Georgia Farmworker Health Program (GFHP)

Policies and Procedures Manual

Migratory and Seasonal Agricultural Workers Health

2024-25

Preface

The State Office of Rural Health (SORH) under the auspices of the Georgia Department of Community Health (DCH) takes its responsibility to improve upon health care and health outcomes in rural Georgia very seriously. It seeks to work with and strengthen existing networks and is dedicated to engaging others in forming a broader health care system to satisfy the expanding needs of Georgia's rural communities. As such, SORH is uniquely positioned to understand the needs of the community it serves. It has, as part of its primary goal, the pursuit and direction of resources to address those needs. Among its efforts is the Georgia Farmworker Health Program (GFHP).

GFHP was established in 1990 within the Department of Human Resources' Office of Primary Care. In January 2000, the Program was transferred to the SORH within DCH. The new SORH was subsequently moved from Atlanta to Cordele, Georgia.

The U.S. Public Health Service is a federal agency in the Federal Security Agency, under the U.S. Department of Health and Human Services, established by the Public Health Service Act (42 U.S.C.S. 201 *et. seq*., 2008) and administered by the Public Health Service Administration. Among other things, the Act allows for the Public Health Service Administration to assign personnel to a state along with supportive salary funding, for the promulgation of regulations necessary to the administration of the Service and for the Secretary of the Public Health Service to determine that a public health emergency exists and make appropriate response including the use of grants from a Treasury fund, the Public Health Emergency Fund (42 U.S.C.S. Sections 215, 216 and 247d). GFHP, as a statewide migrant health center program, receives federal funding under Section 330G of the Public Health Service Act (codified at 42 U.S.C.S. Section 254b).

The Program's federal funding is obtained from the Bureau of Primary Health Care (BPHC) within the U.S. Department of Health and Human Services' Health Resources and Services Administration. The Bureau administers federal funds distributed in accordance with the Migrant Health Program. The Migrant Health Program (MHP) provides grants to community non-profit organizations for a variety of culturally and linguistically competent medical and support services to migratory and seasonal agricultural workers and their families.

In addition to their contract funds, providers may also obtain direct funding or donations from other sources, such as community groups, medical institutions, and local medical care providers. The providers also obtain funds from fees charged the farm workers for the services provided in house. The fees are assessed using a sliding scale based on income and federal poverty guidelines. The scale is revised annually to reflect the federal poverty guidelines that are updated annually. The sites may also establish and charge a minimum flat fee for services;

however, services cannot be denied to patients who are unable to pay the minimum fee. The income generated from these fees is retained by the providers and may be carried over to the following grant year.

Georgia supplements federal dollars received for GFHP with state funds. It has assigned the management of GFHP to SORH. This places considerable fiduciary responsibility upon SORH in its management of GFHP to adhere in the strictest sense to all funding and reporting requirements. It is imperative that GFHP remain in compliance with all applicable federal and state regulations. Both federal and state prohibitions exist concerning the provision of federal and state public benefits or assistance to non-qualified aliens.

The decision to deny federal, state and local public benefits to aliens not qualified to receive them was made by Congress and found in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("Welfare Reform Act"). United States Attorney General Order No. 23532001 states that the Welfare Reform Act, among other things, vests in the Attorney General the authority to specify certain types of community programs, services or assistance for which all aliens remain eligible (66 Fed Reg 3613). Under this Act, aliens who are not "qualified aliens" are generally ineligible for federal, state and local public benefits. However there are a number of specified exceptions to those restrictions. Included in the list of statutory exceptions is a provision authorizing the Attorney General to identify programs, services and assistance to which the Act's limitations on alien eligibility do not apply. Pursuant to the Act, the Attorney General **may exempt only** those types of programs, services and assistance that **meet a three-prong test** set forth by Congress **by satisfying all** of the following three criteria: (1) deliver in-kind services at a community level, including service delivery through public or private non-profit agencies; (2) does not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and (3) are necessary for the protection of life or safety.

While the Welfare Reform Act authorizes exemptions for "programs, services or assistance" that meet the three-prong test, the Attorney General has no authority to provide a blanket exemption for all programs authorized by a single statute. This is because one or more of those programs may fail to meet all of the requirements imposed by the statute. Agencies and service providers must assess a program individually to determine whether it meets the three-prong test. Attorney General Order No. 2353-2001 specifically states that any state or federally funded program that is required as a condition of their funding to employ sliding scales, or to otherwise limit the access to services according to a client's income or ability to pay would not qualify for exemption under the Attorney General's Order. However where community-level health programs serve all eligible clients regardless of their ability to pay and do not administer any type of sliding scale fee schedule or other income test, they are covered by the Attorney General's Order. Specifically, services for Migratory and Seasonal Agricultural workers (MSAW)s must meet the requirements of the three-prong test in order to be exempt under the Order.

Attorney General Order No. 2353-2001 is also specific that service providers and other interested parties should not assume that verification of citizenship or immigration status is required when its program or service is not exempted by the Order. Parties are advised to refer to benefit-granting agencies' interpretations of the term "federal public benefit" as used in the Act in order to determine whether their program is a federal public benefit and therefore subject to the alienage restrictions of the Act. The Order offers the example that the Department of Health and Human Services (HHS) notice of interpretation of federal public benefit. HHS advises that HHS programs not listed in the notice, such as Community Health Centers, and programs under the Ryan White Comprehensive AIDS Emergency (CARE) Act of 1990, as amended by the Ryan White CARE Act
Amendments of 1996 and 2000 (codified under Title XXVII of the Public Health Services Act) and the
Older Americans Act of 1965 (42 U.S.C. Section 3011 *et seq*.), do not meet the statutory definition of "federal public benefit" and therefore do not have to verify the citizenship or immigration status of applicants or recipients.

The Georgia Security and Immigration Compliance Act of 2006 (Senate Bill 529 of the 2006 Georgia General Assembly, enacted as Act 45; 2006 Ga. ALS 457; 2006 Ga. Act 457; 2005 Ga. SB 529; Ga. Comp. R. & Regs. r. 300-10-1-.01(2007)) requires that every agency or a political subdivision of this state shall verify the lawful presence in the United States of any natural person eighteen years of age or older who has applied for state or local public benefits, as defined in 8 U.S.C. Section 1621, or for federal public benefits, as defined in 8 U.S.C. Section 1611, that is administered by an agency or political subdivision of this state. (Georgia Security and Immigration Compliance Act which amended O.C.G.A. Section 50-31-6.) The Act states further that it shall not apply to, and lawful presence in the United States shall not be required where, among other things, (1) for any purpose for which lawful presence in the United States is not required by law, ordinance or regulation; (2) for assistance for health care items and services that are necessary for the treatment of an emergency medical condition, as defined in 42 U.S.C. Section 1396b(v)(3), of the alien involved and are not related to an organ transplant procedure; (3) for public health assistance for immunizations with respect to diseases for which vaccines are developed and for testing and treatment of symptoms of communicable diseases whether or not such symptoms are caused by a communicable disease; (4) for prenatal care; (5) for programs, services or assistance such as soup kitchens, crisis counseling and intervention, and short-term shelter specified by the United States Attorney General, in the United States Attorney General's sole and non-reviewable discretion after consultation with appropriate federal agencies and departments, which:

(A) deliver in-kind services at the community level, including through public or private nonprofit agencies;

(B) do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and (C) Are medically necessary for the protection of life or safety.

Items A, B and C under number 5 above are the same criteria as that used by the Attorney General in the three-prong test exemption under the Welfare Reform Act (Attorney General Order No. 23532001).

Additionally, Attorney General Order No. 2353-2001 stresses that deference is given to the determination, if one has been made, by the benefit granting agency as to whether the program is a federal public benefit. Agencies and service providers should also note that Section 432(d) of the Welfare Reform Act which provides that nonprofit charitable organizations are not required to verify the immigration status of applicants for Federal, State, or local public benefits, may be applicable to their programs. (See Department of Justice, Verification of Eligibility for Public Benefits, 63 FR 41662, 41664 (1998)) (to be codified at 8 C.F. R. pt. 104).

Regulations applicable to federal grants for M health services are found at 42 C.F.R. Part 56.

Attention is called to the requirements of title VI of the Civil Rights Act of 1964 (78 Stat, 252, 42 U.S.C. 2000d *et seq*.) and in particular section 601 of the Act which provides, among other things, that no person in the United States shall on the grounds of national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial participation (42 C.F.R. Section 56.110). A regulation implementing such title VI, which applies to grants for migrant health services, has been issued by the Secretary of Health and Human Services with the approval of the President (45 C.F.R. Part 80). Additionally, Appendix A, Part I of the Civil Rights Act (45 C.F.R. Part 80) lists categories of federal financial assistance to which the Act applies and specifically includes migratory workers health services (section 310, Public Health Services Act, 42 U.S.C. 242h) at number 81, and project grants for services for migratory agricultural workers at number 133 (45 C.F.R. Part 80, Appendix A, Part 1, 81, 133). [1] Also Appendix A, Part 2 of the Civil Rights Act is applicable to continuing assistance to state administered programs for grants to States for establishing and maintaining adequate public health services (section 314d Public Health Service Act, 42 U.S.C. Section 246d) (45 C.F.R. Part 80, Appendix A, Part 2, 21). Regulations for grants for migrant health services are applicable to all grants authorized by section 319 of the Public Health Service Act located at 42 U.S.C. 247d (42. C.F.R. Section 56.101). Federal regulations at 42 U.S.C.S. Section 247d apply to public health emergencies allowing the Secretary to take such action as may be appropriate to respond to the public health emergency.

GFHP is administered by the Director of Migrant Health, Homeless and Special Programs within the

[1] 42 U.S.C.S. Section 242h was transferred and now appears as 42 U.S.C.S. Section 247d.

Office of Rural Health Services. In addition to the Director, the Program has a full time Program Operations Specialist, both of which, are responsible for administering the contracts with the providers, maintaining financial of program activities, and providing technical assistance to the project sites.

Under the SORH, the mission of the Georgia Farmworker Health Program (GFHP) is to improve the quality of life of Georgia's Migratory and Seasonal Agricultural workers (MSAW(s)) and their families by providing high quality, culturally sensitive and appropriate health care to agricultural workers using all available financial, human and technological resources.

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MISSION

The mission of the Georgia Farmworker Health Program (GFHP) is to improve the quality of life of Georgia's Migratory and Seasonal Agricultural workers (MSAW(s)) and their families by providing high quality, culturally sensitive and appropriate health care to agricultural workers using all available financial, human and technological resources.

DEFINITIONS of AGRICULTURE & AGRICULTURAL WORKERS

MIGRATORY AGRICULTURE WORKER: Individuals whose principal employment is in agriculture and who have been so employed within the last 24 months and who established for the purposes of such employment a temporary abode (HRSA Glossary; https://bphc.hrsa.gov).

SEASONAL AGRICULTURE WORKER: Individuals whose principal employment is in agriculture on a seasonal basis and who do not meet the definition of a migratory agricultural worker (HRSA Glossary; https://bphc.hrsa.gov).

AGRICULTURE: The term "agriculture" means farming in all its branches, including cultivation and tillage of the soil; the production, cultivation, growing, and harvesting of any commodity grown in or on, the land; and any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm or in conjunction with an activity described in this clause. This definition also includes Christmas tree farming, pine seedling planting, pine straw collection, and nursery workers.

<table>
<tr><th colspan="3">Section 330(g) or the Public Health Service Act</th></tr>
<tr><th>Migratory</th><th>Seasonal</th><th>Aged/Disabled</th></tr>
<tr><td>Principal employment is agriculture</td><td>Principal employment is agriculture on a seasonal basis</td><td rowspan="3">Former migratory agricultural workers who are unable to work in agriculture due to old age or disability.

Family members of the individuals who meet the stated qualifications</td></tr>
<tr><td>Employed within the last 24 months</td><td>Employed within the last 24 months</td></tr>
<tr><td>Establish a temporary home for the purpose of working in agriculture</td><td>Is not a migratory worker

Has not established a temporary home in order to work in agriculture</td></tr>
<tr><td colspan="3">NOTE: Workers and their family members receive the same classification</td></tr>
</table>

Classifications of Agriculture

Areas of agriculture included in the Migratory and Seasonal Agricultural Workers Health Program are:

- **111 Crop Production**
  - **1151 Support Activities for Crop Production**
  - **1111** Oilseed and Grain Farming
  - **1112** Vegetable and Melon Farming
  - **1113** Fruit and Tree Nut Farming
- **112 Animal Production and Aquaculture**
  - **1152 Support Activities for Animal Production**
  - **1121** Cattle Ranching and Farming
  - **1122** Hog and Pig Farming
  - **1123** Poultry and Egg Production

Refer to the *2017 North American Industry Classification System Manual* for detailed information regarding these classifications.[2]

Agricultural Tasks Performed by Migratory and Seasonal Agricultural Workers

NAICS	Agricultural Sector	Tasks
111	**Crop Production**. "Industries in the Crop Production subsector grow crops mainly for food and fiber. The subsector comprises establishments, such as farms, orchards, groves, greenhouses, and nurseries, primarily engaged in growing crops, plants, vines, or trees and their seeds". http://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=111&search=2012 NAICS Search	• Preparing, irrigating or spraying the fields, orchards or nurseries • Planting, picking, sorting, packing, or transporting fruits, vegetables, grains, nuts, plants, tobacco, hops, flowers, grass, alfalfa, hay, or other agricultural products • Planting trees; working with Christmas trees; picking pine needles or Spanish moss, etc.
1151	**Support Activities for Crop Production** "This industry comprises establishments primarily engaged in providing support activities for growing crops. http://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=11511&search=2012 NAICS Search	• Aerial dusting or spraying • Farm management services • Cotton ginning • Planting crops • Cultivating services • Vineyard cultivation services

[2] https://www.census.gov/eos/www/naics/2017NAICS/2017_NAICS_Manual.pdf: pg. 81-103

112	**Animal Productions and Aquaculture**. "Industries in the Animal Production and Aquaculture subsector raise or fatten animals for the sale of animals or animal products and/or raise aquatic plants and animals in controlled or selected aquatic environments for the sale of aquatic plants, animals, or their products. The subsector includes establishments, such as ranches, farms, and feedlots. Primarily engaged in keeping, grazing, breeding, or feeding animals. These animals are kept for the products they produce or for eventual sale. The animals are generally raised in various environments, from total confinement or captivity to feeding on an open range pasture". http://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=112&search=2012%20NAICS%20Search	• keeping, grazing, breeding, or feeding animals • Caring for chickens, ducks, turkeys, cows, goats, sheep, fish, clams, etc.
1152	**Support Activities for Animal Production** "This industry comprises establishments primarily engaged in performing support activities related to raising livestock (e.g., cattle, goats, hogs, horses, poultry, sheep)". http://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=115210&search=2012 NAICS Search	• breeding services for animals, including companion animals (e.g., cats, dogs, pet birds); • pedigree record services; • boarding horses; • dairyherd improvement activities; • livestock spraying; • sheep dipping and shearing

PROGRAM ELIGIBILITY REQUIREMENTS

Any MSAW, as defined above, is eligible for this program. MSAWs must have agriculture, as defined above, as their principal employment. Disclosure of citizenship or legal status is not required to be eligible for this program. NOTE: MSAWs with third party payment sources, such as Medicaid, are eligible for the program as well. Refer to section titled Financial Systems, for third party billing information.

Eligibility for the Georgia Farmworker Health Program is determined during the registration process. It is important that registration information is accurately completed. The recommended sequence of questions to determine employment eligibility is located on the Georgia Farmworker Health Program Registration Form (see Appendix A).

There are some instances where income documentation is not obtainable, such as mobile camp visits, pop-up clinics and health fairs. Unless an individual follows up at a GFHP service site for continued

treatment or additional health care services, proof of income will not be required in order to be seen that day.

A. Income Requirement

Income status must be determined and verified annually. Income is defined as total cash receipts before taxes from all sources. Forms of **Income** verification are:

- Wages, tips and salaries before any deductions;
- Net receipts from farm and non-farm self-employment;
- Regular payments from public assistance, including
  - Temporary Aid to Needy Families (TANF)
  - Supplemental Security Income (SSI),
  - Emergency Assistance payments
  - Social security
  - Unemployment
  - Worker's compensation
  - Strike benefits from union funds, if applicable
  - Veteran's benefits
  - Training stipends
  - Alimony
  - Child support
  - Military family allotments
  - Other regular support from an absent family member or someone not living in the household
  - Government/private pensions
  - Regular insurance or annuity payments.

Patients can also use recent paycheck stubs and/or direct deposit notifications from the prior month to determine income. Individuals who are unable to provide written verification of income can provide a signed statement briefly explaining source of support. This is known as a self-declaration and should be documented using a Self-Declaration Form (refer to Appendix B). This will serve as proof of income for a total of (90) days. Once the income self-declaration period expires, patients are expected to produce proof of income on their next visit or pay full charges for services. Individuals will not qualify for a sliding fee discount (**Refer to Sliding Fee Discount Policy**: **Appendix C**) until income is verified. Patients will not be refused care regardless of their ability to pay.

B. Definition of Family

Family is defined as a group of people who share common ancestors or a group of people that may be made up of partners, children, parents, aunts, uncles, cousins and grandparents. **Family size** is defined as all who live in the same household including relatives and cohabitants, with some person or persons contributing economic support for the communal unit. Married children and their families must be registered separately even if the married children are living with their parents. If two families live

together, they must be registered separately. The federal poverty guidelines are applied separately to each family and/or unrelated individuals.
Family unit size of one is a family unit of one who is an unrelated individual 15 years or older, who is not living with relatives. This person may be the only person living in a housing unit or may be living in housing in which others live, but to whom the individual is not related by birth, marriage or adoption.

A pregnant woman is counted as two persons in determining family size.

The current Poverty Income Guidelines for income and payment determination can be found at http://aspe.hhs.gov/poverty/ . Reviewers should visit the Web site periodically to ensure that the guidelines have not changed.

PROGRAM MANAGEMENT

Federal regulations, content of the GFHP grant application and strategic plan will guide program design and implementation. The state office's role will be to direct policy development and implementation, program development and implementation, monitoring and evaluation, data collection and reporting, funding requests, training and education for site personnel, a state advisory board, and public information efforts. The state office will also support the governing board of GFHP as required by federal regulations governing migratory/seasonal farm worker programs. Contracted project sites will be responsible for developing a visible program for MSAWs, for providing direct services, documenting services and costs, publicizing the program, linking with other agencies involved with MSAWs, and establishing and staffing local advisory boards. Contracting project sites will also be responsible for documenting data associated with patient care and utilization in the Uniform Data Reporting System (UDS) annually.

A. Clinical Information Systems

Patients' records will be developed and maintained in accordance with Georgia law. The record may include presenting problem, history, physical examination findings, diagnoses, problem list, treatment plan, medication treatments, medication reconciliation, laboratory tests with reports, and medical imaging reports, counseling and education consultation reports and plans for follow up and/or referral as appropriate to the patient's presenting conditions.

Each patient will have a plan of care based on a medically approved protocol. Problems should be prioritized with a date and plan for each problem. Assessment, planning and follow up will reflect the patient's respective life cycle and relative disease prevention and health promotion activities. Sensitivity to culture, language, educational level, environment and transitory status of the patient must be integrated throughout.

With each patient encounter, a staff member, will be responsible for coordinating any needed follow up care. Medical and dental referral authorization forms (voucher forms) are located in Appendix E and F. These forms should be sent to referral physicians, dentists, and other health providers or agencies, with a section to be completed and returned to the issuing clinic indicating action taken and follow-up needed. A time frame for receiving information and follow up for the referral to an outside provider may be established to assure that the information is returned to the referring site. It is recommended that one person employed by the contracted project site be selected for making and following up all referrals whether they be medical or dental to assure that patients received the care. When the report is received the patient record should be updated with the outcome of the referral. The patient record should be routinely reviewed to determine which problems remain unresolved in order to review and reprioritize health care needs with the patient.

Patient data will be entered into the Electronic Medical Record (EMR) system. Name, address, birth date, sex, race/ethnicity, language, occupation, income, family size, appropriate ICD-10 and CPT procedural terminology codes, clinics attended, provider and provider type must be included. This information will be used to compile program data for state and federal reporting as well as to serve as a resource for monitoring clinical outcomes that are essential to quality management.

B. Quality Assurance/Continuous Quality Improvement

The **Quality Assurance/Continuous Quality Improvement (QA/CQI) Guide (See Attachment II)** is to be used by each GFHP project site to conduct periodic in-house chart audits, preceptor reviews, administrative reviews, voucher utilization reviews and instituting standards of care which are essential to quality management.

Clinical outcome baselines for all GFHP sites will serve as the focal point of respective CQI efforts. The clinical outcome baselines will be used to establish targets and measure improvement for life cycles. The clinical outcomes for this implementation plan will be provided by each of the GFHP project sites to generate quarterly QI project data, QI project reports and data comparisons for all GFHP sites combined, improvement recommendations, and targets set by the staff. Each project site may conduct QI activities and report on their success at each quarterly QI meeting. Quarterly updates may be presented to the GFHP Advisory Board. Information will include the measure studied, initial baseline, interventions designed to improve patient care and results of the interventions. Each site will also discuss their next steps to continue to improve performance on the selected measures.

Project sites will be required to participate in chart audits and other quality assurance activities of the GFHP. Projects will also be responsible for the quality management assessment of both the services provided on and off-site as well as services provided within the approved scope of service area. Refer to the **GFHP QA/CQI Plan: Attachment I** for guidance.

HEALTH CENTER REQUIREMENTS

A. Health Center Required Services

Federal guidelines require that MSAWS have access to primary health care services.[3]

The term "required primary health services" means basic health services which, for purposes of this section, shall consist of -

Required Services include:

- General Primary Medical Care - health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives;
- diagnostic laboratory and radiologic services
- prenatal and perinatal services;
- appropriate cancer screening;
- well-child services
- immunizations against vaccine-preventable diseases
- screenings for elevated blood lead levels, communicable diseases, and cholesterol
- pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
- Obstetrical Care: Prenatal, Intrapartum Care (Labor & Delivery, Postpartum Care;
- preventive dental services;
- Coverage for Emergencies during and after hours
- pharmaceutical services as may be appropriate for particular centers;
- Substance Use Disorder Services;
- Case Management, Eligibility Assistance, Health Education, Outreach, Transportation/Access, Translation

Additional Services may include:

- Additional Dental Services
- Behavioral Health Services: Mental Health; Substance Use Disorder
- Vision Screening; Optometry Services
- Physical Therapy
- Environmental Health Services
- Nutrition

[3] Source: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section254b&num=0&edition=prelim

B. Clinical Staffing and Staff Responsibilities

The GFHP will utilize physicians, physicians assistants (PA), nurse practitioners (NP) or nurses, (all in good standing and licensed to practice in the state of Georgia), bilingual outreach and clerical staff workers who will implement the above components, with referral to outlying physicians as needed. Project staff may facilitate access to existing health department resources as appropriate. Contracted sites in GFHP include public health departments, federal qualified health centers and hospital based clinics. In projects which support nurse practitioners, the NP will provide primary care services within the terms and conditions of the approved protocols. This includes services such as blood pressure monitoring, family planning, medication needs for managing diseases such as diabetes and hypertension, physical assessment and diagnosis of primary care issues and immunizations.[4]

C. Credentialing and Privileging

As a federally funded project, GFHP is required to assure that all licensed independent practitioners (LIPs) and other licensed certified practitioners (OLCPs) are credentialed and privileged according to the requirements outlined in the Health Center Compliance Manual (available at https://bphc.hrsa.gov). The Health Center Compliance Manual has included all previous policy information notices (PINs) related to credentialing and privileging of all LIPs and OLCPs. The following information provides definitions and examples of both LIPs and OLCPs.

- **Licensed or Certified Health Care Practitioner:** an individual required to be licensed, registered, or certified by the State, commonwealth or territory in which a Health Center is located. These individuals include, but are not limited to, physicians, dentists, registered nurses, and others required to be licensed, registered, or certified (e.g., laboratory technicians, social workers, medical assistants, licensed practical nurses, dental hygienists, nutritionists). The definition will vary dependent upon legal jurisdiction. "Licensed or certified health care practitioners" can be divided into two categories: a) licensed independent practitioners (LIPs) and b) other licensed or certified practitioners.

- **Licensed Independent Practitioners:** physicians, dentist, nurse practitioner, and nurse midwife or any other "individual permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges" (from Joint Commission on Accreditation of Healthcare Organizations (JACHO).

- **Other Licensed or Certified Health Care Practitioner:** An individual who is licensed, registered, or certified but is not permitted by law to provide patient care services without

[4] Source: https://www.law.cornell.edu/cfr/text/42/491.8

direction or supervision. Examples include, but are not limited to, laboratory technicians, social workers, medical assistants, licensed practical nurses, dental hygienists.

Several documents will be required to as part of the credentialing/privileging process for both LIPs and OLCPs. Some of these documents must be obtained through primary source verification and other may be obtained through secondary source verification. The following information defines primary source and secondary source verification materials. Privileging and competency are also addressed:

- **Primary Source Verification:** Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. Examples of primary source verification include, but are not limited to, direct correspondence, telephone verification, internet verification, and reports from credentials verification

  organizations. The Education Commission for Foreign Medical Graduates (ECFMG®), the American Board of Medical Specialties, the American Osteopathic Association Physician Database, or the American Medical Association (AMA) Masterfile can be used to verify education and training. The use of credentials verification organizations (CVOs) or hospitals that meet JCAHO's "Principles for CVOs" (see Appendix A) is also an acceptable method of primary source verification.

- **Secondary Source Verification:** Methods of verifying a credential that are not considered an acceptable form of primary source verification. These methods may be used when primary source verification is not required. Examples of secondary source verification methods include, but are not limited to, the original credential, notarized copy of the credential, a copy of the credential (when the copy is made from an original by approved Health Center staff).

- **Privileging/Competency:** The process of authorizing a licensed or certified health care practitioner's specific scope and content of patient care services. This is performed in conjunction with an evaluation of an individual's clinical qualifications and/or performance.

Each contracting project site must credential and privilege their LIPs and OLCPs according to the requirements in the Health Center Compliance Manual. GFHP must provide guidance on the process for those organizations not familiar with the federal requirements in the form of a credentialing/privileging policy/procedure that outlines the requirements for each organization. Each contracting project site must maintain a credentialing/privileging file for each LIP and OLCP employed by the organization. This file should be maintained separately from the personnel and/or health file for each individual. The GFHP may audit these files at any time. The information regarding credentialing/privileging must be shared with the GFHP to assure appropriate completion of the process.

In areas where the local MSAW health center is connected to the public health district, MSAWs will be allowed to access the program through any county health department in the target area. While MSAW health program staff will generally establish eligibility and enroll MSAWs, health department staff must be trained by program staff in registration procedures to facilitate this process in the event MSAW health staff are not available.

D. Utilization of Grant Funds

1. Allowable use of Grant Funds:

- Primary care physician office visits (internists, family practice physicians, etc.)
- Minor surgical procedures conducted in physician's office
- Necessary diagnostic lab and medical imaging procedures
- Prescriptions when needed to complete treatment (generic drugs are desirable whenever possible and according to formulary)
- Transportation for patients who would otherwise lack access
- Preventive dental care and emergency care to relieve pain or infection for adults and children, i.e., routine cleaning, gross caries, infections, inflamed gums, toothache (does not include services such as cosmetic dentistry, root canals, dentures, or orthodontics)
- Vision care if related to illness excluding glasses
- Mental health and substance abuse counseling
- Outpatient hospital care
- Referred specialty care as needed

*** The MSAW health program will only pay for those procedures/services within the above categories which is allowable under Medicaid.

2. Use of Hospitals

GFHP staff will provide follow up for the patient, but will not fund or otherwise support inpatient hospitalizations through use of any GFHP funds or services funded by GFHP. Contracted project sites should develop a MOU or MOA to provide inpatient care to those MSAWs that require hospitalization. The agreement should provide details of what services will be provided by the hospital and a mechanism for communicating with the contracted project site regarding discharge and follow up care. Contracted project sites must implement a tracking process that identifies one person by title who is responsible for tracking all patients who are hospitalized or seen in the emergency room. The process must specify a time frame for contacting the patient after the hospitalization episode and make an appointment for a follow up patient visit with the primary care provider at the contracted project site.

Use of the hospital emergency room for non-emergency care should be strongly discouraged. Because grant funds are limited, the program will only pay for emergency room care for true emergencies on an

exception basis with the cost not to exceed $50. The hospital should treat MSAWs needing emergency care as they would any other indigent patient.

3. Prohibited Use of Grant Funds[5]

In accordance with the requirements mandated by the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Division B, Pub. L.
115-245, signed into law on September 28, 2018, which provides funding to the Health Resources and Services Administration (HRSA) for the fiscal year ending September 30, 2019. The intent of this policy bulletin is to provide information on the following statutory provisions that limit the use of funds on HRSA grants and cooperative agreements for FY 2019. Legislative mandates remain in effect until a new appropriation bill is passed setting a new list of requirements. There is one requirement mandated by the FY 2018 Consolidated Appropriations Act 2018 (Public Law 115-141), signed into law on March 23, 2018, that is currently under a continuing resolution. The FY 2019 list of legislative mandates for HRSA award recipients is the same as the FY 2018 list.

(1) Salary Limitation (Section 202)

"None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II."

The Executive Level II salary is currently set at $189,600; however, we anticipate this changing January 1, 2019.

(2) Gun Control (Section 210)

"None of the funds made available in this title may be used, in whole or in part, to advocate or promote gun control." Division B, Title V

(3) Anti-Lobbying (Section 503)

" (a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used, other than for normal and recognized executive legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

[5] Source: https://www.hrsa.gov/sites/default/files/hrsa/grants/manage/grants-policy-bulletin-2019-02.pdf

(b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

(c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control."

(4) Acknowledgment of Federal Funding (Section 505)

"When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state –

(1) the percentage of the total costs of the program or project which will be financed with Federal money;
(2) the dollar amount of Federal funds for the project or program; and
(3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources."

(5) Restriction on Abortions (Section 506)

"(a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion. (b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion. (c) The term ''health benefits coverage'' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement."

(6) Exceptions to Restriction on Abortions (Section 507)

"(a) The limitations established in the preceding section shall not apply to an abortion –

(1) if the pregnancy is the result of an act of rape or incest; or
(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

(d) (1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. (2) In this subsection, the term ''health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."

