replied that the text simply states that there is an appointment at X location at X time. It does not include any patient information.
- Dr. Kilanowski asked about the cost per patient.
 - Ms. Garcia stated that the cost to enroll a patient ranges from \$237 to \$900, depending on the complexity of the case management that is required.
- Dr. Lopez asked if any patients come to the network through the MCN website.
 - Ms. Garcia replied that patients must be referred by an identified provider. MCN only provides case management services.
- Ms. Naqvi asked what an ideal network would look like.
 - Ms. Garcia stated that an ideal network would be structured as a hub, with staff in each time zone. MCN currently has staff in one time zone, with an after-hours system. They are looking at a new platform for the database, which should go live in January 2017.

- Dr. Lopez asked if the network includes children.
 - Ms. Garcia replied that pediatric patients are referred by health centers, and parents must provide consent.

Finger Lakes Community Health

Mary Zelazny, Chief Executive Officer

Ms. Zelazny described how FLCH uses telehealth technology to ensure continuity of care for farmworkers across New York state. She cited numerous challenges that led them to develop their model, including:

- Cultural and language barriers to access care outside of FLCH sites
- Lack of providers in rural areas
- Long distances between healthcare providers
- Costs and liability issues related to enabling services
- Education and training for providers and care managers
- Coordination of access to specialty care.

Farmworker patients face numerous challenges, including access to primary care, access to specialty care in a safe environment, services to address social determinants of health, and access to care when they leave New York.

Telehealth enables FLCH to:

- Offer a wide variety of health and allied services on-site so patients do not have to travel to multiple sites for care
- Leverage technology to reach a wide variety of healthcare providers, regardless of distance
- Offer providers exceptional educational opportunities to learn about clinical issues fact that affect farmworker patients
- Communicate with federally qualified health centers (FQHCs) in other states to ensure access for farmworkers when they leave New York state.

Benefits of telehealth for farmworker patients and families include reduced travel time to healthcare appointments; services can be accessed at the patient's health center; less work time (and wages) lost; culturally competent and inclusive services; and availability of interpretation services.

Benefits of telehealth for providers include direct patient interaction; ability to offer expanded services to farmworker patients; access to clinical collaboration, including for difficult diagnoses; access to continuing medical education.

Benefits of telehealth for the healthcare system include improved access to healthcare services; improved outcomes; better resource utilization; lower cost and efficient use of time.

FLCH offers a wide range of services for children and adults, including teledentistry, telepsychiatry, mental health counseling, digital retinopathy, pediatric neurology and dentistry, HIV/AIDS care, hepatitis C care, pulmonology, dietician services for diabetics, treatment adherence, language interpretation, and precepting of providers.

FLCH also uses telehealth to connect patients to services when they return to their home state. In the past, they sent a CHW to Florida to ensure that patients with chronic illnesses were linked into care at a

local FQHC. They are now piloting a Virtual Case Management program that gives farmworker patients the ability to meet a provider in their home state before they leave New York. The CHW from New York checks in regularly with the patient to ensure consistent access to care. Goals of the pilot are to:

- Assess the current state of patient needs, provider resources, and case management resources in each community
- Assist with access to care
- Promote continuity of care
- Improve quality of care for patients with diabetes
- Collect and analyze qualitative and quantitative data
- Develop a sustainability plan for the model.

FLCH is working with other FQHCs to teach them how to utilize telehealth. They hope to be able to provide a seamless exchange of information once HIT systems are fully operational in all health centers.

Community Health Partnership of Illinois (CHP)

Susan Bauer, Executive Director

Ms. Bauer provided an overview of CHP's approach to ensure continuity of care for farmworker patients, which combines health outreach services and the voucher model. She noted that CHP has been a HRSA grantee since the 1970s. They are dual funded as a nurse-managed voucher program and CHC and now have PCMH recognition.

Challenges to assuring continuity of care include the geographically dispersed population of MSAWs; the dramatic reduction in migrant housing; unpredictable migration patterns due to changes in weather and labor contracts; and lack of insurance to pay for specialists and hospital care.

