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

November 2-3, 2022

Rockville, Maryland

Meeting Minutes

Council Members in Attendance

Jose Salinas, EdD (Chair)
Donalda Dodson (Vice-Chair)
Marisol Cervantes
Angelina Vallejo Cormier
Mary Jo Dudley
Dani Higgins
Maria del Carmen Huertero
Elizabeth Freeman Lambar
Colleen Laeger
Carmen Veguilla-Montañez
Marco Antonio Viniegra, PhD
Karen Watt

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, November 2, 2022

Call to Order

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

Ms. Paul welcomed members and staff to the meeting of the National Advisory Council on Migrant Health (NACMH), which was the first in-person meeting in three years. She noted that the Council has provided recommendations on the health and welfare of migrant and seasonal agricultural workers (MSAWs) since it was established by legislation in 1975. During this meeting, current members would carry on that charge in the footsteps of their predecessors.

Ms. Paul thanked HRSA staff for logistical support and called the meeting to order.

NACMH Chair Opening Remarks

Jose Salinas, EdD, Chair, NACMH

Dr. Salinas welcomed Council members to the meeting and thanked Ms. Paul for providing guidance and support that makes it possible for the Council to focus on important issues.

Dr. Salinas noted that this was his first meeting as chair, and would be the last meeting for Dani Higgins, Angel Calderon, and Carmen Veguilla-Montañez. He thanked the retiring members and former chair Deb Salazar for their meaningful contributions to improve the lives of MSAWs.

Dr. Salinas noted that the agenda for the meeting would focus on recruiting and training of migrant health center (MHC) staff, kidney disease among agricultural workers in the U.S., and prevention of human immunodeficiency virus (HIV) among MASWs.

Ms. Veguilla-Montañez made a motion to approve the meeting agenda as presented. The motion was seconded by Ms. Dodson and carried by unanimous voice vote.

Ms. Huertero made a motion to approve the minutes of the May 2022 meeting. The motion was seconded by Ms. Dodson and carried by unanimous voice vote.

Federal Update
Diana Espinosa, Deputy Administrator, HRSA
Jennifer Joseph, PhD, MSEd, Director, OPPD, BPHC, HRSA

Ms. Espinosa thanked the Council for its support of HRSA and the Health Center Program. She emphasized that it is important for HRSA to hear from stakeholders in order to address challenges and provide the best care for patients, and she noted that NACMH is the only federal advisory committee that provides recommendations on health care for MASWs.

HRSA plays an essential role in increasing access to quality care across the nation through more than 90 programs and over 3,000 grantees. HRSA has funded a growing number of community-based efforts in recent years. Each year, the Health Center Program serves an increased number of patients, with a strong focus on quality.

The Health Center Program began with the signing of the Migrant Health Act in 1962. NACMH was established by Congress in 1975 to provide patients and providers with first-hand knowledge of the challenges facing MSAWs. HRSA is grateful for the Council's 47-year history of striving to improve the health and welfare of the nation's MSAWs. Most Council members serve on the governing board of their local health center, which further strengthens the Health Center Program. The Council's biannual recommendations to the HHS Secretary and the HRSA Administrator enhance BPHC's ability to assist health centers through policy and programs, training and technical assistance, and data and information sharing with other federal and non-federal collaborations and partnerships.

Secretary Becerra has five clear priorities to address national challenges in health and human services: ending the COVID-19 pandemic, reducing health care costs, expanding access to care, tackling health disparities, and strengthening behavioral health. Each of those priorities has a direct impact on the health and welfare of MSAWs.

Ms. Espinosa wished the Council a productive meeting and assured members that HRSA and HHS were looking forward to receiving their recommendations.

Dr. Joseph thanked Council members, Ms. Paul, the interpreters, and the logistics team for their commitment to the Council's work and provided an update on the HRSA Health Center Program.

Health Center Mission and Impact

The mission of the Health Center Program 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. For 60 years, health centers have worked to reduce health inequities by increasing access to affordable, high-quality health care for millions of people.

In 2021, HRSA-funded health centers provided comprehensive primary care to 30.2 million patients, a 43 percent increase since 2012. Health centers rebounded from the effects of COVID-19, with the total number of health center patients and visits returning to pre-pandemic levels, and they served increased numbers of patients experiencing barriers to care. While in-person visits increased across all service categories, health centers worked to optimize telehealth by providing 26.1 million virtual visits in 2021, representing 21 percent of all patient visits. Clinical quality improved in 13 of 18 measures from 2020 to 2021. Decreases in scores for low birth weight, childhood immunizations, tobacco use screening, body mass index (BMI) screening, and use of aspirin for ischemic vascular disease were not dramatic.

Since its inception, the Health Center Program has recognized the impact of social determinants of health (SDOH). Nearly three-quarters of health centers screened patients for social risk factors in 2021, and 21 percent plan to do those screenings in the future.

Health Center Program Funding

In fiscal year (FY) 2022, the Health Center Program received approximately $1.1 billion in ongoing funding, in addition to COVID funds that can be carried forward through March 2023. The investment supported six priorities:

- Optimizing Virtual Care: $54.6 million for 29 awards
- School-Based Service Sites (SBSS): $25 million for 125 awards
- Health Center Controlled Networks (HCCN): $44 million for 49 awards
- ARP-Uniform Data System Patient-Level Submission (ARP-UDS+): $88.6 million for 1,354 awards
- Ending the HIV Epidemic – Primary Care HIV Prevention (PCHP): $20.6 million for 64 awards
- Accelerated Cancer Screening (ACS): $5 million for 11 awards.

The federal government is operating under a continuing resolution (CR) that carries forward funding from the previous year. The President's budget includes the following priorities for FY2023:

- Early Childhood Development: $85 million
- Ending the HIV Epidemic – Primary Care HIV Prevention (PCHP): $50 million
- School-Based Service Sites (SBSS): $20 million
- School-Based Health Centers (new program): $50 million
- Contraceptive Care: $25 million
- Cancer Screening: $10 million
- Quality Improvement Fund – Maternal Health: $25 million for 12-15 awards
- National Training and Technical Assistance Partners (NTTAP): $23.5 million for 22 grantees, including five that support MSAWs.

BPHC Strategic Priorities

BPHC has three priorities to increase access to the health center model of care, improve health outcomes, reduce health disparities, and advance health equity for underserved populations:

- Priority 1: Strengthen health centers to address critical and emerging health care issues and the evolving health care environment
    - Support the health center workforce
    - Advance health center excellence
    - Strengthen the 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
    - Introduce patient-level data reporting
    - Engage in value-based care delivery
    - Promote innovation.
- Priority 3: Expand the reach of the health center model of care in the nation's highest need communities and populations
    - Support comprehensive care service delivery
    - Reach high-need communities
    - Build new partnerships.

Framework to Advance Health Center Excellence

BPHC's framework to assess value-based care takes payment out of the equation. It includes seven performance domains that are critical to increase health center excellence and achieve health equity: quality, patient care, and safety; patient experience; population health and social determinants; access and affordability; workforce; financial sustainability; governance and management. BPHC is committed to helping health centers utilize the tool to assess their needs and advance across the domains.

Strengthen COVID Response and Future Preparedness

HRSA reviewed its response to COVID-19 to identify lessons that could inform preparedness for future public health emergencies. A key element of the health centers' response was the pivot to telehealth. Nearly all health centers (99 percent) offered virtual visits in 2021, compared to 43 percent in 2019.

