

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

**October 20-23, 2020
Virtual Meeting**

Meeting Minutes

Council Members in Attendance

Sharon Brown-Singleton (Chair)
Shedra Amy Snipes (Vice Chair)
Rogelio Aguilar
J. Angel Calderon
Angelina Vallejo Cormier
Donalda Dodson
Dani Higgins
Daniel Jaime
Carmen Veguilla-Montañez
Jonathan Raber
Deborah Salazar
Jose Salinas
Gary Skoog

Federal Staff in Attendance

Strategic Initiatives and Planning Division (SIPD), 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):

- Iran Naqvi, MBA, MHS, Deputy Director
- Esther Paul, MBBS, MA, MPH, Designated Federal Official, NACMH

Tuesday, October 20, 2020

Call to Order/Introductions

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

Ms. Paul introduced herself, welcomed Council members, and thanked the members for their service and stewardship. She noted that the Council was written into law in July of 1975 and has provided the Secretary of the Department of HHS with recommendations on the health and welfare of migrant and seasonal agricultural workers (MSAWs) for 45 years.

Ms. Paul expressed her gratitude to the speakers for their presentations and their ongoing work for the welfare of the nation's farmworkers, and she welcomed guests from MSAW-serving organizations, colleagues from other HHS agencies, and members of the public who were in attendance. She extended special thanks to BPHC colleagues for their leadership and support for this meeting and for their efforts to ensure that the Council's recommendations are implemented.

Ms. Paul honored all who had lost their lives to the pandemic, their grieving families, and the healthcare workers who risk their lives daily.

Ms. Paul said the meeting was dedicated to recognizing and addressing the long-standing challenges to the health and welfare of MSAWs, especially as they continue to put food on our tables during the pandemic. The pandemic has unveiled and multiplied long-standing disparities that farmworkers and other vulnerable populations have suffered as a result of historic structural inequities. The Council would listen to presentations and testimonies, share their personal experiences, and make evidence-based recommendations to the Secretary.

Ms. Paul expressed her gratitude to Council members who were participating in the meeting in spite of having experienced grief, fatigue, personal loss, and other challenges. She noted that this would be the final meeting for Rogelio Aguilar, Daniel Jaime, and Gary Skoog, whose terms were expiring.

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

Welcome and Logistics Round Up

Iran Naqvi, MBA, MHS, Deputy Director, SIPD, OPPD, BPHC, HRSA, HHS

Ms. Naqvi thanked Ms. Paul and acknowledged that the meeting was taking place in the midst of professional and personal challenges.

Ms. Naqvi commended the Council for submitting a recommendations letter to the Secretary focused on the challenges of COVID-19 for MSAWs, despite being unable to meet in person. She expressed her gratitude for Council members' individual and collective commitment to their mission.

Ms. Naqvi thanked Ms. Paul for her leadership in shifting the meeting to a virtual format, and she acknowledged the efforts of her colleagues and the logistics contractor to make that happen.

Ms. Naqvi thanked her colleagues at OPPD for their support and leadership. She closed by urging each Council member to be an integral voice during the meeting.

NACMH Chair Opening Remarks

Sharon Brown-Singleton, MSM, LPN, Chair, NACMH

Ms. Brown-Singleton thanked Ms. Paul, Ms. Naqvi, and BPHC staff for making this meeting possible and thanked Council members for their patience and commitment. She reviewed the Council's purpose and asked members to listen with intent to identify problems and potential solutions. She looked forward to a productive meeting and a team effort to make informed recommendations in a timely manner.

Ms. Brown-Singleton reviewed the agenda for the meeting and asked for a motion to approve it as presented. The motion was made by Ms. Dodson and carried by unanimous voice vote.

Ms. Brown-Singleton called for a motion to approve the minutes of the November 2019 meeting. The motion was made by Ms. Dodson and carried by unanimous voice vote.

NACMH Introductions and Reflections

Council members

Council members introduced themselves and provided updates on their personal and professional lives during this challenging year.

Federal Update

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

Dr. Joseph acknowledged the importance of the Council in these challenging and tumultuous times. She urged the Council to push HRSA to deliver fully on the promise of the health center program to ensure that MSAWs are not just protected but are able to thrive.

Dr. Joseph provided updates on the health center program, with a focus on COVID-19, program funding, health center data on services provided to MSAWs, and two new BPHC initiatives.

COVID-19

BPHC is conducting weekly surveys to understand the contributions and needs of health centers related to the pandemic response. The vast majority of health centers have drive-up or walk-up testing capacity and provide test results in three days or less. Data on the number of patients tested, the number testing positive, and the proportion who are racial or ethnic minorities are updated weekly and posted on the BPHC website (<https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data>).

Survey data on health center operations and staff indicate that nearly all health centers have an adequate supply of personal protective equipment (PPE) for at least the next two weeks. The number of weekly visits compared to pre-COVID visits has increased over time, while the number of sites that are closed temporarily has decreased. The number of staff testing positive was around 500 the week ending October 9, 2020, and only about four percent of staff were unable to work that week.

The pandemic is transforming healthcare delivery and laying the groundwork for the future such as providing care via telehealth. Going forward, health centers will be important in ways that are yet to be discovered. Partnerships will be especially important for delivering vaccines to priority populations. HRSA would welcome the Council's input regarding what health centers should do to be prepared for that effort and to understand the perspective of MSAWs.

COVID-19 Supplemental Funding

Health centers received \$2 billion in supplemental funding for COVID-19 response and testing, including \$365 million for migrant health centers (MHCs). To maximize the impact of those funds, additional resources were also provided to primary care associations (PCAs) that work at the state level, National Training and Technical Assistance Partners that support the work of health centers serving MSAWs, and health center controlled networks (HCCNs).

COVID-19 Survey Data

Dr. Joseph provided survey data on MHCs and non-MHCs from April to September of this year:

- PPE: Health centers have made significant strides to improve their level of readiness. Ninety-four percent of MHCs and 91 percent of non-MHCs reported having adequate PPE the week

ending August 28, 2020, compared to 70 percent and 73 percent, respectively, the week ending April 10, 2020.

- Testing capacity and drive/walk-up COVID-19 testing: MHCs consistently out-perform non-MHCs in these measures. The week ending April 10, 2020, 88 percent of MHCs had testing capacity and 56 percent had drive-up and walk-up testing, which increased to 99 percent and 82 percent, respectively, the week ending September 4, 2020. Comparatively, the non-MHC testing capacity was 81 percent, and drive-up and walk-up testing was 42 percent the week ending April 10, 2020 and 97 percent and 79 percent, respectively, the week ending September 4, 2020.
- Turn-around time for testing results and number of patients tested: The percentage of MHC patients receiving testing results within three days declined from 76 percent the week ending June 19, 2020 to just 19 percent the week ending July 17, 2020, presumably due to the fact that the number of patients tested jumped from about 34,000 to nearly 57,000 in the same period. By the week ending September 4, 2020, 78 percent of testing results were delivered within three days. Those trends were similar for non-MHCs.
- Staff testing positive: There is room for improvement in this area for both MHCs and non-MHCs.
- Number of weekly visits, percentage of visits conducted virtually, staff not able to work: By the week ending September 4, 2020, the number of patient visits at both MHCs and non-MHCs was around 81 percent, compared to the pre-COVID visits. About 47 percent of visits for all health centers were conducted virtually the week ending April 10, 2020; the rate declined to about 28 percent the week ending September 4, 2020, when health centers were operating with a more normal workforce capacity.
- Number of sites temporarily closed: Data in this area show positive trends, with both MHCs and non-MHCs gradually reopening over the course of the pandemic.

Other New Funding for FY 2020

BPHC made the following awards in FY 2020:

- Primary Care HIV Prevention: \$54 million, 195 awards
- Quality Improvement Awards: \$117 million, 1,318 awards
- Capital Assistance for Disaster Response and Recovery Efforts: \$79 million, 165 awards.

FY 2021 President's Budget

The President's budget request includes \$5.7 billion for health centers, including \$1.7 billion in discretionary funding and \$4 billion in mandatory funding. Discretionary funding includes \$137 million for the second year of the Ending the HIV Epidemic Initiative, which remains a high priority for the administration, HRSA, and BPHC. The requested funding would increase the number of health centers providing HIV prevention services in the initiative's targeted geographic regions from 200 to 500. The discretionary budget also includes \$15 million for health centers that serve homeless populations.

The federal government is operating under a Continuing Resolution through December 11. BPHC is providing partial funding to health centers and will reassess the approach when additional information about the FY 2021 budget is available.

2019 UDS Data

Utilization data for 2019 demonstrate the continued success of the health center program. Health centers increased access to care, improved delivery of comprehensive services, and advanced the quality of care.

The 2020 UDS will include additional data to capture the COVID-19 response.

Health centers served 29.8 million patients in 2019. For the first time, health centers served more than one million MSAWs. That milestone is the outcome of intentional strategic planning, systems changes, and relationship building on the part of MHCs and other health centers that serve MSAWs.

The number of MSAWs who received mental health and substance use services increased. In 2019, health center providers screened 11.5 million patients for depression. The number of health centers that provide medication-assisted treatment (MAT) increased by 70 percent since 2017, and the number of patients receiving MAT increased by 121 percent.

Implementation of NACMH July 2020 Recommendations

The Council submitted recommendations in July 2020 in five areas: COVID-19 testing, support for MSAW-serving health centers, safe housing and childcare, H-2A workers' health and safety needs, and protections for MSAWs during the pandemic.

