

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

**November 14-15, 2018
Bethesda, Maryland**

Council Members in Attendance

Adriana Andrés-Paulson (Acting Chair)
Rogelio Aguilar
Sharon Brown-Singleton
Susana Castro
Daniel Jaime
Christopher LaBarge
William Morgan
Amanda Phillips Martinez
Deborah Salazar
Gary Skoog
Shedra A. Snipes

Federal Staff

Strategic Initiatives and Planning Division (SIPD), Office of Policy and Program Development (OPPD), Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS):
Amanda Ford, Senior Advisor, OPPD
Iran Naqvi, MBA, MHS, Deputy Division Director, SIPD
Esther Paul, MBBS, MA, MPH, Designated Federal Official (DFO), NACMH; Public Health Analyst, SIPD

WEDNESDAY, NOVEMBER 14, 2018

Call to Order

Adriana Andrés-Paulson, MSW, MA, MPA, Acting Chair, NACMH

Ms. Andrés-Paulson called the meeting to order and noted that the NACMH chair, Horacio Paras, was unable to attend the meeting due to illness.

Ms. Andrés-Paulson called for a motion to approve the meeting agenda for the current meeting and minutes from the May 2018 NACMH meeting. The motion was made by Ms. Castro, seconded by Fr. LaBarge, and carried by unanimous voice vote.

Federal Update

Jennifer Joseph, PhD, MEd, Director, OPPD – remote presentation

Dr. Joseph reviewed the mission, strategic goals, and funding priorities of the health center program (HCP) and provided an update on federal policies related to migrant health centers.

The mission of the HCP is to improve the health of the nation's underserved communities and vulnerable populations. The program's strategic goals are to increase access to care, advance quality and impact, and optimize operations.

More than 27 million people—one in 12 people across the United States—rely on a HRSA-funded health center for care, including more than one million agricultural workers.

In fiscal year 2018 (FY 2018), BPHC awarded \$568 million to health centers through five programs:

- Expanding Access to Quality Substance Use Disorder and Mental Health Services: 1,232 awards totaling \$352 million, including 157 awards to Migrant Health Centers (MHCs)
- Quality Improvement: 1,353 awards totaling \$125 million, including 174 awards to MHCs
- Capital Assistance for Hurricane Response and Recovery Efforts: 161 awards totaling \$59 million, including 30 awards to MHCs
- Advancing Precision Medicine: 46 awards totaling \$21 million, including 125 awards to MHCs
- Enhancing Behavioral Health Workforce supplement: 54 awards totaling \$11 million, including two awards to MHCs.

BPHC funding for FY 2019 is \$5.6 billion, which is nearly half of HRSA's total budget of \$11.7 billion and represents an increase of \$100 million over FY2018 funds. Nearly 80 percent (\$4 billion) is mandatory funding. The budget includes \$200 million for services to treat substance use disorder (SUD).

Integrating behavioral health and primary care is a major priority for BPHC. Nearly 90 percent of HRSA-funded health centers provide mental health services, and more than two million patients received those services in FY 2017.

Investments in the health center program have resulted in significant cost savings. Medicaid enrollees who receive care at health centers have lower use, and lower costs per patient, than non-health center patients, resulting in an estimated savings of up to \$10 billion annually.

Data from the HRSA Uniform Data System (UDS) for 2017 show a five (5) percent increase in the number of patients who accessed health centers, a six (6) percent increase in the number of visits, and an eight (8) percent increase in the number of providers. Nearly all health centers (99.9 percent) showed an improvement in at least one or more clinical quality measures, and 1,268 health centers met one or more of the Healthy People 2020 (HP2020) goals, an increase of 24 health centers over last year. Nearly one-quarter met or exceeded a clinical quality benchmark for at least one racial/ethnic minority group.

Health centers expanded the delivery of comprehensive services in 2017, and utilization increased for all services. The significant increases in the use of SUD, mental health, and vision services could reflect additional investments in these services.

The health center workforce expanded by 19 percent between 2015 and 2017. BPHC would welcome recommendations from the Council regarding ways to support workforce development for MHCs.

In 2017, health centers served 972,251 migrant and seasonal agricultural workers (MSAWs). However, the percent of MSAW patients served remained at four (4) percent while the total number of MHC patients increased steadily from 2015 to 2017. The proposed public charge rule and the level of provider satisfaction at MHCs present challenges for increasing the number of MSAW patients.

The number of MHC patients who received services for mental health conditions in 2017 was six (6) times higher than the number who received services for alcohol and other substance-related disorders and three (3) times higher than the number of patients who received services for tobacco use disorders. The notable increase in MHC patients who received services for anxiety disorders, including post-

traumatic stress syndrome, and the number of patients who received screening, brief intervention, and referral to treatment (SBIRT) from 2015 to 2017 could reflect additional investments in those services.

Data on outcome measures show that MHCs are keeping pace with other health centers in increasing the percent of patients with controlled high blood pressure and controlled diabetes. That is significant, given the additional complexity of MHC patients.

Health centers are encouraged, but not required, to provide medication-assisted treatment (MAT) for opioid use disorders. The significant increase from 2015 to 2017 in the number of patients receiving MAT, the number of providers who are eligible to prescribe it, and the number of health centers that provide it demonstrates that health centers can respond quickly to the opioid epidemic.

HRSA is looking at strategies to encourage health centers to expand their use of telehealth. The number of health centers offering telehealth services increased by 38 percent from 2016 to 2017. Half of all MHCs provided telehealth services in 2017.

Nearly all health centers (97 percent) have an electronic health record (EHR) system at all sites that is used by all providers. Three-quarters of all health centers used EHR to report on all patients for all clinical quality measures in 2017.