(7) Ban on Funding of Human Embryo Research (Section 508)

"(a) None of the funds made available in this Act may be used for –

(1) the creation of a human embryo or embryos for research purposes; or

(2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

(b) For purposes of this section, the term ''human embryo or embryos'' includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

(8) Limitation on Use of Funds for Promotion of Legalization of Controlled Substances (Section 509)

"(a) None of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act except for normal and recognized executive-congressional communications.

(b) The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage."

(9) Restriction of Pornography on Computer Networks (Section 520)

"(a) None of the funds made available in this Act may be used to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.

(b) Nothing in subsection (a) shall limit the use of funds necessary for any federal, state, tribal, or local law enforcement agency or any other entity carrying out criminal investigations, prosecution, or adjudication activities."

(10) Restrictions on Funding ACORN (Section 521)

"None of the funds made available under this or any other Act, or any prior Appropriations Act, may be provided to the Association of Community Organizations for Reform Now (ACORN), or any of its affiliates, subsidiaries, allied organizations, or successors."

(11) Restriction on Distribution of Sterile Needles (Section 529)

"Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law."

The following Legislative Mandate is part of FY 2018 Consolidated Appropriations Act 2018 (Public Law 115141), signed into law on March 23, 2018, and is part of a Continuing HRSA Grants Policy Bulletin 2019-02E 5 Appropriation that is subject to change following the enactment of future FY19 appropriations.

<u>Division E Title VII</u>

(11) Confidentiality Agreements (Section 743)

(a) None of the funds appropriated or otherwise made available by this or any other Act may be available for a contract, grant, or cooperative agreement with an entity that requires employees or contractors of such entity seeking to report fraud, waste, or abuse to sign internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or contractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.

(b) The limitation in subsection (a) shall not contravene requirements applicable to Standard Form 312, Form 4414, or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

E. Accessible Locations and Hours of Operation

GFHP contract sites must be available and accessible in the service area promptly, as appropriate, and in a manner which ensures continuity of service to the residents of the center's catchment area. In order to maintain compliance:

a. The health center's service site(s) are accessible to the MSAW population relative to where the MSAW population lives or works. Specifically, the health center considers the following factors to ensure the accessibility of its sites:
    - Access barriers (for example, barriers resulting from the area's physical characteristics, residential patterns, or economic and social groupings); and
    - Distance and time taken for patients to travel to or between service sites in order to access the health center's full range of in-scope services.

b. The health center's total number and scheduled hours of operation across its service sites are responsive to patient needs by facilitating the ability to schedule appointments and access the health center's full range of services within the HRSA-approved scope of project (for example, a health center service site might offer extended evening hours 3 days a week based on input or feedback from patients who cannot miss work for appointments during normal business hours).

F. After Hours Coverage

To assure continuity primary health services, the health center must have:
- Provisions for promptly responding to patient medical emergencies during the health center's regularly scheduled hours; and
- Clearly defined arrangements for promptly responding to patient medical emergencies after the health center's regularly scheduled hours.

The GFHP contract sites must fulfill the following requirements to ensure HRSA Health Center compliance:

a. Have at least one staff member present at each approved service site who is trained and certified in basic life support to ensure each site has the clinical capacity to respond to patient medical emergencies during regularly scheduled hours of operation.

b. Have and follow applicable operating procedures when responding to patient medical emergencies during regularly scheduled hours of operation.

c. Have after-hours coverage operating procedures, which may include formal arrangements with non-health center providers/entities, that ensure:
    - Coverage is provided via telephone or face-to-face by an individual with the qualification and training necessary to exercise professional judgment in assessing a health center patient's need for emergency medical care;

- Coverage includes the ability to refer patients either to a licensed independent practitioner for further consultation or to locations such as emergency rooms or urgent care facilities for further assessment or immediate care as needed; and
- Patients, including those with limited English proficiency, are informed of and have the ability to access after-hours coverage, based on receiving after-hours coverage information and instructions in the language(s), literacy levels, and formats appropriate to the health center's patient population needs.

d. Have documentation of after-hours calls and any necessary follow-up resulting from such calls for the purposes of continuity of care.

Prescribed Medications

Whenever possible, GFHP program sites will obtain medications at low or no cost utilizing programs such as the Federal 340-B drug program or free/reduced cost medications through patient assistance programs offered by some pharmaceutical companies.

Dental Services

MSAWs will be provided with preventive dental care, including fluoride supplementation where fluoridated water is lacking, sealant treatment and routine cleanings, fillings and extractions. Anyone enrolled with Medicaid will be referred to dentists accepting Medicaid payment. Dental care and treatment for alleviating pain and/or conditions associated with an emergency will be determined on a case-by-case basis . Contracted project sites may provide dental care to the MSAWs directly or through formal agreement.

Behavioral Health/Substance Use Disorder

Contracted program sites will ensure accessibility to mental health and substance use disorder services, either directly or through formal agreement.

Transportation

Contracted program sites with no transportation assets may use program funds to pay for transportation to enable a MSAW health program patient to obtain health services. Funds will be used sparingly. Medicaid policies and rates will apply. All attempts must be made to obtain "free" transportation before utilizing program funds for this purpose.

FINANCIAL SYSTEMS

The SORH for the GFHP will monitor and evaluate budgets and expenditures on a monthly basis. Cost reports
(Refer to GFHP Cost Report: Appendix F) will be submitted as scheduled in the Deliverables section of the Notice of Grant Award Agreement. If there is a change in the budget from the project's plan, local projects are required to submit a budget revision and explanation of changes to the SORH for approval prior to expending any funds or making any changes to existing budget expenses.

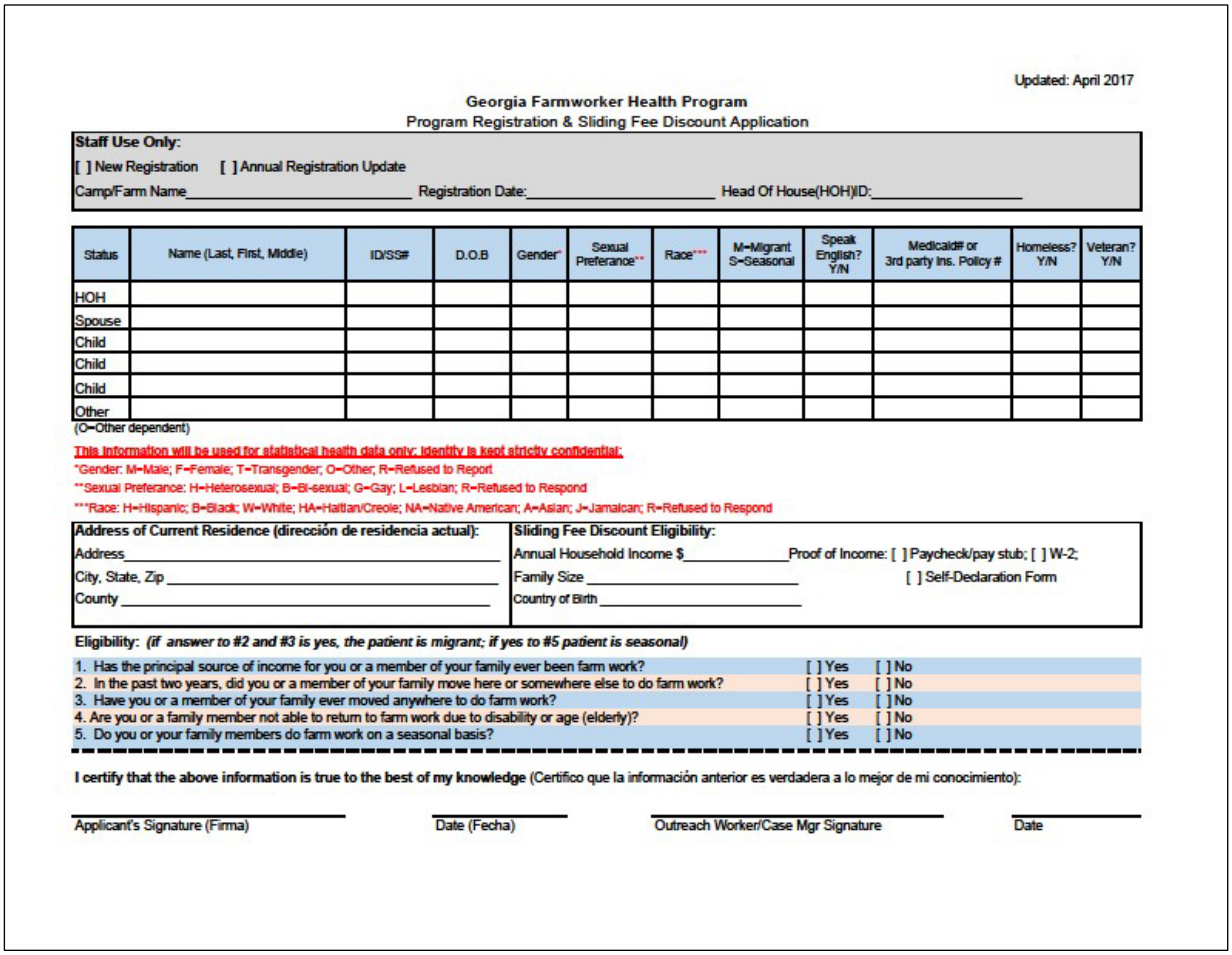
All sites are **required** to submit supporting documentation of all expenses including copies of paid invoices and receipts. This means that each and every invoice must contain an itemized listing of the expenses incurred with the invoice, the grant number and refer to any SORH/DCH approved grant condition changes which relate to the services rendered. The invoice and its supporting documentation will be reviewed by SORH/DCH to ensure adherence to the grant agreement terms and payment will be made accordingly. All travel expenses must adhere to the State of Georgia Travel Regulations policy found at http://www.sao.georgia.gov. Monthly program invoices will be submitted for payment, by the 10 day of the following month and no later than thirty (30) days, to: **Georgia State Office of Rural Health, 502 Seventh Street South, Cordele, GA 31015-1443 or via electronic submission to the GFHP Program Operations Specialist, Tina Register at tregister@dch.ga.gov**

PATIENT REGISTRATION/FINANCIAL ELIGIBILITY

Registration/Income Verification Process

1. Before receiving services a MSAW must be registered for the program. Staff may register persons/families during visits to camps using the approved program Registration Form. Family registration may also be completed electronically in the program's EMR system when MSAWs present at the permanent clinic sites. A registration is valid for one year. Each returning client must be registered annually based on the calendar year. Staff completing the registration process must use the requirements for income verification and definitions of families outlined under the Income Requirement section of the manual.

All registration information must be entered into the program EMR system. A copy of the registration form can be found in **Appendix A.**



Updated: April 2017

Georgia Farmworker Health Program
Program Registration & Sliding Fee Discount Application

Staff Use Only:
[ ] New Registration [ ] Annual Registration Update
Camp/Farm Name_____ Registration Date:_____ Head Of House(HOH)ID:_____

Status	Name (Last, First, Middle)	ID/SS#	D.O.B	Gender*	Sexual Preferance**	Race***	M=Migrant S=Seasonal	Speak English? Y/N	Medicaid# or 3rd party Ins. Policy #	Homeless? Y/N	Veteran? Y/N
HOH											
Spouse											
Child											
Child											
Child											
Other											

(O=Other dependent)

This information will be used for statistical health data only; identity is kept strictly confidential;
*Gender: M=Male; F=Female; T=Transgender; O=Other; R=Refused to Report
**Sexual Preferance: H=Heterosexual; B=Bi-sexual; G=Gay; L=Lesbian; R=Refused to Respond
***Race: H=Hispanic; B=Black; W=White; HA=Haitian/Creole; NA=Native American; A=Asian; J=Jamaican; R=Refused to Respond

Address of Current Residence (dirección de residencia actual):
Address_____
City, State, Zip _____
County _____

Sliding Fee Discount Eligibility:
Annual Household Income $_____Proof of Income: [ ] Paycheck/pay stub; [ ] W-2;
Family Size _____ [ ] Self-Declaration Form
Country of Birth _____

Eligibility: ***(if answer to #2 and #3 is yes, the patient is migrant; if yes to #5 patient is seasonal)***

1. Has the principal source of income for you or a member of your family ever been farm work?	[ ] Yes	[ ] No
2. In the past two years, did you or a member of your family move here or somewhere else to do farm work?	[ ] Yes	[ ] No
3. Have you or a member of your family ever moved anywhere to do farm work?	[ ] Yes	[ ] No
4. Are you or a family member not able to return to farm work due to disability or age (elderly)?	[ ] Yes	[ ] No
5. Do you or your family members do farm work on a seasonal basis?	[ ] Yes	[ ] No

I certify that the above information is true to the best of my knowledge (Certifico que la información anterior es verdadera a lo mejor de mi conocimiento):

Applicant's Signature (Firma) Date (Fecha) Outreach Worker/Case Mgr Signature Date

2. In order for a person to be eligible for the program, they must have participated in agricultural work in the past 2 years and received a portion of their income from agriculture related work.

Verification of income status or agricultural work status shall be requested at least annually during the registration process either by a current paycheck stub or verification letter from their employer. I

Individuals who are unable to provide written verification of income must provide a signed statement of zero income, why they are unable to provide written verification and how they are supporting themselves and their families. This is considered a self-declaration and must be documented by the Self-Declaration Form (refer to Appendix B). This will serve as proof of income for a total of (90) days. Patients are expected to pay full charges if their income cannot be verified at the time self-declaration expires. Clinics should require documentation during specified time periods as a dynamic of quality assurance.

Georgia Farmworker Health Program

Self-Declaration Form

Patient Information	
Patient's Name:	Patient D.O.B:
Address:	Phone Number

Declaration of Employment:

I _____ declare that my principal employment is in agriculture and that presently: [ ] I am working [ ] I am not working

Employer Name:_____

Employer Address:_____

Declaration of Income and Family size:

I declare that my household income for last year was $_____ and that my monthly family income is $_____. I also certify that a total of _____ people--including spouse, children, parents, grandparents, etc--are living in my household.

I certify that the information that I provided is correct and I authorize the health center to use it. I understand that this information will be used to determine my eligibility for a Sliding Scale Discount, and if eligible, I will receive a temporary discount for health services for 90 days.

I have been informed that I must provide the required documentation within 90 days in order to continue to receive the Sliding Fee Discount.
I understand that if I do not provide the required documentation, I can continue to receive my health care services at this center but I will have to pay 100% of my medical bill.
Applicant Signature:_____ Date:_____

PATIENT ENCOUNTERS

Medical visits are documented, individual, face-to-face, or virtual contacts between a patient and a licensed or credentialed provider who exercises independent, professional judgment in providing services. Outreach and enabling encounters consist primarily of case management and health education. The encounter will be face-to-face, and the encounter will be documented in the patient's chart and entered into the EMR with the corresponding CPT or the ICD-10 Code associated with the specific education provided. Services such as transportation and interpretation provided without documentation in the patient's record will not be considered as encounters.

Documentation

To meet the criterion for documentation, health centers must record the service (and associated patient information) in written or electronic form in a system that permits ready retrieval of current data for the patient. The patient record does not have to be complete to meet this standard. For example, a patient receiving documented emergency services counts even if some portions of the health record are incomplete. Providers who see their established patients at a hospital or respite care facility and make a note in the institutional file can satisfy this criterion by including a summary discharge note showing activities for each of the visit dates.

Independent Professional Judgment

To meet the criterion for independent professional judgment, providers must be acting on their own, not assisting another provider, when serving the patient. Independent judgment implies the use of the professional skills gained through formal training and experience and unique to that provider or other similarly or more intensively trained providers. For example, a nurse assisting a physician during a physical examination by taking vital signs, recording a history, or drawing a blood sample does not receive credit as a separate visit. Eligible medical visits usually involve one of the "Evaluation and Management" billing codes.

PROGRAM INCOME, BILLING AND COLLECTIONS

A. Program Income

The non-Federal share of the project budget includes all anticipated **program income** sources such as fees, premiums, third party reimbursements, and payments that are generated from the delivery of services, and from "other revenue sources" such as state, local, or other federal grants or contracts, private support or income generated from fundraising or contributions. In accordance with Section 330(e)(5)(D) of the PHS Act, health centers may use their non-grant funds, either "as permitted" under section 330 or "for such other purposes …not specifically prohibited" under section 330 if such use "furthers the objectives of the project.

Program income must be spent in the current or immediately following fiscal year and will only be used to support, enhance or maintain the site's GFHP in accordance with the grant terms and specifications. Documentation of expenditures of program income must be provided to the SORH and **reported on the monthly and annual cost reports**.

Program income may be used only for **allowable** costs in accordance with the applicable cost principles and the terms and conditions of the award. Sub-awards and contracts under the

grants are subject to the terms of the sub-award or contract with regard to any income generated, but the terms specified by the recipient must be consistent with the requirements of the Notice of Award (NoA).

B. Charges for Services

A **"Nominal Flat Fee Schedule"** has been established to offset the costs of providing services. This "Nominal Flat Fee Schedule" is universal at all GFHP project sites and it defines the flat fees that project sites can charge if a family's income is at or below the federal poverty level. If a client's income exceeds the poverty level guidelines it is expected that the client fees will be based upon full charges. Full charges may not be below the current Medicaid rates or the **minimum flat fee or nominal** amounts. Each contracted project site is responsible for obtaining the current Federal Poverty Guidelines annually. These are available through HRSA websites.

Nominal Flat Fee Schedule – on-site services:

Initial medical appointment	$25.00
Follow up – Acute	No Charge
Follow up – Chronic	$25.00
Rx filled on-site	$ 5.00

Nominal Flat Fee Schedule – Off-site or voucher services– Lower of ½ Medicaid Rate:

Rx – filled off site	**$15.00***
Lab work off site – Voucher	$15.00
Medical Imaging off site – Voucher	$15.00
Provider Referral off site – Voucher	$15.00
Labs on-site	No Charge

(Must use generic meds if available. Only Rx equal to $50 or greater are eligible for voucher)*

If a patient's income is above the Federal Poverty Guidelines (FPG), charges associated with a voucher request are to be based upon the sliding fee discount percentages applied to Medicaid rates.

The GFHP requires that fees paid to outside providers correspond with Medicaid rates for allowable services. An "allowable service" is defined as any service reimbursed by Medicaid. Other services (e.g., transportation, etc.) may have a related fee. Note that there can be several Medicaid rates for each procedure code. Project sites will be required to use the procedure code with the least expensive Medicaid rate.

C. Sliding Fee Scale

The **patient charge** is the amount requested from the patient. The patient will be charged either the Nominal Flat Fee or a percentage of the clinic's "full charges" based on a sliding fee scale. The sliding fee percentage is determined by comparing the family's income to Federal Poverty Guidelines. The following table represents the percentage of the total fees to be charged according to the federal poverty guidelines. **The FPG table must be updated annually and will be used consistently for each patient or case.**

The "**full charges**" will be reported on **the GFHP Monthly and Quarterly Cost Reports**, Appendix F. These fees will apply to all patients, regardless of payer.

The difference between the total of "Full Charges" and the amount of "Patient Charges" is the **sliding fee adjustment**.

MIGRANT HEALTH PROGRAM MONTHLY COST REPORT	Program Name: *Insert site/program name here*	Report Period:	Start date: *mm/dd/yyyy* End date: *mm/dd/yyyy*	Prepa *perso*

REVENUE FOR SERVICES RENDERED:						
	Beginning A/R Balance	Full Charges	Payments Received	Sliding Fee Adjustments	Contractual Adjustments	Ba
1 Medicare						
2 Medicaid						
3 SCHIP (Peachcare)						
4 Other Third Parties						
5 Patients (Self-pay)						
6 Total Services Revenue (sum of lines 1-5)			0.00			
PROGRAM INCOME:			Payments Received			
6 P I			000			

(Cost Report: Page 1; Section 1) Appendix F

D. Collections and Deposit Procedures

Patient collections are funds received from the patient for services received. Every effort will be made to collect the amount charged on the day services are rendered. However, health services cannot be denied to patients who are unable to pay on the date service is needed or rendered.

Each contracted site has internal controls in place to ensure appropriate separation of duties for handling cash and receipts.

E. Bad Debts

The difference between the amount of the patient charge and the amount collected should be written off of the books in accordance with the project's Financial and Billing Policies and Procedures. These uncollected charges are also called **bad debt** (See also Cost Report, Section

1). All project sites are expected to request payment for any services rendered that still have remaining charges attached for prior services. Health care services will not be withheld from those patients with bad debt balances.

Example: ***Anywhere GFHP Project Site***

Nominal Flat Fee: ***$25.00***

Example 1

Patient B is seen at the GFHP Clinic for services. Patient B is married with no dependent children. His annual family income is $13,500 which places the patient in the category of 100% or less of the Federal Poverty Level (FPL). Patient B is required to pay the Nominal Flat Fee (NFF) of $25.00 for services. Patient B only has $15.00 dollars to pay toward his medical visit expense. The GFHP Clinic collects the $15.00 and Patient B still owes the clinic $10.00. Patient B is responsible for the remaining balance of $10.00 and is expected to pay as soon as possible. Listed below is the financial breakdown of services provided.

A. GFHP Clinic Visit

GFHP Clinic visit NFF, patient owes	**$25.00**
Patient B pays toward NFF	**$15.00**
Patient B owes balance on NFF	**$10.00**

Repeat visit to clinic one (1) month later

GFHP NFF for visit	**$25.00**
Balance from prior visit	**$10.00**
Total owed to clinic	**$35.00**
Patient B pays complete balance:	**$35.00**

Example 2

Patient C is seen at the GFHP Clinic for services. Patient C is married with one dependent child. The annual family income is $34,250 which places the patient into the category of 176% to 200% of the FPL. Patient C is charged 80% of full charges. The GFHP Clinic visit full charge is $60.00. Patient C is to pay 80% of the full charge ($60.00 X 80% = $48.00) Patient C owes $48.00 for the clinic visit and pays $35.00. Patient C owes the GFHP Clinic $13.00. The provider evaluates Patient C and provides three prescriptions that are filled on-site at the Clinic. The cost

for three prescriptions is $15.00 ($5 for each Rx filled on-site). Patient C departs the GFHP clinic and owes $28.00 to be collected as soon as possible. Listed below is the financial breakdown of services provided:

A. GFHP Clinic Visit

GFHP Clinic fee	**$60.00**
Sliding fee adjustment	**$12.00**
Charges to Patient C (80% of full charge)	**$48.00**
Patient C payment against clinic charges	**$35.00**
Remaining balance	**$13.00**
On-site prescriptions ($5 each)	**$15.00**
Patient C owes balance of:	**$28.00**

AUTHORIZING & TRACKING REFERRALS

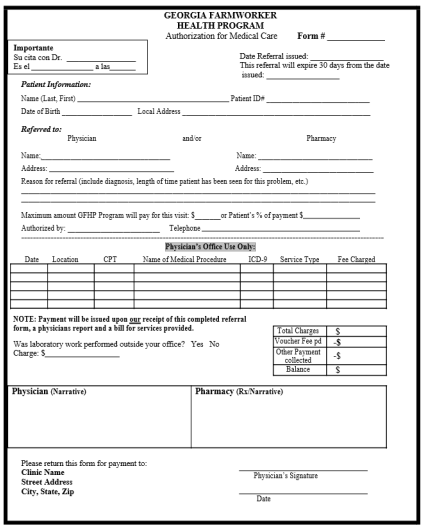
A. Vouchers

Each project will design a method of gatekeeping for referring patients to outside providers. This method will be submitted to SORH as a part of the project's policies and procedures. Generally, the nurse practitioner will provide primary health care. Whenever care is needed from a physician, pharmacist or dentist, a designated member of the project staff will authorize the specific service needed, giving the patient an authorization form **(Appendix E)** to take to the referral provider. The form will clearly state the services requested from the provider with an approximate amount the program will pay. The provider will contact the project site if charges exceed the authorized amount. Patients are required to pay the nominal charge of $15 for referrals or voucher services. The designated staff member who is responsible for making the referral will also follow up with the patient and/or outside provider to determine the status of the referral and obtain reports for inclusion in the patient's medical record. If the referral was not completed due to failure on the part of the patient to keep the appointment, the designated staff member should notify the primary care provider to determine the need to re-appoint the patient or to cancel the referral. All information must be documented in the patient's medical record. All patients regardless of third party payment sources or lack of third party coverage must be followed to assure that patients receive the services and that follow up care is provided to each patient.

Persons with third-party payment sources will be referred to providers, but without an authorization form.

Health providers (physicians, dentists, pharmacists) will be paid either the Medicaid Rate or the provider's usual and customary fee for services, if lower than the Medicaid Rate. **As a guideline, the maximum amount of Federal and State funding authorized per MSAW is $250 per year per user.** If a patient's accumulated medical expenses exceed the threshold listed, promptly contact Director, Georgia Farmworker Health Program for guidance.

Appendix E



GEORGIA FARMWORKER
HEALTH PROGRAM
Authorization for Medical Care Form # _____

Importante
Su cita con Dr. _____
Es el _____ a las _____

Date Referral issued: _____
This referral will expire 30 days from the date issued: _____

Patient Information:
Name (Last, First) _____ Patient ID# _____
Date of Birth _____ Local Address _____

Referred to:
Physician and/or Pharmacy
Name: _____ Name: _____
Address: _____ Address: _____
Reason for referral (include diagnosis, length of time patient has been seen for this problem, etc.)
_____
_____
Maximum amount GFHP Program will pay for this visit: $_____or Patient's % of payment $_____
Authorized by: _____ Telephone _____

Physician's Office Use Only:

Date	Location	CPT	Name of Medical Procedure	ICD-9	Service Type	Fee Charged

NOTE: Payment will be issued upon our receipt of this completed referral form, a physicians report and a bill for services provided.

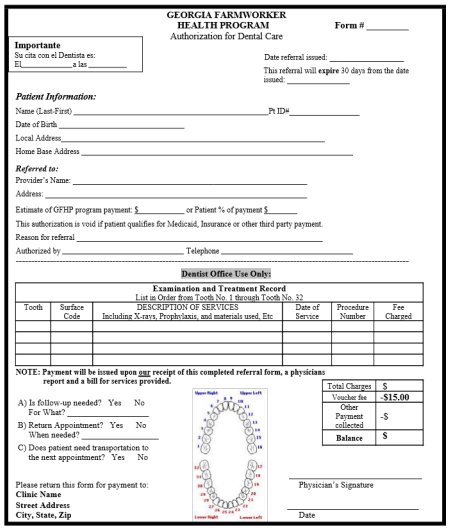
Was laboratory work performed outside your office? Yes No
Charge: $_____

Total Charges	$
Voucher Fee pd	-$
Other Payment collected	-$
Balance	$

Physician (Narrative) | **Pharmacy** (Rx/Narrative)

Please return this form for payment to:
Clinic Name
Street Address
City, State, Zip

_____
Physician's Signature
_____
Date



GEORGIA FARMWORKER
HEALTH PROGRAM
Authorization for Dental Care
Form # _____

Importante
Su cita con el Dentista es:
El_____ a las _____

Date referral issued: _____
This referral will **expire** 30 days from the date issued: _____

Patient Information:
Name (Last-First) _____ Pt ID#_____
Date of Birth _____
Local Address_____
Home Base Address _____

Referred to:
Provider's Name: _____
Address: _____
Estimate of GFHP program payment: $_____ or Patient % of payment $_____
This authorization is void if patient qualifies for Medicaid, Insurance or other third party payment.
Reason for referral _____
Authorized by _____ Telephone _____

Dentist Office Use Only:

Examination and Treatment Record
List in Order from Tooth No. 1 through Tooth No. 32

Tooth	Surface Code	DESCRIPTION OF SERVICES Including X-rays, Prophylaxis, and materials used, Etc	Date of Service	Procedure Number	Fee Charged

NOTE: Payment will be issued upon our receipt of this completed referral form, a physicians report and a bill for services provided.

A) Is follow-up needed? Yes No
For What? _____
B) Return Appointment? Yes No
When needed? _____
C) Does patient need transportation to the next appointment? Yes No

Total Charges	$
Voucher fee	**-$15.00**
Other Payment collected	-$
Balance	**$**

Please return this form for payment to:
Clinic Name
Street Address
City, State, Zip

_____
Physician's Signature
_____
Date

Providers must bill the GFHP by ICD-10 or CPT code. Physicians and dentists requesting payment must state patient's name, diagnosis, treatment, prescriptions ordered, instructions to patient, follow-up, and date of service on the authorization form.

The gatekeeping function can also be assigned to a nurse in a participating county. All documentation will be sent to the MSAW project. Nurses must note in the record why the patient was referred to an outside provider.

If a non-insured, non-Medicaid patient is eligible because of income and family size to pay a percentage of the provider's charges, program staff will determine this percentage. Project staff should note it on the authorization form when the patient comes in for a referral, and send the authorization form to the provider via the patient. The amount due from the patient will be the appropriate percentage of what the GFHP will pay the provider for the service, not a percentage of the usual and customary charge. If a patient is in the 0 percent pay category on the sliding fee schedule, project staff should also note on the authorization form that the patient should be asked by the provider's office to pay the Nominal Flat Fee. If the provider collects any money from the patient, this must be noted on the authorization form that is returned to the local project office.

Participating physicians and dentists will bill third-party payment sources directly. Any arrangements for applicable co-payments or deductibles must be negotiated between the

provider and patient. The GFHP will only pay for those persons not covered by a third party. Regarding injuries, the physicians and dentists must determine if they are work-related and whether or not the farmer carries worker's compensation. If the farmworker is covered by worker's compensation, the physician should bill the worker's compensation insurance. If a farmworker is not covered by worker's compensation, the patient should be treated as any other farmworker without a third-party payer. Physicians and dentists are requested to send copies of all bills submitted to any other party payer to the project site.

The GFHP will assist MSAWs in establishing eligibility for Medicaid/Medicare. The program will authorize services for a patient who is applying for Medicaid or Medicare. If the patient is found ineligible, the program will pay the referral provider. If the patient becomes eligible after payment is made, the referral provider will bill Medicaid or Medicare and refund the GFHP.

Referral providers will not be paid for care provided to MSAW patients who are not enrolled in the GFHP and who have not been given a referral for service by GFHP staff.

Providers should strongly encourage MSAWs to register with the program before seeking medical care.

Referral providers must be informed that GFHP funds are funds of last resort and that the physician must bill insurance, including workers compensation, or Medicaid first.

C. Voucher Tracking

The voucher program allows payment of **up to $250 per year** for farmworkers for services rendered by a specialist which includes but not limited to, medical, dental, and mental health services. Voucher services **may not exceed $350** per year (expenses over $250 may require prior approval). Therefore, it is important to enter all voucher service information into the EMR system.