HRSA has taken steps to address two of the recommendations:

- Recommendation I - COVID-19 Testing: HRSA established a working group that includes the Centers for Disease Control and Prevention (CDC), the National Institute for Occupational Safety and Health (NIOSH), the Department of Labor (DOL), and JBS International to develop COVID-19 questions for the 2021-2022 National Agricultural Workers Survey (NAWS).
- Recommendation IV - Prioritize H-2A workers' health and safety needs: HRSA and DOL will conduct a feasibility study to assess inclusion of H-2A workers in NAWS interviews.

BPHC Reach

Over the last 18 months, BPHC has engaged in a quality improvement and transformation effort to enable the bureau to be resilient in the face of ongoing challenges and position the health center program for a bright future. The new performance framework is called BPHC Reach.

BPHC Reach has five goals and a set of core functions in each area:

- Best place to work: Organize operations and utilize staff expertise and knowledge. Develop and grow the next generation of leaders and staff.
- Compliance with program requirements: Develop program requirements and policies. Conduct compliance assessments.
- Successful implementation of grants: Develop Notices of Funding Opportunity (NOFOs) and award grants. Support implementation of grants.
- High-performing grantees: Collect data and report performance. Provide training and technical assistance (T/TA) to support grantee compliance and performance.
- Recognized leader in primary health care: Lead and participate in national dialogue on primary health care. Establish new strategic priorities and initiatives.

BPHC identified five transformations that are necessary to reach that desired future state:

- Optimize data and technology
- Streamline and enable compliance
- Advance health center quality and performance

- Develop and operating model
- Leverage the health center network.

Advancing Health Center Excellence

BPHC developed a new framework, Advancing Health Center Excellence, to take a more holistic view of performance. The framework aligns with HRSA's mission and is intended to provide a common understanding of what it takes to achieve clinical and operational excellence.

The framework has seven interconnected domains of performance:

- Access and affordability
- Patient experience
- Quality, patient care, and safety
- Population health and social determinants of health
- Financial sustainability
- Workforce
- Governance and management.

Health equity is at the center of the model and is paramount to the mission of the health center program. Each domain includes clear performance expectations that reflect what is required to achieve clinical outcomes and advance health equity.

There are four levels of maturity within each domain: Compliance-driven, Fundamental, Strategic, and Leading. Health centers can achieve different levels of maturity in different domains and can move up or down within each domain. The framework makes it clear that while compliance with program requirements is important, it is not enough to achieve the desired impact of the health center program.

The framework is intended to provide greater transparency and a common understanding of what compliance entails and how to achieve it. Performance expectations for all domains are clearly aligned with the program requirements set forth in the compliance manual for the health center program. The framework provides a clear definition of each performance expectation and detailed descriptions of how health centers can meet them.

The framework will be an important resource for BPHC, health centers, and strategic partners. BPHC can use it to inform focus areas for funding, incentivize progress in certain domains or priority areas, or target T/TA. BPHC plans to develop a dashboard to provide a quantitative understanding of the performance expectations. Health centers can use the framework for self-assessment, strategic planning, strengthening grant applications, informing new community partnerships, or informing T/TA needs. Strategic partners can use it to identify and prioritize T/TA needs for health centers.

Proposed Unmet Need Score 2.0

BPHC is revising the service area needs assessment methodology for its funding opportunities. The most recent New Access Point (NAP) competition included a quantitative measure of need that was based on Zip codes. This change eliminated the requirement for health centers to complete a complicated Need for Assistance worksheet and provided national measures to determine where the need for health center sites was most significant.

BPHC will assess how this measure performed in the NAP competition and will revise it over time. They recently conducted a webinar that discussed the proposed changes in more detail.

National Association of Community Health Centers (NACHC) Update

Rachel A. Gonzales-Hanson, Senior Vice President for Western Operations, NACHC

Ms. Gonzales-Hanson began by noting that the health center program began with a grant of \$198,317 to provide healthcare services to the migrant population. There are now more health center delivery sites in the U.S. than Walmart stores. Although the program has grown, its roots have always been in serving agricultural workers.

Capitol Hill in COVID-19 and Beyond

Health centers are operating under a continuing resolution that extends government funding until December 11, 2020. It includes mandatory funding for health centers, the National Health Service Corps (NHSC), and Teaching Health Centers Graduate Medical Education (THCGME). Negotiations were at a standstill at the time of this meeting.

Congress passed several stimulus funding packages in response to COVID-19:

- Package 1 provided \$100 million in supplemental funding for community health centers (CHCs) and flexibilities around “originating sites” for telehealth in the Medicare Prospective Payment System (PPS). It is important to make those flexibilities permanent.
- Package 2 increased the federal medical assistance percentage by 6.2 points; extended workforce protections, including paid family and medical leave; enhanced unemployment insurance; and increased funding for the Supplemental Nutrition Assistance Program (SNAP) and other food security programs. A recent mandate required healthcare organizations to provide paid leave for non-clinical staff.
- Package 3 (Coronavirus Aid, Relief, and Economic Security [CARES] Act) included \$1.32 billion in emergency supplemental funding for health centers, \$100 billion in grant funding to offset provider revenue losses due to COVID-19, and \$349 billion in fully-forgivable loans to support small businesses, including health centers with less than 500 employees. Health centers with more than 500 employees were not able to take advantage of the Paycheck Protection Program (PPP). Package 3 also included \$200 million to fund telehealth-related expenses.
- Package 3.5 extended the PPP.

The House and Senate passed separate bills in the last few months that would provide \$7.6 billion in COVID relief for CHCs. The Senate version would not extend that funding to look-alike health centers, and there were differences in other provisions. Both bills were in limbo at the time of this meeting.

Telehealth is a major focus, and NACHC is supporting three bills in the House. The bills do not address the need for broadband infrastructure in rural areas, but they would make the Medicare PPS fix permanent and remove the originating site restrictions.

The Senate is working on a bill that would provide additional funding for the NHSC and create an Emergency Service Corps for Surge Capacity. The NHSC plays an essential role in ensuring that the healthcare workforce is strong and prepared.

Section 330 Health Center Grant Funding

Most MSAWs (87 percent) are served by Section 330G health centers, which receive mandatory and discretionary funding. Mandatory funding is provided through the Community Health Center Fund created by the Affordable Care Act in 2010. The Fund was originally authorized for five years, but it has been extended twice in two-year increments. The initial deadline for extending the authorization was more than a year ago. Mandatory funding is currently \$4 billion per year (FY 2019 budget).

Annual discretionary appropriations were the only source of federal grant funding for health centers prior to 2010. Discretionary funding is currently \$1.63 billion per year (FY 2020).

Health centers need both pools of money to maintain current operations and continue to grow.

Workforce Program Funding Extensions

The NHSC and THCGME are critical workforce programs for health centers. The NHSC supports clinicians in underserved areas through loan repayment and scholarships. Sixty percent of those clinicians practice in health centers.

THCGME brings residency training for physicians and dentists into community-based settings, including rural and medically underserved areas. The program has been growing in recent years. Health centers cannot achieve health equity unless they have more clinicians who represent underserved areas and communities of color.

The CARES Act extended mandatory funding for these programs until November 30, 2020.

Surprise Billing

A White House report released in late July supported Congressional proposals. There might be some momentum to reach an agreement, but negotiations were on hold at the time of this meeting.

Health Center Request for the Fourth COVID-19 Funding Package

The pandemic catapulted health centers into the future. The next COVID-19 stimulus package must provide sufficient funding to ensure that they can thrive and prepare for the future. Health centers need infrastructure investments for telehealth and computer systems so they can continue to lead.

NACHC is advocating for the next stimulus package to include \$7.6 billion over six months for immediate coronavirus response needs; \$41.9 billion for five years for the five-year reauthorization of the CHC Fund; \$7.8 billion for five years to extend and expand THCGME and NHSC programs; \$20 billion over five years for infrastructure investments; extension of Medicare telehealth flexibilities and payment parity; and protection of the 340B program.

NACHC is also advocating for including health center look-alikes in the emergency COVID-19 relief funds; extending the PPP to health centers with over 500 employees; and investing in the NHSC and Nurse Corps alongside the creation of the Emergency Service Corps for Surge Capacity.

340B Program

The 340B program makes it possible for health center patients to afford their medications. Health centers use savings from the program to provide more services for patients. Congress is considering a bill that would limit payment for drugs dispensed under Medicaid managed care plans.

NACHC is working with 340B provider groups to develop alternative language that would require Medicaid managed care plans to reimburse for drugs purchased under 340B at the same rate that they reimburse for non-340B drugs and would prohibit states from carving out Medicaid managed care from their 340B programs.

NACHC is urging health center patients and providers to contact their members of Congress regarding the importance of the 340B program and the need to revise the proposed bill.

Social Justice and CHCs

The health center model speaks to social justice. The program began when Robert Kennedy had a conversation with Cesar Chavez and Dolores Huerta about the need for affordable health care for agricultural workers. The health center program is focused on ensuring that people from disenfranchised groups can get the care they need.

Many health center patients are from Black, Indigenous, or other communities of color. NACHC is supporting the George Floyd Justice in Policing Act of 2020 that includes important provisions to address police misconduct.