The Bipartisan Budget Act (BBA) included statutory changes that place a greater emphasis on compliance with all requirements of the health center program. HRSA provides resources and tools to ensure continuing compliance, including an updated compliance manual and site visit protocol, and HRSA staff work closely with health centers to prepare them for site visits and to help them respond quickly to site visit findings.

BPHC is developing a new, holistic Service Area Needs Assessment Methodology (SANAM) that utilizes socioeconomic data and direct measures of health. Four prototypes have been tested and BPHC is in the process of finalizing the methodology in future.

HRSA is modernizing the UDS to reduce the reporting burden, improve the quality of data, and promote a transparent process for making changes to the system.

Discussion

- Ms. Castro asked if the new SANAM had been finalized and when it would be implemented.
 - Dr. Joseph replied that HRSA had decided on the methodology and was prepared to use it for a New Access Point competition, when one is conducted.
- Ms. Brown expressed concern that some health centers do not count/include clinical indicators for MSAW patients in their UDS submissions because it could bring down their quality measures.
 - Dr. Joseph said that was not in accordance with HRSA policy. HRSA is moving toward requiring health centers to use EHR to submit their UDS reports.
- Mr. Morgan asked if the HCP Compliance Manual includes a process to capture feedback from health center chief executive officers (CEOs).
 - Dr. Joseph replied that BPHC updated the compliance manual this year to respond to changes required by the BBA and intends to update it annually. The manual includes a section to obtain feedback. Dr. Joseph also encouraged CEOs to send comments to her directly.

Welcome/Introductions

Esther Paul, MBBS, MA, MHS, DFO, NACMH

Ms. Paul welcomed Council members, staff and guests, and conducted a round of introductions.

Welcome

Iran Naqvi, MBA, MHS, Deputy Director, SIPD, OPPD, BPHC, HRSA

Ms. Naqvi welcomed Council members and staff to the meeting. She thanked Council members for sharing their work and experience to strengthen the Council's recommendations to the Secretary of HHS and for developing an agenda that reflects the significant health care gaps and challenges facing MSAWs. She thanked BPHC and OPPD leadership for their support, acknowledged OPPD staff for assistance with travel and meeting logistics.

Ms. Naqvi thanked Ms. Paul for her commitment to the Council in her role as DFO, and she honored retiring Council members Horacio Paras, Adriana Andrés-Paulson, Susana Castro, Christopher LaBarge, William Morgan, Amanda Phillips-Martinez, and Stephanie Triantafillou.

Ms. Naqvi read a short story about migrant farmworkers and thanked NACMH members for their service on behalf of MSAWs and their families.

Council Listening Session with Policy Division, OPPD, BPHC, HRSA

Leaders

Sharon Brown-Singleton, Member, NACMH

Dalana Johnson, Public Health Analyst, Policy Division, OPPD

Lisa Wald, Public Health Analyst, Policy Division, OPPD

Ms. Brown-Singleton moderated a discussion of priority topics identified by the Council.

Governance and Board Authority

Council members discussed recruitment and retention of farmworker consumer board members for MHCs.

- Ms. Johnson stated that requirements for health center governance are laid out clearly and provide flexibility for MHCs. She noted the Council had expressed concerns regarding recruitment and retention of consumer board members.
- Ms. Brown-Singleton said a key issue is how to get farmworker consumer board members involved so they know they are important.
- Ms. Andrés-Paulsen said that reimbursing board members for lost wages or expenses such as child care or transportation is a challenge because HCP policy states that lost wages cannot be reimbursed if the board member's family income is more than \$10,000 per year.
 - Ms. Johnson stated that the income cap for reimbursement applies to health centers funded under Section 330E. MHCs that only receive section 330(g) may use projects funds to reimburse governing board members for wages lost because of participation on the governing board, irrespective of annual income.
- Mr. Morgan stated that it is difficult for his health center to meet the requirement to have consumer board members because most farmworkers are only in the area for eight weeks, and many of them do not speak English.
- Fr. LaBarge said health centers in his area face the same problem. Attendance requirements also present a challenge, because it can be difficult for MSAWs to attend every board meeting.

- Ms. Castro stated that her health center serves four different geographic areas. Transportation and weather can make it difficult to attend meetings. Some board meetings are held by phone to make it possible to achieve a quorum. There has been significant turnover among newer members, although long-term members continue to serve.
- Ms. Brown-Singleton asked about challenges to retaining consumer board members.
 - Mr. Morgan cited the need to feel comfortable serving on the board.
 - Ms. Andrés-Paulsen replied that many consumer board members feel overwhelmed by the amount of information they have to learn. Her health center offers training, but it is difficult for farmworkers to take time off without pay.
 - Ms. Salazar said many farmworkers do not have support from their employers to attend meetings, even when they are held in the evening.
- Dr. Snipes cited the continuous nature of farm work and noted that asking workers to take time off can jeopardize their employment. We need to develop a new model and encourage employers to provide time off to attend board meetings.
- Mr. Jaime noted that patients who are MSAWs might not be aware that they can serve on the board. It is important to inform them.
- Fr. LaBarge stated that advocates who work with MSAWs could represent their concerns, but they do not meet the requirements for consumer board members.
- Ms. Jaime stated that health centers need to have a clear definition for proper identification of MSAWs to ensure that grant funds are used appropriately.
- Ms. Andrés-Paulsen agreed that it is important to have a clear definition of MSAW and to encourage employers to support farmworkers who serve on boards.
- Mr. Skoog said that MSAWs are often intimidated by the idea of serving on the board due to challenges such as knowledge, education, language, and the time commitment.
- Ms. Castro noted that a valuable consumer board member at her health center was unable to attend meetings because her employer would not excuse her absence.

