

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

**November 2-3, 2016  
Las Cruces, New Mexico**

**Council Members in Attendance**

Edelmiro Garcia (Acting Chair)  
Susana Castro  
Alina Diaz  
Christopher LaBarge  
William Morgan  
Horacio Paras  
Adriana Andrés-Paulson  
Amanda Phillips Martinez  
Stephanie Triantafillou

**Federal Staff**

Office of Policy and Program Development (OPPD), Strategic Initiatives and Planning Division (SIPD),  
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 Division Director  
Esther Paul, MBBS, MA, MPH, Designated Federal Official, NACMH  
Priscilla Charles, Committee Meeting Manager, NACMH

**WEDNESDAY, NOVEMBER 2, 2016**

**Welcome/Call to Order/Introductions**

*Esther Paul, Designated Federal Official, NACMH/Strategic Initiatives Program Division (SIPD), Office of Policy and Program Division (OPPD), Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA)*

Ms. Paul called the meeting to order and welcomed Council members and staff to the meeting.

Edelmiro Garcia, Acting Chair, invited Council members, staff, speakers, and guests to introduce themselves.

Takako Lewis of Lux Consulting Group provided an overview of the electronic meeting binder.

**NACMH Chair Opening Remarks**

*Edelmiro Garcia, Acting Chair, NACMH*

Mr. Garcia welcomed Council members and staff, reminded Council members of the NACMH purpose and mission, and reviewed the agenda for the meeting.

Mr. Garcia called for a motion to approve the agenda for this meeting and the minutes of the May 2016 meeting. The motion was made by Christopher LaBarge, seconded by Horacio Paras, and carried by unanimous voice vote.

## **Federal Update**

*Iran Naqvi, Deputy Director, SIPD, OPPD, BPHC, HRSA*

Ms. Naqvi provided an update on health center funding and strategies and the status of the Council's recommendations.

### Fiscal Year (FY) 2016 Funding

FY 2016 funding for Health Center Program was allocated to four priority areas, as follows:

- Increase access
  - Outreach and Enrollment (\$7 million, 93 awards)
  - Substance Abuse Service Expansion (\$94 million, 271 awards)
  - Oral Health Service Expansion: (\$155.9 million, 420 awards)
  - Zika Response (\$5.7 million, 23 awards)
- Modernize infrastructure and systems
  - Health Infrastructure Investment Program (\$262.4 million, 290 awards)
  - Delivery System Health Information Investment (\$87.4 million, 1,310 awards)
- Improve health outcomes and health equity
  - Quality Improvement Awards (\$100.2 million, 1,304 awards)
- Promote performance-driven, innovative organizations
  - Health Center Controlled Networks (\$100.2 million, 1,304 awards)
  - Patient-Centered Medical Home (PCMH) Recognition for New Grantees (\$8.6 million, 246 awards).

Health center funding also included Affordable Care Act (ACA) Substance Abuse Service Expansion (SASE) Supplement Awards to improve and expand substance abuse services provided by existing health centers, with a focus on medication-assisted treatment for opioid use disorders. HRSA awarded \$94 million to 271 health centers for this program in FY 2016. Only 15 percent of the awardees receive funding for migrant health, and no Migrant Health Centers (MHCs) received SASE funding. Ms. Naqvi suggested that it would be useful to look at the application rate from MHCs.

The President's budget request for FY 2017 includes \$5.1 billion to support quality improvement and performance management activities and to ensure that current health centers can continue to provide essential health care services to their patients. The aim is to serve 27 million patients. The President's budget also proposed to extend current mandatory funding at \$3.6 annually for FY 2018 and 2019.

### Health Center Program Strategies

Ms. Naqvi highlighted two Health Center Program strategies of interest to the Council: increase access, and modernize infrastructure and systems. She noted that the Council was particularly interested in health information technology (HIT).

- Increase access
  - Goals are to increase the number of patients served; increase the percent of patients served in existing service areas, and increase the percent of low-income communities served by health centers.
  - The number of patients served has increased by 42 percent since 2008. Over 1,100 New Access Points were funded since 2009, including \$270 million in FY 2015 for 430 awards
  - Over 18 million individuals were assisted under outreach and enrollment for coverage through the ACA, Medicaid, and the Children's Health Insurance Program (CHIP).

- Health center grantees, look-alikes, and service delivery sites now serve more than 24 million patients across the country. The growth of the program's patients, grantees, and jobs is directly correlated with the launch of the ACA.
- Migrant and seasonal agricultural workers (MSAWs) served by the health center program increased from 2013 to 2015. Health centers served 910,172 MSAWs in FY 2015; MHCs served 90 percent of those patients.
- California, Texas, Florida, Washington, and Oregon have the highest populations of MSAWs, in that order. California, Washington, and Florida have the highest number of MSAWs served by health centers. Texas has more than 300,000 MSAWs, but only 8,716 were served by health centers.
- Community health centers (CHCs) and migrant health centers (MHCs) serve a high proportion of low-income, minority, and uninsured patients. Ninety-two percent of MHC patients are minorities (compared to 62 percent at CHCs), 97 percent are at or below 200 percent of the federal poverty level (FPL), and 76 percent are at or below 100% of the poverty level.
- Modernize infrastructure and systems
  - Nearly 98 percent of health centers have installed electronic health records (EHRs), and nearly 89 percent of health centers have reached Stage 2 standards for meaningful use. Data on adoption and use of EHRs by MHCs will be provided at the next meeting.
  - The next priority will focus on how health centers are maintaining their systems and the extent to which those systems talk to each other.

#### Response to NACMH Recommendations

Ms. Naqvi reviewed HRSA's response to two of the Council's recommendations from the May 2015 meeting:

- Outreach and Enrollment
  - Recommendations: 1) Collaborate with the Department of Labor (DOL) Promote the utilization of health care available to MSAWs and H-2A workers through ACA and MHCs; 2) Demonstrate how quality health care enhances both the lives and productivity of the agricultural workers.
  - HRSA Responses: 1) HRSA provided \$250,000 in supplemental funding to the National Center for Farmworker Health (NCFH) in August 2015 for a national Spanish-language hotline to support outreach and enrollment; 2) Farmworker Justice received supplemental funding for the H-2A Health Access Project to build coalitions and partnerships among Primary Care Associations (PCAs) and health center grantees to promote enrollment in the health insurance marketplace.
- Technology and EHRs
  - Recommendations: 1) Support smaller CHCs to work together in technology agreements to create a better economy of scale; 2) Encourage maintenance of health center ownership and control of data, and more effective use of EHR data, for analysis of health needs and outcomes.
  - HRSA response: 1) HRSA will award approximately \$90 million through the FY 2016 Delivery System Health Information Investment (DSHII) supplemental funding opportunity to strategic investments in HIT by existing health centers; 2) HRSA funded the HIT Evaluation and Quality (HITEQ) Center to help health centers optimize their EHR/HIT systems for continuous, data-driven quality improvement.

Ms. Naqvi announced that Martha Lopez and Edelmiro Garcia would retire from the Council following this meeting. She acknowledged their commitment and contributions to the Council and thanked them for their service.

Ms. Paul noted that four members retired following the May 2015 meeting. BPHC has submitted nomination packages to fill all six vacancies, and the nominations are currently being reviewed. HRSA accepts rolling nominations and maintains a bank of candidates. Council members may refer potential candidates to Ms. Paul.

Ms. Naqvi urged members to promote service on the Council to their colleagues. Migrant Stream forums are excellent opportunities to recruit potential members.

### Discussion

- Adriana Andrés-Paulson suggested that a table at the Migrant Health Conference would be a good way to promote the Council and recruit potential members. She noted she was nominated by someone from Texas. The director of her health center in California was not aware of the Council.
- Stephanie Triantafillou noted that a HRSA representative promoted the Council at the East Coast Migrant Stream forum. She offered to include an information sheet on the Council in the package for the next forum.
- Ms. Paul said she created a document based on the Federal Advisory Committee guidelines. She encouraged Council members to help her refine it.
- Alina Diaz stated that language is a potential barrier. Board members at her health center asked if Council members are required to speak English.
  - Susana Castro replied that the Council has had members who were not fluent in English.
- Ms. Andrés-Paulson stated that the Council should have broader representation. Many MSAWs are from other ethnic backgrounds and do not speak Spanish.
  - Ms. Paul said she would like to broaden outreach and asked Council members to help.
- Ms. Naqvi asked Mr. Garcia what had been meaningful about his participation on the Council.
  - Mr. Garcia said the Council's recommendations resulted in changes that were needed. However, there is more to be done.
- Ms. Naqvi noted that the Council's decision to reduce the number of recommendations helped the Council maintain focus.
- Ms. Paul stated that meeting agendas reflect the Council's interests and are designed to provide information that can result in robust recommendations. The agenda for this meeting would focus on community health workers (CHWs).
  - Ms. Naqvi added that the agenda for this meeting included fewer presentations so Council would have sufficient time to reflect and discuss.
- Mr. Paras stated that health centers have a great deal of support at the federal and state level. They benefit the entire community by providing jobs as well as health care.
- Ms. Triantafillou asked when FY 2016 data would be available.
  - Ms. Paul replied that Uniform Data System (UDS) data are reported for the calendar year. Health centers submit data from January through April. The data are scrutinized carefully before they are posted online. HRSA provides online training, and PCAs also offer training.

