

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

**May 31-June 3, 2022
Virtual Meeting via Zoom**

Meeting Minutes

Council Members in Attendance

Deborah L. Salazar, BS (Chair)
Jose Salinas, EdD (Vice-Chair)
J. Angel Calderon
Marisol Cervantes
Angelina Vallejo Cormier
Donalda Dodson
Mary Jo Dudley
Dani Higgins
Carmen Huertero-Amigon
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

Tuesday, May 31, 2022

Call to Order AND New Member Oath of Office Administration

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

Ms. Paul called the biannual meeting of the National Advisory Council on Migrant Health (NACMH) to order. She noted that the Council has provided the Secretary of HHS with recommendations on the health and welfare of migrant and seasonal agricultural workers (MSAWs) since it was established by law in 1975.

Ms. Paul thanked the Chair, Vice Chair, and members of the Council for their service and stewardship on the NACMH and in their communities. She extended a special welcome to the three new Council members, as well as to the agricultural workers who agreed to provide testimonies, guests from farmworker-serving organizations, and federal officials and colleagues from HRSA and other agencies.

Ms. Paul noted that over the next four days, Council members would listen, learn, and share personal experiences, deliberate on important topics, and lean on data to make evidence-based recommendations that can lead to lasting improvements.

Ms. Paul called the meeting to order and administered the oath of office to new Council members.

NACMH Chair Opening Remarks

Deborah L. Salazar, BS, Chair, NACMH

Ms. Salazar welcomed Council members, guests, speakers, and HRSA staff to the meeting. She noted that during the next four days, the Council would hear presentations from a variety of experts as well as testimonies from agricultural workers themselves about challenges regarding their healthcare.

Ms. Salazar emphasized that each Council member brings an important perspective on the needs of agricultural workers. She reminded the Council of its responsibility to give voice to those who put food on our tables by making recommendations to better serve the agricultural workers in their communities and in the nation.

Ms. Salazar quoted Cesar Chavez: "It is possible to become discouraged about the injustice, we see everywhere. But God did not promise us that the world would be humane and just. He gives us the gift of life and allows us to choose the way we will use our in our limited time on earth. It is an awesome opportunity." She stated that this meeting was an awesome opportunity for the Council.

Ms. Salazar made a motion to approve the minutes of the November 2021 meeting. The motion was seconded by Ms. Higgins and carried by unanimous voice vote.

Ms. Salazar made a motion to approve the meeting agenda as presented. The motion was seconded by Dr. Viniegra and carried by unanimous voice vote.

Federal Update

Jennifer Joseph, PhD, MEd, Director, OPPD, BPHC, HRSA

Dr. Joseph provided an update on the HRSA Health Center Program, including an overview of health centers that serve agricultural worker populations, health centers' COVID-19 response, implementation of the Council's January 2022 recommendations, funding for the program, and collaborations and partnerships to support migrant health.

Overview of Migrant Health Centers

Migrant Health Centers (MHCs) receive funding 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 are MHC grantees. In fiscal year (FY) 2021, MHCs received nearly \$402 million in funding.

Health centers provide critically important services to underserved communities and populations. Clinical quality metrics often exceed national benchmarks, even though the populations they serve have many more social risk factors and other complexities.

Health centers served nearly a million MSAWs in 2020. Most of those patients (859,000) were served by MHC grantees. A small number of agricultural workers are served by health centers that do not receive MHC funding. The number of patients served by MHCs dropped by about four percent from 2019 to 2020. This was comparable to the decrease in health center patients overall and can be attributed to the disruption of healthcare delivery during the pandemic.

The pandemic accelerated the shift from in-person to virtual visits. In-person visits by health center patients decreased by 28.48 million, or 28 percent, from 2019 to 2020, while virtual visits increased from 318,005 to more than 23 million during the same period. HRSA is working to optimize virtual care in a way that maximizes access and delivery of high-quality care.

Health Center Program COVID-19 Response

Health centers have been heroes since the earliest days of the pandemic, ensuring equitable access for underserved communities and populations to critical COVID-19 response tools, including vaccines, testing supplies, therapeutics, and high-quality masks.

Health centers have administered nearly 8.7 million vaccine doses, with more than 1.6 million doses administered by MHCs. MHCs have ordered more than 3.3 million at-home self-tests, 15,600 courses of COVID-19 therapeutics, and nearly 2.2 million N95 masks.

Implementation of January 2022 Recommendations

HRSA has taken the following steps to implement the Council's January 2022 recommendations:

- Recommendation I: Address the public health challenges associated with agricultural labor trafficking.
 - HRSA National Training and Technical Assistance Partners (NTTAPS) will train health centers and legal services partners to: (1) develop strategies and identify tools to improve capacity to support patient-survivors, and (2) establish local collaborations to address violence and exploitation.
- Recommendation II: Address the public health challenges associated with environmental hazards that threaten MSAWs through interdisciplinary and cross-agency efforts.
 - HRSA NTTAPs will conduct an environmental justice symposium to address emerging health and environmental justice issues affecting MSAWs, such as heat stress, wildfire smoke exposure, pesticides, and other topics.
- Recommendation III: Maximize health center effectiveness to improve MSAW health through a HRSA-directed consortium/workgroup with growers' associations.
 - HRSA NTTAPs are developing a health center guide for identifying and developing relationships with local contractors and growers to increase MSAW access to mobile health services, vaccinations, and health education resources.
- Recommendation IV: Integration of community health workers (CHWs) into health center care teams to increase MSAW access to care.
 - HRSA NTTAPs provide health centers with subject matter expertise to measure and analyze the value of CHWs within team-based care models, and conduct a return-on-investment analysis for CHWs.

Health Center Program Funding

HRSA issued the following funding opportunities for health centers in FY 2022:

- Accelerating Cancer Screening (AxCS): \$5 million for approximately 10 awards to increase cancer screening by health centers that have an existing partnership with a National Cancer Institute (NCI) cancer center.

- ARP-Uniform Data System Patient-Level Submission (ARP-UDS+): \$90 million for approximately 1,500 awards to expand patient-level data that will enable health centers to identify disparities and gaps in clinical quality measures and advance the care model.
- School-Based Service Sites (SBSS): \$25 million for approximately 125 awards to expand access to school-based services, including behavioral health, at existing or new sites.
- Ending the HIV Epidemic – Primary Care HIV Prevention (PCHP): \$20 million for approximately 62 awards to continue the existing investment.
- Health Center Controlled Networks (HCCN): \$42 million for approximately 49 awards to support health centers with their health information technology and data needs.
- Additional funding for Native Hawaiian health systems (\$1.5 million) and for services to address Intimate Partner Violence (IPV) (\$500,000).

The president’s FY 2023 budget request includes \$5.7 billion for the health center program, an increase of \$90.3 million. This funding will support nearly 1,400 health centers in providing care to approximately 30.0 million patients, expand the Ending the HIV Epidemic initiative to an additional 40 health centers in the seven states with the highest rural HIV burden. It also includes funds to expand early childhood screening and development services to 425 health centers. This funding will support experts in health centers to ensure that children are reaching their developmental milestones and assist those who aren’t to navigate the systems to get the additional services that they need.

The president’s budget includes a commitment to working with Congress to advance the president’s goal of doubling the federal investment in community health centers. HRSA is ready to expand the footprint of the health centers to additional areas or expand the services of existing health centers if Congress provides the funding.

Training, Collaboration, and Partnerships

HRSA has established a range of collaborations and partnerships to support MHCs:

- National Training and Technical Assistance Partners
- Regional migrant stream forums organized by the National Association of Community Health Centers (NACHC)
- National Advisory Council on Migrant Health (NACMH)
- National Agricultural Workers Survey (NAWS)
- Partnership with the Administration for Children and Families (ACF).

Discussion

- Mr. Calderon asked if the funding opportunities Dr. Joseph described were strictly for community health centers (CHCs). He noted that his rural, agricultural community has traditionally been underserved by local public health and other agencies. He supports an integrated promotora system that addresses both medical issues and behavioral health or mental health concerns. He also asked if funding is available for promotoras to conduct cancer screenings and if public agencies can submit a request for funding.
 - Dr. Joseph replied that HRSA funding is limited to health centers. HRSA often hears about areas where there is great need but no health center, or where existing health centers do not provide the types of care that are needed. Health centers are moving toward an integrated model of care. Ninety-eight percent of health centers provide

behavioral health services, and an increasing number offer substance use disorder services. The administration's commitment to work with Congress to double the investments in the program is based on the need to extend the reach of health centers and bring physicians, behavioral health providers, community health workers, and services such as transportation and translation into new communities. The need is significant. One large health center has 19,000 people on its waiting list for behavioral health services. HRSA is thinking deeply about how to better support health centers in connecting patients to other resources in their community that can address social risk factors that contribute to the behavioral health crisis.

- Mr. Calderon said he wanted to ensure that all of a person's issues are addressed at a single point of care. Agriculture in his area is going through major changes, and farmworkers struggle to find consistent employment. The stress they are experiencing impacts their daily functioning, but employers do not prioritize their health or mental health needs. A good promotora program can address those issues.
- Ms. Dudley said her organization had to rapidly hire and train new people to respond to COVID and had to readjust when that funding ended. Long-haul COVID is devastating for farmworkers, because they cannot work if they are sick, and if they do not work they cannot live in employer-provided housing. The need to cover COVID costs, especially for the uninsured, raises new challenges. She suggested a differentiated approach, based on the number of cases, to address the long-term mental and physical health impacts of those affected by COVID. She also noted that promotora programs are very effective, because providers go where the farmworkers live. It is important to ensure that those programs are well supported.
 - Dr. Joseph replied that long-haul COVID is central to conversations at HRSA, including how to help health centers navigate the realities for patients. They concluded early on that trying to calculate the burden of COVID in any given place was not a realistic way to make funding decisions. In constructing formulas for funding opportunities, HRSA tries to find ways to fill gaps and meet the needs for services that are not otherwise compensated. She would welcome conversations about how to equitably accommodate the realities Ms. Dudley described.
 - Ms. Dudley stated that a high percentage of farmworkers are uninsured. Funding for them to receive services for COVID ended in March 2022. Many are continuing to work while they have COVID. If they don't show up for work, they will lose income and possibly their housing, which may cause the children to lose their school district. It is important to contextualize who the farmworkers are when we talk about their health, because they face a unique set of constraints and limitations.
- Dr. Viniestra stated that limiting funds for cancer screening to health centers that have partnerships with cancer research centers is not helpful for farmworkers. Farmworkers are exposed to carcinogens, but most clinics that serve them are not near a cancer center. He asked if there are any plans to provide cancer screening for farmworkers. Dr. Viniestra also noted that his community has one of the most successful HIV clinics in the state of Washington. HIV is relatively common in that area and there are many instances of sexual exploitation, yet the farmworker population does not have much awareness of HIV or screening. He asked if the HIV prevention funding could be used to create new clinics where services do not currently exist.
 - Dr. Joseph replied that Congress directed HRSA to use the cancer screening funds to support existing partnerships between health centers and cancer centers. The funding requires cancer centers to deploy an outreach specialist and patient navigators in the area served by the health center. It might be possible to do more if Congress provides additional resources in the future. Ending the HIV Epidemic is a 10-year initiative that is

focused on health centers in 57 jurisdictions with the highest HIV prevalence. It could potentially be expanded to support health centers outside of those areas, if funding is available.

