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

May 8-9, 2018
Yakima, Washington

Council Members in Attendance
Horacio Paras (Chair)
Adriana Andrés-Paulson (Vice-Chair)
Rogelio Aguilar
Sharon Brown-Singleton
Susana Castro
Daniel Jaime
Christopher LaBarge
William Morgan
Amanda Phillips Martinez
Deborah Salazar
Gary Skoog
Shedra A. Snipes

Federal Staff
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 Division Director (via phone)
Esther Paul, MBBS, MA, MPH, Public Health Analyst, Designated Federal Official (DFO), NACMH
Priscilla Myles, MPH, Meeting Manager, NACMH (via phone)

TUESDAY, MAY 8, 2018

Welcome/Call to Order/Introductions
Esther Paul, Designated Federal Official, NACMH, SIPD, OPPD, BPHC, HRSA

Ms. Paul called the meeting to order and welcomed new and continuing members, federal staff, and guests from the public. She thanked Mr. Paras and Ms. Andres-Paulson for taking on leadership roles as Chair and Vice-Chair, respectively, and she thanked meeting staff and local partners for their support.

Ms. Myles welcomed the Council members by phone and expressed regrets that she was unable to attend the meeting in person.

Ms. Paul opened the floor for a round of introductions.

NACMH CHAIR OPENING REMARKS
Horacio Paras, Chair, NACMH

Mr. Paras welcomed Council members, staff, guests, and local partners to the meeting and thanked Ms. Phillips Martinez and Fr. LaBarge for their leadership as outgoing Chair and Vice-Chair.

Mr. Paras reviewed the Council's mission and charge. He noted that the role of the Council is to advise, consult, and make recommendations to the Secretary of HHS and the HRSA Administrator concerning

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. The Council's recommendations are based on members' knowledge of the needs and concerns of migratory and seasonal agricultural workers (MSAWs), and presentations made by migrant health researchers, health care providers, and administrators. Council members' understanding of the role and scope of influence of HHS and HRSA.

Mr. Paras pointed out that the Council meets twice a year. One meeting is held in Washington, D.C., where members receive updates from federal officials regarding migrant and seasonal agricultural worker (MSAW) health issues and review Health Center Program (HCP) activities. The second meeting is held in areas where members have the opportunity to receive testimonies from MSAWs and learn about the issues that impact their health. He noted that Council members are volunteers who represent their own health centers and bring the patient's voice to the table.

Mr. Paras stated that the Council was interested in learning more about the experience of MSAWs in the state of Washington, which may be different from other parts of the country.

Mr. Paras pointed out that every year, migrant workers leave their homes and take great risk to achieve a better future for themselves and their families. The men, women, and children who harvest the food we put on our tables suffer from poor housing and are exposed to harmful chemicals and dangerous working conditions. Farmworkers face many health risks and often suffer from lack of access to care and poor health outcomes. They are often unable to speak out against injustices in the field, they suffer from prejudice and harassment, and they lack basic working rights.

Mr. Paras thanked the speakers for donating their time and expertise, the local organizations in Yakima that arranged for farmworkers to provide testimonies and the farmworkers who took time during the busy agricultural season to share their experiences with the Council. He also thanked the federal staff for their support and guidance.

Mr. Paras reminded Council members that they are charged to bring their knowledge of their local community, their experience with migrant health centers (MHCs), and their understanding of the needs of MSAWs.
Mr. Paras closed with a quote from Cesar Chavez: "If you really want to make a friend, go to someone's house and eat with him. The people who give you their food give you their heart."

Mr. Paras called for a motion to approve the meeting agenda. The motion was made by Fr. LaBarge, seconded by Ms. Castro and Mr. Morgan, and carried by unanimous voice vote.

Mr. Paras called for a motion to approve the minutes of the November 2017 meeting. The motion was made by Ms. Castro, seconded by Fr. LaBarge, and carried by unanimous voice vote.

FEDERAL UPDATE
Iran Naqvi, Deputy Director, SIPD, OPPD, BPHC, HRSA

Ms. Naqvi welcomed Council members to the meeting and provided an update on BPHC and the Health Center Program (HCP), HRSA's budget and funding for fiscal year 2018 (FY2018) and FY2019, and BPHC strategic priorities.

Overview of HRSA and BPHC

- HRSA is an agency within HHS charged with increasing access to health care for those who are medically underserved. Its mission is to improve health through access to quality services, a skilled health workforce, and innovative programs. It supports more than 90 programs that provide health care to people who are geographically isolated or economically or medically challenged.
- HRSA does this through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities
- Every year, HRSA programs serve tens of millions of people, including people living with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access quality health care
- BPHC is a bureau within HRSA. Its mission is to improve the health of the nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary healthcare services.

FY 2018 Budget and Funding

- The Consolidated Appropriations Act passed on March 23, 2018 allocated $5.5 billion to BPHC.
- Total HRSA funding for FY 2018 is $11.49 billion. The funding includes an additional $135 million to improve quality of care and expand services for mental health and substance use disorder (SUD) services and $20 million for guaranteed loans for construction, renovation, and modernization of health center facilities.
- The Bipartisan Budget Act signed on February 9, 2018 provided a two-year mandatory funding extension for the health center program, including $3.8 billion in FY 2018, $4.0 billion in FY 2019; $60 million for disaster relief and recovery; and $25 million for *All of Us* research under the Precision Medicine Initiative.

