National Advisory Council on Migrant Health

January 10, 2023

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

Dear Secretary Becerra,

The National Advisory Council on Migrant Health (NACMH, hereby referred to as "The Council") advises, consults with, and makes recommendations to the Secretary of Health and Human Services (HHS) and the Administrator, Health Resources and Services Administration (HRSA). Specifically, the Council is charged with reviewing the health care concerns of migrant and seasonal agricultural workers (MSAW), and making recommendations on the organization, operation, selection, and funding of migrant health centers (MHC) and other entities assisted under section 330(g) of the Public Health Service (PHS) Act, as amended, 42 USC 254(b), with the goal of improving health services and conditions for MSAWs and their families. Please find an overview of the Council's November 2022 meeting and five key recommendations that fulfill our charge.

Before providing the summary of our recommendations below, The Council would like to begin our letter by sincerely thanking the Deputy Administrator of HRSA, Diana Espinosa, for making time to provide opening remarks during the Federal Update. It was an honor to have Ms. Espinosa attend our meeting and set the tone by turning our attention toward HRSA's goals.

In the sections below, please find The Council's review and recommendations toward improving services for MSAWs and their families.

Overview

The Council's most recent meeting was held in Rockville, Maryland on November 2-3, 2022, providing the Council an opportunity to meet in person after three years of pandemic-imposed restrictions on travel and in-person gatherings. During this meeting, we received updates from HRSA senior leaders:

- Federal Update

  - Diana Espinosa, Deputy Administrator, HRSA, Department of Health and Human Services
  - Jennifer Joseph, PhD, MSEd, Director, Office of Policy and Program Development, Bureau of Primary Health Care, (BPHC), HRSA
  - Tracey Orloff, MPH, Director, Strategic Partnerships, Office of Quality Improvement (OQI), BPHC, HRSA

We also received updates on MSAW health, including the following presentations:

- National Association of Community Health Centers (NACHC) Update
  - Rachel A. Gonzales-Hanson, Interim President and Chief Executive Officer, NACHC
- Panel Presentation and Discussion: Growing, Recruiting and Retaining a Migrant Health Center Workforce
  - Grace Wang, MD, MPH, FAAFP, Senior Fellow Public Health Integration & Innovation, National Association of Community Health Centers, MD
  - Elena Thomas Faulkner, MA, Chief Executive Officer, National Institute for Medical Assistant Advancement, CO
  - Ethan Kerns, DDS, Chief Dental Officer, Salud Family Health, CO
  - Bill Rau, SPHR, SHRM-SCP, Vice President of Human Resources, Salud Family Health, CO
- Incidence and prevalence of Kidney Disease Among US Agricultural Workers
  - Roxana Chicas, PhD, RN, Assistant Professor, Nell Hodgson Woodruff School of Nursing, Emory University, GA
- Addressing the Public Health Implications of the Social and Cultural Factors that Place Migrant Agricultural Workers at Risk for Human Immunodeficiency Virus (HIV) / Sexually Transmitted Infections (STI)
  - Jesús Sánchez, PhD., Associate Professor, Department of Sociobehavioral and Administrative Pharmacy, Nova Southeastern University, FL

Recommendations

While the nation went on lockdown, agricultural workers were designated "essential workers" to preserve the nation's food supply chain. However, access to care for these essential workers remains a significant challenge despite documented accounts that these workers bore a disproportionate impact of the pandemic due to the nature of their work and living conditions. It is well documented that health disparities, including disparities related to COVID-19, are symptoms of broader underlying social and economic inequities that reflect structural and systemic barriers and biases across sectors. Though good quality health care is essential to health, it is a relatively weak health determinant. Research shows that social determinants of health - the conditions in which people are born, grow, live, work and age - are the primary drivers of health.[i] Health inequities experienced by MSAWs are rooted in the confluence of adverse circumstances related to the nature of their occupation, conditions of employment, migration, socioeconomic status, race and ethnicity. An honest effort towards bringing meaningful change would need to be rooted in a sound understanding of the unique confluence of circumstances, to inform the multifaceted response required to address them. This would require strategies that engage the social welfare and health care systems simultaneously to help address the historical inequities that plague MSAW life. The recommendations set forth herein shed light on some of these cross-sector challenges, such as addressing stigma and invisibility associated allostatic load,[ii] increasing access to health care and enabling service providers; increasing access to linguistically and culturally appropriate care;

diversifying the health care workforce; a cross agency evaluation of the health care challenges resulting from documentation status related stress and anxiety for a large number of MSAWs could also help reduce health disparities. It is also time for systemic changes such as adoption of Medicaid expansion to include low-income adults in the states that have not yet expanded, some of which are large agricultural employers that benefit significantly from the labor of agricultural workers. Since health inequities are rooted in conditions external to the health care system, it is important that health insurers and payors, including the federal government reform their payment models to provide appropriate reimbursement to support health care providers to identify, monitor, assess, and address the underlying social determinants of health.[iii]

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

Recommendation I

Address an Emerging Public Health Concern Associated with Kidney Disease and Heat-Related Conditions, Exacerbated by Extreme Temperatures due to Climate Change

The risk of heat-related death is 35 times more likely for agricultural workers than for any other occupational group. Recent studies have shown that working in a hot and humid environment is associated with an increased risk of developing heat-related acute kidney injury (AKI) among agricultural workers. Over time, this could lead to chronic kidney disease of unknown etiology (CKDu). It is referred to as an unknown etiology because those affected lack the traditional risk factors of chronic kidney disease (CKD), such as old age, obesity, diabetes, hypertension, and nephrotoxic drug use. Repeated episodes of heat stress followed by improper hydration have been found to cause repeated kidney injury. Data collected through the Girasoles Study found that 49 percent of agricultural workers in Florida that participated in the research experienced core body temperatures above 100.4 degrees Fahrenheit. Additionally, 43 percent of the workers reported two or more heat-related symptoms, and 33 percent were found to have AKI on at least one workday. This study also looked at various cooling intervention methods, specifically the effects of cooling vests and cooling bandanas, for lowering the core body temperature of agricultural workers. The study showed that the less expensive cooling bandana was more comfortable and more effective in lowering the core body temperature, proving that heat-related kidney injury is preventable with proper hydration (water and electrolytes) and cooling intervention methods.[iv]

The Council recommends that HRSA take the following actions:

I. Collaborate with other federal agencies and research organizations to fund research that broadens the understanding and impact of long-term environmental heat exposure on CKDu and AKI among agricultural workers.