- Council members discussed the fact that Texas had very few MSAW patients compared to the large number of farmworkers in the state.
  - Ms. Andrés-Paulson commented that many MSAWs from Texas are served by MHCs in California. Also, health centers do not always identify MSAW patients. They need training to ask the question in a way that patients understand.
  - Ms. Paul noted that the Council could help call attention to training that is available to help MHC staff learn how to identify patients correctly.
  - Rev. LaBarge observed that MSAWs who live in Texas do not identify themselves as migrants when they are in Texas. Health center staff need to understand that they are MSAWs, regardless of where they are served.
  - Ms. Triantafillou suggested that many MSAWs from Texas might be served at health centers in surrounding states, such as New Mexico. Mr. Paras added that some might obtain medical services in Mexico.
  - The Council could recommend that UDS collect data on MSAWs who receive health care in neighboring states or Mexico.
  - Mr. Morgan noted that Haitian MSAWs who work in Pennsylvania live in Florida and might be counted in both states.
  - Ms. Triantafillou stated that patients are counted in states where they are served.
  - Ms. Naqvi noted that the map reflects the number of patients served; they are not necessarily unduplicated.
  - Rev. LaBarge suggested that intake questions should reflect the definition of MSAWs criteria. For example: Have you had to move because of your work in the past three months? Do you work in agriculture?
  - Mr. Garcia said that questions can raise concerns about immigration status. Intake staff should first ask if the patient is an agricultural worker, then ask if they have moved.
  - Ms. Paul noted that Migrant Clinicians had made a presentation at the Council May meeting on “Health Network” a system to track patients as they move. This was a possible way to ensure that the numbers are not duplicated. Accurate data are important to articulate what services are needed, when they are needed, and where they are needed.
  - Ms. Naqvi said it is important for the Council to understand the data so it can develop relevant recommendations.
- Ms. Diaz asked how the Census identifies MSAWs.
  - Rev. LaBarge stated that the Census uses April 1 as the basis for determining residence status (e.g., homeless or migrant). UDS data reflect patients who are served. Census data are less accurate, because the full count is only conducted every 10 years.
- Ms. Andrés-Paulson said it is important to account for MSAWs who do not use MHCs for their health care.
- Ms. Triantafillou asked if Ms. Naqvi had spoken with anyone from Texas regarding this issue.
  - Ms. Naqvi said she wanted to review this information with the Council before taking that step.

### **Social Determinants of Migrant Farm Worker Health: Evidence for Policy Action**

*Melina Juárez, MA, Robert Wood Johnson Foundation Doctoral Fellow, Center for Health Policy, University of New Mexico*

Ms. Juárez described key social determinants of MSAW health and presented policy recommendations based on those factors. She noted that a social determinants of health framework reflects an upstream

perspective that looks at the root causes of population health, such as socio-economic factors, the physical environment, health care, and health behaviors.

Data sources for the presentation and recommendations included the 2011-2012 Department of Labor National Agricultural Worker Survey (NAWS), a 2012 Health Center Study (Bogges & Bogue 2014), a California Agricultural Worker Health Survey (Quandt et al. 2011), a Nebraska study (Ramos et al. 2015), two North Carolina studies (Quandt et al. 2011, Kearney et al. 2016), and other studies.

Key health disparities/priorities for MSAWs:

- Diabetes: Farmworkers have a higher prevalence of Type 1 and 2 diabetes than the general Latino population (7.8 percent, compared to 6.1 percent).
- Vision: CA Agricultural Worker Health Survey indicated 2/3 farmworkers reported never having had an eye screening (Villarejo 2003); more recent data indicates 74.4 percent never had an eye exam, and 70 percent “never thought about” getting an eye screening (Quandt et al. 2016). A North Carolina study indicates: 22 percent surveyed reported fair or poor vision and 20 percent reported difficulty seeing in certain situations (Quandt et al. 2011).
- Behavioral health: Discrimination, marginalization, and isolation contribute to an increase in depressive symptoms. More than 30 percent of MSAW respondents in one study reported high levels of stress, and 45.8 percent reported depression.
- Musculoskeletal: Seventy-nine percent of MSAWs in a 2015 study reported physical pain. Sixteen percent of respondents in the 2009-2010 National Agricultural Workers Survey (NAWS) reported at least one physical problem.

Demographics of MSAWs:

- The population of MSAWs is estimated to be 1.2-2.5 million. Fifty-three percent are under age 44, 63 percent have less than a high school education, and 76 percent primarily speak Spanish at home. About 48 percent are undocumented immigrants.
- The number of indigenous MSAWs is increasing, and many do not speak Spanish. Some of those workers face discrimination within the Latino community.

Socio-economic status of MSAWs:

- Households with children are increasing—approximately 30 percent of MSAWs have one or two children. The number of MSAWs earning more than \$20,000 has quadrupled since 2000. Nearly two-thirds (63 percent) have less than a high school education.

Place as a determinant of health for MSAWs:

- The majority of MSAWs are from Mexico.
- The number of MSAWs has decreased by half since 2001, and fewer are migrating.
- MSAWs populations are highly concentrated in the west coast; those in the midwest and southeast are more dispersed.
- Three-quarters of MSAWs in the southwest work in metropolitan areas, while 46 percent in the northeast are in rural areas.

Work as a determinant of health for MSAWs:

- One-third of MSAWs have more than 15 years’ experience.
- Heat- and pesticide- related illnesses are prevalent, despite regulations.

- One-third of the respondents in one study reported three or more symptoms of heat-related illness (HRI) in the past week, and three-quarters said they had no HRI prevention training.
- One study found that greenhouse workers are experiencing negative birth outcomes from pre-pregnancy pesticide exposure. Protective gear is often impractical and gets in the way of fast-paced work. MSAWs report that some employers fail to provide basic safety equipment or offer clean water for hand washing.

Health care access and barriers for MSAWs:

- Only one-third of farmworkers had health insurance, but 83 percent of children are insured.
- Cost of care is the biggest barrier. Other barriers include language and legal status.
- Private clinics and providers are the most-used services.

Policy implications:

- Socio-economic status: Most farmworkers are fairly young (25-44). The need for safety net programs for elderly farmworkers and their families will increase, especially for those who do not qualify for government programs because of their immigration status.
- Place: Farmworkers are regionally concentrated. Location plays a role in determining whether MSAW communities are rural or metropolitan. It also affects costs and access to care, crops and working conditions, workplace regulations, and the social climate toward Latinos and immigrants.
- Labor/economic status: Most farmworkers live in poverty despite increases in income. Fifty-nine percent earn less than \$20,000 per year (the FPL for a family of three is \$19,790).
- Policy: State laws on pesticide exposure and HRI vary in the degree of protection and training required of employers. The health needs of farmworkers in new destinations (e.g. Georgia, North Carolina, Alabama) reflect sociopolitical dynamics. Anti-immigrant laws and environments exacerbate the effects of isolation, leading to depression and anxiety disorders.

Ms. Juárez offered three areas of possible policy options based on her research:

- Option 1: Refocus on community governance and voice
  - Assure that Migrant/Community Health Centers (M/CHCs) have adequate processes for inclusion and parity in decision making under the “51% Board of Directors” rule for federally qualified health centers (FQHCs).
  - Increase the number of engaged farmworkers who help CHCs develop interventions tailored to the needs of their communities.
- Option 2: Expand the role and use of CHWs/promotores de salud
  - CHWs lack a sustainable funding mechanism that supports their role in promoting population health. HRSA could work with the Centers for Medicare and Medicaid Services (CMS), the National Association of Community Health Centers (NACHC), and CHW networks to develop financing mechanisms that allow for Medicaid and other types of reimbursement for CHWs.
  - Promising models include inclusion of CHWs by managed care organizations (MCOs) and in value-based payments.
- Option 3: Invest federal resources to increase collaboration between MHCs and academic teaching hospitals.
  - Teach the social determinants of migrant health in medical schools
  - Provide opportunities for service learning

- Establish medical-legal partnerships.

Ms. Juárez offered three additional points for the Council’s consideration:

- Increase and incorporate the insider lens when conducting research.
- Increase ethnographic research to understand the needs and concerns of MSAW populations.
- Improve communication and increase cooperation between agencies, organizations, and communities.