The current climate is an opportunity to highlight how health centers have stepped up to do the right thing in their communities. For example, the White Bird clinic in Oregon developed a mobile crisis intervention program called CAHOOTS (Crisis Assistance Helping Out on the Streets). The CAHOOTS Act introduced by Senator Wyden of Oregon would provide \$25 million in Medicaid grants to implement emergency mobile response and enhanced Medicaid funding for individuals who need emergency mental health or treatment for substance use disorder.

What to Expect in the Coming Months

When Congress returns from recess in mid-November, NACHC will focus on ensuring consistent and reliable funding for CHCs, the NHSC, and the THCGME program beyond November 30. The prospect for this and other issues will depend upon the outcome of the elections.

AgWorker Access Campaign

The AgWorker Access campaign is a national initiative to increase access to quality health care for America's agricultural workers and their families, with a goal of serving two million agricultural workers and their families in CHCs and MCHs.

Health centers reached the milestone of serving one million agricultural workers in 2019. That achievement is a tribute to a partnership that extends beyond health centers to include other programs and agencies. The campaign is building relationships with State Monitor Advocates, farm bureaus, and growers. Growers support the campaign because it will help build a healthier workforce. Others support the campaign because it will build a healthier nation.

The AgWorker Access task force developed strategies in four priority areas: promising practices, community partnerships, distribution strategies, and legislative policy.

The National Center for Farmworker Health (NCFH) developed an excellent graphic showing how the various stakeholders and components of the campaign fit together.

At the end of the day, everyone is working to get to the same place, which is to support agricultural workers and their families. The Council is an integral part of that effort.

Discussion

Ms. Brown-Singleton asked if the charts Dr. Joseph presented included data from migrant voucher programs.

- Dr. Joseph said that was the case.

Ms. Brown-Singleton referenced the flexibility for health centers to bill as originating sites for telehealth services and asked if Dr. Joseph had data on telehealth visits for MSAWs.

- Dr. Joseph said that BPHC could look at the weekly surveys and UDS data for this year to get an understanding of MHCs' use of telehealth technology. There is strong anecdotal evidence that the flexibility made a significant difference in health centers' ability to use telehealth. There is also a new appreciation of the importance of reimbursement for telephonic visits in addition to video-based visits.

Mr. Skoog asked Ms. Gonzales-Hanson how proposed changes to the 340B program would benefit pharmaceutical companies.

- Ms. Gonzales-Hanson said the proposed changes would be detrimental to health center patients and the health sector because it would be more expensive for health centers to purchase medications. The current focus is on pharmacies that provide prescriptions under contract with a health center, but NACHC expects that the bill would also impact health centers that have in-house pharmacies. Some lawsuits have been filed, and NACHC will probably file a lawsuit asking HRSA to hold the pharmaceutical industry accountable. NACHC has heard from health centers and PCAs across the country and is taking this issue very seriously. Some legislators understand that health centers need to be able to take advantage of the savings.
- Skoog asked if the proposed changes would influence a health center's decision to have their own pharmacy.
- Ms. Gonzales-Hanson said she would advise health centers to keep their pharmacy services in-house if possible.

Ms. Vallejo Cormier said this seems to be the ideal time to make a concerted effort to get permanent funding for health centers and asked who would lead that charge.

- Ms. Gonzales-Hanson said NACHC is urging its members and health center advocates to raise their voices, because Congress listens to constituents. It will take a major campaign with a coherent message and a coordinated approach. This is a good time for that effort. Vulnerable populations have relied on health centers during the pandemic because they trust them.

Dr. Snipes asked what led to the increase in the number of MSAW patients served in 2019.

- Ms. Gonzales-Hanson cited two factors: training of frontline staff to identify agricultural workers so health centers can take credit for what they are already doing, and partnerships and outreach

to let MSAWs know about the health centers. She noted that the Migrant and Seasonal Head Start (MSHS) program developed a mobile app that to locate the closest health center.

Panel Presentation: Impact of the COVID-19 Pandemic on MSAW, and Designing a National Data Strategy for Injury Prevention and Control to Restructure MSAW Care

Amy K. Liebman, MPA, Director of Environmental and Occupational Health, Migrant Clinicians Network (MCN)

Dr. Laszlo Madaras, Chief Medical Officer, MCN

Alan Mitchell, Executive Director, HealthEfficient, Health Center Controlled Network

Overview of MCN

Dr. Madaras provided an overview of MCN's services and noted that its mission is "To be a force for health justice for the mobile poor."

MCN's Health Network was created by health center clinicians nearly 30 years ago to provide continuity of care for mobile patients with diseases such as HIV, diabetes, and tuberculosis. The program is based in Austin, Texas, with offices in Salisbury, Maryland; Greencastle, Pennsylvania; Clinton, New York; Chico, California; and McAllen, Texas. They have worked in Puerto Rico since Hurricane Maria.

MCN has more than 10,000 constituents, including health educators, nurses, primary care providers, dentists, social workers, community health workers (CHWs), outreach workers, and medical assistants. They work with clinicians, federally funded MHCs and CHCs, state and local health departments, MSAWs, and mobile poor immigrants.

The MCN Health Network is a system for care management, referral tracking, and follow-up for patients who are on the move, both nationally and internationally. It offers toll-free access, expert and culturally competent staff, storage and transfer of medical records, health education, patient care, and coordinated services. The ability to transfer medical records eliminates repetitive services

The Health Network was created to provide care management for patients with tuberculosis (TB) and was originally called TBNet. It now offers care management for diabetes, cancer, HIV, prenatal care, and general health, including COVID. The network has more than 12,000 enrollments and works with 2,951 clinics in the U.S. and over 114 countries. It provides a bridge between patients and their providers, resulting in fewer patients lost to follow up and more patients who complete or continue treatment.

Protecting Agricultural Workers from COVID-19 through Testing and Post-Test Support

MCN hosted a series of webinars and learning sessions to help frontline clinicians address the challenges of the pandemic. The webinars are available in English and Spanish on the MCN website (<https://www.migrantclinician.org/archived-webinars.html>).

Separating people is a guiding principle of good epidemiology in the face of a pandemic, but many MSAWs live in crowded housing. To control the pandemic, it is important to offer separate housing for MSAWs who have tested positive and are sick, those who are in isolation because they were exposed, and those who have tested negative or show signs that they are not sick after a certain number of days.

MCN developed a set of principles to help farm owners prepare for testing agricultural workers and protecting them from COVID-19:

- Test workers upon arrival and prior to exposure to the current work crew.

- Contact authorities to encourage the acquisition of tests that will provide results within 48 to 72 hours.
- Connect with a local CHC or agricultural worker advocacy organization to secure resources and support to prepare for and conduct testing for agricultural workers.
- Provide separate housing with kitchen and bathroom facilities that are not shared with others. Providing housing is an essential part of testing.
- Provide food for COVID-19 positive workers and families in isolation. Contact organizations in the community that can provide food support.
- Provide workers with a medical care plan.
- Provide wage relief and return-to-work policies so workers are not reluctant to speak up about symptoms or get tested.
- Develop partnerships with a CHC or MSAW advocates to develop trainings and resources before testing begins.

MCN developed a detailed algorithm that integrates these principles with a series of questions for farmers.

Vaccine Campaign

COVID vaccine development is at the starting line, not the finish line. Vaccines need to be thoroughly tested before they are distributed to the public.

Dr. Madaras offered the following recommendations:

- National evidence-based testing with long-term funding
- A national, equitable, and well-funded vaccine strategy
- Vaccinations for other pulmonary conditions, such as flu and pneumonia, and tetanus boosters that include pertussis vaccine
- Internet hotspots where farmworkers can access telemedicine
- Explore the use of dogs that can detect COVID-19.

Farmworker Health and Safety During COVID-19

Ms. Liebman discussed challenges to MSAW health and safety during COVID-19 and reviewed potential policy and regulatory recommendations.

Farmworkers have been deemed “essential” workers, along with meat, chicken, and seafood processors and dairy workers. These essential workers have borne the brunt of some of the most challenging outcomes of the pandemic. They are largely Black, indigenous, Latinx, immigrants, and other people of color who are affected disproportionately by COVID-19. It is critical to understand the link between racial and ethnic health disparities and the type of work these individuals do. MSAWs and other essential workers do not have the option of working from home.

Surveillance data are essential to determine the link between the farmworker population and the extent of the pandemic. Purdue University estimated that at least 150,000 farmworkers have been infected with COVID-19. Another study in pre-publication found that rural counties with more non-English speaking households and more farmworkers had significantly higher levels of mortality, as did counties with higher levels of poverty and more residents over the age of 65.

The farmworker population experiences many vulnerabilities, including low-wage jobs, occupational dangers and health risks, cultural and language differences, immigration status, migratory lifestyle, lack of regulatory protection, and lack of access to health care, insurance, or financial resources.

The National Labor Relations Act of 1935 excluded agricultural workers from the federal protection for collective bargaining. Although some states have addressed that, the legacy has greatly impacted farmworkers. The Fair Labor Standards Act of 1938 excluded small farm employers from the minimum wage requirement, exempted agricultural employees from overtime, and permitted child labor. This “farmworker exceptionalism” extends beyond labor laws. Agricultural workers are exempted from Workers’ compensation policies, Occupational Safety and Health Administration (OSHA) standards, and the Environmental Protection Agency (EPA) worker protection standards for pesticide exposure.

The U.S. entered COVID-19 with a population that has historically been left out of labor protections and health and safety protections. Worker health and safety is public health, yet farmworkers do not have paid sick leave or housing and transportation that allow for physical distancing. When an individual worker lacks these protections, it impacts their family and eventually the entire community.

