

# U.S. Department of Health and Human Services National Advisory Council on Migrant Health (NACMH)

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**May 25-28, 2021  
Virtual Meeting**

## **Meeting Minutes**

### **Council Members in Attendance**

Sharon Brown-Singleton (Chair)  
Shedra Amy Snipes (Vice-Chair)  
J. Angel Calderon  
Angelina Vallejo Cormier  
Donalda Dodson  
Dani Higgins  
Carmen Veguilla-Montañez  
Jonathan Raber  
Deborah Salazar  
Jose Salinas

### **Federal Staff in Attendance**

Strategic Initiatives and Planning Division (SIPD), Office of Policy and Program Development (OPPD), Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS):

- Esther Paul, MBBS, MA, MPH, Designated Federal Official, NACMH

### **Tuesday, May 25, 2021**

#### **Call to Order/Introductions**

*Esther Paul, MBBS, MA, MPH, Designated Federal Official, NACMH*

Ms. Paul welcomed and thanked Council members for their service and stewardship, noting that some members had suffered serious personal loss since the last meeting. She extended a welcome to the agricultural workers who would provide testimonies on the second day of the meeting, and she thanked the speakers for their generosity in sharing their expertise.

Ms. Paul welcomed officials in attendance from the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMSHA), the Office of Health Equity, and the Federal Office of Rural Health Policy at HRSA, and the New York State Department of Health. She thanked the BPHC Office of Quality Improvement for their role in implementing the Council's recommendations, and she expressed her gratitude to leadership and colleagues at OPPD.

Ms. Paul stated that over the next four days, the Council would listen, share personal experiences, and lean on data and science to make evidence-based recommendations on behalf of the nation's farmworkers. She noted that farmworkers had suffered disproportionately to put food on our tables during the pandemic, which unveiled and multiplied long-standing health disparities that are the result

of historical structural inequities. The Council's task would be to consider how lessons learned during the pandemic can be used to create lasting improvements.

Ms. Paul called the meeting to order with words from Senator Robert Kennedy: "Each time a man stands up for an idea or acts to improve the lot of others, he sends forth a tiny ripple of hope, and crossing each other from a million different centers of energy those ripples build a strong current."

### **NACMH Chair Opening Remarks**

*Sharon Brown-Singleton, MSM, LPN, Chair, NACMH*

Ms. Brown-Singleton welcomed Council members, guests, speakers, and HRSA staff. She thanked Ms. Dodson for her continued engagement despite her personal loss and offered sincere condolences on behalf of the Council.

Ms. Brown-Singleton thanked Ms. Paul for convening an excellent group of presenters on topics of structural inequities, unique challenges of indigenous migrant and seasonal agricultural workers (MSAWs), social determinants of health (SDOH), national updates, and the opportunity to engage with farmworkers from Oregon during the testimony session.

Ms. Brown-Singleton invited Council members to share one positive thing that had happened since the previous meeting. Council members expressed gratitude for the availability of vaccines, new relationships between community organizations that support farmworkers, resilience of staff members, and community support for vaccination and testing efforts.

Ms. Brown-Singleton reviewed the agenda for the meeting and called for a motion to approve it as presented. The motion was made by Mr. Salinas, seconded by Ms. Cormier, and carried by unanimous voice vote.

Ms. Brown-Singleton called for a motion to approve the minutes of the October 2020 meeting. The motion was made by Mr. Salinas, seconded by Ms. Dodson, and carried by unanimous voice vote.

### **Structural Inequities Fueling Health Disparities, Including the Disproportionate Impact of COVID-19 on Migrant and Seasonal Agricultural Workers**

*Seth M. Holmes, MD, PhD, Co-Chair, Berkeley Center for Social Medicine, Co-Director, MD/PhD Track in Medical Anthropology, and Associate Professor, University of California Berkeley*

Dr. Holmes introduced the concept of structural competency, provided examples related to COVID-19, and presented a broad set of recommendations for the Council's consideration. He stressed the need to understand health and health care in the context of social, political, and economic structures that produce injury, disease, and health inequities for different groups of people and the importance of confronting and responding to those structures.

Dr. Holmes presented a literature review of all articles published in English related to immigrant health.<sup>1</sup> Nearly 80 percent of the articles focused on the behavior of the immigrant or migrant as the cause of their health problems, and close to 15 percent focused on the person's culture. Only five percent of the articles focused on structural factors such as policies, discrimination, racism, the types of jobs people have, or living conditions. The authors argued that, given the epidemiologic data, those are the most important factors that produce sickness or health.

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<sup>1</sup> <https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-032013-182419>

Dr. Holmes defined social structures as the policies, economic systems, and other institutions (including judicial systems, schools, etc.) that have produced and maintain contemporary social inequities and health disparities, often along the lines of social categories such as race, class, gender, and sexuality.

Using the image of a racetrack to illustrate the difference between “equity” and “equality,” Dr. Holmes noted that “equality” implies that people start at the same place, forgetting that some people must run further to reach the end because they encounter barriers. The term “equity” acknowledges that reality.

“Structural competency” is a new framework developed by health professionals, social scientists, and patients over the past decade to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures. A 2014 article by Jonathan Metzl and Helena Hansen in *Social Science & Medicine* argued that shifting from focusing on the individual encounter to include institutions, policies, and other structural factors can help clinicians and clinical systems impact health inequalities.<sup>2</sup> An article by Dr. Metzl and legal scholar Dorothy Roberts in the *AMA Journal of Ethics* discussed how structural competency can be used to confront structural racism within medicine and how health-related factors previously attributed to culture or ethnicity also represent downstream consequences of larger structural contexts.<sup>3</sup>

Research by the Structural Competency Working Group found that structural competency training shifted health professionals’ understanding of factors that produce disease and health and increased their empathy and solidarity with patients.<sup>4</sup> Dr. Holmes suggested that increased empathy might also counteract some of the burnout that clinicians have been experiencing.

Dr. Holmes outlined the key components of structural competency:

1. Recognizing the influences of social, economic, and political structures on health
2. Recognizing the influences of structures on the possibility of good health care
3. Responding to the influences of structures in health care
4. Responding to the influences of structures beyond health care
5. Structural humility (listening to and learning from patients and communities).

The traditional model of the social determinants of health focuses on the impact of poverty and inequality on poor health outcomes. Structural competency focuses on the policies, economic systems, and forms of discrimination, such as racism, that lead to poverty and inequality.

Dr. Holmes outlined two important concepts within structural competency:

- Structural violence looks at social arrangements that put individuals and populations in harm’s way, such as location and socio-economic hierarchies. These arrangements are structural because they are embedded in the political and economic organization of the social world, and they are violent because they cause injury to people (Paul Farmer, et al, 2006).
- Structural vulnerability is the risk that an individual experiences due to structural violence. It shifts the focus from seeing an individual or community as vulnerable to looking at how social inequalities make some people more vulnerable.

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<sup>2</sup> <https://www.sciencedirect.com/science/article/pii/S0277953613003778?via%3Dihub>

<sup>3</sup> <https://journalofethics.ama-assn.org/article/structural-competency-meets-structural-racism-race-politics-and-structure-medical-knowledge/2014-09>

<sup>4</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5377882/>

Structural vulnerability is not caused by, nor can it be repaired by, individual agency or behaviors. Public health and medicine must focus on changing the context to be more just so that all populations, including MSAWs, can thrive and be healthy.

Dr. Holmes presented a Structural Violence Assessment Tool that he and others developed to determine the impact of structural factors in eight domains: financial security, residence, risk environments, food access, social network, legal status, education, and discrimination.<sup>5</sup>

Dr. Holmes presented a case study of an emergency room (ER) patient who was found on the street intoxicated. The standard medical history and default provider interpretation would attribute the problem to a history of heavy drinking. A structural competency approach would look at factors contributing to that behavior, including systemic marginalization and violence against indigenous communities in Mexico, trade policy that impacts local farming economies, racialized low-wage labor markets, immigration policy, health insurance policy, and local policies that contribute to high rents and displacement of low-income individuals.

A structurally competent approach to migrant health would focus health care, research, interventions, policies, and programs on the structures that affect the health of MSAWs. Adopting this approach would address the fundamental causes of health and illness and would avoid blaming patients or communities.

Dr. Holmes stressed that research is one of the structures that impact migrant health. The questions we ask determine the knowledge we produce, which determines what practitioners do. A disproportionate amount of research funded by the National Institutes of Health (NIH) is focused on genetics. Dr. Holmes encouraged the Council to recommend that NIH and other agencies fund research on social structures, economic structures, and policies that affect the health of MSAWs.

Dr. Holmes described research he conducted on structural factors related to farmworker health and COVID-19, including the impact of immigration raids on public health during the pandemic and the lack of personal protective equipment (PPE) or adequate housing for those whose work was deemed essential. His work in Florida with Partners in Health and Doctors Without Borders revealed inequities in living and working conditions, testing and contact tracing, and resources for isolation as well as ongoing inequities in care for indigenous MSAWs.

Dr. Holmes highlighted effective community responses in Florida, including a poster made by the Coalition of Immokalee Workers to promote the use of masks, multilingual community education for indigenous MSAWs, making and distributing PPE, and the use of Community Health Workers (CHWs). He also described a collaboration between the Coalition of Immokalee Workers, Partners in Health, and Migrant Clinicians Network to provide mobile follow-up services for migrating workers.

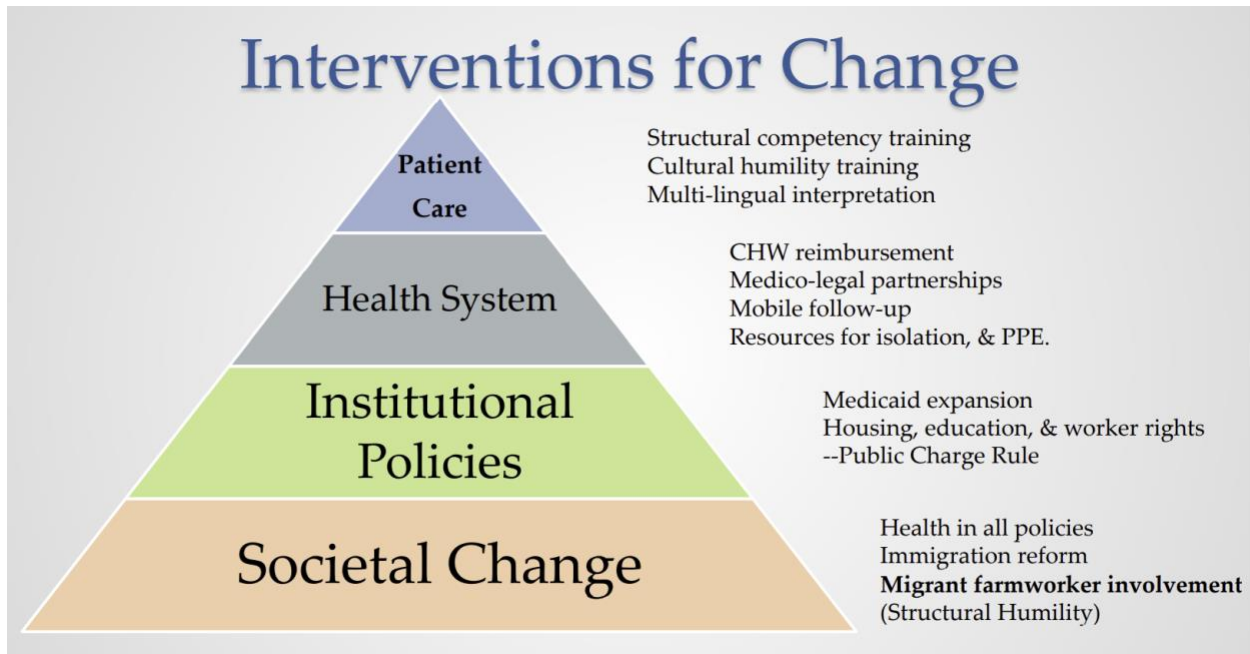
Dr. Holmes presented four recommendations to address structural inequities for farmworkers:

- Strengthen the health system for farmworkers, including respectful services and multi-lingual interpretation.
- Strengthen social, economic, labor, housing, and immigration policies that impact farmworkers.
- Determine which partners are needed.
- Ensure that farmworkers' voices are prioritized.

