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

June 6-7, 2017
North Bethesda, Maryland

Council Members in Attendance
Amanda Phillips Martinez (Chair)
Christopher LaBarge (Vice-Chair)
Susana Castro
Alina Diaz
William Morgan
Adriana Andrés-Paulson
Stephanie Triantafillou

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):
- Matthew Kozar, Division Director
- Iran Naqvi, MBA, MHS, Deputy Division Director
- Esther Paul, MBBS, MA, MPH, Public Health Analyst
- Priscilla Myles, , MPH, Meeting Manager, NACMH

Dalana Johnson, Public Health Analyst, Policy Division, OPPD, BPHC, HRSA
Steven Hirsch, Administrative Coordinator, Federal Office of Rural Health Policy, HRSA

TUESDAY, JUNE 6, 2017

Welcome/Call to Order/Introductions
Iran Naqvi, MBA, MHS, OPPD, SIPD, BPHC, HRSA, HHS

Marlynne Brown of Lux Consulting Group provided options for meal accomodations for council members through the hotel and other hotel logistics.

Ms. Naqvi welcomed Council members, federal staff, and public visitors to the meeting. She expressed appreciation for the Council's valuable recommendations to improve care provided at migrant and community health centers, thanked federal and contractor staff for their support, and acknowledged Esther Paul for her commitment and dedication to the work of the Council.

Ms. Naqvi noted that the Council has the power to shed light on the dilemmas that migrant and seasonal agricultural workers (MSAWs) encounter daily. She urged the Council to let the voice of Cesar Chavez speak through them: "I've always maintained that it isn't the form that's going to make the difference. It isn't the rule or the procedure or the ideology, but its human beings that will make it."

Ms. Paul stated that it was a privilege to support the work of the Council. She then opened the floor for introductions of Council members, staff, and visitors.

NACMH Chair Opening Remarks
Amanda Phillips Martinez, Chair

Ms. Phillips Martinez noted that this was the Council's forty-second year. The role of the Council is to develop recommendations to the Secretary of HHS and the Administrator of HRSA concerning 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. Council members come from different parts of the country, bringing their knowledge of MSAWs, their expertise in the operations of MHCs, and their commitment and enthusiasm. The meeting would provide an opportunity for Council members to educate each other and federal partners regarding the health and healthcare needs of MSAWs.

Ms. Phillips Martinez called for a motion to approve the meeting agenda. The motion was made by Mr. Morgan, seconded by Ms. Castro, and carried by general consent.

Ms. Phillips Martinez called for a motion to approve the minutes of the November 2016 meeting. The motion was made by Fr. LaBarge, seconded by Ms. Castro, and carried by general consent.

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

Dr. Joseph provided an overview of BPHC and the Health Center Program, followed by updates on BPHC budget and funding, policies and programs, and quality improvement (QI) initiatives.

Overview of BPHC

- The mission of BPHC is to improve the health of the nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary healthcare services.
- BPHC has four key strategies to support the effectiveness of the Health Center Program: increase access to primary health care services; modernize primary care infrastructure and systems; improve health outcomes; and promote performance-driven, innovative organizations.
- The Health Center Program includes nearly 1,400 organizations and more than 10,400 service delivery sites. In fiscal year 2015 (FY2015), health centers served more than 24 million patients—including 910,172 agricultural workers--and employed nearly 189,000 people. Health centers serve one in 13 people in the U.S., one in 10 children, and one-third of those living in poverty. (Data for FY2016 have not been released.)
- MHCs operate in challenging circumstances. More than 90 percent of their patients are racial or ethnic minorities, and a similar percentage live in poverty. MHC patients are more likely than those of other health centers to be uninsured and to need services in languages other than English. To meet those needs, MHCs must provide more enabling services than other health centers.

Budget and Funding

- BPHC recently received its budget for the remainder of FY2017. In the final appropriation, Congress directed the Bureau to focus resources on mental health and substance abuse. This reflects the new Secretary's priorities as well as the needs of MSAWs. Mental health and trauma-informed care are significant issues for MSAWs, and substance abuse is also prevalent. It is important for MSAWs to have access to specialty care.
- BPHC awarded $51 million for 75 New Access Point (NAP) grants earlier in the fiscal year. It is unclear whether NAP funding will be an option going forward. The Bureau hopes to fund another round of Quality Improvement awards this year.

- The President's budget for FY2018 indicates a commitment to continue the Health Center Program by proposing level funding. Congress will determine the final budget.
- The Health Center Program is facing a fiscal cliff. The program budget includes $5.6 billion in mandatory funding that was written into the Affordable Care Act (ACA). That funding, which represents 70 percent of the annual budget, will expire on September 30 unless Congress extends it. Loss of that funding also threatens the Children's Health Insurance Program (CHIP) and the National Health Service Corps (NHSC). BPHC staff are providing information to Congress regarding the impact of this reduction in funding.

Policy Updates

- Service Area Overlap: The Bureau is developing a policy to determine when service area overlap becomes a problem and a decision making process to follow when a health center proposes to locate an expansion site in the service area of another health center.
- Telehealth: Telehealth is an important model for MHCs, because they can serve patients where they are. HRSA will provide technical assistance (TA) to help health centers understand how to provide and document telehealth services.
- Compliance Manual: BPHC is revising the Compliance Manual to clearly outline what a health center must do to meet the requirements set forth in Health Center Program statute and regulations. HRSA compliance oversight will be tied to the manual. The manual will also outline how health centers can achieve effective implementation of program requirements ("Shoulds") and clinical and operational excellence ("Best Practices").

Program Updates

- HRSA streamlined the Change in Scope Process to support faster decision making. Feedback and Uniform Data System (UDS) data indicate that this goal has been achieved.
- Supplemental Funding Quarterly Progress Reports: Health centers received additional funding to supportACA outreach and enrollment. Health centers no longer need to submit quarterly reports, because the data are now captured in the UDS.
- Service area competition (SAC) and patient targets: Health center funding is now tied to achievement of patient targets. Revised SAC guidance will be issued in June. Health centers have an opportunity to "right size" their patient target.

Patient Safety and Risk Management

- Health Center Program requirements include systems and processes to improve patient safety and risk management. Compliance with program requirements will be a pre-requisite for Federal Tort Claims Act (FTCA) deeming.
- The BPHC website has a tips sheet that walks people through the FTCA process as well as information on training and TA related to patient safety and risk management.
- The 21st Century Cures Act extends FTCA coverage to volunteer health professionals at health centers as of October 1, 2017. The Primary Care Digest will include updates to the FTCA Manual, application guidance, and related TA.

UDS Update

- The UDS is being modernized to reflect improvements in patient-centered care and to automate data submission. HRSA expects this will improve data quality and make the reporting experience simpler, less burdensome, and more stable.