- Ms. Huertero-Amigon asked about the date for the environmental justice symposium and the implementation timeline for HRSA's response to recommendations.
 - Dr. Joseph said she would provide more specific details.
 - Ms. Paul said she would share that information with the Council.

Council Introductions and Reflections

Ms. Salazar invited Council members to introduce themselves and to describe what they do and why they feel called to serve on the Council.

Colleen Laeger (Colorado) has served on the board of directors of Salud Family Health Centers for 35 years and currently serves as its Vice-Chair. She lives in one of the top 10 agricultural counties in the U.S. and sees the work that farmworkers do and the conditions in which they live. She is honored to be appointed to the Council.

Carmen Veguilla (Puerto Rico) is a farmworker and knows what it takes to do that work. The Council is important to support the health of farmworkers, particularly those who come from other countries. Appropriate health services are a basic need, and they are very important.

Karen Watt (New York) is a fruit grower and employs farmworkers. She serves as the Chair of the board of Oak Orchard Health and also works with the National Center for Farmworker Health. This is her second term on the Council.

Angelina Cormier (Montana) grew up on a farm, and her first paid job was harvesting beets for a neighboring farmer. A retired math and Spanish teacher, she has served on the Montana Migrant and Seasonal Farmworker Council for many years and currently serves as the Chair.

Elizabeth Freeman Lambar (North Carolina) worked as an outreach worker in Florida, New Jersey, and North Carolina. She found the work fulfilling and saw how important that role is in the health of farm workers. She currently serves as the director of the North Carolina Farmworker Health Program.

Angel Calderon (California) grew up in a farmworker family. He recently retired from a career in behavioral health and has served on the board of directors of Ampla Health since 2012. Serving on the Council is important to him because it gives a voice to the farm workers he represents.

Jose Salinas (Ohio) grew up in a farmworker family that migrated to Texas, Florida, and Ohio following the crops. His first pair of glasses and first trip to the dentist was with the migrant health program. He is the director of the Ohio Migrant Education Center, which serves the educational needs of migrant children. He also serves on the board of his local MHC and the board of MHP Salud.

Dani Higgins (Florida) works in migrant education in central Florida, where she specializes in mentoring migrant youth. She serves on the board of the Central Florida Health Care and started a non-profit organization to meet the needs of farmworkers in her community. She serves on the Council to be a stronger voice for the population she works with, because "to whom much is given, much is required."

Donalda Dodson (Oregon) is a public health nurse by background. She currently serves as the executive director of Oregon Child Development Coalition, which provides Migrant and Seasonal Head Start programs. She also serves on the board of Neighborhood Health Center, which provides migrant health services. She feels called to advocate and create paths for farmworkers and their families.

Carmen Huertero-Amigon (California) grew up on an estate with thoroughbred horses, where her father worked. His terminal illness due to pesticide exposure propelled her to work in this field. She has worked for many years in affordable housing and started a non-profit to improve the well-being of low wage earners. She also serves on the advisory board of TrueCare, which is a federally qualified MHC.

Marco Viniegra (Washington) was born in Mexico and came to the U.S. as an academic to teach at Harvard University. When he moved to the Washington, he became a teacher for migrant and Latinx students and eventually became a school administrator. He has been a board member for Community Health Care in Tacoma, which serves many migrant workers, and currently serves as its chair.

MaryJo Dudley (New York) grew up on a vineyard and did farm work throughout her youth. She is the director of the Cornell Farmworker Program at Cornell University and serves as a board member at Finger Lakes CHC, where she chairs the farmworkers sub-committee.

Deborah Salazar (Colorado) grew up in Omaha and lived in Mexico for many years. She feels called to be a bridge between the two cultures. She worked at a Hispanic clinic when she returned to the U.S and helped start a migrant program in southern Illinois. She currently serves as the migrant health director at Salud Family Health Centers, and she is passionate about serving those who feed us.

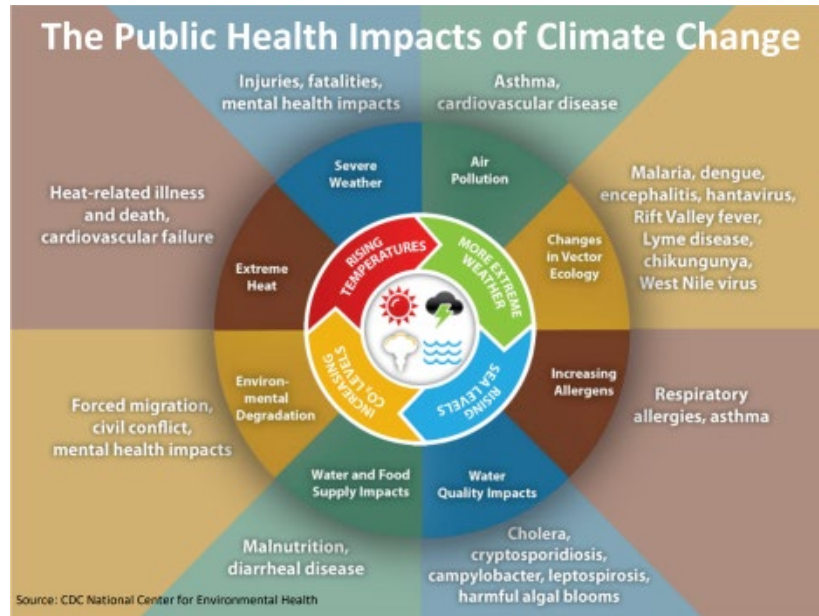
Public Health Impact of Climate Change on Agricultural Workers

Miranda Dally, MS, Center for Health, Work, and Environment, Department of Environmental and Occupational Health, University of Colorado

Ms. Dally noted that she developed her presentation with Dr. John Valdes, who is the interim director of the HHS Office of Climate Change and Health Equity (OCCHE). She provided an overview of climate change, described how climate change impacts human health, discussed how agricultural workers are uniquely affected by climate change, and reflected on what should be done to protect them.

Climate change is the effect of rising greenhouse gases, which can lead to rising temperatures, more extreme weather events such as hurricanes, and rising sea levels. The following graphic from the National Center for Environmental Health at the Center for Disease Control and Prevention (CDC) illustrates how these factors create conditions that impact public health.¹

¹ <https://www.cdc.gov/climateandhealth/effects/default.htm>



Climate change can affect anyone’s health, regardless of their occupation or personal factors. However, agricultural workers are at increased risk of experiencing the negative health consequences of climate change because the nature of their jobs exposes them to environmental hazards for longer periods of time and in greater intensity than most people.

Climate change impacts agricultural workers’ health through eight pathways:

- **Increasing temperature:**
 - Annual average temperatures have increased in most of the continental U.S. in the past 22 years. Temperatures in the Pacific region, which has a high concentration of farmworkers, have increased by 1.5 to 2 degrees.² Increased heat places more strain on the body, especially when working outdoors.
 - **Health impact:** Increased mortality from heat illness, exacerbation of underlying medical conditions, traumatic injuries, and chronic kidney disease.
- **Air pollution:**
 - In 2020, nearly 100 million people lived in counties where air pollution exceeded the exposure limit for one or more pollutants, including smoke from wildfires.³ Agricultural workers do not have the option to stay inside when air quality is unsafe.
 - **Health impact:** Asthma exacerbation, allergic diseases, chronic diseases.
- **Water quality:**
 - The percent of the land areas experiencing drought in the Continental U.S. has increased significantly since 2000.⁴ Drought increases the concentration of pollutants, and it can also increase expenses for farmers, increase the risk of wildfires, and alter the ecosystem in ways that reduce crop yields.
 - **Health impact:** Diarrhea, cholera, dysentery, hepatitis A, typhoid.

² <https://nca2014.globalchange.gov/report/our-changing-climate/recent-us-temperature-trends#:~:text=U.S.%20average%20temperature%20has%20increased,expected%20to%20continue%20to%20rise>

³ <https://www.epa.gov/air-trends/air-quality-national-summary>

⁴ <https://droughtmonitor.unl.edu/DmData/TimeSeries.aspx>

- Extreme weather events:
 - The frequency of extreme weather events (e.g., drought, wildfires, freezing, cyclones, severe storms, winter storms) has increased dramatically over the past 40 years.⁵ These events have both economic and health consequences.
 - Health impact: Traumatic injuries and post-traumatic stress disorder (PTSD).
- Ultraviolet (UV) radiation:
 - The intensity of UV radiation has increased over the last 30 years and is expected to continue to increase.⁶ Common protections such as sun-blocking clothing can make workers more susceptible to the heat.
 - Health impact: Skin cancer, premature aging, eye damage, and immune system suppression.
- Vector-borne diseases & biological hazards:
 - Climate change has altered the distribution of vector-borne diseases and the use of pesticides. Workers are exposed to diseases that were not previously a concern, and rates of pesticide poisoning have increased in those areas.⁷
 - Health impact: Lyme disease, skin irritation, and cancers from increased pesticide use.
- Displacement:
 - Climate change can be a factor in displacement of populations, as increased heat leads to lack of water for agriculture or human settlement.⁸
 - Health impact: Diminished sense of self and social interaction; conflict and violence.
- Industrial transition:
 - Changes in agriculture due to climate change will have consequences for workers.⁹
 - Health impact: Job insecurity, under-employment, and unemployment.

The health outcomes of climate change for agricultural workers are influenced by social and behavioral factors that affect their ability to adapt or respond to exposure pathways they encounter at work. These factors include age and gender; race and ethnicity; poverty; housing and infrastructure; education; discrimination; access to care and community health infrastructure; pre-existing health conditions.¹⁰

Agricultural workers' vulnerability to climate change is increased by environmental justice factors, such as proximity and exposure to environmental stressors; unique exposure pathways; physical infrastructure, including poor housing; multiple stressors with cumulative and compounding impacts; and capacity to participate in decision making.¹¹

⁵ [Billion-Dollar Weather and Climate Disasters | National Centers for Environmental Information \(NCEI\) \(noaa.gov\)](#)

⁶ [NASA - UV Exposure Has Increased Over the Last 30 Years, but Stabilized Since the Mid-1990s](#)

⁷ <https://www.cdc.gov/niosh/topics/pesticides/animatedmap.html>

⁸ <https://www.whitehouse.gov/wp-content/uploads/2021/10/Report-on-the-Impact-of-Climate-Change-on-Migration.pdf>

⁹ Weisbach, Michéle et al. Agriculture 4.0 - A state of the art review focused on electric mobility. Revista Ciência Agronômica 2020 (51). (<https://doi.org/10.5935/1806-6690.20200103>)

Adapted from: DE CLERCQ, M., vats, A.; BIEL, A. 2018. Agriculture 4.0: The Future of Farming Technology.