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<sup>5</sup>[https://journals.lww.com/academicmedicine/Fulltext/2017/03000/Structural\\_Vulnerability\\_Operationalizing\\_the.18.aspx](https://journals.lww.com/academicmedicine/Fulltext/2017/03000/Structural_Vulnerability_Operationalizing_the.18.aspx)

Dr. Holmes presented a graphic illustration of interventions for change at the societal, institutional, health system, and patient care levels.



Dr. Holmes closed by presenting a list of resources on social structures and healthcare, social structures and migrant health, structural vulnerability and migrant health, and structural competency.

### Discussion

Mr. Calderon asked how community health centers (CHCs) and migrant health centers (MHCs) impact structural competency.

- Dr. Holmes replied that CHCs and MHCs can address structural competency in a number of ways, such as paying CHWs; providing emergency funding to help patients deal with issues that impact their health, such as electricity shut-offs or housing issues; working with other community organizations to avoid eviction or find housing; clinicians who treat MSAWs with respect and do not blame them for the structural barriers that confront them; and clinics that provide interpretation in numerous languages. The opposite of structural competency occurs when a clinician blames a farmworker for their pesticide poisoning. Dr. Holmes noted that structural competency training programs include an opportunity for participants to identify how their clinic or program ameliorates or intensifies the effects of the structural determinants of health at all levels.

Ms. Dodson noted that public health departments are beginning to look at upstream issues, and popular education emphasizes asking people rather than simply telling them. These trends provide an opportunity to emphasize structural issues.

- Dr. Holmes agreed that popular education has had a positive effect, such as considering MSAWs to be experts on their own bodies. He noted that “upstreamists” often stop short of identifying the structural forces that create inequalities. When a child comes into a clinic with an illness linked to lead poisoning, clinicians are now aware that homes in certain neighborhoods have lead paint. It is also important to focus on the ways that structural racism, anti-immigrant

prejudice, and policies such as redlining make it more likely that certain categories of people will live in those homes and be put at risk for lead poisoning.

Ms. Veguilla-Montañez noted that medical insurance is limited for vulnerable populations in Puerto Rico, especially farmworkers. She asked what Dr. Holmes would recommend.

- Dr. Holmes cited recent data showing that less than 10 percent of MSAWs have health insurance and MHCs reach less than 15 percent of the intended population. He offered three recommendations: include MSAWs in all medical insurance, provide funding for CHWs, and look at how health professionals are trained. He noted that many indigenous Mexican farmworkers in California will not go to MHCs in their communities because they experience discrimination and racism. Most of them go to a private clinic, where they have to pay more.

### **Indigenous Migrant and Seasonal Agricultural Workers in the U.S.: Their Vital Contributions and Unique Challenges**

*Sarait Martinez, EdD, Executive Director, Binational Center for the Development of Oaxacan Indigenous Communities (Centro Binacional para el Desarrollo Indígena Oaxaqueño, CBDIO)*

Dr. Martinez introduced herself as an indigenous Zapotec from the state of Oaxaca, Mexico, and the daughter of migrant workers. She noted that Mexico has 62 indigenous communities, and one-third of the population speaks a pre-colonial language. Oaxaca is one of the most diverse states, with 17 different ethnic groups.

Dr. Martinez noted that “indigenous” means native to a particular place. Colonization dispossessed indigenous peoples in Mexico of their historical identity and forced them to adopt a racial identity that put them at a disadvantage and discriminated against them. Many indigenous people may not speak Spanish or may speak Spanish as a second language. Conditions in their communities are harsh, and many do not have running water, education, clinics, or hospitals.

The recent migration to the U.S. includes indigenous communities from several states in Mexico and Central America. Discrimination follows them across the border. Indigenous migrants in the U.S. face greater disadvantages compared to the Mexican *mestizo* population due to lack of Spanish-speaking skills, harsher economic conditions in both Mexico and the U.S., and racism from Americans and other Mexicans.

CBDIO promotes the right to migrate, but they believe that migration should not be forced. While migration has always existed within Mexico, the migration of indigenous families to the U.S. began in the 1960s and 1970s with the Bracero Program. Massive migration began in the 1980s. In the early 1980s, most migrants were men who came for the season and returned home. The number of families increased after the passage of the Immigration Reform and Control Act (IRCA) of 1986.

Indigenous communities need to be counted. Many organizations do not know how many indigenous farmworkers they serve because their intake form does not identify them. When the only option on a form is “Latino/Hispanic,” indigenous people feel as if they do not exist.

CBDIO conducts strong campaigns to ensure that their community is counted in the Census. Although the 1990 Census registered only one Mixtec family in California, independent research conducted by the California Institute for Rural Studies in 1991 found that 50,000 indigenous migrants were working in the

fields of California. The Indigenous Farmworker Study conducted in 2008 and 2009 estimated that there were 120,000 indigenous farmworkers in California, plus 45,000 children.<sup>6</sup>

CBDIO participated in the COVID-19 Farmworker Study conducted by a coalition of researchers and community-based organizations (CBOs) in California, Oregon, and Washington in the summer of 2020.<sup>7</sup> The study found that California has about 800,000 farmworkers. Most have seasonal jobs, with an average annual income of \$18,000. Many migrate from coast to coast or within California. Ninety-six percent were born in Mexico, 57 percent are unauthorized to work in the U.S., and 37 percent have health insurance. Many indigenous farmworkers live in overcrowded housing due to the high cost of living; this exacerbated the impact of COVID-19 within their community.

The proportion of indigenous farmworkers among all Mexican farmworkers increased from less than 10 percent in 1991 to nearly 30 percent in 2008, while the proportion of Mestizo farmworkers decreased. This corresponds to the adoption of the NAFTA free trade agreement, which devastated the local economy and corn harvest in Oaxaca.

Indigenous migrants in the U.S. perform the most physically demanding and least rewarding jobs, including farm work and construction. They are exposed to pesticides and have long working hours. Their work sites have no toilets and no water for hand washing or drinking. They earn the minimum wage or less. A 1993 study found that Mixtec workers were more likely to accept jobs paying less than the minimum wage and more likely to be victims of non-payment and other violations of labor law.

The COVID-19 Farmworker study conducted 327 interviews with Zapotecs, Triquis, and Mixtecs in California. Fifty-two percent of the respondents reported a decrease in their work hours and a loss of income. Fifty-seven percent said they had a harder time paying for food during the pandemic. Fifty-nine percent said the cost and lack of insurance were barriers to accessing healthcare. Fifty-four percent said their worksites provided face coverings; labor contractors provided the fewest masks. Only three percent of indigenous-speaking workers reported that they received PPE training, compared to nearly 20 percent of non-indigenous speakers.

Indigenous speakers suffered disproportionately from COVID-19 due to conditions at work, poor experiences at health clinics, and the lack of information in indigenous languages. To address the lack of information, local and regional governments formed a partnership and launched the Language Justice campaign. The campaign contracted with CBOs to inform workers about the right to interpreters, create videos in indigenous languages, and advocate for language justice in clinics, hospitals, and other sectors.

Dr. Martinez noted that multiple indigenous languages are spoken in Oaxaca, including four that are common in California. When providing interpreters, it is not enough to know that someone is from Oaxaca or that they speak Mixteco, because the languages vary by region, district, and town. In addition, many languages in Oaxaca do not have a written form.

Dr. Martinez offered the following recommendations for providing services to indigenous farmworkers:

- Learn about local organizations that work with immigrant and indigenous populations.
- Establish mutually beneficial partnerships.
- Be flexible about the times you offer services.
- Be curious about the life/work context of the person you are helping.

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<sup>6</sup> [www.indigenousfarmworkers.org](http://www.indigenousfarmworkers.org)

<sup>7</sup> <http://covid19farmworkerstudy.org>

Dr. Martinez shared key recommendations from a recent paper on actualizing cultural humility for indigenous Mexican farmworkers:

- Develop workshop resources that are visual in nature and at primary education reading level.
- Work with translators from the community to account for linguistic and cultural nuances and ensure accurate translations.
- Ensure that materials do not perpetuate stereotypes.
- Format resources so workers can easily access and carry them in agricultural settings.<sup>8</sup>

Dr. Martinez closed by sharing recommendations from the COVID-19 Farmworker Study:

- Develop hotlines aligned with state and regional Departments of Health that are staffed by individuals from farmworker communities to support reporting of violations and streamline access to critical information.
- Pass single-payer universal health care that includes all workers, regardless of citizenship status.
- Contract and fund locally-based farmworker-serving CBOS, clinics, and agencies to manage emergency response work and to hire and train linguistically and culturally competent staff.
- Communicate consistent, culturally, and linguistically appropriate public health and safety messaging. For the sake of diversity, inclusion, and equity, consider the needs of non-English speakers and use more audio-based tools.
- Remove the exclusion of farmworkers from overtime pay, minimum wage, and other worker protections like collective bargaining.
- Support a complete, inclusive pathway to citizenship for all essential workers and their families so that documentation status is not a barrier to accessing social support.
- Dedicate funds for rapid, equitable distribution of vaccines that involve trusted farmworker-serving organizations.

## Discussion

Ms. Cormier noted that the new Economic Recovery Act does not specifically mention health centers and asked what could be done to change that.

- Dr. Martinez noted that many undocumented people were left out of that support, and critical institutions like health centers are often left behind. That does not serve the well-being of farmworker communities, especially in times of crisis. Collective advocacy is needed to ensure that indigenous farmworkers have access to resources. Farmworker communities faced many threats in addition to COVID-19, including wildfires and other disasters. Adequate funding is needed across the board for individuals and key institutions.

Ms. Cormier asked how to develop resources for indigenous communities that do not speak Spanish.

- Dr. Martinez replied that many indigenous farmworkers understand enough Spanish to navigate the system. Flyers should provide basic information, such as the date, time, and directions. Details can be provided through one-on-one conversations.

## Federal Update

*Jennifer Joseph, PhD, MEd, Director, OPPD, BPHC, HRSA*

Dr. Joseph provided an update on the HRSA Health Center Program, including program fundamentals, health centers' COVID-19 response, health center programs and funding, implementation of recommendations submitted by the Council in December 2020, the framework for advancing health

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<sup>8</sup> <https://link.springer.com/article/10.1057/s41276-020-00279-z>



center excellence and value, and updates to the Service Areas Needs Assessment Methodology (SANAM).

