National Advisory Council on Migrant Health

July 10, 2019

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

Dear Secretary Azar,

The National Advisory Council on Migrant Health (NACMH, hereby referred to as "The Council") advises, consults with, and makes recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS) and the Administrator, Health Resources and Services Administration (HRSA). Specifically, the Council is charged with reviewing the health care concerns of migrant and seasonal agricultural workers (MSAW), and the organization, operation, selection, and funding of migrant health centers (MHC) and other entities assisted under section 330(g) of the Public Health Service (PHS) Act, as amended, 42 USC 254(b), with the goal of improving health services and conditions for MSAWs and their families. Please find an overview of the Council's May 2019 meeting and five key recommendations that fulfill our charge.

Overview
The Council met on May 22-23, 2019 in Brockport, New York – a northeastern agricultural region centrally located within upstate New York where dairy and apple industries are prominent. The estimated number of MSAWs living in New York is 90,000, and approximately 27 percent of them are served by HRSA grantees within the state. During the 2-day meeting, we received updates from HRSA senior leaders. Additionally, the Council heard presentations from the following:

- Mary Jo Dudley, MRP, BA, Director, Cornell Farmworker Program, Cornell University, Ithaca, NY on: **Overview of Agriculture and Migrant and Seasonal Agricultural Workers in New York**
- Rebecca I. Fuentes, Workers' Center of Central New York on: **Working and Living Conditions on New York Dairy Farms**
- Joseph Gallegos, Senior Vice President for Western Operations, National Association of Community Health Centers (NACHC): **NACHC Update**
- Rose Duhan, President and CEO, Community Health Care Association of New York State (CHCANYS) and James Shuford, Project Manager, Migrant Health, HRHCare Community

Health NY on: **Overview of New York State Farmworker Health and the New York Farmworker Health Workgroup**
- Dr. Anthony Mendicino, Jr, DDS, Director of Dental services, Finger Lakes Community Health Center, NY and Dr. Rachel Nozzi, Chief Dental Officer, Oak Orchard Health, Brockport, NY on: **Migrant and Seasonal Agricultural Worker Oral Health Needs and Best Practices**
- Cheryl Seymour, MD, Medical Director at Maine Migrant Health Program, Augusta ME on: **Migrant and Seasonal Agricultural Worker Geriatric Care Needs.**

The Council also heard testimonies from eleven (11) MSAWs from upstate New York and Newark, New Jersey, as well as two (2) community health workers (CHWs) who provide services to MSAWs in the upstate New York region. The testimonies provided vivid accounts of conditions that impact MSAW health, including:

Labor
- Harsh labor conditions on dairy farms (long hours, pesticide exposure, no access to clean drinking water, no designated place to eat during breaks);
- Sub-standard housing (housing provided by employers);
- Challenges with insufficient oversight to implementation of occupational safety standards, especially on small farms;

Substance use
- Heavy use of painkillers for back and shoulder pain; the potential for addiction is a concern of the Council.

Aging
- Aging MSAWs experience a high incidence of chronic disease. It was unclear if chronic disease issues are caused or exacerbated by consistent lack of access to regular primary care.
- Additional issues included inadequate timely care of illnesses (delayed appointments), lack of geriatric care and enabling services. All of these resulted in poor transitions in care for aging farmworkers.

Behavioral Health
- Unrecognized and unmet behavioral health needs largely resulting from the trauma of migration, navigating a new community and the cultural stigma associated with seeking care for mental health issues, have a significant negative impact. Farmworkers also expressed concerns regarding insufficient social outlets. The Council is particularly concerned regarding a consistent lack of awareness of the availability of behavioral health services among MSAWs who testified; as proper behavioral treatment can mitigate work-related and other stressors.

Oral Health
- Pressing need for oral health services for children and adults including: (1) lack of awareness regarding links between chronic diseases such as cardiovascular illness and oral health; (2) fear of oral health procedures (i.e., pain) that impacts MSAWs willingness to use oral health services, and (3) high cost of dental insurance, which all too often results in MSAWs being uninsured and subsequently not seeking treatment.

Access to Care

- Challenges with accessing healthcare services, including: (1) insufficient information on healthcare insurance options for MSAWs and H2A workers; (2) lack of transportation to MHCs (3) long and impractical waiting times for appointments; (4) excessive and unrealistic out-of-pocket costs for medical treatment; (5) perceived discrimination from MHC staff when seeking health care; (6) lack of awareness of available resources and services at MHCs; (7) limited access to medically necessary specialty care; (8) lack of understanding of the importance of an annual physical exam; and (9) lack of interpreters at MHCs and hospitals.