(<https://www.marshmcclennan.com/content/dam/mmcweb/insights/publications/2018/november/agriculture-4-0/Oliver-Wyman-Agriculture-4.0.pdf>)

¹⁰ U.S. Global Change Research Program, [Health2016.globalchange.gov](https://www.health2016.globalchange.gov)

¹¹ Guidance on Considering Environmental Justice During Development of Regulatory Actions, U.S. Environmental Protection Agency (EPA), 2015.

Pay structures and workers' compensation laws impact agricultural workers' ability to limit their environmental exposure and protect their health. The federal Fair Labor Standards Act (FLSA) excludes agricultural workers from overtime pay. In states with no overtime laws or where agricultural workers are not covered by those laws, workers do not have rights to overtime pay.¹² Hourly workers or those who do piece work may have to decide between taking a break or doing as much work as possible. Workers' compensation laws in some states exclude workers who are not state residents.¹³ Workers in states that do not have workers' compensation laws may fear for their jobs if they report an injury.¹⁴

Climate change also has economic consequences. Increasing temperatures are associated with reduced productivity and higher rates of occupational illness and injury, leading to loss of jobs and income.^{15 16 17}

OCCHE was created by Executive Order in 2021. It has three priorities: climate and health resilience for the most vulnerable, climate actions to reduce health disparities, and health sector resilience and decarbonization. OCCHE works collaboratively with various agencies within HHS and has convened an interagency working group that includes a component on occupational health.

Ms. Dally emphasized three takeaway messages:

- Climate change is compounding existing stressors and health disparities.
- Agricultural workers are at risk, given their compounding vulnerabilities.
- We have the power to protect agricultural workers from climate change.

Discussion

- Ms. Salazar asked what recommendations Ms. Dally would offer for the Council's consideration.
 - Ms. Dally said her personal recommendation would be to work with agricultural communities to understand their needs and priorities. Researchers are often invested in their definition of the problem and how to address it. It is important to talk to those who have direct personal experience to ensure that proposed solutions are practical.
- Ms. Dudley noted that some states are working on heat protection policies and asked how state-level policies interact with federal policies for farmworkers. She agreed that it is critical to be in contact with workers to ensure that recommendations genuinely reflect their reality and needs.
 - Ms. Dally replied that OCCHE is looking at how state-level policies to protect workers are playing out and what the federal government can learn from them.
- Dr. Viniestra referenced the map Ms. Dally presented showing lost wages due to global warming. He asked to what extent OCCHE is in contact with workers in the U.S. who are most affected by

¹² <https://www.farmworkerjustice.org/overtime-map>.

¹³ <https://www.farmworkerjustice.org/workers-compensation-map>.

¹⁴ <https://sites.uw.edu/pols385/tag/farm-workers>.

¹⁵ The Lancet DOI: (10.1016/S0140-6736(18)32594-7).

¹⁶ Dally M., Butler-Dawson J., Krisher L, Monaghan A, Weitzenkamp D, Sorensen C, et al. The impact of heat and impaired kidney function on productivity of Guatemalan sugarcane workers. PLoS One. 2018;13(10):e0205181. Epub 2018/10/05.

¹⁷ Dally M, Butler-Dawson J, Sorensen CJ, Van Dyke M, James KA, Krisher K, Jaramillo J, Newman LS. Wet bulb globe temperature and occupational injury rates among sugarcane cutters in Southwest Guatemala. Int. J. Environ. Res. Public Health 2020, 17(21).

these conditions and whether climate issues might be affecting global trade and farmworkers outside the U.S.

- Ms. Dally said the map was based on modeling studies that include assumptions that certain temperatures are too hot for workers. Those assumptions might not be reflected in reality, because workers may choose to work in higher temperatures. In her research, Ms. Dally works through academic-private partnerships to engage directly with workers and their employers. She did not have information on how climate change impacts global policies. She offered to look into that issue and get back to Dr. Viniegra.
- Mr. Calderon noted that he lives near a town that was destroyed by wildfires in 2018. The presentation explained why agricultural workers in his area now start working at 6:00 a.m. and are home by 1:30 or 2:00 p.m. Some people have lost a lot of hours of work. Climate change is affecting the mental health of everyone, especially agricultural workers. Every community health center needs to address that.
- Dr. Salinas noted that the map Ms. Dally presented showed scattered cases of Lyme disease in Ohio and a dense concentration across the state line in Pennsylvania. He asked if that was due to underreporting in Ohio and stressed the need to provide accurate information to workers.
 - Ms. Dally said the slide was not based on her research. She would look at the article and get back to Mr. Salinas.
- Ms. Watt noted that the data on farmworkers' family income levels were from 2014. She suggested that Ms. Dally contact NCFH for more recent data.
- Ms. Lambar noted that many environmental risks are outside of the control of individual workers. She asked if there is a role for the Department of Labor to look at heat standards nationally. Outreach workers spend a lot of time on education, but there should be other avenues to protect workers.
 - Ms. Dally replied that the Occupational Safety and Health Administration (OSHA) is in the rulemaking process for a national heat standard. Public health puts the burden on the worker. We can educate workers, but we need structural changes to empower them to do what we recommend.
- Dr. Salinas referenced the discussion of industrial transition and noted that crop patterns are shifting as climate change impacts growing conditions. That, in turn, impacts the migration patterns of workers who follow those crops.
- Ms. Dudley commented that industrial transition varies by crop. Many fruits and vegetables still need to be harvested by hand. She noted that maps have been generated to show where certain kinds of crops will be able to be grown in the future, given shifts in rainfall, temperature, and other factors. Climate change predictions and mapping could benefit from that work to understand where workers will be going.
 - Ms. Dally appreciated Ms. Dudley's suggestion. Much of the public health response has been in reaction to what is happening. It is important to be prepared for what is coming.
 - Ms. Dudley noted that dairy workers do not migrate. Heat protections and climate change predictors for those workers would be different than for fruit and vegetable commodities.
 - Ms. Dally commented that the term "farmworkers" overlooks the fact that every segment of agriculture is different. That is why she recommends talking to workers to understand their situation and their needs.
- Ms. Higgins asked if it would be possible to see qualitative data and the interview questions that are used in this research. The H-2A workers in her area are paid by how much they can get done in a short amount of time. She has seen an increase in heat-related illness and hospitalization.

There is a great deal of misinformation about regulations to make drinking water accessible to workers. It would be helpful to know why the education that outreach workers provide is not effective or how to do more preventive work in this area.

- Ms. Dally replied that researchers at the University of California-Davis and Emory University have done qualitative work with farmworkers. NCFH also has resources. However, the qualitative component of this work is lacking. As researchers try to include health in climate change modeling, qualitative research will be important to understand how to make interventions that are grounded in the culture.
- Ms. Cormier noted that when sugar beet harvesting in Montana became mechanized, farmers sacrificed quality and quantity in order to eliminate the need to take care of workers. She asked if information was available on trends in mechanization to let workers know about changes that are coming and retrain them for different jobs.
 - Ms. Dally was not aware of specific examples, but she offered to look into it.
 - Ms. Dudley said that New York has a combination of H-2A workers who come for the harvest season only and year-round workers who combine different kinds of work for different commodities in the area. Agriculture is not uniform, even in the same area. Big-picture research on climate change should be combined with on-the-ground qualitative research to inform policy. Otherwise, policies do not reflect reality.

Meeting Wrap Up and Adjourn

Jose Salinas, EdD, Vice-Chair, NACMH

Dr. Salinas summarized the presentations and discussions of the first day of the meeting and reviewed the agenda for the second day.

Council members shared their reflections on the information presented by the speakers.

Ms. Salazar adjourned the meeting for the day at 4:17 p.m.

Wednesday, June 1, 2022

NACMH Chair Welcome

Deborah L. Salazar, BS, Chair, NACMH

Ms. Salazar called the meeting to order and reviewed the agenda for the day.

National Association of Community Health Centers (NACHC) Update

Rachel A. Gonzales-Hanson, Interim President and CEO, NACHC

Ms. Gonzales-Hanson noted that 2022 is the 60th anniversary of the Migrant Health Act and thanked the Council for their work to improve the health and well-being of agricultural workers. She then provided an update on policy and legislative matters that impact health centers, the status of the AgWorker campaign, and a new collaboration with the Robert Wood Johnson Foundation (RWJF) to change the health care delivery system in the U.S.

Policy and Legislative Matters

Health Center Capital Needs

A study conducted in 2021 found that health centers need \$17.5 billion for capital projects in the next five years to build, expand, or renovate their facilities to meet patients' medical, mental health, and oral health needs.¹⁸

The Build Back Better legislation that was passed by the House last year included \$2 billion for health centers, including 330 grantees. The scope of the bill may change due to concerns about inflation and spending that have led to delays in Senate consideration.

Supporting the Health Center Workforce

The health center workforce is a key priority for NACHC. The American Rescue Plan included \$1.3 billion for three key primary care workforce programs: the National Health Service Corps (NHSC), Nurse Corps, and Teaching Health Center Graduate Medical Education (THCGME). The Build Back Better Act included \$5.87 billion for those programs. The upcoming budget request is expected to invest \$700 billion in programs to train mental health and substance use disorder clinicians.

A recent NACHC survey found that nearly 70 percent of health centers have seen up to one-quarter of their staff leave over the past six months. Most of those who left were in non-clinical positions, including nursing support, administrative, and clerical. NACHC is working with partners to develop a more robust strategy for non-clinical workforce development, including CHWs/promotoras.

Protecting Access to the 340B Program

The 340B program allows health centers to purchase pharmaceuticals at a substantial discount, with a requirement to utilize the savings for their operations. Pharmaceutical companies are beginning to push back against this program. Four drug companies announced restrictions to health center contract pharmacies, and pharmaceutical companies are pursuing litigation in multiple venues. As part of that litigation, the pharmaceutical companies are putting pressure on health centers to provide patient information that should not be shared. In a separate development, the Governor of California signed an executive order that shifts 340B savings from health centers to the state budget.

NACHC supports the PROTECT 340B Act (HR 4390) to ensure that health centers can maintain their savings. Twenty-two states have passed legislation to protect the program, and 13 states are considering legislation. NACHC is working with other national state-based groups to promote a model bill.

Telehealth

Telehealth was extremely important for the agricultural worker population during the pandemic. The telehealth exemptions in the Public Health Emergency declaration allowed a 6,000 percent increase in telehealth visits in 2020. The 2021 NACHC survey found that telephone-only telehealth visits were particularly important for health center patients during the pandemic.

The emergency declaration is expected to continue through July 2022. The recent spending bill included a 151-day extension (through March 2023), but a permanent fix is needed to provide a long-term path

¹⁸ <https://caplink.org/capital-needs-2021>

forward on telehealth. NACHC has supported several bills and will continue to push for certainty for health centers.

Medicaid Redeterminations

Policies for enrolling in Medicaid and the Children's Health Insurance Program (CHIP) vary by state, which creates challenges for migrant and seasonal populations. NACHC advocates for a reciprocity model for enrollment in these programs. Medicaid agencies must work more closely with safety net providers, especially health centers, to ensure that patients maintain their coverage.

