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

May 24-25, 2023

Lutz, Florida

Meeting Minutes

Council Members in Attendance

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

Federal Staff in Attendance

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

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

Wednesday, May 24, 2023

Call to Order

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

Ms. Paul welcomed Council members and guests to the meeting of the National Advisory Council on Migrant Health (NACMH). She noted that the Council was written into statute in 1975 and has been providing the Secretary of HHS with recommendations on the health and welfare of migrant and seasonal agricultural workers (MSAWs) for 48 years.

Ms. Paul thanked the new and continuing Council members for their service. She extended special thanks to the Council Chair and Vice-Chair for their assistance in preparing for this meeting. Ms. Paul welcomed the distinguished speakers who would share their expertise and thanked them for their work on behalf of MSAWs. She welcomed guests from Migrant Health Centers (MHCs), other migrant-serving organizations, and her colleagues from HRSA and other federal agencies who were attending in person and virtually. She also thanked her colleagues the HRSA Office of Strategic Business Operations and the Office of Quality Information for their work to implement the Council's recommendations.

Ms. Paul pointed out that the NACMH is the only national-level body that advises the Secretary on the long-standing health and welfare concerns of MSAWs. Over the next two days, the Council would listen, learn, share firsthand experiences, and deliberate to make informed, evidence-based recommendations.

Ms. Paul called the meeting to order. She invited the Council to enter this time with determination to address persistent inequities and a resolve to be hopeful, because only hope can blaze a path forward.

Opening Remarks
José Salinas, EdD, Chair, NACMH

Dr. Salinas welcomed Council members to the meeting and thanked Ms. Paul for her leadership and support. He emphasized that the meeting was the starting point of the work with which the Council is charged; the real work would begin when members draft the letter to the Secretary. Dr. Salinas noted that the testifiers would look to the Council to be their voice, and he urged every member to participate actively in developing the recommendations that become part of the official letter.

Dr. Salinas called for a motion to approve the minutes of the November 2022 meeting. The motion was made by Ms. Laeger, seconded by Ms. Dodson, and carried by unanimous voice vote.

Dr. Salinas called for a motion to approve the agenda for this meeting. The motion was made by Dr. Viniegra, seconded by Ms. Huertero, and carried by unanimous voice vote.

Federal Update
Jennifer Joseph, PhD, MSEd, Director, OPPD, BPHC, HRSA

Dr. Joseph provided an update on the HRSA Health Center Program (HCP) and Migrant Health Center (MHC) grantees. Her presentation included an review of the HCP mission and impact, an overview of MHCs, an update on health center funding for fiscal year (FY) 2023, the president's budget for FY 2024, BPHC strategic priorities, a health center workforce initiative, modernization of the Uniform Data System (UDS), a framework to advance health center excellence, the impact of health center COVID-19 response programs, health centers' pivot to telehealth, health centers' response to Medicaid redetermination following the end of the public health emergency, support for health center participation in value-based care, interagency collaboration within HHS, efforts to accelerate innovation and sustain the impact of the Health Center Program, and initiatives to build partnerships at the local, state, and national level.

Health Center Program Mission and Impact

The mission of the HCP is to improve the health of the nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services.

In calendar year (CY) 2021, health centers expanded access to primary care, serving a record 30.2 million patients.[1] They advanced access to equitable care for medically underserved communities, serving patients who identify as racial/ethnic minorities, have incomes at or below 200 percent of the Federal Poverty Level, and/or experience barriers to care. Health centers also made strides in clinical quality, with upward trends in quality measures for maternal and child health, mental health, and screening and prevention after declines in 2020.

[1] HRSA Uniform Data System (UDS), 2020-2021

Migrant Health Centers – Overview

MHCs are funded under section 330(g) of the Public Health Service (PHS) Act to deliver comprehensive, high quality, culturally competent preventive and primary health care services to MSAWs and their families. Currently, 175 health centers receive Section 330(g) funding.

MHC grantees received approximately $1.1 billion in ongoing funding in fiscal year (FY) 2022. They served most of the MSAWs who were visited health centers in 2021 (888,337 of nearly 1,015,162).[2]

FY 2023 Funding Update

HRSA made a wide range of investments in FY 2023. Grants were awarded for three programs: Expanding COVID-19 Vaccination ($350 million, 1,471 awards), Accelerating Cancer Screening ($11 million, 22 awards), and Quality Improvement Fund-Maternal Health ($65.5 million, 35 awards).

Reviews are underway or will soon begin for four programs: National Training and Technical Assistance Partnerships ($23.5 million, approximately 22 awards), Ending the HIV Epidemic-Primary Care HIV Prevention ($34.75 million, approximately 100 awards), a new grant for Early Childhood Development ($30 million, approximately 150 awards), and School-Based Service Expansion ($25 million, approximately 70 awards).

HRSA will soon announce a new grant for health centers that sustained hurricane damage ($65 million, approximately 130 awards).

President's FY 2024 Budget

The president's budget for FY 2024 includes $7.1 billion for health centers, which represents an increase of $1.3 billion over the FY 2023 appropriation. The proposed budget increases mandatory funding over three years to provide a stable source of funding, creates a pathway to double funding over five years, supports health centers in serving three million additional patients, for a total of 33 million patients, and requires all health centers to provide mental health/substance use disorder services. Increased investments include $700 million in new funds to expand behavioral health services; $250 million to extend health center hours of operation; and $150 million in new access point (NAP) funding to expand service sites in areas of highest need.

The budget also includes $172 million for Ending the HIV Epidemic (an increase of $15 million), $85 million to support the expansion of early childhood screening in 275 additional health centers (increase of $55 million), and $20 million for cancer screening in support of the President's Cancer Moonshot initiative (increase of $10 million).

BPHC Strategic Priorities

The Bureau has three strategic priorities that are grounded in the HCP mission:

- Priority 1: Strengthen health centers to address critical and emerging health care issues and the evolving health care environment.

[2] UDS, 2020-2021.

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

Health Center Workforce Well-Being

HRSA recently conducted a survey to identify the key drivers of workforce well-being nationally. The survey included questions related to job characteristics (tenure, hours worked, years of experience), leadership (mission orientation, supervision, leadership, workplace culture and values, administrative burden), experience and attitudes (moral distress, meaningfulness, work-life balance, compensation and benefits, recognition, workload, workflow, decision latitude, team dynamics), resources (professional growth, training, resources), and demographics.

Nearly half of the HRSA-supported health centers participated in the survey, with a 36 percent response rate. HRSA is analyzing the responses and will use the findings to inform HRSA programs, policies, and training and technical assistance (T/TA) to improve workforce well-being.

HRSA intends to share the data widely. Preliminary dashboards were disseminated in April 2023 to provide health centers with top-level aggregate results. Final dashboards to be released this summer include an individual dynamic dashboard for each participating health center; a Primary Care Association (PCA) dashboard with aggregate results for the state and potential access to health center-level dashboards; and public access to dashboard results with no health center identification.

UDS Modernization

The UDS Modernization Initiative is a continuous effort to reduce the annual reporting burden, improve data quality to better measure the impact of services, and promote transparency. The initiative includes a new system for reporting patient-level data, known as UDS+.