Fundamentals of the Health Center Program

Nearly 1,400 health centers operate more than 11,000 service delivery sites for nearly 26 million patients. They provide patient-centered, comprehensive, integrated care by offering a range of services, that:

- Deliver high quality, culturally competent, comprehensive primary care and supportive services, regardless of patients' ability to pay
- Operate under the direction of a patient-majority governing board comprised of autonomous community-based organizations
- Provide services regardless of patients' ability to pay on a sliding fee scale
- Respond to the unique and individual needs of the community
- Meet requirements regarding administrative, clinical, and financial operations.

In 2016, there were 58 look-alikes.

BPHC Strategic Goals and Objectives

- The strategic priorities set by the HHS Secretary are directed at improving access to mental health and substance abuse services, and opioid use disorder treatment and recovery, and addressing childhood obesity.
- BPHC's strategic goals serve the mission of the health center program.

- Strategic Goal 1: Increase access to primary health care
    - Mental health services:
        - In 2016, health centers reported more than 8.5 million mental health visits, a 37 percent increase from 2014.
        - From 2014 to 2016, health center depression screening and follow-up increased by 21 percent.
    - Substance abuse and opioid treatment and recovery services:
        - Health centers saw 142,000 substance abuse patients in 2016, a 41 percent increase from 2014.
        - About 1,700 certified health center physicians with a Drug Addiction Treatment Act waiver provided medication-assisted treatment to more than 39,000 health center patients.
        - BPHC was appropriated more than $200 million for the Access Increases in Mental Health and Substance Abuse Services (AIMS) funding. The funding will support 1,178 health centers to expand and integrate their mental health and substance abuse services.
        - HHS has a five-point strategy to fight the opioid epidemic:
            - Improving access to treatment and recovery services
            - Targeting use of overdose-reversing drugs
            - Strengthening our understanding of the epidemic through better public health surveillance
            - Providing support for cutting-edge research on pain and addiction
            - Advancing better practices for pain management.
    - Childhood obesity:
        - The prevalence of childhood obesity among health center patients (40 percent) is more than double the national average (17 percent).
        - In 2016, about 63 percent of health center patients 17 years old and younger received weight assessments and counseling for nutrition and physical activity preventive services—a six percent increase from 2014.
- Strategic Goal 3: Optimize BPHC Operations
    - Components of the strategy are compliance with program requirements, effective implementation of program requirements, and clinical and operational excellence.
        - BPHC Project Officers provide oversight to ensure that grantees comply with all program requirements.
        - Primary Care Associations are state or regional nonprofit organizations.
            - Provide training and technical assistance (T/TA) to improve programmatic, clinical, and financial performance and operations.
            - They provide leadership and administration; operational, administrative, and quality improvement support and; information regarding resources available under Public Health Service Act (PHS) Section 330.
        - National Cooperative Agreements provide free training and technical assistance (T/TA) to support existing and potential health center grantees and look-alikes. They manage learning collaboratives, state/regional/national trainings, webinars, newsletters, toolkits, and fact sheets.

Program Funding, FY 2000-2017

- The health center program has grown five-fold from FY 2000 to FY 2017 (approximately $1 to $5 billion).
- Discretionary funding has been relatively level since FY 2011 (approximately $1.58 billion in FY 2011 to $1.49 billion in FY 2017), while mandatory funding increased from approximately $1 billion to $3.51 billion over the same periods.

FY 2019 Budget and Funding

- The president's budget request includes $5.1 billion for the health center program, which will ensure that current health centers can continue to provide essential healthcare services to their patient populations.
- The budget request includes an additional $400 million for health centers to combat opioid abuse, including $200 million to provide quality improvement incentive payments to health centers that implement evidence-based models to address behavioral health, including opioid addiction.

Resources to support the health center program include the BPHC website (https://www.bphc.hrsa.gov/), BPHC Primary Healthcare Digest (weekly e-newsletter), a BPHC Helpline, the BPHC project officers, TA provided through the National Cooperative Agreements (NCAs), and a Primary Care Association (PCA) in each state.

Ms. Naqvi asked the Council to let her know what kind of information from HRSA would be helpful for future meetings.

Discussion

- Mr. Paras commended HHS for its focus on substance abuse and opioid treatment.
- Ms. Phillips Martinez asked if BPHC had data on MSAWs who accessed substance abuse services.
    - Ms. Naqvi said 2017 data were not available yet, but she would have them for the November meeting.
- Ms. Andres-Paulson said it would be helpful to have data on how HHS priorities such as the opioid epidemic have affected MSAWs. She noted that alcohol abuse is more prevalent than opioid use among MSAWs.
    - Ms. Naqvi noted that Ms. Paul synthesizes information from various Primary Care Associations State of the State Calls on activities focusing on substance abuse and opioid addiction. If she encounters content specific to the MSAW population on this topic, she will provide it to NACMH in the future.
    - Ms. Paul said she would check to see if specific data regarding opioid use in the MSAW population was available.
    - Ms. Salazar commented that in Colorado, opioid abuse has had a greater impact on the families of MSAWs than on farmworkers themselves.
    - Joseph Gallegos noted that most health centers that receive MHC funding also receive regular health center funding. The Uniform Data System (UDS) provides aggregated data. Many MSAWs come in for lower back pain due to the type of work that they do and could be at risk for addiction if they are prescribed opioids. A profile of MHC patients could help create awareness among clinicians and avoid potential addiction.
- Fr. LaBarge noted that MHCs also serve families of MSAWs. He stated that retired workers and children might be at greater risk of opioid addiction.

- Dr. Snipes asked if the Council's recommendations could be implemented if they addressed areas outside of the Secretary's priorities.