#### Discussion

- Mr. Morgan stated that pesticide protections are required by law; they are not a policy issue.
  - Rev. LaBarge commented that employers can skirt the law, because many MSAWs are undocumented and will not report violations.
  - Ms. Juárez noted that many MSAWs in California are hired by contractors.
- Ms. Andrés-Paulson asked about outreach efforts to increase MSAW enrollment in coverage under the ACA.
  - Lisa Cacari-Stone (University of New Mexico) replied that enrollment varies by states. The most effective outreach is conducted by a trusted person who is based in the community.
  - Rev. LaBarge stated that health centers need to be visibly involved in the enrollment process and should provide a navigator who will go to the migrant camps.
  - Ms. Diaz noted that many MSAWs get enrollment information through text messages or word of mouth.
  - Dr. Cacari-Stone noted that MSAWs want their family members to be covered. Enrollment messages should focus on the family.
- Amanda Phillips Martinez noted that grants from the Patient-Centered Outcomes Research Institute (PCORI) are an excellent way for health centers to build capacity to engage patients in meaningful ways. Community-based non-profits and CHCs get bonus points in the application process. Grant funds can be used to provide child care and transportation for MSAWs.
  - Dr. Cicari-Stone suggested that HRSA could issue a special call for MHCs to apply for PCORI grants.
- Mr. Paras asked what recommendations the Council could put forward.
  - Ms. Juárez replied that Option 1 (refocus on community governance and voice) would be the most important recommendation.

#### **New Mexico Primary Care Association Update**

*David Roddy, Executive Director, New Mexico Primary Care Association*

Mr. Roddy provided an overview of health centers and migrant health in New Mexico:

- New Mexico has 17 FQHCs, plus several look-alikes, county-funded, and tribal health centers, with more than 600 sites across the state.
- In 2015, New Mexico health centers served about 343,000 patients, including 18,457 MSAWs. This represents one in six New Mexicans, compared to one in 15 nationally.
- New Mexico provides \$12 million in state funds to help health centers provide services to uninsured patients. That funding is jeopardized.
- New Mexico has three MHCs. The two largest (Ben Archer, with 11 sites in Dona Ana, Luna, Otero, and Sierra counties and La Clinica de Familia, with 13 sites in Dona Ana County). The third MHC is a new homeless program.

- Agriculture in New Mexico generates \$2.6 billion per year. Dairy products account for about 39 percent of the state’s agricultural receipts. The leading crop is hay used to feed cattle, followed by pecans. New Mexico is a leading producer of chili peppers and onions. Cotton, grain, sorghum, and wheat are also grown in the state.
- New Mexico had a significant migrant stream in 1970, along with significant seasonal agricultural work. MSAWs faced many problems, including housing, pesticides, childcare, and health care. Interventions included some migrant housing, programs for migrant children, and farmworker clinics during the harvest season. The clinics conducted some outreach to workers in the field
- The Home Education Livelihood Program (HELP) was formed in 1965 by the New Mexico Council of Churches to improve the lives of farmworkers and other low-income New Mexico residents. They have provided services to more than 800,000 individuals to date. HELP incorporated a housing non-profit, Tierra del Sol, to achieve their primary mission of helping agricultural workers obtain and hopefully own affordable homes. They also provided education for agricultural workers and their children, plus job training and on-the-job training. Although their mission did not include health, HELP ran seasonal clinics and formed La Clinica de Familia in 1976. HELP incorporated three Regional Farmworker Councils as the focal point for their programs.
- The migrant stream today is much smaller. Contracted day employees brought by bus from Juárez have replaced migrant and local laborers hired directly by farmers. There are fewer opportunities for seasonal laborers due to more mechanization and less manual labor. Dairy is the predominant agricultural sector. A great deal of produce is imported from Mexico.
- The farm work environment has improved due to the banning of the short hoe in 1999 (24 years after California) and better sanitary and safety conditions in the fields. In June 2016, the New Mexico Supreme Court overturned a 100-year old law allowing farmers and ranchers to opt out of workmen’s compensation insurance for agricultural employees.
- HRSA funding for migrant health has doubled in the past seven years, while the patient population has increased by only 11 percent. Health centers have dramatically increased the quality and comprehensiveness of services for all patients through EHRs and PCMH accreditation.
- New Mexico health centers are focusing on outreach and greater use of CHWs to engage farmworkers and bring them into the healthcare system. Some health centers are advocating for a focus on the social determinants of health, which is the approach that HELP took in the 1970s.

Mr. Roddy stated that M/CHCs must strive to improve patient engagement, do a better job of evaluating the risks and vulnerabilities common to the farmworker population, and bring additional resources to address the social determinants of health and treat illnesses in the farmworker population.

#### Discussion

- Ms. Triantafillou asked about the demographics of the farmworker population in New Mexico.
  - Mr. Roddy replied that all MSAWs are in the southern part of the state, primarily the Rio Grande valley. Ninety-percent are in Dona Ana County.

#### **Council Reflections**

Council members discussed the morning presentations.

- Ms. Andrés-Paulson said the presentations were excellent and provided a great deal of relevant information. The interactive format was good. In the future, it would be nice to have more speakers like Ms. Juárez who present from their own experience.
- Ms. Diaz stressed that the Council has work to do. Farmworkers are still sick, and they still have problems accessing the health system. The Council needs to listen to promotores and voices that are silent.
- Ms. Phillips Martinez said it was helpful that Ms. Naqvi organized her presentation around the HRSA priorities, because that is how the Council needs to frame its recommendations. It was also helpful that Ms. Juárez presented policy recommendations at three levels. The disconnect between policy and reality is grave. The Council and health centers are in the best position to bring farmworkers' voice to the policymakers.
- Mr. Morgan stated that that the MSAWs his health center serves are a small part of the larger Latino community, which has similar needs and challenges. He asked whether farmworker health could be linked to the larger picture.
  - Ms. Paul said Mr. Morgan's question highlighted the importance of the health center program. Health centers are the one place where anyone can be served, regardless of employment status or insurance, because they are not permitted to turn anyone away. It is important to hold onto that, and make them more accessible. Promotores play an important role in making people aware of the services that health centers provide.
- Rev. LaBarge said the Council must be mindful that its focus is MSAWs. MSAWs are only a small percentage of the patient population at most health centers. The Council's recommendations apply to health centers that receive funding as MHCs.
- Ms. Diaz stated that language barriers make it difficult for MSAW board members at her clinic to be actively involved.
  - Mr. Garcia said that every board member should be encouraged to speak up.
  - Ms. Phillips Martinez asked if HRSA has capacity-building resources that could facilitate more meaningful participation by farmworker board members.
  - Ms. Diaz suggested that Title VI requirements could be used to provide documents in languages other than English. The health center needs their voices in its board meetings.
  - Ms. Castro noted that there is no requirement to hold board meetings in English. Board meetings at her health center are held in Spanish, with discussions in both English and Spanish. It is important to ensure that board members can participate. Translation should be provided, if it is needed.
  - Ms. Andrés-Paulson stated that NACHC offers a pre-conference training program on how to be an effective board member. The NACHC meeting in Washington, DC had a session on legislative advocacy and one on MHCs. Her health center provides funding for board members to attend the NACHC conference, and they provide an on-boarding program to ensure that new board members are engaged and involved. It is the responsibility of board members to help others be more vocal.
- Ms. Castro said it was helpful to have a framework for the Council's recommendations. Ms. Naqvi's presentation highlighted the importance of more uniform data collection and a more informed intake process. Ms. Juárez provided important context and policy options.
- Mr. Morgan noted that it is difficult for MSAWs to be board members, because they move and they are a minority on the board if the health center is not an MHC. Eastern states are different from those in the west—farms are smaller, and many farmworkers are African American. Health and language problems are also different. He asked how the Council can deal with those differences when it makes its recommendations.

- Rev. LaBarge commented that a significant proportion of patients at his health center are seasonal workers on H-2A visas. They do not fit the definition of MSAWs, because they work in fishing industry (as opposed to aquaculture).

### **Project ECHO (Extension for Community Healthcare Outcomes)**

*Venice Ceballos, CCHW, Manager, Community Health Worker Programs, University of New Mexico (UNM) Health Sciences Center*

Ms. Ceballos described the ECHO teleconferencing model developed at UNM and its use in training CHWs. She presented a video to introduce ECHO ([https://www.youtube.com/watch?v=2IBfyOIL4\\_s](https://www.youtube.com/watch?v=2IBfyOIL4_s)).

The ECHO model uses technology to build expertise and create a community of practice, similar to grand rounds in a hospital setting. Different ECHO clinics are held throughout the month (diabetes, addiction, chronic pain, etc.). Specialists share information freely, and any type of provider can join. The model has expanded worldwide, because it is effective.

In 2009, UNM expanded the ECHO model to train CHWs. The four-month program provides brief initial training followed by case-based, applied learning. It is delivered in three phases:

- Phase 1: Coming together and skills building (one day, face-to-face)
- Phase 2: Community of Practice and TeleECHO clinics (16 weeks)
- Phase 3: Evaluation and graduation (one day, face-to-face).

The ECHO model allows CHWs to present their cases to the entire network of providers during Phase 2. CHWs apply the recommendations made during the ECHO session and provide an update at a later session.

