

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

May 22-23, 2019

Brockport, NY

Meeting Minutes

Council Members in Attendance

Daniel Jaime (Chair)
Sharon Brown-Singleton (Vice Chair)
Rogelio Aguilar
J Angel Calderon
Angelina Vallejo Cormier
Donalda Dodson
Dani Higgins
Daniel Jaime
Carmen Veguilla Montañez
Jonathan Raber
Deborah Salazar
Jose Salinas
Gary Skoog
Shedra A. Snipes

Federal Staff

Strategic Initiatives and Planning Division (SIPD), Office of Policy and Program Development (OPPD),
Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA),
U.S. Department of Health and Human Services (HHS):
Iran Naqvi, MBA, MHS, Deputy Director
Esther Paul, MBBS, MA, MPH, Designated Federal Official, NACMH

The National Advisory Council on Migrant Health (NACMH/Council) met in Brockport, New York on May 22 and 23, 2019 to review health care concerns of migrant and seasonal agricultural workers (MSAWs) and issues pertaining to the organization, operation, selection, and funding of migrant health centers (MHCs) and other entities assisted under section 330(g) of the Public Health Service Act as amended, 42 USC 254(b). The goal of the meeting was to develop recommendations to the Secretary of HHS and the Administrator of HRSA to improve health services and conditions for MSAWs and their families.

WEDNESDAY, MAY 22, 2019

Welcome/Call to Order/Introductions

Iran Naqvi, MBA, MHS, Deputy Director, SIPD, OPPD, BPHC, HRSA, HHS
Esther Paul, MBBS, MA, MPH, Designated Federal Official, NACMH

Ms. Paul opened the meeting and welcomed the new Council chair and Vice Chair, new and continuing Council members, and speakers and guests. She then introduced Ms. Naqvi.

Ms. Naqvi expressed her commitment to the concerns of MSAWs. She urged Council members to use their voices, experience, and passion to ensure that HRSA continues to address the needs of this vulnerable population.

Ms. Naqvi invited members to introduce themselves and state why the Council is important to them.

NACMH Chair Opening Remarks

Daniel Jaime, Chair, NACMH

Mr. Jaime welcomed Council members and thanked them for their commitment to making a difference in the lives of MSAWs.

Mr. Jaime called for a motion to approve the agenda for this meeting. The motion was made by Mr. Skoog and seconded by Mr. Aguilar.

Mr. Jaime called for a motion to approve the minutes of the NACMH November 2018 meeting. The motion was made by Ms. Salazar and seconded by Mr. Skoog.

Council Vice Chair, Sharon Brown-Singleton, welcomed Council members and encouraged them to share their thoughts and knowledge freely.

Federal Update

Jennifer Joseph, PhD, MsEd, Director, OPPD, BPHC, HRSA

Dr. Joseph thanked Ms. Paul and Ms. Naqvi for their support of the Council and thanked Council members for advising HHS on the health care needs of MSAWs. She then provided an update on the HRSA Health Center Program, including policies, priorities, and funding for MHCs.

HRSA has five strategic goals: 1) Improve access to quality health care and services, 2) Foster a health care workforce that is able to address current and emerging needs, 3) Enhance population health and address health disparities through community partnerships, 4) Maximize the value and impact of HRSA programs, and 5) Optimize HRSA operations to enhance efficiency, effectiveness, innovation, and accountability. These goals provide an overarching framework for BPHC programs, including MHCs.

In fiscal year 2017 (FY 2017), HRSA-funded health centers served more than 27 million people, including nearly 1 million MSAWs. This represents one in 12 people across the United States.

HRSA's budget for FY 2019 is \$11.7 billion. Nearly half of that funding (\$5.6 billion) was allocated to BPHC programs, including health centers.

Funding for health centers grew steadily between 2000 and 2010 and increased dramatically in 2011 due to the five-year mandatory funding included in the Affordable Care Act (ACA). The mandatory funding has increased every year and has been extended twice for two years; it now represents 70 percent of the program budget. Discretionary funding, which must be appropriated by Congress each year, makes up the rest of the program budget. The program is facing a fiscal cliff on September 30, when discretionary funding for FY 2019 and the two-year mandatory funding extension will both expire. BPHC is optimistic that the situation will be resolved in time, but they are analyzing the impact if Congress delays or fails to approve the funding for FY 2020.

BPHC issued five new funding opportunities for health centers in FY2019:

- Integrated Behavioral Services Expansion: \$200 million for approximately 1,375 awards of \$145,000 each
- Quality Improvement: \$100 million
- New Access Points: \$50 million for approximately 75 awards of \$650,000 each
- Oral Health Infrastructure: \$76 million for approximately 250 awards of \$300,000 each
- Health Center Controlled Networks: \$42 million for approximately 50 awards.

Funding for substance use disorder (SUD) and mental health service expansion has increased significantly since FY 2014. HRSA has four programs in this area, for a total of \$544 million in ongoing funding. Health centers are being asked to do more to demonstrate accountability for these funds.

The president's budget request for FY 2020 includes \$5.6 billion for the health center program. It is essentially flat funding, with \$4.0 billion in mandatory funding for FY 2020 and 2021 and \$1.626 billion in discretionary funding. The budget includes \$50 million in new spending to support a government-wide initiative, Ending the HIV Epidemic: A Plan for America. The initiative aims to end the HIV epidemic within 10 years by presenting people at high risk of HIV with pre-exposure prophylaxis (PrEP). The initiative targets seven rural states and 48 counties with high incidence of HIV. HRSA will begin by working with health centers that receive funding through the Ryan White HIV/AIDS Program to serve patients with HIV; they intend to support all health centers over time.

The HIV initiative includes four components: 1) Respond rapidly and effectively to clusters and outbreaks of new HIV infections; 2) Diagnose all people as early as possible after transmission, 3) Treat HIV infection rapidly and effectively to achieve viral suppression, and 4) Prevent transmission among people at highest risk using proven prevention interventions, including PrEP and education. A detailed flowchart to implement this approach was included in the meeting materials.

Health center data for FY 2018 will be available soon. Data from previous years show that access to comprehensive care expanded significantly from FY 2015 to FY 2017. The number of patients who received SUD, mental health, and vision services increased by 44 percent, 37 percent, and 34 percent, respectively, and the number of patients who received dental services increased by 18 percent. Increased funding in these areas resulted in changes in the workforce, as health centers hired more providers to deliver these services. This shift reflects the evolution of care teams and HRSA's increased understanding of what works to support service delivery and improve patient outcomes.