More information is available at https://bphc.hrsa.gov/datareporting/reporting/udsmodernization.html

Advance Health Center Excellence

HRSA's new framework to advance health center maturity and innovation includes seven key domains that are aligned with its mission: quality, patient care and safety; patient experience; population health and social determinants/drivers of health (SDOH); access and affordability; workforce; financial sustainability; and governance and management. Health equity is the foundation of the framework. The domain areas interact to achieve a common aim of more systematic performance, with the ultimate goal of advancing health equity.

A health center can achieve various levels of maturity across domains (compliance-driven, fundamental, strategic, and leading), with the ability to move up and down.

HRSA is developing tools for health centers to assess their current performance in each domain, set goals to improve in one or more of the domains, and identify data-driven, evidence-based capabilities, activities, behaviors, and resources to reach a higher level of performance. HRSA's national T/TA partners (NTTAPs) are working with health centers to utilize the framework.

Impact of Health Center COVID-19 Response Programs

Health centers have been the model for ensuring equitable access to vaccines, antiviral therapeutics, testing, and masks. As of January 31, 2023, health centers ordered over 14 million vaccine doses, with 76 percent administered to racial and ethnic minorities and over three million to special populations; ordered 127,538 doses of therapeutics, with 59 percent administered to racial and ethnic minorities and over 15,000 administered to special populations; and ordered over 40 million self-test kits and 18 million masks.

As a result of these efforts, the public is looking to health centers to be responsive to all kinds of urgent and emerging issues and to help other agencies understand how to address the needs of underserved populations and bring an equity lens to their work.

Pivot to Telehealth

Health centers pivoted to telehealth and related flexibilities out of necessity during the pandemic. In 2021, 99 percent of health centers offered virtual visits, compared to 43 percent in 2019.

HRSA's first Quality Improvement Fund investment is looking at how health centers can optimize the use of telehealth for different populations.

HRSA updated the COVID-19 Frequently Asked Questions to clarify that health centers may deliver in-scope services through telehealth to individuals who are not current patients for the duration of the public health emergency (PHE) and released a draft Policy Information Notice (PIN) about the use of telehealth with new patients. They expect to finalize the policy within the next month.

Unwinding the PHE and Medicaid Redetermination

The end of the PHE comes at a challenging time for health centers. American Rescue Plan funds are being spent down, mandatory funding for the HCP needs to be reauthorized, and workforce challenges have increased the cost of care.

Medicaid redetermination will leave an estimated 50 million people without health insurance. To address this challenge, HRSA is sharing updates from the Centers for Medicare and Medicaid Services (CMS) with the HCP community and stakeholders and is leveraging its network of health center outreach and enrollment workers to support the anticipated surge in Medicaid enrollment.

Supporting Health Center Participation in Value-Based Care

HRSA is committed to helping health centers transition to value-based care that is focused on outcomes rather than visits. Resources include T/TA to support health information technology (HIT), data infrastructure, and capacity building; support for clinical quality and performance, including Patient-

Centered Medical Home (PCMH) accreditation; a new Quality Improvement Fund to advance care delivery; the Health Center Excellence framework to support health center innovation and performance improvement; and UDS+ patient-level data to help health centers target quality improvement and equity efforts.

Interagency Collaboration within HHS

HRSA is supporting the CMS Innovation Center (CMMI) in its effort to engage safety net providers in the 2021 Strategy Refresh to Advance Health Equity (https://innovation.cms.gov/strategic-direction). More information on that initiative will be available in the near future.

Accelerating Innovation in the Health Center Program

HRSA has several mechanisms to build health centers' capacity to innovate, including Quality Improvement Fund awards to test new ideas to transform primary care delivery, prize challenges to propose and test small-scale innovation to address SDOH and poor health outcomes, and leveraging partnerships with PCAs, Health Center Controlled Networks (HCCNs), and NTTAPs to deliver T/TA.

Strategic Initiatives to Advance and Sustain Health Center Program Impact

HRSA has five strategic approaches to maximize the impact of the HCP and address the need for expanded access: identifying the highest need areas for HCP expansion, identifying service expansion gaps and benchmarks, optimizing NAP funding to focus on areas with the highest need, the health center excellence framework, and the new BPHC 2035 initiative to help health centers respond to potential futures.

Building Partnerships

HRSA is committed to building and supporting local, state-wide, and national partnerships to maximize the impact of health centers. HRSA funds five NTTAPs to support MHCs: Farmworker Justice, Health Outreach Partners, MHP Salud, the National Center for Farmworker Justice, and Migrant Clinicians Network (MCN). HRSA welcomes the Councils recommendations regarding meaningful and effective partnerships to serve MSAWs.

Discussion

Dr. Holmes noted that health equity underlies all of the levels in the framework for excellence. He asked how HRSA considers the SDOH and structural factors that affect MSAW communities.

- Dr. Joseph replied that the framework is grounded in health equity. The purpose of the HCP is to disproportionately focus resources in areas or populations that are underserved. The model is evolving to focus more specifically on the domain of population health and SDOH, the kinds of things that health centers would do to move along the continuum of performance in that area, and the ways that domain cuts across all areas of performance. For example, equity is part and parcel of clinical quality, because part of that domain is using the data to understand the gaps in the population you serve and then changing your care delivery to close those gaps. Equity also ties in with the governing board. You can have a patient majority without having those members provide meaningful input that ensures the health center is most responsive to the patients it serves. HRSA wants health centers to question themselves and learn from each other what works in different settings to improve the health of populations that have been disenfranchised

and have multiple social drivers. The health center may not be able to address those factors, but they come into play in how care is planned and how the health center does its work.

Dr. Holmes said he is part of a network of organizations that are trying to make the frameworks even more specific.

- Dr. Joseph said HRSA would welcome input on the next level of the self-assessment guide.

Dr. Holmes commented that he works with indigenous farmworker communities that were the focus of the Council's recommendations two years ago. He expressed concern that many HRSA-funded clinics do not provide easy access for those farmworkers to communicate in languages they speak. He asked if that is addressed in the plan for health centers.

- Dr. Joseph replied that in recent years, HRSA has not had resources to support a major service expansion that would include enabling services that facilitate access to care, including translation.

Dr. Holmes noted that health centers in California that serve indigenous patients do not always have indigenous people on their board. As a result, the people who make decisions may not be fully aware of the needs of that population. He wondered how the Council could make a recommendation to encourage health centers to use that flexibility specifically for indigenous populations.

- Dr. Joseph said that it would be helpful for HRSA to have input on the space between what is required and what is optimal.

Dr. Viniegra asked how HRSA plans to use the increased funding for school-based clinics. The health center where he is on the board has a school-based clinic. Students and their families open up to providers about their lives, especially in the dental chair. Those conversations help the center identify issues and needs.

- Dr. Joseph replied that HRSA is receiving applications for the current funding opportunity, and the president's budget proposes additional investments. In some communities that means a new school-based site, in others it means adding one or more services at an existing site. Behavioral health services are required for all applications, and oral health services are an allowable use of funds.

Ms. Laeger asked if the proposed budget includes any approaches to increase the workforce.

- Dr. Joseph stated that the National Health Service Corps (NHSC) and the Teaching Health Center program have mandatory funding that needs reauthorization. There are many conversations at HRSA about how the president's budget would address that need because workforce development is critical. Bureau of Health Workforce (BHW) resources are not the only solution. It is important to look comprehensively at what HRSA can do to support health centers. There are good examples of health centers developing their own workforce. HRSA would welcome the Council's suggestions about how to help health centers support their staff and reflect the community they serve.

