National Advisory Council on Migrant Health

January 10, 2020

The Honorable Secretary Azar, J.D.
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar:

Established over 44 years ago, The National Advisory Council on Migrant Health (NACMH, hereby referred to as "The Council") continues to advise, consult with, and make recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS), The Honorable Alex Azar, and to the Administrator of the Health Resources and Services Administration (HRSA), Mr. Thomas Engels. The Council is honored to fulfill this charge twice per year by reviewing the health care concerns of migrant and seasonal agricultural workers (MSAW), as well as the organization, operation, selection, and funding of migrant health centers (MHC) and other entities assisted under section 330(g) of the Public Health Service Act as amended, 42 USC 254(b), with the goal of improving health services and conditions for MSAWs and their families.

Before providing the summary of our recommendations below, ***The Council would like to begin our letter by sincerely thanking the Administrator of HRSA, Mr. Thomas Engels,*** for taking the time to provide opening remarks at our meeting. Mr. Engels reiterated HHS and HRSA priorities, as well as addressed our direct questions. It was an honor to have Mr. Engels attend our meeting. He set the tone by turning our attention toward HRSA's goals, and we are especially grateful that he took extra time to discuss these priorities with us.

In the sections below, please find The Council's review and recommendations toward improving services for MSAWs and their families.

Overview
The Council's most recent meeting was held in Rockville, Maryland on November 6–7, 2019 at the newly renovated HRSA headquarters building. During the two-day event, we received updates regarding the health of patients served by health centers, as well as the types of services provided. Additionally, the Council heard presentations from:

- HRSA leadership
- Joseph Gallegos, Senior Vice President for Western Operations, National Association of Community Health Centers (NACHC): **NACHC Update**;
- Rebecca Young, MA, Senior Project Director-Community Engagement, and Iris Figueroa, JD, Staff Attorney of Farmworker Justice on: **Violence in the Field**;
- Cheryl Seymour, MD, Medical Director of Maine Migrant Health Program, Augusta, ME on **Structural Differential Considerations in Migrant and Seasonal Agricultural Worker Health Care**;

In addition, a panel presentation and discussion on the Demographic Profile of United States Farmworkers as well as Housing Options and Concerns was presented by:

- Susan Gabbard, PhD of JBS International and Daniel Carroll, Employment and Training Administration, Office of Policy Development and Research, U.S. Department of Labor (DOL) on **Overview of the National Agricultural Workers Survey**; and
- Jennifer Lee, Senior Analyst, Division of Immigration and Farm Labor, Office of Policy, Wage and Hour Division, DOL on **Agricultural Worker Protections in Law, H-2A Program and Housing;** and
- Ed Franchi, Director, Agricultural Worker Program, Keystone Rural Health Center, Chambersburg, PA on **Health Center Perspectives.**

In accordance with The Council's charge under section 330(g) of the Public Health Service Act as amended, 42 USC 254(b), and emphasizing the goal of improving health services and conditions for MSAWs and their families, we submit the following recommendations for your consideration.

Recommendations

In this letter, The Council will emphasize one main objective – to increase the number of MSAWs served to 2 million. To achieve this, we present an overarching recommendation for a ***"Healthy Farmworker 2030"*** initiative along with a set of related goals that align with HRSA objectives to improve the state of health of MSAWs and their families over the next 10 years. As the Secretary and Administrator are aware, the National Healthy People initiative is developed each decade with a new set of science-based, 10-year objectives with the goal of improving the health of those living within the United States.[i] Although National Healthy People 2030 objectives outline priorities and needs of the overall American population, the highly unique nature of MSAW lives and lifestyles require a corresponding and unique set of health priorities and objectives that can be addressed over time. To address this, we provide three main recommendations for the "Healthy Farmworker 2030" initiative.

<u>Healthy Farmworker 2030</u>

Recommendation I

The *"*Ag Worker Access Campaign" is a national initiative to **increase access** to quality healthcare for America's agricultural workers and their families.[ii] The primary aim of the Ag Worker Access Campaign emphasizes collective commitments to a longstanding goal of serving at least 2 million farmworkers through the Health Center Program (HCP). In support of this important goal, our recommendations request that HRSA and the Bureau of Primary Health Care (BPHC) provide the

procedural and administrative supports necessary to reach a population of 2 million MSAWs served by health centers. To do this, we recommend that:

1. The operational site visit (OSV) process establish a protocol of accountability that requires health centers to meet their declared target of MSAWs served, along with both monetary incentives and penalties for met and unmet goals, respectively.
2. Value Based Care (VBC) and Quality of Service (QS) indicators are routinely evaluated to confirm and ensure that proportions of funding established for the use of clinics to serve MSAWs is, indeed, used to reach/serve MSAWs and their families.