The number of agricultural worker patients served by health centers increased from 910,172 in FY 2015 to 972,251 in FY 2017. Sixty percent of those served in FY 2017 were seasonal workers, and 30 percent were migratory workers. Ten percent of MSAW patients were served at health centers that do not receive migrant health funding.

The number of MHC patients diagnosed with anxiety disorders, including post-traumatic stress disorder (PTSD), increased from 25,000 to nearly 34,000 from 2015 to 2017. This corresponds to an increase in MHCs' use of screening, brief intervention, and referral to treatment (SBIRT). SBIRT was offered to 3,601 patients in FY 2015, 15,180 patients in FY 2016, and 48,148 patients in FY 2017.

Other indicators of success are increased numbers of MHC patients with controlled high blood pressure and controlled diabetes.

The use of medication-assisted treatment (MAT) for patients with SUD has grown significantly. The number of MHCs providing MAT increased by 31 percent from FY 2016 to FY 2017, and the number of providers at MHCs who were eligible to prescribe MAT increased by 92 percent when the definition was expanded to include physician assistants and nurse practitioners. The number of MHC patients who received MAT increased by 82 percent during that period.

Compliance with program requirements is essential for health centers to maintain funding. To help health centers maintain continuous compliance, BPHC developed a new compliance manual (CM) that clarifies Health Center Program requirements; created a Health Center Site Visit Protocol (SVP) and a conditions library; provides technical assistance to health centers; and developed new oversight processes to help health centers resolve preliminary issues before those issues are codified on a Statement of Awards.

In response to the Council's feedback in November 2018, BPHC updated the SVP to highlight flexibilities related to reimbursement of migrant health center. MHCs permitted use of project funds to reimburse governing board members for participation in board activities, for wages lost irrespective of annual income; Section 330 (e & g) grantees permitted use of project funds to reimburse governing board members for wages lost, using following guidelines for permissible income levels: family: < \$10,000; single: < \$7,000. (Income defined by the health center); MSAWs permitted board meeting attendance through teleconference/other electronic communication and MHCs permitted up to two-thirds of the non-patient board members who derive more than 10 percent of their annual income from the health care industry (as opposed to other grantees, allowed no more than half of the non-patient board members).

These efforts have resulted in fewer applications being awarded with conditions, faster resolution of conditions, and fewer one-year project periods. In calendar year 2018, the top five areas where conditions were placed were the sliding fee discount program, clinic staffing, board authority, billings and collections, and contracts and sub awards. BPHC will look at these areas more closely to determine how they can proactively support health centers before site visits are conducted. They believe they are on the right path, and they would welcome more stakeholder feedback.

HRSA is exploring ways to use data to drive outcomes and demonstrate return on investment. In 2017, BPHC began to link service area funding to achievement of patient targets. The Bureau also makes quality Improvement awards to recognize high-performing health centers.

BPHC is exploring value-based funding to incentivize desired clinical quality and community health outcomes. BPHC funded an environmental scan in early 2019 and shared the results of the assessment in May. The Bureau will develop approaches for value-based funding in summer 2019, create models in fall 2019, test models in winter-spring 2020, and implement the plan in summer 2020. Results of each step will be shared with the public. A key question is how to measure value, especially for vulnerable populations. HRSA welcomes feedback from Council members and MHCs to ensure that MSAWs' needs are reflected in this process.

Discussion

- Mr. Aguilar asked why funding for health centers increased dramatically in 2011.
 - Dr. Joseph replied that the mandatory funding included in the Affordable Care Act (ACA) began in 2011. HRSA used that funding to increase health center sites and expand services.

- Mr. Calderon said some migrant health centers in his geographical area were concerned that they might lose funding if they do not serve enough MSAWs. He asked if health centers are required to serve a specific number of MSAWs.
 - Dr. Joseph said HRSA does not specifically link MHC funds to the number of patients served. However, HRSA has a statutory responsibility to ensure that a specific percentage of the total health center funding goes to MHCs. Serving more MSAWs helps HRSA meet that requirement.
- Dr. Salinas referred to the slide showing the breakdown of agricultural workers served by health centers in 2017 and asked if the percentage of seasonal workers included those with H2A visas.
 - Ms. Paul stated that MSAW patients who migrate and set up a temporary abode are counted as migratory; seasonal agricultural workers have employment in agriculture on a seasonal basis and who do not meet the definition of a migratory agricultural worker.
 - Dr. Joseph suggested that if there was value in knowing the number of H2A workers served at MHCs, the Council could make a recommendation in that area.
 - Dr. Salinas said it would be helpful for health centers to capture their data accurately, for organizing data based services.

Overview of Agriculture and Migrant and Seasonal Agricultural Workers in New York

Mary Jo Dudley, MRP, BA, Director, Cornell Farmworker Program (CFP), Cornell University

Ms. Dudley provided an overview of MSAWs in New York State and factors that impact their health and healthcare.

CFP's mission is to improve the living and working conditions of farmworkers and their families, to seek recognition for farmworkers' contributions to society, and to seek their acceptance and full participation in local communities. CFP envisions a state and nation in which farmworkers receive equal protection under law, earn a living wage, live in comfortable housing, are safe and healthy, receive due respect as workers and as individuals, and participate fully in their communities

Agriculture is a \$5.4 billion industry in New York State. One quarter of the state is farmland, with more than 36,000 farms; half are small farms. Nearly 60 percent of the agriculture is labor-intensive.

Although the demographics of the Eastern Migrant Stream have changed since the late 1800s, migrant farm work has consistently been a way for people with limited English proficiency to earn an income.

CFP conducted ethnographic interviews to inform the services they provide to farmworkers. Questions included: What motivated you to leave home? How did you leave home? Why did you choose this location? What is your day-to-day experience? What do you like about it? What do you wish was different? What do you want to do in the future (one year, five years, 10 years)?

Migration stories help health providers understand the traumas of migration. Farmworkers interviewed by CFP identified three main reasons for migrating: economic opportunity, fleeing violence (including residues of war), and looking for adventure.

Farmworkers identified a number of priorities, including immigration concerns, how to navigate in new communities, how to improve workplace relations, options for learning English, and access to services.

Farmworkers cited many factors that influence their health, including long working hours, physically demanding work, poor housing conditions, insufficient social outlets, stress associated with immigration status, limited access to fresh fruits and vegetables, and pesticide and chemical exposure.

Farmworkers face numerous mental health challenges, including cultural factors. Most are young men who migrate without a spouse. They want to bear their burdens and do not want to be considered “loco.” Health centers need to find ways to make behavioral health services attractive to farmworkers.

