

2013

Prevention and Health Promotion among Vulnerable Populations on the U.S.-México Border

SYNTHESIS REPORT

October 31, 2013



Providing international leadership to optimize health and quality of life along the United States-México border

For additional information, please visit the BHC website at www.borderhealth.org.

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The results of these meetings provided the foundation in preparation of this synthesis report.

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Finally, the success of any such initiative is dependent on the interest and dedication of all of health and human services stakeholders and advocates. As such, the NMOBH greatly appreciates the professionalism of all of these participants who dedicated their time to share their experiences and innovative ideas during the stakeholder planning meetings.



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EXECUTIVE SUMMARY

In 2012, the United States–México Border Health Commission (BHC) introduced a new initiative, *Prevention and Health Promotion among Vulnerable Populations on the U.S.-México Border*, to improve access to health and human services and referrals for the most vulnerable border population cohorts residing on the U.S. side of the U.S.-México border and to promote improved preventive and primary care and health outcomes. To carry out this activity, the BHC, through the New Mexico Department of Health Office of Border Health (NM-OBH) and the California Department of Public Health Office of Binational Border Health (CDPH COBBH), convened six regional stakeholder planning meetings with two meetings each held in California, Arizona, and Texas (one including Southwestern New Mexico). The goal of these stakeholder meetings was to gather input from stakeholder agencies and organizations that provide health and human services and/or advocate for improved access to these services for vulnerable populations on the U.S. side of the U.S.–México border region.

Over 200 participants representing over 130 agencies and organizations attended the six meetings that included, among others, local and state health and human services' agencies, community health centers, hospitals, school districts, faith-based organizations, advocacy groups, representatives of the Mexican Consulate and their *Ventanillas de Salud (Windows to Health)* program, and the BHC México Section. In each meeting, participants were asked a series of open-ended questions related to the definition of *vulnerable populations*; health and human services disparities; service access barriers; communication outreach methods with vulnerable populations; the role of community health workers; and the roles and relationships with local, state, and federal government agencies, the Mexican consulates, and the BHC.

Among all regional stakeholder meeting participants, general consensus on cohorts comprising vulnerable populations was identified as follows:

- Low-income and indigents
- Homeless
- Uninsured and underinsured
- Limited and non-English speakers
- Elderly
- Migrant laborers and farmworkers
- Newer immigrants
- Undocumented immigrants

Behavioral and mental health, including substance abuse, were identified as the most important unmet health care needs. This was followed by the lack of facilities, qualified workforce, and health insurance, which result in unmet needs for primary and preventive services. In terms of unmet human services, insufficient staff to meet the demand, followed by a lack of basic human services, especially low-income housing and transportation, was identified. This correlated with the most pursued referrals requested by vulnerable populations, including access to primary care and health insurance; economic and job assistance; and basic human needs such as housing, utilities, transportation, and food assistance.

To improve vulnerable population knowledge on how to access health and human services, participants indicated that improved public information and outreach, such as using radio and television, while effective, should better reflect National Culturally and Linguistically Appropriate Services (CLAS) standards. Participant consensus identified that improved outreach through community health workers (CHWs) is the most effective mechanism to not only improve information dissemination but also to act as a bridge between clients/patients among vulnerable populations and health and human services providers. Participants suggested that CHWs be fully and systematically integrated into the health care model, that

interagency agreements be used to improve coordination and cross-referrals among CHWs, and that the role of CHWs be expanded to include client/patient navigation (including expanded Medicaid and marketplace insurance under the U.S. Affordable Care Act and México's *Seguro Popular [México's universal health care program]*), health screenings, and primary care extenders for continuity of care.

Regarding the role of local, state, and federal agencies and their relationship to local and regional health and human services providers, participants in the six regional stakeholder planning meetings indicated that improved communication, coordination, and effective partnerships and network development are the most important actions necessary to improve efficiency in providing vulnerable populations health and human services access.

Stakeholders suggested that government entities improve their needs assessments at the regional level and use this data to plan and evaluate health and human services programming and to inform funding decisions. Furthermore, health and human services providers recognized that relationships with Native American tribes and nations should be improved through cultural competency and communication and should involve tribal governments and Indian Health Services as partners in interagency networks, local and regional coalitions, and health councils.

While most U.S. border region providers offer health and human services to numerous migrants and immigrants of Mexican heritage, participants identified that coordination with Mexican consulates and their respective Ventanillas de Salud program is generally quite limited. As such, all stakeholder meeting participants recommended the consulates and the Ventanillas de Salud join local and regional interagency meetings and networks, coalitions, and health councils as venues to improve communication and coordination of health and human services provisions to Mexican heritage migrants and immigrants. Cross-training among providers and the consulates/Ventanillas was suggested to better understand each entity's roles and range of services, as well as to facilitate enrollment in expanded Medicaid, private marketplace insurance, and Seguro Popular.

Participants also identified that the BHC's mission, goals, and activities are not fully understood among stakeholders. As such, participants identified that the BHC's role should include facilitating continuous networks with local, state, and federal agencies, as well as local and regionally-represented health and human services providers and advocates; carrying out health and human services needs assessments in the border region; and using resulting data at regional, borderwide, and national levels to influence policy making, planning, and resource allocation on both sides of the border.

Based on the combined regional meeting results, the following recommendations were provided to BHC to inform BHC future programming regarding improved access to health and human services for vulnerable populations:

- Develop a policy initiative focusing on improving access to the most vulnerable of populations residing in the border region.
- Use the Healthy Border 2020 initiative to create a new baseline for monitoring health-related data on topic areas chosen for inclusion, including access to care, as well as targeted assessments on barriers to access and solutions to overcome these.
- Support the development, capacity, and visibility of regional binational coalitions as platforms to coordinate the planning, fundraising, implementation, and evaluation of binational border health programs.

- Support efforts in each of the border states to disseminate information and educate vulnerable populations on the existence and advantages of using 2-1-1 referral services, an information and referral services call center and online searchable database that connects people with needed community services and volunteer opportunities in the United States.
- Promote inclusion of the 13 Mexican consulates and Ventanillas de Salud located in the border region as active members in local and regional coalitions in their respective outreach areas and encourage the development of interagency agreements with health and human services providers to improve migrant and immigrant access to services.
- Advocate for a policy under which community health workers are deemed essential to the U.S. health care system with the Centers for Medicare and Medicaid Services recognizing and remunerating their services.
- Work with the U.S. Department of Health and Human Services/Office of Global Affairs' Health Resources and Services Administration (HRSA) and nursing and medical schools located in the border region to develop a programmatic strategy for cultivating health and human services professionals, including resurrecting and expanding the HRSA-funded Health Careers Opportunity Program and advocating for more physicians under the National Health Service Corps to the border region, with emphasis on recruiting assignees from border communities.
- Develop both a policy advocacy strategy and a public information strategy to raise the BHC's visibility as a recognized leader in border health and implement these strategies in relation to federal, state, and local government agencies and legislators, as well as with local and regional health and human stakeholder organizations and the interagency coalitions that convene them.

As the BHC continues to focus on improving access to care for vulnerable populations, this Synthesis Report serves as a basis for future strategic planning.

INITIATIVE OVERVIEW

In 2012, the United States–México Border Health Commission (BHC) introduced the initiative *Prevention and Health Promotion among Vulnerable Populations on the U.S.-México Border* to improve access to health and human services and referrals for the most vulnerable border population cohorts residing on the U.S. side of the U.S.-México border region and to promote improved preventive and primary care and health outcomes that can benefit low-income families, indigents, migrants and immigrants, and other at-risk groups.

To carry out this activity, the BHC, through the New Mexico Department of Health Office of Border Health (NM-OBH) and the California Department of Public Health Office of Binational Border Health (CDPH COBBH), convened six regional stakeholder planning meetings to assess agencies and organizations that provide, or advocate for, health and human services in the U.S.-México border region. Individual summary reports were prepared and sent to participants for their review and input. Their feedback serves as the principal basis for the preparation of this synthesis report.