BPHC resources to support the Health Center Program include the BPHC website (http://www.bphc.hrsa.gov/), a weekly e-newsletter, a BPHC Helpline, the BPHC project officers,

technical assistance provided through the National Cooperative Agreements (NCA), and a Primary Care Association (PCA) in each state.

Dr. Joseph encouraged Council members to contact her with questions or feedback regarding the Health Center Program.

Welcome/Opening Remarks
Tanya Bowers, MHS, Deputy Associate Administrator, BPHC, HRSA

Ms. Bowers greeted the Council on behalf of HRSA Associate Administrator, Jim Macrae. She emphasized that the Council's work helps BPHC address the many challenges that MSAWs face each day.

Ms. Bowers noted that the new Secretary of HHS has three key priorities: mental health, the opioid abuse crisis, and childhood obesity. She encouraged the Council to consider these issues when formulating their recommendations.

Ms. Bowers acknowledged that the Council has several vacancies and noted that the process to approve nominations was delayed due to the transition to a new administration. BPHC hopes the Council will have a full complement of members by the next meeting.

Ms. Bowers encouraged the Council to contact BPHC for any support they need.

Discussion

- Fr. LaBarge said his local police chief stated that the opioid crisis had moved from prescription drugs to heroin.
    - Ms. Bowers stated that the opioid crisis is now a community issue that involves public health, law enforcement, and education. The public safety aspect is important, and first responders deal with it directly. Adressing the problem will require community attention and participation.
- Ms. Andres-Paulson asked how health centers could address the opioid crisis without funding.
    - Ms. Bowers replied that federal funds had been allocated to address this issue, including support provided through the Department of Justice. The opioid crisis is a complex challenge that changes daily, which is why it is a priority for this administration. The federal government can impact policy and funding, but solutions lie at the community level. Communities must share success stories so they can adapt them to their own circumstances.
- Ms. Phillips Martinez asked Council members to share what they had seen in their communities related to the Secretary's three priorities.
    - Fr. LaBarge stated that his health center was questioning whether to continue the patient-centered medical home (PCMH) model, because they do not receive additional funding for additional staff. The local hospital has only five beds for pediatric mental health. Childhood obesity is a cultural and economic issue, because junk food is cheaper than fruits and vegetables. Prescribers are part of the opioid crisis.
    - Mr. Morgan stated that his area has a significant shortage of mental health professionals. The local high school identified 1,000 students who needed mental health care. Few mental health providers in the area speak Spanish.

- Fr. LaBarge stated that telehealth is an excellent way to provide mental health services, but those services are not billable.
    - Ms. Bowers stated that BPHC received significant feedback regarding billable visits, and the Secretary expressed interest in this issue. BPHC has also received consistent feedback about the shortage of mental health providers. It will be important to address these challenges to meet the needs of the communities that health centers serve.

National Association of Community Health Centers (NACHC) Federal Policy Update
Joseph Gallegos, MBA, Senior Vice President for Western Operations, NACHC

Mr. Gallegos provided an update on federal policy related to NACHC's legislative priority areas for 2017, which are Medicaid, Community Health Center (CHC) grants, workforce, and Section 340B.

CHC Funding

- The fiscal cliff is the major threat to health centers in 2017. Health center funding will expire on September 30, if Congress does not act. Vehicles to address this are limited and controversial. CHCs have bipartisan support, but coordination will be critical.
- Congress reached final agreement on the FY17 spending package to fund the federal government through September 30, 2017. The omnibus bill maintains historic commitments to CHCs, including $1.5 billion in discretionary Section 330 grant funding. It also reflects congressional interest in expanding the next generation of the health center workforce, and it includes $1.5 million to expand telehealth access and create a "Telehealth Center of Excellence" at HRSA.
- The FY2017 budget does not address the funding cliff. If Congress does not act, health center funding would be cut by 70 percent, reversing 25 years of bipartisan investment in the Health Center Program. MHCs would lose approximately $340 million in funding.
- NACHC is asking Congress to 1) sustain health center funding on a long-term basis by fixing the cliff, and 2) target new investments to address increased demand and ensure stability for patients. They are emphasizing four messages:
    - CHCs are the healthcare solution
    - Congressional inaction would lead to a 70 percent cut in funding
    - The federal investment is the key to the care/business model
    - In an uncertain coverage environment, health centers are key.

Medicaid

- Medicaid is the largest revenue source for federally qualified health centers (FQHCs). Forty-nine percent of health center patients are covered by Medicaid, and health centers serve one-sixth of all Medicaid beneficiaries. It has a unique prospective payment system (PPS) for health centers.
- Major changes on the table include repeal of ACA Medicaid expansion, proposals to shift to block grants or "per-capita allotments", and increased flexibility for state programs.
- The American Health Care Act (ACHA) passed by the House would phase out the ACA Medicaid expansion by December 31, 2019; end the penalty for both individuals and employers; and require expansion beneficiaries to maintain continuous coverage or face a steep financial penalty when they sign up again. It would also overhaul how Medicaid is structured and financed, capping federal payments to states based on the number of enrollees. The Medicaid program would not grow as rapidly as the cost of delivering care.
- NACHC is asking Congress to 1) support a strong Medicaid program that works for health centers and their patients, and 2) ensure that any effort to repeal or change the ACA includes plan for continuity of meaningful coverage and access to care.

- As Congress considers state flexibility, NACHC is emphasizing the following points regarding the importance of maintaining the health center PPS:
    - CHCs cannot continue to serve 12 million Medicaid patients without the PPS
    - The PPS ensures that federal grant funds are not diverted to cover underpayments
    - Health centers represent value, serving one-sixth of all Medicaid patients for less than two percent of total Medicaid spending
    - The current system is flexible, and many states use an alternative payment methodology.
- NACHC is urging health centers to complete a Medicaid Impact Statement to illustrate how the proposed changes would impact their patients and ability to provide services. Include stories …

National Health Center Week

- National Health Center Week is August 13-19. The theme for this year is "America's Health Centers: The Key to Healthier Communities." The goals are to 1) enhance the visibility and profile of CHCs, MHCs, homeless health centers, and public housing health centers, and 2) generate community pride and build support for the health centers program. Each day will have a special thematic focus (e.g., Elected Officials Day on August 13; Agricultural Worker Health Day on August 17).
- Mr. Gallegos urged Council members to invite local, state, and federal elected officials to visit their health centers on August 13.