II. Collaborate with the US Department of Labor (DOL) to:
   - Include heat-related kidney diseases as an occupational hazard.
   - Evaluate the combination of MSAW vulnerability factors from workplace exposure resulting from work intensity, and duration, workers sensitivity based on age, gender, etc., and adaptive capacity factors such as hydration, clothing, work hygiene that mediate a worker's heat stress

response to the hazard to inform policies that influence MSAW vulnerability, and for developing national level public health interventions.

III. Train M/CHC providers and outreach staff to accurately identify and screen agricultural workers for heat-related AKI, CKDu and decreased renal function associated with environmental heat exposure, to ensure timely diagnosis and treatment, including timely testing of the common renal biomarkers consistent with kidney injury.

IV. Develop a culturally and linguistically appropriate campaign to reduce the risks of heat-related AKIs and other heat-related illnesses to include:
- A media campaign targeting the agricultural community to increase awareness about the occupational hazards associated with extreme heat.
- The development of an educational intervention toolkit for agricultural workers, healthcare providers, and agricultural employers that promotes hydration, cooling bandanas, and other ways to reduce risk among agricultural workers.
- Partnerships with diverse agencies/organizations to provide M/CHCs with information related to kidney health hazards, cooling bandanas and electrolytes as risk reduction tools to provide to MSAWs.

Background

The Problem

Exposure to extremely hot weather conditions, lack of shade, as well as limited hydration opportunities, puts MSAWs at higher risk of AKI and chronic kidney disease (CKD) than any other occupation. The Pan American Health Organization called attention to the growing CKDu epidemic in 2013, and its implications on the U.S. agricultural worker population cannot be ignored.[v] CKDu is a multifactorial disease that is often asymptomatic, hence reducing the prevalence will require robust studies on causal mechanisms and on interventions that can reduce morbidity and mortality in this vulnerable population. It is difficult to ascertain the significance of the problem because the transitory nature of agricultural work makes studying the issue extremely challenging. However, the kidney health risks of migrant workers are serious and can no longer be overlooked. Recent small studies have shown a direct link between kidney disease and the physically demanding work that agricultural farm workers engage in to survive, often during extremely hot weather.

Opportunities and Impact:

Increased cases of AKI, CKDu and kidney disease-related morbidity among agricultural workers is beginning to receive attention. The record high temperatures across the nation are putting the human body under increased stress. Immediate interventions are needed to reduce the increasing heat-related illnesses among agricultural workers while further research is conducted so that health care providers, policy makers, and migrant support networks can understand the prevalence and severity of the issue, to take steps towards addressing the problem.

Recommendation II

Agencies Under the Health and Human Services Administration Collectively Address Long Standing Barriers to Accessing Health Care Faced by Agricultural Workers

Pandemic related health challenges coupled with exposure to climate-fueled occupational health risks, place MSAWs, a community that was already at increased risks with limited health access, at a heightened risk for poor health outcomes. Obtaining health care for vastly disenfranchised MSAWs is deeply affected by the multifaceted limitations in availability, accessibility, and affordability of health care and enabling services. Although health centers are present in all 50 states, for a significant number of MSAWs, health care and resources may be available, but not accessible or affordable for this socially, geographically and linguistically isolated population. The Health Center Program (HCP) requirements include implementing a sliding fee discount scale (SFDS) to make care affordable. However, there are often multiple issues that contribute to care not being affordable: high nominal fees, migrant workers' seasonal income being annualized, which falsely inflates their perceived annual income; wages lost for attending medical appointments, which can be increased with long waits; the high cost of medication, if not covered under the 340B Drug Pricing Program, and transportation costs associated with accessing care. Availability of care is often impacted by insufficient after-hours service, location of services, lack of local specialty care options, lack of transportation, and delayed care due to insufficient walk-in appointments. The migratory nature of the agricultural worker population can make the accessibility and integration of behavioral health, oral and pharmacy services even more challenging, amongst a plethora of other documented challenges that can lead to poor health outcomes and health disparities.

The Council recommends the following actions:

I. HRSA direct support for Primary Care Associations (PCAs) to:
   - Ensure collaboration with HRSA National Training and Technical Assistance Partners (NTTAP) focused on addressing MSAW health and welfare concerns to ensure cooperative inter-state and intrastate strategies to eliminate gaps and support efficient use of available resources.
   - Designate a PCA staff member/champion to monitor the MSAW health and welfare challenges in their state, and work with the state's M/CHCs to ensure agricultural workers receive access to care. This effort must include support for health centers in identifying agricultural workers in their service area. It is critical that CHCs that do not receive migrant health funding understand they must not turn away agricultural workers.

II. The effective collection and use of data on MSAW health disparities and needs:
   - Utilize data from the Uniform Data System (UDS) and the US DOL's data on occupational illness, injury and death among agricultural workers to create a national dashboard comparing MSAWs with non-MSAWs in the area of health access, health disparities and occupational injury and illness.
   - Collaborate with other federal agencies such as the DOL and Centers for Disease Control (CDC) to increase the collective understanding about the health disparities experienced by MSAWs.
   - Support the establishment of easy-to-use, virtual reporting mechanisms for agricultural workers to anonymously report hazards, illness, injury and death in their living and working environment to increase monitoring, investigations and rapid interventions.