#### *Health Center Program Fundamentals, Model of Care, and Fast Facts*

Dr. Joseph reviewed the fundamentals of the health center program. Health centers serve high-need areas and populations. They are patient-directed and governed by patient-majority boards. They provide comprehensive primary care and enabling services. No one is turned away, and fees are based upon the ability to pay. Health centers collaborate with other community providers to maximize resources and efficiencies in service delivery. Finally, health centers are accountable and must meet performance requirements regarding administrative, clinical, and financial operations.

Primary care is at the core of the health center care model, along with enabling services that facilitate access to care, such as case management, transportation, and health education and outreach. Outreach services provided by promotores de salud and community health workers (CHWs) are fundamental to the program and are required as part of the model of care.

The care model has expanded over the years to include integrated mental health services, substance use disorder prevention and treatment, and oral health and vision services.

HRSA funds nearly 1,400 health centers that operate more than 13,000 service delivery sites. Nearly 30 million patients rely on a health center for care, including more than one million agricultural workers. The value of having a network of patient-directed organizations that are trusted in their communities and ready to stand up in a public health emergency has become clear during the pandemic.

#### *Primary Health Care Priorities*

HRSA recently developed four goals and associated visions to move the health center program into the future and serve as funding priorities for the coming years:

- Goal: Increase access to the health center model of care in the nation's highest-need communities and populations.
  - Vision: Every high-need community has access to the health center model of care.
- Goal: Increase access to a comprehensive range of services for health center patients.
  - Vision: All health center patients have access to patient-centered services that address both clinical and social barriers to health.
- Goal: Activate and accelerate evidence-based, innovative models of care delivery to improve health outcomes, reduce health disparities, and advance health equity for underserved and vulnerable populations.
  - Vision: Health centers lead the nation in delivering high-quality care that advances health equity for underserved and vulnerable populations.
- Goal: Upgrade, modernize, and expand facilities to support expanded access to high-quality care, advance health center performance, and support evolving health care delivery models.
  - Vision: Health centers operate state-of-the-art facilities that optimize service delivery in medically underserved communities.

#### *COVID-19 Response*

Dr. Joseph presented a breakdown of the COVID-19 supplemental funding awarded to health centers and MHCs since March 2020 and the training and technical assistance (T/TA) funds awarded to Primary Care Associations (PCAs), National Training and Technical Assistance Partners (NTTAPs), and Health Center Controlled Networks (HCCNs).

Dr. Joseph presented graphs showing health center COVID-19 responses and the impact of the pandemic on health center operations. MHCs did very well in comparison to non-MHCs for overall testing capacity, drive- and walk-up testing capacity, and the relative numbers of staff who tested positive over the past year.

The impact of COVID-19 on MHC operations mirrored that of non-MHCs, as measured by weekly visits pre- and post-COVID, visits conducted virtually, and the percent of staff who were unable to work. Fewer MHCs were temporarily closed due to the pandemic than non-MHCs.

All health centers have been actively engaged in vaccine administration since January. As of May 14, nearly a million health center patients and staff had completed their immunization series. Nearly one-quarter of those vaccinations were administered by MHCs.

### *Funding Updates*

In fiscal year 2021 (FY21), the American Rescue Plan (ARP) awarded \$7.68 billion to support COVID-19 vaccinations, COVID-19 response and treatment, primary care capacity, recovery, and stabilization, and minor alterations and renovations. The funding included \$1 billion in non-competitive capital funding for health centers; \$32.8 million for strategic partners (HCCNs, PCAs, and NTTAPs); \$145 million for health center look-alikes; and \$20 million for Native Hawaiian health systems.

FY21 funding for ongoing health center priorities includes National Hypertension Control Initiative Supplemental Funding for Health Centers (\$89.5 million for 496 awards), Primary Care HIV Prevention (anticipated funding of \$48 million for up to 175 awards), and School-Based Service Sites (anticipated funding of \$5 million for 25 awards).

A new competitive funding opportunity for FY22 will provide support for health centers to innovate and test approaches to maximize access to virtual care and improve health center outcomes for underserved communities. The program evaluator will coordinate shared, real-time learning across funded health centers, support evaluation of projects, and document and disseminate effective strategies and lessons learned. The Notice of Funding Opportunity (NOFO) was released on May 17, 2021, with a program start date of March 1, 2022.

### *Program Updates*

Dr. Joseph announced that the Health Center Program Compliance Manual is now available in Spanish.<sup>9</sup> HRSA welcomes feedback to improve the document at [Health Center Program Support](#).

HRSA intends to issue a Notice of Proposed Rulemaking to implement the prior administration's Executive Order on Access to Affordable Life-Saving Medications, which will increase access to affordable insulin and injectable epinephrine.

HRSA has updated the Site Visit Protocol that is used to assess health center compliance with program requirements.<sup>10</sup>

### *Updates on NACMH Recommendations*

The Council submitted recommendations in December 2020 in four areas:

1. MSAW protections during COVID-19

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<sup>9</sup> <https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/health-center-manual-spanish.pdf>

<sup>10</sup> <https://bphc.hrsa.gov/programrequirements/site-visit-protocol>

2. National data strategy to improve MSAW health and welfare
3. Toxic stress in MSAW children
4. Strategies to prevent occupational injuries in MSAWs.

Dr. Joseph provided updates on recommendations 1 and 3:

- *Recommendation 1:* ARP funds awarded to MHCs will increase protections for MSAWs during COVID-19. A new direct distribution program will increase health centers' ability to obtain COVID-19 vaccines, and MHCs can use capital improvement funding to purchase mobile units or other vehicles to support access to care.
- *Recommendation 3:* BPHC has been in conversations with colleagues in the Maternal and Child Health Bureau and multiple external stakeholders regarding early childhood development and child health in general. President Biden has expressed support for that focus and has talked about integrating child development into the health center model of care. There are many opportunities to address the intersection of child development and toxic stress.

#### *Advancing Health Center Excellence and Value*

Dr. Joseph stated that the value proposition of health centers is access to care and improving health in the nation's underserved and socially vulnerable populations. BPHC identified seven domains of performance that make a health center successful in achieving that mission: access and affordability; patient experience; quality, patient care, and safety; population health and social determinants of health; financial sustainability; workforce; and governance and management.

Advancing health equity is the foundation of the new model. Creating a distinct domain focused on social determinants of health supports HRSA's commitment to that mission.

A health center can achieve various levels of maturity across domains and can move up and down within each one. Going forward, HRSA's quality improvement awards will recognize health centers for improvement in meeting performance expectations in each domain.

#### *Service Area Needs Assessment Methodology (SANAM) Updates*

BPHC has proposed changes to the measures and weights in the Service Area Needs Assessment Methodology that would be used in a future New Access Points competition if resources are available. Detailed information and an opportunity to provide feedback are available at the Health Center Program Strategic Initiatives website (<https://bphc.hrsa.gov/programopportunities/strategic-initiatives>).

#### **Strategies to Prevent and Mitigate COVID-19 among Agricultural Workers: A CDC AND NCFH Partnership**

*Alfonso Rodriguez Lainz, PhD, DVM, MPVM, Epidemiologist, Division of Global Migration and Quarantine, U.S.-Mexico Unit, Centers for Disease Prevention and Control (CDC)*

*Sylvia Partida, MA, Chief Executive Officer, National Center for Farmworker Health (NCFH)*

Dr. Lainz and Ms. Partida described a partnership between the CDC and NCFH to protect agricultural workers during the COVID-19 pandemic.

Dr. Lainz noted that while MSAWs are considered essential critical infrastructure workers, they are also at higher risk for COVID-19. Risk factors include overcrowded working and living conditions, shared transportation, immigration status, low-socio-economic status, and limited access to health care.

There is limited published data on the COVID-19 burden among MSAWs. However, multiple news reports have described deaths and outbreaks among farmworkers, and state and local surveys have documented barriers of access to testing, treatment, housing, isolation/quarantine, and PPE. Organizations and federal agencies that serve agricultural workers have limited capacity, and their activities are not well coordinated. There is no national plan to provide farmworkers with vaccinations or other services related to COVID-19.

CDC's Emergency Operations Center has multiple task forces and teams with activities related to agricultural workers. As part of its pandemic response, CDC established a Farmworkers Interest Group with representatives from multiple task forces to share information and coordinate activities.

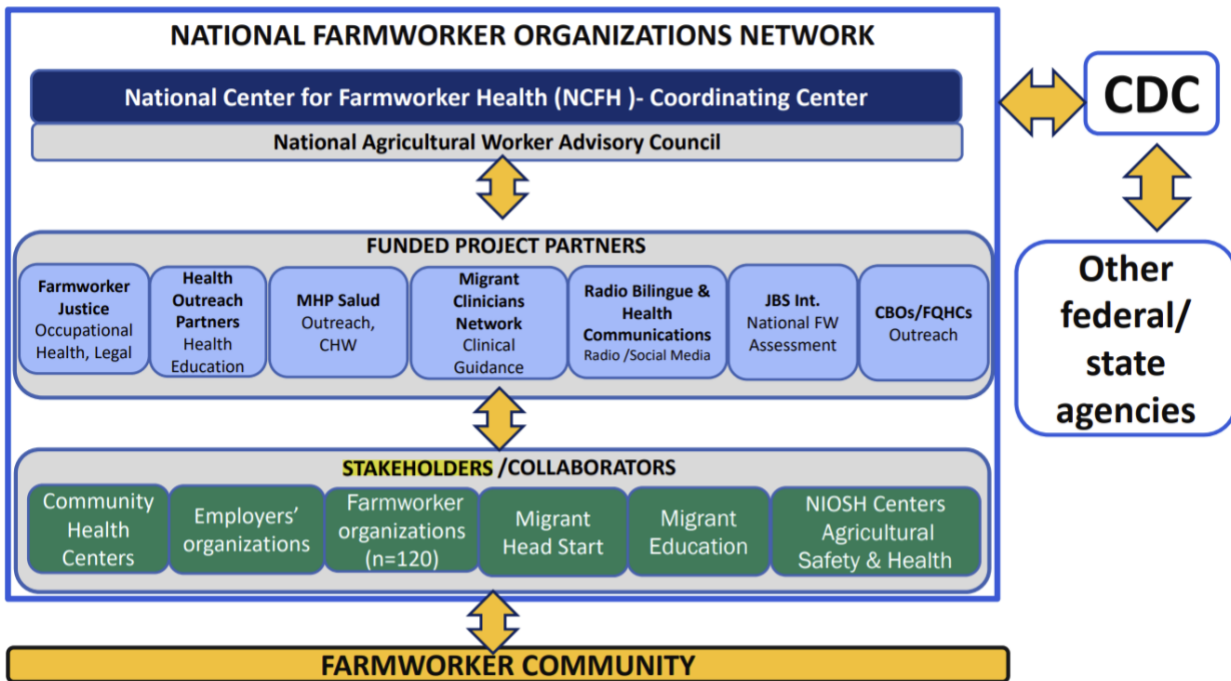
Dr. Lainz outlined CDC initiatives to address COVID-19 among agricultural workers:

- COVID-19 prevention guidance for agricultural workers, employers, and partners
  - Multiple guidance documents and tools
  - Webpage and toolkit for H-2A workers and employers.
- Technical support to health departments
  - Webinars and conference calls with CDC experts
  - CDC teams deployed to assist with surveillance data analysis, community assessments, and outbreak investigations
  - CDC Agriculture Data dashboard (under development), with data on the number of agriculture workers by county (including H-2A), farm locations, CHCs, and farmworker-organizations.
- Assessment of mobility patterns of MSAWs
  - Objective: Document the best current evidence on farmworkers' mobility patterns (e.g., origin, destination, travel routes)
  - Methodology: Analysis of existing data sources, key informant interviews, participatory mapping conducted by expert teams in the U.S. and Mexico.
- COVID-19 prevention program for H-2A workers
  - Free, voluntary COVID-19 testing before workers arrive to the U.S.
  - Health education and information for workers about access to health care in the U.S.
  - Implemented through panel physicians in Mexico, in collaboration with U.S. farmworker employers and U.S. Consulates in Mexico
  - Potential model for other prevention strategies, including vaccines.
- Partnership with the National Center for Farmworker Health (NCFH) to strengthen the public health emergency response coordination and outreach capacity of farmworker-serving organizations.