Additionally, the Council also received public comment from Mary Zelazny, CEO of Finger Lakes Community Health (FLCH), on important challenges faced by FLCH. Her challenges are as follows:

- Concerns for the safety of FLCH Community Health Workers (CHW) who visit homes or housing located at worksites, largely because they are threatened by crew leaders.
- Children between the ages of 15-18 presenting as patients at FLCH with non-family members or distant relatives.
- Farmworkers being fearful of leaving farms to handle personal care needs. Ms. Zelazny reported that such fear could lead to virtual slavery for many of the agricultural workers who are afraid to "rock the boat" in fear of losing their jobs.

Recommendations

In context of the evidence and testimonies heard, and in accordance with the charge given to the Council, we submit the following recommendations for your consideration:

Recommendation I

The Council recommends that the Secretary ensure that HRSA Bureau of Primary Health Care (BPHC) fully integrate and adopt culturally-informed Trauma Informed Care as a standard of practice at health centers serving MSAWs.

This recommendation is an addendum to previous appeals made by the Council, as trauma informed care is a repetitive and heightened concern and the Council would appreciate an immediate implementation. Former recommendations include:

- Adoption of universal screening using a trauma-focused screening instrument with all health center patients (December 2017, Recommendation 1.4);
- Training for providers and staff in motivational interviewing, trauma informed care, and social determinants of health (December 2018, Recommendation 4.1); and
- Ensuring that health center infrastructure supports patient-engagement strategies, and services are delivered in ways that are understandable and beneficial to health, and quality of life (December 2018, Recommendation 4.3).

Background

Research indicates MSAWs often experience "triple trauma" - trauma in their home country, trauma of migration, and trauma in the new country.[i] MSAWs are also subject to acculturative stressors that make them more vulnerable to mental distress.[ii],[iii] Altogether, these factors make MSAWs susceptible to depression and other forms of mental distress [iv], [v],[vi]and post- traumatic stress disorder (PTSD).[vii],[viii] In order to more effectively address the complex social, economic, and migration-related factors that

contribute to MSAW disease burden, “trauma-informed care framework” provides a promising potential for tailoring primary care and mental health services.[ix]

A growing body of literature suggests that Latinos do not consider anxiety, depression and PTSD mental illness, largely due to cultural stigmas. However, although mental illness generally carries significant stigma among Latino patients, cultural idioms such as *coraje, nervios*, *susto* and *mal de ojo* do not.[x] Moreover, a majority of immigrant Latino populations report experiencing at least one culture-bound syndrome in their lifetime.[xi] Latinos’ use of cultural idioms to describe mental distress may be masking a more extensive prevalence of depression, anxiety and post-traumatic stress disorder (PTSD) among immigrants who are not likely to report symptoms according to Western diagnostic categories.[xii]

To overcome some of these barriers, the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR includes a glossary of “cultural-bound syndromes.” The term culture-bound syndrome denotes “recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category [and] are generally limited to specific societies or culture areas.”[xiii] The lack of understanding of culture-bound syndromes as they relate to the physical and mental health of MSAWs, by health care providers, could result in inappropriate care for the population the MHCs are charged to serve.

Because cultural idioms of distress have been shown to be a clinical indicator of psychiatric vulnerability among MSAWs, promoting attention to (as well as distribution and adoption) of existing cultural models of trauma informed care can simplify and tailor mental health messaging to be culturally appropriate, and therefore, resonate strongly with the MSAW population. Based upon this, we appeal to the Secretary to encourage HRSA to promote the use of cultural idioms as a part of trauma informed care to better address the physical and mental health needs of the MSAW population.

Recommendation II

The Council urges the Secretary to encourage HRSA to seek pathways for financially supporting *required services* as specified in 42 USC 254b, Part (b) I (A) (iii – v).[xiv] Specifically, we invite the Secretary’s attention to: (1) the provision of enabling services via support for culturally and linguistically competent staff/community health workers (CHW); and (2) adequate availability of staff persons who are fluent in the language spoken by a predominant number of MSAW patients served by the MHC.[xv]

Unfortunately, there are no current reliable sources of funding for these critical services. Therefore, the Council recommends that BPHC:

- Explore supplemental funding options for the provision of enabling services to address the social determinants of health.
- Monitor the funding for sustained provision of enabling services during health center site visits. Additionally, assess the collective impact of this funding through the annual Uniform Data System reporting.
- Explore supplemental funding opportunities to support CHW training and certification programs. Such programmatic funding is necessary to include CHWs into clinical care teams and Patient Center Medical Home (PCMH) programs.