III. Implement the best practices and lessons learned from health centers to develop, implement, and evaluate innovative, evidence-based strategies to:
- Create a *Best Practices with MSAWs* campaign that identifies and highlights interventions that increase access and/or address health disparities and occupational hazards, through Health Center peer learning at Stream Forums and other venues.
- Enhance HRSA HCP oversight to incentivize MHCs to create an operational plan that details the strategies for identifying and serving agricultural workers in their catchment area.

IV. As pandemic flexibilities approach an end, HRSA continue to support and increase the use of telehealth to enable more widespread adoption of this technological solution to overcome access related barriers.
- As the nation shut down due to the pandemic, health centers regrouped and responded to the pandemic challenge by pivoting to telehealth and mobile health services. It is important that HRSA support and grow the implementation of these innovative strategies, by assisting health centers to navigate the complex health care environment that influences care provision.
- HRSA support the state and regional PCAs and Health Center Controlled Networks (HCCN) to bridge the digital divide for agricultural workers, by establishing state and regional Agricultural Digital Alliances for successful implementation of telehealth in rural and frontier areas, utilizing the lessons learned from the North Carolina Farmworker Health Program (NCFHP) Internet Connectivity Project.[vi]
- HRSA allocate sufficient funding for telehealth equipment, personnel, training, and protocols tailored to MSAWs.
- Collaborate with CMS to expand legitimizing telehealth as a billable and reimbursable service.

V. HRSA dedicate funding for mobile health clinics to deliver care for hard-to-reach MSAW populations at farms and migrant camps, by:
- Supporting M/CHCs to expand mobile care to underserved communities by ensuring funding includes:
  - A robust plan for sustainability to prevent interruptions in care delivery.
  - Developing resources for health centers operating mobile units.
  - Allowing health centers flexibility to utilize their grant funded mobile units during the off-season to continue the delivery of critical services to marginalized populations.

VI. HRSA provide more rigorous oversight/monitoring of M/CHCs.
- To ensure MHCs provide language access services for locally spoken languages by MSAWs.
- HRSA track the training and development of culturally and linguistically proficient staff / CHWs.
- Require health centers to demonstrate how they have integrated special populations into their disaster preparedness plans with specific evidence of outreach to the agricultural worker population where appropriate.
- HCP encourage and incentivize health centers to provide bridge case management services to mobile patients who may be leaving or arriving in health center service areas. Hence HCP support to develop programs such as Health Network[vii] must be underscored.

- Require health centers to document partnership efforts and provide individualized training and technical assistance (T/TA) to ensure the health centers engagement strategies are tailored to meet unique needs of the geographic area and patients, e.g., mobile vans, community-based events, health fairs and vaccination events.
- Provide reporting metrics that recognize and incentivize continuity of care and wraparound services to MSAWs.

Background

The Problem
The pandemic highlighted not only the disproportionate impact public health emergencies can have on vulnerable populations, but also that health disparities make our entire population vulnerable, as the health and economic wellbeing of our essential workers and our nation are inseparable. Simultaneously, MSAWs have been at the heart of natural disasters as well.

MSAW access to care barriers include poverty, language and cultural barriers, lack of health insurance, cost of services, transportation, little control over work schedules, continuity of care, fear, and for a significant segment of agricultural workers, the lack of rights afforded to citizens make them more susceptible to occupational risks, labor exploitation and trafficking. Agricultural workers have been historically excluded from social and labor protections, despite working in one of the most dangerous and lowest-paying occupations in the country.[viii] Structural racism and health inequities are exacerbated by differences in policies and forces that facilitate these issues, as systems of oppression can lead to health inequities because of experienced disadvantages and lack of opportunities.[ix] [x] Structural racism as a key determinant of population health has also been cited to explain the disproportionate burdens of COVID-19 found among racial minorities.[xi] [xii]

Power differentials in the workplace, dehumanization of workers, racism, discrimination, and coercion via threats to report agricultural workers to immigration enforcement influence behavior because agricultural workers feel unable to report violations of workplace regulations, request protective equipment, or ask their employer for accommodations to help reduce COVID-19 risk. The fear of job loss, being labeled as unemployable, or being reported to Immigration and Customs Enforcement (ICE) are important deterrents to requesting adequate safety and occupational standards. This working environment fosters a culture of silence, condones abuses and retaliation, and exacerbates mistreatment of workers, which can be particularly dangerous for these workers during the pandemic.[xiii] These have been historical barriers for MSAW access to care. Many health centers effectively address these barriers through unique service delivery models, as well as the unique strategies employed to reach this population during the pandemic, that have the potential to yield long-term change to improve the health and wellbeing of agricultural workers and their families.

In 2020, HCP virtual visits increased by nearly 6,000 percent, providing 28.05 million more virtual visits than in 2019. However, the successful continuation and expansion of the use of telehealth is directly linked to its ongoing financial support. Calendar year 2021 Uniform Data System data indicates approximately 48 percent of health center patients were Medicaid beneficiaries, hence state level decisions can have wide ranging impacts on the health center patient population.[xiv] The Council is concerned about the impact the loss of Medicare and Medicaid support will have on telehealth services for HCP patients. Through the Public Health Emergency (PHE), health centers are eligible to provide

telehealth services to Medicare beneficiaries as distant site providers. However, this flexibility is scheduled to expire at the end of the PHE. With respect to Medicaid telehealth coverage, in general, states have the option to determine whether to cover telemedicine; what types of telemedicine to cover; where in the state it can be covered; how it is provided/covered; what types of telemedicine practitioners/providers may be covered/reimbursed based on Medicaid statute/regulation.

