National Advisory Council on Migrant Health

July 19, 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 the organization, operation, selection, and funding of migrant health centers (MHC) and other entities assisted under section 330(g) of the Public Health Service (PHS) Act, as amended, 42 USC 254(b), with the goal of improving health services and conditions for MSAWs and their families. Please find an overview of the Council's May 2023 meeting and three key recommendations that fulfill our charge.

Overview

The Council met on May 24-25, 2023, in Tampa, Florida. Agriculture plays a vital role in Florida's economy, with more than 47,500 farms and ranches spread across approximately 9.7 million acres. Florida has one of the largest agricultural workforces in the country with over 100,000 hard-working agricultural workers who fuel the state's growth and economic success. Though they earn a marginal income themselves, Florida's agricultural workers are the engine that drives Florida's row crop, citrus, nursery, cattle and dairy sectors generating billions of dollars in revenue and employment for others in agriculture, food processing, sales and marketing. In 2020 during the pandemic, farm cash receipts from marketing Florida agricultural products amounted to $7.41 billion.[i] These agricultural workers enrich the nation not just with their economic contributions, but with their rich cultural contributions to the communities in which they live and work. Florida's iconic citrus groves and nurseries in Central and South Florida, vegetables grown across the state's farms, dairies and ranches provide Florida's residents with a large and stable economic base as well as healthy, fresh, nutritious food.

While the majority of Florida's farmworkers are originally from countries in Latin America, a significant percentage of these are not Spanish speakers, speaking one of several native (indigenous) languages. The state also has sizable subpopulations of Haitian/Caribbean Islander, and African Americans performing crop work. Florida, along with Texas and California, is regarded as the three receiving states for migrant agricultural workers (MAWs) because most MAWs claim one of these three states as their home. This is generally where the migrant streams begin and where the farmworkers return once the

season has ended, to await the start of the next season. Florida is also one of the geographic areas with the longest growing seasons.[ii] Often MAWs travel alone to follow the crops, enduring separation from their families, but many also migrate together as families. HRSA-supported health centers in Florida served approximately 1.7 M patients in calendar year 2021, of which 43,130, were agricultural workers or dependents.[iii]

The NACMH meeting provided the Council an opportunity to meet in person. During this meeting, we received updates from HRSA senior leaders:

- Federal Update on Health Center Program Efforts
  - Jennifer Joseph, PhD, MSEd, Director, Office of Policy and Program Development, Bureau of Primary Health Care, (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
- Florida Association of Community Health Centers (FACHC) Update
  - Jonathan Chapman, MBA, President and Chief Executive Officer, FACHC
- Agricultural Worker Health: Addressing Barriers to Cancer Screening, Diagnosis and Treatment
  - Cathy D. Meade, PhD, RN, FAAN, Senior Member & Professor, Health Outcomes and Behavior, Division of Population Science; Founder, Tampa Bay Community Cancer Network, Moffitt Cancer Center, Florida
  - Margarita Romo, Founder and Executive Director, Farmworkers Self-Help, Inc., Florida
  - Diana Lopez, RN, Director of Nursing, Suncoast Community Health Centers, Inc., Florida
- Early Childhood Health and Welfare Concerns of Migrant and Seasonal Agricultural Worker Households
  - Javier Rosado, PhD, Professor & Director of Clinical Research, Center for Child Stress and Health, Florida State University College of Medicine, Immokalee Campus, Florida

The Council also received personal testimonies from ten MSAW women, and remarks on MSAW health and welfare conditions from two patient advocates serving MSAWs in the Tampa, Florida area. The testifiers shared the challenges they face regarding:

- Access to equitable, comprehensive, linguistically and culturally relevant health care and enabling services.
- Availability of timely, quality affordable preventive, primary and behavioral health care; and continuity of care provision as they migrate across state lines for work.
- Availability of culturally and linguistically relevant health education literature, and culturally competent and structurally competent health center providers and staff.

The scarcity of trusted sources providing reliable health and welfare information draws attention to the important need to grow trusted messengers in the communities served by migrant and community health centers, and the need to incentivize and prioritize collaborations with local community-based organizations and growers. The high cost of care, obstacles to missing work to seek care, and difficulty with navigating the health care system indicate the need for mobile health clinics and community health workers/promotoras. The critical need for sanitary, quality, safe, and affordable agricultural worker housing was also identified as an important challenge to MSAW health and welfare.

The Council recognized that the aforementioned challenges must be understood and addressed based on the conditions of occupational employment and migration, to ensure that the unique MSAW needs are recognized as different from the general needs of the underserved populations served by community and migrant health centers.

The testifiers and patient advocates raised concern about the Florida Senate Bill 1718, being signed into law. They shared how stress and anxiety about immigration enforcement is affecting agricultural workers mental health and willingness to access health services. The FACHC presentation indicated that while the state law goes into effect on July 1, 2023, some local health centers have already started observing a decrease in numbers of patients seeking care and some MSAWs testified that some local health centers had started cancelling appointments, thus denying them care. Migrant health stakeholders are concerned about the long-term impact of the law on MSAW health outcomes.

The Council discussed and is concerned about the significant impact of the state law on the mental and physical health of the MSAW population served by HRSA supported health centers. This is of concern because 86 percent of agricultural workers in the US are foreign-born, and 45 percent of all US agricultural workers are undocumented.[iv]

The Council also discussed the urgency to protect and re-structure the 340B Drug Pricing Program, to ensure the program supports true safety-net providers and the communities they serve, and to put the program on a sustainable path for the future. HRSA-supported health centers are under extreme financial strain due to losing 340B savings and are willing to work with any 340B stakeholders for solutions. The Council urges that policymakers pursue an independent third-party analysis for recommendations on critically needed change to curb abuse and uphold the original intent of the program to help support safety-net providers serving low-income and vulnerable populations access affordable medicines and health care. Reforming the 340B program will create stability and certainty for M/CHCs and patients.

The Council reviewed all the information presented during the meeting, and engaged in iterative discussions about what comprehensive, evidence-based issues aligned with their experiences and concerns in the regions they represent. Three overarching areas of concern emerged, forming the content of the recommendations presented in this letter.

