National Advisory Council on Migrant Health

January 9, 2024

The Honorable Secretary Becerra, J.D.
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Becerra,

The National Advisory Council on Migrant Health (NACMH, hereby referred to as "The Council") advises, consults with, and makes recommendations to the Secretary of Health and Human Services (HHS) and the Administrator, Health Resources and Services Administration (HRSA). Specifically, the Council is charged with reviewing the health care concerns of migrant and seasonal agricultural workers (MSAW), and the organization, operation, selection, and funding of migrant health centers (MHC) and other entities assisted under section 330(g) of the Public Health Service (PHS) Act, as amended, 42 USC 254(b), with the goal of improving health services and conditions for MSAW and their families. Please find an overview of the Council's November 2023 meeting and three key recommendations that fulfill our charge.

Overview

The Council met in-person on November 1-2, 2023, at the HRSA Headquarters in Rockville, MD. During the meeting, we received updates from HRSA senior leaders:

- Federal Update on Health Center Program Efforts
    - Jennifer Joseph, PhD, MSEd, Director, Office of Policy and Program Development (OPPD), Bureau of Primary Health Care (BPHC), HRSA
- Overview: HRSA, BPHC National Training and Technical Assistance Partnerships Serving Migrant health Centers
    - David Bates, MBA, MHCM, Lead, National Partnerships Team, Strategic Partnerships Team, Office of Quality Improvement (OQI), BPHC, HRSA

We also received the following presentations from migrant health stakeholders:

- National Association of Community Health Centers (NACHC): Update
    - Rachel A. Gonzales-Hanson, Interim President and Chief Executive Officer, NACHC

- Integrating Medical-Legal Partnerships at Migrant and Community Health Centers to Address Agricultural Worker Health Disparities
    - Bethany Hamilton, JD, Director, National Center for Medical-Legal Partnerships (NCMLP), Milken Institute School of Public Health
    - Jacqueline Baños, MPH, Senior Research Associate, NCMLP

- Overview: Farmworker Health Network
    - Allison Jones, MA, Director of Learning and Development, MHP Salud, and Chair, FHN
- Strengthening Enforcement of Pesticide Regulations for Agricultural Worker Health and Safety
    - Mayra Reiter, MSIS, MSES, MPA, Project Director, Occupational Safety and Health, Farmworker Justice
    - Alexis Guild, MPP, Vice President of Strategy and Programs, Farmworker Justice
- Eliminating Disparities Resulting from Patient Mobility
    - Deliana Garcia, Chief Program Officer International and Emerging Issues, Migrant Clinicians Network
- Digital Equity as a Social Determinant of Migrant and Seasonal Agricultural Worker Health
    - Leslie E. Cofie, PhD, Department of Health Education and Promotion, College of Health and Human Performance, East Carolina University
    - Jocelyn Romina Santillán-Deras, Digital Inclusion Projects Coordinator, NC Farmworker Health Program (NCFHP), Office of Rural Health (ORH), NC Department of Health and Human Services (DHHS)
    - Natalie D. Rivera, MPH, Broadband Access Projects Coordinator, NCFHP, ORH, NC DHHS

The American Psychological Association Services, Inc. provided public comment to draw attention to MSAW mental health disparities, the need to extend access to care, and the adoption of evidence-based integrated care for MSAW, especially older MSAW, women, and children.

The Council reviewed the information presented during the meeting, and engaged in iterative discussions about what comprehensive, evidence-based issues aligned with their experiences and concerns in their regions. Three key issues emerged, forming the content of the recommendations presented in this letter.

Recommendations

In accordance with The Council's charge under section 330(g) of the Public Health Service Act as amended, 42 USC 254(b), emphasizing the goal of improving health services and conditions for MSAW and their families, and in context of the evidence presented at this meeting, we submit the following recommendations for your consideration.

Recommendation I: Support and encourage the integration of Medical-Legal Partnerships (MLP) at Migrant and Community Health Centers.

