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

## November 6-7, 2019
## Rockville, MD

## Meeting Minutes

## Council Members in Attendance

Daniel Jaime (Chair)
Sharon Brown-Singleton (Vice Chair)
Rogelio Aguilar
J. Angel Calderon
Angelina Vallejo Cormier
Donalda Dodson
Dani Higgins
Carmen Veguilla Montañez
Jonathan Raber
Deborah Salazar
Jose Salinas
Gary Skoog
Shedra A. Snipes

## 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):

- Iran Naqvi, MBA, MHS, Deputy Director
- Esther Paul, MBBS, MA, MPH, Designated Federal Official, NACMH

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The National Advisory Council on Migrant Health (NACMH/Council) met in Rockville, Maryland on November 6 and 7, 2019 to review the health care concerns of migrant and seasonal agricultural workers (MSAWs) and issues pertaining to the organization, operation, selection, and funding of migrant health centers (MHCs) and other entities assisted under section 330(g) of the Public Health Service Act as amended, 42 USC 254(b). The goal of the meeting was to develop recommendations to the Secretary of HHS and the HRSA Administrator to improve health services and conditions for MSAWs and their families.

## Wednesday, November 6, 2019

### Call to Order/Introductions

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

Ms. Paul called the meeting to order and welcomed Council members, meeting staff, and guests.

HRSA meeting manager, Rebecca Yobouet, and logistics contractor, Morgan Pinckney, reviewed logistics for the meeting.

**NACMH Chair Opening Remarks**

*Daniel Jaime, Chair, NACMH*

Mr. Jaime welcomed Council members, meeting staff, and guests and led a round of introductions.

Mr. Jaime called for a motion to approve the minutes of the May 2019 meeting. The motion was made by Mr. Skoog and seconded by Dr. Snipes.

Mr. Jaime called for a motion to approve the agenda for this meeting. The motion was made by Ms. Brown-Singleton and seconded by Mr. Aguilar.

Ms. Yobouet reviewed procedures for reimbursement of Council members' travel expenses.

Ms. Brown-Singleton reviewed the purpose of the meeting and outlined factors for Council members to consider when developing recommendations.

**Welcome**

*Iran Naqvi, MBA, MHS, Deputy Director, SIPD, OPPD, BPHC, HRSA, HHS*

Ms. Naqvi welcomed Acting Administrator of HRSA, Thomas J. Engels, to the meeting and outlined his background and accomplishments.

**Opening Remarks**

*Thomas J. Engels, Acting Administrator, HRSA*

Mr. Engels warmly welcomed Council members and migrant health stakeholders to the meeting. He stated that HRSA's impressive staff does all they can to ensure that people across America have access to high-quality healthcare services. They reach tens of millions of people each year by providing grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, and state, local, and tribal governments.

HRSA's health center program plays a central role in increasing access to care, while raising the standard for the quality of health care nationwide. In 2018, health centers provided care to more than 28 million people in underserved areas across the nation and nearly a million MSAWs.

Mr. Engels noted that the health center program began as the migrant health program (MHP). The NACMH was established in November 1975 to ensure that MHC patients had a say in how care was provided in those health centers.

Mr. Engels congratulated Council members for continuously striving to improve the health and welfare of the nation's MSAWs. He acknowledged that most Council members also serve on the board of their local MHC. HRSA appreciates their service to the community, which is at the heart of HRSA's mission to provide quality, comprehensive, community-based health care. The Council's bi-annual recommendations help BPHC review its ongoing initiatives to assist health centers through policy and programs, training and technical assistance (TA), and data and information sharing.

Mr. Engels outlined the priorities of HHS Secretary Azar and HRSA's role in achieving them:

- Value-based care: Use health insurance reform to improve the affordability and availability of health insurance, so that everyone has access to personalized health care that meets their individual needs and budgets.
- Prescription drug prices: HHS is working on lowering prescription drug prices for all Americans, without interrupting innovation.
- The opioid crisis: Health centers play a leading role in this effort. HRSA awarded more than $200 million to help health centers meet the need for high-quality behavioral health (BH) services and substance use disorder (SUD) treatment that are integrated in primary care and rural settings. The investment is paying dividends. The number of patients receiving medication-assisted treatment (MAT) at HRSA-funded health centers increased by 142 percent, from 2016 to 2018.
- Ending the HIV Epidemic: A Plan for America: HRSA is at the forefront of this initiative. Health centers and the Ryan White HIV/AIDS program play a key role in providing diagnostic, testing, and HIV prevention services. The President's 2020 budget proposed $15 million in new spending to expand pre-exposure prophylaxis (PReP) and HIV/AIDS services, outreach, and care coordination. Funding opportunities are currently open for eligible health care centers and Ryan White HIV/AIDS program grantees.
- Increasing access to oral health care: In September 2019, HRSA awarded more than $85 million to nearly 300 health centers nationwide to support oral health infrastructure enhancements.

Mr. Engel said he looked forward to receiving the Council's recommendations. He thanked and congratulated Council members for their work in their communities and on the Council and urged them to remain steadfast in their commitment to MSAWs.

Discussion

- Dr. Snipes asked what happens to health care centers that are not functioning well in communities that need them. She felt there should be a balance between ensuring compliance and continuing funding to provide services where they are needed.
    - Mr. Engel replied that pulling funding for a health center is the last option, because people in the community rely on the services it provides. Before that happens, HRSA does everything possible to help the center become successful. If a grantee is not meeting its obligations, HRSA encourages other awardees in the area to fulfill the grant. HRSA recently began rewarding programs that demonstrate extra initiative and meet certain goals, in an effort to encourage competition between health centers.
- Ms. Naqvi asked if HRSA has a goal of reducing maternal mortality.
    - Mr. Engel expressed concern that the U.S. has one of the worst maternal mortality rates in the world, and the numbers have increased in last 30 years. It is important to make sure that women get the care they need from the beginning. A child without a mother has a difficult start in life. HRSA is doing everything possible to make progress and is working with partners across the country to ensure patients in rural and urban communities have access to quality care.

**Federal Update**

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

Dr. Joseph provided an update on the Health Center Program, including funding, services provided to MSAWs, and policy and program updates.

Uniform Data Systems (UDS) data for 2018 were finalized in August. HRSA-funded health centers served more than 28 million people last year, including nearly one million MSAWs. BPHC is pleased by the increase in the number of MSAWs served.

Funding

BPHC awarded nearly $500 million through six funding opportunities in FY 2019:

- Integrated Behavioral Health Services Expansion: $200 million, 1,208 awards
- Quality Improvement: $107 million, 1,273 awards
- New Access Points (competitive funding): $50 million, 77 awards
- Oral Health Infrastructure (competitive): $85 million, 298 awards
- Health Center Controlled Networks (competitive): $42 million, 49 awards
- School-Based Health Centers (competitive): $11 million, 120 awards.

The president's budget for FY 2020 includes $5.6 billion for health centers, including mandatory funding of $5.4 billion per year in FY 2020 and 2021, $1.626 billion in discretionary funding, and $50 million in proposed new funding in support of the HIV initiative.

