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

November 1-2, 2023

Rockville, Maryland (In-person and Virtual)

Meeting Minutes

Council Members in Attendance

Marco Antonio Viniegra, PhD (Chair)
Maria del Carmen Huertero (Vice-Chair)
Marisol Cervantes, MA
Donalda Dodson
Mary Jo Dudley, MS
Carolyn Emanuel-McClain, MPH
Seth Holmes, PhD, MD
Elizabeth Freeman Lambar, MSW, MPH
Colleen Laeger
Juan Manuel Mota, Jr., BA
Teng Vang, BA, MS

Federal Staff in Attendance

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

Esther Paul, MBBS, MA, MPH, Designated Federal Official, NACMH
Mayra Nicholas, MPH, MBA, Senior Public Health Advisor, OPPD, BPHC

Wednesday, May 24, 2023

Call to Order

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

Ms. Paul extended a warm welcome on behalf of HRSA to those attending in person and virtually, including HRSA Administrator Carole Johnson, Associate Administrator Jim Macrae, other HRSA leaders and federal staff, presenters, and members of the public. She extended a special welcome to the four Council members attending their first meeting at the HRSA Headquarters and congratulated the new chair and vice-chair for fiscal year (FY) 2024.

Ms. Paul noted that over the next two days Council members would listen, learn, share personal experiences, deliberate about the health and welfare concerns of migrant and seasonal agricultural workers (MSAWs), and compile evidence-based recommendations that have the potential to change the story for MSAWs. She urged Council members to enter their time together with resolve and optimism.

Ms. Paul called the meeting to order following her remarks.

Welcome and Opening Remarks
Carole Johnson, MA, Administrator, HRSA

Administrator Johnson thanked Council members for their leadership and service in difficult times over the last three years. She commended the Council for building trust within the farmworker community and helping HRSA make strides in serving farmworkers and the health center workforce.

Inflation and the unwinding of Medicaid following the end of the Public Health Emergency increased the need for health center funding. Mandatory funding for the health center program expired on September 30, and the annual appropriation is also at stake. The government is currently operating under a continuing resolution. HRSA is working closely with health centers and partners to make sure that resources are available. There is broad bi-partisan support for this work. HRSA looks forward to finding ways to maximize the impact of its programs if additional resources are provided.

HRSA has prioritized addressing the needs associated with behavioral health, maternal mortality, and the health center workforce. Behavioral health needs were an issue before the pandemic and have continued to grow. MSAWs have many sources of anxiety, and health centers need to provide appropriate support. HRSA is focused on ensuring that resources are available and integrated with primary care.

The maternal mortality crisis is also a priority for this administration. Health centers need to provide support for MSAW women, including better care for chronic disease that impacts health outcomes negatively.

This is a difficult time for the health center workforce. HRSA is focused on supporting retention and growing the next generation of professionals, including steps to ensure that clinical training for primary care providers includes rotating into sites that serve MSAWs. HRSA is committed to ensuring access to services provided by clinicians who understand the needs of this population.

Administrator Johnson thanked Council members for their commitment and assured them that she looked forward to their recommendations.

Welcome and Remarks
James Macrae, MA, MPP, Associate Administrator, BPHC, HRSA

Mr. Macrae welcomed Council members to HRSA, thanked them for their work, and congratulated the new chair and vice-chair.

The last three years challenged and stretched everyone in ways that were not anticipated and brought a spotlight to disparities. Community health centers (CHCs) and migrant health centers (MHCs) made sure that the populations that need preventive health services received them in the best possible way.

The first health center that Mr. Macrae visited was an MHC in West Virginia. That experience underlies his commitment to ensuring that health centers make it as easy as possible for MSAWs to receive the highest quality care.

The Council's recommendations matter. HRSA considers them carefully and takes action where it can. Recommendations that address issues beyond HRSA's programs provide an opportunity to engage with

colleagues across HHS and the federal government. Mr. Macrae urged the Council to continue to push HRSA to think bigger about what they can accomplish.

The Council's recent recommendations are reflected in HRSA's actions. HRSA made its first investment in early childhood development, and the president's budget for FY 2024 almost doubles that amount. HRSA increased investments in school-based health centers and proposed an additional $25 million for 2024. The Senate version of the mandatory funding bill includes $55 million for that program.

HRSA heard the Council's recommendation to do more in the area of behavioral health. The president's budget for 2024 makes mental health and substance use disorder services a requirement for health centers and includes $700 million to support that effort.

Most of HRSA's funding is directed to specific programs, but some of it is not. HRSA is interested in the Council's perspectives on what would have the biggest impact in the area of enabling services.

HRSA heard the Council's concern about the need to deliver services when people can access them, and the president's budget includes significant funding for expanded hours. HRSA would welcome the Council's advice on how to craft funding opportunities to ensure greater access.

HRSA sees the impact of climate issues on patients and communities. They are working closely with the new HHS Office of Climate Change and Health Equity (OCCHE) to identify key issues for patients at CHCs and MHCs. HRSA would welcome recommendations to guide their priorities in this area.

HRSA launched a customer engagement initiative to provide better support to health centers and be more responsive to their needs and priorities. They would welcome recommendations in that area.

Discussion

Ms. Dudley was pleased to learn about the formation of a long COVID research center, given the heavy incidence among the farmworker population. She asked how the research will be translated into a form that will be helpful to support farmworkers who are experiencing long COVID.

- Mr. Macrae said that the Office of Long COVID Research is located within the HHS Office of the Assistant Secretary for Health (OASH), with studies conducted by the National Institutes of Health (NIH). HRSA would welcome recommendations about how to get findings to the field.

Dr. Holmes requested more information about the new HHS office on climate change.

- Mr. Macrae replied that OCCHE was formed two years ago within OASH and is coordinating efforts across HHS. BPHC is looking at how to reduce the climate impact of health center operations, identify the impact of climate issues on the populations they serve, and support mitigation strategies. They are also looking at how to use disaster-response resources to focus on prevention strategies. HRSA would welcome suggestions from the Council in these areas.

Ms. Emanuel-McClain thanked Mr. Macrae for getting the early childhood development funds out to the field quickly. As one of the grantees, she looks forward to building a program for the target population.

Dr. Viniegra asked how BPHC would support behavioral health care beyond emergency services.

- Mr. Macrae said BPHC was preparing an issue paper for the HRSA Administrator on how to use the new resources and what the additional requirements would entail. Ninety-five percent of

health centers currently offer mental health services, and about 70 percent offer substance use disorder (SUD) services. Key issues are how to support health centers that have never provided those services, how to build a continuum of care for health centers that currently offer them, and how to differentiate CHCs from the new Certified Behavioral Health Clinics, which serve individuals with more severe issues. BPHC wants to move beyond emergency care and integrate behavioral health into primary care. They would welcome the Council's suggestions.

NACMH Chair Opening Remarks
Marco A. Viniegra, PhD, Chair, NACMH

Dr. Viniegra stated that he was honored to serve as Chair of the Council, leading with other leaders to empower each other. He emphasized that it is members' collective effort that results in recommendations that matter. Council members serve for a short time, but their work can have an impact and strengthen the Council beyond what they do individually.

Dr. Viniegra thanked Administrator Johnson and Mr. Macrae for attending the meeting and reminded them that the Council's recommendations truly matter for MSAWs. Council members have the privilege of hearing the voices of farmworkers whose testimonies inform the recommendations. He urged Council members to remember that the value of their work is reflected in the benefits they bring to those who need them the most and the Council's first priority is to improve farmworkers' lives.

Dr. Viniegra called for a motion to approve the meeting agenda. The motion was made by Ms. Laeger, seconded by Ms. Emanuel-McClain, and carried by unanimous voice vote.

Dr. Viniegra called for a motion to approve the minutes of the May 2023 meeting. The motion was made by Mr. Mota, seconded by Dr. Holmes, and carried by unanimous voice vote.

Office of Policy and Program Development (OPPD) Update
Jennifer Joseph, PhD, MSEd, Director, OPPD, BPHC, HRSA

Dr. Joseph provided an update on the HRSA Health Center Program and MHC grantees. Her presentation included an overview of 2022 health center data, HRSA's response to the Council's latest recommendations, an update on FY 2023 funding and an overview of funding for FY 2024, BPHC strategic priorities, findings of the health center workforce well-being survey, the Health Center Patient Survey (HCPS), initiatives to strengthen HRSA's COVID-19 response, the BPHC Customer Experience program, and activities to support health center participation in value-based care delivery.

Dr. Joseph prefaced her remarks by affirming HRSA's commitment to listen to the Council and translate its recommendations into things that make a difference for the population they care about. She noted that the recommendations build upon one another over time. Part of BPHC's responsibility is to help all health centers see that they have a role in serving agricultural workers across the country.

2022 Health Center Data Overview

More than 30 million people relied on HRSA-supported health centers for care in calendar year 2022, including one in nine children, one in six Medicaid patients, 9.6 million rural residents, and one million agricultural workers. School-based service sites serve nearly a million patients.

MHCs served 840,000 MSAW patients in 2022, which is 83 percent of the total. The balance of the MSAW patients were seen by other community health centers (CHC) and FQHC look-alikes. BPHC is looking at how to improve services for at non-MHCs, what incentives it can provide for improvement, and what questions to include in grant applications to determine applicants' knowledge of the needs of the agricultural worker community.

Health centers provide high-quality care that meets or exceeds national benchmarks. Health center performance overall improved on 12 of 18 clinical quality standards, and 91 percent of health centers improved their performance on at least six measures. Two-thirds of health centers exceeded a comparable national benchmark for hypertension control. Many MHCs have received Community Health Quality Recognition (CHQR) awards for enhancing access, advancing health information technology (HIT), reducing health disparities, and qualifying as a patient-centered medical home.