National Association of Community Health Centers (NACHC) Update
Joseph Gallegos, MBA, Senior Vice President for Western Operations, NACHC

Mr. Gallegos provided updates on federal policies that impact health centers and the status of NACHC's Ag Worker Access 2020 campaign. He noted that he shared his slides with NACHC's Agricultural Worker Health Committee and suggested that the Council consider holding future meetings in conjunction with NACHC's annual conference.

Health Center Funding

- The funding cliff has been fixed, thanks to extensive bi-partisan support. The Bipartisan Budget Act passed in February 2018 extended the mandatory health center funding for two years. It also extended funding for the National Health Service Corps (NHSC), the Teaching Health Centers Graduate Medical Education (THCGME), the Children's Health Insurance Program (CHIP), and other programs.
- The funding extension included technical changes and a statutory cleanup of Section 330. NACHC and HRSA provided significant input regarding the changes, and NACHC has no concerns about the final version.
- HRSA will determine how to distribute the additional $600 million.

Next Issues for Congress

- Deferred Action for Childhood Arrivals (DACA) expiration/immigration reform
- FY19 appropriations
- Opioid epidemic response.

President's FY19 Budget

- Provides continued support for CHCs, NHSC, and THCGME
- Includes $10 billion to combat the opioid epidemic, including $400 million for health centers
- Cuts the overall HHS budget by 21 percent, including large cuts to HRSA
- Includes the Graham-Cassidy Affordable Care Act repeal and replace legislation.

NACHC's 2018 Legislative Agenda

- Federal grant funding: FY 19 appropriations, long-term stability for the funding cliff
- Medicaid: State-federal connection; protections for the program at large and the Prospective Payment System for federally qualified health centers (FQHCs)
- Behavioral health/SUD treatment/opioid crisis: Increased funding for health centers, adding billable providers
- 340B drug pricing program: Maintaining health center access
- Telehealth: Reimbursing CHCs as distant and originating sites
- Workforce issues are included throughout the agenda
- Policy resources are available at http://www.nachc.org/policy-matters/.

Ag Worker Access 2020 Campaign 2.0

- The goal of the campaign is for MHCs to serve two million MSAW patients by 2020.
- MSAW patients served at MHCs increased from 804,000 in 2010 to 957,000 in 2016. In addition, about 88,036 MSAWs are served at CHCs each year.

- Campaign 2.0 strategies include:
    - Broaden the campaign beyond the health center network to local community-based organizations
    - Develop MOUs to promote partnerships and collaborations (e.g., Migrant and Seasonal Head Start [MSHS], migrant education, farmworker housing units, churches and synagogues, and farmers/growers)
    - Broaden and diversify the role and composition of the campaign task force
    - Continue to train patient registration staff on migrant health definitions
    - Work with BPHC on administrative policy and service delivery models and tools (e.g., voucher programs, mobile teams/vans, co-location with farmworker housing units, face-to-face encounters, and rural telehealth).
- The 2017 Midwest Migrant Stream Forum identified a wide range of innovations to increase access, such as board resolutions to make increased access for MSAWs a priority, incentives for staff, and diabetes self-management classes.
- The task force had four recommendations for HRSA:
    - Clarify the level of flexibility for MHCs to institute an expedited Scope of Project review and approval process for health centers and voucher programs that want to mobilize health teams and co-locate with area partners to increase access.
    - Bring telehealth into the 21st century by revising the definition of a "user" and an "encounter" to allow health centers to count a telehealth visit via video as a face-to-face medical encounter
    - Work with the Centers for Medicare and Medicaid Services (CMS) to legitimize telehealth as a billable and reimbursable service under Medicare and Medicaid, which will encourage other payers to do the same
    - Incentivize and orient CHCs to more deliberately identify, serve, properly register, and record in the UDS all special populations served, even if the CHC is not funded to serve a specific special population.
- Information and resources are available at http://www.ncfh.org/ag-worker-access-2020.html.

Mr. Gallegos closed with a quote from an MHC consumer board member: "We all need a lawyer at least once in our lifetime. We all need a doctor at least three times per year. We all need an agricultural worker at least three times per day."

Discussion

- Mr. Aguilar asked when telehealth might become a covered service.
    - Mr. Gallegos replied that telehealth should be a common tool to deliver care, especially in rural areas, but a great deal of legislative work is needed to make telehealth a reimbursable service under Medicaid and Medicare. Telehealth has been used for many years, but issues such as provision of services across state lines and differences in state licensing requirements have not been addressed, and broadband infrastructure needs to be improved in rural areas. NACHC is working with Congress, HRSA, and CMS to address administrative and regulatory issues. Recommendations from the Council would be helpful.
- Mr. Morgan asked if there were any efforts at the state level to facilitate telehealth across state lines.
    - Mr. Gallegos stated that NACHC is asking CMS to look at those barriers. Medicaid is more challenging, because it includes both federal and state funding. However, reciprocity of Medicaid funding already exists between some states.