Ms. Partida provided an overview of the CDC-NCFH partnership, which was developed through a five-year cooperative agreement.<sup>11</sup> The objective of the partnership is to identify emerging needs and develop strategies to address them.

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<sup>11</sup> <http://www.ncfh.org/covid.html>



The project entails collaboration and communications among multiple organizations to receive information from farmworkers and organizations that serve them and share that information with the CDC and other federal and state agencies. An advisory council representing stakeholders and collaborators, including employers and farmworkers, provides feedback and guidance on project activities and strategies.

Ms. Partida outlined project activities and strategies:

- A needs assessment conducted early in the pandemic to better understand the impact of COVID-19 and provide policy recommendations to support project implementation.
- Rapid national and regional assessments, in partnership with JBS International, to monitor knowledge, attitudes, and practices related to prevention behaviors and vaccine confidence
- Literature reviews
- Listening sessions and focus groups with employers, farmworkers, and CBOs
- A national directory of farmworker-serving organizations
- Funding and T/TA to support outreach efforts across the country
- A national radio and social media campaign, in partnership with Radio Bilingue
- Information on COVID-19 testing and vaccination for farmworkers provided through a national, toll-free information and referral service (Una Voz para la Salud/Call for Health) and WhatsApp
- Mexico-based H-2A worker outreach and health education
- Adapt CDC guidance to increase its relevance for employers and farmworkers
- Inventory and evaluate existing educational resources for farmworkers
- Develop or adapt educational materials to increase their effectiveness for farmworker populations, with a focus on materials in indigenous languages
- Support implementation of COVID-19 prevention strategies.

The pandemic has taught farmworker-serving organizations how to work together more effectively, to reach out to non-traditional partners, and to deploy strategies such as telehealth and digital outreach to enhance farmworkers' access to health care, testing, mitigation strategies, and vaccines.

The project has funded nearly 20 demonstration projects to identify and document promising practices to prevent COVID-19, including strategies to increase vaccine confidence. It is also supporting T/TA for farmworker-serving organizations, CHWs, and agricultural employers.

The NCFH/CDC partnership is disseminating project activities through a website and social media, a weekly bulletin (“De Sol a Sol”), engaging and leveraging partner and stakeholder networks, and presentations and conference workshops.

Strategic planning to address future emergencies is an important aspect of the partnership. NCFH is developing an interactive farmworker data dashboard that communities can use to integrate farmworkers in their emergency response plan. They are also conducting a crowdsourced project to map mobility pathways, providing technical assistance and farmworker data research support to local and state public health authorities, and providing support for farmworker-focused coalitions.

CDC recognizes agricultural workers as a priority population for preparedness and response during emergencies, including pandemics. The CDC-NCFH partnership can improve community outreach through sustained support, coordinate activities among federal agencies, and monitor and evaluate MSAWs’ access to, uptake of, and knowledge and attitudes toward prevention measures. It can also be used for non-emergency health issues.

## **Discussion**

Ms. Veguilla-Montañez asked if it would be possible to offer vaccines at places where MSAWs gather, such as airports, bus stations, schools, and churches.

- Ms. Partida replied that many federally qualified health centers (FQHCs) and other organizations are looking at innovative ways to provide the vaccine, including churches and community centers. FQHCs have an advantage because they can use a mobile unit or take a health care team to an offsite location.

Dr. Snipes said the farmworker dashboard was groundbreaking. She asked how NCFH would crowdsource it, what data sources would be used, and whether it would be updated on a continual basis. She also asked if data were available on which vaccines farmworkers have been able to access and which ones have been completed for the population.

- Ms. Partida replied that the dashboard includes the NCFH population estimate based on public data from the U.S. Department of Agriculture (USDA) Census of Agriculture, plus National Agricultural Worker Survey (NAWS) coefficients regarding migrant and seasonal and spouse and dependent status. They will also use information on H-2A certification from the Department of Labor, data on seasonality, and information from FQHCs and CBOs. They hope to include employer location, but they cannot make that part of the dashboard available to the public. The dashboard will be updated as new data becomes available.
- Ms. Partida clarified that crowdsourcing will be used in a pilot project to understand mobility patterns. The methodology has not been fully developed. She would be happy to share it with the Council to obtain feedback.
- Ms. Partida said she did not have data on which vaccines MSAWs have received. NCFH receives information from FQHCs that report to HRSA. She did not know if those reports indicate which vaccines were provided. NCFH heard anecdotally that many FQHCs that serve farmworkers or initially favored the Johnson & Johnson (J&J) vaccine because vaccine supplies were limited and the populations were highly migratory. There has been more hesitancy around vaccine uptake since the pause in administering the J&J vaccine, but that is not surprising. An employer in a

recent CDC listening session said the group that conducted an onsite clinic brought all three and let the individuals choose. That would be ideal.

Ms. Cormier asked how NCFH recruited growers to participate in the advisory council.

- Ms. Partida said it can be helpful to emphasize that growers need a healthy workforce for their business to be successful. COVID-19 presents an opportunity for farmworker advocates to extend a hand to employers. This is a national effort, and farmworkers are a critical workforce. There are many examples of how FQHCs and CBOs have established those relationships. The first step is to understand who the employers are in your area.
- Dr. Lainz added that the National Council of Agricultural Employers is interested in collaborating with CDC and NCFH. Vaccinations are providing that opportunity. He also noted that CDC and HRSA leadership met recently to identify data needs and surveillance, including the possibility of having MHCs serve as sentinel clinics to monitor testing positivity and vaccination of farmworkers. CDC also needs good communications materials to educate the community and providers. There are further opportunities for collaboration between CDC and HRSA to address the needs of this population. He offered to take the Council's recommendations to CDC leadership.

Ms. Brown-Singleton adjourned the meeting for the day at 5:04 p.m.

## **Wednesday, May 26, 2021**

### **Recap of Previous Day**

*Shedra Amy Snipes, Ph.D., Vice-Chair, NACMH*

Dr. Snipes welcomed Council members and guests to the second day of the meeting. She noted that simultaneous interpretation was offered to ensure language equity and reviewed the process to choose whether to listen to the meeting in English or Spanish.

Dr. Snipes reviewed the first day of the meeting and noted that it coincided with the anniversary of the killing of George Floyd. That event increased awareness of structural violence and sparked a social justice movement, and the previous day was an opportunity for the Council to think about those issues.

Dr. Snipes urged the Council to reflect on the history of the movement it represents. United Farm Workers president Teresa Romero stated: "The farmworker movement and the civil rights movement has always stood together." Black and brown communities have fought together to remove injustice in their communities and to support the dismantling of policies that prevent equity. The Council stands on the shoulders of a movement, and its advocacy is aligned with the struggle for freedom, dignity, and humanity. As Dr. Martin Luther King, Jr. wrote to agricultural labor leader, Cesar Chavez: "Our separate struggles are a real one. A struggle for freedom, for dignity, and for humanity."

During the testimony sessions, Dr. Snipes urged the Council to think about the broad social, economic, political, and anti-immigrant/minority forces that impede health equity for MSAWs; social and structural violence that affect the health and well-being of farmworkers; areas where structural competency training, culturally humility, and a health-in-all-policies approach might improve care for MSAWs; ways in which greater language justice would improve the work of MHCs; and ways in which structural humility could increase awareness of indigenous workers and other communities that are not fully represented in health center data.

Dr. Snipes also asked the Council to be mindful of the health center program fundamentals and the funding priorities for FY 21 and FY22, including hypertension control, HIV prevention, school-based services, and virtual care. The health center domains and performance expectations in the context of health equity provide an important framework for listening to those who would provide testimonies, and the Council should embed those voices in its recommendations for change.

The Council is supported by an extensive network of organizations and a vast array of stakeholders and collaborations. Dr. Snipes encouraged the Council to listen for ways in which those organizations could help move the Council's recommendations forward.

Dr. Snipes outlined her conclusions from Day 1:

- The communities we advocate for deserve to live and work in a world that first honors their human ethical rights.
- Our lens should be to advocate for the health and well-being of MSFs, which stem from social and service barriers, including injustice.

Dr. Snipes reviewed the agenda for the rest of the day.

### **Testimony Sessions Structure and Ground Rules**

*Donalda Dodson, Session Chair and Coordinator*

Ms. Dodson stated that the Oregon Child Development Commission (OCDC) recruited seven agricultural worker families who have children in OCDC's Migrant and Seasonal Head Start (MSHS) program and three members of OCDC's staff to provide testimonies to the Council. Agricultural family members participate in OCDC's policy council and are involved in community decisions related to agricultural workers. One OCDC staff member has represented MSAW families on a CDC advisory council.

The testimonies would reflect their experiences, and those of their community, related to the impact of COVID-19 on workers and their families, the needs of indigenous MSAWs, legal medical partnerships, Oregon wildfires, and the health needs of migrant families.

The testimonies would be provided by Zoom. Those who testified would keep their cameras on unless their Internet connection would not support the video function.

### **Testimony Sessions**

*Agricultural Workers and Oregon Child Development Commission (OCDC) Staff*

Seven agricultural workers and three OCDC staff provided testimonies to the Council regarding the impact of COVID-19 on workers and their families, indigenous MSAWs and their needs, legal medical partnerships, the Oregon wildfires, and the health needs of migrant families.

The testimony questions are provided in Appendix A. The following is a thematic summary of the responses in each area.

**The Impact of COVID-19 on Workers and their Families**

- All but two of those who testified had family members who got COVID-19, and some had relatives who died. Several got COVID-19 themselves, including two who were pregnant.
- Many agricultural workers who have symptoms do not get tested because they are afraid of losing their jobs.



- Agricultural workers have received conflicting messages about the vaccine from doctors and the media. Some heard from their doctors that the vaccine would not prevent them from getting COVID-19, but it would prevent serious effects or death.
- Many agricultural workers are afraid that the vaccine has serious side effects.
- Misinformation has created a lot of fear about vaccination. A social media story about a negative side effect or a death can create a great deal of hesitancy within the community. Some agricultural workers have spread a rumor that the vaccine is a government plan to implant a chip that will collect personal information.
- Many people in the rural communities where agricultural workers live and work are opposed to masks, social distancing, and vaccines.
- One strawberry farm had more than 60 positive cases. Workers had to keep working until the health department made a site visit and enforced a quarantine.
- Food banks and other community resources provided critical support during the pandemic and the wildfires. OCDC connected many people to the services they needed.
- Some families could not get stimulus payments, unemployment, and other benefits that were available to citizens.
- The Open Door Clinic in Klamath Falls is using a van to provide onsite vaccinations.
- OCDC received a grant from the Oregon Health Authority to provide information on the vaccine and help the community get access to vaccinations. They are holding vaccination clinics at their centers and working with local school districts to provide the vaccine.
- There is a need for collaboration between Oregon and California to make sure that workers who migrate are vaccinated or have access to the vaccine.
- Social distancing and quarantine were stressful for this community because they place a high value on being together. Many suffered from depression, but they would not talk about it.
- Agricultural workers were considered essential during the pandemic, but they were not a priority when it came to getting the vaccine.
- Dealing with the bills for COVID-19 treatment was more difficult than the physical recovery.
- The pandemic forced OCDC to find different approaches and tools to hold classes and communicate with their families, including Internet, Zoom, texting, and local radio.