Ms. Huertero asked about strategies to address the gap in access to health care. She noted that new clinics have opened near each other in Southern California, while other areas have limited access.

- Dr. Joseph replied that HRSA has not had resources to expand access points since 2018. At that time, they received many more applications than they could fund with $50 million. There is a pent-up demand to expand into underserved areas. The president's budget includes $150

million for NAP grants. When HRSA funds are not available, health centers can add a new site by requesting a change in scope. HRSA looks at data in the area to make sure the proposed expansion would not compromise the viability of other health centers. HRSA introduced an "Unmet Need" score in 2019 to address that issue when funding is available. They are also looking at using priority points as an incentive to place sites in areas with the greatest need.

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

Ms. Gonzales-Hanson provided an update on changes in NACHC processes and procedures, health center legislative priorities for 2023, health center funding, health center workforce challenges and funding, a new initiative to save the 340B drug program, and the economic impact of health centers.

Transformation of NACHC Processes and Procedures

NACHC has gone through challenging times and is taking steps to ensure a better working environment and a stronger organization for the future, with a focus on community-governed primary care systems. NACHC values its partnerships with CHCs and MHCs, health center networks, PCAs, HRSA, and other organizations, which bring greater awareness of health centers and the populations they serve, including MSAWs and their families.

NACHC's board of directors will interview the top candidates for the CEO position when they meet in June. They hope to have someone in place by the end of the summer.

NACHC invested in staff development and completely revamped its organizational structure to ensure that they have the resources and skill sets to support over 1,400 health centers with 15,000 health care delivery sites. They also implemented a performance improvement plan and conducted outreach to strengthen existing partnerships and build new ones.

Health Center Legislative Priorities for 2023

NACHC's three legislative priorities for this year are critical to the foundation of the program:

- Health center funding: Expand the reach of the program to serve communities, deepen services to existing health center patients, and shore up existing health centers to address inflation and workforce challenges.
- Health center workforce: Advocate for continued funding that supports primary care providers and clinical support staff.
- ASAP 340B: Building consensus with likely allies and unlikely partners around a new approach to stabilize the 340B drug discount program and protect access for health centers.

Health Center Funding

The FY 2024 health center appropriations received strong bi-partisan support. NACHC is grateful for the advocacy of health center experts, health center staff, and PCAs.

The congressional health care agenda has many competing priorities beyond funding for health centers and workforce development. In negotiations over the debt ceiling some members of Congress have expressed interest in enforcing spending reductions and enacting further tax cuts.

Inflation has resulted in a $2.1 billion loss of health center purchasing power, and 100 million Americans lack reliable access to primary care. NACHC is aggressively pursuing health center funding to ensure that health centers remain a top priority for policymakers and that the funding is renewed on time, including funds for base adjustments.

The mandatory portion of the HCP grant, which is 70 percent of the budget, expires on September 30 of this year, along with mandatory funding for the NHSC and THC programs. At a minimum, Congress must renew both the mandatory funding and annual discretionary funding at current levels.

Health Center Workforce

The health center workforce has been a persistent challenge. Pre-pandemic staff shortages, growing salary gaps, burnout and fatigue, and early retirement contribute to the problem. A recent NACHC survey showed that health centers were losing staff at an alarming rate, particularly nursing and administrative staff. Nearly all of the health centers that responded said additional federal funding that would allow them to offer competitive salaries was a top priority.

NACHC is advocating for additional core funding for the NHSC and THC as well as funding for the nursing corps and nurse practitioner residency programs, behavioral health development programs, and a flexible, HRSA Innovation Fund that would allow health centers to develop a workforce that reflects the patients they serve. NACHC is working with the National Rural Health Association and the National Council on Mental Wellbeing to develop additional approaches to address this problem.

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

ASAP 340B is a collaborative effort to ensure that safety net providers have unfettered access to discounted medications for vulnerable and uninsured patients. The coalition includes NACHC, leaders from the biopharmaceutical industry, and advocacy organizations.

The 340B program has enabled health centers to reinvest savings to improve patient care, as Congress intended when the program was created 30 years ago. The program is in jeopardy due to restrictions by manufacturers and pharmacy benefit companies (PBMs) combined with abuses by some covered entities that are allowed to spend their 340B profits in ways that do not benefit patients.

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

More information on this initiative is available at https://www.asap340b.org. Questions may be directed to Vacheria Keys, JD, NACHC's Director of Policy and Regulatory Affairs (vkeys@nachc.com).

Economic Impact of Health Centers

In 2021, health centers served over 30 million patients for the first time in a single year. Health centers are an economic engine in their communities, supporting more than 500,000 jobs across the nation and creating nearly $85 billion in economic output and more than $37 billion in labor income.

Additional resources are available at https://www.nachc.org/.

Discussion

Ms. Freeman Lambar appreciated Ms. Gonzales-Hanson's comments on support for administrative staff losses at health centers. She noted that the recent growth, which began prior to the pandemic, places additional stress on management. She stressed the need to keep the infrastructure strong in addition to funding to increase services.

- Ms. Gonzales-Hanson replied that the need for infrastructure development is why the base adjustments are important. Without that funding, health centers are unable to grow or even support what they currently offer.

Mr. Mota said the 340B program is very important to the health center where he is a board member. He asked Ms. Gonzales-Hanson about the main source of opposition to the coalition.

- Ms. Gonzales-Hanson said the opposition comes primarily from large hospitals that might not be transparent about how they are using the savings. The coalition's strategy would allow eligible entities to continue to benefit from the program if they are willing to put the money back into services. The coalition is focusing on the safety net providers for whom the program was created because they have the fewest resources. She acknowledged that they might have to negotiate with the pharmaceutical industry, but a lower discount is better than losing the program. Other proposals do not have bipartisan support and do not address the problem.

Ms. Huertero asked if there is any research showing the possible implications if a solution is not found to the 340B problem.

- Ms. Gonzales-Hanson said the coalition is currently gathering data to quantify the impact and is working on a tool that health centers can use to determine how it would impact their budget.

Dr. Holmes asked how NACHC is working to highlight social and structural factors such as food insecurity, housing, and labor rights).

- Ms. Gonzales-Hanson replied that NACHC created a new position of Vice President for Public Priorities, with staff who are working to affect the social drivers of health, including environmental health, housing, and food insecurity. NACHC also created a screening tool, PRAPARE, that most health centers use to identify social and environmental drivers of health for their patients. NACHC is working with health centers to help them understand the issues and develop skills to address them. They are also working with partners that are familiar with those issues.
- Dr. Holmes said a network of people, including some MHCs, is beginning to focus on developing structural competency as a framework for addressing these issues. There is an ongoing study that could be interesting at some point.

Dr. Holmes asked how NACHC is addressing the needs of MSAWs who speak indigenous languages.

- Ms. Gonzales-Hanson acknowledged that this is challenging for health centers, because workers from a single country like Mexico can speak many different languages. Health centers are doing

the best they can, but it is not enough. It is important to understand the culture as well as the language.
- Dr. Holmes noted that some organizations in California provide interpretation services for indigenous Latin American languages.