HRSA issued a draft Scope of Project and Telehealth Program Information Notice (PIN) and is inviting public comment through November 14, 2022. The PIN establishes policy guidance for health centers that offer telehealth within the HRSA-approved scope of project and describes considerations and criteria for providing services to patients via telehealth.

Uniform Data System (UDS) Modernization (UDS+)

HRSA is introducing patient-level data reporting to the UDS in an effort to reduce the reporting burden, improve data quality, and increase granularity to better evaluate Health Center Program services and outcomes and identify training and technical assistance needs. The additional data can also be used to advance quality improvement research.

Innovation and Supporting Readiness for Value-Based Payment

HRSA is engaging with the Centers for Medicare & Medicaid Services Innovation Center (CMMI) to develop value-based care models that address barriers to participation for health centers and other safety net providers.

Accelerating Innovation in the Health Center Program

HRSA funds innovation in the Health Center Program in three ways:

- Quality Improvement Fund (QIF): Unique one-time funding to test new ideas for primary care delivery, such as the FY2022 QIF to optimize virtual care and the proposed QIF to improve maternal health outcomes. HRSA would welcome suggestions for future focus areas.
- Prize Challenges: One-time seed funding to support costs for innovate strategies to address social determinants of health and poor health outcomes (challenge.gov).
- Training/Technical Assistance (T/TA): Funding for primary care associations, HCCN, and NTTAPs.

Building New Partnerships

HRSA is committed to building and leveraging partnerships at the local, state, and national levels to facilitate access to care and services that address health-related social needs. The Council's recommendations have identified ways in which HRSA can utilize those partnerships to improve the health of MSAWs.

Discussion

- Ms. Higgins asked if Dr. Joseph could provide data on the use of telehealth visits by the MSAW population so the Council could identify barriers.
    - Dr. Joseph said she could provide data on the use of telehealth by MHCs. She would find out if any of the Optimizing Virtual Care grantees are focusing on agricultural workers.
- Dr. Salinas asked if the health centers that assess social risk factors use an existing template or created their own.
    - Dr. Joseph said the annual survey asked health centers if they screen for social risk factors and, if so, what tool they use. Most health centers used the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PREPARE). Dr. Joseph said she would provide information on the percentage of health centers that use that tool.
- Dr. Viniegra noted that "innovation" can often mean finding ways to do more with less. He asked what kind of innovation BPHC expects from health centers.
    - Dr. Joseph replied that BPHC sees innovation as the creation of new value, something that has not been done before. The purpose of innovation funding is to create the evidence base for new approaches and demonstrate the value of looking beyond the reimbursement-based model. Challenge grants are focused on the creation of new value at a smaller scale. The current challenge grant is looking at ways to engage with community partners to meet the health-related social needs of health center patients.
- Ms. Higgins asked what social risk factors are included in the UDS and if the Council could obtain samples of the questions that are included in a social risk screening.
    - Dr. Joseph said the UDS includes data on food insecurity, housing, and several other factors. She offered to provide a sample screening tool.
- Ms. Freeman-Lumbar asked if the funding opportunities for behavioral health include support for outreach staff and enabling services, which are critical for serving MSAWs. She noted that outreach workers experienced significant burdens caring for MSAWs during the pandemic and asked if funding to support wellness of health center staff would include them.
    - Dr. Joseph thanked Ms. Freeman-Lumbar for raising those concerns so HRSA could amplify them. HRSA recognizes the need for enabling services to facilitate access to care and to connect health centers with communities. They have always considered enabling

staff to be an allowable use of funds, and they are advocating to expand the use of funds for services that are not reimbursed. Provider wellness is a concern on many levels. HRSA is trying to determine how it can support health centers, given the increased cost of care and high turnover rates. The issue is connected to concerns about reauthorization of funding for the Health Center Program and the end of COVID funding.

- Ms. Dudley called attention to the higher incidence of long COVID among MSAWs. Those who cannot work are at risk of losing employer-provided housing and their children have to move out of their school district. COVID funding is over, but the pandemic is not.
    - Dr. Joseph stated that HRSA is committed to getting resources for health centers to address long COVID. The Council can give voice to the issue and can help HRSA understand what kinds of interventions would be helpful.

Overview: HRSA, BPHC National Training and Technical Assistance Partnerships Serving Migrant Health Centers

Tracey Orloff, MPH, Director, Strategic Partnerships, Office of Quality Improvement (OQI), BPHC, HRSA

Ms. Orloff provided an overview of partnerships funded by BPHC to increase access to care, improve health outcomes, and promote health equity for MSAWs.

National Training and Technical Assistance Partnerships (NTTAPs)

HRSA funds more than 100 organizations that provide T/TA resources for health centers. The NTTAPs engage in many collaborative activities, and they participate in a National Resource Center Advisory Group to leverage their work and reduce duplication.

Five NTTAPs provide resources for health centers that serve MSAWs:

- Farmworker Justice (FJ) provides T/TA related to federal and state policy and legislation impacting access to health care for agricultural workers and their families, with a focus on environmental justice.
- Health Outreach Partners provides T/TA on outreach and enabling services (e.g., transportation), program planning and development, needs assessment and evaluation, and community collaboration.
- Migrant Clinicians Network (MCN) provides T/TA on all aspects of clinical care and issues impacting patients, providers, and clinic systems.
- MHP Salud provides /TA to help health centers develop, implement, and sustain community health worker (CHW)/promotores de salud programs.
- National Center for Farmworker Health (NCFH) provides T/TA related to health center governance, administration, and patient education.

A number of NTTAP activities are relevant to the Council's most recent recommendations:

- Impact of climate crisis on MSAWs
    - FJ conducted an environmental justice symposium and produced an issue brief (*The Climate Crisis and its Impact on Farmworkers*).
    - MCN and FJ conducted a workshop on recognition, management, and prevention of heat-related illness among agricultural workers and introduced a new clinician's guide.
    - MCN and FJ will conduct a presentation on improved screening and recognition of occupational health as an SDOH for MSAWs and their families.

- Public health challenges resulting from COVID-19
    - The Special and Vulnerable Populations (SVP) NTTAPs conduct a bi-monthly COVID-19 Forum to identify, share, and promote promising practices and highlight challenges.
    - FJ developed a song and video for MSAW children to encourage COVID-19 vaccination.
    - The Winter 2022 edition of MHP Salud's quarterly newsletter for CHWs and program staff features an article on emerging issues among MSAW populations.
    - MHP Salud published a Resource Guide for Health Centers that outlines how CHWs can support COVID-19 vaccination efforts.
    - NCFH publishes a quarterly factsheet in English and Spanish on the impact of COVID-19 on agricultural workers.
- Access to adequate and safe housing
    - The National Center for Health in Public Housing (NCHPH) and the National Nurse-Led Care Consortium published a *Healthy Together* toolkit with resources on health center collaborations with local housing authorities and community-based organizations serving residents of public housing and low-income housing, including MSAWs.
    - NCHPH conducted a webinar on partnership opportunities for health centers, housing organizations, and the EnVision Center Initiative of the U.S. Department of Housing and Urban Development (HUD).
    - NCFH held a panel discussion on effective community partnerships to address transportation and housing as SDOH.