CHWs obtain an endorsement for each skill they demonstrate. Endorsement for counseling skills has been added to the program.

UNM developed toolkits in response to participants' feedback, and they developed facilitator guides so the model can be adapted in other communities.

UNM developed multiple CHW "specialist" ECHO training programs:

- Diabetes: 150 trainees since 2009
  - Good Health and Wellness: 65 trainees since 2015.  
(The curriculum has been modified for tribal communities.)
- Addiction: 130 trainees since 2011
- Mental Health: 9 trainees in 2014
- Care of Complex Populations: 16 trainees in 2014
  - Prison Peer Education (40-hour curriculum for CHWs in prison): 400 trainees since 2009 (<https://www.youtube.com/watch?v=0pgXDhT1K74>)
  - Family Obesity Prevention: 25 trainees since 2015.

UNM is developing a new curriculum on prevention of child abuse and neglect that will be pilot tested in April 2017.

UNM was recently funded by HRSA to train CHWs in Community Addiction Recovery Support as part of a national initiative to address the opioid epidemic. The program will use the TeleECHO model without the face-to-face component. The target audience is 200 FQHCs across the country.

UNM received federal funding to develop ECHO innovative care models in which multi-disciplinary teams that include CHWs are trained together to provide intensive outpatient care for complex, high-cost patients insured by Medicaid. CHWs play a key role in engaging patients, addressing social issues, and providing health coaching.

Ms. Ceballos noted that CHWs are a growing profession, and research has confirmed the effectiveness of the ECHO approach. It is time to take the ECHO model to the next level. Reimbursement for CHW services is an important aspect and should be consistent across the country.

### Discussion

- Ms. Naqvi noted that some of the programs had a small number of trainees.
  - Ms. Ceballos replied that the general content was developed first. Some of the smaller programs were a response to specific funding.
- Ms. Triantafyllou asked about leadership development for CHWs.
  - Ms. Ceballos said the program recruits graduates from the cohort as “community faculty” to ensure that it has a CHW feel. They would like to develop specialized training for CHW supervisors and trainers, but there is no clear pipeline at present. The next generation of leaders and supervisors should have experience as CHWs.
- Ms. Naqvi asked what it costs to develop a specialized curriculum.
  - Ms. Ceballos stated that each program costs about \$100,000. The main cost is the face-to-face training. Teleconferencing is offered through a Zoom account. The new model funded by HRSA is less expensive, because it does not include a face-to-face component.
- Mr. Paras asked if trainees provide medical advice.
  - Ms. Ceballos replied that ECHO programs include a nurse. CHWs often want to provide advice that is outside the scope of their duties. The challenge is to determine what information they can provide in simple language, while remaining within their scope.
- Mr. Paras asked how the ECHO program documents best practices.
  - Ms. Ceballos replied that they conduct pre- and post-testing of participants’ knowledge, attitudes, and competence. Some employers require ECHO training as part of the orientation for new hires.
- Ms. Andrés-Paulson asked how the ECHO programs are funded.
  - Ms. Ceballos stated that most of the programs are grant funded. They are partnering with a program that wants to use CHWs in schools that do not have school nurses, and they are looking for other funding options.
- Ms. Phillips Martinez noted that New Mexico is a national leader for CHWs. It is challenging to develop the profession when each state takes its own path. She asked how the federal government could support the development of state or local approaches to ensure sustainability.
  - Ms. Ceballos said there has been some discussion about creating a national CHW association that brings together states across the spectrum. Minnesota allows reimbursement for CHWs, but for limited services. North Dakota has a state amendment for certification. The question is how to expand the profession, while preserving core values.

- Ms. Phillips Martinez asked how the federal government can work with CHCs/MHCs to ensure that CHWs can use their skills appropriately.
  - Ms. Ceballos replied that her office rolled out a curriculum for CHW supervisors that includes a toolkit. A multidisciplinary approach requires an ability to understand roles and build good working teams.
- Ms. Triantafillou raised the issue of incentives and noted that some programs think CHWs should not be paid.
  - Ms. Ceballos replied that some programs pay CHWs for reducing cost. Payment is difficult when working with MCOs. Clinics do not always have a category in their budget for CHW services. UNM promotes financial compensation. If we want to keep CHWs, we have to pay them. It is important to advocate for compensation.
  - Ms. Triantafillou noted that states are moving in different directions regarding certification. Many states spent a lot of money to develop their training program, and it is important to avoid duplication of effort. Certification, curriculum, and sustainability: are key issues.
- Ms. Andrés-Paulson commented that CHWs are saving money for organizations and helping patients improve their health.
  - Ms. Ceballos said some hospitals value CHWs, but they give them the hardest patients. The ECHO model is a multidisciplinary approach. Infrastructure to support CHWs is needed and should focus on training and supervision to maintain a successful program. States are moving quickly, but they do not provide structure.

### **Discussion of Possible Recommendations**

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

- Ms. Triantafillou noted that transportation is a barrier to health care and suggested this as a topic for a future meeting. She would like to know more about a grant awarded to Health Outreach Partners (HOP) to research transportation options for MSAWs. The Council could make a recommendation to promote more models for transportation to facilitate access to health care.
- Rev. LaBarge suggested that the definition of MSAWs should be expanded to include those who work in fishing.
- Ms. Phillips Martinez reported that she worked with group in Vermont that wanted to seek MHC funding for a health center that served dairy workers. They were told that dairy workers are not considered to be migrant or seasonal workers.
- Ms. Castro recommended continued funding for CHWs/promotores in CHCs.
- Ms. Diaz commented that promotores' notes are not included in a patient's EHR. They should be an equal member of the interdisciplinary team.
  - Ms. Ceballos stated that some clinics have CHWs add their comments under the provider's notes, and some have a separate section for CHWs. There should be consistency across the health care system.
  - Mr. Garcia said that the UDS system should collect data on CHWs as providers when certification is implemented.
- Ms. Diaz stated that Title VI regulations should be enforced to make information accessible to all health center board members.

Council members discussed the possibility of holding the Spring 2017 meeting in North Carolina rather than Washington, DC to coincide with the arrival of H-2A workers. Ms. Triantafillou said she would work with Ms. Paul to develop a justification for that proposal. Council members also discussed the possibility of meeting in conjunction with the annual Migrant Health Conference or a migrant stream forum.

## **CHW Act: Development of a Strong and Competent CHW Workforce through Training and Certification**

*Claudia Macias, Office of Community Health Workers (OCHW), New Mexico Department of Health*

Ms. Macias described New Mexico's policy framework and training and certification programs for CHWs. She began by providing a historical perspective:

- 2003: The New Mexico legislature adopted Senate Joint Memorial 76 (SJM76) recommending the development of standardized, core-competency-based training and certification for CHWs.
- 2006: The New Mexico CHW Advisory Council was established to carry out the objectives of SJM76, in partnership with CHWs, healthcare providers, community based organizations, tribes, the Indian Health Service, state agencies, and other stakeholders.
- 2008: OCHW was established within the New Mexico Department of Health (DOH) to work on certification, with no funding.
- 2014: The Community Health Workers Act passed with full support of the legislature, as part of the governor's Workforce Development Initiative. The Act took effect on January 30, 2015.

CHWs are uniquely positioned to act as bridges between their communities and the health and community service systems. They have a holistic understanding of the cultural values and issues in the communities in which they work, and they often live in the same neighborhoods as those they serve.

OCHW is responsible for certification of CHWs in New Mexico. The benefits of voluntary certification include standardization of skills; appropriate utilization and assignment based on skills; increased acknowledgment and respect as para-health professionals and critical partners in health care teams; increased self-esteem; potential for reimbursement from MCOs and state and federal entities; potential for higher wages; and continuing education opportunities.

OCHW is focused on certification through grandfathering or training. Grandfathering honors the experience of CHWs who have served their communities for many years. Candidates must have worked as a CHW before May 21, 2014 and must have worked as a CHW for at least two years. OCHW will offer training through the OCHW core competency curriculum and specialty tracts, or through an OCHW-approved training program offered by community colleges or community-based organizations.

The OCHW generalist curriculum includes 10 core competencies and an optional specialty track in clinical support skills. OCHW will add more specialty tracks in the future. The training is free, but participants must pay \$45 for a background check and must cover their childcare or transportation expenses.

Ms. Macias emphasized the importance of sustainable funding for CHWs. New Mexico Medicaid does not currently reimburse for CHW services. OCHW will build partnerships with other entities to advocate for reimbursement of CHW services and will continue discussions with the New Mexico Human Services Department (which administers Medicaid) and MCOs regarding this issue.

## Discussion

- Ms. Naqvi asked about the attrition rate among CHWs.
  - Ms. Macias replied that CHWs who get certified under the grandfathering program are committed for the long term because this is what they do--it is not a career. Some who are looking at the training see it as a stepping stone to another career.
- Ms. Naqvi noted similarities to the Home Visiting program and commented that safety can be a concern in some cases.
  - Ms. Macias stated that the CHW training includes tools to recognize a dangerous situation. Most CHWs are not concerned about safety, because they are there to help.