Background for Recommendation I

The Health Center Program (HCP) is a vital part of our healthcare system, providing access to over 28 million patients in underserved areas.[iii] Health centers serve close to a million MSAW patients annually. However, there is an estimated population of over 2.5 - 3 million MSAWs in the United States.[iv] The HCP served approximately 972,251 MSAWs in 2017,[v] and 995,232 MSAWs in 2018.[vi] This represents a 2.36 percent increase of 22,981 agricultural workers and their families from 2017.

The Problem: In 2017, it was targeted that health centers would increase the number of MSAW workers and family members served by 15 percent each year over the next five years. Unfortunately, health centers continue to fall short of this important goal. Moreover, the Ag Worker Access Campaign's primary objective was to reach the longstanding goal of serving at least 2 million farmworkers through health centers by the year 2020.

The Council believes that adjusting OSV and VBC protocols around funding could assist in meeting these important goals. The Council thus recommends that, when conducting OSVs, BPHC require health centers to be held accountable to the MSAW funding that they receive. Specifically, we recommend that additional screening questions address how each migrant health center is conducting outreach, how the nominal fee is implemented from their perspective, and how the health center is addressing transportation needs – a key area of concern that inhibits health center access. It is imperative that the BPHC holds MHCs accountable to the funding they receive for providing care to this vulnerable population by including language in the OSV and VBC protocols that addresses how MSAWs are being served through effective outreach efforts and that the monetary allocation of MHC funding is appropriate for the number of MSAWs they are serving.

Additionally, the board of directors should hold the health center management responsible for carrying out the purpose of the MHC, to include providing care that meets MSAWs unique needs inclusive of effective outreach, transportation, and a nominal fee from the patient's perspective.

The Explanation: Both public and private payers have begun focusing on novel payment and care-delivery models to promote value-based, high-quality, and affordable care. The goal of these alternative payment models are to achieve better outcomes at a lower cost through performance-based payment models that promote patient-centered, population-based, high-quality, coordinated, accessible, and effective care.[vii] The Council believes that, in light of the growing emphasis on quality reporting, it is important to understand factors influencing the capacity and readiness of health centers to participate in quality reporting. For example, a patient target is the sum of patient projections from awarded health

care program applications for operational funding. HRSA uses the patient target to ensure that Service Area Competition (SAC) applicants are aware of the number of patients expected to be served in each announced service area. [viii]

The Council recommends changes to OSV and VBC protocols to promote advances in payment models that allow health centers to better achieve its patient target goals. We specifically point to the current Site Visit Protocol (SVP), updated August 2019, which includes no questions on how MSAW populations are serviced; furthermore, the word "migrant" is only mentioned twice in the SVP and is not in reference to how MSAWs are serviced, but addresses the service site (i.e., migrant camp). Further, details available at the SAC Technical Assistance website, indicate that the patient target is used to assess health center progress toward serving the number of patients for which funding was awarded (Service Area Announcement Table (SAAT)). Thus, MHCs must be held accountable to the patient targets they set for funding. Moreover, the funding allocation for CHC versus MHC is within the total patient target and does not constitute specifically how many MSAWs a MHC grantee has to serve, and this must be defined.[ix]

Opportunities and Impact: Achieving the goals of increasing the population of MSAWs served at health centers, as well as strengthening the financial sustainability of serving the MSAW population will require new models of paying for health services and technologies that deliver better value for money. Thus, we also encourage the use of balanced incentives and penalties that provide new and fair models that will depend on encouraging delivery of reaching the target MSAW population as a measure of value. HRSA and BPHC are large investors in the public health safety net system. According to Uniform Data Set (UDS) data, grants from the BPHC represented a mean of 27 percent of total income for the CHCs in our sample; Medicaid paid for 48 percent patients overall in 2018.[x] Thus, BPHC and HRSA have an invested stake in the targets of MSAWs served, when funding is provided for that specific purpose.