#### *Indigenous MSAWs and Their Needs*

- Indigenous farmworkers often put off health care because providers do not have interpreters who speak their languages. They are embarrassed to ask for clarification when they do not understand because they do not want to look like fools.
- Family members who speak Spanish often serve as translators, though they may not understand medical terms.
- An indigenous farmworker described her family's experience migrating within Mexico before coming to the U.S. Her father brought them to the U.S. to follow the dream of a better life.
- Hispanic and indigenous families are very close to their families, culture, and religion. There is a great deal of community support. When times are hard, people help each other. When work is available, they call everyone in the community.

#### *Legal Medical Partnerships*

- Agricultural workers do not have information about their rights and the protections that are available to them, such as the Family Medical Leave Act (FMLA). Information may be posted in the break room, but no one reviews it with them.

- Fear of retaliation prevents workers from speaking up. Those who do speak up are often told there is no more work for them.

### *Oregon Wildfires*

- The wildfires added another layer of stress on top of COVID-19.
- Many families lost everything. Others had to evacuate and could not find their relatives. They did not have a choice to stop working to be with their families.
- Many migrant families continued to go to work when the oxygen levels were dangerous, with only a face mask for protection.
- Many families were afraid to ask for help because it might affect their immigration status.
- It was difficult to find affordable housing before the fires, and it is almost impossible now. Houses are bought by people from out of state who can pay for repairs. The Phoenix-Talent area, where many agricultural workers live, lost more than 2,000 homes and an entire mobile home park.

### *Health Needs of Migrant Families*

- There are not enough clinics, and the waiting lists are long. One woman's husband has been on a waiting list for three years and has not received a call.
- There are great disparities in access to health care between urban and rural areas.
- Many clinics do not have doctors who speak Spanish.
- Many agricultural workers do not visit doctors because insurance is too expensive.
- Dental care and mental health resources are limited, especially in rural areas.
- Many agricultural workers cannot access health care services because the clinic is more than an hour away and they do not have a car.
- Many workers do not have access to dental care and cannot afford a private dentist.
- Clinics provided mobile services in the past, but not recently.
- Some doctors at the community clinic are not kind to farmworkers.
- The lack of insurance made it difficult for one woman's husband to access treatment for anxiety.
- Agricultural workers often have to choose between getting health care or going to work so they can pay the bills.
- Many employers do not let agricultural workers make medical appointments during working hours, but clinics are not open after working hours. Workers are afraid they will lose their jobs if they take time off.
- Many undocumented workers are afraid to apply for services they are qualified to receive for themselves or their children because of the public charge policy.
- Many agricultural workers do not know whom they can trust. It is important to build relationships and trust.
- Some agricultural workers use home remedies to alleviate symptoms when they cannot afford medical care.
- Promotores/CHWs can create connections and provide support for families.
- Trauma is stigmatized in the community, which is a barrier to seeking mental health care.
- Telemedicine could work for the younger generation, but the older generation has difficulty using technology. Internet access is not reliable, and many people have limited data plans. It is difficult to build a relationship through telemedicine.
- Facebook and text messaging are effective ways to reach agricultural workers.
- "Low income is more expensive in the long run."

Meeting Wrap-up and Adjourn  
*Shedra Amy Snipes, Vice-Chair, NACMH*

Dr. Snipes summarized key points from the testimonies:

- Only two of those who testified said they were not affected by COVID-19.
- Farmworkers who were vaccinated are strong advocates for the vaccine.
- Co-morbid factors, including pregnancy and aging, were complicating factors during COVID-19.
- Community clinics are overcrowded and there are not enough of them.
- There is a lack of affordable dental services.
- Sometimes doctors are not very kind.
- Employers do not understand that workers cannot make medical appointments after work.
- MSAWs fear they will be terminated if they speak up.
- Parents have to choose between working and health.
- Workers do not know who they can trust or where to go for services.
- Some choose to eat rather than spend money on health.
- There is misinformation about the vaccine.
- There is a lack of affordable housing, possibly related to the fires.
- Agricultural workers were considered essential during the pandemic, but they were no longer essential once the vaccine was rolled out.

Dr. Snipes assured those who testified that the Council was listening and would continue to listen.

Ms. Brown-Singleton adjourned the meeting for the day at 4:58 p.m.

## **Thursday, May 27, 2021**

### **NACMH Chair Reflections and Welcome**

*Sharon Brown-Singleton, MSM, LPN, Chair, NACMH*

Ms. Brown-Singleton called the meeting to order and welcomed Council members and guests.

Ms. Brown-Singleton shared reflections on the previous day and reviewed the agenda for the third day of the meeting. She urged the Council to listen with intent so the speakers' expertise would enable the Council to formulate recommendations that align with the needs of MSAWs.

### **National Association of Community Health Centers (NACHC) Update**

*Rachel A. Gonzales-Hanson, Senior Vice President for Western Operations, NACHC*

Ms. Gonzales-Hanson provided an update on the health center COVID-19 vaccine program and efforts to expand vaccine resources in rural areas; policy and legislative matters, including the president's proposed budget, the American Jobs Plan, immigration policy, telehealth legislative priorities, and rural health legislation; health center funding, including workforce investments; a patient risk assessment tool to address the social determinants of health; and an update on the Ag Worker Access Campaign.

#### *Vaccine Update*

As of May 14, almost 11 million health center patients were tested for COVID-19, with a 12 percent positivity rate, and almost five million patients had completed their vaccinations.

Health centers are taking an aggressive approach to ensure that all health center patients are vaccinated as soon as possible, using onsite vaccinations, mobile vans, and pop-up clinics. Health centers are making significant progress toward the goal of vaccinating at least 70 percent of patients ages 12 and above by the end of the year. Health centers had administered more than six million vaccinations as of May 14, and more than 35,000 adolescents ages 12 to 17 were vaccinated at health centers the following week.

The Department of Defense (DoD) has been working with BPHC to get rapid COVID testing to health centers by late summer. The tests will be helpful for mobile populations, including MSAWs.

NACHC is working with the National Rural Health Association (NRHA) to have more information and resources available in rural areas, including vaccine hesitancy toolkits for rural health care providers, rural faith-based communities, and farmers and ranchers. Those resources should also reach MSAWs.

The ARP added \$4.8 billion for health centers, including funding for testing.

Health centers initially thought the single-dose J&J vaccine would be better for agricultural workers due to the mobile nature of their jobs, but media reports that the vaccine was less effective raised questions about promoting it for less fortunate people. Health centers are making an extra effort to ensure that choices are offered to all patients.

BPHC and CDC recently launched a program to provide vaccines directly to health centers without going through their states. Health centers can choose from the vaccines that BPHC has in stock. Initial reporting requirements for excess doses have been relaxed.

Ms. Gonzales-Hanson suggested that lessons learned from the vaccine distribution process could inform recommendations for similar emergencies in the future.

### *Policy and Legislative Matters*

#### *FY 2022 Budget*

The Biden Administration's \$1.5 trillion budget outline released in April called for nearly \$132 billion for the Department of Health and Human Services (DHHS), representing a 23 percent increase.

The budget outline includes \$8.7 billion for CDC to support core public health improvements and better prepare for and respond to emerging threats, representing the largest increase in nearly two decades; \$1.6 billion for the Community Mental Health Block Grant, more than double current funding; and \$10.7 billion to address the opioid crisis, including research, prevention, treatment, and recovery support—an increase of \$3.9 billion over FY21. Ms. Gonzales-Hanson noted that methamphetamine and other drugs are more prevalent than opioids in many rural areas. A broader approach to substance abuse funding would allow communities to use the resources where they are needed.

The budget outline did not specify the amount of funding for the health center program. NACHC is advocating for \$2.2 billion in funding for FY22. Health centers lost a great deal of funding and revenue during the pandemic, and it is critical to ensure they do not fail. Funding to stabilize the workforce is also essential to ensure the continuity of the health center program.

### *Infrastructure Investment*

While the \$2.7 trillion American Jobs Plan does not specifically mention CHCs, NACHC is supportive of infrastructure investments that would fund health center capital projects.

NACHC is engaging in ongoing conversations with Congressional staff on other key items of the NACHC agenda, including funding to expand health center services and provide additional years of mandatory funding; workforce development funding for the National Health Service Corps (NHSC) and Teaching Health Centers (THCs), including a provision to direct placements to health centers; and funding to ensure the permanence of telehealth beyond the current public health emergency (PHE).

### *Immigration*

The U.S. Citizenship Act of 2021 creates a pathway to citizenship for qualifying undocumented immigrants by establishing a transitional “Lawful Prospective Immigrant” (LPI) status that would give them work authorization and make them eligible to apply for a “green card” and then for U.S. citizenship. Some stakeholders are concerned that the bill denies those holding LPI status access to health care and human services programs, including subsidies under the Affordable Care Act.

In April, the House passed two bills that would affect millions of undocumented immigrants. The Dream Act would provide a path to citizenship for about 2.5 million people brought to the country unlawfully as children. The Farm Workforce Modernization Act would provide a path to legal status for farmworkers who are in the country illegally, estimated to be at least 1.2 million workers. Some would be permitted to gain a green card if they pay a fine and stay in the industry for an additional four to eight years, depending on how long they had been doing farm work. Both bills face an uphill climb in the Senate.

### *Telehealth*

Legislative priorities for CHCs include:

- Ensure permanent Medicare telehealth coverage beyond the PHE by removing distant and origination site restrictions, promoting provider pay parity to an in-person visit and safeguarding audio-only coverage.
- Increase broadband and infrastructure funding and allow innovative uses of federal funds for CHCs in rural and underserved areas.

These policies would bridge the rural and urban digital divide for CHC patients while promoting quality, equitable, and flexible care.

The CONNECT for Health Act of 2021 would permanently allow FQHCs and rural health clinics to provide telehealth services in Medicare as distant sites and be paid equal to an in-person visit.

### *Rural Health Legislation*

The Mobile Health Care Act would expand the allowable use criteria in the New Access Points grant program to include part-time mobile clinics and renovation, acquisition, and new construction of health centers to increase access to affordable, accessible, quality health services in rural and underserved communities.

### *Health Center Funding*

The president has committed to doubling funding for health centers. NACHC hopes this does not include an expectation to double the number of patients. CHCs need additional resources to stabilize the services they currently provide. The numbers must be balanced.

### *Workforce Update*

Workforce investments in the ARP include \$800 million for the NHSC, \$200 million for the Nurse Corps Loan Repayment Program, and \$330 million for THCs to increase the Per Resident Amount and expand the number of programs.

NACHC will advocate for the American Jobs Plan/American Families Plan to include additional workforce funding that would provide a comprehensive, long-term approach to develop the health careers pipeline, including efforts to increase the number of rural and minority students. The TRIO program was an effective model.

### *Online Resources*

The NACHC website has a wide array of policy resources ([www.nachc.org/focus-areas-policy-matters](http://www.nachc.org/focus-areas-policy-matters)).