## **Experiences from the Field**

### CHW Programs

*Juana Carreón, CHW Program Coordinator, Ben Archer Health Center, NM*

Ms. Carreón noted that she understands the migrant experience because she was born in New Mexico, but raised in Chihuahua, Mexico. She was hired at Ben Archer Health Center for a program that provided literacy education. When she noticed that farmworkers had many needs beyond learning to read and write, she began to take promotores with her. The promotores helped farmworkers access healthcare services and later helped them obtain U.S. citizenship. Ms. Carreón eventually became a promotora and now coordinates Ben Archer's CHW program.

Ms. Carreón noted that CHWs/promotores are knowledgeable about the communities they serve and the local, state, and federal services that are available for their communities. They provide prevention, not intervention. Their role is to empower families to help themselves and increase their coping skills by providing information, knowledge, and tools.

The priority of the Ben Archer Health Center is to sustain the CHW program without having to rely on grants. Many promotores do not think certification is in their interest, because they have to pay out of pocket and must be re-certified every two years.

## Discussion

- Ms. Naqvi commented that many HRSA grants include a sustainability component. She asked about the cost of certification.
  - Ms. Ceballos replied that certification has pros and cons. Funders have told the DOH that CHWs will not be reimbursed unless they are certified.
  - Ms. Macias noted that it took many years of setting the stage to get the legislature to support CHWs and pass the law. They now need to demonstrate that they have a trained workforce to set the stage for reimbursement. Certification is voluntary in New Mexico, but OCHW is promoting it in order to get reimbursement.
- Ms. Diaz said it is important to find other ways to maintain the program.
  - Ms. Carreón replied that Medicaid or Medicare reimbursement would make CHW services more sustainable. Ben Archer has social workers, and some CHWs have a bachelor's or associate degree. Funding for the children and families program requires an associate degree. If the program is changed to require a bachelor's degree, the health center would lose staff.

### Farmworker Housing Opportunities

*Sal Estrada, Executive Director, Housing and Economic Rural Opportunity, Inc. (HERO)*

Mr. Estrada noted the strong connection between quality housing and good health and discussed the role of non-profit development agencies in developing housing for farmworkers.

The Tierra del Sol Housing Corporation is a non-profit corporation that was formed to help low- and moderate-income families obtain adequate housing, social services, and employment opportunities. They receive funding through U.S. Department of Agriculture (USDA) Rural Development programs, including the Section 514 grant program and Section 516 loan program.

Tierra del Sol is one of the first non-profit organizations to combine USDA funds and low-income housing tax credits to build quality housing for farmworkers. The farm labor rental housing they built in Las Cruces and Deming includes amenities such as dishwashers, large bedrooms, laundry facilities, and community rooms. They are currently developing an energy-efficient housing complex in Hatch, NM, and they want to develop housing within a catchment area that includes West Texas and Southern New Mexico to stabilize the farm labor workforce.

Mr. Estrada proposed several recommendations for HHS and HRSA:

- Collaborate and form coalitions with other agencies (e.g., USDA, HUD, state financing agencies) to promote quality housing that will improve health for farmworkers and their children.
- Support long-term funding for health centers to provide social services (e.g. Head Start, WIC) and use promotores to link farmworkers to those services.
- Advocate for rental assistance for farmworker housing, such as Department of Labor programs to support temporary and permanent farmworker housing and USDA Section 514 farmworker housing.

### Discussion

- Ms. Naqvi asked whether the supply of farmworker housing in southern New Mexico was meeting the demand.
  - Mr. Estrada replied that funding applications required Tierra del Sol to document a market for this type of housing. There are more than 5,000 farmworkers in Hatch, where agriculture dominates the economy. The new 24-unit complex in Las Cruces has seven vacant units. The vacancies could be due to the declining number of farmworkers, or they could reflect the impact of mechanization.
- Ms. Naqvi noted that the Department of Education was listed as a partner.
  - Mr. Estrada stated that education needs to be included in any collaboration. All of the students at Hatch high school are children of farmworkers. Farmworker education programs utilize technology so students can continue their studies as they migrate. A model program in West Texas provides the full range of services for farmworkers' children, such as bi-lingual education and English-language acquisition. Case managers track the students and provide assistance as needed.
- Rev. LaBarge noted that the USDA program does not address housing needs of H-2A workers.
  - Mr. Estrada said he did not know of programs to address that issue. He noted that the National Rural Housing Conference would be held in Washington, DC in late November and would be an appropriate place for those discussions. Leasing agents have specific criteria of who can qualify for housing (e.g., USDA requires the head of household to have the proper documentation).

- Ms. Phillips Martinez noted that a colleague was advocating for tax credits for low-income housing developments to include space for health services. She asked what that provision should include, whether it would be an incentive for developers, and whether it would be feasible to develop such a program.
  - Mr. Estrada replied that housing tax credits are determined at the federal level; states determine the application requirements. New Mexico has a set-aside for rural farm labor housing. Tierra del Sol advocated for a modification to include urban housing, because many farmworkers live in metropolitan areas. The biggest problem at the national level is the federal requirement to document state tax credits, while the state requires documentation of federal funds.

## **Discussion of Possible Recommendations**

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

### Farmworker Housing

- Ms. Phillips Martinez suggested it would be useful to explore mechanisms for collaboration with HUD and USDA for demonstration grants or pilot programs to connect health services and farmworker housing.
- Ms. Andrés-Paulson noted that California requires developers to set aside one percent of housing for farmworkers. The St. Joseph Health Center in Los Angeles has developed affordable housing for seniors. Those might be models to consider.
- Ms. Paul suggested that the need for housing could be linked to social determinants of health.

### CHWs

- Rev. LaBarge said it is important to document the impact of CHWs in order to address sustainability.
- Ms. Andrés-Paulson stressed the need for mechanisms to reimburse CHWs.
- Ms. Paul suggested that a set of core competencies may be necessary for CHWs to be recognized as a legitimate component of the workforce.
- Mr. Morgan said core standardization is essential, with flexibility for adaptation.
- Ms. Diaz emphasized that CHW training should be affordable and meaningful.
- Ms. Phillips Martinez asked if CHWs could be included in basic funding for MHCs.
- Ms. Naqvi noted that a UDS category to include CHWs in the workforce for enabling services was added in April 2016 and would take effect in February 2017.
- Rev. LaBarge proposed that HRSA work with CMS, MCOs, and insurance companies to include funding for CHWs in the cost of services.
- Ms. Andrés-Paulson noted that most CHCs are pursuing PCMH designation. It would be useful to recognize the role of CHWs in meeting those requirements.

### Engagement of Farmworker Board Members

- Ms. Triantafillou stated that MHCs should do as much as possible to recruit and maintain MSAWs on their boards.
- Ms. Andrés Paulsen noted that board representation is a program requirement. HRSA Project Officers should review the grantees each year to determine their eligibility.
- Mr. Garcia said a recommendation was not needed in this area, since it is a funding requirement.

## DAY TWO

### Recap from Previous Day

*Amanda Phillips Martinez, NACMH*

Ms. Martinez provided a comprehensive review of the presentations and discussions of Day One.

### National Association of Community Health Centers (NACHC) Update

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

Mr. Gallegos welcomed Council members to his home state, New Mexico, and thanked them for their work on behalf of one of the most disenfranchised populations in the country. He then provided an overview of NACHC's legislative agenda and an update on the Ag Worker Access Campaign and commented on recognition and core competencies for CHWs.

#### NACHC Legislative Agenda

Health centers are located in 98 percent of Congressional districts, and there is strong bipartisan support for the program. The presidential election was overshadowing the Congressional agenda at the time of this meeting. NACHC will work with whomever occupies the White House following the election and will continue to educate new members of Congress.

NACHC's 2016 legislative agenda has three priorities: stabilizing funding for the CHC program, workforce development to staff the safety net, and highlighting health center innovations.

Health center funding is a significant concern. The appropriation for base funding in the discretionary budget is stable at \$1.5 billion. However, the Affordable Care Act Health Centers Fund, which is currently \$3.6 billion, is set to expire in September 2017. Funding for CHCs will be cut by 70 percent if no action is taken. This would affect every health center, not just those that were newly funded or expanded, and it would eliminate funding for the National Health Service Corps (NHSC) and the Teaching Health Centers (THC) program. The resulting impact on migrant health centers could amount to a loss of as much as \$300 million in funding, which currently supports 2.3 million visits annually. The best option for health centers is long-term funding to stabilize funding and address the funding cliff.