REPORTING

A. Annual Uniform Data System Report (UDS)

The Uniform Data System (UDS) is an integrated reporting system used by all grantees funded for Community Health Center, Migratory and Seasonal Agriculture Worker, Health Care for the Homeless, and Public Housing Primary Care, under the Health Center grant program administered by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA). The data collected through this report are analyzed to ensure compliance with legislative mandates, report program accomplishments, and justify budget requests to the U.S. Congress. The data help to identify trends over time, enabling HRSA to

establish or expand targeted programs and identify effective services and interventions to improve the health of underserved communities and vulnerable populations. UDS data are compared with national data to look at differences between the U.S. population at large and those individuals and families who rely on the health care safety net for primary care. UDS data also inform Health Center Program grantees, partners and communities about Health Centers and their patients.

The UDS report is a performance report, submitted annually through the HRSA Electronic Handbook (EHB). The report consists of data collected during the previous calendar year.[6] UDS data from each contract site will be due at the discretion of SORH.

B. COST REPORTING

The GFHP Program Cost Report **(Appendix F)** is a board approved format that tracks all financial elements needed to complete the UDS report each year. Cost reports are submitted monthly, quarterly and annually as stated in each grantees contract with the Department of Community Health (DCH). Annual reports are to be based on the calendar year (CY) and the grant fiscal year (FY) which is June 1st to May 31st. Program income, In-kind donations, and all program expenditures where federal grant funds were utilized for payment will be reported on the GFHP Cost Report(s). Inkind contributions or services refers to the value of donated items and the value of donated/volunteer time contributed to the MSAW health program income. In-kind donations or services should be recorded and documented in detail. The total in-kind amount is to be reported on monthly, quarterly and annual cost reports. Cost Reports and other financial reports will be submitted with monthly invoices to the GA State Office of Rural Health.

Appendix F: Page 1 - GFHP Cost Report

MIGRANT HEALTH PROGRAM MONTHLY COST REPORT	Program Name: *Insert site/program name here*		Report Period: Start date: *mm/dd/yyyy* End date: *mm/dd/yyyy*			Prepared by: *insert name of person preparing report here*		Page 1 of 4
REVENUE FOR SERVICES RENDERED:								
	Beginning A/R Balance	Full Charges	Payments Received	Sliding Fee Adjustments	Contractual Adjustments	Bad Debt	Ending A/R Balance	Change in Balance
1 Medicare								
2 Medicaid								
3 SCHIP (Peachcare)								
4 Other Third Parties								
5 Patients (Self-pay)								
6 Total Services Revenue (sum of lines 1-5)			0.00					
PROGRAM INCOME:			Payments Received					
6 **Program Income**			0.00					
OTHER REVENUE SOURCES:			Amount Received					
7 Migrant Program Grant Funds			0.00					
8								
9								
10								
11 Total Other Revenue (lines 6-9)								
VALUE OF DONATED VALUE			Value Received					
12								
13 Net Donated Cost			0.00					
Total Revenue, Grants & Donated value (6+7+11+13)			0.00					

[6] Uniform Data System (UDS) - Bureau of Primary Health Care, Created by Daniel D Maramba, last modified by Sachin Kapoor on May 08, 2015; https://help.hrsa.gov/display/EHBSKBFG/Uniform+Data+System+%28UDS%29++Bureau+of+Primary+Health+Care

Appendix F: Page 2 - GFHP Cost Report

MIGRANT HEALTH PROGRAM MONTHLY COST REPORT	Project site: *insert project site and name here*					Report Period: Start: End:				Report Prepared by: *Insert name here*		Page 2 of 4
		F.T.E.	Salary	Fringe Benefits	Travel	Equipment	Building Rent	Contracted Services	Other Operating	Total Expenditures	Donated Value	Depreciation
Personnel:												
Medical Staff	Staff Pos/Title											
1										0.00		
2										0.00		
3										0.00		
4										0.00		
5										0.00		
TOTAL			0.00	0.00						0.00		
Enabling Staff	Staff Pos/Title											
6										0.00		
7										0.00		
8										0.00		
9										0.00		
10										0.00		
11										0.00		
TOTAL			0.00	0.00						0.00		
Administrative Staff	Staff Pos/Title											
12										0.00		
13										0.00		
14										0.00		
15										0.00		
16										0.00		
TOTAL			0.00	0.00						0.00		
All Other (non-personnel) Direct Service Costs:												
Medical												
17 Medical/ Other Direct												
18 Lab												
19 X-ray												
19 Pharmacy (not including pharmaceuticals)												
20 Pharmaceuticals												
21 Dental												
22 Mental Health/Psychiatry												
23 Substance Abuse												
24 Vision Services												
25 Other Professional Services												
a. Physician Oversight												
b. Medical Staff Training/CME's												
c. Telecommunications Cost 1/3												
d. Fuel/Vehicle Maintenance/Ins 1/3												
e. Copier/Maintenance 1/3												
f. Postage 1/3												
26 Voucher Services												
a. Medical Voucher												
b. Dental Voucher												
c. Mental Health Voucher												
d. Pharmacy Voucher												
e. Vision Voucher												
f. Other Vouchers												
27 Medical Supplies												
28 Medical Equipment												
Total Medical Costs									0.00	0.00		
Enabling												
26 Case Management												
27 Transportation												
28 Outreach												
29 Patient & Community Education												
30 Eligibility Assistance												
31 Translation/Interpretation												
32 Other Enabling Services												
a. Telecommunications Cost 1/3												
b. Fuel/Vehicle Maintenance/Ins 1/3												
c. Copier/Maintenance 1/3												
d. Postage 1/3												
e. Enabling Supplies												
f. Other Enabling Cost												
Total Enabling Service Cost									0.00	0.00		
Administrative												
Overhead and Totals												
33 Facility												
a. Rent												
b. Utilities												
c. Janitorial Services												
d. Lawn Services												
e. Other Facility Cost												
34 Administration												
a. Telecommunications Cost 1/3												
b. Fuel/Vehicle Maintenance/Ins 1/3												
c. Copier/Maintenance 1/3												
d. Postage 1/3												
e. Administrative Fees												
f. Administrative Supplies												
g. Other Administrative Cost												
Total Overhead Costs (sum of lines 33a-e + 34a-g)							0.00		0.00	0.00		
			←		Program Expenditures				→	TOTAL	Non-Cash Costs	
TOTAL MEDICAL COSTS										0.00		
TOTAL ENABLING COST										0.00		
TOTAL ADMINISTRATIVE COST										0.00		

Expenditures reported on **page two** of the cost report MUST be supported by accurate supporting documentation. Copies of invoices and corresponding paid checks should be available for audit. All expenditures should be in compliance with budget requests submitted and approved by the contractor.

Appendix F: Page 3-GFHP Cost Report

Other Costs - Breakdown	Migrant Health Facility: _____ Funding Period: Start: End:												Page 3 of 4
Cost Type	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOTAL
Travel Costs													
Travel													0.00
Vehicle Costs													
Vehicle maint/repair													0.00
Vehicle Insurance													0.00
Fuel													0.00
Telecommunications													
Telephone													0.00
Cell Phone													0.00
Internet													0.00
Office Supplies													
Admin O/S													0.00
Medical O/S													0.00
Vouchers													
Medical													0.00
Dental													0.00
Mental Health/Psychiatry													0.00
Substance Abuse													0.00
Vision Services													0.00
Pharmacy Services													0.00

Page three of GFHP cost report will be used to report the breakdown of expenditures for "Other Costs".

Appendix F: Page 4 – GFHP Cost Report

Monthly Program Income Expenditures	Migrant Health Facility: _____ Funding Period: Start: End:												Page 4 of 4
Cost Type	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOTAL
Medical													
A. Personal Services													0.00
B. Regular Operating													0.00
C. Direct Benefits													0.00
D. Travel													0.00
E. Equipment													0.00
F. Facility Cost													0.00
G. Per Diem & Contracts													0.00
H. Pharmacy													0.00
I. Motor Vehicle													0.00
Enabling													
A. Personal Services													0.00
B. Regular Operating													0.00
C. Direct Benefits													0.00
D. Travel													0.00
E. Equipment													0.00
F. Facility Cost													0.00
G. Per Diem & Contracts													0.00
H. Pharmacy													0.00
I. Motor Vehicle													0.00
Administrative													
A. Personal Services													0.00
B. Regular Operating													0.00
C. Direct Benefits													0.00
D. Travel													0.00
E. Equipment													0.00
F. Facility Cost													0.00
G. Per Diem & Contracts													0.00
H. Pharmacy													0.00
I. Motor Vehicle													0.00
TOTAL per month	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Page four of the cost report will be used to track monthly program income expenditures.

Please Note: All **Case Management (CM)** activity is to be entered as an encounter. This is required information that is included in the annual UDS report. The main qualifications/activities for CM as accepted by UDS include:

a. Assessment of the client's needs and personal support systems,
b. Development of a comprehensive, individualized service plan
c. Coordination of services required to implement the plan
d. Client monitoring to assess the efficacy of the plan, and
e. Periodic re-evaluation and adaptation of the plan as necessary.

BOARD AUTHORITY

The GFHP Advisory Board is required to:

- Establish and maintain a governing board that is responsible for oversight of the Health Center Program project.
- Develop bylaws which specify the responsibilities of the board.
- Assure that the center is operated in compliance with applicable Federal, State, and local laws and regulations.
- Hold monthly meetings and record in meeting minutes the board's attendance, key actions, and decisions.
- Review and evaluate the annual performance the GFHP Project Director/Chief Executive Officer (CEO).
- Have authority for establishing or adopting policies for the conduct of the GFHP and for updating these policies when needed. Specifically, the GFHP advisory board must have authority to:
    - Adopt policies for financial management practices and a system to ensure accountability for center resources (unless already established by the public agency as the Federal award or designation recipient), including periodically reviewing the financial status of the health center and the results of the annual audit to ensure appropriate follow-up actions are taken;
    - Adopt policy for eligibility for services including criteria for partial payment schedules;
    - Establish and maintain general personnel policies for the health center (unless already established by the public agency as the Federal award or designation recipient), including those addressing selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices; and ○ Adopt health care policies including quality-of-care audit procedures.
- Adopt health care policies including the:
    - Scope and availability of services to be provided within the Health Center Program project, including decisions to subaward or contract for a substantial portion of the services;
    - Service site location(s); and

- Hours of operation of service sites.

- Review and approve the annual Health Center Program project budget.
- Develop its overall plan for the Health Center Program project under the direction of the governing board.
- Provide direction for long-range planning, including but not limited to identifying health center priorities and adopting a three-year plan for financial management and capital expenditures.
- Assess the achievement of project objectives through evaluation of health center activities, including service utilization patterns, productivity [efficiency and effectiveness] of the center, and patient satisfaction.
- Ensure that a process is developed for hearing and resolving patient grievances.

Each GFHP project site is to have a local Advisory Board and the program, as a whole, will maintain a GFHP Advisory Board that provides oversite for all GFHP program sites. Each board is to have "meaningful input into the program design, implementation and evaluation." Additionally, GFHP has established a QA/CQI Network to assure accessibility, quality performance, and improvement as well as cost effectiveness of primary care services available to MSAWs in Georgia. **(Refer to the GFHP Board By-laws: Attachment III)**.

BOARD COMPOSITION

In order to demonstrate compliance, the GFHP Advisory Board must adhere to the following:

- Consist of at least 9 and no more than 25 members
- The majority [at least 51%] of the health center board members must be patients served by the health center. These health center patient board members must, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender.
- Non-patient health center board members must be representative of the community served by the health center and must be selected for their expertise in relevant subject areas, such as community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.

- Of the non-patient health center board members, no more than one-half may derive more than 10% of their annual income from the health care industry.
- A health center board member may not be an employee of the center, or spouse or child, parent, brother or sister by blood or marriage of such an employee. The project director [Chief Executive Officer (CEO)] may be a non-voting, ex-officio member of the board.
- The health center bylaws or other internal governing rules must prescribe the process for selection and removal of all governing board members. This selection process must ensure that the governing board is representative of the health center patient population. The selection process in the bylaws or other rules is subject to approval by HRSA.
- In cases where a health center receives an award/designation under section 330(g), 330(h) and/or 330(i) and does not receive an award/designation under section 330(e), the health center may request approval from HRSA for a waiver of the patient majority board composition governance requirement by showing good cause.

APPENDICES

Appendix A …….. Program Registration Form

Appendix B …….. Self-Declaration Policy & Form

Appendix C…….. Sliding Fee Discount Policy

Appendix D…….. Encounter Form

Appendix E…….. Referral/Voucher Forms

Appendix F…….. Cost Report

ATTACHMENTS

Attachment I …….. QA/CQI Plan

Attachment II…….. QA/CQI Guide

Attachment III…….. Credentialing & Privileging Policy

Attachment IV…….. GFHP Board By-Laws

Attachment V…….. GFHP Conflict of Interest

Attachment VI……GFHP Strategic Plan

Attachment VII……GFHP Needs Assessment

Georgia Farmworker Health Program

Program Registration & Sliding Fee Discount Application

Status	Name (Last, First, Middle)	ID/SS#	D.O.B	Gender*	Sexual Preference**	Race***	Migrant or Seasonal	Speak English? Y/N	Medicaid# or Ins. Policy #	Homeless? Y/N	Veteran? Y/N
HOH											
Spouse											
Child											
Child											
Child											
Other											

(O=Other dependent)

This information will be used for statistical health data only; identity is kept strictly confidential:

*Gender: M=Male; F=Female; T=Transgender; O=Other; R=Refused to Report

**Sexual Preference: H=Heterosexual; B=Bi-sexual; G=Gay; L=Lesbian; R=Refused to Respond

***Race: H=Hispanic; B=Black; W=White; HA=Haitian/Creole; NA=Native American; A=Asian; J=Jamaican; R=Refused to Respond

Address of Current Residence (dirección de residencia actual):	**Sliding Fee Discount Eligibility:**
Address_____	Annual/Monthly Household Income $_____Proof of Income: [ ] Paycheck/stub
City, State, Zip _____	Family Size_____ [ ] W-2; [ ] Self-Declaration Form
County _____	Country of Birth _____

Eligibility: ***(if answer to #2 and #3 is yes, the patient is migrant; if yes to #5 patient is seasonal)***

1. Has the principal source of income for you or a member of your family ever been farm work?	[ ] Yes	[ ] No
2. In the past two years, did you or a member of your family move here or somewhere else to do farm work?	[ ] Yes	[ ] No
3. Have you or a member of your family ever moved anywhere to do farm work?	[ ] Yes	[ ] No
4. Are you or a family member not able to return to farm work due to disability or age (elderly)?	[ ] Yes	[ ] No
5. Do you or your family members do farm work on a seasonal basis?	[ ] Yes	[ ] No

I certify that the above information is true to the best of my knowledge (Certifico que la información anterior es verdadera a lo mejor de mi conocimiento):

_____ _____ _____ _____

Applicant's Signature (Firma) Date (Fecha) Outreach Worker/Case Mgr Signature Date

Migrant Health Advisory Board
Georgia Farmworker Health Program

Policy Adopted by Board	Date: 06/10/16
Policy Reviewed by Board	Date: 05/05/17
Policy Revisions approved by Board	Date: 03/12/18

POLICY & PROCEDURE: **Self-Declaration and Program Registration**
EFFECTIVE DATE: 02/10/2016
REVISED DATE: 05/05/2017

PURPOSE: To establish a mechanism for assuring access to care for patients that cannot provide the required verification documents.

POLICY: When an individual seeks services at the health center for the first time and does not have the required documentation for patient registration and/or income verification, they may use a self-declaration.

The self-declaration will be accepted and their declared income will be used to provide discounted services for a period of 30 days. The patient will be advised that they must bring the required documentation within 30 days prior to their next visit.

At the end of the 30-day period, the patient will be charged full price for further services until they can provide income verification documents unless there are extenuating circumstances, in which case the CFO or designee may extend the discount period for an additional length of time.

RESPONSIBILITY: Patient Services Representatives (PSR) and Department Supervisors

PROCEDURE:

1. Any patient unable to provide proof of income will be allowed to sign a Self-Declaration
2. The income and family size noted in the self-declaration form will be used to determine the sliding fee discount.
3. The PSR will assure that the patient understands that the discount is temporary and is aware of the discount's expiration date. The PSR will explain to the patient the required verification documents that they must bring within 30 days of next visit.
4. The PSR will check that the Patient Registration Form and Sliding Fee Scale Application are complete and will verify that required signatures are collected.
5. The PSR will enter information in the management information system and set the sliding scale discount to expire in 30 days from the date of the self-declaration.

Georgia Farmworker Health Program
Self-Declaration Form

Patient Information	
Patient's Name:	Patient D.O.B:
Address:	Phone Number

Declaration of Employment:

I_____declare that my principal

employment is in agriculture and that presently: [ ] I am working [ ] I am not working

Employer Name:_____

Employer Address:_____

Declaration of Income and Family size:

I declare that my household income for last year was $_____and that my

monthly family income is $_____. I also certify that a total of _____

people--including spouse, children, parents, grandparents, etc.--are living in my household.

I certify that the information that I provided is correct and I authorize the health center to use it. I understand that this information will be used to determine my eligibility for a Sliding Scale Discount, and if eligible, I will receive a temporary discount for health services for 30 days.

I have been informed that I must provide the required documentation within 30 days in order to continue to receive the Sliding Fee Discount.

I understand that if I do not provide the required documentation, I can continue to receive my health care services at this center but I will have to pay 100% of my medical bill.

Applicant Signature:_____Date:_____

Georgia Farmworker Health Program

Policy Adopted by Board	Date: 02/10/16
Policy Revisions approved by Board	Date: 07/22/21, 2/17/22, 3/16/23, 2/15/24
Federal Poverty Scale Updated	Date: 02/05/24 Tiffany Hardin

POLICY: SLIDING FEE DISCOUNT (SFD) PROGRAM

PURPOSE: To ensure access to care for Georgia Farmworker Health Program (GFHP) patients regardless of their ability to pay.

POLICY STATEMENT: The GFHP shall assure that financial barriers to care provided by voucher contractors are minimized for Program clients who meet certain eligibility criteria.

IMPLEMENTATION: All patients at or below 200% of Federal Poverty Guidelines (FPG) will have access to a Sliding Fee Discount (SFD). Eligibility for discounts under the SFD will be based solely on income and family size. Patients with income at or below 100% of FPG will receive a full discount and patients between 100% and 200% of FPG will receive a partial discount. No patient with income in excess of 200% of FPG will receive a discount under the SFDS. The SFD will assure that all SFD patients have access to all services within the approved scope of project under the HRSA Section 330 grant.

All patients of GFHP will be notified of the availability of the SFD ***utilizing prominent signage in waiting rooms and/or exam rooms, etc. or patient brochures and/or the agency website.*** (GFHP should choose the methods that will be used by the different contracting agencies. This information should be submitted to the main offices of GFHP and kept on file for future reviews). Notification methods will utilize appropriate language and literacy levels for the populations being served.

The SFD will be based on a schedule of fees developed by each contracting agency and approved by the Board of GFHP. The schedule of fees will be designed to cover the reasonable costs of providing services to patients and will be consistent with locally prevailing rates.

The SFD will be update annually for changes to the FPG. Each contracting agency will be required to update their schedule of fees to reflect the changes in the FPG and submit the revised fee schedule to the GFHP board for approval. The schedule of fees will be kept on file in the main offices of the GFHP. The changes to the fees must be incorporated in the SFD within 30 days of publication of the Federal Register containing the changes to the FPG.

For the purposes of this policy, "income" will be defined as:

Total cash receipts before taxes from all sources. These include wages, tips and salaries before any deductions; regular payments from public assistance, social security, unemployment, worker's compensation, strike benefits from union funds, veteran's benefits, training stipends, alimony, child support and military family allotments or other regular support from an absent family member or someone not living in the household; government

employee pensions, private pensions and regular insurance or annuity payments; income from dividends, interest, rents, royalties or income form estates and trusts. For eligibility purposes, income does not refer to the following money receipts:

- Any assets drawn down as withdrawals from a bank
- Sale of property, house or car
- Tax refunds, gifts
- One-time insurance payments or compensation for injury
- Also, to be disregarded in non-cash income, such as the bonus value of food and fuel produced and consumed on farms and the inputted value of rent from owner-occupied farm or non-farm housing.

For purposes of this policy, "family size' will be defined as:

The family size consists of the applicant and number of individuals who qualify as an IRS dependent of the applicant. This includes the applicant, spouse, dependent children and any other individual that qualifies as a personal exemption for tax reporting purposes. Each contracting agency will use the IRS definition of a dependent to determine family size, even if the applicant does not file a tax return.

If a patient is a student over 18 years of age, living at home, or is employed and living at home (a young adult not fully emancipated) and is claimed by his/her parent(s) or legal guardian(s) as a dependent for purposes of income tax, the child and their income, will be considered with the parent(s) or guardian(s) income when determining sliding fee discount eligibility and family size.

If a patient is not considered a dependent and is not claimed on the parent(s) or guardian(s) income tax then he/she can file a separate SFD application and eligibility will be determined on his/her income alone.

SFD coverage will be available for 1 year from the date of application. Patients will be re-evaluated annually for SFD.

PROCEDURES:

The GFHP evaluates the SFD program, at least once every three years, by collecting and analyzing annual Uniform Data System (UDS) Reports and Electronic Health Record (EHR) utilization data reports which give GFHP and its Advisory Board the ability to assess the rate at which patients in each SFD discount pay category, as well as those at or below 100% of the FPG, are accessing health center services. Data results of patient satisfaction surveys are used to evaluate the effectiveness of the GFHP sliding fee discount program, from the patient's perspective, to determine if there are any financial barriers to care. GFHP Advisory Board utilizes collected data to identify any barriers to care and implements changes in policy and procedures as needed.

1. The SFD will be applied uniformly to all clients who qualify (those with incomes at or below 200% of the Federal Poverty Guidelines [FPG]) as follows:

   A. Sliding Scale Level/Payment Category **A** – At or below 100% of FPG: 100% discount (patient pays a nominal charge per visit of $25.00 for medical, behavioral/mental health, and vision and dental services);

   B. Sliding Scale Level/Payment Category **B** – >100% to 133% of FPG: 75% discount (patient pays a fixed amount which is higher than the charge for Patients in Payment Category A);

   C. Sliding Scale Level/Payment Category **C** – >133% to 166% of FPG: 50% discount (patient pays a fixed amount which is higher than the charge for Patients in Payment Category B);

   D. Sliding Scale Level/Payment Category **D** – >166% to 200% of FPG: 25% discount (patient pays a fixed amount which is higher than the charge for Patients in Payment Category C); and

   E. Sliding Scale Level/Payment Category **E** – >200% of FPG: No discount (patient pays 100% of charges).

   Fees are set to cover reasonable costs and are consistent with locally prevailing rates or charges for the service. The SFD schedules establish the nominal fee amount to be charged to patients in Category A and minimum fee amounts to be charged to clients in Categories B – D for all in-scope services per visit.

   Note the following information related to the SFD schedules/program:

   A. The SFD program does not apply to pharmacy services. On-site pharmacies (340B): Patients who are prescribed medications to be filled on-site will pay a Nominal fee of $5.00 per prescription. Patients needing a single prescription to be filled off-site that costs $50 or more will be required to pay a co-pay of $15. GFHP will be responsible for the additional cost. Only single prescriptions $50 or greater are eligible for a voucher; all other medications must be prescribed for generic if available.

   B. Patients who require off-site or voucher services will be charged a co-pay of $15.00. Fees incurred during off-site/vouchered appointments will be paid by GFHP. There will be a voucher/referral limit of $250 per patient per year in an attempt to avoid unnecessary referral/voucher services. The annual voucher limit amount will be reassessed annually pending voucher utilization review. There will be no out-of-pocket fees charged to patients for specialty services.

      GFHP ensures that fees for referred/voucher services will be discounted for individuals and families whose annual incomes are at or below 100% of the current FPG. Patients and their families with an annual income above 100% of the current FPG and at or below 200% of the FPG will receive an equal or greater discount for specialty services than if

the health center's SFDS were applied to the referral provider's fee schedule; and individuals and families at or below 100% of the FPG receive a full discount or a nominal charge for these services.

C. The GFHP Advisory Board will annually approve revisions to the SFD schedules based on the Federal Poverty Guidelines published each year in the Federal Register.

D. The GFHP Advisory Board will also review and approve the nominal charges to ensure they are not presenting a barrier to care from the patients' perspective. Input on the affordability of nominal fees will be obtained through patient satisfaction surveys, and adjustments will be made, as applicable, to further reduce financial barriers to care. Results of patient satisfaction surveys will be presented to the GFHP Advisory Board annually.

   Nominal charges will be fixed amounts that do not reflect the true value of the service(s) provided. In addition, they will be less than the fee paid by a patient in the first "sliding fee discount pay class" beginning above 100% of the FPG.

E. Qualification for SFD and discount pay classes will be assessed annually during the eligibility determination process for GFHP services.

F. Eligibility for SFD is based on income and family size and are defined as follows:

   - Family is defined as all persons related by birth, marriage, and/or adoption who reside together.

   - Income is the annualized salary from the previous year, and is defined as total cash receipts before taxes (wages, salaries, public assistance/unemployment compensation, retirement payments, Social Security, alimony, etc.).

G. As part of the eligibility determination process, outreach staff and contractors will provide information on the SFD program to all patients uniformly. Patients will be provided with the GFHP Eligibility Form for completion. Assistance with completing the form will be provided as needed.

   Clients will also be made aware of the availability of the SFD program through signage in appropriate languages posted in the waiting areas (required at all contract sites), brochures, flyers, and other means of communication, as necessary.

H. Applicants must provide a copy of one of the following documents to be deemed eligible for the SFD program: most recent pay stub, prior year W-2 tax form, or a letter from their employer. Adequate information must be made available to determine eligibility for the SFD program. Information will be kept in the strictest confidence and will be maintained in accordance with the GFHP's policy for record retention.

I. Self-declaration of income may be used in special circumstances. Patients who are unable to provide written income verification must complete and sign the GFHP Self-Declaration Form, and provide the reason(s) they are unable to furnish required

documentation. The completed form will be presented to the GFHP Director or a designee for review and final determination of the sliding fee discount pay class. Self-declared clients will be responsible for 100% of their charges until management determines the appropriate class.

J. In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances (e.g., family emergency, job loss, and inability to pay) and will be up to the discretion of voucher contractors. For such rare instances and to assure consistency in implementation, voucher contractors will be instructed to contact the GFHP Director or a designee for appropriate guidance and action. Any waiving of charges should be documented in the client's file along with an explanation.

K. Patients with third party insurance that does not cover or only partially covers fees for in-scope GFHP services may be eligible for SFD based on income and family size. In such cases, the charge for each SFD pay category is the maximum amount an eligible patient in that pay level is required to pay for a certain service, regardless of insurance status.

   Below are scenarios that seek to clarify the application of this provision:

   - Jane Doe has medical insurance and received an in-scope medical service with a GFHP voucher provider. Upon completion of the eligibility process, it was determined that Ms. Doe is at 90% of the FPG based on her income and family size. Ms. Doe's medical service is not covered by her insurance and the charge for the service is $100.00. Since she is eligible for a SFD and she is at Payment Category A, the fee to be charged is $25.00, not $100.00.

   - John Doe has dental insurance and received an in-scope dental service with a GFHP voucher provider. Upon completion of the eligibility process, it was determined that Mr. Doe is at 150% of the FPG based on his income and family size. Mr. Doe's dental service cost $500.00, but he has not met his $1,000.00 deductible. Since he is eligible for a SFD and he is at Payment Category C, the fee to be charged is $35.00, not $500.00.

   - Janice Doe has medical insurance and received an in-scope medical service with a GFHP voucher provider. Upon completion of the eligibility process, it was determined that Ms. Doe is at 125% of the FPG based on her income and family size. Ms. Doe's insurance co-payment amount is $30.00. Since she is eligible for a SFD and she is at Payment Category B, the fee to be charged is $30.00, not $40.00.

L. Clients eligible for SFD are <u>not required</u> to apply for Medicaid or another health insurance as a condition of SFD program participation.

2. Compliance with this policy will be confirmed periodically and will be a condition of continued contractual relationship with the GFHP. The GFHP will utilize its existing Quality Improvement/Utilization Review process (annual peer reviews) to confirm contractor compliance.

3. This policy will be evaluated and revised, as appropriate, at least once every three (3) years and on an as needed basis to assure compliance with applicable Health Resources and Services Administration/Bureau of Primary Health Care requirements and to further reduce financial barriers to care for patients. Patients perspective of nominal fee charges will be assessed annually through GFHP Patient Satisfaction Surveys.

RESPONSIBILITY:

The GFHP Director shall be responsible for ensuring that the implementation of this policy is being executed by all contract program sites.

