# National Advisory Council on Migrant Health

December 10, 2020

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

Dear Secretary Azar,

The National Advisory Council on Migrant Health (NACMH/Council) advises, consults with, and makes recommendations to the Secretary of the U.S. Department of Health and Human Services (DHHS) 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. In the sections below, please find an overview of the most recent meeting and the Council's recommendations toward improving the health and welfare of MSAWs and their families.

***Overview***

The Council held a virtual meeting on October 20-23, 2020. During the four half-day meeting, we received updates from HRSA senior leaders and presentations from the following:

- Rachel A. Gonzales-Hanson, Senior Vice President for Western Operations, National Association of Community Health Centers (NACHC) – NACHC Update
- Laszlo Madaras, MD, MPH, SFHM, Chief Medical Officer, Migrant Clinicians Network (MCN) - COVID 19 pandemic, Clinical Impact on MSAWs
- Amy K. Liebman, MPA, MA, Director of Environmental and Occupational Health, MCN - COVID 19 pandemic, Policy lessons from the Impact on MSAW
- Alan Mitchell, Executive Director, Health Center Controlled Network, NY -Designing a National Strategy for Prevention and Control to Restructure MSAW Care
- Lorann Stallones, MPH, PhD, Professor, Department of Psychology, Colorado State University; Director, Colorado Injury Control Research Center, CO – Injury Prevention and Control in Agricultural Workers

- Elena Reyes, PhD, Clinical Professor, Florida State University College of Medicine (FSUCOM), Immokalee Health Education Site; Director, Center for Child Stress & Health, FSUCOM -Toxic Stress in MSAW Children and the COVID 19 Pandemic
- Sylvia Partida, MA, Chief Executive Officer, National Center for Farmworker Health, Buda, TX - Toxic Stress in MSAW Children

The Council also heard testimonies from twelve (12) MSAWs from Longmont and neighboring areas in CO. The testifiers provided vivid accounts of conditions regarding the impact of the Covid-19 pandemic on their overall well-being, as well as toxic stress within MSAW families. **We would like to draw special attention to the following findings:**

**Impact of the Covid-19 pandemic**

- The testifiers provided poignant examples of how the pandemic has affected their work and their lives. Several testifiers had family members who tested positive, some of whom were critically ill.
- The vast majority were misinformed about COVID 19 prevention, testing, contact tracing, symptom recognition, as well as the parameters around when to receive testing. Some expressed a belief that one does not need to be tested unless you have symptoms. They also showed confusion about when to seek medical attention. Most of the testifiers said they didn't need to get tested because they didn't have symptoms and would get tested if necessary, but many were hesitant due to a) fear of testing positive, b) stigma associated with the disease, and c) fear of job loss associated with contracting coronavirus;
- Most of the testifiers said that their workplace was their primary source of information on how to protect themselves and their families, followed by media and television.
- Finally, testifiers said that their employers do not generally provide masks or other personal protective equipment (PPE). One said that their farm manager offered masks but did not encourage workers to use them.

**Toxic Stress in Migrant Children**

- Testifiers offered accounts of several factors that cause them to be anxious, sources of stress, solutions that help decrease the intensity of stress, traumas, obstacles, concerns with seeking medical care or educational opportunities, and hope for the future of their children. We will expand upon these indications in the recommendations below.
- Lack of parental proficiency with internet and computer related skills and school closures has resulted in an extreme source of stress for most testifiers. Parents expressed the strongest concerns regarding challenges with virtual learning for MSAW children because of their inability to manage technology and other demands. Yet, there is a passion for children receiving an education and a desire for children to return to school.
- Testifiers indicated mistrust in the healthcare system alongside a need for trusted sources within the health center staff, such as community health workers (CHW).
- MSAW women are fearful of the long-term impacts of Covid-19 for themselves and their families, yet hopeful for the future of their children.

**Injury Prevention & Control**

- Testifiers indicated that they do not receive appropriate PPE from employers, nor are they encouraged to use masks or appropriate clothing;

**Services for MSAW children with Special Needs**

- Testifiers highlighted lack of awareness and information on services available for MSAW children with special needs;

Additionally, six council members shared the challenges faced by the health centers they represent, as follows:

- Health centers with mobile units were able to resume the delivery of care to MSAWs after the initial lockdown quickly, and recommend mobile units as an effective model of care for MSAWs;
- Telehealth adoption amongst MSAWs has not been as successful as anticipated during the pandemic primarily because of limited access to broadband;
- There is a critical need for culturally competent health care services at the community level for COVID 19 testing, early detection, contact tracing and referral to treatment;
- The pandemic has had a widespread adverse impact on MSAW children, and concerted efforts are needed to address this including but not limited to mental health services and trauma informed care (TIC) in schools and Migrant Head Start;
- Providing access to care for MSAWs during the pandemic has drawn attention to an urgent need to bridge gaps in emergency preparedness at the health center level.