Recommendations

In accordance with The Council's charge under section 217 of the PHS Act, Title 42 U.S.C. § 218, emphasizing the goal of improving health services and conditions for MSAWs and their families, and in context of the evidence presented at this meeting, we submit the following recommendations for your consideration.

<u>Recommendation I</u>: Acknowledge and Address the Health and Welfare Consequences of an Inadequate Immigration Policy on the Nations Migrant and Seasonal Agricultural Workforce

The Council calls on the Secretary to harness the power of their office to support a national initiative to draw attention to the social, economic, institutional, and political structures as they affect the nations primarily immigrant agricultural workforce. We further call upon the Department of Health and Human Services to support this initiative by bringing together

stakeholders through a multisectoral, national strategy to enable the coordination, collaboration, and capacity-building necessary to understand immigration as a defining social determinant of health,[v] to adequately respond to the health and welfare needs of the nation's agricultural workforce.

The U.S. Department of Labor's National Agricultural Workers Survey (NAWS) data on farmworkers' legal immigration status indicates that in 2018–20, 41 percent of the nation's crop workers did not hold immigration status authorization.[vi] NAWS data also indicates that of the farmworkers interviewed in 2019–2020, approximately 63 percent were born in Mexico, almost 30 percent were born in the US or Puerto Rico, and 5 percent were born in Central America.[vii] The coronavirus pandemic however led the federal government to deem these farmworkers essential. Having spent much of their lives in the US evading law enforcement, they were provided a letter[viii] from their employer declaring that the Department of Homeland Security (DHS) considered them "critical to the food supply chain." The detrimental health impacts of immigration enforcement on individuals and the ripple effect on households and beyond, signify the experiences of millions of individuals who are important to our nation's food system.

Therefore, the Council urges the Secretary of HHS to:

- Promote interagency collaboration with the DHS to address the serious immigration concerns expressed by agricultural worker patients to ensure full access to healthcare services for MSAWs, and to extend and reinforce the implementation of federal protections for access to health care, pursuant to the Emergency Medical Treatment and Labor Act (EMTALA),[ix] which ensures that all patients regardless of citizenship or immigration status have access to emergency medical treatment. The Council further requests expansion of the provisions of EMTALA to preventive and primary integrated health care, to promote MSAW health and welfare and to avoid the high cost of emergency care use.
- Facilitate HRSA partnership with other HHS agencies to further the understanding of immigration as a social determinant[x] of health to add to the current HRSA understanding of The Social Determinants of Health (SDOH)[xi] to provide migrant and community health centers (M/CHC) guidance on how immigration enforcement influences health, and how the Health Center Program and other health systems can support the wellbeing of immigrant workers, their families and communities.
- Enable HRSA to support The National Center for Medical-Legal Partnership, a National Training and Technical Partner (NTTAP), to equip M/CHC providers and health center staff with information and resources on immigration protections and laws to address the unique deep-rooted, inequitable systemic realities and practices that shape the health and wellbeing of MSAWs.
- Request HRSA to support the development of M/CHC training and technical assistance curricula to:
  - Train promotoras who work on the frontlines on basic medical legal issues; and develop and distribute print copies of relevant culturally and linguistically appropriate literature through "promotoras" and health outreach workers.
  - Educate M/CHC staff about the protections for medical care to respond to patient concerns about policy changes and immigration status.
  - Incentivize M/CHCs to use tools like PRAPARE[xii], the Accountable Health Communities Screening Tool[xiii] and the Structural Vulnerability Assessment Tool[xiv] to screen patients for a

range of social problems. To address the identified problem, incentivize M/CHCs to establish medical legal partnerships to provide pro-bono legal assistance available onsite to provide access to information on immigration laws and protections, as well as information about the availability of pro-bono immigration attorneys through promotoras, clinics, school-based health center sites, mobile health clinics, etc.

- Support M/CHCs to explore opportunities for widespread adoption of best practices as illustrated by models of partnership between medical and legal professionals tested in states like California, Oregon, Washington, New York, Massachusetts, among others.[xv]

- Request HRSA to support state Primary Care Associations (PCA) to stay abreast of changes in state immigration policies and enforcement practices that affect the mental health and well-being of agricultural worker patients, and the resulting tensions among migrant and community health center staff, providers, and patients. This effort must include documenting:
  - How the current laws in the state contradict federal protections for immigrants seeking medical assistance and create fear among the undocumented MSAW population that M/CHCs serve.
  - The impact of the law on MSAW care-seeking behavior and care utilization; and
  - PCAs in collaboration with HRSA NTTAPs lead the development of community-based solutions to address stress, and anxiety about immigration enforcement.

  As illustrated by the testimonies presented to the Council, the general fear and panic in the MSAW community resulting from the anticipated impact of the Florida Senate Bill 1718, it is critical that M/CHCs have a clear understanding and local support for employing federal protections for MSAW access to health care services. The rights of farmworkers and responsibilities of farmers are delineated in the Migrant and Seasonal Agricultural Worker Protection Act (MSPA),[xvi] which apply to both documented and undocumented workers. At a time in the history of our nation when staffing shortages is one of the biggest challenges facing public health professionals, they should not be further burdened by the ethical dilemma of having to choose between their duty to provide care to patients and their governments' political agendas.[xvii],[xviii]
- Have HRSA, in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), lead an evidence based public health initiative to study the impact of the mental health epidemic in progress in the US agricultural worker population living under the constant threat of immigration enforcement. The findings from this effort should result in:
  - Collecting, analyzing, and sharing behavioral health data and its consequences on the general wellbeing of the individual, family and community, to collaborate with other Federal agencies to evaluate potential support from other programs for MSAWs and improve policies.
  - Informing the preventive health, primary care, and mental health services provided by M/CHCs to the nation's migrant and seasonal agricultural workers.
  - Providing grants and guidance to states, territories, and local communities to promote equity, and trauma-informed approaches.
  - Developing a MSAW specific Toolbox that provides resources to support a holistic and comprehensive approach to healthcare for MSAWs, that emphasizes prevention and early intervention. This includes resources for accessing and utilizing health and enabling services information and materials that address these anxieties through the behavioral health programs offered by M/CHCs. Comprehensive care should include funded integrated behavioral health services beyond emergency mental health care to provide adequate patient home based care. This approach emphasizes referrals to culturally and linguistically competent behavioral health providers as opposed to practitioners who do not have cultural and linguistic competencies. The

importance of integrated care must be emphasized to ensure referrals do not result in additional costs to the patient. As indicated by the testimonies received, patients often do not seek care because of this additional cost and wait time resulting in diminished hours of work.