- Mr. Paras asked if Mr. Gallegos knew of any best practices of health centers that are addressing the opioid issue.
    - Mr. Gallegos replied that NACHC is working with health centers to identify and document best practices. Issues include the need for clinicians to be trained on addiction, the importance of a multi-disciplinary, team-based approach (e.g., clinicians, pharmacists, and social workers), and the need for a champion within the health center. A state registry of clinicians who are licensed to prescribe narcotics is also important.
- Mr. Morgan expressed concern that the focus on opioids masks a larger problem, which is the increasing use of heroin.
    - Mr. Gallegos agreed that the issue is complex. He noted that many patients are using marijuana for pain management instead of opioids in states where it has been legalized.
- Ms. Andres-Paulson stated that different definitions of MSAW create a barrier for collaboration across agencies and make it difficult to access services.
    - Mr. Gallegos stated that the MHP definition includes "farm work in all of its branches." MSHS, which is also under HHS, is looking at making their definition consistent with the MHP. The Department of Labor has a different definition of agriculture.
- Mr. Jaime cited the case of a MSHS family in Florida that does not have Medicaid. He asked if health centers that receive migrant health funding can provide services under a sliding fee scale for patients who do not have Medicaid coverage.
    - Mr. Gallegos replied that 90 percent of children in MSHS have coverage through Medicaid or CHIP. Health centers can apply a sliding fee scale to serve patients who do not have that coverage. MSHS grantees often pay health centers for children who do not have coverage.
    - Ms. Salazar noted that MHC grantees cannot discriminate against any group of patients. Payment policies must be consistent.
    - Mr. Gallegos stated that health center boards set the co-pay level. There needs to be a balance to ensure that cost is not a barrier to access.

Northwest Regional Primary Care Association (NWRPCA) Update
Seth Doyle, Manager, Community Health Improvement Program, NWRPCA

Mr. Doyle provided an overview of the NWRPCA, discussed the importance of the social context of disease, and outlined potential avenues to address issues identified by NWRPCA members.

<u>NWRPCA Overview</u>

- NWRPCA strengthens CHCs and MHCs in the Northwest by leveraging regional power and resources on their behalf. Members include 100 health centers in Idaho, Oregon, Washington, and Alaska, including 26 migrant health grantees. They serve more than 1.7 million patients, including 139,229 MSAWs.
- Agriculture in the Northwest is a multi-billion-dollar industry. The region is a leading producer of apples, cherries, potatoes, onions, wheat, hops, and Christmas trees.
- NCFH estimates that the region has approximately 896,000 MSAWs, more than half of whom are in Washington.
- The service penetration rate is about 15 percent, which is consistent with the national average. NWRPCA conducted a training on accurate identification of MSAWs for all migrant health grantees in the region as part of the Ag Worker Access 2020 Campaign.

<u>Social Determinants of Disease</u>

- Public health has shifted in recent years to acknowledge the social context of disease.

- The former director of the Centers for Disease Control and Prevention (CDC), Tom Frieden, developed a Health Impact Pyramid as a framework for public health action (https://binged.it/2rMODzs). The pyramid shows that while socioeconomic factors (e.g., poverty, education, housing, inequality) have the greatest impact on health, most resources are allocated to the top (e.g., clinical interventions, counseling and education).
- Social determinants of health (SDOH) that affect farmworker populations include poverty/low wages; work conditions/exploitation; living conditions; food security; education/literacy; language; access to health care; and immigration policy/discrimination.
- NWRPCA is looking at how to help health centers address the situations that affect the patients they serve. Key areas of training and TA include outreach, cultural competence, customer service, health literacy, and clinical issues.

Potential Opportunities for Improvement

- Provide funding opportunities for expansion of outreach programs, along with training opportunities (and budget allocation) for outreach program staff, including community health workers (CHWs) and *promotoras/es de salud*.
- Increase resources to help health centers accurately identify and register MSAW patients, to include understanding and correctly interpreting definitions in statute.
- Expand resources for improved data collection, including farmworker enumeration studies and surveillance of farmworker health issues and access to health care.

Discussion

- Mr. Morgan stressed the importance of health literacy. Health centers need to know how to educate patients who may not know the proper terms for parts of their body, and how to prepare documents so they are more accessible.
    - Mr. Doyle agreed, and he noted that one MHC put pictures of activities on their intake form to help identify MSAW patients. Innovative approaches like that are needed to develop accessible materials.
- Ms. Andres-Paulson asked how training on SDOH could be expanded for providers.
    - Mr. Doyle replied that opportunities to raise awareness of SDOH among the existing workforce are increasing for all types of providers. It is critical to find ways to better prepare the future workforce. The "Beyond Flexner Alliance" is a movement to modernize standards for graduate medical education and integrate training on SDOH.
- Dr. Snipes noted that current research suggests that social determinants are responsible for 40 to 50 percent of health outcomes. She expressed concern that some states do not even have outdated data on the number of MSAWs. The last HHS survey was conducted many years ago.
- Ms. Paul asked Mr. Doyle which agencies should be responsible for conducting enumeration studies.
    - Mr. Doyle replied that BPHC would be in the best position to conduct effective numeration studies, because it is the only agency that is currently required to collect and report data on MSAW patients. He noted that NCHF has an established methodology that was developed by Alice Larson.
    - Ms. Paul noted that the UDS only captures MSAWs who are already in the system. There is a need to find ways to identify those who are outside the system. She pointed out that HRSA provides some funds towards the National Agricultural Worker Survey (NAWS).