Migrant Health Stream Forums

BPHC supports annual Migrant Health Stream Forums coordinated by NCFH in each of the three traditional migratory streams (Western, Midwest, and Eastern). The forums provide an opportunity for participants to discuss regional and national trends that affect MSAWs and share successful strategies for addressing MSAWs' health and well-being. They offer multiple-track programs to meet the educational needs of the diverse health center workforce and provide networking opportunities for presenters and participants to build new relationships and partnerships.

Council on Special Populations (CSP)

The CSP is an internal council at BPHC that meets quarterly to share trends and changes in operations, programming, and policies that impact the development, coordination, and delivery of TA activities to increase access to quality health care for special populations.

A CSP meeting with Migrant Health NTTAPs in August 2022 identified three top issues: continuing challenges to access to care; post-disaster health and well-being; and visibility of and equitability in serving MSAWs among non-Migrant Health Program funded partners.

Primary Care Associations (PCAs)

PCAs are state or regional nonprofit organizations that provide T/TA to help safety-net providers improve programmatic, clinical, and financial performance and operations. They facilitate collaboration between health centers and governors, Medicaid directors, and state health departments to educate those organizations on the Health Center Program and its value to patients and to work with health centers on the best approaches to meet the needs of their constituents. Those relationships made it possible for PCAs to respond quickly when COVID hit.

PCAs collaborate with NTTAPs to provide T/TA and share interventions that meet the health equity needs of special populations. Partnerships and cross-disciplinary collaboration between PCAs and NTTAPs make it possible to conduct the Migrant Health Stream Forums.

Health Center Controlled Networks (HCCN)

HCCNs are networks of 10 or more health centers that work together to strengthen and leverage health information technology (IT) and data to improve health centers' operational and clinical practices that result in better health outcomes for the communities they serve. HRSA currently funds 49 HCCNs.

HCCNs collaborate with NTTAPs to develop strategic approaches to increase access to health care for special populations, including MSAWs. As members of the Task Force for the Ag Worker Access Campaign, HCCNs provide strategic direction and guidance for the campaign's efforts to increase the number of MSAWs and their families served by health centers.

Interagency Collaborations

HRSA participates in two interagency collaborations that are relevant to the Migrant Health Program:

- Department of Labor (DOL)/HRSA Interagency Agreement (IAA): This partnership combines HRSA and DOL resources to improve survey and analytical services and reports regarding the National Agricultural Workers Survey (NAWS).
- Administration for Children and Families (ACF) and HRSA Memorandum of Understanding (MOU): The MOU established collaboration between HRSA/BPHC, the Office of Child Care, and the Office of Head Start (OHS) Migrant and Seasonal Head Start Program (MSHSP). In 2021, HRSA-supported health centers served 3,384 MSHSP children (approximately 19 percent of the children enrolled in the program).

Discussion

- Ms. Higgins asked if the Council could have a list of the access to care challenges that were identified during the August CSP meeting.
    - Ms. Orloff said she would share the issue brief with the Council.
- Dr. Salinas asked what impact MHP Salud has had on the community.
    - Ms. Orloff replied that MHP Salud's advocacy led to increased use of their CHW/promotora model across the country, especially since the pandemic. Several states have begun to license CHWs, which creates an avenue for reimbursement.
- Ms. Huertero asked what efforts are in place to enforce compliance with H-2A housing regulations, which was highlighted in the Council's recommendations from the last meeting.
    - Mayra Nicolas, BPHC, said HRSA was in the process of analyzing the Council's recommendations to determine how to amplify them with other agencies.
- Ms. Dudley asked if promotoras have been actively involved in strategies to support MSAWs with long COVID. She noted that her research found that one in three agricultural workers experienced long COVID symptoms, which is higher than the CDC average of one in five.
    - Ms. Orloff said the Innovation Center is looking into resources and strategies to address long COVID. She asked if Ms. Dudley could share her data.
    - Alfonso Rodriguez-Lainz, PhD, Division of Global Migration and Quarantine, Centers for Disease Control and Prevention (CDC) said Ms. Dudley'se data would be important for CDC.
- Dr. Rodriguez-Lainz encouraged Ms. Orloff to follow-up with CDC regarding opportunities for collaboration. His office recently responded to the hurricanes in Florida, and migrant workers

were one of the populations of concern. He noted that he is working on a project with NCFH through a cooperative agreement.

- Ms. Orloff said her office works with CDC on COVID issues through the Innovation Center. She would talk with them regarding opportunities for collaboration.

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

Ms. Gonzales-Hanson discussed policy and legislative issues that impact health centers, including NACHC legislative priorities for 2022, health center funding, health center access to the 340B drug pricing program, workforce development, telehealth, and Medicaid redeterminations when the Public Health Emergency (PHE) expires. She also introduced the "Gather Voices" tool that NACHC is using to support grassroots advocacy efforts.

Progress on NACHC priorities

Congress permanently authorized the extension of the Federal Tort Claims Act (FTCA) to include malpractice coverage for volunteer clinicians at federal health centers. This will result in significant savings for all health centers.

Congress passed the bipartisan MOBILE Health Care Act, which makes it possible for a mobile medical clinic to obtain grant funding as a new delivery site even if it is not associated with a permanent, full-time site. The legislation will enable more health centers to provide services for MSAWs.

Health Center Funding

The Health Center Program has two funding streams: discretionary appropriations that must be passed every year (currently $1.7 billion) and mandatory funding through the Health Center Trust Fund that was created by the Affordable Care Act (currently $4 billion).

The current 3-year extension of mandatory funding will expire at the end of FY2023. The president has stated a commitment to double the federal investment in health centers, but the administration has not put forth a specific plan to accomplish that goal. NACHC is engaging in conversations with key people and is waiting to see what will happen.

NACHC's priorities for the reauthorization are to expand the reach of the health center system, deepen the services provided by health centers, and shore up existing health centers. To that end, NACHC is sponsoring research to demonstrate the value of health centers. Including: a study to gauge unmet needs in underserved communities; review of UDS data and other sources to examine what it would take to provide more comprehensive service, including behavioral health, dental, and enabling services; and a study to document the impact of inflation on the current grant's purchasing power and the economic impact of health centers.

A recent NACHC survey found that 70 percent of health centers rated base grant adjustments as their first or second priority, while service expansion was the first or second priority for 60 percent. New access points and capital were the first or second priority for one-third of health centers. Half of all health centers want to provide behavioral health services, and dental services are also a key priority.

Despite spending fatigue in Congress, NACHC is working with bipartisan champions on a bill to extend and increase health center mandatory funding. The bill will be introduced in December and reintroduced

when the new Congressional session begins in January. The goal is to secure passage of the legislation before the trust fund expires in 2023.

NACHC is also advocating for reauthorization of the National Health Service Corps (NHSC, $310 million per year) and the Teaching Health Center Graduate Medical Education program (THCGME, $126.5 million per year).

340B Drug Pricing Program

Recent HRSA data show that nearly 80 percent of purchases through the 340B program are from disproportionate share hospitals. Federal grantees account for 13 percent of purchases. Health centers account for only 5 percent of purchases, and they are mandated to reinvest the savings in services.

Drug companies are restricting access to medications that save lives, and multiple companies are suing HRSA in multiple venues. NACHC is supporting the PROTECT 340B Act (HR4390) to ensure that health centers maintain their savings. NACHC could use the Council's support to convince the administration of the importance of the 340B program and to urge HHS to find ways to hold manufacturers accountable for the impact of withholding medications from patients.