SORH
State Office of Rual Health
A Division of the Georgia Department of Community Health

GEORGIA FARMWORKER HEALTH PROGRAM

Medical / Behavioral Health / Vision / Dental
Sliding Fee Discount Schedule
Updated: February 5, 2024

FAMILY SIZE	*0% - 100% of FPG* **Pays $25.00** ***Pay Category A*** (Nominal Fee)	*>100% - 133% of FPG* **Pays $30.00** ***Pay Category B***	*>133% - 166% of FPG* **Pays $35.00** ***Pay Category C***	*>166% - 200% of FPG* **Pays $40.00** ***Pay Category D***	*>200% of FPG* **Pays 100%** ***Pay Category E*** (No Discount)
1	$15,060 Or less	$15,061 to $20,030	$20,031 to $25,000	$25,001 to $30,120	$30,121 or more
2	$20,440 Or less	$20,441 to $27,185	$27,186 to $33,930	$33,931 to $40,880	$40,881 or more
3	$25,820 Or less	$25,821 to $34,341	$34,342 to $42,861	$42,862 to $51,640	$51,641 or more
4	$31,200 Or less	$31,201 to $41,496	$41,947 to $51,792	$51,793 to $62,400	$62,401 or more
5	$36,580 Or less	$36,581 to $48,651	$48,652 to $60,723	$60,724 to $73,160	$73,161 or more
6	$41,960 Or less	$41,961 to $55,807	$55,808 to $69,654	$69,655 to $83,920	$83,921 or more
7	$47,340 Or less	$47,341 to $62,962	$62,963 to $78,584	$78,585 to $94,680	$94,681 or more
8	$52,720 Or less	$52,720 to $70,118	$70,119 to $87,515	$87,516 to $105,440	$105,441 or more

- For families/households with more than 8 persons, add $5,380 for each additional person.
- FAMILY is defined as all persons related by birth, marriage, and/or adoption who reside together.
- INCOME is the annualized salary from the previous year and is defined as total cash receipts before taxes (wages, salaries, public assistance/unemployment compensation, retirement payments, Social Security, alimony, etc.).
- The Sliding Fee Discount Schedule is based on Federal Poverty Guidelines and is updated annually.
- **HHS Effective Date: January 17, 2024**
- **Refer to: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines**

Georgia Farmworker Health Program
Medical Encounter Form

Patient Name_____ Patient I.D. # _____ Patient DOB _____

Date of Service_____ Provider Name_____ Provider Type: MD NP PA RN LPN

Service Site _____ Clinic ☐ Mobile Clinic ☐ Camp ☐

Payment Source: Private Insurance ☐ Self-Pay ☐ Other ☐ _____

Office Visit:	New Pt	Estab Pt
ProblemFocused	☐ _____	☐ _____
		☐ _____
Expanded PF	☐ _____	☐ _____
		☐ _____
Detailed	☐ _____	☐ _____
		☐ _____
Comprehensive	☐ _____	☐ _____
	☐ _____	☐ _____
		☐ _____
		☐ _____
		☐ _____

Home Visit:	New Pt	Estab Pt
20 Minutes	☐ _____	☐ _____
30 Minutes	☐ _____	☐ _____
45 Minutes	☐ _____	☐ _____

Health Check:	
Age 0-12 months	☐ _____
Age 1-4 years	☐ _____
Age 5-11 years	☐ _____
Age 12-17 years	☐ _____
Age 18-39 years	☐ _____
Age 40-64 years	☐ _____
Infant; regular	☐ _____
Child; regular	☐ _____
Adult; regular	☐ _____

Case Management:	
BP follow-up; documented	☐ _____
BP; abnormal	☐ _____
CM; general	☐ _____
Phone call	☐ _____
Referral	☐ _____

Alcohol/Substance Abuse (SBIRT):
Screening,Brief intervention & referral

15 to 30 Minutes	☐ _____
30+ Minutes	☐ _____
Interpretation	☐ _____
Transportation	☐ _____

Procedures:	
Audiometry	☐ _____
Ear Lavage	☐ _____
EKG	☐ _____
Eye Exam; Comp	☐ _____
Eye Exam; Inter	☐ _____
Nail Avulsion	☐ _____
Nail Removal	☐ _____
Sutures; exclude face	☐ _____
Sutures; face	☐ _____
Suture Removal; no anesth	☐ _____

Injections:

IM injection (admin)	☐ _____
Influenza	☐ _____
Pneumococcal	☐ _____
TDaP (Tetanus)	☐ _____

Pharmacy:	
Depo Provera	☐ _____
Glucometer Strips	☐ _____
Glucose Meter	☐ _____
Rx Services_____	☐ _____

Lab Work:					
CBC	☐ 85025	H. Pylori	☐ 86677	Surgical Pathology;Level IV	☐ 88305
Chlamydia	☐ 86631	Lead Screen	☐ 83655	Testosterone; total	☐ 84403
CMP	☐ 80053	Lipid Panel	☐ 80061	Throat Culture	☐ 87070
Drug Screen	☐ 80101	Microalbumin urine	☐ 82043	Thyroid Panel	☐ 80092
Fecal Occult	☐ 82270	PAP; general (+PAP lab)	☐ 88141	TSH	☐ 84443
Gen Probe	☐ 87800	PAP Thin Prep	☐ 88142	Urine Culture	☐ 87086
Glucagon Tolerance	☐ 82946	PPD Skin test	☐ 86580	Urinalysis; auto	☐ 81003
Glucose, blood strip	☐ 82948	Pregnancy Test; blood; qual.	☐ 84703	Urinalysis; non-auto	☐ 81002
Gonorrhea	☐ 87850	Pregnancy Test; urine	☐ 81025	Wet Mount	☐ 87210
Hemoglobin	☐ 85018	PSA	☐ 84153	Wound Culture	☐ 87075
HgA1c	☐ 83036	Rapid Flu	☐ 87804		
Hepatitis Panel	☐ 80074	Rapid Strep	☐ 87880	Other_____	☐ _____
HIV-1 & 2 test	☐ 86703	RPR; Serology	☐ 86592		
		Sed Rate	☐ 85651		

Screen/Exam/Health Ed					
Alcohol Abuse Ed	☐ _____	Drug Abuse Ed	☐ _____	HTN Screen (BP)	☐ _____
Alcohol abuse Screen	☐ _____	Drug Abuse Screen	☐ _____	Lung Cancer Ed	☐ _____
Anemia	☐ _____	Ears/Hearing	☐ _____	Nutrition	☐ _____
Routine screen PAP	☐ _____	Eyes/vision	☐ _____	Occupational Hazard	☐ _____
Gynecologic Exam + PAP	☐ _____	Family Planning Ed	☐ _____	Physical Activity Counseling	☐ _____
Rtn GYN Exam; w or w/o PAP	☐ _____	Contraceptive management	☐ _____	Pesticide Exposure	☐ _____
Breast Cancer Ed	☐ _____	Contraceptive services	☐	Prenatal Health	☐ _____
Breast Cancer Screen	☐ _____	STD Ed	☐ _____	Prostate Cancer Ed	☐ _____
Cancer; other	☐ _____	STD Screen	☐ _____	Prostate cancer screen	☐ _____
Cancer; skin	☐ _____	General Health	☐ _____	Testicular Cancer	☐ _____
Diabetic Screen	☐ _____	Hepatitis	☐ _____	Tuberculosis (TB)	☐ _____
Domestic Violence screen	☐ _____	HIV Ed	☐ _____	TB Screen	☐ _____
		HIV Screen	☐ _____		

Clinical - UDS required:

- Child Immun. status ok ☐ _____
- Cervical Cancer Educ. ☐ _____
- Pap results rec'vd oth prov ☐ _____
- Cervical cancer screening ☐ _____
- BMI documented _____ ☐ _____
- Nutrition Counsel 15+min ☐ _____
- Nutrition: Reassessment ☐ _____
- Nutrition: Group Ed ☐ _____
- BMI Screening ☐ _____
- Physical Activity assessed ☐ _____
- Tobacco use assessed ☐ _____
- No tobacco use ☐ _____
- Smoking Prevention ☐ _____
- Smoker ☐ _____
- Smokeless tobacco user ☐ _____
- Smoker advised to quit ☐ _____
- Smoke counseling ☐ _____
- Smoking cessation 10+min ☐ _____
- Smoking cessation Tx ☐ _____
- Asthma, persistent ☐ _____
- Asthma:Pharm.Tx documented ☐ _____
- Colon Cancer Scr; other prov ☐ _____
- Colon Cancer Screening ☐ _____
- Lipid Lowering Therapy ☐ _____
- Lipoid disorder screening ☐ _____
- Aspirin/Anti-thromb therapy ☐ _____
- CABG Status ☐ _____
- Cardiovascular risk ☐ _____
- PTCA Status ☐ _____
- Hypertension Ed ☐ _____
- Diabetes Ed ☐ _____
- Diabetic eye exam referral ☐ _____
- Dental Health Ed ☐ _____
- Dental screen ☐ _____
- Oral Health Screen non-pro ☐ _____
- Mental Health Ed ☐ _____
- Depression Ed ☐ _____
- Anxiety Screen ☐ _____
- Depression Screen ☐ _____
- BH Counseling ☐ _____
- MH assessment non-pro ☐ _____
- Psych Dx; Interview Adult ☐ _____
- Psych Dx; Interview Child ☐ _____

Diagnoses:

- Abdominal Pain ☐ _____
- Abnormal Breast; female ☐ _____
- Abnormal Cervical findings ☐ _____
- Acne ☐ _____
- ADD/ADHD ☐ _____
- Alcohol Abuse ☐ _____
- Alcohol Dependence ☐ _____
- Alcohol intox.; acute ☐ _____
- Allergic URI ☐ _____
- Allergies; unspecified ☐ _____
- Amenorrhea ☐ _____
- Anemia; Iron deficient ☐ _____
- Anxiety disorder ☐ _____
- Asthma ☐ _____
- Arthritis; unspecified ☐ _____
- Bronchitis; Acute ☐ _____
- Bronchitis; Chronic ☐ _____
- CAD ☐ _____
- Candidiasis; vaginal ☐ _____
- Cerumen impaction ☐ _____
- Chest wall pain ☐ _____
- Chlamydia infection ☐ _____
- Conjunctiva Abrasion ☐ _____
- Conjunctiva hemorrhage ☐ _____
- Conjunctivitis ☐ _____
- Constipation ☐ _____
- Contact dermatitis/eczema ☐ _____
- Cough ☐ _____
- Cystitis ☐ _____
- Dehydration ☐ _____
- Dental caries ☐ _____
- Dental abscess ☐ _____
- Dental pain ☐ _____
- Depression ☐ _____
- Dermatitis ☐ _____
- Diabetes; Type II, non-insul ☐ _____
- Diabetes; Type I, insulin ☐ _____
- Diabetes; uncontrolled ☐ _____
- Diarrhea ☐ _____
- Dizziness ☐ _____
- Drug addiction ☐ _____
- Dysuria ☐ _____
- Elevated blood pressure ☐ _____
- Episodic mood disorder ☐ _____
- Erectile Dysfunction ☐ _____
- Exposure to heat/cold ☐ _____
- Fatigue ☐ _____
- Fever (Pyrexia) ☐ _____
- Finger injury; nonspecific ☐ _____
- Gastritis; acute ☐ _____
- Gastritis; atrophic ☐ _____
- Gastroenteritis ☐ _____
- GERD ☐ _____
- Gonorrhea ☐ _____
- Hand injury; nonspecific ☐ _____
- Headache ☐ _____
- Headache; Migraine ☐ _____
- Head Lice ☐ _____
- Hemorrhoids ☐ _____
- Hepatitis B ☐ _____
- Hepatitis C ☐ _____
- Herpes; genital ☐ _____
- Herpes; simplex ☐ _____
- Herpes; zoster ☐ _____
- HIV; symptomatic ☐ _____
- HIV; type II ☐ _____
- Hives ☐ _____
- H. Pylori ☐ _____
- Hypercholesterolemia ☐ _____
- Hyperlipidemia ☐ _____
- Hypertension ☐ _____
- Hyperthyroidism ☐ _____
- Hypothyroidism ☐ _____
- Impetigo ☐ _____
- Influenza ☐ _____
- In-grown toenail ☐ _____
- Insomnia ☐ _____
- Lack of normal develop ☐ _____
- *delayed weight gain ☐ _____
- *failure to thrive ☐ _____
- Low back pain ☐ _____
- Lumbar sprain ☐ _____
- Mental disorder; other ☐ _____
- Mood disorder; other ☐ _____
- Myalgia/Myositis ☐ _____
- Nausea with Vomiting ☐ _____
- *Nausea (only) ☐ _____
- *Vomiting (only) ☐ _____
- Neck Pain ☐ _____
- Non-Compliance; Hx ☐ _____
- Obstruct. Eusta. Tube ☐ _____
- Onychomycosis ☐ _____
- Otitis external; inf. ☐ _____
- Otitis media; acute ☐ _____
- Otitis media ☐ _____
- Overweight/Obese ☐ _____
- PAP; Abnormal ☐ _____
- PID ☐ _____
- Pelvic Pain; female ☐ _____
- Penile lesion; benign ☐ _____
- Pesticide poisoning ☐ _____
- Pharyngitis ☐ _____
- Pneumonia ☐ _____
- PPD+ (non-TB) ☐ _____
- Pregnancy test; negative ☐ _____
- Pregnancy test; positive ☐ _____
- Pregnant state; incidental ☐ _____
- Pterygium ☐ _____
- PTSD ☐ _____
- Rash ☐ _____
- Rhinitis; allergic ☐ _____
- Scabies ☐ _____
- Sebaceous Cyst ☐ _____
- Sinusitis ☐ _____
- Sprain/strain; ankle ☐ _____
- Sprain/strain; knee ☐ _____
- Sprain/strain; shoulder ☐ _____
- Stomatitis ☐ _____
- Strep throat ☐ _____
- Stye (Hordeolum Ext) ☐ _____
- Substance induced d/o ☐ _____
- Syphilis ☐ _____
- Tendonitis ☐ _____
- Thrush ☐ _____
- Tinea corporis ☐ _____
- Tinea cruris ☐ _____
- Tinea Pedis ☐ _____
- Tobacco dependence ☐ _____
- Tonsillitis ☐ _____
- Tuberculosis (TB) ☐ _____
- Upper respiratory infection ☐ _____
- Urethritis; unspecified ☐ _____
- Urinary tract infection ☐ _____
- Underweight ☐ _____
- Viral syndrome ☐ _____
- Vulvovaginitis ☐ _____
- Weight gain ☐ _____
- Weight loss ☐ _____

GEORGIA FARMWORKER HEALTH PROGRAM
Authorization for Medical Care
Clinic Name
Clinic Address, Phone, Fax

Form # _____

Importante
Su cita con doctor es: El_____
a las_____

Date Referral issued: _____ This referral will expire 30 days from the date issued. Expiration date: _____

Patient Information:

Name (Last, First) _____ Patient ID# _____

Date of Birth _____ Local Address _____

Referred to:

Physician and/or **Pharmacy**

Name:_____ Name: _____

Address: _____ Address: _____

Reason for referral (include diagnosis, length of time patient has been seen for this problem, etc.)

_____

_____

Maximum amount GFHP Program will pay for this visit: $_____or Patient's % of payment $_____

Authorized by: _____ Telephone _____

Physician's Office Use Only:

Date	Location	CPT	Name of Medical Procedure	ICD-9	Service Type	Fee Charged

NOTE: Payment will be issued upon <u>our</u> receipt of this completed referral form, a physician report and a bill for services provided.

Was laboratory work performed outside your office? Yes __ No __
Charge: $_____

Total Charges	$
Less Voucher Fee pd	**-$15.00**
Less Other Payment collected	-$
Remaining Balance	**$**

Physician (Narrative)	**Pharmacy (Rx/Narrative)**

Please return this form for payment to:
Clinic Name
Street Address
City, State, Zip

_____
Physician's Signature

_____
Date

GEORGIA FARMWORKER HEALTH PROGRAM
Authorization for Dental Care

Clinic Name
Clinic Address, Phone, Fax

Importante
Su cita con el Dentista es:
El_____a las _____

Date referral issued: _____

This referral will **expire** 15 days from the date issued: _____

Patient Information:

Name (Last-First) _____Pt ID#_____

Date of Birth _____

Local Address_____

Home Base Address _____

Referred to:

Provider's Name: _____

Address: _____

Estimate of GFHP program payment: $_____ or Patient % of payment $_____

This authorization is void if patient qualifies for Medicaid, Insurance or other third-party payment.

Reason for referral _____

Authorized by _____ Telephone _____

Dentist Office Use Only:

Examination and Treatment Record List in Order from Tooth No. 1 through Tooth No. 32					
Tooth	Surface Code	DESCRIPTION OF SERVICES Including X-rays, Prophylaxis, and materials used, Etc	Date of Service	Procedure Number	Fee Charged

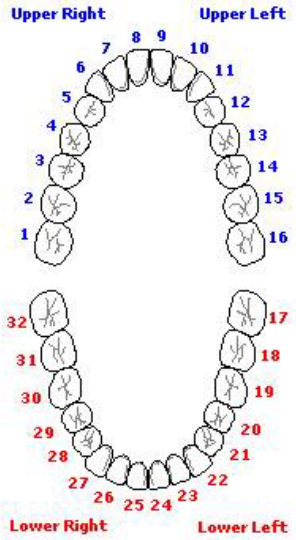
NOTE: Payment will be issued upon our receipt of this completed referral form, a physician report and a bill for services provided.

Total Charges	$
Less GFHP Voucher fee	-$ 15.00
Less Additional Payment collected	-$
Remaining Balance	**$**

A) Is follow-up needed? Yes No
For What? _____

B) Return Appointment? Yes No
When needed? _____

C) Does patient need transportation to the next appointment? Yes No



_____
Physician's Signature

_____
Date

State Office of Rural Health
Georgia Department of Community Health

Revised 09/15

MIGRANT HEALTH PROGRAM MONTHLY COST REPORT	Program Name: *Insert site/program name here*	Report Period: Start date: *mm/dd/yyyy* End date: *mm/dd/yyyy*	Prepared by: *insert name of person preparing report here*	Page **1** of 4

REVENUE FOR SERVICES RENDERED:

		Beginning A/R Balance	Full Charges	Payments Received	Sliding Fee Adjustments	Contractual Adjustments	Bad Debt	Ending A/R Balance	Change in Balance
1	Medicare								
2	Medicaid								
3	SCHIP (Peachcare)								
4	Other Third Parties								
5	Patients (Self-pay)								
6	Total Services Revenue (sum of lines 1-5)			0.00					

PROGRAM INCOME:

		Payments Received
7	**Program Income**	0.00

OTHER REVENUE SOURCES:

		Amount Received
8 9 10 11	Migrant Program Grant Funds	0.00
12	Total Other Revenue (lines 8-11)	

VALUE OF DONATED VALUE

		Value Received
13 14	Net Donated Cost	0.00
	Total Revenue, Grants & Donated value (7+12+14)	0.00

	MIGRANT HEALTH PROGRAM MONTHLY COST REPORT	Project site: *insert prodject site and name here*				Report Period: Start:		End:		Report Prepared by: *Insert name here*		Page **2** of 4
			F.T.E.	Salary	Fringe Benefits	Travel	Equipment	Building Rent	Contracted Services	Other Operating	Total Expenditures	Donated Value	Depreciation
	Personnel:												
	Medical Staff	Staff Pos/Title											
1											0.00		
2											0.00		
3											0.00		
4											0.00		
5											0.00		
	TOTAL			**0.00**	**0.00**						**0.00**		
	Enabling Staff	Staff Pos/Title											
6											0.00		
7											0.00		
8											0.00		
9											0.00		
10											0.00		
11											0.00		
	TOTAL			**0.00**	**0.00**						**0.00**		
	Administrative Staff	Staff Pos/Title											
12											0.00		
13											0.00		
14											0.00		
15											0.00		
16											0.00		
	TOTAL			**0.00**	**0.00**						**0.00**		
	All Other (non-personnel) Direct Service Costs:												
	Medical												
17	Medical/ Other Direct												
18	Lab												
19	X-ray												
19	Pharmacy (not including pharmaceuticals)												
20	Pharmaceuticals												
21	Dental												
22	Mental Health/Psychiatry												
23	Substance Abuse												
24	Vision Services												
25	Other Professional Services												
a.	Physician Oversight												
b.	Medical Staff Training/CME's												
c.	Telecommunications Cost 1/3												
d.	Fuel/Vehicle Maintenance/Ins 1/3												
e.	Copier/Maintenance 1/3												
f.	Postage 1/3												
26	Voucher Services												
a.	Medical Voucher												
b.	Dental Voucher												
c.	Mental Health Voucher												
d.	Pharmacy Voucher												
e.	Vision Voucher												
f.	Other Vouchers												
27	Medical Supplies												
28	Medical Equipment												
	Total Medical Costs										**0.00**	**0.00**	

	Enabling												
26	Case Management												
27	Transportation												
28	Outreach												
29	Patient & Community Education												
30	Eligibility Assistance												
31	Translation/Interpretation												
32	Other Enabling Services												
a.	Telecommunications Cost 1/3												
b.	Fuel/Vehicle Maintenance/Ins 1/3												
c.	Copier/Maintenance 1/3												
d.	Postage 1/3												
e.	Enabling Supplies												
f.	Other Enabling Cost												
	Total Enabling Service Cost										**0.00**	**0.00**	
	Administrative												
	Overhead and Totals												
33	Facility												
a.	Rent												
b.	Utilities												
c.	Janitorial Services												
d.	Lawn Services												
e.	Other Facility Cost												
34	Administration												
a.	Telecommunications Cost 1/3												
b.	Fuel/Vehicle Maintenance/Ins 1/3												
c.	Copier/Maintenance 1/3												
d.	Postage 1/3												
e.	Administrative Fees												
f.	Administrative Supplies												
g.	Other Administrative Cost												
	Total Overhead Costs (sum of lines 33a-e + 34a-g)							**0.00**		**0.00**	**0.00**		
						Program Expenditures					**TOTAL**	**Non-Cash Costs**	
	TOTAL MEDICAL COSTS										**0.00**		
	TOTAL ENABLING COST										**0.00**		
	TOTAL ADMINISTRATIVE COST										**0.00**		

Other Costs - Breakdown

Migrant Health Facility: _____

Funding Period: Start: End:

Cost Type	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOTAL
Travel Costs													
Travel													0.00
Vehicle Costs													
Vehicle maint/repair													0.00
Vehicle Insurance													0.00
Fuel													0.00
Telecommunications													
Telephone													0.00
Cell Phone													0.00
Internet													0.00
Office Supplies													
Admin O/S													0.00
Medical O/S													0.00
Vouchers													
Medical													0.00
Dental													0.00
Mental Health/Psychiatry													
Substance Abuse													0.00
Vision Services													0.00
Pharmacy Services													0.00

Monthly Program Income Expenditures

Migrant Health Facility: _____

Funding Period: Start: End:

Cost Type	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOTAL
Medical													
A. Personal Services													0.00
B. Regular Operating													0.00
C. Direct Benefits													0.00
D. Travel													0.00
E. Equipment													0.00
F. Facility Cost													0.00
G. Per Diem & Contracts													0.00
H. Pharmacy													0.00
I. Motor Vehicle													0.00
Enabling													
A. Personal Services													0.00
B. Regular Operating													0.00
C. Direct Benefits													0.00
D. Travel													0.00
E. Equipment													0.00
F. Facility Cost													0.00
G. Per Diem & Contracts													0.00
H. Pharmacy													0.00
I. Motor Vehicle													0.00
Administrative													
A. Personal Services													0.00
B. Regular Operating													0.00
C. Direct Benefits													0.00
D. Travel													0.00
E. Equipment													0.00
F. Facility Cost													0.00
G. Per Diem & Contracts													0.00
H. Pharmacy													0.00
I. Motor Vehicle													0.00
TOTAL per month	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

The Georgia Farmworker Health Program

Plan Adopted by Board	Date: 07/06/2015
Plan Reviewed by Board	Date: 03/17/2016
Plan Revisions Approved by Board	Date: 08/14/2017
Plan Updated	Date: 08/29/2023

POLICY/PLAN: Quality Improvement and Quality Assurance

I. Introduction and Statement of Purpose

The Georgia Farmworker Health Program (GFHP) is a migrant health voucher program located within the State Office of Rural Health (SORH) and Georgia Department of Community Health (DCH). The GFHP is a hybrid model Migrant Voucher Program. The GFHP receives only Section 330(g) Migrant Health Funding. The DCH/SORH provides funding through sub-recipient agreements with health care agencies to provide direct patient care, outreach and education by using a combination of a mid-level practitioner model and a voucher program model. Specialty care is provided through a voucher system with local area providers to deliver a combination of case management, health education, medical and dental services.

In order to ensure that the program supports the provision of quality care, improved patient outcomes and a safe work environment, the program has implemented a Quality Improvement and Quality Assurance Plan (QI/QA Plan). The plan was developed to actively involve the program's contract sites and include feedback from our target population. The QI/QA plan includes an emphasis on HRSA's clinical performance measures. The program strives to integrate quality improvement into all aspects of operations.

II. Scope

The scope of GFHP's QI/QA plan is all-encompassing and meant to serve as a guide to all QI/QA across the program. It is an ongoing cycle of assessment, planning, training, reporting, monitoring and evaluation. The plan:

- Establishes a structure for quality improvement that actively involves the program's Director, Mid-level providers and administrative personnel from contract sites.
- Describes annual activities geared towards safety, quality care and improved health outcomes
- Describes key initiatives
- Meets HRSA's QI/QA Plan requirements for health centers

III. Administrative Responsibility

The primary responsibility for implementing, managing and monitoring GFHP's QI/QA efforts is assigned to the Quality Improvement (QI) Committee, which is comprised of the GFHP Program mid-level providers, outreach staff and QI/QA personnel from each of the project

sites and an elected member of the GFHP Migrant Health Advisory Board to serve as QI/QA Committee Liaison.

The QI/QA Committee, along with QI/QA teams at each contract site where GFHP supports medical care, is tasked with operationalizing quality improvement initiatives. The QI/QA Liaison and GFHP Program Director will meet with the QI/QA Committee quarterly. The QI/QA Committee Liaison will report all QI/QA efforts and identified issues directly to the GFHP Migrant Health Advisory Board during regularly scheduled meetings and on an as needed basis.

The following is a summary of the primary decisions and tasks related to quality improvement and quality assurance, and which positions within the organization are responsible, approve, consulted or informed of each.

Decision or Task	Responsible	Approves	Consulted
Health Care Plan – GFHP's clinical measures	Project Site Directors	Program Clinical Director, GFHP Migrant Health Advisory Board	HRSA's UDS manual, GFHP administrative staff, farmworkers and contract sites
QI/QA Plan	Program Director, QA Contract Site Team	Program Clinical Director, GFHP QI Liaison, GFHP Migrant Health Advisory Board	GFHP administrative staff and contract sites
QI/QA Activities	Project Site Directors, QA Contract Site Team	Program Clinical Director, GFHP QI Liaison, GFHP Migrant Health Board	GFHP administrative staff and contract sites

IV. Agency-wide Committee Structure

Quality improvement and assurance activities are conducted by:

a) **Quality Improvement Leadership Team**
The QI/QA Committee serves as the umbrella committee for quality and security initiatives and activities for the QI/QA teams comprised of QA coordinators and/or mid-level providers at each of the contract sites. The committee is led by the QI/QA Liaison and includes the GFHP Program Director.

The QI/QA Committee will meet 4 times a year (generally every 3 months).

The QI/QA Committee meetings and activity will be communicated to the GFHP Advisory Board by the QI/QA Liaison and GFHP Program Director. The following is a sample schedule of yearly QI project plan points of discussion and progress:

1. January – Spring/Summer Projects; data reporting evaluation

2. April – Grant year agenda; Performance Measures goals & discussion
3. July - Fall Project discussion; CY-end reporting evaluation
4. October – Strategic planning to set goals for up-coming CY

b) **Quality Improvement Contract Site Teams**
Contract sites will have local QI/QA teams consisting of a medical provider, an outreach worker and an administrator. Teams coordinate QI/QA efforts at the contract site level. Tasks include setting at least 2 clinical goals and participating in Plan-Do-Study-Act (PDSA) cycles to implement and monitor changes geared to improvements.

Contract Site QI/QA teams will meet on a regular basis, at least five times per year. Suggested times to meet:

1. CY start-up discussion in January to set goals
2. Pre-peak season meeting to discuss strategy for season
3. After peak season ends to adjust strategy
4. Start of Grant year (June) to update contract site's health care plan
5. Calendar year end UDS preparation to discuss year end results

c) **GFHP Migrant Health Advisory Board**
- QI/QA reports are provided by QI/QA contract site teams to the GFHP Migrant Health Advisory Board during regularly scheduled board meetings
- Review and approve GFHP's QI/QA Plan
- Review and approve the organization's Health Care Plan
  - Review the results of quality and patient satisfaction audits & site data trend reports
  - Review continuity of care (medical and enabling)
  - Review the results of clinical QI/QA initiatives

V. Quality Assurance Activities

Numerous activities comprise GFHP's QI/QA Plan. The following describes the major quality improvement efforts:

a) **Risk Management:** GFHP contract sites follow their agency's risk management policy and protocols. Providers delivering medical services on behalf of the Georgia Farmworker Health Program must have malpractice coverage, which is to be secured by the health care organization contracting with the provider. Organizations that do not normally provide clinical services should notify their insurance carrier regarding clinical activities that will be arranged by their agency.

b) **Incident Reporting:** Incidents, such as needle sticks or work-site injuries, should be managed by contract site protocols. This allows for the most expedient evaluation of and response to the incident. If an individual would like to discuss the incident's management with the Georgia Farmworker Health Program's Director, that is permissible, however, the responsibility for managing incidents lies at the individual contract sites.

c) **Patient Satisfaction:** All GFHP contract sites are required to submit quarterly farmworker feedback surveys. The surveys assess patients' needs as well as their satisfaction with the provision of services. Surveys may be conducted through contracted third-party organizations to achieve comprehensive results. The results are compiled by site and program wide; findings will be submitted to the GFHP Migrant Health Advisory Board for review. Results will be used in future grant applications to address areas of concern. GFHP Surveys are conducted through third party vendor Crossroads Group, Inc. Reports are received by GFHP Director and contracted sites for review.

d) **Medical Audits:** GFHP contract sites that receive funding for medical services sign a grant contract each funding year stating that their medical director may have access to medical records for review as this is a grant required deliverable. Monthly data audits are to be performed by the contract site director to assess progress of clinical measures included in the UDS report and review QA/QI activities. The contract site director is to submit findings to the GFHP Director and is expected to address areas of weakness.

e) **Clinical Reviews:** GFHP Program Clinical Director will conduct quarterly clinical site visits in which the following areas regarding farmworker health services are discussed:

- Physician Preceptor Reviews
- Medical Chart Reviews
- Credentialing and privileging
- Review of Vouchers Utilization
- Communication between outreach workers and providers
- Inclusion of Health Assessment in medical record
- Availability of interpretation services
- Documentation
- Identification of farmworker patients
- Method of addressing chronic problems, occupational health, and preventive care of farmworkers
- Staff training needs
- Administration audit

f) **Credentialing & Privileging:** All Licensed Independent Providers and Licensed Healthcare Workers who are hired or contracted by GFHP or its contracted sites must be credentialed and granted privileges to provide services to migrant and seasonal farmworkers. Licensed Independent Providers include, but are not limited to physicians, physician assistants, nurse practitioners, dentists, and nurses who see patients independently. Licensed Healthcare Workers who care for patients under a medical provider's orders include Registered and Licensed Practical Nurses, Clinical Medical Assistants, Social Workers, Dental Hygienists, Registered Dieticians, Physical Therapists, Occupational Therapists, Speech Therapists and Laboratory

Technicians. The Privileging and Credentialing Checklist will be completed for each new hire and every 2 years thereafter, the license will be checked online each year, and the National Provider Database will be queried routinely.

g) **Operational/Strategic Planning:** Individual site consultations involving the GFHP Program Director, contract site outreach coordinators and contract site directors are held with each site to examine their provision of services, program data, farmworker feedback surveys and their clinical continuous quality improvement outcomes. GFHP provides updates on HRSA program requirements, a summary of the most recent UDS data, and examines UDS trend data. Discussion to gain ideas and feedback from contract site staff about new initiatives, program forms, policies and procedures, and the status of GFHP's strategic plan.

h) **Annual Farmworker Health Outreach Trainings:** Farmworker health trainings will be offered on an annual basis. Training is to be provided in accordance with program improvement based on best practices regarding health education, case management, farmworker health topics, and related resources.

i) **Voucher Utilization Review:** The contract site QI/QA Coordinator will complete quarterly data reports indicating the number of patients served, the number and type of encounters, patients seen by county, transportation and interpretation services provided, number and type of resources provided (condoms, vitamins, car seats, etc.), number and type of referrals made, and type of health education provided. Annual trend data developed for each contract site shows the data for the most recent UDS year and the previous 3 years.