HHS is currently operating under a continuing resolution that provides mandatory and discretionary funding for health centers on a month-to-month basis through November 21, 2019.

Supporting HHS Priorities

Health centers played a key role in supporting the Secretary's priorities in 2018:

- Ending the HIV Epidemic: Conducted 2.4 million HIV tests, served 190,000 people living with HIV/AIDS
- Addressing the Opioid Crisis: Served 2.5 million SUD/BH patients in 12.3 million visits; 142 percent increase in MAT patients and 188 percent increase in MAT providers since 2016
- Promoting Maternal Health: Served 563,000 prenatal care patients; delivered 172,000 babies
- Advancing Value-Based Care: Served 1 in 5 Medicaid patients nationwide, 1 in 5 self-pay/uninsured patients, 1 in 34 patients with private insurance, and 1 in 20 Medicare patients. HRSA invests in the value of health centers that know the communities they serve and put patients at the center of care.

Health centers also supported the Secretary's priority to reduce diabetes.

Ending the HIV Epidemic: A Plan for America

This initiative aims to reduce the HIV epidemic by 90 percent in 10 years by providing PreP to people at high risk of HIV in geographic "hot spots" across the country. HRSA is providing outreach funds for health centers in targeted areas that have Ryan White funding to identify people who are at high risk and have not been tested. The initiative will expand to other health centers over time, with a goal of including every health center. Health centers that are not currently part of this effort are encouraged to learn what is happening in their community so they will be ready to participate.

Supplemental Appropriations for Disaster Relief Act, 2019

This appropriation will support health centers for expenses directly related to a covered disaster or emergency or disaster response and recovery related to hurricanes, typhoons, wildfire, and earthquakes in calendar year (CY) 2018 and tornadoes and floods in CY 2019. Estimated funding is $79 million. HRSA is also helping health centers improve their capacity to respond to disaster.

MSAWs Served in 2018 by Health Center Funding Type

The total number of MSAW patients increased from 972,251 in 2017 to 995,232 in 2018. Most of the increase was at health centers that receive migrant health funding.

There was an increase in the number of MHC patients served for depression and other mood disorders and anxiety disorders, including post-traumatic stress disorder (PTSD). That change might reflect the increased number of patients served. At the same time, the number of MHC patients who received screening, brief intervention, and referral to treatment (SBIRT) services declined significantly, along with the number of patients who received counseling for smoking and tobacco use cessation. Factors for the decrease cannot be determined from UDS data.

Selected Health Center Program Activities

National training and technical assistance (T/TA) partners funded by HRSA developed resources in response to the Council's recommendations from May 2019, including strategies for trauma-informed care, materials to support language access, resources to address transportation barriers to care, community health worker programs to address aging in place, support for continuity of care for mobile patient populations, and sliding fee scale considerations for health centers serving MSAWs.

BPHC proposed changes to modernize the UDS and capture data on social determinants of health (SDOH). In 2019, the UDS asked health centers if they screen for SDOH and what screening tools they use. In 2020, the UDS will collect data on the number of patients who screen positive for lack of access to transportation, housing issues, food insecurity, and financial strain. The data will help BPHC determine what resources are needed to address those issues.

In 2017, the UDS collected data on the number of health centers offering telehealth services for primary care, specialty care, mental health, oral health, and other services. The UDS expanded the list in 2018 to include SUD, dermatology, disaster management, and consumer and professional health education to better understand the types of telehealth services health centers are providing.

Service Area Request for Information (RFI) and Policy Development Timeline

In April 2019, BPHC released an RFI to help it make informed decisions when a health center proposes to add a site in a location that overlaps the service area for another health center. The RFI requested feedback on factors such as proximity, urban versus rural areas, performance, and unmet need. BPHC received more than 600 responses during the 60-day comment period. At the time of this meeting, BPHC was reviewing the feedback. It will draft a policy, as appropriate, in Winter 2020. The goal is to create a policy that makes decision-making more transparent.

Continuous Compliance

BPHC recently updated the Compliance Manual and Site Visit Protocol to give health centers an opportunity to respond to findings of non-compliance that could result in conditions placed on their award. Because of these changes, more health centers are ultimately compliant, but fewer health

centers have no findings of non-compliance at the conclusion of their site visit. The situation has improved, but there is more to be done.

BPHC 2022: Establishing a Clear Vision for the Future

BPHC's vision for 2022 is to use a dynamic, data-driven approach to increase the impact of the health center program with each dollar spent. The approach includes initiatives that are using research and evidence-based decision making to assess unmet needs, strengthen and modernize UDS reporting, grow health IT capabilities, and improve grantee performance management.

BPHC's overarching goal is to support health centers to be leaders in primary care by shifting the focus from compliance to performance improvement. To do that, BPHC is developing a data-driven, value-based grantee performance management system that provides incentives for health centers to advance across seven performance domains. Key challenges are how to define the performance domains and levels within each domain and how to help individual health centers move up the ladder across the continuum of success.

BPHC staff will support health centers in specialized ways, emphasizing customer-oriented work. Health Center Liaisons will serve as the "go-to" staff to administer and mange grants; Compliance Specialists will monitor and address compliance; and Technical Experts will build health center capacity and improve quality and performance.

Data and technology will enable BPHC to understand where health centers are across the continuum and target funding effectively. It will also provide opportunities for peer-to-peer interaction.

Discussion

- Mr. Calderon asked if BPHC has statistics on specific services provided to MSAWs.
  - Dr. Joseph said BPHC can break out most of the UDS data, as the Council requests.
- Mr. Calderon asked if there is specific funding for transportation services for MSAWs.
  - Dr. Joseph said BPHC is aware of the need for ongoing funding to expand enabling services, including transportation.

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

*Joseph Gallegos, Senior Vice President for Western Operations, NACHC*

Mr. Gallegos provided an update on funding for the community health center (CHC) program and key workforce programs and the status of the Ag Worker Access campaign.

Funding

Prior to 2010, CHCs were funded exclusively through an annual discretionary appropriation from Congress. In 2010, Congress created a dedicated five-year fund to support program growth due to implementation of the Affordable Care Act. The fund was re-authorized in two-year increments in 2015 and 2018.

Congress also funds two workforce programs that are critical for CHCs. The National Health Service Corps (NHSC) supports clinicians in underserved areas through loan repayment and scholarships. The Teaching Health Centers Graduate Medical Education program (THCGME) brings residency training for physicians and dentists into community-based settings.

CHC funding in FY19 included $4 billion in mandatory funding and $1.6 billion in discretionary funding. In September, Congress passed a continuing resolution that extended current funding for CHCs, NHSC, THCGME, other program extensions, and Medicaid relief for Puerto Rico and other U.S. territories through November 21. While this ensured that there would be no gap in services, it is important for Congress to agree on long-term funding for CHCs, workforce programs, and provisions related to surprise medical billing and drug pricing. The best-case scenario would be for Congress to agree on a long-term budget before November 21. The fallback plan would be another short-term funding extension. Failure to achieve agreement or pass an extension before November 21 would result in a government shutdown and no assurances for the timing of CHC funding.