Farmworkers have been blamed for causing outbreaks due to the conditions in which they work and live, when in reality work is the driver for many cases of COVID-19 among farmworkers.

Gerardo Reyes Chavez of the Coalition for Immokalee workers put it well when he said: “You hear the job that we do is essential, but you realize as a worker you are not treated as essential. You are treated as dispensable.”

MHCs in many states have stepped up to help farmworkers address the challenges they face with COVID, with varying outcomes:

- An MHC in Wisconsin got an emergency order from the governor to help growers prepare for the migrant season. They used their mobile unit to test workers in the camps, providing an example of a strong relationship between the CHC, growers, and community partners.
- In Pennsylvania, responding to COVID-19 has strengthened relationships between the migrant health program and farmers.
- An MCN board member who played a critical role in developing the testing algorithm faced challenges in implementing it at her MHC, because North Carolina did not make it mandatory for growers to test their workers.
- An MHC in Iowa spent much of its COVID-19 stimulus funds to ensure that housing was available for workers who test positive and need to quarantine.
- In Maine, a partnership between the state health department, the growers’ association, and a CHC partnership helped minimize the spread of COVID-19 by arranging to test workers in New Jersey before they got on a bus to come to Maine for the blueberry harvest. Workers who tested positive were isolated.
- The MCN board chair worked hard to get regulations passed in Oregon. There were still many challenges, because some regulations did not go far enough and many workplaces were unprepared for the pandemic.

Community trust was a key component in these examples. Partnerships and outreach workers were essential. Overall, the lack of guidance and regulations at the national level and the variation in state policies has resulted in a haphazard approach to a public health crisis.

Ms. Liebman noted that 11 states adopted temporary standards or emergency orders specific to farmworkers, including provisions for PPE, physical distancing, workspace disinfection, worker testing, changes to housing and transportation to reduce the spread of the virus, and paid sick leave. Those standards were urgently needed to address the pandemic, but they are not permanent. We need a strong infectious disease standard that includes all workplaces and all workers.

Steps toward a National Data Strategy for the MSAW Population

Mr. Mitchell provided an overview of HealthEfficient, which is one of 49 HCCNs nationwide that were created to help health centers improve clinical and operational performance through the use of health information technology. HealthEfficient is the fourth-largest grantee in the program. Its members include health centers that serve the MSAW population.

A case study of a 46-year-old MSAW with type 2 diabetes who traveled from Florida to upstate New York illustrated the type of situation that a national data strategy could address. The worker's A1C was 9.2 when it was taken in Florida six months ago. His score on a standard depression screening tool was relatively high, but he left the area before a mental health referral could be completed. A social determinants of health screening conducted at a health center in New York found that JL regularly experiences food insecurity and housing insecurity, but that health center did not screen him for depression.

The case study raises a number of questions that a national data strategy could help to answer:

- What problems are likely to arise for the farmworker and for care providers who have an incomplete picture?
- How is the farmworker's A1C trending, and how can his risk be assessed and managed?
- How can providers in other regions be aware of the farmworker's mental health status and address issues in the screening?
- How can providers offer wraparound services to address housing and food security and provide continuity for the farmworker?
- What gaps in the data strategy for MSAWs can be seen in this case study?

In addition to benefits for clinical interventions, an MSAW-specific national data strategy would help policy makers and program administrators identify population-level indicators of health status and risk. Data on current trends, geographic variation, and emerging issues can be used to inform MSAW-specific investment of resources.

MSAWs should receive the best possible healthcare despite barriers related to social determinants of health and technology. Healthcare providers would benefit from comprehensive health records for this population. Providers and policy makers need insight on the population health status and common metrics of quality and value. A national data strategy for MSAWs would provide timely, accurate, and comprehensive data to support those decisions.

A national data strategy will have to address some major barriers. Many MSAWs move from region to region, confounding traditional health information exchange models. Patients lack access to reliable connectivity to their health data. Patients lack a standard patient identifier and standard markers used in patient matching, such as a fixed address. Electronic health record systems vary across regions and lack interoperability, and there is no infrastructure for a national health information exchange.

Those barriers are offset by numerous strengths. MHCs and CHCs are a well-defined system of care for the MSAW population. Fundamental technologies exist, but they have not been applied to solve these cases. Measure sets and collection tools exist and are applicable to the MSAW population, including the HRSA UDS, the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), and the Patient Health Questionnaire-9 (PHQ-9) depression screening tool.

PRAPARE can be integrated into electronic health records and other data exchanges. Having data available across a large population as they move from one place to another and aggregating the data at a population level can help identify resources to address social determinants of health. At the patient level, standard capture of this data would help health centers provide better care and services.

The first step in developing a data strategy is to define goals based on the problems to be solved at the population level and the patient level. The next steps are to identify the financial and technological resources needed, articulate a timeline for achieving specific goals, determine technology solutions, and identify measure sets that will capture the data points needed to solve the identified problems.

A national health information exchange for MSAWs would build on the AgAccess campaign and the HHS Nationwide Health Information Network Exchange (NHIN). Patient data would follow the patient and could be accessed by providers with the patient's consent. Key measures would build on the UDS and PRAPARE. Data would be captured by CHCs and CHWs who work with MSAWs. The exchange could leverage the NHIN and other resources of the HHS Office of the National Coordinator for Health Information Technology.

Developing a national data strategy would entail a multi-stakeholder strategic planning process. Potential stakeholders include patients, healthcare providers, support and service providers, government agencies, private industry, and subject matter experts.

Mr. Mitchell offered the following recommendations for consideration:

- Support efforts to grow the NHIN
- Convene diverse stakeholders
- Develop a national data strategy for MSAWs, including a strategy for a National Health Information Exchange
- Invest resources in solving the patient identifier challenge
- Focus on existing measure sets and tools
- Iterate sequential improvements.

Discussion

Ms. Higgins stated that most MSAWs in her area are not H-2A workers. They live in private housing provided by farmers, and they are unable to quarantine. She asked how the recommendations on housing could be applied in that situation.

- Ms. Liebman noted that H-2A employers are required to provide safe housing, which provides opportunities for better regulations for MSAWs who are not H-2A workers. Local health departments need funding for quarantine housing. The entire family or group living unit should be part of the public health concern.

Ms. Paul asked how a national data strategy could support other recommendations.

- Dr. Madaras replied that it will be important to overcome patients' reluctance to provide data to a government data. MCN is able to collect and share PRAPARE data because they build trust between the clinician and the patient.
- Mr. Mitchell stressed that informed consent is essential in order to share patient data with another provider. The data strategy might need a legal framework to protect the data for the intended use. Patient privacy and consent were foremost in developing the NHIN.
- Ms. Liebman said it is critical to understand what is happening to this population before we can make policy decisions. We currently have estimates of the number of MSAWs impacted by COVID-19, but we do not have data.
- Mr. Mitchell said he envisioned expanding the work that MCN and others have already done to provide data in challenging and normal times. UDS data are not suitable for making real-time decisions, because they are only provided once a year.

Mr. Calderon stressed the need to provide continuous services for MSAWs, including care for COVID-19. He noted that the local public health agency did not look at his community until the infection levels were much higher than in other parts of the county. There was a substantial number of cases, but farmworkers refused to be tested for fear of losing their jobs.

- Dr. Madaras noted that rapid testing can address concerns about losing time at work. Farmworkers deserve the same treatment as college students, who get rapid testing several times a week. MCN's team of contact investigators for TB is a major factor in the low incidence of TB in the U.S. and could be expanded for COVID-19. A coordinated national effort for contact tracing would be better than the current piecemeal approach.
- Ms. Liebman agreed about the need for services that maintain continuity of care. MSAWs were designated as essential workers, but resources were not provided to ensure that their workplaces are safe. As a result, COVID-19 outbreaks spread from farm to farm and community to community.
- Mr. Mitchell stated that a national data strategy and the mechanism to exchange data are needed now and can work in parallel. We should do whatever we can to solve the problems.

Ms. Brown-Singleton adjourned the meeting for the day at 5:05 pm.

Wednesday, October 21, 2020

Welcome and Overview of July 2020 NACMH Recommendations

Shedra Amy Snipes, Ph.D., Vice-Chair, NACMH

Dr. Snipes provided an overview of the recommendations the Council submitted in July 2020 regarding COVID-19 and MSAWs. She began by expressing gratitude to the many farmworkers who shared their narratives to help the Council understand the context of injury, environmental exposures, and health. She read a quote from a farmworker that captured the importance and beauty of this work:

"It is very nice to work in the field, because all of the people that work in the field are producing food for the entire world. Because the entire world eats from the field and not from the offices, not from the warehouses, not from the stores, but from the field."

Dr. Snipes noted that past efforts to improve public health have focused on food and nutrition. In addition to the nutritional content of food, the ways in which food is produced—and by whom—have

emerged as prominent health and social issues. Looking at a broad range of social determinants of health will highlight how the food system, including its players and contributors, matters for health.

In the absence of systematic surveillance data on COVID-19 and MSAWs, the Council based its recommendations on reports from the media, such as the following examples:

- A watermelon farm in Alachua County, Florida that tested 100 farmworkers found 90 confirmed positive cases, though only one person had symptoms.
- On June 25, 2020, farmworkers living at a housing facility in Oxnard, California were tested after two residents tested positive. By July 7, 204 out of 216 tested positive at the dorm-style facility.
- All 200 workers at a Tennessee farm tested positive for COVID-19.