VI. Policies & Procedures

GFHP maintains board approved policies and procedures to ensure that services are provided safely, confidentially, and in compliance with HRSA health center expectations. The following policies and procedures can be found in GFHP's Policy and Procedure Manual:

- Quality Improvement and Quality Assurance
- Credentialing and Privileging Policies
- Strategic Planning
- Program Qualification and Registration
- HIPAA and medical records management
- GFHP Database
- GFHP Encounter Forms

VII. Communication of Information

a) **Resources**
The GFHP Program Director sends e-mails throughout the year encouraging Migrant Health Conference attendance from each of the contract sites as

resources for health education, quality improvement and networking for medical and enabling staff.

b) **Outreach Manual**
GFHP provides Outreach Manuals to all contract sites with guidance about initiating and maintaining a farmworker health program, with a special focus on outreach and enabling services.

c) **Site Visits**
GFHP Director conducts periodic site visits to provide general guidance and technical assistance; to monitor the provision of services and EMR utilization; to oversee program requirements and compliance; and to conduct financial monitoring.

d) **Farmworker Health Trainings: Clinical Staff/Outreach/Governance**
The GFHP Project site directors along with the GFHP Migrant Health Advisory Board discuss program highlights and needs monthly during scheduled board meetings. This provides board members and each contract site an opportunity to discuss special initiatives, trainings/training needs, quality initiatives and other program related topics.

VIII. Annual Evaluation

The GFHP Program Director will meet with each contract site's program director and local QI/QA team to examine data and evaluate achievements. A final CQI report is submitted to the GFHP Migrant Health Advisory Board for review and approval.

IX. Revisions to the QI/QA Plan

This QI/QA Plan is intended to be flexible and readily adaptable to changes in current initiatives, regulatory requirements and in the healthcare system overall. The Plan will be regularly reviewed by the GFHP Director and Quality Improvement Committee to assess the viability of the Plan and the inclusion of all appropriate QI and QA activities.

X. Key Initiatives

During 2023-2024, GFHP is focusing on the following initiatives:

a) **Focus #1 -**Improving mental health among Migrant and Seasonal Farmworkers (MSFWs). This will be done by first training all outreach staff on how to recognize and respond to common mental health concerns such as anxiety, depression, PTSD, suspected Alcohol Use Disorder (AUD) and Substance Use Disorder (SUD) among farmworkers. Outreach staff and selected clinical staff will be trained using the Mental Health First Aid™ curriculum which emphasizes supporting patients with local referrals and resources for mental and behavioral health. Contract sites will develop their own QI/QA projects around mental health using the Plan-Do-Study-Act model. The QI/QA Committee will also begin to track depression screening as a new clinical measure.

b) **Focus #2 -**Improving hypertension control and implementing enhanced patient education efforts on the importance of blood pressure monitoring and medication compliance for MSFWs with hypertension. All contracted sites participated in the recent National Hypertension Control Initiative (NHCI) program launched by the American Health Association. The QI/QA Committee will share best practices for providing culturally sensitive patient education around the importance of target blood pressure goals for MSFWs.

c) **Focus #3 –** Improving HgbA1C measures as an indicator of improved diabetes care for MASAs. The QI/QA Committee will rededicate efforts to providing high quality care and patient education around the prevention and treatment of prediabetes and type 2 diabetes in the farmworker community. We will do this through updated training for clinical and outreach staff.

d) **Focus #4 –** The QI/QA Liaison and GFHP Director will engage the QI/QA Committee members in discussion and research activities related to population research so that the GFHP can gain a better understanding of the changing demographics of each of our contracted sites given the recent changes to Georgia's domestic and H2A contracted worker populations.

Georgia Farmworker Health Program (GFHP)

State Office of Rural Health (SORH)
Georgia Department of Community Health (DCH)

Quality Assurance / Continuous Quality Program Manual

(QA/CQI Manual)

April 2024

Georgia Farmworker Health Program (GFHP)

QA/CQI Program Manual

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Georgia Farmworker Health Program (GFHP)

QA/CQI Program Manual

Chapter I

Purpose/Background

Purpose:

The purpose of the Quality Assurance/Continuous Quality Improvement (QA/CQI) Program Manual is to provide specific standards, measurement tools, and processes for improving the quality of healthcare provided to migrant and seasonal farmworkers (MSFWs). The GFHP QA plan will include four dimensions of quality, pertinent to health care delivery, along with identified indicators and/or data sources: (1) **Quality of service delivery** that will focus on provider credentialing, and patient satisfaction assessments; (2) **Quality of care** that will focus on peer reviews, utilization reviews, and patient medical records; (3) **Quality of work force and work environment** that will focus on personnel records, and administrative reviews; and (4) **Quality of health status measures/screenings** that will focus on clinical measures for each identified lifecycle.

Because of the unique differences among the GFHP project sites, this Manual should be used as a basis for standardization of the basic elements of a quality management program. It is not intended to replace existing contracting agencies' QA/CQI plans but to be used in conjunction with current agency protocols. The purpose for this approach is to enhance current QA and CQI programs by ensuring specific MSFW program requirements and/or elements are in place. The GFHP has been mandated to implement a uniform QA/CQI program in order to comply with federal regulations. This plan is a template for developing uniform procedures and protocols required of all GFHP project sites while maintaining flexibility to accommodate federal, state, county, district, and/or agency requirements.

Background:

The GFHP was created in 1990 to serve migrant and seasonal farmworkers and their dependents. The Program currently provides primary healthcare services in 21 rural Georgia counties through six project sites with an estimated labor force of over 75,000 MSFWs. The GFHP is a Federal/State-funded program designed to ensure the availability of and accessibility to essential primary healthcare services for those MSFWs who have the most limited access and face the greatest barriers to care. Its purpose is to improve the general health status of Georgia migrant and seasonal farmworkers by providing (1) cost effective, culturally-appropriate primary healthcare services; (2) arranging for other levels of healthcare through collaboration and advocacy; (3) working collaboratively with local organizations and groups; and (4) finding alternative funding sources and equipping MSFWs with skills, through health education and outreach, to better understand their healthcare options in terms of health status and accessing care.

Georgia Farmworker Health Program

QA/CQI Program Manual

Chapter II

Provider Credentialing

In order to provide quality health care to eligible migrant and seasonal farmworkers, provider credentials and verification are required. All contract physicians, dentists, and mid-level providers must have a valid license to practice in Georgia. Institutional providers, such as the local hospital, federally-funded community health centers, or county health departments, have their own internal quality assurance programs required by regulatory agencies and may be willing to share their findings with the project. **Refer to BPHC Policy Information Notice 2001-16 and 2002-22 for policy guidance.**

Contracting agencies for the project sites will review provider credentials every two years. All contracting agencies provider credentialing policy must meet state and federal credentialing requirements. Primary Source Verification (Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner) is required. Examples of Primary Source Verification include direct correspondence, internet verification, and reports from credentials verification organizations (CVO's). Also, hospitals that meet JCAHO's "Principles for CVO's" are an acceptable method of primary source verification. Contractors shall make available, copies of practitioner credentialing documents for review by the Director, Migrant Health, Homeless, and Special Programs or is representative. Verification of credentialing is required on all providers including contract providers and/or participating community volunteer providers. A credentialing checklist is provided as a guide to ensure a complete credentialing review is performed prior to engaging a provider.

Georgia Farmworker Health Program
QA/CQI Program Manual

Credentialing Checklist

****Each provider must have this Checklist completed prior to the start of his/her tenure with the GFHP**

Provider Name:(as listed with the licensing board) _____
License number:_____ DEA number:_____
Date of verification: _____
Expiration date of licenses: _____

Source of Verification	Date of verification	Comments
1. Primary Source Verification.		
a. Georgia Secretary of State Website Query.		
b. Credentialing verification letter from CVO.		
c. Credentialing verification letter from a JCAHO certified hospital.		
2. National Practitioner Data Bank (NPDB) Information Query		
3. Secondary source verification (if required)		
a. DEA registration (as applicable)		
b. Hospital admitting privileges		
c. Immunization status current		
d. Life support training current		

Comments:

_____

_____

_____

_____

_____

_____

_____

Georgia Farmworker Health Program

Chapter III

Physician Preceptor Review

In order to promote accountability and improve patient care, a physician preceptor must conduct a clinical record review on **10 percent** of all mid-level providers' medical record entries **Monthly**. Each GFHP project site that is staffed with a mid-level provider currently has a physician preceptor under contractual agreement or memorandum of understanding.

The physician preceptor is to conduct a clinical record review using the GFHP Physician Preceptor Review Checklist and forward a copy of their overall findings to the appropriate Program Coordinators. The Program Coordinators are to maintain a file of all Physician Preceptor Reviews for review by the Director, Migrant Health, Homeless, and Special Projects during site visits.

Rationale:

a. Promotes accountability and improves quality of patient care;
b. Provides information to assess knowledge and skills of protocols/standards for evaluation; and
c. Stimulates personal and professional development

Review/Grading criteria for audit form:

Put a check in the box if criteria are present and satisfactory. Add the number of checks for each criterion and put in the # column. Convert the number of checks to percentages and put in the % column. Add the total percentages and divide by the total number of criteria reviewed to determine average compliance.

Georgia Farmworker Health Program

Physician Preceptor Review Checklist

Provider under review: _____
Date: _____

Reviewer: _____ Title: _____

Criteria for Review	1	2	3	4	5	#	%
1. Medical record identifier							
2. Legible and appropriate documentation format							
3. Documentation of appropriate:							
a. Past history and history relevant to current complaint							
b. Examination							
c. Lab and/or diagnostics							
d. Assessment and plan (to include education and follow-up)							
4. Problem list current							

Compliance Score: _____ (Compliance score goal is >90%)

Comments / recommendations:

_____
_____
_____
_____
_____
_____
_____

Georgia Farmworker Health Program

Chapter IV

Utilization Review of Vouchers

All GFHP project sites utilize a voucher program to refer patients to outside providers for services not provided for on site. Generally, the nurse practitioner/mid-level provider will provide primary healthcare. When care is needed from a physician, dentist or pharmacist, project staff will complete a voucher authorization form. Because of the potential cost to the project site for services provided by an outside provider, it is necessary to conduct a utilization review of services being provided.

Patients and potential clients should be advised that the voucher program does not provide emergency care. Migrant and seasonal farmworkers should be provided with instructions on how to call for an ambulance, and directions to hospital emergency rooms in the area. This information is to be widely disseminated so that valuable time is not lost when a true medical emergency arises. Examples of medical emergencies include the following (not an all-inclusive list):

- Bleeding which cannot be stopped
- Difficulty breathing
- Convulsions
- Compound fractures
- Eye Injuries
- Fever of 104 degrees or more
- Heat Stroke
- Possible miscarriage or imminent delivery
- Vomiting blood
- Loss of consciousness
- Severe abdominal or chest pain

The program coordinator at each project site will perform concurrent utilization reviews through the process of issuing vouchers, approving vouchers for payment, and arranging follow-up care. **A utilization review will be conducted on all patients with more than two encounters per quarter for which vouchers were issued.** The following checklist is to be utilized to determine compliance with voucher policies.

Review/Grading criteria for audit form:

Put a check in the box if criteria is present and satisfactory. Add the number of checks for each criteria and put in the # column. Convert the number of checks to percentages and put in the % column. Add the total percentages and divide by the total number of criteria to determine average compliance score.

Georgia Farmworker Health Program

Utilization Review of Vouchers

Criteria for Review	1	2	3	4	5	#	%
Record identifier							
Patient is registered into the GFHP							
Appropriate signature on authorization							
Reason for referral documented							
Fee conforms to Medicaid rate							
Patients percentage of payment listed							
Amount paid to provider includes deductions for any client payment							
Provider completed requested services							
Narrative report provided by participating voucher physician / dentist.							
Services provided were consistent with services requested							
Payment made to participating voucher physician/dentist/pharmacist							
Pharmacist dispensed authorized drug							
Generic rate charged unless provider specified brand name							

Program Coordinators are to maintain a log of all Vouchers authorized and the appropriate utilization review forms associated with each voucher.

Compliance score: _____ (Compliance score goal is 100%)

Signature of Program Coordinator: _____ Date: _____

Georgia Farmworker Health Program

Chapter V

Medical Records Audit

The GFHP is committed to delivery of high quality, comprehensive health care, therefore, written medical records that are clear, legible, and well organized, are a necessary prerequisite for this process. A medical record is to be initiated on all new patients entering the system. All medical records are to be filed and maintained according to accepted ambulatory health care standards. All record entries will be in **BLACK or BLUE** ink.

The contractor has ownership of patient medical records and will maintain them in accordance with clinic policy. If requested, the contractor is responsible for providing migrant and seasonal farmworkers and their dependents with a copy of the medical record before they leave the area.

The contractor is responsible for maintaining the confidentiality of all medical records and complying with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

A medical record audit is to be conducted on 10 charts per month. The review will be based on medical record maintenance. A medical records review checklist form has been developed.

Georgia Farmworker Health Program

Medical Record Audit

Project Site: _____ Auditor: _____ Date: _____

	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	#	%
Medical record identifier							
Problem list updated and complete							
Signed patient consent							
Signed HIPAA acknowledgment							
Immunization status assessed							
Drug allergies listed							
Medication list current							
Health education documented							
Risky behaviors/habits noted							
Lab/X-ray tests and reports are present and signed by provider							
Appropriate signatures on forms							
Voucher forms placed in record (if applicable)							
Follow-up appointments listed/scheduled							
Patient registration forms on file and current.							

Put a check in the box if criteria are present and satisfactory. Add the number of checks for each criterion and put in the # column. Convert the number of checks to percentages and put in the % column. Add the total percentages and divide by the total number of criteria reviewed to determine average compliance score.

Compliance Score: _____ (Compliance score goal is >90%)

Comments:

_____

_____

_____

_____

_____

Georgia Farmworker Health Program

Chapter VI

Patient Satisfaction Assessment Surveys

Patient satisfaction assessments are conducted by third party vendors. These surveys play a valuable role in obtaining information from the MSFW population about needs and views of the health care services being provided. Project sites are to review feedback from assessments to address any patient grievances and data to improve patient encounters and health outcomes.

The information is used to assess the quality of care, as well as barriers to care experienced by farmworkers so that improvements may be made. The results of the surveys are to be maintained at the project sites. Evidence of review by the sites' local advisory boards shall also be maintained at the project site.

Georgia Farmworker Health Program

Chapter VII

Administration Audit

The GFHP uses contractual agreements between multiple health care agencies. In order to ensure that uniform health care services are provided to the MSFW population, the GFHP has developed basic policies that all project sites are to implement to ensure uniformity. It is the intent of the GFHP to enhance the project sites delivery of healthcare services to the MSFW population and not to replace existing procedures or policies.

All project sites are to maintain on site the following policies and/or procedures.

1. GFHP Policy and Procedures Manual
2. Financial tracking policy
3. GFHP QA/CQI Manual
4. Local QA plan
5. Clinical protocols
6. HIPAA Policy and Procedures
7. Contractual agreements and memorandum of understandings/memorandum of agreements related to the delivery of healthcare and dental services.
8. CLIA waivers for project sites with laboratory capability
9. All local policies relating to the delivery of healthcare services

In addition, each project site is to implement and maintain the following boards, policy and/or procedures:

Advisory Board:

- Meets on a quarterly basis
- Members will include MSFW representatives, community agencies, etc.
- Member names are displayed and available to the clients upon request
- Develop and forward minutes of all meetings to the Director, Migrant Health,
- Homeless and Special Programs

Patient "Bill of Rights":

- Displayed in obvious areas (waiting rooms) and disseminated to center clients
- Published in appropriate languages

Sliding Fee Scale:

- Displayed in obvious areas (waiting rooms)
- Published in appropriate languages
- States that services will be provided regardless of patient's inability to pay

Building safety checks (conducted by local Fire Marshall or agency Safety Officer):

- Fire Hazards
- Fire Extinguishers (inspected & tagged)
- Emergency exits identified
- Hazardous material storage

Hours of Operation:

- Accessible
- After hour access available
- **Weekend access available**
- After hour referral procedures available

Health education pamphlet:

- Available in appropriate languages
- Displayed in obvious areas (waiting rooms)

An administrative audit is to be conducted on an annual basis. The purpose of this audit is to make appropriate policies and procedures readily available for staff members; ensure a safe working environment for clients and staff; and provide a means to educate clients on their rights.

Project sites are to use the following audit form as a means to document compliance.

Georgia Farmworker Health Program

Administration Audit

	Available Yes – No – N/A	Comments
GFHP Policy and Procedures Manual		
Financial tracking policy		
GFHP QA/CQI Manual		
Local QA/CQI Plan		
Clinical protocols available		
HIPAA Policy and Procedures		
Contractual agreements MOU/MOAs on file		
CLIA waiver posted		
Local agency's policies for healthcare services		
Advisory Board established and functional		
Patient Bill of Rights displayed		
Sliding fee scale displayed		
Building safety checks conducted		
Hours of operation displayed		
Health education pamphlets in appropriate languages		

Georgia Farmworker Health Program

Chapter VIII

Quality Assurance / Continuous Quality Improvement Committee

The GFHP has instituted a QA/CQI Committee to assure accessibility, quality and cost effectiveness of primary care services available to migrant and seasonal farmworkers in Georgia. The GFHP QA/CQI Committee will be responsible for evaluating, monitoring, and promoting continuous improvements in the quality of health services provided to the migrant farmworkers by the various project sites.

The primary function of the GFHP QA/CQI Committee will be:

A. Monitoring of identified issues in the QA/CQI Plan
B. Review and make recommendations regarding quality assurance/improvement findings
C. Identify quality improvement opportunities

The GFHP QA/CQI Committee will consist of:

A. Director, Georgia Farmworker Health Program and Healthcare for Homeless Programs;
B. Quality Improvement Manager who serves on the Migrant Health Board and is appointed by board vote;
C. Program Directors from all project sites; and
D. Mid-Level providers and Nursing representative from all project sites

Meetings will be held on a quarterly basis. The QA/CQI Committee will meet in conjunction with the monthly GFHP meetings.

The GFHP will utilize the **FOCUS PDCA** approach for performance improvement. The approach is as follows:

F Find a process to improve
O Organize a team that knows the process
C Clarify the current knowledge of the process
U Understand the cause of the process variation
S Select the process improvement

P Plan the process to improve
D Do the improvement
C Check the study results
A Act to hold and sustain the improvement

Any staff member that discovers a process or policy that can be enhanced, streamlined or made more efficient is to complete the Quality Improvement Process Form and forward to the QA Committee for consideration and/or action.

Georgia Farmworker Health Program

Quality Improvement Process Form

Process or Policy identified for improvement:

_____
_____
_____
_____

Nature of the problem:

_____
_____
_____
_____

Recommended improvement action:

_____
_____
_____
_____

Date forwarded to the QA Committee: _____

Action/s taken by the QA Committee:

1. Process improvement team assigned _____
2. Disagree with recommendation _____
3. Recommendation implemented _____
4. Follow-up of process improvement scheduled _____
5. Improvement process completed _____

Comments:

_____
_____
_____
_____

Georgia Farmworker Health Program

Chapter IX

Schedule of Events

The following is a schedule of events and/or reports associated with the QA/CQI Plan. All Project Coordinators are to ensure that all aspects of the program are implemented and appropriate reports are forwarded to the Director, Migrant Health, Homeless, and Special Program.

Item/Topic	Number of checks / reviews	Periodicity
Provider Credentialing	All healthcare providers	Bi-annually
Physician Preceptor	10% of all mid-level provider record entries	Monthly
Utilization Review	All vouchers meeting identified standards	Concurrent
Medical Record Reviews	10 medical records	Monthly
Patient Satisfaction Assessment Surveys	All patient encounters during a one-week period.	Weekly with Monthly/Quarterly reports provided
Administration	All identified topics	Annually

Migrant Health Advisory Board

Georgia Farmworker Health Program

Policy Adopted by Board	Date: 07/07/15
Policy Reviewed by Board	Date: 06/10/16
Policy Revisions approved by Board	Date: 3/12/18

POLICY: Provider Credentialing & Privileging

Georgia Farmworker Health Program (GFHP) must have qualified providers that ensure quality and continuity of care. In order to accomplish this, the health center will define standards for assessing and confirming the qualifications of a licensed or certified healthcare practitioner. This policy applies to all health center practitioners, employed or contracted, volunteers and locum tenens, at all health center sites.

PURPOSE: To ensure that the medical needs of the people in the service area are met.

DEFINITION: Licensed Independent Practitioner (LIP) - An individual required to be licensed, registered, or certified by the State. These individuals are permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. These Individuals include, but are not limited to, Physician, Nurse Practitioner, and Physician Assistants.

PROCEDURE:

I. Licensed Independent Practitioner Credentialing

A. Credentialing will be performed by the designated credentialing personnel for each of the six contractors by evaluating the applicant prior to employment. This evaluation will include and be submitted to the individual contractor:

1. An employment application with the applicant's signature verifying correctness and completeness of all information. This application should include a statement certifying:

   - Any inability to perform essential functions of the position, with or without accommodations.
   - Denial of illegal drug use
   - History of loss of license and/or felony convictions
   - Loss or limitation of medical privileges or disciplinary activity

2. A signed and dated Release Agreement to request information from employers/hospitals and references.

The following documents will be obtained through primary source verification:

1. Documentation of all medical school and residency program verification. This may be a copy of the Degree Verify or Student Clearinghouse query, official transcripts or letter from the institution issuing the degree verifying that the individual has completed the requirements for the degree and/or residency program.

2. Documentation of all board eligibility and/or certification from appropriate professional website such as American Medical Association.

3. Documentation of state license from the appropriate board issuing the license for that discipline.

4. ECFMG and AMA profile verification on foreign graduates

The following information is obtained through secondary source verification:

1. A copy of current DEA certificate.
2. A copy of the applicant's current malpractice coverage, carrier name and scope of coverage.
3. A list of hospitals where the applicant has been granted admitting privileges over the past 3 years with a copy of the current privileges for that hospital.
4. A list of all UPIN, Medicare, Medicaid and Blue Cross Blue Shield numbers
5. A listing of three (3) Professional references upon initial hire
6. A listing of all previous practice locations, including complete address and telephone numbers.
7. Government Issued Identification
8. Immunization & PPD
9. Basic Life Support Training certificate

B. The Director of the GFHP contracting site will make initial contact with the provider recruit by telephone and by mailing information regarding the health center and the service area, etc., as deemed appropriate.

C. If it is determined by the Director of the GFHP program contracting site that the applicant is a suitable candidate for the (specify GFHP program site here) then the individual will be invited for an interview.

D. The Director of the GFHP contracting site will query the National Practitioner Data Bank to verify malpractice history and any current or past license sanctions/restrictions. This will be completed initially and every two years during the re-credentialing/re-privileging process. Letters should also be sent to selected references, past employers, agencies, etc. to

obtain information on the applicant's competence, character, and ethical qualifications.

E. An interview will be scheduled with the Director /CEO of the GFHP contracting site Director/CEO, Medical Director, and Board Chairperson.

F. Based on recommendations following the interview and review of the applicant's documentation, the Medical Director will report to the Board of Directors concerning the final decision.

H. The Director/CEO of the GFHP contracting site and Human Resources will negotiate a contract with the provider regarding salary and benefits.

1. Copies of all verifications will be retained by the Director/CEO of the GFHP contracting site to be kept on file.

2. Privileges for LIPs
   - Verification of current clinical competence via training, education and as available reference reviews. This may be accomplished through letters from previous employers documenting current clinical competence or through a letter from the residency program (for new graduates) verifying current clinical competence for the privileges requested by the LIPs. The privileges should also be appropriate for the clinical practice site and Scope of Project (Form 5A)

K. The credentialing and privileging coordinator responsible for credentialing and privileging will review and present findings to the CEO & Medical Director, then they will present to the GFHP Migrant Health board with one of the following recommendations:

- **APPROVAL:** This is a recommendation to the GFHP Migrant Health Board that they approve the requested privileges without revision or substantial modification.
- **DISAPPROVAL:** This is a recommendation to the Board of Directors that they disapprove of the requested privileges in their entirely.
- **APPROVAL, WITH REVISIONS:** This is a recommendation to the GFHP Migrant Health Board that they approve the requested privileges with specific revisions. The revisions here would generally represent a significant curtailing or reduction in the allowed privileges, but could also represent an expansion of delineated.
- **RESERVE OR HOLD:** This is a decision to table or postpone the decision until such time that the applicant could provide further information to support the requested privileges. This would normally only apply to procedures being performed but could also apply to other scope of service issues.

L. In the event of a privileging decision has been placed on hold, a specified time must be set

(normally 30 days) for the applicant to produce the information to the Credentialing & Privileging employee to ensure the timely processing of the application for privileges. Once the specified time has passed, the CEO, Medical Director and GFHP Migrant Health Board may make the decision based on the information available.

M. The governing board will approve the determination that the provider meets the credentialing and privileging requirements.

N. If the credentialing and privileging process is not completed before employment start date, temporary approval is granted by the governing board or appointed alternate personnel, for no longer than 120 days. Upon completion of credentialing and privileging, documents are presented to the GFHP Migrant Health Board for approval.

II. Temporary Privileging

A. It is not GFHP policy to grant temporary privileges to LIP. There are only two exceptions that allow for the Director/CEO of the GFHP contracting site to issue temporary privileges. These are:
   - To fulfill an important patient care need.
   - When an applicant with a complete, clean application is awaiting review and approval of the medical staff executive committee and the governing body.

B. Temporary privileges will be granted for no more than 90-days with no extension allowed.

C. To allow temporary privileging all candidates must have completed the following requirements:
   - Completed all application requirements
   - Primary Source Verification as described previously in this policy
   - Secondary Source Verification as described previously in this policy
   - National Practitioner Data Bank (NPDB) query as described previously in this policy

D. Failure to comply with any of the above requirements, including inaccurate or missing items on the credentialing and privileging application cannot be allowed temporary privileges.

III. Appeals Process

A. GFHP allows Licensed Independent Practitioners a process to appeal restrictions of credentialing and privileging. The process begins at the contracting site and then proceeds to the board for final decisions.

B. At times decisions may be based on the ability of the clinical staff to support the requested

privileges of the provider. In this case, reconsideration will occur after support staff receives the appropriate training to support the practitioner.

C. In the case of concerns about the practitioners' skill set, the process is:

- Upon notification of the privileging decision, the practitioner has fifteen (15) days to respond in writing to the GFHP contracting site Director/CEO and Medical Director requesting reconsideration. The request must include documentation of training and experience of the provider making the request. This may also include recommendations from previous employers indicating clinical competence to perform the requested privileges.

- After a meeting with the LIP to hear his/her request for reconsideration and supporting documentation, the GFHP contracting site Director CEO/Medical Director have fifteen (15) days to respond in writing. Should more time be required to research evidence-based guidelines or query FTCA helpline the practitioner is notified that an extension of time is required. A final decision will be provided in writing to the LIP no later than 45-days of the initial request.

- All decisions are final with LIP having another opportunity to discuss at the next re-credentialing and privileging cycle.

Privileging Revision or Renewal Requirements

1. The revision or renewal of a LIP's privileges should occur at least every 2 years and should include (a) primary source verification of expiring or expired credentials, (b) a synopsis of peer review results for the 2-year period (c) and/or any relevant performance improvement information. Similar to the initial granting of privileges, approval of subsequent privileges is vested in the governing board which may review recommendations from either the clinical director, or a joint recommendation of the medical staff (including the Clinical Director) and the Chief Executive Officer, or delegate this responsibility (via resolution or bylaws language) to be implemented according to approved policies and procedures (including methods to assess compliance with these policies and procedures).

2. The revision or renewal of privileges of other licensed or certified health care practitioners should occur at a minimum of every 2 years. Verification of current licensure, registration and certification is by supervisory evaluation of performance that assures that the individual is competent to perform the duties described in the job description.

V. Other Licensed or Certified Health Care Practitioners

DEFINITION: Other Licensed or Certified Health Care Practitioners - An individual who is licensed, registered, or certified but is not permitted by law to provide patient care services without direction or supervision. These individuals include, but are not limited to registered nurses and licensed practical nurses.

PROCEDURE:

A. Credentialing of other Licensed or Certified Personnel will be performed by the GFHP contracting site's QI Coordinator, or other authorized individual, prior to employment. This evaluation will include:

Primary Source Verification

1. License, Registration or Certification Verification - The QI Coordinator or other authorized individual will access this information via the internet at www.sos.ga.gov, which is the Georgia Secretary of State website.