There are several points that would help confirm the impact of the Healthy Farmworker 2030 Initiative. Moreover, in the light of the discussions to seek pathways for serving additional MSAWs. The Council urges the BPHC to pursue the following opportunities and information:

1. To assess the collective impact of enabling services funding through the annual Uniform Data System (UDS) reporting HRSA's Program Assistance Letter (PAL) - Proposed UDS Changes for Calendar Year 2020[xi] - provides an overview of changes to HRSA's 2020 UDS, to be reported by HCP awardees and look-alikes in February 2021. The PAL addresses standardized assessment(s) to collect information on the social determinants of health (SDOH) or social risk access to quality, culturally competent comprehensive primary health care services for MSAWs and their families. Resources such as PRAPARE, iHELP, and WellRx; and number of patients that screened positive for lack of transportation and access to public transportation, housing, food insecurity, and financial strain can be used to inform and reinforce requirements to adhere to MSAW patient targets.

2. In September 2019, the Office of Quality Improvement's Data and Evaluation Division published an article in the Health Affairs Journal titled Enabling Services Improve Access To Care, Preventive Services, and Satisfaction Among Health Center Patients. The results confirm the value of systematic delivery of enabling services in reducing access barriers and improving satisfaction among health center patients. Additionally, The Agricultural Connection

Community[xii] provides a collection of workforce information and technical assistance resources that support career services and training for MSAWs. This venue can be used to post information about local health centers. Finally, the DOL State Monitor Advocate network is willing to disseminate the information on health centers and the availability of health care. The Council urges BPHC to pursue these relationships to provide local health center information.

Recommendation II

In order to reach the goal of **improving services** to MSAWs, with the overall objective of reaching the target of 2 million MSAWs served, it will be critical for HRSA to establish a series of protocols designed to project its future needs. For example, for years, the data collected through the National Agricultural Workers Survey (NAWS) has been critical to the design of programs and services that best meet the needs of the general farmworker population. Thus, we ask HRSA to continue its commitment to support and strengthen the NAWS. While the current NAWS data provides important insights into the demographic conditions of the crop workers in America, it does not include H-2A workers and others who work in areas that meet the definition of agriculture in all its branches, as defined by the Office of Management and Budget developed North American Industry Classification System (NAICS). Thus, The Council recommends:

1. Health centers establish partnerships with industry, growers and labor contractors in their service area to determine how the labor force is changing, as well as how health centers can best access potential patients during their contracted period. Included in the discussion should be a clear understanding of how workers will be properly transported to the respective health centers.
2. As the numbers of H2A workers increase, HRSA collaboration with governmental agencies such as the DOL to establish a registry to identify their locations would be critical to addressing their health care needs.
3. HRSA remain abreast of population demographic shifts, including a shift from single males to single females, to prioritize future health care needs for health centers and the populations they serve.
4. HRSA partner with the DOL in order to expand the coverage of the farmworker survey to include H-2A workers, those that meet the definition of NAICS agriculture in all its branches, and the families of these groups in order for NAWS to better complement HRSA data on healthcare visits by providing reliable data on farmworkers available to compare health center patients to the larger population, to enable decisions about care provision.
5. Establishment of a working group to develop, merge and analyze existing data. We specifically recommend that HRSA partner with other agencies to collate and/or expand data collection related to MSAWs with the aim of informing and monitoring health interventions at the federal level. The development of a cross-agency collaboration could produce a framework that includes "common rule" updates to facilitate secondary use of data for research, common Data Use and Reciprocal Support Agreements, common enforced technical functionalities and specifications based on standard application programming interfaces (APIs), and data portability from Health Insurance Portability and Accountability Act (HIPAA)-covered entities.

Background for Recommendation II:

Since the NAWS survey started in 1989, the demographics of the farmworkers have shifted. Recent findings suggest that there are fewer U.S.-based migratory workers today, which has declined from 49 percent in 2000 to just 19 percent in 2016. Moreover, the average MSAW age has increased from 31 years to 38 years over this same period.[xiii] Finally, there are more women working in the fields, and more than 50 percent of the agricultural workers surveyed are parents.[xiv] In addition to the changing social demographics, the number of H2-A visa crop and livestock workers have more than doubled, showing a significant increase from 89,000 to over 196,000 workers of those surveyed.[xv]

The Problem: NAWS is an employment-based, random sample survey of U.S. crop workers. Currently, its sampling design does not include persons employed at eligible establishments who do not perform crop-related work, such as livestock and dairy workers, unless such workers also perform crop-related work. Moreover, the NAWS excludes crop workers with an H-2A visa (a temporary-employment visa for foreign agricultural workers). Finally, any report from the NAWS also excludes the family members of the above groups.