OBJECTIVES AND METHODOLOGY

The goal of the stakeholder planning meetings, conducted as workshops, was to gather input from local and regional stakeholder agencies and organizations that provide health and human services and/or advocate for improved access to these services for vulnerable populations on the U.S. side of the U.S.–México border. Meeting objectives included the following:

- Define the number and nature of population cohorts who have limited or no access to health and human services and barriers to access within the outreach sub-regions of each workshop location.
- Define and rank the disparities to health and human services access that adversely affect these population cohorts (e.g., primary health care, health education/literacy, housing, basic human services, pharmaceuticals, and specific clinical therapies).
- Identify current health and human services referral systems and networks, their efficacy, and gaps in these systems.
- Propose strategic and operational interventions aimed at removing barriers, improving access and referrals to services, and improving primary and preventive health care and basic human services provisions for vulnerable populations.

The New Mexico, Texas, Arizona, and California Offices of Border Health collaborated in selecting each of the stakeholder meeting regions and in developing the list of invited participants, organizations, and agencies. Stakeholders were identified from, among others, local and state health and human services agencies, community health centers, hospitals, school districts, faith-based and civic service organizations, advocacy groups for the rights and access to services for vulnerable populations, representatives of the Mexican Consulate and their Ventanillas de Salud program, and the BHC México Section.

Over 200 participants representing over 130 agencies and organizations attended the meetings. The six regional stakeholder planning meetings are listed below:

- Holtville, Imperial County, California—*March 19, 2013*
- San Diego, California—*March 21, 2013*
- El Paso, Texas (including West Texas and Southwestern New Mexico)—*April 10, 2013*
- Nogales, Arizona—*April 15, 2013*

- San Luis, Arizona—*April 17, 2013*
- Eagle Pass, Texas—*April 23, 2013*

Each regional meeting followed a standard agenda that included a moderator presenting workshop objectives and expectations; presentations on health and human services disparities; a review of available health and human resources, organizations, and activities; and a plenary to discuss perceived disparities and gaps in services.

Participants were also distributed into three breakout groups focusing on the following topics: community health workers (CHWs), communications, and health and human services providers. They were provided a list of open-ended questions, some of which were identical for all three groups and several particular to each.¹ The following questions were common to all breakout groups:

- How do you define *vulnerable populations* in your area?
- What should the role of community health workers be in improving access to health and human services for vulnerable populations in your area?
- What would you suggest to improve communication, referrals, and outreach to migrants and immigrants of Mexican heritage?
- What would you propose to improve activity coordination between health and human services providers and the Mexican Consulate and Ventanillas de Salud program?

Breakout group responses were entered into electronic audience polling software for subsequent discussion and interactive participant ranking by priority during the plenary.²

COMBINED STAKEHOLDER PLANNING MEETING RESULTS

In preparation of this synthesis report, rankings developed during the stakeholder planning meetings were combined and re-ranked. The combined results are intended to reflect borderwide ranking of perceived health and human services disparities and barriers to access; suggested priority interventions to improve access; and perceptions of the roles and responsibilities of federal, state, and local government authorities, the Mexican Consulate, and the BHC in reducing barriers and improving access to health care and human services.

Definition of Vulnerable Populations

All breakout groups were asked the following question: *How do you define “vulnerable populations” in your area?* While responses varied, general consensus centered on the following population cohorts considered to be the most vulnerable:

- Low-income and indigents
- Homeless
- Uninsured (and underinsured)
- Limited and non-English speakers

¹ The same set of questions was provided to breakout groups in all six regional meetings.

² Individual stakeholder planning meeting reports were generated to capture regional perspectives on the definition of *vulnerable populations*, perceived health and human services disparities, as well as barriers to and proposed solutions for improving access to health services.

- Elderly
- Migrant laborers and farmworkers
- Newer immigrants
- Undocumented immigrants

Other cohorts mentioned among the most vulnerable but perceived as more important due to their regional location, included the following: Native Americans, disabled/handicapped, mentally ill, and children (especially in single-parent households).

Unmet Needs of Health and Human Services

The CHW group was asked the following question: *What do you see as the four most important unmet health care needs in your area?* The following figure illustrates what participants ranked as the most important unmet health care needs. Behavioral and mental health services, including those related to substance abuse, were identified as the most important unmet needs. The next two identified were limited access to facilities, providers, and insurance and lack of preventive services and screenings. Finally, the lack of specialized clinical services and care was common throughout the border region but especially in rural and smaller urban areas.

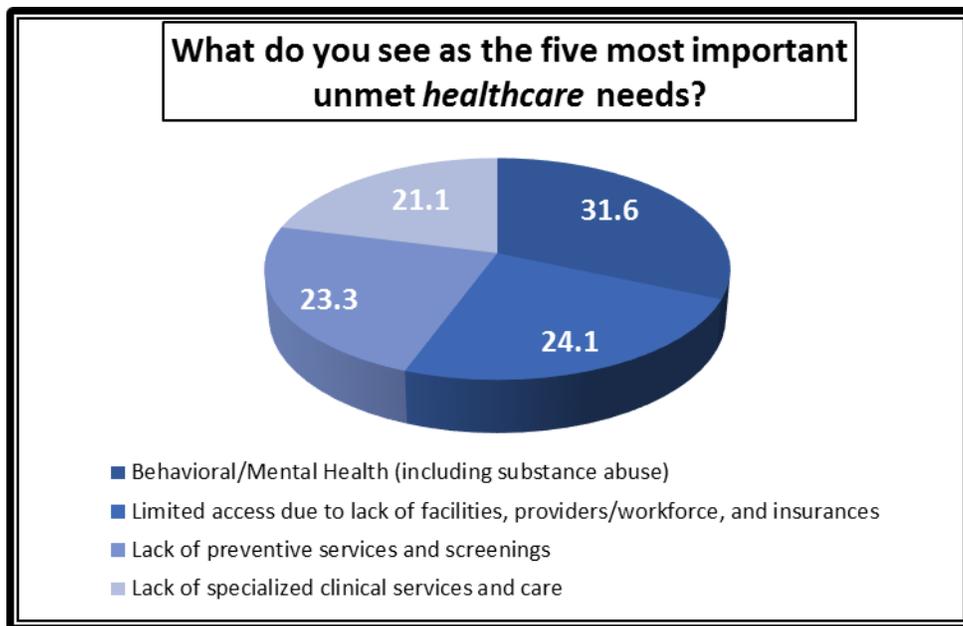


Figure 1. Ranked results (%) of unmet healthcare needs

Similarly, the CHW group provided answers to the following question: *What do you see as the five most important unmet human service needs in your area?* Figure 2 illustrates what participants ranked as the most important unmet human service needs. The highest ranked need was for additional workforce and staff to provide services and guidance for these services. Transportation was identified as not readily available to low-income residents, especially in rural and smaller urban areas where minimal public transportation infrastructure exists, if any, which complicates efforts to access any type of service.

Housing and access to related basic services, such as electricity, heating and cooling, and even safe drinking water and waste disposal, was identified as not attainable for many due to the limits of family

income, indigence, unemployment, and underemployment. The lack of outreach, especially in terms of multimedia that meet Culturally and Linguistically Appropriate Services (CLAS) standards and use of face-to-face encounters with CHWs limit health literacy promotion, as well as knowledge of available services. Finally, a dearth of services for certain populations due to isolated rural areas, lack of transportation, or simply the lack of program outreach and providers was also identified.