The successful implementation of telehealth in rural and frontier areas is disproportionately impacted by the nation's digital divide. Digital disenfranchisement contributes to negative health outcomes and is critical to meaningful progress toward health equity.[xv] Investing in resources promoting broadband to address the specific needs of agricultural workers has the potential to improve access via telehealth. As an example, the North Carolina Farmworker Health Program (NCFHP) successfully implemented the NCFHP Internet Connectivity Project[xvi] during the pandemic to respond to the urgent need for internet access to disseminate health information, support family connections, and provide telehealth services during COVID-19 isolation and quarantine. This effort addressed the barriers to care recognizing that internet access is not a required utility under North Carolina's migrant housing standards and for farmworker housing. Typically provided by the employer in North Carolina, internet set up is often situated in remote[xvii] locations in rural areas where poor cell phone reception and limited options for internet connectivity contribute to the "digital divide." The NCFHP Internet Connectivity Project[xviii] developed and implemented three models of internet connectivity solutions for agricultural workers, from June 2020 to December 2021. The first intervention placed 448 devices across the state to provide internet access to more than 3,184 agricultural workers during the 2021 peak farming season. The intervention trained community health workers (CHWs) and provided them with mobile hotspots to distribute to agricultural workers with poor or no internet connection during coronavirus outbreaks and isolation or quarantine orders. The devices were then collected at the end of the season like a library lending model. Each hotspot provided internet for up to 10 to 20 devices at any given time. For the second model, growers were reimbursed up to $1,000 per housing unit for the set-up of internet services. Qualifying purchases included routers, antennas, infrastructure build-out, and service plans. The third intervention targeted locations requiring more than a hotspot to provide access to more than 20 agricultural workers, or for farms without the option of wired connection because of availability and reach of local internet service. This third intervention also provided Internet hubs via a fixed rugged cellular network router and antenna capable of providing Internet access for up to 100 devices.

To enhance the above models, the NCFHP partnered with the North Carolina Broadband Infrastructure Office to develop a farmworker housing intake process to identify the ideal internet connectivity model for various locations. East Carolina University developed Spanish-language digital literacy training and videos for agricultural workers.[xix] NCFHP also partnered with community and governmental organizations to form the North Carolina Agriculture Digital Alliance. It is important to build on this experience and dedicate resources to expand this model to other underserved areas through cross training and funding opportunities.

It is well established that mobile clinics have been essential in the fight against COVID. Innovative models of care take health care beyond brick-and-mortar spaces, and leveraging different modalities provides the way forward. As an example, early during the pandemic, Proteus Inc., a M/CHC adopted a new model of service delivery utilizing telemedicine primary care visits, followed by in-person visits when necessary. The trusted relationship developed over many years between the employer and Proteus

staff enabled the success of this multifaceted approach to make inroads for providing access to health care that simultaneously addressed challenges with the social determinants of health.[xx]

Opportunities and Impact

As indicated by the above examples, M/CHCs rose to the pandemic challenges and demonstrated commitment to this population by employing innovative and unique strategies to deliver care. Many lessons have been learned and recorded, it is now time to provide incentives to expand the implementation of these best practices to address the historical health and welfare inequities faced by agricultural workers and their families.

This population moves frequently, following various agricultural harvests, and the state residency requirements imposed by Medicaid create a significant access barrier that most migrant agricultural workers cannot overcome. Even though Medicaid in general is failing to meet the health needs of qualified migrant agricultural workers because of their migratory lifestyle, several states such as Wisconsin and Texas have attempted to integrate migrant agricultural workers into both their state-run Medicaid and public health systems with varying degrees of success.[xxi] The lessons learned from these solutions should be examined and employed in other geographic regions.

Further, The Maximizing Outcomes through Better Investments in Lifesaving Equipment for (MOBILE) Health Care Act provides an unprecedented promising opportunity for health centers to utilize federal funds through the New Access Points funding to establish new mobile health care delivery sites.

Recommendation III

Address the Nation's Migrant and Community Health Center Workforce Shortage Crisis

At the onset of the COVID-19 pandemic the nation's health care workforce, including the M/CHC workforce, was already in peril, but the pandemic has exacerbated rates of employee attrition driven by competition and pandemic stress. The strain of the pandemic is exacerbating challenges that already existed to retain and recruit a high-quality workforce at health centers, which serve our nation's most under-resourced and hard-to-reach communities. The Council honors the health center workforce and recognizes that the most important factor in the current health center landscape is the vulnerability of its workforce. Immediate action is necessary to ensure MSAWs and all medically underserved populations across the country have access to timely quality care. M/CHCs take on the responsibility to serve the most vulnerable communities. Increased expenses, underemployment, and the competition from for-profit health employers has made it even more difficult to sustain services and is increasing staff burnout. Ninety two percent of health centers report they would have experienced additional turnover without funding from the American Rescue Plan (ARP), but as ARP funds are coming to an end, that gap needs to be filled urgently. It is critical that HRSA receive additional funding to allow the provision of salaries commensurate with those of competing employers.