Ag Worker Access 2020 Campaign

- The AgWorker Access 2020 Campaign is a joint effort of NACHC and the National Center for Farmworker Health (NCFH). The goal of the campaign is to double the number of agricultural workers served by CHCs by 2020.
- The campaign has three strategies:
    - Take credit where credit is due: Identify and report all MSAW patients
    - Open hearts, open doors, open access: Develop strategies, partnerships, and collaboration with key stakeholders that serve MSAWs
    - Building capacity for growth: Emphasize the need for flexible policies and resources from HRSA to increase access and serve all those in need.
- The number of agricultural workers served by Section 330g-funded MHCs and CHCs increased slightly in recent years, from 790,226 in FY2013 to 910,172 in FY2015.
- The campaign established Memoranda of Understanding (MOUs) with key stakeholders to form a collaborative network that includes national and regional organizations and vendors of services for health centers.
- Health center board members offered numerous recommendations during an open discussion at the 2017 National Agricultural Worker Conference. The complete list of recommendations was included in the electronic binder for this meeting.

Mr. Gallegos closed with a quote from a health center board member: "We all need a lawyer at least once in our lifetime. We all need a doctor at least three times per year. We all need an agricultural worker at least three times per day."

Discussion

- Ms. Andres-Paulson expressed concern that patients of MHCs would be reluctant to contact their members of Congress. She also emphasized the need to improve the ability of front desk staff to identify agricultural workers and reduce their fear of self-identification.

    - Mr. Gallegos replied that consumer board members are in an excellent position to educate legislators about the impact of MHCs. He urged Council members to contact and educate policy makers at all levels during Health Center Week in August. Many patients are fearful of losing benefits and other risks. It is important to educate and assure patients that MHCs are safe places to receive care. Front desk staff need to find ways of soliciting information without intimidating them.
- Mr. Morgan commented that information and education materials are often beyond patients' reading level, in both English and Spanish. Patients cannot give informed consent if they do not understand the documents.
- Ms. Diaz questioned whether it was realistic to ask MHC patients to invite legislators to visit health centers.
    - Mr. Gallegos stated that members of Congress who are aware of the Health Center Program need to be reminded of the looming deadline. New members of Congress need to be educated about health centers. He stressed that reaching hearts can help to change minds.
- Ms. Triantifillou asked if NACHC had data on the number of families that are not attending MHCs or participating in patient council meetings.
    - Mr. Gallegos said participation in patient councils had declined, but he did not have hard numbers. It is important to reach out and find ways of serving this population. HRSA should provide flexibility in service delivery and should emphasize the importance of promotoras and outreach workers to bridge the gap. Health center boards should work with executive leadership to increase the emphasis on these services.
- Ms. Diaz asked if it would be possible to meet the AgWorker 2020 goals if the H2A visa program is eliminated.
    - Mr. Gallegos stated that the H2A visa program was expanding and would not be eliminated. NACHC has been working to educate health centers about the unique challenges and needs of this population.

Council Reflections

Council members discussed the presentations and identified issues that could inform their recommendations. Key issues and considerations were as follows:

- Flexible funding and policies to enable MHCs to conduct outreach and provide care to MSAWs where they are.
    - Alternative service delivery models, such as mobile vans.
    - Require health centers to have promotoras and provide transportation services.
- Mental health
    - Address the need to deliver mental health services for children in the current climate.
    - MHCs need guidelines about how to implement trauma-informed care in health centers, especially for pediatric patients.
    - Mental Health First Aid is a powerful tool that can be used with many types of patients.
- MHCs need easier mechanisms to form partnerships that can help to provide services. MOUs can be complicated, and it takes time to establish them.
- Presentations at future meetings should help the Council make recommendations that are relevant to the new priorities at HHS.
- It is not always clear how to classify patients who are agricultural workers. Some MHCs serve three types of patients: migrant, semi-migrant, and those who work in factories.
- H2A visa migrant workers cannot utilize migrant housing. Migrant camps do not always meet health department standards.

Language Assistance and Communication Standards in the Culturally and Linguistically Appropriate (CLAS) Standards

Gemiraud Daus, MA, Office of Health Equity (OHE), HRSA

Mr. Daus informed the Council that OHE works to reduce health inequalities so that communities and individuals can achieve their highest level of health. It serves as the principal advisor to the Administrator of HRSA on issues related to health equity and language access.

Mr. Daus discussed language assistance in health care and the role of the CLAS Standards in achieving language access.

Key Terms

- A Limited English Proficient (LEP) individual does not speak English as his or her preferred language and has a limited ability to read, write, speak, or understand English in a manner that permits him or her to communicate effectively and have meaningful access to and participate in the services, activities, programs, or other benefits administered or funded by HRSA. (A new term, "Limited Language Proficient," shifts the focus to the organization, rather than the individual.)
- Language access is achieved when individuals with LEP can meaningfully access HRSA's services, activities, programs, and benefits.
- Language assistance consists of all oral and written language services needed to assist LEP individuals to achieve language access.

Language Assistance

- Language assistance helps individuals understand their care and service options and participate in decisions regarding their health and health care. It also improves patient safety and reduces medical error related to miscommunication, and it helps organizations comply with the requirements of Title VI of the Civil Rights Act of 1964 and other relevant federal, state, and local requirements.
- Translators and interpreters perform different services. A translator renders written documents from one language into a second language. Interpreters render spoken or signed messages into a second language. HRSA requires translators and interpreters to be proficient in at least two languages and to have the appropriate training and experience for their position. Interpreters must also abide by a code of professional ethics and standards.

CLAS Standards

- The CLAS Standards were originally developed in 2000. They were updated in 2013 to reflect a more comprehensive and complex understanding of culture and health and new national policies and legislation.
- The CLAS Standards were designed to advance health equity, improve quality, and help eliminate health disparities. They consist of a Principal Standard, and 14 individual standards that are organized around three themes:
    - Principal Standard: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
    - Standards 2-4: Governance, Leadership, and Workforce
    - Standards 5-8: Communication Assistance
    - Standards 9-15: Engagement, Continuous Improvement, and Accountability.

- The communication assistance standards are to offer communication and language assistance (Standard 5), inform individuals of the availability of language assistance (Standard 6), ensure the competence of individuals providing language assistance (Standard 7), and provide easy-to-understand materials and signage (Standard 8).
- Three of the Health Center Program requirements address language assistance: Requirement 2: Required and Additional Services; Requirement 5: After-Hours Coverage; and Requirement 7: Sliding Fee Discounts. The HRSA site visit guide includes those requirements.

Resources for Language Access and CLAS Standards

- Think Cultural Health (https://www.thinkculturalhealth.hhs.gov) is the website for the CLAS Standards. It includes a crosswalk between the CLAS Standards and other standards and performance metrics; an interactive map showing the implementation of the standards across the country; and the *Blueprint for Advancing and Sustaining CLAS Policy and Practice*.
- *What's in a Word? A Guide to Understanding Interpreting and Translation in Health Care* (http://www.ncihc.org/assets/documents/publications/Whats_in_a_Word_Guide.pdf)
- Certification Commission for Health Interpreters
- National Board of Medical Interpreters.

