# National Advisory Council on Migrant Health

July 17, 2017

The Honorable Secretary Thomas E. Price, M.D.
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Price:

The National Advisory Council on Migrant Health (NACMH/Council) advises, consults with, and makes recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS) and the Administrator, Health Resources and Services Administration (HRSA). This concerns the organization, operation, selection, and funding of migrant health centers (MHC) and other entities assisted under section 330(g) of the Public Health Service Act as amended, 42 USC 254(b) to improve health services and conditions for migratory and seasonal agricultural workers (MSAWs) and their families.

During our meeting, held on June 6-7, 2017, we received updates from HRSA senior leadership and the National Association of Community Health Centers (NACHC). Additionally, the Council heard presentations from:

- HRSA Office of Health Equity on Language Assistance and Communication in the Culturally and Linguistically Appropriate Services (CLAS) Standards;
- Health Outreach Partners on Transportation and Access to Care: The Transportation Initiative;
- Penn State University on Using Ethnography and Bio-qualitative Research to Study How Cultural Beliefs, Behaviors, and the Environment Merge to Influence Agricultural Worker Health;
- Wake Forest University School of Medicine on Eye Symptoms and Use of Eye Protection Among Seasonal and Migrant Farmworkers;
- George Washington University on Migrant Health Centers and Their Patients: Geiger Gibson/RCHN Community Health Foundation Research Study; and
- The Health Information Technology, Evaluation, and Quality (HITEQ) Center on Supporting Migrant Health Centers' Effective Use of Health Information Technology.

On behalf of the Council that met June 6-7, 2017 and in accordance with the charge given to the Council, we submit the following recommendations for your consideration.

Recommendation 1: Background

The Health Center Program (HCP) is a vital part of our healthcare system, providing access to over 25 million patients in underserved areas.[i] The HCP served approximately 920,158 MSAWs, in 2015.[ii] Ninety percent of MSAWs served received care at a MHC. MHCs serve a population that faces numerous barriers to care and coverage – they serve higher numbers of children, racial/ethnic minorities, persons who are best served in a language other than English, and are low income (<200 percent federal poverty level). They demonstrate cost effectiveness by outperforming other health centers on quality measures

such as asthma care, low birth weight and cervical cancer screening, despite having a significantly lower ratio of full time equivalent providers.[iii]

HRSA's Bureau of Primary Health Care's HCP grants are the foundation of community health center (CHC) funding. This funding serves as a mechanism for growth in service delivery sites and is vital to the provision of services to un- and underinsured individuals. Medicaid is the largest revenue source for CHCs – forty-nine percent of CHC patients are Medicaid beneficiaries, and CHCs serve one in six of all Medicaid beneficiaries. The total cost for this care accounts for less than two percent of total Medicaid spending, which results in savings amounting to 24 percent on total costs, compared to other providers.[iv] The Medicaid Prospective Payment System (PPS) extends the HCP grant investment, by paying health centers a fair rate to ensure that grants are not diverted to cover underpayments by Medicaid.[v]

There is currently uncertainty around sufficient HCP funding, the continued availability of Medicaid, and the HCP PPS rates. In addition, the HCP is facing a fiscal cliff. The program budget includes $3.6 billion in mandatory funding, which represents 70 percent of the annual program budget. This funding will expire on September 30, 2017 unless Congress extends it.[vi] This uncertainty has implications for the ability of migrant and community health centers to recruit and hire clinical providers, make plans for service expansion and invest in infrastructure and capital improvements. Health centers serve on the frontline to provide necessary disease prevention and containment and rapid response to emerging health issues like substance abuse, serious mental illness, and Zika, among others. Without sufficient funding to sustain the health center program, Medicaid and the availability of HCP PPS rates, MHCs will not have the capacity to meet the health care needs of MSAWs and our rural communities. In addition, this would have significant negative economic impact on the local economies of communities where the health centers are located. Currently, CHCs employ 188,852 people and generate $39 billion in economic activity.[vii]

A sustainable rural health system depends on a network of community health centers that are able to leverage public and private insurance payments to provide low cost and high quality integrated health care. CHCs are cost effective in rural and frontier communities because they can offer vision care, primary care, dental care and mental and behavioral health services under one roof.