***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 – MSAW Protections During the COVID 19 Pandemic**

More than 190,000 agricultural workers have tested positive for COVID-19 nationwide.[i] The widespread misinformation about the transmission of the virus, testing and contact tracing procedures has contributed to a disproportionate number of MSAWs contracting COVID-19 nationwide. There are no comprehensive mandatory national regulations and industry-wide guidelines for testing or reporting of positive COVID 19 cases among agricultural workers. Hence, insufficient implementation of available guidance has resulted in workplaces that are unprepared to protect their workers. There is also no reliable agricultural worker data base for providers serving MSAWs, as a result of which they have had to rely on reports of case clusters among agricultural workers through the media. Even though farmworkers are deemed "essential workers," they continue to lack worker regulatory protections afforded to other worker categories. Additional vulnerabilities such as low-wages, inherent dangers and health risks of the occupation, cultural and language differences, migratory lifestyle, lack access to health care, lack of health insurance and financial resources further jeopardize MSAW health.

The Council makes the following recommendations to protect MSAWs during the Covid-19 pandemic:

1. Department of Labor (DOL), Occupational Safety and Health Administration (OSHA) adopt emergency regulations to protect agricultural workers during the pandemic to fill the gaps in MSAW health protection disparities. OSHA recently revised their guidance, and now requires employers to record COVID-19 illnesses contracted at work, however, employers with 10 or fewer employees still do not have recording obligations; they need only report work-related coronavirus illnesses that

result in a fatality or in-patient hospitalization.[ii] The DOL must also consider emergency policy to provide wage relief for MSAWs in isolation who cannot work due to contracting the virus. Temporary Standards or Emergency Orders must at a minimum provide guidelines on, a) PPE provision by employers and mandatory usage; b) Physical distancing; c) Workplace disinfection; d) Testing MSAWs for COVID 19 at mandatory intervals; e) Changes to housing and transportation designed to reduce the spread of the coronavirus; and f) Paid Sick leave.

2. HRSA collaborate with Centers for Disease Control (CDC) and OSHA to design and implement a national plan to ensure: a) COVID 19 testing, contact tracing and follow up care policy for agricultural workers that includes mobile test sites at farms and MSAW camps, especially in rural areas where transportation to hospitals and health centers is a challenge for workers and their families; and b) MSAW access to COVID 19 vaccine through "set-asides" for susceptible populations.

3. HRSA BPHC Primary Care Associations collaborate with local and state health departments, migrant and community health centers (M/CHCs), growers and agribusiness stakeholders and farmworker representatives to develop a comprehensive risk mitigation strategy to protect farmworkers at a state and regional level. The strategy must include:
   - Evidence based protocols for on-farm testing and related health education, for use by clinical and outreach staff.
   - Providing farms with best practices to ensure implementation of any statewide emergency order that outlines specific measures that must be met on farms.
   - A Risk Mitigation Strategy document outlining each M/CHCs overall approach, including pandemic related education, communication, and logistics measures, testing results management, post-outbreak support, and other considerations.
   - User friendly communication tools with scripts for first engagement with farm owners, starting with arrival at the farm, COVID-19 education on symptoms, testing, safety measures, and test responses.
   - Training and workflow protocols that are appropriate for farm arrival and testing. Such documents are essential in providing mobile health staff, farm owners and labor contractors with specific and detailed recommendations for implementing safety and health measures delineated in the state's emergency regulations.

4. The HRSA Health Center Program (HCP) continue implementing services and resources that help M/CHC efforts towards the prevention, protection, and treatment of the COVID-19 in MSAWs and their families, by:
   - Allocating financial and technical assistance to providers who are a recognized source of trust in the farmworker community, including physicians and community health workers (CHWs).
   - Developing a national HRSA, M/CHC COVID testing policy that includes mobile test sites at farms and MSAW camps where transportation is a challenge for workers and their families.
   - Exploring options to expand telehealth services so MSAWs using various communication devices that overcome challenges with broadband access.
   - Developing a campaign that includes providing masks and suitable PPE equipment to protect against the contagion.