Response to NACMH Recommendations

The Council submitted three recommendations in July 2023:

- Recommendation I: Acknowledge and address the health and welfare consequences of an inadequate immigration policy on the nation's migrant and seasonal agricultural workforce.
- Recommendation II: Address the unique and critical early childhood development health and welfare concerns of MSAW households.
- Recommendation III: Promote equitable access to health care and enabling services for agricultural workers by addressing the multifaceted barriers that impact MSAW health and welfare.

BPHC is analyzing the recommendations to find ways to integrate them into their programs and promote the issues within HHS and to the public.

FY 2023 Funding Update

HRSA awarded nearly $670 million in FY 2023 for the following programs:

- Expanding COVID-19 Vaccination: $350 million/1,471 awards ($4.3 million/155 awards for migrant health)
- Accelerating Cancer Screening: $11 million/22 awards ($242,897/3 awards for migrant health)
- Quality Improvement Fund – Maternal Health: $67 million/36 awards ($11 million/6 awards for migrant health)
- National Training and Technical Assistance Partners (NTTAPs): $23.5 million/22 awards ($5 million/5 awards for migrant health)
- Ending the HIV Epidemic – Primary Care HIV Prevention: $18 million/46 awards ($464,851/4 awards for migrant health)
- Early Childhood Development: $30 million/$151 awards ($1.6 million/25 awards for migrant health)
- School-Based Service Expansion: $25 million/77 awards ($1.1 million/10 awards for migrant health)
- Capital Assistance for Response and Recovery Efforts (CARE): $64 million/111 awards ($6 million/6 awards for migrant health)
- COVID-19 Bridge Funding for Health Centers: $81 million/1,463 awards ($17 million/174 awards for migrant health)

BPHC would welcome recommendations about how to use the CARE resources to help health centers respond to climate change.

FY 2024 Funding

The president's budget for FY 2024 communicates HRSA's priorities, including a dramatic increase in funding for behavioral health services.

FY 2024 Funding

New Funding	President's Budget	House and Senate Action to Date
Behavioral Health Services (mandatory)	$700 million	TBD
Expanded Hours (mandatory)	$250 million	TBD
New Access Points (mandatory)	$150 million	TBD
Primary Care HIV Prevention (discretionary)	*$15 million new*	*House and Senate – no increase*
Early Childhood Development (discretionary)	*$55 million new*	*House and Senate – no increase*
Cancer Screening (discretionary)	*$10 million new*	*House and Senate – no increase*

Ongoing Program Funding	President's Budget	House and Senate Action to Date
Quality Improvement Fund	*$50 million*	*House and Senate – no increase*
Primary Care Associations	*$68 million*	*House and Senate – no increase*
Service Area Competition	*$1.7 billion*	*House and Senate – no increase*
Native Hawaiian	*$27 million*	*House and Senate – no increase*

Mandatory funding for the Health Center Program expires this year and must be reauthorized. There has been no response from Congress to date regarding that portion of the budget.

Congress did not support the proposed increases in discretionary funding, but it did not propose any cuts. It is uncertain when the appropriations bill will be passed or what it will include.

BPHC Strategic Priorities

BPHC's strategic priorities aim to increase access to the health center model of care, improve health outcomes, reduce health disparities, and advance health equity for underserved populations.

- Priority 1: Strengthen health centers to address critical and emerging health care issues and the evolving health care environment.
    - Goals: Support the health center workforce, advance health center excellence, strengthen COVID response and future preparedness, improve health center and partner engagement.
- Priority 2: Activate and accelerate evidence-based and innovative or new high-value models of care delivery for underserved and vulnerable populations.
    - Goals: Introduce patient-level data reporting, engage in value-based care delivery, promote innovation.
- Priority 3: Expand the reach of the health center model of care in the nation's highest need communities and populations.
    - Goals: Support comprehensive care service delivery, reach high-need communities, build new partnerships.

It is critical to support health centers in responding to emerging issues, including climate-related events and communities impacted by violence. Health centers must have the tools and resources they need to be successful in the future. BPHC is looking at what the new Executive Order on artificial intelligence means for the health center program.[1]

Patient-level data reporting will transform how health centers understand their patient population. BPHC would welcome the Council's feedback regarding what principles health centers should take into account to provide value-based care to MSAW patients.

Health Center Workforce Well-being Survey

BPHC conducted a survey this year to assess the well-being of the health center workforce. The results show that health center staff are highly engaged, mission-driven, and have a high level of job satisfaction. They are also tired.

HRSA will award a two-year technical assistance (TA) contract to address the outcomes and key drivers of workforce well-being. Its national partners will address health workforce issues through 2024.

BPHC would welcome recommendations regarding how health centers can promote the well-being of their workforce.

Health Center Patient Survey

BPHC surveyed health center patients in 2022 to inform quality improvement activities, funding opportunities, and TA. The survey consisted of one-on-one interviews with more than 4,400 patients at 102 health centers regarding their sociodemographic characteristics, health conditions, health behaviors, access to and utilization of health care services, and satisfaction with health care services.

Survey participants reported more positive experiences at health centers than other types of health care facilities. Ninety-seven percent would recommend their health center to family and friends, and 94 percent were satisfied with how their medication was explained to them. Compared to Medicaid patients, health center patients reported higher rates of having a respectful provider who listens and spends enough time with them.

Advancing COVID-19 Priority Initiatives

BPHC is committed to helping health centers be successful in COVID-19 response and preparedness. Key activities include health center engagement, partnerships with health centers and other agencies to better reach underserved populations, educating health centers about COVID-19 variants, supporting equitable vaccination for children, and support for administering COVID-19 therapeutics.

Dr. Joseph acknowledged the Council's concern about long COVID among MSAWs. It will be challenging to address this issue now that the emergency resources for COVID are no longer available.

[1] https://www.whitehouse.gov/briefing-room/statements-releases/2023/10/30/fact-sheet-president-biden-issues-executive-order-on-safe-secure-and-trustworthy-artificial-intelligence/

BPHC Customer Experience Program

BPHC launched a customer experience program to improve engagement and support for health center grantees and partners. Elements of success include a consistent cross-bureau approach for assisting grantees, with clear lines of accountability; streamlined and standardized tracking of health center support requests; simplified and centralized communication between stakeholders; enhanced and streamlined knowledge sharing; and improved stakeholder satisfaction.

Supporting Health Center Participation in Value-Based Care Delivery

BPHC wants to ensure that health centers have the resources they need to provide value-based care, as described in Strategic Priority 2. Resources for that effort include training and TA (T/TA), incentives for clinical quality and performance, a dedicated Quality Improvement Fund, a Health Center Excellence Framework that supports innovation and performance improvement in seven key domains, and enhancing the Uniform Data System (UDS) to provide patient-level data.

Discussion

Ms. Freeman Lambar asked when HRSA will know what Congress decides about FY 2024 funding.

- Dr. Joseph said this was unknown. The appropriations process for discretionary funding is separate from mandatory funding. HRSA has drafted funding opportunities for all of the requested programs that are consistent with the proposed legislation. The budget request includes resources to provide health centers with TA to become compliant with the new behavioral health requirements. Almost half of the funding in Senate bill is focused on base adjustment for health centers, national partners, and primary care associations (PCAs).

Ms. Freeman Lambar asked if there was still room for recommendations regarding FY 2024 funding and what would be helpful.

- Dr. Joseph replied that BPHC can revise the funding opportunities until they are published. The Council has provided good feedback on the intersection of primary care and behavioral health. It would be helpful to know what expanded hours should look like to serve MSAW patients. BPHC would welcome informal feedback regarding that issue.

Dr. Viniegra asked if BPHC's commitment to equitable care delivery includes funding for lesbian, gay, bisexual, transgender, queer/questioning, and intersex (LGBTQI+) populations.

- Dr. Joseph replied the president issued an Executive Order to advance equality for LGBTQI+ individuals, and health centers must comply with state and federal law.[2] She noted that many health centers have experienced challenges providing gender-affirming care, and she urged the Council to put this issue on the table.

Dr. Viniegra commented that workforce issues always come down to pay. People love working in health centers, but they can earn more elsewhere.

- Dr. Joseph replied that base funding adjustments are intended to help with that overarching need. BPHC would welcome suggestions on what they can do in partnership with others.

[2] https://www.whitehouse.gov/briefing-room/presidential-actions/2022/06/15/executive-order-on-advancing-equality-for-lesbian-gay-bisexual-transgender-queer-and-intersex-individuals/

Ms. Dudley noted that the Council's most recent recommendations spoke to state policies that put MSAWs at risk of immigration, detention, and deportation despite federal protections for access to health care. She asked what HRSA's role is in communicating with other federal entities to ensure that federal protections are enforced.

- Dr. Joseph replied that legal issues are outside of BPHC's role. The HHS Office of Civil Rights would be the logical place to address this situation. The administration is concerned about immigration, and it is an important issue for Secretary Becerra. The Council should not hold back on making recommendations about what HRSA and HHS should do in this area.
- Ms. Dudley said it would be helpful for BPHC to provide guidance on how the Council should pursue such topics in its recommendations.

Ms. Huertero noted that the number of MSAWs served by health centers decreased in 2022. She asked if BPHC has any strategies to increase that number and how the Council can assist in that effort.

- Dr. Joseph noted that HRSA's national partners receive funding to do that work.

HRSA Strategic Partnerships Serving MSAWs

David Bates, MBA, MHCM, Team Lead, National Partnerships Team, Strategic Partnerships, Office of Quality Improvement, BPHC, HRSA

Mr. Bates provided an overview of BPHC's Office of Quality Improvement (OQI) and HRSA-funded partnerships to support health centers and improve MSAW health.

