National Advisory Council on Migrant Health

December 24, 2018

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

Dear Secretary Azar,

The National Advisory Council on Migrant Health (NACMH/Council) advises, consults with, and makes recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS) and the Administrator, Health Resources and Services Administration (HRSA). 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 MSAWs and their families.

During our meeting, held on November 14-15, 2018, the Council received updates from the following HRSA leaders:

- Jennifer Joseph, PhD, MSEd, Director, Office of Policy and Program Development, Bureau of Primary Health Care (BPHC), HRSA, BPHC:
  Federal Update: Health Center Program Policy and Program Development
- Tia-Nicole Leak, PhD, Team Lead, National Partnerships Team, National Cooperative Agreements, Office of Quality Improvement, BPHC:
  HRSA, BPHC National Cooperative Agreements Serving Migrant health Centers
- Michelle M. Washko, PhD, Acting Director, National Center for Health Workforce Analysis, Bureau of Health Workforce (BHW), HRSA:
  Recruitment and Retention of Health Care Providers

Additionally, the Council heard presentations from the following national, regional and state-level organizations:

- E. Roberta Ryder, President & Chief Executive Officer, National Center for Farmworker Health:
  Progress and Lessons Learned through the AG Worker Access 2020 Campaign
- Karen Mountain, MBA, MSN, RN, Chief Executive Officer, Migrant Clinician Network:
  Patient Engagement Strategies
- Meredith Rapkin, Esq. Executive Director, Justice at Work:
  Human Trafficking in Agriculture
- Wilma Alvarado-Little, MA, MSW, Associate Commissioner, New York State

Department of Health; Director, Office of Minority Health & Health Disparities Prevention:
Importance of Health Literacy for Migrant and Seasonal Agricultural Worker Health

The Council also received public comments:

- Hanni Stoklosa, MD, MPH. and Vicki Rosenthal, MSW, HEAL (Health, Education, Advocacy, Linkage) Trafficking, and Anita S. Teekah, Esq., ATEST (Alliance To End Slavery and Trafficking) jointly commented on challenges regarding human trafficking, patient engagement and provision of essential health services for migrant agricultural workers.

- Katherine Chon, Director, Office on Trafficking in Persons (OTP), Administration for Children and Families (ACF), U.S. Department of Health and Human Services provided data to support that migrant health workers often face challenges accessing workplaces, with employers sometimes banning health care providers and/or legal aid from employer-controlled housing facilities. Some of these concerns have raised red flags for exploitation and human trafficking conditions.

On behalf of the Council that met November 14-15, 2018 and in accordance with the charge given to the Council, we submit the following recommendations for your consideration.

Recommendation I

NACMH recommends that HRSA renew its effort to increase access to care for MSAWs by systemizing a national and state-level outreach plan, based on an accurate identification of the number of MSAWs and family members eligible for Health Center Program (HCP) services. Accuracy is highly contingent upon standardized definitions for enumeration of MSAWs. As well, systematic processes and procedures are required to identify, screen, and refer MSAWs. When implemented, HRSA will be able to gauge the accurate penetration rate of successful outreach efforts. This will also enable HRSA to accurately plan and interpret the impact of the HCP on MSAWs and their families. The following strategies will contribute towards the success of this effort:

(1) ***Establish data and information sharing agreements at points where agricultural workers interface with private organizations and federal agencies. Private organizations may include growers associations; Department of Labor registered farm labor contractors and Legal Services Corporations. Examples of Federal agencies include Occupational Safety and Health Administration and the National Institute for Occupational Safety and Health, as they fulfill responsibilities for recommending and implementing health and safety standards in agriculture.***
(2) ***Standardize patient intake processes to ensure self-identification is not a barrier to accurate MSAW identification by providing HCP grantees with ongoing training and technical assistance.***
(3) ***Hold MHC and their Board of Director's accountable for the migrant funding they receive, to establish and evaluate progress of the identification of MSAWs; MHCs should define their outreach to MSAW, as part of the compliance requirements.***