- Provide funding and targeted technical assistance to health centers to hire and train CHWs from local communities.
- Explore the merits and feasibility of implementing a national certification program for CHW's.
- Provide funding opportunities/reimbursement and targeted technical assistance to HRSA grantees to develop models of collaborations and/or networks with local employers/producer associations.
- Extend partnerships with local and state agencies like Occupational Health and Safety Administration (OSHA) and U.S. Environmental Protection Agency (EPA) to better support MSAWs access to care. For example, *The National Migrant and Seasonal Head Start Collaboration Office Effective Partnerships Guide*,[xvi] represents the combined effort of the Administration for Children and Families (ACF), HRSA, and NACHC, to provide guidance on creating partnerships to assure access to quality, culturally competent comprehensive primary health care services for MSAWs and their families.
- Utilize new access point and supplemental funding opportunities to encourage the development and testing of Alternative Service Delivery Models to meet MSAW health care needs.

Background
Proactive, patient-centered CHW interventions improve MSAW access to primary care.[xvii] Further, CHWs play a critical role in achieving health equity and are naturally positioned to support MSAWs in overcoming barriers, to improve health outcomes.[xviii] The implementation of the aforementioned is critical, as MSAWs face multiple barriers to care because they often live in rural areas where there is no public transportation available to them. Since, workers often reside in housing provided by employers on the farm, rural isolation, poor housing conditions in farmworker labor camps, cultural and linguistic isolation make MSAWs especially vulnerable to poor health outcomes. Additionally, employment in an industry that exposes workers to elevated risks of occupational injury and chemical exposures often goes unnoticed, increasing farmworker vulnerability.[xix]

The positive impact that CHW-led programs have on health often have significant economic effects for individuals, healthcare organizations, and society, making them valuable liaisons for MSAW's. Research demonstrates that CHWs enhance patient experience, strengthen care coordination, improve clinical outcomes, and can help to control health care costs. CHWs also bring an understanding of patients' culture, language, and communities to the health care team, identifying obstacles patients face and tailoring health management strategies to meet each patient's needs.[xx] CHWs play a critical role in rural and isolated communities by providing culturally and linguistically relevant services to MSAWs. They help MSAW patients navigate health care systems, educate MSAW's on health promotion, health care and enabling services available to them at MHC's and in the community.

Targeted outreach and funding for CHW-led enabling services are essential. Studies have shown that health centers with CHWs in place provide high quality primary care for their patients, with higher rates of screening and health promotion counseling. However, Medicaid prospective payment rates and section 330 grants have not kept up with the new paradigm and cost of patient care. Since CHWs are not adequately reimbursed or funded for the provision of enabling services, health centers absorb the costs at the expense of other services or reaching new patients. Thus, provision of funding mechanisms, either directly from HRSA or through collaborations with other federal agencies to share the costs, could provide successful CHW-led strategies to improve MSAW health outcomes. [xxi].

Recommendation III

The Council urges the Secretary's support for HRSA to explore innovative solutions for meeting MSAW specific transportation needs as specified under HRSA Strategic Plan Goal 1. Specifically, the Council recommends that HRSA initiate cross-agency efforts that eliminate transportation-related barriers by initiating collaboration between health policy makers, urban and rural planners, and transportation experts to create solutions that address limited transportation options among MSAWs in rural areas.

Transportation barriers are routinely indicated as a significant barrier to patients receiving the full spectrum of care. To address the transportation needs of MSAWs, the Council recommends that BPHC:

- Provide supplementary funding to enable MHCs to provide transportation for MSAW patients for ongoing primary care, chronic disease management, to prevent missed appointments, to eliminate delayed care, and missed or delayed medication/prescription use.
- Where appropriate, fund capital investments for appropriate transportation vehicles, including their operational and maintenance costs.
- Allocate funding for medical and dental mobile units that can travel to rural and isolated MSAW employment sites for service delivery.
- Require MHCs to gather patient level data, through the annual Uniform Data System reporting, that allows an analysis of transportation barriers (e.g., cost, mode of travel, public transit options, safety, and vehicle access).
- Track transportation related data to correlate it to objective outcome measures such as missed appointments, rescheduled appointments, delayed medication fills, and changes in clinical outcomes. This would help clarify both the impact of transportation barriers and the types of future transportation interventions needed.