Background

Immigration enforcement has serious mental health impacts on the heavily undocumented farmworker populations. Increased immigration enforcement efforts have a direct correlation with the psychosocial stress that induces a multifaceted physiologic response that affects multiple systems, including the autonomic, endocrine, and immune systems. Bodily responses to acute stressors are often adaptive in the short term, mobilizing the body and mind to respond to threats by inducing a "fight or flight" response.[xix] For example, immediate physiological responses to an acute stressor (e.g., fielding questions about one's legal status, or an encounter with a law enforcement or ICE officer, correctly recalling one's rights during a home raid) include increased heart rate and breathing, a cascade of glucocorticoid hormones that activate a release of glucose into the bloodstream, and mobilization of blood flow away from nonurgent functions such as digestion or immune response.[xx] Over time, however, chronic activation of a stress response induces chronic "wear and tear" on multiple physiologic systems—sometimes known as "allostatic load" or "weathering"—which in turn increases the risk for chronic mental and physical health conditions.[xxi] State legislation that requires reporting of immigration status at healthcare facilities has negative effects on healthcare access for MSAWs. Increased border enforcement efforts, raids of immigrant communities, separation of immigrant families as well as recent breaches of information sharing about immigration status between agencies (IRS, ICE, DHS) derived from immigrants applying for driver's licenses and Individual Tax Identification Numbers, have serious mental health impacts on the majority undocumented agricultural worker populations as illustrated by Migrant Justice versus DHS and ICE, First Amended Complaint, 5:18-cv-00192-gwc (United State District Court - District of Vermont February 07, 2019.[xxii]

This was further corroborated by direct testimonies heard during the May 2023 NACMH meeting wherein MSAW mothers shared their fears of seeking health care in the state of Florida due to immigration requirements enforced at hospitals due to SB1718. This has resulted in a growing mistrust of health care agencies, personnel, and services. Within this environment of mistrust, MSAWs resort to emergency care only when in dire need. This results in increased costs for medical care, and a hesitancy to address health concerns until they have advanced to a more serious illness and disease. Similarly, this has serious impact in the community and the families, making the cycle of mistrust and lack of timely care chronic and leading to more serious illness and disease.

Opportunities and Impact

An analysis by University of Southern California's Center for the Study of Immigrant Integration shows that nearly 8.2 million U.S.-born and naturalized citizens live with at least one unauthorized family member, 72 percent of which are children. Therefore, when a policy of enforcement and mass deportation targets the estimated 11 million unauthorized immigrants living in the US, it also threatens the well-being of millions of citizens and their families, and erodes their trust in their community and the government.[xxiii] Research shows that immigrants who fear deportation avoid public spaces and interaction with police officers.[xxiv] In areas that see more immigration enforcement, unauthorized immigrants are fearful of driving, going to work, accessing much-needed health care, taking their

relatives to school, or even doing something as mundane as walking down the street. This erosion of trust makes the entire community vulnerable because children are less likely to advance in school and people are fearful of reporting crimes, coming out as witnesses, or reporting domestic violence abuses. Apart from the harm to families and communities, an economic argument for having sensible immigration policies has also been offered based on how individual states and industries will also suffer from losing unauthorized workers from their workforce.[xxv]

<u>Recommendation II</u>: Address the Unique and Critical Early Childhood Development Health, and Welfare Concerns of Migrant and Seasonal Agricultural Worker Households

The Council calls on the Secretary to sponsor an all of government and beyond approach to draw attention to the disproportionate predisposition of MSAW children and families to childhood social and economic adversity and the resulting trauma and long term physical and mental health impact of toxic stress; and commit to cross agency efforts to collaboratively create a reliable evidence base to inform federal programs serving MSAW households to address the critical challenges to improve the long-term well-being of MSAW children.

Approximately 3 million MSAWs[xxvi] are a vital component of the U.S. agricultural industry. Despite their important contributions, MSAWs are a marginalized population who live in poverty and have poor health indicators.[xxvii] In addition to the insecure and low-paid nature of the work, seasonal migrant workers are often socially isolated or excluded and geographically isolated. Frequent moves, interrupted schooling and demeaning racial epithets are features of the lives of many migrant workers' children. While these conditions are deplorable for all age groups, some of the most vulnerable are young children. Still too young to labor in the fields with their parents, in regions that do not provide migrant head start or other forms of day care or education programs, these children may be left in the camps for long hours, either alone or under the inadequate supervision of older siblings. The high-risk environment in which they live includes exposure to toxic pesticides, different forms of social exclusion, economic marginalization, and educational obstacles, which predispose the population to health disparities. Early childhood exposure to environmental phenols, phthalates, pesticides, and/or trace elements, are associated with increased odds of a diagnosis of autism spectrum disorder, developmental delay, and other early concerns related to differences in behaviors, metabolism, or toxicokinetics.[xxviii]

The Council therefore recommends that HHS Promote and Grow Collaborations across HHS Programs and Efforts to enable:

- The HHS agencies tasked with addressing the diverse dimensions preserving and promoting equity for all, address the MSAW health and welfare disparities by establishing intersectoral/interagency collaboration among diverse federal and non-federal entities including state and community based organizations/agencies to address MSAW adversities during pregnancy and early childhood, resulting from undernutrition, stress, poverty, violence, chronic illnesses and exposure to toxins, among others to prevent disruptions in brain development, with consequences that endure throughout life and into future generations. Address the MSAW physical and mental health disparities that result from systematically experiencing greater obstacles to health based on their occupational, migration and social status by planning and implementing efforts that:
    - Increase the visibility and acceptance of MSAWs in receiving communities to address stigma and related mental health impact through the creation of public service campaigns that highlight

the importance of their occupational contributions to the US gross domestic product and food security.
    - Ensure Systems for collecting data and information that usually tend to focus on settled populations and overlook those who migrate and typically do not stay in one location long enough to get onto the radar of local governments. To enable them to create initiatives to document and map the health and welfare conditions and needs of migrant and seasonal workers so that they can receive the appropriate level of services.
    - Ensure adequate planning and resources to support care provision once local government and municipal entities have accurately tracked MSAWs and their needs. Meeting those needs requires coordination among many different agencies: health, education, water, sanitation, housing, and day care, among others.
    - Establish clear rules and norms for cooperation to enable timely seamless transfer of data and information amongst the collaborating entities to ensure they get the basic services that are critical for MSAWs and their children.
- HHS to invest in school-based health centers (SBHCs) to mitigate the health effects of a maladaptive and unequal social ecosystem while simultaneously working to improve the ecosystem itself. SBHC's perform these functions by providing medical, mental/ behavioral, dental, and vision care directly in schools where young people spend much of their time, maximizing their opportunity to learn and grow. SBHC history, health outcomes, cost-benefit, and impact on health equity indicate SBHCs increase access to health services for children, families, and communities, which ultimately leads to positive short- and long-term outcomes in service of a broad range of stakeholders.[xxix] These efforts need to include necessary resources to partner with agencies and local organizations in addressing the mental health needs of migrant children through various mechanisms, such as:
    - Funding to establish on-site mental health clinics or services, hire and train school based mental health professionals, such as counselors or social workers, to provide direct services to students.
    - Grant funding to foster school mental health collaborations to cover hiring, training, program development and resource acquisition for programs that focus on evidence-based practices, cultural and structural competency, and strategies for engaging with diverse populations and navigating cultural nuances.
    - Supporting collaborative school-based initiatives that address the mental health needs of migrant children. For example, funding for schools to develop, implement, and evaluate collaborations with mental health providers, community organizations, or cultural centers to provide culturally sensitive counseling services, group therapy sessions, or psychoeducation programs.
    - Funding to train school staff on migrant children-centered care, cultural competence, cultural humility, structural competence, and effective strategies for supporting the mental health of migrant children.
    - Supporting the implementation of data collection systems, to conduct assessments and evaluate outcomes related to the effectiveness of the mental health programs for migrant children to identify areas of improvement, track progress and demonstrate the impact of the program.
    - Funding to foster best practices and initiatives that provide the framework for successful models addressing the mental health needs of migrant children. This can serve a two-fold purpose, as a metric for measuring the efficacy of initiatives and sharing evidence based-strategies with promising approaches by:
        - Organizing conferences, webinars, and even workshops to share knowledge and experiences between schools, agencies, and organizations working with migrant populations.

    - Supporting the creation and development of resource materials, toolkits, and guidelines that provide practical information and guidance for schools, agencies, and organizations engaged in addressing the mental health of migrant children.
- HRSA to collaborate with Department of Education (DOE) to ensure that MSAW children have access to wraparound enabling services to address the adverse social determinants of health to ensure a healthy life, and the critical support needed to succeed in education even if their families must migrate during certain agricultural seasons and therefore change school districts. The lack of staff support during the family's occupational migration is a serious problem that hinders their ability to succeed in school and language abilities, which has negative consequences through their entire life course. This limits their future socioeconomic growth and job opportunities and perpetuates ongoing and future health disparities. Furthermore, the HRSA-DOE partnership should also provide specific staff support to develop and implement proper educational programs to address the challenges of agricultural migration.
- HRSA Bureau of Primary Health Care (BPHC) to collaborate with HRSA's Maternal and Child Health Bureau to leverage:
    - The National Survey of Children's Health (NSCH)[xxx], the largest national and state-level survey on the health and health care needs of children, their families, and their communities to gather data and information on the unique MSAW physical and mental health disparities and their impact on early childhood development.
    - Maternal, Infant, and Early Childhood Home Visiting (MEICHV) Program,[xxxi] administered to support at-risk communities to ensure they receive the appropriate support to raise children who are physically, socially and emotionally healthy and ready to succeed. Approximately 40 percent of MSAWs served by M/CHCs are under 18 years of age, and approximately 83 percent of MSAWs served live below a 100 percent of poverty level. Considering the similarity in target populations served by the M/CHCs with the MIECHV Program,[xxxii] tailoring its existing structures to make them culturally, linguistically and structurally competent to serve MSAWs would extend HRSA's reach and mission.
    - Migrant and community health centers that received HRSA-funding to expand early childhood development care through increased screenings and follow-up services to ensure children from MSAW households in their communities are accurately identified and services are tailored to meet the unique needs of their communities including:
        - Strengthening and expanding the availability of early childhood screenings to help identify developmental or behavioral conditions, language delays, or other needs, such as food insecurity and housing instability, that can contribute to gaps in school readiness and follow-up services that are vital for ensuring that MSAW parents and kids get the support they need and have the tools to lead healthy lives.
        - Training, strengthening and using a culturally and linguistically competent health center workforce to ensure continuity of care provision during the period of occupational migration.
    - HRSA-funded health centers operating more than 3,400 school-based service sites in schools across the country:
        - Serve as the hub to meet the special needs of children that migrate with parents as they follow the harvest in conjunction with continuity of care plans and digital modalities for offering care.
        - The Health Center Program (HCP) School-Based Service Expansion (SBSE, HRSA-23-097) funding to expand access to primary health services, including mental health services,

through school-based service delivery sites include prioritizing migratory parents and children.
    - Implement data collection systems, conduct assessments, and evaluate outcomes to study the effectiveness of their mental health programs for migrant children, to identify areas of improvement, track progress and demonstrate the impact of their programs.
- HRSA, BPHC leverage its collaboration with Migrant and Seasonal Head Start (MSHS):
    - To enable MSHS centers to implement primary prevention strategies that reduce the likelihood of early adversity and its harmful effects on children and promote resilience in development. This can be achieved through behavioral health promotion and providing social emotional support for children and families in collaboration with M/CHCs.
    - For children already exposed to adversity, staff can focus on preventing subsequent exposure. This can be achieved through evidence based, enabling services interventions which protect against harm, promote recovery, and lead to flourishing lives. Promising approaches to this goal include establishing a medical home for MSHS enrollees at the local M/CHC;[xxxiii] reducing stress by expanding access to high-quality, trauma-informed early intervention,[xxxiv] early care and education, and home visits.[xxxv]
    - Expand provision of MSHS and other forms of day care and educational opportunities for MSAW children in the diverse localities, regions, and states where it is not sufficient or unavailable.