Secondary Source Verification

1. Government issued picture identification is required
2. Immunization and PPD status- (if not current, this is the procedure)
    - The QI Coordinator will refer the individual to the project site's designated health facility for a PPD Screening and if a Positive PPD is acquired then the individual will then be referred to the local hospital for a chest x-ray.
    - The QI Coordinator will test the hepatitis vaccination status of the individual. If the individual is in agreement; the vaccine will be offered and administered free of charge by the GFHP program site.
3. Verification of education
4. Verification of training
5. Verification of current competence-Supervisory evaluation per job description
6. Approval Authority - Supervisory function per job description
7. Health Fitness – evaluation by a LIP within the organization and documented in the personnel file
8. Drug Enforcement Administration registration (as applicable)
9. Hospital admitting privileges (as applicable)
10. Life Support Training (as applicable)
11. National Practitioner Data Bank query every two years

Reference: PIN 2002-22: Clarification of Bureau of Primary Health Care Credentialing and Privileging Policy Outlined in PIN 2001-16

Credentialing and Privileging Checklist
Licensed Independent Practitioners

Check the appropriate category:

_____Initial Credentialing/Privileging
_____Privileging Renewal (Required every two years)

Provider Type (Please select the appropriate type)
_____Physician
_____Dentist
_____Physician Assistant
_____Nurse Practitioner
_____Nurse Midwife
_____Licensed Clinical Social Worker
_____Nutritionist
_____Other: Please specify_____

Credentials and Privileging	Type of Verification	Verification Source	Date Verified or Reviewed	Initials of Person Who Verified or Reviewed	Expiration Dates, as applicable
Licensure	Primary	State Licensing Board			
Curriculum Vitae *(For re-credentialing obtain attestation by practitioner that CV has not changed since initial credentialing)*		Copy of CV			
Education/Training (Not required for re-credentialing) 1. Graduation from medical school 2. Residency 3. Board Certification, if applicable	**Primary** (confirm that that the highest of the three levels of education has been appropriately verified)	ECFMG ABMS AOA AMA			
Board Certification ☐ Yes ☐ No	Primary				

Credentials and Privileging	Type of Verification	Verification Source	Date Verified or Reviewed	Initials of Person Who Verified or Reviewed	Expiration Dates, as applicable
Current Competence to Practice	Primary	CME's & References if not Board			
Health/Fitness *(ability to perform requested privileges)*	Confirmed statement	Confirmed statement			
DEA	Secondary	Copy of DEA			
Malpractice Insurance, if applicable	Secondary	Copy of malpractice insurance			
NPDB Query by center or a self-query provided by the practitioner	Required, if reportable	NPDB			
Government issued Picture ID *(Not required for re-credentialing)*	Secondary	Driver's License or other appropriate ID			
Immunization Status Current ☐ Yes ☐ No	Secondary	Confirmed Statement			
PPD Status Current ☐ Yes ☐ No	Secondary	Confirmed Statement			
Life support training	Secondary	Copy of training certificate			
Hospital Admitting Privileges	Secondary	Attestation by provider, include names of hospitals and status			

Credentials and Privileging	Type of Verification	Verification Source	Date Verified or Reviewed	Initials of Person Who Verified or Reviewed	Expiration Dates, as applicable
Verification of current competence to provide services specific to each of the center's care delivery settings	Primary Source, based on peer review of credentials presented	Approval by Medical Director or jointly by medical staff, Medical Director and CEO			
Quality/Clinical Improvement Performance (Re-credentialing only)		Assessment of identified performance (e.g. peer review process, clinical performance			

Medical Director/CEO/Designated Credentialing Personnel Review

Date Medical Director Review of Credentials: _____
Medical Director Signature: _____

Medical Director Recommendation

- ☐ Recommend approval of credentialing and privileging by Governing Body
- ☐ Recommend approval of credentials and privileges by Governing Body.

Governing Body Approval

Governing Body Review Date: _____

Governing Body Recommendation:

- ☐ **Approve Credentialing and Privileging**
- ☐ **Deny Credentialing and Privileging** *(Provide practitioner with appeal process for all denials)*

DEFINITIONS:

Licensed Independent Practitioner: Physician, dentist, nurse practitioner or any other individual permitted by law and the organization to provide care and services without direction or supervision within the scope of the individual's license and consistent with individually granted clinical privileges.

Primary Source Verification is the process by which the organization verifies credentialing information directly from the entity that originally issued the credential to the practitioner (e.g., state licensing board) Data sources may include oral, written, Internet, cumulative reports, and agents of approved sources (e.g., FSMB)

Secondary Source Verification is required even when primary source verification is not required. Example methods include, but are not limited to, the original credential, notarized copy of the credential, a copy of the credential (when the copy is made from an original by approved Health Center staff)

Credentialing and Privileging Determinations should be stated in writing by the Health Center's governing board (or alternative mechanism as described in a governing board approved waiver). Ultimate approval authority is vested in the governing board which may review recommendations from either the Medical Director or a joint recommendation of the medical staff (including the Medical Director) and the Chief Executive Officer. Alternatively, the governing board may delegate this responsibility (via resolution or bylaws) to an appropriate individual to be implemented based on approved policies and procedures.

Resources:

- BPHC Policy Information Notice 2002-22
- BPHC Policy Information Notice 2001-16

PRIMARY SOURCE VERIFICATION

This format can be used for Verification of Completion of Medical School, Verification of Residency Program, Verification of Board Certification, or/and online Verification of ECFMG and AMA

RE: Verification of Completion of Medical School

_____, M.D.

Social Security Number _____

Dear Sirs:

We are evaluating the application of the above referenced physician for employment with our organization and need to verify the information specified below. A copy of this individual's Release Agreement is included. We appreciate your time and effort in providing this verification by completing the information below and returning this form in the enclosed self-addressed, stamped envelope.

Thank you.

_____
CEO

I verify, on behalf of our institution, that the above referenced physician has the credentials as indicated below.

Graduation Date of Medical School _____

_____
Signature & Title

RELEASE
AGREEMENT

I hereby authorize Georgia Farmworker Health Program (GFHP), by its agents or representatives to consult with members of the medical staff of other centers and/or hospitals with whom I have been associated and with all others who may have information bearing on my competence to pursue the clinical privileges I have requested, my character, and ethical qualifications for staff membership. I also release from liability all individuals and organizations that provide information in good faith and without malice at the Center's request concerning my qualifications for staff appointment and clinical privileges.

A COPY OF THIS STATEMENT SHALL BE AS BINDING AS THE ORIGINAL.

Signature of Applicant _____

Date _____

,BY-LAWS
Georgia Farmworker Health Program
Advisory Board

Policy Adopted by Board	Date: 07/07/15
Policy Reviewed by Board	Date: 11/08/17, 05/15/18, 8/14/19, 11/19/20, 12/16/21, 12/15/22
Policy Revisions approved by Board	Date: 03/12/18, 05/15/18, 8/14/19, 11/19/20, 12/16/22,12/15/22,09/15/23

I. Purpose

The purpose of the Georgia Farmworker Health Program (GFHP) Migrant Health Governing Board shall be to:

- provide community-based leadership and guidance in support of the organization's mission of providing quality, affordable primary health care services to migrant and seasonal farmworker's (MSFW) in Georgia; and
- to make recommendations about migrant health care issues and promote continued quality improvement in migrant health care.

II. Required Authorities and Responsibilities

The responsibilities of the Migrant Health Governing Board are to:

- hold monthly meetings where a quorum is present;
- approve GFHP project budgets and applications for funding;
- monitor the financial status of the GFHP, including review of the annual audit;
- approve health center services, locations and hours of operation of GFHP sites;
- conduct strategic planning at least once every three years, which at minimum addresses financial management and capital expenditure needs; and improvement assessments and other information received from GFHP management, and ensuring appropriate follow-up actions are taken regarding:
    - achievement of project objectives;
    - service utilization patterns;
    - quality of care;
    - efficiency and effectiveness of the GFHP; and
    - patient satisfaction, including addressing any patient grievances

- evaluate the performance of the health center program Director annually;
- establish or adopt policy related to the operations of the health center;
- assure that the health center operates in compliance with applicable Federal, State and local laws and regulations.
- provide input on issues related to the health status of rural populations in Georgia;

III. Membership

The GFHP Migrant Health Governing Board shall be comprised of a minimum of nine (9) members and no more than fifteen (15) and will be attached to the Georgia State Office of Rural Health. Members are appointed by nomination and board member voting. There is no limit to term of service.

- Classes of Membership:
    - **Active** – voting member;
    - **Ad hoc** – a nonvoting member but participates by contributing data and insight for the success and best interest of the GFHP.
- Board members must attend a majority of the meetings which are held monthly. Four (4) consecutive absences in a calendar year, **without prior notification to the GFHP**, will result in member's release from the board.
- Members of the Board shall serve without compensation unless unusual circumstances arise (i.e. repeated lack of a quorum to hold an official meeting) in which case the board will require a unanimous vote to compensate members for attendance.

III. Meetings

- The Board will meet monthly as required by Health Resources and Services Administration (HRSA).
- A 12-month meeting calendar is to be drafted and board approved annually as required by HRSA.
- GFHP board meetings and meeting activity will be scribed into minutes to be retained on file by the health center program Director.
- No meeting may be held without advance notice unless unusual circumstances necessitate a special meeting of the board. Special meetings of the Board shall convene upon the call of its chairperson, the board, or the health center program Director. The Migrant Health Governing Board will be notified immediately of the date, time and place of such meeting.

- Any meeting of the Board may be called for the purpose of conducting business via teleconference or for purposes of ratifying a proposed action through written correspondence (either telecopied or mailed). Such a meeting will require prior notice; any action must comply with the by-laws governing quorum and official action.
- All meetings and record of the Board and any committees established under the purview of the Migrant Health Board shall be subject to the Open Meetings Act (O.C.G.A. 50-14-1 et seq and the Open Records Act (O.C.G.A. 50-18-70 et seq).
- The Board may establish any committees or subcommittees necessary to carry out duties and responsibilities. (i.e., GFHP Quality Improvement (QI) Committee)

IV. Quorum and Official Action

- A majority (51%) of all members (excluding vacant positions) shall constitute a quorum to hold a meeting; A majority of active (voting) members is necessary to conduct business that will require a vote. In the event that active member attendance does not result in a quorum, voting ballots will be provided to all active members via web survey (i.e., www.surveymonkey.com).
- The Board encourages cooperative decision-making with a value placed on input from all members. An affirmative vote of one-half of the active members present, provided that a quorum exists, is required for official action.

V. Officers and Committees

- *Officers*. The officer positions of the Board shall be a chair, vice-chair, a secretary, a treasurer, and a Quality Improvement liaison. Officers are elected from the members.
- *Member Resignation:* Member must submit a letter of resignation from their position on the board to GFHP Director and GFHP Migrant Health Advisory Board.
- *Election of Officers:* The Advisory Board Chair and all other officers are elected through open nomination and the active member voting process. In case of a tie, a decision will be made by a flip of a coin.
- *Term of Officers:* There are no term limits of service for officer positions.
- *Duties of Officers*. The chairperson shall preside over all meetings of the Board, call special meetings as needed, appoint committees, and generally manage all actions of the Board. The board chair shall also be assisted in his or her duties by staff of the State Office of Rural Health. The vice-chair shall generally lend positive assistance to the chair in the conduct of business, shall serve as parliamentarian, and shall in the absence of the chair perform all duties of the chair. The vice-chair shall be assisted in his or her duties by staff of the SORH. The secretary shall assist SORH staff in the scribing and preservation of the minutes and records of the Board. SORH staff, with assistance from the board secretary, shall notify members of the Board in writing of all meetings. The secretary shall perform other such duties as may be delegated by the chair. The Quality

Improvement Committee Liaison shall provide oversight of the GFHP QI Committee and deliver a quarterly report of committee activities to the GFHP Migrant Health Governing Board for board review and approval if required.

VI. Parliamentary Authority

The GFHP Migrant Health Governing Board bases its opinions and instruction upon *Robert's Rules of Order Newly Revised.* The most widely used parliamentary authority in the United States, this book (often abbreviated *RONR*) was first published as the *Pocket Manual of Rules of Order for Deliberative Assemblies* in 1876. Since then, the book has been expanded and updated several times. The current edition is *Robert's Rules of Order Newly Revised,* 11th edition (2011).

VII. Conflict of Interest

Blood relatives up to and including second cousins and relatives by marriage or adoption which includes spouse and in-laws of members of the Board, employees, consultants, agents, and contractors will not be hired in any capacity requiring compensation and/or fringe benefits and will not be contracted to furnish goods or services for GFHP.

Board members, employees, consultants, agents, contractors or those who provide goods and services to the GFHP shall disclose business or personal relationships, including nepotism, that create actual or potential conflicts of interest (Refer to GFHP Conflict of Interest Policy).

The conflict of interest policy shall apply to any interested person.

VIII. Amendments to By-Laws

The Board may amend its by-laws with a three-quarter vote at a meeting where a quorum of active members is present. Any proposed amendment to the by-laws, pursuant to the meeting notice guidelines, must be presented to the Board prior to the meeting at which action is to be taken. By-laws will undergo board review annually.

IX. Dissolution of Board and Program Assets

In the event the Georgia Farmworker Health Program ceases to exist all assets and property of this program shall be liquidated at the direction of the Georgia Department of Community Health and all members of the Migrant Health Governing Board shall be notified immediately.

Migrant Health Advisory Board
Georgia Farmworker Health Program

Policy Adopted by Board: 07/07/15
Policy Reviewed by Board: 06/10/16, 03/12/18, 12/15/22
Policy Revisions approved by Board: 03/12/18, 12/15/22

POLICY: Conflict of Interest

PURPOSE: The purpose of this policy is to protect the interests of Georgia Farmworker Health Program (GFHP) when entering into a transaction or arrangement that might benefit the private interests of a board member or office. Also, it serves to protect the interests of the GFHP if the Directors or Management are entering into transactions or arrangements that directly or indirectly conflict with the interests of GFHP. The terms of this policy are intended to supplement any statutory conflict of interest provisions and are in no way intended to limit any applicable state or federal laws governing conflicts of interest.

POLICY STATEMENT:

The GFHP practices written standards of conduct that apply, at a minimum, to its procurements paid for by the Federal award. Such standards:

- Apply to all health center employees, officers, board members and agents involved in the selection, award, or administration of such contracts;
- Require written disclosure of real or apparent conflicts of interest;
- Prohibit individuals with real or apparent conflicts of interest with a given contract from participating in the selection, award, or administration of such contract;
- Restrict health center employees, officers, board members and agents involved in the selection, award, or administration of contracts from soliciting or accepting gratuities, favors, or anything of monetary value for private financial gain from such contractors or parties to sub-agreements (including sub-recipients or affiliation organizations); and
- Enforce disciplinary actions on health center employees, officers, board members, and agents for violating these standards.

Board members, employees, consultants, agents, contractors or those who provide goods and services to the GFHP shall disclose business or personal relationships, including nepotism, that create actual or potential conflicts of interest.

This policy shall apply to any interested person.

DEFINITIONS:

1) Interested Person. Any Director, principal officer, member of a committee with Board-delegated powers, employee, or agent who has a direct or indirect Financial Interest, as defined below, is an Interested Person. If a person is an Interested Person with respect to any entity of which the GFHP is affiliated, he or she is an Interested Person with respect to all entities in the healthcare system.

2) Financial Interest. A person has a Financial Interest if the person has, directly or indirectly, through business, investment, or family:

   (a) an ownership or investment in any entity with which the GFHP has a transaction or arrangement;

   (b) a compensation arrangement with the GFHP or with any entity or individual with which the GFHP has a transaction or arrangement; or

   (c) a potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which the GFHP is negotiating a transaction or arrangement.

Compensation includes direct and indirect remuneration as well as gifts or favors that are substantial in nature.

A Financial Interest is not necessarily a conflict of interest. A person who has a Financial Interest may have a conflict of interest only if the appropriate Board or committee decides that a conflict of interest exists.

PROCEDURES:

- Board Member Eligibility

  Any person interested in serving or nominated to serve on the GFHP Board will be required to complete a questionnaire to determine if a potential conflict of interest exists. (Refer to GFHP Board Member Eligibility Questionnaire)

- Duty to Disclose

  Regarding actual or potential conflicts of interest, it is the duty of an existing member or interested person to disclose the existence of his or her personal or business Financial Interest and all material facts. Interested Persons must complete the board approved Board Member Eligibility Questionnaire to be reviewed by the Board and members of committees with Board-delegated powers considering the proposed transaction or arrangement.

- Determining Whether a Conflict of Interest Exists

After disclosure of the Financial Interest and all material facts, and after any discussion with the Interested Person, he or she shall leave the Board or committee meeting while the determination of a conflict of interest is discussed and voted upon. The remaining Board or committee members shall decide if a conflict of interest exists.

1) Procedures for Addressing real or apparent Conflict of Interest

   (a) Any existing member or Interested Person may make a presentation at the Board or committee meeting to be documented in the meeting minutes. After such presentation, he/she shall leave the meeting during the discussion of, and the vote on, the transaction or arrangement that result in the conflict of interest.

   (b) The Chair of the Board or committee shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.

   (c) After exercising due diligence, the Board or committee shall determine whether the GFHP can obtain a more advantageous transaction or arrangement with reasonable efforts from a person or entity that would not give rise to a conflict or appearance of interest.

   (d) If a more advantageous transaction or arrangement is not reasonably attainable under circumstances that would not give rise to a conflict of interest, the Board or committee shall determine by a majority vote of the disinterested directors whether the transaction or arrangement is in the GFHP's best interest and for its own benefit and whether the transaction is fair and reasonable to the GFHP and shall make its decision as to whether to enter into the transaction or arrangement in conformity with such determination.

   (e) No employee, board member, contractor, or agent may participate in the selection, award or administration of a contract supported by state, federal or private funds if a real or apparent conflict of interest may be involved. Such a conflict would arise when an employee, board member, contractor, or agent or any member of his or her immediate family, partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in the firm selected for an award.

   (f) Board members, employees, contractors, agents shall neither solicit nor accept gratuities, favors, or anything of monetary value from contractors or parties to sub-agreements. Corporate Standards of Conduct and Code of Ethics provide disciplinary actions for violations of such standards by board members, employees, or agents of the Health Center.

2) Violations of the Conflicts of Interest Policy

   (a) If the Board or committee has reasonable cause to believe that a member has failed to disclose actual, apparent, or potential conflicts of interest, it shall inform the member of the basis for such belief and afford the member an

opportunity to explain the alleged failure to disclose (i.e., An active board member who enters into a contract agreement with a GFHP project site to provide services in exchange for financial payment constitutes a conflict of interest.)

(b) If, after hearing the response of the member and making such further investigation as may be warranted in the circumstances, the Board or committee determines that the member has in fact failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action including removal from the board of directors or in the case of the board's employee termination.

Records of Proceedings: The minutes of the Board and all committees with Board-delegated powers shall contain:

1) the names of the persons who disclosed or otherwise were found to have a Financial Interest in connection with an actual or potential conflict of interest, the nature of the Financial Interest, any action taken to determine whether a conflict of interest was present, and the Board's or committee's decision as to whether a conflict of interest in fact existed.

2) the names of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection therewith.

Annual Statements: Each Director, principal officer, and member of a committee with Board-delegated powers shall annually sign a conflict of interest statement which affirms that such person:

(a) has received a copy of the Conflicts of Interest Policy;

(b) has read and understands the policy; and

(c) has agreed to comply with the policy

CONFIDENTIALITY

Confidentiality: It is understood the GFHP is private, not-for-profit and as such, all of its governance, administrative, fiscal, management information systems, health information systems, and clinical affairs are confidential and private. It is understood and the members pledge individually and as a group to honor the code of confidentiality as it relates to all documents and verbal conversations, discussions, meetings, decisions, and plans. It is further understood that defiance of privacy and confidentiality are immediate grounds for permanent dismissal from the GFHP Migrant Health Board.

CONFLICT OF INTEREST STATEMENT

At this time, I am a board member, committee member, or an employee of the following organizations:

_____

_____

_____

This is to certify that I, as described below, am not nor at any time during the past year have been:

1) A participant, directly or indirectly, in any arrangement, investment or other activity with any vendor, supplier or other party doing business with Georgia Department of Community Health/ Georgia State Office of Rural Health which has resulted or could result in personal benefit to me.

2) A recipient, directly or indirectly, of any payments or loans or gifts of any kind or any free service or discounts or other fees from or on behalf of any person or organization engaged in any transaction with Georgia Department of Community Health/Georgia State Office of Rural Health.

3) Regarding actual or potential conflicts of interest, it is my duty to disclose the existence of any personal, business or financial interest and all material facts to the Board and members of committees with Board-delegated powers considering the proposed transaction or arrangement.

Any exceptions to the numbered items above are stated below with a full description of the transactions and of the interest, whether direct or indirect, which I have (or have had during the past year) in the persons or organizations having transactions with the Georgia Department of Community Health/Georgia State Office of Rural Health.

_____

_____

_____

Date: _____ Signature: _____

Print Name: _____

Georgia Farmworker Health Program (GFHP)

Strategic Plan 2023-2026

Reviewed & Revised by Board: 8/17/23

Approved by Board: 8/17/23

The mission of the Georgia Farmworker Health Program (GFHP) is to provide high quality, person-centered, culturally sensitive healthcare to migratory and seasonal agricultural workers (MSAWs) using all available financial, human and technological resources.

Goal 1: Strengthen and expand the current network of organizations providing services to migratory and seasonal agricultural workers (MSAWs)

Objective 1.0 Increase the cohesiveness of the current network of clinics, health centers, community and academic partners, and stakeholder collaborations

Action Items:

- Review at least annually policies and procedures specific to the agricultural health program for members to follow
- Share best practices among the GFHP clinics and health centers to improve quality of care for agricultural workers (i.e. through Board member self-assessments)
- Conduct Quality Improvement (QI) quarterly meetings with all clinics and health centers
- Leverage technology to continue to increase communication between GFHP clinics and health centers
- Foster collaboration between partners and stakeholders to provide high quality services
- Evaluate opportunities to expand community and academic partnerships

Goal 2: Increase access to care for migratory and seasonal agricultural workers (MSAWs) and their families

Objective 1.0 Connect and collaborate with agricultural community to educate about the Georgia Farmworker Health Program (GFHP) services

Action Items:

- Liaise with agricultural specialists and university partners to increase knowledge of services and patient education available to employers
- Attend Georgia Migrant Education conventions in the region
- Organize and attend local health fairs for migratory and seasonal agricultural workers (MSAWs)
- Attend state grower convention with information on the GFHP (i.e. Georgia Agricultural Labor Relations Forum hosted by the Georgia Fruit and Vegetable Growers Association)

Goal 3: Improve the quality of patient care provided to migratory and seasonal agricultural workers (MSAWs)

Objective 1.0: Monitor UDS measures quarterly and develop Quality Improvement (QI) projects to improve performance on selected measures

Action Items:

- Continue QI network among farmworker clinics and health centers with selected QI projects for specific measures
- Design QI projects that will improve quality of patient care

Goal 4: Improve understanding of data collection among farmworker clinics and health centers and educate Advisory Board members about data utilization

Objective 1.0: Standardize data entry and reporting requirements

Action Items:

- Participate in annual training on UDS measures required by HRSA for reporting purposes using EcW webinars or conferences, QI meetings to discuss UDS measures and troubleshooting, and trainings offered through the Georgia Association of Primary Care
- Standardize data entry and requirements on the electronic medical record by providing staff training
- Provide Board training on interpretation of UDS measures and clinic/health center patient satisfaction scores
- Develop a tool to collect evaluation data for clinical overview activity for Board review and input
- Monitor UDS clinical measures annually
- Monitor various financial measures quarterly to ensure that grant funds are used to achieve program goals

Goal 5: Explore and develop methods for improving continuity of care for migratory and seasonal agricultural workers (MSAWs) in Georgia

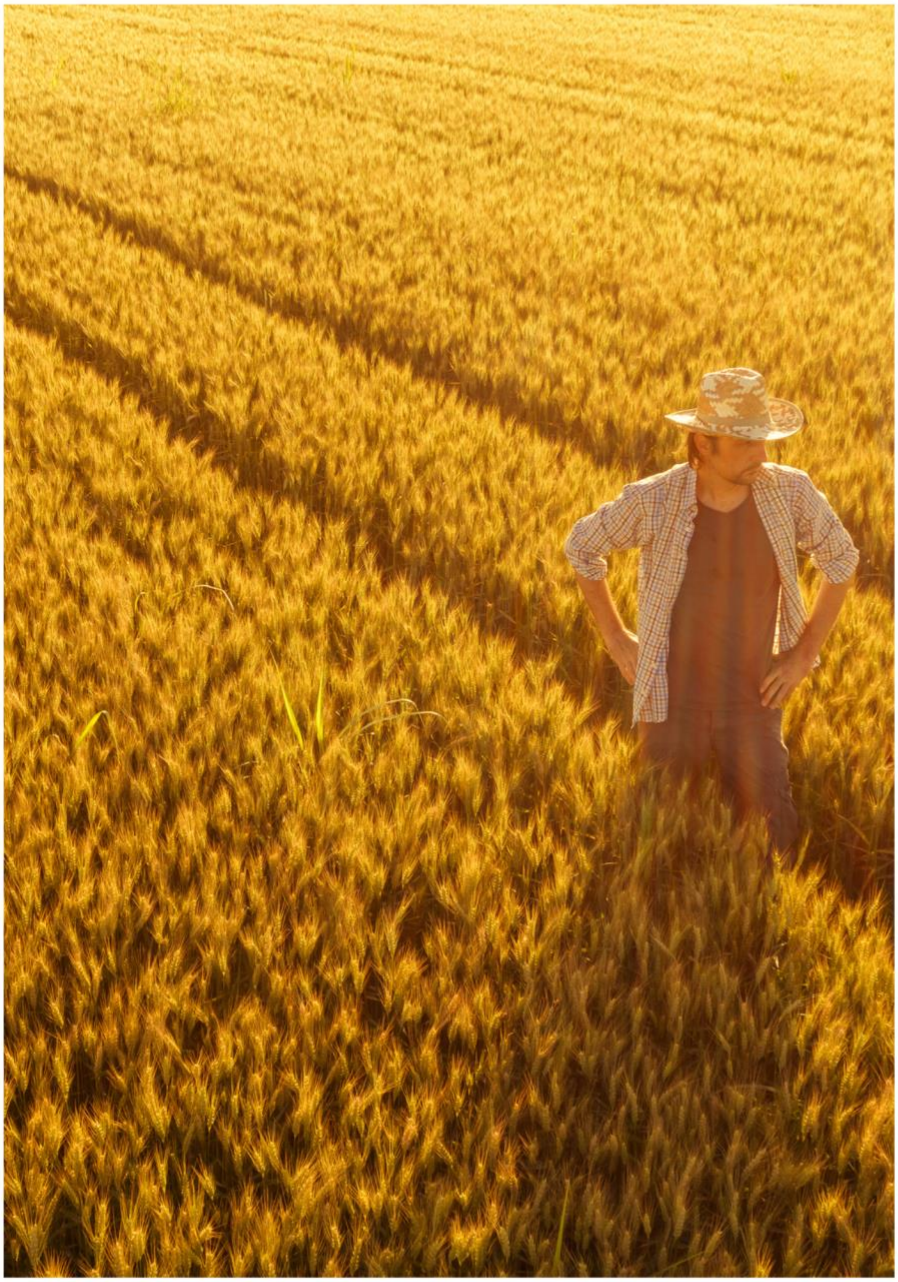
Objective 1.0 Increase the number of patients who are able to access care once they leave the Georgia farmworker service area

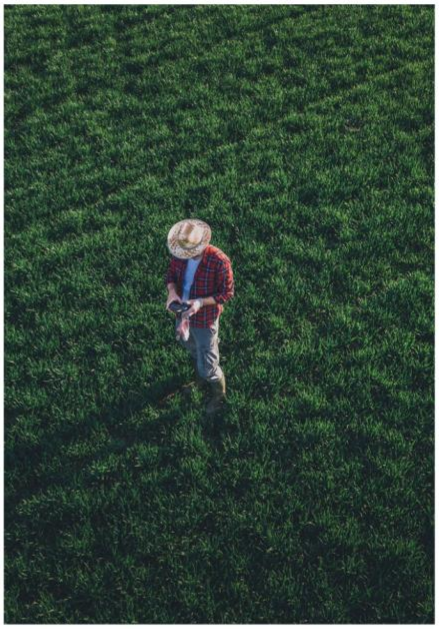
Action Items:

- Explore utilization of a health information network among the six farmworker clinics and health centers

Georgia Farmworker Health Program

Health Services Needs Assessment





2022

SORH
State Office of Rural Health
A Division of the Georgia Department of Community Health

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Assessment of the Need for Health Services among Farmworkers in Georgia

Georgia Farmworker Health Program

State Office of Rural Health

Georgia Department of Community Health

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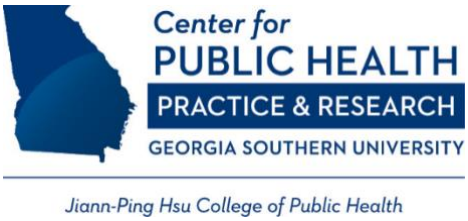

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Executive Summary

Background and Approach

The Center for Public Health Practice and Research (CPHPR) with the Jiann-Ping Hsu College of Public Health at Georgia Southern University, in conjunction with the State Office of Rural Health (SORH) and the six Georgia Farmworker Health Program (GHFP) sites completed the 2022 assessment of needs of the Georgia farmworker population.

The assessment includes an enumeration of farmworkers in the state, a demographic description of those served by the six GHFP sites, a description of most frequent diagnosis for the farmworkers and their dependents, an assessment of the health services provided to farmworker population, and recommendations to improving access to care and services provided.

Key Findings

- Patients seen at the migrant health clinics in Georgia are predominantly low-income, non-English speaking and uninsured Hispanic male migrant farmworkers.
- Clinic visits declined significantly in 2020 and 2021 following the onset of the COVID-19 pandemic.
- The pandemic resulted in a decline in clinic utilization, productivity, and performance in quality measures.
- Despite an overall decline in the number of visits for medical services, patients with chronic conditions who utilized services during this period recorded more medical visits on average.

Recommendations

It is recommended that the GFHP and service sites pursue the following strategies to improve delivery of needed health services within the service area:

- Increase number of trained, bilingual staff at each of the clinics.
- Create public relation opportunities to highlight the importance of migrant farmworker care.
- Expand professional development and incentive opportunities for all clinic staff.
- Review voucher services criteria and eligibility to ensure more services are covered.

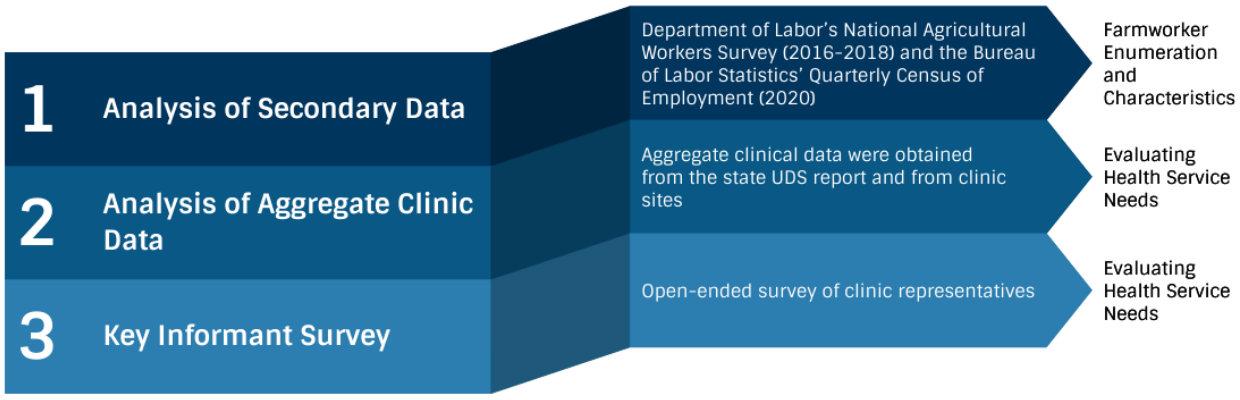
Approach

PURPOSE

The purpose of this study was to assess the need for health services among farmworkers in Georgia. The findings would assist the Georgia Farmworker program in health services planning and improvement efforts.