Toolkits and other resources are available at the Health Center Resource Clearinghouse that NACHC developed with funding from BPHC (<https://www.healthcenterinfo.org>).

### *Protocol for Responding to an Assessing Patients' Assets, Risks, and Experiences (PRAPARE)*

PRAPARE is a holistic patient risk assessment tool developed by NACHC, the Association of Asian Pacific Community Health Organizations (AAPCHO), and the Oregon Primary Care Association (OPCA) to engage patients in assessing and addressing SDOH.

The model uses promotores de salud/Community Health Workers (CHWs) to collect standardized assessment data. NACHC hopes that the success of this tool will demonstrate the value of CHWs and convince third-party payers to reimburse health centers for their time.

PRAPARE data can be used to accelerate systemic change at the patient, organizational, community, payer, and policy level.

PRAPARE is available in 26 languages and has been validated at CHCs for comprehension and cultural competence. The tool was introduced in 2019, and many health centers have been using it to meet the requirement to collect data on individual patients' social risk factors.

NACHC provides training for promotores/CHWs to collect the data. More information is available at [www.nachc.org/prepare](http://www.nachc.org/prepare), including the impact of COVID-19 on PRAPARE domains.

### *Ag Worker Access Campaign Update*

The Ag Worker Access Campaign is a national initiative to increase access to quality health care for agricultural workers and their families.<sup>12</sup> The campaign's goal is to increase the number of MSAWs and their families served in CHCs and MHCs to two million per year. Health centers surpassed the one-million mark in 2019; 2020 data were not available at the time of this meeting.

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<sup>12</sup>[www.ncfh.org/ag-worker-access.htm](http://www.ncfh.org/ag-worker-access.htm)

The Ag Worker Access Campaign Task Force has been successful in engaging additional partnerships that are providing support and resources.

The campaign has many elements, with a focus throughout on serving agricultural worker families. The NACMH plays an important role in supporting the campaign.

### **Discussion**

Mr. Calderon noted that undocumented MSAWs are highly resistant to receiving vaccinations and other health services. He heard that Mexican consulates were providing vaccinations for Mexican nationals and asked if Ms. Gonzales-Hanson could provide information about that.

- Ms. Gonzales-Hanson said she had heard about the consulates playing a role, but she did not have any details. NACHC is working with contractors and other organizations to let MSAWs know that it is safe to obtain the vaccine and other health services. She noted that there are many factors involved in vaccine hesitancy.

Mr. Calderon stated that an important factor in reaching the Ag Worker Access goal is how clinics identify agricultural workers. If a farmworker's wife is asked, "Are you an agricultural worker?," she might say no, because she considers herself to be a homemaker.

- Ms. Gonzales-Hanson replied that a conversational approach is the most effective way to obtain the information. NCFH has an excellent program to train health center staff on how to do that.

Mr. Calderon noted that some CHCs are reluctant to hire promotores because the position is non-billable. He was pleased that the Biden budget includes specific funding for them.

- Ms. Gonzales-Hanson expressed concern that many clinics will continue to implement programs where promotores are expected to donate their time. They need to be paid. She hoped that programs established with the new funding will provide a salary and benefits. She also expressed concern that institutions of higher learning want to tap into this funding to launch certification programs. Certification has value, but it is more important for promotores to be trusted by the community. The funding should go to them.

### **Health Center COVID-19 Vaccine Program and Strategic Partnership Efforts to Improve Migrant and Seasonal Agricultural Worker Health**

*Tracey Orloff, MPH, Director, Strategic Partnerships Division (SPD), Office of Quality Improvement (OQI), BPHC, HRSA*

Ms. Orloff provided an overview of the Health Center COVID-19 Vaccine Program and efforts of the Strategic Partnership Division (SPD) to improve MSAWs' health.

#### *Health Centers and COVID-19*

BPHC provided funding in four major tranches to address COVID-19 in FY 2020-2021:

- Coronavirus Supplemental Funding for Health Centers: \$100 million, 1,381 awards to help health centers prevent, prepare for, and respond to COVID-19
- Coronavirus Aid, Relief, and Economic Security (CARES): \$1.3 billion, 1,387 awards to detect coronavirus and prevent, diagnose, and treat COVID-19 and to maintain and increase health centers' capacity and staffing levels to address the PHE and learn how to work virtually
- Expanding Capacity for Coronavirus Testing (ECT): \$583 million, 1,385 awards

- American Rescue Plan Act (ARP): \$6.1 billion, 1,377 awards to support health centers' programs and infrastructure to address COVID-19 and prepare for the post-COVID service environment, and to support SPD grantees.

HRSA and CDC launched the Health Center COVID-19 Vaccine Program to ensure that the nation's underserved communities affected by COVID-19 are equitably vaccinated. The program directly allocates a limited supply of COVID-19 vaccine to select HRSA health centers that specialize in caring for hard-to-reach and disproportionately affected populations. It was implemented in three phases:

- Phase 1 invited 250 health centers that serve large volumes of agricultural workers, residents of public housing, individuals experiencing homelessness, and patients with limited English proficiency.
- Phase 2 invited 700 new health centers that serve high proportions of low-income and minority patients, provide services to rural frontier populations, operate Tribal/Urban Indian Health Programs, and/or utilize mobile vans to deliver services.
- Phase 3 invited the remaining 520 HRSA-funded health centers, expanding access to COVID-19 vaccination for underserved communities and vulnerable populations across the country.

As of May 7, health centers and look-alikes had administered more than 3.6 million doses of COVID-19 vaccines through the vaccine program. Seventy-two percent of the patients who received the vaccine were racial and/or ethnic minorities. Four percent of the doses went to MSAWs, three percent went to patients experiencing homelessness, four percent went to patients who are residents of public housing, and 24 percent went to patients with limited English proficiency.

The Health Center COVID-19 Vaccination Dashboard is an excellent resource for tracking vaccine distribution and access (<https://data.hrsa.gov/topics/health-centers/covid-vaccination>).

The Health Center Resource Clearinghouse has a number of resources on the COVID-19 vaccine (<https://www.healthcenterinfo.org/priority-topics/covid-19/>).

CDC published COVID-19 Resources for Agricultural Workers and Employers (<https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-agricultural-workers.html>).

Resources from Migrant National Training and Technical Assistance Partners (NTTAPs) include:

- Migrant Clinicians Network: [FAQ: The COVID-19 Vaccine and Migrant, Immigrant, and Food and Farm Worker Patients](#)
- MHP Salud: [Tips from Your Community Health Worker \(English and Spanish\)](#)
- NCFH: Webinar on Mass Media & Communication Strategies for Increasing Agricultural Worker Vaccine Confidence (in English and Spanish, <http://www.ncfh.org/archived-webinars.html>)

#### *Strategic Partnership Efforts to Improve MSAW Health*

BPHC's Strategic Partnership Division funds 21 NTTAPS in four categories:

- Special populations: MSAWs, people experiencing homelessness, residents of public housing
- Vulnerable populations: School-aged children; lesbian, gay, bisexual, and transgender populations; older adults; Asian Americans, Native Hawaiians, and other Pacific Islanders
- Health Center Development Areas: Clinical workforce development, health workforce recruitment and retention, capital development and growth, health information technology and data, oral health care, medical-legal partnerships, intimate partner violence prevention
- National Training and Technical Assistance Center: Health Center Resource Clearinghouse, National Health Center Needs Assessment.



The NTTAPs coordinate among themselves to provide resources and support to help health centers and look-alikes achieve clinical and operational excellence.

Five MSAW NTTAPs provide services and technical assistance to health centers to increase access to care, improve health outcomes, and promote health equity.

- Farmworker Justice provides T/TA related to federal and state policy and legislation impacting access to health care for MSAWs and their families, with a focus on environmental justice.
- Health Outreach Partners provides T/TA on outreach and enabling services, program planning and development, needs assessments and evaluation, and community collaboration, particularly targeting MSAWs.
- Migrant Clinicians Network provides T/TA on all aspects of clinical care and issues impacting patients, providers, and clinic systems through consultation, patient tracking, bridge case management, and clinical education.
- MHP Salud provides T/TA to health centers to develop, implement, and sustain promotores de salud/CHW programs.
- NCFH provides T/TA related to health center governance, administration, and patient education.

Recent NTTAP partnership efforts include:

- Special Populations Roundtable on the Health Center COVID-19 Vaccine Program
- COVID-19 vaccine fotonovela to boost vaccine acceptance among low-literacy agricultural workers
- 2021 Virtual Forum for Migrant and Community Health
- Social Determinants of Health Academy
- Special and Vulnerable Populations Diabetes Task Force.

HRSA established two formal interagency collaborations that support MSAW populations:

- *The Administration for Children and Families (ACF) and HRSA Memorandum of Understanding (MOU)* set forth the collaboration between HRSA/BPHC and the ACF Office of Child Care and Office of Head Start (OHS) and the Migrant and Seasonal Head Start Program (MSHSP). In 2019, health centers served 37 percent of the 23,299 children enrolled in Migrant Head Start. HRSA/ACF activities have included resources to increase physical activity and healthy nutritional practices among children and families, a Health Partnership Learning Collaborative, and a presentation at the Virtual Forum for Migrant and Community Health on the benefits of MOUs between Migrant Head Start programs and health centers.
- *The Department of Labor (DOL) and HRSA Interagency Agreement (IAA)* combines resources to improve survey and analytical services and reports regarding the NAWS, to obtain data that can be used to better serve the MSAW population.

Ms. Paul thanked Ms. Orloff for her leadership in responding to the Council's recommendations and for preparing a detailed implementation document every six months.

Ms. Orloff stated that the Council's recommendations are invaluable to help BPHC and the Office of Quality Improvement better meet the needs of MSAWs.

## Discussion

Dr. Snipes noted that the proportion of MSAWs who have been vaccinated lags behind the general population. She asked what HRSA is doing to address barriers beyond vaccine hesitancy that would help the Council draft recommendations to increase the vaccination rate for MSAWs.

- Ms. Orloff replied that BPHC has learned a great deal about what is and is not working and what the barriers are. Weekly reports from health centers, bi-weekly surveys of PCAs, and anecdotal reports have shown that CHWs and promoters make a significant difference in addressing concerns because they have trusted relationships within the community. Mobile vans and other ways to take vaccines to the community are also effective. We know these approaches work; it is a matter of expanding them.

Dr. Snipes asked if Ms. Orloff had data on which vaccines were actually administered to MSAWs.

- Ms. Orloff said her understanding was that health centers initially received a combination of Pfizer, Moderna, and J&J vaccines and would alter their requests based on what was working in their communities. Health centers are now testing transfer programs to trade vaccines if one has a limited supply and another has extra doses.
- Dr. Snipes asked how many vaccines were administered in each category.
  - Ms. Orloff did not know if HRSA has that information.
  - Ms. Paul said she would follow up on that question.

Ms. Cormier commended HRSA on developing the fotonovela. She asked if it had been completed and how it would be distributed.