    - Mr. Jaime said he had spoken to growers in his area to determine how many H-2A visa workers they employ. Based on the information they provided, only 10 percent of the workers are seen at the local health center.
    - Mr. Doyle noted that Washington State is now one of the largest H-2A worker states in the country. That population has increased dramatically in recent years.
- Mr. Skoog asked if financial factors or other systemic issues make employers reluctant to state how many MSAWs they employ and make MSAWs reluctant to identify themselves.
    - Ms. Andres-Paulson said there are many factors, including fear of identification and different forms of employment, including contract labor.
    - Mr. Doyle noted that health centers also collect data on family members. One of the issues is the definition of who counts as a family member.
    - Dr. Snipes noted that the USDA census of agriculture does not collect any data on employees, and the NAWS does not have questions about H-2A workers. The missing layers of data make it impossible to obtain an accurate estimate of the MSAW population.
- Ms. Phillips-Martinez asked if tools such as the NACHC Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) could motivate health centers to collect data on SDOH.
    - Ms. Andres-Paulson noted that outreach workers and social workers at her health center use informal methods to collect information on social factors.
    - Ms. Brown-Singleton reported that health centers in North Carolina are piloting the PRAPARE tool, and CHWs are helping to move the model forward. She noted that CHWs and outreach workers have always collected information on SDOH. It is important to integrate them within the clinical setting.
    - Mr. Doyle stated that PRAPARE is a promising approach. The Prevention Institute's community-centered health home model is another way in which health centers could engage with communities to address SDOH.

Council Reflections

Mr. Paras opened the floor for Council members to share their experiences or reflections on the morning session.

- Dr. Snipes told the Council that she graduated from the University of Washington and lived in Central Washington for two years while she collected data for her dissertation. During that time, she also worked on farms alongside MSAWs. She expressed her gratitude for the privilege of serving on the Council and her appreciation for the experience of other Council members.
- Mr. Morgan commented that most Council members have worked on farms at some time. He suggested that it would be helpful for policymakers to have hands-on experience in the fields.
- Ms. Salazar noted that she lived in Mexico for 19 years, where her work with a group of women led her to see herself as a bridge between two cultures. She got involved in migrant health when she returned to the U.S. 10 years ago. She sees her work on the Council as a way of continuing to be a bridge and to support the people who put food on our tables.

Testimonies

The Council heard testimonies from 14 MSAWs and promotores from Yakima, Quincy, and Wenatchee regarding access to and quality of health care, health concerns, mental health issues, chronic disease, diet and nutrition sexually transmitted diseases, occupational hazards and injuries, changing demographics, and changing work.

Discussion of Possible Recommendations

Council members identified issues that emerged from the testimonies that could inform their recommendations:

- Lack of bilingual, bicultural providers
- Importance of enabling services
- Health centers do not assess the need for additional supports or screen for mental health issues
- Lack of educational materials in Spanish
- Doctors do not provide follow up documentation regarding occupational injuries
- Safety issues in the field lead to chronic disease or injury
- Lack of trust between providers and patients
- Pesticide exposure
- Lack of resources.

WEDNESDAY, MAY 9, 2018

Recap of Previous Day
Adriana Andres-Paulson, Vice-Chair, NACMH

Mr. Paras called the meeting to order.

Ms. Andres-Paulson summarized the key issues from the presentations and testimonies of the previous day. She highlighted four main topics that emerged from the testimonies:

- Need for bilingual/bicultural services
- Need for enabling services
- TA for health centers/clinics
- Expanded hours of service to promote access.

Ms. Andres-Paulson also noted there was a consensus among Council members regarding the need for accurate enumeration of agricultural workers.

Migrant and Seasonal Agricultural Worker Regional Health Issues/Trends
Mary Jo Ybarra-Vega, MS, LMHC,

Ms. Ybarra-Vega noted that her parents and husband were farmworkers and she had worked in the fields herself. She then provided an overview of Washington state crops, nutrition and chronic disease, sexual health, the MSAW workforce, occupational hazards for MSAWs, and issues and recommendations for advocacy.

Washington State Crops

- Key crops in Washington include apples, pears, wheat, raspberries, potatoes, hops, hay, mint oil, cherries, peas, nursery, carrots, grapes, and, more recently, marijuana.
- In addition to being an agricultural community, Quincy, WA is home to six data centers due to the availability of hydropower and fiber optics.

Nutrition and Chronic Disease in Grant County

- Many people in Grant County, including MSAWs, are unaware of proper nutrition and eating a healthy diet. Eighty percent of adults and 77 percent of adolescents do not get enough fruits

and vegetables. Thirteen percent run out of food, skip meals, eat less, eat poorly, or go hungry because they cannot afford food.

- Most children of MSAWs receive free or reduced lunch at school. Income-eligible individuals are not applying for food aid due to the anti-immigrant climate.
- Twenty-eight percent of adults in Grant County have high blood pressure, 40 percent have elevated cholesterol, and one-third are obese.

Latinos and Chronic Disease

- Twenty percent of Latinos in Washington State have less health insurance than the general population. Many H-2A workers do not know they are eligible for coverage.
- Sixteen percent of Latinos in Washington experience food insecurity, one-quarter have no personal physician, and 14 percent forgo medical care due to cost.
- Forty-four percent of those who die before the age of 65 in Washington State and two-thirds of those who die before age 50 are Latino. Latinos in Washington are less likely to receive breast cancer screening, get a flu shot, see the dentist, or have an annual medical check-up, and they are twice as likely to die from liver disease.

Chronic Disease in Grant County

- Heart disease is the leading cause of premature death in Grant County. Cancer is the leading cause of death in Quincy.
- One-third of adults in Grant County are obese, and one-third of 10^{th} graders are overweight.
- One in 11 individuals have asthma.
- Diabetes is the sixth leading cause of death in the county.
- The only deaths that are recorded as an occupational health issue are those that occur at the workplace. Deaths from chronic disease, long-term occupational exposure to chemicals, or injuries resulting from repetitive-motion farm labor are not recorded as resulting from inappropriate occupational health and safety conditions.