Health Center Funding

Stable, long-term funding for health centers is a key priority for NACHC and is essential for a program that serves more than 29 million patients per year. Short-term appropriations that must be renewed each year have operational impacts on health centers and their patients. The health center program has had bi-partisan support for nearly 30 years, and it is important for that support to continue.

The health center program currently receives base funding of \$1.7 billion in discretionary funding, plus \$4 billion from the Community Health Center Fund (CHCF). The CHCF was created with a five-year authorization in FY11 to support the expansion of the health center program as part of the Affordable Care Act. This mandatory funding was extended through two-year authorizations in FY16 and FY18, a one-year authorization in FY20, and a three-year authorization in FY21. The current extension, which represents two-thirds of the funding for health centers, will expire in 2023.

NACHC hopes to have a strong bi-partisan bill introduced in January 2023 to extend and increase health center mandatory funding to avoid a fiscal cliff in October. A discretionary funding fix will probably also be needed. NACHC will pursue a short-term patch if Congress does not act in time.

Potential reauthorization priorities are to expand the reach of the health center program, deepen the services health centers provide, and strengthen existing health centers.

Health Center Advocacy Network

NACHC created the Health Center Advocacy Network to build, strengthen, and nurture a community of advocacy leaders, including patients. Policy papers, toolkits, and other resources are available at <https://www.hcadvocacy.org/2022-top-legislative-priorities>.

Ag Worker Access Campaign

The Ag Worker Access Campaign was created by NACHC and NCFH as a national initiative to increase the number of MSAWs and their families served in health centers to two million.

To achieve that goal, the campaign's activities are focused on four areas:

- Understanding and addressing MSAWs' unique needs and the barriers they face related to accessing health care
- Ensuring C/MHC staff receive the training and technical assistance they need to effectively outreach to the agricultural worker population and accurately classify and report them in the Uniform Data System (UDS)
- Identifying and disseminating promising practices for increasing access to care for MSAWs

- Supporting local/regional/state coalitions between C/MHCs and other entities that serve agricultural workers.

The campaign works with agricultural worker families and C/MHCs to assess needs, identify barriers to care, and document and track numbers served. NACHC's Ag Worker Committee establishes priorities, develops strategies, and engages stakeholders. The Ag Worker Access Campaign Task Force is part of that committee, along with a Stabilizing Revenue Workgroup and an Administrative Policy Workgroup.

The objectives of the campaign are to develop promising practices, community partnerships, distribution strategies, and recommendations for administrative and legislative policy and circulate them to health centers and organizations that are trying to affect social determinants of health. The campaign works with HRSA and NACMH and submits reports to the Secretary of HHS as well as to MSAW families.

In 2021, the Campaign Task Force sponsored its first webinar series, *Developing Collaborations with State Monitor Advocates*. This year, the task force developed and implemented an engagement strategy for primary care associations (PCAs). Other activities for 2022 are to build partnerships, identify promising practices, and plan a new webinar series. The next webinar, *60 Years of Migrant Health: Migrant Health Program History and the Agricultural Worker Experience*, will be held on June 28 at 1:00 p.m. CT. The registration link is <https://bit.ly/3yxReKX>.

Council members and others can join the campaign at <https://bit.ly/39V6Ap9>.

Raising the Bar: Health Care's Transforming Role

Raising the Bar (RTB) is a new project that NACHC launched in collaboration with RWJF to change the way health care is delivered in the U.S. The goal of the project is to accelerate health care's engagement in efforts to achieve health equity, improve the health and well-being of individuals and communities, and enhance the health care experience of individuals and their families.

Recognizing that multiple sectors must work together to address this issue, the project is focused on the roles and responsibilities of healthcare organizations and institutions in both clinical and non-clinical settings.

The project convened a broad, participatory process to get feedback on long-standing roles and challenges for health care from patients, communities, and different parts of the industry. Based on that input, the project developed five foundational principles through which health care can approach equity and excellence:

- Commit to a mission of improving health and well-being
- Systematically pursue health equity, racial justice, and the elimination of all forms of discrimination
- Serve the community as an engaged, responsive, and proactive partner
- Share and effectively use resources, influence, and power
- Earn and sustain trusting relationships.

The framework for the healthcare industry to implement those principles is based on four transformational roles and associated actions:

- Provide whole-person care to achieve health equity
 - Actively promote and facilitate access to care for all in ways that accommodate diverse life circumstances and needs
 - Establish and sustain a trusting environment where everyone feels they are welcomed and treated with dignity and respect
 - Provide holistic, effective, high-quality care responsive to plans co-created with individuals, families, and caregivers.
- Employ and support a diverse health workforce
 - Invest in and grow leaders who advance and embed equity, quality, and value across the organization
 - Employ and cultivate a representative workforce at all levels
 - Create and sustain workplaces and jobs where employees can be healthy, thrive, and help guide effective and equitable care
 - Leverage procurement to ensure the diversity and well-being of contract workers.
- Engage with individuals and organizations in the community, prioritizing those most affected by inequities
 - Meaningfully involve individuals from the community in governance and decision-making
 - Build trusting relationships with individuals and organizations in the community
 - Respect and build on the expertise and power of individuals and organizations in the community.
- Advocate for and invest in health equity
 - Actively advocate for and adopt payment reforms, especially those that align investments with the mission of improving health and well-being
 - Use health care's voice to shape public understanding about the importance of health equity and dismantling racism and all forms of discrimination
 - Use power and influence to advocate for health equity in the development and implementation of public policies
 - Use investment and procurement power to contribute to the health and resilience of communities.

Discussion

- Ms. Dudley noted that the non-clinical workforce, including promotoras, is more effective in reaching the population, but it is more expensive. The health center where she serves on the board used COVID funding to hire and train more people, but it is hard to fill the gaps since the funding ended. She asked if RWJF would fund training for more promotoras. Ms. Dudley also noted that extending support for telehealth is important, but telehealth does not solve all problems.
 - Ms. Gonzales-Hanson replied that RWJF has programs for training promotoras, but NACHC's collaboration does not include funding for those activities. NACHC is working with promotora groups across the country to identify effective training programs and find funding for them. The National Association of Community Health Workers (NACHW, nachw.org) is trying to build advocacy for the issues Ms. Dudley mentioned. Ms. Gonzales-Hanson did not know the extent to which they are collaborating with groups that provide training. One of the NTTAPs that receives HRSA funding, Health Outreach Partners (HOP, <https://www.outreach-partners.org/>), also provides training. NACHC is trying to find ways to support training for non-clinical staff, but funding from Congress is

tight. One strategy might be to identify other foundations that can help with training. The key would be to fund train-the-trainer programs to develop in-house capacity.

Panel Presentation: Addressing Vaccine Hesitancy in Migrant and Seasonal Agricultural Workers

Eva Galvez, MD, Virginia Garcia Memorial Health Center, Oregon

Alma Galván, MHC, Senior Program Manager, Migrant Clinicians Network

Ed Franchi, Director, Agricultural Worker Program, Keystone Rural Health Center, Pennsylvania

Eva Galvez

Dr. Galvez shared lessons learned from the COVID-19 vaccination campaign at Virginia Garcia Memorial Health Center in northern Oregon and reflected on how to forge a path to increase access to vaccines for farmworkers. She noted that her parents were Mexican immigrants and seasonal farmworkers. Her childhood dream was to be a doctor and provide care to MSAWs.

Addressing Vaccine Hesitancy

Vaccine hesitancy is linked to long-standing mistrust that is rooted in historical and present-day injustices and systemic inequities that make farmworkers feel that they are not valued. Other factors include lack of familiarity with the health system; language, literacy, and cultural factors; and lack of access to health care. Misinformation and disinformation thrive in that context. We need to address those inequities if we want to promote access to vaccines.

Virginia Garcia's vaccine campaign is one case study. In January 2021, the COVID-19 vaccine was only available at mass vaccination centers in downtown Portland. Patients reported barriers to transportation, difficulty navigating the electronic portal to make an appointment, fear of police and military presence at the sites, and fear of providing personal information. Patients were willing to get the vaccine, but they wanted to get it from their doctor.

To address these concerns, the health center partnered with state and local public health agencies to secure large amounts of vaccines and transformed their primary care clinics into vaccine centers that were open to all community members, without requiring proof of insurance or identification. The health center's approach involved everyone from front desk staff to doctors. People could walk in without having to use a computer or make an appointment. The vaccine centers were open during evenings and weekends, with bilingual staff to reduce cultural and linguistic barriers. The vaccines were administered by trusted providers.

A mobile medical van took the vaccine to migrant camps, where the health center has a long history of providing basic health care. They partnered with local nurseries, employers, and community-based organizations (CBOs) to make it possible for workers to get vaccinated. To date, the health center has vaccinated more than 80,000 people.

This successful campaign offers three key lessons:

- Increase access by removing barriers
- Access alone is not enough; you must also have patients' trust
- CBOs and federally qualified health centers (FQHCs) are ideally positioned to do this work.

Based on these lessons, Dr. Galvez offered four strategies to address vaccine hesitancy:

- Bolster FQHCs and invest in a healthcare workforce that reflects and represents the community.
- Increase access through strategic partnerships in the local community.
- Strengthen CBOs, including growers, faith-based leaders, and others.
- Increase access to culturally and linguistically appropriate health information delivered through a variety of communication methods in order to reach more people.

To strengthen FQHCs, we need to increase funding to continue to provide free vaccines and testing and to support mobile medical units specifically for farmworker outreach. We also need to develop and sustain a workforce that reflects the community by decreasing barriers to higher education, supporting pipeline programs for doctors, nurses, medical assistants, and CHWs, and providing living wages.

Strategic partnerships between public health agencies and primary care providers increase access to services. People trust their providers, not the healthcare system. We should leverage this to increase trust in public health, making local clinicians the “face” of public health.

Partnerships with CBOs can increase access to services and promote trust in the system. We should promote integration and on-going partnerships so we are prepared for future pandemics or public health crises, and we should use CBOs’ expertise in the community to address health disparities.

Misinformation and Disinformation

An article in *The New Yorker* stated that 57 percent of Latinx people were more likely to use social media as their primary source of information about COVID-19.¹⁹ Patients are using social media instead of going to health centers because we have not been able to customize health information.

It is not enough to translate materials into Spanish. We need to consider literacy, language, culture, values, and beliefs. We need to understand that people have different learning styles. We need to understand where the community wants to get their information. Our community partners can help us tailor our health information.

Misinformation thrives when there is a foundation of mistrust. Trusted messengers are keys to correcting misinformation and increasing trust in the system, and they emerged as key players in promoting trust in the vaccines. They often have close ties to and represent the community. We should develop a healthcare workforce from the community to increase the pool of trusted messengers, and we should sustain a network of local, trusted voices that can be “activated” in the face of a health crisis.

Social media must be an area of focus. The community is increasingly using it as a source for health information, and it is an essential tool to spread important health information quickly. We should teach the community to assess the information they receive before they share it with others.

We must ultimately work to dismantle systemic barriers and inequities that exclude farmworkers. Health care must be at the table when policies are being created.