To stabilize funding, NACHC is asking Congress to:

- Support health center funding in the FY 2017 annual appropriations process
  - To date, 70 percent of House members have signed the Bilirakis-Green letter and 62 Senators have signed the Wicker-Stabenow letter (new records in both houses).
  - Congress signed a Continuing Resolution in October that extended current funding for all federal agencies through December 9. Congress will have to address funding beyond December 9 when it reconvenes following the election. The outcome is unclear.
- Request level discretionary funding (\$1.5 billion)
- Commit to taking action before the September 2017 deadline to make the Health Centers Fund permanent.

The Senate version that NACHC worked on before the Continuing Resolution included a provision that \$50 million of health center funding would be earmarked for mental health services in CHCs to address gun violence. It also dedicated \$50 million to deal with opioid misuse and treatment in CHCs.

Policy signals indicate that Congress is looking at health centers to become involved in the front lines of public health issues, such as the Zika virus, water contamination in Flint, and prescription opioid abuse. This speaks well for the ability of health centers to partner with communities and serve as leaders. However, they should not lose sight of their mission and the work they have been doing.

To address the workforce crisis, NACHC is asking Congress to:

- Fully fund the NHSC at the president's budget request (\$380 million)
- Invest in the THC program (short- and long-term)
- Pass the Family Health Care Accessibility Act to include volunteer providers under the Federal Tort Claims Act
- Pass the CONNECT for Health Act to improve CHCs' access to telehealth technology
- Reauthorize and fund Nurse Practitioner Training.

These strategies will help alleviate the severe shortages in the healthcare workforce. A national CHC workforce survey found that 95 percent of health centers have vacancies for physicians, and 70 percent have a family physician vacancy. If fully staffed, CHCs could serve two million additional patients. (The percentage for MHCs is unknown, because most MHCs are also funded as CHCs and do not have designated staff for migrant patients.)

To support health center innovations, NACHC is asking Congress to:

- Join the Bipartisan Caucus on Community Health Centers
- Visit a CHC during a district work period or during National Health Center Week.

The funding cliff is different now than it was in 2015. Health centers are less associated directly with divisive politics around the Affordable Care Act, and there is strong support in Congress for mandatory CHC funding. It will cost at least \$3.6 billion to sustain the program, plus funding for NHSC and THC. The most likely scenario is a safety net package in which everything goes together, with CHIP as the anchor.

#### Ag Worker Access 2020 Campaign

Legislation requires that 8.6 percent of the total appropriation for CHCs is allocated to migrant health. Funding has increased over the past five years, while the number of MSAWs served declined. NACHC and the National Center for Farmworker Health (NCFH) launched the Ag Worker Access 2020 campaign to reverse that trend. NACHC's Committee on Ag Worker Health established a dedicated task force to guide the campaign.

The goal of the campaign is for MHCs to serve two million MSAWs by 2020. Every MHC grantee has been asked to increase the number of MSAWs it serves by 15 percent each year through 2020. Health centers that do not receive Migrant Health funding are asked to report all patients who meet the MSAW definition, per UDS criteria.

The campaign is focused on states with highest numbers of farmworkers (Texas, California, Washington, Oregon, Florida). UDS data for 2015 showed a penetration rate of about 20 percent. This was a modest increase from 2014, but there is still a significant need.

The campaign is promoting partnerships with organizations at the local, state, and national level to create a national coalition. They are asking MHCs to reach out to partners in their areas to improve access to care for farmworkers. In Florida, the Coalition of Florida Farmworker Organizations, Migrant

Clinicians Network, and FQHCs in Dade County are collaborating to address the Zika virus. NACHC is promoting collaborations between Migrant/Seasonal Head Start and FQHCs to have health centers be the health care home for Head Start children and their families.

Accurately documenting MSAW status is a challenge. Patients who do not self-identify make it difficult for CHCs to capture data for UDS reporting. The campaign is providing training for health center staff to identify family members who meet the definitions of “migrant” and “seasonal workers.” NACHC created a learning community on its website for health centers to access resources, share best practices, and provide notices of training and webinars ([www.nachc.org](http://www.nachc.org)). The NCFH website explains the campaign, provides materials that can be downloaded, and suggests ways to get involved ([www.ncfh.org](http://www.ncfh.org)).

The Ag Worker Access 2020 Task Force will send a letter to all MHCs to reassess and reform their migrant health programs for today’s environment. The modest increase in the number of MHC users in 2015 shows that the campaign is working.

### CHW Recognition and Core Competencies

Mr. Gallegos addressed the issue of recognizing CHWs as a profession and identifying core competencies. He stated that core domains need to be evaluated and compared across states. Accreditation and certification will require a certain amount of training. Promotoras who do not have formal training are the link between the health center and the community, and they should not be displaced. A group called “3Cs” is trying to develop national, unified standards for CHWs and has asked NACHC to review and endorse their materials

Mr. Gallegos thanked the Council for the recommendations it submitted following the previous meeting in support of NACHC priorities. He proposed two potential recommendations for this meeting:

- Provide funding to sustain CHWs as a profession. The best option would be to require Medicaid and insurance providers to pay health centers a certain amount per patient each month for services they provide.
- Develop alternative service delivery models for migrant health (e.g., voucher programs, mobile units, health centers located within farmworker housing).

### Discussion

- Mr. Paras said he would urge his clinic to support the Ag Worker Access 2020 campaign. He supported the proposed recommendation to partner with organizations that develop affordable housing and noted that his clinic would look into building a new facility near a migrant camp.
  - Mr. Gallegos noted that H-2A and undocumented workers are a major force in the local economy, and they need options because they are not eligible for public housing. Health centers can facilitate discussions with growers, churches, and other local organizations and create coalitions to develop alternative models of housing that are affordable for anyone, regardless of status.
- Mr. Morgan commented that there are fewer and fewer migrant camps, which makes it difficult to find MSAWs, even when the grower knows where they are. Front desk staff are not always able to identify migrant patients.
  - Mr. Gallegos replied that promotores know who and where MSAWs are.
- Ms. Triantafillou asked when the funding for MHCs was doubled.
  - Mr. Gallegos stated that George W. Bush doubled the program as part of a rural initiative. The funding was doubled again during the Obama administration, and it could

potentially double again. The question is how health centers will use the funds. The model needs to be revised, perhaps by adding some forms of specialty care.

- Ms. Triantafillou asked if there was any discussion about extending the NHSC program to non-clinical health professionals, such as social workers.
  - Mr. Gallegos replied that the loan repayment program has been focused on primary care providers. Some health centers want to add cardiologists and other specialties. The question is where primary care ends. NHSC is a crucial arm of the workforce, and it should reflect the model of care at health centers.
- Mr. Garcia stated that the Council supports Ag Worker Access 2020 campaign, because access is one of the most important issues the Council can address.

## Promotore Testimonies

The Council heard testimonies from CHWs/promotores from the Ben Archer Health Center to inform the Council's recommendations to the Secretary of HHS. Questions and responses were as follows:

What does a promotor/a do?

- We work with families, go to their homes, and provide information about many topics. We provide resources and speak on their behalf. We are there for them. We show them that “no” is not always the final answer. We have programs to help their children be successful and work in another field when they are older.
- We have people who work in the fields. They know me, because I worked in the fields for many years. I help them with letters, teach them about pesticides and diabetes, help them with transportation—whatever they need. Most of the people who ask for help are field workers.
- It is a hard job, and it is not from 9 to 5. I help our people with whatever they need. Sometimes we have to do more than our work and seek resources for our people.
- We do many things to promote the health of people in the community. I do prenatal care and early childhood development. We also help with transportation, any kind of service the person needs. We do not specialize in one thing—it is always new, and very interesting.
- The work is different in different communities. I work with psychologists and interpret for patients, including field workers and those who come from Mexico. I help them make phone calls to Social Security and other services.
- A promotora helps people who need to be educated. We help them with insurance, medications, we call Social Security--everything.
- A promotora is someone from the community who has the trust to provide a service. Many times, the community does not have trust. You have to earn it. A promotora is the bridge between the doctor and the person. Many times, there is no telephone. The promotora goes to the field to convey the message. I love my profession, because I also work in the fields. A promotora informs, educates, and supports the community. When someone has a tragedy, the promotora is there to support the individual and the family. Many families have just arrived from Mexico, Central America. The promotora sees the injustice, because she has big ears and big eyes. We support the rights of the people. We need more promotoras.

What do you like about your work, and why?

- This is a serious job, and I take it seriously, from my heart. I want to help families get ahead in life, and I want them to be taken seriously. They are not less of a person, just because they work in the fields.

- I like my job--I think it is very important. I'm happy to help people who really need the help. As a former field worker, I understand them and know what they need.

What would you change in your job as a promotor/a, and why?

- I would like it to be considered as a true profession.
- To be taken seriously and to have more training. We do not need a profession to be a promotora, but I would like more training to know what to do.
- I would like to have a more open role so I can help as much as needed. We work from the time we get up until we go to bed; sometimes they knock on our doors at night. When I'm at Walmart, they ask me to help them choose items. I work a lot, it's stressful, but I love it, especially when we help people who work in the field. They are very grateful, and it fills my heart. Sometimes we work without pay. It doesn't matter, because the appreciation we receive from the people is the best pay.
- We already promote health, but we should do more for the fieldworkers. Many are ill, and we should do something bigger.
- We need more time to do our work. We don't need to check in or check out. Our work should be valued.