OQI's goals are to expand health center capacity, activate and accelerate innovation, foster a culture of data-driven decision-making and improvement, and develop strategic partnerships and collaborations. The Strategic Partnership division administers BPHC's cooperative agreements, including national T/TA partners (NTTAPs), PCAs, health center controlled networks (HCCNs), and interagency collaborations. Strategic Partnerships also provides administrative oversight for the Council on Special Populations(CSP) and the BPHC Health Center Patient Survey.

National Health Center Training and Technical Assistance Partners

HRSA funds 22 organizations that provide T/TA for health centers. The NTTAPs engage and collaborate with other HRSA-supported T/TA partners to maximize the impact of their work.

Five NTTAPs provide support for MSAWs: Farmworker Justice, Health Outreach Partners, Migrant Clinicians Network (MCN), MHP Salud, and the National Center for Farmworker Health (NCFH). Their services help health centers deliver comprehensive care, address emerging public health issues and health needs, improve operational effectiveness and quality, and advance health equity. They also provide resources to address the Council's recommendations.

The MSAW NTTAPs collaborate with PCAs to coordinate annual migrant health stream forums to discuss regional and national trends affecting MSAWs and share strategies to address their health and well-being. Each forum is located in one of the three traditional migratory streams.

Council on Special Populations

The CSP informs HRSA leadership of issues that are important for the delivery of health center services to special populations that receive services at health centers, including MSAWs, people experiencing homelessness, residents of public housing, and other health center populations (Asian Americans,

Native Hawaiians and Other Pacific Islanders, LGBTQI+, school-aged children, and older adults). The Strategic Partnership division provides administrative support and tracks action items.

The CSP meets quarterly to hear from subject-matter experts knowledgeable about underserved populations. The August 2022 meeting focused on conditions affecting MSAWs.

Primary Care Associations

HRSA funds 52 state or regional 52 organizations that provide T/TA to health centers and look-alike and facilitate collaboration between health centers and governors, Medicaid directors, and state health departments.

Health Center Controlled Networks

HCCNs are networks of health centers working together to strengthen and leverage HIT to improve health centers' operational and clinical practices. HRSA funded 49 HCCNs through FY 2022. HCCNs collaborate with NTTAPs to develop strategic approaches to increase access to comprehensive, integrated primary health care for special populations, including MSAWs. Examples include participation in the Ag Worker Access Campaign task force and partnership with NCFH to increase access to care.

Interagency Collaborations

Strategic Partnerships manages two interagency collaborations that support MSAWs:

- The Department of Labor (DOL) and HRSA Interagency Agreement (IAA) combines resources to improved analytical services and reports for the National Agricultural Workers Survey (NAWS). The IAA provides HRSA/BPHC with access to NAWS analyses and findings and enables BPHC to take the lead in identifying and prioritizing future health research domains for the survey.
- The Agency for Children and Families (ACF)/HRSA Memorandum of Understanding established collaboration between HRSA/BPHC, the Office of Child Care, and the Office of Head Start Migrant and Seasonal Head Start (MSHS) Program. Activities include learning collaboratives, presentations at Migrant Stream Forums and the National MSHS Association Conference, and MSHS representation at the Migrant Stream Forum Planning Committees.

2022 Health Center Patient Survey

Strategic Partnerships coordinated the HCPS to complement UDS administrative data with insights on health center patient experiences. The survey dashboard and public use files can be accessed at https://data.hrsa.gov/topics/health-centers/hcps.

Discussion

Dr. Holmes noted the Liaison Committee on Medical Education adopted structural competency as an important topic for medical training. The Council has mentioned structural competency as a factor in its recommendations and two NTTAPs have incorporated it in training sessions, but the presentations this morning did not address it. He asked if HRSA is engaging with that topic.

- Mr. Bates replied that BPHC is not intentionally holding off on addressing that issue. They would be glad to connect with the NTTAPs that have begun to do work in this area and share that learning with other organizations.
- Dr. Holmes asked if HRSA could recommend that structural competency be part of the NTTAPs' work or create a learning collaborative or hub.

- Mr. Bates said the most deliberate way to do that would be to incorporate the language into the Notice of Funding Opportunity (NOFO) for the NTTAPs, as they did with social determinants of health (SDOH). BPHC can also work with its partners to utilize the skill sets they have.

Ms. Huertero asked if the Council could benefit from the takeaways of the CSP's August 2022 meeting on MSAWs or future meetings.

- Mr. Bates appreciated the recommendation. He suggested that his office could ask speakers to integrate the Council's recommendations into their discussion points for future meetings.

Ms. Dudley noted that the passage of Florida Senate Bill 1718 led to an influx of MSAWs to New York and other states because they are afraid their immigration status will be reported if they seek health care in Florida. The Council recommended interagency collaboration with the Department of Homeland Security to reinforce the implementation of federal protections for access to healthcare pursuant to the Emergency Medical Treatment and Labor Act. Dr. Joseph recommended taking the issue to OCR, but undocumented farmworkers and health centers who serve them are unlikely to do that. Since the issue appears to fall in the area of interagency partnerships, Ms. Dudley asked what Strategic Partnerships could do to ensure that federal legislation is enforced.

- Mr. Bates noted that the Council's recommendations go to the Secretary, but BPHC and the NTTAPs can reinforce the importance of this issue. Access is one of the most important parts of the health center program, and it is the first objective for all NTTAPs. The presentation on medical legal partnerships during this meeting would be relevant to this question.

National Association of Community Health Centers (NACHC) Update
Rachel A. Gonzales-Hanson, Interim Chief Operations Officer

Ms. Gonzales-Hanson outlined NACHC's mission and strategic pillars, introduced NACHC's new president and Chief Executive Officer (CEO), described NACHC's prescription for the primary care workforce, provided an update on NACHC's Alliance to Save America's 340B Program (ASAP 340B), discussed the climate on Capitol Hill, reviewed NACHC's legislative priorities, and shared resources to mobilize support for health centers.

NACHC Mission and Strategic Pillars

NACHC was founded in 1971 to promote efficient, high-quality, comprehensive health care that is accessible, culturally and linguistically competent, community-directed, and patient centered for all.

NACHC's strategic pillars are equity and social justice, empowered infrastructure, skilled and mission-driven workforce, reliable and sustainable funding, improved care models, and supportive partnerships.

NACHC President and CEO

NACHC's new president and CEO Kyu Rhee, MD, MPP is a former National Health Service Corps and CHC physician. Dr. Rhee's vision is for all health centers to be providers of choice, employers of choice, and partners of choice with the "seven Ps" of the health system (providers, payers, purchasers, policymakers, producers, pioneers, and patients).

Primary Care Workforce

NACHC's prescription to address the health of the primary care workforce is focused on retention, recruitment, and reform. NACHC conducted the HRSA workforce well-being survey, which found that

health center staff are highly engaged, have high job satisfaction, and are more likely to report that they are not burned out. Drivers of those outcomes were a strong sense of mission orientation, meaningfulness, social support, supervision, leadership, and teamwork.

Primary care represents only 5.7 percent of the $4.3 trillion spent on health care in the U.S. That needs to change. We need more funding, reimbursement, and professional training for primary care.

Alliance to Save America's 340B Program (ASAP 340B)

The 340B program is essential for patients. It is critical to protect cost savings for health centers, especially in rural and frontier areas where most MSAWs are located.

The ASAP 340B campaign has 10 policy principles: make 340B a true safety-net program for patients; ensure 340B prescriptions are offered to patients at a discount; update the 340B patient definition with strong safeguards; establish clear criteria for 340B contract pharmacy arrangements to improve access; prevent middlemen and for-profit entities from profiting off the 340B program; update and strengthen 340B hospital eligibility requirements; address standards for 340B child sites and subgrantee eligibility; create a neutral 340B claims data clearinghouse; facilitate public reporting on 340B program data; and establish enforceable rules and enhance federal administration and oversight of the 340B program.

ASAP 340B has created awareness and support among members of Congress and gained visibility in print and online media. New materials at www.asap340B.org detail the campaign's principles and potential impact, and the list of partners continues to grow. Targeted local events during National Health Center Week demonstrated the broad coalition of support. NACHC is working with the 340B workgroup and PhRMA to translate the policy principles into legislative recommendations.

NACHC Legislative Priorities

The uncertainty on Capitol Hill is fueled by many factors that influence what is achievable, and there are stark differences on funding between the House and the Senate. The new speaker of the House will have to address the need for institutional stability, government spending beyond November 17, 2023, extension of health center funding, and the Defense Authorization bill.

NACHC is focused on maintaining bipartisan support for health centers. Its legislative priorities are health center funding, workforce funding, and protecting the 340B program. It is important to shore up existing health centers to address inflation and workforce challenges.

The 3-year extension of the Community Health Center Fund (CHCF) expired on September 30, 2023. NACHC is advocating for permanent authorization of both the CHCF and discretionary appropriations so health centers have stable funding and can plan for the future.

The Tri-Committee bill in the House includes provisions from the unanimous Energy and Commerce Committee bill. The fate of the bill is influenced by House leadership uncertainty, the House Freedom Caucus, Democratic complaints, and concerns of major hospital groups.

The bipartisan bill passed by the Senate Committee on Health, Education, Labor, and Pensions includes a 45 percent increase in health center funding, including new requirements on behavioral health and nutrition services, a 15 percent increase in the base grant for health centers, $3 billion in capital funding, and significant funding for workforce programs. More advocacy is needed to build broad support.

Resources to Mobilize Support

Ms. Gonzalez-Hanson urged Council members to use the "Gather Voices" storytelling tool to record their stories about the importance of health centers (https://www.hcadvocacy.org/gather-voices-storytelling/). Additional tools are available at https://linktr.ee/hcadvocacyteam.

Discussion

Ms. Dudley asked for guidance on how the Council's recommendations can reinforce NACHC's message, including specific aspects of implementation.