On July 21, 2020, the Council submitted five recommendations to the Secretary of HHS to address the impact of COVID-19 in the MSAW population. Highlights are as follows:

- Recommendation 1
 - In lieu of a guideline-only approach, develop federally mandated and enforceable policies and procedures that require farm owners to follow CDC recommendations for COVID-19, including testing for MSAWs.
 - Action taken: In September 2020, HRSA participated in a technical working group (TWG) to support the development of questions related to COVID-19 for the 2021-2022 NAWS.
- Recommendation 2
 - Provide HRSA funding for health centers that serve increasing and unique MSAW needs.
 - Provide reimbursement to health centers that incur extra COVID-19 related costs.
 - Because of shortages in care, suspend closing of centers and reductions in funding until after the COVID-19 pandemic is resolved.
- Recommendation 3
 - Ensure that the Rural Housing Service of the U.S. Department of Agriculture (USDA) provides emergency funding (at no additional cost to MSAWs) that allows spacing of farmworker beds, living areas, kitchens, bathroom, etc.
 - Ensure that housing capacity limits are informed by best practices from medical and public health standards.
- Recommendation 4
 - Partner with DOL to expand the coverage of the NAWS to include H-2A and all MSAWs that meet the Office of Management and Budget definition of agriculture all its branches, based on the North American Industry Classification System (NAICS).
 - Make targeted outreach efforts to support COVID-19 testing and follow-up on the healthcare needs of H-2A workers.
- Recommendation 5
 - Draw the attention of Congress to the critical need to overcome shortages in PPE, such as respiratory masks, to enable hazard protection for MSAWs.
 - Strategically draw attention to farmworkers' health needs and the urgent need to extend federal emergency paid leave protections related to COVID-19 to cover farmworker employees, regardless of the size their employer's farm.

Testimony Sessions Structure and Ground Rules

Deborah Salazar, Session Chair and Coordinator

Ms. Salazar recruited 12 MSAWs who work in Colorado to provide testimonies (six women and five men). Nine of the testifiers work in the fields, one works at a dairy farm, and one works at a greenhouse.

The testimonies would be provided in two sessions. The first session would focus on COVID-19 and toxic stress and migrant children, and the second session would focus on COVID-19 and injury prevention. Dr. Snipes would take the lead for questions on COVID-19, Ms. Dodson would take the lead for questions on toxic stress, and Mr. Aguilar would take the lead for questions on injury prevention.

Testifiers would be seated at an appropriate distance to comply with COVID-19 precautions. Each testifier would have 15 minutes to provide their testimony. Testifiers could abstain from answering any question, and there would be no follow-up to questions a testifier chose not to answer.

Testimony Sessions I: Impact of COVID-19 in MSAWs and Toxic Stress and Migrant Children *Migrant and Seasonal Agricultural Workers*

MSAWs provided testimonies to the Council on COVID-19, toxic stress and migrant children, and injury prevention. The testimony questions are provided as Appendix A. A thematic summary of the responses in each area is provided below.

COVID-19

Testifiers answered questions about how the pandemic has affected their lives, where they get information about COVID, what they know about how to stay safe and get tested, and their thoughts and feelings about testing and the vaccine.

The testifiers provided poignant examples of how the pandemic has affected their work and their lives. Several had family members who tested positive, some of whom were critically ill.

Most of the testifiers said that their workplace was their primary source of information on how to protect themselves and their families, followed by media and television. Many said physicians are a trusted source of information.

Many of the testifiers shared misinformation about COVID-19 symptoms and testing. Two testifiers said that children could not go outside, while others did not think that children could be infected. Some expressed a belief that you do not need to be tested unless you have symptoms.

The testifiers demonstrated some confusion about when to seek medical attention. They did not describe any local efforts for contact tracing.

Most of the testifiers said they would get tested if necessary, but many were hesitant due to fear of testing positive or stigma associated with the disease. Some expressed hesitancy about taking a vaccine, but they would take one that was approved by their doctor.

Testifiers said that their employers do not generally provide masks or other PPE. One said that their farm manager offered masks but did not encourage workers to use them.

Toxic Stress and Migrant Children

Testifiers responded to questions about situations that cause them to be worried or anxious, sources of stress in the last year, solutions that help decrease the intensity of stress, traumas they may have suffered as a child, obstacles or concerns with seeking medical care or educational opportunities, and hope for the future of their children.

The testifiers consistently said that virtual learning is a challenge for migrant children. Many were concerned for their co-workers, and some expressed mistrust in the healthcare system.

One testifier described a good system for children with special needs in his area.

Injury Prevention and Control

Testifiers responded to questions about access to proper work clothes to perform their jobs, job safety concerns, job safety and training, working conditions (including extreme cold or heat, types of relief breaks during work hours, and availability of drinking water), and safety when working with chemicals.

All of the testifiers said they received training for the jobs they perform.

The testifiers said they are responsible for providing their own work clothes, but they did not describe that as a problem. They are also responsible for providing their own PPE, including sunglasses and sunscreen.

In general, the testifiers expressed few concerns about injuries.

Day 2 Wrap-up

Sharon Brown-Singleton, MSM, LPN, Chair, NACMH

Ms. Brown-Singleton stated that the agenda for Day 3 would include an open discussion of key takeaways from the testimony sessions.

Ms. Paul thanked Ms. Salazar for recruiting farmworkers to provide testimonies and organizing a successful session.

Ms. Brown-Singleton adjourned the meeting for the day at 4:50 p.m.

Thursday, October 22, 2020

NACMH Chair Reflections and Welcome

Sharon Brown-Singleton, MSM, LPN, Chair, NACMH

Ms. Brown-Singleton summarized the previous day of the meeting. She noted that topics that emerged from the testimonies could inform the agenda for future meetings.

Ms. Brown-Singleton reviewed agenda for the day and asked Council members to listen with intent and ask questions that could inform potential recommendations.

Ms. Paul thanked the representatives of partner organizations that serve MSAWs who were observing the meeting and thanked the interpreters and logistics staff who were working in the background.

Injury Prevention and Control in Agricultural Workers

Lorann Stallones, MPH, PhD, Professor, Department of Psychology, Colorado State University; Director, Colorado Injury Control Research Center

Dr. Stallones provided an overview of her research on the concerns of seasonal farm workers in Colorado, with a focus on the causes of injuries. The long-term goal of this work was to better understand issues that would help improve the design of injury prevention strategies. The study also identified issues related to human rights and injury risk.

The researchers conducted a pilot survey and used Social Cognitive Theory (SCT) to analyze the qualitative data. SCT provides a framework for understanding human behavior in terms of beliefs and knowledge, past behavior, and the social and physical environment.

Dr. Stallones presented key findings of the pilot study:

- Activities that resulted in injuries at home: Farmworkers described falls, cuts, overwork, and pesticide poisoning and exposure. They were also concerned about burns.
- Housing: Farmworkers described concerns about the poor quality of their housing and overcrowding.
- Traveling to and from work: Farmworkers described concerns about drivers who drink, driver fatigue, speed, and weather issues.
- Activities to reduce or prevent injuries: Farmworkers said it was their responsibility to work cautiously and to pay attention to their own behaviors.
- Pesticides: Farmworkers described the need to wear masks , gloves, and long-sleeve shirts to prevent exposure to pesticides, sun, and dust. They expressed a belief that the pesticides in the U.S. are more toxic than the pesticides used in Mexico and a belief that Mexican workers are strong and resistant to the pesticide poisons. They described a view that the long hours and years of working in the field lead to lung problems. They felt that gloves were important, but they might impede their ability to work.
- Working conditions: Farmworkers said there was a lack of work equipment provided by the employers or contractors. They attributed some of their injuries to poor communication between their supervisors and their bosses.
- Environment: Farmworkers mentioned exposure to the sun, wind, and dirt. They were concerned about exposures to pesticides, including drift from crop dusting at adjacent farms.
- Motivation: Farmworkers said they were motivated to use safe practices because they were in the U.S. to financially support their families. The issue of family came up repeatedly.

The researchers used the pilot survey data to develop a set of interview questions. The interviewer was a native Spanish speaker who was the Migrant Health Director at a family health center and oversaw a mobile health unit that provides primary medical care at worksites and housing facilities. The Institutional Review Board at Colorado State University approved the study. Participants provided written consent and received an honorarium of \$20.

Ninety-nine interviews were conducted in Spanish at migrant housing locations in Colorado. The interviews were translated into English for analysis. Two members of the research team read the transcripts. NVivo qualitative software was used to organize and code the responses.

Dr. Stallones summarized key findings of the study:

- Working conditions: Human rights issues related to injury and illness include hours of work, wages and payment schedule, labor relations (foreman, employer, and employees), and physical hazards related to housing, sun exposure, and pesticide exposure.
- Pesticides: Many workers mentioned pesticide training and provided evidence of issues of concern that are addressed in the Worker Protection Standard. Human rights issues in this area include not being able to comply with the guidelines, lack of access to clean water and permission to wash hands, and lack of needed PPE (e.g., masks, gloves). Many workers felt that the employer should provide PPE.
- Housing: Issues of concern included pesticide application near housing, safety concerns related to theft and assault, lack of Spanish instructions for use of appliances, and overcrowding resulting in lack of access to toilets, bathing, and/or kitchen.
- Transportation: Transportation between housing facilities and the work site is provided by employers. Workers expressed concern about safety issues such as the lack of seatbelts, overcrowding, and driver behaviors.