Telehealth

Council members discussed barriers and opportunities related to the use of telehealth.

- Fr. LaBarge noted that Medicare and Medicaid funds are distributed by state agencies, and Maryland does reimburse mental health services provided by telehealth. He also expressed concern about disparities in HCP grant funding between urban and rural areas.
- Ms. Andrés-Paulsen stated that her center provides services by telehealth even if they are not reimbursed, because care is more important than payment. Challenges include technology, including the cost of equipment; availability of dedicated space for telehealth sessions; and provider training. There has been pushback from some providers at her center.
- Ms. Wald noted that about half of all health centers provide mental health services by telehealth, but many centers find it challenging. She asked the Council for examples of opportunities to increase the use of telehealth.
 - Mr. Aguilar stated that reimbursement for telehealth services would be important in Idaho, especially for mental health.
 - Mr. Morgan said his health center does not have any Spanish-speaking mental health providers, so they have to rely on interpreters. Telemedicine would enable them to utilize providers who speak Spanish.
 - Ms. Andrés-Paulsen emphasized the need for continuing education for providers at all levels to learn how to utilize telehealth, the need for providers to be culturally

competent, and the need for licensing reciprocity so centers can utilize providers in another state.

- Ms. Wald noted that HRSA's Bureau of Health Workforce (BHW) funded partnerships between health centers and academic medical centers in 2017 to train providers to utilize telehealth. That program should have an impact in the near future.
- Ms. Brown-Singleton asked if Council members had experience with tele-monitoring.
 - Ms. Phillips-Martinez replied that a program in South Dakota was tracking mothers with gestational diabetes, but they could not upload the data directly.
 - Fr. LaBarge noted that cell phone coverage becomes more difficult close to state lines, which poses as a barrier especially in rural areas.
 - Dr. Snipes stated that her research group uses cellphone apps to assess the health behaviors of MSAWs. Participants are given a phone, which they return at the end of the study. Data stored in the app are uploaded when the participant is close to a cell tower. Researchers use text messages to remind participants to submit their data.

Workforce

Council members discussed how MHCs could address provider turnover.

- Ms. Andrés-Paulsen said her center has a program to promote interest in health care careers among minorities. She stressed the need for incentives to attract providers, such as loan repayments for mental health providers or housing.
- Ms. Castro stated that providing competitive salaries are a challenge. She suggested that recruitment should begin at medical schools and nursing schools, because students are more altruistic.
- Fr. LaBarge noted that a provider might be willing to relocate, but there may be no employment opportunity available for their spouse.
- Mr. Morgan stated that every psychiatrist in his area is from South Asia, because their visa requirements stipulate that they must serve in a rural area.
- Ms. Andrés-Paulsen expressed concern that mental health providers do not always have hospital admitting privileges.
- Mr. Skoog stated that his health center found it easier to hire behavioral health providers than dental or primary care providers. He noted that medical schools often have clubs for students in various specialties. He suggested that health centers consider providing a hiring bonus and highlight educational and cultural resources in the community.
- Fr. LaBarge noted that his health center struggles with retention of midwives and obstetricians due to the time commitment and irregular hours.

Outreach and Enabling Services

Council members discussed challenges related to outreach and enabling services.

- Fr. LaBarge noted that his health center wanted to offer Sunday hours, but many farmworkers go shopping on Sundays. He added that reimbursement for outreach services is challenging.
- Ms. Andrés-Paulsen stated that some MSAW employers are reluctant to let outreach workers come onsite. Farmworkers are often reluctant to use mobile clinics due to the presence of immigration authorities in the vicinity.
- Ms. Brown-Singleton stated that outreach is a required service, but the compliance manual does not address how to meet that requirement. She asked the Policy Division staff how health centers were held accountable for identifying MSAW patients.

- Ms. Salazar stated that her health center struggles with funding for outreach tools.
- Mr. Jaime stated that outreach is needed to connect health centers with employers that contract for H2A visa workers. Workers do not receive screenings unless they are sick, it is difficult for them to get time off to see a doctor, and they often pay out of pocket because they do not know that they could receive services at no cost if they identified themselves as MSAWs.
- Ms. Castro said her health center conducts outreach visits before work starts or during the lunch hour. The arrangement is not ideal, but they have access to the workers.
- Ms. Johnson asked Council members for their suggestions on how to increase population of MSAWs served at MHCs.
 - Ms. Salazar replied that her health center invites growers to participate in programs throughout the year and participates in events sponsored by growers.
 - Ms. Andrés-Paulsen stated that San Diego County Health Department holds programs on farms, such as “Love Your Heart” day on February 1, where they conduct screenings and provide information on services.
 - Mr. Jaime said his center has partnerships with community agencies and includes them in monthly meetings.
 - Mr. Skoog stated that outreach workers at his health center took the new CEO to visit a farm so she would be familiar with their work. The health center gives farmworkers bicycle lights as an incentive to build relationships.
 - Mr. Aguilar said his health center partners with community organizations such as Catholic Charities and St. Alfonso Hospital and highlights them at their annual gala.

Ms. Wald thanked Council members for their suggestions and said she would share their comments with her colleagues at BPHC and HRSA.

Ms. Johnson thanked the Council for the opportunity to meet with them and understand what HRSA can do to help this important population. She assured them that she would respond to their concerns, especially with issues related to the compliance manual.

