### Objective
To increase understanding about how Migrant Health Voucher Programs (MHVPs) comply with the Bureau of Primary Health Care’s Health Center Program Requirements and the unique challenges that they face.

### Migrant Health Voucher Programs
MHVPs are an alternative model to free-standing migrant health centers to fill a unique need within the Health Center Program. The work of MHVPs helps the Bureau of Primary Health Care fulfill its mission to provide comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations. While health centers provide care to patients in their immediate service area, voucher programs (VPs) extend services into communities often throughout the entire state to ensure that large and small pockets of migrant and seasonal farmworkers have access to high quality primary and preventive services during the time they reside in the location. This document outlines the strategies used by VPs to meet the 19 Program Requirements and the unique challenges that they face.

Voucher programs are described in PIN 94-7 as having 3 distinct models: the Service Coordinator Model, The Nursing Model and the Midlevel Practitioner Model. The Service Coordinator Model is a basic model used when anticipated patient volume is very low. It is characterized by the absence of on-site medical personnel. Clients with health programs are referred to community providers and VP staff provides outreach, case management, health education, interpretation, transportation, and other enabling services. The Nurse Model provides all functions of the service coordination model in addition to direct nursing care. The nurse screens, triages, and makes referrals. Nurses also keep a medical record for each patient, provides health education, preventive services, case management and follow-up. The Midlevel Practitioner Model provides on-site triage and treatment as directed by established protocols with a supervising physician and as permitted by the state laws in addition to the services provided in the other 2 models. Currently, although some voucher programs can be described as one of these three models, many programs have adopted components of all three models to meet the needs of farmworkers in their services area. It is important to keep in mind the variety of programs within this model when examining a voucher program or referencing PIN-94-7.

“A Voucher Project may be warranted in areas where the numbers and/or density of MSFWs [Migrant and Seasonal Farmworkers] cannot justify the establishment of a migrant health center based on the traditional medical delivery system model, existing provider organizations cannot qualify or are unwilling to serve as grant recipients, and existing providers have the capacity to meet much of the primary health care needs of the MSFWs. Those areas are generally characterized by limited agribusiness and/or short harvests and should be identifiable as suitable for vouchers throughout a review of the state profiles... The cost of establishing and staffing migrant health centers (MHCs) for short periods of time may render the medical model health center unfeasible. The reduced numbers of MSFWs can be more efficiently served by contracting with local health resources.” PIN 94-7 p.1-2 The rationale for establishing voucher programs is still relevant today in 2012, not only the structural issues discussed above, but also based on need within the FW population. For example, there are more males, more migrants, higher poverty and lower insurance rates compared with patients seen at community health centers and compared with farmworker populations seen at migrant health centers.

“Because the funding for migrant health has never been adequate to pay for all levels of care needed by all eligible beneficiaries, priority must be given to assuring access to primary care. Voucher projects are expected to meet all MHC [Migrant Health Centers] regulations and directives, except as specifically waived or interpreted in this document [PIN 94-7]”

“Many of the expectations for traditional medical model MHCs are inappropriate for voucher projects. This document [PIN 94-7] addresses the most important of those modified expectations. Voucher projects should discuss, with PHS regional office staff, opportunities to improve efficacy and effectiveness which would require waiving of specific requirements.” PIN 94-7 p. 2

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<th>Column 1</th>
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<tbody>
<tr>
<td>PHS 330 Program Requirements</td>
<td>Reference information from PIN 94-7</td>
<td>Identified MHVP challenges to comply with Program Requirements</td>
<td>List the strategies use by VP to meet each of the PR</td>
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MHVPs and NCFH Collaboration (11.28.2012)
### PHS Section 330 Program Requirements

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<th>Section 330 Program Requirements</th>
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<tr>
<td><strong>Section I: Need</strong></td>
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| I. NEEDS ASSESSMENT              | Health center demonstrates and documents the needs of its target populations; updates its service area when appropriate. [Section 330(k)(2) and Section 330 (k)(J) of the PHS Act] | • Service area is often statewide  
• Lack of information/uniform data collection concerning migrant/seasonal farmworker health  
• US Census data lacks adequate representation of farmworkers (FWs)  
• US Department of Agriculture’s Census of Agricultural Workers | • Multiple methods are utilized to collect input directly from FWs when gaps in data exist (i.e. feedback surveys, focus groups, town hall meetings, advisory, committees, promotores de salud as key informants.  
• Use of data from public health departments and agencies serving farmworkers, if available  
• Use of National data to reference since it is often not available at the state level |
| **Section II: Services**         | Voucher programs are expected to use a care coordination model with an emphasis on the provision of enabling services. |                          |                          |
| II. SERVICES                    | Health center provides all required primary, preventative, and enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. [Section 330(a) of the PHS Act] | • Voucher programs (VPs) provide access to required services directly and/or through contractual agreements, and because VPs have dedicated funds to reimburse others for care (i.e. access to specialty care) they may be more likely to assure that access occurs (versus having a referral arrangement with no funds).  
• Voucher programs strive to negotiate reduced rates, and often leverage a significant amount of care.  
• Enabling services are provided to create access to primary, preventative and other appropriate care. |  |
### III. STAFFING