Background

Community and MHCs currently serve approximately a million MSAWs.[xxii] However, transportation continues to remain an important barrier to healthcare access. Ninety nine percent (99%) of the MSAW population is transportation disadvantaged, meaning that they lack continuous and reliable transportation.[xxiii] Although MSAWs have a migratory lifestyle, many are dependent upon the transportation of crew leaders to new locales.[xxiv] Only 42 percent of MSAWs report having a car available for them to use in the United States[xxv]; Approximately 33 percent report having no transportation at all.[xxvi] Thus, a large number of MSAWs are dependent on others (such as their employers) for transportation to meet basic needs, including buying groceries, washing laundry, and obtaining health care services. The lack of transportation further exacerbates rural geographic and social isolation. When MSAWs are heavily dependent upon their employer to seek medical care, it becomes a potential conflict of interest for the employer, who may be unwilling to transport their employees to health care appointments during competing work hours.

Although some MHCs have vans to transport patients, the number of vans is systematically reported as insufficient for the population by MSAWs and clinic staff alike.[xxviii]

Recommendation IV

The Council would like to draw the Secretary's attention to the unique health challenges and unaddressed needs faced by aging farmworkers. The nature of agricultural work, including but not limited to the constant bending over to pick crops or weeding fields, accelerates physical weathering of the body in the aging farmworker. In addition to the trauma and lasting detrimental impact on MSAWs backs and knees, exposure to pesticides and extreme temperatures take a toll on physical health over time. Finally, aging MSAWs report working long hours, 6-7 days per week. Altogether, aging farmworkers are unable to access health care services to prevent chronic diseases or gain treatment for the injuries they may sustain on the job. Aging also brings on additional physical limitations. Unlike their younger counterparts, they are no longer able to work the 12-hour shifts and may often be let go or fired. There are no retirement benefits and pensions for MSAWs. This not only brings on emotional hardship, but they also cannot afford to pay for healthcare. Based upon this compelling account, the Council recommends that HRSA implement the following:

- Defined standards of geriatric care for MSAWs based on the nature of agricultural work performed and their unique circumstances, such as standard screenings for geriatric patients.
- Incentives for health centers to accurately identify and classify MSAWs, to enable successful implement these standards.
- Ensure the health centers provide MSAW specific education and case management programs for chronic disease management among aging workers.
- Provide financial relief to aging farmworker populations through subsidized care or through Medicare and Medicaid expansion programs.
- Facilitate the development of mechanisms for portability of health information from one health center to another, as the MSAW ages (e.g., when seeking care in a location near relatives) as well as between the US and the MSAW home countries. This will better serve the large number of aging MSAWs returning to their home countries.

Background

Although the average life expectancy for the US general population is 78.69 years of age,[xxix] and most Americans plan to retire around 65 years of age, for economic reasons many seasonal farmworkers have no choice but to keep working. Farmworkers have no pensions and retirement benefits. The US Department of Labor statistics indicate the average age of farmworkers in America is 38 years old. The average life expectancy for farmworkers is 49 years old, indicating farmworkers are at a higher risk of early death.[xxx] These circumstances and statistics create a unique problem for MSAWs and those that provide them health care. An example of this disparity is provided below.

Dairy farm workers endure harsh working conditions: long hour's - often 12 hour shifts with no overtime pay, 6 days a week, in extreme weather conditions. In a recent New York State study: (1) two-thirds of dairy farm workers surveyed had experienced one or more injuries while on the job. Sixty-eight percent of those injured said the damage was serious enough to require medical attention, but some were too afraid to tell their boss; (2) one-third of workers surveyed had received no job training, and of those who were trained, the training was often insufficient; (3) dairy farm workers' principal safety concerns stemmed from aggressive cattle, operating heavy machinery, using chemicals, and slippery or insecure conditions of farm working environments. These dangers are exacerbated by the lack of job and safety training. More than 80 percent of dairy farm workers in New York are estimated to live and work on

farms with too few workers to fall under Occupational Safety and Health Administration (OSHA) jurisdiction for inspection and sanctioning.[xxxi] Much evidence suggests that physical weathering of the body in such conditions is associated with accelerated aging in farmworker populations**.**

Having worked minimum or near-minimum wage jobs, aging farmworkers face immense financial burden. Inability to work as they used to because of age, physical limitations due to occupational illness or injury, often receiving no social security benefits and no retirement fund, which brings on enormous financial hardship. For many MSAWs, retirement is marked by financial insecurity and health challenges.[xxxii] It is imperative that we take care of the needs the aging agricultural workers face, often due to their hard work and years providing food for our country.