**The Council supports the critical role that the HCP and Medicaid play in the provision of health care to migrant and seasonal agricultural workers, and recommends that the Secretary ensure the sustainability of the HCP by:**

a. **Ensuring a level of funding that will sustain all current health center sites and activities, and allow for growth to meet need for health care services in underserved, high need areas;**
b. **Preserving the Medicaid federal Prospective Payment System for health centers; and**
c. **Supporting the health centers in their role as front line responders to emerging health care needs, like childhood obesity, trauma and serious mental illness, and substance abuse, in MSAWs and rural communities.**

<u>Recommendation 2: Background</u>

Agriculture ranks among the most hazardous industries. Prolonged exposure to extreme weather and pesticides and physical labor that includes heavy lifting, use of machinery and tools, and repetitive motion have significant health impacts on agricultural workers, putting workers at very high risk of

fatal and non-fatal injuries. Approximately 100 agricultural workers suffer a lost-work-time injury each day, and the 2015 fatality rate was 19.2 deaths per 100,000 workers.[viii] Pesticides are the only chemical legally released into the environment with the purpose to kill living organisms. Although farmworkers are not the target of pesticides, they experience harm. The federal Environmental Protection Agency estimates put exposure levels at 3.2 to 4 Million farmworkers annually, with 300,000 acute cases/year.[ix]

Eye injuries are one example of occupational injury and risks that MSAWs are exposed to daily. Prolonged exposure to dust, sunlight and chemicals, as well as dangers of injury from tools and machinery and debris from harvesting work can affect MSAWs ability to work effectively and compromise their safety and health. Visual impairment has a significant effect on quality of life as evidenced by its association with symptoms of anxiety, depression, mobility, disability, self-rated health, and even mortality.[xxixii] A study using a National Health and Nutrition Examination Survey (NHANES) sample (2005-2008) comparing persons with farming, fisheries, forestry (FFF) as longest lifetime occupation with others found that those employed in FFF industries were 1.76 times more likely to experience vision difficulties than non-FFF.[xiii]

The existing regulations for protecting worker safety defined in the Occupational Safety and Health Administration (OSHA) General Duty Clause state that employers "shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." However, worker protections in agriculture are weaker than other industries. In addition, there are challenges with enforcements, particularly on smaller farms. Use of personal protective equipment (PPE) is low among farmworkers because of barriers to use, including: cost; difficulty and impracticality of use;[xiv,xv] it slows the productivity of work;[xvi] and its use can jeopardize workers' ability to identify hazards.[xvii]

**Migrant Health Centers have the potential to play an important role in preventing injury and illness, and effectively treating work-related injuries. The Council recommends that the Secretary direct HHS and HRSA support health centers in this work by:**

- **a. Directing the Bureau of Primary Health Care to implement:**
    1. **Health education and outreach efforts to train and equip MSAWs to avoid work-related exposures and injuries;**
    2. **Trainings for health educators and outreach workers to conduct eye safety education and screenings at housing units and in the clinic; and**
    3. **Screening and practice standards at CHCs, that would result in the better identification of occupational injuries and illness by health care providers. For example, requiring MHCs to conduct vision and eye injury screenings at clinic visits, unless recorded for the year.**
- **b. Encouraging the development and dissemination of MHC best practices in the formation of partnerships between MHCs to facilitate provision of corrective lenses (e.g., with Lion's club and local vendors) and PPE (e.g., vendors, growers associations, etc.).**
- **c. Forming federal and regional partnerships with OSHA to expand education of workers on work safety, first aid, injury reporting and the use of PPE. With community health workers (CHW) and health educators serving as key partners in health and safety education for MSAWs.**

Recommendation 3: Background

Access to health care continues to remain a challenge for MSAWs. Linguistic and geographic isolation remain barriers to accessing primary healthcare, resulting in delayed treatment and the provision of costlier care in hospital emergency rooms rather than in the more effective and appropriate primary care setting. MSAWs are often isolated in rural and frontier areas and face significant barriers to accessing care. A dearth of bilingual healthcare providers in many rural communities means that MSAWs may not have access to culturally and linguistically appropriate services.