(4) ***Provide incentives to MHCs that increase MSAW patient enrollment.***
(5) ***Allocate funding for a designated special population liaison at the MHC executive level, to increase compliance with intake and MSAW identification protocol.***
(6) ***Support service provision to improve access through non-traditional outreach efforts including a voucher program, and collaborations with Migrant Head Start programs and Migrant Education.***
(7) ***Fund MHCs to implement evidence based outreach and health education programs utilizing culturally competent promotoras.***[i]
(8) ***Fund mobile health units that go out to the rural communities.***
(9) ***Collaborate with CMS to create effective telehealth reimbursement to increase access for MSAWs in remote locations.***

Background:
The last substantial enumeration study of MSAWs was done in 2000. This count covered only ten (10) states. The data is now outdated (18 years old) and incomplete in that it counts the western and central states, when other data shows that there is a large MSAW population in the eastern states. For example, New York[ii] is one of the leading apple producing states in the country but was not included in the count. There have been many changes that affect the MSAW population, including their number and characteristics, resulting in changes in patterns of farmworker migration in the past two decades.

The current estimates of the MSAW population are not a reliable source of information for HRSA to accurately assess needs. For example, Uniform Data System (UDS)[iii] submissions for calendar year (CY) 2017 obtained from over 1,400 community and migrant health center sites across the US indicate that the HCP currently serves approximately 20 percent of the nation's MSAW population.[iv] These estimates are based upon a count of the number of MSAWs in the nation that is out dated. UDS data on MSAWs served by the HCP may also not accurately reflect all MSAWs served by the HCP. Not all MSAWs self-identify during patient registration and accurate data collection is largely dependent on health center staff.

HRSA provides funding to support the National Agricultural Worker Survey (NAWS), a random sample survey of US crop workers, conducted by the Department of Labor (DOL). However, data collected through this instrument is neither sufficient for an estimation of a total number of MSAWs, nor provides a complete picture of the health needs of MSAWs as per the HRSA definition. The DOL and HRSA have significant differences in the definition/identification of MSAWs. DOL surveys crop workers, which does not include all MSAWs that work in farm labor and are eligible under the HRSA definition, such as livestock workers, post-production workers employed in processing plants and truck drivers. NAWS also excludes H2A workers, who increasingly make up a large number of migrant agricultural workers, the Department of State issued over 134,000 visas to H2A workers in 2016, which accounts for approximately seven (7) percent of the crop workforce in the US. Additionally, there is a discrepancy between the DOL and HRSA definition of a migrant worker, NAWS defines a migrant worker as someone that traveled 75 miles to do agricultural work, while HRSA does not include mileage in their definition. NAWS does not include crop workers not employed in agriculture in the last year, while HCP includes retired agricultural workers as its target population.[v]

An accurate definition of the need for services for its target population is contingent on standardized definitions for enumeration of MSAWs, as well as systematic processes and

procedures to identify, screen, and refer MSAWs in order to gauge the accurate penetration rate of successful outreach efforts.

Recommendation 2

The United States (US) is heavily reliant on MSAWs in the agricultural sector to plant and harvest crops. The dependence of large agricultural companies on seasonal labor creates many employment opportunities for MSAWS in the agricultural sector, but also presents opportunities for exploitation of labor. The Council recognizes the important role that the HCP, with its network of health centers located across the US, can play in advancing the three key strategies set forth by the HHS Strategic Plan.[vi] The anti-trafficking mission for the plan includes raising awareness to help identify victims; getting victims connected to restorative services; and equipping community organizations to help victims become survivors. The Council recommends that in alignment with the HHS Strategic Plan, HRSA support HCP grantees to:

(1) Raise awareness of labor trafficking by increasing health center capacity to better identify victims of labor trafficking. This may include:

- ***Training staff (front office and clinical) to appropriately screen, identify and refer people who are or have been trafficked. Training should include but not be limited to:***
  - ***Knowledge that trafficking is a reportable offense by all clinic staff.***
  - ***Ongoing training on the intersection of mental health and trafficking, to increase staff capacity to support MSAWs in socially determined circumstances (lost wages, false promises, long hours, exploitation, etc.)***
  - ***Equipping staff and providers with resources and tools such as those created by the National Human Trafficking Center[vii].***
  - ***Supporting provider capacity building and practice improvement by providing continuing medical credits for trafficking victim identification.***
- ***Expand outreach services to better identify MSAWs and provide information about medical, mental health and other support services available. Outreach must necessarily include going to farms and offering point-of-contact services, which are often the only option for establishing contact with MSAWs due to lack of transportation, inability to miss work and other barriers to care.***
- ***Provide victims primary care and mental health services.***