Promotores/as have been an essential part of the CHP care team since 1996, providing health education, screening services, and referrals and helping agricultural workers navigate the healthcare system.

CHP's Care Team model for coordination of care includes providers (medical, dental, behavioral health); an Outreach/Promotores Coordinator; an ACA Outreach and Enrollment Coordinator; a Patient Services Specialist; and clinic and organizational leadership.

Case studies of promising practices developed by CHP were included in the meeting materials.

CHP sees numerous opportunities for improvement, such as bringing more health care directly to MSAWs where they live and work (e.g., through portable outreach clinics); establishing more voucher provider sites, including FQHCs; and improving the tracking system for referrals and Medicare Advance Beneficiary Notices.

Discussion

- Dr. Lopez asked if the migrant populations in New York and Illinois included indigenous people.
 - Ms. Bauer said another service area had some Mizteca from Oaxaca as well as some refugees.
 - Ms. Zelazny replied that New York has a large refugee program that is referring many refugees to farmworker jobs. FLHC has seen workers from Somalia, Burma, and other countries.
 - Ms. Garcia stated that undocumented workers are being displaced by refugees.

- Ms. Philips-Martinez asked how CHP was able to sustain promotoras and how FLCH developed their telehealth infrastructure.
 - Ms. Bauer stated that CHP’s promotora program began with a research grant from the National Institute of Occupational Safety and Health; they now use HRSA funds. Promotoras are independent contractors, not employees, because it is important for them to be independent of the health center. They receive flat weekly stipend and make their own decision as to how they will conduct their outreach.
 - Ms. Zelazny replied that funding for telehealth is limited. FLCH has learned to do it in a cost-effective way, using webcams rather than high-end equipment. They are now advising other health centers in this area.
- Dr. Kilanowski asked how FLHC engages specialists to participate in their program, since Medicaid does not provide reimbursement for telehealth.
 - Ms. Zelazny said that FLHC pays all providers who participate in telehealth services.
- Dr. Moreno stated that the cost of utilizing a number of different clinicians (Nurse, counselor and psychiatrist during one visit)providers especially for behavioral telehealth is a key barrier (high cost) to utilization of telehealth.
 - Ms. Zelazny replied that their specialists have become experienced in telehealth and are beginning to train lower level providers. The specialist cannot bill for telehealth, and the health center cannot bill for the nurse who presents the case. FLHC is moving away from fee-for-service to value and quality of care. Paying for a telehealth session with a specialist is less expensive than paying for a CHW to take a patient to Rochester.
- Dr. Moreno said he would like to learn how to develop a sustainable model for tele-psychiatry in rural communities.
 - Ms. Zelazny stated that FLCH involves the psychiatrist, the primary care physician, and the care team. xx has significant experience.
- Ms. Naqvi asked how well the HRSA “Find a Health Center” website was working.
 - Ms. Zelazny replied that the site works well, but in many cases there is no health center in the location in question.
 - Ms. Bauer said the site helped a patient find a health center, but the first appointment was three months away.
 - Ms. Garcia noted that some MSAWs do not have access to the Internet or a computer.
- Ms. Andrés-Paulson asked whether health plans were supporting the models presented by the speakers.
 - Ms. Zelazny replied that health plans were showing a great amount of interest in telehealth.
 - Ms. Garcia stated that health plans do not support the Health Network, because it is not part of a health center.
 - Ms. Bauer stated that the greatest challenge is overcoming the traditional, office-based model of care coordination. Policy and nursing school curricula need to be revised to reflect the importance of outreach.
- Mr. Paras asked how the Health Network works with individuals who are about to be deported.
 - Ms. Garcia stated that everyone who is detained is given a chest x-ray; those with positive tests are put in quarantine and immediately connected to the network. Health Network coordinates with the home country.
- Ms. Castro asked if FLHC uses internal interpreters or vendors for tele-interpretation.
 - Ms. Zelazny replied that they use vendors for American Sign Language; all others are internal.