The Explanation: The accurate and comprehensive collection of MSAW data is critical when designing programs and services for this isolated population, so it is imperative that the surveying of workers in the H-2A program be included in the NAWS survey. The H-2A program allows U.S. employers or U.S. agents who meet specific regulatory requirements to bring foreign nationals to the United States to fill temporary agricultural jobs. The crop worker population has changed becoming older and more female. Moreover, the national crop worker patients of health centers include higher numbers of older, sicker and uninsured patients compared to other providers.

Opportunities and Impact: Efforts are underway to support a wider adoption of The National Migrant and Seasonal Head Start Collaboration Office Effective Partnerships Guide. Efforts include making the guide available through the Primary Health Care Digest. This resource should be used to assist in growing partnerships.

Additionally, the primary purpose of the NAWS survey is to monitor the terms and conditions of agricultural employment and assess the conditions of hired workers who are currently employed in crop and crop-related work. The survey also generates information for various Federal agencies that oversee farmworker programs. To be interviewed, workers must be hired by an eligible establishment and working at an eligible task. Eligible establishments are those classified in the NAICS as Crop Production (NAICS code 111) or as Support Activities for Crop Production (NAICS code 1151).

In order to carry out this sampling protocol, the NAWS field interview personnel travel to farms without knowing the proportion of individuals who will not be eligible to survey (H-2A, livestock, etc.). This increases costs of implementing the survey. In order to decrease costs, and expand the information available to health centers, we encourage the expansion of eligibility of the NAWS survey population.

HRSA currently supports the DOL with some funding for the NAWS. However, the data obtained is insufficient to estimate the total number of MSAWs who are eligible for HRSA HCP care. This is a result of the definitional differences of a MSAW between the HRSA and DOL, the eligible HCP MSAW population is larger than the population counted as farmworkers by the DOL. The Public Health Service

(PHS) Act recognizes individuals and families for whom migrant labor is their principal, although potentially not their only, form of labor. It also includes workers who perform both crop and other types of farm labor duties (e.g., livestock) within a 24-month period, allowing for transitional health care despite the seasonality of agricultural labor. This differs from the more narrowly defined DOL/NAWS definitions where a migrant farmworker is "a person who reported jobs that were at least 75 miles apart or who reported moving more than 75 miles to obtain a farm job during a 12-month period." The NAWS is not a population-based census survey, and as stated earlier it does not sample persons with an H-2A visa, farmworkers who have worked outside of agriculture for more than one year and persons who do not perform crop-related work.

Information provided to guest workers by the H-2A program (DOL) should include the eligibility process for health insurance through the marketplace as well as eligibility for financial assistance and cost-sharing reductions that can lower the cost of health insurance. HRSA published "A Guide for Rural Health Care Collaboration and Coordination."[xvi] This resource discusses how rural providers can work together to identify health needs in their communities, create partnerships to address those needs, and develop a "community minded" approach to health care. The guide includes case studies illustrating how providers in two communities created networks and partnerships to improve the efficiency of care, optimize resources, and improve the lives of their residents. Such a resource should be used widely to connect with industry leaders, including growers, in a partnership to reach farmworkers and allow them access during work hours.

Recommendation III

The Council would like to draw special attention to health disparities and poor health outcomes that are the direct result of structural variables and violations in human rights. Unfortunately, the low wages, sexual harassment and abuse that many workers in general are exposed to are some of the human rights violations that agricultural workers also face. The Council sees these not only as violations of human rights, but also recognizes the structural systems in place such as policies, economic systems as well as other institutions that contribute to the social and health inequities within MSAW communities. To remedy this, The Council recommends that:

1. The Department of Health and Human Services consider initiating conversations across departments to address structural interventions that would promote MSAW health. For example with the Departments of Labor, Agriculture, Justice, Education.
2. HRSA, at the HCP level, raise awareness of the high prevalence of sexual harassment and other human rights violations in agriculture by increasing health center capacity to better identify victims. This may include:
    - Training staff (front office and clinical) to appropriately screen, identify and refer people who are or have been harassed.
    - Equipping staff and providers with appropriate resources and tools, such as "Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care."[xvii]
    - Establish collaborations with federal and non-federal partners engaged in anti-harassment efforts to increase capacity of all agencies/organizations to better serve MSAWs and ensure consistent access to health and enabling services by collaborating with local workforce

programs, Migrant Head Start and Migrant Education to cross train staff in screening, identification and referral for victims.