- Encouraging M/CHCs to create local alliances and collaborative agreements with housing and education agencies to strengthen health efforts addressing the underlying social determinants of health.

5. HRSA proactively create a plan to support implementation of the National Academies of Sciences, Engineering, and Medicine's Draft Preliminary Framework for Equitable Allocation of a COVID-19 Vaccine,[iii] ensuring the following considerations:
   - The vaccine is available in an expedient and timely fashion to all MSAWs regardless of insurance status or ability to pay. MSAWs are essential workers and a vulnerable population critically at risk, hence the plan must proactively consider the barriers to MSAW care such as transportation, fear, inability to leave work during planting and harvesting hours.
   - In order to achieve targeted levels of vaccine acceptance, HRSA should support the creation and dissemination of vaccine information in languages spoken by diverse agricultural communities, including (but not limited to) Spanish, Haitian Creole, and other indigenous languages. HRSA should act proactively to produce materials in in low-literacy formats.
   - To reach the widest possible audience HRSA consider using a wide variety of formats, partnerships, and media.

**Background**

Because of the lack of national surveillance specific to MSAWs, we relied heavily upon the testimonies of farmworkers to accompany the limited availability of data. Testifiers provided personal accounts of the disproportionate impact that this contagion has had on farmworkers due to the factors listed above in the description of the testimony session. MSAWs generally lack adequate housing to facilitate proper social distancing and are adversely affected by the absence of a fair compensation program for those who test positive for the virus and are required to quarantine. The testimonies also elicited a fear and avoidance of testing, on account of stigma and fear of wage loss. Contact tracing is essential to quelling a pandemic, but there are reports that when farmworkers test positive, often they're not asked any contact tracing questions, nor are they given any information about what they should do to seek follow up care for themselves and protecting others.[iv]

*The Problem*

There was a serious lack of educational information on protections against COVID-19 and how to get the proper testing for the virus. Access to crucial health services and suitable PPE were some of the most notable concerns that were evident in 2020. Another reoccurring theme was the inadequate facilities in the camps and work areas necessary to maintain proper social distance and frequent lack of hygiene stations for proper handwashing.

While the pandemic continued to ravage the nation, MSAWS endured co-occurring traumas including wildfires that ravaged large areas of Western US. During the grape harvest, for example, farmworkers toiled alongside the fires sending hazardous dense smoke. This forced many agricultural workers to make a choice between prioritizing their health and earning badly needed wages. Despite plummeting air quality, many farmworkers continued to work for an extra dollar per hour because of the fires, lacking the luxury of thinking about the long-term health effects of the smoke. Agricultural workers were among the most vulnerable as the disaster unfolded. As some agricultural workers picked crops through a blanket of smoke, others waited at home for a chance to work again. Unfortunately, misinformation about the virus spread quickly through trusted sources like neighbors, family, and

compadres. In some areas, people were confused about when to seek medical attention and many testing sites required appointments and were hard to find. The lack of information in Spanish and indigenous languages from Mexico and Central America, has added to the confusion.[v]

*Opportunities and Impact*
According to the most recent data from HRSA, most farmworkers lack health insurance and access to regular medical care.[vi] Only about 25 percent of farmworkers and their families currently seek care at an M/CHC. There is a clear need for implementing a campaign that includes a marketing effort employing electronic media and vibrant informational posters in various languages, distributed in places frequented by MSAWs. Physicians, employers and CHWs are a trusted source in the MSAW community and could serve as a vehicle in a national strategy. Furthermore, the deployment of mobile clinics by M/CHCs to farms and workplaces would provide a great opportunity for services like vaccinations, annual screenings, mental health support and COVID-19 testing without MSAWs being absent from their work responsibilities. Which has the potential for a good return on investment for a HRSA investment in mobile units. Fostering relationships with recognized and trustworthy non-profit entities and universities can also reinforce mutual health efforts, lower costs by combining valuable community resources and expand the reach of the M/CHCs.

**Recommendation II – National Data Strategy to Improve MSAW Health and Welfare**

The Council recommends that HRSA renew its effort to increase access to care for MSAWs by implementing a National Data Strategy to develop, translate, and apply evidenced-based interventions to enhance MSAW health and welfare. The Council recognizes that the pathway to improving MSAW care will depend on identifying and addressing needs and interventions both at the patient and population level. Hence, closing the gap will require gaining insight into, and making good individual and population-level health care decisions. To achieve this, data must be timely, accurate and comprehensive. **Therefore, the Council recommends that HRSA:**

1. Leverage the Nationwide Health Information Network (NHIN), a program under the Office of the National Coordinator for Health Information Technology (ONC), to improve the quality and efficiency of healthcare, by establishing a mechanism for nationwide health information exchange.[vii] The NHIN providing the foundation for the secure exchange of health information to support meaningful use.