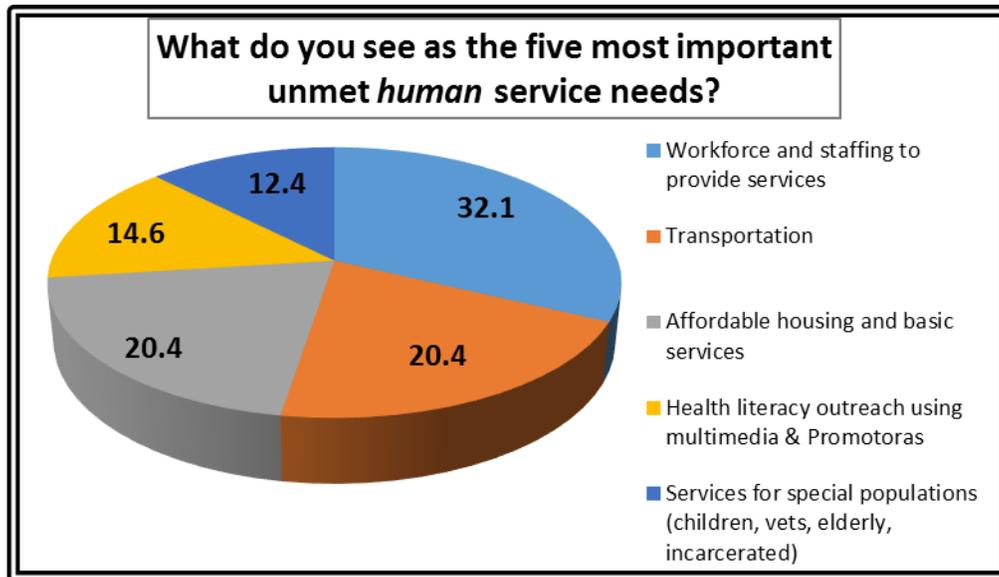


Figure 2. Ranked results (%) of unmet human service needs

Health and Human Services Referrals

The CHW group in each of the regional meetings answered the following question: *What organizations, providers, coalitions, or services are used most frequently by vulnerable populations in your area for referrals on health care and human services?* This question was proposed to determine relative demand for certain services. As can be anticipated, responses varied by region in the types of referrals requested, thus, reflecting the socioeconomic composition and size of the communities. For instance, in San Diego County, California, and El Paso, Texas, which are highly urbanized, housing, economic support, and food banks were the most common referrals. However, in smaller urban and rural regions such as San Luis and Nogales, Arizona, and Eagle Pass, Texas, and Imperial County, California, the higher rated referrals were for health care services, legal aide, housing, the Supplemental Nutrition Assistance Program (SNAP), Mexican consular services, and employment opportunities.

The CHW group was asked the following question: *In your area, what do you see as the top five referrals that are requested by vulnerable populations?* In response, Figure 3 depicts the top requested referral for services taken collectively throughout the border region (**note:** only four were provided). By far, residents request referrals in order to access primary care services and to obtain insurance (largely Medicaid and Medicare). Nearly equally ranked were referrals for economic and job assistance and guidance on where to obtain basic human needs for the following: affordable housing, assistance in paying utilities, transportation, and food assistance. The final most requested referral was for behavioral and mental health services.

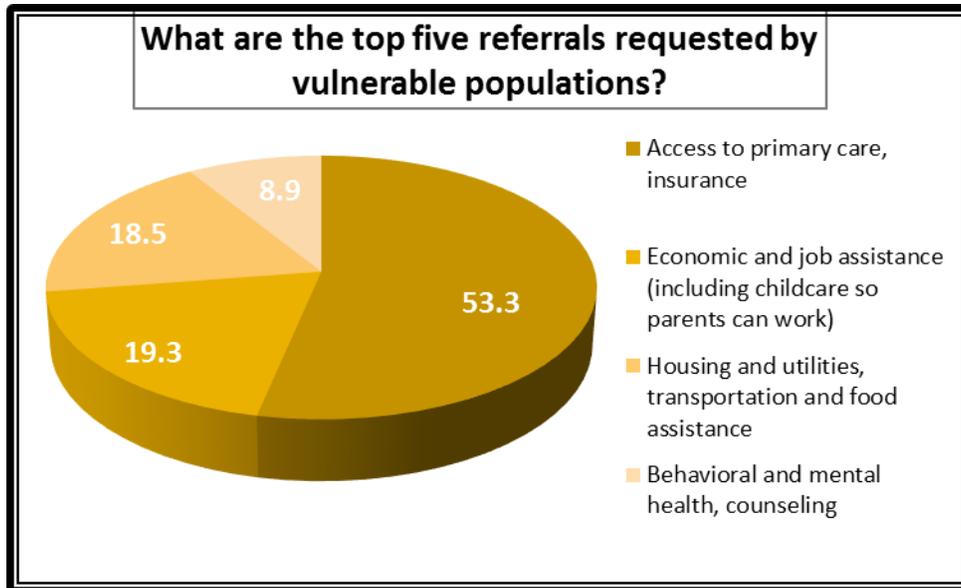


Figure 3. Ranked results (%) of top referrals requested by vulnerable populations

The CHW group was asked to respond to the following information request: *Identify up to five actions or activities that will improve access to information and referrals for vulnerable populations to access health and human services.* Figure 4 illustrates the most important actions recommended to improve vulnerable population access to health and human services information and/or referrals. The majority of participants proposed that improving education and outreach regarding available services, especially at the community level, was the most effective approach. These efforts should involve more creative outreach and culturally-appropriate strategies, especially expansion in the roles and utilization of community health workers in face-to-face (door-to-door) encounters. This outreach should be combined with improved public information using CLAS-appropriate multimedia. Promoting the use of existing and/or improved 2-1-1 services and updated resource directories were also identified as beneficial. Improved networking and partnerships among agencies and organizations were also identified as a means to improve service provision coordination and cross-referrals and reduce the numbers of unserved clients. In addition, participants noted that personnel need additional capacity building and cultural competency training to better serve vulnerable populations.

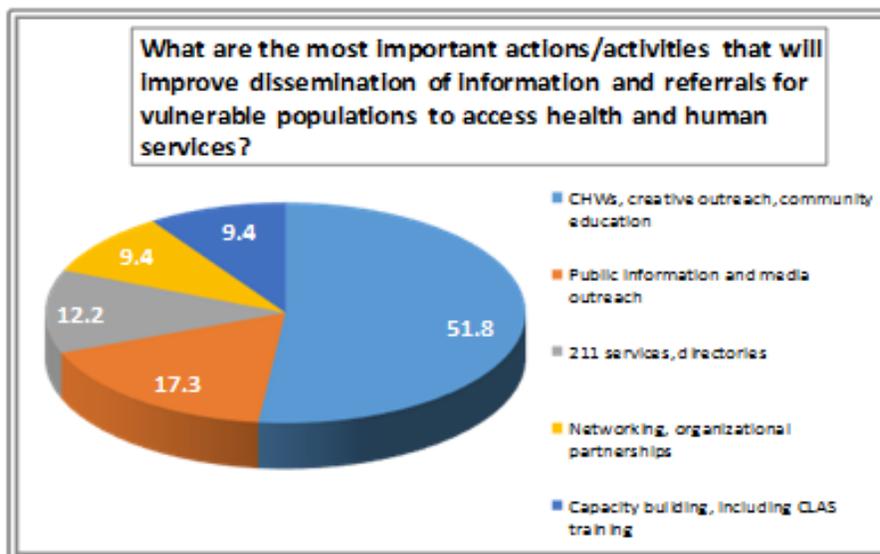


Figure 4. Ranked results (%) of most important actions to improve access of information to health and human services for vulnerable populations

Communications with Vulnerable Populations

The communications breakout group in each regional meeting was asked the following question: *What are the barriers to improving vulnerable populations' education and understanding concerning their health and wellbeing?* Recurring barriers mentioned included culture and language, educational attainment and health literacy levels, and access to communication infrastructure (Internet, social media). Other barriers mentioned were limited provider outreach, transportation, citizenship status, and religious beliefs.

The communications breakout group was also asked the following question: *Currently, what are the most effective community-based mechanisms used by vulnerable populations to get information on health risks and education?* This question produced unified responses among the regions that peer-to-peer outreach by CHWs was the most effective, followed by community meetings (community health councils, town halls, church gatherings, neighborhood associations, etc.), and providers in community health centers. Other mechanisms mentioned in one or more regional meetings included schools, 2-1-1 referral services, and health fairs.