Discussion

- Ms. Andres Paulson asked if the CLAS Standards address the use of children as interpreters.
    - Mr. Daus said that the standards do not specifically address that issue.
    - Ms. Castro noted that HRSA requires translators and interpreters to have appropriate training and experience.
    - Mr. Morgan stated that his hospital does not allow any family member to serve as an interpreter.
    - Ms. Diaz noted that in some cases, there is no option, such as when the patient speaks a rare, indigenous language.
- Ms. Phillips Martinez asked how to incentivize adherence to the standards, especially for centers that have few LEP patients.
    - Mr. Daus replied that HRSA cannot enforce adherence to the CLAS Standards, because they are voluntary.
    - Ms. Castro noted that health centers are not mandated to provide translated materials for a language spoken by less than five percent of patients.
- Ms. Diaz expressed concern that clinics often claim that providers are bilingual, when they are not proficient in the second language.
    - Mr. Daus stated that the best practice is to test the providers. It is important for providers to know their level of fluency. Training of the healthcare workforce should address this issue.

Transportation and Health Access: The Transportation Initiative
Oscar C. Gomez, BA, CEO, Health Outreach Partners (HOP)

Mr. Gomez described HOP's initiatives to address transportation and health access for MASWs. He noted that CHCs and other safety net institutions regularly cite transportation as a major barrier to accessing health care. Lack of transportation results in delayed or missed medical appointments, interrupted care, inability to comply with prescribed health management plans, difficulty making and keeping follow-up appointments, poor health outcomes, and increased use of emergency departments.

In 2011, HOP received funding from the Kresge Foundation for a three-year project, Overcoming Obstacles to Health Care: Transportation Models that Work. HOP identified and documented successful patient-centered transportation models at CHCs and CBOs around the country, provided policy recommendations, and provided training and TA to address transportation barriers at the community level. The project report is available at: https://outreach-partners.org/wp-content/uploads/2017/06/FTA-Comm-Profiles-2.pdf

HOP launched its Transportation Initiative in March 2016 to build on its work with the Kresge Foundation. The initiative has two components: Not Just a Ride, funded by HRSA/BPHC, and Rides to Wellness Community Scan, funded by the Federal Transportation Administration of the U.S. Department of Transportation.

Not Just a Ride

- The project included a transportation evaluation methodology for CHCs, a health center and PCA learning collaborative, interactive online state resource maps, and a QI toolkit.
- HOP partnered with PCAs in California, North Carolina, and Maine; three CHCs in each partner state; and The Results Group.
- The QI toolkit guides users through the steps of conducting a needs assessment and a Plan-Do-Check-Act (PDCA) continuous QI process: https://outreach-partners.org/2016/10/19/transportation-quality-improvement-toolkit/.
- An infobook, *Transportation & Health Access: Where Are We Now and Where Can We Go?,* is available at: http://outreach-partners.org/blog-post/transportation-health-access-now-go/.

Rides to Wellness (R2W) Community Scan

- The project was designed to quantify the financial impacts of missed appointments. It had two components: a national survey of health centers, Veteran's Administration Medical Centers, and private providers to identify the impact of lack of transportation on healthcare costs, and a set of community profiles highlighting transportation solutions with promising opportunities for return on investment.
- CHCs reported that transportation is a barrier to care for 45 percent of their MSAW patients. MSAWs reported that transportation impacts their ability to make medical appointments.
- The survey found that patient-centered transportation increases access to individual support systems, promotes a greater sense of independence, increases social support and reduces feelings of isolation, enables treatment adherence to medication, diet, and exercise, and addresses social determinants of health such as job security, job opportunities, health food, access to child care and school, and safety.

Discussion

- Ms. Naqvi asked if there were any data correlating the lack of transportation with infant mortality.
    - Mr. Gomez said he was not aware of any data in that area.
- Ms. Naqvi asked if HOP looked at the impact of transportation barriers on the bottom line for health centers.
    - Mr. Gomez said HOP did not study that directly, but they were trying to determine that from the data they have. He noted that some health centers double book appointments to protect against lost income.
- Ms. Phillips Martinez asked what services have the greatest impact on transportation barriers.

    - Mr. Gomez cited telehealth services, location of clinics near public transportation, and "one-stop shopping" models that provide several services in one location (e.g., health care, legal services, and housing services).
- Ms. Andres Paulson asked if immigration was a factor in availability of transportation.
    - Mr. Gomez replied that immigration was not a factor in the transportation study, but it impacts HOP's work in other areas.
- Mr. Gomez noted that several states were seeking waivers from Medicaid reimbursement of non-emergency medical transportation. He offered to provide additional information regarding that issue following the meeting.
- Ms. Naqvi asked what recommendations Mr. Gomez would suggest for the Council's consideration.
    - Mr. Gomez replied that the *Transportation & Health Access* infobook outlines many strategies. He offered the following examples: 1) provide federal funding to expand cross-sector partnerships to develop new transportation models, 2) provide HRSA funding for the "one-stop shopping" model, 3) provide funding for mobile clinics, and 4) provide incentives in NAP funding for health centers to consider transportation routes when choosing locations for new clinics.
- Ms. Diaz asked if health centers had considered partnerships with Uber and Lyft.
    - Mr. Gomez expressed concern that this option could become a boutique service for less-marginalized patients. He emphasized that public-private partnerships are key. One of the cities that HOP studied offers a shuttle service funded by local businesses.

Using Ethnography and Bio-Qualitative Research to Study How Cultural Beliefs, Behaviors, and the Environment Merge to Influence Agricultural Worker Health

Shedra Amy Snipes, PhD, Director, Bio-Qualitative Research Lab, Department of Bio-Behavioral Health, The Pennsylvania State University

Dr. Snipes described the use of ethnographic tools to identify cultural beliefs and behaviors that influence farmworkers' health and described a mobile health (mHealth) intervention to promote pesticide safety and the use of personal protective equipment (PPE).

Background

- Farmworkers are the only working group who experience the harm of pesticides on a daily basis. The Environmental Protection Agency (EPA) estimates that 3.2 to 4 million people are exposed to pesticides annually, resulting in 300,000 acute cases per year. Lifetime exposure increases the risk of chronic diseases, including breast cancer, prostate cancer, non-Hodgkin's lymphoma, Parkinson's disease. Field workers have similar pesticide exposure as those who spray, mix, or load pesticides, as measured by pesticide levels in house dust and urine.
- The Occupational Safety and Health Administration mandates PPE to reduce employee exposure to chemical hazards that cannot be controlled by other measures.
- PPE is recommended, but not required, for fieldworkers.
- PPE has many benefits, but efforts to promote its use by farmworkers have had limited success.
- Ethnography is a scientific approach to examine how beliefs are coupled with behaviors. Dr. Snipes used ethnographic tools to understand embedded cultural concepts that influence farmworkers' decision-making regarding PPE use. Her studies found that farmworkers find PPE difficult and impractical to use because it reduces their productivity, it limits their ability to identify hazards, and it challenges cultural beliefs, such as "machismo" or "organism."