The Council recommends the following actions:

I. The Secretary use the power endowed to his office to support and retain Health Center employees to:

- Ensure the US Congress understands that the Health Center Program, the safety net for our nation's underserved populations, is under grave threat and recognize the urgency of investing in and strengthening the nations M/CHC workforce. This calls for immediate congressional action to ensure adequate financial support to address the most common reasons for workforce attrition.
- Create a cross-agency task force to systematically investigate and document the high rates of M/CHC workforce attrition, to create a short- and long-term workforce training and retention plan to maintain the viability and current reach of the Health Center Program.
- Fund sub-agencies charged with conducting research to collaborate with HRSA for research and demonstration projects focused on M/CHC staff well-being. This is critical for addressing the M/CHC workforce burnout.
- Support federal efforts that incentivize state-based workforce expansion efforts, considering that state workforce policy priorities impact health center staff, such as:
    - Medicaid reimbursement for non-clinical staff and greater flexibility in laws and regulations related to interstate practice for various provider types.
    - Extending the role of allied health care providers to play a larger role in team-based care by easing state scope of practice laws and regulations.
- Support HRSA to create an action plan to incentivize the recruitment and retention of the highest ranked categories of workforce lost, including nurses, administrative, behavioral health, dental, and enabling staff.
- Re-shape the siloed and fragmented reimbursement landscape to incentivize the use of integrated care teams and expand the list of billable providers on integrated care teams, including enabling staff.
- Oversee a nationwide effort that engages diverse federal and state agencies, and community-based stakeholders to promote community development, by providing:
    - Targeted opportunities to develop new health care access points whether brick and mortar, mobile clinics or telehealth digital hubs, with the expectation of hiring and training the people in the community with sufficient support for enabling staff to ensure MSAWs are linked to the new access points and to assist with integrated and coordinated care.
    - A pilot Community Health Worker Service Corps program to increase enabling services while serving as a pipeline for all roles within the M/CHC structure.
    - Funding to create collaborative alliances and programs to support sustainable growth for health centers and local populations, including creating training opportunities for local area residents, high school students, and community-based religious, and educational organizations, to create inter professional health care teams.
- Take urgent action to deem all M/CHC staff as members of the public health workforce. The pivotal role by health centers in carrying forward the national response to the COVID-19 pandemic and numerous climate related emergencies clearly demonstrates the nation's dependance on the health center workforce to actualize/implement a rapid national level response.

II. Provide additional and sustained funding for the following HRSA programs to ensure that health centers can retain current staff and broaden the pipeline for the future workforce.

- The National Health Service Corps (NHSC) is critical to creating and sustaining the health center workforce pipeline, enabling thousands of NHSC primary health care clinicians to serve people with limited access to health care in high-need areas.

- The Teaching Health Center Graduate Medical Education (THCGME) program that currently supports medical and dental residency programs, the majority of which are at M/CHCs be expanded to equip all M/CHCs to be designated as Teaching Health Centers. Graduates of the TCHGME program are more likely to practice in rural and medically underserved settings compared to physicians overall.
- The expansion of the Nurse Corps Scholarship Program to recruit, train and retain residents from underserved areas by financing training and educational costs in exchange for a commitment to working in a health care shortage area after graduation. This offers a way forward to slow down the nurse attrition currently threatening health centers.
- Reliable sustained funding for Title VII Health Professions and Title VIII Nursing Workforce Development Programs is critical to ensure the future health center workforce reflects the diversity, skills, and needs of the population it serves.

III. Restore and preserve the wellbeing of the nation's safety net.

- HRSA collaborate with CMS and states to create a plan for M/CHCs to strengthen interprofessional care teams and better align the workforce with the communities they serve by expanding and diversifying the primary care workforce in medically underserved areas where there is a shortage of health professionals.
- HRSA receive appropriate funding for the Health Center Program to enable individual health centers to compete with larger health institutions and reflect the value of the services they offer to boost workforce morale and economic stability.
- Create opportunities for M/CHCs to prioritize building an organizational culture that empowers staff and implements practices that ensure a safe, stable and reliable work environment, including employee assistance initiatives such as child and adult care, flexible work schedules, creating a sense of belonging and a sense of ownership in the growth of the center.
- Allocate targeted funding to HRSA for M/CHCs that serve agricultural workers to ensure M/CHCs have the financial stability necessary to sustain economic and professional growth of the health center workforce while maintaining the increased level of services needed for the MSAW community.
- Engage the HRSA NTTAPs to design community health workforce training programs that train staff for their roles in interprofessional care teams.
- Support efforts to equip M/CHCs with cutting edge facilities to spark innovation, outreach and diagnostic tools that support professional fulfillment aspirations of health center staff.

<u>Background</u>

Cardinal to any successful community health center lies its active engagement with its target populations in ways that will transform their knowledge, attitudes, and motivation, to address the social, economic, environmental, and structural factors that determine their ill health. The health center model of care decreases the use of costly care choices, such as visits to emergency departments and hospitals.[xxii] Health center patients also had 24 percent lower spending compared to non-health center patients across all services provided.[xxiii] There has been a measurable increase in health center patients, but funding to support the workforce levels required to serve the increased number has not kept up, despite rising staffing costs. Additionally, health center revenues and funding are unable to compete with compensation/reimbursement and benefits provided by for-profit health care systems.

A National Association of Community Health Centers report indicates that in 2021, health centers experienced unprecedented rates of workforce attrition with 68 percent of health centers reporting losing 5-25 percent of their workforce, and 15 percent of health centers reported losing 25-50 percent of their workforce. Although leaving one's current job or reducing work hours may provide individual relief, these actions further strain a health care workforce already struggling to address deeply rooted access concerns. This creates an urgent need for investing in health center staff, diversifying billable providers, and investing in staff well-being once hired. This vulnerability of the health center workforce directly impacts not only the day-to-day provision of access to care, but if unaddressed it has the potential to impact the long-term viability of individual health centers and eventually the HCPs ability to carry forward its safety net role for the most vulnerable populations of the nation.