- Explore methods of leveraging existing data sets or tailoring of future data collection to better characterize the relationship between the unmet social needs of MSAW and health outcomes. We specifically recommend that HRSA:
  - Consider aggregating PRAPARE survey data at a national level for MSAW patients as means to track and assess its commitment to health equity.
  - Identify regional or state-based policy differences or interventions and develop methods of monitoring changes in health outcomes that may correlate with these interventions.
  - Consider the unique characteristics of MSAWs when engaged in broader conversations about data collection and return on investment for interventions in the social determinants of health.

Background for Recommendation III:

Paul Farmer defines structural violence as social arrangements that systematically bring subordinated and disadvantaged groups into harm's way and put them at risk for various forms of suffering.[xviii]

The Problem: Researchers committed to advancing social justice have sought to "resocialize" suffering by tracing its origins to political-economic processes, social structures, and cultural ideologies. Farmworkers in the United States are one population that systematically endure conditions of structural violence, including deplorable wages and endemic poverty, forms of stigma and racism, occupational health and safety hazards, poor health and limited access to health care services.[xix, xx] Thus, a tradition of legal exceptionalism has historically regarded farm labor as distinct from other kinds of work.

The Explanation: The average income of the nearly two million farm workers in the United States is between $10,000 and $12,499. Farmworkers also face numerous obstacles to receiving health care including lack of transportation, lack of paid sick leave, risk of job loss if they miss work, and human trafficking.

Low wages, harsh working conditions, and a lack of legal protection, combined with an ever increasing demand for cheap labor, have resulted in growing numbers of forced labor abuses.[xxi] Trafficking in persons, or human trafficking, is often confused with human smuggling. Human smuggling involves the willing transport of one person by another between locations or across international borders, whereas trafficking in persons involves the involuntary movement and/or sale and exploitation of a person against their will.[xxii] Human smuggling is considered a "crime against the state," whereas human trafficking is considered a "crime against the person."

> *"The trauma caused by the traffickers can be so great that many people may not identify themselves as victims or ask for help, even in highly public settings." (Department of Homeland Security[xxiii])*

Opportunities and Impact: There is a growing recognition that the root cause of health disparities are structural in nature, i.e. policies, systems and institutions that create or maintain inequity in the SDOH. While there is a continued need for funding and other technical support of services that address the non-

medical social needs of patients (e.g., enabling services), ultimately direct attention to the structural drivers of the SDOH is required in order to close the gap in health equity.

Attention to structural forces is especially important to address the health disparities seen in the MSAW community. It has been well documented in population surveys and direct testimony from farmworkers, MHCs and other stake-holders, that MSAWs frequently lack adequate and safe housing, independent transportation, available healthy food and knowledge of or access to support in addressing workplace health concerns.

Our recommendation is to support MSAWs through policy-based assistance and prevention programs by providing incentives to the community health centers that have such programs in place. Much of the SDOH screening and innovation to date is focused at the level of individual community health centers, which helpfully facilitates partnerships and interventions at local and regional levels. Thus, interventions to address the SDOH in the MSAW community need to be prioritized at the national or federal level. As with regional and local interventions, the needs assessment, planning, execution and assessment of any intervention will require multi-disciplinary, cross-sector collaboration. This type of planning and intervention could align with the proposed ***Healthy Farmworker 2030*** initiative as well as the ***Healthy People 2030 Goals*** including:

- Eliminating health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Creating social, physical, and economic environments that promote attaining full potential for health and well-being for all.
- Engaging leadership, key constituents, farmworkers and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

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

Sincerely,

/Daniel Jaime/

Chair, National Advisory Council on Migrant Health

cc:
Thomas Engels
James Macrae, MA, MPP
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Esther Paul, MBBS, MA, MPH

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