NACHC is advocating for Congress to take urgent action to extend the CHC Fund for five years, with increases over time to allow for growth. Health centers are small businesses and need to plan for the future. Without sustainable and predictable funding, they will continue to experience operational and service-related impacts, which jeopardizes patient care. In addition, health centers are meeting unprecedented demand for services. The NHSC and THCGME programs need additional resources to support current and future workforce needs.

Ag Worker Access Campaign

Ag Worker Access is a national initiative launched in 2016, with an overarching goal of increasing the number of farmworkers served by CHCs to two million by 2020, with a goal for each health center to increase the number of agricultural workers served by 15 percent each year over the next five years.

Although the current policy environment has had negative impact on the number of agricultural workers who seek care, the number grew slightly in the past year.

The campaign is led by a 21-member task force composed of representatives of state, regional, and national organizations that share a commitment to improving access to care for MSAWs. NACHC, the National Center for Farmworker Health (NCFH), and Northwest Regional Primary Care Association (NWRPCA) serve as co-chairs.

The task force developed a three-pronged strategy to achieve the goals of the campaign:

- Credit where credit is due: Accurately identify and report all MSAW patients being seen in health centers, regardless of whether the health center receives migrant funding
- Open hearts, open doors, open access: Reach out to ag workers who are not currently being served. Develop partnerships and collaboration with community-based providers. Develop innovative strategies to reach more MSAWs.
- Build capacity to sustain growth: Ensure sufficient funding to support potential growth in services needed for an increased number of MSAW patients.

NACHC urges all CHCs and MHCs that serve MSAWs and their families to be involved in the campaign, along with individuals, organizations, and networks of health centers that share a commitment to this special population. Individuals are encouraged to share the importance of the campaign with friends and colleagues, get others involved, and follow and promote the campaign on social media. Organizations are encouraged to establish a board resolution affirming their commitment to increasing access to MSAWs, promote partnerships and collaborations with other organizations that serve this population, and promote the campaign on their website and in presentations.

Campaign resources are available on the NCFH website (http://www.ncfh.org).

**Overview: HRSA, BPHC National Cooperative Agreements Serving Migrant Health Centers**

*CDR Tracy Branch, DHSc, Senior Advisor, Strategic Partnerships Division, Office of Quality Improvement, BPHC, HRSA*

CDR Branch provided an overview of national cooperative agreements (NCAs) that provide training and technical assistance (T/TA) for health centers, HRSA interagency agreements, and promising practices for site visits. She noted that the NCAs would soon be called the National Health Center Training and Technical Assistance Partners (NHCTTAP).

HRSA funds 20 NCAs to address the needs of special populations, vulnerable populations, and health center developmental areas. One NCA serves as a national resource center for all health centers.

The NCAs provide T/TA, disseminate promising practices, and coordinate activities to support potential and existing health center program awardees and look-alikes across the nation. They are critical to the BPHC mission to support health centers' clinical and operational excellence.

The Migrant Health Act signed by President Kennedy in 1962 provided community health services for agricultural workers and their families. Legislation passed in 1964 as part of President Johnson's War on Poverty created Head Start and the food stamp program. In 1975, the health center program was authorized in Section 330 of the Public Health Service Act. In 1996, the CHC Program, MHC Program, Health Care for the Homeless Program, and the Public Housing Primary Care Program were consolidated under Section 330.

MHCs provide comprehensive, culturally and linguistically appropriate services for MSAWs and their families, with a focus on primary care. In 2018, 174 MHCs served 995,232 MSAWs and their families, an increase of 2.36 percent from 2017.

Five Migrant Health NCAs provide services and TA to help health centers increase access to care, improve health outcomes, and promote health equity. They work collaboratively to avoid duplication of services and enhance the work they provide. Each organization brings unique subject matter expertise:

- Farmworker Justice (FJ) provides T/TA related to federal and state policy and legislation impacting access to health care, with a focus on environmental justice.
- Migrant Clinician Network (MCN) provides T/TA on aspects of clinical care and issues impacting patients, providers, and clinical systems.
- Health Outreach Partners (HOP) provides T/TA on outreach and enabling services, program planning and development, needs assessments and evaluation, and community collaboration.
- MHP Salud provides T/TA to help health centers develop, implement, and sustain Promotores de Salud (Community Health Worker) programs.
- National Center for Farmworker Health (NCFH) provides T/TA related to health center governance, administration, and patient education.

The NCAs have developed promising practices and products addressing HRSA's priorities:

- Diabetes/childhood obesity: Special and Vulnerable Populations Diabetes Task Force formed by 15 NCAs (coordinated by MCN); article on Addressing Childhood Obesity through Family Physical Activity in *La Esperanza* newsletter (MHP Salud).
- Substance use/opioid use: Migrant stream forum sessions led by NCAs.
- Mental health/behavioral health: Accessing Behavioral Health Services: Health Network Case study (MCN); digital story on overcoming depression (NCFH).

- Health workforce: Series of webinars hosted by MCN.
- SDOH: SDOH Academy formed by 14 NCAs to develop, implement, and sustain interventions with health centers and integrate that work in communities. The Academy presented 19 shared learning opportunities in 2017 and 2018.

Other promising practices and products include:

- Webinar series on transportation barriers and office hours (HOP).
- Ag Worker Access 2020 Campaign led by NCFH and NACHC and supported by 45 percent of MHCs and numerous organizations.
- Workshops at migrant stream forums on the impact of state and federal policies on access to care (FJ), occupational and environmental health (FJ), and strategies to address fear and discrimination in agricultural worker communities (HOP).
- Quarterly *Health Policy Bulletin* (FJ).

The NCAs are working on addressing ongoing challenges facing MSAW populations, including difficulty accessing health care; health and well-being following exposure to environmental hazards or disasters; and the need to increase the cultural awareness of site visit consultants.

HRSA has several interagency collaborations that support MHCs.

- A memorandum of understanding (MOU) between HRSA and the Administration for Children and Families (ACF) enables BPHC to collaborate with the Office of Child Care, Office of Head Start (OHS), and the Migrant and Seasonal Head Start Program (MSHSP).
- An interagency agreement with the Department of Labor (DOL) allows HRSA to support DOL in fielding the National Agricultural Worker Survey (NAWS).

The migrant NCAs have developed promising practices for MHCs, including peer-to-peer learning for staff training (HOP), a communications portal for members of the Increase Access to Care network (NCFH), a culturally appropriate health center brochure (FJ), and the case management resources for MCN Health Network staff.