¹⁹ <https://www.newyorker.com/news/daily-comment/the-latinx-community-and-covid-disinformation-campaigns>.

Alma Galván

Ms. Galván discussed considerations to address vaccine hesitancy and disinformation in MSAWs, including challenges and systemic/structural barriers; the nature of myths, disinformation, and misinformation; and how to promote equity and improvement of health among MSAWs.

Challenges and Systemic Barriers

Challenges that contribute to vaccine hesitancy include health literacy and health system literacy, health beliefs, family structures, language and literacy issues, discrimination, fear due to immigration status, distrust of government and institutions, and isolation.

MSAWs face systemic barriers in the health system, immigration system, an academic system that does not value their experience, and public policies regarding worker benefits (e.g., access to health insurance, paid sick leave, personal protective equipment, and housing).

The Nature of Misinformation/Disinformation

Misinformation is unintentional, while disinformation is intended to create confusion. Factors involved in misinformation include trust, language, message delivery, information channel, cultural values, access, and politics.

Information and misinformation spread like a virus. Exciting messages spread even faster, which can be deadly. We must critically assess information before we share it. We can intervene in misinformation by double-checking facts and asking the sender how they know the information is true.

Strategies to Promote Equity and Improve Health among MSAWs

Ms. Galván offered three recommendations:

- Integrate CHWs into local public health COVID-19 response and reconstruction efforts. Take advantage of CHWs' status as trusted messengers and their role in promoting and improving health equity. Customize health education to incorporate culture, values, and belief systems. Build networks and coalitions that empower disadvantaged communities.
- Build alliances with CBOs and local public health agencies. Avoid short-term solutions that are not sustainable, and fund long-term interventions to build a health infrastructure that strengthens both parties. Provide technical assistance to engage the public health system and the community. Develop Requests for Proposals (RFPs) in languages that CBOs can understand.
- Strengthen alliances with health departments. Develop partnerships to address the impact of COVID-19 on the community and better meet the needs of vulnerable populations who suffer from the impact of the disease. Develop community mobilization strategies between vulnerable communities and local and state health departments.

Ed Franchi

Mr. Franchi provided an overview of Keystone Health and the Keystone Agricultural Worker Program, discussed challenges to vaccination for agricultural workers, and described the steps Keystone has taken to address barriers to vaccination among MSAWs.

An article co-authored by Ms. Galván identified five challenges to vaccination for agricultural workers: the inherently mobile nature of the population, vaccine-specific factors, distrust in government and

healthcare, misinformation, and baseline challenges and barriers, such as language and cultural factors, health literacy, and insurance.²⁰

Mr. Franchi described how Keystone has addressed these challenges and discussed what is needed to fully address those barriers.

- Inherently mobile nature of the MSAW population
 - Issues: Many farms are remote, and MSAWs lack transportation. Vaccine providers do not consistently provide vaccine cards. Some growers are opposed to vaccination, which can impact access for workers they hire.
 - Actions: Keystone hired contract providers to provide vaccination services on farms across the state. Doses are reported to the Pennsylvania system, and workers receive a record of their vaccinations. Keystone vaccinated 1,000 more workers in 2021 than in 2020.
 - What is needed: Invest in health centers in rural communities or mobile units. Assist workers with transportation.
- Vaccine-specific factors
 - Issues: Storage/temperature requirements; vials have 10 doses (20 for booster).
 - Actions: Keystone purchased portable refrigerators and is coordinating events to minimize waste.
 - What is needed: Provide more options in rural communities. Develop streamlined funding opportunities to respond to public health emergencies.
- Distrust in government and healthcare
 - Issues: Immigration, bad perception of government and the healthcare system.
 - Actions: Keystone staff are educating farmworkers on the vaccine and COVID. Keystone provided CHW training for 10 employees and is providing additional training on behavioral health issues.
 - What is needed: Educate providers about the H-2A program. Create a campaign to address distrust.
- Misinformation
 - Issues: Many unfounded perceptions; distrust of the system.
 - Actions: Keystone is providing brochures and educational materials in different languages and formats, including text messages, and is bringing vaccination services to the workers.
 - What is needed: Initiate a national campaign to increase understanding of the role of MSAWs and the issues they face.
- Baseline challenges and barriers
 - Issues: Language and cultural factors. Health literacy and insurance.
 - Actions: Keystone is hiring bilingual staff, including a nurse who speaks Haitian Creole, and increasing the number of contracted clinics.
 - What is needed: Initiate regulations to remove barriers. Raise the perception of farmworkers as valued and essential workers in the nation's food supply.

²⁰ Christine M Thomas, Amy K Liebman, Alma Galván Jonathan D Kirsch, William M Stauffer, Ensuring COVID-19 Vaccines for Migrant and Immigrant Farmworkers, *American Journal of Tropical Medicine and Hygiene*. 2021 Apr 13;104(6):1963-1965.

Discussion

- Mr. Calderon said that farmworkers in his area were reluctant to get tested or vaccinated because they were afraid of losing work. Once farmworkers began to get COVID, many of them decided to get the vaccine.
- Ms. Higgins asked Dr. Galvez what the Council could recommend to build trust.
 - Dr. Galvez replied that building trust takes time. Partner with organizations that were part of the community before the crisis hit, instead of expecting people to go to a mass vaccination site. Having a bilingual/bicultural staff is not enough. Hiring providers from the community they serve is a good way to build trust. We need to promote healthcare careers in our communities, starting from an early age, and we need to increase scholarships and remove barriers for students who need to work while they attend medical or nursing school so they can support their families. Build the workforce, and then build long-lasting partnerships with CBOs that are part of the community.
 - Mr. Franchi stated that changing culture is a long-term process. A campaign to boost the public perception of farmworkers is critical.

Housing and Health Disparities: Addressing the Public Health Impact on Migrant and Seasonal Agricultural Workers

Carmen Amignon, Council Member, NACMH - Moderator

Sara A. Quandt, PhD, Professor, Wake Forest School of Medicine

Brianna Cardoza, Chief Development Officer, TrueCare

Ms. Amignon facilitated a discussion with Dr. Quandt and Ms. Cardoza regarding the health impact of housing on MSAWs.

Sara Quandt

Dr. Quandt reviewed her research comparing grower-provided housing to housing regulations in North Carolina, discussed common health outcomes of housing conditions, and discussed how housing facilitates COVID transmission. She noted migrant housing conditions and regulations have not changed significantly since the study was conducted in 2010.

Farmworker Housing and Regulations

Grower-provided housing (either grower-owned or contracted) is most often provided for migrant workers, and not for seasonal workers. Housing must be provided for H-2A visa holders and must meet federal (OSHA) and state regulations for farmworker housing. States are expected to inspect and enforce regulations.

Community housing is short- or long-term housing obtained by workers themselves. There are no farmworker-specific regulations, but the housing must meet local housing regulations. Regulations are enforced at the local level.

Nationally, most farmworkers do not live in housing for which there are farmworker-specific regulations.

2010 Study Comparing Farmworker Housing to Regulations in North Carolina

Dr. Quandt and her colleagues surveyed grower-provided housing in 186 camps across 16 counties in North Carolina. They obtained permission from workers to inspect their housing. They did not ask

growers for permission. Two-thirds of the camps had some H-2A workers. About half had 10 or fewer residents. Sixty-one percent had only one dwelling.

The researchers compared the housing to 39 of the 79 state regulations covering general camp conditions, sleeping room, bath, toilet, kitchen, and laundry facilities. They used state labs to test water quality and collected wipe samples for pesticides.

The researchers found violations at all of the camps, ranging from 4 to 22 per camp. One-third of the camps had unsafe drinking water. Most of the violations were in sleeping rooms (rodents and cockroaches; mattress on the floor; bed shared with another worker; crowding; and mold), kitchen (refrigerator temperatures over 45 degrees; rodents and cockroaches; no refrigerator, stove, or fire extinguisher), laundry (no washing machine or tub), and bath (visible water damage).

The researchers also looked at heat in housing, because workers have no means to recover from extreme exposure to heat in the fields if they come home to housing that is equally hot. They calculated the heat index by measuring temperature and relative humidity in a bedroom and the common room in farmworker dwellings after 4:00 p.m. in early summer, middle summer, and late summer. About 15 percent of the sleeping rooms were in the “no danger” range (less than 80 degrees); the remaining 85 percent were at the “caution” (80-90 degrees) or “danger” range (91-103 degrees). Air conditioning was not sufficient to lower the temperatures below the caution or danger ranges in late summer.

Additional concerns included privacy or security issues (no privacy for toilets or showers; no key to the external door of the dwelling); pesticides (traces of 23 different pesticides, including some with discontinued registrations and some not registered in North Carolina); and social isolation (camps not visible from the road were in worse shape; most camps had no transportation for workers).

Violations typically increase over the summer, as more workers arrive and camps fall into disrepair. Camps with H-2A workers had fewer violations.

Housing and Health Outcomes

The housing violations identified in the study are linked to a wide range of health outcomes:

- Crowding: Communicable diseases (including COVID), mental health issues
- Refrigerator temperatures/lack of cleanliness: Food-borne disease
- Poor water quality: Water-borne diseases
- Mold, mildew: Respiratory symptoms, asthma
- Rodent/cockroach infestation: Respiratory symptoms, asthma
- Heat: Heat illness, exhaustion (leading to unintentional injuries)
- Pesticides: Poisoning (particularly among children), long-term neurological issues
- Lack of privacy or security: Mental health, lack of hygiene
- Social isolation: Depression, lack of access to health care, domestic violence.

COVID-19 Prevention and Housing

Farmworker housing is often crowded. The average household size is twice the U.S. average, and many households include multiple families or unrelated persons. There is a high turnover in housing due to the agricultural cycle.

Crowding places farmworkers at high risk for COVID transmission. Social distancing is not possible. Workers share bathrooms, kitchens, and laundry rooms with other adults who have different daily contacts. There is no space for ill workers to quarantine or for their contacts to self-isolate.

Much of the communication on COVID has focused on individuals. Prevention needs to happen at the household level. Households can be social networks through which information flows.

Worksite prevention can miss what happens in housing. Prevention efforts are most appropriate for grower-provided housing. Whole-household vaccination campaigns should be included with worksite vaccination efforts.

Recommendations

Dr. Quandt offered two recommendations for the Council's consideration:

- Provide cooling in housing for workers.
- Address crowding in housing to alleviate transmission of infectious disease.

These recommendations would require changes in regulations and increased enforcement. Current regulations are not stringent enough to respond to current conditions of extreme heat and infectious diseases, and they are not being enforced.

Brianna Cardoza

Ms. Cardoza provided an overview of the migrant health program at TrueCare and the population that it serves and discussed approaches to address housing and health disparities in agricultural workers.

Migrant Health at TrueCare

TrueCare (formerly known as North County Health Services) was established as an FQHC in 1971 serving north San Diego County and Riverside County, California. They currently have 11 sites and a mobile unit and will soon add new two sites and two mobile units. TrueCare offers comprehensive primary care, dental, behavioral health, women's health, chiropractic, and cardiology services for nearly 60,000 patients a year. They are a designated MHC.