- Ms. Gonzalez-Hanson said it is important for health centers to continue to have the protection of the federal requirement prohibiting them from asking about patients' immigration status.
- Ms. Dudley noted that the Council articulated that point in its recommendations from the previous meeting; the challenge is how to make that happen. Going to OCR is not viable.
- Ms. Gonzalez-Hanson said the protection has been in place for a long time. She offered to contact NACHC's general counsel to clarify the history of the legislation and said she would provide the information to Ms. Paul.

Integrating Medical-Legal Partnerships at Migrant and Community Health Centers to Address Agricultural Worker Health Disparities

Bethany Hamilton, JD, Director, National Center for Medical-Legal Partnership (NCMLP), Milken Institute School of Public Health, The George Washington University
Jacqueline Baños, MPH, Senior Research Associate, NCMLP

Ms. Hamilton and Ms. Baños described the medical-legal partnership (MLP) approach, how health centers have adopted it, benefits of MLP for MSAWs and MHCs, and resources available from NCMLP. They noted that NCMLP is a HRSA-funded NTTAP.

The MLP Approach

MLP's integrate the expertise of legal and health care professionals providing opportunities for collaboration to help patients resolve social, economic, and environmental factors that contribute to health disparities and have a remedy in civil law. It is a flexible, evidence-based, public health and social justice intervention designed to meet the needs of the community.

MLPs embed lawyers within a health care team to provide legal assistance to address patients' social needs and training to build the health care team's ability to respond to SDOH. This results in healthier patients and communities, a stronger health center workforce, and improved health equity.

The components of MLP are a "lawyer in residence," a formal agreement between health care and legal organizations, a target population, screening of patients for legal needs, designated resources, information sharing, training on SDOH, and legal staffing.

Legal Services Corporation documented that 55 million low-income households in the U.S. do not have access to legal services. The number is greater among MSAWs. Legal services can help health care teams address SDOH related to income and insurance, housing and utilities, education and employment, legal status, and personal and family stability.

MLP is one of the only interventions that can identify, address, and prevent both individual needs and underlying policies. Training activities and direct legal services help health centers address individuals' legal needs. By detecting patterns in patients' needs and using upstream strategies to target unhealthy policies, MLPs prevent future problems and advance health equity.

Health Center Adoption of MLP

In 2014, HRSA recognized civil legal aid as an "enabling service," which allowed health centers to provide legal services under Section 330 grants. Health centers are the fastest-growing sector for MLP adoption because they have substantial knowledge of the communities they serve and provide care to the most vulnerable and underserved communities.

An environmental scan found that 150 to 200 health centers across the country currently operate MLPs, including at least 11 MHCs; an additional 100 to 150 are in the planning stages.[3] Most respondents reported that they screen for legal needs and refer patients to civil legal aid; health centers with an MLP were more likely to offer those services. Many respondents indicated that they work with immigrant communities on issues related to immigration, which may include MSAWs. Health center MLPs also address legal issues related to worker's compensation, discrimination, disability, record expungement, domestic violence, and other concerns.

A literature review conducted by NCMLP documented the effectiveness of this approach,[4] and research has identified areas where MLPs can make an impact for MSAWs. Studies have found that traditional models of care are impractical for Latino farmworkers,[5] children make up a significant portion of the agricultural workforce,[6] there are few coordinated efforts to address the health effects of migration,[7] and trafficking and exploitation of agricultural workers increased during the pandemic.[8]

The environmental scan identified challenges to sustaining or expanding MLP programs, including funding, lack of awareness of MLP services and value, MLP staffing shortages, competing priorities at the health center, not enough demand from patients, and low interest from clinic staff and providers.

Benefits of MLP for MSAWs

MLPs can improve health equity and outcomes for MSAWs through labor rights advocacy, immigration assistance, access to housing and safe living condition, social services navigation, cultural competency training, language access, community outreach and education, and policy advocacy. They enable MHCs to address complex SDOH issues, facilitate access to essential legal services, prevent and alleviate health disparities, educate and empower their MSAW patient population, and drive systemic change by addressing the root causes of inequities and disparities faced by migrants.

NCMLP Resources

NCMLP resources on MLPs include:

---

[3] Report: Environmental Scan of Medical-Legal Partnerships in Health Centers
[4] https://medical-legalpartnership.org/download/literature-review-2013-2020
[5] Tulimiero, et al. 2021. https://pubmed.ncbi.nlm.nih.gov/32603004/
[6] Arnold, et al, 2021. https://doi.org/10.1177/10482911211017556
[7] Castañeda, et al., 2014.https://www.annualreviews.org/doi/10.1146/annurev-publhealth-032013-182419
[8] Polaris Project, 2021. https://polarisproject.org/wp-content/uploads/2021/06/Polaris_Labor_Exploitation and Trafficking of_Agricultural_Workers_During_the_Pandemic.pdf

- The 2022-2023 environmental scan of MLPs (referenced above)
- A toolkit to help health centers plan and implement MLPs[9]
- MLP guide for organizations serving agricultural workers, developed by Farmworker Justice.[10]

Additional information is available at www.medical-legalpartnership.org.

Discussion

A meeting participant asked how nursing staff agencies can partner with MLPs, health centers, and migrant camps to ensure proper care and follow up for MSAWs.

- Ms. Hamilton stated that the "M" in MLP includes the full range of health professionals. Some refer to themselves as "health justice partnerships" because they encompass more than physicians or the clinical team. There are a number of nurse-led legal partnerships, including some that are focused on specific issues such as maternal health.

Ms. Huertero asked about the sources of funding for the 11 MHPs at MHCs.

- Ms. Hamilton said funding is a challenge that affects sustainability. NCMLP resources such as the MLP Toolkit and issue briefs offer detailed information on funding mechanisms. Many MLPs use a braided funding approach that combines sources such as philanthropic grants or insurance reimbursement. The duration of funding is as important as the dollar amount. 2014 was pivotal for health centers, because they could use Section 330 funding for civil legal aid.

A Myra Reiter asked what activities NCMLP offers to help health centers understand the benefits and structure of MLPs.

- Ms. Hamilton said NCMLP provides training and resources for health centers and potential legal aid partners through funding as a HRSA NTTAP. They hold an annual conference and attend other conferences. They are working with the Legal Services Corporation, the American Bar Association, and others to bring attention to the value of civil legal aid attorneys and the benefits of MLP as a public health intervention.

Dr. Holmes requested additional information on the implementation guide.

- Ms. Hamilton replied that the toolkit, environmental scan, and medical-legal partnership guide are available at the NCMLP website.

Overview: Farmworker Health Network
Shannon Patrick, MPH, Health Strategy Specialist, MHP Salud, and Chair, FHN

Ms. Patrick described the resources and services of the Farmworker Health Network (FHN), which consists of the five MSAW-serving NTTAPs. FHN supports leadership development within health centers and increased access to care for the MSAW population. It also serves as a resource to health center staff and boards on health topics and emerging issues affecting MSAWs.

FHN member organizations provide the following services:

- MHP Salud develops and implements innovative community health worker (CHW) programs and provides technical assistance on how CHWs improve health outcomes for MSAWs and how

[9] https://medical-legalpartnership.org/mlp-resources/health-center-toolkit/
[10] https://www.farmworkerjustice.org/wp-content/uploads/2020/06/MLP-Guide-2020-FINAL.pdf

health centers can integrate CHWs into their clinical care team. Resources and information are available at www.mhpsalud.org.

- Migrant Clinicians Network (MCN) creates practical solutions at the intersection of vulnerability, migration, and health. Their work includes resource development, education, research, bridge case management, worker health and safety, psychosocial support for providers, advocacy, and peer networking. Resources and information are available at www.migrantclinician.or.
- Health Outreach Partners (HOP) provides training, consultation, and resources to help health centers, PCAs, and safety-net health organizations build strong, effective, and sustainable health outreach models. Resources are available at www.outreach-partners.org.
- Farmworker Justice seeks to empower farmworkers and their families to improve their living and working conditions, immigration status, health, occupational safety, and access to justice. Their work includes litigation, administrative and legislative advocacy, T/TA, coalition-building, public education, and support for union organizing. Resources are available at www.farmworkerjustice.org.
- National Association of Community Health Centers (NACHC) provides training for health center professionals and administers the Health Center Resource Clearinghouse. Resources are available at www.nachc.org.
- The National Center for Farmworker Health (NCFH) provides information services, T/TA, and a variety of products to CHCs and MHCs as well as organizations, universities, researchers, and individuals involved in farmworker health. Resources are available at www.ncfh.org.

FHN coordinates the Health Center Resource Clearinghouse, an extensive database of resources from 21 NTTAPs. The clearinghouse is managed by NACHC and can be accessed at www.healthcenterinfo.org.

FHN projects for 2023-2024 include *Agricultural Worker Health 101* presentations at the three regional migrant stream forums and updating *FHN Key Resources for Agricultural Workers*, which highlights the relevant resources of each FHN partner.

Strengthening Enforcement of Pesticide Regulations for Agricultural Worker Health and Safety
Mayra Reiter, MSIS, MSES, MPA, Project Director, Occupational Safety and Health, Farmworker Justice
Alexis Guild, MPP, Vice President of Strategy and Programs, Farmworker Justice

Ms. Reiter and Ms. Guild described the regulatory framework for pesticides, enforcement of pesticide regulations, pesticide incident surveillance, and FHN's role and activities to enhance pesticide enforcement. They also offered recommendations to improve pesticide safety.

Regulatory Framework for Pesticides

The Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) regulates the approval, sale, and distribution of pesticides. The law includes a Worker Protection Standard (WPS) that growers must comply with for the safety and health of farmworkers.

The Federal Food, Drug, and Cosmetics Act (FFDCA) is an amendment to FIFRA that governs the amount of pesticide residue that is allowed on food, stated in parts per million. Foods that exceed pesticide tolerances may not be legally sold.