- The findings of the initial studies led to questions for further research: Where does PPE go wrong? Where do interventions go wrong? Is our scientific approach to protection flawed? How can innovative, creative structures be used to go beyond existing frameworks of PPE use?

Mobile Health for Farmworkers

- Mobile health (mHealth) uses electronic tools to collect or dispense information. It is a viable option to deliver health messages to farmworkers, because most farmworkers own a smart phone and are receptive to using technology to receive information and manage health conditions.
- Dr. Snipes designed a study to evaluate the ability of mHealth messaging intervention components to improve PPE adherence over a 30-day period. The study had two intervention components: PPE that was feasible to wear, and pesticide risk messages that were informed by ethnographic research. The mHealth approach included a mobile phone app to deliver a daily survey and provide individually tailored feedback. Participants were farmworkers engaged in fieldwork in the Rio Grande Valley of Texas. Variables included participants' level of language acculturation and social acculturation, sex, training, years working in agriculture, and income.
- Conclusions from the study were that:
    - PPE provision along with mHealth messaging is a strong interventional component for adherence to occupational safety
    - Linguistic acculturation barriers may be associated with PPE use among Hispanic agricultural workers, but provision of PPE and messaging may overcome those barriers.

Dr. Snipes offered the following recommendations:

- Patient education programs should include PPE provision for all workers and accommodations for low-acculturated workers and those with English language limitations
- mHealth messaging has strong potential, but cultural perspectives are important. Individually tailored feedback is effective.
- Linguistic acculturation barriers may be associated with PPE use. Ethnography and culturally relevant messaging may overcome those barriers.

Discussion

- Mr. Morgan asked if it makes a difference if growers insist that workers use PPE.
    - Dr. Snipes said she had not met a grower who insisted that field workers use PPE, but PPE use is higher when growers supply it.
- Mr. Morgan suggested that it might be effective to train a worker who is an influential member of the community.
    - Dr. Snipes stated that a study in Florida found that approach made a difference.
- Ms. Andres Paulsen commented that comfort and cost were important factors in PPE use.
    - Dr. Snipes agreed and noted that the use of gloves differs by crop and location.
- Ms. Andres Paulsen asked if pesticide application affected PPE use and whether workers were notified when pesticides were being applied.
    - Dr. Snipes said her study asked workers if crops had been sprayed that day, and how they knew. Some growers informed workers in advance, but others did not.
- Ms. Naqvi asked if there was a difference in PPE use between growers who follow the rules and those who do not.
    - Dr. Snipes replied that she did not recruit growers for her study. In her experience, smaller growers are more likely to minimize hazards. Larger farms are subject to more oversight.

- Ms. Philips Martinez asked if health centers could apply the mHealth model and culturally relevant messaging for their patients.
    - Dr. Snipes stated that she intended for her research tool to be used by others. She noted that most health centers are already using some form of mHealth, such as a mobile website. mHealth can be as simple as text messages, and programs are available to send messages automatically. The messages she developed for the study could be embedded in other platforms. She would need to determine how to implement the model in a clinic setting.
- Mr. Gomez commented that many growers are compliant, while others put the responsibility on contractors. Crew leaders have more impact than growers, because they determine workers' hours and provide training. Pesticide education is usually offered once during the season and includes many topics in addition to use of PPE. It might be effective to embed PPE training in a discussion of farmworkers' rights, because they are interested in that issue.
    - Dr. Snipes noted that her research on stress among MSAWs found that "knowing your rights" was an important mitigating factor.

Facilitated Discussion on Possible Recommendations

Council members discussed gaps, issues, and potential recommendations:

<u>Transportation</u>

- Explore cross-sector partnerships at the federal level, including public-private partnerships
- Mobile clinics
- One-stop shops (primary care, dental, pharmacy)
- Health centers can leverage resources to expand transportation (e.g., Tulsa program)
- Co-location of health centers with housing programs (senior model), grocery stores, laundromats, etc.
- Promote patient-centered strategies (e.g., vouchers, mHealth, etc.).

<u>Flexible funding opportunities</u>

- Explore flexible funding and policies to support MHCs' ability to provide care for farmworkers where they are.

<u>Secretary's priorities</u>

- Strengthen mental health evaluation for MSAWs
    - Explore mHealth opportunities to support patients in their ongoing spectrum of care (e.g., appointments)
    - Mental Health First Aid training
- Childhood obesity
- Opioid abuse: The Council needs more information about the prevalence of opioid use among MSAWs (potential topic for next meeting).

<u>Ag Worker 2020 Campaign</u>

- Continue to support and raise awareness of the campaign.

<u>Impact of the fiscal cliff</u>

- Emphasize the impact on programs that are vital to the health of Americans (e.g., CHCs, CHIP, NHSC)
- Build new investments
- Sustain funding
- Support a strong Medicaid program that does not put patient coverage at risk

- Add language to NAP funding opportunity announcements (FOAs) to encourage MHCs to address key challenges (e.g., transportation, mental health, etc.)
- Explore partnerships to support primary and specialty care services at health centers
    - Share promising practices around building relationships
    - Provide federal incentives to build those partnerships.

Pesticide exposure

- PPE should be required, not recommended, for field workers (OSHA is the stakeholder)
- Train providers to properly identify pesticide exposure (e.g., checklist of questions)
- Address occupational hazards in training of clinicians/primary care providers.

Plain language/health literacy

- Increase awareness of CLAS standards
- Ensure that literature is written at a grade-school level.

WEDNESDAY, JUNE 7, 2017

Recap of Previous Day
Fr. Chris LaBarge, STL, Vice-Chair, NACMH

Fr. LaBarge summarized the presentations, key issues, and discussion points from the first day of the meeting.

Vision Health of Migrant and Seasonal Agricultural Workers
Sara A. Quandt, PhD, Professor, Epidemiology & Prevention, Wake Forest University School of Medicine, Department of Public Health Sciences

Dr. Quandt reviewed the literature on vision and eye health among MSAWs, presented recent UDS data on vision health care, and proposed recommendations related to vision health.