Workforce Issues

A NACHC survey found that nearly 70 percent of health centers lost staff at all levels over the previous six months. New approaches and creativity are essential to meet current and future needs.

NACHC is reaching out to HRSA and is working with the National Rural Health Association, the National Council for Mental Wellbeing, and other partners to develop short-, medium-, and long-term solutions to address workforce issues. NACHC is also developing legislative champions and creating an advocacy plan to build consensus for a multi-sector healthcare workforce approach that could be paired with NHSC and THCGME program extensions.

Telehealth

Telehealth became an important way for health centers to serve patients during the pandemic. There is strong bipartisan support to extend the flexible Medicare policies that were granted during the PHE, which expires in January 2023. Congress passed a 151-day extension to provide additional time to find a solution. The House passed bipartisan legislation that would continue the policies until December 2024. NACHC is working to ensure that those policies become permanent.

Medicaid Determination following the PHE

The Families First Act Coronavirus Response Act (FFCRA) of 2020 provided states with a 6.2 percent increase in their federal share of Medicaid if they did not disenroll patients. The continuous coverage requirement enabled 90 percent of health centers to provide more services.

States will restart their eligibility requirements when the PHE expires, which could result in many enrollees losing coverage. At the same time, health centers will lose the additional workforce funds they received during the PHE. It is essential to prepare health centers to help patients re-enroll and to educate elected officials and federal agencies about the impact of these events.

"Gather Voices" Advocacy Tool

NACHC's formula for getting results in Washington to support the health center agenda is a comprehensive approach that involves stakeholders at all levels, including PCAs, HCCNs, and health center boards, staff, and patients.

NACHC's Health Center Advocacy Network is using the "Gather Voices" storytelling tool to share health center voices on social media and other platforms. Ms. Gonzalez-Hanson encouraged Council members who would like to share their stories to contact Jennifer Turner, Manager of Grassroots Advocacy (jturner@nachc.org) and to visit www.hcadvocacy.org/join to participate in the advocacy network. She provided email addresses for key NACHC staff and encouraged Council members to contact them with any thoughts, questions, or feedback.

Discussion

- Ms. Veguilla-Montañez noted that private insurance companies are opening clinics in Puerto Rico for patients with insurance or Medicare Advantage. MSAWs cannot access those clinics.
    - Ms. Gonzales-Hanson said that is also happening in the U.S. She encouraged the Council to submit a recommendation to HHS to address this situation.
- Ms. Higgins referenced NACHC's research to identify unmet needs for underserved populations. She asked how NACHC can ensure that MSAWs' needs are considered, since those populations are often hidden.
    - Ms. Gonzales-Hanson replied that health centers need to partner and share information with community organizations who know how to reach agricultural workers, such as food pantries and migrant programs.
- Ms. Watts stressed that it is essential to get farmers involved in advocacy for health centers. She encouraged NACHC to partner with state and national farmer organizations.
    - Ms. Gonzales-Hanson said that she had taken preliminary steps to develop relationships with the American Farm Bureau Federation and would pursue that further.

Public Comments

Sarah Prager, Research and Evaluation Manager, National Center for Farmworker Health

Ms. Prager introduced the Farm Labor Data Dashboard that NCFH is developing through a cooperative agreement with the CDC (http://www.ncfh.org/dashboard.html). The goal of the dashboard is to provide farmworker advocates and public health officials with easy access to data they can use to plan and implement programs for farmworkers in their service area.

The dashboard includes the following pages:

- General Population: Provides direct and estimated numbers of all farmworkers employed in animal production and crop production, including H-2A, undocumented, and workers with other visas, residency, or U.S. citizenship, plus financial dependents who reside in the U.S. Does not include disabled or retired farmworkers, owner-operators, and unpaid family members who work on a farm. Numbers reflect where workers are employed, not where they live. Data sources are the U.S. Census of Agriculture (number of directly-hired workers), NAWS (number of dependents in the U.S.), and the Quarterly Census of Employment and Wages (QCEW), collected by the Bureau of Labor Statistics (number of jobs by month, for states and counties).
- H-2A Population Trends: Annual number of H-2A agricultural workers by state and county; monthly number of H-2A workers employed by state or county; and monthly number of H-2A

workers arriving in the state or county. Data source is the DOL Office of Foreign Labor Certification.

- Explorer (Mapping Tool): Map layers include H-2A worksites and housing sites; Migrant Health Centers; Community Health Centers; and farm locations inspected by the Occupational Safety and Health Administration (OSHA) and Wage and Hour Division (WHD) at DOL.

Ms. Prager demonstrated how health centers and others can use the dashboard to determine the optimal timing and location for services and interventions. She noted that organizations can download and overlay the data with data from their own sources, such as UDS health outcomes data.

Discussion

- Ms. Dodson asked if the mapping tool includes all MSAWs or only H-2A workers.
    - Ms. Prager replied that the tool includes locations of H-2A workers because there is a national source of public data. There is no comparable data source for other MSAWs.
- Dr. Viniegra asked how the dashboard accounts for workers without documentation.
    - Ms. Prager stated that the estimate is based on the number of workers in the Census of Agriculture. It assumes that employers fully report the number of workers they hire. It is not possible to determine which workers have documentation.
- Ms. Cormier noted that the mapping tool can be used to identify locations with high concentrations of workers. She asked if NCFH anticipates funding to include data on those in less-concentrated areas, since MHCs are charged with serving all MSAWs.
    - Ms. Prager replied that the dashboard was launched this summer. They are working with CDC to refine the tool.

Katherine Chon, Office on Trafficking Persons, Administration for Children and Families, HHS

Ms. Chon provided updates on how HHS is implementing the Council's November 2021 recommendations to address the public health challenges associated with agricultural labor trafficking.

Activities to raise awareness about labor trafficking:

- Class 6 of the ACF Human Trafficking Leadership Academy developed recommendations on assessing and responding to risk factors among migratory families to prevent labor trafficking.
- ACF launched an online training program to strengthen the capacity of healthcare providers and service agencies to work with foreign national minors who have experienced trafficking. The program is designed to strengthen screening, develop trauma-informed responses, and connect children and their families to services.
- HHS is updating its national public awareness campaign on trafficking. Priority populations include MSAW adults and children.

Activities to expand programs:

- ACF increased its investments in services for labor trafficking victims. The Notice of Funding Opportunity for a new victim assistance program included bonus points for formal partnerships with MHCs. Grants were awarded to programs in California and Missouri.
- ACF awarded new demonstration grants to strengthen the healthcare response to human trafficking, including services for survivors of labor trafficking. Grants were awarded to programs in Mississippi and New Jersey.

Activities to establish anti-trafficking partnerships with federal agencies:

- ACF is participating in federal inter-agency efforts to strengthen protections for temporary workers, including provisions to increase accountability for exploitative employers, labor contractors, and their agents and to strengthen protections regarding recruitment and treatment of workers.
- Other federal interagency groups are working on identifying forced labor in healthcare and public health supply chains, including food and agriculture, and improving direct care services, including childcare and elder care.

Activities to establish collaboration to better understand the scope of labor trafficking and engage in prevention:

- ACF released a call for submissions for a special issue of the official journal of the Office of the Surgeon General, *Public Health Reports,* that will focus on the impact of COVID-19 on interpersonal violence, including working conditions in agriculture and other industries that have been disproportionately impacted by human trafficking.