The Council recommends HRSA Implement Evidence Based Approaches and Training Across HRSA Supported Programs as follows:

- HRSA-supported clinical and public health programs, projects and services including M/CHCs adopt a structural competency framework. Structural competency has been shown to be effective in many health contexts including in relation to COVID[xxxvi] and argued to be especially important in relation to agricultural health and safety.[xxxvii]
    - HRSA require structural competency as a framework for the M/CHCs, and related HRSA programs addressing the social inequities affecting the health of MSAWs, by:
        - Providing structural competency training[xxxviii] for M/CHC staff.
        - Creating mechanisms to measure compliance with structural competency, for example following how health programs address, respond to and improve aspects of structural vulnerability.[xxxix]
- HRSA promote collaborations between HRSA-supported clinics and legal services. This is critical for addressing the most important structural factors that hinder the health and wellbeing of MSAWs and MSAW children, including factors such as labor exploitation and inadequate housing. There is increasing attention to the labor exploitation of MSAW children and the serious health and wellbeing consequences thereof.[xl] Twenty seven percent of MSAWs live with someone who has been incarcerated, or is incarcerated, often for minor crimes without having family funding for bail. Research indicates that incarceration decreases health and well-being in multiple indicators both during and after incarceration even for family members who were never incarcerated.[xli] This significantly impacts MSAW youth and their relatives interacting with the criminal justice system, hence it is important for HRSA to support the development of medico-legal partnerships, therefore:
    - HRSA continue to support the National Center for Medical Legal Partnerships, a HRSA national training and technical assistance partner that provides training on integrating legal expertise into

health care settings to help health centers address the social and legal structural problems at the root of many health inequities.
    - HRSA support medico-legal partnerships in HRSA-supported clinics to assist MSAW families navigate the justice system both in relation to labor exploitation and the criminal justice system as it affects MSAW children and youth.
- Migrant and community health centers provide outreach to recruit children from MSAW households to serve as a medical home and provide pediatric primary health care (PPHC) to ensure:
    - Compassionate and culturally relevant care that is accessible and affordable. Services that recognize the interconnectedness of the mental health needs of both parents and children in migrant families.
    - Services are delivered by care teams that include pediatricians and advanced practice pediatric providers. Making care accessible and affordable. PPHC that provides health supervision, guidance and promotion of physical and mental wellbeing, age appropriate cognitive and social growth and development, including timely screening for disease prevention.[xlii]
    - Integrated primary and behavioral health services for both parents and children within the same setting are crucial for MSAWs faced with numerous barriers to accessing care. This requires establishing behavioral health clinics, providers, or programs that offer services for the entire family, promoting collaboration between adult and pediatric mental health providers, and ensuring effective communication and coordination between providers.
    - The care plan integrates continuity of care to aid early diagnosis and treatment of acute and chronic disease using skilled, culturally sensitive care managers to assess individual needs, coordinate care across various service providers, and ensure comprehensive support throughout the healing process.
    - Culturally responsive mental health services that are tailored to the unique needs and experiences of migrant families and reduce language, cultural, and social barriers. This is dependent on resource allocation for cultural competence training for mental health providers, encouraging the recruitment, training, and retention of a diverse and bilingual staff, as well as support the development and implementation of culturally appropriate assessment and treatment approaches.
    - Structurally competent care critical to provide mental and physical health services that understand and respond to the social, institutional, and economic context in which migrant families live, work, and go to school. This is dependent on resource allocation for structural competence training for mental and physical health providers, as well as recruitment, training and promotion of diverse and multilingual staff, as well as support for the development of structurally competent assessment and treatment approaches.
    - Prioritize community outreach efforts to ensure MSAWs are aware of the available resources, enabling services, and support systems. This includes targeted multimedia communication campaigns, multilingual materials, and partnerships with community leaders and centers of influence to promote MSAW awareness and engagement.
    - HRSA invest in the professional development of cross trained education and health service providers to increase awareness of a higher risk for early childhood adversity in MSAW children, trauma knowledge and skills to recognize and address the diagnosis, and increase access to trauma-informed care (TIC) and services.[xliii]
- HRSA-supported collaborations and efforts train providers to conduct screening as part of a comprehensive approach to assessment, referral, and follow-up in cross generational programs (e.g., Early Intervention [OSEP: IDEA Part C], home visiting: e.g. MIECHV Program, Head Start/Early Head Start),[xliv] early care and education,[xlv] pediatric care settings,[xlvi] child welfare,[xlvii] mental health,

and other services for children and their families.[xlviii] [xlix] Research indicates that training in TIC not only improves providers' skills and knowledge, but also improves behavior and mental health outcomes among children with post-traumatic stress.[l]

- Train providers to use a comprehensive, two generational, trauma-informed, strengths-based approach to addressing childhood adversity, where screening is only one component of TIC and the child's exposure and related reactions (i.e., symptoms) are identified.
  - Screening be conducted using a reliable and valid, culturally sensitive and linguistically and age-appropriate tool, that accounts for adversity pertaining to the social determinants of health (e.g., poverty, homelessness, discrimination, migration) in addition to household-level challenges. It is critical that the tool used is specific to the patient's background to ensure patients from minority subgroups are not subsumed within a larger ethnic group. For example, many "validated" tools for Latinx or MSAW or Latino or Latin American immigrant populations do not consider indigenous people who are extremely different culturally, linguistically and in terms of socioeconomic status.
  - Support and provide resources for the development of a knowledge base focused on diverse populations – especially including indigenous Latin American migrants and MSAWs – who are often overlooked or subsumed within larger social categories utilized in public health and psychosocial research.
  - Support and provide resources for contextual quantitative, qualitative and ethnographic research into the strengths and needs of diverse populations of MSAWs – including indigenous Latin American migrants and MSAWs. The unique cultural, linguistic, economic, and social strengths and needs of these populations are often overlooked within larger ethnic and social categories utilized in public health and psychosocial research and health care systems.
  - Providers be trained in skills to obtain a comprehensive developmental history, to develop an individualized care plan without causing undue stress or re-traumatizing children and families. The plan should identify each child's strengths and challenges across multiple areas of development and is not based on deficits alone.
  - Establish a clearing house for evidence-based treatments and services for care providers to stay up to date and identify interventions that are supported by evidence and designed for the appropriate population.
- Enhance the availability of parenting education for agricultural workers. Parent support and education are critical to the success of any early childhood development effort and acknowledge the important role parents play in promoting the children's mental health. Parenting support programs that provide guidance, education, and training to migrant parents are essential for:
  - Providing parents with new skills and increased awareness of their child's behavior and needs; awareness of their own emotional health; knowledge, and skills on raising their children in positive ways; and
  - Increasing the family's coping skills by acknowledging the impact of toxic stress and trauma on their family and addressing the challenges of acculturation, allostatic stress, and enhancing the parents' ability to support their children's mental well-being.
- Increase the local areas awareness of multilingual MSAW communities, by recognizing that MSAW communities speak not only English and Spanish, but also indigenous languages, and other language such as Haitian Creole. School and after school programs respectfully acknowledge this strength of the community. Teaching some of these languages to foster respectful integration of diverse MSAW populations.

