National Advisory Council on Migrant Health

June 20, 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 (DHHS) 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.

The Health Center Program (HCP) provides healthcare services to approximately 26 million people in the United States, serving the most vulnerable populations in urban, rural and frontier communities. Leading the nation in providing integrated, patient-centered medical care, almost 73 percent of health centers are accredited as Patient-Centered Medical Homes.[i]

During our meeting, held on May 8-9, 2018, the Council received updates from HRSA's Bureau of Primary Health Care (BPHC) leadership. Additionally, the Council heard presentations from the following:

- Joe Gallegos, Senior Vice President for Western Operations, National Association of Community Health Centers.
- Seth Doyle, Manager, Community Health Improvement Program Northwest Regional Primary Care Association
- Mary Jo Ybarra Vega, MS, LMHC, Quincy Community Health Center, SW Quincy, WA
- Richard A. Fenske PhD, MPH, Associate Chair and Professor, Department of Environmental and Occupational Health Sciences, University of Washington, Pacific Northwest Agricultural Safety and Health Center.
- Simon Mendoza-Moreno, Physician's Assistant, and Daisy Rivera, Psychologist, Columbia Valley Community Health, WA

The Council also heard testimonies from 14 MSAWs and promotor/as (community health workers) from across the state of Washington. The testimonies indicated that there were unmet needs in the areas of mental health, concerns with workplace physical and emotional safety, presence of substance use, and prevalence of chronic diseases, and food insecurity, as follows:

- The nature of work and residing in rural communities leads to numerous barriers to accessing health care. Limited by available options for insurance and provider shortages in the local area, members of the same family often have to travel to different health centers to receive care, particularly for specialty care, e.g., mental health, often several hours away from home. This leads to significant loss of wages.
- Workplace safety and timely access to treatment following work place injury remain a high concern. Demanding jobs and less decision latitude are common and result in diverse occupational hazards. Testifiers also described instances where physicians failed to submit injury related documentation, either in a timely manner or not at all, to Washington State's Department of Labor and Industries.
- Healthy food being cost prohibitive, and the lack of actual availability, farmworkers and their families often eat to feel full rather than for good nutrition. They expressed concern for greater risk of developing chronic diseases such as diabetes, and those who already suffer from chronic illnesses have great difficulty managing their illnesses.

On behalf of the Council that met May 8-9, 2018 and in accordance with the charge given to the Council, we submit the following recommendations for your consideration.

Recommendation I

The NACMH recommends that HRSA collaborate with relevant federal and non-federal stakeholders to undertake and lead an effort towards a national and state-by-state enumeration of the MSAW population, for an accurate identification of the number of MSAWs and family members eligible for HRSA services. This will enable HRSA to both identify need for services, accurately plan and interpret the impact of the HCP on MSAWs and their families.

Background:

Systematic monitoring and analysis of health data for MSAWs is critical to understanding the level of health improvement planning for the nation. However, the last substantive enumeration of MSAWs occurred in the Fiscal Year (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 measurement standards. The portrait of existing enumeration data is incomplete – strongly favoring western and central states. The population of MSAWs is robust in eastern states as well, but they are nearly absent in enumerative data. For example, New York State grows more apple varieties than any other state in the U.S. with state of Pennsylvania being responsible for 65 percent of all mushroom production in the U.S. According to the HRSA Health Equity Report of 2017, MSAWs represent a segment of the U.S. population at risk of experiencing a shortage of providers, per specific geographic area. However, the population per specific geographic area is unknown, and the level of the shortage (or its improvement) remains unexamined.