Dr. Stallones noted that transportation issues are not addressed in most workplace injury prevention strategies and have not been part of the human rights conversations for workers. Human rights advocates have focused on safe transportation from sending countries to receiving countries; they have not addressed issues of transportation between housing and the work site. Because the U.S. has not adopted the United Nations' Convention on Migrants' Rights, unauthorized immigrants working in agriculture are exposed to extreme hazards of illegal border crossing in addition to workplace hazards.

Many of these findings overlap with COVID-19 risks for MSAWs and impact the challenge of trying to prevent COVID-19 in this population.

Discussion

Mr. Calderon noted that DOL statutes for guest workers are meant to ensure the safety of agricultural workers. In his area, dust from the rice harvest carries over to adjacent neighborhoods, which also happens when pesticides are applied in the fields. Dust and pesticides can cause allergic reactions, infection, and contamination. Some of the people who are affected are undocumented, and they get lost in the process. He asked if Dr. Stallone's study found a similar situation in Colorado or if there was any legislation to address those issues.

- Dr. Stallones said the study did not ask about immigration status, and she did not know the percentage of respondents who were undocumented. There is a heightened awareness about pesticide poisoning at the clinic where the interviewer works because the medical director is concerned about pesticide poisoning; that might not be the case everywhere in Colorado. Worker Protection Standards are not helpful if training does not take place, the workers do not receive the appropriate PPE, or the provisions are not enforced. We could do better in that area.

Mr. Raber asked if the study found concerns related to violence, especially violence against women, at the workplace or due to insecure housing.

- Dr. Stallones stated that some of the workers who were interviewed described male-to-male violence due to drinking. There were very few female agricultural workers in the survey. The Department of Housing and Urban Development (HUD) has programs that focus on homeowners in low-income communities, but they have not been actively engaged in discussions of improving housing for temporary workers.

Mr. Skoog noted that conditions in Colorado are consistent with those in upstate New York, where many MSAWs work in orchards. Patient Engagement Services (PES) staff at his health center told him that the most common injuries they have seen are sprained and twisted ankles, wrist injuries, and some eye injuries. PES staff transport workers to the hospital or clinic, and they have signed people up for workman's compensation, which is available in New York regardless of immigration status. Many injuries to MSAWs are underreported because workers do not want to be seen as weak or are concerned that their contract will not be renewed for the next season if they are seen as a liability.

- Dr. Stallones stated that providing PPE for eyes could reduce hazards for those types of injuries. MSAWs who work in New York are fortunate, because most states do not provide workman's compensation for undocumented workers.

Ms. Higgins stated that some of the issues Dr. Stallones described are also prevalent in Florida, and problems have been exacerbated in the last seven months. Some workers who would normally travel to northern states had to work in Florida over the summer, and many suffered from dehydration and heat stroke. Minors have been working in the fields when schools were closed, often without PPE. She asked what the Council could recommend to protect young workers.

- Dr. Stallones replied that young workers need more in-depth training before they go into the workforce. Youth work training is being promoted across many industries, including the restaurant industry in Florida. NIOSH has a Childhood Agricultural Injury Prevention Initiative with guidelines for different ages of youth and different types of jobs. The Council could build on that and recommend more training for young MSAWs. New workers need to know how to work as safely as possible and need training on how to use PPE. Dehydration and heat stress are major problems for agricultural workers. Workers must have access to clean drinking water and shade, and they must be given rest periods.

Ms. Paul asked about injuries related to exposure to cold.

- Dr. Stallones replied that most agricultural work in Colorado is not done in cold weather, but that is changing. Injury prevention requires proper clothing and equipment and the ability to get out of the cold. Agricultural workers have limited ability to take care of themselves. It is imperative to put programs in place to make sure workers have what they need to stay warm or stay hydrated. Those who work near wildfires need respiratory protection. She has been working to inform communities about that issue.

Dr. Snipes asked why women were not represented in the pilot study and whether the findings reflected differences based on the injury experiences of males vs. females. She also noted that the finding about Mexicans being stronger and more able to take the strain of agricultural work pointed to historic racism in agriculture (beginning with slavery) that promoted misogynistic myths about "strong" ethnic workers as well as to Linda Hunt's work on machismo and injury and her own work. She asked what actions HRSA and other agencies could take to combat these issues through policy.

- Dr. Stallones replied that the pilot study reflected the fact that there are few female MSAWs in Colorado. A wide range of things are different between males and females, but she did not have data to answer the question about injuries. She suggested that the finding about Mexicans being stronger reflects the culture of machismo that is perpetuated in agriculture, where even non-Latino farmers will deny that they are injured before they will see a doctor. Those perceptions must be tackled in order to make sure workers get the prevention tools or medical care they need when they are injured; that work must be done through peer-to-peer conversations led by people who come from the community. The most important policy step that HRSA could take would be to provide funding for everyone to have access to medical care and mental health services, regardless of documentation. Working across sectors to address that issue would benefit everyone.
- Dr. Snipes said Linda Hunt's work on men in central Mexico who tested pesticides to prove that they were healthy and strong reflects pervasive cultural notions. However, her own ethnographic work, testimonies provided to the Council, and NAWs injury profiles show that male and female workers alike are willing to work through devastating and painful injuries because they are desperately poor. The key factors are systemic poverty, racism that says that brown and Latino and Asian people who have migrated to this country do not deserve protection, and the healthy desire of parents who want to provide food for their children.
- Dr. Stallones agreed that those are critical factors. We may not be able to tackle machismo, but we can have a major impact if we tackle the economic disparities and situations that make it impossible for people to take time off to address injuries and other health conditions.

Mr. Raber said another factor is employer and community expectations regarding what workers can endure. Most Americans would not be willing to work in those conditions, yet we continue to raise the expectations for MSAWs. He asked what policy recommendations might put farmworkers in an economic position where they could address an injury.

- Dr. Stallones suggested that the Council should recommend that wage and labor laws that were written for other workers be applied in agriculture.

Ms. Veguilla-Montañez asked what kind of data is available on degenerative diseases caused by agricultural work, such as arthritis, sprains, and rheumatism. She noted that she has bone spurs in her knees and skin damage from injuries that were not treated when they occurred because she was young and strong. She did not learn the proper way to use the tools until she was older.

- Dr. Stallones said this example is similar to the conditions facing all workers in the U.S. We do a poor job when a young worker is injured, and the cumulative impact of injuries is not known until many years later. When a young worker exposed to pesticides develops cancer later in life, it is not generally seen as an occupation-related illness. Musculoskeletal problems due to years of bending, lifting, and heavy carrying will not be considered as an agricultural injury unless we document the exposures, which is not the case for any workforce in the U.S. The situation is compounded when workers go back to their countries and do not return to the U.S. We need policy changes to address the issue in a more holistic way. Workers also need training in proper bending and lifting techniques, and the work setting could be modified so that injuries are less likely to occur. It will not be perfect, but we can do better.

Mr. Skoog asked to what extent systemic racism plays a role in implementing policies that will help MSAWs access the resources they need.

- Dr. Stallones said this issue is profoundly important. She noted that health and social service agencies in her area denied having any Spanish-speaking patients or clients, despite the presence of a small MSAW population. A newspaper in New York blamed MSAWs for an outbreak of COVID in the community. MSAW advocates need to emphasize that farmworkers provide an important service for all of us at the risk of their own health and well-being and we cannot find workers in this country who are willing to work in those conditions. It will take strong messages from advocates for MSAWs to change the tide.

Ms. Vallejo Cormier referenced the quote that MSAWs are considered essential workers, but they are treated as dispensable, and she added that they are also treated as invisible workhorses. When she was working in the fields, a schoolmate said her father told her Mexicans have an extra bone in their back, so it doesn't hurt them to work all day. She noted that agricultural workers are rarely highlighted in advertisements applauding essential workers, and she asked what could be done to address that.

- Dr. Stallones said that everyone needs to promote the message that agricultural workers provide an essential service. The people who do the work need to be valued at the level of their contribution. The central message should be: "No farms, no food." Agricultural work was not part of occupational safety and health until the 1980s. The percentage of workers is small, but the number of people they feed is huge. We have to keep asking for better standards.
- Mr. Calderon said the only way to address this is to unionize, as farmworkers did in California in the 1960s and 70s. Not every MSAW is represented by a union.

Toxic Stress in MSAW Children and the COVID-19 Pandemic

Sylvia Partida, Chief Executive Officer, National Center for Farmworker Health (NCFH)

Elena Reyes, PhD, Clinical Professor, Regional Director Southwest Florida, Florida State University College of Medicine (FSUCOM), Immokalee Health Education Site; Director, Clinical Health Psychology Postdoctoral Fellowship Program; Director, Center for Child Stress & Health, FSUCOM

Ms. Partida introduced the partnership between NCFH and FSUCOM to support research, dissemination, and training of best practices in integrated primary care for the prevention, screening, and treatment of toxic stress in children from MSAW families. The partnership began in 2017 and provides training for health care teams at community health centers.

Dr. Reyes provided a definition of adverse childhood experiences (ACEs) and toxic stress, reviewed the impact of toxic stress on children from MSAW families, discussed the impact of the COVID-19 pandemic on children from MSAW families, and offered recommendations to address the negative impact of toxic stress on children from MSAW families.

ACEs include abuse, neglect, household dysfunction. Standard screenings do not capture other adverse events that impact agricultural families, such as fear of deportation, discrimination, family separation, historical trauma, transient lifestyle, and inadequate housing.