The Food Quality Protection Act (FQPA) of 1966 amended FIFRA and the FFDCA to establish a new standard for the Environmental Protection Agency (EPA) to approve pesticides. EPA takes a risk-only approach to exposure through food and other non-occupational routes, approving pesticides if there is a

"reasonable certainty that no harm will result." It takes a cost-benefit approach to occupational exposure, in which a certain amount of harm to workers is acceptable if EPA determines that the benefits outweigh the harm.

Risks and benefits of pesticide use are not equally distributed. Many of the costs, especially health costs, accrue to farmworkers, while most of the benefits accrue to growers and others.

The WPS aims to protect workers through information (notifications about pesticide applications, training on pesticide safety), protection (provision of personal protective equipment), and mitigation (use of buffer zones during pesticide applications, decontamination requirements).

There is no national standard or requirement to monitor workers for pesticide exposure. EPA relies on passive surveillance to gather information on pesticide incidents, which usually consists of reports on pesticide poisonings. Only a handful of states collect and investigate these reports systematically.

Enforcement

Under FIFRA, the authority to enforce pesticide regulations is delegated by EPA to the states. The state agency in charge may be a department of agriculture, environmental agency, or other entity. States receive federal funding for enforcement; they can also use state funds.

Enforcement is uneven between states due to differences in funding and the responsible agency. States are only required to report on enforcement activities carried out with federal funds; reporting on state-funded enforcement is optional. A review of EPA reporting data for 2014-2019 found a high rate of WPS non-compliance (0.56 violations per inspection, on average).[11]

Oversight of state enforcement activities is hampered by incomplete data. Only about one percent of agricultural facilities are inspected per year. Work conditions observed by inspectors may not reflect what workers experience on a day-to-day basis because many inspections are announced in advance.

Pesticide Incident Surveillance

There is no national system for reporting pesticide illness and injury. EPA and the National Institute for Occupational Safety and Health (NIOSH) at the Centers for Disease Control and Prevention (CDC) administer the SENSOR Pesticides Program, a surveillance system for pesticide incidents. SENSOR is underfunded, and participation is voluntary. In most years only 10 to 12 states participate.

SENSOR data and other pesticide incident reports can inform regulation, compliance, and enforcement activities at the state and federal levels. Thirty-one states require clinicians and others to report pesticide illness and injury. Reporting is optional in six states, and the remaining states do not have a system to collect data.

Clinicians play an important role. Farmworkers who become ill may not tell their employer due to fear of retaliation. It is important for clinicians to know the pesticide surveillance requirements in their state, whether they are required to report the data, and how to submit a report.

[11] Jordan, W. (2022) Protecting Farmworkers from Pesticide Exposure: Why EPA and States Must Fix the Broken Enforcement System. Unpublished.

FHN Role and Activities

FHN partners provide training and technical assistance to health centers to support farmworker health. Activities include training and informational resources for clinicians on WPS and pesticide incident reporting requirements and screening farmworkers for occupational risk factors; training and resources for CHWs; educational resources for farmworkers; and policy analysis and advocacy.

FHN resources include:

- *Clinician's Guide to EPA's Worker Protection Standard*[12] and *Clinician's Guide to FIFRA and FQPA*[13] developed by Farmworker Justice and MCN
- Occupational Data for Health fact sheet developed by NACHC[14]
- Training for clinicians on pesticide incident reporting requirements and workers' compensation requirements
- An interactive map developed by MCN and Farmworker Justice that enables clinicians to easily determine pesticide reporting and workers' compensation requirements in their state[15]
- Training and resources for CHWs (*Healthy Homes, Healthy Kids*[16] curriculum developed by Farmworker Justice, *Farmworker Outreach Promising Practices Guide*[17] developed by NCHF)
- *Aunque cerca…sano*[18] comic book to inform farmworker families on how to reduce pesticide risks for children developed by MCN, National Children's Center for Rural and Agricultural Health and Safety, and the National Farm Medicine Center
- *Exposed and at Risk: Opportunities to Strengthen Enforcement of Pesticide Regulations for Farmworker Safety,*[19] by the Center for Agriculture and Food Systems at Vermont Law School and Farmworker Justice.

Recommendations to Improve Pesticide Safety

The speakers offered the following recommendations to improve pesticide safety:

- Allocate more resources to the SENSOR pesticide surveillance program.
- Increase support for clinician education on pesticide illness and injury reporting requirements.
- Expand opportunities for clinician training on the prevention, recognition, and treatment of pesticide-related illness.
- Increase support for mobile health clinics to improve farmworker access to health services and diagnosis and treatment of pesticide exposure in the workplace.

Discussion

Ms. Huertero asked about the amount and duration of funding for states to participate in SENSOR.

[12] https://www.farmworkerjustice.org/wp-content/uploads/2020/07/FJMCN-WPS-Clinician-Guide_June-2020.pdf
[13] https://www.farmworkerjustice.org/wp-content/uploads/2012/08/2016-FIFRA-FQPA-Clinicians-Guide-Online.pdf
[14] https://www.nachc.org/wp-content/uploads/2022/12/NACHC-Occupational-Data-for-Health-Info-Sheet.pdf
[15] https://www.migrantclinician.org/pesticide-reporting-and-workers-compensation-agriculture-interactive-map.html
[16] https://www.farmworkerjustice.org/wp-content/uploads/2015/04/FJ-Healthy-Kids-curric-Residential-Pest-Lead.pdf
[17] https://outreach-partners.org/wp-content/uploads/2023/01/Promising-Practices-Full-Report.pdf
[18] https://www.migrantclinician.org/file/240871/download?token=gI4QttL2
[19] https://www.farmworkerjustice.org/wp-content/uploads/2022/09/Pesticide-Enforcement-Final-web.pdf

- Ms. Reiter replied that every state has a different agreement with EPA. In 2022, Congress approved $2.5 million over five years to support and expand SENSOR programs, using pesticide registrant fees paid to EPA.

Dr. Holmes asked what the Council could recommend to help people working in states that do not have pesticide reporting requirements.

- Ms. Reiter said it would be helpful to provide additional grants for states to develop a pesticide incident surveillance system.

Ms. Freeman Lambar noted that North Carolina requires providers to report suspected pesticide illness due to exposure. She asked if that was a national standard or a specific state requirement.

- Ms. Reiter replied that some states do not have a reporting requirement and do not conduct systematic surveillance. There are multiple approaches, and multiple strands of data.

Ms. Freeman Lambar asked if there was a similar surveillance system for heat illness.

- Ms. Reiter stated that CDC gathers data on heat illness. There have been studies using emergency room data, but there is no specific surveillance system that covers farmworkers. Only four states have heat standards. The issue is not getting the attention it needs.

Public Comments

Javier Rosado, Ph.D, Professor and Director of Clinical Research, Center for Child Stress and Health, Florida State University College of Medicine, Immokalee Campus

Dr. Rosado provided public comments on behalf of the American Psychological Association Services, Inc. (APA Services), the companion organization of the American Psychological Association. He emphasized the importance of mental health services for MSAWs and highlighted key stressors that affect the mental health of older MSAWs women, and children of farmworkers.

APA Services shared two avenues for improving the mental health services for MSAW communities:

- Adopt a population health-based approach to extend access to care and reframe mental health services to meet patients wherever they are in the community. The U.S. Department of Agriculture's Farm and Ranch Stress Assistance Network can serve as a model for training teachers, clergy, and other laypersons to screen for early signs of mental health distress.
- Adopt evidence-based models of integrated care to ensure that mental health providers and primary care providers can collaborate in treating patients co-existing medical and mental health needs and provide a warm handoff for services.

The comments also stressed the need for FQHCs and other federally supported service sites to have the mental health testing, assessment, and treatment tools they need to expand their range of services.

The accompanying letter is included as Appendix A.

NACMH Reflection and Discussion

Regional Issues

Council members shared issues affecting MSAWs in their regions.

Ms. Cervantes shared findings from a survey the health center in Idaho she represents. When MSAW patients were asked to identify barriers they were experiencing within the health care system, they identified several areas of concern. The areas of concern include knowledge insufficient understanding of how the US health care system operates to navigate it effectively, especially when they are referred to an outside specialist, including how to pay for a specialty care; concerns about needing to rely on their children as translators; and the lack of health literacy and continuity of care to manage chronic diseases.

Ms. Dudley drew attention to the ongoing prevalence of long COVID among farmworkers in upstate New York and asked if this was the case in other regions. She reported that farmworkers were concerned about the cost of the COVID vaccine, testing, and treatments and were hesitant to get the new vaccine. The health center she represents is working with long COVID centers to find ways to provide treatment and clinical supports at migrant camps and farms. She was interested in how HHS long COVID research findings could be translated into practice at health centers. Ms. Dudley reiterated the need for a strategy to address the situation where state policies push people to move to states where seeking health care is not linked to immigration enforcement. The civil rights legal infrastructure requires a plaintiff, and undocumented farmworkers and health centers do not want to be in that position.

Mr. Mota reported that the biggest issue at his health center in the Central Valley of California is that federal guidelines that determine whether patients qualify for sliding-fee scales are not evolving at the same rate as the minimum wage. As a result, beginning next year, many patients at the health center will no longer qualify for Medi-Cal or sliding fees.

Dr. Holmes said families he works with told him about people who had severe heat-related illness or death, despite good heat standards in California. He had not heard about long COVID in the populations he works with. He continues to hear that indigenous populations with different linguistic and cultural backgrounds experience less functional access to care, including at MHCs.

Dr. Viniegra described a push for telehealth resources in Washington State. However, this is of concern because the increased use of telehealth may result in a decrease in the quality of care. Many online translation programs are not accurate. The lack of a human presence, or the consistent presence of a monitor as a mediator between the patient and physician, decreases the quality of care and impacts the number of patients served at many clinics. People prefer translation to be provided by a person, in the room.