H2A workers have unique needs, and many are confused about health insurance and taxes. It is important for providers to recognize those needs.

Earlier this year, CFP surveyed health providers and board members at Finger Lakes Community Health, Oak Orchard, and Hudson Valley Health. Questions were: What are the top three current areas of strength in provision of health services to farm workers? What are the three most important service areas that could be strengthened? What are the three most important things that would be needed to address areas that could be strengthened? What would be needed to strengthen healthcare?

The following were the top responses to each question:

- Areas of strength: Language support, transportation, and affordability.
- Areas to be strengthened: Language support, affordability, increase capacity.
- Important things to address: Increased funding, language support, transportation.
- What is needed to strengthen healthcare: Increase funding, language support, cultural responsiveness, outreach, affordability.

Farmworkers view transportation to clinics and clarity about billing as the most important factors.

Health centers need to accommodate the needs of people who are isolated by geography, social status, and language. Spanish is a second language for an increasing number of farmworkers. Skits are more effective than written materials for communicating with them.

CFP conducts research on public perceptions of immigrants. The Empire State Poll is a telephone survey of a random sample of 800 households, plus an additional 300 rural households in New York State. It includes two questions: How do undocumented immigrant farmworkers impact local communities? What should happen to undocumented farmworkers with a good work history? The Cornell National Social Survey (CNSS) collects public opinion toward undocumented immigrant farmworkers through a randomized annual telephone public opinion survey of 1,000 individuals across the U.S.

Responses to these surveys indicate that public opinion is not reflected in public policy. In 2008, 57 percent of respondents to the Empire State Poll said undocumented immigrant farmworkers have a positive impact on communities. In 2017, 75 percent of respondents held that view. CNSS findings were similar. In 2017, 26 percent of respondents said undocumented workers have a positive impact, and 22 percent said they have a very positive impact. In 2018, 39 percent said undocumented workers have a positive impact, and 27 percent said their impact was very positive.

The New York State legislature is considering two bills that would impact MSAWs:

- NYS Farmworker Fair Labor Practices Act (FFLPA): Current labor law in New York excludes agricultural workers from protections provided to all other workers. This bill would remove those exclusions and grant agricultural workers a day of rest each week, overtime pay after 40

hours a week and eight hours a day, collective bargaining rights, regular health and safety inspections for all farmworker housing, and Unemployment and Workers' Compensation Insurance regardless of farm size. The legislature has considered versions of this bill over 80 years. The current version has broader legislative support, though the language may be revised.

- **Green Light Bill:** This legislation would expand access to drivers' licenses to all New Yorkers, regardless of immigration status.

Discussion

- Ms. Higgins said she has seen an increase in young men bringing children with them, and many have not been single parents before. She asked if CFP's interview includes questions about age.
 - Ms. Dudley replied that the interview includes extensive questions about age, education, family, and other factors.

Working and Living Conditions on New York Dairy Farms

Rebecca J. Fuentes, Workers' Center of Central New York (WCCNY)

Ms. Fuentes described working and living conditions on dairy farms in New York State based on a 2017 report, *Milked: Immigrant Dairy Farmworkers in New York State* (<https://milkedny.org>). The report presents the findings of a study conducted by WCCNY, the Worker Justice Center of New York (WJCNY), Syracuse University, and Cornell University. Researchers conducted 88 structured interviews on 43 farms in central, western, and northern New York in 2014 and 2015. The interview included more than 200 questions about work, migration, community, and organizing.

The objectives of the report were to advocate for farmworker rights, tell farmworkers' stories about abuses in dairy farms as workplaces, inform consumers about the conditions faced by dairy farmworkers, and submit policy recommendations to the New York State government.

Key findings were as follows:

- Dairy farmworkers are subject to a system that excludes them from basic labor rights. Workers are overworked and underpaid (12-hour shifts, six days per week, with earnings just above minimum wage). Twenty-eight percent have knowingly suffered wage theft.
- Eighty-eight percent of dairy farmworkers believe their employer cares more about the cows than the workers.
- Dairy jobs are risky and unsafe. Dangers include aggressive cows and bulls, heavy machinery, chemicals, and slippery, insecure conditions. Two-thirds of dairy farmworkers have been injured on the job one or more times; two-thirds of those who were injured needed medical attention. Nearly three-quarters said protective equipment available is not adequate. One-third said they were not trained to do their jobs. Most training is brief and conducted by other immigrant workers.
- Eighty percent of dairy farmworkers work on farms that are too small for the Occupational Safety and Health Administration (OSHA) to inspect, even if there is a fatality on the farm.
- Housing for dairy farmworkers is substandard and unsafe. Issues include bugs or insects, no locks on doors, holes in the floor or walls, insufficient ventilation, bathrooms in poor condition, insufficient heating, no potable water, broken stoves, a broken roof, and no electricity.
- Workers said they only leave the farm about once every 11 days, primarily due to fear of immigration enforcement. Nearly half said they had been detained at least once.

- Dairy farmworkers face social isolation and exclusion. Nearly two-thirds feel isolated, and more than half feel they do not belong to the community, and 80 percent feel depressed.

Discussion

- Mr. Calderon noted that Cesar Chavez educated farmers about the importance of having healthy workers. He said his community health center invites farmers to participate in their annual celebration.
 - Ms. Fuentes agreed that it is important to talk to employers. When her organization conducts protests at farms, farmworkers receive their payments the following day.
- Ms. Salazar said dairy farmers in her area were resistant to outreach efforts. She asked if the extent of resistance was different for different types of farms.
 - Ms. Fuentes said WCCNY chose to focus on dairy farmworkers, because organizations to support other types of farmworkers were already in place. As an advocacy organization, their primary communication is with the workers, not the farmers. The Attorney General of New York recently issued an opinion that anyone who is invited by a farmworker has a right to be on a farm.
- Mr. Jaime asked what she would recommend to address the concerns of dairy farmworkers.
 - Ms. Fuentes suggested that workers have better access to health services, including education and support; migrant health center check-ins several times a year; more coordination with grassroots organizations that provide services; better education about workers' rights, including access to Medicaid or health insurance; and mobile clinics.
- Mr. Aguilar said many of the conditions in New York are also common in Idaho. He asked if the study had any unexpected findings.
 - Ms. Fuentes said they learned that some small farms have an unusual schedule, with four hours of work, four hours of rest, and another four hours of work. Workers want to be involved in making changes. Membership in WCCNY gives them a sense of belonging.
- Mr. Calderon asked if mental health services are available for dairy farmworkers who are depressed or suffer from mental illness.
 - Ms. Fuentes said mental health support is limited, and there are not enough bilingual providers. These services are very important in the current environment.
- Ms. Naqvi asked what the threshold is for farms to qualify for OSHA inspections.
 - Ms. Fuentes said a rider to OSHA's funding prevents the agency from inspecting or enforcing compliance with its standards on farms that employ fewer than 11 non-family workers. Most dairy farms have fewer than 10 workers.
- Ms. Naqvi asked if there are advocacy organizations for dairy farmworkers in other states.
 - Ms. Fuentes said she was aware of organizations in Vermont and Wisconsin. Conditions for dairy farmworkers in those states are similar to those in New York.
 - Mr. Raber said he had seen similar conditions in Pennsylvania. Employers feel pressure from many directions, including animal rights and workers' rights organizations.
- Mr. Skoog asked if organic farmers are more responsive to addressing workers' issues.
 - Ms. Fuentes said conditions are terrible on some organic farms, while they are better on others. While some organic farm organizations are very progressive, "organic" does not necessarily mean "good for workers."