(2) Link MSAWs who have been trafficked/exploited to restorative services by:

- ***Expanding the number of health center medical-legal partnerships by providing grantees technical assistance on how to create or leverage partnerships and establish referral pathways.***

(3) Establish collaborations with federal and non-federal partners engaged in anti-trafficking efforts to increase capacity of all agencies/organizations to better serve MSAWs and ensure consistent access to health and enabling services by:

- ***Utilizing and disseminating the vast array of resources and trainings made available by the Office on Trafficking in Persons within the HHS Administration for Children and Families.***
- ***Working with community based organizations such as Justice at Work; HEAL Trafficking and Alliance to End Slavery in their endeavors to help victims become survivors.***

- ***Collaborate with local workforce programs, Migrant Head Start and Migrant Education to cross train staff in screening, identification and referral for victims of trafficking.***

Background

The HHS 2018-2022 Strategic Plan, under Strategic Objective 3.2 to safeguard the public against preventable injuries and violence or their results, includes the charge to:

> *"Assess and increase the capacity of medical and behavioral health practitioners, nonprofits, faith-based and community organizations, licensed social workers, child welfare professionals, housing authorities, and public health agencies to provide comprehensive and survivor-informed services for victims of human trafficking."*[viii]

Persons who are trafficked in agriculture are unlikely to report violations because of the fear of dismissal, threats to notify the police or IRS, isolated housing and other forms of exploitation. The Typology of Modern Slavery: Defining Sex and Labor Trafficking in the United States, by Polaris[ix] gives the most complete listing of the many forms of human trafficking in the United States. Although most attention is paid to trafficking related to the sex trade, there are over two dozen types of modern slavery. Of particular interest to this Council are forms of trafficking related to agriculture in the broadest definition of that term. These include agriculture and animal husbandry, landscaping, forestry and logging. Trafficked agricultural workers are subjected to abuses including: underpayment, longer work shifts, limited or no breaks, lack of restroom facilities located in close proximity to work, no shelter from the sun, pesticide and heat exposure, limited access to water, etc. Other examples of exploitation include sexual harassment, including demands for sex and assault. [x]

While trafficking is a reportable offense, there are challenges with identifying cases of labor trafficking. Labor trafficking victims are harder to identify than sex trafficking victims, given that international victims may be mistaken for smuggled immigrants. Further, the victimization of labor trafficking victims (many of whom are male) may be seen as less compelling than that of sex trafficking victims (many of whom are young women).[xi] A study conducted by the National Institute of Justice to examine labor trafficking among MSAWs in North Carolina found that at least 25 percent of the workers experience labor trafficking, and approximately 30 percent workers experience other abuses, including restrictions of movement, passport confiscations, threats and verbal abuse.[xii]

MSAWs who are victims of labor trafficking may lack access to health care, (including immediate medical attention, sexual assault evaluations, substance use disorder counseling), emergency housing, food, and clothing. Commonly overlooked medical problems that agricultural laborers sustain include chemical burns from pesticides, resulting respiratory problems, infertility and birth defects. If access to health services is not consistent or reliable, individuals may face dire health and mental health consequences.