Background

- Threats to vision health for agricultural workers include environmental risks (e.g., tools, chemicals, exposure to dust, sunlight) and disease (e.g., diabetes, hypertension, age-related changes).
- Agricultural workers need good distance vision to operate vehicles, farm equipment and see hazard signs. Near vision is important for accurate work, avoiding hazards, and reading hazard warnings on pesticide labels.

- Work protection regulations are less stringent for agriculture than for other industries, and there are issues of enforcement on small farms.

Literature Review

- Visual acuity
    - A study using National Health and Nutrition Examination Survey (NHANES) data found that persons in farming, fisheries, and forestry occupations were nearly twice more likely to have vision problems than those in other occupations.
    - Two studies of MSAWs in North Carolina found a disproportionate number of self-reported vision problems.
    - A study that compared self-reported and measured visual performance found that self-reports were less accurate among individuals with vision problems.
- Eye symptoms

    - Studies of eye symptoms found that many MSAWs reported itching, pain, or redness at the end of the workday.
    - Tasks associated with irritation included packing crops, applying fertilizer, being in fields as they are sprayed, and early re-entry to sprayed fields. Early re-entry posed the greatest risk.
- Eye injury hazards
    - An assessment of 28 farming operations employing MSAWs in Michigan and Illinois identified a wide array of previously unreported eye injury hazards, including physical and mechanical hazards and sources of chemical exposure.
- MSAW eye injury rates
    - Injuries are only counted when they are reported and the worker takes time off from work.
    - A study of 300 Latino male MSAWs in North Carolina found a rate of lost work time injuries that was more than three times the rate reported for agricultural crop production nationwide.
- Pterygium
    - Pterygium is a corneal growth that affects people who spend a great deal of time outdoors. Age, dust, irritants, and exposure to ultra-violet light are key risk factors.
    - Outcomes include lost vision and social stigma. Treatment involves surgery; prevention is preferable.
    - A large study found that pterygium was present in nearly one-quarter of MSAWs.
- Vision healthcare
    - MSAWs report low usage of vision care. The majority have never had an eye exam, primarily because they never thought about it.
- Eye protection practices:
    - MSAWs reported a variety of work-related and social reasons for non-use of eye protection (e.g., little perceived risk of injury, eye protection was not mandatory or was not provided).

<u>Interventions to Improve Vision Health</u>

- "<u>Black Dirt" intervention, Hudson Valley, New York State</u>: The intervention included eye wash drops, protective eyewear, an in-person presentation on eye health, and a pocket card on eye protection and eyewash. The intervention group had significantly less eye pain after eight weeks. The outcome was more pronounced in those who wore the glasses and used the eye drops. The study noted that different tasks and different seasons may require different eyewear. Eyewear durability was an issue. The saline drops were popular. A process evaluation found that subjects wanted more community engagement.
- <u>Midwest intervention (Southeast Michigan and Northern Illinois)</u>: The intervention included community health worker outreach, training, and protective eyewear, in three combinations. The use of safety glasses was very low pre-intervention. The intervention that included all three components was most effective.
- <u>Florida intervention</u>: The goal of the intervention was to increase the acceptance and use of safety glasses among citrus workers and change attitudes toward safety glasses usage. The community-based approach included social marketing by CHWs, who modeled safe behavior, educated workers, and administered first aid. The control group received glasses only. The use of safety glasses more than doubled in the intervention group, particularly among younger workers.

All three interventions had modest results. Employer encouragement or requirement to wear protective lenses was not a factor in any of the interventions. The degree of community input and intensity of the intervention appear to drive results.

UDS Data on Vision Care

- Vision care represented a small fraction of health center staffing in FY2015 and less than one percent of clinic visits by MSAWs.

Dr. Quandt offered the following recommendations to improve eye health of MSAWs:

- Enforce existing regulations (i.e., the OSHA General Duty Clause)
- Require employers to provide appropriate safety equipment to reduce eye injury and illness. (Employers could partner with clinics.)
- Require eye protection when workers are exposed to hazards. (Clinics could play a role.)
- Require eye safety education of workers, including eye protection, eye first aid, and means of reporting injuries. (CHWs could play a role.)
- Conduct vision screenings at all clinic visits, unless one was recorded for the previous year, and encourage outreach workers to conduct screenings and eye safety trainings at camps.
- Screen for pterygium at all clinic visits and include patient education in outreach trainings.
- Form partnerships to facilitate provision of corrective lenses, when necessary (e.g. Lion's Club grants, partnerships with local vendors).

Discussion

- Ms. Triantifillou asked if the National Agricultural Workers Survey (NAWS) included questions related to vision.
    - Dr. Quandt said she was not aware of any vision health questions in the NAWS.
- Ms. Diaz said that most cases of eye problems at her clinic were among workers at dairy farms.
    - Dr. Quandt replied that the studies she reviewed did not include with dairy workers. She noted that the Centers for Agricultural Work and Safety at the National Institute for Occupational Safety and Health were conducting studies among dairy workers.
- Mr. Morgan noted that many MSAWs in his area are older African Americans and Haitians. He asked if data were available for those populations.
    - Dr. Quandt said she did not know of any studies that collected vision data among those populations.
- Fr. LaBarge asked if a health center would need to revise its scope to provide vision care.
    - Ms. Johnson stated that a change of scope would not be required to add optometry or ophthalmology if the health center documented a need in the patient population.
    - Dr. Quandt noted that it would be difficult to identify the need without doing vision screening.
- Ms. Triantifillou asked if it was possible to determine whether any MHCs provided vision care.
    - Dr. Quandt replied that the number was unlikely to be significant, because so few health centers provide vision care is so low overall.

How are Migrant Heath Centers and their Patients Faring Under the Affordable Care Act?
Sara Rosenbaum, JD, Harold and Jane Hirsh Professor of Health Law and Policy and Founder, The Geiger Gibson Program, Milken School of Public Health (MSPH), The George Washington University (GWU)

Ms. Rosenbaum summarized the findings of a report on how the ACA affected access to care for MSAWs (https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Migrant-Health-Centers-Patients-Under-Affordable-Care-Act.pdf).

Key points were as follows:

- In FY2014, health centers served 892,000 agricultural workers and their family members.
- Since 2003, the number of agricultural workers served by health centers grew by 28 percent, an increase of almost 200,000 patients.
- Health centers in California, Washington, Florida, and North Carolina served 71 percent of all MSAW patients.
- MHCs have significantly lower ratios of full-time equivalent (FTE) physicians, mid-level providers, and medical workers, but they outperformed other health centers on quality measures related to cervical cancer screening, asthma care, and low birth rates.
- MHCs have higher average percentages of uninsured patients than other health centers, and agricultural workers and their children are more likely than other low-income adults and children to be uninsured.
- Medicaid is the largest insurer at MHCs. Patients covered by Medicaid increased from 35 percent of all MHC patients in 2003 to 47 percent 2014.
- Medicaid expansion had a dramatic impact for MHCs and MSAWs.
    - MHCs in Medicaid expansion states have 20 percent fewer uninsured patients than those in non-expansion states.
    - Among the MHCs serving the highest proportion of MSAWs, patients in non-expansion states were more than twice as likely to be uninsured as those in expansion states.
    - MHCs in Medicaid expansion states showed significant increases in the average percentage of patients with private insurance. MHCs in non-expansion states also had more patients with private insurance, because the threshold for subsidies dropped to the poverty rate.
- An increasing number of agricultural workers are remaining in stable locations, which could make it easier to maintain and utilize Medicaid coverage.