Discussion

- Mr. Calderon asked if site visit consultants look for specific numbers of MSAWs served by various programs, such as diabetes and conditions related to substance abuse.
    - CDR Branch replied that it is becoming possible to drill down through UDS data to look at specific variables, including special and vulnerable populations. They hope to be able to provide that information in the near future. It is important to have a clear picture of the patients served, what they need, and health center performance.
- Mr. Jaime referenced the Ag Worker 2020 goal and noted that there is still a gap in serving H-2A workers. Health centers have not identified strategies to reach those workers, and growers do not provide information about health care.
    - CDR Branch replied that health literacy is a challenge for both patients and providers. Enabling services and partnerships with community organizations are important. Churches can play an important role in providing information about resources for MSAWs. It behooves employers to make sure their workers have access to care.
- Ms. Higgins asked about the extent to which a site visit looks at whether a health center is using its migrant funding to provide services to MSAWs.
    - CDR Branch stated that project officers focus on whether a health center is providing the required services outlined by the HCP. She did not know the extent to which site

visit consultants focus on specific services provided to MSAW patients. She offered to investigate further regarding how they look at those needs.
    - Ms. Paul noted that one component of a site visit is a meeting with the board. A health center that receives migrant health funding must have a MSAW on their board.
    - CDR Branch stated that HRSA provides training each year before consultants conduct site visits. She would make sure that diabetes services for MSAWs are a priority for site visits in future years and are included as a component of the training.
- Ms. Vallejo Cormier asked if there was a way to find out how many H-2A workers are in Montana and where they are located.
    - Ms. Salazar offered to provide the link for a website with that information.
- Mr. Salinas stated that serving two million MSAWs is an attainable goal, but H-2A workers need transportation and permission from their crew leader to access health care. It is important to build partnerships with growers and crew leaders and to stress the value of a healthy workforce.
    - CDR Branch stated that employers need to know about the Farmworker Bill of Rights. Mobile units can eliminate the need for transportation, but workers still need to be given time to use the services.
- Ms. Vallejo Cormier expressed concern that H-2A workers are viewed as disposable, because they can be replaced easily.
    - CDR Branch stated that BPHC's initiative on intimate partner violence and human trafficking, which she co-leads, has seen a great deal of unreported exploitation in the H-2A population. We need to raise awareness, be vigilant, and advocate wherever we can.
- Dr. Snipes requested clarity about the characteristics of the 45 percent of MHCs that are supporting the Ag Worker Campaign compared to those that are not, in terms of the quality.
    - Gladys Cate stated that the MHCs that have committed to support the campaign include both high performers and those that are struggling. She offered to contact NCFH to get more detailed information.

**Violence in the Fields**

*Rebecca Young, MA, Senior Project Director - Community Engagement, Farmworker Justice; Iris Figueroa, JD, Staff Attorney, Farmworker Justice*

Ms. Young and Ms. Figueroa described barriers to care and healthy lifestyles for MSAWs, provided an overview of sexual harassment in agriculture, and presented a video on violence in the fields that they developed with funding from the Occupational Safety and Health Administration (OSHA).

Farmworker Justice is a national non-profit that seeks to empower farmworkers and their families to improve their living and working conditions, immigration status, occupational safety, health, and access to justice.

Farmworkers face numerous barriers to care and healthy lifestyles, including cultural issues (e.g., language, literacy, medical knowledge, health care practices and beliefs, and dietary practices); lack of social support due to social exclusion or isolation; food insecurity and/or lack of access to healthy foods; poverty, which results in lack of reliable transportation, lack of insurance, and substandard housing; limited job security, which increases the chance that workers will stay in a dangerous or questionable job; fear of retaliation; constant mobility, which causes discontinuity of care; immigration status; racism; and confusion about the U.S. health system.

FJ defines sexual harassment in agriculture as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. It is illegal if acceptance or rejection of sexual advances affects a worker's job or working conditions or if the harassment creates a hostile or offensive work environment and interferes with a worker's ability to do the job.

The most recent data on sexual harassment in agriculture are from 1993. An organization that works with farmworkers reported that 90 percent of female farmworkers in California reported that sexual harassment and abuse are a problem. The San Francisco District Office of the U.S. Equal Employment Opportunity Commission found that sexual harassment was rampant among farmworker women.

FJ partnered with Lideres Campesinas (LC), a California nonprofit dedicated to improving the lives of farmworker women and their families, on an OSHA-funded project, Breaking the Silence. The project aims to educate farmworker communities and beyond about the prevalence and risks associated with violence in the fields and provide farmworkers with the skills to identify risks of violence, barriers to reporting, and resources surrounding workplace violence for farmworker families in their community. The project is built on the principles of popular education. It is linguistically and culturally appropriate and includes hands-on training and activities.

FJ and LC conducted a needs assessment, developed a discussion guide and training materials, and produced a short video to encourage discussion of this sensitive issue. The script for the video was developed in collaboration with farmworker women, including those who speak indigenous languages. The actors were volunteers from the community. The team produced the video in Spanish with English subtitles and in Mixteco with Spanish subtitles.

The speakers showed the video to Council members and facilitated a brief conversation about their responses, using questions from the discussion guide developed for the project.

The speakers outlined practical steps to prevent harassment and the process for filing a formal complaint.

The speakers offered the following policy recommendations:

- Provide funding to ensure that health centers have the resources they need for outreach staff/community health workers to educate agricultural worker patients about sexual harassment.
- Encourage health centers to partner with community-based organizations.

<u>Discussion</u>

- Ms. Paul asked if video had been shown at health centers.
    - Ms. Young replied that LC tested the discussion guide with a group of female farmworkers. When the materials are finalized, FJ will post the video and discussion guide on their website. The purpose of this grant was to develop the resources; it did not include funding for outreach. FJ hopes to obtain funding to support an outreach campaign that would include clinics.
- Ms. Vallejo-Cormier asked if the video would be distributed in time to share it with farmworkers before the next field season.
    - Ms. Young replied that the video and discussion guide were completed, but they had not been published yet. She would ask FJ's director if those resources could be shared with the Council.

- Ms. Dodson asked if the video would include messages to empower women and to educate growers, who stand to lose workers due to harassment.
    - Ms. Young replied that bringing women together to share information about harassment is a form of empowerment. She agreed that it is important to involve crew leaders so they can see the importance of creating a safer working environment.
- Mr. Calderon stated that these incidents affect the entire community. He stressed the importance of education and collaboration with other agencies so farmworkers can get the services they need.
    - Ms. Young noted that the policy recommendation addressed the need for education and collaboration with local partners.
- Ms. Higgins said she would like to have seen the woman in the video take action. The video shows a number to call, but there is no indication that anyone made a call.
    - Ms. Figueroa replied that the video is intended to provoke a reaction and start a conversation about steps workers can take.
    - Ms. Young added that FJ hopes to obtain funding to develop a full training program on this topic that will use the video and include more comprehensive information about preventive measures and the process for filing a complaint.
    - Ms. Vallejo-Cormier suggested that the next version should include information to help children avoid situations that would put them in danger.
- Mr. Skoog stated that the situation is unlikely to improve without political and economic pressure on those who are responsible for allowing those behaviors to exist.
    - Ms. Figueroa agreed about the need for policy changes.

**Structural Considerations in Migrant and Seasonal Agricultural Worker Health Care**

*Cheryl Seymour, MD, Medical Director, Maine Migrant Health Program, Augusta, ME*

Dr. Seymour presented a structural differential approach to expand how we imagine, understand, narrate, investigate, and address the causes of illness and health disparities. She noted that the concept comes from medical anthropology.