Recommendation 3

The Council recommends that HRSA explore diverse avenues for recruiting and retaining a quality, skilled workforce. Improving the rural-urban maldistribution of the healthcare workforce is critical to an equitable availability of the advances of modern healthcare to rural

and underserved populations, including MSAWs. Addressing provider shortages and maldistribution in the rural healthcare workforce would require a multifaceted approach including:

(1) An expansion of the National Health Service Corps (NHSC) to recruit and retain sufficient numbers of primary care medical, dental, and mental and behavioral health professionals to adequately staff HCP grantees located in rural and underserved areas. The expansion initiative can be strengthened by including additional dimensions including but not limited to the following:

- ***Create academic opportunities in rural areas to recruit rural students to health careers, empasizing a high value in "growing its own" to attract students from high-need areas and to educate and train them with the hope that they will return to those areas to practice.***
- ***Establish rural regional centers for health workforce development in medically underserved and health professions shortage areas. The goal of such center would be to develop local academic and community talent with an emphasis on recruiting minority, and economically and educationally disadvantaged students.***
- ***Provide rural training opportunities for current clinicians, and clinical training opportunities for allied health professionals, medical and nursing students.***
- ***Provide subsidies and incentives to recruit and retain rural physicians and other healthcare providers over and above loan repayment, such as a signing bonus.***
- ***Expand the occupations that NHSC currently supports to include allied health professionals.***
- ***Address the need for bilingual and bi-cultural providers, especially for behavioral health providers.***
- ***Licensure reciprocity and reimbursement across state lines to facilitate care provision using telemedicine.***

(2) Targeted funding to support ongoing research for long-term evidence based solutions for improving recruitment and retention of an evolving rural health workforce, which includes:

- ***Original research to identify factors that influence health workforce recruitment, retention and professional development in rural areas, such as:***
    - ***Identifying and defining training needs by provider type, and how and where the training should be made available.***
    - ***Social determinants/contexts that influence retention and attrition of providers.***
    - ***Identifying key resources currently not available, but that would increase provider retention.***
    - ***Identifying rural care provision needs and evaluating types of providers needed to fulfill the specific need.***
- ***Going beyond the traditional medical model to study functions/roles fulfilled by each provider type in the care delivery system and audit all available technology solutions to support their role are necessary to forecast future workforce needs, and plan for evidence based workforce development.***

Background

Approximately one-fifth of the nation's population lives in rural areas,[xiii] but only about one-tenth of the nation's physicians are located there.[xiv] This is considered to be one reason rural

Americans have higher rates of death, disability and chronic disease than their urban counterparts. Of the 2,050 rural U.S. counties, 77 percent are designated as health professional shortage areas. It is estimated that approximately 4,000 additional primary care practitioners are needed to meet current rural health care needs. Key workforce challenges include potential shortages and oversupply, resulting in a maldisribution of providers especially in oral and behavioral health occupations. National data indicates that there are many providers in the U.S., but state and local data shows that providers are not necessarily practicing where they are most needed. Insurance and reimbursement rates are also key factors contibuting to the maldistribution of providers in addition to limited workforce diversity, and failure to use health workers to the maximum potential offered by their education and skills. There is an urgent need to assess the impact of a changing health care system on the need for individual health occupations, in order to have comprehensive data to inform future health workforce decisions.

In the current conditions, most future health professionals come from urban areas as rural students often face inadequate preparation in keystone math and science topics that facilitate students towards medical careers.[xv] A general decline in the number of medical students entering family medicine, internal medicine, and general pediatrics is having a more pronounced impact in rural locations.[xvi] An increase in the number of clinicians that complete medical training such as residency and internship programs in rural areas may help to oversome the decline.

Relatedly, recruitment and retention challenges on account of a smaller number of rural health professional training sites, and lower reimbursement rates make it challenging to recruit physicians to rural communities. Non-physician providers – primarily physician assistants (PAs) and nurse practitioners (NPs) – have been major components of the rural health workforce, but the proportion of PAs entering generalist practice has declined, and the number of NPs has fallen dramatically in recent years,[xvii] further exacerbating rural workforce shortages. Turnover is also very expensive in health care and demands an all out effort towards retention of rural providers. For example, the American Organization for Nurse Executives has determined that the turnover cost per nurse is at least double the nurse's salary.[xviii]

BHW, HRSA works to strengthen the nation's health workforce, connecting skilled professionals to communities in need by developing, distributing, and retaining a competent health workforce. The National Center for Health Workforce Analysis (NCHWA), BHW conducts research on a broad range of issues to inform BHW program planning, development, and policy-making, including using HRSA's Health Workforce Micro-Simulation model to produce estimates and projections of the current and future supply of providers in health occupations.[xix] NCHWA efforts ensure ongoing research and provide technical assistance on collection, analysis, and reporting of health workforce data related to health equity, emerging health workforce issues, and allied health professions such as the first-ever analysis of demand for community health workers. The current and future success of the HCP network of health centers that served over 27 million patients in 2017 is critically dependent on the availability of a well-qualified health workforce, committed to serve in the nations underserved areas.