Recommendations to Address Chronic Disease in MSAWs

- Include Chronic Disease Self-Management Education (CDSME) as part of the treatment plan at health centers
- Develop CDSME to address mental health issues
- Have promotoras deliver CDSME programs for MSAWs
- Provide funding for CDSME programs and allow C/MHCs to bill for them.

Sexual health and MSAWs

- MSAWs cannot or will not take time from work for care. Factors include lack of knowledge about where to get services, concerns about the cost, limited transportation, and lack of providers who speak Spanish.
- MSAWs are targeted by the sex trade. Ninety percent of MSAWs are men who are here for nine months at a time. Drugs and alcohol are factors.

Recommendations to Address Chronic Disease in MSAWs

- Create a sexual health flipchart for outreach and C/MHC staff
- Create apps to inform H-2A workers about social and health services across the U.S.
- Create a call-in number for workers with health questions (especially H-2A workers)
- Create region-wide sexual health and prevention coalitions for MSAWs
- Include promotora programs in primary care teams

- Provide funding to develop promotora programs and enhance existing programs
- Promote binational work with visa processors to promote "come healthy/leave healthy" concepts for H-2A workers.

Future MSAW Workforce

- Marijuana is the new crop for MSAWs in Washington now that it is legal in the state.
- The North Carolina Growers Association, Inc. and the Washington Farm Labor Association were the largest employers of H-2A workers in the country
- Most H-2A workers live in the North Central corridor of the state and work in the fruit tree industry.
- Local MSAWs are losing housing to H-2A workers.

Occupational Hazards for MSAWs in Washington

- The most common occupational hazards are falls, cancer, repetitive-strain injuries, sexual abuse, injuries involving farm equipment, chronic lower respiratory disease, extreme climate changes, poor nutrition, mental health issues, and long-term effects of pesticides and injuries.

Advocacy/Recommendations

- Develop partnerships between agriculture and health
- Create national workgroups that include H-2A workers
- Promote bi-national prevention with H-2A contractors
- Fund promotora programs at C/MHCs
- Create a national video about cultural humility that is mandatory for employees of C/MHCs.

Ms. Ybarra-Vega noted that the National Partnership for Action (NPA), which includes Regional Health Equity Councils (RHECs) across the country, are working on similar issues. She encouraged Council members to become familiar with this initiative (https://www.minorityhealth.hhs.gov/npa).

Discussion

- Ms. Naqvi asked how the figures she presented for nutrition in Grant County compared to the general population.
    - Ms. Ybarra-Vega replied that the figures she presented were for the general population; she did not have data on MSAWs. She expressed concern about the prevalence of food insecurity in the area and noted that the monthly Second Harvest program in Quincy has lines around the block, with many people driving from surrounding communities.
- Mr. Paras asked if there are opportunities to educate H-2A workers regarding their rights.
    - Ms. Ybarra-Vega replied that Washington, North Carolina, California, and Florida collaborated to identify and address issues related to H-2A workers. She stressed that NACMH will need to address this population in the future.

Occupational and Environmental Hazards and Injuries Impacting Migrant and Seasonal Agricultural Worker Health

Richard Fenske, PhD, MPH, Associate Chair and Professor, Department of Environmental and Occupational Health Sciences, University of Washington; Associate Director, Pacific Northwest Agricultural Safety and Health Center (PNASH Center)

Dr. Fenske provided an overview of research on occupational and environmental hazards that impact the agricultural workforce in Washington State, including injuries, pesticide exposure, heat-related illness, pediatric asthma, and sexual violence.

Farmworker Injuries

- Worker's compensation in Washington State is managed through the Department of Labor and Industries. Data are based on claims that are accepted, which are a fraction of those that are filed.
- The north-central region, which is highly agricultural, has the highest percent of hospitalizations paid by worker's compensation.
- Falls represent about half of all agricultural injuries in Washington and are more common among farmworkers than any other occupation. Most of those falls are from ladders.
- Work-related asthma caused or worsened by plant material appears to be low, but data are limited.

Pesticide Exposure

- An integrated approach developed by the PNASH Center has been successful in preventing pesticide exposure. The program monitors levels of cholinesterase in pesticide handlers and removes workers when their level becomes dangerous. Although the approach is effective, levels of pesticide-related illness in Washington have not decreased significantly.
- The PNASH Center is studying a notification system for pesticide exposure.
- A PNASH Center study found that pesticide drift has increased significantly in recent years. Fifty-six percent of cases were among workers on another farm, and 28 percent were nearby residents. The Washington State legislature formed a special committee to address this problem. Newer sprayers have lower drift.

Heat-Related Illness

- A survey of 100 Latino orchard workers found that 31 percent had symptoms of heat-related illness, two-thirds did not have heat-related illness training in the last year, 19 percent were very concerned about hot weather affecting their health, and half were "a little bit" concerned about hot weather affecting their health.
- The risk of heat-related injury among workers who do piece-rate work is six time higher than for those who have an hourly wage. The risk is four times higher for those who have more than a three-minute walk to the toilet. The risk is highest during the cherry harvest in June and July.
- The Washington Outdoor Heat Exposure Rule for Agriculture requires employers to take specific actions between May and September, including training on heat exposure, requirements to provide drinking water, and requirements to relieve and monitor employees who show signs or symptoms of heat exposure.
- Acute kidney injury has been associated with heat strain and piece-rate work. This issue merits future research.

Pediatric Asthma

- The PNASH Center is conducting a study with groups in the lower Yakima Valley to reduce pediatric asthma. The use of an air filter system in the home appears to have beneficial effects.