Ms. Chon encouraged Council members to let researchers know about the call for journal submissions and to contact her office regarding the activities she described.

Panel Presentation and Discussion: Growing, Recruiting, and Retaining a Migrant Health Center Workforce

Grace Wang, MD, MPH, FAAFP, Senior Fellow, Public Health Integration and Innovation, NACHC
Elena Thomas Faulkner, MA, Chief Executive Officer, National Institute for Medical Assistant Advancement (NIMAA)
Ethan Kerns, DDS, Chief Dental Officer, Salud Family Health
Bill Rau, SPHR, SHRM-SCP, Vice President of Human Resources, Salud Family Health

Grace Wang, MD

Dr. Wang described NACHC's efforts to develop the workforce of the future. She noted that developing a highly skilled, mission-driven, culturally competent workforce is one of NACHC's strategic pillars.

Two-thirds of health centers participating in a NACHC survey in April 2022 reported that they had lost up to 25 percent of their workforce in recent months. Nurses represented the highest-ranked category of workforce loss. Key reasons for staff departure were better financial opportunities at a larger healthcare organization and pandemic-related stress.

NACHC's workforce development approach has four components:

- Health center staff well-being
    - The U.S. Surgeon General recently published *Addressing Health Worker Burnout*, an advisory on building a thriving health workforce. The advisory cited the "Moral Distress and Moral Injury" issue of Team Care CONNECTIONS magazine, which NACHC developed in collaboration with Arizona State University and A.T. Still University. A study of more than 2,000 clinicians working in outpatient safety net practices during the first nine months of the pandemic found that 72 percent had experienced work-related moral distress, which is a disconnect between what you believe is right and what you are able to do. The Surgeon General's new framework for workplace mental health and well-being outlines five essential strategies to address this important issue.
- Policy and payment to support health center teams in value-based care

    - Numerous studies have shown that a team-based approach to primary care significantly reduces the amount of provider time needed to care for average adult patients. Reimbursement mechanisms should support this approach.
- All health centers are teaching health centers
    - NACHC adopted a "Growing Our Own" strategy to develop the health center workforce of the future. A 2021 consensus report by the National Academies of Sciences, Engineering, and Medicine, Implementing High-Quality Primary Care, includes an objective to train primary care teams where people live and work. This approach is embedded in the history of the health center movement, as exemplified by the Tufts Delta Health Center in the 1970s (described in Out in the Rural by Thomas J. Ward, Jr.).
- All health center staff are members of the public health workforce.
    - Health centers' response to the COVID-19 pandemic clearly demonstrated their pivotal role in ensuring equal access to prevention and treatment.

The example of the Tufts Delta Health Center illustrates six essential elements of health center workforce development that can be applied today:

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

Elena Thomas Faulkner

Ms. Faulkner described NIMAA's training program for medical assistants (MAs) and the role of allied health professionals in creating a more equitable workforce. She illustrated her presentation through the story of a third-generation agricultural worker who became interested in a health career when Salud Family Health Center's mobile unit came to the greenhouse where she worked.

NIMAA has a mission of serving low-income and agricultural worker communities. Their training program is shorter and less expensive than other alternatives. It includes an externship that allows students to apply skills from the outset, and it prepares students for the credentialing exam.

The MA workforce is diverse, and NIMAA students reflect the demographics of their communities. NIMAA students see their work as a foundation for future roles in health care. One-third of the students surveyed by the University of Washington previously worked in another occupation, and 56 percent planned to seek training or employment in another healthcare occupation.

Allied health professions can be more accessible for NIMAA's target populations. The community-based strategy for workforce development engages residents of underserved communities, reflects community diversity, offers accessible entry points, and provides a foundation for future advancement.

NIMAA's community-based recruitment model starts by working with a clinical partner to recruit students from the community, with an eye toward hiring from the community or advancing existing employees. Interviews with the clinical partner are part of the admissions process, which increases the likelihood that the student will eventually be hired by the employer.

Clinical partner pipeline investments such as tuition support, reduced hours, and maintenance of benefits while employees are in school demonstrate commitment to community members and staff. This in turn encourages retention of students and employees.

Medical assistants have numerous career options. NIMAA's MA Certificate Program can serve as a stepping stone to higher-level MA positions. Some MAs articulate to an associate degree or beyond to pursue careers in nursing or medicine.

MA programs can play a role in NACHC's "Grow Your Own" model. NIMAA currently works with 50 health centers across 17 states to place students in a clinical environment. The biggest constraint to participating in NIMAA training programs is staff time to precept the students.

Ethan Kerns, DDS

Dr. Kerns described the Career Ladders program for support team members at Salud Family Health. The program's comprehensive curriculum develops confident and qualified front-line staff.

Research shows that people with advanced job knowledge and skills enjoy being at work and provide superior service to patients. In addition, patients are more satisfied with their experience. Career Ladders prepares new team members to be successful, refreshes the knowledge of more experienced team members, and ensures that all staff have the same knowledge and skills.

Courses are designed to appeal to a variety of learning styles and relay valuable content that prepares staff to improve their job skills and pass certification exams and competencies. Coursework is taken online using Salud's Learning Management System (LMS), IKG Pro Learning. Courses take 30 to 40 minutes to complete, depending on the topic and discipline. Staff must score 80 percent or higher on a knowledge check at the end of the course to receive credit and advance to the next course.

Salud developed curricula for eight frontline staff positions: Contact Center Agent, Customer Service Associate, Dental Assistant, Dental Clinic Coordinator, Enrollment Specialist, Medical Records, Pharmacy Technician, and Medical Support Staff.

Each Ladder includes an orientation and five levels (Apprentice, Level 1, Level 2, Level 3, Level 4). Apprentice and Level 1 are required for all employees. The higher levels are optional. The levels are color coordinated, and lanyards and badges reflect the level the employee has achieved.

To advance in Ladders, an employee must complete the course work in the LMS, pass a final exam with a score of 80 percent or better, have a current employee evaluation that "Meets Expectations" or "Exceeds Expectations," and have no written Employee Counseling Notices from their supervisor within the last six months. New hires must complete the orientation within 90 days of hiring. Employees must achieve the Apprentice level by the end of their first year of employment and Level 1 by the end of the second year. The supervisor is notified if the employee does not complete the training on time. Employees who fail to complete their courses and final exam within 30 days are dismissed from their role, but they are eligible to apply for any open frontline position for which they are qualified.

The Dental and Pharmacy Technician programs include certification exams. Salud developed the exams in consultation with subject matter experts and nationally recognized exam boards of the American Medical Technologists (AMT) and the Pharmacy Technician Certification Board (PTCB). Colorado law

requires all Pharmacy Technicians to pass their certification exam within 18 months of their hire date. Salud applied for and became a PTCB-recognized education/training program.

Salud reviews the course content on a regular basis to ensure that it is up to date and reflects changes in the staff model. They are in the process of developing Level 4, which is a capstone project that will draw upon everything the employee has learned up to that point to identify a problem that impacts patient care at SALUD and develop a solution to address it.

The Career Ladders program is linked to compensation. Staff receive a small increase in base pay when they complete Level 1, and those who complete all levels will receive a bonus.

The Career Ladder has helped Salud recruit and retain staff, which is critical during a workforce shortage. It has also standardized staff training and helped frontline staff be successful in their roles.