Identifying Topics for NACMH November Recommendations and Future Meetings

The Council reviewed issues that emerged from the presentations and discussed topics for recommendations and future meetings.

Ms. Dodson suggested adding MLPs to the menu of resources to implement other recommendations.

Dr. Holmes said the MLP presentation was relevant to many issues the Council has discussed, including conflicts between state and federal laws, immigration, housing, structural and social determinants of health, follow-up health care, and occupational health.

Ms. Dudley said it would be interesting to know if other states were seeing MSAWs arrive from Florida. She suggested looking at what kinds of legal support currently exist and how to build on them.

Mr. Vang was interested in learning more about pesticide poisoning and expressed concern about cancer in his community. He would like to see more studies on pesticide exposure among MSAWs.

Ms. Huertero was interested in how the Council's interest in MLPs and its concern about the lack of national standards on pesticides could be aligned to craft a recommendation.

Ms. Emanuel-McLain cited the need to train health center physicians to recognize pesticide poisoning. Another Council member suggested adding a health center performance measure related to reducing disparities in that area.

Mr. Mota described a successful pilot program at his health center and others in California that brings fully licensed physicians from Mexico to do rotations in health centers. This model could help address workforce needs.

Council members identified the following potential topics for the next meeting:

- Impact of climate change, with a focus on heat illness and air quality
- Structural competency as a framework for looking at health, perhaps with a presentation by the Structural Competency Workgroup
- A presentation on MLPs in practice, with presenters from health centers using that approach responding to issues identified by the Council
- Federal proposals for immigration reform that target farmworkers, such as the Farm Workforce Modernization Act
- Mental health challenges of long COVID and approaches to address them
- Pain management and substance abuse following injuries
- Framework to improve chronic care management for MSAWs
- Approaches to improve health literacy for MSAWs
- Translation services that serve the needs of diverse MSAW populations, perhaps with speakers from binational indigenous farmworker organizations
- Strategies to increase provider recruitment and retention
- Strategies to improve structural and cultural competency of health center staff.

Wrap Up and Adjourn
Marco A. Viniegra, PhD, Chair, NACMH

Dr. Viniegra reviewed the presentations and discussions of the first day and adjourned the meeting at 4:43 p.m.

Thursday, November 2, 2023

Call to Order and Recap from Previous Day
Maria del Carmen Huertero, Vice-Chair, NACMH

Ms. Huertero called the meeting to order and summarized the first day of the meeting, highlighting key issues and takeaways from the presentations and Council discussions.

Eliminating Health Disparities Resulting from Patient Mobility
Deliana Garcia, Chief Program Officer International and Emerging Issues, Migrant Clinicians Network

Ms. Garcia discussed the impact of mobility on health for patients and patient populations and described MCN's approaches to eliminate disparities resulting from mobility.

Ms. Garcia offered two case studies to highlight key differences in mobility and the ability of people to obtain the type of care they deserve. The first was a union worker in a paper mill who severed a tendon on one finger. He was seen right away, received surgery, and received three months of physical therapy and workers compensation, with accommodations so he would have the opportunity to heal. The second patient was an uninsured broccoli worker who cut off the tip of one finger. He was taken to the emergency room and dropped off on his own, with no insurance and no one to help him understand what was happening. The patient was told the injury had nothing to do with his work. He was given three days of pain medication so the wound could close, but he was unable to work until it healed. He did not return to care and was ultimately lost to follow-up.

Many systemic issues impact MSAW health, including access to care, access to safe working conditions, the ability of clinicians to recognize MSAWs' presenting conditions, and structural policies. Health for farmworkers is health for entire families because systemic issues affect people regardless of their age or where they are in the work cycle.

MCN was formed in 1984 to enable clinicians who serve MSAWs to work in a unified fashion and learn from each other about the impact of migration on health. MCN envisions a world based on health justice and equity, where migration is never an impediment to health. Its mission is to create practical solutions at the intersection of vulnerability, migration, and health.

MCN's services include resource development, education, research, bridge case management, worker health and safety, psychosocial support for providers, advocacy, and peer networking. Their initial constituency was health center clinicians who provided care for MSAWs. As they came to understand that people move in and out of the agricultural workforce and migrate across the country for many reasons, they expanded their work to include collaboration with clinicians at state and local health departments and education and case management services for underserved migrants and immigrants.

The number of individuals living outside their country of origin would constitute the fifth-largest country in the world. Recent trends in migration in the U.S. include an increase in refugees, a shift in the population seen at border sites, and a continued influx of migrants from Central America and Mexico. Agricultural work continues to be the lowest rung on the economic ladder, and traditional MSAW populations now face challenges as others seek the same jobs.

More women are leaving their countries of origin and entering the U.S., which impacts the health services that are needed. Pregnant women who enter the country during late pregnancy are often denied prenatal care because health centers are reluctant to enroll them because of the delay in seeking and receiving care. This is further complicated by community and migrant health centers concern over how late entry into care may influence the health centers outcomes measurement because Health Center Program performance is measured by the percentage of prenatal care patients who entered prenatal care during their first trimester.

One in seven U.S. residents is an immigrant, and one in eight is a native-born U.S. citizen with at least one immigrant parent. MCN is concerned about mixed households in which undocumented parents are fearful of seeking services for which their U.S.-born children are qualified.

Agricultural workers' mental and physical health is impacted by working and living conditions and by structural issues such as discrimination, immigration status, language and cultural barriers, continuity of care, and the lack of regulatory protections.

Decisions about health care for MSAWs are often based on the dichotomy of "underserved" versus "undeserved." Critical decisions are made about who deserves access to care, and the quality of care they receive, by virtue of their birth, language, color, or gender. Migrants are rejected and alienated from services they deserve as a matter of human rights.

Migration presents both vulnerabilities and opportunities. Migrants are looking for opportunities. Seeing them as vulnerable does not help them achieve the opportunities they seek and can limit what we are willing to do for them.

Physical health issues that migrant and other mobile underserved populations face are similar to those faced by the general population, but they are often compounded migratory lifestyle, living conditions, and occupation. Limited formal education and language barriers can make it difficult to understand education about worker safety.

Migrants also face mental health challenges, including separation from families, isolation, discrimination, and fear related to their immigration status. A recent study found that providing a phone card so workers could call home made a difference in their reported mental health status.

Continuity of care is challenging for migrant populations. Agricultural workers may seek care only when necessary and may need to move during treatment. Communication between providers is difficult if patients' records are not portable. Electronic health record systems are often not inter operable, and migrant patients do not always know how to ensure that the next provider has their health records.

Differences in culture and language impact service delivery and make it difficult for MSAWs to make health care decisions in collaboration with providers. It is important for health centers to understand the need for multilingual services and the importance of relevant training and continuing education for staff at all levels.

Health center operations can also present challenges for mobile populations. Factors include availability of walk-in appointments, office hours that include evenings and weekends, capacity to meet the demand for services, and transportation services.

The cost of care is an important factor influencing the utilization of health care services. Additionally, many migrant patients are uninsured, and outreach and enabling services are not always reimbursable.

MCN is exploring adaptations in three areas to serve migrant populations more effectively:

- Cultural adaptations: Culturally sensitive education in appropriate languages and literacy levels that addresses cultural health beliefs and values
- Mobility adaptations: Portable medical records and bridge case management; EHR transmission to other health centers

- Appropriate service delivery models: Case management; lay health promoters; outreach and enabling services; coordination with schools and worksites; mobile units.

MCN's Health Network eliminates mobility as a barrier to care by integrating care management with referral tracking and follow-up. The pilot was initially focused on patients with tuberculosis. It was later expanded to include diabetes, cancer, and prenatal care and now includes any health condition that might impact continuity of care. The Health Network has cared for more than 15,000 people to date and supports individuals who migrate within the U.S. and between the U.S. and more than 114 countries.

Additional information and resources are available at www.migrantclinician.org.

Discussion

Dr. Holmes referenced an article in the *New England Journal of Medicine* Ms. Garcia had co-authored that illustrated how Health Network provided continuity of care for a 39 year old pregnant migrant farmworker.[20] He described how Health Network provided follow-up care for indigenous farmworkers in Florida during the first months of the pandemic who had to move before the results of their COVID tests were known, and he expressed concern that a 35-year old worker with diabetes who was diagnosed in Washington State is now blind and on dialysis because he did not receive follow-up care in California. Dr. Holmes asked what the Council could recommend regarding continuity of care.

- Ms. Garcia replied that continuity of care is currently defined as being within a health center system. When a patient goes to another health center system in a different geographic region, it is seen as neither direct care nor outreach and education. She asked the Council to recommend a broader, more patient-centered definition of continuity of care and mechanisms to fund it. She also asked the Council to recommend expansion of enabling services, including transportation, and to look at how health centers interpret the performance metric for prenatal care. It would be helpful to provide support for health centers who admit patients in late-term pregnancy who would otherwise receive no prenatal care.

Dr. Viniegra expressed concern about the classification of patients as either English speakers or Spanish speakers when an increasing number of migrants do not speak Spanish or speak Spanish as a second or third language. He noted that the Council had discussed MSAWs' preference for live translators rather than automated services.

Ms. Dudley noted the difficulty of providing or expanding enabling services in the face of funding cuts and the challenge of finding practitioners who are willing to do the kind of work that is needed to support farmworkers and to live in rural areas. She asked Ms. Garcia to articulate the order of importance of these issues, from a national perspective.

- Ms. Garcia said it is unfortunate that CHWs are seen as enabling services rather than critical staff. She would recommend integrating CHWs more fully into clinical teams, with shared decision-making; expanding residency programs to include rotations in health centers, with less focus on hospital-based education; adjusting health centers' expectations that clinicians will spend their entire career in a rural community; and increasing respect for family physicians.
- Ms. Dudley asked if it would be helpful to offer a signing bonus for clinicians who do their residencies at an FQHC. Ms. Garcia replied that an incentive that makes serving at a health center more attractive would be a benefit.