New Wage-Hour Guidance on Joint Employment and the H-2A Program

Megan Horn Essaheb, Staff Attorney and Health Policy Analyst, Farmworker Justice

Alexis Guilde, Health Policy Analyst, Farmworker Justice

Ms. Essaheb and Ms. Guilde provided an overview of the H-2A program and the DOL's new wage-hour guidance on joint employment. They noted that the program is growing, with 140,000 positions certified in FY2015, compared to 48,000 positions certified in FY2005. Florida, Georgia, and North Carolina saw significant growth.

Protections for H2-A agricultural guest workers include:

- DOL certification program
- U.S. recruitment protections and the 50 percent rule
- Prohibition on H-2A workers paying recruitment fees
- Housing
- Transportation
- Guarantee that workers will be paid at least 75 percent of anticipated hours
- Adverse Effect Wage Rate (employers must pay the equivalent of the minimum wage in that state)
- Workers' compensation.

Most H-2A workers are young men between 18 and 35 years old. The vast majority are from Mexico.

Structural issues in the H-2A program include indebtedness of workers, non-immigrant status, isolation and family separation, incentives for employers to discriminate against domestic farmworkers, and inadequate enforcement.

Recent trends include an increase in H-2A labor contractors. Workers move frequently and are more difficult for outreach workers to locate. Many workers are housed in hotels and off-site housing.

Outreach workers can use the DOL website showing the location of H-2A job orders.

H-2A workers face a number of challenges to accessing health care. They have limited access to clinics and are more isolated than the general population. SLIDE

H-2A workers are required to enroll in health insurance. They qualify for a 60-day Special Enrollment Period that begins the day they enter the U.S., but this can be challenging to accomplish. Workers must disenroll from health insurance before leaving the U.S. Coverage is difficult for migrant H-2A workers who work for labor contractors, because coverage is not portable.

H-2A workers are required to file taxes. Those who enroll in insurance generally qualify for tax benefits. H-2A workers do not qualify for Medicaid due to their immigration status.

Challenges to ACA enrollment for H-2A workers include:

- Lack of knowledge about the ACA
- Limited amount of time to enroll, and many workers to enroll in a short period of time
- Limited enrollment options
- Inclusion of dependents outside of the U.S.

- Document verification
- Incorrect eligibility determinations.

Post-enrollment challenges include lack of familiarity with the U.S. health system or health insurance; lack of a mailing address and/or infrequent access to postal services; and the disenrollment process.

Farmworker Justice proposed the following Recommendations related to ACA enrollment for H-2A workers:

- Collaboration between HHS and the State Department to provide information about the ACA and CHCs to H-2A workers at the U.S. consulate where they apply for their visa
- Collaboration between HHS and DOL to ensure H-2A workers are informed about their rights and obligations under the ACA while in the U.S.
- Additional funding opportunities to support outreach and enrollment efforts by CHCs in areas with H-2A workers
- Training for Marketplace call center representatives on H-2A workers and other non-qualified immigration statuses to ensure they provide correct information to consumers
- Funding for farmworker-based community organizations to provide outreach and enrollment services.

Joint employment is a situation in which a worker is employed by two entities that are considered jointly responsible for complying with labor protections. The law establishing joint employment relationships is especially important in agriculture, because many farm operators use labor contractors and deny that they are the “employer.”

The DOL Wage and Hour Division issued new guidance on joint employment in January 2016. The interpretation restates good court decisions and previous guidance, which will help to overcome bad court decisions.

H-2A workers face challenges regarding joint employment. They are excluded from the MSAW Protection Act; H-2A regulations have a weaker standard for enforcement that is not addressed by the new guidance; and H-2A farm labor contractors are on the rise.

Farmworker Justice has numerous resources for H-2A workers, including materials in English, Spanish, and Haitian Creole.

Discussion

- Dr. Moreno noted that MHCs are funded to serve MSAWs, and H-2A workers do not meet that definition. It is challenging for health centers to serve the increasing number of H-2A workers. He asked if it was possible to anticipate the number of workers who will arrive in various locations so that health centers can prepare to serve them.
 - Ms. Guild replied that H-2A workers are included in the current definition of MSAWs, but workers may not want to volunteer that information. Connecting an H-2A worker with a health center is beneficial for both the worker and the health center.
 - Ms. Essaheb stated that Farmworker Justice was advocating for DOL to require employers to provide transportation to health care, in addition to grocery stores.
- Dr. Moreno asked what conditions prompt workers to visit Legal Aid.