TrueCare has seen a consistent downward trend in the number of MSAW patients they serve since 2016, when many farms and nurseries in their service areas began to close for a variety of reasons.

The migrant population that TrueCare serves is about 61 percent female, with an average age of 40 to 60. Nearly half are uninsured. Health disparities include higher rates of asthma, diabetes, and hypertension. They often live in poor housing, and their income makes it difficult to purchase healthy food or medications such as insulin.

Social Determinants of Health

Social determinants of health such as education, salary, housing, and personal behaviors can have a greater impact on an individual's health status than the care the health center provides. Health centers must shift their focus to upstream efforts and take a more proactive approach in addressing housing issues if they are to reduce disparities for their patients, particularly the migrant population.

Health Centers and Housing

Health centers cannot address housing challenges alone. It is essential to build and sustain partnerships.

TrueCare has begun to build partnerships with nurseries and farms where many of their patients work. Working collaboratively to develop shared goals is in the best interest of these businesses, because they want their workers to be in good health.

Health centers must also build and sustain partnerships with housing providers. There is very little grower-provided housing in Southern California. MSAWs live in multi-use or mixed family housing and affordable housing. The increased demand for stable, affordable housing and the need for coordination across service systems requires focused health and housing teams that serve a shared population.

TrueCare has established well-integrated partnerships with formal memoranda of understanding (MOUs) that ensure the commitment of both parties and solidify shared responsibility.

Health and Housing Partnership Models

- On-site health center: In this model, a health center is co-located with housing. It works well for a high-need population by addressing the need for access to care and appropriate housing. The health center could be on the premises of a housing camp or in the retail space of an affordable housing complex designed specifically for the migrant population. In addition to having healthcare readily available, resources and education can be provided directly in the housing community, including special services such as vaccination clinics. The model requires a shared goal and mutual responsibility of both partners and active participation by all health and housing systems.
 - Recommendation: Prioritize partnerships with affordable housing developers to build out health services in tandem with the housing project to ensure that both health services and housing are tailored to the needs of the population.
 - Resources needed: Funding that includes a requirement for developers to include health or social services.
- Mobile health services: Provide flexibility to bring healthcare where it is needed most for underserved or hard-to-reach populations. A mobile unit can bring services to scattered-site housing or to the job site, removing barriers to care. Individuals can seek care during a break, immediately after a shift, or at their housing. Partnerships are critical to ensure a mutual understanding of where and when the mobile unit will deliver services.
 - Resources needed: Start-up costs to build a unit, plus operational funding for staffing and maintenance.
- Off-site health center: This model allows for connections in the community beyond housing partners or nurseries and farms (i.e., with additional CBOs) or among multiple farms, nurseries, and housing complexes. Proximity and transportation are important to ensure that the location does not become a barrier to care.
 - Resources needed: Robust referral mechanism.

If funding is available to implement these partnership models, the health center could be the direct applicant. In the first model, the health center could leverage funding and other opportunities from housing developers and serve as a critical partner by bringing other CBOs to the table to provide additional expertise.

Additional TrueCare Best Practices

TrueCare is engaged in upstream efforts to address social determinants of health and barriers to care beyond housing. These include food distribution twice a month through a partnership with Feeding San Diego; food boxes delivered to specific farms, nurseries, or housing units; application assistance for Medicaid and food stamps; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs in health centers for pregnant mothers and young children; and free transportation services for appointments at the health center.

TrueCare has an organizational commitment to addressing social determinants of health and building partnerships. The 2022-2024 strategic plan includes a goal to “connect to the communities we serve.”

Ms. Cardoza closed her presentation by emphasizing the following points:

- A new type of safety net must emerge that includes a collaborative approach to housing and health.
- Partnerships should be expected to yield tangible outcomes.
- Healthcare service providers are critical to the housing equation.

Discussion

- Ms. Huertero-Amigon asked Ms. Cardoza how the onsite or mobile health centers could change housing conditions that lead to poor health outcomes.
 - Ms. Cardoza replied that while those models would not address housing directly, they would mitigate health issues that are exacerbated by housing conditions. For example, patients with asthma or diabetes can get regular treatment and manage their health.
 - Ms. Huertero-Amigon noted that developers who receive funding to provide affordable housing for a special needs population are required to meet certain standards and pass inspections. Partnerships with those developers could be key, because they have a common mission of ensuring the well-being of residents.
- Ms. Higgins noted that sometimes the location of housing is the barrier to accessing healthcare.
 - Dr. Quandt agreed and noted that there are hundreds of small camps in North Carolina with about 10 people. It can be difficult for outreach workers or mobile units to serve all of them. In California, most farmworkers live in urban areas, which makes the TrueCare models more feasible.
- Mr. Calderon noted that he is on the city council of his hometown, where he advocates for the safety and well-being of the community. Ms. Cardoza’s materials would be very relevant.
- Ms. Dudley asked how easy it had been for TrueCare to find developers who are interested in investing in farmworker housing projects. Her health center found it difficult to do that, despite the availability of federal funds, even when they offered matching funds.
 - Ms. Cardoza replied that developers might not be interested in providing farmworker housing, but they are open to following the money and working with partners. TrueCare found it more effective to approach them from the perspective of affordable housing and geography.
 - Ms. Huertero-Amigon noted that it took one complex in her community over 10 years to get 80 units designated for agricultural workers.
 - Ms. Dudley commented that her health center in New York State had to use community block grants, which required the county to commit specifically to farmworker housing.

- Ms. Higgins stated that the housing situation in Florida was bad five years ago, but now it is a crisis. There is nowhere for people to go, crowding is getting worse, and they do not have rent control. She asked what recommendations the Council could make that would have an impact.
 - Dr. Quandt replied that this is a difficult issue. The existing regulations are outmoded in an era of climate change and increasing heat, because they were established when barracks were the standard. They include a requirement to provide heat but no requirement to provide air conditioning.
 - Ms. Cardoza said that even when developers build additional housing, it takes years from planning to execution. TrueCare has found it more effective to focus on advocacy at the local level and getting more attention on the housing crisis.
 - Ms. Huertero-Amigon said she worked for two decades with a developer of affordable housing. She recommended that farmworkers put themselves on a waiting list for affordable housing. She offered to send Ms. Higgins a list of developers of affordable housing in Florida.
- Dr. Viniegra asked if documentation status was a barrier to requesting housing and if the Council should address that in its recommendations.
 - Ms. Huertero-Amigon said that immigration status is not a factor in applying for affordable housing, but applicants have to verify their income to demonstrate eligibility.
 - Dr. Quandt stated that immigration status is not an issue for H-2A workers.
 - Ms. Dudley noted that H-2A housing is highly regulated, but most MSAWs are not in that program. Federal housing funds require an approved immigration status.
 - Dr. Quandt stated that undocumented workers can rent housing in rural communities in North Carolina.
 - Dr. Paul noted that the primary role of the Council's recommendations is to address issues where HRSA or HHS have a role in their implementation.
 - Ms. Dudley noted that HRSA could play a pro-active role in enforcement of regulations. Housing for H-2A workers must be inspected before the season. The only mechanism to inspect housing for undocumented workers is the county health department. If the housing is deemed unsuitable, the worker loses their housing and their employment, and their children lose access to the school district. The Council must ground its recommendations in who the farmworkers are and the constraints they face.
 - Dr. Quandt said that her research found that even with H-2A inspections, the housing is sub-standard. Often there is other grower-provided housing that is occupied by workers who are undocumented. While they would not affect all workers, it is worth trying to strengthen the regulations that HHS does have for migrant housing.
 - Ms. Higgins suggested that one approach could be to focus on the impact on farmworker children. Sub-standard housing can be a form of trauma that can impact their physical health.

Meeting Wrap Up and Adjourn

Deborah L. Salazar, Chair, NACMH

Ms. Salazar summarized the key points from the presentations during Day 2.

Ms. Salazar made a motion to adjourn for the day. The motion was seconded by Ms. Huertero-Amigon and carried by unanimous voice vote.

The meeting was adjourned at 4:23 p.m.

Thursday, June 2, 2022

Recap from Previous Day

Jose Salinas, EdD, Vice-Chair, NACMH

Dr. Salinas called the meeting to order and noted that Ms. Salazar provided a detailed recap at the end of the previous day.

Testimony Session Ground Rules

Donalda Dodson, Member, NACMH

Ms. Dodson stated that the purpose of the testimony session was to hear directly from those who are impacted by the topics that were the focus of this meeting, including health and housing, the COVID pandemic, and global warming and weather conditions.

The testimony questions were generated by the Council and agreed upon in advance of the meeting (see Appendix A).

The testimonies would be provided by parents and community members involved with Migrant Head Start and family education programs at the Oregon Child Development Coalition (OCDC) as well as current OCDC staff. Ms. Dodson thanked them for sharing their thoughts and experiences and assured them that their contributions would help the Council formulate its recommendations.

Testimonies

*Moderator: Karelia Harding, Parent Engagement and Equity Manager, OCDC (Moderator)
OCDC Parents, Community Members, and Staff*

Ms. Harding greeted the Council, thanked those who would provide testimonies, and thanked the Council for inviting them to share their experiences.

Testifiers shared information about their background, their experiences as agricultural workers in Oregon, the challenges they have faced while seeking health care, the impact of the COVID-19 pandemic, including long-term effects from COVID infection (long COVID) and the mental health impact of the pandemic on children and adults. They also testified about inadequate access to safe agricultural worker housing; the first hand impact of climate change; the issues that cause them the most stress; the areas of their work life that they would like to see changed or improved; and their hopes for the future.

Highlights of the testimonies are summarized below.

Personal Background

Testifier backgrounds ranged from individuals who had accompanied migrant farmworker parents, who are first generation agricultural workers, and individuals from agricultural families who now serve agricultural workers.