The Health Center Program (HCP) supports the HRSA mission to achieve health equity for the nation's medically underserved populations using innovative efforts to provide access to high-quality healthcare

services. There is a growing awareness that social, structural, and economic conditions in the environments where people live, work, and age determine their health and quality-of-life outcomes and risks. It is well known that migrant and seasonal agricultural workers (MSAW) frequently labor for employers who fail to respect the minimum wage laws or practice other forms of wage theft, work under unhealthy or dangerous conditions, or are made to live in grossly substandard housing. Employment abuses in agriculture are challenging to address because farm work is not covered by many important labor protections enjoyed by most other workers in this country. Nonetheless, farmworkers can rely on some of the provisions of the federal Fair Labor Standards Act ("FLSA") and the Migrant and Seasonal Agricultural Worker Protection Act ("AWPA") to provide minimum levels of worker protections.[i] MSAW regularly experience what has come to be known as a "justice gap," in other words, unequal access to legal support. This justice gap influences evidence-based social and structural determinants of health such as access to education[ii], housing stability[iii], employment[iv], energy security[v], immigration status[vi], freedom from the threat of violence[vii], exposure to pesticides[viii], and beyond.

Medical-legal partnerships at migrant health centers (MHC) have the potential to bridge the justice gap and have a positive impact on MSAW health and welfare. A national survey of healthcare organizations and legal organizations operating medical-legal partnerships indicates that 86% of health professionals reported improved patient health outcomes due to MLP service.[ix] Yet, only 11 of the 152 (7%) federally funded MHCs currently offer this evidence-based, cost-effective, and essential health and enabling service to their patient base and catchment area.

The Council, therefore, recommends the following actions:

1. HHS addresses MSAW health equity and closes the justice gap by providing priority funding for the urgent and significant expansion of MHC sites and emphasizes MLP as a critical enabling service.
2. Provide migrant and community health centers (M/CHCs) annual training demonstrating how enabling services can successfully include "civil legal aid services" as an integral component of the health care delivery system. Additionally, provide technical assistance, including Learning Collaboratives and other incentives for existing health centers with MLP to share lessons learned with other M/CHCs.
3. Include designated start-up MLP funding within "healthcare workforce support" to include funding for paralegals and/or attorneys housed in agricultural worker serving health centers that are interested in establishing a new MLP.
4. Increase priority funding for geographic areas with legal deserts to incentivize partnerships between agricultural workers, health centers, and well-established MLP partnerships. This would expand access to legal support as an essential component of the successful delivery of health care services, thus closing the justice gaps. This could include increased funding for Health Center Controlled Networks and health centers interested in initiating an MLP.
5. Provide funding for research for strategic integration into the Migrant and Community Health Care Centers, and its effectiveness of MLP in relation to MSAW social determinants of health, health care access, health care quality, and health status.

Background

Important and growing research indicates that the justice gap has significant adverse effects on health, health care access, and health care quality of specific communities, including immigrants in general,[x]

minority groups,[xi] and MSAW specifically.[xii] Drawing from the experience of implementing MLP, research shows that "high use leads to higher costs and poorer quality outcomes[xiii]." A closer examination of health supports for high-utilizing patients reveals that challenges are "often driven by psychosocial, financial, and societal barriers to care and points to a lack of coordination between health care, social service, and civil legal aid infrastructure."[xiv]

Quality health care relies on more than the direct health care provider supports. For some time now, it has been acknowledged that factors such as 'social determinants' of health and, more recently, 'structural' contributors to health status dramatically impact individual health and well-being. Low-income and other vulnerable communities are often the most compromised. They often have less access to basic needs and opportunities and do not have equal opportunities to thrive or reach optimal health. Sanne Magnan emphasizes in her article Social Determinants of Health 101 for Health Care, "Medical care is estimated to account for only 10 to 20% of the modifiable contributors to healthy outcomes for a population[xv]. The other 80 to 90% are Social Determinants of Health."[xvi]

Many complex health-related social problems are entrenched in federal, state, and local policies and laws requiring expertise in poverty and administrative law. Through MLP, lawyers can directly resolve specific problems for individual patients while helping clinical and non-clinical staff navigate system and policy barriers and transform institutional practices. Legal assistance can also disrupt the cycle of returning people to unhealthy conditions that would otherwise bring them right back to the clinic or hospital. The health care system needs the right workforce to tackle social problems once detected. It is not only that insufficient funds are being invested in health but also where and how the money is spent. This is important when addressing medical issues without giving sufficient attention to mental health challenges associated with the social and economic conditions that contribute to poor physical health.

MLP help with complex and intractable problems; they can leverage considerable knowledge and expertise to advance local and state policies that lead to safer and healthier environments. Enabling legal services complements the medical providers' efforts to address medical issues by beginning to tackle the socioeconomic contexts and causes of poor health and, in turn, decrease the need for ongoing care. Through MLP, attorneys become an important part of the healthcare team, and their presence in various care settings is similar to that of any other specialist. In addition, MLP have been shown to save patient health care costs and recover cash benefits.[xvii]

There is great potential for health care and legal professionals to join forces to promote population health, making legal services a normative part of the healthcare system. Research on MLP illustrates the positive impact legal expertise and service can have on individual patients.