One of the most relevant threats to health center workforce attrition comes from losing staff to competing health care institutions due to economic inflation. Better financial opportunity at a larger health care organization was the most common reason for staff departure. Stressors from the ongoing pandemic were also a top reason reported by staff for leaving.[xxiv]

One of the avenues for ensuring job and economic stability for the health center workforce is to extend the designation and benefits provided to members of the public health workforce. The national response to the COVID-19 pandemic and numerous climate related emergencies have clearly demonstrated the nation's dependance on the health center workforce to implement national level health efforts. It is important that the nation recognize the sacrifices and contributions of this workforce by including them in the nation's public health workforce. This would not only provide economic stability to individuals incentivizing them to work for M/CHCs, but also position M/CHCs to serve as an economic engine for the community and provide the stability of a reliable workforce to health centers.

It is also important that current policies and payment methodology be reviewed and reshaped to support health center teams in value-based care. Numerous studies have shown that a team-based approach to primary care significantly reduces the amount of provider time needed to care for average adult patients. Health center implementation of interprofessional care teams, and reimbursement mechanisms to support this approach offer an avenue of hope.

A 2021 consensus report by the National Academies of Sciences, Engineering, and Medicine, titled Implementing High-Quality Primary Care,[xxv] includes an objective to train primary care team members from communities where people live and work. This approach is also embedded in the history of the health center movement, as exemplified by the Tufts Delta Health Center in the 1970s.[xxvi] Designating and positioning all health centers to serve as teaching health centers for the local community offers a win-win opportunity for all prior cited reasons.

Health center staff well-being demands immediate attention. The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce *Addressing Health Worker Burnout*[xxvii] reminds us that "Our health depends on the well-being of our health workforce." The advisory cites the "Moral Distress and Moral Injury" issue of NACHCs Team Care CONNECTIONS magazine.[xxviii] This study found that 72 percent of more than 2,000 clinicians working in outpatient safety net practices during the first nine months of the pandemic had experienced work-related moral distress, defined as a disconnect between what you believe is right and what you are able to do. The Surgeon General's new Framework for

Mental Health & Well-Being in the Workplace,[xxix] outlines five essential strategies to address this important issue. The nation owes this special attention to those who have cared for the nation's most vulnerable at peril to themselves.

Opportunities and Impact

Primary care is the only health care segment where an increased supply is associated with better population health and more equitable outcomes. Primary care provided at M/CHCs is a common good, which makes the strength and quality of the nation's primary care services a public concern. The humble beginnings of the community health center movement provide many lessons from its earliest days to justify the common good. One such example from the Tufts Delta Health Center illustrates six essential elements of health center workforce development that can be applied today:

- Embrace the role of the health center as a community economic engine
- Use health center workforce efforts to address community health issues
- Establish external partnerships to achieve the first two elements
- Use health center staff as teaching faculty
- Develop a health center-specific workforce pipeline and pathway
- Use regional and national networks and relationships to pursue workforce opportunities.

Over the past 60 years the US health care safety net has grown to over 1,400 M/CHCs that serve the most vulnerable in more than 14,000 service delivery sites located in underserved communities across the nation. In 2021, these health centers served more than 30 million people, including one in three people living in poverty and one in five rural residents. The workforce that made this possible is now hurting. It is now the nation's turn to create opportunities that enable this workforce to keep the momentum of their impact moving forward, to serve the common good.

Recommendation IV

Address the Public Health Challenges Associated with Social and Cultural Factors that Place Migrant Agricultural Workers at Risk for Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs)

The social dimensions that contextualize the life of the nation's migrant agricultural workforce provide little escape from their marginalized status, and poor physical and mental health. Health status is directly linked to social, economic, and societal integration. Most available health and social services are often more successful with reaching the more stable and less transient agricultural workforce, including workers with H-2A visas, as compared to agricultural workers who may be unauthorized and move regularly, and who may be part of multiple sexual networks.[xxx] Unauthorized immigration is hidden, criminalized, and stigmatized, which makes outreach with health and enabling services challenging. Social conditions can contribute to frequent heavy alcohol use, which increases the risk of unprotected sex. These activities, and the elevated levels of mobility, necessitate the urgent need to provide basic access to health and enabling services to this population.

The Council calls on the Secretary to support a national initiative to address HIV/STI in migrant agricultural workers (MAW), by bringing together stakeholders through a multisectoral, national strategy that draws collectively on public and private resources to enable the coordination, collaboration,

and capacity building necessary to develop effective community-based interventions for HIV/STI prevention, care and treatment.

The Council recommends the following actions:

I. HRSA, Bureau of Primary Health Care (BPHC) collaborate with the HIV/AIDS Bureau to create opportunities for Ryan White grantees and M/CHCs to work towards the adoption of HIV care and treatment interventions to reduce MAW HIV health disparities. Over the last three decades the HRSA Ryan White HIV/AIDS Program has successfully transformed the lives of people living with HIV in the general population. We call on HRSA to ensure that Ryan White grantees, that are M/CHCs, prioritize serving MSAWs to extend their knowledge and benefits to ensure the unique needs of migrant agricultural workers are addressed.

II. Establish partnerships with federal agencies such as the DOL and Administration for Children and Families, HHS and other organizations that are charged to work at the intersection of agricultural labor and health, to share information on HIV/STI and enable pathways for cooperative actions to jointly combat this silent epidemic.

III. BPHC, DOL and Centers for Disease Control (CDC), Deployment Globally Mobile Populations Team (Global Migration Task Force) and organizations such as Migrant Clinicians Network collaborate to:
- Develop HIV/STI standards of care for MAWs to ensure education and care is culturally relevant and responsive to the unique needs of MAWs.
- Conduct community-based research informed by MAWs and local health center affiliated community health workers that is ethnographically grounded to create an evidence base that can be used to set standards for:
    - How marginalized MAWs access health care to identify opportunities for outreach.
    - An understanding of best practices for MAW specific trauma-informed care.
    - Establishing implementation of HIV/STI health education and care.
- Develop an evidence base providing information on issues related to structural determinants of migrant health and the social suffering of mobile populations.
- Standardize guidelines for information provided by hotlines to streamline access to critical information and ensure hotline staff include individuals from farmworker communities to respond to queries in a culturally relevant manner.
- Provide recommendations for Health Center primary and preventive care encounters to include conversations around the patient's work and assessment for possible HIV/STI exposure.

