National Advisory Council on Migrant Health

December 19, 2024

The Honorable Secretary Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Becerra,

The National Advisory Council on Migrant Health (NACMH, hereby referred to as "the Council") advises, consults with, and makes recommendations to the Secretary of Health and Human Services (HHS) and the Administrator of the Health Resources and Services Administration (HRSA). Specifically, the Council is charged with reviewing the health care concerns of migrant and seasonal agricultural workers (MSAW) and the organization, operation, selection, and funding of migrant health centers (MHCs) and other entities assisted under section 330(g) of the Public Health Service (PHS) Act, as amended, 42 USC 254(b), with the goal of improving health services and conditions for MSAW and their families. Please find an overview of the Council's October 2024 meeting and two key recommendations that fulfill our charge.

Overview

The Council met virtually on October 22–23, 2024, and received updates from the following:

- HHS Secretary's Initiative on Protecting Farmworkers from Extreme Heat and Wildfire Smoke
    - Ana Mascareñas, MPH, Counselor to the Secretary, Office of the Secretary, HHS
    - Jenny Keroack, MPH, Policy Advisor, Office of the Secretary, HHS
- HRSA Health Center Program
    - Matt Kozar, MPH, Director, Strategic Initiatives, Office of Policy and Program Development (OPPD), Bureau of Primary Health Care (BPHC), HRSA
    - Tia-Nicole Leak, PhD, Deputy Director, Strategic Initiatives, OPPD, BPHC, HRSA
    - Mayra Nicolas, MPH, Senior Public Health Policy Analyst, Policy, OPPD, BPHC, HRSA

We also received a presentation from a migrant health community leader:

- National Center for Farmworker Health (NCFH), Farmworker Health Network (FHN)
    - Gladys Carrillo, Director, NCFH, and Chair, FHN

Council members contributed their significant expertise to the discussions, informing the review of progress on actions related to the NACMH's recommendations from the past 3 years. Two key issues emerged, forming the content of the recommendations presented in this letter.

Recommendations

<u>Recommendation I</u>: The Council recommends that HHS take the following actions to ensure the continuity of excellence in health care supports for MSAW:

1. **Make quality awards available to centers that see a high percentage of MSAW patients based on the value of additional services required to meet the needs of this hard-to-reach population but that are not captured in the Uniform Data System (UDS) report.**
2. **Provide supplemental awards, referenced in the PHS Act, to support "additional health services" to develop public health educational interventions related to environmental and occupational health issues that impact the health and well-being of agricultural workers.**
3. **To address the higher cost of care of MSAW, adjust funding formulas for supplemental funding to include additional increases based on the number of total encounters provided to agricultural workers.**

Background

Health centers that provide services to MSAW dedicate significant staff time and financial resources to reduce barriers to care and provide accessible, high-quality services to this hard-to-reach population. This often includes: (1) scouting to identify migrant labor camps; (2) conducting outreach to connect with workers and build rapport and trust; (3) completing time-consuming health assessments and follow-up visits; and (4) traveling to farm sites and residences to provide mobile medical services. Farm and home visits provide the opportunity to observe the workers' surroundings and assess environmental risks that would not be evident within the health center. Such care also allows centers to extend their reach and link workers to the health center when additional needs are identified. This patient-centered approach has significant benefits for the patients and also allows the service providers to better understand what their patients are experiencing.

However, this level of care takes time, involves a team of support staff, and often results in fewer encounters compared to services provided in a clinic. In addition, many of the additional services provided do not generate patient encounters and so can go unnoticed when comparing data from the UDS. For example, per the UDS manual, the following services do not qualify as a countable visit when conducted offsite: health screenings or outreach (e.g., COVID-19 tests, blood pressure checks), group visits (other than for behavioral health), tests and ancillary services (e.g., lab tests, imaging), dispensing or administering medications (e.g., vaccines), health status checks (e.g., health histories, follow-up checks), and other ancillary or supportive services (e.g., women, infants, and children services; transportation). Largely, these services cannot be counted because they do not meet the definitions for independent professional judgment, or because they are ancillary or supportive services. This is an understandable distinction for services that are provided within a health center. However, many of these services are an essential part of MHCs' approach to connect with patients who would otherwise not access care on their own.

In addition, in states where much of the agricultural worker population is uninsured and has low income, most care—even what would be seen as "billable" care—generates little to no insurance or patient revenue. Therefore, the absence of sufficient funding for these "required" services and the lack of

funding for "additional" services, which are critical to providing patient-centered care, create significant financial strain on already tight budgets and put these necessary supports at risk. The lack of sufficient funding also makes it difficult to adequately compensate staff for late-night and weekend hours, adding to difficulties with recruitment and retention.