- Mr. Raber said there are many smaller dairy farms in his area, which makes it hard for health workers to locate farmworkers. He asked if the situation was similar in New York.
 - Ms. Fuentes said there are 5,700 registered dairy farms in upstate New York, from small farms with one worker to large ones with 60 workers, and many in between. WCCNY needs to do more education and sit at the table with other groups.
- Ms. Dudley noted that there are coalitions of service providers in New York. It is important to let farmworkers know about the services that are available, but the cost of effective outreach in upstate New York is huge because of the distances involved. Outreach workers need to have contact information for service providers in order to refer farmworkers to them.
- Ms. Vallejo Cormier asked if WCCNY informs farmers about services that are available to them.
 - Ms. Fuentes said WCCNY works primarily with workers. However, they recognize the need to share their expertise with employers.

Public Comment

Mary Zelazny, Chief Executive Officer, Finger Lakes Community Health, provided public comment regarding the impact of human trafficking on MSAWs:

Finger Lakes Community Health (FLCH) is one of three Migrant and Community Health Center programs in New York State, providing services to about 9,100 Ag Workers each year, and also provides access to care for ag workers in 42 counties of New York State as one of 16 Migrant Voucher Programs in the US.

Community health workers (CHW) are critical to the work that FLCH does across New York, serving as the glue that holds ag worker services together. The care management services CHWs provide enable FLCH patients to access care and achieve better health outcomes. FLCH CHWs are hired from the communities they serve and FLCH has several former ag workers on staff. CHWs reach out to the ag workers at their homes, places of work, schools, and places of worship to connect them with services available to them. Though FLCH CHWs focus on health care concerns, finding a health home for the farmworkers and their families, they also link farmworkers to WIC, housing, food sources, Migrant Head Start, Migrant Education and other needs. This work puts on the front lines and deeply involved in the farmworker community.

Ms. Zelazny reported that this work has often become dangerous for CHWs. FLCH workers believe that human trafficking has increased in Western New York and, as a result, their CHWs have experienced situations that have put them in peril. For example, FLCH has been providing care management services in Chautauqua County for many years. Three FLCH CHWs have recently had to leave their employment with FLCH in that county due to threats from crew leaders and others who are connected to farmworkers. In one instance a CHWs car tires were slashed, she was threatened with being beaten up, and finally she received death threats if she continued to provide help to the farmworkers. She had no choice but to quit. Two CHWs left FLCH due to threats made against them.

In the Finger Lakes region, FLCH has also observed children especially of 15-18-year olds seeking care, accompanied by non-family members or distant relatives. Last season FLCH had one female immigrant patient who was working as a sex worker for farmworkers.

Ms. Zelazny also reported that farmworkers very often do not leave the farms, go shopping or to church, relying on others to do their errands. Farmers and dairy producers often do not want workers to leave the farms. This has created a system of virtual slavery for too many of FLCH

farmworker patients because they fear losing their jobs, their ability to stay in the United States to work and send money home to their families.

FLCH continues to work with partners in the region to identify potential human trafficking and continually educates staff on what to look for. However, FLCH is increasingly concerned to send CHWs out to some of the farmworker locations for fear of what they might encounter. FLCH is also concerned about farmworkers that are living under these circumstances.

Testimonies

The Council heard testimonies from 11 MSAWs and two CHWs from upstate New York. The testimonies provided vivid accounts of conditions that impact the health of MSAWs, including labor conditions on dairy farms (long hours, pesticide exposure, no access to water, no place to eat during breaks); poor housing; violations of occupational safety standards; fear of deportation; and lack of transportation.

The farmworkers who testified described challenges that MSAWs face in accessing healthcare services, including long waiting times for appointments; perceived discrimination in clinics; limited access to specialty care; lack of interpreters at hospitals; lack of information on insurance for H2A workers; lack of services and poor transitions in care for aging farmworkers; excessive out-of-pocket costs; fear of oral health procedures; stigma of mental health issues; lack of awareness that behavioral health services can mitigate work-related stress; lack of understanding of the importance of a full annual physical check-up; and lack of awareness of available resources and services.

Travel Reimbursement Procedure

Iran Naqvi, MBA, MHS, Deputy Director, SIPD/OPPD/BPHC/HRSA

Ms. Naqvi reviewed the procedures and timeline for travel reimbursement.

THURSDAY, MAY 23, 2019

Recap of Previous Day

Sharon Brown-Singleton, MSM, LPN, Vice-Chair, NACMH

Ms. Brown-Singleton summarized the key issues that emerged from the presentations and testimonies on the first day of the meeting.

National Association of Community Health Centers (NACHC) Update

Joseph Gallegos, Senior Vice President for Western Operations, NACHC

Mr. Gallegos provided an update on NACHC's activities to support the health center program and MHCs, including legislative priorities, funding for health centers and workforce programs, the "public charge" rule, and the Ag Worker Access 2020 Campaign. He also described an initiative to promote partnerships between federally qualified health centers (FQHCs) and Migrant and Seasonal Head Start (MSHS) programs.

Legislative Priorities

In early 2019, health center advocates educated nearly 100 new lawmakers in the House and Senate, new House leadership, and new committee chairs regarding the importance of the health center program. Health center funding has been a demonstration of bipartisanship in the House and Senate.

The congressional agenda is likely to include topics such as drug pricing; Medicare and public health extenders, including FQHCs; rural health concerns; a new budget cap deal; and the debt ceiling. Congress may also address additional opioid legislation, infrastructure investments, and immigration reform.