METHODOLOGY

A mixed methods approach was used for the study, which included the analysis of qualitative secondary data and qualitative data from an open-ended survey of GFHP clinic sites.



Secondary Data Analysis. Data were obtained from the 2016-2018 Department of Labor's National Agricultural Workers Survey and 2020 data from the Bureau of Labor Statistics' Quarterly Census of Employment and Wages. Together, these data were used to estimate the number of farmworkers and dependents in Georgia (following a methodology previously described).[1] [2] The National Agricultural Workers Survey was also used to describe characteristics of farmworker populations in the region.

[1] Abernathy, L (2010). The Need for Farmworker Housing in Florida. Retrieved on July 11, 2017, from http://www.shimberg.ufl.edu/publications/RMS_FW_w_cover.pdf

[2] Georgia State Office of Rural Health (2017). Assessment of the Need for Health Services among Farmworkers in Georgia.

Analysis of Aggregate Clinic Data. Aggregate clinical data were obtained from the state Uniform Data System (UDS) report for 2016-2018. Each farmworker clinic also provided aggregate clinical information to help the researchers complete any gaps.

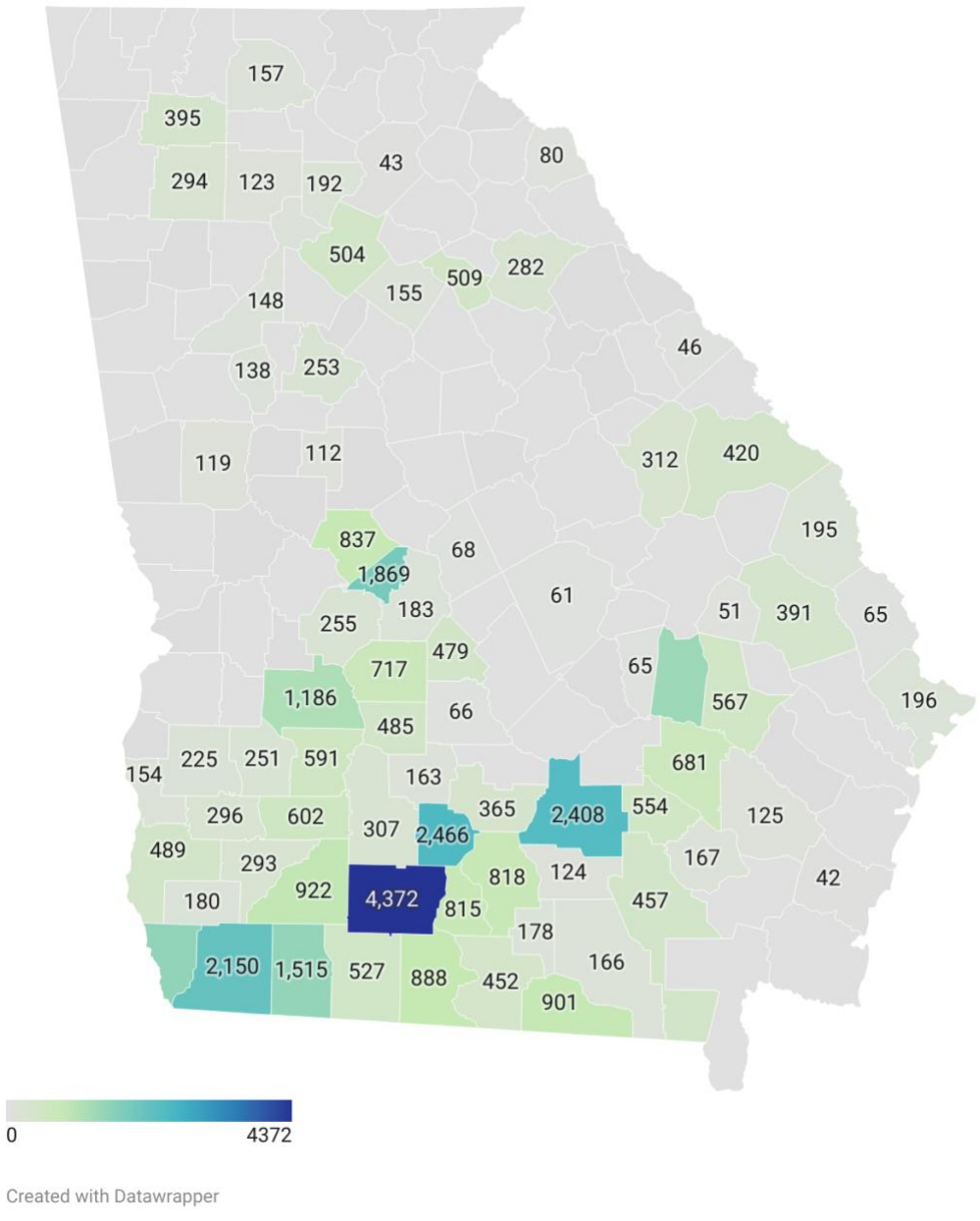
Survey of GFHP Clinic Sites. Qualitative data were obtained through an open-ended survey of clinic sites. Each site identified at least one representative to participate in the survey. A total of 6 clinic staff, representing each of the clinics, participated in the survey. A review of the open-ended responses was conducted to identify common themes. All findings from this assessment are reported by state level and not by site to protect the confidentiality of the site representatives.

Findings

CHARACTERISTICS OF THE GEORGIA FARMWORKER POPULATION

In 2020, there were an estimated 39,610 seasonal and migrant farmworkers in Georgia. This represented a 5% decline from reported 2018 estimates. There were an estimated 48,973 dependents in 2020.

Map 1. Farmworker Estimates by County: 2020



Demographic Characteristics *of* Farmworkers

State-specific demographic and socioeconomic data on the farmworker population is sparse. However, data from the 2016-2018 National Agricultural Workers Survey indicates that the 66% of farmworkers in the Southeast Region of the country (which includes Georgia), are male with an average age of 39 years. Most are married (55%) and are parents (55%). Two out of three farmworkers in the region are Hispanic. In terms of race, the breakdown is as follows: 29% White, 14% Black/African American and 57% other race. Foreign-born individuals make up the majority of farmworkers in the Southeast region (61%). One out of two farmworkers (50%) in the Southeast were born in Mexico.

Socioeconomic and Cultural Characteristics

According to the 2016-2018 NAWS, two out of three farmworkers in the Southeast region (64%) have less than a 12th-grade education, and a third (30%) have family incomes below the poverty level. Approximately a quarter (22%) do not speak English at all; only 45% speak English well.

Employment Characteristics

According to the 2016-2018 NAWS, farmworkers in the Southeast Region have been employed in the US agricultural industry for an average of 15 years and have worked with their current employer for an average of 6 years. Most (98%) are employed by growers, and the rest (2%) are employed by contractors. On average, they work 45 hours a week and 37 weeks in a year. A little over half (53%) engage in field work; 40% work in nurseries; 5% in packing houses and 2% engage in other farm-related activities.

Migrant workers made up 12% of the farmworker population in the Southeast Region; 88% of workers were seasonal workers. Accompanied farmworkers (i.e., farmworkers living with a spouse, children, or parents, or minor farmworkers living with their siblings) made up 42% and 67% of the migrant and seasonal farmworker populations, respectively.

Health Status and Access

Health Care Needs. Approximately three out of ten farmworkers (28%) from the Southeast region who completed the NAWS reported having at least one chronic condition. Compared to migrant farmworkers, seasonal farmworkers were more likely to report unfavorable health outcomes. Migrant farmworkers were less likely to report a chronic condition compared to seasonal farmworkers (17% vs. 30%). The most common chronic condition reported was high blood pressure (9% overall; 9% among seasonal vs. 6% among migrant farmworkers)), followed by diabetes. Eight percent reported having diabetes (8% among seasonal vs. 7% among migrant farmworkers).

Health Care Utilization. Over half (61%) of farmworkers in the Southeast region reported that they had used healthcare in the US within the last two years. Among those using healthcare services in the US, most had sought care at private physician offices (46%), community health centers or migrant clinics (33%), dental clinics (9%), hospitals (9%), emergency rooms (2%) or other health care services (1%). Compared to seasonal farmworkers, migrant farmworkers were more likely to seek care at community health centers/migrant health clinics (32% (seasonal) versus 37% (migrant)) and less likely to seek care at private medical doctor's offices (48% (seasonal) versus 36% (migrant)).

Health Insurance Coverage. About a third of farmworkers in the Southeast surveyed in the 2016-2018 NAWS (32%) reported that they had health insurance for themselves. Seasonal farmworkers were more likely to report having health insurance for themselves, compared to migrant workers (35% (seasonal) versus 12% (migrant)). More than a third of all surveyed Southeast farmworkers (40%) reported that they paid out of pocket for their most recent health services visit. A higher proportion of migrant farmworkers (70%) reported paying out of pocket for care, compared to seasonal workers (35%).

Barriers to Health Care Access. Among those needing healthcare services, the most cited barriers to healthcare access included cost (28% of farmworkers in Southeast region identified it as a barrier to healthcare access; 26% seasonal vs.

Notably, barriers to healthcare access tend to be more pronounced for migrant farmworkers than for seasonal farmworkers.

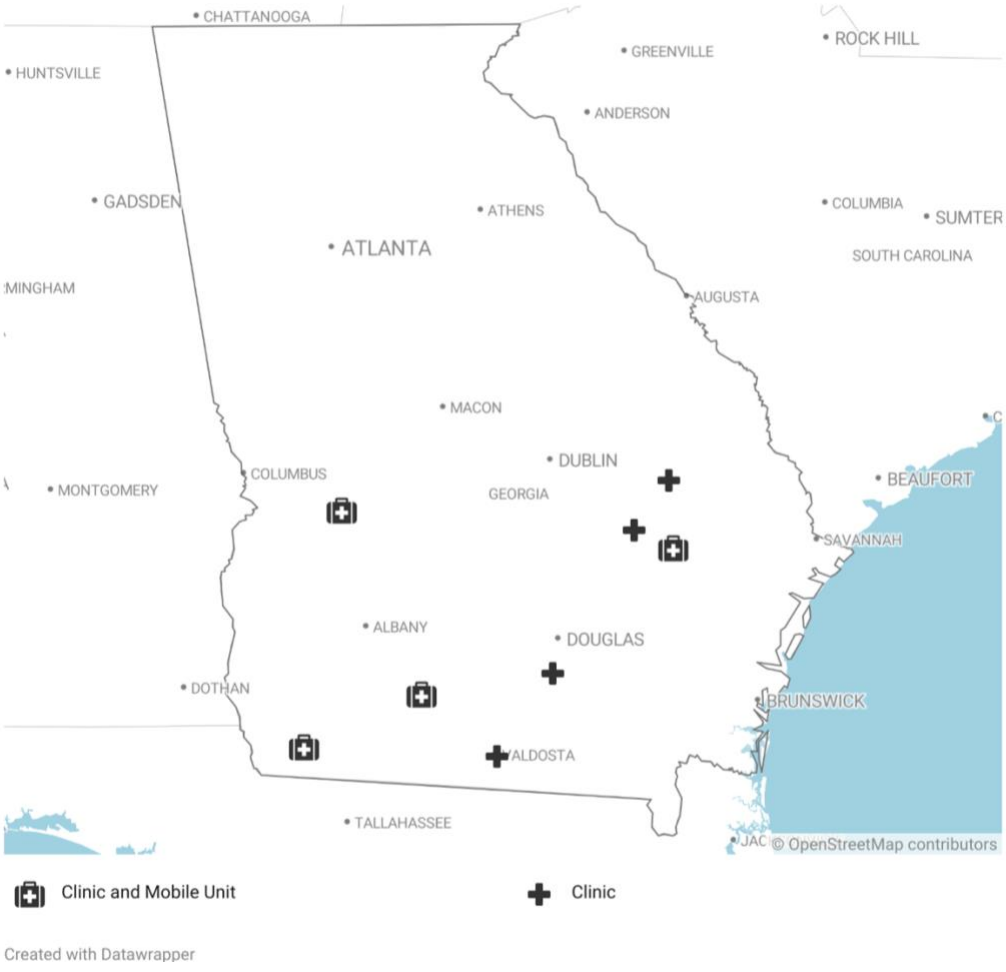
41% migrant); language (3% overall; 1% seasonal vs. 14% migrant) and transportation (1% overall; 1% seasonal vs. 3% migrant).

Collectively these findings are similar to those previously reported from the 2013-2016 NAWS and also corroborate findings from previous studies on the migrant farm worker population.

Migrant Clinics in Georgia

There are six federally funded migrant clinics under the Georgia Farmworker Health Program serving farmworkers in Georgia. They are in Atkinson, Colquitt, Decatur, Lowndes, Schley, and Tattnall Counties and serve a combined 21 counties. Maps 1 shows estimates of farmworkers by county served by the clinics, while estimates of farmworkers and dependents are provided in Map 2.

Map 3. Clinic Sites



CHARACTERISTICS OF PATIENTS SERVED IN MIGRANT HEALTH CLINICS IN GEORGIA

Clinic Census

There were 14,334, 9,057 and 11,017 patients seen across the six migrant clinics in Georgia in 2019, 2020 and 2021, respectively. Following the onset of the COVID-19 pandemic in 2020, the number of clients served declined by 37% in 2020, and 23% in 2021, relative to 2019 levels.

Patients seen at the migrant health clinics in Georgia are predominantly low-income, non-English speaking and uninsured Hispanic male migrant farmworkers.

Sex

Consistent with past trends, most clients were male (Figure 1). In comparison with the nation, migrant clinics in Georgia see relatively fewer female patients (Figure 2).

Figure 1. Sex Distribution of Patients, 2018-2021

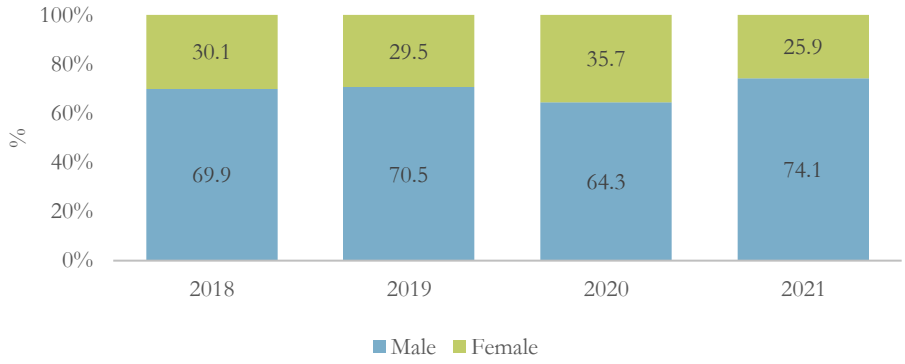
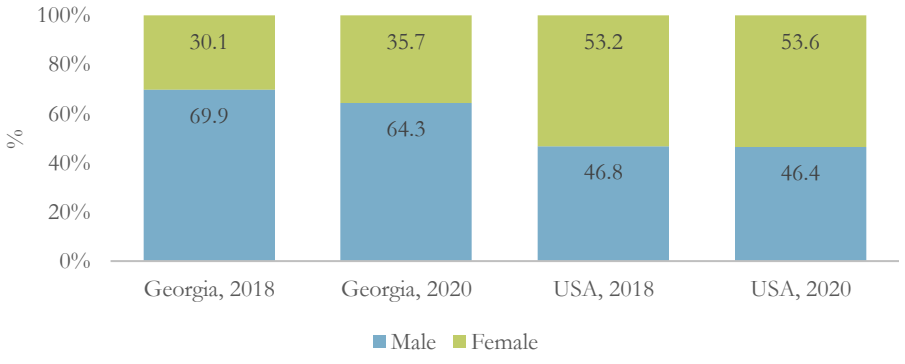


Figure 2. Sex Distribution of Patients: Georgia and National Comparison, 2018-2020



Age

Between 2018 and 2021, and consistent with past trends, most patients seen at the clinics were between the ages of 18 and 64 years (Figure 3). Children and elderly made up less than 10% and 5% of the patient population, respectively (Figure 3). Declines in client visits were more pronounced for children following the pandemic; in 2019, children made up approximately 8% of all migrant clinic patients in Georgia, this dropped to about 5% in 2020 and 3% in 2020 (Figure 3). On the other hand, the proportion of elderly seen at the migrant clinics increased in 2020 and 2021, compared to the pre-pandemic period (Figure 3). Compared to males, a higher proportion of females seen at Georgia's migrant clinics are children and elderly (Figures 4 & 5). In comparison with the nation, migrant clinics in Georgia see relatively fewer children (Figure 6).

Figure 3. Age Distribution of Patients, 2018-2021

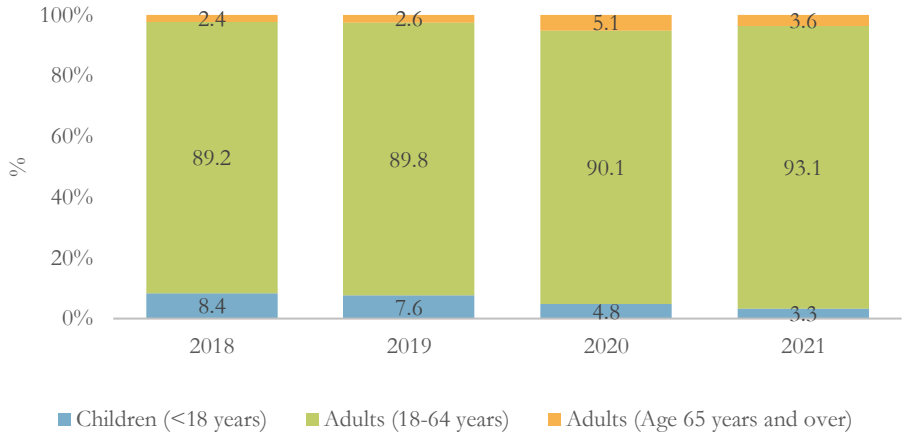


Figure 4. Age Distribution of Patients, 2018-2021: Females

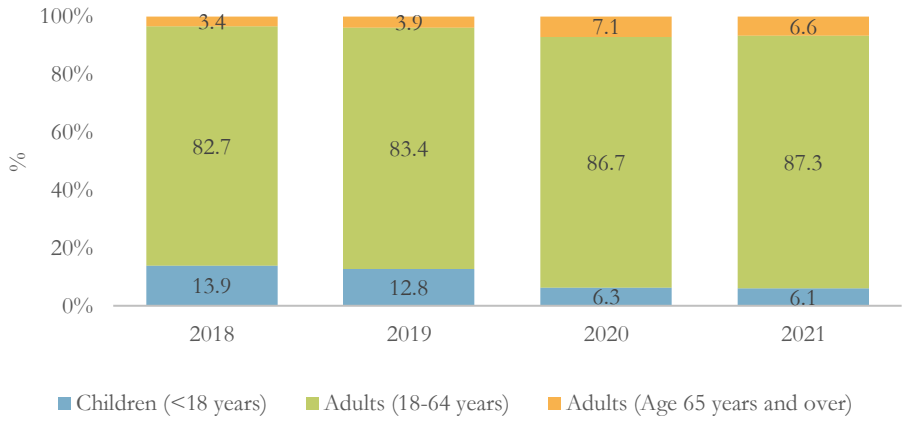


Figure 5. Age Distribution of Patients, 2018-2021: Males

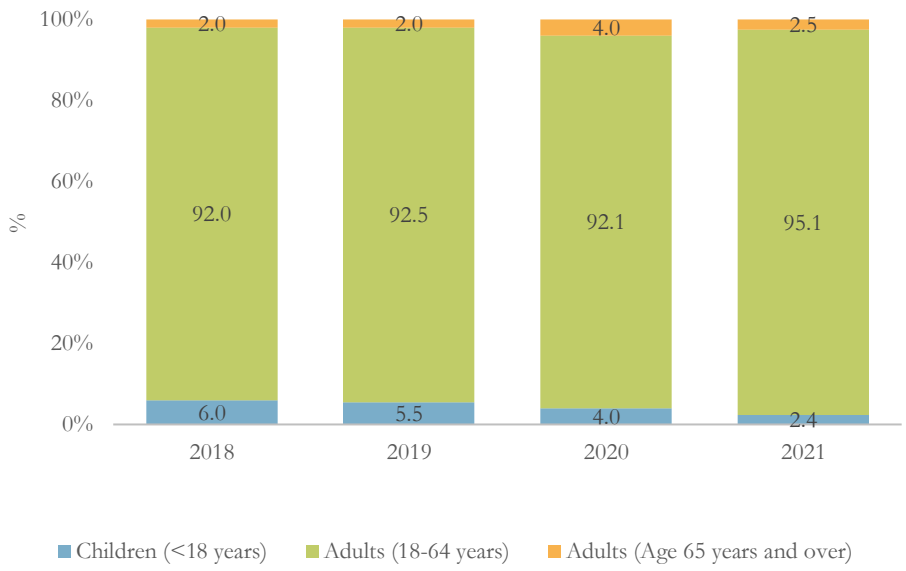
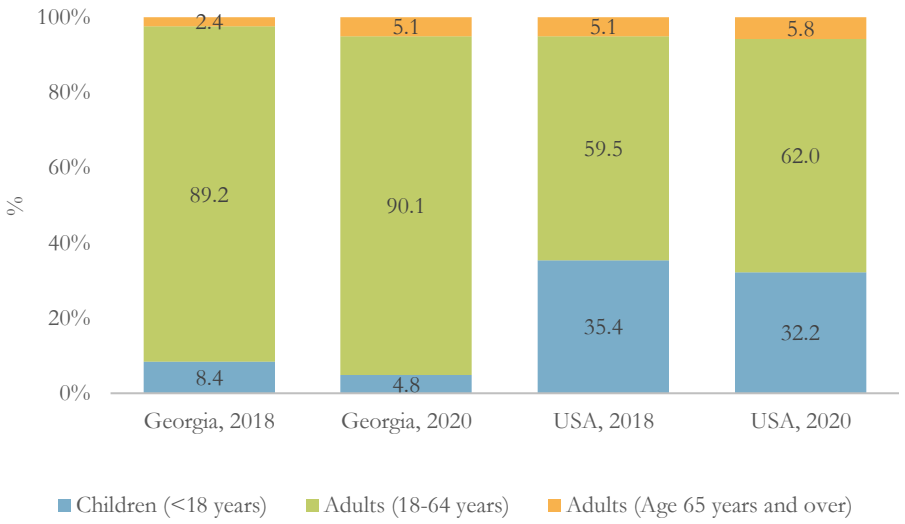


Figure 6. Age Distribution of Patients: Georgia and National Comparison, 2018-2020



Race

Hispanics/Latinos made up almost nine out of every ten farmworkers in Georgia from 2018-2021 (Figure 7). The race/ethnic distribution has consistent across years, except for 2020 and 2021, when the proportion of "Non-Hispanic White/Caucasian" and "Non-Hispanic Blacks/African-Americans" decreased, respectively. In comparison with the nation, migrant clinics in Georgia see a higher proportion of Blacks/African Americans (Figure 8).

Figure 7. Race/Ethnicity Distribution of Patients with Known Race/Ethnicity, 2018-2021

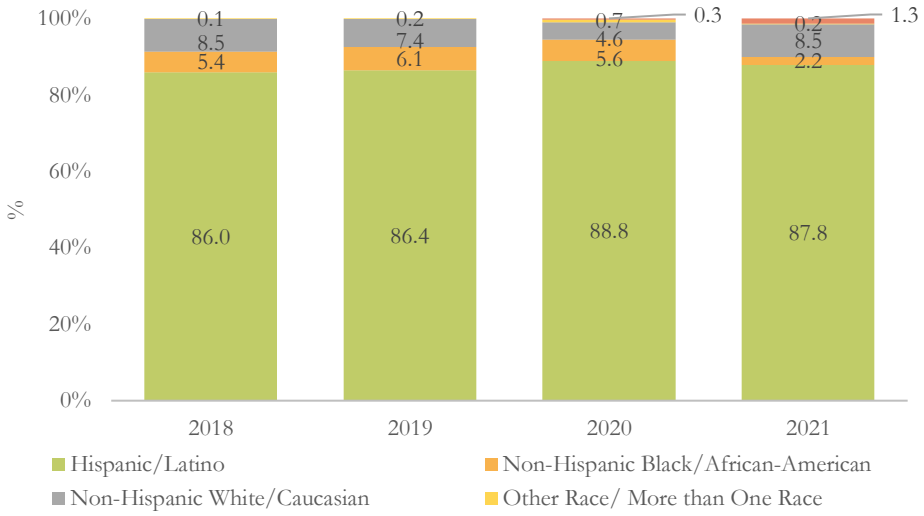
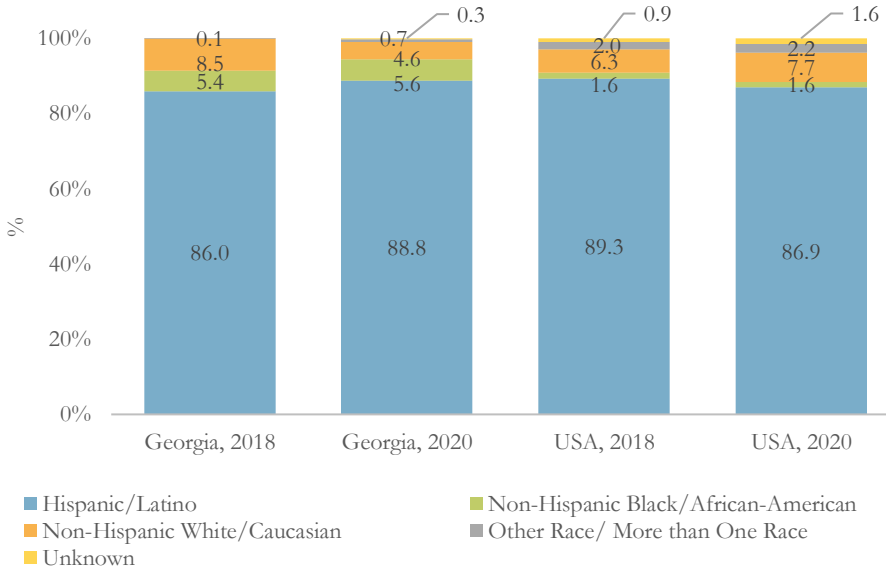


Figure 8. Race/Ethnicity Distribution of Patients: Georgia and National Comparison, 2018-2020



Income

At least eight out of every ten farmworkers seen at the state's migrant clinics lived at or below the federal poverty limit in 2018-2021 (Figure 9). Notably, the proportion of Georgia migrant clinic patients who lived at or below the federal poverty limit declined in 2020, but increased in 2021, compared to 2019 (Figure 9). In comparison with the nation, a higher proportion of patients seen in migrant clinics in Georgia live in poverty (Figure 10).

Figure 9. Income Distribution of Patients with Known Income, 2018-2021

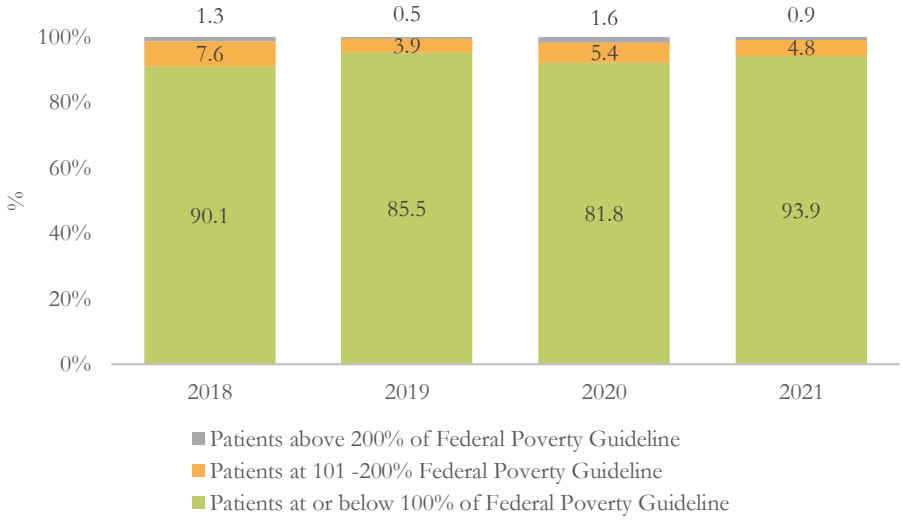
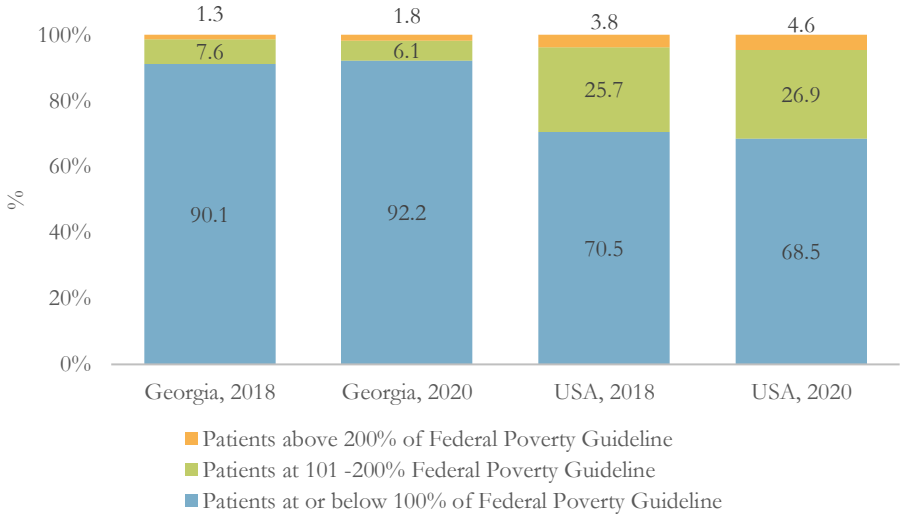


Figure 10. Income Distribution of Patients with Known Income: Georgia and National Comparison, 2018-2020



Worker Classification

Approximately two-thirds of patients seen at migrant clinics in Georgia between 2018 and 2019 were classified as migrant workers. This declined to a little over half between 2020 and 2021 (Table 5), indicating a steeper decline in clinic utilization among migrant farmworkers during the pandemic period (Figure 11). In comparison with the nation, Georgia generally sees a higher proportion of migrant farmworkers in its clinics (Figure 12).