- Ms. Essaheb replied that H-2A workers only seek legal assistance if conditions are intolerable; less-extreme violations often go unreported. The interview process often uncovers serious situations, such as trafficking.
- Ms. Triantafillou stated that her organization in North Carolina asked a growers’ association that coordinates transportation and visas for H-2A workers to provide information about CHCs when they process workers upon arrival. The association provided list of farms that hired the workers, which made it possible to link them to health services. It is in the growers’ best interest to ensure that they are in compliance.
 - Ms. Guild commended North Carolina for enrolling a significant number H-2A workers, thanks to a coalition that created state-wide strategies and best practices. She noted that the growers’ association was producing a video about the ACA that will be shown on the bus from Mexico to North Carolina.
- Mr. Paras asked if health assessments are part of the recruitment process.
 - Ms. Essaheb said there is no requirement to conduct a health assessment.
- Ms. Castro asked why H-2A workers are excluded from the MSAW Protection Act.
 - Ms. Essaheb replied that this provision was a compromise between those representing growers and farmworkers when the legislation was revised in 1986. It creates another incentive to prefer H-2A workers over domestic workers. This issue is a high priority for Farmworker Justice in its work on immigration reform.
- Dr. Moreno asked if H-2A workers receive clear information on their rights regarding living conditions.
 - Ms. Essaheb stated that workers receive materials, but it is difficult to know if they read them. Outreach would be helpful.
- Ms. Guild noted that the employer mandate is now in full effect. She urged Council members to determine whether employers are offering coverage and whether workers are signing up for it.

Discussion of Potential Recommendations

Council members discussed the presentations and identified potential issues for recommendations:

Gap	Recommendation to Address the Gap
H-2A workers lack knowledge about the ACA	<ul style="list-style-type: none"> • An interagency partnership between DOL and HHS to examine Ventanillas de Salud data on H-2A workers’ productivity levels and access/use of health services, per ACA guidelines/requirements
<p>Transforming/developing resources and alternative media/tools (e.g., videos, ads, etc.) to disseminate information for individuals with low literacy levels.</p> <p>Some health care information is not understandable to all migrant workers (literacy, education, language, cultural competence, etc. complicates awareness/ comprehension) and does not always reach them.</p>	<ul style="list-style-type: none"> • Funding for CHCs and MHCs to provide outreach and enabling services/ensure information for workers is understandable (stronger marketing to reduce fear). • Ensure CHC/MHC quality measure targets performance/outcomes of outreach and enabling services
Program requirements regarding enabling services such as transportation are not sufficiently specific.	<ul style="list-style-type: none"> • Include a measure relevant to types of enabling services provided.

Revisions to the Environmental Protection Agency (EPA) Agricultural Worker Protection Standard Rule

Kevin Keaney, Certification and Worker Protection Branch, Office of Pesticide Programs, EPA

Mr. Keaney provided an overview of revisions to the Agricultural Worker Protection Standard (WPS) rule, which is designed to reduce exposure to pesticides. The goals of the revision are to:

- Improve occupational protections for agricultural workers and handlers to make them comparable to those for workers in other industries covered by OSHA
- Reduce acute occupational pesticide exposures and incidents
- Reorganize and streamline the rule to make it easier to understand and follow
- Address concerns raised through years of stakeholder engagement.

The WPS framework includes three components:

- Inform: Training; pesticide safety information; notification; information exchange
- Protect: Restricted entry intervals (REIs); personal protective equipment (PPE); application exclusion zones (AEZs); suspend applications
- Mitigate: Routine decontamination supplies; emergency eyewash; emergency assistance.

Agricultural employers on crop-producing establishments and employees of commercial pesticide-handling establishments are responsible for providing WPS protections. Those who are protected by include farmworkers, pesticide handlers, and other persons during pesticide applications.