Early adversity has lasting impacts, including injury, mental health, maternal health, infectious disease, chronic disease, and risky behaviors. It can also affect education, occupation, and income.

The impact of stress depends on its severity. Positive stress, such as concern about taking a test, causes mild elevations in stress hormone levels. Tolerable stress, such as the death of a loved one, leads to

serious, temporary stress responses buffered by supportive relationships. Toxic stress results in prolonged activation of stress response systems in the absence of protective relationships.

Extreme activation of the stress response causes distress for the child and may lead to negative psychological and physical health outcomes. The evidence is so strong that the American Academy of Pediatrics recommends screening at all well child visits. It is important for health care providers to look at what is going on and the child's response to those events.

The standard screening tool underestimates the extent to which children of MSAWs are exposed to toxic stress. There is growing evidence that early adversity becomes biologically embedded in the brain, leading to chronic activation of the stress response system.

Signs of toxic stress in children include problems in school, becoming easily irritated or easily distracted, hyperactive and impulsive behavior, difficulty relaxing and concentrating, becoming withdrawn, appearing dazed or forgetful, shutting down emotionally, headaches, and stomach aches.

ACEs occur in the context of adverse community environments, including poverty, discrimination, community disruption, violence, poor housing quality, and the lack of opportunity, economic mobility, and social capital.

The COVID-19 quarantine has increased stressors for parents, such as fear of infection, virus-related stigma, lack of supplies, financial stress, frustration, and boredom or isolation. Those stressors increase the risk of separation, social exclusion, neglect, abuse, and exploitation. For children, the stress can manifest as irritability, clinginess, hyperactivity, aggression, regression, and sleep problems. Quarantine places children at increased risk for depression, withdrawal, feeling inadequate, and trauma triggers.

COVID-19 stressors among children include social isolation, difficulty adhering to or understanding social distancing requirements, academic concerns or challenges with online learning, technology factors, inadequate facilities to quarantine, limited access to supportive relationships due to school closures, feeling unsafe, economic hardship, fear that testing will expose the community to the virus, and stigma associated with a COVID-19 diagnosis.

There are three tiers of interventions for toxic stress:

- Universal preventive interventions: General parent education targeting health literacy provided by behavioral health promotoras, and universal screening during well-child visits by primary care providers
- Selective preventive interventions: Targeted interventions for developmentally appropriate areas, parent guidance, and parent training
- Indicated preventive interventions: Evidence-based interventions for physical/behavioral problems.

To achieve the goal of a healthy child and a future healthy adult, we need early identification of problems, emotionally healthy parents who have good coping skills, children with coping skills and good emotional regulation, and trauma-informed educators.

To predispose children to positive outcomes in the face of adversity, integrated care and behavioral health promotores can facilitate supportive adult-child relationships; build a sense of self-efficacy and

perceived control; provide opportunities to strengthen adaptive skills and self-regulatory capacities; mobilize sources of faith, hope, and cultural traditions; teach positive parent-child integration; and address maternal mental health, including anxiety, depression, and experiences of maltreatment.

Dr. Reyes offered the following recommendations:

- Integrated behavioral health in migrant clinics to provide culturally appropriate screenings and interventions
- Access to tele-mental health services
- Clinic partnerships with Head Start programs and schools
- Workforce development that is developmentally, culturally, and linguistically appropriate
- Use of media (e.g., asynchronous training videos).

Dr. Reyes noted that FSU has developed culturally and linguistically appropriate materials for public messages and parent education (www.fsustress.org).

Discussion

Mr. Calderon said toxic stress has been a major issue in his own work with children and adults. Participating in soccer was a good intervention for one young man. His adult patients have shown increased levels of post-traumatic stress, which also affects their children. In many cases, children are referred to clinicians who have no context for addressing their problems. He asked how Dr. Reyes would promote her research in communities where it is desperately needed.

- Dr. Reyes said involving the young man in sports was a good example of a supportive community relationship. Her group is training schools and community organizations to provide trauma-informed care. They developed a train-the-trainer model that includes a video to provide on-going impact. She encouraged Mr. Calderon to contact her or the National Child Traumatic Stress Network.
- Mr. Calderon said he attended a training program for mental health promotores at the University of South Florida, and they now have a team in his county. California' mental health services tax funds behavioral health for special communities, including MSAWs. They have the resources, but training on behavioral health issues for MSAWs has not been institutionalized.
- Dr. Reyes agreed that it is essential to understand the population you are serving. She noted that the pandemic has led to new ways to provide training.

Dr. Snipes asked what resources are available to help MSAWs with little or no literacy complete online screening tools.

- Dr. Reyes said her program developed a kiosk for screening that lets patients choose between written materials designed for low-literacy readers or audio instructions in Creole, Spanish, or English. Patients can point to their answers on a graphic response sheet.

Ms. Higgins said she had noticed dramatic behavior changes among high school students she works with who are recent immigrants from Guatemala as a result of the pandemic. They were expected to work in the fields during the summer, and they do not have access to the Internet. She expressed concern about the possible long-term effects and asked what could be done to address them.

- Dr. Reyes replied that the American Psychological Association produces an annual report called *Stress in America* (<https://www.apa.org/news/press/releases/stress/2020/report>). The 2020 report was issued recently and is focused on the impact of COVID-19. She suggested that Ms. Higgins form a group to help students learn how to talk about feelings and develop basic coping

strategies. Adolescents need to know that they are not alone and that others are feeling the same way. She noted that the Immokalee Clinic is seeing more pregnant teenage girls with no resources, and she asked Ms. Higgins to contact her so they could collaborate.

Public Comments and Council Discussion

There were no public comments.

Council members shared reflections on the impact of the pandemic on their communities.

- Ms. Higgins said MSAWs in her area were facing challenges with access to transportation before the pandemic, and they live in a food desert. The closure of schools and Migrant Head Start centers was very abrupt. Parents still had to work, but they did not know what to do with their children. There was very little information and a great deal of misinformation. Stress increased when everything became virtual, because the population is not tech savvy. Youth joined the workforce when schools closed. The clinic sent a mobile unit, but people were reluctant to be tested. Those who tested positive stayed in the camps without protection, and cases exploded. Work was reduced in the area, because the demand for flowers and produce went down when restaurants and theme parks closed. Many MSAW families who traveled to other states had to quarantine for two weeks before they could work, and they returned to Florida with very little income. Students are returning to schools, and there is a fear of new infections. Telehealth is not working with the families at her clinic. Building trusting relationships with MSAWs is difficult in any case, and even harder through a screen. COVID has exacerbated existing behavioral health problems. Her clinic does not offer behavioral health services, and she does not know where people can access that care, especially those who speak Haitian Creole, Spanish, and indigenous languages. A recommendation on behavioral health could have a long-term impact.
- Ms. Veguilla-Montañez said the health center where she works as a volunteer is offering telemedicine services in addition to in-patient services, and they have a mobile unit that serves remote areas. The Interamerican University of Puerto Rico advised clinic staff on how to stay safe during community outreach efforts. The clinic distributes gloves, soap, bottled water, and eye protection. They created a holistic, interdisciplinary emotional and mental health support program to strengthen people emotionally, spiritually, and physically. Ms. Veguilla-Montañez developed a sanitation and hygiene program in coordination with the University of Mayaguez. They distribute hand sanitation kits to agricultural workers, and they provide training on hand sanitation and wearing masks. They developed humorous videos and other tools to reach people through Facebook and social media. The clinic is also helping to deliver food to seniors and people who are at risk or live in remote locations. They are constantly inventing and re-inventing. This situation is a continual process of teaching and learning—especially learning.
- Mr. Calderon said the pandemic has been difficult for everyone. In Northern California, no one was prepared. He has about 50 clients, about half of whom are MSAWs, and has not been able to see them in person since the pandemic began. Many of his clients have post-traumatic stress disorder, and recovery requires connection and empowerment. The town of Greeley, which is the smallest in Butte County, had the highest number of cases in the county. The health department had literature and masks, but they failed to do anything in Greeley. Four people he knew died of COVID, because the community was not educated. His clinic held free testing events in Greeley, but they had to cancel testing events when smoke from the wildfires became too thick. Mr. Calderon worked with families displaced by the fire. Many people lost everything

and will not be able to rebuild, because they do not have insurance. These are challenging times, but MSAWs and immigrants are resilient. Cultural competency is essential.