Figure 11. Worker Classification, 2018-2021

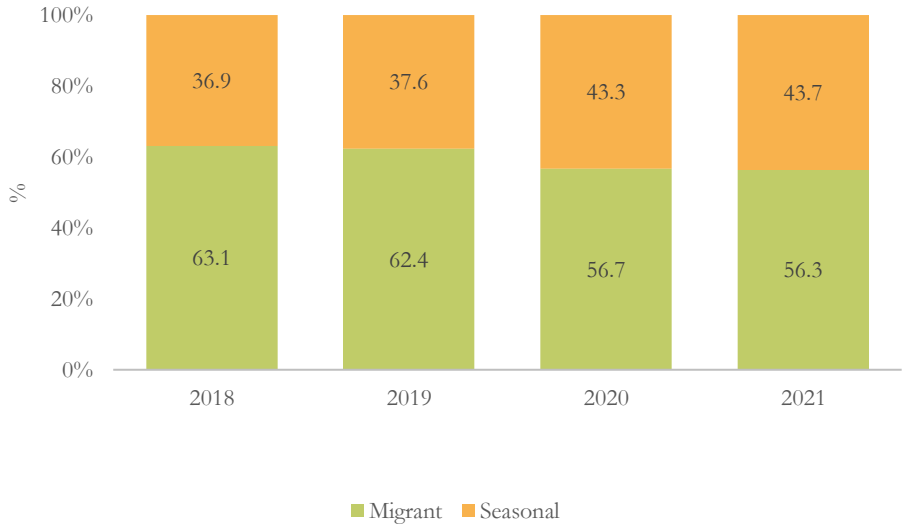
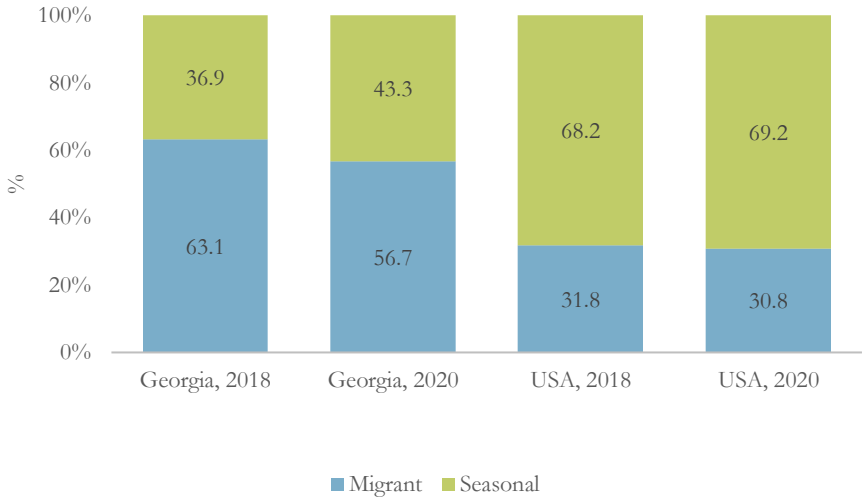


Figure 12. Worker Classification: Georgia and National Comparison, 2018-2020



Health Insurance

All patients seen at migrant clinics in Georgia in 2018-2021 were uninsured. Comparatively, in 2020, only about a third of patients (33%), with known insurance information, seen in migrant clinics nationally were uninsured.

Language

Most patients seen at migrant clinics in Georgia are best served in a language other than English (Figure 13). In comparison with the nation, Georgia generally sees a higher proportion of non-English speaking patients in its clinics (Figure 14).

Figure 13. Best Served in a Language Other than English, 2018-2021

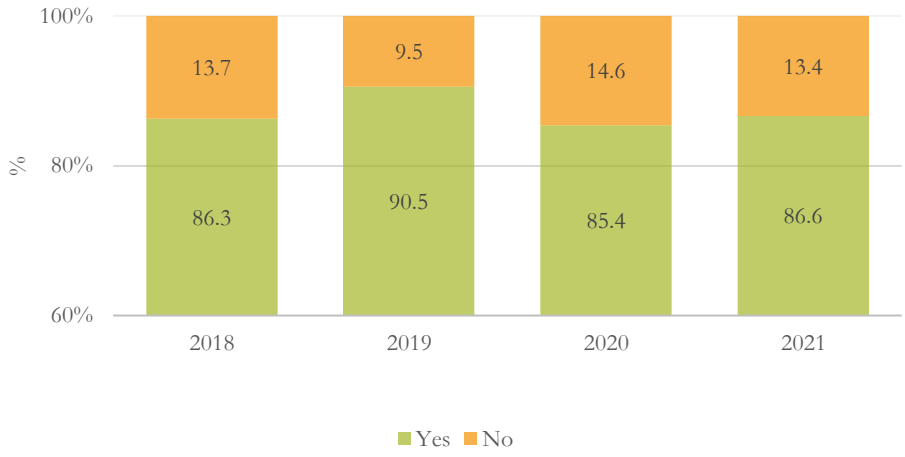
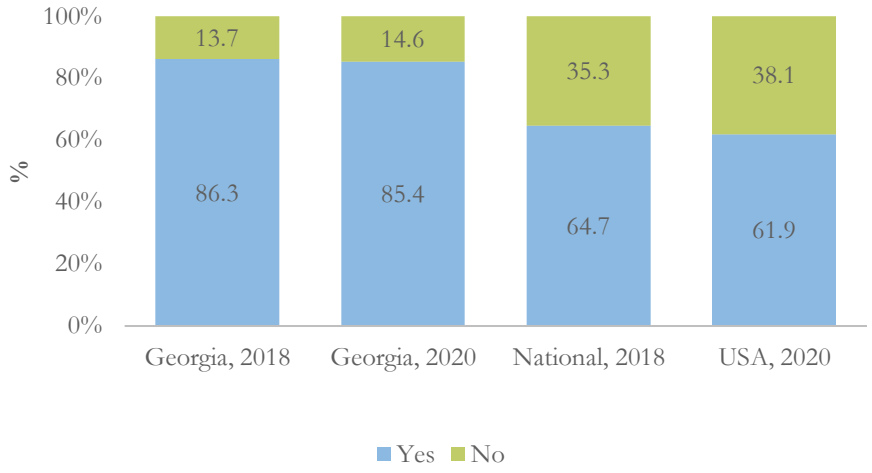


Figure 14. Best Served in a Language Other than English: Georgia and National Comparison, 2018-2020



HEALTH SERVICES UTILIZATION IN MIGRANT HEALTH CLINICS IN GEORGIA

Services

Clinic visits declined significantly during the pandemic.

The total number of visits made in 2019, 2020 and 2021 were 45,609, 20,976 and 21,830 respectively. Clinic visits declined significantly during the pandemic. Visits declined by 54% and 52% in 2020 and 2021, compared to 2019. Most visits were made for medical (67% in 2018; 73% in 2020 & 79% in 2021) and enabling services (27% in 2018; 24% in 2020 & 19% in 2021). The proportion of visits for mental health increased in 2020 and retuned to pre-pandemic levels in 2021. There were no substance abuse services recorded (Table 1).

On average each patient made 3.2 visits in 2019. This decreased to 2.3 visits per patient in 2020 and 2.0 visits per patients in 2021 (Table 2). The proportion of medical services provided at migrant clinics in the state increased in 2020-2021, compared to the pre-pandemic period (i.e., 2018-2019) (Figure 15). Compared to the nation, migrant clinics in Georgia provide fewer dental and other services (including vision and mental health/substance abuse services) and more enabling services (Figure 16).

Table 1. Types of Services Provided

	2019		2020		2021	
	# VISITS	%	# VISITS	%	# VISITS	%
Medical Services	30,582	67.1	15,327	73.1	17,321	79.3
Dental Services	1337	2.9	458	2.2	264	1.2
Mental Health Services	140	0.3	149	0.7	76	0.3
Substance Abuse Services	1022	2.2	73	0.3	10	0.0
Vision Services	28	0.1	0	0.0	4	0.0
Enabling Services	12,301	27.0	4,969	23.7	4,155	19.0
Other Professional Services	199	0.4	0	0.0	0	0.0
TOTAL VISITS	**45,609**	**100.0**	**20,976**	**100.0**	**21,830**	**100.0**

Table 2. Number of Visits by Service

	2019			2020			2021		
	# Visits	# Patients	Visits per Patient	# Visits	# Patients	Visits per Patient	# Visits	# Patients	Visits per Patient
Medical Services	30,582	13,832	2.2	15,327	8,709	1.8	17,321	7,727	2.2
Dental Services	1337	602	2.2	458	249	1.8	264	144	1.8
Mental Health Services	140	84	1.7	149	93	1.6	76	31	2.5
Vision Services	28	28	1.0	0	0	N/A	4	4	1.0
Enabling Services	12,301	12,301	1.0	4,969	4,969	1.0	4,155	4,155	1.0
Substance Abuse Services	1,022	832	1.2	73	39	1.9	10	4	2.5
Other Professional Services	199	199	1.0	0	0	N/A	0	0	N/A
TOTAL VISITS	**45,609**	**14334**	**3.2**	**20,976**	**9057**	**2.3**	**21,830**	**11017**	**2.0**

Figure 15. Types of Service Provided, 2018-2021

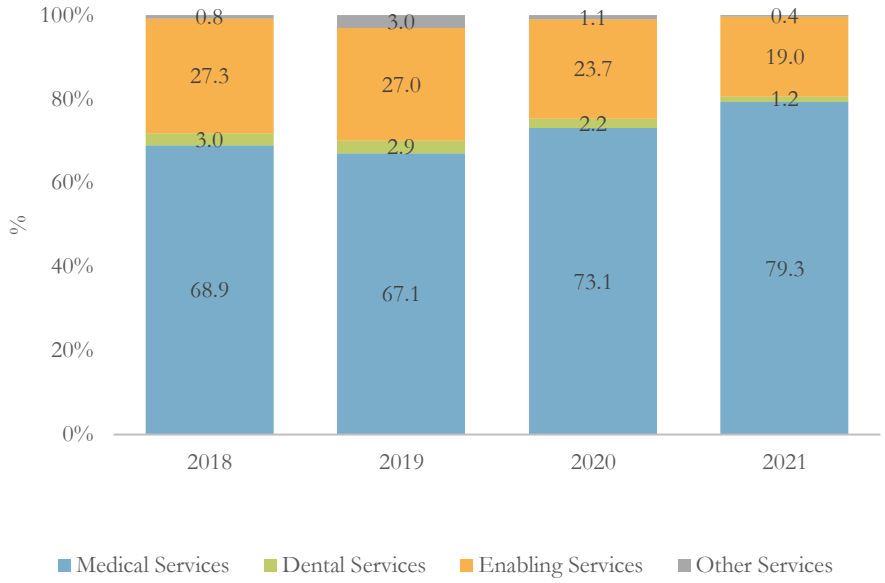
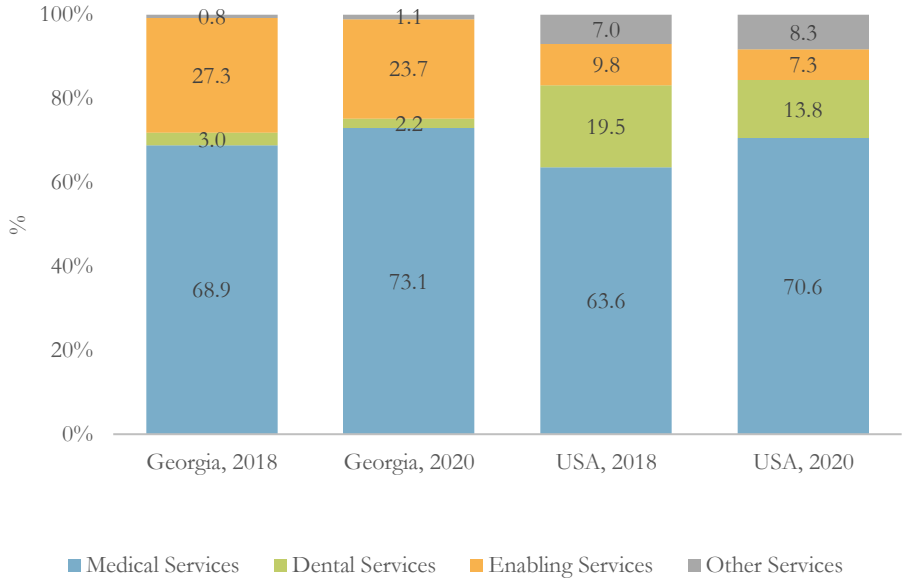


Figure 16. Types of Services Provided: Georgia and National Comparison, 2018-2020



Staffing

The pandemic resulted in a general decline in clinic productivity. However, physician productivity increased significantly at the onset of the pandemic in 2020.

Overall staffing level was stable between 2019 and 2020 (68 FTE) but decreased by 11.2 full-time equivalent in 2021 (56.8 FTE). The significant decline in visits following the pandemic (i.e., in 2020 and 2021) (Figure 17) resulted in a decrease in the number of visits per FTE in both years (54% decline in 2020 relative to 2019, and 43% decline in 2021 relative to 2019) (Table 3).

At the provider level, the total number of visits per FTE decreased at the onset of the pandemic in 2020 for NPs/PAs, nurses, and patient/community education specialists, but not for other health professionals (Table 8). The number of visits seen per physician FTE increased significantly from 2145 in 2019 to 3153 in 2020 – a 47% increase. By 2021, the number of physician visits per FTE had decreased to 1404 (Table 8). The number of visits provided per mental health provider FTE increased by 6% between 2019 and 2020, but declined by 57% between 2020 and 2021

Compared to the nation, Georgia's migrant clinics generally utilize NPs/PAs more for the delivery of medical care. However, notably in 2020 Georgia relied more on physicians for the delivery of medical care compared to 2018 (Figure 18).

Table 3. Staffing

	2019			2020			2021		
	# Visits	FTE	Visit per FTE	# Visits	FTE	Visit per FTE	# Visits	FTE	Visit per FTE
Physicians	3540	1.65	2145	3153	1	3153	1067	0.76	1404
NP/PA	23456	10.84	2164	11001	10	1100	12487	9.39	1330
Nurses	3586	9.04	397	1173	13	90	3767	6.34	594
Dentists	651	0.5	1302	381	0	N/A	155	0.1	1550
Dental Hygienists	686	0.95	722	77	1	77	109	0.02	5450
Case Workers	3532	2.5	1413	1722	1	1722	1574	1.5	1049
P/CE Specialists	8769	1.87	4689	3247	2	1624	2581	1.5	1721
LMHP and Staff	140	2.75	51	149	2.75	54	76	3.25	23
Other Personnel	1249	37.87	33	73	0	162	14	33.95	0.4
TOTAL STAFF	45609	67.97	671	20976	68.00	308	21830	56.81	384

NP/PA - Nurse Practitioners/Physician Assistants; LMHP - Licensed Mental Health Providers; P/CE Specialists - Patient/Community Education Specialists

Figure 17. Staffing Trends, 2018-2021

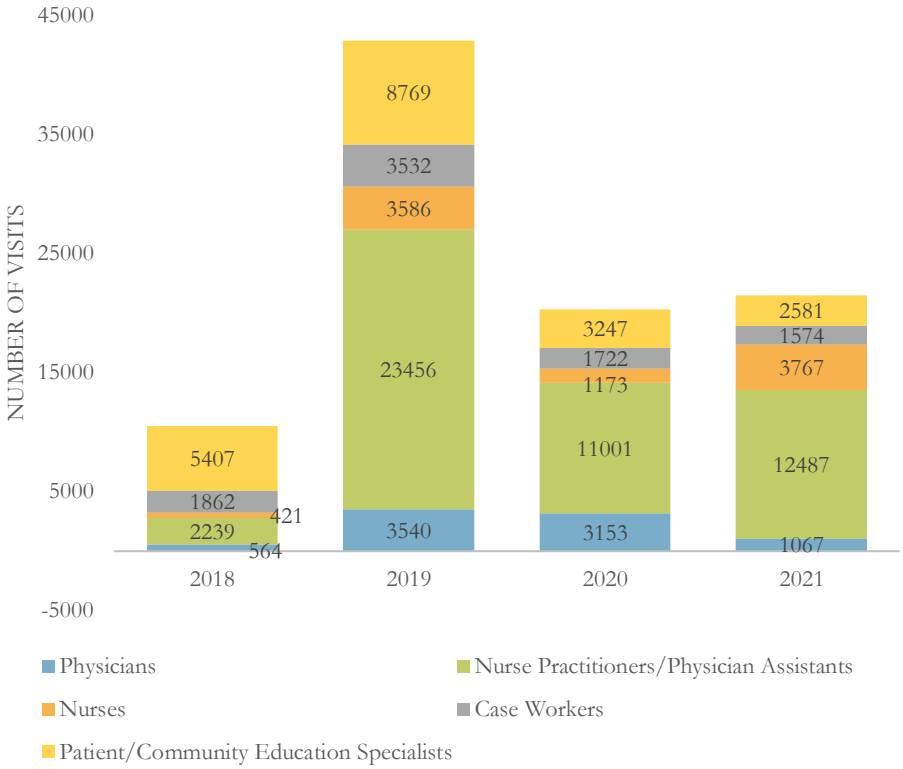
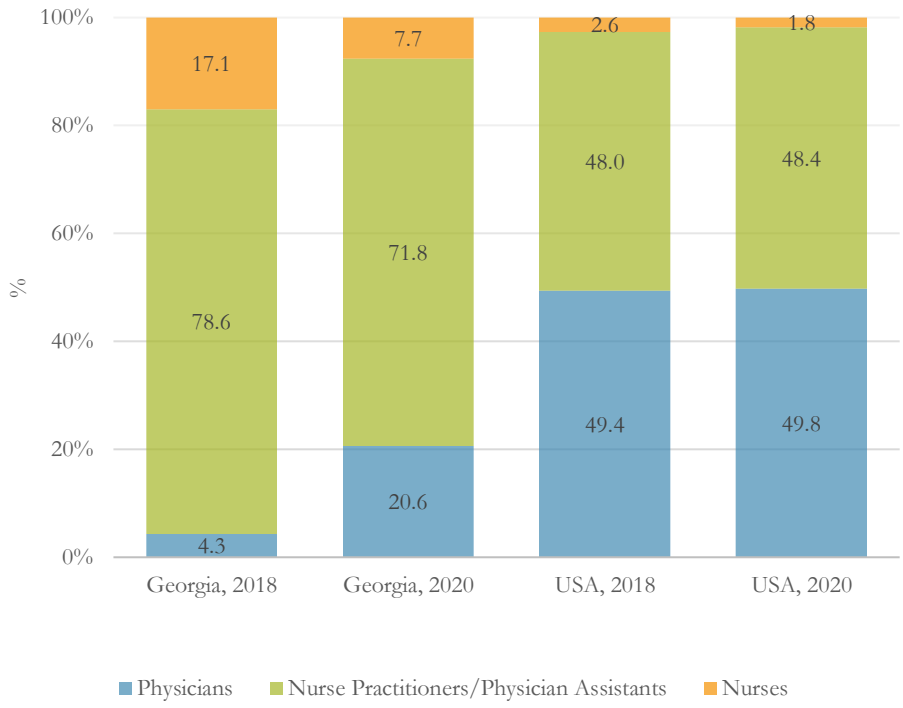


Figure 18. Medical Visits by Provider: Georgia and National Comparison: 2018-2020



DIAGNOSES AND CLINICAL OUTCOMES OF FARMWORKERS SEEN AT CLINIC SITES

Common Diagnoses

The pandemic resulted in an overall decline in the number of visits for medical services. However, patients with chronic conditions who utilized services during the pandemic recorded more visits on average.

Table 9 presents information on selected diagnoses across all clinic sites. The most common conditions experienced by farmworkers seeking healthcare at the states' six migrant clinics between 2019 and 2021 were overweight and obesity, hypertension, and diabetes. This finding corroborates the findings from the NAWS as well as other literature that show a disproportionate burden of these conditions among the Hispanic population, compared to the general population.

Between 2019 and 2021, the total number of visits declined for all common conditions, except for anxiety, which increased by 8%. Despite the general decline in visits, however, the average number of visits made per patient increased over the same period for several medical conditions, including overweight/obesity, hypertension, diabetes, heart disease, anxiety and depression, and asthma. The average visit per patient increased notably by 12% and 30% respectively for heart disease and asthma (Table 4).

Table 4. Selected Diagnoses

	2019			2020			2021			% Change (2019-2021)	
Selected Diagnoses (all sites)	# Visits*	# Patients	Visit per Patient	# Visits*	# Patients	Visit per Patient	# Visits*	# Patients	Visit per Patient	Visits	Visit per Patient
Overweight and Obesity	11,848	7,527	1.6	9,969	5,730	1.7	7,945	4,721	1.7	-32.9	6.9
Hypertension	2,893	1,392	2.1	2,373	1,032	2.3	2,438	1,062	2.3	-15.7	10.5
Diabetes Mellitus	2,589	1,036	2.5	2,359	878	2.7	2,401	887	2.7	-7.3	8.3
Tobacco Use Disorder	1022	832	1.2	477	470	1.0	915	732	1.3	-10.5	1.8
Heart Disease (selected)	264	153	1.7	268	131	2.0	242	125	1.9	-8.3	12.2
Anxiety disorders including PTSD	280	150	1.9	281	140	2.0	303	160	1.9	8.2	1.5
Depression and other mood disorders	307	200	1.5	157	95	1.7	181	113	1.6	-41.0	4.3
Contact dermatitis and other eczema	177	155	1.1	87	77	1.1	107	94	1.1	-39.5	-0.3
Asthma	222	128	1.7	169	85	2.0	156	69	2.3	-29.7	30.4
Sexually transmitted infections	106	66	1.6	89	78	1.1	28	18	1.6	-73.6	-3.1
Dehydration	67	61	1.1	21	20	1.1	18	17	1.1	-73.1	-3.6
Chronic lower respiratory diseases	130	80	1.6	35	24	1.5	41	31	1.3	-68.5	-18.6
Abnormal cervical findings	55	36	1.5	26	26	1.0	6	6	1.0	-89.1	-34.5
Abnormal breast findings, female	52	39	1.3	21	19	1.1	15	14	1.1	-71.2	-19.6
Exposure to heat or cold	18	18	1.0	8	7	1.1	9	9	1.0	-50.0	0.0
COVID-19	0	0	0.0	331	325	1.0	118	N/A	N/A	N/A	N/A
Childhood Conditions											
Otis Media and Eustachian Tube Disorders	72	59	1.2	26	22	1.2	11	9	1.2	-84.7	0.15

*# visits regardless of primacy

Clinical Outcomes

There were mixed results in terms of clinical outcomes between 2019 and 2021. Diabetes control and the proportion of low birthweight births worsened in 2021, compared to 2019 and 2020, whereas hypertension control improved during the same period. The proportion of low birthweight births increased dramatically to 66% in 2021 (Table 5).

Table 5. Selected Clinical Outcomes

	2019	2020	2021
Select Clinical Outcomes	Percent	Percent	Percent
Diabetes	**N=968**	**N=822**	**N=826**
Poor control: Diabetes patients with Hba1c greater than 9% or with no tests performed during the year	41.6	40.3	44.8
Hypertension	**N=705**	**N=1,030**	**N=1,055**
Proportion of patients with controlled hypertension	55.5	51.9	61.0
Births	**N=112**	**N=94**	**N=50**
Very low birthweight: Proportion of live births less 1500 grams	0	0	8.0
Low birthweight: Proportion of live births 1500 grams – 2499 grams	8.9	7.4	66.0

Clinical Measures

Performance on quality clinical measures declined in the wake of the pandemic. On all quality measures, except for statin therapy, performance declined in 2021 compared to 2019 (Table 6). Colorectal and cervical cancer screening rate are notably low at approximately 15% and 28%, respectively in 2021 (Table 6).

Table 6. Selected Clinical Measures

	2019	2020	2021	Improvement/Decline
Selected Clinical Measures	%	%	%	2019 vs. 2021
Children 2 years of age who received age-appropriate vaccines by their 2nd birthday	42.3	0.0	N/A	N/A
Female patients aged 23-64 years who were screened for cervical cancer	29.5	24.1	28.0	Declined
Patients aged 50-75 years with appropriate colorectal screening	16.7	11.6	14.5	Declined
Children and adolescents 3-17 years with documented BMI, nutrition, and physical activity counseling	86.2	76.3	67.1	Declined
Adult patients with documented BMI and appropriate follow-up plan documented if BMI is outside of normal parameters	84.4	94.6	50.0	Declined
Patients aged 18 years or older who were screened for tobacco use one or more times in the measurement year or prior year and (2) those found to be a tobacco user received cessation counseling intervention or medication	92.7	54.2	92.3	Stable
Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy	53.1	67.1	62.4	Improved
Patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	48.1	43.2	45.5	Declined
Patients 12 years of age and older who were (1) screened for depression with a standardized tool and, if screening was positive, (2) had a follow-up plan documented	78.2	69.2	68.9	Declined

FARMWORKER ACCESS TO HEALTH SERVICES

Input From Clinics

Representatives (N=6) from the six clinics participated in open-ended survey during the month of May 2022. Each clinic returned a completed survey. Representatives from each clinic responded to the survey. Survey respondents included clinic managers, program directors, and a chief executive officer. Clinic contacts were shared by the Georgia Migrant and Seasonal Farmworker Program and an email was sent to each clinic contact provided. The clinics were given one week to complete the survey. Data from the Qualtrics online survey tool was exported and reviewed for recurring themes concerning Georgia's migrant farmworkers' top health issues and the assessment of health services they received.

Top Health Needs. Based on the analysis of the survey data, the top three health issues reported by the respondents are cardiovascular disease (high blood pressure), diabetes and obesity. Other identified health issues included mental health, specifically depression, backaches, and dermatology issues. Adequate mental health services are still noted as a service that is needed but lacking in availability and accessibility. The clinics that noted some in-house counseling still indicated the service could be improved with bilingual services and additional health education services.

Barriers to Care. Clinics identified language barriers and access to adequate resources as obstacles to care among this population. Language barriers can increase medical non-compliance in addition to decreasing access to healthy lifestyle options. Compliance with proper diet and provider follow-up appointments is difficult for the farmworkers.

> *"Just like the general population, obesity, hypertension, and diabetes seem to be the most diagnosed health problem. Education along with behavioral health modification and medicine could lead to positive changes. Transportation is [also] a need that this population has. Traveling in groups in a foreign county can create a barrier to care and medicine." - Clinic Representative*

Additional barriers for clinics when serving this population include access to transportation, clinic hours and work schedule commitments. Transportation was mentioned by most participants as a top barrier for this population.

Transportation and Compliance

Access to transportation and client compliance remain as some of the top barriers to providing adequate services to migrant farmworkers. Health conditions that rely heavily on behavior modification continue to impact this population and therefore proper treatment and maintenance are impeded by the client's ability to keep appointments and remain compliant with care. As noted in previous assessment reports, non-compliance is not directly linked to farmworker motivation, but more likely related to other issues such as lack of transportation and reduced access to care based on the clinic hours and the worker's schedule. Previous assessments identified transportation as the top barrier to service. It impacts the ability for farmworkers to seek follow-up care that is often vital in maintaining long-term wellness. In addition, farmworkers are unlikely to miss time from work to attend appointments.

Another noted barrier impacting compliance to care is the lack of trained staff and interpretative services available to assist with communication. Clinics might have access to interpretive services and staff, but access is limited. In some clinics, only 1 staff member is bilingual.

Primary Care

Majority of clinics offer primary and secondary prevention care to the farmworkers. Services such as health education, access to medications, and lab diagnostics were all identified as common services offered across all clinics. Two clinics noted the ability to offer mental health counseling in addition to the health education and laboratory services. This is notable because previous assessments indicated this was a critical service that was lacking. Mental health services were hard to provide because clinics were reliant on outside partners. These partnerships were hard to develop, and transportation made it difficult for clients to keep appointments. With only two clinics identifying counseling services that

are provided in-house, this demonstrates slow progress to address an identified need. The lack of mental health providers is a local, state, and national challenge exacerbating the challenge for underserved populations such as Georgia's farmworkers.

Additional Challenges

Even though progress is being made to address mental health, access to mental health care remains an issue for the farmworkers. Other services clinics identified as services of need include expanded pharmaceutical access, women's health, prenatal care, and dental. Some of these services are available but require outside agreements with specialized health care providers. There are limited providers that are willing to participate in farmworker health and the cost is often unaffordable for the population.

COVID-19

Clinics were asked about the impact of COVID-19 on their services. Most responses indicated that care and outreach were negatively impacted. Some clinics experienced limited outreach because farms would not allow clinic staff onsite. In addition, clinics began losing staff to new job opportunities and staff burnout issues.

Recommendations

The following are the recommendations which emerged from the needs assessment.

- **Increase number of trained, bilingual staff at each of the clinics. This continues to be one of the top requests from the six grantees.**

Clinics could increase access to services by extending clinic hours if more staffing was available. Ideally, trained, bilingual staff is needed to best address the needs of the farmworkers.

- **Create public relation opportunities to highlight the importance of migrant farmworker care.**

Community outreach to improve or change perceptions of the need for good migrant farmworker care is needed. Perhaps this is linked to the amount of funding available for clinics offering care. Sharing the importance of these services may assist with increasing funding to improve services.

- **Expand professional development and incentive opportunities for all clinic staff.**

Continuing education would greatly benefit the clinic staff. Lack of trained staff is identified as a barrier to service provision. If clinics offered opportunities for professional development, it could assist new and veteran staff in learning more about the population and effective ways to improve patient compliance. Suggestions included:

⇒ *Recorded trainings for new and existing staff to maintain skills.*

⇒ *Trainings for customer service, s phone etiquette and the role of translator training and materials for community health workers*

- **Review voucher services criteria and eligibility to ensure more services are covered.**

Cost of specialized care is a barrier for farmworkers and for providers that serve as partners. If voucher services were increased this could assist with affordability of services and medications.

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