Overview: HRSA, BPHC National Cooperative Agreements Serving Migrant Health Centers

Tia-Nicole Leak, PhD, Team Lead, National Partnership Team/National Cooperative Agreements, Office of Quality Improvement, BPHC

Dr. Leak provided an overview of the national cooperative agreements (NCAs) that provide training and technical assistance (TA) to help MHCs increase access to care, improve health outcomes, and promote health equity for MSAWs:

- Farmworker Justice provides training and TA related to federal and state policy and legislation impacting access to health care for agricultural workers and their families, with a focus on environmental and occupational health and the H2A Agricultural Guest Workers Program
- Health Outreach Partners provides training and TA on outreach and enabling services (e.g., transportation), program planning and development, needs assessments and evaluation, and community collaboration, particularly targeting MSAWs.
- Migrant Clinicians Network provides training and TA on all aspects of clinical care and issues impacting MSAWs, providers and health centers.
- MHP Salud provides training and TA to health centers to develop, implement, and sustain Promotores de Salud (Community Health Workers) Programs.

- National Center for Farmworker Health provides training and TA related to health center governance, administration and patient education.

The National Association of Community Health Centers (NACHC) serves as a national resource center for all health centers.

NACHC and the NCAs recently conducted a unified need assessment across all health centers to develop a coordinated approach to provide training TA and for MHCs in four key areas:

- Health care access: MHCs need strategies to address the impact of immigration policy
- Workforce: MHCs need to broaden their training programs and budgets to include non-clinical staff
- Training and TA: MHCs need to train front-line staff to make it less challenging for MSAWs to engage health centers
- Community health worker (CHW) and outreach programs: MHCs have limited funding to implement and sustain these programs and face challenges in following up with agricultural workers after referrals.

Discussion

- Ms. Adriana-Paulsen stated that it is important to have the right workforce, including promotora programs, and a budget for training. Partnerships with universities can help to address workforce challenges. Finding providers who are bilingual and bicultural is challenging for health centers nationwide. She noted that her center has an in-house program to train promotoras and partners with another center to conduct a Medical Assistant training program for local youth.
- Mr. Jaime supported the emphasis on training front-line staff to identify MSAWs.
- Fr. LaBarge noted that a great deal of training is now being delivered through webinars, rather than one-on-one.
 - Dr. Leak said the increasing use of webinars reflects the need to maximize resources.

Progress and Lessons Learned through the Ag Worker Access 2020 Campaign

E. Roberta Ryder, President & Chief Executive Officer, National Center for Farmworker Health

Ms. Ryder provided an overview of the history and priorities of NCFH and discussed lessons learned and recommendations from the Ag Worker Access (AWA) 2020 campaign.

NCFH was formed in 1989 as the successor to the National Migrant Referral Project, Inc., which was focused on family planning. Its primary constituency is community and migrant health centers (C/MHCs). The mission of NCFH is to improve the health status of farmworker families through the provision of innovative training, technical assistance, and information services to C/MHCs.

NCFH functions as a bridge between health centers and BPHC. Their activities target two audiences:

- Learning collaborative audiences: Work with MHC staff members on a one-on-one basis to test and implement models of care
- National audiences: Disseminate promising and proven practices to all C/MHCs for broad implementation.

The Ag Worker Access 2020 Campaign is aligned with BPHC Strategic Goal 1, to increase access to quality care. As of 2017, C/MHCs were serving only 18 percent of the estimated population of MSAWs, nationwide. The campaign's vision is that America's agricultural worker population and their family

members are fully integrated into the HRSA C/MHC system, and care is delivered in a manner that does not compromise quality and is designed to improve the health status of the population as a whole, regardless of ability.

NCFH and NACHC co-founded the campaign. NCFH co-chairs the AWA 2020 Task Force, which includes Primary Care Associations (PCAs), the NCAs, and C/MHC leadership and innovators. The task force will be expanded in 2019 to include other MSAW service organizations.

The campaign's aims are to give credit where credit is due; open hearts, open doors, open access; and build capacity to sustain growth.

Collaboration is essential to the success of the campaign. Partners include BPHC, MHC networks, Task Force members, NCAs, PCAs, the Farmworker Health Network (FHN), other migrant service organizations, and Increasing Access to Care (IAC) networks in Washington State, Central California, and the Central Coast of California.

The campaign has developed a number of tools and resources, including a sample resolution to secure board commitment; a bilingual digital story to facilitate patient self-identification and registration; and a web portal for IAC networks to share information, tools, and resources.

The campaign is focused on systems-level change to create internal checks and balances, increase access for MSAWs, and assure accountability through regular monitoring.

The campaign provides national recognition and financial rewards for MHCs that make the most progress in increasing access for MSAWs and showcases their activities at NACHC's Annual Agricultural Worker Conference.

The campaign's communication channels include Facebook and Twitter accounts, the NCFH blog, the monthly *NCFH News Digest*, and a campaign website (<http://www.ncfh.org/ag-worker-access-2020.html>).

Ms. Ryder described systemic challenges that impact MSAW access:

- Patient identification, registration, and inclusion
 - All special populations should be identified and registered
 - Section 330(g) definitions are complex and hard to understand
 - Frequent front desk staff turnover demands ongoing training and retraining
 - Failure to identify and report on special populations results in skewed UDS data.
- Access to financial resources
 - MHCs have a high percentage of uninsured patients and low reimbursement rates
 - Notice of Funding Opportunity forces choices between health center sustainability and mission and the population needs and payer mix, which makes it difficult to make the "value proposition" or return on investment
 - One size does not fit all.

Ms. Ryder provided examples of successful strategies to increase access:

- ALTURA's Outreach Team created partnerships with farm labor field managers to take health screenings and outreach events directly to the fields in areas where MSAWs work during the grape harvest season in Tulare, CA.