Background

MSAW families are transient, traveling over 4,000 miles for seasonal employment available only during the harvest season for different crops and agricultural produce, and must continuously and frequently uproot. Typically, this requires that they do not stay long enough to get the basic services that are critical for them and their children. These workers traverse the US in family units or as single adults. There are several "streams" of travel that MSAWs follow, most which originate in southern states, Mexico, or Central America.

Systems for collecting data and information tend to focus on settled populations and overlook those who move or migrate. Many families qualify for Medicaid, but it is not portable from one state to the next, so they are not covered as they travel and must continually reapply. Each time a family reapplies, delays in processing leave parents and children without critical coverage. Some MSAW families do not have access to health insurance, and the price of fee-for-service health care is prohibitively high, especially for preventive care. MSAWs and their children face numerous health hazards having limited resources and control over day to day circumstances.

Children experience the world through their parents or caregiver's life experiences. The first year of a child's life is mostly home-based where they are surrounded by both parents or a single parent, until the child goes to school. Most children form a healthy bond with their parents, which leads to a strong healthy attachment with their parents and familial bonds that last a lifetime. Children with healthy and strong attachments are nurtured, supported, encouraged, and positively reinforced. They leave their home equipped to face the world and interact appropriately with peers and society in general.

Most children will experience some disruption of this process in the form of household dysfunction or a significant emotional event such as a divorce or the loss of a parent. A child's mental health can mirror a parent and/or family's mental health. When children experience extreme dysfunction, abuse, and/or neglect that reaches traumatic levels, it affects their physical health and brain development at an early age. These children grow up with Adverse Childhood Experiences (ACEs). Children with unaddressed ACEs are vulnerable to repeating the patterns they have learned in their childhoods. These children will bring dysfunction into the lives of their children and so on. This is called the cycle of intergenerational trauma. Intergenerational trauma is not just a pattern of behavior learned and repeated, it is a brain development issue. Research has demonstrated that individuals who have experienced multiple adverse childhood experiences (ACEs) are at greater risk for mental health and substance use (MH/SU) challenges, and conversely, many of these individuals with MH/SU challenges are at greater risk for traumatic events.

Opportunities and Impact

HRSA Bureau of Primary Health Care (BPHC), administers federal grant support to 1,400 community health centers in all 50 states and territories.[li] In 2021, M/CHCs provided care to nearly 1 million MSAWs and their families across the nation. MHCs have the potential to play a cardinal role to address MSAW challenges with access to care. However, when agricultural workers do access health care, the provider is often unaware of conditions and symptoms brought on by the trauma of migration, structural inequalities affecting MSAW families, as well as pesticides, chemicals, airborne contaminants and other

products used in agriculture. The lack of relevant provider training and information often leads to misdiagnosis or delay in treatment. The lack of a point of access for routine care or use routine care continuously over time, coupled with the inability to access prior health records often results in improper care.

Implementing a trauma-informed framework and a structural competency framework into the primary care setting can help M/CHCs better support individuals with ACEs and reduce greater risk for mental health, substance use, and other traumatic events. Structural competency is a recent and promising development in clinical and public health training to address and respond to the social determination of health.[lii] Structural competency teaches trainees in any clinical or health-related field – including policy makers and social workers – to understand the social structures that affect the health and wellbeing of patients and communities, and to respond to ameliorate health disparities and work effectively for health equity.[liii] Structural competency training has been shown to increase understanding of health equity and the social determination of health as well as to increase empathy among health professionals toward their patients.[liv]

<u>Recommendation III</u>: Promote Equitable Access to Health Care and Enabling Services for Agricultural Workers by Addressing the Multifaceted Barriers that Impact MSAW Health and Welfare

The Council recommends that HRSA renew its effort to increase access to care for MSAWs by implementing a well-defined strategy to respond to identified gaps, by developing and implementing evidenced-based interventions to enhance MSAW health and welfare. MSAWs face unique barriers to care resulting from the nature of agricultural work, structural inequities that negatively impact the social determinants of their health. They face stigma and exclusion from receiving communities, as well as inadequate access to transportation, long travel distances and technology gaps. An unfamiliar medical system, lack of health insurance high cost of care, as well as limited evening and weekend clinic hours, long wait times and cumbersome scheduling procedures, language barriers and insufficient interpretation services, insufficient availability of continuity of care provision and income-based financial challenges exacerbated by insufficient respect for, and enforcement of workers' rights are significant barriers to health care utilization among this population.