Breakout groups were also asked to respond to the following information request: *Identify up to five of the most popular media sources for vulnerable populations to access their information on health risks and education.* While responses varied by region with six responses provided, radio was identified as the most effective medium since most border residents regularly listen to both U.S. and Mexican radio stations. In fact, meeting participants in Imperial County and Eagle Pass suggested that radio stations respectively in Mexicali, Baja California, and Piedras Negras, Coahuila, would be the most effective in reaching many vulnerable populations on the U.S. side with public service announcements (PSAs) and health education spots.

Television (for both sides of the border) was identified as the next most popular medium for accessing health information with word of mouth still recognized as a highly effective way to disseminate information. While other media identified included newspapers, social media, and posters and flyers, these were identified as less effective due to the limited number of users among vulnerable populations.

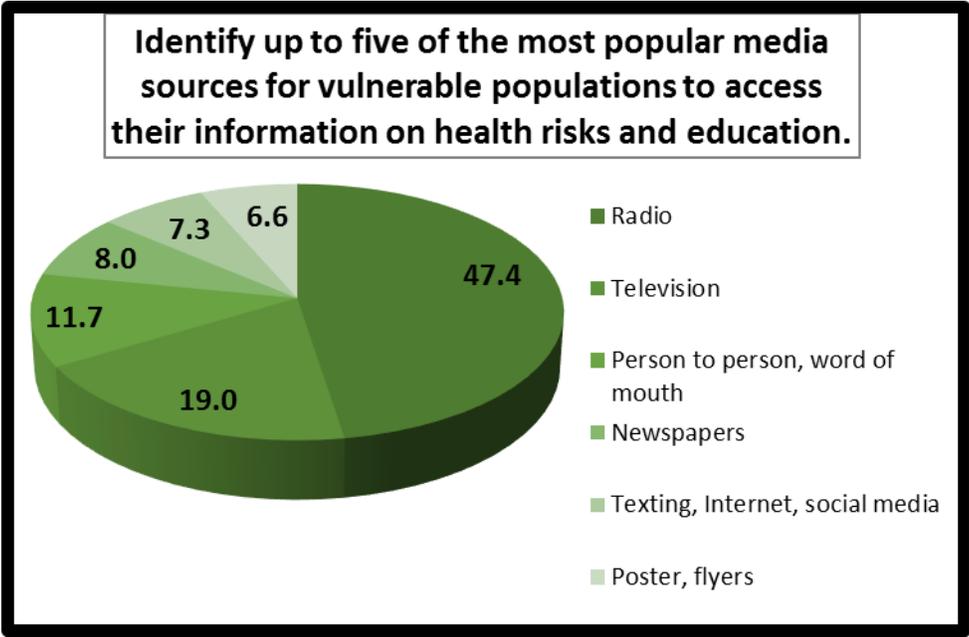


Figure 5. Ranked results (%) of most popular media sources for vulnerable populations to access information

Related to media outreach, participants were also asked to rank answers in response to the following information request: *Identify up to five effective strategies, methods, tools, and/or media that should be used to better disseminate or communicate information on health risks and education for vulnerable populations.* This request was intended to identify and prioritize best strategies to communicate health information to vulnerable populations beyond multimedia. Per Figure 6, peer-to-peer outreach by CHWs was identified as the most effective approach to disseminate health information, followed by community meetings/fora and health fairs; radio PSAs, 2-1-1 referral services, and social media; and social gathering places such as churches, schools, and grocery stores (**note:** only four responses were provided).

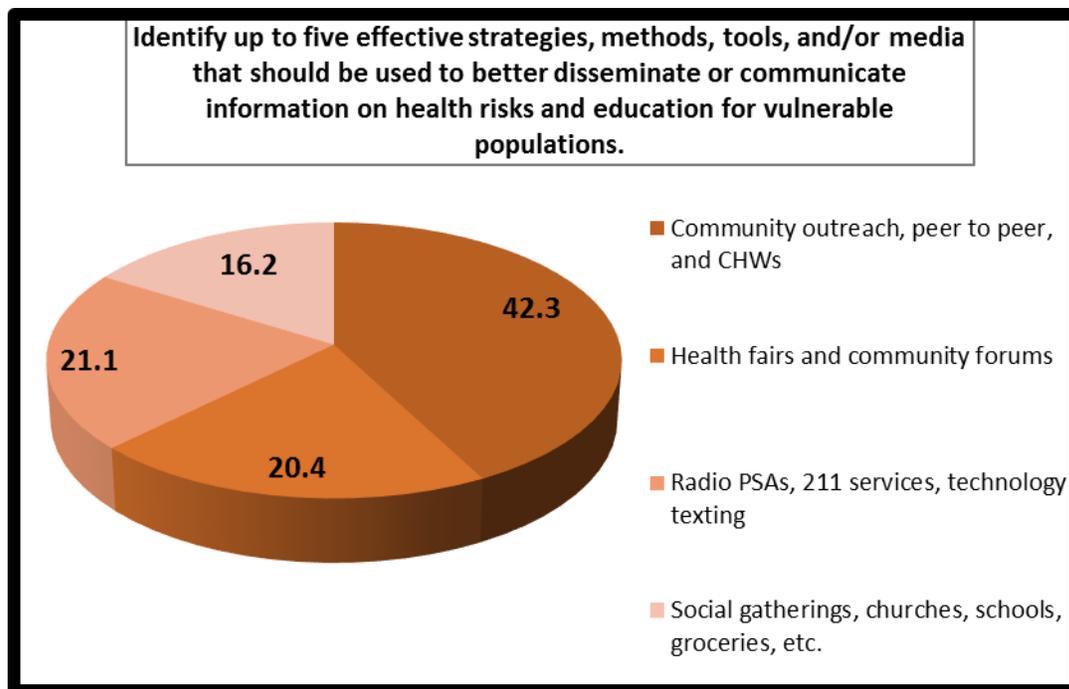


Figure 6. Ranked results (%) of strategies, methods, tools and/or media that should be used to communicate health information to vulnerable populations

Relationship of Vulnerable Populations with Community Health Workers

All breakout groups were asked the following question related to the CHWs: *What should be the role of community health workers (CHWs) in improving access of vulnerable populations to health and human services in your area?* All stakeholder meeting participants indicated that CHWs should serve as the bridge between health care providers and the client/patient. This role was further defined in terms of CHWs serving as an integral part of a health care team as follows: 1) peer-to-peer educators, 2) navigators to facilitate vulnerable populations’ access to health and human services and resources, including expanded Medicaid and the Health Insurance Marketplace under the Affordable Care Act (ACA), 3) provider extenders in continuity of care, and 4) patient advocates.

The communications group was also asked to respond to the following information request: *Identify up to five actions or activities needed to maximize the effectiveness and impact of the work of community health workers to improve vulnerable populations’ access to health and human services.* Based on the combined stakeholder responses (**note:** only four responses were provided) indicated in Figure 7 below, participants stressed the need to develop interagency agreements to coordinate with entities who have not traditionally used CHWs with those who have (e.g., hospitals with community health centers). This would include agreements among various organizations and agencies to establish networks that facilitate cross-referrals for clients/patients and ensure that vulnerable populations gain access to relevant and timely services. Full CHW integration into the health care model was identified as a structural policy action that could formalize the CHWs’ role in areas where they can be used more effectively in a coordinated network of care. Participant consensus was also noted that the CHWs’ role should expand across a wide range of duties, including health screening, health education, continuity of care, as well as client/patient navigation. Finally, as part of their formal integration into the health care model, CHWs should be trained and certified in their roles and hold credentials as testament to this certification.