- Mr. Raber said his health center was not prepared at the beginning of the pandemic and quickly ran out of PPE. The pandemic strengthened some community partnerships, because they had to pull together in new ways. The area had a significant spike early on, and it impacted many seasonal agriculture workers. He and his colleagues were concerned that the community would blame the farmworkers for the pandemic rather than seeing them as victims. The pandemic strengthened the health center's relationship with the Movement for Immigrants. They are working together on public service videos and getting local leaders and pastors in the Spanish-speaking community to share them. The health center was better prepared when the migratory workers began to arrive. They increased testing over the summer and provided free testing for those without insurance. They opened testing sites close to two COVID hotspots and are doing prevention work at farms. Farmworkers in the area who are from Guatemala and other parts of Central America speak indigenous languages rather than Spanish.
- Ms. Salazar said her health center had to close their mobile unit when the pandemic began. She reached out to the farms to let them know that the clinic was open, and mobile unit staff started working in the call center. The farms now call her directly, and she makes appointments for the workers. At the beginning of the pandemic, mobile unit staff took workers' temperatures and provided educational materials on COVID-19. The health center offers free testing for MSAWs and farm owners, but only one owner has accepted the offer. Farmers provided one or two weeks of sick pay for workers who got COVID-19, which was a new policy. The recent social unrest made Ms. Salazar aware of white privilege and the health equity aspect of her work.
- Ms. Dodson said COVID-19 cases among workers led some growers to shut down their fields, reopen, and shut down again. When the Head Start centers closed, they started providing thousands of food boxes to families. The centers have since reopened. Wildfires destroyed more than 2,300 homes in two towns where many Head Start families lived, and some staff members are living in tents and burned-out garages after losing their homes. Support services are available, but some families are reluctant to accept help due to fear of deportation. Head Start staff are providing education and helping families find resources. The air quality index was 400 to 600 for two weeks, making it extremely dangerous for workers in the field (levels above 10 are cause for concern). Some growers shut down for a few days, but they could not stay closed for two weeks. Rental properties are hard to find, and families are sharing houses, which increases the risk of COVID-19. The families are coping, the communities are coming together, and the children are being served in the centers. Head Start mental health consultants are providing remote services. Their main concern is how to address situations that are less overt. The consultants are training in trauma-informed practices to help staff recognize underlying factors for behaviors they see in children. The Head Start program anticipates more mental health issues and added a new staff position to address that concern.

Day 3 Wrap-up

Sharon Brown-Singleton, MSM, LPN, Chair, NACMH

Ms. Brown-Singleton invited Dr. Snipes to share her observations on the day.

Dr. Snipes expressed concern about some of the testimony findings, including the extent of misinformation or lack of information around COVID-19 testing, the need for workers to provide their own PPE, and the lack of PPE in circumstances where it needs to be replaced often.

Dr. Snipes commended her colleagues on the Council who are working on the frontlines with farmworkers and advocating for their needs. She closed with quotes from Martin Luther King, Jr.:

- “We are not makers of history. We are made by history.”
- “Our lives begin to end the day that we become silent about things that matter.”
- “Nothing in the world is more dangerous than sincere ignorance or conscientious stupidity.”
- “Never be afraid to do what is right, especially when the well-being of a person is at stake. Society’s punishments are small compared to the wounds that we inflict on our soul when we look the other way.”
- “Life’s most persistent and urgent question is: What are you doing for others?”
- “A genuine leader is not a searcher of consensus, but a molder of consensus.”

Ms. Paul expressed her gratitude for the opportunity to work with the Council. She thanked her colleagues at HRSA and the logistics team for supporting the meeting.

Ms. Brown-Singleton adjourned the meeting for the day at 4:50 p.m.

Friday, October 23, 2020

Formulation of Letter of Recommendations to the Secretary of DHHS

NACMH members

Ms. Brown-Singleton welcomed Council members to the final day of the meeting and outlined the process for developing the letter of recommendations. She noted that the Council would work in the following teams to develop recommendations in three areas:

- COVID-19 and National Data Strategy: Shedra Amy Snipes (lead), Carmen Veguilla-Montañez, Jose Salinas, Deb Salazar
- Toxic Stress in Migrant Children: Donalda Dodson (lead), Angie Cormier, Angel Calderon, Dani Higgins
- Injury Prevention: Rogelio Aguilar (lead), Daniel Jaime, Jonathan Raber, Gary Skoog.

Ms. Brown-Singleton said she would develop a summary of the key issues from the testimonies, presentations, and Council discussions.

Council members discussed key issues and potential recommendations in each thematic area and agreed on a timeline for developing and submitting the letter.

Potential Collaboration with OSHA

Whitney Long, Public Health Contractor, OSHA

Ms. Long informed the Council about OSHA’s project to assess existing occupational guidance and determine whether additional guidance is needed to protect workers during the COVID-19 pandemic. The goal of the project is to identify gaps and develop resources for various populations.

Ms. Long is part of a team that is looking at shared or group housing, which is relevant to MSAWs. The project is looking at many other areas that are relevant to MSAWs, especially during a pandemic, including field sanitation, PPE, and drinking water.

OSHA is holding virtual meetings with stakeholders in dozens of industries to identify needs and overarching themes. They would like to have input from people involved with the MSAW community to develop guidance or supporting materials for farmworkers and those who assist them.

Ms. Paul said that she would talk to Ms. Long in the coming week to discuss how to move forward.

Closing – Wrap Up/Summary

Sharon Brown-Singleton, MSM, LPN, Chair, NACMH

Ms. Brown-Singleton noted that Mr. Aguilar, Mr. Skoog, and Mr. Jaime would retire from the Council following this meeting. The departing members expressed their gratitude to HRSA and their fellow Council members and shared reflections on what their time on the Council had meant to them. Ms. Paul thanked each of them for their service.

2021 Meetings

Ms. Paul announced that the dates of the 2021 meetings would be May 25 to 28 and November 2 to 5. The May meeting would be held virtually. The format of the November meeting would depend on the course of the pandemic.

Ms. Paul asked each Council member to recruit one or two MSAWs or promotores from their area who could provide testimonies.

Ms. Paul thanked the Council for their patience in preparing this first virtual meeting. Council members discussed what worked well and what should be modified to make future virtual meetings more successful.

Council members identified potential topics for the next meeting, including nutrition and food insecurity, special needs for MSAWs, the 340B program for MHCs, the aftermath of COVID for MSAWs, and the rapidly evolving policy framework for MSAWs.

Ms. Naqvi, Ms. Paul, and Council members thanked Ms. Brown-Singleton for her leadership as Council chair.

Ms. Brown-Singleton called for a motion to adjourn. The motion was made by Ms. Dodson and carried by voice vote. The meeting was adjourned at 5:08 p.m.

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

October 20-23, 2020
Virtual Meeting

Appendix A: Testimony Questions

Testimony Session I: Impact of COVID-19 in MSAWs and Toxic Stress and Migrant Children

Topic 1: COVID-19

Lead: Shadra Amy Snipes

1. Thank you for the work you are doing as an essential worker during COVID-19. I would like to start by asking you if there is anything that you wish to share with the Council on how the pandemic has affected your life.
2. COVID-19 requires several items to reduce the spread of symptoms. Have you received information on how to protect yourself and your family or on COVID testing? If so, by whom? What are your feelings about the information that has been presented to you?
3. Question related to receiving the vaccine: Have you heard any information on the vaccine? Will you receive it if offered? If no, what is your hesitation?

Topic 2: Toxic Stress and Migrant Children (Trauma):

Lead: Donalda Dodson

Subject Matter Experts: Angie Cormier, Dani Higgins, Gary Skoog, Deb Salazar

Trauma:

1. Tell us about what you do for work and include how often you may take breaks?
 - a. *Are you able to get adequate rest from your field or dairy farm work?*
2. Are there certain situations that cause you more anxiety or more worried e.g. leaving the farm, being in large groups, needing to visit a strange or new location?
 - b. *Has this interfered with you seeking other employment opportunities?*
3. Do you have some worries or concerns that you carry with you at all times? Or What do you see as the most important factor that has caused you stress in the last year?
 - c. *Is family separation a concern for you? How have you been able to deal with this?*
 - d. *Do you have any fear of loss of job, loss of childcare, loss of housing, deportation? How do you deal with these?*
 - e. *Are you comfortable speaking about anything which can make you fearful on the job or at home?*
4. Have you been able to find solutions to any that help decrease their intensity? Your health center?
5. Can you speak about any particular trauma you may have suffered as a child?
6. Are there any obstacles/concerns with seeking medical care, education opportunities?
7. What would your hope be for the future of your children?

Additional Question:

- What services would you like to have at your local clinic that you don't currently have right now?

Testimony Session II: Impact of COVID-19 and Injury Prevention and Control in MSAWs

Topic 1: COVID-19

Lead: *Shedra Amy Snipes*

(Same questions as in Session I)

Topic 2: Injury Prevention and Control

Lead: *Dr. Jose Salinas*

Subject Matter Experts: *Roger Aguilar, Daniel Jaime, Jonathan Raber, Angel Calderon, Carmen Veguilla*

Clothing and Apparel:

- Broad Question: *How has appropriate clothing (e.g. coverage from the weather, protective such as long sleeves, caps) been an obstacle for you with regards to working in either extreme cold or heat or even in crops that may have pesticide?*
- 1. What clothing issues did you have when you arrived?
- 2. Is access to proper work clothes a problem?
- 3. Have you had to spend your own money for clothing?
- 4. Is there anything you're lacking now to dress for the job you're currently doing?

Job Safety:

- Broad Question: *Do youth work for your employer, and if so what types of safety concerns do you have specific to youth?*
- 1. What types of job-related injuries have you experienced or observed?
- 2. What kind of specialized tools do you use for your assigned job(s)?
- 3. Do you feel that you receive proper training on the equipment you use on the job to prevent injuries?
- 4. What are some of the safety concerns that you currently have?
- 5. How do you report issues of safety on your job site?

Weather Conditions (Heat/Cold):

- Broad Question: *What examples can you provide of working in extreme hot (or cold) conditions while on the job and what types of relief/breaks are available to you during work hours?*
- 1. Where do you go for relief from extreme heat or cold conditions while on the job?
- 2. What kind of breaks are built into your workday?
- 3. How is drinking water made accessible to you while on the job?
- 4. How are bathroom breaks handled?

Chemical Safety

- Broad Question: *What type of training, education, and equipment have you received to properly handle chemicals, and was training and education provided in a language that you understand*
- 1. How often are you around dangerous chemicals?