Florida Association of Community Health Centers (FACHC)
Jonathan Chapman, MBA, President and CEO, FACHC

Mr. Chapman provided an overview of FACHC operational and policy concerns, state legislation impacting health centers, and migrant health programs at several Florida health centers. He also shared migrant health experiences and perspectives from outreach workers and other staff.

Florida CHCs

Federally qualified health centers (FQHCs) in Florida served 1,750,188 patients in 2021, an increase of 15 percent since 2017. They had more than 5.3 million in-person visits and more than 700,000 virtual visits.

One-third of Florida health center patients self-reported as a minority in 2021, and one-quarter said they were best served in a language other than English. Two-thirds were living below the federal poverty level (FPL), and 88 percent were living below 200 percent of FPL. About 30 percent were uninsured.

Florida has 47 Section 330 grantees and seven look-alikes. There are 817 Section 330 locations across the state, including mobile units and administrative sites, with nearly 12,000 total staff. The number of MSAWs or dependents they served declined from 52,726 in 2017 to 43,130 in 2021. Key factors were reduced agricultural acreage due to urban development and storm damage and problems identifying migrant patients correctly.

Health centers in Florida have an economic impact of more than $3.1 billion.

FACHC Clinical Operations

FACHC's Clinician Advisory Council provides strategic planning and guidance for clinical operations. Monthly Clinical Roundtables offer training and networking opportunities for Chief Medical Officers, Chief Dental Officers, and Behavioral Health Directors from health centers across the state.

The clinical work plan reflects HRSA priorities, including behavioral health integration, HIV prevention and treatment with a focus on PrEP, diabetes management, cancer screenings, with a focus on SDOH.

Special projects include partnerships with Southeast Regional Clinicians Network at Morehouse School of Medicine to identify post-pandemic lessons for clinical operations; NOVA Southeastern Medical School Geriatric Workforce and Education Program to develop geriatric-friendly programs, services, and spaces; the Florida Centers for Independent Living to educate providers on how to accommodate patients with physical barriers; the Florida Perinatal Quality Collaborative to increase referrals between hospitals and primary care for mothers and babies; Humana and the American Cancer Society to increase colorectal cancer screenings; and DentaQuest to increase access to oral healthcare for children with special needs. FACHC's Director of Clinical Operations serves on the Lieutenant Governor and State Surgeon General's Routine Screening Roundtable and on a range of Priority Area Workgroups at the Florida Department of Health as part of the State Health Improvement Plan.

State Legislation Impacting Health Centers

The Florida state legislature approved a budget that includes funding to create local partnerships that will use state and local funds for direct services and expand school readiness slots ($30 million); Dental Loan Repayment Program ($2 million); Health Care Education Reimbursement and Loan Repayment Program ($16 million); Low Income Housing Energy Assistance Program (LIHEAP) ($16 million); and the Medical Education Reimbursement and Loan Repayment Program ($10 million).

The budget does not include $10 million that was requested to help FQHCs with additional costs related to Medicaid redetermination for an estimated 900,000 Floridians.

The legislature approved Pharmacy Benefit Manager (PBM) reform to reduce the cost of pharmaceuticals for all patients, expansion of the Children's Health Insurance Program (CHIP) from 200 percent of FPL to 300 percent, and continuation of the audio-only telehealth reimbursement.

A new immigration law, Florida Senate Bill 1718, includes several provisions related to immigration, particularly undocumented workers. Transportation across state lines is now a felony, state and local funds cannot be used for the creation and use of identification cards, employers with more than 25 employees must use E-Verify, and hospitals who accept Medicaid are required to collect information on undocumented immigrants. Most of these provisions will not affect health center operations, but FACHC is concerned that hospitals will not see undocumented patients.

The state enacted limitations on COVID-19 vaccination and mask requirements and added a provision to protect providers who deny care due to a conscience-based objection. FACHC is waiting to see if there are ways in which the provider protection is misused.

Florida's conceal and carry law was expanded to include any type of weapon. Health centers have the right to ban weapons from their facilities, but patients can keep weapons in a car in the parking lot.

A new law prohibits the storage of personal medical information outside the U.S. It is unclear how this will be enforced, given the number of technology companies based in other countries and the use of satellite servers.

FACHC Experiences in Migrant Health

Outreach workers and other staff at Florida health centers raised concerns based on their experience working with MSAW patients:

- The new law requiring hospitals to report undocumented immigrants may discourage immigrants from seeking care anywhere or taking advantage of public programs for which they are eligible.
- The new law about transporting undocumented immigrants will compound transportation barriers.
- Many undocumented immigrants will be inclined to leave Florida, despite the fact that they have children who were born here (mixed-status families). This will have a profound impact on agriculture and other sectors, exacerbating labor shortages and food insecurity and increasing the price of food and other goods.
- The increasingly hostile immigration climate discourages undocumented immigrants from seeking help from law enforcement or assistance after hurricanes or other natural disasters.

- Florida agricultural employers increasingly rely on H2A workers who are documented, but those workers are subject to various degrees of abuse.
- Increasing temperatures put farmworkers at greater risk of heat-related illnesses. They are also the ones hardest hit by more frequent and more powerful storms, because they typically live in substandard housing, lack transportation, live in poverty, and are either ineligible for disaster assistance or afraid to seek it.

Mr. Chapman described migrant health services and concerns of three Florida health centers:

- MCR Health in Bradenton served 165,511 patients in 2021 (58 percent increase since 2017), including 3,041 MSAWs and their dependents. They have seen a recent increase in cancelled visits, patients moving out of state, and patients waiting until they are sick to seek health care. The health center has had increased operational costs and decreased revenue. Their strategies to reach the MSAW community include Spanish ads on Hispanic radio, word of mouth, and the use of financial counselors. Challenges for MSAW patients include the loss of work opportunities when orange groves are displaced by economic development and potential loss of health care coverage due to Medicaid redetermination.
- Community Health Centers, Inc. (CHC) in Orlando served 62,968 patients in 2021 (5 percent decrease since 2017), including 2,359 MSAWs and their dependents. They offer non-traditional hours to accommodate MSAWs' work schedules, and they routinely educate providers and clinical support staff on how to recognize symptoms of heat stress, exposure to pesticides, and signs of potential abuse. Challenges for migrant patients include transportation and fear of being asked for paperwork.
- Premiere Community Health Care in Dade City served 38,767 patients in 2021 (23 percent decrease since 2017), including 1,355 MSAWs and their dependents. They are partnering with the Pasco School District and Farmworkers Self-Help in rebuilding post-Covid. They train staff to recognize MSAWs and conduct MSAW focus groups, and they provide English and Spanish guidance for staff and patients. Some staff and the Board Chair are former MSAWs. Patients have voiced fear and experiences with raids. Some farms welcome their services, while others do not.

Discussion

Dr. Holmes noted that he volunteered with Doctors Without Borders in Immokalee at the beginning of the pandemic. They partnered with the health center in Immokalee, MCN, and the global health organization, Partners in Health. The health center network sent testing kits, and the coalition pooled money to provide housing for people who needed isolation. The coalition worked with a local multilingual radio station that brought in doctors and nurses to answer questions about Covid and translated their responses into Spanish, Hmong, and indigenous Latin American languages.