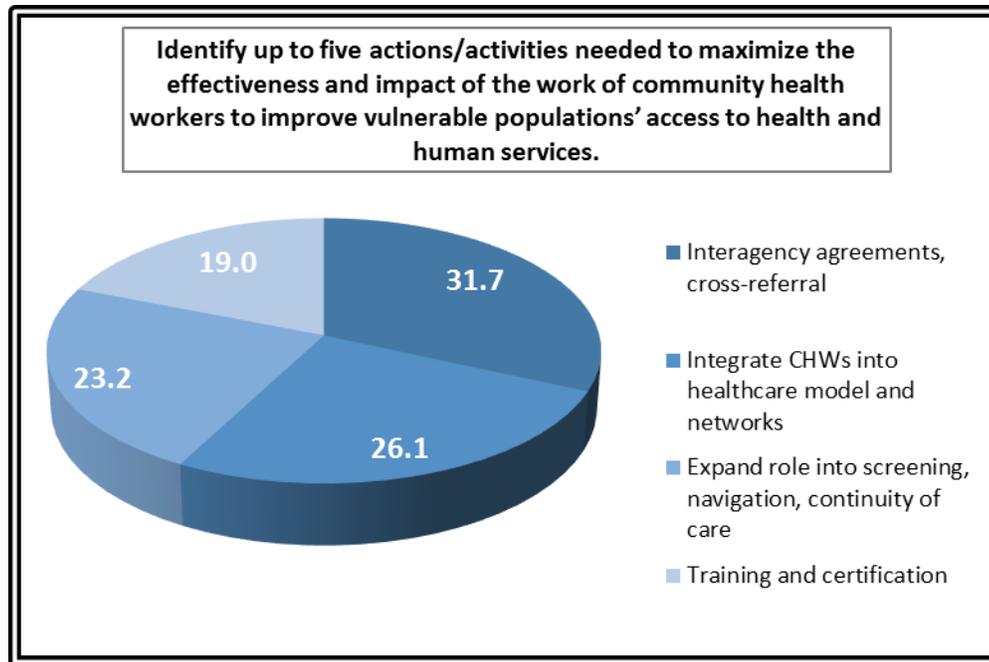


Figure 7. Ranked results (%) of actions needed to maximize the impact of community health workers

Relationship with Local and State Government Service Providers

The service provider breakout group for each regional meeting was asked the following question: *What is the current role of local and state government agencies in improving access of vulnerable populations to health and human services in your area?* Adequate funding provisions for facilities and workforce were mentioned with the most frequency, especially for federally-qualified health centers (community health centers), which serve as the principal portals for primary and preventive care for most vulnerable populations. Several breakout groups acknowledged the government's role in educating the general population and in facilitating training and continuing education for health and human services providers. The role of local and state governments in advocating for policies that improve vulnerable population's access to services was also recognized, as well as mandating and regulating policies. It was also identified that local and state governments should strive to streamline application processes for benefits and services, as these can often be rather complicated and bureaucratic.

The service provider breakout group was also asked to rank their responses to the following information request: *Identify up to five actions or activities to be carried out between health and human service providers and local and state government agencies to improve access for vulnerable populations.* Based on the responses shown in Figure 8 below (**note:** only four responses were provided), even though increased funding to improve facilities and the health and human services workforce rated very high, the need for improved communication and partnerships through more effective networking was identified as the most important action to improve access for vulnerable populations. The lack of coordination and top-down decision making often practiced by local and state governments, with limited understanding of the challenges vulnerable populations often face, was cited as a limitation in targeting resources. Since minorities comprise the majority of vulnerable populations, improved cultural sensitivity on the part of local and state governments was identified as a related and needed action. This led to the third most important action cited by participants: that local and state governments need to improve their health and human services needs assessments to better inform planning and improve evaluation in order to make evidenced-based policy and funding decisions. Improved assessments and planning would, thus, better target current barriers to access for vulnerable populations and, in effect, reduce or remove them.

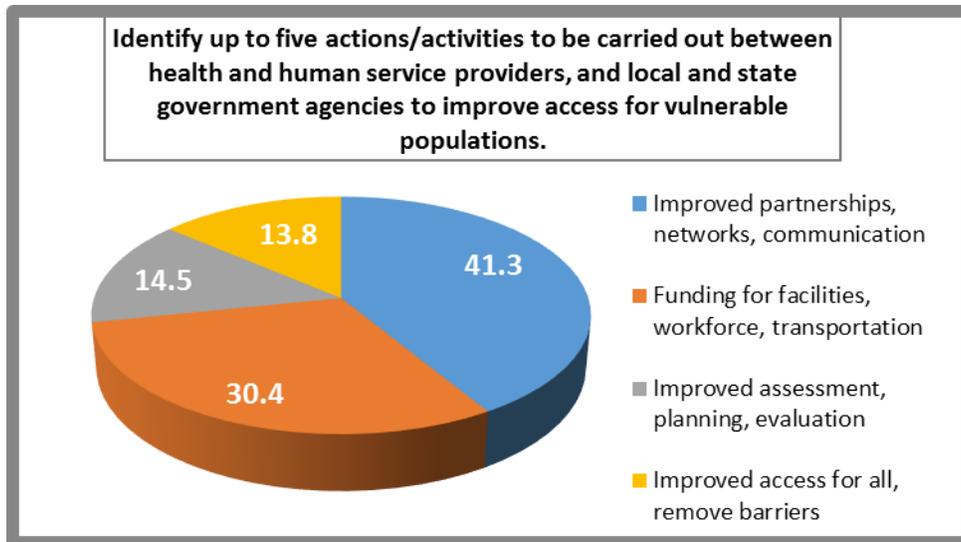


Figure 8. Ranked results (%) of most important actions to be carried out between health and human services, local, and state governments to improve access to healthcare for vulnerable populations

Relationship with Sovereign Native American Nations and Tribes

Since Native American communities are located in or adjacent to all six regions where planning meetings were convened, all service provider groups were asked to respond to the following question: *What actions or activities would you suggest to improve communication, referral, and outreach to members of Native American Nations or tribes in your area?* Stakeholder participants identified the need for cultural competence among health and human services providers as the most important attribute for improving communication with, and access for, Native American communities. Consensus was identified that developing relationships of respect with these communities and their leaders is needed, not only referring to their status as sovereign nations but also recognizing that CLAS-appropriate standards need to be applied. Indian Health Services (IHS) need to be better integrated into existing interagency networks and community health councils, not identified as separate entities in the health care system. As more tribal members are moving away from their traditional homelands to urban areas, non-IHS providers need to be proactive in outreach to Native American clients/patients, and local and state government interaction need to be vastly improved. Eligibility for off-reservation Native Americans to access health and human services should be addressed at the policy as well as provider level.

Relationship with Federal Government Entities

The service provider breakout group in each of the regional meetings was asked the following question: *What is the current role of federal government agencies in improving access of vulnerable populations to health and human services in your area?* Similar to local and state governments, the role of federal government agencies was defined in resource allocation to support health and human services provisions, and in terms of regulating policies and programs, to include proper services delivery enforcement. The range of federal government agency activities was identified as vast, including, but not limited to, funding for federally-qualified health centers; overseeing Medicaid and Medicare, health education, and workforce development; and, most recently, implementing the Affordable Care Act. Even with its multifaceted role, stakeholders indicated that federal agency participation in local and regional networks was limited, and that “partnerships” do not really exist. This potentially was identified in part on how U.S. Department of Health and Human Services’ personnel are distributed geographically, with most staff located in federal regional offices (Region 6 in Dallas and Region 9 in San Francisco), and some in state

capitol cities. Finally, regional meeting participants indicated that binational health care programming was also the lead role and responsibility of federal agencies, even though local and regional providers should be involved.

The service provider breakout group were asked to rank their responses for the following information request: *Identify up to five actions or activities to be carried out between health and human service providers and federal agencies to improve access for vulnerable populations.* As noted in Figure 9 below, stakeholders largely suggested that federal agencies improve their outreach and communication with local and regional health and human services providers and actively participate in partnerships and networks to better coordinate targeting resources and ensuring effective programming. As part of this, federal agencies should carry out better health and human services needs assessments at the regional level, not limiting themselves to data gathered and compared at the state or national level, or only from the U.S. Census. This should be accompanied with improved evaluation frameworks that focus on the impact of programs, with continuing or expanded funding based on successful outcomes. The third most important action was expanding health insurance access to vulnerable populations although many border residents may not qualify due to citizenship status. The federal agencies' role in educating consumers was also highlighted but, again, recognizing the need for CLAS-appropriate communication and media strategies. The fourth most important action was directly related to the second: program funding should be directly related to priorities and needs that are derived from improved needs assessments and evaluation. Stakeholders perceived that current funding formulae are not responsive to actual needs which, in effect, gets distorted at the local and regional level.