In a 2016 survey of medical-legal partnership programs noted that clinicians at their hospital or health center anecdotally reported the benefits of MLP as:

1. 85% Improved health outcomes for patients
2. 64% improved patient compliance with medical treatment
3. 38% Improved ability to perform "at the top of their license."[xviii]

MLP teams often detect patterns in patients' needs that reveal opportunities to advance policy solutions for whole communities. These programs advance health and well-being.

Medical-legal partnerships are an evolving service model where legal and health care professionals collaborate with the patient to resolve social, economic, and environmental factors that contribute to health disparities and have a remedy in legal assistance. Adding this enabling service that facilitates access to care helps all to work to the top of their license, maximizing services and decreasing negative secondary impacts.

Research illustrates many benefits of medical-legal partnerships; however, many areas where farmworkers typically reside have a notable shortage of attorneys that provide these supports.[xix,xx] This is of particular concern for farmworkers who neither have the time nor access to transportation to travel to urban centers. Decreased access to legal support in rural areas is also related to the aging of attorneys nationwide and the trend for young attorneys to work in urban areas.

Opportunity and Impact

In the calendar year 2016, MLP helped more than 75,000 patients resolve legal issues that were impeding good health, trained more than 11,000 healthcare providers to understand better and screen patients for health-related social needs, and engaged in clinic- and policy-level projects designed to improve health and health equity for entire communities.[xxi] MLP lawyers are experts in civil legal aid, advocating for patients on both an individual and a systemic level and focusing primarily on a core set of legal domains, frequently referred to by the acronym I-HELP® (income and insurance, housing, and utilities, education and employment, legal status, and personal or family stability). Clear associations exist between socioeconomic risks and health, and these risks are often amenable to legal interventions.[xxii]

By building the patient-care team's capacity to handle civil legal problems, MLP allow team members to work at the top of their license. When identified in a health care setting, civil legal problems are often detected earlier, enabling the civil legal aid community to prevent these problems before they cascade into crises, achieving better outcomes with fewer resources. When lawyers are embedded in the health care team and present during case management discussions that identify specific civil legal problems, the attorneys help the team better understand how to address them.[xxiii]

Healthcare Access and Quality - Research has assessed the impact of addressing patients' civil legal problems – social, financial, or environmental- on improved healthcare. The study of a pilot MLP illustrated that the most common legal issues affecting the health of patients were housing (preventing evictions, securing housing subsidies, and improving substandard conditions) and access to public benefits (appealing wrongly denied benefits). Other civil legal problems were related to domestic violence (securing restraining orders), access to care or coverage of health care services, and mental health/incapacity. This pilot MLP indicated that healthcare use and costs dropped when the medical-legal team addressed a patient's civil legal problems.[xxiv] The study also showed that inpatient and Emergency Department use decreased by more than 50%, and overall costs (as defined by charges) fell by 45%.[xxv] "While high use leads to higher costs and poorer quality outcomes, it is often driven by psychosocial, financial, and societal barriers to care and points to a lack of coordination between health care, social service, and civil legal aid infrastructure."[xxvi]

The data also suggested a decrease in 30-day and seven-day readmission rates among the identified patients.[xxvii] By embedding the lawyer in the health care team and being present during case management discussions, the pilot project was able to identify specific civil legal problems and help the team better

understand how to address them. Throughout the pilot, it became clear that high use was often a marker for unaddressed civil legal problems.

Income and Insurance - MLP have been shown to save patients' health care costs and recover cash benefits. A three-year study of a rural MLP provided patients legal assistance with insurance problems, Social Security benefits, family law issues, and end-of-life guidance. During the study period, the rural hospital experienced a 319% return on its investment in MLP services by recovering dollars for clinical services that were previously unable to be reimbursed before the MLP helped patients become insured. Patients also experienced a wide range of social, health, and health care benefits.[xxviii]

Housing and Utilities - One multi-year study investigated the impact of medical-legal partnership services in an academic pediatric primary care setting.[xxix] During the study period, healthcare providers at this pediatric healthcare institution made 1,808 referrals to its MLP for legal services. Patients referred were more likely to have asthma and developmental delay/behavioral disorder than the general clinic population, and the referrals were most commonly made related to problems with housing and income/health public benefits. There were positive legal outcomes in 89% of referrals affecting nearly 6,000 cohabitating children and adults and translating into nearly $200,000 in recovered back benefits for those individuals."[xxx]