- Mr. Chapman said FACHC works closely with the health center network. They are a strong partner.

Ms. Freeman Lambar expressed concern about the emotional toll of the new legislation, especially for undocumented individuals. She asked how people are coping from a behavioral health standpoint.

- Mr. Chapman replied that FACHC staff are talking to legislators to understand the implications of the legislation. One outreach worker was concerned that the new law would divide families and force children to leave the state where they were born.

Ms. Huertero asked how FACHC determines what to track in order to measure the long-term impact on health centers of changes in immigration law.

- Mr. Chapman said there are many possible metrics. It will be important to track and measure the long-term effects of the legislation, because state laws can have a national impact.

Farmworker Testimonies

Migrant and Seasonal Agricultural Workers

The Council heard testimonies from 10 female MSAWs who work in Plant City, Florida and Michigan. They shared their experiences and concerns related to access to primary and specialty care, prevention and screening for cancer, health care costs and insurance, language and cultural issues, child development, mental health services, food security and nutrition, housing and environmental conditions, outreach and transportation, and changes in immigration law.

Access to Primary and Specialty Care

- A testifier said it takes her mother weeks or months to get an appointment for a physical, and she has to pay for childcare. Another testifier said it takes two weeks to a month to get an appointment when her children are sick.
- A testifier said she had a stroke when she was working in Michigan three years ago at age 20. She does not get the help she needs in Florida.
- Testifiers said the clinic in Plant City provides services for children, but not adults. They did not understand why.
- A testifier said Hispanics do not look for health care services, especially men. Her husband says, "It's better to be strong."
- A testifier reported that her health center is supposed to be open until 7 p.m. but they close at 5 p.m.
- Testifiers said clinics should provide more information when they make referrals, especially regarding costs and payment.
- A testifier said there is a clinic in one of the three locations where she works in Michigan, but appointments are often several months away. She was not aware of any mobile clinics.
- Testifiers said mobile clinics only provide quick check-ups and tests, such as blood pressure and vision tests.
- A testifier said mobile clinics go to the fields where she works in Michigan, and some clinics are open on Saturdays. She said the quality of health care in Michigan is better than in Florida.
- Testifiers described challenges transferring health records between states. They said it is easier to carry their records, but they have to call many times to get them and health centers charge them to make a copy. One testifier said a health center in another state lost her records. Testifiers were not aware of MCN's Health Network, a cost-effective virtual case management program that helps migrants with ongoing health needs to find care at their next destination.

Prevention and Screening for Cancer

- A testifier who had an abnormal pap smear said the health center gave her a referral but did not help her make an appointment. It was stressful to receive that news, and she did not know of any organizations that would help her.
- A testifier said she had to wait two months to get a screening from a specialist because she did not have insurance. She got an earlier appointment at a clinic that works with uninsured patients. She does not know what type of cancer she has.

- A testifier who was told that she might have cancer said she needs to work when she is sick so she can support her children. She was worried about leaving her children alone.
- A testifier said a health center in Michigan has dedicated days for cancer screening for women.
- A testifier said she had not been told about the risk of cancer when doing farm work. Another testifier said someone came to the field where she worked in Michigan and talked about the risk of cancer and the importance of annual testing.
- A testifier was concerned that the health center keeps postponing her appointment for a pap smear because the doctor is busy.

Health Care Costs and Insurance

- A testifier said she had to pay $100 for specialty care. They did not offer installments.
- A testifier said the health center prescribed a medication for her husband that cost $300.
- Testifiers said interpretation should be provided in person, not on a video screen.
- A testifier said her mother has a kidney infection and high cholesterol, but she will not go to receive care because it would be too expensive.

Language and Cultural Issues

- Many of the testifiers said that they speak Mixteco. One testifier said she did not speak Spanish until she was 15, and her parents do not speak Spanish.
- Testifiers reported that most MSAWs in Plant City speak one of two variants of Mixteco.
- Testifiers expressed concern that older people in their community who do not speak Spanish are not treated the same as other patients.
- A testifier reported that the health center refers her to places where no one speaks Spanish. She does not want to take her daughter out of college to be her interpreter.
- Testifiers reported that health centers no longer allow family members to serve as interpreters.
- Testifiers were concerned that clinics give fliers to people who cannot read.
- Testifiers said health centers should have bilingual staff, including those who speak Mixteco.

Child Development

- A testifier reported that her brother was behind in school. The Immokalee health center referred him to a speech therapist, but it was far away and her mother does not drive.
- A testifier reported that her son was referred to speech therapy and occupational therapy. The Early Steps program did not transition him on time, and he spent five months without therapy. She was concerned that she would have to interrupt his treatment and start over when she goes to another state, and she did not know if her son would get disability coverage.

Mental Health Services

- Testifiers said that people are under stress, but no one talks about mental health. People might be more open to receiving care if it was described as services for anxiety or depression.
- A testifier was concerned that farmworkers have no time to talk to someone about what they are experiencing.
- Testifiers said they did not know how they would pay for mental health care.
- A testifier said that she and her siblings experienced trauma when their father was deported. Other testifiers said their children have anxiety and stress.

- Testifiers were concerned about bullying and fighting in school. One testifier said many families struggle with teenagers, but no one wants to talk about it.
- Testifiers said schools need more counselors, including those who speak Spanish.
- A testifier was concerned that mental health providers are in a different county.

Food Security and Nutrition

- Testifiers said they will never let their children go hungry. They know people who put their children's food before their own health.
- A testifier said having enough food depends on whether you have work or money. Her mother has an Electronic Benefit Transfer (EBT) card and relies on food distribution programs.
- A testifier said she works 12 hours a day in a kitchen because there is not enough farm work.
- Testifiers said they get information from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) on how much food a child needs to be healthy.
- Testifiers were concerned that some people qualify for medical services, but not food assistance.

Housing

- Testifiers said housing is a challenge in Florida. Rent can be as high as $1,000 per month for a two-bedroom trailer shared by several families.
- Testifiers said that when they travel, they do not know what they will find until they get there.
- Testifiers described unhealthy conditions in migrant housing, including insects, snakes, rats, dirty carpets, holes in the walls and floor, and lack of air conditioning.
- Testifiers said they do not trust the drinking water in migrant housing. They buy bottled water to drink and boil tap water for bathing.
- Testifiers said that landlords take advantage of undocumented people by refusing to make repairs or cutting off water.

Environmental Risks

- Testifiers knew that heat stroke occurs when people work in the sun and do not drink water. One testifier reported that her cousin nearly died of heatstroke when he first started working.
- A testifier who picked strawberries in three locations said she never received any education about proper handwashing.
- A testifier said she heard you can get sick from dust, but she did not know what kind of illness or how to protect herself.
- Testifiers said farmworkers are only paid for what they produce. When there are crops to pick, they have to do as much as they can. Breaks are optional, and they are not paid for that time.
- A testifier reported that workers are scolded if they pause because they are tired.
- Testifiers described significant pesticide exposure. Sometimes the pesticide sprayer comes right behind them, other times they pick on one side of a field while they spray on the other side. Employers do not tell them what they are spraying, what complications they might experience, or what to do post-exposure.
- A testifier said she was trained about pesticide exposure when she first arrived in the U.S. Another said she received that information in Michigan.
- A testifier who experienced the hurricane in 2022 said citizens got help, but migrants got nothing. Another testifier said she received help from her children's school.