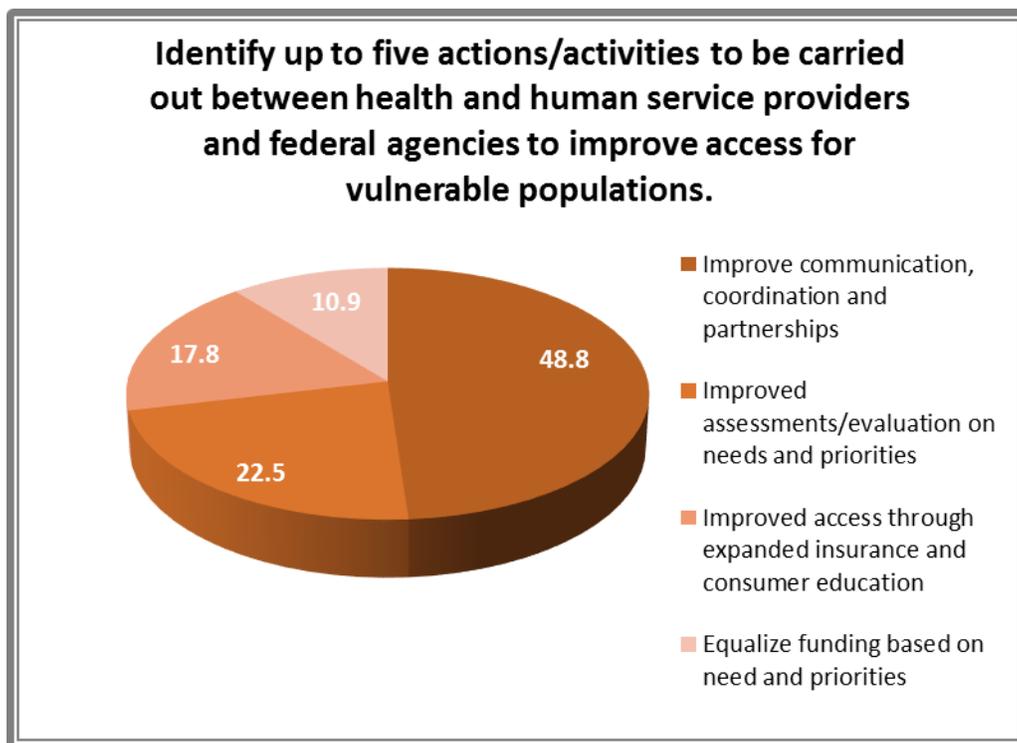


Figure 9. Graph showing ranked results (%) of actions to be carried out between health and human services providers and federal agencies to improve access to healthcare for vulnerable populations

Relationship with the Mexican Consulates and Ventanillas de Salud Program

All breakout groups were asked two questions relating to Mexican heritage residents (including migrants and immigrants) in the United States and the role of the Mexican consulates: 1) *What would you suggest to improve communication, referral, and outreach to migrants and immigrants of Mexican heritage?* and 2) *What would you propose to improve coordination of activities between health and human services providers and the Mexican Consulate and Ventanilla de Salud?* Answers reflected, on one hand, that nearly all providers made health and human services available to residents of Mexican heritage and that, for some providers, the majority of their clients/patients were of Mexican heritage. However, only a limited number of providers were working in some fashion or coordinating activities with the Mexican consulates and Ventanillas de Salud program that serve their respective jurisdictions.

The first question regarding improved communication, referral, and outreach to migrants and immigrants of Mexican heritage, elicited a wide range of responses. Several responses indicated that many of Mexican heritage tend to isolate themselves for cultural reasons from the mainstream. As such, they are hesitant to get involved with community affairs and participate in community-based activities. In part, this is believed to be related to their reactions to negative messaging from political factions, which are played out in the media. Stakeholders suggested that schools and community leaders spread positive “proud of heritage” messages to change the tone in the media. Building trust in, and better communication with, Mexican heritage communities was identified as a bridge to better migrant and immigrant participation in health and human services systems.

Limited English-speaking ability is indeed a barrier, and assimilation into the U.S. system and culture is a structural goal, but language assimilation usually takes two to three generations.³

Understanding the U.S. health care system was another response. This correlates with responses indicating that migrants and immigrants need improved knowledge on the availability and processes to access health and human services. Service providers need training in cultural competency and also need more bilingual staff to better serve the limited-English and Spanish-speaking only populations.

For the second question regarding improved coordination of activities between health and human services providers and the Mexican Consulate and Ventanilla de Salud, many providers responded that they were not aware of all the services offered. As such, it was identified that more information should be circulated in the media and in community meetings. While the Mexican consulates do carry-out “mobile consulates” in different parts of their respective jurisdictions, these are not always well coordinated with local health and human services providers and are often missed opportunities for improved health promotion and education and enrollment for services in which Mexican heritage residents may be eligible. Participants also indicated that many legal Mexican heritage residents in the United States are eligible and can access services in México vis-à-vis Seguro Popular, but they have not been enrolled.

A recurring suggestion made during all six regional meetings was that Mexican consulates and the Ventanillas de Salud should participate in interagency meetings and networks, local coalitions, community health councils, and similar fora. This correlated with recurring suggestions that the consulates and Ventanillas de Salud program develop partnerships with more health and human services providers and together coordinate outreach of health and human services provisions to residents of Mexican heritage. Many regional stakeholder participants also suggested the consulates/Ventanillas and services providers hold cross-training workshops for staff and CHWs, share bilingual education materials, and work with U.S.-based service providers to coordinate health promotion.

³ Pew Hispanic Research Center, *Assimilation and Language*, Survey Brief on the 2002 National Survey of Latinos, March 2004.

Relationship with the U.S.-México Border Health Commission

The service provider breakout group was asked the following question in each of the regional meetings: *What is the current role of the U.S.-México Border Health Commission (BHC) in improving access of vulnerable populations to health and human services in your area?* Participants in the Imperial County and San Diego, California, meetings and the meeting in El Paso, Texas, expressed difficulty answering this question due to their limited knowledge of the BHC. In effect, the meeting format was modified to include a BHC overview for subsequent sessions in Arizona and Texas. Despite these efforts, responses were still somewhat disparate and limited to some of the providers who had actually participated in a Commission-sponsored event, such as Border Binational Health Week (e.g., health fairs, health promotion events) and some who had received a Commission publication. However, some did identify the BHC's role as serving as the liaison between the U.S. government and U.S.-México border entities.

Regional meeting participants were asked to rank their responses to the following information request: *Identify up to five actions or activities to be carried out between health and human services providers and the Commission to improve access for vulnerable populations.* Per Figure 10 below, all participants identified improved networking among health and human services providers and the BHC as an important step toward improving services access for vulnerable populations. Participants suggested that annual or semi-annual regional meetings, similar to the stakeholder planning meeting, would be useful to forge improved coordination with the BHC. Secondly, participants indicated that the BHC should work with local and regional stakeholder organizations and agencies to produce better needs assessments and use data collected to propose binational border health priorities and program planning. One of the actions identified as outside the purview of local and regional health and human services providers, but within that of the BHC, was increasing involvement in developing policies and advocating for improvements in health and wellbeing of U.S.-México border residents. Finally, participants suggested that equitable funding be made available on both sides of the border to address border health and wellbeing issues. Participants identified that disparate funding levels across the border and lack of cross-border health care coordination make it challenging to achieve improvements in the quality of services provided and in health outcomes.