Low-income households face common chronic housing problems with known health risks and legal remedies. The MLP presents a unique opportunity to address housing problems and improve patient health through legal assistance in clinical settings. Study findings suggest that providing access to legal services in the healthcare setting can effectively address widespread health disparities rooted in problematic housing.[xxxi] Energy insecurity, specifically, produces adverse health consequences. In one study of a hospital-based pediatric practice that added an MLP, utility certification requests and approvals increased by 65%, preventing utility shut-offs for hundreds of families with vulnerable children.[xxxii]

In addition, MLP can shift professionals' awareness - potentially including cultural and structural competence - as they work to improve housing and health trajectories for indigent groups using legal approaches.[xxxiii]

Including a lawyer on the healthcare team is a key element of the medical-legal partnership approach, which integrates the expertise of healthcare, public health, and legal aid professionals to address and prevent civil legal problems affecting health.

Recommendation II: Develop funding opportunities that support comprehensive, integrated, multi-level approaches to support positive mental health outcomes and provide inclusive, culturally, and linguistically relevant care that is designed to address the unique mental and substance use needs of agricultural workers and their family members.

Following BPHC's three strategic priorities for fiscal year 2024, grounded in the Health Center Program mission (Priority 1: Strengthen health centers to address critical and emerging health care issues and the evolving health care environment. Priority 2: Activate and accelerate evidence-based and innovative or new high-value models of care delivery for underserved and vulnerable populations. Priority 3: Expand the reach of the health center model of care in the nation's neediest communities and populations),[xxxiv] we recommend that preeminence is given to funding applicants that propose increasing the number of

behavioral health specialist enabling staff. Incorporating behavioral health specialist enabling staff should follow a different model tailored to serve the diverse needs of MSAW population across the US.

These models could include, but are not limited to, care coordination teams, in-person and virtual peer support services, as well as mobile mental health services, tele-behavioral health, tele-behavioral health assisters to assist with digital navigation, digital health and literacy activities, and targeted approaches for older agricultural workers, adolescents, and women. Furthermore, applicants who include flexible hours to meet the needs of MSAW patients, including bonus pay for all staff providing services after 6 p.m. and on weekends, supplies and activities aimed at reducing isolation, stress, anxiety, and depression and increasing community engagement and physical activity, should be prioritized above all. This includes applicants who propose opportunities for community activities designed to act as protective tools for mental health, reducing isolation, stress, anxiety, and depression and increasing community engagement and physical activity. These may include community-based events, teaching and training, digital health and literacy activities, and targeted approaches for older and retired agricultural workers, adolescents, and women.

An innovative perspective developed in 2014 by Helena Hansen and Jonathan Metzl, which can provide a framework to improve the quality of mental health services in alignment with BPHC's priorities, is that of structural competency.[xxxv] A viewpoint rooted in structural competency integrates knowledge from the social sciences and humanities along with insights from social medicine, which perceives health as intricately linked to social and economic circumstances. While cultural competency centers on recognizing individual biases, structural competency broadens this perspective to encompass the economic and social frameworks that underpin health outcomes.[xxxvi] With a structural emphasis approach, clinicians, medical educators, and enabling staff are more able to identify the problems facing MSAW patients, as well as to design innovative paths to address new problems and be active participants in the development of training, education, integrations of clinical care with community advocacy, and collaborations between clinicians and organizations such as migrant workers groups and immigrant rights groups. Thus, we recommend that this is included as part of the training and education for medical practitioners and health center staff towards a shift in perspective where healthcare providers view cultural presentations and health behaviors through a structural lens to recognize how social structures contribute to inequalities and affect access to healthcare. As part of these efforts, fostering programs that facilitate collaboration with experts from diverse fields such as sociology, anthropology, law, and public health to gain a comprehensive understanding of structural determinants impacting healthcare.

The Council, therefore, recommends the following actions to expand the reach and approach of the health center model of care in the nation's highest-need communities and populations:

1. Strengthen health centers through additional funding to address critical and emerging healthcare issues and the evolving healthcare environment and incorporate behavioral health specialist enabling staff into care coordination teams and activate and accelerate evidence-based and innovative or new high-value models, like including structural competency as a new frame for medical education, training, and institutional analysis of care delivery for underserved and vulnerable populations.
2. Integrating structural competency in medical and health center staff education with an emphasis on interdisciplinary work that delves into the complexities of social, economic, and political structures impacting health outcomes.