Outreach and Transportation

- A testifier whose husband needs dialysis said the clinic would not provide transportation.
- Testifiers said health centers need promotoras.

Immigration Changes in Florida

- Testifiers heard that clinics are cancelling appointments because they cannot provide services to undocumented patients.
- A testifier said she will not go to work if farms have to verify legal status.
- Testifiers said the changes are frightening for children. They are anxious about what will happen.
- Testifiers said people are not going to hospitals or appointments because they are afraid to be separated from their children.
- Testifiers said families are splitting up because some members do not have work permits.

Wrap Up and Adjourn
José Salinas, EdD, Vice-Chair, NACMH

Dr. Salinas adjourned the meeting for the day at 4:51 p.m.

Thursday, May 25, 2023

Call to Order
José Salinas, EdD, Vice-Chair, NACMH

Dr. Salinas called the meeting to order and thanked Council members for a productive first day.

Recap from Previous Day
Donalda Dodson, MPH, RN, Vice-Chair, NACMH

Ms. Dodson summarized the first day of the meeting, highlighting key points and takeaways from the presentations and testimonies.

Agricultural Worker Health: Addressing Barriers to Cancer Screening, Diagnosis, and Treatment
Cathy D. Meade, PhD, RN, FAAN, Senior Member/Professor, Tampa Bay Community Cancer Network, Moffitt Cancer Center
Margarita Romo, Founder and Executive Director, Farmworkers Self-Help, Inc.
Diana Lopez, RN, Director of Nursing, Suncoast Community Health Centers, Inc.

Dr. Meade moderated a panel on MSAW health, with a focus on cancer screening, diagnosis, and treatment for MSAWs. The speakers discussed the cancer burden for MSAWs, described effective, community-based programs, and provided recommendations to address cancer disparities.

Cancer Statistics

About two million individuals will be newly diagnosed with cancer in the U.S. this year, including about 162,410 in Florida. About 610,000 people in the U.S. will die from cancer this year.

At least 42 percent of newly diagnosed cancers are preventable. Almost half of cancer deaths are linked to preventable causes, such as tobacco use, exposure to ultraviolet light or chemicals, obesity, and vaccine-preventable infections.

The continuum of cancer care begins with understanding the origin of the disease and continues through prevention, detection, diagnosis, treatment, and survivorship. Interventions in the areas of cancer prevention and early detection would have the greatest impact for MSAWs.

Unlike other populations, it can be challenging to find resources and support for cancer survivors in MSAW communities.

Cancer Disparities

The National Cancer Institute (NCI) defines cancer health disparities as adverse differences between population groups in cancer measures such as incidence (new cases), prevalence (all existing cases), morbidity (cancer-related health complications), mortality (deaths), survivorship and quality of life after treatment, burden of cancer or related health conditions, screening rates, and stage at diagnosis.[3]

Health disparities have no single cause and no single solution. SDOH contribute significantly to inequity. MSAWs suffer disproportionately from cancer due to agricultural-exposures and social factors such as lower income, limited health literacy, travel distance to screening sites, and lack of health insurance, transportation, or medical leave. They are less likely to have recommended screening tests and to be treated according to guidelines than those who do not encounter those obstacles.

A person's ability to navigate the healthcare system depends on factors such as where they are from, their perceptions and beliefs, insurance status, and experience with the immigration system. As the farmworker testimonies demonstrated, transportation and travel time are major barriers to care for MSAWs, along with the need for services and information in an appropriate language.

The "discovery to delivery" disconnect is a determinant of the unequal burden of care. Grassroots outreach is important to share research discoveries with the farmworker community.

Cancer Burden for MSAWs

Epidemiologic data on cancer among MSAWs is limited, varied, and inconsistent because it is difficult to study populations who move often and have differing exposures or environmental conditions. Research among farmworker communities has found higher incidence of oral, lip, stomach, and skin cancers; higher mortality rates for stomach cancer; higher rates of late-stage breast cancer and poorer survival; higher rates of prostate cancer among men and multiple myeloma and melanoma among women; increased risk for chronic health conditions; and low utilization of cancer screenings.[4]

Cancer risk conditions for MSAWs include agriculture-related exposures to UV light and chemical pesticides that contain carcinogens. More information is needed about occupational health measures, general cancer patterns, demographics (race/ethnicity), work setting/environmental exposures, and lifestyle and psychosocial factors in this population.

---

[3] https://www.cancer.gov/about-cancer/understanding/disparities

[4] Togawa et. al., 2021; Kugel & Seda, 2021; Colt et. Al., 2001; Dodd et. Al., 2016; Kachuri et. al., 2017; Knoff et. al., 2013; Matias et. Al., 2022; Mills et. Al. 2009.

Reducing Cancer Disparities

Strategies to reduce cancer disparities in MSAWs must include cancer prevention, education, and community engagement.

- Prevention: Research, national policies, and educational programs are needed to raise awareness, reduce exposure to cancer risk factors, and ensure that people receive the necessary cancer prevention information, access, and support.
- Education: Agricultural workers need information about the importance of prevention and screening, what symptoms to look for, how to access the healthcare system, and how to get treatment, follow-up care, and support. Inclusion, trust, and appropriate content are critical.[5]
- Community engagement: Mutually beneficial, intentional partnerships and civic collaborations expand access to resources and create linkages to follow-up care. Bi-directional outreach and community-academic partnerships are critical elements.[6]

The Tampa Bay Community Cancer Network (TBCCN) is a model for effective community-academic partnerships. The network was formed in 2005 by the Moffitt Cancer Center and more than 30 community partners to reduce cancer health disparities through outreach, training, and research, with a focus on prevention. TBCCN initiatives include a promotora-led cervical cancer education intervention among women from a farmworker community (¡Es Por Mi Bien!); a low-literacy, dual language intervention to promote colorectal cancer (CRC) screening in community clinics (Community Cares); and an evidence-based intervention (CARES-REACH) to increase rates of effective CRC screening in clinics in central and southwest Florida, with a focus on repeat screening.

Communications and Health Literacy

Healthy People 2030 distinguishes between personal and organizational health literacy. Personal health literacy is the degree to which individuals can find, understand, and use information and services to inform health-related decisions and actions for themselves and others. Organizational health literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Efforts to improve individual health literacy should pay equal attention to the role of community-based organizations and healthcare and government systems in communicating health information effectively. The mnemonic device "Get REAL" can help organizations develop communications materials that are Relatable, Engaging, Actionable, and Literacy-friendly.

Recommendations

Dr. Meade offered the following recommendations to address cancer disparities among MSAWs:

- Cancer prevention and early detection: Ramp up cancer prevention efforts through established screening, education, and detection methods. For example, support and fund the expansion of mobile units and neighborhood outreach.