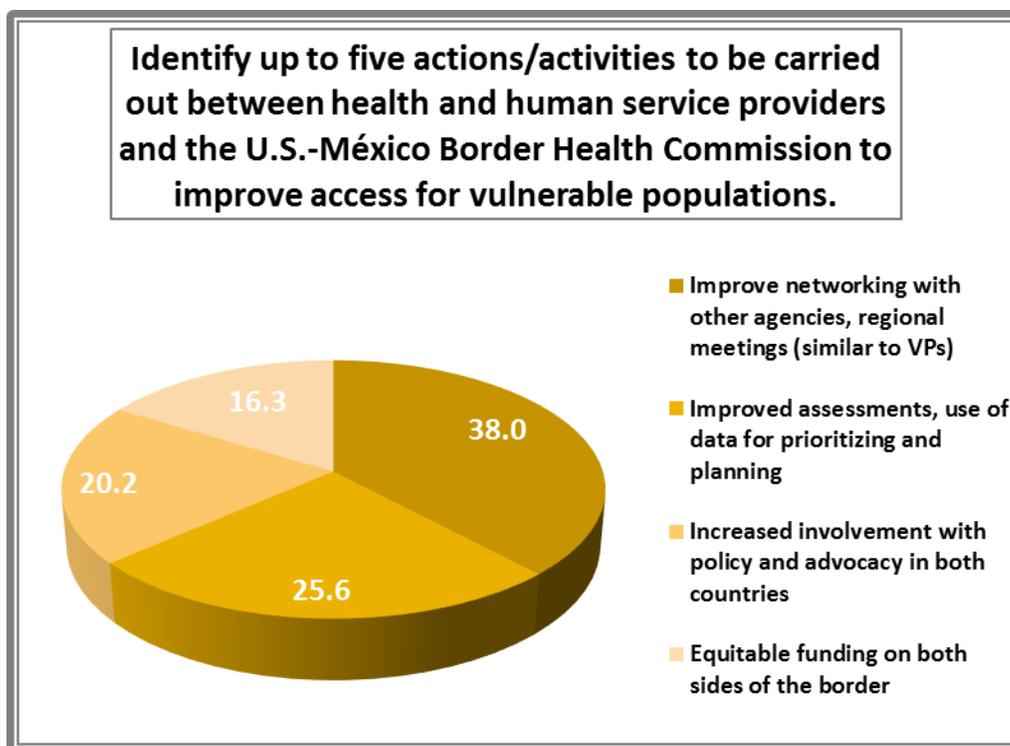


Figure 10. Graph showing ranking results (%) of actions to be carried out between health and human services providers and the Border Health Commission to improve healthcare access for vulnerable populations

SUMMARY FINDINGS AND CONCLUSIONS

General consensus from representatives of over 130 agencies and organizations active in the provision of and/or advocacy for health and human services to vulnerable populations on the U.S.-México border was achieved on various items. These included the following: cohorts who are defined as vulnerable populations; perceptions on unmet health and human services; and recommendations concerning strategies in reducing barriers to access, as well as the role of health and human services providers, local, state, and federal government agencies, the Mexican consulates and their Ventanillas de Salud program, and the U.S.-México Border Health Commission.

Cohorts Defined as Vulnerable Populations

The following cohorts were considered vulnerable populations in all six regions: low-income and indigents, homeless, uninsured (and underinsured), limited and non-English speakers, elderly, migrant laborers and farmworkers, newer immigrants, and the undocumented. Immigrants, and especially the undocumented, were the least likely to have employer-based health insurance, a medical home, or recent contact with a health provider for primary and/or preventive care.⁴

Perceptions on Unmet Health and Human Services

Behavioral and mental health, including substance abuse, was identified as the most important unmet health care need. This was followed by the lack of facilities, qualified workforce, and health insurance,

⁴ Institute of Medicine, *Coverage Matters: Insurance and Health Care*, October 2001.

which result in unmet needs for primary and preventive services. In terms of unmet human services, insufficient staff to meet the demand was identified, followed by a lack of basic human services (especially low-income housing and transportation). This correlated with the most sought-after referrals requested by vulnerable populations as follows: access to primary care and health insurance; economic and job assistance; and basic human needs of housing, utilities, transportation, and food assistance.

Recommended Strategies in Reducing Barriers to Access

Lack of knowledge among vulnerable populations concerning available health and human services and how to access those services was a recurring issue cited in all six meetings. Participants indicated that although improving public information and outreach, such as using radio and television, can be effective, media strategies should better employ Culturally and Linguistically-Appropriate Services (CLAS) standards.

Community health workers (CHWs) were identified as the most effective mechanism to improve information dissemination. This role was further defined in terms of CHWs serving as an integral part of a health care team as follows: 1) peer-to-peer educators, 2) navigators to facilitate vulnerable population access to health and human services and resources, including expanded Medicaid and the Health Insurance Marketplace under the Affordable Care Act (ACA), 3) provider extenders in continuity of care and 4) patient advocates.

Improved communication, coordination, and the development of effective partnerships and networks was cited as the most important action to improve overall efficiencies in providing vulnerable populations access to health and human services. Stakeholders suggested that government improve their needs assessments at the regional level and use these data to plan and evaluate health and human services programming, especially considering the cultural and linguistic diversity in the border region.

Participants further indicated that funding formulae consider equalization based on needs assessments, cultural awareness, and evaluations reflecting best practice and promising interventions at the community level. Also, health and human services providers recognized that they need to improve their relationship with Native American tribes and nations with better cultural competency awareness and communication and involve tribal governments and Indian Health Services as partners in interagency networks and local and regional coalitions and health councils.

Inasmuch as providers in the U.S. border region offer health and human services to numerous migrants and immigrants of Mexican heritage, coordination with Mexican consulates and their respective Ventanillas de Salud program is quite limited. Many participants indicated that they were unaware of the types of services the consulates and the Ventanillas de Salud program provide.⁵ As such, stakeholder participants recommended that the consulates and the Ventanillas de Salud join in local and regional interagency meetings and networks, coalitions, and health councils as venues to improve communication and coordinate effective provision of health and human services to Mexican heritage migrants and immigrants. Cross-training among providers and the consulates/Ventanillas de Salud program was suggested to better understand each entity's roles and range of services, as well as to coordinate outreach to these vulnerable population cohorts, including facilitating enrollment in expanded Medicaid, ACA, and Seguro Popular.

It was concluded that the U.S.-México Border Health Commission's (BHC) mission, goals, and activities were not readily understood among many of the stakeholders who attended the planning meetings, linking the BHC narrowly to Border Binational Health Week, health fairs, and some of its publications. As such, stakeholders identified that the BHC's role should be to facilitate continuous networks with local, state,

⁵ Representatives of the Mexican consulates in El Paso and Calixico were invited and made presentations as part of the agendas of stakeholder planning meetings held in those locations.

and federal agencies, as well as local and regionally-represented health and human services providers and advocates. The BHC's role in carrying out health and human services needs assessments in the border region was also highlighted, including using data at regional, borderwide, and national levels to influence policymaking, planning, and resource allocation on both sides of the border.

RECOMMENDATIONS to the BHC

Policy and Advocacy

The following recommendations were identified with respect to how the BHC can inform policymakers in both the United States and México regarding improving health access for the most vulnerable border populations:

- Formally recognize CHWs as integral elements of the U.S. health care system and endorse eligibility for reimbursement under Medicare and Medicaid (as well as private insurances).
- Promote binational insurance instruments that provide coverage and link services on both sides of the border for Mexican migrants and immigrants.
- Enhance binational infectious disease surveillance, epidemiology, and response to outbreaks⁶.
- Enhance funding for binational tuberculosis control programs and differential payment for binational tuberculosis cases, which often require two to five times the resources to manage.
- Increase funding under the National Health Service Corps (NHSC) and increase physician assignments to border communities, recruiting especially from those medical students originating in the border region.
- Resurrect and expand the HRSA-coordinated Health Careers Opportunity Program (HCOP) that aligns formal high school-to-college education tracks for minority and rural-based students into allied health careers, which can be broadened to include human services professionals.
- Expand nursing and medical schools in the border region to increase the number of primary and family practice clinicians (including expansion of loan repayment programs in exchange for services in rural and minority majority communities).
- Utilize greater broadband and Internet access for vulnerable populations, including low-income and rural residents, to facilitate access to health-related information and to take full advantage of emerging telemedicine technologies and virtual continuity of care between patients and their providers.
- BHC members should educate Executive and Legislative branches of both governments for needed changes that can inform policy initiatives.