The final rule includes the following key changes:

- Training interval and grace period
 - Annual training for workers and handlers and no grace period
 - All new training requirements will be fully enforceable in January 2017, except new content. New content will be required in January 2018.
- Trainer qualifications
 - Handlers are no longer qualified to provide training
 - Training materials and train-the-trainer (TTT) courses must be EPA-approved
 - Completion of any EPA-approved TTT course qualifies a person to train in any jurisdiction, unless explicitly prohibited.
- Verification of training
 - Employers must keep training records for two years
 - Rule specifies what the record must include
 - Must provide a copy of records to inspectors or workers/handlers upon request
 - Voluntary training verification card system was removed.
- Additional content for worker training
 - How to report suspected violations to lead agency
 - More detail on existing topics
 - More detail on hazards from pesticide exposure on clothing and how to avoid exposure
 - Potential hazards to children and pregnant women from pesticide exposure
 - Meaning of the Safety Data Sheets
 - Specific information about other new WPS protections for workers (e.g., protections from retaliation).
- Additional content for handler training
 - Handlers must be at least 18 years old

- How to recognize, prevent, and provide first-aid for heat-related illness
- Handlers should receive respirator fit-testing, training, and a medical evaluation if they are required to wear a respirator by the product labeling
- Handlers must suspend a pesticide application if anyone is in the application exclusion zone
- Specific information about other new WPS protections for handlers.
- Training methods
 - Location must be reasonably free from distraction and conducive to training
 - Qualified trainer must be present during the entire training program
 - Training materials must be EPA-approved.
- Posting requirements
 - For outdoor production, warning signs must be posted when the REI is greater than 48 hours
 - Post on the border of any worker housing within 100 feet of the treated area
 - Signs must be removed or covered within three days of the end of the application or REI.
- Keep and display pesticide application and hazard information
 - Display SDS at central display location
 - Keep records for two years from REI date
 - Upon request, give access/copies to workers, handlers, treating medical personnel, and “designated representatives.”
- Agricultural employer duties
 - Ensure workers do not enter areas where pesticides were applied until application information and SDS are displayed, and until REI has expired and warning signs have been removed or covered, except for early entry permitted by rule.
- Pesticide safety information
 - Current WPS: Safety poster displayed at central location; certain safety information specified.
 - Revised WPS: Safety information displayed at central location and certain decontamination sites; additional information required on display.
- Minimum age requirements
 - The final rule establishes a minimum age of 18 for handlers and early entry workers.
- Respirator requirements
 - When a respirator is required by the labeling, handler employer must provide handlers with medical evaluation, fit test, and respirator training before the handler performs any activity requiring the respirator
 - Handler employer must document completion and maintain records for two years.
- Decontamination supplies
 - Current WPS:
 - Employers must provide “sufficient amount of water so that the workers/handlers may wash thoroughly”
 - If handler is using a product that requires eye protection, one pint of water must be immediately available to each handler.
 - Revised WPS:
 - Provide one gallon of water for each worker and three gallons for each handler and each early entry worker, measured at the beginning of the work period

- If handler is using a product that requires eye protection or using closed system under pressure, a system for delivering eye flush water must be immediately available at each mix/load site for handler eye flushing
 - If applicator is using a product that requires eye protection, one pint of water must be immediately available to each applicator.
- Protections for early entry workers
 - Added oral notification requirements, but eliminated requirement for recordkeeping of completion of oral notification
 - Added a minimum age requirement.

Outreach and implementation will include the following components:

- Education of all stakeholders (webinars, presentations, training, and courses for states and tribes)
- Develop educational resources (fact sheets, comparison tables, How to Comply manual)
- Enforcement resources (WPS compliance monitoring strategy, updated WPS inspection guidance, inspector pocket guides)
- WPS worker and training materials.

EPA is updating pesticide safety training materials for workers and handlers. Materials for workers will be developed in different languages at and will be appropriate for low literacy. Targeted materials will be developed for different sectors (i.e., greenhouses, nurseries, specialty crops). EPA will also develop TTT materials.

The president asked EPA to coordinate with other agencies that deal with similar constituencies, including DOL and HHS. Mr. Keane asked the Council for feedback on how to work together.