- Sea Mar CHC in Seattle, WA initiated a Farmworker Mapping Project to identify demographics, needs and barriers to health care access.
- Salud Family Health Centers in Ft. Lupton, CO introduced an Introduction to Ag Worker Health as part of its new hire orientation, obtained board member buy-in, required attendance at “All Staff” meetings at each clinic, and was an early adopter of mobile delivery systems.

Ms. Ryder stated that enabling services, telehealth, mobile, and portable services are critical elements for optimal service delivery to MSAWs.

Ms. Ryder outlined lessons learned to date:

- The “ask” about agricultural worker status is challenging due to the complexity of legislative definitions
- There are huge disincentives for MSAWs to self-identify
- There are few incentives for C/MHCs to properly identify and register all special populations
- Voucher programs and enabling services are essential and undervalued
- It is difficult to make the business case to serve MSAWs
- New Start, Expanded Capacity, and Service Expansion funding mechanisms do not support and sustain increased access for all C/MHCs
- Success is dependent on the dedication of human resources, including board and staff
- Maintaining focus on service to MSAWs is fragile, easily lost through staff and board turnover, and not secured by systemic policy.

Ms. Ryder offered recommendations to increase access for MSAWs:

- Incentivize patient identification, registration, and UDS reporting for all CHCs and all special populations, and engage PCAs in the process
- Provide special populations funding for service delivery modes that address patient need
- Promote accountability by designating a special populations liaison at the CHC leadership level and maintain special populations programs over time.

Discussion

- Ms. Brown-Singleton requested examples of disincentives for MSAWs to self-identify.
 - Ms. Ryder stated that most Americans do not understand the difference between migrants, immigrants, and refugees, and the national environment is anti-migrant. NCFH promotes a series of questions that make it easier for a patient to self-identify, such as asking if they are engaged in agricultural work, rather than asking if they are a migrant, CHCs that do not receive MHC funding have no incentive to identify MSAW patients. It is important to create mechanisms at the national, state, and local level.

Patient Engagement Strategies

Karen Mountain, MBA, MSN, RN, Chief Executive Officer, Migrant Clinician Network (MCN)

Ms. Mountain outlined challenges facing agricultural worker patients and strategies to engage them.

Ms. Mountain noted that the women’s movement and the AIDS crisis led to an awareness of the importance of patient engagement. Health disparities collaboratives led by BPHC were the first national initiative that utilized patient engagement strategies to improve patient outcomes. The collaboratives introduced self-management contracts that held patients accountable for disease management and health outcomes, with goals set by the patient.

Health centers remain committed to the importance of patient engagement and the need to create systems that consider the realities of patients' lives. The recent focus on social determinants of health (SDOH) is an important step, because it takes into account a patient's socio-economic, cultural, and environmental conditions; social and community networks; and individual lifestyle factors.



Patient engagement is critical to the success of value-based care. Strategies to promote patient engagement include:

- The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), which helps health centers understand and respond to patients' SDOH and engage them more effectively in their care
- Trauma-informed care
- Patient self-management strategies
- Team-based approach to health care with a strong, integrated CHW component
- Motivational interviewing to support behavioral change
- Goal setting.

The MCN Health Network is an effective approach to meet the needs of agricultural clients and eliminate health disparities due to patient mobility. Patients can access the network from any location through a toll-free number. The goal of the Health Network is to provide continuity of care and maintain patient contact until the patient no longer needs a treatment modality or is safely under the care of another health provider.

Ms. Mountain offered six pathways to support patient engagement:

- Ensure that health center infrastructure supports patient-engagement strategies
- Promote team-based care with incorporation of CHWs
- Incorporate agricultural workers' needs into SDOH screening
- Provide organization-level training on motivational interviewing, trauma informed care, and SDOH
- Maintain continuity of care for mobile patients
- Support the transition to value-based care.

Discussion

- Dr. Snipes requested the source of the graphic on SDOH.

- Ms. Mountain replied that MHN adapted the graphic from literature on SDOH. She said she would provide specific information following the meeting.
- Ms. Triantafillou asked if the MCN Health Network’s toll-free number was available on a 24/7 basis.
 - Ms. Mountain replied that the toll-free number is staffed from 7:30 a.m. to 6:30 p.m.

Discussion of Possible Recommendations

Council members discussed key issues that emerged from the presentations and identified potential recommendations to address them.

Issue: MHCs serve only 18 percent of the nationally estimated number of MSAWs. The last substantive enumeration of MSAWs occurred in the FY 2000. The enumeration covered ten states, and was coordinated by the Migrant Health Program, BPHC, HRSA, DHHS, to provide estimates for MSAWs who were within the DHHS target group. The data is now 18 years old, covers only ten states, and is outdated by all standards.

- Potential recommendations:
 - HRSA lead an effort towards an accurate identification of the number of MSAWs and family members eligible for HRSA services, nationally
 - Create incentives for health centers to use of the AG Worker 2020 tools for identification and registration of all MSAWs
 - Promote quarterly monitoring
 - Create executive-level liaison for special populations
 - Use National Institute of Occupational Safety and Health (NIOSH) cooperative agreements to reduce injuries in specific agricultural sectors as a model for agreements between BPHC and growers to increase the use of health centers by MSAWs.

Issue: State-based licensure presents challenges for telehealth across state lines

- Potential recommendation: Promote licensing reciprocity.

Issue: Need to increase patient engagement to improve health outcomes and support the transition to value-based care

- Potential recommendation: Promote patient engagement strategies identified by MCN.

THURSDAY, NOVEMBER 14, 2018

Recap from Previous Day

Deborah Salazar, BS, Member, NACMH

Ms. Andrés-Paulson called the meeting to order.