3. Provide ongoing training that emphasizes understanding the intersections between broader societal forces and patient care affecting MSAW and broadening clinical perspectives to foster an understanding of how external elements such as policies, institutional norms, and societal determinants shape health experiences.
4. Health Centers employ bilingual and bicultural staff, interpreters, or language interpretation services to address common challenges faced by MSAW like language barriers, stigma on mental health, fear of immigration related consequences.
5. Utilize mobile health units to reach workers who have limited access to transportation to make mental health services easily accessible, readily available and less time-consuming for farm workers, given the nature and demands of their work. This could also address the lack of digital inclusion that many MSAW experience.
6. Integrate mental health screenings into their routine healthcare services to effectively identify early signs of depression, anxiety and other mental health conditions, enabling timely intervention and support.
7. Strengthen policies and programs to address the mental health needs of MSAW through investments in initiatives that promote social inclusion, reduce isolation, decrease mental health disparity, create opportunities to establish connections and access support.

Background

Behavioral health is a consistent and increasingly prioritized topic of concern among those working with agricultural workers. The Migrant Clinicians Network acknowledges it is "one of the most important and challenging issues facing migrant and agricultural workers in the united States."[xxxvii] Agricultural workers and their family members face increased risks associated with their living and working environments, which can compromise their health and wellness, especially when they experience isolation, discrimination, barriers to care, and limited social support, all of which are exacerbated by migration. The COVID-19 pandemic, social and economic insecurities, and weather changes may create additional stressors and minimize protective factors affecting workers' resiliency and healthy coping mechanisms.

Prior to the pandemic an examination of data of 915,725 agricultural workers and their family members who received health care services at Migrant Health Centers in 2019 found that mental health disorders were one of the most commonly reported diagnoses.[xxxviii]

To ensure the holistic health and well-being of agricultural workers, it is of utmost importance to devise comprehensive strategies that effectively educate them about the significant impact of mental health. This entails addressing various challenges such as language barriers, limited transportation options, the stigma surrounding mental health, apprehensions regarding immigration-related matters and their consequences, as well as opposition towards ongoing care for migrant and seasonal farm workers.

Traditionally, the Social Determinants of Health (SDH) has worked as a clinical and research frame that encompasses non-medical factors, like environmental conditions where people are born and live, affecting a wide array of health outcomes and risks, thus significantly impacting health disparities – the unjust differences in health within and among nations.[xxxix]

However, a newer approach, Structural Competency, challenges this framework. It suggests that various health factors, previously associated with environment, culture, or ethnicity, stem from larger structural contexts. These include decisions concerning healthcare systems, food distribution, zoning laws, local

politics, urban infrastructures, biases, and even core definitions of health and illness. Solely focusing on SDH, therefore, leaves healthcare providers ill-prepared to address the biological, socioeconomic, and racial effects of decisions shaping these structural elements, further widening health and wealth gaps.[xl]

The barriers to mental health and substance use disorder services are significant for agricultural workers and their family members, including the lack of service providers with the cultural and linguistic background of farmworker patients and scarce evening hours for behavioral health services. In addition, the reliance on digital access and literacy that became essential during the pandemic to meet social and health needs has been sustained. The lack of digital inclusion for agricultural workers compromises their health and wellness, contributing to increased isolation and lack of access to care. Digital inclusion is now seen as a "super social determinant of health" because of the reliance on internet access and navigation. In the Digital Equity: Social Determinants of Agricultural Workers' Health presentation, testimonies from farmworkers were shared about how access to the internet and the ability to communicate with friends and family reduced feelings of isolation, a risk factor for poor mental health.

The mental health needs of MSAW and their families require strategies that encompass various factors influencing health across the patient's life, as indicated by the National Center for Farmworker Health. A structural competency approach emphasizes that mental health isn't separate from other interacting factors, such as toxic stress, which affects both mental and physical health and is influenced by societal elements and larger structural contexts. Reframing "mental health services" as accessible within communities, especially in rural areas with limited mental health resources, is vital. Behavioral health interventions for MSAW must consider the heightened risks, compromised protective factors, migratory nature of a large portion of the population, and unique and varied needs of different ages and regions. Interventions should focus on responding to acute needs and establishing opportunities for the agricultural community to reestablish protective factors and reduce feelings of isolation, exclusion, and discrimination through group activities and community connections. Therefore, educating family members, friends, teachers, clergy, etc., in early detection and screening for mental health distress in places like camps, schools, churches, and agricultural co-ops can be effective, building community resilience and social ties as protective factors and self-monitoring as a form of health agency. Programs like the USDA's Farm and Ranch Stress Assistance Network offer flexibility to meet unique rural community needs.[xli]