[20] https://www.nejm.org/doi/full/10.1056/NEJMp1811501

Ms. Freeman Lambar noted behavioral health may become a required service, with additional funding. She asked what the best way would be to provide behavioral health services for MSAWs and their families in a way that would meet the needs of that population, given the challenges of accessing care in the traditional model.

- Ms. Garcia replied that behavioral health services should focus on the conditions that affect MSAWs' mental health, including social isolation and separation from loved ones. Social supports such as sewing circles, cooking, or gardening can be conducted outside of a health center and do not need to be called mental health interventions.

Digital Equity as a Social Determinant of Migrant and Seasonal Agricultural Worker Health
Leslie E. Cofie, PhD, Assistant Professor, Department of Health Education and Promotion, College of Health and Human Performance, East Carolina University (ECU)
Jocelyn Romina Santillán-Deras, Digital Inclusion Projects Coordinator, North Carolina Farmworker Health Program (NCFHP), Office of Rural Health (ORH), North Carolina Department of Health and Human Services (NC DHHS)
Natalie D. Rivera, MPH, Broadband Access Projects Coordinator, NCFHP, ORH, NC DHHS

The speakers discussed digital equity as a "super" SDOH and described lessons learned from projects to advance digital equity for MSAWs in North Carolina.

Key Concepts

The digital divide is the gap between those who have affordable access, skills, and support to effectively engage online and those who do not. People of color, low-income households, and rural communities are most affected by this divide.

The digital divide can be bridged through digital equity, where everyone and every community has the right to digital technology, internet access, and the tech skills they need to fully engage in society, democracy, and the economy.

Digital inclusion refers to the activities necessary to ensure that all individuals and communities, including the most disadvantaged, have access to digital technologies and the internet.

The digital divide is the issue; digital equity is the goal; digital inclusion is the work to achieve that goal. The pandemic brought into focus the correlation between digital equity and health equity.

Digital health care strategies include the use of EHRs, telehealth, wearable devices, remote patient monitoring, personalized medicine, mobile health apps, and emerging fields like big data and artificial intelligence to enhance healthcare delivery, diagnosis, treatment, and overall well-being.

Digital Equity and MSAWs

Digital equity is a "super" determinant of health that encompasses all domains of SDOH. Lack of internet access or not knowing how to use it makes it difficult to connect with providers via telehealth and can lead to uninformed health decisions when individuals do not have access to information.

The digital divide for agricultural workers includes limited broadband infrastructure in rural areas; migrant housing challenges; cell phones as the sole internet-enabled device; limited digital literacy

training and technical support in preferred languages; limited privacy for telehealth conversations in migrant housing; and limited EHR interoperability.

Digital Inclusion Interventions

Student Action with Farmworkers (SAF) at East Carolina University conducted two pilot projects to promote digital equity for MSAWs. The first project provided computer training and internet hotspots in migrant farmworker housing. The second provided iPads, hotspots, and library-based information literacy training to youth participating in the Migrant Education Program (MEP).[21]

The pilot projects served as a foundation for three additional interventions:

- Health Disparities Resources Project provided MSAW families across 12 organizations with computer devices and internet access.
- Migrant Education Laptop Distribution Project provided 100 laptops to MEP students and trained 36 MEP staff across North Carolina on information literacy skills.
- Internet Provision to Agricultural Workers in North Carolina tested three models to provide access to over 4,500 MSAWs: reimbursing growers for setting up internet in migrant housing, lending hotspots in locations where wired connections were not possible, and creating internet hubs in larger migrant housing locations.

Project Evaluation

The researchers conducted a process evaluation for all three projects to identify accomplishments and critical stakeholders, identify lessons learned to improve future implementation, and provide actionable information for partner organizations.

Evaluation data were collected through individual interviews in English with farmworker service providers (health center CHWs, non-governmental organizations, MEP staff) and owners and managers of farms as well as interviews in Spanish with MSAWs. The interview guide included questions related to project implementation challenges and lessons, project benefits, and sustainability.

The following themes emerged from the evaluation:

- Pre-project challenges: Lack of broadband infrastructure; cost of maintaining internet plans; poor wifi/cellular coverage; isolation due to lack of services
- Process implementation: Project recruitment leveraged services and information offered by providers; training for service providers and MSAWs; resources received and used; on-going challenges, including slow wifi
- Project benefits: Enhanced access to care and health information; improved quality of life of MSAWs; improved communication; increased self-efficacy of service providers.
- Post-project challenges: Identifying appropriate technology and Internet services; cost; long-term adoption of internet connectivity programs
- Recommendations: Provide additional training for service providers; build partnerships with foremen and growers.

The evaluation provided evidence that digital access remains a challenge for MSAWs and their families and clearly identified the benefits of implementing digital inclusion projects in the MSAW community. It also highlighted lessons that will be useful for future interventions and programing.

[21] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6466499/

Recommendations for Integrating Digital Equity to Promote MSAW health

The presenters offered the following recommendations based on their research:

- Adopt a community-centric, multifaceted approach that involves MSAWs, CHWs, and providers from the outset and addresses challenges in multiple areas
- Include digital health in CHW training programs
- Identify immediate solutions for internet connectivity
- Develop broadband initiatives for strategic and long-term planning
- Provide technical support in the appropriate language and address privacy and security issues
- Improve interoperability of EHRs
- Provide convenient access to platforms and applications
- Develop an innovative and sustainable plan for ongoing digital health training and support.

Discussion

Ms. Cervantes asked who developed the training content for the project and whether the researchers conducted a needs assessment.

- Dr. Cofie replied that the researchers conducted focus groups with CHWs to determine what resources and information they wanted. The La Paz Library at East Carolina University and partners at North Carolina State University helped to develop the resources. The project advisory board ensured that the research addressed the needs of MSAWs and service providers.

Ms. Huertero asked if the presenters could provide information on mental health outcomes for the 4,500 MSAWs who participated in the internet access project.

- Dr. Cofie said assessing the mental health outcomes of project participants was not in the scope of the initial project. They could conduct that type of study in the future.

Dr. Viniegra asked if the project included telehealth training for medical providers and if the researchers had considered that many Latinx MSAWs are resistant to telehealth due to cultural factors.

- Dr. Cofie said their work to date had focused on MSAWs rather than medical providers. There is still a lot of work to be done.
- Ms. Rivera noted that NCFHP recently received funding from NIH to conduct a community-led health equity structural intervention that will look at models of care, including CHWs and telehealth. The project will include listening sessions and a community assessment to identify appropriate approaches to address identified challenges.
- Ms. Santillán-Deras added that the State Office of Digital Equity and Literacy is looking at ways to incorporate agricultural populations in the North Carolina State Digital Plan, including telehealth. NCFHP received a two-year grant to ensure that MSAWs are ready to participate in digital health services. One deliverable is to compile curricula for digital navigator training. They will involve CHWs in that process. NCFHP is also part of the North Carolina Agricultural Digital Alliance, which includes organizations from health, education, and agriculture as well as internet service providers.
- Ms. Rivera pointed out that telehealth access includes the ability to make phone calls as well as video calls. Outreach workers need to be able to contact medical providers.
- Dr. Cofie acknowledged that the challenges experienced by MSAWs are context specific. NCFHP is committed to assessing specific issues before they develop an intervention.

Facilitated Discussion on Possible Recommendations to the Secretary of DHHS

Council members identified a range of issues that emerged through the presentations:

- Health equity: Importance of digital equity and inclusion; need to increase structural competency among providers; role of medical-legal partnerships in addressing social determinants and legal barriers to access.
- Recruitment, retention, and training: Funding support for clinicians to do residencies at MHCs; incentives for nursing programs; California model of expanded licensing requirements for physicians trained outside of the U.S.; retention of front-office and support staff; impact of pandemic on outreach workers; cost and availability of housing in rural communities; update federal salary guidelines; importance of continued funding and base adjustments.
- Continuity of care: Ability of health centers to provide prenatal care for patients who come into care late in pregnancy without jeopardizing clinical performance metrics; expanding definition of care management to serve patients who move out of state; better models for chronic care management.
- Behavioral health: Revise NOFOs to include CHWs and enabling services; contributing factors, including childhood stressors and access to legal services; impact of long COVID, isolation, and mobility; role of digital equity to reduce isolation.
- Pesticide exposure: Reporting standards, inspection, and enforcement; medical literacy for patients; training for practitioners in. Consider gathering more information at future meetings before developing a recommendation.
- Access to care: Include NOFO requirement for health centers to demonstrate how they identify and meet the needs of MSAWs; include enabling services as part of ongoing system of care.
- Long COVID among MSAWs: How to apply new research findings to this population.
- HRSA priorities: Behavioral health, expanded hours, new access points.

Based on the discussion, Council members chose three topics for actionable recommendations to improve health and healthcare for MSAWs: medical-legal partnerships, with a focus on equity; behavioral health, with a focus on structural competency, continuity of care, and the role of CHWs; and workforce recruitment, retention, and training.

Council members agreed on a timeline to develop the recommendations and submit the letter to the Secretary of HHS and the HRSA Administrator.

Travel Reimbursement Processing
Elaine Garrison, BPHC, HRSA

Ms. Garrison reviewed the process for reimbursement of travel expenses and noted that the deadline for submitting the travel voucher and non-meal receipts was November 10. She encouraged Council members to contact her by email or phone if they have any questions or encounter any problems.

Formulation of Letter of Recommendations to the Secretary of DHHS

Council members worked in groups to discuss the recommendations and assign roles to develop them.