2. Equip M/CHCs adapt to telehealth service use by advocating for legislation towards permanent parity in telehealth reimbursement for all insurers; allocate sufficient funding and guidance for telehealth equipment, personnel, training, and protocols; and implementing telehealth systems tailored to vulnerable populations.[viii]

3. Utilize current electronic health records to, a) better identify MSAWs using a standardized demographic questionnaire, and b) once accurately identified, improve the quality of care provided to MSAWs by standardizing a questionnaire that gathers information on unique MSAW health exposures and challenges.

4. Collaborate with diverse federal and nonfederal MSAW serving stakeholders towards developing a network that unites M/CHCs and human services organizations, utilizing a shared technology that enables a coordinated, community-oriented, person-centered approach for delivering care to

MSAWs across the nation, including when they migrate to follow the harvest. HRSA build on currently available tools such as Migrant Clinician Networks, Health Network a bridge case management and care coordination program for migrating agricultural workers, and NACHC Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Toolkit.[ix] The PRAPARE tool helps providers better understand their patients' social determinants of health, and electronically connect patients with identified needs to community resources and allows for feedback and follow up. This solution ensures accountability for services delivered, closes the loop on every referral made, and reports outcomes of that connection. Ensure the Strategy utilizes the expertise of the HRSA Health Controlled Networks (HCCN) to include:

- A periodic and accurate service area needs assessment of the number of MSAWs in the service area and the US, for an accurate determination of unmet need. HRSA improve MSAW identification and services to this target population, by collaborating with the DOL, and national and community based MSAW serving stakeholders across the nation.
- Determining a path to close the gap between the established numbers of MSAWs in the local area derived from the above effort, and MSAWs and family members eligible for HCP services, and numbers served by M/CHCs in the corresponding service area.
- Enabling M/CHCs improve their clinical and operational performance by using health information technology, collaborative efforts, providing necessary support to deliver efficient, data-driven, evidence-based care to all vulnerable populations.
- Support for M/CHCs to contract with telehealth interpreter and translation services to provide equitable access and care. Requiring all telehealth platforms contracting with M/CHCs to provide multilingual support to deliver equitable access to telehealth services.
- Pathways to address the problems resulting from a high frequency of low-income patients lacking health and digital literacy. Virtual telehealth platforms adopted by M/CHCs must ensure the interfaces of applications utilized are intuitive and easy to navigate. M/CHCs train patient navigators, care coordinators, and implement shared decision-making support efforts that bridge the health literacy divide, and guide patients who are not familiar with telehealth systems.
- MSAW challenges with access to high-speed internet, consistent telephone services, and phones or computers with video conferencing capabilities. HRSA explore avenues to:
    - Address disparities in ownership of digital devices, enabling access to devices, portable hot spots, and phone-charging stations.
    - Provide affordable communication services and cellular data to low-income populations to maintain their outpatient care using the Federal Communications Commission (FCC) Lifeline program.[x]

**Background**

MSAWs face unique barriers to care resulting from the nature of farm work, structural inequities that negatively impact the social determinants of their health and technology gaps. Based on the information received by the Council through the Federal Update, there appears to be a promising opportunity to align the proposed National Data Strategy effort with HRSA's Advancing Health Center Excellence framework to improve care for MSAWs served by M/CHCs.

Though the Coronavirus Aid, Relief, and Economic Security (CARES) Act infused $1.32 billion toward the COVID-19 response and for maintaining CHC capacity, many health centers are struggling, as many were unprepared for the abrupt swing toward telehealth. Calendar year (CY) 2019 Uniform Data System (UDS) data indicates at the start of the pandemic 43 percent CHCs and 48 percent MHCs provided

clinical care using telehealth.[xi] M/CHCs not using telehealth reported several barriers to implementation.[xii] Thirty-six percent cited lack of reimbursement, 23 percent lacked funding for equipment, and 21 percent lacked training for providing telehealth. A greater proportion of rural clinics reported inadequate broadband services as an issue.[xiii]

*The Problem*

HRSA currently has no set infrastructure for a national health information exchange, resulting in an urgent need for a national data strategy that contains accurate and current data on a population level as well as a patient level, to capture information that reflects the needs of each individual patient to eliminate barriers to MSAW health and welfare. This makes it difficult to ensure continuity of care for MSAWs migrating to follow the harvest, irrespective of their location. MSAWs often lack access to technology for their health information to follow them. This is further complicated by barriers such as the absence of a standard patient identifier. Even though HRSA has made large investments in enabling M/CHCs obtain electronic health records, incompatible systems prevent the sharing health information between health centers.