- Ms. Orloff replied that the fotonovela can be downloaded from the Health Center Resource Clearinghouse. It is available in Spanish<sup>13</sup> and English.<sup>14</sup>
- Ms. Veguilla-Montañez asked if the resources could be expanded to reach indigenous farmworkers.
- Ms. Orloff said the resources can be made available if they know where the populations are located and what languages they speak. If Ms. Veguilla-Montañez could contact the Health Center Resource Clearinghouse and provide that information, the NTTAPs could see what language support is available at health centers near those groups. She noted that NCFH has a directory of COVID-19 resources in indigenous languages.<sup>15</sup>

### **Addressing the Social Determinants of Agricultural Worker Health Using Medical-Legal Partnerships**

*Iris Figueroa, Director of Economic and Environmental Justice, Farmworker Justice*

*Alexis Guild, Director of Health Policy and Programs, Farmworker Justice*

Ms. Figueroa and Ms. Guild discussed structural barriers to health care access, the use of medical-legal partnerships (MLPs) to address the social determinants of agricultural worker health, and challenges and innovative practices related to MLPs in farmworker communities.

Ms. Guild noted that Farmworker Justice is a national organization that seeks to empower farmworkers and their families to improve their living and working conditions, immigration status, occupational safety and health, and access to justice. They are a national T/TA partner under HRSA and a member of the

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<sup>13</sup> <https://www.farmworkerjustice.org/wp-content/uploads/2021/04/Fotonovela-SPANISH.pdf>

<sup>14</sup> <https://www.farmworkerjustice.org/wp-content/uploads/2021/04/Fotonovela-ENGLISH.pdf>

<sup>15</sup> [http://www.ncfh.org/covid\\_resources\\_for\\_ag\\_workers.html](http://www.ncfh.org/covid_resources_for_ag_workers.html)

Farmworker Health Network. Their support for health centers is focused on policy analysis and facilitating partnerships between health centers and CBOs.

### *Structural Barriers to Health Care Access*

Ms. Guild provided an overview of the agricultural farmworker population, based on demographic data from the NAWS<sup>16</sup> and data on H-2A workers from the DOL Office of Foreign Labor Certification.<sup>17</sup>

There are an estimated 2.4 million farmworkers in the U.S. The total population is around four million, including family members. The vast majority (76 percent) are foreign-born, 83 percent are Hispanic, and about 74 percent report Spanish as their dominant language. Approximately six percent of agricultural workers are indigenous. Nearly half of all agricultural workers are without work authorization. In FY20, 275,430 workers were in the U.S. on temporary, non-immigrant H-2A visas.

Social determinants that directly impact farmworker health include living and working conditions, physical health, and mental health. Farmworkers also face structural and societal barriers, including discrimination, immigration status, language, continuity of care, and the policy environment.

- Living conditions: Agricultural workers tend to be isolated from the rest of the community and unfamiliar with community resources, including health centers. They often live in crowded conditions due to limited income. H-2A workers have employer-provided housing. Lack of transportation contributes to isolation.
- Working conditions: Agriculture is one of the most hazardous occupations. Barriers to accessing health care include lack of sick leave, non-traditional work hours, unfamiliarity with workplace rights, and fear of employer retaliation.
- Discrimination: Agricultural workers face discrimination due to lack of language access, especially those from indigenous communities; immigration status; cultural barriers; and poverty and low wages.
- Policy: Agricultural workers are directly impacted by policies related to occupational safety and health, immigration, and health care. Many labor laws exclude MSAWs. The lack of workplace protections made agricultural workers extremely vulnerable to COVID-19.

### *Role of Medical-Legal Partnerships (MLPs) to Address SDOH*

It is important to partner with legal services to address structural barriers and social determinants. Core MLP activities include legal assistance, training, clinic-level changes, and policy change strategies.

In farmworker communities, MLPs can promote coordination of resources, encourage knowledge-sharing about farmworker issues, empower farmworkers to improve their health and their living and working conditions by connecting them to health and legal services and address systemic problems that lead to poor health outcomes.

A traditional, fully integrated MLP may not be feasible or appropriate in farmworker communities. Examples of farmworker MLPs include referral systems, cross-training on health and legal issues that affect farmworkers, policy advocacy, and board participation.

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<sup>16</sup> <https://www.dol.gov/agencies/eta/national-agricultural-workers-survey>

<sup>17</sup> [https://www.dol.gov/sites/dolgov/files/ETA/oflc/pdfs/H-2A\\_Selected\\_Statistics\\_FY2020.pdf](https://www.dol.gov/sites/dolgov/files/ETA/oflc/pdfs/H-2A_Selected_Statistics_FY2020.pdf)

Ms. Figueroa discussed MLP challenges and innovative practices in farmworker communities:

- The seasonal nature of agricultural labor can impact MLP staffing needs. All staff must understand their role in the MLP. Frequent meetings and good communications are essential to coordinate activities.
- MLPs have a variety of funding sources, including federal and state grants, academic institutions, and private institutions. It is important to determine whether there are any limitations on the use of funds, such as immigration status. It is also important to track intake, referrals, and outcomes secure funding, and demonstrate the economic impact, including improved health outcomes.
- Health center staff must learn to recognize health and legal issues and identify patients who can be helped by MLP services.
- Occupational injuries and illnesses are common among agricultural workers. MLPs should have someone on staff who can guide patients through the worker's compensation process.
- Introducing an MLP can impact existing relationships. An employer may be comfortable having health care providers onsite, but that relationship might be strained if the provider is collaborating with legal service providers.

Ms. Figueroa described medical-legal interventions to address issues related to COVID-19 in farmworker communities:<sup>18</sup>

- Issue: Many farmworkers cannot afford to miss work if they need to quarantine or experience vaccine side effects.
  - Intervention: Improve access to replacement income and paid leave; protect against employer retaliation.
- Issue: H-2A workers struggle to access COVID-19 testing, vaccines, and resources.
  - Intervention: Provide COVID-19 education to H-2A workers at employer-provided housing.
- Issue: Need for coordination among community partners to promote COVID-19 information and vaccination.
  - Intervention: Convene a coalition to share information, collaborate, and problem solve.

#### *Policy Recommendations*

- Support programs and funding to address structural barriers, such as telehealth, mobile clinics, language access, outreach/promotoras de salud, MLPs.
- Leverage partnership with DOL to promote information sharing about workplace rights to farmworker patients.

Ms. Figueroa provided a list of resources on MLPs for agricultural worker communities that are available through Farmworker Justice (<http://farmworkerjustice.org>) and an MLP toolkit for health centers developed by the National Center for Medical-Legal Partnerships (NCMLP).<sup>19</sup> She noted that NCMLP is also a HRSA-funded NTTAP.

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<sup>18</sup> Adapted from Monterey County MLP Webinar, New Medical-Legal Partnership Practices and Strategies in Agricultural Worker Communities, December 3, 2020 (<https://medical-legalpartnership.org/mlp-resources/webinar-agricultural-worker-communities/>).

<sup>19</sup> <https://medical-legalpartnership.org/mlp-resources/health-center-toolkit>

## Discussion

Mr. Calderon described a case in which a farmer is denied access to CHWs and asked what FJ would do in that situation.

- Ms. Figueroa replied that FJ does not provide direct legal services, but they work with legal services providers across the country. Access is a key issue for legal service providers, and it varies by state. If Mr. Calderon could let her know where the situation occurred, she would connect him with a legal service organization in that state.
- Ms. Guild added that legal services organizations often do outreach to H-2A workers. They can help health centers identify those workers and expand their outreach.

Ms. Cormier expressed interest in developing an MLP at her health center, where one board member is an attorney. She asked how many health centers use an attorney as an adviser for patients, how they do that, and what the results are.

- Ms. Figueroa said she could ask NCMLP for data on the total number. One option is to have an attorney who is available part-time at the health center, and providers make a referral. Other options are to offer a phone consultation or referrals.

Ms. Veguilla-Montañez asked if there is a pathway for promotores to be trained to address legal issues.

- Ms. Guild replied that two of the NTTAPs—MHP Salud (<https://mhpsalud.org/>) and Health Outreach Partners (<https://outreach-partners.org/>)—provide T/TA on how to integrate outreach workers and promotores in health centers. Many partnerships between health centers and legal services organizations begin through relationships established by those workers.

Ms. Dodson stated that the model of social determinants for farmworker health could help create a greater understanding of agricultural farmworkers among the general population. She asked if FJ plans to make that model available.

- Ms. Guild replied that the current administration's emphasis on health equity provides many opportunities to discuss the impact of social determinants on agricultural workers and other underserved populations and how they can be addressed at the individual, community, and policy levels.

Norma Marti of the North Carolina Community Engagement Alliance (NC CEAL) stated that her organization relies extensively on CHWs. Many are undocumented and have worked for years as volunteers because health centers cannot hire them. She asked how they could be included in the labor force.

- Ms. Figueroa replied that immigration policy is a major component of the issues FJ addresses. Some organizations and private donors do not have those constraints. Some states have made progress at the local level, but a fundamental change will require legislation at the federal level.
- Mr. Calderon said a program he coordinated in Northern California was able to provide a stipend for an undocumented individual who served as a promotora in her community.
- Ms. Guild stated that COVID-19 has highlighted the important role of CBOs as trusted sources of information and access to services. HRSA just announced funding for CBOs to support vaccine access. That recognition is due to the role of CHWs at those organizations.

## Public Comments

Ms. Brown-Singleton opened the floor for public comments.

*Gayle Thomas, MD, Medical Director, North Carolina Farmworker Health Program*

Dr. Thomas described a collaboration between the North Carolina Farmworker Health Program and the North Carolina Growers Association to vaccinate H-2A farmworkers upon arrival.

The NCFHP is in the Office of Rural Health in the North Carolina Department of Health and Human Services. During the pandemic, they have made stronger connections with colleagues at the Departments of Commerce and Labor, and especially at the Agricultural Extension program. Those connections formed the basis of their approach to vaccinating farmworkers.

Each of North Carolina's 100 counties has an Agricultural Extension office. The state committed one agricultural extension agent from each office to assist in the effort to vaccinate farmworkers in that county. NCFHP paired each extension agent with a Farmworker Health outreach worker, or CHW, and connected each team with the vaccine providers in their county, including the health department and FQHCs. They provided the extension agent with the arrival dates for registered migrant farmworkers so the agent could contact the growers and help them access vaccines for their workers through on-farm vaccine events or appointments at clinics.

NCFHP recently connected with the North Carolina Department of Commerce so their outreach workers could offer vaccines to farm labor contractors.

NCFHP is connecting the various organizations, hosting virtual team introductions, and hosting ongoing meetings.

NCFHP asked the agricultural extension agents to report the number of vaccinations given to farmworkers each week. To date, 88 of the 100 teams have reported a total of 13,998 doses and 7,495 fully vaccinated workers.

One large farm employer that processes around 9,000 workers each year through a central arrival site gave NCFHP permission to offer the J&J vaccine upon arrival using a large, state-contracted vaccine company. To date, they have held 10 events and vaccinated 2,030 workers, with an average of 90 percent uptake of the vaccine among arriving workers.

The program has encountered numerous challenges. The J&J pause caused them to miss about 1,000 workers because they could not pivot quickly to the Moderna vaccine. It is difficult to find workers for their second dose of Moderna once they fan out across the state. The J&J doses in North Carolina are about to expire, and they do not know if they will be able to replenish the supply.

Language capability for a large group of non-English speakers is an additional challenge. DHHS is helping to pay for interpreters to support the project with the large employer and for a vaccine event for Haitian Creole-speaking workers.

NCFHP believes that Internet access is as essential as water and electricity to farmworkers. They are using some of their federal COVID funds to purchase and distribute hot spots to migrant camps. Last year they focused primarily on camps that were experiencing outbreaks and workers who were in isolation. This year they have been able to distribute them more broadly, along with stronger routers that support more devices. They have also been able to collaborate with the North Carolina Agromedicine Institute to reimburse growers who choose to install broadband in their migrant camps.