Salud learned a number of lessons about developing a training program:

- Identify which positions need additional on-the-job training
- Keep modules short and concise
- Create your curriculum with clear learning outcomes that can be tested and measured
- Use a course development program (e.g., Articulate 360 or Adobe Captivate) and utilize subject-matter experts
- Create a roadmap for courses and learning outcomes, and work from there to develop courses.

Bill Rau

Mr. Rau identified three key elements of in workforce development—performance management, managing effective teams, and compensation—and outlined approaches and resources to address them.

Approaches to performance management include:

- Adopt a growth mindset: In Mindset: The New Psychology of Success, Carol S. Dweck, PhD, describes two habits to develop a growth mindset. The first is to shift from saying, "I'm not good at this" to "I'm not good at this yet." The second is to always improve, which includes willingness to experiment, a focus on progress over time, and a desire to learn from others.
- Develop quality performance conversations: In Your Brain at Work, Dr. David Rock presents a neuroscience-based approach to help managers utilize the brain's threat/reward and avoid/approach responses to hold more effective performance conversations with employees.

Dr. Rau highlighted resources to address three aspects of managing effective teams:

- Understanding team effectiveness: Google identified five dynamics that characterize effective teams: psychological safety, dependability, structure and clarity, meaning, and impact. Individuals on teams with higher psychological safety were less likely to leave and more likely to harness diverse ideas from their teammates. The Five Dysfunctions of a Team by Patrick Lencioni presents strategies to address absence of trust, fear of conflict, lack of commitment, avoidance of accountability, and inattention to results.
- Managing change: The "switch" framework developed by Chip Heath and Dan Heath helps managers increase their capacity to respond to change (Switch: How to Change Things when Change is Hard, or https://heathbrothers.com).
- Workplace culture and engagement: Built on Values by Ann Rhoades stresses the importance of defining the behaviors that support organizational values, and then living those values. The

Advantage by Patrick Lencioni provides a framework and tools to achieve organizational health. The Gallup organization identified the 12 most effective measures of employee engagement. The CliftonStrengths Assessment is an excellent tool to identify employees' strengths.

Dr. Rau noted that employee retention is the number one recruitment strategy. Compensation is one factor in retention, along with having effective managers and an organizational culture that engages employees. Compensation should be thoughtful, but one size does not fit all. Health centers must balance market factors such as signing bonuses and frequent adjustments with internal concerns such as pay equity. Total compensation includes the organization's medical plan, retirement plan, and other benefits. A focus on maximizing base pay could jeopardize resources for those benefits.

Discussion

- Ms. Huertero asked about the cost and return on investment for a health center to develop an internal training program.
    - Dr. Kerns said that it took Salud about 40 hours to develop each 30- to 40-minute course.
    - Mr. Rau noted that the total cost includes additional compensation for employees who complete the program.
    - Ms. Laeger stated that Salud has always had a philosophy of investing in employees. The Ladders program has increased employee satisfaction and retention, which is a clear return on investment.

Facilitated Discussion on Possible Recommendations to the Secretary of DHHS
Donalda Dodson, Vice-Chair, NACMH

Ms. Dodson facilitated a discussion of the issues that emerged during the presentations from the first day. Council members identified the following topics for possible recommendations:

- Increasing partnerships across federal departments and agencies
- Staff wellness
- Emergency preparedness and response – providing essential information to MSAWs, who are often the last to receive relief and support
- Education to increase awareness of climate change among children
- Early childhood development: identification of children who are not meeting benchmarks
- Labor trafficking
- Environment: lack of access to drinking water in living or working areas during drought conditions
- SDOH screening: what is currently being asked, additional questions to understand SDOH for MSAWs
- Long COVID among MSAWs
- Staff retention and development
- Telemedicine: approaches to increase the efficacy of encounters; additional services and protections for areas where there are barriers and staff are not trusted
- Data on use of mobile units
- Dashboard: inclusion of data on seasonal workers and workers without migratory documentation
- 340B program: data on agricultural workers' use of health center and mobile unit pharmacies.

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

Dr. Salinas reviewed the agenda for the second day of the meeting.

The meeting was adjourned for the day at 5:00 p.m.

Thursday, November 3, 2022

Opening Remarks
Jose Salinas, EdD, Chair, NACMH

Dr. Salinas called to order and reviewed the presentations and key points of the previous day.

Dr. Salinas noted that Chalmers R. Carr, a South Carolina peach farmer who spoke at a recent symposium held by the Interstate Migrant Education Council applies for approximately 1,200 H-2A workers each year. The speaker predicted that more H-2A workers would bring their families on H-4 visas, which are temporary, non-immigrant visas for spouses and children under age 20. H-4 visa holders are not allowed to work, and children must attend school. Housing and meals for the spouse and children are the responsibility of the H-2A worker. The whole family must return to their country of origin at the end of the season. This program could help H-2A workers who suffer from the stress of being away from home. It would also impact migrant education programs, because of the increase in the count of eligible children who can qualify for Title I - Part C services.

Incidence and Prevalence of Kidney Disease Among U.S. Agricultural Workers
Roxana Chicas, PhD, RN, Assistant Professor, Nell Hodgson Woodruff School of Nursing, Emory University

Dr. Chicas described Emory University's research to determine the prevalence of heat-related kidney disease among agricultural workers in Florida and to test the feasibility of preventive interventions.

2021 was the sixth hottest year on record, and the past decade was the hottest of the modern world. Heat waves occurred in Canada and other places that had never seen them. The average U.S. crop worker experienced summertime heat extremes of 94.7 ° Fahrenheit (F). The 20 counties with the most crop workers experienced heat extremes from 78 ° to 109 °F. The risk of heat-related death is 35 times higher for agricultural workers than for any other occupational group.

The 2017 Girasoles study, conducted with the Farmworker Association of Florida (FWAF), was one of the first to measure heat-related illness (HRI) among agricultural workers in the U.S.[1] The objectives of the study were to characterize heat exposure and work activities of Florida agricultural workers; characterize the population's physiological response to heat exposure and HRI symptoms; and determine the extent to which environmental factors, work characteristics, and individual characteristics influence the physiological response to heat. Workers were monitored for three days using an ingestible core temperature monitor and a heart-rate monitor.

[11] Mac, V., & McCauley, L. A. (2017). Farmworker Vulnerability to Heat Hazards: A Conceptual Framework. *Journal of nursing scholarship : an official publication of Sigma Theta Tau International Honor Society of Nursing*, *49*(6), 617–624. https://doi.org/10.1111/jnu.12327.

The study found that 49 percent of the workers had core body temperatures that exceeded 38° Celsius (C)/100.4°F (the threshold for heat stroke) on one of the three days, and 10 percent had core body temperatures that exceeded 38.5 °C. Forty-three percent reported two or more HRI symptoms. One-third of the workers had heat-related acute kidney injury (AKI) on at least one workday, based on the Kidney Disease Improving Global Outcomes (KDIGO) criteria of an increase in serum creatinine of at least 0.3mg/dL. Additional modeling showed that the likelihood of AKI increases by 47 percent for each five-degree Fahrenheit increase in the heat index.

The Girasoles findings led to a pilot study to test the feasibility of cooling interventions to protect workers.[2] One group of workers wore a cooling bandana, one group wore a cooling vest, one group wore both a cooling bandana and a cooling vest, and a control group wore no cooling device. Most of the workers said the cooling devices were comfortable and helped them stay cool. The bandana was the most protective of core body temperature exceeding the 38°C threshold, while the vest alone and the combination of a vest and bandana were not protective.