The typical lenses to explain why people are sick are biology, behavior, and "culture"/social needs/community. In his book, *Fresh Fruit, Broken Bodies,* Seth Holmes suggests that social structures are a fourth lens.

Social structures are large forces such as policies, economics, and social hierarchies that produce and maintain modern social inequities and health disparities, often along the lines of social categories such as race, class, gender, sexuality, and ability.

Paul Farmer stated: "Social violence is one way of describing social arrangements that put individuals and people in harm's way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people."

Dr. Seymour presented five steps to develop and refine a structural differential:

1. Intentionally expand the scope of clinical inquiry to include structural factors.
2. Use tools such as the structural vulnerability checklist to frame and inform a broad list of hypotheses.
3. Gather perspectives from outside the exam room.
4. Learn about the historical context.
5. Partner with patients in their communities to clarify and prioritize relevant issues and actions.

Commonly cited barriers to health (e.g., poverty, mobility, fear, social isolation, lack of transportation, access to healthy food, job insecurity, racism, inadequate housing, literacy/language access, occupational hazards) often result from larger structural forces, including labor and agricultural policies, international trade policies, international political and economic instability, nativist rhetoric, police and immigration action in communities, and structural racism and individual bias in healthcare access and delivery.

We can engage with structures if we recognize and name them as direct causes of illness, see patients as structurally vulnerable (using screening tools to assess risk), and collaborate across disciplines to learn more and create interventions.

Assistant Secretary of Health, ADM Brett P. Giroir, MD, outlined the many factors that play a role in determining an individual's health outcome, beginning with the impact of social institutions, social hierarchies, and economic systems on policies and programs. He noted that the benefits are often dissociated from the people making the investment.

Dr. Seymour presented four considerations:

- The Centers for Medicare and Medicaid Services (CMS) and private health systems are working to change payment models and partner with states and cities in collaborative change. Where are the ongoing gaps in those plans that miss MSAWs?
- Data demonstrate that return on investment is challenging, even in a closed health system. How can we leverage existing national MSAW data or alter data collection to inform and/or evaluate structural interventions?
- Are there other opportunities to utilize the challenges faced by MSAWs as an accessible example of structural violence in order to help shift the narrative about the root causes of health disparities?
- What conversations can be had across departments to address structural interventions that would promote the health of MSAWs and others?

Dr. Seymour presented two recommendations:

1. Collate existing data sets and/or expand/focus data collection related to MSAWs, with the aim of informing and monitoring structural interventions at the federal level.
2. Establish a standing federal committee with leadership from multiple departments in order to address root causes of health inequity.

The themes of Healthy People 2030—closing gaps, cultivating healthier environments, health and well-being across the lifespan, and increasing knowledge and action—are relevant to this discussion.

Until we as a community can acknowledge the deep-rooted causes of inequity, we will not be able to address health disparities.

<u>Discussion</u>

- Dr. Snipes suggested that the first step would be to merge datasets at various levels and noted that state-level datasets include some of the indicators. She asked how the Council could present the concepts Dr. Seymour described so others would hear and understand them.
    - Dr. Seymour said it would be important to show the correlations between social structures and clinical indicators. Some can be addressed at the local level, but the structural factors that impact MSAWs are much larger.

- Dr. Joseph noted that the UDS only provides organizational-level data. HRSA is looking at the potential to collect patient-level data. However, the data would have to be de-identified, and it would be important to determine who can access the data for research.
- Mr. Calderon referenced ADM Giroir's statement that benefits are often dissociated from people who make the investments. He noted that CHCs that may have begun by serving the needs of MSAWs, may often shift their focus to serving the community at large.

**Facilitated Discussion on Possible Recommendations**

Council members discussed issues and themes from the presentations that could inform the Council's recommendations to the Secretary of DHHS. They identified the following issues:

- Sexual violence as a health care issue
- Value-based care
- Accountability for the number of MSAW patients served
- Gaps in identifying MSAW patients
- Outreach to MSAWs as a performance objective for health center CEOs
- Health literacy
- Infant and maternal mortality
- Equity of services
- Resources for research
- Partnerships between MHCs and growers to connect H-2A workers to health care and inform them of their rights
- Cultural competency for consultants conducting site visits
- Barriers to accessing care
- Impact of housing on health care.

Council members discussed the need to identify priority issues, clearly define the problems, and draft actionable recommendations.

Mr. Jaime called for a motion to adjourn the meeting for the day. The motion was made by Ms. Vallejo Cormier and seconded by Ms. Salazar.

The meeting was adjourned for the day at 5:00 p.m.

## Thursday, November 7, 2019

**Mr. Jaime called the meeting to order.**

**Recap from Previous Day**

*Sharon Brown-Singleton, MSM, LPN, Vice-Chair, NACMH*Ms. Brown-Singleton provided a high-level overview of the first day of the meeting.

**Demographic Profile of United States Farmworkers**

*Susan Gabbard, PhD, JBS International*

*Daniel Carroll, Employment and Training Administration (ETA), Office of Policy Development and Research, U.S. Department of Labor (DOL)*

Dr. Gabbard described changes in U.S. agriculture over the past 20 years, based on the 2017 Census of Agriculture (COA) and presented findings from the National Agricultural Worker Survey (NAWS) on crop workers' demographics and health.

Census of Agriculture

The COA is conducted every five years by the U.S. Department of Agriculture. It includes three labor questions regarding directly hired workers, hired labor expenses, and contract labor expenses.

Changes in agriculture in the past 20 years have increased the demand for farmworkers, making it more difficult for growers to find workers.

NAWS Findings

The NAWS is an annual random-sample survey of 1,500 to 3,000 crop workers and their family members in the continental U.S. It is a reliable source of information on crop worker demographics. It has limited regional coverage and no local data.

The NAWS sampling universe overlaps with the Section 330g definition of agriculture and MSAWs. However, it excludes groups that make up approximately one-third of the eligible population for MHCs, such as formerly employed agricultural workers, H-2A workers, livestock workers, aged or disabled farmworkers who are no longer doing crop work, or their family members. On the other hand, it includes data on 330g-eligible workers and their dependents who are not seen at health centers.

Legal and economic changes in the last 20 years have impacted the crop labor supply. New U.S. laws and more enforcement make it more difficult to cross the U.S.-Mexico border. Increased immigration enforcement makes migration difficult within the U.S. Economic growth, improved social programs, and decreased birth rates in Mexico reduced incentives for Mexican citizens to migrate to the U.S.