Opportunities and Impact

Behavioral health specialist enabling staff can assist with identifying workers, building rapport and trust, continuously assessing patients' behavioral health needs, assisting with warm referrals, serving as a telehealth assister, and providing crucial information to the care team to help ensure integration of care and continuity of services, as well as promote community-lead interventions as indicated above. Digital navigators can help address the digital divide and contribute to digital health and health equity.

Similarly, an approach from the lens of structural competences can support the efforts of all enabling staff and medical providers, facilitating a deeper, more complex and rich understanding of the realities and experiences MSAW face when dealing with mental health challenges in particular, and all health-related challenges in general. Research demonstrates that despite the integration of cultural competency into health care professional education and practice, health care providers struggle to understand how health systems contribute to health inequities, such as those shaped by racism, racialization, and isolation.[xlii] Therefore, an approach to mental health that includes a structural competency framework can improve the

quality of the services provided and the data collected to further advance the priorities and programs supported by BPHC.

Given the complexities of the needs and the challenges to access care, Dr. Rosado, in his presentation at the November 2023 Meeting, recommends "reframing "mental health services" as something people find not just in a traditional office but in their community." This could involve expanding behavioral health assessment and a broader range of services to provide interventions and treatment. The National Center for Farmworker Health also acknowledges that identification, treatment, and overcoming behavioral health issues among agricultural workers can be difficult due to the numerous barriers to care they experience.[xliii]

Therefore, an area in particular need of attention for MSAW, behavioral health, could greatly benefit from a structural competency approach. Over the past few years, HHS and HRSA have been able to document the increasing need for behavioral health across communities, including MSAW, and have allocated resources to tackle what is now a mental health crisis across the nation.

Recommendation III: Confront obstacles to accessing healthcare through initiatives that change entrenched patterns of unequal access to and differential quality of care for MSAW.

Unique and widely preventable social and structural factors impede access to care and impact the health and welfare of Migrant and Seasonal Agricultural Worker (MSAW) populations across the country. Agricultural workers face diverse workplace hazards, including injury from machinery and repetitive motion and illness from exposure to zoonotic disease, pesticides, and heat. Additionally, MSAW often lack access to care on account of mobility, stigma experienced in receiving communities, provider shortages at the health centers experienced in caring for MSAW, cultural and language barriers, and structural biases. Agricultural workers also face numerous obstacles to receiving health care, including lack of transportation, lack of paid sick leave, risk of job loss if they miss work, and human trafficking. Low wages, harsh working conditions, and a lack of legal protection, combined with an ever-increasing demand for cheap labor, have resulted in growing numbers of forced labor abuses.[xliv]

Through this set of recommendations, the Council draws the Secretary's attention to three access-impeding issues that HRSA can address through its oversight of the Health Center Program with the necessary support from the Secretary's office.

Recommendation III A

Support methods to increase retention, recruitment and training needs of Federally Qualified Health Centers to improve services for MSAW by addressing the current retention, recruitment and talent gaps in our healthcare system.

Migrant and Community Health Centers face challenges in recruiting providers and staff often due to their patient populations, geographic locations, budgetary constraints, and the physician shortage facing healthcare as a whole. This is a multi-faceted issue caused by many problems such as growing populations and aging demographics, physician retirements, the increase in healthcare needs, geographic disparities, provider burnout, and training pipeline challenges.

Therefore, the Council recommends that HRSA implement the following strategies to support the

retention, recruitment and training needs in our healthcare system:

1. Secretary works with Congress to ensure stabilized Federal funding for Migrant and Community Health Centers through the annual budget process to provide centers with the ability to prepare budgets more accurately, schedule staff pay increases and better storm the effects of inflation and environmental stressors regarding pay in the private sector. This would increase the capacity of health centers to prioritize those situations when HRSA strategizes rolling out new monies.
2. HRSA initiate cross-sector initiatives, including working with recruiting firms to contract with providers before they complete residency and engage in bidding wars for the highest dollar to sustain M/CHCs in their role as the nation's health care safety net.
3. HHS find new pathways to fund and support HRSA to address the attrition of health care workers serving at migrant and community health centers and recruits seeking employment by enabling health centers with resources to provide competitive compensation in keeping with the health care market forces and meeting providers' demands for work/life balance. The cost of recruiting and retaining providers and all staff in health centers is prohibitive with current funding levels. Urgent action is necessary to address provider burnout, but M/CHCs lack the resources needed.
4. Implement protocols for staff and providers to have more flexible scheduling, adequate support staff, and manageable patient loads, attracting those seeking a better work-life balance.
5. Invest in technology and automation to streamline administrative processes to lift the burden of duties that lead to burn out and impact retention.
6. HHS, Centers for Medicare & Medicaid Services, and HRSA collaborate to implement emergency solutions to address the provider shortage crisis in medically underserved areas (MUA) of the US by establishing agreements and lifting individual state compliance and licensing requirements to allow physicians and dentists to practice in MUAs. In addition, HRSA and Commissioned Corps of the U.S. Public Health Service (USPHS) initiate unconventional collaborations that encourage states to adopt a universal simplified enrollment/credentialing process for USPHS providers to be able to serve across state lines and bill and receive payment for services rendered in a timely fashion.
7. HRSA increase investment in Teaching Health Centers (THC) to help alleviate provider shortages and increase the availability of a culturally informed workforce to address the health care provider shortages created by a lack of providers trained in primary care.
8. Revise programs and policies to invest in and expand support for foreign medical school graduates and physician Visa Sponsorships, as many programs are already in place (e.g., CONRAD 30) but very limited.
9. Invest in programs currently underway (e.g., California Medical Arts Assembly Bill 1045) to replicate successful models that address shortage of healthcare providers in medically underserved communities.

Recommendation III B

The HHS family of agencies collaborate in their areas of specialization to study and strike at the root causes to bring down cultural and linguistic barriers that impede the health and welfare of MSAW and other underserved communities.

Disparities in health care quality can result from a combination of factors at the patient, health worker, and service levels. In particular, the healthcare worker-patient relationship has been documented as

playing an essential role in patient care. Healthcare workers' attitudes and biases toward MSAW and other underserved patients influence their behavior, medical decisions, quality of care, and health outcomes. Therefore, the HCP training and technical assistance efforts must include opportunities to improve health center staff competencies to deal with culturally diverse populations, promote quality of health care, and obtain positive health outcomes for MSAW patients. The interaction between health workers and patients from ethnic minorities is influenced by socio-demographic and cultural background, expectations of health care, language barriers, and communication difficulties. Studies also indicate that the health worker-patient relationship may be mediated by health workers' beliefs, perceptions, and attitudes toward MSAW. Attitudes toward immigrants and negative stereotypes have been associated with health workers' characteristics, professional experience, and lack of knowledge and competencies to deal with cultural diversity.

Therefore, the Council recommends that HRSA implement the following strategies to help mediate cultural and linguistic barriers:

1. Provide M/CHCs with priority points for funding, incentives, and/or quality badges for providing culturally informed care.
2. Invest in culturally informed enabling services (e.g., Mobile clinic units, telehealth services, partnerships with culturally competent mental health professionals) to improve the engagement of MSAW.
3. Require M/CHC to employ linguistically appropriate staff to provide outreach, intake, and transportation services for MHW.
4. Require M/CHCs to maintain open access in appointment schedules to accommodate same-day appointments for MSAW during peak seasons.
5. Provide incentives to health centers that provide health care (via telehealth, mobile health services) at farm locations after hours during harvesting season.

Recommendation III C

BPHC work with National Training and Technical Assistance Partners (NTTAPs) to review and integrate Structural Competency as a training category.

Structural and cultural competency training is essential for health center staff to provide quality care for MSAW as well as all health center patient populations. It is also recommended that non-bias communication training be highlighted in the existing NTTAP trainings as required learning for health centers. This would support the ongoing development of providers and medical staff at health centers in the United States.

1. Review structural competency as a topic of interest for National Technical Training Assistance Partners (NTTAP) to incorporate into new and existing trainings for ongoing development of providers and all staff at health centers.
2. Require NTTAPs to provide non-bias communication training to all funded health centers.