The past two decades have seen many changes to the US MSAW population, including their numbers, demographic composition, related characteristics and changes in patterns of farmworker migration. HRSA assessment of the number and composition of MSAWs in need of health care is contingent on an accurate enumeration of MSAWs. This will require systematic processes and procedures to identify, screen, and refer MSAWs, to gauge the accurate penetration rate of successful outreach efforts. The UDS submissions for CY 2019 indicates that the HCP currently serves approximately 25-30 percent of the nation's MSAW population.[xiv] Accurate MSAW identification is influenced by the variability in M/CHC staff skills during intake, creating an urgent need for standardizing EHR intake forms/data.

*Opportunities and Impact*

The FCC released funding to procure telehealth services and devices,[xv] similar targeted funding mechanisms from states and the federal government has the potential to scale and equip hundreds of M/CHCs with the necessary telehealth capabilities.[xvi] However, having technology is not sufficient. Trained personnel are key to a high-functioning telehealth system along with support from information technology specialists and other collaborations. The successful implementation and scaling of telehealth will require robust protocols, systems and leadership efforts by HRSA Health Controlled Networks.

Finally, the pandemic has shed light on the lack of national level data to inform an evidence based clinical and policy response. There has been misinformation about how this public health emergency has affected the MSAW population, and often the only available information on the pandemics impact on MSAWs has been dependent on reporting provided by the media. This calls for a national data strategy to guide the care needs of a population whose service is deemed as an essential service.

**Recommendation III – Toxic Stress in MSAW Children**

Trauma and toxic stress are ongoing realities for many MSAW families, but since the pandemic began school and daycare closures resulting from the pandemic and the wildfires in western US states are impacting MSAW children disproportionately. Farmworker parents are hesitant to send their children back to school for fear of contracting the virus, but on the other hand, the experience the stress of navigating the unfamiliar world of e-learning. This has contributed to mental health issues in both adults

and children who feel isolated in camps, is a deep concern for farmworker parents. There is a demonstrated need for culturally sensitive and linguistically appropriate psychological supports and mental health services that are responsive to the needs of MSAW children and youth. The Council humbly calls on Secretary Azar and Administrator Engels to use their uniquely positioned offices to not only draw attention to the predisposition of MSAW children and families to disproportionate levels of childhood adversity, trauma and resulting toxic stress but commit to cross agency efforts and collaborations across the DHHS.

**The Council recommends:**

A. Collaborations across DHHS Programs and Efforts, and
B. Implementation of Evidence Based Approaches and Training across DHHS Programs and Efforts.

*A. Collaboration across DHHS Programs, and Efforts*

1. That HRSA Bureau of Primary Health Care (BPHC) explore avenues for collaborating with HRSA's Maternal and Child Health Bureau to leverage its Maternal, Infant, and Early Childhood Home Visiting (MEICHV) Program,[xvii] administered to support at-risk communities to ensure they receive the appropriate support to raise children who are physically, socially and emotionally healthy and ready to succeed. The HCP served over 1 million MSAWs and families, in 2019. Approximately 40 percent of MSAWs served are under 18 years of age, and approximately 83 percent of MSAWs served live below a 100 percent of poverty level. Considering the similarity in target populations with the MIECHV Program,[xviii] tailoring its existing structures to make them culturally and linguistically competent to serve MSAWs would extend HRSA reach and mission, and earn a valuable return on investment for the nation in due time.

2. By law, state and territory grantees of the MIECHV Program may use up to 25 percent of the funding to implement promising approaches that undergo rigorous evaluation and have the potential for yielding rich best practices.[xix] Tailoring the MIECHV Program to meet the unique needs of the US MSAW population would also provide lessons learned for other culturally and linguistically similar underserved ethnic populations.