Recommendation V

The Council recommends that BPHC review its current criterion for setting sliding fee discount schedule. To minimize financial barriers to care for patients who meet certain eligibility criteria, the Health Center Program requires grantees to establish a sliding fee discount program that includes a schedule of discounts for services/sliding fee discount schedule (SFDS). We specifically call upon BPHC to require health centers to factor in patient economic realities as they implement the individual health centers compliance of the sliding fee discount scale program. The Council further urges the setting of a flat nominal charge at a level that would be nominal from the perspective of the patient. Based on feedback from NACMH patient board members and MSAWs, the Council urges that section 330g grantees provide care at a rate reflecting the MSAWs ability to pay, rather than the actual cost of the service provided. This implementation standard should also be extended to referral agreements and/or contracts with providers as indicated on Form 5A, column II and column III by requiring MHCs ensure the following:

- The calculation of MSAW income for SFDS is based on a 40-hour workweek, over a full 12 months. MSAWs may sometimes present only one pay stub or no pay stub. We caution the use of this as a default for the 12 months of pay. A single paystub may not accurately reflect the MSAW's annual income, as most do not work a full 12 months of the year. Adequate questions at in-take should gain information on precise annual income.
- MSAW patients with higher insurance copays are not required to pay more. Ensuring patients pay what they would if they were accurately assessed for the sliding fee discount program, or their insurance premium, whichever is lower.

Background

Due to the seasonal nature of the work on many crop farms, the large majority of crop workers do not work year round even if they work for more than one farm in a single year. Based on data from the U.S. Department of Labor's National Agricultural Workers Survey (2015-2016), farmworkers averaged 33 weeks of farm work within the past year. Respondents worked an average of 45 hours a week, with women working 40 hours and men 46 hours.[xxxiii] Working these limited periods throughout the year does not always guarantee a pay stub that would accurately reflect the patient's annual income, making it difficult for health centers to calculate the appropriate sliding fee discount. Hence, MSAW annual income assessed based on a single pay stub, does not take into consideration the limited time for which a MSAW may work within the year – in most cases equivalent to only 6-9 months.

The average annual individual income for farmworkers is approximately $15,000-$17,499.[xxxiv] This limited income provides a challenge when accessing primary care services; the challenge is greater when MSAWs pay for specialty services. Ensuring that MSAWs are not charged higher than what they would pay on the sliding fee discount program ensures services stay accessible and affordable.

The sliding fee discount program is an important mechanism for making care accessible for MSAWs. However, in its current form of implementation it often does not fully ensure that financial inability is not a barrier to seeking care. As a potential model for HRSAs consideration, we urge attention to the process used by migrant education. A child identified as belonging to "migrant/seasonal farmworker" category based on their parent's current work situation, is eligible for the Free School Lunch Program. Parents are not required to provide financial proof or complete lengthy paperwork usually associated with applying for social programs. U.S. Department of Agriculture (USDA) took this position as almost all migrant workers, by the nature of the work they do, live below the poverty line. Asking for proof of eligibility when it is known that nearly all MSAWs are impoverished could be considered burdensome and unnecessary. It has been approximately a decade since the USDA and other federal agencies have made this determination. To date, no abuse of this system has been documented and the categorical language still stands. Because HRSA currently lacks a methodology that ascertains the health centers sliding fee scale is not a barrier to seeking care, and because implementation of an appropriate scale is one of the top five areas of HRSA grantee non-compliance,[xxxv] HRSA may consider a strategy similar to USDA, to enable access to care for MSAWs.

In closing, we are appreciative for the honor extended to us in serving on the National Advisory Council on Migrant Health. The Council recognizes the valuable role that agricultural workers play in our economy and in our countries domestically produced food supply. We thank the Secretary for your service, and for your consideration of our recommendations on behalf of those, we serve.

Sincerely,

/Sharon Brown-Singleton/
Sharon Brown-Singleton, MSM, LPN
Vice-Chair National Advisory Council on Migrant Health

cc:
George Sigounas, Ph.D., MS
James Macrae, MA, MPP
Jennifer Joseph, Ph.D., MSEd
Esther Paul, MBBS, MA, MPH

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