NACHC's legislative priorities include ensuring mandatory and discretionary funding for FQHCs, extended funding for the National Health Service Corps (NHSC) and the Teaching Health Centers Graduate Medical Education (THCGME) program. Other priorities include 340B drug pricing, Medicaid, behavioral health, and telehealth.

Funding for Health Centers and Workforce Programs

Prior to 2010, FQHCs were funded exclusively through the annual budget. As part of the ACA, Congress created a special five-year, \$11 billion fund to boost health center capacity. FQHC advocates succeeded in getting two-year extensions for the mandatory funding in 2015 and 2018. The current mandatory funding of \$4 billion per year will expire on September 30, 2019 without Congressional action.

Without sustainable and predictable funding, health centers will experience operational and service-related impacts, jeopardizing patient care. Health centers are small businesses and need to be able to plan for the future. NACHC is asking members of Congress to co-sponsor at least one bill to extend stable, long-term funding for the health center program.

Prior to the ACA, annual "discretionary" appropriations were the only source of federal grant funding for the health center program. Current discretionary funding is \$1.63 billion. The House included an additional \$50 million for FQHCs in its draft appropriations bill. The Senate had not addressed appropriations at the time of this meeting.

The NHSC and THCGME are key workforce programs whose funding will expire without Congressional action. NHSC supports clinicians in underserved areas through loan repayment and scholarships. THCGME supports residency training for physicians and dentists in community-based settings, most of which are FQHCs. Residents trained in FQHCs are more likely to stay and practice in rural and underserved areas. Funding for both programs need to be extended.

"Public Charge" Concerns

In 2018, a proposed rule was issued to expand the definition of "public charge." This proposed rule refers to the definition of public charge including a person's use of means-tested, publicly funded benefits such as Medicaid and the Supplemental Nutrition Assistance Program (SNAP). The change would make it more difficult for legally present immigrants using the publically funded benefits to become lawful permanent residents. The Department of Homeland Security received more than 200,000 public comments on the proposed rule. They must review all public comments before they publish the final rule.

The final rule will not go into effect until 60 days after it is published, and it will not be retroactive. NACHC urges health centers to inform patients that there is no benefit to withdrawing from Medicaid or SNAP at this time.

NACHC has extensive resources to help Council members stay engaged and informed about these and other issues. Policy papers, a blog, fact sheets, infographics, and other resources are available at www.nachc.org/policy-matters.

Ag Worker Access 2020 Campaign

AgWorker Access 2020 is a national initiative to increase access to quality healthcare for America's agricultural workers and their families. The overarching goal is to increase the number of agricultural workers who use FQHCs to two million by 2020. The campaign has made incremental progress in recent years, despite anti-immigrant sentiments. Community and migrant health centers served 972,251 farmworkers in FY 2017, and may have reached the one-million mark in FY 2018.

The campaign has three strategies to achieve its goals:

- Credit Where Credit is Due: Accurately identify and report all agricultural worker patients being seen in health centers, regardless of whether the center receives migrant health funds.
- Open Hearts, Open Doors, Open Access: Reach out to agricultural workers who are not currently being served, including H2A workers. Develop partnerships and collaborations with other community-based providers that result in increased access for agricultural workers. Develop innovative strategies to reach more agricultural workers.
- Build Capacity to Sustain Growth: Ensure sufficient funding to support potential growth in services that will be needed to serve an increased number of agricultural workers (e.g., primary care, dental, SUD and mental health treatment, pharmacy, and enabling services).

NACHC co-chairs the Access 2020 Campaign Task Force with the National Center for Farmworker Health (NCFH) and the Northwest Regional Primary Care Association (NWRPCA). The task force has 21 members representing FQHCs (including MHCs), state and regional PCAs, health care collaborative networks, HRSA national cooperative agreements (NCAs), and organizations representing education, housing, labor, and the faith-based community. They hope to engage farmers and growers and the business community.

The task force encourages individuals and organizations to be part of the campaign. Resources are available on the campaign website (<http://www.ncfh.org/ag-worker-access-2020.html>). Additional training resources are available at the websites of task force member organizations.

Migrant and Seasonal Head Start

NACHC has launched a partnership with the National MSHS Collaboration Office (MSHSCO). MSHSCO has a cooperative agreement with the HHS Administration for Children and Families (ACF), which administers the Head Start program. ACF is a sister agency to HRSA.

In 2016, health centers only served about 10 percent of the 34,000 children enrolled in MSHS, and MSHS incurred significant expenses referring children to providers. NACHC worked with MSHSCO to create a memorandum of understanding (MOU) between HRSA and ACF to support collaboration between FQHCs and MSHS programs. As a result, FQHCs now serve about 35 percent of MSHS children.

In 2018, NACHC worked with MSHSCO and HRSA to develop a revised version of the *Effective Partnerships Guide: Improving Oral Health for Migrant and Seasonal Head Start Children and their Families* (<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/effective-partnerships-guide-oral-health-mshs-v3.pdf>).

Mr. Gallegos encouraged the Council to recommend that the *Effective Partnerships Guide* and the MOU be implemented broadly to better serve farmworkers' children.

Discussion

- Dr. Snipes asked who created the partnerships guide.
 - Mr. Gallegos said the Guide was developed under the leadership of MSHSCO director, Guadalupe Cuesta, in collaboration with representatives of HRSA, NACHC, and the ACF Office of Head Start (OHS). He noted that OHS wants to extend the MOU more broadly so that FQHCs can be the health care home for all Head Start children.
- Dr. Snipes asked Mr. Gallegos to clarify his proposed recommendation.
 - Mr. Gallegos said that an initial step would be for HRSA to promote the use of the partnerships guide and the MOU. A larger step would be for both HRSA and ACF, as HHS agencies, to encourage their grantees to utilize the guide and develop partnerships at the local level.
- Mr. Raber noted that in South Central Pennsylvania he had seen collaborations between FQHCs, Head Start, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). He asked if there were any national efforts to promote collaboration between FQHCs and WIC or local departments of public health.
 - Mr. Gallegos said NACHC has observed collaboration between FQHCs and all service providers that are part of the community infrastructure. He was not aware of any efforts to promote collaboration with WIC specifically. FQHCs generally have a strong relationship with public health agencies without an MOU. WIC and immunization programs are generally funded through block grants to the states, while MSHS is funded at the federal level. He would encourage state PCAs to develop similar models for collaboration between FQHCs and local health departments so they can serve families in a more comprehensive, integrated manner.
- Mr. Salinas noted that many of the testimonies cited lack of transportation as a barrier to health care. He asked if NACHC had seen a similar need.
 - Mr. Gallegos replied that FQHCs receive funding from HRSA to support enabling services, including transportation. Those services are critical for MHCs, but they are not reimbursable through Medicaid or private insurance. NACHC and the other NCAs have urged HRSA to issue guidance that would hold health centers accountable for providing enabling services and to ensure that they are not compromised when there are budget restraints. Mr. Gallegos suggested that health centers look at partnerships and collaboration with organizations that provide services for similar populations.
- Ms. Naqvi noted that in May 2018, the Council highlighted the importance of identifying MSAWs at intake. She asked what NACHC would recommend to address that need.
 - Mr. Gallegos replied that NACHC is working on that issue as part of the Ag Worker Campaign. The high level of turnover at the front desk is a major factor. Health centers need to do a better job of recruitment and retention for those positions, because they play a key role in identifying those patients and reporting them in the Uniform Data System. In addition, HRSA should require health centers to provide specific strategies to identify and meet the needs of all special populations, including agricultural workers, the homeless, and veterans.