Migrant health centers and migrant health voucher programs are tasked with reducing health risks of a population that may face unique risks. In addition to taking extra measures to ensure access to the required primary health services expected of all health centers, as defined in the PHS Act, migrant programs spend a lot of time and effort providing services that are classified as "additional services," also described in the PHS Act, including a range of environmental health services and a myriad of occupation-related health services and prevention programs.

When health centers are solely evaluated based on the number of unduplicated patients seen, number of service encounters provided, and select quality care indicators, much of the benefits and impact of the "additional" services they provide may be overlooked. By definition, migrant farmworkers are primarily mobile, resulting in significant challenges for them to receive continuous care and for health centers to demonstrate sustained health outcome improvements.

Impact

Funding adjustments and quality awards would enable federally qualified health centers (FQHCs) that provide health care services to MSAW to be more adequately compensated, facilitating increased quality of care and improved staff recruitment and retention. They would also serve as an incentive for health centers to increase the delivery of otherwise uncompensated care that can have a very positive health impact on this population.

Recommendation II: The Council recommends that HRSA focus efforts on increasing workforce development, recruitment, and retention at health centers that look to increase the longevity of services by new and veteran health care providers serving MSAW.

Background

A thriving community health center workforce is the backbone of community health centers because the workforce is the bridge between the centers and their communities. Considering the vital importance of the health center workforce, a formal and specialized approach to recruitment must be established, especially one that represents the cultures being served. Unfortunately, health centers continue to face workforce challenges due to high attrition rates, employee turnover, and minimal incentives to entice health care workers to stay for the long term.

In 2022, the National Association of Community Health Centers[1] surveyed members about workforce attrition and found that staff departure was most frequently mentioned to be related to financial opportunity, especially at large health organizations. Therefore, creating a health care workforce pipeline is necessary for the longevity of all health centers and to ensure continuity of care, especially

[1] National Association of Community Health Centers, *Current State of the Health Center Workforce: Pandemic Challenges and Policy Solutions to Strengthen the Workforce of the Future,* 2022, https://www.nachc.org/wp-content/uploads/2022/03/NACHC-2022-Workforce-Survey-Full-Report-1.pdf.

for vulnerable populations such as MSAW, further strengthening the need to think about and build innovative approaches.

The Council recommends the following strategies to recruit and retain a robust health center workforce:

1. Funding recommendations
    a. Provide training on culturally responsive and trauma-informed care.
    b. Establish the health center as a collaborative training center to develop educational pathways for staff at all levels to experience job shadowing, mentoring, and on-the-job training.
    c. Support the leveraging and marketing of existing scholarships, tuition assistance programs, and other incentives to FQHC staff.
    d. Support avenues for FQHCs to better compete with larger employers through salary increases and bonuses, focusing on difficult-to-recruit positions.

2. Policy recommendations
    a. Conduct research that identifies the factors (other than competition with for-profit institutions) contributing to workforce attrition.
    b. Support incentives for employee recruitment and retention, such as National Health Service Corps repayment program awards that extend the incentive for scholarship awards for those who stay after satisfying their loan repayment or scholarship requirements.
    c. Create technical assistance and culturally representative training centers to broaden the pipeline for future health care providers, especially primary care physicians and registered nurses who work with agricultural workers.
    d. Develop a framework that guides and establishes uniformity for community and interagency partnerships that is focused on collaborative processes, with a clear vision and mission for a service delivery model that focuses on MSAW.

Opportunity and Impact

High-quality primary care is the foundation of the health care system and contributes to the health and well-being of patients. With quality health care access, especially to primary care, minor health problems can be mitigated before they spiral into chronic diseases. Reducing emergency department visits adds to cost-reduction measures across health care systems. Migrant community health centers are designed as primary care health service centers that serve vulnerable populations such as MSAW and are an ideal place to seek care.

Facilitating MSAW access and engagement with MHCs increases primary care visits, prevents chronic illness, and promotes quality of life. Investing in recruitment, training, and retention of health center staff will increase the effectiveness and outcomes of mobile health units, extended clinic hours, and digital health navigators, which, implemented alone, will not yield the successes that can be achieved by investing in recruiting and retaining health center staff. Growing and strengthening our health center

workforce, which cares for our nation's most vulnerable and hard-to-reach communities, will impact and change the current situation.

Conclusion

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

Sincerely,

Mary Jo Dudley
Chair, National Advisory Council on Migrant Health

cc:
Carole Johnson, Administrator, HRSA, HHS
James Macrae, MA, MPP, Associate Administrator, BPHC, HRSA, HHS
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