Ms. Salazar summarized the presentations and discussions from the first day of the meeting.

Recruitment and Retention of Health Care Providers

Michelle M. Washko, PhD, Acting Director, National Center for Health Workforce Analysis (NCHWA), Bureau of Health Workforce (BHW), HRSA

Dr. Washko discussed health workforce challenges in the U.S. and NCHWA’s research to inform program planning and policy development.

Key workforce challenges include potential shortages and oversupply, maldistribution of providers, limited workforce diversity, failure to use health workers to the maximum of their education and skills, the need to assess the impact of a changing health care system on the need for individual health occupations, and the lack of comprehensive data to inform health workforce decisions.

The mission of BHW is to improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need. In FY 2017, BHW awarded more than \$1 billion through more than 40 programs to increase the nation's access to quality health care by developing, distributing, and retaining a competent health workforce.

NCHWA conducts research on a broad range of issues to inform BHW program planning, development, and policy-making. They use HRSA's Health Workforce Micro-Simulation model to produce estimates and projections of the current and future supply of providers in health occupations (<https://bhw.hrsa.gov/health-workforce-analysis/research/projections>). NCHWA will release the first-ever analysis of demand for CHWs in the near future.

BHW supports nine Health Workforce Research Centers that conduct research and provide TA on collection, analysis, and reporting of health workforce data related to health equity, long-term care, allied health professions, oral health, behavioral health, and emerging health workforce issues.

NCHWA uses data from a wide range of surveys conducted by U.S. government agencies, along with non-governmental resources such as the American Medical Association Master File, to understand the nation's health workforce.

NCHWA recently updated *The U.S. Health Workforce Chartbook*, which provides a summary of 34 health care and health support occupations in the U.S. (<https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/hrsa-us-health-workforce-chartbook-in-brief.pdf>).

NCHWA funds and maintains Area Health Resources Files, which include county, state, and national-level data in eight areas, including health care professions and health professions training (<https://data.hrsa.gov/topics/health-workforce/ahrf>).

The impact of BHW efforts to recruit and retain providers is difficult to measure. NCHWA uses the National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS) to track where physicians and advanced practice nurses are practicing. There is no uniform identifier to track other health professionals and health support occupations. NCHWA is working with federal agencies and professional organizations to rectify that situation.

All federal agencies that publish occupational data for statistical purposes are required to use the Standard Occupational Classification (SOC) taxonomy, which assigns a code for most occupations in the U.S. economy and includes a definition of that occupation. The SOC is revised every 10 years. The most recent revision assigned codes to many health workforce occupations, including the first code for CHWs. The revised taxonomy will allow NCHWA to collect better data, which in turn will make it easier to train the right people to serve the right populations.

The National Sample Survey of Registered Nurses (NSSRN) is the primary source of data to project the supply and demand for nursing resources. NCHWA is collaborating with the Census Bureau to conduct an expanded version of the survey that will be released in 2019.

Discussion

- Ms. Brown-Singleton stated that the maldistribution of health care providers is more difficult to address than the shortage of providers.
 - Dr. Washko agreed that maldistribution is a significant issue, especially for oral health and behavioral health occupations. National data show that there are enough providers in the U.S., but state and local data show that they are not practicing where they are most needed. Insurance and reimbursement rates are key factors.
- Ms. Andrés-Paulson noted that nursing shortages are often filled by nurses from other countries and asked if NCHWA collects data on foreign-trained health workers.
 - Dr. Washko stated that NCHWA examines the influx of international workers to the extent that it affects the domestic workforce.
- Fr. LaBarge noted that Dr. Washko's slides included data on provider ethnicity, but not the language spoken. He stressed the need for bilingual and bi-cultural providers, especially in behavioral health.
- Ms. Triantafillou asked what Dr. Washko would recommend to address the challenges she cited.
 - Dr. Washko stressed the need to improve datasets overall and to create datasets that would make it possible to assess the impact of telehealth providers.
- Dr. Snipes asked if CHWs and patient navigators have the same occupational code and expressed concern that data might not accurately capture how their roles are operationalized.
 - Dr. Washko replied that the SOC classifies occupations, not job titles. Patient navigators are currently included under the code for CHWs. If they can demonstrate that they do something substantially different than CHWs, they could get their own code.
- Dr. Snipes asked if Dr. Washko had data on what kinds of individuals are drawn to practice in rural environments.
 - Dr. Washko replied that NCHWA currently compares national and state data. During this fiscal year, they hope to compare rural versus urban areas, and possibly also suburban areas. They will begin by looking at various physician occupations.
- Ms. Andrés-Paulson asked what type of data would make it possible for NCHWA to identify best practices to retain providers in rural areas.
 - Dr. Washko replied that research on physicians and nurses suggests that providers who are trained in a rural area tend to stay there. Research on other professions would be helpful. The National Council of State Boards of Nursing is trying to create a unique identifying number for registered nurses, similar to the NPI. Encouraging employers to use those numbers would make it possible to track the distribution of nurses.
 - Areas where in the Council could support NCHWA work: 1) collect better data on how telehealth is employed by providers and used by patients, 2) fund research on training and retention of health care providers in rural and underserved rural areas, beyond physicians, and 3) adopt the individual identifier for nurses.
- Ms. Andrés-Paulson asked what could be done to recruit minorities to serve in rural areas.
 - Dr. Washko offered two recommendations: 1) Expand the National Health Service Corps to go beyond loan repayment (i.e., support training in rural areas) and expand the occupations that it supports, and 2) Conduct original research that looks at the health workforce in rural areas to identify factors that led them to practice there. She noted that it would be important to step away from the traditional medical model and look at all providers in the system.