<u>Discussion</u>

- Fr. LaBarge noted that 90 percent of MHC patients are uninsured in states that did not expand Medicaid. He asked how the fiscal cliff would impact those centers.
    - Dr. Rosenbaum replied that centers that do not have a diversified revenue base will not survive if health center funding drops by 70 percent. She stressed that Medicaid outreach and enrollment are extremely important for all health centers, even those in areas where patients are more likely to be uninsured. Health centers with a more fragile insurance base merit close attention from HRSA for grant funding. HRSA should be mindful that MSAWs are affected disproportionately by any changes in federal policy related to Medicaid or health center funding. HRSA should also be mindful that income-adjusted subsidies are extremely important for older MSAWs.
- Fr. LaBarge noted that many MHC patients were newly insured under the ACA. He expressed concern that those patients would not see a medical provider if they lose their coverage.
    - Dr. Rosenbaum stated that the proposed changes would take the healthcare system back to the late 1980s, when Medicaid made up less than 15 percent of the revenue. Services that are considered “high cost” would be eliminated. Health centers serving high numbers of MSAWs in Medicaid expansion states would suffer the most from the proposed changes to Medicaid. The American Health Care Act (AHCA) passed by the House does not allow states to utilize a waiting list. It is unknown whether the Senate’s version of the bill would provide that flexibility.

- Ms. Andres Paulsen stated that health centers must find creative ways to serve their patients in the changing environment.
    - Dr. Rosenbaum noted that the greatest uncertainty was for health centers with high farmworker populations in non-expansion states, and those with high homeless populations. HRSA should pay close attention to changes that would affect those centers.
- Ms. Triantifillou asked if funding cuts would affect the voucher program.
    - Ms. Johnson replied that the voucher program would be impacted by any changes to funding for the Health Center Program.
- Ms. Phillips Martinez asked what recommendations Dr. Rosenbaum would suggest for the Council's consideration.
    - Dr. Rosenbaum stated that large health centers with healthy revenue streams and a diverse patient population have many options. Health centers that serve the most vulnerable, medically fragile, financially vulnerable populations in states with low-performing Medicaid programs and a fragile private insurance market have very little ability to weather even slight downturns. She would recommend that HRSA put those centers on a "closer watch" list. Health centers are expected to deal with normal risk, but the potential risks are beyond what any health center board could be expected to manage. Her study shows that health centers are significantly affected by having a diversified funding base. They can increase their revenue by adding a pharmacy and increasing services for populations such as children and Medicare beneficiaries. In recent years, many health centers have expanded preventive services for women of childbearing age, even in non-expansion states.

Update on the HITEQ Center: Supporting Migrant Health Centers in Optimizing the Use of Health Information Technology (Health IT)
Susan Friedrich, MBA, John Snow Incorporated

Ms. Friedrich provided an update on the HITEQ Center, which was launched in 2016 as a HRSA-funded NCA. HITEQ collaborates with HRSA partners such as PCAs and NCAs to help health centers fully optimize their electronic health record (EHR)/HIT systems.

HITEQ Services

- A searchable, web-based knowledge base with resources, toolkits, training, and calendar of events (hiteqcenter.org)
- Workshops and webinars on health IT and data-driven QI topics
- Technical assistance and responsive teams of experts to work with health centers on specific challenges or needs.

HITEQ Focus Areas

- Health IT-enabled QI
- EHR selection and implementation
- Health information exchange
- Achieving meaningful use
- Health IT and QI workforce development
- Value-based payment
- Privacy and security
- Electronic patient engagement
- Population health

- Telehealth.

HITEQ Training and TA

- Webinars on a range of health IT topics that are recorded and archived on the HITEQ website.
- Workshops are designed to be co-hosted by PCAs or health center controlled networks (HCCNs). HITEQ provides the speaker and curriculum at no cost to the host organization.
- HITEQ TA to MHCs has included:
    - Recommendations regarding privacy and security and options for secure texting for a remote tablet/app tool to capture migrant health data in the field.
    - Recommendations regarding improvements to a data dashboard that tracks performance of contracted providers who serve migrants.
    - Participation in the UDS training to help health centers identify migrant patients.

Clinical Quality Reporting and EHR Systems

- HITEQ reviewed five years of UDS data to identify national trends in clinical quality. Key findings were:
    - Clinical compliance rates measured by EHR-derived data (all patients) were significantly lower than those measured by sampled data. The difference persisted across years.
    - Performance on process measures increased steadily for both EHR and sampled data.
    - Adoption of EHR for UDS reporting increased rapidly.
- HITEQ can help health centers analyze their compliance with any performance measure over time.
- Comparative performance data from 2011-2015 for migrant-only MHCs, mixed MHCs, and non-MHCs:
    - Diabetes, hypertension, pap tests: Performance on clinical measures was consistently high across health centers.
    - Colorectal cancer: Performance improved significantly for migrant-only MHCs.
    - Adult weight: Performance improved significantly across health centers.
    - Child weight and activity: Performance improved across health centers, and most significantly for migrant-only MHCs.
    - Depression: Performance improved across health centers, and most significantly for migrant-only MHCs.
    - Tobacco: Performance improved across health centers, with greater improvement for migrant-only MHCs.
    - Other indicators: Migrant-only MHCs have limited participation in PCMH and have made limited progress in meaningful use of EHR. Participation in HCCNs is low for migrant-only MHCs, but relatively high for mixed MHCs.

Discussion

- Ms. Diaz asked how long patients' medical records remain in the system and how much information can be shared.
    - Ms. Friedrich replied that health centers retain data as long as a patient is active, and for three years after they are no longer active. Health centers archive much of their data when they change EHR systems. Scanned data are not searchable.
- Ms. Phillips Martinez asked what could be done to increase awareness of HITEQ resources.
    - Ms. Friedrich stated that NACHC is creating a national resource center, which will be linked to HITEQ. Workshops at conferences help to increase awareness. BPHC recently created an integrated web service (IWS) that links HITEQ to any topic related to health IT. There are more than 1,400 health centers, and HITEQ has only existed for two years.