Based on the testimonies provided during this meeting, the Council recognizes that the pathway to improving MSAW access to care will depend on identifying and addressing needs and interventions both at the patient and population level. Traditional models of care that require patients to access health care services at brick and mortar facilities are impractical for MSAWs and must be complemented with innovative models bringing health care services to the community. To reduce access barriers and improve health outcomes for this structurally vulnerable population, recommended models should provide care in proximity to the agricultural communities, offer services at times outside of business hours, support adequate transportation to and from primary and specialty health care, and encourage culturally and linguistically competent staff and providers to better understand their health care needs.[lv]

The Council recommends addressing Stigma and Exclusion to Advancing Equity as follows:

- HHS initiate cross agency and department initiatives to address structural interventions that would promote MSAW health. For example, initiate collaborations with the Departments of Labor, Agriculture, Justice, Education.
- HRSA acknowledge and address the disproportionate impact of social stigma and exclusion on MSAWs related to their socioeconomic status, immigration concerns, the implicit challenges associated with moving from state to state, language barriers, cultural impact on health practice by raising awareness at the Health Center Program level and increasing health center capacity to:
  - Prioritize MSAW health care needs by setting aside appointments and providing more extensive and accessible urgent care services.
  - Train staff (front office and clinical) to appropriately screen, identify and refer people who are or have been traumatized.
  - Address perceived discrimination from MHC staff when seeking health care.
  - Equip staff and providers with appropriate resources and tools, such as structural competency, to understand structural vulnerability to address disparities in clinical care.
  - Establish collaborations with federal and non-federal partners engaged in anti-harassment efforts to increase capacity to better serve MSAWs and ensure consistent access to health and enabling services by collaborating with Migrant Head Start and the Title I, Part C, Migrant Education Program to cross train staff in screening, identification and referral for victims of harassment.
- HRSA funding demonstrate that it recognizes the unique and disproportionate level of MSAW disparities and prioritize its commitment to equity by:
  - Setting priority points for applicants that serve MSAWs in its funding opportunities, and
  - Provide financial incentives to M/CHCs recognized for providing high quality care to MSAWs.

The Council also recommends closing the Transportation Gaps by enabling the following:

- HHS promote and support transportation models that ensure all MSAW have timely access to basic health services and for and addressing serious medical crises as follows:
  - Initiating cross-agency efforts that address transportation related barriers by initiating collaboration between health policy makers, urban and rural planners, and transportation experts to create solutions that create sensible and affordable transportation options among MSAWs in rural areas.
  - The National Institutes of Health consider community-based transportation interventions as part of their community focused research interventions to develop innovative, cost-effective approaches to transportation for farmworkers that can be replicated in rural areas where there is limited public transportation.
  - Pilot, and if successful, finance options that provide safe transportation for agricultural workers while providing earning potential for rural residents who speak the language of most of the agricultural workers in their region.
  - Periodic review and assessment of transportation models to ensure that all MSAW can access health services expeditiously when they need them.
  - Encourage states to support the ability of MSAW to take safe driving classes and to have legal driving licenses, which will allow them to attend clinic appointments as well as to work in the food system more effectively. The MSAW testimonies we heard gave evidence for the importance of drivers licenses for attending health care appointments and for working in agriculture.

- HRSA, Bureau of Primary Health Care should:
  - Allocate funding for medical and dental mobile units that can travel to rural and isolated MSAW employment sites for service delivery.
  - Provide supplementary funding to enable MHCs to provide transportation for MSAW patients for ongoing preventive and primary care, and chronic disease management. This support will help prevent missed appointments eliminating delayed care, and missed or delayed medication/prescription use.
  - Fund capital investments for appropriate transportation vehicles, including their operational and maintenance costs.
  - Require MHCs to:
    - Establish a transportation provision plan that provides vouchers to transport MSAWs to health and enabling services appointments; gathers patient level data that is consolidated through the annual Uniform Data System reporting, and allow an analysis of transportation barriers (e.g., cost, mode of travel, public transit options, safety, and vehicle access).
    - Track transportation related data to correlate it to objective outcome measures such as missed appointments, rescheduled appointments, delayed medication fills, and changes in clinical outcomes. This would help clarify the impact of transportation barriers and the types of future transportation interventions needed as well as the steps in the transportation systems where obstacles most commonly occur.

The Council recommends addressing Clinic Hours, Wait Times and Scheduling Challenges as follows:

- HRSA address the barriers to seeking care associated with inappropriate M/CHC hours of operation, long and impractical waiting times for MSAWs to be seen by a doctor on the day of their appointment, followed by rushed encounters with providers. Challenges associated with navigating a complex health care system and long wait times for scheduling an appointment were also cited as deterrents to receiving timely appointments, and contribute to lack of rapport with health care systems and ineffective health care. The impact of these barriers is further complicated by the occupational migration of this population as they follow the harvest for employment and may need to move before appointment dates become available.
- In context of the evidence gathered from the testimonies, the Council recommends that M/CHCs:
  - Tailor their hours of operation to feasible out of business hours schedules that recognize that MSAW work demands and the inability to obtain time off during business hours prevent them from accessing services.
  - Recognize MSAW unique circumstances and needs, and respond by addressing these barriers through their appointment scheduling plan.
  - Build relationships of trust with local growers to schedule mobile unit visits to provide preventive, primary, dental and enabling services at work sites and migrant housing.
  - Employ and train linguistically and culturally sensitive staff and providers, including promotoras who understand the challenges of occupational migration and are equipped to respond appropriately.
  - Establish care plans for all MSAW patients including continuity of care coordination with M/CHCs along the particular migrant stream.
  - Receive financial support for interstate communication and coordination of health services.

The Council recommends addressing Continuity and Coordination of Timely Care.

As a result of the interstate and intrastate migratory patterns MSAWs follow due to temporary agricultural employment complicated by long wait times for appointments in many primary care and specialty clinics, many fail to receive timely care they need to address complex health conditions that result from the nature of the work they perform. It is critical that HRSA funded Primary Care Agencies, Health Center Controlled Networks and M/CHCs collaborate to ensure MSAWs receive the comprehensive array of health and enabling support services they need. The Council recommends that HRSA:

- Commit to evaluating that the care provided at migrant health centers conforms to the standards of care grounded in the evidence base available, and responds to MSAW social realities.
- Provide financial support for interstate communication and coordination of health services among grantees that support MSAWs as they migrate from state to state and/or collaborate with organizations that provide interstate communication and coordination of health services (such as, for example, Migrant Clinicians Network's Health Care Network).
- Create funding opportunities to address the critical staffing challenges faced by M/CHCs, to ensure a workforce that is equipped to support MSAW unique needs.
- Support and develop care coordination systems committed to data-sharing involving decisions at the provider level for tracking and monitoring ongoing health conditions and medication plans.
- Implement a fully integrated electronic health record system or client database for M/CHCs to track MSAW care coordination efforts.
- Provide funding to sustain and grow community health workers to help coordinate healthcare for individuals with complex health conditions and serve as a connection between the target population and health, human, and social services organizations.