3. HRSA seek a pathway to collaborate with Department of Education, Office of Special Education Programs (OSEP) to seek assistance for at risk MSAW children.[xx] OSEP leads the nation's efforts to improve outcomes for children, ensuring access to fair, equitable, and high-quality education and services. This HRSA-OSEP partnerships can enable MSAW children to overcome trauma and toxic stress, providing opportunities to lead purposeful and fulfilling lives through benefits available under the Individuals with Disabilities Education Act (IDEA).[xxi]

4. BPHC leverage its partnership with Migrant and Seasonal Head Start (MSHS) to:
   - To enable MSHS centers implement primary prevention strategies that reduce the likelihood of early adversity and its harmful effects on children and promote resilience in development. This can be achieved through behavioral health promotion, providing social emotional support for children and families in collaboration with M/CHCs.
   - For children already exposed to adversity, staff can focus on preventing subsequent exposure. This can be achieved through evidence based, enabling services interventions which protect against harm, promote recovery, and lead to flourishing lives. Promising approaches to this goal

include establishing a medical home for MSHS enrollees at the local M/CHC;[xxii] reducing stress by expanding access to high-quality, trauma-informed early intervention,[xxiii] early care and education, and home visiting.[xxiv]

5. The National School-Based Health Care Census indicates that there are approximately 2,584 school-based health centers (SBHC) in 48 of 50 states, DC, and PR (2016 – 2017).[xxv] Approximately 20 percent of these centers receive funding through the HRSA HCP, which are often are operated as a partnership between the school and a community health organization.[xxvi] These centers are uniquely positioned to work with the school staff to adopt an interdisciplinary approach to develop TIC capacity by training staff to screen for adversity and provide stigma free follow up care by facilitating a family's access to evidence-based treatment and supports.

6. HRSA collaborate with the Substance Abuse and Mental Health Administration's (SAMHSA) National Child Traumatic Stress Initiative (NCTSI) which seeks to improve treatment and services for children, adolescents, and families who have experienced traumatic events to establish M/CHC "Toxic Stress Reduction Centers/ Misiones," in order to provide stress and anxiety management for MSAWs. The establishing of these "Misiones" along the geographical paths that MSAWs travel as they migrate to follow the harvest across the US, will ensure continuity and consistency in TIC for MSAW children and families.

7. M/CHCs are uniquely positioned to immediately elevate this pressing need, that has been exasperated by the COVID 19 pandemic and urgently implement the strategies suggested below.
   - HRSA, BPHC mandate all M/CHCs to include toxic stress screening and management as part of every well child visit and annual physical examination as a part of the regular required services provided by the center.
   - HRSA, BPHC fund and mandate all M/CHCs serving MSAWs to train a cadre of promotoras/CHWs that receive culturally and linguistically appropriate training on TIC and related mental health challenges faced by MSAW children and families. Train and re-train to enhance knowledge and skills regarding toxic stress and trauma-induced behavior identification and interventions to provide social/emotional supports in the community setting. CHWs are also home grown means for identification and cultivation of community protective factors, which can mobilize sources of faith, hope, and cultural traditions to support MSAWs and their families.

8. DHHS expand the integration of CHWs within existing programs to more fully leverage their expertise and skills, to maximize the value of CHWs in addressing the adverse social determinants of health, improving quality of care and reducing health expenditures to improve the health and welfare of MSAWs and other underserved communities across the nation.[xxvii] CHWs have the potential to contribute to diverse aspects of a successful national strategy, coming from the communities they serve, uniquely positions CHWs for a clear understanding of the source of poor outcomes and related expenses, their eyes and ears on the ground can help focus our health and social services system towards a coordinated and comprehensive identification and reduction of risk. The Council recommends additional federal support for CHWs through the following DHHS programs to leverage their full potential:
   - CDC provide guidance to state, and local public health departments and other relevant stakeholders build cross-cutting, evidence based comprehensive CHW programs to set standards

for community practice. This should include information regarding the availability of funds to hire, train and deploy community health workers.
- Centers for Medicare and Medicaid Services (CMS) collaborate with states to enable and encourage the integration of CHWs in programs that provide a comprehensive range of social, behavioral, and economic supports.
- CMS publicize the clarification that Medicaid funding allows: 1) diagnostic, screening, preventive and rehabilitative services; and 2) CHW services that address social determinants of health.