IV. BPHC reinforce National Training and Technical Assistance Partner capabilities to create a tailored response to address social and cultural factors that place migrant agricultural workers at risk for HIV and STIs:
- Launch a culturally appropriate campaign around knowing your HIV/STI status developed through community-based organizations and MAW partnerships.
- Support local capacity to communicate consistent culturally and linguistically relevant public health and safety messaging, while considering the needs of non-English/Spanish and other languages spoken by MAWs in the area, through diversity, inclusion, and equity efforts. Recognize that input from MAWs is an important part of the process of producing materials and programs to serve them, including:

  - Emphasizing the relationship between alcohol abuse and risky behaviors and targeting the four psychosocial mediators of preventive behavior: traditional view of gender roles, knowledge of HIV prevention, perceived barriers to condom use, and efficacy of condom use.
  - Developing workshop resources that are visual in nature and at a primary education reading level.
  - Working with translators from the MAW community to account for linguistic and cultural nuances and ensure accurate translations.
  - Ensuring that materials do not perpetuate stereotypes and include input from survivors when producing materials and programs to serve individuals in their former situation.
  - Formatting resources so workers can easily access and carry resources in agricultural settings.
- Provide regular training and retraining of all M/CHC staff including front desk and providers at all levels on the unique MAW vulnerability.
- Expand innovative programs, such as Specialty Care Access Network (SCAN) developed by Migrant Clinicians Network and its partners to develop a network of MAW specific HIV/STD sub-specialists across the country.
- Continue support to develop MAW-specific care provision models for community health centers working in partnership with community-based HIV/STI prevention programs. Ensure that such programs exist in strong, reliable partnership with health centers and can reduce the likelihood of failure of identification for at-risk individuals.
- Create community programs to educate the receiving communities about the nation's dependence on MAWs for the agricultural sector and the viability of the food supply chain, history of the US dependance on migrant agricultural labor and challenges associated with migration in order to address associated stigma.
- Educate and train M/CHC workforce to create an awareness of the unique needs of patients experiencing migration and their increased vulnerability to HIV/STI.
- Develop a HIV/STI training program and cadre of community health and medical legal workers. This should include provider level training on the use of a Trauma Informed approach to MAWs who may have been victimized for the provision of victim assistance in health care settings.

Background

The Problem

Agricultural workers in the US are disproportionately affected by the intersecting epidemics of human immunodeficiency virus (HIV) and sexually transmitted infections (STIs).[xxxi] HIV prevalence has been reported between 2.6 and 13 percent[xxxii] [xxxiii] among agricultural workers in the eastern US, whereas within the general US population, the HIV prevalence is estimated to be 0.6 percent.[xxxiv] Representative data on seroprevalence rates for MAWs are limited, but available data suggests that rates are high.[xxxv] [xxxvi] Agricultural workers experience severe health and social problems and are at greater risk than the general US population because of poverty, poor housing, malnutrition, difficult working conditions and marginalization.[xxxvii]

Poverty, limited education, mobility, and isolated living conditions predispose agricultural workers to risk factors associated with HIV/STI. Studies indicate that lifestyle factors such as harsh labor, poor living conditions, discrimination, and loneliness, may increase alcohol consumption and related high-risk sexual behaviors. This vulnerability can be exacerbated by inadequate or incorrect HIV transmission knowledge, multiple partners and long absence from families, cultural influences of *machismo* and *familismo*, alcohol and other drug use, and hostility of the host community. Lifetime use of condoms among agricultural workers has been identified as low, while sex with multiple partners, partners with histories of STI and commercial sex workers have been identified as relatively common. Rates of using commercial sex workers among single men and those living apart from their wives are higher than 40 percent, measured both in men returning to Mexico[xxxviii] and in those residing in the United States.[xxxix] Women agricultural workers in Florida and California have been found to be at greater risk than men in sexually acquiring HIV owing to the failure to use condoms and the practice of exchanging sex for money. Women's knowledge of transmission is inaccurate, and concerns about being seen as promiscuous lead to the choice not to carry condoms.[xl] [xli]

Opportunities and Impact

Undiagnosed and unsupported HIV/STI has a multidimensional impact on MAWs that could lead to adverse health outcomes for individuals and the agricultural community. Undiagnosed infections can lead to chronic health problems including death. Additionally, because MAWs constitute a transient community, it makes it particularly challenging to keep those diagnosed with HIV/STIs supported in clinical settings to achieve and maintain viral suppression.

Migration allows the spread of infection if there is no diagnosis and treatment. This is of concern to M/CHCs in how they support and continue to manage HIV/STI cases in their community. The network of M/CHCs across the nation are uniquely positioned to address this epidemic through the implementation of a MSAW specific national effort, led by CHWs and supported by Migrant Clinicians Network's Health Network,[xlii] a cost-effective virtual case management program that helps migrants with ongoing health needs to find care at their next destination. HRSA support to Migrant Clinicians Network and its partners to develop a MAW-specific Specialty Care Access Network (SCAN) of HIV/STD sub-specialists across the country to address the unique needs that cannot be met by generalists offers the possibility of stemming this silent pandemic through culturally and linguistically competent care. These efforts while targeted at improving MAW lives, will also reap benefits for the HRSA efforts to stem the HIV/AIDs epidemic.