Title VI of the Civil Rights Act of 1964 sets the expectation for nondiscrimination for recipients of federal services and organizations receiving federal funds. Any health center receiving federal funding has a duty to provide meaningful access to language assistance and 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.[xviii]

**The Council recommends that the Secretary direct HHS and HRSA to:**

a. **Support meaningful access to language assistance at health centers by ensuring appropriate training and technical assistance to:**
    1. **Increase awareness and implementation of CLAS Standards among clinical and non-clinical staff;**
    2. **Develop appropriate and sustainable solutions to address challenges associated with translation at rural health centers; and**
    3. **Simplify health messaging and ensure patient education literature is written at grade-school level.**
b. **Further support emerging practices like mobile health (MHealth) and the Community Health Worker model, that have shown promise for improving health knowledge and behavior in patients experiencing geographic and linguistic isolation. MHealth can be used to deliver culturally and linguistically appropriate health information, behavior prompts (e.g., use of PPE) through smart phones and other mobile devices. It has also shown promise for enhancing patient medication adherence and assisting MSAWs in effectively self-monitoring their health conditions.[xix]**

Recommendation 4: Background

As stated above, MSAWs are also often isolated in rural and frontier areas where there are limited or no public transportation options; access to transportation is a significant barrier to seeking health care. It is estimated that in any given year at least 3.6 million Americans do not obtain medical care because of transportation barriers. In a national survey of community health centers, responding clinics reported that transportation was a barrier to care for 45 percent of their MSAW patients. Missed appointments are costly, with health centers reporting an average loss of $175 per missed appointment[xx].

Healthcare delivery models that bring health care to patients where they live and work would be effective ways of addressing the geographic and transportation barriers to care. Strategies like Mobile Health, and Community Workers and care delivery models like housing/healthcare partnerships and "one-stop shops" are key to ensuring access to care. CHWs serve as a bridge between patients and health and social service agencies, support patients by providing health information, assisting with appointments and provide follow-up to ensure patient adherence to clinical recommendations.[xxi] CHWs can serve as care coordinators and navigators for individuals who face barriers to healthcare access. CHW programs are not stand-alone interventions, but should be a critical part of a community healthcare system that provides accessible and appropriate health care to its patients.[xxii]

Federal and state aging agencies and private housing development agencies provide relevant models for private/public partnerships to address healthcare needs of patients who face barriers to accessing care. Housing and health partnerships can lead to improved health, safety and quality of life for MSAWs by offering on-site health services.[xxiii]

**Migrant health centers are ideal sites to pilot programs that support the development of sustainable payment models for transportation, telemedicine, and effective outreach and education strategies. The Council recommends that HRSA utilize New Access Point Funding Opportunity Announcements and supplemental funding opportunities to encourage the development and testing of Alternative Service Delivery and Funding Models to meet MSAWs healthcare needs most effectively. Specific recommendations include:**

a. **Supporting local public-private partnerships with entities like housing developers and private transportation providers to develop rural-relevant models for providing mobile health services and developing transportation initiatives to improve access to care.**
b. **Developing flexible funding models and policies to support more efficient and effective models of delivering high quality health care to MSAWs. This could include funding to support transportation models or the establishment of health and housing partnerships.**
c. **Strengthening partnerships at the federal level between HRSA, the Department of Labor and the Department of Aging to explore opportunities to combine services and develop models for co-location to reach geographically isolated underserved populations with health care.**

*We all need a lawyer at least once in our lifetime. We all need a doctor at least 3 times per year. We all need an agricultural worker at least 3 times per day.*[xxiv]

The Council recognizes the essential role that agricultural workers play in our rural economy and in the production of our countries domestically produced food supply. Agriculture is a vital engine of our country's economy and the lifeblood of many of our rural and frontier communities. We thank the Secretary for your service and for your consideration of our recommendations on behalf of those we serve.

Sincerely,

Amanda P. Martinez
Chair, NACMH

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

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[vii] NACHC http://hcpsocal.org/wp-content/uploads/2017/03/HCP-Member-Talking-Points-for-PI-2017.pdf
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[xvii] Ethnography-Informed Interventions: Using Mobile Assessments To Tailor Pesticide Safety Messages Among Mexican Immigrant Farmworkers Shedra Amy Snipes, Ph.D., Assistant Professor, Department of Biobehavioral Health, Penn State University
[xviii] HHS LEP Guide: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html
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