Health center maintains a core staff as necessary to carry out all required primary, preventative, & enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed, and privileged. [Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act]

- Staffing can be quite low as many VPs are housed within Public Health offices, state Primary Care Associations, Section 330 health centers, etc.
- Voucher programs credential staff or contract providers who provide care and services directly to farmworkers.
- Because voucher programs often rely on a large referral network to provide care to FWs, the credentialing program requirements (PR) is often obligated through contractual terms (i.e. attest that their providers are board certified).
- Voucher programs also audit contracts to assure compliance.

### IV. ACCESSIBLE HOURS OF OPERATION/LOCATIONS

Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. [Section 330(k)(3)(A) of the PHS Act]

- Scope verification process often does not take into consideration the many locations that direct care take place in, or the changeability of locations due to mobility of FW population.
- Voucher programs offer evening/weekend hours during the agricultural season and/or with mobile units targeting labor camps for when FWs are in the area for a short period of time.
- Job descriptions and contractual terms state requirement of extended hours to meet FW needs.

### V. AFTER HOURS COVERAGE

Health center provides professional coverage during hours when the center is closed. [Section 330(k)(3)(A) of the PHS Act]

- Seasonal clinicians may not be in position to extend after hours coverage to migrant patients.
- Not all reimbursed/voucher providers offer extended hours.
- Voucher contracts specify that after-hours coverage extend to farmworkers who are patients of record.
- In cases where it is not feasible to offer 24/7 coverage, the voucher programs inform farmworker on procedures to follow in case of a medical emergency.
- Voucher programs educate FWs about what constitutes an emergency, how to decide when to go to the hospital, and how to call 911.

### VI. HOSPITAL ADMITTING PRIVILEGES AND CONTINUUM OF CARE

- Only midlevel practitioner models VPs have physicians on
- Voucher providers almost always have local admitting privileges assuring that FW patients
## PHS Section 330 Program Requirements

### Migrant Health Voucher Program Exceptions (PIN 94-7)

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<td>Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. [Section 330(k)(3)(L) of the PHS Act]</td>
<td>May be hospitalized when necessary</td>
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### Section III: Management & Finances

#### VII. SLIDING FEE DISCOUNTS

Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient’s ability to pay. This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.*

No discounts may be provided to patients with incomes over 200% of the Federal poverty guidelines.* [Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f)]

| Voucher programs often do not receive reimbursement from private or public insurances and are generally providing a full discount to their patients, charging only a nominal fee. Because many voucher programs provide services in the community at a patient’s home or camp quarters to reduce barriers to care, the nominal fee is often waived in these outreach settings. Voucher programs assess farmworker eligibility for sliding fee scale (SFD), negotiate those discounts with contracted providers, and pass those discounts onto farmworkers through the voucher system. |

### VIII. QUALITY IMPROVEMENT/ASSURANCE PLAN

Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include:

- A clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care.*
- Periodic assessments of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the

| Voucher programs often have very complex continuous quality improvement plans to monitor the quality of services provided directly or through the voucher programs who are contracted to serve FWs. Voucher programs use quality improvement (QI) best practices to assure quality of care, including: systematic review of charts, peer review, PDSAs, utilization reviews, patient satisfaction surveys and on-going provider education. |

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"At no time should the patient’s ability or inability to pay be a barrier to the provision of care“ (p.13, PIN 94-7)
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<td>health center; and such assessments shall:*</td>
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<td>at VPs may be smaller than free-standing health centers so the results can vary significantly from year to year without an actual change in the provision of services occurring.</td>
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<td>o Be conducted by physicians or other licensed health professionals under the supervision of physicians,*</td>
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<td>Voucher program work with a small budget and spend the majority of the grant for direct care or voucher care, therefore, the funds are not enough to support a traditional key management staff.</td>
<td>The size of the voucher program and whether or not it is part of a larger CHC system determines the makeup of the management team. For example, several voucher programs have an Executive Director that serves as the Chief Executive Officer, the Chief Information Officer and the Chief Financial Officer. In addition, voucher programs may have management team members who are responsible for direct care and service as well as administrative duties.</td>
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<td>o Be based on the systematic collection and evaluation of patient records,* and</td>
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<td>o Identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.*</td>
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<td>[Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25(c)(2), (3) and 42 CFR Part 51c.3030(c)(1)-(2)]</td>
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**IX. KEY MANAGEMENT STAFF**

Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior review by HRSA of final candidates for Project Director/Executive Director/CEO position is required. [Section 330(k)(3)(H)(ii) of the PHS Act and 45 CFR Part 74.25(c)(2),(3)]

**X. CONTRACTUAL/AFFILIATION AGREEMENTS**

Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meet Health Center program requirements. [Section 330(k)(3)(I)(ii), 42 CFR Part 51c.3030(n), (t), Section 1861(aa)(4), Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a)(2)]

- Difficult to negotiate full contract with provider who may only do a few visits a year for voucher program
- Although some voucher programs provide direct services, many voucher programs have contracts or other formal written agreements to provide access to primary care.
- When a voucher program contracts with an agency to provide or arrange for the required services, the written agreement may be between the subcontractor and the provider as opposed to directly with the HRSA 330g grantee.

**XI. COLLABORATIVE RELATIONSHIPS**

- Voucher programs specialize in partnerships and

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<td>Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing Federally Qualified Health Centers in the service area or provides an explanation for why such letter(s) of support cannot be obtained. [Section 330(k)(3)(B) of the PHS Act]</td>
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<td>collaborations with other health care and service providers in order to facilitate access to care to farmworkers since they are often covering large regions or the entire state with limited resources.</td>
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**XII. FINANCIAL MANAGEMENT AND CONTROL POLICIES**
Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions and material weaknesses cited in the Audit Report. [Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21, and 74.26]

- Financial stability expectations need to be different from those of a free standing health center (i.e. revenue streams from state and private insurance)
- Voucher programs adhere to the Generally Accepted Accounting Principles and federal audit requirements.
- Voucher programs that do not have a 330e component are primarily utilizing BPHC funds to support the provision of services to a highly uninsured and low income population of farmworkers (See Section vii).

**XIII. BILLING AND COLLECTIONS**
Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. [Section 330(k)(3)(F) and (G) of the PHS Act]

"At no time should the patient’s ability or inability to pay be a barrier to the provision of care" (p.13, PIN 94-7)

- Enabling services are not billable
- Reimbursement for services may be minimal or non-existent (i.e. majority of farmworkers are below 100% of the FPL)
- When determining eligibility VPs also determine possibility of third party reimbursement for both public and private insurance.
- Collection of copays and nominal fees help to cover costs of providing care.

**XIV. BUDGET**
Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. [Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25]

- The cost of mileage and transportation services is often much higher than a 330e because the enabling and medical staff are either bringing care to farmworkers
- Voucher programs often leverage care by utilizing low reimbursement rates (i.e. Medicaid rates), keeping administrative costs down and prioritizing enabling services.
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<td>or active in transporting the patients to the evening clinic or other clinic arrangement • Financial performance measures for health centers may not be feasible to accomplish for voucher programs</td>
<td>• Meaningful Use requirements (i.e. funding for purchasing EHR) for VP is a major challenge • Service coordination voucher models need funding to purchase a good service coordination or population management program rather than an EHR</td>
<td>• All voucher programs utilize a data system to organize data and submit reports. Numerous voucher programs utilize FHASES. FHASES (Family Health Administration System Electronic Services) is a secure web-based application that provides centralized data and report management. FHASES supports medical, dental, mental health, case management, and health education encounters. FHASES is certified as a complete EHR.</td>
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XV. PROGRAM DATA REPORTING SYSTEMS
Health center has systems which accurately collect and organize data for program reporting and which support management decision making. [Section 330(k)(3)(ii) of the PHS Act]

XVI. SCOPE OF PROJECT
Health center maintains its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards. (45 CFR Part 74.25)

• Difficult to maintain up-to-date scope due to numerous changes in service locations every year (contractual agreements may vary widely year-to-year) • Farmworkers’ mobility determines location of sites • Difficult to define service sites that are not standard health centers

• Many voucher programs work with numerous providers throughout their state through contractual agreements. These contractual arrangements may change from year to year depending on where there are gaps in care for farmworkers in the state. The challenge that occurs for voucher programs when completing or maintaining the scope of project can be 1) maintaining an up-to-date scope because of numerous changes in service locations annually and 2) appropriately defining service sites that are technically neither “screening” sites nor full blown operating health centers.