---

[5] Meade, CD. Community Health Education and Engagement. *Community/Public Health Nursing: Promoting the Health of Populations (*8th ed.), in MA Nies & M McEwen (eds). St. Louis: Elsevier. (2022), pp 129-166 [Chapter 8].
[6] Clinical/Translational Science Awards Consortium, Community Engagement Key Function Committee. Task Force on Principles of Community Engagement; https://www.atsdr.cdc.gov/communityengagement/pce_what.html USDHHS 2011 -NIH Publication No. 11-7782; World Health Organization, Jones et al., 2020; Meade 2022

- Education/training: Build a cadre of well-trained community outreach workers/promotoras. For example, train-the trainer programs for cancer education (e.g., pesticide education), health literacy, and navigation skills. Link these efforts to early childhood health programs.
- Networks: Strengthen and expand community capacity via intentional collaboratives and partnerships to advance coordinated cancer prevention, diagnosis, timely treatment, and follow-up and survivorship efforts.
- Advocacy access: Promote enhanced access, financial coverage, and reimbursements for cancer care actions at the national level, including cancer screenings, diagnostics, follow-up care, and vaccinations.
- Research: Strengthen and support the evidence base of research and education approaches to advance cancer prevention, diagnosis, treatment, and survivorship efforts that address the local context. For example, earmark funding for partnership projects with local communities.
- Dissemination: Expand the availability of resources in the HRSA data warehouse to facilitate sharing of evidence-based practices, curricula, measures, and culturally and language-specific resources and tools for use by migrant and community health centers.

Insider Perspectives

Ms. Romo said the testimonies from the previous day raised issues that she encountered in her community 40 years ago. Farmworkers Self-Help has accomplished a great deal, but there is much more to do. Many agricultural workers cannot get to the services that exist.

Ms. Lopez said her health center is trying to get back to where they were before the pandemic. They have struggled with staff shortages in all areas. They have had a mobile medical unit since 2015, but they have only been able to take it into camps to provide services to H-2A workers in the past three years; they would like to expand that effort. Health centers need support at the community level, including other agencies. It is important to hold health centers accountable for what they said they would do. Health centers in Florida are trying to determine the impact of the new legislation and are letting the MSAW community know that health centers are a safe place for them. Her center is focused on reminding patients of the importance of preventive services that they missed during the pandemic.

The panelists discussed how cancer screening and detection could be improved. Ms. Romo noted that MSAWs face multifaceted problems, and she emphasized that information must be disseminated in a way that they can understand. Farmworkers Self-Help emphasizes education, advocacy, and organizing. They recently received a grant for their cancer education program for women (Project Well), and they have a four-acre park where they hold health fairs and host weekly visits by a mobile unit that offers mammograms and diabetes screening. They have gained many partners over the past 40 years, beginning with TBCCN. Ms. Romo noted that programs like hers can educate people, but they need to know where to send them for services.

Ms. Lopez stated that health centers need promotoras to educate patients about the importance of screening, and they need navigators to connect patients to treatment. She expressed concern that few specialty care providers accept uninsured patients, and she noted that patient portals and telemedicine can make it challenging for MSAW patients to utilize the healthcare system.

Discussion

Dr. Salinas commented that services have improved in the past 30 years, but the farmworker population has changed. The higher proportion of foreign workers brings challenges that did not exist in the past.

Dr. Viniegra stated that telehealth creates additional barriers because people need Internet access and an appropriate device, and they need to know how to use the technology. Screens do not adequately permit doctors to detect signs of domestic abuse, malnutrition, or co-morbidities. Dr. Viniegra noted that there does not seem to be any funding for research on telehealth as a barrier, and he asked the panelists about their experience with telehealth.

- Ms. Lopez replied that her health center began to use telehealth at the beginning of the pandemic, when patients would stay in their cars and the provider would conduct a virtual visit. They now have a portal for patients to set up telehealth appointments. They are working on creating guidelines for the types of services that are appropriate for telehealth visits. Telehealth is allowed for new patients, but they must be seen in the clinic within a reasonable time to establish a face-to-face relationship. There has been a learning curve for providers, but the health center would like to expand this service. Ms. Lopez noted that telehealth does not work as well as in-person visits for some migrant patients.
- Ms. Dudley commented that telehealth has helped to overcome the lack of providers who can go where people live.

Ms. Dudley noted that the Council's recommendations should be as specific as possible. She asked the panelists to identify their top three priorities.

- Ms. Lopez said her priorities were mobile units, promotoras/community health workers/navigators, and programs to encourage primary care providers to work in CHCs. Health centers need providers that understand the population and want to continue the work that has been done in this setting for the last 50 years.
- Ms. Romo cited the need to prepare healthcare professionals for the reality of working in poor communities and to train front desk staff to treat patients with respect.
- Dr. Meade stressed the need for engaging education that has a human touch, and integration with existing programs in the community, with a focus on youth. She emphasized the value of community-academic partnerships.

Ms. Dudley commented that outreach workers and promotoras at the health center where she serves on the board have provided cancer education by talking to people waiting in line at events such as mobile consulate visits.

Ms. Huertero noted that the testimonies mentioned the need to pay for referrals. She asked if 340B savings could be used to subsidize those costs for patients.

- Ms. Lopez replied that health centers need the 340B program to provide low-cost medications to their patients. In-house pharmacies remove barriers. Health centers always need funds for additional programs, and they need visionaries to make things happen. It is hard to work with specialists who do not understand their population.

Early Childhood Health and Welfare Concerns of Migrant and Seasonal Agricultural Worker Households

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

Dr. Rosado described three high-priority gaps in the status of young children from MSAW households and offered evidence-based recommendations to improve screening, prevention, and interventions for

adverse childhood events (ACEs), toxic stress, and cumulative exposure to chemical and non-chemical stressors.

Gap/Unmet Need 1: ACEs and Toxic Stress Prevention among MSAW Families

Toxic stress is the extreme, frequent, or extended activation of the stress response that causes distress for the child and may lead to negative psychological and physical health outcomes.

Young children from MSAW families commonly experience adverse events that can cause toxic stress. Children may experience physical, emotional, or sexual abuse or physical or emotional neglect. They may also experience household dysfunction, such as a caregiver with untreated mental illness, an incarcerated relative, domestic violence, substance abuse, and/or divorce. Household dysfunction makes it difficult for children to form meaningful relationships that can buffer the effect of toxic stress.

Agricultural families are also impacted by adverse events beyond the household, including job-related stress, deportation fears, discrimination, family separation, historical trauma, transient lifestyle, and inadequate housing.

ACEs increase the risk for health conditions and problems during adulthood, and toxic stress from ACEs negatively impacts childhood development related to the brain, the immune system, and the stress-response system. Children with six or seven risk factors have a 90 to 100 percent chance of a developmental delay by age three that is serious enough to require special services when they reach school. Later in life they are more likely to smoke, use alcohol frequently, and face higher unemployment rates. They are also less likely to graduate from high school and to have health insurance. Fortunately, some negative health impacts can be reversed through appropriate prevention or treatment.

Gap/Unmet Need 2: ACEs and Toxic Stress Prevention Strategies with a Two-Generation Approach

ACEs can have an intergenerational effect. Parental ACEs increase the risk for developmental delays in their children, with negative consequences cycling through a lifetime and across generations.

Integrated care is an effective approach for toxic stress screening and prevention in MSAW families. Integrated care involves an interprofessional team working together to develop a treatment plan to address a family's mental health, health behaviors, and life stressors. Integrated care should include the use of clinical pathways, which are structured workflows for specific conditions to ensure that patients receive help from the right people at the right time.