Border Health Assessments

The BHC should develop a HB 2020 baseline database and update it annually for borderwide use, with open U.S.-México border stakeholder access to assist with planning and monitoring purposes. One issue to consider in developing the database was that of scale, wherein data is made available at county/municipality levels (or even the sub-county level) so that data can be effectively applied at the level of local jurisdictions and/or regions.

⁶ Funding under the Early Warning Infectious Disease Surveillance program lapsed in 2012.

Other recommendations to improve border health assessments also included the following: 1) develop specialized and targeted assessments, using qualified researchers from border region universities, to develop a more intensive assessment of barriers and solutions to accessing health and human services and 2) include research issues related to current systems and processes used by government agencies and service providers to enroll and track clients for such services.

Networking

The BHC should put more emphasis and resources into supporting the development, capacity, and visibility of regional binational coalitions. These coalitions should be strategically formed around operating binational health councils (also known as COBINAS) and/or similar existing coalitions and strive to include all relevant health and human services stakeholders on both sides of the U.S.-México border. The BHC should also consider providing funding for coalition officers training and members in areas such as planning and evaluation, grant-making, and public relations, moving into more programmatic actions, which can bring about improvements in access and services delivery systems and improved interagency communication and coordination for cross-referrals. The coalitions' work should also be identified in the binational context, as residents in these regions access services on both sides of the border and include the Mexican consulates and their Ventanillas de Salud program where possible.

2-1-1 Referral Services

The BHC support efforts in each of the border states to disseminate information and educate vulnerable populations on the existence and advantages of using 2-1-1 referral services, as follows: 1) manage directories for nearly all health and human services and providers in their calling regions; 2) offer bilingual/multilingual and culturally sensitive assistance; and 3) keep calls with clients confidential. Education outreach could come in the form of multimedia (bilingual radio PSAs, posters, and flyers/pamphlets) distributed to all health and human services stakeholder organizations, as well as strategic gathering places including health fairs, senior centers, Ventanillas de Salud, grocery stores, etc. This effort should be coordinated with 2-1-1 services in each respective region.

Mexican Consulates and Ventanillas de Salud

The BHC better integrate efforts under the Mexican Secretariate of Health's *Estrategia Integral para la Salud del Migrante (Integrated Migrant Health Strategy)* with its current initiative Prevention and Health Promotion among Vulnerable Populations on the U.S.-México Border (PHPVP), as the overall goal of both initiatives is to improve health and human services access for U.S.-México border residents, including Mexican migrants and immigrants, and cohorts who have been identified as vulnerable populations. The activities being carried out under the current BHC initiative, Prevention and Health Promotion among Vulnerable Populations, were developed not only to complement the Integrated Migrant Health Plan, but also to facilitate strengthening the relationship between the Ventanillas de Salud program and the numerous health and human services providers working in border counties of all four U.S. border states.

Community Health Workers

The BHC support efforts under which CHW services be recognized and reimbursed by the Centers for Medicare and Medicaid Services (CMS), thereby, reflecting the new focus under the Affordable Care Act on overall wellness and client-centered care. CHWs would contribute to improvements in client navigation, enrollment in Medicaid/insurance exchanges, culturally and linguistically-appropriate health education, and promotion and prevention interventions, in effect, contributing to more effective continuity of care, health outcomes, and reduction in overall health care costs for both the United States and México.

The BHC support actions that habilitate effective CHW certification and training programs in each of the three U.S. border states that currently do not have any credentialing process (currently, only Texas has a program). Furthermore, the BHC provide guidance under the HHS/Office of Global Affairs (OGA) cooperative agreements in all four of the U.S. border states to contribute to CHW certification and training programs and to begin organizing and delivering CHW training in core and specialization capacities, including, but not limited to, computer/Internet skills; cultural competency; client and community assessment; peer-to-peer communication and interpersonal skills; teaching/pedagogy in health literacy; public and private insurance navigation (ACA, Seguro Popular); human services navigation; health screening (e.g., high blood pressure, cholesterol); in-home health and safety; prevention interventions (e.g., nutrition and physical activity); continuity of care of chronic diseases; and in-home health care. Ventanillas de Salud staff should be invited to these training events.

Workforce Development

The BHC work with HHS/OGA and the Health Resources and Services Administration (HRSA) to develop a programmatic strategy for cultivating health and human services professionals from border communities. This strategy should consider expansion of HRSA's HCOP as a measure to navigate high school-to-college education tracks for minority and rural-based students into allied health careers. The strategy should also consider advocating for more physicians to the border region under the NHSC, with emphasis on recruiting assignees from the U.S.-México border region.

The BHC consider convening deans of medical and nursing schools located in the U.S.-México border region to form a coalition to support both HCOP, increase recruitment of students from the border region, and advocate for more NHSC assignees.

The BHC support efforts for more public-private partnerships to expand the capacity of nursing and medical schools, especially for minority (Hispanic, Native American) and rural students from the border region to increase the supply of primary and family practice clinicians, including advocacy among members' respective state legislatures for loan repayment programs targeting students now residents of the border region.

Branding

The BHC develop both a policy advocacy strategy and a public information strategy to raise its visibility as a recognized leader in support of its mission: *to provide international leadership that can optimize health and quality of life along the U.S.-México border.*

These strategies could address the following at a minimum:

- *E-BH Bulletin*—Proactively enroll all possible government agencies and provider organizations in the E-Border Health Bulletin and use the bulletin send out resources.
- *Bilingual Public Information Campaigns*—Develop and fund bilingual public information campaigns using multimedia throughout the U.S.-México border region, working with broadcasters (e.g., radio and television affiliates in México and the U.S.) to broadcast similarly targeted PSAs, novelas, documentaries, and audio and video educational serials.
- *Press Releases*—Send out press releases on upcoming BHC-sponsored conferences and meetings, including the Annual Meeting of the BHC, as well as newsworthy border health data, studies, reports, best practices, and success stories in collaboration with health and human service stakeholder agencies and organizations, as appropriate, to develop local, regional and/or state-specific features.
- *BHC Website (www.borderhealth.org)* —
 - Redesign to be more user-friendly.

- Create a toggle for English and Spanish versions in which the web design and materials presented are mirrored as much as is feasible in each language. The website should serve as a clearinghouse of relevant border and border health and human services information of interest to policy and decision makers, public health practitioners, students and researchers, and the general public.
- Include a separate data section, in which Healthy Border 2020 baseline data sets and annual updates on tracking indicators are presented, potentially also including query tools to help researchers, students, and providers ascertain analyses pertinent to their work.
- Ensure links are provided to other website resources with relevant information and data sets, and/or documents, serving as a resource repository.

As the BHC continues to focus on improving access to care for vulnerable populations living in the U.S.-México border region, the conclusions and recommendations identified in this Synthesis Report will serve as a basis for future strategic planning.

APPENDIX

Agendas

- [Holtville, Imperial County, California](#)—*March 19, 2013*
- [San Diego, California](#)—*March 21, 2013*
- [El Paso, Texas](#) (including West Texas and Southwestern New Mexico)—*April 10, 2013*
- [Nogales, Arizona](#)—*April 15, 2013*
- [San Luis, Arizona](#)—*April 17, 2013*
- [Eagle Pass, Texas](#)—*April 23, 2013*

Participant Questions

- [Group 1](#)
- [Group 2](#)
- [Group 3](#)

2-1-1 Directories

- [California](#)
- [New Mexico](#)