NAWS data illustrate demographic shifts in the crop worker population:

- The percentage of migratory workers declined from 49 percent to 19 percent from 2000 to 2016, while the number of H-2A visa crop workers doubled between 2014 and 2018.
- The average age of crop workers increased from 31 to 38 years, the number of women increased from 21 to 32 percent, and the number of parents went from 48 to 55 percent.
- Circulatory migration between Mexico and the U.S. has become more difficult. In 2000, 37 percent of crop workers crossed the border, compared to only nine percent in 2016.
- Eighty-four percent of crop workers are Hispanic, and six percent are indigenous. Sixty-eight percent were born in Mexico, 25 percent were born in the U.S. or Puerto Rico, and six percent were born in Central America.
- Crop workers now have an average of eight years of education, compared to six years in 2000. Only 10 percent have a high-school diploma, and 37 percent have only six years of education. Twenty-nine percent say they speak English well, while the same percent say they do not speak any English. Forty percent say they do not read any English, while 28 percent say they read English well.
- Slightly more than half of crop workers have children, 13 percent are married with no children, and 30 percent are single. Most parents have one or two children; only 10 percent have four or more children. One-third of parents use center-based childcare, but the majority of childcare for children under six is provided by family members.
- One-third of farmworkers are at 100 percent of the poverty level. Most are between 100 and 200 percent of the poverty level. Median family income is between $20,000 and $30,000.

Nearly 90 percent of crop workers live in off-farm housing; about half of that housing is in the private rental market. One-third of crop workers reported that they live in crowded housing.

Nearly two-thirds of crop workers own or are buying a vehicle, and 58 percent drive to work. Many others share rides; very few get to work by a bus, truck, or van provided by their employer.

The NAWS has a great deal of data on crop workers' health:

- Nearly all of crop workers reported that their children have health insurance. Slightly less than half have insurance for themselves, and slightly more than half of their spouses have insurance.
- Government programs are the primary source of health insurance, primarily due to Medicaid expansion and the Children's Health Insurance Program (CHIP). About 30 percent of workers and 14 percent of their spouses have employer-provided insurance.
- About 70 percent of crop workers said they had a healthcare visit in the last two years in the U.S. or abroad.
- The share of crop workers who said they were diagnosed with chronic conditions increased from 10 percent in 2000 to 22 percent in 2016. The change could be due to the increased number of workers who saw a healthcare provider, the aging workforce, or both.
- Twenty-nine percent of crop workers said their last healthcare visit was at a health center, and 43 percent saw another provider. Twenty-eight percent said they had no healthcare visits.

NAWS data make it possible to compare health center patients to the larger population and look at decisions about where MSAWs go for care. However, the NAWS only asks about the most recent provider, and the response depends upon the worker's ability to identify a CHC/MHC.

About half of the crop workers whose most recent visit was to a CHC/MHC were under 40, and 53 percent were male. Only 17 percent were migrant workers. Slightly more than half had a spouse and/or children. About one-quarter said they had been diagnosed with a chronic condition.

Forty-three percent of the crop workers who visited a CHC/MHC had health insurance, 27 percent of their spouses had insurance, and 85 percent of their children were insured. Spouses of those who saw other providers were more likely to be uninsured. Slightly more than half of crop workers who were insured, 60 percent of their spouses and 93 percent of their children had government coverage.

Compared to crop workers whose most recent visit was to a health center, those who saw other providers were slightly more likely to be male, less likely to have children, and slightly less likely to have been diagnosed with a chronic condition. Workers who saw other providers were more likely to have health insurance, as were their spouses and children. They were less likely to have government-provided insurance.

Crop workers who reported no recent provider visits were more likely to be under 40, male, and migrant than those who visited a health center. They were less likely to have a spouse or children and much less likely to have a chronic condition. Less than one-third of workers and their spouses who reported no provider visits had insurance, but nearly all of their children had government insurance.

In summary:

- Since 2000, the crop worker population has become older and more female. Crop workers continue to be mostly Hispanic/Latino.
- More crop workers have families, and more families have children. Workers are migrating less, and fewer crop workers live away from their families.
- More crop workers have insurance, but 53 percent are still uninsured. More than two-thirds are using U.S. health care. About one in five has been diagnosed with a chronic condition.

- MHCs and CHCs serve one in five crop workers overall and two in five crop workers who receive care. Crop worker patients of health centers are older, sicker, and uninsured than those who see other providers.

Mr. Carroll reviewed the history, collaborative aspects, and costs of the NAWS, described past and current health question domains, and outlined potential survey goals going forward.

The NAWS was created in 1989 to address the DOL's mandate under the Immigration Reform and Control Act of 1986 (IRCA). The purpose of the NAWS was to determine if IRCA would result in a shortage of agricultural workers between 1990 and 1993. The survey has continued because it helps inform a number of federal programs that were created to help agricultural workers, including Migrant and Seasonal Head Start, migrant health, migrant education, and the National Farmworker Jobs Program. It also helps address routine and periodic information needs for various federal agencies.

The survey is conducted in 12 sampling regions across the country. Each region is surveyed three times a year, using a multi-stage, stratified sampling methodology.

The NAWS has a research data file where data can be analyzed at the 12-region level, and a public data files, where data can be analyzed for six regions. The public data file includes research reports, presentations, and data tables with demographic and employment data for each region.

The NAWS is a multi-agency funded effort. Non-DOL funding is sporadic and is typically associated with new survey questions. ETA meets quarterly with HRSA to determine the direction of the survey. It meets less regularly with other agencies.

Questionnaire development is a collaborative undertaking. DOL could use more help in this area.

Current survey domains include pesticide handling, chronic disease, preventive health, general anxiety disorder, access and use of digital devices, and education and training. In the past, the survey has included questions on respiratory health, occupational injury, tobacco and alcohol use, depression, job demands and control, and clothes laundering and hygiene practices.

The NAWS is a cost-efficient survey. In the past 10 years, the average annual contract cost was $3.1 million. Non-DOL agencies typically transfer funds to ETA for the NAWS when they add questions to the survey. DOL is proposing legislation to require non-DOL agencies to contribute to annual base costs.

Potential survey directions include:

- Return to IRCA roots (add labor-supply and job-satisfaction questions)
- Create a Community of Practice or Technical working Group to provide additional and ongoing subject matter expertise on survey questions and design
- Establish a release date for reports and public data files.
- Expand the survey to include additional populations, including H-2A and livestock workers.

<u>Discussion</u>

- Ms. Naqvi asked why the crop worker population is aging.
    - Dr. Gabbard replied that workers are tending to remain in their farm jobs and age in place. Fewer workers are moving to other industries as they did in the past.
- Mr. Aguilar asked why H-2A and livestock workers are excluded from the NAWS and noted that many of those workers fall into the Medicaid gap.

    - Mr. Carroll replied that those workers are excluded because the legislative purpose of the survey is to determine whether there would be a shortage of seasonal agricultural workers.
    - Dr. Gabbard proposed the following recommendations: continue the NAWS, add H-2A workers, ensure that the patient survey collects information on dependents, and analyze existing farmworker data in the patient survey.
- Dr. Snipes asked if including H-2A workers would impact the cost of the survey.
    - Mr. Carroll replied that labor expenditures dictate where the teams go to find crop workers. Expenditures for H-2A workers are included in the COA. The NAWS currently sends interviewers to North Carolina, Georgia, and California, where most of the workforce consists of H-2A workers. The cost of the NAWS would decrease if the teams could interview those workers.
- Ms. Paul asked how including H-2A workers would impact the data sets.
    - Mr. Carroll replied that they would have to increase the sample size and possibly revise the methodology.
- Ms. Vallejo-Cormier asked if fear of being stopped and deported was impacting participation in the NAWS.
    - Mr. Carroll replied that during a recent public comment period, DOL received many suggestions to add questions about fear due to changes in enforcement. The survey has a high level of participation, because interviewers are experienced in developing rapport with both employers and crop workers.
- Mr. Calderon asked who sponsors the H-2A visa program.
    - Mr. Carroll replied that the program is administered by the Department of Homeland Security, the Department of Justice, and DOL. DOL manages the labor certification process for employers.