- Dr. Snipes suggested that HRSA could issue a call for proposals to identify the key factors that lead health professionals to practice in rural and underserved areas.
- Dr. Washko noted that the federal government has nine different definitions of “rural,” and the definition of “health profession shortage area” has evolved. It might not be feasible to centralize the definitions, but they could be more transparent.

Human Trafficking in Agriculture

Meredith Rapkin Rapkin, Esq., Executive Director, Justice at Work

Ms. Rapkin provided an overview of labor trafficking in agriculture and services that are available to MSAWs who are victims of trafficking.

The Trafficking Victims Protection Act defines labor trafficking as, “the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.” Fraud can consist of making false statements about an individual’s immigration status.

Although labor trafficking is believed to be more widespread than sex trafficking, it is more difficult to identify because victims do not usually self-identify. Only 16 percent of calls to a national human trafficking hotline from 2007 to 2016 were about labor trafficking.

Justice at Work provides linguistically and culturally appropriate services for low-wage immigrant and migrant workers in the state of Pennsylvania, regardless of immigration status. They focus on underserved communities of farmworkers, mushroom workers, food processing workers, and landscapers. Most of their trafficking clients are adult men.

Justice at Work gives victims of trafficking the tools they need to leave the situation and the support they need to report the crime. Victims and their family are usually eligible for special visas that can lead to permanent residency and citizenship.

Justice at Work formed a medical-legal partnership with an organization in Philadelphia that provides mental health services to undocumented immigrants. Most of their trafficking clients accept referrals for those services.

Factors that impact the mental health of trafficking victims include false promises regarding wages, housing, or immigration status; threats to report the individual to immigration authorities or police; violent behavior; blacklisting with other employers; withholding pay; verbal abuse and humiliation; isolation or control of activities; exploiting other vulnerabilities; and very long hours.

Ms. Rapkin offered recommendations to help health care providers identify and assist victims of labor trafficking:

- Train all staff to spot red flags
- Add an intake question that asks if the patient has ever felt unsafe at work
- Provide mental health services in Spanish—or whatever language is prevalent—at a time and/or in a manner that can be easily accessed by working people
- Partner with a local legal aid organization that has immigration expertise.

Discussion

- Ms. Castro asked if labor trafficking is a reportable offense.
 - Ms. Rapkin replied that all forms of trafficking are reportable under federal law. Some states also have laws, which tend to be more specific.
- Mr. Skoog expressed concern that a person who comes forward may face reprisals.
 - Ms. Rapkin replied that most victims do not pursue legal action until they have left the situation. Justice at Work has helped clients relocate
- Ms. Naqvi stated that the proposed intake question does not address the factor of fear, and she suggested that a series of questions might be more effective. She asked how to ensure people get the services they need.
 - Ms. Rapkin replied that providers are reluctant to add more questions to the intake protocol. It is more effective to focus on identifying red flags, with follow-up questions.
 - Ms. Naqvi suggested that CHWs could help identify victims and make referrals for services.
 - Ms. Rapkin agreed that would be an effective strategy.
- Dr. Snipes asked if the proposed safety question would capture wage theft.
 - Ms. Rapkin replied that it is easier for medical staff to ask a safety question. Justice at Work would be happy to help organizations develop additional questions.

Discussion of Possible Recommendations

Council members revised and expanded the list of issues for recommendations.

Issue: Increase the percentage of MSAWs who access MHCs

- Potential recommendations:
 - Promote the Ag 2020 patient identification
 - Increase access
 - Make part of the UDS
 - Increase outreach for those not served.

Issue: Workforce

- Potential recommendations:
 - License reciprocity for services across state lines
 - Expand the NHSC subsidies beyond loan repayment
 - Collect data on factors that lead health care professionals to serve in rural and underserved areas
 - Create NPI numbers for professions other than physicians
 - Analysis of CHW data in new report
 - Expand research for recruitment and retention, especially in rural areas
 - Increase data sharing within and across agencies
 - Increase partnerships with other agencies (e.g., USDA, DOL)
 - BHWET program
 - Call for proposals on original research.

Issue: Improve infrastructure to support patient engagement

- Potential recommendations:
 - Utilize MCN Health Network to improve continuity of care
 - Patient compliance
 - Bridge case management

- Special Population Liaison (Migrant Head Start model)
- Mobile units and voucher program
- HRSA agreements with the agricultural industry.

Issue : Telehealth

- Potential recommendations:
 - Reimbursement for services
 - Data on telehealth services.

Issue: Agricultural human trafficking

- Potential recommendations:
 - Reference HHS priorities and the Secretary’s participation in an inter-agency task force
 - Links to substance use and mental health
 - Train providers and intake staff to identify red flags
 - Provide Continuing Medical Education credits for victim identification
 - Promote medical/legal partnerships
 - Track violators and offenders.

Importance of Health Literacy for Migrant and Seasonal Agricultural Worker Health

Wilma Alvarado-Little, MA, MSW, Associate Commissioner, New York State Department of Health, and Director, Office of Minority Health and Health Disparities Prevention

Commissioner Alvarado-Little discussed how culture and language affect the relationship between the individual, health care providers, and the health care system and offered strategies to encourage the provision of effective communication for MHC patients.

Health literacy affects people’s ability to navigate the health care system, including filling out complex forms and locating providers and services; to share personal information, such as health history, with providers; engage in self-care and chronic-disease management; and to understand mathematical concepts such as probability and risk.