*B. Implement Evidence Based Approaches and Training across DHHS Programs and Efforts.*

1. The Secretary direct DHHS to invest in the professional development of a cadre of cross trained education and health service providers to increase trauma knowledge and skills. Ensure optimal implementation of the Support for Patients and Communities Act., a federal legislation that supports states efforts to increase access to trauma-informed services.[xxviii] Training providers to conduct screening as part of a comprehensive approach to assessment, referral, and follow-up in cross generational programs (e.g., Early Intervention [OSEP: IDEA Part C], home visiting: e.g. MIECHV Program, Head Start/Early Head Start),[xxix] early care and education,[xxx] pediatric care settings,[xxxi] child welfare,[xxxii] mental health, and other services for children and their families.[xxxiii] [xxxiv] Research indicates that training in TIC not only improves providers' skills and knowledge, but also improves behavior and mental health outcomes among children with post-traumatic stress.[xxxv]
2. Train providers to utilize a comprehensive, trauma-informed, strengths-based approach to addressing childhood adversity, where screening is only one component of TIC and the child's exposure and related reactions (i.e., symptoms) are identified.
   - Screening be conducted using a reliable and valid, culturally sensitive and linguistically and age appropriate tool, that accounts for adversity pertaining to the social determinants of health (e.g., poverty, homelessness, discrimination, migration) in addition to household-level challenges.
   - Providers be trained in skills to obtain a comprehensive developmental history, to develop an individualized care plan without causing undue stress or re-traumatizing children and families. A plan that identifies each child's strengths and challenges across multiple areas of development and is not based on deficits alone.
   - Establish a clearing house for evidence-based treatments and services in order for care providers to stay up to date and identify interventions that are supported by evidence and designed for the appropriate population.
3. Enhance the provision of parenting education availability for agricultural workers. Provide parents with new skills and increased awareness of their child's behavior and needs; e awareness of their own emotional health; knowledge, and skills on raising their children in positive ways; increasing the family's coping skills by identification of the impact of toxic stress and trauma on them and their family, to name a few.

**Background**

The US spends significantly more money per capita on health care services than any other nation in the world,[xxxvi] but lags in terms of key outcome measures, including health equity,[xxxvii] and patient perceptions of safety, efficiency, and effectiveness. The primary sources of these adverse health and social outcomes are risk factors.[xxxviii] [xxxix] Ongoing mental health disparities in MSAWs and families have been attributed to the trauma associated with migration, the ethnic minority position, poverty, their

specific cultural background and the widely known adverse social determinants of health.[xl] There is an urgent need for comprehensive, trauma-informed science based approaches that account for social-structural adversity and recognize, understand, prevent and respond effectively to childhood adversity in MSAW children and youth.[xli] [xlii]

*The Problem*

There is a demonstrated need for culturally sensitive and linguistically appropriate psychological supports and mental health services that are responsive to the needs of MSAW children and youth. Children of immigrants often financially and emotionally support their parents during difficult situations in a challenging U.S. system that leaves them without a federally mandated living wage, accessible health care, and/or affordable housing. Children also often serve as cultural language brokers for their families' collective survival at home and at work. Circumstances of hardship lead parents to often set high expectations on their children to succeed, given their own incredible sacrifices, including migration.

The scope of adversities includes policy-related conditions, such as severe poverty; housing instability; prejudice and discrimination based on race, ethnicity, sexual orientation; historical or community-level experience of violence and trauma, interrupted schooling; and poor physical and mental health. Because trauma can potentially lead to toxic stress, a type of stress caused by "strong, frequent, and/or prolonged adversity." Without adult support, toxic stress disrupts the development of brain architecture and function, while increasing the risk for poor physical health, limited social-emotional skills, and cognitive impairment,[xliii] it is essential to recognize the diverse challenges that MSAW children and families may face every day, for planning an appropriate multi-disciplinary response MSAW children and families unique needs.

*Opportunities and Impact*

The existing US health and education structures are well positioned to provide services that consider the needs of underserved MSAW children and families, particularly in light of demographic trends and the current inequity in health and educational resources and outcomes that are associated with this population. The recognition of the importance of childhood adversity lies at the heart of any planned effort directed at the promotion of child well-being, but the response must extend beyond adversity screening strategies. [xliv] [xlv] [xlvi]. Adverse Childhood Experiences (ACEs) impact lifelong health and opportunities. Findings show that more than 1 in 4 children in the US have been exposed to at least one adverse event, with racial/ethnic minority children more likely to disproportionately experience adversity in early childhood. Exposure to four or more ACEs before age 18 is considered clinically significant, this means that even before entering preschool, more than 1 in 10 children are on a path that could make later school and economic success more difficult. Economic difficulty is the most common form of adversity.[xlvii] Trauma is widespread and it differently affects the more vulnerable. Trauma affects how individuals approach health services. Preparing service providers to be 'trauma informed' assists them to understand the prevalence and impact of trauma among their service recipients and within the work force itself. The integrated knowledge of trauma into policies, procedures, and practices has the potential to resist re-traumatization. Any effort directed at this problem must go beyond fixing children and families but be grounded in increasing awareness that this population is at greater risk. It must be about improving the social emotional competencies of staff and health center resources to assist MSAWs and their families.