Working in a hot and humid environment is associated with an increased risk of developing heat-related AKI among agricultural workers. As noted, 33 percent of the workers in the Girasoles study had AKI on at least one workday. A 2017 study of agricultural workers in California found that 12 percent had AKI, and the odds of AKI increased 34 percent for those who experienced heat strain.[3] A 2020 study found that 15 percent of agricultural workers in California had AKI, and the odds increased by 92 percent for workers with a heavy workload.[4] A meta-analysis of heat strain that included diverse populations, exposures, and occupations found a 15 percent incidence of AKI among those who worked in high ambient temperatures for at least six hours per day, five days per week, for two months of the year.[5]

Based on those findings, the Emory team conducted a two-year longitudinal study that examined heat stress and kidney injury in Florida agricultural workers. The objective of the study was to determine if renal biomarkers of AKI and sustained decreases in renal function were associated with environmental and exertional heat exposure among agricultural workers in Florida. The study found a progressive increase in the percentage of piece-rate workers that met the criteria for AKI after a workday from January 2020 (21 percent) to August 2022 (43 percent). The prevalence of AKI among hourly workers was around 10 percent throughout the study.

One of the most important ways to prevent heat illness is to drink enough fluids. The National Institute for Occupational Safety and Health (NIOSH) states that water is generally sufficient to maintain

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[2] Chicas R, Xiuhtecutli N, Elon L, et al. Cooling Interventions Among Agricultural Workers: A Pilot Study. Workplace Health & Safety. 2021;69(7):315-322. doi:10.1177/2165079920976524.

[3] Moyce, S., Armitage, T., Mitchell, D., & Schenker, M. (2020). Acute kidney injury and workload in a sample of California agricultural workers. *American journal of industrial medicine*, *63*(3), 258–268. https://doi.org/10.1002/ajim.23076.

[4] Moyce, S., Armitage, T., Mitchell, D., & Schenker, M. (2020). Acute kidney injury and workload in a sample of California agricultural workers. *American journal of industrial medicine*, *63*(3), 258–268. https://doi.org/10.1002/ajim.23076

[5] Flouris, A. D., Dinas, P. C., Ioannou, L. G., Nybo, L., Havenith, G., Kenny, G. P., & Kjellstrom, T. (2018). Workers' health and productivity under occupational heat strain: a systematic review and meta-analysis. The Lancet. Planetary health, 2(12), e521–e531. https://doi.org/10.1016/S2542-5196(18)30237-7.

electrolyte balance. They suggest electrolyte drinks for prolonged sweating, but they do not provide guidelines on how much to drink.

Studies in Central America have found that agricultural workers are at risk of developing chronic kidney disease of unknown etiology (CKDu) that is associated with rising temperatures. Sugarcane workers who self-reported drinking water with electrolytes had a lower risk of developing AKI. A study in Guatemala found that five liters of electrolyte solution per day was the best quantity to drink.

The Emory team designed the first field-based study to test hydration rates among agricultural workers in the U.S. The study looked at the feasibility of implementing hydration interventions in agricultural workplaces and estimated the impact of the intervention on post-workday hydration status and incidence of AKI. One group drank five liters of plain water per day, and another group drank five liters of an electrolyte solution. The electrolyte group drank less than the water group, but none of them met the criteria for AKI and in most cases their glomerular filtration rate (GFR) levels remained steady or increased. Both groups increased their hydration. The results are not statistically significant, but they are encouraging.

Dr. Chicas outlined additional strategies to protect workers' renal health:

- Modify working conditions (move physically demanding activities to cooler times of the day, provide cooled or shaded areas for rest breaks, provide cool drinking water)
- Provide uniforms (hats; long and loose-fitting clothing made of light-weight, breathable materials in light colors; cooling personal equipment)
- Monitor workers (personnel trained in heat stress conduct on-site monitoring of workers, designated worker at each site who can call for emergency medical services, annual heat stress training for supervisors and workers, buddy system, weather warning systems, self-pacing for heat mitigation, piece-rate pay reform, Acclimatization Plan)
- Provide wearable technologies to monitor workers
- Train clinicians in climate-related occupational risks and assessment of renal function
- Educate MSAWs on kidney health, hydration, and ways to prevent HRI
- Train more CHWs to provide resources and patient education
- Expand agricultural workers' access to health care.

Dr. Chicas emphasized that heat-related kidney injury is preventable, but it requires buy-in at all levels. The Oregon OSHA adopted permanent rules for heat illness prevention standards in May 2022. Workers can be protected without sacrificing productivity.

<u>Discussion</u>

- Ms. Higgins noted that most of the public health outreach efforts are provided by non-profits. She expressed concern about the future of those programs when COVID funding ends.
    - Dr. Chicas said her program is trying to get additional funding so their community partner can continue to educate agricultural workers and growers on the impact of climate change and how to protect workers. The Emory School of Nursing got HRSA funding to train CHWs and provide financial support for community organizations. Researchers need to go after funds and have a community partner that can use the funds wisely.
- Ms. Huertero noted that consumption of water requires access to restrooms and time for breaks. She raised concern about the quality of water, especially in areas experiencing drought.

    - Dr. Chicas replied that many workers said they did not like the water on-site, so they brought their own. The researchers purchased water for the hydration study. The workers in that study reported that they felt better when they drank more water and did not report concerns about access to restrooms. She did not have information on water quality in areas experiencing drought.
- Dr. Salinas asked about the source of funding for the studies.
    - Dr. Chicas replied that the study was funded by NIOSH.
- Ms. Higgins asked if the prevalence of AKI was higher among certain age groups or gender and if any of the women in the study were pregnant.
    - Dr. Chicas replied that the prevalence among piece-rate workers was the same for men and women, while the prevalence among hourly workers was higher for women. Two of the women in the study were pregnant.
- Ms. Freeman stated that HRI is prevalent among MSAWs in North Carolina. She appreciated the information on the link between heat and AKI and asked if Dr. Chicas could suggest any recommendations regarding the role of HRSA and health centers to address this issue.
    - Dr. Chicas said many workers are not aware of HRI. When they become aware, their risk of AKI is already high. Clinicians should screen MSAW patients for kidney function and educate them on kidney health. CHWs are crucial because they come from within the community. It is also crucial to advocate for federal heat protection standards.
- Ms. Dudley asked Dr. Chicas if Emory would expand its CHW training program and if they would have the capacity to partner with several MHCs to apply for an innovation grant.
    - Dr. Chicas replied that about 45 percent of MSAWs in their longitudinal study got the COVID vaccine after CHWs provided education. Education provided by CHWs on heat stress and kidney health could be equally effective. Emory is always looking for partners to conduct studies. FFWA contacted them to do research 13 years ago. The agricultural worker community asked them to focus on the health impact of heat.
- Ms. Cormier noted that when masks were first mandated, there were not enough to meet the demand. She asked if this might happen if cooling bandanas are promoted, and she asked if Dr. Chicas could provide the source of the bandanas.
    - Dr. Chicas replied that the cooling bandanas are reusable, so supply should not be an issue. They found the bandanas online, and there are many sources.
- Ms. Dudley asked if Emory would be interested in partnering with NCFH or a similar organization to approach industry about providing workers with cooling bandanas at no cost.
    - Dr. Chicas said they would be very interested in exploring a partnership.
    - Ms. Watt noted that she is on the board of NCFH and offered to share the information with them.
- Dr. Salinas asked why growers were hesitant to participate in the study.
    - Dr. Chicas said some growers believed that nothing could be done about the heat, or they were doing enough to protect the workers, or that workers pushed themselves.