**Demographic Profile of United States Farmworkers: H-2A Workers**

*Jennifer Lee, Analyst, Wage and Hour Division, DOL*

Ms. Lee described the purpose and scope of the H-2A visa program, outlined employers' contractual obligations, reviewed worker protections, and provided resources for information on workers' rights. She noted that DOL is responsible for worker protections for the H-2A visa program and the Migrant and Seasonal Agricultural Worker Protection Act (MSPA).

Purpose of the H-2A program

The Immigration and Nationality Act (INA) allows employers to import temporary foreign agricultural workers by applying for certification that (a) there are not sufficient workers who are able, willing, and qualified, and who will be available at the time and place needed, to perform the labor or services involved in the petition, and (b) the employment of the alien in such labor or services will not adversely affect the wages and working conditions of workers in the United States similarly employed.

The program has a wide range of regulations and protections that cover H-2A visa workers and domestic workers who are doing the same work ("corresponding employment"). They include:

- Preferential treatment prohibited: The employer must offer terms and working conditions to U.S. workers that are not less favorable than those offered to H-2A workers and may not impose any restrictions or obligations on U.S. workers that will not also be imposed on H-2A workers.
- Positive recruitment: The employer is required to conduct DOL-specified recruitment activities and must accept referrals of eligible U.S. workers.

- 50% rule: The employer must provide employment to any qualified, eligible U.S. worker who applies for the job opportunity until 50 percent of the period of the work contract has elapsed.
- Layoff and displacement of U.S. workers: No layoffs are allowed within 60 days of the date of need, except for lawful, job-related reasons. If a layoff has occurred, the employer must first offer the job opportunity to laid-off U.S. workers before hiring any H-2A workers.
- Payment of required wages: The employer must pay the highest applicable wage in effect at the time work is performed. Wages may be calculated based on hourly or piece rates.
- 3/4 guarantee: The employer must guarantee to offer employment for a total number of hours equal to at least three-fourths of the workdays in the contract period.
- Transportation: The employer must provide or pay for transportation and daily meals to the place or employment or reimburse workers once 50 percent of the contract period has elapsed. They must also provide or pay for return transportation and daily meals upon completion of the work contract period and must provide daily transportation between the camp and fields at no cost. Transportation must comply with all applicable laws and regulations and must meet safety standards, driver licensing, and vehicle insurance standards specified in MSPA.
- Housing: The employer must provide housing at no cost to H-2A workers and workers in corresponding employment who are not reasonably able to return to their residence within the same day. Housing must be inspected and approved prior to occupancy. Rental or public accommodations must meet local standards and must be paid directly by the employer.
- Meals: The employer must provide three meals per day to each worker at no more than a DOL-specified cost or furnish free and convenient cooking and kitchen facilities.
- Disclosure: The employer must provide a copy of the work contract to each worker no later than the time at which the H-2A worker applies for the visa, or no later than the first day of work for domestic workers. The contract must be in a language the worker understands and must specify all deductions that will be made. Undisclosed deductions are not permitted.
- Disclosure: The employer must provide a copy of the work contract to each worker no later than the time at which the H-2A worker applies for the visa or the first day of work for those in corresponding employment. The contract must be in a language understood by the worker.
- Deductions: Certain deductions are specifically prohibited, and undisclosed deductions are impermissible. Deductions for expenses that are for the primary benefit of the employer may not bring an employee's wages below the H-2A required wage rate.
- Notice of Worker Rights: The employer must the rights and protections of H-2A workers and workers in corresponding employment in English and another language, as necessary, in a location where employees can readily see it. The poster may be obtained from DOL.

Information and outreach materials are available at the Wage and Hour Division website (https://www.wagehour.dol.gov). A help line is available at 1-866-4US-WAGE (1-866-487-9243).

**Housing Options and Concerns**

*Ed Franchi, Director, Agricultural Worker Program, Keystone Rural Health Center, Chambersburg, PA*

Mr. Franchi discussed legal provisions for seasonal farm workers' housing in Pennsylvania, the housing inspection process, and farmworkers' housing-related health concerns.

Agriculture is a major industry in Pennsylvania, accounting for $38.6 billion in food product exports. Approximately 45,000 to 50,000 MSAWs are employed in the state each year.

Keystone Rural Health Center serves 40 of the 67 counties in Pennsylvania. In 2018, Keystone's Agricultural Worker Program served 2,900 MSAWs in 13 clinics and conducted 640 site visits.

Agriculture is the second most dangerous occupation in the U.S., after mining. Poor housing is an occupational risk, in addition to pesticide exposure, muscular strain or trauma, motorized machines, poor sanitation, and exposure to heat or sun.

Pennsylvania Code includes 20 provisions for seasonal farm labor camps. The Pennsylvania Department of Agriculture conducts housing inspections in collaboration with the Pennsylvania Department of Labor and Industry and reports the findings to the U.S. DOL. Federal standards only apply if housing is provided under the H-2A program.

Concerns include:

- The state does not have an enforcement arm to determine if a farm is housing workers.
- Inspection results are not posted (workers must file a Right-to-Know request)
- The Pennsylvania Code pertaining to farm labor camps was last updated in 1996.
- Federal regulations on farm labor housing were last updated in 2005.
- Pennsylvania has nearly 60,000 farms, but only 350 seasonal farm labor camps.
- The lack of a "master list" of farms in the state and the number of workers they employ makes it difficult to anticipate the services they will need.

<u>Discussion</u>

- Mr. Jaime stated that many Migrant Head Start families report unequal conditions for H-2A workers and migrant workers. He asked if immigration status affects enforcement of protections.
    - Ms. Lee replied that DOL enforces labor protections regardless of immigration status. Investigators often find employers offering preferential conditions to H-2A workers. Anyone who is aware of preferential treatment may file a complaint; it does not have to be the worker. Wage and Hour Division offices across the U.S. have multi-lingual staff.
- Mr. Jaime said he had heard that some employers in Florida do not allow H2-A workers to work elsewhere during the gap between the early and late citrus seasons.
    - Ms. Lee stated that an employer that does not provide work during the gap may be in violation of the 3/4 guarantee.
- Mr. Salinas noted that he had seen a great deal of abuse by labor contractors in Ohio.
    - Ms. Lee said the number of H-2A labor contractors increased rapidly in recent years, along with the dramatic growth of the H-2A program. H-2A labor contractors tend to be less likely to cover their financial obligations and more likely to have substantive violations. She urged Council members to contact DOL if they observe any violations.
- Mr. Salinas expressed concern that many H-2A workers do not know if they have health insurance and are reluctant to take time off to see a doctor if they are sick or injured.
    - Mr. Jaime added that many employers do not allow outside organizations to access the migrant camp, which makes it difficult to provide information on services that are available. Many H-2A workers continue to work when they are sick because they want to return the following year.
- Ms. Brown-Singleton referenced the online recruitment requirements and asked how many domestic farmworkers can access the website.
    - Ms. Lee said a new rule requires employers to submit job orders to DOL/ETA, which will post the information on seasonaljobs.gov. They moved the process online because newspaper ads were becoming expensive. Employers are required to contact domestic employees from the previous year, since most recruitment happens through word of

mouth. Domestic farmworkers can apply directly to the employer; they do not need to go through the website.