In a perfect world, what message would you send to the Secretary of HHS so the work of promotor/as would be better recognized and better paid?

- We could work better with other agencies (e.g., insurance companies, doctors, hospitals) so we can be a voice for patients. Sometimes the patient has questions after they visit the doctor. The promotor/a could speak on their behalf with doctors, nurses, and others. Insurance companies have case managers who speak on behalf of the insurance company; we could speak on behalf of the patients.
- Farmworkers do not have Medicaid or insurance, and they cannot afford to pay out of their pockets. They should be paid more so they can afford insurance.
- Our job should be valued. Take into account our effectiveness, our ability to connect with field workers—doctors and nurses cannot reach them.
- I would like to see more promotoras in the communities so we are taken seriously and can help people better.
- Promotoras should be held in the highest regard—not just in clinics, but also in courts and other places. Promotoras are the bridge between the people and the doctor, the community, the grocery store. We are all human. I am not more than anyone else. I help others so they can feel comfortable. We all need to have a voice, and we are their voice.
- We go to the fields, go where individuals are—if they cannot come to us, we go to them. We do that now, but we need to do more, so we need more promotoras.
- We would like to have a salary and health insurance that shows our job is valued. We would like our community to have more promotoras to take the message of prevention about colon cancer, sexually transmitted diseases, arthritis, and healthy eating to children and adults. There is so much need in our community, and we really need help. We need more promotoras to take the messages. Transportation is a problem—farmworkers do not have a driver's license, and their children miss school because there is no one to take them to the doctor. Many health professionals do not have interpreters.

Some clinics integrate promotoras in the medical team. Does it work?

- I have worked in the clinic almost 18 years and have worked on chronic illnesses as part of the doctor's team. It was a very good experience. Patients and doctors trust promotoras.

Ben Archer is a system that works. Do you have experience with other systems?

- Hospitals often release patients, but they do not understand the information. They would benefit from having promotores.
- Patients do not have the ability to talk to the doctor. We have been with patients we transported for some other reason—the referral comes from the clinic to the hospital.

Providers often need to convey messages to male patients. How can we recruit more male promotors?

- I started as a field worker, and I know what they need. We were afraid to apply for services, because we didn't know about them. My motivation is to learn more, so others can benefit. I got my legal documents and got a scholarship because I worked in the field. Men trust other men who have worked in the field.

Mr. Garcia informed the promotores that the Council would formulate a recommendation based on the information they shared.

### **Farmworker Testimonies**

The Council heard testimonies from farmworkers from the Las Cruces area to inform the Council's recommendations to the Secretary of HHS. Questions and responses were as follows:

Where are you working? Have you worked somewhere else? What kind of crops do you harvest?

- I worked in Hatch for 19 years, harvesting chiles and onions.
- I worked in Hatch for 19 years and in other states. I harvest green and red chile and onions.
- I worked in Hatch for 10 years, harvesting chiles and onions.
- I worked for 16 years picking and sorting chiles, onions, and zucchini. It is a very hard job.
- I worked with many crops and pecans.
- I worked in the fields when I was younger. I have worked for 13 years in a jalapeno plant where we also process green tomatoes.
- I have worked in fields since age 12, harvesting chiles, watermelon, and onions.
- I began working in Mexico at age five and started working in the US at age 17. I love to work in fields. I like to share with the field workers and learn what brought them to this country. They usually want to have better opportunities for themselves and their children. I have also worked as a masseuse since I was 16. I graduated in 2006 from a program in therapeutic massage, but I haven't been able to pass the test. Now I work with field workers and help them with paper work. Ben Archer gave me an opportunity that helped me become more confident. Now I teach about diabetes, heat stroke, and many other things. I used to do more things that promotoras do, because they go in and out of the clinic.

How do you find a job?

- The contractor lets us know when the season will start. The rancher talks to the contractor. Many times we don't see the rancher.
- I work directly with the rancher, but a foreman gives the instructions.
- The contractor places the call and lets us know when and how we will work. Sometimes our friends give us the information.

- Sometimes the contractor calls one of us, or we let each other know when we will start working.
- I am a leader at the factory. We call the workers, but they need to submit their application.
- I work through a contractor.
- In New Mexico, we usually work with a contractor. The rancher has too many other responsibilities.

What do you do when you get sick? Do you know where to go?

- When my husband and I get sick, we go to the Ben Archer clinic in Hatch.
- I don't have insurance, because I don't qualify. The best option for me is to go to Mexico, because it costs less.
- I go to the Ben Archer clinic in Hatch. Sometimes they are closed at night, so we have to go to Las Cruces. We don't always have a good vehicle, so we have to find a ride.
- I go to Clinica del Salud in Las Cruces. They give us a card as a migrant and don't charge us for services. I have to renew the card every year.
- I go to Ben Archer, and I also have a card. I go to Mexico for things that aren't covered here, such as dental care.
- I go to Mexico or my mother, who is a traditional healer.
- I go to the Ben Archer clinic in Deming. We also have a hospital and other clinics. Most field workers go to Ben Archer, as do others who do not work in the field. They have good services.

How would you rate the services you receive? What challenges have you experienced in accessing health care?

- I go to Ben Archer a lot. They need more doctors. The receptionist takes care of us quickly, but it takes a long time for the doctor to see you. I have to go to work. I don't go back, because the doctors take so long.
- They are very kind at Ben Archer, but they need more doctors. It takes a month and a half to get an appointment. If I am really sick, I need to go somewhere else.
- My daughter is qualified for care at Ben Archer in Silver City. They sent me to Ben Archer in Columbus, and they treated us very well. I don't qualify for benefits.
- I have four children. Their care is provided at Ben Archer. I work in the fields and am paid by the hour. We lose time when we go to the clinic. Our work can't wait for us. We need more doctors. All of us have insurance. I am happy with the service.
- The clinic provides good care, and they are very nice. I haven't needed to go anywhere else.
- I receive very good care at Ben Archer. They can get me an appointment the same day or the next day for an emergency. It takes about a month to see the dentist, so I go to Mexico.
- I haven't had anything.
- I've been to several locations at Ben Archer and got very good care. I went to hospitals in Truth or Consequences. The clinic in Deming serves people from many places, so there are long waits.

If you have been injured at work, did you let your boss know?

- No.
- I got bitten by a rattlesnake. The clinic in Hatch did not have anyone who could help me, so I had to go to Las Cruces. We need more doctors.
- I have never had any problems at work.
- I was injured at work. The contractor sent the doctor to me. He gave me two weeks leave, and the owner gave me leave. Some contractors do things right. But we struggle to get help when we can't work.

- I haven't needed help, but some bosses don't pay if you are injured and you can't work.
- I've seen many accidents. The company we work for requires us to report it right away so they can document it.
- I haven't been injured, but my mother broke her hip and had surgery on her knee. We got \$25 every two weeks as compensation.

Is there anything else you would like to share about how to improve your health or the health of field workers?

- New Mexico has been classified as the poorest state in the U.S. Other states have many services for farmworkers. People treat each other right. New Mexico doesn't get what they have. There are not enough promotoras or interpreters.
- We need more communication from the contractors. They do not apply pesticides where I work, but they are used in the next field and we get headaches. We need to know if we should cover our faces. They need to be responsible if an accident happens at work. My father injured his foot and had many problems.

Please share any comments about clinic schedules, interpreters, and transportation.

- The clinic is not that far, and most of the doctors and nurses speak Spanish. My daughter helps when I need it.
- The local clinic does not have appointments after 5:30. I have to drive 30 minutes to Las Cruces.
- The clinic hasn't given us any information about our health. The promotoras have given us that information.
- The promotoras help me fill out the forms and check to see if my children have been vaccinated, etc.
- Promotoras offer classes about pesticides, etc.
- New Mexico is a very poor state. There are no hospitals in small towns. We need promotoras to be the bridge between doctors and schools. They take groceries to older adults, and provide coats for children. But what they provide depends on the clinic.

Would your boss allow you to leave if you had a medical appointment?

- We work by contract. When we have an appointment, we aren't paid for the day, so we don't go to work.
- They want us to let them know a day ahead, and they will give you permission.

Do contractors provide basics (e.g., bathrooms, water, breaks)?

- They provide water and bathrooms. When it is very hot, they send us home.
- They provide water and bathrooms, but they are not always clean.
- Everything is fine when the supervisor comes to inspect. They should come on a random basis. The bathroom is cleaned once a week, which is not enough for 130 people.

Has Ben Archer informed you that they have board members who represent farmworkers?

- They have told us, but there is not enough money to pay for another doctor. In Hatch, they need small hospitals for emergencies at night. The clinic in Deming is open until 8 pm. The clinic does everything it can to help us, but they need funding to run programs.