Meeting Wrap Up and Adjourn
Marco A. Viniegra, PhD, Chair, NACMH

Dr. Viniegra thanked Council members for a productive meeting. He encouraged them to remember the farmworkers on whose shoulders they stand as they develop their recommendations and to remember that the Council has an impact.

Ms. Paul thanked Council members on behalf of HRSA for the expertise and commitment they bring to their work.

The meeting was adjourned at 4:50 p.m.

APPENDIX A
Public Comments: Letter from American Psychological Association Services, Inc.

AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES, INC.

October 5, 2023

National Advisory Council on Migrant Health
Health Resources & Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Council Members:

On behalf of the American Psychological Association Services, Inc. (APA Services), I want to thank you for the opportunity to join this crucial and timely conversation around the mental health of migrant farmworkers in advance of your November meeting. APA Services is the companion organization of the American Psychological Association, which is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as over 146,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

We write to express a few salient points to the Council and emphasize the importance of mental health for migrant and seasonal farmworkers. Specifically, we highlight for the Council the need for more attention to older migrants, women, and children of farmworkers and utilizing a population health-based approach to extending access to care and adoption of evidence-based integrated care. In addition, it is critical to ensure that Federally Qualified Health Centers (FQHCs) and other federally supported sites of service have the tools necessary to screen, assess, and treat signs of mental health distress.

Aging migrant workers

Migrant workers face a number of social and environmental stressors that can impact the mental health of this community. These include, but are not limited to, higher rates of chronic medical conditions such as heart disease, exposure to toxic chemicals and other dangerous workplace conditions, substandard housing, and fear concerning immigration status. At the same time, there are several barriers to accessing mental health care that are particularly relevant to migrant workers, such as an insufficient mental health workforce in rural areas, a lack of culturally competent services available in the area, and social stigma around seeking mental health treatment. By some recent estimates[1], the overall prevalence of depression and anxiety among migrant workers was over 38% and over 27% respectively; however, given the barriers to treatment described above, APA Services believes this represents a significant underestimation of the total mental health needs of this community.

[1] Hasan SI, Yee A, Rinaldi A, Azham AA, Mohd Hairi F, Amer Nordin AS. Prevalence of common mental health issues among migrant workers: A systematic review and meta-analysis. PLoS One. 2021 Dec 2;16(12):e0260221. doi: 10.1371/journal.pone.0260221. PMID: 34855800; PMCID: PMC8638981.

APA.ORG
APASERVICES.ORG
Advocating for APA members and psychology
750 First Street, NE
Washington, DC 20002-4242
202.336.5800
202.336.6123 TDD

We feel the crisis affecting aging migrant workers must be highlighted and addressed. Often this segment of the population is forgotten. Younger workers are often offered work protections while specific protections for older workers are not considered. Often these individuals have devoted their lives to working in the fields or other agricultural work, and when they reach an age when they can no longer work or have physical difficulties, they are either forgotten or not extended sufficient benefits to help them survive. Often these issues can be compounded with issues related to immigration status. Aging workers may not feel free to apply for benefits due to their immigration status and may be at a loss to seek general help. Their mental health may then in turn suffer as well as their physical health. We ask that as you consider the mental health and general health of migrants, you especially consider the older workers.

Women and Children

We also want to highlight the issues of women workers and children of farmworkers. There are many dangers that these two groups face including educational disruptions and toxic stress for children and the sexual abuse of women. Migrant women especially face the risk of violence and sexual assault. Women who live in rural areas are highly impacted by gender-based violence and exploitation.[2] Furthermore, the statistics are alarming for migrant women who have experienced sexual abuse: 31.4% of migrant women reported experiencing sexual abuse and 10.7% have dealt with another form of violence.[3] This data demonstrates that this segment of the population is especially vulnerable to abuse and violence.

Children from migrant farm-worker families face several stressors including educational disruptions, dislocations, and social and educational disadvantages.[4] Acculturation challenges and experiences of discrimination for children of ethnic minority agricultural worker families are also salient stressors particularly for families in rural areas.[5] These stressors put children at high risk for mental health problems particularly depression and anxiety.[6] Additionally, children from migrant agricultural worker families are often exposed to toxic stress and adverse childhood experiences like household dysfunction stemming from the transient lifestyle. These stressors are associated with emotional symptoms, hyperactivity/inattention problems and behavioral

---

[2] Arena, V. (2022). Migrant women face greater risk of violence and assault. Latinas in Business Inc.

[3] Kessler, G. (n.d.). Statistic on sexual assault of migrant women is from an unrepresentative sample. The Washington Post. https://www.washingtonpost.com/politics/2019/live-updates/trump-white-house/live-fact-checking-and-analysis-of-trumps-2019-state-of-the-union-address/statistic-on-sexual-assault-of-migrant-women-is-from-an-unrepresentative-sample/

[4] Taylor, Z.E., Ruiz, Y., Nair, N., & Mishra, A.A. (2022). Family support and mental health of Latinx children in migrant farmworker families. Applied Developmental Science. 26(2). 329-346. https://doi.org/10.1080/10888691.2020.1800466

[5] Carlo, G., Crockett, L.J., Streit, C., & Cardenas, R. (2016). Rural Latino/a youth and parents on the Northern Great Plains: Preliminary findings from the Latino Youth Care Project (LYCP). In L.J. Crockett & G. Carlo (Eds.), Rural ethnic minority youth and families in the United States: Theory, research, and applications (pp. 165-183). Springer International Publishing.

[6] Taylor, Z.E., Ruiz, Y., & Nair, N. (2019). A mixed-method examination of ego-resiliency, adjustment problems, and academic engagement in children of Latino migrant farmworkers. Social Development, 28 (1), 200-217.

difficulties during childhood. [7] [8] We invite the Council to consider this data and the specific health needs of migrant women and children of farmworkers as you consider making your recommendations.

Population Health

The access challenges faced by the migrant worker community are in many ways emblematic of a larger problem with how we address mental health symptoms in this country. The way that our current treatment system is structured and funded tends to focus its attention solely on those experiencing severe symptoms or those experiencing an active mental health crisis. Those with more subtle signs of an early mental health disorder are largely left to fend for themselves. Additionally, treatment of mental health needs is largely seen as separate from treatment of medical needs.

A population health-based approach, by contrast, aims to address the cultural, economic, systemic, historical, environmental, relational, and occupational contexts that influence health status, wellbeing, and functioning across the patient's lifespan.[9] The challenge posed by access in rural areas requires a reframing of "mental health services" as something people find not just in a traditional office but in their community. Patients must be met wherever they are in the community, and the community institutions, resources, and facilities trusted by members of that community must be utilized to expand access to mental health treatment. Family members, teachers, clergy, and other laypersons can all be trained on evidence-based practices on detection and screening for early signs of mental health distress. Schools, churches, and agricultural co-ops are all great examples of sites where clinicians can embed an array of screening, assessment, and treatment resources. Programs such as the United States Department of Agriculture (USDA's) Farm and Ranch Stress Assistance Network provide rural communities with the flexibility they need to meet the unique needs of their citizens.

Integrated Care

The evidence is clear that the physical and mental health of a patient are interconnected, and while many migrant worker communities lack a provider, facility, or clinic specifically dedicated to mental health treatment, many of them have access to a primary care clinic. Supporting adoption of evidence-based models of integrated care—including the Primary Care Behavioral Health model and the Collaborative Care Model, as well as approaches that blend these two models—is essential to ensuring that mental health providers, including those located remotely, can collaborate with primary care practices to treat the patient's interrelated medical and mental health needs.

---

[7] Rosado, J.I., Reyes, E., Montgomery, J., Wang, Y., Malloy, C., & Simpson-O'Reggio, A.M. (2023). From planning to implementation: Developing an ACE screening protocol in a rural integrated primary care clinic serving Latino children. Clinical Practice in Pediatric Psychology. https://doi.org/10.1037/cpp0000478.

[8] Rosado, J.I., Ramirez, A., Montgomery, J. Reyes, E., & Wang, Y. (2021). Adverse childhood experiences and its association with emotional and behavioral problems in U.S. children of Latino immigrants. Child Abuse & Neglect, 112, 104887-104887. https://doi.org/10.1016/j.chiabu.2020.104887

[9] American Psychological Association (February 2022), Psychology's Role in Advancing Population Health. https://www.apa.org/about/policy/population-health-statement.pdf.

AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES, INC.

Through these models of care, primary care practices collaborate with and facilitate warm handoffs to mental health clinicians, whether co-located in the same clinic or remotely via telehealth. Integrated health care models also frequently involve the sharing of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological, and social needs of the patient. As a result, the stigma around seeking mental health treatment is lowered, and the patient has a regular means of accessing treatment. We urge the Council to consider ways in which health care facilities involved in the treatment of migrant communities can sustainably adopt some form of integrated care to better serve the mental health needs of these communities.

Federally supported treatment sites such as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are currently a key source of access to medical care for those from migrant farm worker communities. In 2022, over 800,000 patients received care from specially designated Migrant Health Centers.[10] As part of its November meeting, we hope that some of the conversation will center around supplying these critical facilities with the tools, including but not limited to the integrated care models described above, to expand their mental health testing, assessment, and treatment offerings to include a broader range of services.

Thank you again for your leadership and the work of this Council. We look forward to helping in any way we can. If APA can be of further assistance, please contact Serena Dávila or Andrew Strickland in our advocacy office at sdavila@apa.org or astrickland@apa.org.

Sincerely,

Katherine B. McGuire
Chief Advocacy Officer

[10] Health Resources and Services Administration, 2022 Special Populations Funded Programs. https://data.hrsa.gov/tools/data-reporting/special-populations.

APA.ORG
APASERVICES.ORG
Advocating for APA members and psychology
750 First Street, NE
Washington, DC 20002-4242
202.336.5800
202.336.6123 TDD