Recommendation V

HRSA Continue to Receive Support to Build Capacity for Robust Public Health Responsiveness and Preparedness to Adequately Understand and Respond to the Continuing COVID 19 Challenges, and Future Threats

Post-COVID conditions, although not fully understood, pose amplified risks for historically marginalized populations.[xliii] The COVID-19 pandemic continues to challenge the nation's health care systems in unparalleled ways. "We are learning to fly the plane as we build it." That is a phrase heard over and over during the COVID-19 pandemic, especially during the first year. Amidst the chaos, the Health Center Program rose to the challenge with support from the American Rescue Plan Act (ARPA)

funding. This funding will end on March 31, 2023, although the pandemic is not predicted to become endemic until 2024. Through the Expanding COVID-19 Vaccination initiative, HRSA announced a new $350 million initiative for M/CHCs to increase COVID-19 vaccinations this winter by addressing the unique access barriers experienced by the underserved populations they serve. Though these funds build on the American Rescue Plan funding to combat COVID-19, they are available for a limited timeframe and constrained by the scope of activities that they can be used for. Additionally, the newly announced funds to support continued vaccination efforts at M/CHCs are only available for a 6-month period and health centers are receiving a significantly smaller level of support than previously awarded. Therefore, it is critical that HRSA expand its COVID 19 response to include a strategy to specifically address post-COVID conditions.

The Council recommends the following actions:

I. HRSA provide continued funding for M/CHC to support the public health response and preparedness to ensure:

- Appropriate care to agricultural workers with post-COVID conditions with prevailing access to care challenges described in earlier sections of this document, who are more likely to be uninsured and lack access to health and enabling services availability.
- M/CHCs have sustained capacity to provide trauma informed care and response to the continued challenges posed by the COVID-19 pandemic and post-COVID conditions.
- The M/CHC workforce at the heart of the nation's COVID 19 response, who have faced significant physical and emotional burdens during the pandemic, are not burdened with additional stressors when ARPA-supported colleagues are terminated, which will counteract workforce wellness activities and exacerbate health center staffing concerns.
- M/CHCs have adequate staffing and are not limited in their capacity to build on "lessons learned," as well as maintain and develop new and expanded partnerships developed during the pandemic, to increase public health preparedness.
- M/CHCs have adequate resources to facilitate wellness and recovery activities for enabling, front-line staff and providers across the board.

II. HRSA inform future MSAW health and welfare efforts by developing an evidence base on the ongoing impact of the pandemic and post-COVID conditions, and the experiences of approximately 1M agricultural workers served in 2021. Suggested strategies include, but are not limited to:

- HRSA review the M/CHC data collected, and research conducted by migrant health stakeholders, NTTAPs and HCCNs to increase understanding of the prevalence and impact of post-COVID conditions among agricultural workers.
- HRSA collaborate with CDC as they analyze healthcare data, and partner with clinicians to learn more about post-COVID conditions to promote equity in healthcare access and utilization for people with post-COVID conditions.
- Create and disseminate MSAW-specific culturally and linguistically relevant clinical guidance and education materials for healthcare providers, patients, and the public to improve understanding of post-COVID conditions.

Background

The American Rescue Plan Act funding has supported M/CHCs to coordinate COVID-19 response efforts, provide direct services, and increase outreach, education, and testing. This funding is necessary for much needed supplies, equipment and vaccines. Furthermore, M/CHC staff and other public health professionals need the support to respond to new information about the virus daily, adjust workflows, institute measures to reduce exposure risks of staff and patients, launch information campaigns and communication strategies, initiate new partnerships, launch testing and vaccination events with a special focus on reaching communities at increased risk, including migrant and seasonal agricultural workers. Increased investments in relationships, trust building, and constant communication were front and center to communities' receptiveness to new health information and recommendations.

As indicated in earlier sections of this document agricultural workers have faced increased risks during the COVID-19 pandemic, as will be true for future public health emergencies, related to frequent migration, isolation, congregate living arrangements, lack of internet access, and barriers to accessing health care and information. Although vaccines have reduced the severity of COVID-19 symptoms in most cases, there is still a need for continued education and vaccine campaigns to keep the agricultural community protected and reduce the likelihood of post-COVID conditions (Long COVID). Recent research highlights the increased risks for agricultural workers to successfully access quality health care due to significant structural racism and health inequities, with concerns related to long COVID. Agricultural workers are less likely to be diagnosed and treated and some studies are indicating increased rates of post-COVID conditions among workers who have tested positive, compared with the general population. [xliv]

Opportunities and Impact

Information and data provided during the November 2022 NACMH meeting Federal Update stated that M/CHCs are rebounding from the COVID-19 pandemic, with the total number of patients and visits increasing to pre-pandemic levels. It is crucial that HRSA support and monitor the health and wellness of M/CHC staff and patients responding to and recovering from the effects of the ongoing COVID-19 pandemic.

The Council also received HRSA's summary of lessons learned for future public health emergency response efforts, one of which focuses on the role of health centers with their readiness, including fiscal viability and operational capacity and preparedness for various types of emergencies. Rebound, recovery and preparedness will be difficult to achieve with a recovering and reduced staff. Without continued support, health centers will be forced to reduce their staff capacity and services, and as a result will not be equipped to fully support the health needs of agricultural workers and their families.

This recommendation aligns with one of the Bureau of Primary Health Care's strategic priorities to strengthen health centers to address critical and emerging health care issues and the evolving health care environment.

In closing, we appreciate the honor extended to us in serving on the National Advisory Council on Migrant Health. The Council recognizes the valuable role agricultural workers play in the nation's

economy and in our country's domestically produced food supply. We thank the Secretary for your service, and for your consideration of our recommendations on behalf of those we serve.

Sincerely,

/Jose Salinas, EdD./
Chair National Advisory Council on Migrant Health

cc:
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