Background:

Health Centers have only received flat baseline funding for the past 13 years while the COVID-19 pandemic and inflation have driven up costs substantially. While additional Federal funds were made available during and after the COVID-19 pandemic, these have since sunset, but the programs instituted by the health centers during that time have continued to a major extent (e.g., payroll, supply increases). Continuing Resolutions as passed by Congress create a great deal of anxiety amongst the administration and staff of health centers. Many across the U.S. are either cutting services and staff or totally closing health centers. This has a direct and detrimental impact on the underserved patients that they are obligated, both legally and morally, to serve.

Health centers are well-positioned to meet the needs of medically underserved communities. To do so, increased investment is needed for health centers to expand their network of providers and to ensure that frontline staff are able to provide quality care efficiently and effectively through improved technologies. Health centers rely on federal funding to provide care to patients on a sliding fee scale. Though federal funding has increased by 14% since 2015, the per-patient, inflation-adjusted value of health center funding has declined by 27%.

The number of medically disenfranchised people has nearly doubled from 56 million in 2014. This increase is attributable to consolidation across the health system and a worsening shortage of primary care providers, driven by increased provider specialization, an uneven distribution of providers, and mass resignation following the COVID-19 pandemic.

The council has previously noted needs in the realm of learning and development in previous letters and finds that there are continued opportunities to be highlighted for improvement. As the medical field develops and providers are more conscious of the kind of care patients need, it is always best practice to consider new models of thinking. As a council, it has become increasingly popular in certain areas to discuss the concept of structural competencies, as described in Recommendation II. This concept by itself is an important model to take into consideration as it can provide insight on the root causes of health disparities that are experienced by migrant and seasonal agricultural workers (MSAW).

It has also come to the attention of several council members that there is a need for better training on non-biased communication for all staff. An example of this would be when clinical or administrative staff are working with indigenous MSAW groups that visit health centers. The barriers that these patients face is due to the inexperience of staff when interacting with non-familiar patient groups at their clinics. The ability to be professional and welcoming to all patients should be a cornerstone for all health centers.

Opportunities and Impact

With additional funding, health centers could extend their network of providers into medically disenfranchised communities to provide affordable, high-quality care to more patients.

Investing in innovative and successful pilot programs, like California Medical Arts Assembly Bill 1045, with the purpose of replicating the model across the country, would help address the workforce shortage in our highest-need communities. California Medical Arts Bill AB 1045 is an agreement at the state level between the state of California and the National Autonomous University of Mexico Medical school. The program is collaborative joint research one where physicians rotate 3-year rotations within

the state at M/CHCs. In its infancy, the idea was to address the lack of Spanish speaking healthcare providers. Over the years it has now helped address the shortage and lack of healthcare providers as challenges have evolved. The program is in its pilot phase and has had great success with patient experience and quality of care based on the feedback inquiries made at M/CHC level. While this program can help address the recruitment challenges faced by M/CHCs and the provider shortage on a national level, it is only a temporary solution to a permanent problem, a more effective long-term approach is revising, changing, and expanding existing programs.

Expansion of existing federal programs are also necessary to address the gap in culturally competent providers. Working with the U.S. Citizenship and Immigration Services to revise, change, or expand CONRAD 30 relative to state needs, demographics and populations is another opportunity to fill the gap in providers in various underserved communities serving MSAW. CONRAD 30 is a federal program in the United States that allows J-1 visa waivers for foreign physicians who commit to working in underserved areas, often rural and medically underserved for a certain period of time. The program is named after section 220(c) of the Immigration and Nationality Act, it permits the waiver of the two-year home residency requirement for J-1 Visa holders in exchange for service in underserved communities. The program only has a very limited number of 30 slots per state, which is nowhere near sufficient to fill our shortage and the state is disproportionately populated with very different needs, resulting in varying degrees of success in different states. Expanding this program could be effective in addressing the shortage in healthcare professionals in medically underserved communities by allowing International Medical Graduates who have completed their residency training in the United States to remain in the country to be part of the healthcare workforce. It is extremely limited.

Additionally, the opportunity for NTTAPs to prioritize training topics on structural competency, in addition to cultural competency and non-bias communication, is crucial to addressing the needs of MSAW patient populations as well as all communities that health centers serve. NTTAPs are uniquely positioned to ensure that all health center staff receive mandatory ongoing training to develop a deeper understanding of the populations they serve and to provide quality and competent care for all underserved communities.

In closing, we appreciate the honor of serving on the National Advisory Council on Migrant Health. The Council recognizes the valuable role that agricultural workers play in our economy and in our country's domestically produced food supply. We thank the Secretary for your service and for your consideration of our recommendations on behalf of those we serve.

Sincerely,

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cc:
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