- Mr. Jaime asked about the maximum length of employment for H-2A workers and the status of discussions to extend it to one or two years.
    - Ms. Lee replied that H-2A employment is considered temporary or seasonal work, which is defined as no more than 10 months. Sheepherding is an exception, because it is considered a year-round occupation. There is some interest in changing the definition, but it would require a statutory change.
- Ms. Naqvi asked what the data show regarding how long it takes to address a complaint.
    - Ms. Lee said she did not have that information. She outlined the steps that are taken once a complaint is received and noted that DOL has a system to prioritize complaints. Complaints related to health or safety, child labor, and housing go to the top of the queue. DOL collects back wages and civil penalties from employers based on the findings of an investigation.
- Ms. Dodson asked if there are cases of retaliation when workers file a complaint for back wages.
    - Ms. Lee replied that DOL anti-retaliation provisions protect any worker who files a complaint or testifies during an investigation. All complaints are confidential.
- Mr. Salinas asked if the grower is responsible when a labor contractor is found guilty of abuse.
    - Ms. Lee state that DOL can hold the employer responsible for any violation, including an association that files as a joint employer with member growers.
- Mr. Jaime asked what the Council could recommend to better protect H-2A workers or help them be aware of their healthcare rights.
    - Ms. Lee said she could not answer that question because her work in the area of contractual obligations does not include health care.
- Ms. Paul asked if there is an entity at the state level that health centers could contact.
    - Ms. Lee replied that state workforce agencies receive funding from ETA. Recruitment goes through them, and they conduct housing inspections. The agencies have a different name in each state.
- Ms. Veguilla Montañez asked if there is a registry of H-2A workers.
    - Ms. Lee said that DOL and DHS maintain a list of employers, but they do not have a list of individual workers.
- Ms. Veguilla Montañez asked if DOL and HRSA have any initiative or collaborative agreement regarding H-2A workers.
    - Ms. Lee replied that there is no existing agreement, but DOL and HRSA could create one, if needed.
- Mr. Calderon asked if anyone works with growers to encourage them to observe workers' rights.
    - Mr. Franchi stated that Keystone's ag worker program has established excellent relationships with growers over 30 years. Only one employer asked them not to return.
    - Ms. Lee noted that ETA publishes H-2A disclosure data on its website (www.foreignlaborcert.doleta.gov/performancedata.cfm).
- Mr. Raber asked what health centers serve counties in Pennsylvania that do not have large numbers of agricultural workers.
    - Mr. Franchi replied that a number of federally qualified health centers in other counties have 330g funding. He noted that most counties in Pennsylvania have farms, and demand is great in some counties that Keystone does not serve. He intends to do some research to determine what counties are not served by a health center.

- Ms. Higgins stated that housing for farmworkers in central Florida is substandard, but workers have few options due to the shortage of affordable housing.

**Facilitated Discussion on Possible Recommendations**

The Council reviewed key issues that emerged during both days of the meeting and grouped them into the following themes for potential recommendations:

- Growth of the H-2A population
    - Health implications
    - Isolation
    - Restricted access
- Existing tools
    - Tailor tools to address health literacy
    - Expand access
- Data
    - Accountability for serving MSAWs
    - Strengthen the NAWS (include H-2A, livestock workers)
    - Population census
    - Merge existing datasets (UDS, NAWS, COA) to enhance understanding of the population
- Enabling services
    - Housing and transportation as upstream causes of chronic conditions
- Farmworker goals for Healthy People 2030
- Human rights as a health issue (sexual violence, human trafficking, mental health).

Council members discussed HHS priorities and agreed to focus their recommendations on pressing needs for MSAWs. They suggested that Dr. Joseph could create a map showing how issues that affect the MSAW population align with HRSA goals.

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

<u>Next Steps</u>

The Council reviewed the thematic clusters and agreed to formulate an overarching goal of "Healthy Farmworkers 2030" with four objectives: work toward the Ag Worker campaign target of serving two million MSAWs; forecasting the future MSAW population; data; and human rights as a health issue.

The Council agreed that the letter of recommendations would thank the Acting Administrator for visiting the meeting and acknowledge his interest in the MSAW population.

The Council agreed on a process and schedule to develop the letter:

| WHAT | WHO | WHEN |
|---|---|---|
| **Develop outline** | Ms. Brown-Singleton | November 13, 2019 |
| **Develop draft sections:** Develop information for each section and send to group leads (cc HRSA) | Work toward 2 million served: Ms. Brown-Singleton (lead), Ms. Higgins, Mr. Aguilar<br>Forecasting the future: Mr. Jaime (lead), Mr. Skoog, Mr. Salinas<br>Data: Mr. Calderon (lead), Dr. Snipes, Ms. Veguilla Montañez<br>Human rights: Ms. Salazar (lead), Ms. Vallejo Cormier, Ms. Dodson, Mr. Raber | November 18, 2019 |
| **Submit sections to Dr. Snipes** | Section leads | November 22, 2019 |
| **Draft 1:** Incorporate input, do first edit, and submit to full Council for comments (cc HRSA) | Dr. Snipes | November 27, 2019 |
| **Feedback:** Send comments on the draft to Dr. Snipes (cc HRSA) | All Council members | December 4. 2019 |
| **Final Draft:** Incorporate feedback and submit the final draft to HRSA | Dr. Snipes | December 9, 2019 |

2020 Meetings

Ms. Paul announced that the 2020 meetings would be held on May 6 and 7 in Longmont, Colorado and November 4 and 5 in Rockville, MD. A new chair and vice-chair would lead those meetings.

Ms. Paul noted that Ms. Salazar would help with arrangements for the meeting in Colorado. Council members agreed to provide Ms. Paul with potential topics and speakers for the meeting.

**Closing – Wrap Up/Summary**

*Daniel Jaime, Chair, NACMH*

Mr. Jaime thanked Council members for taking the time to participate in this meeting and for striving to make a difference in the lives of those who cannot advocate for themselves.

Ms. Naqvi thanked Ms. Paul and Ms. Yobouet for their outstanding support and thanked Council members for another excellent meeting.

Mr. Jaime called for a motion to adjourn. The motion was made by Mr. Skoog and seconded by Ms. Vallejo Cormier.

The meeting was adjourned at 5:00 p.m.