• The administrative office may or may not be located in an area of high need but the service
area represents areas where there are significant numbers of migrant and seasonal farmworkers. Several voucher programs scope of service areas are comprised of multiple counties (2-8) or even statewide and transportation to the clinics are provided as needed or mobile medical clinics are used to meet the needs of the population.

- Voucher programs are often filling the gap in services for states where there is a high number of migrant and seasonal farmworkers. Arrangements are usually made to establish full-time or temporary sites to meet the high demand for services during the agricultural season. The issue of overlap is an important one to explore because it is possible that the voucher programs could be instrumental in assisting migrant health centers with meeting increased demands during the peak season. For example, there may be 400 blueberry workers who come into an area for 4 weeks. While a single health center may have difficulty reaching and serving this population in such a short period of time, a voucher program could assist with identifying, screening and treating patients onsite as well as referring patients with additional needs to the migrant health center.

### Section IV: Governance

**XVII. BOARD AUTHORITY**

Health center governing board maintains appropriate authority to oversee the operations of the center, including:

- Holding monthly meetings;
- Approval of the health center grant application and budget;
- Voucher programs may seek approval to utilize advisory councils

- The Governing Boards of voucher programs have appropriate authority to oversee the operations of the health center unless they have been approved to have an Advisory Board where the board would then endorse as opposed to approve operation activities.
**PHS Section 330 Program Requirements and Migrant Health Voucher Program Expectations**

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<td>Selection/dismissal and performance evaluation of the health center CEO;</td>
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<td>Selection of services to be provided and the health center hours of operations;</td>
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<tr>
<td>Measuring and evaluating the organization’s progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization’s mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and</td>
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<td>Establishment of general policies for the health center. [Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304]</td>
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<td>Note: In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center. [Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv)]</td>
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**XVIII. BOARD COMPOSITION**

Health center governing board is composed of individuals, a majority of whom are being served by the center and, who as a group represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically:
- Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization,*
- The remaining non-consumer members of the board shall be representative of the community in which the center’s service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and

<p>| | Voucher programs may see a waiver to have a board that is not made up of 51% users as long as they have mechanisms to incorporate patient feedback into the program | Difficult to recruit farmworker board members due to the mobility of the FW population, seasonality of agricultural work, as well as language and transportation barriers. | Several voucher programs request a waiver for this requirement. Alternative mechanisms to engage farmworkers and seek meaningful feedback include: focus groups, surveys, town hall meetings, etc. |
| | | | Non-consumer board members are often connected to FW communities or issues (i.e. representatives from legal services, clinicians who have past experience of caring for FWS, etc. |</p>
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<td>other commercial and industrial concerns, or social service agencies within the community.*</td>
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<td>• No more than half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.*</td>
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<td>Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). [Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304]</td>
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<tr>
<td>XIX. CONFLICT OF INTEREST POLICY</td>
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<td>Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center employee. The Chief Executive may serve only as a non-voting ex-officio member of the board.* [45 CFR Part 74.42 and 42 CFR Part 51c.304[b]]</td>
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<tr>
<td>• Voucher program bylaws or as approved policies include provisions that prohibit conflict by board members, employees, consultants and those who furnish goods or services to the health center.</td>
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REQUEST FOR ASSISTANCE

Migrant Health Voucher Programs would like to request the formation of a work group to work closely with the Bureau of Primary Health Care assigned staff to examine program expectations and requirements that pose significant challenges to voucher programs to facilitate further exploration of the unique challenges and ways in which the Bureau could support voucher programs in order to ensure that all programs are in compliance. It would be helpful if the first topic could on scope of services, so that voucher programs can be consistent on how VPs define their sites.

Consider assigning 1-2 project officers for voucher programs that are well-versed in farmworker health, the special population programs and how the voucher model(s) are operationalized.

Consider assigning a policy representative from HRSA who can become an "expert" in voucher programs so that they can have the role of assessing the need for exceptions to PALs, PINs, funding opportunities and other HRSA program expectations. For example, there is a need for consistency with how voucher programs define their Scope of Project. It would be helpful 1) having a dedicated person who could give clear, consistent guidance on this and 2) allowing VPs to update their Scopes of Project accordingly through a quick process so that they can all have Scopes that reflect the actual types of sites and services that they provide.

Consider having Migrant Clinicians Network continue to work closely with voucher programs so that they can assist them with meeting the clinical expectations of HRSA appropriately and with relevant examples or references.

Consider continuing the support of the National Center for Farmworker Health to assist with facilitating the coordination of the voucher programs so that peer learning continues through the sharing of best practices for the provision of care and for meeting the HRSA expectations.