Recommendation 4

The Council recommends that HRSA prioritize investing in an initiative to bolster MSAW health literacy to improve the quality of care and health outcomes. The HHS Strategic Plan Objective 1.2[xx] calls on HRSA to provide health information in culturally appropriate and health-literacy-appropriate levels, and in alternative formats, such as in languages other than English, to improve access to health information. The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions will drive patient engagement in self-management of disease, disease prevention activities and adherence to treatment regimens. Improving MSAW health literacy would be best accomplished through multi-sector efforts that bring together health center providers and staff, local communities, patients and families. The Council recommends including the following implementation considerations/efforts in the initiative:
(1) Health literacy efforts that follow a bidirectional approach – for providers as well as patients. To improve patient outcomes all stakeholders need to have a clear understanding of the importance of health literacy in working with MSAWs. To this end, health centers should invest in training providers and staff in:

- ***Effective communication methods for delivering patient-centered health information and services/care.***
- ***Motivational interviewing, trauma informed care, and social determinants of health.***

(2) Patients with limited English proficiency receive access to accurate and actionable health information in the language they are proficient, in order to make informed decisions about their health and health care.
(3) Ensure that health center infrastructure supports patient-engagement strategies, and services are delivered in ways that are understandable and beneficial to health, and quality of life.
(4) Continuity of care is maintained for highly mobile patients, using tools such as Health Network[xxi] to maintain a patient in care until they no longer need a treatment modality, or are safely under the care of another health provider.

Background
The HHS National Action Plan to Improve Health Literacy is key to the success of our national health agenda and is based on two core principles: (1) All people have the right to health information that helps them make informed decisions, and (2) Health services should be delivered in ways that are easy to understand and that improve health, longevity, and quality of life.[xxii] Culture and language affect the relationship between the individual, health care providers, and the health care system. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. An individual's health literacy level affects their ability to navigate the health care system, including filling out complex forms and locating providers and services; willingness to share personal information, such as health history, with providers; and engage in self-care and chronic-disease management. Patient engagement is critical to improving health outcomes and to the success of value-based care. This engagement depends on the patient being health literate.

Patient-centered care is clinical care that is "respectful of, and responsive to individual patient preferences, needs and values[xxiii]" Patient-centered care is necessarily driven by clear communication and understanding between provider and patient. It is important to recognize

that diversity within a language across cultures and nationalities can complicate efforts to communicate effectively. Clear communication that is culturally and linguistically appropriate is key to providing quality health services. It is critical for providers to understand their patients' cultural background and what is important to them. Without adequate training, it can be challenging to find culturally relevant ways for providers to communicate important clinical information to patients as well as more abstract concepts like advance directives, living will, power of attorney, or surrogate decision-making.

Health literacy must be an important component of provider training curriculum because effective communication is essential to establishing doctor-patient trust, which is important for addressing barriers to patient outcomes. Exploring the barriers to the access, initiation, navigation and receipt of healthcare by MSAWs is also important to achieving patient engagement. Improving health literacy is critical to achieving the objectives set forth in *Healthy People 2020* and, more broadly, key to the success of our national health agenda.

Closing

We extend our appreciation for the honor of serving on the National Advisory Council on Migrant Health. The Council recognizes the essential role that agricultural workers play in our economy and in our countries domestically produced food supply. We also recognize the complexity of the needs of the individuals, and the enormous efforts already being implemented by HHS. We thank the Secretary for your service, for your support of our efforts to date, and for consideration of our current recommendations.

Sincerely,

Adriana Andres-Paulson, MSW
Acting-Chair, NACMH

cc: George Sigounas, Ph.D., MS
James Macrae, MA, MPP
Jennifer Joseph, Ph.D., MSEd
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