Ms. Friedriech intended to ask the HITEQ advisory committee to propose strategies to increase awareness of its services.

- Ms. Phillips Martinez asked if HITEQ had connections with project officers for the other NCAs.
    - Ms. Friedrich replied that HITEQ's project officer has excellent relations with PCAs and HCCNs across the country and with project officers for the other NCAs. HITEQ has conducted customized workshops for half of the PCAs and HCCNs. Ms. Friedrich hoped those organizations would share the information with their members.

Formulation of Letter of Recommendations to the Secretary of HHS

Ms. Phillips Martinez noted that the letter of recommendations based on this meeting would be the Council's first communication with the new Secretary. She proposed the following framework for the letter:

- Introduction to the history and purpose of the Council
- Introduction to MASWs and their contribution to our rural and national economy
- Introduction to MHCs and their contribution to the economies and health of rural and local communities
- Specific recommendations.

Council members supported the proposed structure and identified the following points to include in the introduction:

- Acknowledge the Secretary's priorities and note that the Council needs additional data to respond to those issues.
- Emphasize the role of health centers as frontline providers of healthcare for vulnerable populations, including chronic and emerging challenges, including chronic disease, childhood obesity, and mental health and substance abuse.
- Emphasize the impact of uncertainty on access to health care, mental health care, and other vital services for MSAWs.

Council members identified major gaps, their adverse effects on MSAWs and their families, and potential recommendations to address those gaps.

Gap/Issue (Root Cause) and Adverse Effect(s)	**Recommendation to Address the Gap**
<u>Gap/Issue</u> Uncertainty Job instability Fear of losing home, family separation, etc. <u>Adverse Effect(s)</u> Impact on mental health and access to care Impact on financial viability of health centers	• Explore flexible funding and policies to support MHC's for outreach and provide care for farmworkers where they are. • Fund pilot programs for a flexible payment model for transportation, telemedicine, and outreach and education using mHealth • Solidify healthcare coverage and services for MSAWs.

Gap/Issue (Root Cause) and Adverse Effect(s)	Recommendation to Address the Gap
Gap/Issue MSAWs are in rural and hard-to-reach communities MSAWs lack transportation Health services are not accessible. Adverse Effect(s) Isolation Missed appointments Delayed care, resulting in higher costs.	• Provide flexible funding opportunities to support alternative service delivery models and bring healthcare to MSAWs. • Add language in NAP FOAs around key challenges (e.g., transportation, mental health, etc.). • Bring healthcare to farmworkers. • Expand opportunities for health centers to build capacity for language and culturally-appropriate services. • Invest in the continued development of telehealth, mHealth, and other effective delivery models. • Continue to support sustainable models for outreach, education, and clinical extender services, including CHWs/promotoras. • Explore public and private partnerships with DOT and VA, including mobile clinics and one-stop shop options. • Promote access to patient centered transportation strategies. • Explore co-location of health centers with other program

Gap/Issue
Fiscal cliff
Proposed changes to Medicaid
 	
Adverse Effect(s)
Reductions in funding threaten the viability of health centers, including MHCs, and the NHSC.
	• Build new investments.
	• Sustain funding for the Health Center Program.
	• Support a strong Medicaid program
	• Explore partnerships/collaborations to support primary and specialty care services at health centers
	  o Share promising practices
	  o Direct federal incentives to build those partnerships.

Gap/Issue (Root Cause) and Adverse Effect(s)	Recommendation to Address the Gap
Gap/Issue Pesticide exposure	• Increase health center awareness of pesticide exposure and related health issues • Train providers in how to properly identify pesticide exposure (e.g., checklist of questions for clinic visits) • Develop appropriate service delivery models for MSAWS o One stop shops, piloting integrated models with housing, transportation and health o Partnerships between public and private entities- transportation partnerships between health centers and local transportation and businesses as an example o Migrant head start, health center, migrant education. • Collaborate with OSHA to require PPE for field workers.
Gap/Issue Plain language/health literacy	• Increase awareness and implementation of CLAS Standards • Ensure that patient literature is written at grade-school level • Simplify messaging • Address translation challenges.
Gap/Issue High percentage of MSAWs who are uninsured or on Medicaid Lack of providers and programs Adverse Effect(s) High levels of trauma, unmet mental health needs	• Increase focus on mental health. • Maintain funding for outreach and enrollment. • Conduct outreach and enrollment throughout the year.
Gap/Issue AgWorker 2020 Campaign	• Continue to support and publicize the campaign.

Council members agreed that future meetings should focus on the Secretary's priorities (i.e., childhood obesity, mental health, and opioid abuse). They noted that mental health is a significant issue for MSAWs, and they emphasized the need to learn more about opioid use among MSAWs.

Wrap Up/Summary
Amanda Phillips Martinez, Chair

Next steps

Council members agreed on the timeline for the letter of recommendations:-

WHAT	WHO	BY WHEN
First draft to Ms. Phillips Martinez, and Ms. Paul	Fr. LaBarge	6/9/17
Second draft to Fr. LaBarge and Ms. Paul	Ms. Phillips Martinez	6/16/17
Final draft to Ms. Paul for full Council input	Fr. LaBarge	6/19/17
Council input to Ms. Paul	All Council members	6/23/17
Final draft to HRSA	Fr. LaBarge	6/26/17

Next meeting

Council members proposed to hold the next meeting on November 7-8 or November 8-9, 2017. Preferred locations were North Carolina (Asheville, Research Triangle, or Greensboro), Washington State, or San Diego. Proposed agenda topics were:

- Mental health/substance abuse issues for MSAWs (e.g., opioids, other substances, trauma)
- MHC practices for mental health screening and service provision
- Data (NAWS)
- Childhood obesity (Migrant Head Start)
- H2A Visa Program
- Tobacco field work/ Green Tobacco Sickness (GTS)
- Farmworker testimonies.

Ms. Andres Paulsen agreed to develop a questionnaire for the farmworker testimonies.

Reimbursement and Logistical Information
Priscilla Myles, MSPH, Meeting Manager, NAMCH

Ms. Charles provided guidance regarding reimbursement policy and procedures.

Council members provided feedback on the meeting:

- The pace of the meeting provided time to reflect on the content of the presentations.
- The presentations were excellent, and the topics were useful.
- The hotel and meeting room were good.
- The electronic binder was excellent.
- Staff were accessible.

Council members offered the following suggestions for future meetings:

- Provide minutes of the previous meeting in advance so members can review them.
- Include time at the outset of the meeting for members to share their experiences and expertise related to the agenda topics. Provide the topics in advance, and create a questionnaire that members can use to gather information from their board/medical director/outreach director.

The meeting was adjourned at 5:00 p.m.