Overview of New York State Farmworker Health and the New York Farmworker Health Workgroup

Rose Duhan, President & CEO, Community Health Care Association of New York State (CHCANYS)

James Shuford, Project Manager, Migrant Health, HRHCare Community Health

Ms. Duhan provided an overview of FQHCs in New York State and the services they provide to farmworkers.

New York State has 68 FQHCs, including three MHCs, that serve 2.3 million patients (one in nine New Yorkers) at 800 sites. Eighty-nine percent of their patients are considered low income, compared to 32 percent of the general population. Medicaid reimbursements account for nearly 60 percent of FQHCs' revenue. New York's Medicaid program ensures access to health care for immigrants who would not be covered in other states.

There are approximately 90,000 agricultural workers in New York State, 27 percent of whom are seen at FQHCs. The three MHCs serve 81 percent of the MSAW patients. Twenty-four other FQHCs served at least 20 MSAW patients in 2017.

CHCANYS is concerned about the impact of the proposed public charge rule, which appears to have had a chilling effect on Medicaid enrollment and the number of patients who access health centers.

Mr. Shuford described the activities of the New York Farmworker Health Workgroup (NYFHW) and his mapping project to help health centers locate MSAWs and develop strategies to meet their needs.

NYFHW was formed to accurately identify and report all agricultural worker patients served; identify and develop partnerships with farm owners, community-based organizations, and other stakeholders; and share promising practices to enable access to care for agricultural workers. Its members include the three MHCs in New York, CHCANYS, the Cornell Farmworker Program, and Bassett Healthcare Network.

The group's first project was an interactive training webinar conducted in collaboration with CHCANYS and NCFH. The program was designed to help front-line staff in all New York FQHCs understand the MSAW population and accurately identify and report patients.

Mr. Shuford presented maps he developed using MSAW population data from the National Center for Farmworker Health (NCFWH) and FQHC data from the HRSA Data Warehouse. The first map overlaid the estimated MSFW population with FQHC sites and their MSAW patient volume across the state. This type of map could help MHCs and PCAs coordinate efforts to provide services where they are needed.

The second map presented NCFWH estimates of crop workers, animal workers, and MSFW dependents by county. MSAWs who work in fields and those who work in dairies may require different resources, and their work schedules may have implications for outreach strategies. An awareness of labor dynamics can help health centers develop effective strategies to serve MSAWs.

Discussion

- Mr. Aguilar noted that Mr. Shuford's second map showed a county in western New York that was strikingly different from the rest of the state.
 - Mr. Shuford replied that Chautauqua County in western New York is highly agricultural and has a large number of MSAWs. He pointed out that eastern Long Island also has a high population of MSAWs, which many people find surprising.

- Mr. Calderon said the testimonies indicated that MSAWs do not understand the types of behavioral health services that are available and there is still a stigma around mental health. The waiting period for appointments was another area of concern. He asked what health centers in New York were doing to address those issues.
 - Mr. Shuford stated that HRHCare was working on developing a trauma-informed care program. He stressed that health centers need to build the infrastructure to provide appropriate services before they implement universal screening for trauma.
 - Ms. Duhan stated that New York State FQHCs are working on integrating primary care and behavioral health to reduce stigma and increase the services that are available. All FQHCs in New York State are certified as Patient-Centered Medical Homes, which means they must ensure that emergency services are available on a 24-hour basis, and they must provide extended hours and a 24-hour telephone line. New York health centers recognize the importance of serving farmworker patients in a timely manner, but they need to have enough providers.
- Mr. Raber stated that the stigma around behavioral health includes a lack of awareness of the type of services that are available. He asked what the Council could recommend to address that.
 - Mr. Shuford replied that increased awareness and education only happens through outreach. Those are the services that health centers need the most, but no one pays for them. The large-scale structural inequities of agricultural work are the root cause of stress and mental health issues.

Migrant and Seasonal Agricultural Worker Oral Health Needs and Best Practices

Anthony Mendicino, Jr., DDS, Director of Dental Services, Finger Lakes Community Health Center (FLCHC)

Rachel Nozzi, DDS, Chief Dental Officer, Oak Orchard Health (OOH)

Dr. Mendocino described oral health care gaps and needs for MSAWs and their families and outlined best practices to address them.

Oral health is one of greatest unmet health needs of MSAWs. Gaps include lack of access to oral health care; lack of oral health education and preventative treatment; and the prevalence of early childhood caries in MSAW children.

Poor oral health reduces quality of life and is related to systemic chronic conditions such as stroke, heart and lung disease, and diabetes. MSAWs experience 150 to 300 percent more decayed teeth than their peers, and at least half of MSAW children have at least one to three teeth with decay. Dental caries among children is five times more common than asthma and seven times more common than hay fever.

Access is the most common challenge to good oral health for MSAWs. Barriers include lack of insurance and high cost of services, lack of transportation, threat of wage or job loss, limited clinic hours, linguistic barriers, lack of oral health knowledge, legal issues, social/economic status, fear, and lack of trust.