Addressing the Public Health Implications of Social and Cultural Factors that Place Migrant Agricultural Workers at Risk for Human Immunodeficiency Virus (HIV)/Sexually Transmitted Infections (STI)
Jesús Sánchez, PhD, Associate Professor, Department of Sociobehavioral and Administrative Pharmacy, Nova Southeastern University, FL

Dr. Sánchez described his research to identify social and cultural factors that place Latino migrant agricultural workers (LMAWs) in South Florida at risk for HIV and STIs and to develop effective community-based interventions for HIV prevention. The studies were conducted through Project Salud,

which is a partnership between academic researchers and community-based organizations such as FWAF, faith-based organizations, and other groups.

The migrant agricultural worker (MAW) population in South Florida is diverse. Eighty-five percent are of Latino origin, with Spanish as their predominant spoken language. Three-quarters are male. About half (both male and female) report that they are married, but they do not necessarily live with their partner. They range in age from 13 to late 60s, with an average age of 33. They have an average of seven years of formal education in their country of origin.

A few studies have linked migration-mobility to increased HIV incidence and vulnerability. This vulnerability can be exacerbated by inadequate or incorrect HIV transmission knowledge, multiple partners and long absence from families, cultural influences of machismo and familismo, immediate survival problems (e.g., housing, employment, medical care), alcohol and other drug use, hostility of the host community, and the difficulty of outreach and engagement. A few studies conducted among MAWs suggest that lifestyle factors (e.g., harsh labor, poor living conditions, discrimination, and loneliness) may increase alcohol consumption and related high-risk sexual behaviors.

Dr. Sánchez conducted a survey to obtain data on alcohol use and risk factors among LMAWs in South Florida that could be used to develop evidence-based recommendations. Participants in the study reflected the demographic profile of this population. Eighty-eight percent did not have medical insurance, and a similar number said that a community clinic was their primary source of medical care. Nearly two-thirds said they had thought about visiting a doctor but did not go. Lack of insurance was the main reason they did not seek care, but some cited their immigration status. Limited access to health care often results in self-medication.

There is a strong need to increase awareness of high-risk behaviors in this population. Two-thirds said they engaged in unprotected vaginal sex, while less than 10 percent said they knew about HIV. A significant percentage said they engage in alcohol use on a regular basis. Frequent heavy drinking is prevalent in the community, and many engage in unprotected sex under the influence of alcohol.

Project Salud used the survey findings to develop an intervention for HIV prevention for LMAWs. The intervention emphasizes the relationship between alcohol abuse and risky behaviors and targets four psychosocial mediators of preventive behavior: traditional view of gender roles, knowledge of HIV prevention, perceived barriers to condom use, and efficacy of condom use. Florida International University developed a curriculum to train community members to deliver the intervention and conduct motivational interviews. The CDC included the model in its Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention.

It is widely accepted that conventional, single-shot interventions are likely to fail to adequately help LMAWs to adopt and maintain HIV risk reduction behaviors in a constantly shifting personal and social environment. There is also a well-documented need to tailor effective HIV prevention interventions for this population that are not simply cultural adaptations of existing interventions. Culturally adapted interventions must prompt community engagement and participation at every phase.

It is critical to provide the LMAW community with the capacity and infrastructure to prolong community-based HIV prevention activities over time. LMAWs are more likely to benefit from HIV prevention efforts that are supported at the community level, sustained over time, and address other community needs.

Community-based participatory research (CBPR) has emerged as a model to address the limitations of conventional research and equitably involve all partners in the research process. Barriers to using this approach with the LMAW population include knowledge gaps, different priorities, the need to build infrastructure and skills, and communication. Knowledge gaps can be addressed by co-learning and training programs. Differing priorities can be bridged by creating synergy with other programs, such as oral health. CHWs can help build infrastructure and skills. Smartphone apps are an effective way to address communication barriers.

Discussion

- Dr. Viniegra noted that much of the presentation centered on heterosexual practices. However, male and female MSAWs often engage in homosexual practices when away from home, and there is growing research on queer people who migrate. Men who have sex with men (MSM) have the highest rate of transmission of HIV.
    - Dr. Sánchez acknowledged the need to address that research gap. It can be difficult to recruit participants due to the prevalence of machismo and traditional gender roles within the population. His team recently conducted a pilot study that used the Grindr app, and they are working with community partners to engage participants who do not fall into traditional categories of gender identity.
- Ms. Higgins asked if sex workers were included in the studies.
    - Dr. Sánchez acknowledged that the use of sex workers is prevalent in this community, even among those who are married. The researchers are working with the community to develop interventions to address this high-risk behavior.
- Dr. Rodriguez-Lainz noted that the agricultural worker population in Florida includes a large number of Haitians and an increasing number of workers who speak indigenous languages. Florida also has a high number of temporary workers from Mexico who go back and forth. He asked if Dr. Sánchez had identified any specific risk factors in those populations.
    - Dr. Sánchez said his research to date has focused on Spanish-speaking Latino MAWs. The Haitian population deserves to be considered on its own, but the researchers have not done that work yet and they have not found a way to address the language and cultural barriers with indigenous workers who do not speak Spanish. It is challenging to conduct interventions with workers who go back and forth. The pilot study that used the Grindr app could be relevant for those workers as well as for other highly mobile populations, such as tourists.
- Ms. Dudley asked if Dr. Sánchez had considered partnering with organizations that develop educational materials in indigenous languages.
    - Dr. Sánchez said they are looking at partnering with community organizations that work with the Haitian population and other ethnic groups and with companies that develop smartphone apps in other languages.
- Dr. Salinas asked what recommendations the Council could make to address the issues Dr. Sánchez discussed.
    - Dr. Sánchez said the key to long-lasting impact is to develop capacity and infrastructure so the community can develop initiatives to address any health issues that affect them.

Facilitated Discussion on Possible Recommendations to the Secretary of DHHS
Donalda Dodson, Vice-Chair, NACMH

Ms. Dodson facilitated a review of the issues that were discussed during the meeting. Council members selected five priority topics for actionable recommendations that would directly impact MSAWs: telemedicine; strengthening the labor force; HIV/STIs; kidney disease and heat-related conditions; and long-haul COVID-19.

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

Travel Reimbursement Processing
Elaine Garrison, BPHC, HRSA

Ms. Garrison reviewed the process for reimbursement of travel expenses. She noted that the deadline for submitting receipts was November 11, and she assured Council members that she would be available to help them navigate the system.

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

Council members suggested potential topics for the May 2023 meeting:

- Early childhood education (developmental milestones, access to resources, need for data)
- Chronic illness/chronic pain (contact MCN for potential speakers)
- Cancer in MSAWs
- Nutrition and food security
- Health support for different types of agricultural workers (migrant, seasonal, year-round, H-2A)
- Impact of inflation on SDOH (food, housing, transportation)
- Depression in MSAWs
- Elderly MSAW population.

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

Dr. Salinas thanked the retiring members for their contributions to the Council.

The meeting was adjourned at 4:57 p.m.