The *National Action Plan to Improve Health Literacy* (DHHS 2010) laid the foundation for many health literacy initiatives. Other resources include the National Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards) and the Institute of Medicine publication, *Attributes of a Health Literate Organization* (https://www.iom.edu/~media/Files/Perspectives-Files/2012/Discussion-Papers/BPH_HLit_Attributes.pdf).

Patient-centered care is communication based and is essential to addressing issues contributing to health disparities. Providers who do not speak the patient’s language must use additional skills to continue to provide excellent, patient-centered care. Clear communication that is culturally and linguistically appropriate is key to providing quality health services.

Language access and language assistance are not the same. HHS states that language access is achieved “... when individuals with limited English proficiency (LEP) can communicate effectively with HHS employees and contractors and participate in HHS programs and activities.” Language assistance consists of “... all oral and written language services needed to assist individuals with LEP to communicate effectively with HHS staff and contractors and gain meaningful access and equal opportunity to participate in the services, activities, programs, or other benefits administered by HHS.”

Diversity within a language across cultures and nationalities can complicate efforts to communicate effectively. For example, there are 11 words for “drinking straw” in Spanish. It is critical to know where patients are from and what is important to them.

Cultural views about issues such as mental health can impact efforts to communicate effectively. It can be challenging to find culturally relevant ways to communicate abstract concepts such as advance directives, living will, power of attorney, or surrogate decision-maker.

Ms. Alvarado-Little offered a process to develop culturally relevant health education materials:

1. Learn about your community
2. Draft the brochure using plain language
3. Test it with your audience
4. Revise and test it again
5. Keep in touch with the community as you promote it to ensure they feel involved and your resource continues to be effective

It is important to understand the intended audience when developing materials. Key questions are: Who do they consider to be credible sources of information? What is their preferred language? What is their preferred mode of getting information? What is their motivation for change?

Ms. Alvarado-Little suggested ways in which health care providers can improve health literacy:

- Build trust
- Keep in mind the community’s perspective when providing oral and/or written messages
- Address skills of both sides (i.e., health information providers and community members)
- Use health literacy principles in communication and materials development
- Use health literacy resources
- Train health professionals
- Practice the Teach-back Method
- Inform the community by providing basic literacy and health literacy skills and education on steps to maintain personal health, preventive care, and chronic disease management
- Utilize a professional interpreter and address them by the appropriate title
- Review materials for cultural relevance
- Keep in mind the importance of health literacy and effective communication.

Discussion

- Mr. Morgan observed that many English-speaking patients cannot understand basic medical concepts, and terms such as “medical home” and “behavioral health,” are difficult to translate into other languages. He noted that many people who have difficulty reading will not read type in small print.
 - Ms. Alvarado-Little replied that it is important to understand the range of challenges that a person might experience, especially when they are from a minority population. Sometimes a graphic is better than text.
- Fr. LaBarge said he finds it helpful to look online for materials in the patient’s country of origin to get a sense of what types of materials will be effective.
- Ms. Andrés-Paulson stressed that discussing concepts such as advance directives include cultural assumptions that go beyond literacy.

- Mr. Jaime asked what the Council could recommend to improve health literacy.
 - Ms. Alvarado-Little stressed that it is important to: 1) clarify the role of health literacy in working with MSAWs, 2) determine what definition of health literacy is aligned with that work, 3) identify areas in which health literacy is important, and 4) identify the intersection between health literacy and cultural competency and between health literacy and language access.
- Ms. Castro noted that health literacy is important for patient safety. Patients must be able to disclose information about their health to providers, and providers must ensure that the patient understands their questions and instructions.
- Ms. Triantafillou stated that the health care system is complex for everyone, and health literacy goes beyond language.
- Ms. Andrés-Paulson said it would be helpful if providers had an awareness of health care systems in other countries.
- Ms. Phillips Martinez noted that the discussion of health literacy illustrated the importance of having patients represented on health center boards.
- Dr. Snipes suggested that health literacy should be included in the curriculum for providers, because communication is essential to establishing doctor-patient trust.
- Ms. Andrés-Paulson noted that health literacy is linked to workforce development and telehealth.

Formulation of Letter of Recommendations to the Secretary of DHHS

Council members reviewed the issues that emerged during the meeting and agreed to focus the letter of recommendations on access to health centers by MSAWs, workforce mal-distribution, and agricultural human trafficking.

Council members agreed on the timeline for the letter and individuals responsible for each step:

WHAT	WHO	WHEN
Draft 1	Fr. LaBarge & Ms. Andrés-Paulson	November 19
Draft sections: Develop background and draft recommendations for each section; send drafts to Ms. Andrés-Paulson	<u>Increasing access:</u> Ms. Salazar & Ms. Brown-Singleton <u>Workforce:</u> Fr. LaBarge, Mr. Skoog, Ms. Triantafillou <u>Trafficking:</u> Mr. Jaime, Mr. Morgan, Ms. Phillips Martinez	November 28
Draft 2: Incorporate input, do first edit, and submit to full Council for comments	Ms. Andrés-Paulson	December 3
Feedback: Send comments on the draft to Dr. Snipes	All Council members	December 10
Final Draft: Incorporate feedback into a final draft; submit the final draft to HRSA	Dr. Snipes	December 17

Closing – Wrap up/Summary

Council members discussed the meeting scheduled for May 22-23, 2019 in Rochester, New York.

Council members proposed agenda topics, including:

- Presentation on farmworkers in New York
- Farmworker participation in health center boards
- Oral health
- Nutrition
- Sexual harassment
- Aging farmworkers.

Mr. Skoog said he would organize a tour of health centers in the area.

Mr. Jaime offered to coordinate the planning to obtain testimonies from agricultural workers. Council members agreed that the format of the testimony session at the May 2018 meeting could serve as a model for the next meeting.

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