The Council recommends Promoting Health Literacy, Including Health Systems Navigation Ability for MSAWs.

- Most MSAWs experience challenges navigating the US health care system. Additionally, they also lack information on the importance of routine physicals, dental check-ups and preventative screenings. M/CHCs can play an important role in addressing this barrier as follows:
  - Serve as a resource for MSAWs on how to use available health care services; and
  - Play a role in the development of health literacy resources for the community.
- The council recommends the creation of MSAW specific guidelines and resources to enhancing health literacy. These guidelines and resources tailor the Centers for Disease Control Health Equity Guiding Principles for Inclusive Communication[lvi] for health communication products to meet the cultural, linguistic, environmental, and historical context of the community. For example, this could include conversations around integrated health solutions, include material at a proper reading level for all patients and having staff that can communicate appropriately with patients in their primary languages.
- Informational sessions provide information and opportunity to ask questions about the U.S health system. This is particularly important for the MSAW community, to address the complexity of navigating the system in different states, public and private systems, clinics and hospitals, etc.[lvii]

The Council recommends Enforcing the Provisions of the Migrant and Seasonal Agricultural Worker Protection Act (MSPA) Housing Requirement.

- HRSA collaborate with DOL to ensure the implementation of the MSPA regulations established to protect agricultural workers from substandard and dangerous conditions. The MSPA requires housing inspection and compliance with federal and state safety and health standards, provides itemized statements of earnings and deductions, and ensures that vehicles for worker transportation meet federal and state safety standards and insurance requirements and that each driver is properly licensed. The goal of these regulations is to protect all farmworkers from substandard and dangerous conditions.

Background

Over 80 percent of US farmworkers are Latino, 95 percent of whom are immigrants.[lviii] Poor access to health services among Latino farmworkers stems from multiple factors: their rural locale, lack of health insurance in most states, lack of linguistically appropriate services and information, and structurally vulnerable status as immigrants. Agricultural workers are low paid, often uninsured employees in a hazardous industry. Health is a human right and unfortunately agricultural workers experience numerous barriers to realizing their human right to health.

Time constraints and risks of job loss prevented patients from seeking care. Regular clinic hours are not feasible as work demands and the inability to obtain time off during business hours prevent them from accessing services. Sometimes MSAWs who are not in control of their schedule leave work late in the afternoon or evening. Often, so as not to miss work and not lose their job, they are not able to seek care. Additionally, difficulty with scheduling appointments and delay in the availability of appointments is a barrier to health care services use. The next available appointment is often weeks, or months away. Once at the clinic, even with an appointment, testifiers experienced wait times of 2 to 5 hours. Migrant agricultural workers experience fragmented care from multiple providers and inadequate sharing of clinical information. This is critical for MSAWs with chronic or complex health conditions that require ongoing care and support. Coordination of care requires ongoing relationships and seamless interactions among multiple providers to support, manage and deliver care that best meets people's comprehensive health needs. Therefore, timely continuity and coordination of care is a priority.

Lack of transportation is a known barrier and is linked to the social determinants of health. A testifier at the NACMH meeting indicated that "In some instances the free transportation offered by a clinic in their area is only available at 7am, even when the appointment is scheduled for 3pm. When there is no other way to get to see the doctor, you have no other choice." Closing transportation gaps caused by poverty and the migration requirements of farmworkers is critical. Health centers with robust transportation support ensure that the location does not become a barrier to care.

Although MSAWs have migratory work requirements a significant number of them are transportation disadvantaged, many are dependent upon the transportation of crew leaders to new locales. Only 42 percent of MSAWs report having a car available for them to use in the United States; approximately 33 percent report having no transportation at all. And among those who have a car, there are difficulties obtaining a driver's license in many states, which would ensure safer transportation to and from work, the grocery store and health care. Thus, a large number of MSAWs are dependent on others (such as

their employers) for transportation to meet basic needs, including buying groceries, washing laundry, and obtaining health care services. The lack of transportation further exacerbates rural geographic and social isolation. When MSAWs are heavily dependent upon their employer to seek medical care, it becomes a potential conflict of interest for the employer, who may be unwilling to transport their employees to health care appointments during competing work hours. Although some MHCs have vans to transport patients, the number of vans is systematically reported as insufficient for the population by MSAWs and clinic staff alike. [lix] [lx] [lxi] [lxii]

Opportunities and Impact

MSAWs face unique barriers to care resulting from the nature of agricultural work, language barriers, transportation, lack of health insurance and financial challenges. Additionally, the inappropriate M/CHC hours of operation, long and impractical waiting times, and rushed encounters with providers continue to impact quality of care for MSAWs. Based on these facts and on the testimonies provided by the ten brave testifiers, the Council recognizes that traditional models of care alone are not sufficient to improve MSAW access to health. By HRSA developing well-defined strategies and implementing evidenced-based interventions to enhance health and welfare, it can effectively respond to the identified gaps and address some of the challenges associated with moving from state to state. There is an opportunity for developing nurturing collaborative partnerships with the Departments of Labor, Agriculture, Justice, Education to create cross agency and department initiatives that can address structural interventions that promote MSAW health. This also offers the possibility for HRSA-funded Primary Care Agencies, Health Center Controlled Networks and M/CHCs to collaborate to ensure MSAWs receive the health and enabling support services they need.

In closing, we appreciate the honor of serving on the National Advisory Council on Migrant Health. The Council recognizes the valuable role that agricultural workers play in our economy and in our 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,

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

cc:
Carole Johnson, Administrator, HRSA, HHS
James Macrae, MA, MPP, Associate Administrator, BPHC, HRSA, HHS
Jennifer Joseph, PhD, MSEd, Director, Office of Policy and Program Development, BPHC, HRSA
Esther Paul, MBBS, MA, MPH, Designated Federal Official, NACMH, BPHC, HRSA

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