Health and Housing

Testifiers discussed challenges related to housing and access to health care for agricultural workers in Oregon, including their personal experiences and those of others they knew. Their testimonies included the following issues:

- Housing is very expensive in Oregon. In many cases, several families share a house, with one family in each room. Some families live in a garage. A testifier who rents a home with her husband and four children said other workers often ask her if they can rent a room because grower-provided housing is crowded.
- In many cases, grower-provided housing is not furnished. Workers have to provide everything, including furniture, bedding, and kitchen equipment. The kitchen and bathroom are shared.
- A group of 15-20 workers, including three women, rented a house together. The women had a separate bedroom, but they had to share bathrooms with the men. The men would bother them when they had been drinking. One woman returned to Mexico because the situation was so difficult.
- Grower-provided housing limits workers' freedom. They are isolated unless the grower takes them into town.
- Some growers are putting workers in hotels to avoid H-2A housing regulations, with four to six in a room. The workers have no privacy, those who get sick cannot isolate, and they cannot accept food donations because they have no kitchen.
- A testifier said that growers hire people to work in the fields, but they do not check-in after they arrive to see how they are doing. It would be nice to have more oversight.
- When Washington County created regulations and increased supervision to protect families and children in migrant camps, growers stopped bringing families to the area and began to hire H-2A workers, who are mostly single men.
- Growers in Klamath Falls are hiring more H-2A workers to replace seasonal workers who are getting older. One grower provides housing that meets the requirements. The other two are placing workers in hotels. Several H-2A workers told OCDC staff that they were sleeping outside in a tent.
- The wildfires in 2020 destroyed a mobile park in Jackson County that housed many agricultural workers. Most of those families did not have insurance and lost everything. Many were undocumented and did not qualify for assistance from the Federal Emergency Management Agency (FEMA). Some families moved to 70 to 80 miles Klamath Falls, where they stayed in hotels or in tents at the fairgrounds. Some moved in with other families. OCDC lost many of the families in its programs due to the lack of affordable housing.
- Some employers are in compliance with regulations, but others could benefit from enforcement. Families who work in urban areas have more resources and know where to go. Those in rural areas have fewer options and are more isolated, so growers can get away with more violations.
- OCDC has many community partners that can help families who experience housing violations, including Legal Aid.
- OCDC staff are unable to observe housing conditions for H-2A workers because the camps do not allow visitors, but they hear stories at the clinic. The information they get depends on how much the workers are willing to share, because they could lose their jobs. Some older seasonal workers are willing to put up with anything so they will be called back.
- Workers who attended an OCDC vaccine clinic in Klamath Falls reported that they had lived for three weeks without electricity.

- Some employers are more responsive than others when it comes to providing their workers with access to health information or services.
- Klamath Falls does not have promotoras or a health center. Access to health information depends on the relationship that agencies have with employers and supervisors. Some employers are very welcoming, but others have to approve what the agencies plan to do and the materials they provide. It would be helpful if employers were on the same page so workers can get the same information. Workers often call OCDC asking where they can get information or support.
- Water quality in the migrant camps is generally good because it has to be tested before they can open for the season. The health center and OCDC take drinking water to the camps when temperatures are high.
- By law, workers are supposed to have drinking water and restrooms, but the facilities are not always located near the fields where they are working.
- OCDC is a mandated reporter and takes the responsibility seriously. Parents who serve on the Policy Council are trained to serve as mandated reporters.
- The dehydration death of an older worker last year was a horrible situation. Agricultural workers are accustomed to working without a break and are often fearful about taking one. Age, physical conditions, and exposure to the sun or heat increase the risk.
- H-2A workers know that there are regulations to ensure that they are in a safe environment, but there is no accountability. Employers should know that those who work in the fields are working for a better future for themselves and their family. They are doing a job that no one else wants to do, and they should be respected as human beings. Following the regulations is one way to do that. Those who break the regulations should know that there are consequences, such as not having their contract renewed.
- Some employers promise a certain number of hours or wages, but when the workers come there is no work, and they have to leave within weeks of arriving. Employers have to pass inspections to bring people in, but once the workers are here there is no follow-up.

COVID Pandemic

Testifiers described the impact of the COVID-19 pandemic on agricultural workers in Oregon, including long COVID and the mental health impact on adults and children. Their testimonies included the following issues:

- COVID-19 has had a big impact on OCDC families. Those who get sick are not able to stay home and rest because they are afraid of losing their job. If they ask for time off, they are told that they are replaceable. As a result, they go to work sick and expose people at home and at the workplace. OCDC has seen COVID go through whole families.
- In many cases, family members are unable to quarantine when they are sick because they share housing.
- One employer told workers who were not vaccinated to go home so they would not be exposed. The testifier lost many days of work as a result.
- People who were vaccinated got COVID more than once because others came to work sick.
- OCDC has seen an increase in the need for mental health support during the pandemic. Mental health issues are often seen in a negative light in the Hispanic/Latino community, but OCDC is working with families to help them talk about it. There is a need for more mental health services in Spanish or other languages spoken by the community.

- OCDC has advocated with the Oregon Health Authority for mobile clinics to increase access to health and mental health services, especially in rural areas.
- A member of the OCDC COVID-19 Response Team said she was not vaccinated when she first started in that position because she was concerned about how quickly the vaccine was developed. When her mother and mother-in-law got sick and another relative died, she began to think about what would happen if she could not be there for her children, and she felt she could not advocate for the vaccine if she was not vaccinated. Her research reassured her that the vaccine had been tested and was safer than getting COVID. She takes care to get information from credible sources, including the Centers of Disease Control and Prevention (CDC), Johns Hopkins University, the county health department, and other CBOs.
- People in the migrant community have missed a lot of work due to COVID, which is difficult because many of them live paycheck to paycheck. They have been less concerned about losing their jobs since OCDC began holding vaccine events.
- There was a lot of hesitancy about the vaccine in the migrant community. Many people did not know where the vaccine clinics were, or they heard from family members that it was a hoax, or the vaccine would make them more sick than COVID, or they thought vaccination would implant a chip.
- There were many barriers when the vaccine first came out, because only certain groups could get it. The vaccine has been very accessible for the past year, and most medical offices give vaccinations without an appointment. There is a great deal of publicity about where to get vaccinated.
- OCDC partners with another CBO to conduct vaccine clinics. The largest had 250 people, most of them undocumented immigrant families.
- One testifier said her mother has missed a lot of work due to recurring COVID. Her symptoms include dizziness, aches and pains, and trouble breathing. The first time it happened she thought it was a heart attack. They are monitoring her symptoms and testing her on a regular basis.
- The main providers of vaccines in Malheur County are the county health department and Valley Family Health Care.
- OCDC distributes masks and COVID test kits to families each month. They get additional supplies from the health department or OSHA.
- Attitudes toward COVID in Malheur County are more lax these days.
- A testifier from Washington County gets information on COVID-19 from the news and information from the clinic.
- The impact of COVID on testifiers' families includes mild cases, hospitalization, death, and long-COVID. All five people in one testifier's home got COVID this year.
- Testifiers described the mental health impact of COVID, including depression, panic attacks, and fatigue from long-haul COVID. It has been hard for many to get better.
- One testifier got COVID for the first time one week after starting a new job, between her first and second doses of the vaccine. She was initially hesitant about getting the vaccine because of what she heard on the news about how quicky it was developed and the lack of long-term studies. She changed her mind when an unvaccinated friend who was hospitalized pointed out that if her children got sick, she would not be able to visit them in the hospital if she was not vaccinated.
- The vaccine is easy to get in Malheur County. There are many family events with vaccine clinics, and they offer incentives such as food baskets and gift cards.
- Undocumented people have equal access to the vaccine because there are many clinics and they do not ask about your status.

- People’s attitudes toward COVID are changing. Case numbers are lower, there are fewer deaths or severe cases, and people are getting the vaccine. People understand that it is real, and they know they have to get their shots to help get the numbers down.
- The Oregon State Health Department had a comprehensive plan to support the community. OCDC received funding to provide outreach, education, and wrap-around services for migrant communities and communities of color on COVID-19. The funding allowed them to cover rent, utility bills, and medical bills for people who had COVID and provide safety packs with monitors, face masks, and hand sanitizers. They also partnered with the Oregon Food Bank to provide food boxes.
- One testifier who is vaccinated said her son wants to be vaccinated, but she is scared to do that. He has not gotten COVID being unvaccinated, and she would prefer to keep it that way. She and other testifiers who were hesitant to vaccinate their children discussed the kinds of information that would help them make that decision and the best way to share that information.

Global Warming/Weather Conditions

Testifiers described the impact of global warming and severe weather conditions on agricultural workers in Oregon. Their testimonies included the following issues:

- OCDC has gotten donations of long-sleeve shirts, hats, and sunscreen for migrant workers, but workers do not necessarily think about using sunscreen or wearing protective clothing when they come to work.
- Families get exposed to pesticides, because employers do not always inform them when they will be applied.
- Migrant workers continued to work during the wildfires when the air quality was extremely unhealthy. It should not happen, but it does.
- There were several wildfires around Klamath Falls in 2021, and they got smoke and ashes from fires in California and the Medford area in Jackson County. People relocated to Klamath Falls from California. One fire impacted Tribal Head Start families. People were working in the heat and when the air quality was hazardous.
- Social media played a big role during the wildfires. Workers posted pictures of themselves working with nothing but a bandanna or face mask over their nose and mouth.
- After a death last summer due to extreme heat, Oregon passed a law that prohibits outside work above certain temperatures. Agricultural work now starts much earlier, which means OCDC staff have to be ready to open the Head Start center at 3:00 a.m.
- An ice storm last winter took out the electricity for a week, and the extreme cold damaged cherry crops. That will hurt families who come during cherry season.
- Migrant families work in all weather, from below-zero temperatures in winter to extreme heat in summer. Most houses in Southern Oregon do not have an air conditioner. Fire seasons are longer due to many years of drought. The air quality is horrible during wildfires, and most workers do not have the proper equipment. They send their children to school because they value education and because the schools have cleaner air. The poor air quality affects everyone, including those who have chronic illnesses or effects from COVID. People continue to work because they have been told they can be replaced if they don’t show up.
- When plastic dividers were added to protect strawberry workers during COVID, the heat was so intense that workers passed out. Workers are not allowed to leave the machine to get water. They carry water with them and look for ways to keep themselves cool.

- Drought conditions have led to a legal case between agricultural employers and tribal communities over water rights, and there are severe restrictions on water use. Most farms have one building with air conditioning where workers can cool off. Very few houses have air conditioners. The stores run out of them quickly.
- Younger workers are getting sick because they do not know how things work. They need more information about signs of dehydration and how to stay safe.
- People work in extreme weather conditions because they need to work, not to prove that they are good employees. If people hydrate more, they need to use the restroom more. Some employers count the number of restroom breaks their workers take. They do not consider the health effects of their rules. People complain about the price of food, but we will not have fruits and vegetables in the stores if we lose more workers.
- Testifiers said they began to notice changes in weather patterns in the last 10 years. It started to impact them personally over the last few years. One testifier said she noticed her utility bills were increasing. Another said she noticed changes in enrollment patterns for OCDC programs as families arrived earlier than in the past.
- Testifiers said that extreme weather conditions affect their mental health because they worry about whether they are doing enough for the workers and their families. One said that every conversation about health seems to be connected to mental health.
- Accommodations for weather-related challenges such as shade, break times, or access to water depend on the employer's sense of accountability. Workers are concerned that if they complain too much they will be replaced. Some employers provide a truck with a water tank, but workers have to wait until the truck comes to their field or they happen to go where the truck is located. Some employers provide an emergency building where workers can cool off when they are overheated, but the workers have to know it is available.
- Some undocumented workers have complained that supervisors treat them differently than documented workers in terms of breaks or other things. Other workers complained that Hispanic supervisors treat them worse than American supervisors.
- Oregon now has an extreme heat protection rule, but it took a death for that to happen. Testifiers questioned whether that was a victory when employers are asking workers to start at 3:00 or 4:00 in the morning.

Other Concerns

- One testifier expressed concern about her young children walking to school alone in the wake of the school shooting in Texas. She talked to her husband about working at night so she can walk to school with them.
- Childcare is a challenge for agricultural workers. One testifier takes her older son to work with her in the fields during summer vacation.
- Many undocumented people do not have health insurance. They are afraid that they might lose their job or that something could happen to them if they ask for help or go to a clinic or hospital. Workers and families need to have the correct information.

