



National Advisory Council on Migrant Health

February 16, 2011

Members of the Negotiated Rulemaking Committee
on the Designation of Medically Underserved Populations
and Health Professions Shortage Areas:

We send this correspondence to you on behalf of the National Advisory Council for Migrant Health (the Council). We understand that the Negotiated Rulemaking Committee on the Designation of Medically Underserved Populations and Health Professions Shortage Areas (NRC) has been charged with reviewing and making recommendations to the Secretary for updating the criteria used to define medically underserved areas and populations, as well as health professional shortage areas. The Council recognizes that any changes to these criteria will affect funding for Community and Migrant Health Centers (CMHCs). Because these centers are central to health care delivery to migrant and seasonal farm workers and their families (MSFWs), the Council would like to underscore, for the NRC, the distinct contribution of non-financial access barriers to vulnerability among farm workers.

MSFWs have heightened vulnerability to many non-financial barriers to accessing health services, as compared to probably any other special populations served by HRSA. As a result, CMHCs are uniquely situated both to provide and to *assure* health care for them. Key non-financial barriers encountered differentially by MSFWs, compared to other special populations served by HRSA, derive from the distinct social and economic realities of farm workers' lives—e.g., heightened mobility, linguistic and social isolation, poverty, and fear (see Council letter to Secretary Leavitt, April 2008). Moreover, pressure to work long and evening hours, and to travel long distances to seek work pose challenges to health service delivery to MSFWs by even the best equipped CMHCs. To address these gaps, CMHCs stand virtually alone, in the United States, in their development and use of enabling services to reduce health access barriers for MSFWs. By providing an array of population specific outreach efforts—such as the use of *promotoras* and interpreters, and use of mobile health units to increase population penetration by extending the reach of providers, CMHCs are unparalleled in their ability to provide a culturally relevant workforce, and therefore to play a key safety net role in assuring access to high quality and integrated health care for MSFWs.

As your committee continues to deliberate, towards making final recommendations to the Secretary by this July 2011, the Council asks that you consider the differential access barriers presented to MSFWs and that you act to protect them by:

1. Assuring that any changes made to the criteria for designating medically underserved populations and health professions shortage areas DO NOT decrease the availability of CMHCs for MSFWs.

To this end, we support your consideration of MSFWs as a special population with inherent and heightened vulnerability, such that centers seeking to serve them should face no barriers with regards to criteria identifying them as eligible to receive CMHC funds. Moreover, large proportions of MSFWs lack health insurance, are categorized as unqualified for receipt of public health insurance, and encounter numerous barriers to receipt of care from private providers;



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therefore, MSFWs will be excluded from the benefits anticipated to flow to non-farm workers in the U.S. from the Patient Protection and Affordable Care Act of 2010.

2. Remaining cognizant of the importance of non-financial barriers to health care receipt by and continuity for MSFWs, and consider including non-financial access barriers as criteria for determination of a medically underserved population. These non-financial barriers include, but are not limited to: heightened intra- and international mobility, geographic isolation from health centers, provider-patient linguistic differences, lack of cultural relevance of providers, lack of transportation, immigration related fear of discovery, and challenges related to population outreach. We ask that you remember that these factors continue to function as barriers to care for MSFWs even when a health center is available and/or there otherwise may be sufficient numbers of providers in an area. For this reason, the CMHC model of combining integrated health care delivery with the availability of skilled outreach professionals who are trusted by MSFWs is needed to assure care for MSFWs, regardless of general area indicators of population income or even numbers of health care providers.

If the Council can provide you any further information that may help you with your deliberations related to assuring care for MSFWs, please do not hesitate to contact us.

Sincerely,

/s/

Andrea C. Weathers, M.D., Dr.P.H.
Chair

/s/

Michael DuRussel
Vice-Chair

cc: Secretary Sebelius
Dr. Mary Wakefield
Mr. Jim Macrae
Capt Henry Lopez
Dr. Marcia Gómez