Sexual Harassment Prevention in Agriculture

- The PNASH Center conducted focus groups and used the findings to develop a training video to prevent sexual harassment in agriculture. A promotional trailer is available at https://vimeo.com/179345478/60047830f7.
- The PNASH Center used key prevention messages developed by farmworker women to create wallet cards, radionovelas, and DVDs for health center waiting rooms.

Discussion

- Ms. Naqvi asked if Dr. Fenske had any data on the return-to-work rate for injuries and how MSAWs learn how to file claims.
    - Dr. Fenske said data were not available on that issue. Farmworkers learn about the claims process through clinics or by word of mouth.
    - David Olsen (Columbia Valley Community Health) stated that MHC staff are trained to look for symptoms and conduct outreach in camps.
- Mr. Paras asked if employers have a role in helping workers file a claim.
    - Dr. Fenske said he did not know if employers played a role. He noted that workers must miss three days of work before they can file a claim.
    - Anne Soiza (Department of Labor and Industries) clarified that a claim can be filed by a worker or an employer. Clinics will ask patients if their injury is work-related. Employers are required by law to transport employees who are injured while at work.
- Ms. Andres-Poulson commented that MSAWs who testified on the previous day said they are not notified when pesticides are being sprayed.
    - Dr. Fenske said that the agricultural industry says notification is time consuming and costly. The state legislature looking at this issue.
- Ms. Ybarra-Vega asked if there was any follow-up with the individuals in the pesticide drift study regarding their health.
    - Dr. Fenske said the Department of Agriculture is responsible for evaluating and filing a citation for any situation that involves human exposure; the Department of Health also conducts an investigation. He did not know whether those agencies follow up with individuals to determine the extent of their illness or when they are able to return to work. If they file a worker's compensation claim, the case is tracked by the Department of Labor and Industries.
- Mr. Paras asked if other states had done anything to solve the problem of pesticide drift.
    - Dr. Fenske replied that a county in California was conducting a pilot program to implement a notification system. The PNASH Center has reviewed notification systems, including those in other countries. There are some notification systems for situations where pesticides drift onto organic crops, but there are very few notification systems for pesticide drift onto workers.
- Mr. Morgan asked if there were any regulations related to wind speed.
    - Dr. Fenske replied that in the U.S., the label is the law. Pesticide labels generally place a limit of 10 miles per hour. The Environmental Protection Agency (EPA) recommends a range of three to 10 miles per hour. Applicators are required to record the wind speed at the time of application. The PNASH Center found that more than half of the records

were incomplete. They recommended that the reporting system be improved. California has had a reporting system since the 1970s.

- Ms. Soiza stated that agricultural workers in most states are not covered by worker's compensation. California and Washington are at the leading edge on this issue.
- Dr. Snipes said that when she was working in the fields, women covered themselves so they would be less vulnerable to sexual harassment, not to prevent pesticide exposure. She asked if Dr. Fenske had any recommendations based on the research he presented.
    - Dr. Fenske said there is a need for better mechanisms for notification and recording, along with a commitment to collect that information. Additional funding for outreach activities conducted by the State Department of Health would be helpful. Dr. Fenske said he would ask the researchers to provide specific recommendations.
- Mr. Skoog asked if organic farmers are a lobbying force in the state.
    - Dr. Fenske said this was a growing sector of agriculture in Washington. Organizations of certified organic growers could play a role in educating legislators about the value of preventing drift.

Improving Migrant Health and Occupational Safety through Integrated Biopsychosocial Approach
Simon Mendoza-Moreno, PA-C, MCHS, Physician's Assistant, Columbia Valley Community Health
Daisy Rivera, LMHC, Mental Health Counselor, Columbia Valley Community Health (CVCH)

Mr. Mendoza-Moreno and Ms. Rivera described an integrated approach to address migrant health. The speakers noted that nurses and nurse practitioners have traditionally been trained in a biopsychosocial approach. That approach is beginning to be infused in training for physicians and other health professions.

<u>Key Terms</u>

- A biopsychosocial approach considers biological, psychological, and social factors that contribute to a person's overall health.
- Integrated care occurs when a team of primary care and behavioral health clinicians work together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. The care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

<u>Journey of a Migrant Worker</u>

- Pre-flight: Workers may experience poverty, violence, and trauma.
- Flight: Workers may experience trauma, malnutrition, harsh conditions, and bodily injuries.
- Resettlement: Workers may experience poverty, lack of resources, harsh work conditions, child labor, language barriers, long days, isolated locations, and trauma.
- The cycle repeats as workers follow the crops and migrate to the next location.

<u>Cultural Considerations</u>

- Many MSAWSs come from a collectivistic, family-oriented culture ("familismo").
- Cultural and community protective factors include contact with family in the country of origin; availability of local culture; availability and utilization of community resources that are culturally and linguistically competent; religion/belief in God; support from a romantic partner; having someone to confide in; sense of control; and endurance.

Mental Health in MSAWS

- Female MSAWs report greater levels of depression and anxiety than their male counterparts do.
- Male Latino MSAWs are at proportionately higher risk of heavy episodic drinking (HED) and alcohol dependence due to stress. The risk is even higher for Latino sexual and gender minorities.
- Greater job demands and less decision latitude, which are common among MSAWs, have been associated with more musculoskeletal and depressive symptoms and worse mental health.

Impacts on Children of Migrant Workers

- Economic hardship and discrimination are significant stressors for children in Latino MSAW families. They are also at risk for child labor.
- Children of migrant workers have a high prevalence of mental health disorders and are less likely to receive appropriate assessment and treatment due to access barriers and the lack of culturally and linguistically competent providers.
- Children of MSAWs have a higher prevalence of obesity, elevated blood pressure, anemia, and stunting than U.S. and Mexican children.