Discussion

- Dr. Lopez asked if the training materials would be field tested.
 - Mr. Keane replied that EPA recognizes that training must be delivered in a language that workers can understand.
- Dr. Kilanowski suggested that information be disseminated through Future Farmers of America; Dennis Murphy at Pennsylvania State University, who is putting together a clearinghouse on agricultural health and safety; and the Agricultural Safety and Health Council of America.

Discussion of Next Council Meeting

Dr. Kilanowski opened the floor for discussion of the next Council meeting, which was tentatively scheduled for the first week of November.

Council members suggested Florida, New Mexico, Southern California, Sacramento, and El Paso as potential locations. They noted that access to farmworkers who can provide testimonies was an important consideration.

Council members proposed the following topics for the next meeting: mental and behavioral health; voucher programs; telemedicine (rationale and use); and financial of operations of FQHCs. Dr. Moreno suggested that the topics should be inter-related so the Council could develop cohesive recommendations.

Formulation of Letter of Recommendations

Council members identified the following issues as high priorities for the letter of recommendations:

Gap	Recommendation to Address the Gap
Low penetration rate (19.8%) of migrant workers utilizing MHCs	<ul style="list-style-type: none"> A. Increase awareness of MHCs among MSAWs. B. Address migrant perceptions that might serve as a barrier for accessing care. C. Collaborate with DOL.
Inconsistent access to care for MSAWs	<ul style="list-style-type: none"> A. Highlight indicators/guidelines that reference expectations around culturally competent care and the quality of care experience for MSAWs. B. Actively communicate that to health centers. C. Create a list/matrix of the different definitions of MSAWs D. Lack of clinical providers and behavioral specialists.
<p>Lack of alignment/communication across HRSA focusing on models impacting migrant health centers.</p> <p>Smaller CHCs/MHCs have a tendency to outsource and lose control of data without additional funds.</p>	<ul style="list-style-type: none"> A. Make data warehouses economical. B. Implement limitations/restrictions on HIT funds (e.g., reduce outsourcing). C. Future resources to house large data sets. D. Insufficient internal capacity to handle data (e.g., paying vendors during UDS reporting).
Difficulty finding information related to MHCs	<ul style="list-style-type: none"> A. Update HHS/HRSA websites with user-friendly resources for non-English speaking populations, such as widgets in Spanish, Creole, etc. (ensure accessibility for mobile users).

Council members agreed to table recommendations related to HIV/AIDS, telemedicine, and farmworker housing for a future meeting.

Council members agreed on the following timetable for preparation of the letter:

WHAT	WHO	BY WHEN
Draft letter and send to Chair	Rev. LaBarge	May 24
Edit draft and send to Council	Kilanowski	May 30
Review and provide feedback	All Council members	June 3
Incorporate revisions	LaBarge	June 5
Submit to HRSA	Kilanowski	June 6

Reimbursement and Logistical Information

Priscilla Charles, Committee Meeting Manager, NACMH

Ms. Charles reviewed the policy and procedures for completing and submitting travel reimbursement forms. She noted that receipts could be scanned and submitted as PDF files. All documents that are submitted electronically must also be submitted in their original form. Vouchers must be submitted within five business days (Thursday, May 26).

Closing, Wrap-up and Summary

Ms. Naqvi requested feedback on the structure of this meeting to assist in developing the agenda for the next meeting. Council members provided the following comments:

- The agenda should include fewer presentations and more time for discussion.
- Continue to provide the documents on a flash drive.
- The gaps and recommendations worksheet was a useful tool.
- Consult with Council members regarding farmworker testimonies.
- Consider obtaining testimonies from promotoras, possibly alternating with farmworker testimonies.

Ms. Naqvi emphasized the importance of ensuring that testimony sessions are productive and relevant to the work of the Council. Ideally, the information obtained from testimonies should be incorporated in the recommendations that arise from the meeting.

Ms. Naqvi thanked Council members for a productive meeting and acknowledged Ms. Paul for her contributions and support.

The meeting was adjourned at 4:22 p.m.