MHCs have a board of directors, and 51% are required to be farmworkers. Have you been told about that or invited to participate?

- (No responses to this question.)

Have you been asked to respond to a survey by phone or by mail asking about services at the clinic?

- Sometimes they have given us something like that.

Do your salaries pay you enough to buy healthy food? How much do you need to qualify for services?

- In Hatch, we are supposed to be paid \$7.50 an hour, but they only pay \$7.25. If we complain, they tell us to go somewhere else. The cost for everything is going up, but our pay does not.
- My children got coverage, but I could not qualify if I make more than \$200/month. Insurance costs \$400/month. We can't live on \$200 month, and we can't afford \$400 for insurance. We only make \$7.50/hour.

Do you live in public housing? If not, what are the conditions that affect your health?

- I have my own house.
- We are not given housing, unless you have a special permit during the season. Otherwise, we have to rent.

How and where did you first encounter a promotora?

- At Ben Archer, I asked for help filling out a document.
- When I was pregnant with my child. Thank God I found her—she helped me a lot, I found a friend in her.
- My daughter is a promotor/a, so I trust her.
- My sister—we call her “the little advocate.”
- We know where they are, and they know how to find us. They are always there, and they help us a lot, even for something simple, like reading a letter.
- When I was pregnant for the first time—they treated me as if they were the one who was pregnant.

What services are available for children, like Head Start?

- In my area, they provide childcare during the season (May-December). They help with milk and diapers, and they are very good teachers. They provide bus transportation, but there is no one to care for them after bus drops them off. I take them to my mother in the early morning. She takes them to daycare and picks them up, but she has things to do.
- The daycare center is very nice. I would take them to my neighbor, but they don't always want to help.
- It is difficult when you have several children. I can't afford to pay for daycare.
- There are many women who take care of children during the day; they feed them breakfast and a meal.
- I always have problems finding someone to care for my children. Sometimes I only work two hours. How can I pay for childcare? I have four children. My mother helps, but she is in a program.

Do you have any other comments?

- When it is hot, we get up at 5:30 in the morning and we have to work very fast to pick onions. The contractor does not want us to go when we are tired.

- Sometimes the employment office asks us questions, but we are afraid to answer because we don't want to lose our jobs.

What recommendations would you like to make to the Secretary of HHS?

- We need a hospital.
- The clinic needs more doctors.
- We need a hospital and doctors. The clinic in Hatch does not have weekend hours.
- We need more doctors and insurance that is affordable.
- We need a bigger hospital, and more doctors at the clinics.
- We need weekend hours at the clinic in Hatch.
- We need evening or weekend hours so we don't lose work.
- More hospitals won't help if we don't have insurance.
- We need a larger hospital in Deming.
- We need more mobile clinics during the harvesting season.

Mr. Garcia thanked the farmworkers for coming and for sharing their experiences. The Council would try to do more to help then by making recommendations to the Secretary.

### Formulation of Letter of Recommendations to the Secretary of HHS

Council members discussed the presentations and testimonies and identified the following gaps as high priorities for the letter of recommendations:

Gap	Recommendation to Address the Gap
CHWs/Promotores: <ul style="list-style-type: none"> <li>• Funding challenges and lack of standardization (e.g., certification)</li> <li>• Reimbursement challenges</li> <li>• Attrition rates.</li> </ul>	<ul style="list-style-type: none"> <li>• Continue to promote CHWs as bridge builders between patients and clinics and find a way to have them funded via value based health care delivery.               <ul style="list-style-type: none"> <li>◦ Increase collaboration with MCOs, CMS and other stakeholders.</li> <li>◦ Evaluate certification opportunities for CHWs (e.g., core competencies, liability, and scope).</li> <li>◦ Build upon the HRSA toolkit.</li> <li>◦ Encourage compensation for services provided by CHWs (e.g., Medicaid/Medicare reimbursement or fee-for-service).</li> <li>◦ Explore promising practices or funding formulas for health centers to sustain a CHW workforce.</li> <li>◦ Improve reporting measures for properly identifying CHWs.</li> <li>◦ Recognize the importance of CHWs as part of the value-based health care delivery system (e.g., national recognition).</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>▪ CHWs play a key role in achieving Ag Worker Access 2020 goals by identifying MSAWs and connecting them to care.</li> <li>◦ Address funding challenges and sustainability of Promotores programs post-grants.</li> <li>◦ “Grandfather” individuals to avoid exclusion.</li> <li>◦ Look at models (e.g., ND) to replicate nationwide.</li> </ul>
Affordable housing	<ul style="list-style-type: none"> <li>• Explore mechanisms for collaboration between federal agencies (e.g., HRSA, HUD, and USDA) and the private sector to look at demonstration or pilot programs to connect health services and farmworker housing. <ul style="list-style-type: none"> <li>◦ Replicate public housing health centers or school-based health centers.</li> </ul> </li> <li>• Emphasize affordable housing as a social determinant of health.</li> </ul>
Access to care	<ul style="list-style-type: none"> <li>• Use “Project ECHO” or similar tele-health/telemedicine strategies to increase workforce and provide innovation in community and migrant health centers.</li> <li>• Evaluate funding opportunities to implement mobile units and/or voucher programs to solve access issues (e.g., barriers to transportation). <ul style="list-style-type: none"> <li>◦ Encourage health centers to develop relationships with housing projects to conduct health visits/screenings.</li> <li>◦ Encourage collaboration with other social service agencies.</li> </ul> </li> </ul>

## Closing/Wrap-Up

### Next Steps

Council members agreed on the following timeline for preparing the letter of recommendations:

WHAT	WHO	BY WHEN
Draft letter and send to Ms. Phillips Martinez, Mr. Garcia, and Ms. Paul	Rev. LaBarge	11/8/16
Revise letter and send to Rev. LaBarge, Mr. Garcia, and Ms. Paul	Ms. Phillips Martinez	11/15/16
Prepare final draft	Rev. LaBarge	11/17/18
Send final draft to full Council and Ms. Paul	Rev. LaBarge	11/18/16

Submit comments to Rev. LaBarge and Ms. Phillips Martinez	All Council members	11/21/16
Prepare final draft incorporating comments	Rev. LaBarge	11/28/16
Submit final draft to HRSA	Rev. LaBarge	11/28/16

### Next Meeting

Council members continued the discussion of where to hold the next meeting, including the proposal to meet in North Carolina so the Council could visit the processing center for H-2A workers.

Ms. Paul noted that the current contract does not have a budget for Council site visits. She asked the Council to consider what role a site visit would have in informing the recommendations.

Ms. Triantafyllou stated that a description and photos of the processing center would not have the same impact as seeing it in action. North Carolina has a large H-2A population, and the Growers Association is very experienced at managing the influx of workers. A strong collaboration with the Grower's Association helped to get a significant number of H-2A workers enrolled in coverage.

Ms. Naqvi stated that she would consider the request.

Council members discussed possible topics and speakers if the meeting is held in North Carolina:

- North Carolina PCA
- Processing H-2A workers (President of the Grower's Association)
- Housing for H-2A workers
- NACHC update.

Council members discussed possible topics and speakers if the meeting is held in Washington, DC:

- Behavioral health/substance abuse (including opioids)
- Use of UDS data for quality improvement
- Transportation: Update on HOP research
- Traditional healers: Impact on use of health centers; complement to MHC services
- Vision care: Example of best practices for MSAWs.

### Wrap-Up

Council members provided feedback on the meeting:

- Ms. Diaz appreciated working as a whole group to develop the recommendations. The travel was challenging, with many stops.
- Mr. Paras said the hotel was very nice. The presentations were good, and logistics were handled well.
- Ms. Andrés-Paulson said the hotel was wonderful. The speakers were great, and the Council had opportunities to interact. She appreciated being able to experience a cultural event (Dia de los Muertos).
- Ms. Castro said the location was excellent, with restaurants in walking distance. The agenda was robust, but not overloaded, and the meeting was very productive meeting. She appreciated the support of OPPD.
- Ms. Phillips Martinez appreciated the agenda, which provided opportunities to deepen discussions with speakers and created a comfortable structure for interacting with guests.

- Rev. LaBarge appreciated that OPPD responded to the Council’s feedback on the meeting in May, especially regarding teleconference presentations.
- Ms. Triantafillou noted that the coordination of the testimonials was excellent, and the testimonies themselves were meaningful.
- Mr. Morgan noted that the translation services were much better this time, and the process for testimonies went well. The farmworkers were eloquent, and their confidence increased during the course of the session.

Council members expressed their appreciation for the Lux Consulting Group logistics team.

### **Reimbursement and Logistical Information**

*Priscilla Charles, Committee Meeting Manager, NACMH*

Ms. Charles provided each Council member with two UPS envelopes and reviewed the policy and procedures for reimbursement. She urged Council members to submit their travel vouchers and receipts as soon as possible, and no later than November 11.