Implementation science is the scientific study of methods and strategies that facilitate the uptake of evidence-based research and practice by practitioners and policymakers. Dr. Rosado's team uses the Exploration-Preparation-Implementation-Sustainment (EPIS) model, in which change is implemented in stages or steps. Providing health centers with an implementation science framework would help to ensure that mandated interventions are effective, meaningful, and sustainable.

Dr. Rosado's team at the Center for Child Stress & Health at the Florida State University College of Medicine has developed a two-generation approach for primary care toxic stress screening, prevention, and treatment for MSAW families (the Caracol project). The clinical pathway for the project includes screening expectant mothers for ACEs on their first pregnancy visit, consultation by a mental health provider, and introduction to an infant and early childhood mental health (IECMH) specialist who links

the family to resources, child development screening, and parental support and education. The child's development is monitored for the first five years of their life. This approach ensures that the family has the critical protective factors that the child needs to prevent adverse experiences.

Gap/Unmet Need 3: Prevention and Treatment of Cumulative Exposures to Chemical and Non-chemical Stressors Among Children from MSAW Families

Exposures to mixtures of chemical environmental contaminants, such as pesticides, and non-chemical environmental stressors, such as ACEs, create pathological synergies that can lead to additional health risks to children from MASW families.[7] Children may be at greater risk to environmental contaminants than adults due to differences in behavior and biology.[8] Pollutant exposure during pregnancy and early childhood has been associated with adverse neurodevelopment, childhood cancers, and other adverse health outcomes.[9] Children in farmworker communities may be exposed to agricultural chemicals through ambient air, water, and soil.

Dr. Rosado's team applied for a grant from the Environmental Protection Agency (EPA) to do a study and intervention on the synergy between toxic stress and environmental hazards. If funded, they will add screening for environmental hazards to the existing schedule for the Caracol project. Chemical exposure will be measured through hair and urine samples from expectant mothers, periodic biospecimen samples from the child, water and air samples at the child's home, and air samples at childcare centers. They are planning a pilot study to test the use of skin patches to analyze exposure.

Recommendations

Dr. Rosado offered recommendations to address ACEs and toxic stress among MSAW families:

- Improve screening, prevention, and interventions for toxic stress in primary care settings.
- Utilize two-generation (parent-child) approaches in the prevention and treatment of toxic stress.
- Use integrated care teams (including non-traditional interdisciplinary members) to develop meaningful and innovative clinical pathways to provide interventions for at-risk families.
- Utilize implementation science strategies and models to ensure the effectiveness of interventions.
- Encourage university-MHC partnerships to improve and enhance healthcare services.
- Address cumulative exposures to chemical and non-chemical stressors among children from MSAW families.
- Develop methods and approaches to measure exposures and characterize health risk from cumulative exposures to chemical and non-chemical stressors.
- Prioritize the implementation of efficient and effective prevention and intervention measures.
- Establish partnerships with federal agencies such as the EPA for synergy around the intersection of chemical and non-chemical stressors and health outcomes for children from MSAW families.

[7] Lewis, A. S., S. N. Sax, S. C. Wason and S. L. Campleman (2011). "Non-chemical stressors and cumulative risk assessment: an overview of current initiatives and potential air pollutant interactions." Int J Environ Res Public Health 8(6): 2020-2073.

[8] U.S. EPA, Environmental Protection Agency (2021), Policy on Children's Health. Washington, DC: EPA Printing Office. (https://www.epa.gov/system/files/documents/2021-10/2021-policy-on-childrens-health.pdf)

[9] U.S. EPA, Environmental Protection Agency (2005), U.S. EPA. 630-P-03-003F. Guidance on Selecting Age Groups for Monitoring and Assessing Childhood Exposures to Environmental Contaminants.

- Bring together stakeholders through national strategies that draw on public and private resources for capacity- and knowledge-building to combat the pathological synergies produced by exposure to chemical and non-chemical stressors.

Discussion

Dr. Viniegra noted that historical trauma has been widely studied among descendants of Holocaust survivors and is increasingly studied among African American and Native American populations. Based on data from these groups, it would be safe to assume that historical trauma is present among MSAWs. A good starting point would be to provide training for primary care providers on ACEs, historical trauma, and co-morbidity. Dr. Viniegra asked how the model Dr. Rosada presented could be implemented in sites that are struggling to have a promotora or a mobile unit and for people who are struggling to access and afford care.

- Dr. Rosada agreed that it may be necessary to work under the assumption that everyone is impacted to a certain extent by historical trauma. Regarding implementation challenges, he noted that the health center where he works added one component at a time. The university-FQHC partnership provided funding opportunities as well as a new generation of professionals who have innovative ideas and are not afraid to do things differently. The extensive advocacy work in Immokalee helped them get funding from private, non-profit organizations.

Dr. Holmes thanked Dr. Rosada for including structural and social adverse experiences in his model of ACEs. Those factors are extremely important for the MSAW population, and they are often left out of traditional models. He asked how Dr. Rosada's program keeps structural ACEs in mind and how the program implements the screening schedule, given the mobility of MSAW families.

- Dr. Rosada replied that the program stays connected to families when they migrate, although there are limitations to what they can do across state lines. The IECMH specialist follows up with families continuously, and some of the work is done virtually. Most of the families consider Immokalee their home and return to the health center at some point. The program is notified whenever patients come into the health center and uses those alerts to catch up with them. Regarding structural ACES, he noted that it is impossible to screen for every potential stressor. Some issues can be identified during home visits, but most are captured during their encounters with the families. It is less about screening, and more about relationship building.

Travel Reimbursement Processing
Elaine Garrison, BPHC, HRSA

Ms. Garrison reviewed the process for reimbursement of travel expenses and noted that the deadline for submitting the travel voucher and non-meal receipts was June 2. She encouraged Council members to contact her by email or phone if they have any questions.

Facilitated Discussion on Possible Recommendations to the Secretary of DHHS
Marco Antonio Viniegra, PhD

Dr. Viniegra facilitated a discussion of key issues that emerged from the presentations and testimonies to identify priorities for specific, actionable recommendations to improve health and healthcare for MSAWs. Throughout the discussion, Council members emphasized the importance of adopting a health-in-all-policies approach to address the social drivers of health.

The Council consolidated an initial list of 15 topics into three priority areas: the impact of immigration policy on health; ACEs, child health, and maternal health in a structural social context; and eliminating barriers to care.

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

Meeting Wrap Up and Adjourn
José Salinas, EdD, Chair, NACMH

Council members suggested potential topics for the November 2023 meeting, including emergency preparedness; update from MCN; access to education for MSAW children; affordable housing communities; health literacy/educational base for health; digital literacy and access to telehealth; staff retention and training; and the impact of stigma on treatment of MSAW patients, including mixed-status families.

Council members agreed that input from MSAWs is critical to develop effective recommendations. They discussed how to modify the format of testimony sessions and the possibility of including testimonies from providers and staff.

Ms. Paul noted that Dr. Salinas and Ms. Dodson's terms as Chair and Vice-Chair would end on July 3, 2023, and she announced that the Secretary appointed Dr. Viniegra and Ms. Huertero to serve one-year terms as Chair and Vice-Chair, respectively, as of July 4, 2023.

Ms. Paul thanked the Council members, HRSA staff, and logistics providers for a successful meeting.

The meeting was adjourned at 4:45 p.m.