## Recommendation IV – Injury Prevention in MSAWs

Approximately 2.1 million hired crop workers are employed annually on farms in the US. In 2014 approximately 13 percent of these were youth. Every day, about 100 agricultural workers suffer a lost-work-time injury.[xlviii] Agriculture is one of the most hazardous industries in the US with a fatality rate of 20.4 deaths per 100,000 workers.[xlix]Though transportation incidents, including tractor overturns were the leading cause of death, the high incidence of exposure to COVID 19 has added on to the risk of behavioral and mental health issues such as anxiety, depression and toxic stress. Therefore the Council recommends:

1. HRSA lead the formation of federal and regional partnerships with OSHA to expand education of workers on work safety, first aid, injury reporting and the use of PPE. With CHWs and health educators from M/CHCs serving as key partners in health and safety education for MSAWs.

2. OSHA create appropriate guidelines and their implementation to provide farmworkers with adequate and appropriate PPE to protect from viruses, molds, natural elements, pesticides, and chemicals.

3. OSHA create special guidelines for training youth and farmworkers new to the occupation.

4. BPHC in collaboration with its training and technical assistance partners enable M/CHCs to provide health education and outreach efforts to train and equip MSAWs to avoid work-related exposures and injuries utilizing culturally and linguistically competent staff/CHWs fluent in the language spoken by a predominant number of MSAWs served.

## Background/Problem

The existing regulations for protecting worker safety defined in the OSHA General Duty Clause states that employers "shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." However, worker protections in agriculture are weaker than other industries. In addition, there are challenges with enforcements, particularly on smaller farms. Farmworkers are regularly exposed to extreme weather with inadequate PPE, chemicals and pesticides, and physical labor that includes heavy lifting and repetitive motion, climbing high ladders at fruit orchards, harsh labor condition on dairy farms, long hours, pesticide exposure, no access to clean drinking water, no designated place to eat during breaks. Pesticides are the only chemical legally released into the environment with the purpose to kill living organisms. Although farmworkers are not the target of pesticides, they experience harm. The federal Environmental Protection Agency estimates put exposure levels at 3.2 to 4 million farmworkers annually, with 300,000 acute cases/year. Use of PPE is low among farmworkers because of barriers to use, including: cost; difficulty and impracticality of use;[l] it slows the productivity of work; and its use can jeopardize workers' ability to identify hazards.
Often crowded and poor living conditions increase the risk to other illness, and taking into consideration other social determinants of health like trauma of migration, navigating a new community and the cultural stigma associated with seeking care for mental health issues, leads to a high risk for injuries.

Often financial hardship causes injured workers to return to work prematurely or continue working without seeking medical care. One quarter of injured subjects who thought medical care was needed never received care, and a larger number did not receive care promptly. The more conscientious

enforcement of existing laws could do much to protect the health of farmworkers. For example, whether in an indoor or outdoor environment where cold stress conditions are possible, employers and workers should be aware of symptoms of cold-related illness and injury, not only in themselves but also in their coworkers, and be prepared to immediately notify their supervisor, provide first aid, and seek prompt medical assistance (e.g., call 911).

*Opportunities and Impact*

Acts such as the Farm Laborers Fair Labor Practices Act implemented in NY is an example of opportunities that other states can implement as a model.[xlix] This Act, sets important labor requirements for farm employers, owners, and operators. This includes changes regarding requirements for workers' compensation, disability benefits and paid family leave coverage. All employers are required to provide workers' compensation coverage for their employees, regardless of annual payroll. Employers are also required to post the mandatory workers' compensation notice of compliance poster in both English and Spanish. In addition, employers and particularly farm contractors must notify the employer owner or operator of the farm where the injury occurred. Employers are prohibited from discriminating against employees for requesting workers compensation, employers are responsible for paying for workers' compensation coverage and employers cannot take any deductions from employees to pay for coverage. The wider implementation of farmworkers friendly laws such as this would be beneficial both for farmworkers and the nation.

In closing, we appreciate the honor extended to us in serving on the National Advisory Council on Migrant Health. The Council recognizes that the farmworkers' presence increases the overall economy in the regions in which they work. We thank the Secretary for your service, and for your consideration of our recommendations on behalf of those, we serve.

Sincerely,

/Sharon Brown-Singleton, MSM, LPN/
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