HRSA currently provides funding to the National Agricultural Worker Survey (NAWS), a

Department of Labor (DOL) employment-based, random sample survey of U.S. crop workers. However, the data is insufficient to estimate the total number of MSAWs who are eligible for HRSA HCP care. The definitional differences between the HRSA and DOL could mean that the potential eligible HCP MSAW population may be larger than the population counted as farmworkers by the DOL. The PHS Act also recognizes individuals and families for whom migrant labor is their principal, although potentially not their only, form of labor. The PHS Act includes workers who perform both crop and other types of farm labor duties (e.g., livestock) within a 24-month period, allowing for transitional health care despite the seasonality of agricultural labor. This differs from the more narrowly defined DOL/NAWS definitions where an MSAW is "a person who reported jobs that were at least 75 miles apart or who reported moving more than 75 miles to obtain a farm job during a 12-month period." The NAWS is not a population-based census survey nor does it sample persons with an H2A visa or persons who have worked outside of agriculture for more than one year. Persons who do not perform crop-related work are also excluded (e.g., livestock agriculture) from the NAWS.

This indicates an urgent need for an updated enumeration of MSAWs and their families, to accurately identify the population eligible for HRSA services. In the absence of current data, the ability to provide accurate estimates of the current size and distribution of MSAWs is nullified, and renders the HRSA Health Equity efforts unmeasured.

Recommendation II

The Council recommends that HRSA collaborate with the Centers for Medicare and Medicaid Services (CMS) to legitimize tele-health as a billable and reimbursable service covered by the FQHC Medicare and Medicaid Prospective Payment Systems. This change will facilitate other third-party payers to mimic such action. In order to support this, the Council recommends that:

- ***CMS provide guidance to state Medicaid agencies on simplifying state licensure requirements that are an impediment to billing.***
- ***HRSA review and leverage promising strategies for expanding access to mental health services through tele-mental health.***
- ***HRSA support CMS in a modification of billing processes so that health centers have the capacity to bill as both the originating and distant site providers***
- ***HRSA address the gaps in Federal Tort Claims Act (FTCA) coverage for tele-health services.***

Background:
Most MSAWs are located in isolated and rural areas where provider recruitment challenges compound the usual barriers to mental and behavioral health services. Tele-medicine and tele-psychiatry can be an effective solution to meet MSAWs mental health needs, in the provision of integrated health care. However, widespread adoption of telehealth services by health centers is limited largely due to lack of adequate reimbursement to support their development and sustainability. In addition, state variations in licensing requirements and service site definitions also act as barriers to effective telemedicine implementation.

NACMH urges HRSA to encourage health center providers to participate in the Interstate Medical Licensure Compact (IMLC)[ii] or similar utilization of store and forward technology, to provide patients facing barriers to accessing services in-person access to specialists remotely, or

in other states. Store and forward technology can improve care for patients while reducing the overall cost of care.

The Council recommends that CMS expand remote patient monitoring (RPM) reimbursement to include HCP providers, and encourage State Medicaid programs to consider replicating the model in the Medicaid program for patients with chronic conditions, similar to Medicare reimbursement for private providers' billing for RPM services to Medicare beneficiaries.[iii]

NACMH strongly urges HRSA to collaborate with CMS to modify billing processes to enable health centers to bill as both the originating and distant site providers if they are providing telemedicine or tele psychiatry services to a patient located at a different originating health center site. Current reimbursement policies subject telemedicine and tele psychiatry services to the same restrictions as face-to-face visits. Unfortunately, this limitation misses one of the primary benefits of telehealth services, which is to eliminate transportation barriers for patients.

Recommendation III

The Council recommends that HRSA continue investing in training and technical assistance programs that promote the expansion of health center capacity to adequately meet the behavioral health needs of MSAWS by:

- ***Collaborating with CMS to ensure all behavioral health providers are able to bill for their services***
- ***Promoting ongoing culturally competent training for behavioral health providers on Substance Use Disorders (SUD), depression and other behavioral health issues MSAWs face***
- ***Funding programs that train and employ community health workers/promotoras to provide health education and enabling services to help MSAWs navigate through the health system***

Background:

Farm work is physically demanding and MSAWs are at a high risk for workplace injury and chronic pain, which often leads them to self-medicate. Research indicates poor occupational safety is associated with musculoskeletal, depressive symptoms, and worse mental health overall.[iv] The MSAW lifestyle puts them at risk for SUD and can lead to higher rates of anxiety and depression. Stressors like social isolation and stressful working conditions are the strongest contributor to anxiety and depression.[v] Research indicates that the trauma of migration makes them more likely to use alcohol and illicit drugs or develop a SUD.[vi]

MHCs receive technical assistance and training to support the provision of culturally competent care and support to MSAWs and their families. CHWs most often belong to the community and are well suited to identify mental health risk factors and SUD among MSAWs and their families, and can play a key role in linking patients into care. The Council endorses HRSA investments towards the expansion of mental and behavioral health services, including SUD treatment and encourages HRSA to identify and disseminate promising practices related to the provision of prevention education, patient navigation and clinical services to MSAWs suffering from SUD.

Recommendation IV

The Council recommends that HRSA implement a comprehensive approach to chronic disease prevention and management for MSAWs, by:

- ***Encouraging MHCs and CHCs to collaborate with local partners to provide increased, consistent and sustained access to healthy and culturally relevant foods for MSAW***
- ***Employing standard data collection tools (e.g., PRAPARE) to assess food insecurity in patients and families during primary care visits***
- ***Providing training and technical assistance to MHCs to ensure that community health workers, health outreach workers and clinicians:***
    - ***Address preventive care and Chronic Disease Self-Management Education (CDSME), and common co-morbid mental health issues by integrating mental health screenings and services into primary care visits,***
    - ***Provide relevant patient education and support inside and outside of the clinic walls, and***
    - ***Focus on preventive care of MSAW children and young adults to decrease overweight/obesity incidence and proactively ameliorate future incidence of chronic disease progression.***

Background:

MSAWs provide the food on US tables and are vital to the economy; however, they frequently struggle to ensure they have sufficient and nutritious food on their tables. Food insecurity among farmworkers has been identified as a significant issue.[vii],[viii],[ix]. Researchers have also identified that households with food insecurity were more likely to have a member of the family affected by depression, colloquially referred to as "nervios."[x] In addition, these households are associated with children being overweight or obese, lacking a quality food source, and eating cheaper food.[xi] A Pennsylvania study on the health and nutrition of Hispanic MSAWs identified significant food insecurity, negative food choices, less fruits and vegetables consumption, and consumption of beef, pork, whole milk, deep fried foods, sweets, sugary juice, rice and tortillas. Cost was a major contributor towards these food choices. MSAWs opted to buy food on sale, eat leftovers, ate less of more expensive foods and consumed fast food and food from buffets.[xii] Higher vulnerability to developing diabetes among farmworkers is multifactorial and includes stress, exposure to pesticides, and consuming unhealthy foods that are cheap as well as lack of safe areas for physical activity.[xiii]

The 2017 HRSA Health Equity Report indicates rural areas have a higher incidence of smoking, obesity, physical inactivity, and alcohol use. It also indicated that men doing farming and manual labor have a 30-58 percent higher cardiovascular mortality risk than those employed in executive and managerial occupations. An important element of chronic disease management is physical activity. Hispanic workers are less likely to report recommended levels of leisure-time physical activity (24 -27 percent versus 33 -37 percent for non-Hispanic workers).[xiv]

Chronic disease self-management is the first step to addressing chronic disease in order to improve health outcomes for any patient. It is therefore imperative that health centers serving MSAWs articulate an effective strategy for chronic disease self-management, to interrupt poor food choices, and provide culturally appropriate health, nutrition and exercise education that will influence health outcomes. Establishing partnerships to address food insecurity; employing

CHWs to facilitate access to healthier food options and educate on chronic disease risks and management; and the provision of integrated health and mental health care, migrant health centers can play a key role in preventing and better managing chronic diseases among our country's farmworkers and their families.

In 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 country's domestically produced food supply. We recognize the complexity of the needs of the individuals. We thank the Secretary for your service, and for your consideration of our recommendations on behalf of those we serve.

Sincerely,

Horacio Paras
Chair, NACMH

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

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