More than 2,000 farmworkers have gained Internet access through this initiative, allowing them to access telehealth and teletherapy services and set up remote monitoring devices for conditions such as

hypertension. The lack of broadband in many rural areas has been a challenge. NCFHP is advocating at the state level to address that issue.

### Discussion

Ms. Cormier noted that NCFHP provided a list of growers to the extension workers. She asked if health centers in other states could request a similar list.

- Dr. Thomas replied that they submitted a request for public records to the Department of Commerce to obtain a list of registered farmworkers. The list did not include undocumented farmworkers and seasonal families, who can only be found through individual contacts by outreach workers. They also requested a list of registered migrant farmworker camps from the Department of Labor. She noted that North Carolina is one of the largest users of the H-2A program; the public records might not be as useful in states with fewer H-2A workers.

Ms. Marti noted that NC CEAL's Latino/Hispanic Community Response Team has been working on how to address vaccine hesitancy and engage the Latino community. An organization that works with farmworkers told them that much of the vaccine hesitancy is due to concerns about missing a day or two of work. She asked if there are ways to incentivize growers to offer up to two days of sick leave for anyone who is vaccinated, such as by reimbursing them for the missed labor.

- Dr. Thomas supported that idea and noted concerns about missing work also contributed to hesitancy around testing. A bill that was introduced to the state legislature to reimburse growers who compensate workers for lost wages did not pass, although a bill did to reimburse growers who provide housing for isolation.

Ms. Higgins commented that there was a great deal of hesitancy related to the J&J vaccine due to the pause and opposition from religious groups. She asked if NCFHP offers a choice of vaccines.

- Dr. Thomas replied that the J&J vaccine is the only one that is available at the H-2A arrival site. Farmworkers who prefer a different vaccine are given contact information for the Farmworker Health outreach worker in the county where they will be employed so they can make an appointment. She noted that concerns about the J&J vaccine were more prevalent among seasonal workers. There was little to no hesitancy among the H-2A workers.

Dr. Snipes asked what the success rates have been for follow-up with H-2A and non-H-2A workers. She also stated that the J&J vaccine is not the only strategy that should be implemented for farmworkers. There are ways to follow up with MSAWs and their families regarding vaccination.

- Dr. Thomas replied that many of the on-farm vaccination programs have been using the Moderna vaccine. It is easy to schedule the second dose because they know where the worker will be. The H-2A workers are only at the arrival site for a few hours before they spread out across the state. Tracking them for their second dose is difficult.

*Norma Marti, Minority Outreach Consultant, NC CEAL*

Ms. Marti noted that NC CEAL is one of 22 research teams in the U.S. funded by the NIH Community Engagement Alliance (CEAL) Against COVID-19 Disparities initiative.<sup>20</sup> Their focus is to conduct community-based research to address vaccine hesitancy among historically marginalized populations.

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<sup>20</sup> <https://covid19community.nih.gov/>

NC CEAL has been meeting since January. They have a Latino/Hispanic Community Response Team, an African American Community Response Team, and an American Indian/Native American Community Response Team, each with a community co-lead, a faculty co-lead, and a program manager.

The Latino/Hispanic Community Response Team is convening groups from across the state to identify successful strategies for messaging and gaining trust within the community in North Carolina. They are collaborating with partners in Arizona and California to develop simplified messaging for languages other than Spanish. Potential formats include animation and fotonovelas.

NIH funding will support the program through February 2022.

*Gira Ravelo, PhD, Research Professor, Florida International University, NIH CEAL program*

Dr. Ravelo is part of a CEAL team that is conducting research with diverse groups of Latinos in Miami and the farmworker community in Miami-Dade County through strategic focus groups and surveys.

The team developed educational materials to address vaccine hesitancy and tested them through the focus groups. They plan to develop messages that can be shared through multimedia and social media, based on feedback from the focus groups.

The focus groups have been completed. They are still collecting survey data.

Trust is extremely important to these communities, and disinformation and conspiracy theories are major factors in vaccine hesitancy. Dr. Ravelo and other members of the team have developed relationships with these communities over many years, which made it possible to conduct this research. They plan to use community leaders and CHWs to disseminate the information they develop.

The team has learned that the farmworkers are getting much of their information through social media, especially Facebook and WhatsApp. They also listen to popular personalities on television.

## **Discussion**

Ms. Brown-Singleton asked what lessons have been learned that could help us respond more effectively to future pandemics.

- Dr. Ravelo said the biggest obstacle has been contradictory information in the media. People do not know what to believe. All of the focus groups raised the issue of the politics of the vaccine. It is critical to address the political divide.
- Ms. Marti said the most effective strategy is to keep things simple and local. The information must be simple, honest, and culturally respectful.

Mr. Calderon stressed the need to acknowledge how lethal the pandemic has been. Many of the issues that his clients face are related to unresolved grief. He is planning a community vigil to remember all who have been lost.

Ms. Cormier asked if there was any information that compares the number of COVID cases and deaths among MSAWs compared to the general population.

- Ms. Marti replied that medical and vaccination records do not include a person's occupation.
- Ms. Brown-Singleton said her health center used an online sign-up form that specifically asked if people worked on a farm, but she did not know if others did that.



- Ms. Paul noted that the meeting binder included a study on excess mortality associated with COVID-19 in California in 2020.<sup>21</sup> The highest rate was among farmworkers.

Ms. Higgins asked if there is a way to know which vaccines farmworkers have been given by region and the percentage of migrants vaccinated by region.

- Ms. Brown-Singleton said that if vaccinations were entered into the Unified Data System as visits, the data would be captured. But not all health centers recorded them as a visit.

### **Meeting Wrap-Up and Adjourn**

*Sharon Brown-Singleton, Chair, NACMH*

Ms. Brown-Singleton thanked the presenters and Council members. She noted that the following day would be devoted to developing the Council's recommendations.

Ms. Brown-Singleton adjourned the meeting for the day at 4:58 p.m.

## **Friday, May 28, 2021**

### **Formulation of Letter of Recommendations to the Secretary of DHHS**

*NACMH members*

Ms. Brown-Singleton welcomed Council members to the final day of the meeting and outlined the process for developing the letter of recommendations.

Council members identified key issues that emerged from the testimonies and presentations and discussed potential recommendations in four thematic areas: access to care, accountability, social determinants of health and structural inequities, and access to care for indigenous populations.

Council members agreed to work in the following teams to develop a draft of each section:

- Access to care: Deb Salazar, Jose Salinas
- Accountability: Angel Calderon, Dani Higgins
- Social determinants of health and structural inequities: Donalda Dodson, Jonathan Raber
- Access to care for indigenous populations: Angie Cormier, Carmen Veguilla- Montañez

Ms. Brown-Singleton said she would develop the introduction and the section on farmworker testimonies.

Dr. Snipes said she would combine the draft sections and develop the full letter.

Council members agreed on a timeline for developing and submitting the letter.

### **Closing – Meeting Wrap-Up and Adjourn**

*Sharon Brown-Singleton, Chair, NACMH*

Ms. Brown-Singleton thanked the interpreters and the notetaker for their excellent support.

Ms. Paul commended Ms. Brown-Singleton and Dr. Snipes for their outstanding service as Council Chair and Vice-Chair, respectively. She announced that Deb Salazar would serve as chair for the coming year and Jose Salinas would serve as Vice-Chair.

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<sup>21</sup> <https://doi.org/10.1101/2021.01.21.21250266>

Ms. Paul congratulated Ms. Salazar on receiving the 2021 Outstanding Service Award for Migrant Health from NACHC.

**Next Meeting**

Ms. Paul stated that the November meeting could potentially be conducted in person. The final decision would be confirmed in the near future.

Council members identified potential topics for the next meeting, including justice for migrant women, nutrition and food insecurity, trauma-informed care, medical coverage for agricultural workers, and systems-level change.

Ms. Salazar thanked Ms. Brown-Singleton and Dr. Snipes for their excellent service.

Ms. Brown-Singleton thanked Ms. Paul for her leadership and support.

Ms. Paul thanked the logistics contractor for their excellent support.

Ms. Brown-Singleton adjourned the meeting at 4:54 p.m.

# **U.S. Department of Health and Human Services National Advisory Council on Migrant Health (NACMH)**

**May 25-28, 2021  
Virtual Meeting**

## **Appendix A: Testimony Questions**

### **I. Impact of Covid-19 on workers and their families:**

1. What do you know about the Covid-19 vaccines?
2. Do you know others who have chosen not to be vaccinated? What are their reasons?
3. How has COVID affected your ability to work? More down periods, less work available?
4. Have you or a family member been affected by COVID infections?
5. Did you or someone you know need to be isolated in quarantine away from family? How were those costs covered? How was that experience?
6. Were there times when you needed to weigh having enough money for food or rent and going to work against the risk of COVID infection?
7. Were there times when you knew someone was positive for COVID or a contact of COVID yet they were requested to continue working?
8. If someone tests positive for COVID at your job, what is the practice for informing the employees and quarantining?
9. Do you feel that your family's health care needs are being met? Have you and your family members received the proper support and follow-up by the health care providers?
10. What made you decide to move to the USA?
11. What barriers do you feel you and your family have to access appropriate and comprehensive care for them and their family?
12. Do you have any fear or reluctance accessing medical services? If yes, why?
13. Are you able to have medical insurance for you and your loved ones?
14. What has been your worst experience with access to medical support, medicines, and doctors? Why?
15. What is the situation with vaccine hesitancy and personal protective equipment, in Oregon? Are the local health centers working on these issues?

### **II. Indigenous Migrant and Seasonal Agricultural Workers and unique needs:**

1. Tell me something very special or beautiful about your country that most people don't know. How can we build upon this pride to reach more farmworkers like you?
2. Do you feel health care providers offer the appropriate interpreting services needed for communicating your health concerns with the doctor?
3. Did you require transportation services to get to a health provider for health care services? Was a mobile health unit ever utilized at your place of employment?
4. Do you feel that health centers are aware of the health needs of the farmworkers in their service area? And do they offer flexible times for farmworkers?
5. Are there home remedies that you bring from your home country that you feel help cure certain ailments? Tell us about some of them.

**III. Legal Medical Partnerships (MLPs):**

1. What are best ways to building a cooperative relationship with employers? And what can employers do to connect their workers to the valuable services and resources available to them?
2. In some situations where the employer is abusing the worker, they often isolate the victim from the rest of the worker crew to avoid getting caught. Can you validate this?
3. What have you encountered as some of the leading issues with farmworkers as it relates to medical/legal issues?
4. It would be interesting to know how much the workers know about MLPs and how to inform their co-workers about this resource as well as the integrated health and wellness services available to them.

**IV. Oregon Wildfires:**

1. Did your family have problems with the wildfires that Oregon had last year? What kinds of issues did they have?
2. Did you know people who were affected by the wildfires? What happened to them, or what was their need?
3. What was the impact you had with forest fires? For example:
  - a. Did you have to keep working?
  - b. Did they have to provide you with the necessary equipment to protect yourself?
  - c. Did you have to evacuate or move from your home due to the fires? Did you have a safe place to protect your family?
  - d. Did you face medical problems due to the fires? Do you feel that you received the necessary medical help during this time?

**V. Thinking about the health needs that migrant families face:**

1. What do you think is the greatest need for migrant or low-income families around health, and why?