FLCHC provides a wide range of evidence-based solutions to address these problems, including:

- Head Start and early intervention, including oral health education to parents of MSAW children
- WIC and perinatal education
- Teledentistry program
- Summer school program for migratory children
- Evening hours at all sites

- Oral health education to pregnant women
- Application of low-cost fluoride varnish to prevent decay
- Medical/dental integration to apply fluoride varnish at well-child checks
- Application of low-cost silver diamine fluoride to prevent progression of decay
- Educating parents at open house/parent meetings on prevention and causes of tooth decay
- Establishing self-management goals with adult and pediatric populations
- Motivational interviewing at dental appointments
- Sealants on adult and deciduous molars
- Caries risk assessments using open-ended questions
- On-site facilitated enrollers to help with insurance
- Use of Care Coordination/Care Manager to support patient compliance.

Recommendations for FQHCs to improve oral health outcomes:

- Collaborate with MSHS programs to develop an early intervention program that includes on-site dental services (examination, dental cleaning, application of fluoride varnish, application of silver diamine fluoride if decay is present) and education of parents on prevention
- Offer oral health care evening hours
- Provide care coordination and oral health education to all patients
- Collaborate with WIC programs to provide services and education to pregnant women
- Collaborate with an institution- or hospital-based pediatric service that can treat children with need
- Provide in-camp oral health screenings of MSAWs to prioritize treatment needs and identify emergencies.

Dr. Nozzi provided an overview of diabetes and oral health. She noted that diabetes is the seventh-leading cause of death in the U.S. The rate of diagnoses diabetes in the Hispanic population is 12.1 percent, compared to 9.4 percent of the population overall.

Periodontal disease is a chronic inflammatory disease that affects the gum tissues and bone that support teeth. According to the Centers for Disease Control and Prevention, nearly half of all adults have some form of periodontal disease. It is more prevalent and severe among diabetics and has been called the “sixth complication” of diabetes. Periodontal disease has been linked to negative effects on blood glucose control and to the progression of diabetes.

MSAWs appear to lack awareness of the importance and need for proper oral health care. Fewer MSAW patients at OOH utilized dental services in 2017 and 2018. They cited many reasons for not pursuing dental treatment, including loss of income, lack of time off, fear of deportation or not being selected to work in subsequent years, political climate, lack of transportation, and more pressing concerns (e.g., money, health, providing for their family).

Oral health initiatives at OOH to serve MSAWs include transportation, attempts to accommodate same-day appointments, evening migrant blocks, and comprehensive patient engagement services to assist patients with translation, referral follow-up, and scheduling appointments. OOH distributes dental goody bags with OOH dental business cards to migrant communities, and they provide prophylaxis, exams, and sealants to children enrolled in the Migrant Education Program. The Albion site provides fluoride varnish at well-child visits, provides dental education to parents, and refers patients to OOH

Brockport for dental appointments. The OOH Mobile Dental Unit is parked at the Albion site in summer months and offers same-day dental visits.

OOH tried to implement designated farmworker days on the mobile dental unit in 2018, including transportation to the Albion site for those who were interested in a dental appointment. They did not succeed because workers did not want to miss a half day of work and farmers were resistant to the plan.

Under a new oral health initiative, OOH refers medical patients with HbA1c greater than 9 for oral health screenings. OOH hopes that dental care will help stabilize blood glucose levels for those patients.

Dr. Nozzi offered the following recommendations to improve oral health of MSAWs:

- Reduce barriers to care by offering accommodating hours and same-day appointments whenever possible; ensuring provider availability in rural areas; funding mobile dental units; providing dental education for translators; and providing transportation services.
- Provide dental education and continued encouragement for integrated health services.

Discussion

- Dr. Mendocino was asked how FLCHC sustains its teledentistry services.
 - He replied that the health center covers teledentistry through other funds because they feel the service is important.
- Dr. Mendocino was also asked about what he thought about proposals to have dental hygienists provide services outside of clinics.
 - Dr. Mendocino supported this approach. He did not share the concern that it would take patients away from health centers, because those patients are not coming for those services. The dental therapist program in Minnesota is working well, and Certified Dental Assistants can now provide services in New York. All professionals should work to the highest level of their training.
- Ms. Vallejo Cormier asked if OOH provides translators with a glossary of oral health terms.
 - Dr. Nozzi said OOH does not have an oral health glossary, but she offered to look into it.
- Mr. Calderon stated that designated farmworker days for oral health care was the right approach. He hoped that OOH would give it another try.
 - Dr. Nozzi agreed and thanked him for his support.

Migrant and Seasonal Agricultural Worker Geriatric Care Needs

Cheryl Seymour, MD, Medical Director, Maine Mobile Health Program (MMHP)

Dr. Seymour provided an overview of the healthcare needs of aging MSAWs.

MMHP provides mobile care seasonally and year-round voucher care, serving 1,200 patients annually from Latino, Haitian, Jamaican, and Native American communities. They have seasonal medical and behavioral health staff and 10 year-round, full-time CHWs.

According to the National Agricultural Workers Survey (NAWS), the average age of farmworkers is now 38. Geriatric MSAWs (age 65 and above) work an average of 41 hours per week. Although they represent about five percent of MSAW patients at MMHP, they account for 21 percent of patients with diabetes and 18 percent of patients with hypertension.

Health concerns of aging MSAWs include the burden of chronic disease, risk of polypharmacy, greater risk of injury, multiple recommended screening and prevention tests, transitions in family roles and life stages, and behavioral health needs that impact chronic disease outcomes.

Aging MSAW patients at MMHP are more likely to have uncontrolled chronic hypertension, high blood pressure, and uncontrolled diabetes, and they are more likely to identify as black (Haitian or Jamaican)

Social determinants of health that impact MSAWs include language, health literacy, housing, transportation, insurance, legal status, mobility, occupational exposures, and poverty. In 2015-2016, 49 percent of MSAWs did not have work authorization, 53 percent were uninsured, 33 percent lived in “crowded” housing, and 77 percent spoke a primary language other than English.

Structural forces that impact aging MSAWs include immigration and labor policies, anti-immigration rhetoric, and agricultural labor and housing policies.

Gaps and unmet needs for aging MSAWs can be grouped into three areas:

- Chronic disease management: Aging MSAWs need services that are culturally relevant, linguistically appropriate, and accessible outside of typical clinic hours and locations
- Transitions of care: Successful transitions require accurate and timely sharing of information and address both chronic disease and acute care.
- Access to specialty care: Access is limited by financial barriers. Insurance eligibility is tied to legal status and stable residence. Free care applications, if successful, take time, which delays care. Insurance or free care is typically not portable across state lines.