Meeting Wrap-Up and Adjourn

Deborah L. Salazar, BS, Chair, NACMH

Ms. Salazar expressed heartfelt thanks who all who provided testimonies. She assured them that the information they shared would be vital to the recommendations the Council would make to benefit agricultural workers.

Ms. Salazar made a motion to adjourn the meeting for the day. The motion was seconded by Dr. Viniegra and carried by unanimous voice vote.

The meeting was adjourned at 4:52 p.m.

Friday, June 3, 2022

Facilitated Discussion - Formulation of Letter of Recommendations to the Secretary of DHHS

Deborah L. Salazar, BS, Chair, NACMH

Marco Viniegra, PhD, Council Member, NACMH

Ms. Salazar welcomed Council members to the final day of the meeting and outlined the process for developing the letter of recommendations.

Formulation of Letter of Recommendations to the Secretary of DHHS

NACMH members

Council members discussed the testimonies and presentations and identified the following key issues:

Climate Change

- Farmworkers feel strongly that work has to go on despite extreme weather conditions, because they need to work.
- Workers do not get the breaks they need to manage their hydration. Access to water is a basic need.
- Bathroom breaks are an issue, even with hydration systems in place. Some growers count the number of times workers take a bathroom break and count the breaks against them. In some cases, the restrooms are a distance away and not easy to reach.
- The public is warned to stay indoors when air quality is poor, but farmworkers need to be outside. The consequences of air quality affects workers to the point that it impacts the number of people who engage in this type of work.
- Farmworkers need proper protection when air quality is low and enforcement of regulations regarding exposure.
- Farmworkers reported that as the days get hotter, shifts start early in the morning, sometimes as early as 1:00 a.m. Those who do not want to work under those conditions are warned that others will replace them.
- Immigration is interwoven with the issues of climate change. Those who are undocumented are the most vulnerable because they are willing to work in the most dangerous conditions without complaining in order to remain under the radar.
- There is a lack of good sources of information on how to properly handle heat stress.
- The reliance on social media can be related to the level of literacy. Farmworkers are requesting that brochures and other printed materials include pictures as well as words. This is especially important for those who speak indigenous languages.
- There is a need to understand how commodities are changing due to climate change because it affects where employment is available across the country.
- Wildfires have destroyed some agricultural areas. It would be important to know where these crops are being grown and how the fires are affecting the migration of workers.
- Stronger regulations at the federal level make it easier for states to follow. Strong enforcement is also necessary.

- Most states are ill prepared to handle disasters, and the impact of disasters on farmworkers is often overlooked.
- Workers are fearful of accessing FEMA or do not know how to access it or who can access it.

Vaccine Hesitancy

- The testimonies indicate that farmworker families do not have a reliable source of information about vaccines.
- We need to reinforce the positive side of taking the vaccine to encourage people to get vaccinated.
- The testimony about a child requesting to be vaccinated rather than the parent making the decision highlights the fact that schools are trusted sources of information.
- Community events provide multiple opportunities for workers to get the vaccine.
- The control that growers have over workers can be a barrier, especially when they do not believe in the vaccine. Growers should be mandated to cooperate in getting vaccines to workers.
- It is critical to build long-term trust and relationships.

Long COVID

- Agricultural workers with long COVID are not getting the assistance they need.
- The undocumented population is hesitant to see a doctor for COVID treatment.
- Testifiers described mental health issues related to the pandemic, such as panic attacks or absenteeism due to anxiety. Long-haul COVID causes additional stress due to the stigma surrounding mental health.
- Testifiers described concerns about costs for mental health coverage and health care for long COVID.
- It is important to think about what kinds of safety nets need to be in place to assist those with long COVID.

Health and Housing

- There is a lot to be done to ensure adequate housing for farmworkers.
- Testifiers described a lack of compliance or enforcement of housing regulations for H-2A workers.
- Regulations are circumvented, and they are not the same from state to state. There is a need for a consistent process for enforcing these regulations.
- There is no registry of state regulations on housing for farmworkers.
- Testifiers described rental housing that was shared by women and men, which made the women vulnerable to harassment.
- There is a need for designated funding for affordable housing for designated populations such as agricultural workers and their families, or relocation funds to subsidize housing costs for families living in substandard conditions.
- Lice and transmissible diseases are consistent issues. Information on handwashing and cleanliness is needed to keep people healthy.
- Mobile clinics are important to provide on-site services to families.
- Internet service should be a required utility in migrant housing to provide access to telemedicine and help workers maintain social connections that support mental health.
- The health center program needs stable, long-term funding and funding for telehealth.

Based on the discussion, the Council agreed that the letter of recommendations would address three issues: climate change; vaccine hesitancy, long COVID, and mental health (combined to address overlapping issues); and health and housing.

Council members formed the following teams to develop each section of the letter:

- Climate change: Marco Viniega (Team Lead), Donalda Dodson, Carmen Veguilla, Dani Higgins
- Vaccine hesitancy/Long COVID/Mental health: Jose Salinas (Team Lead), Angel Calderon, Marisol Cervantes, Elizabeth Lambar, Karen Watt
- Health and housing: Colleen Laeger (Team Lead), Angelina Cormier, Carmen Huertero-Amigon

Council members agreed on a process and timeline for developing and submitting the letter. They also agreed to develop a separate recommendation regarding the importance of the 340B program.

Closing – Meeting Wrap-Up and Adjourn

Deborah L. Salazar, BS, Chair, NACMH

Ms. Paul noted that this was Ms. Salazar's last meeting. She thanked Ms. Salazar for her contributions to the Council over the past four years and her ongoing support for agricultural workers.

Ms. Salazar said it had been an honor and a pleasure to serve on the Council.

Ms. Paul announced that Dr. Salinas would serve as the Chair for the upcoming year and Ms. Dodson had been nominated to serve as Vice-Chair. She looked forward to working with them.

Next Meeting

Council members identified potential topics for the next meeting, including HIV/AIDS; early childhood development, disabilities, and mental health; the impact of toxic stress and trauma on families and children; mental health; Internet access and telemedicine; and Internet access and education facilities for workers in remote locations.

Ms. Paul stated that the final selection of topics would depend on the availability of speakers and other factors. She noted that topics that are not chosen could be considered for future meetings.

Ms. Huertero-Amigon said it would be helpful to have an update on the implementation of previous recommendations, especially regarding pesticides and CHWs. Ms. Paul said that meeting minutes and prior recommendations are available on the NACMH website (<https://www.hrsa.gov/advisory-committees/migrant-health>). She can provide updates on specific recommendations upon request.

Ms. Salazar made a motion to adjourn the meeting. The motion was seconded by Ms. Veguilla and carried by unanimous voice vote.

The meeting was adjourned at 4:32 p.m.

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

May 31-June 3, 2022
Virtual Meeting

Appendix A: Testimonies Session Questionnaire

Session Date: June 2, 2022

Introductory Questions

1. What is your name, where were you born, and how old were you when you came to work in agriculture in the USA?
2. Why did you come?
3. How many people do you have in your family, are there women and children, and do you all live together?
4. What crops or agricultural industry do you and your family members work in?
5. How many years have you done this work?
6. Do you migrate/travel to do the work that you do, or do you stay and work in the same community?
7. If you migrate, how many times in a year do you migrate, and do you follow the same route each time?
8. Do you travel with the same group of workers/contractor each time?
9. How has your job changed over the last few years?
10. How has the increased cost of food, housing, health care, etc., impacted you personally?
11. Have you experienced an increase in your pay in the last three years?
12. Have you received health care in the past year and where did you receive it?
13. Do you know that there are health clinics where you can receive care at an affordable cost, in most places in the USA?

Health and Housing

1. Does your employer provide you with housing? If yes...
 - a. How many people do you share your bedroom with?
 - b. Is it furnished with heating and cooling?
 - c. Can you open and shut the door and windows?
 - d. Are you provided with beds and bedding?
 - e. Does it have an indoor bathroom with a working shower?
 - f. Do you have the privacy you need?
2. How would you describe your housing conditions?
 - a. Good; Acceptable; Crowded; Clean/Unacceptable?
 - b. Are there any infestations like roaches?
3. Do any health workers/promotores visit your housing community?
4. If the housing is provided by your employer, are you permitted to have visitors?
5. How often do inspectors come to check the safety and cleanliness of the housing?
6. If one of the house mates/family members is sick is there enough place for isolation?
7. Is there anything else about your housing that you would like us to know about?

COVID Pandemic

1. How did you learn about the COVID-19 pandemic, and do you think you know enough about the disease to take care of yourself and your family?
2. Where do you get your COVID related information?
3. Is the information available in the language you understand best?
4. How has COVID changed your health and livelihood?
5. Do you understand what “long COVID” is?
6. Did you or someone in your family struggle with/struggling due to long-COVID? If yes, what is that experience like?
7. How is your communication with relatives since the start of the COVID pandemic?
8. How has COVID impacted your relationship with family members?
9. Have you had close friends or relatives get severely ill or die from COVID? Were they able to receive the care they needed?
10. What impact has COVID had on your job?
11. What has changed in your work environment? (Example, proof of vaccine, personal protective equipment (PPE), etc.)
8. How do you feel about using PPE? Are you obligated to wear it while on the job?
9. Did you contract COVID? If so, were you able to get help for it medically and emotionally?
10. Are you fully vaccinated? Why or why not?
 - a. Did a health worker ever contact you to tell you about vaccination?
 - b. Are the vaccines readily available in your area?
 - c. What barriers do you face in receiving the COVID-19 vaccines?
 - d. What concerns do you have regarding the vaccines?
11. Were you ever hesitant to receive the COVID vaccine?
 - a. If yes, then why?
 - b. If you were hesitant and still got the vaccine, what made you change your mind?
12. During the COVID pandemic, what organizations reached out to help you? Two years after the start of COVID, are these organizations still offering assistance?
13. Do you know anyone that did not receive vaccination because they are undocumented?

Global Warming/Weather Conditions

1. Have you been impacted by extreme summer heat, fires, or severe storms?
2. Do you know someone who has been impacted by weather-related conditions in your community?
3. How long ago did the change in weather start impacting you?
4. How do extreme weather conditions affect your health?
5. What accommodations do you receive at work for weather-related challenges?
 - a. Is there a place with shade where you can take respite when it gets too hot?
 - b. Are you permitted to take breaks and leave work early when the weather gets too hot?
 - c. Are you provided adequate clean drinking water during work hours? If not, how do you stay hydrated?
 - d. On extremely hot days, are you checked for heat stress?
6. How have extreme weather conditions affected your finances? (Example, transportation expenses, clothing you require for work, the number of hours that you are able to work in a day, etc.)

Conclusion

1. What is the biggest concern or issue that causes you the most stress, and why?
2. Is there someone you can share the concern with, possibly seek professional help?
3. What areas of your work life would you like to see changed or improved?
4. What are your hopes for the future? If you have children, what are your hopes and dreams for them?