Health Disparities

- Latinos have the highest rates of fatal and non-fatal workplace injuries. Two-thirds of injured Latino workers in 2016 were foreign-born migrant workers.
- Cases of HIV are increasing among Latinos, while they are decreasing overall.
- Occupational injury significantly increases the odds of depression in MSAWs.
- Latino patients are less likely than all other races to have a primary care provider.
- Latino patients are more likely than other ethnic groups to have poor communication with their healthcare providers.

Barriers to Healthcare Access for MSAWs

- Barriers to healthcare access include lack of transportation; loss of work hours resulting in loss of income; lack of bicultural and bilingual medical and behavioral health providers; lack of culturally appropriate health and trauma screeners; lack of finances and/or health insurance; lack of information on health care; fear of deportation; and exclusion from the National Labor Relations Act.

Recommendations to Improve Health Services

- Integrate behavioral health into primary care settings.
- Increase grant funding for migrant camp outreach to include medical and behavioral health screenings in a culturally and linguistically appropriate manner.
- Educate providers and staff on basic immigration laws and where MSAWs can access supportive services in their communities through medical-legal partnership.
- Increase funding to train and recruit bicultural and bilingual medical and behavioral health providers.

Discussion

- Fr. LaBarge noted that the church is at the center of Latin American towns. Religion provides opportunities to build community, and it does not need to be priest-centered.
- Ms. Andres-Paulson noted that an integrated approach is part of the patient-centered medical home (PCMH) model. Failure to offer that could be a compliance issue.

    - Ms. Rivera stated that research has found that Latinos prefer a warm hand-off. They are unlikely to follow up when they are given a referral, because it is just a piece of paper.
- Ms. Phillips-Martinez asked about the role of health centers in training providers about SDOH, connections between SDOH and a biopsychosocial approach, and how funding could be targeted for training.
    - Mr. Mendoza-Moreno replied that home visits provide much more insight into a patient's situation than questionnaires or interviews conducted in a clinic.
    - Mr. Olsen noted that CVHC is committed to integrated care that takes social issues into account. They are part of a cross-sector group in four counties in central Washington that includes health care, schools, faith-based organizations, and housing organizations. He stressed that health is not the same as health care.
- Mr. Morgan expressed concern that data on Latinos does not capture differences in sub-populations.
    - Ms. Rivera agreed and noted that some Central American populations have higher cases of dementia. It is important to understand what factors account for those differences.
- Mr. Jaime asked about the extent of collaboration between health centers and the Mexican consulate.
    - Ms. Ybarra-Vega said her health center has a long history of collaboration with the Mexican consulate, including joint outreach activities using a mobile unit provided by the consulate.

Discussion and Formulation of Letter of Recommendations to the Secretary of DHHS

Council members generated a list of key issues that emerged through the presentations and testimonies, including telehealth, data, enabling services, occupational health, chronic disease, nutrition, biopsychosocial approaches/SDOH, technical assistance, sexual health, sexual harassment, health literacy, occupational safety, and substance use disorders.

Using a voting process, Council members selected data, telehealth, biopsychosocial approaches/SDOH, substance use disorders, and chronic disease as priorities for their recommendations.

Council members identified key issues to address in each priority area:

- Data
    - Enumeration of MSAWs
    - Lack of data
    - Appropriation
    - Interagency collaboration to link available data.
- Telehealth
    - Collaboration with CMS for reimbursement
    - Federal Torts Claim Act (FTCA)
    - Licensing across states
    - Definition of "user" and encounter
    - "High tech."
- SDOH
    - Training and TA
    - Holistic/integrated services, including outreach that includes promotoras
    - "Causes of the causes"
    - Identify and practice to increase effectiveness

    - Assessments (e.g., PRAPARE).

- Substance use disorders
    - Training and TA
    - Partnerships to address substance use
    - Context: lower back pain leads to risk of self-medication
    - Families (children, older adults).

- Chronic disease
    - Consistency of care (continuity when migrating, state-to-state reciprocity)
    - Technology (portability of electronic health records, collaboration with the CMS Center for Innovation)
    - Chronic Disease Self-Management Education (including nutrition and food insecurity).

Council members agreed on a timeline for developing the recommendations and individuals responsible for each component.

WHAT	**WHO**	**WHEN**
Draft 1	Fr. LaBarge	May 18
Draft 2: Flesh out data and background and focus recommendation(s); send input to Ms. Phillips Martinez	Data: Dr. Snipes Telemedicine: Ms. Brown-Singleton SDOH: Ms. Phillips Martinez SUD: Ms. Salazar Chronic disease: Ms. Castro	May 21
Draft 3: Incorporate input, do first edit, and submit to full Council for comments	Ms. Phillips Martinez	June 1
Draft 4: Send comments on the draft to Ms. Phillips Martinez	All Council members	June 8
Draft 5: Incorporate feedback into a final draft; submit the final draft to HRSA	Ms. Phillips Martinez	June 15

Closing, Wrap up/Summary

Council members proposed to hold the next meeting in Washington, DC on November 14-15, 2018. They identified potential agenda topics, including human trafficking; patient engagement strategies; health literacy (best practices, culturally and linguistically appropriate materials); and recruitment and retention of providers.

Council members proposed to invite speakers from relevant HHS agencies, such as the CMS Center for Innovation, the Office of Telehealth, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Agency for Healthcare Research and Quality (AHRQ).

The meeting was adjourned at 5:40 p.m.