Dr. Seymour offered recommendations to address those gaps and needs:

- Chronic disease management: Expand the CHW model to delineate and promote a focused role for CHWs in chronic disease education and case management. Advocate for expansion of reimbursement for CHW services.
- Transitions of care: Support the expansion of the Health Network case management program administered through Migrant Clinician’s Network and expand services to track and report chronic diabetes.
- Access to specialty care: Increase enrollment for eligible MAWs in private insurance, Medicaid, and Medicare. Advocate for standardization of free care policy, unrelated to immigration status. Advocate for portability of insurance coverage. Increase technical assistance to MHCs around navigating free care applications and insurance enrollment, with a focus on geriatric MSAWs.

Facilitated Discussion: Letter of Recommendations to the Secretary of DHHS

Council member Shedra Snipes, PhD facilitated a discussion of issues and themes from the presentations and testimonies that could inform the Council’s recommendations to the Secretary of DHHS. Council members identified the following issues:

- Oral health: waiting time for appointments, cultural services, interpreters, dental hygienists
- Aging farmworkers: lack of services, need to go back to their country, expanded funding for CHWs, transitions to care, insurance
- Dairy: labor conditions (long hours, no breaks), pesticide exposure, no access to water, housing conditions (lack of heat, lack of space), no place to eat during work hours
- Importance of enabling services
- Human trafficking

- Need for access to specialty care (e.g., pediatric dentists, aging farmworkers)
- Need for transportation, CHWs, access to appointments
- MSAWs do not understand the importance of a full check-up
- Fear, compounded by financial issues, access to transportation, access to resources
- Staggering amount of out-of-pocket costs.
- Combination of physical fear due to lack of information about medical procedures, and fear related to immigration issues
- Need for linguistically and culturally appropriate education materials regarding health services
- Occupational hazards
- Lack of awareness that mental health practitioners can mitigate work-related stress
- Lack of reimbursement for transportation services
- HRSA incentives for reimbursement of CHW services
- Establish relationships with growers to facilitate access to outreach and services
- Culturally relevant information to increase providers' understanding of patients
- Portability of insurance across state lines
- Culturally relevant information about behavioral health
- Health literacy to increase awareness of available resources
- Impact of long hours in dairy industry on ability to access health care
- Health care providers are no longer welcome in the field
- Impact of the public charge rule
- HRSA support for Ag Worker 2020 Campaign
- Transportation and financing – develop a population density index to reflect the needs of sparsely populated states
- Readily available information for farmworkers, inform providers about working conditions, focus on collaborative efforts, collaborate with faith-based organizations, invest in resources for communication
- Value-based services
- Investigate models of success and models of failure
- Transitions/hand-offs/continuity of care
- Farmworker health insurance program
- HRSA app for farmworkers
- Encourage the use of existing protocols for behavioral health
- Culturally defined symptom surveillance for behavioral health
- Access to specialists for geriatric patients
- Social determinants of health: housing (e.g., lack of heat, lack of space, infestation), trauma, labor conditions (e.g., long hours in dairy industry, OSHA violations, lack of information on workers' rights)
- Cultural and context-specific information
- Need for data linkages (e.g., Migrant Head Start, MCN, NCFH, UDS, NACHC, CMS, NAWs, HRSA)
- Training for front-line staff at all FQHCs to identify MSAWs.

Dr. Snipes consolidated the issues into four thematic groups:

Enabling Services

- Transportation and transportation finance
- Readily available services

- Access to providers
- Value-based reimbursement
- CHW reimbursement/funding

Transitions: Handoff and Continuity of Care

- Insurance portability
- Issues with aging and transitions
- Access to appointments
- Integrated screening (i.e., behavioral health)

Social Determinants

- Labor conditions and violations
- Immigration and migration trauma
- Financial burdens
- Unmet living needs, housing conditions
- Cultural and context-specific information

Data Linkages

- Linking available data sets
- Theory testing

Using a voting process, Council members selected the following priority topics for recommendations:

- Transportation and transportation financing
- CHW reimbursement/funding
- Cultural and context-specific information
- Insurance portability
- Aging and transitions.

Formulation of Letter of Recommendations to the Secretary of DHHS

Ms. Naqvi noted that HRSA recently engaged in a brainstorming process to identify funding concepts that could be utilized in the event that additional funding becomes available on short notice. A key suggestion was to invite subject matter experts to provide input regarding funding priorities.

Council members discussed issues to include in recommendations in each thematic area.

Transportation and Transportation Finance

- Transportation is a required service for all health centers, but it is difficult to implement that requirement due to financial barriers. Capital and operational funding is essential to enable all FQHCs to provide universal transportation.
- Transportation remains a serious impediment for appropriate health care for MSAWs. Some patients defer care because they do not have transportation.
- Other programs can serve as models (e.g., Head Start).

CHW Reimbursement/Funding

- CHW services are a critical resource for MSAWs and help to reduce cost of care, but they are not a reimbursable expense.

- Return on assets (ROA) calculation can help health centers demonstrate value.
- Reinforce the Council’s previous recommendations.
- Provide incentives for health centers that utilize CHWs.

Cultural and Context-specific Information

- Develop telenovelas and skits.
- Identify leaders/influencers within the MSAW community who can disseminate information about services.
- Identify MSAW patients who can serve as CHWs.
- Conduct an educational campaign using the media.
- Pilot a program using “champion” farmers/growers, churches, and promotoras to disseminate information about mental health services.

Sliding Fee Compliance and Enforcement (formerly Insurance Portability)

- Differences from state to state make it difficult for health centers and workers.
- Nominal fee is still a burden for many MSAWs.
- Enforce compliance regarding the sliding fee scale.
- Sliding fee should be based on a 40-hour pay stub.
- Sliding fee scale fees should apply for specialists.
- Use WIC program as a model for portability.
- Explore avenues to create a fixed, national sliding fee scale for MSAWs.

Aging and Transitions

- Aging MSAWs have a higher prevalence of chronic illnesses and are more vulnerable to the accumulation of illnesses over time.
- Theories and evidence around biological aging indicate that MSAWs are at strong risk of telomere shortening.
- MSAWs do not have pensions, and many are not eligible for Social Security.
- Define a standard of care for geriatric MSAWs and ensure implementation of the standard.
- Increase funding to ensure that geriatric MSAWs continue to receive care when they are unable to pay.

Ms. Brown-Singleton reminded Council members of the deadline for travel reimbursement documents.

Ms. Naqvi thanked Council members for an excellent meeting and their commitment to making a difference in the lives of MSAWs and thanked Ms. Paul for her work on behalf of the Council.

Ms. Paul thanked Ms. Naqvi for her ongoing support and expressed her appreciation for the Council.

The meeting was adjourned at 5:30 p.m.