

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

**November 7-8, 2017
Raleigh, North Carolina**

Council Members in Attendance

Amanda Phillips Martinez (Chair)
Christopher LaBarge (Vice-Chair)
Rogelio Aguilar
Adriana Andrés-Paulson
Susana Castro
Alina Diaz
Daniel Jaime
William Morgan
Horacio Paras
Stephanie Triantafillou

Federal Staff

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 Division Director
Esther Paul, MBBS, MA, MPH, Public Health Analyst
Priscilla Myles, MPH, Public Health Analyst

TUESDAY, NOVEMBER 7, 2017

Welcome/Call to Order/Introductions

Esther Paul, Designated Federal Official, NACMH, SIPD, OPPD, BPHC, HRSA

Ms. Paul welcomed new and continuing Council members, speakers, and public visitors to the meeting and opened the floor for a round of introductions.

NACMH Chair Opening Remarks

Amanda Phillips Martinez, Chair, NACMH

Ms. Phillips Martinez welcomed Council members and other meeting participants and reviewed the Council's mission and charge. She noted that the role of the Council is to advise, consult, and make recommendations to the Secretary of HHS and the HRSA Administrator concerning the organization, operation, selection, and funding of migrant health centers (MHCs) and other entities assisted under section 330(g) of the Public Health Service Act. The NACMH recommendations are based on Council members' knowledge of the needs and concerns of migratory and seasonal agricultural workers (MSAWs), health providers, and administrators and Council members' understanding of the role and scope of influence of HHS and HRSA and the strategic initiatives of BPHC.

Ms. Phillips Martinez pointed out that the Council meets twice a year. The first meeting for 2017 was held in Washington, D.C. The Council chose to hold this meeting in the Southeast to learn more about

the experience of MASWs in this region, and challenges and health issues that are unique to this area, such as Green Tobacco Sickness.

Ms. Phillips Martinez thanked the speakers for donating their time and expertise and the local organizations in North Carolina that arranged for farmworkers to provide testimonies during this meeting. She also thanked the federal staff for their support and guidance.

Ms. Phillips Martinez reminded Council members that they bring their knowledge of their local community, their experiences with MHCs, and their understanding of the needs of MSAWs.

Ms. Phillips Martinez noted that migrant workers leave their homes and take great risks to achieve a better future for themselves and their families. These men, women, and children labor in the fields and harvest the food we put on our table every day. They suffer from poor housing conditions, dangerous working conditions, and are exposed to harmful chemicals and dangerous working conditions. Farmworkers face many health risks and often suffer from lack of access to care and poor health outcomes. They are often unable to speak out against injustices in the field and suffer from prejudice, harassment, and the lack of basic working rights.

Ms. Phillips Martinez shared the United Farm Workers' reflection:

Show me the suffering of the most miserable, so I may know my people's plight.

Free me to honor others, for we are present in every person.

Help me to take responsibility for my own life, so that I can be free at last.

Grant me courage to serve others, for in service there is true life.

Give me honesty and patience, so that I can work with other workers.

Bring forth song and celebration, so that there is joy alive among us.

Let that joy flourish and grow, so that we will never tire of the struggle.

Let us remember those who have died for justice, for they have given us life.

Help us love even those who hate us, so we can change the world.

Ms. Phillips Martinez called for a motion to approve the meeting agenda. The motion was made by Ms. Castro, seconded by Mr. Paras, and carried by general consent.

Ms. Phillips Martinez called for a motion to approve the minutes of the June 2017 meeting. The motion was made by Ms. Andrés-Paulson, seconded by Mr. Paras, and carried by general consent.

Federal Update

Iran Naqvi, MBA, MHS, Deputy Division Director, OPPD, BPHC, HRSA

Ms. Naqvi provided an overview of BPHC and the Health Center Program, update on the budget and funding for fiscal year 2017 (FY2017) and FY2018, and BPHC strategic priorities.

Overview of BPHC

- The mission of BPHC is to improve the health of the nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary healthcare services.
- The Health Center Program includes nearly 1,400 organizations that operate more than 10,400 service delivery sites. In FY2016, nearly 26 million people—one in 12 people across the U.S.—relied on a health center for care, including nearly one million MSAWs.

- More than 90 percent of MHC patients are racial or ethnic minorities, and a similar percentage live in poverty. MHC patients are more likely than those of other health centers to be uninsured and to need services in languages other than English. MHCs provide more enabling services than other health centers.
- 59 percent of MSAWs served by the health center program are seasonal workers; 31 percent are migratory workers. About 10 percent receive services at health centers that are not funded as MHCs.

Budget and Funding, FY2017

- BPHC awarded New Access Point (NAP) grants to 14 MHCs (\$10 million) and Quality Improvement Awards to 172 MHCs (more than \$18 million). In addition, BPHC awarded more than \$26 million to 152 MHCs under the new Access Increases in Mental Health and Substance Abuse (AIMS) program.
- The President's budget request for FY2018 includes \$5.1 billion for BPHC's health center program. Congress passed, and the president signed, a Continuing Resolution that will extend discretionary programs through December 8, 2017.
- Mandatory funding for the health center program, which represents 70 percent of the budget, expired on September 30, 2017.

BPHC Strategic Goals and Objectives

- Strategic Goal 1: Increase access to primary health care
 - Increase the number of underserved communities and vulnerable populations with access to primary health care
 - The number of health center patients increased by 151 percent from 2001 to 2016. From 2014 to 2016, the number of patients who received mental health and substance abuse services increased by 43 and 41 percent, respectively.
 - Expand access to comprehensive services
 - Most health centers provide four or more types of services (e.g., medical, dental, behavioral health, vision, and enabling services).
 - Mental health services (HHS priority): The number of mental health visits increased by 37 percent from 2014 to 2016; health center depression screening and follow-up increased by 21 percent from 2014 to 2016.
 - Substance abuse and opioid treatment and recovery services (HHS priority): The number of patients diagnosed with substance-related disorders increased by 41 percent from 2014 to 2016.
 - Childhood obesity (HHS priority): The prevalence of childhood obesity among health center patients is more than twice the national average. In 2016, about 63 percent of health center patients 17 years old and younger received weight assessments and counseling for nutrition and physical activity preventative services (a six percent increase over 2014).
 - Strengthen health center capacity to respond to urgent and emergent issues
 - Substance abuse and opioid treatment and recovery services (HHS priority): In 2017, BPHC awarded more than \$200 million through the AIMS program.
 - OPPD has two staff dedicated to urgent and emerging issues (e.g., Zika virus, disaster response).
- Strategic Goal 2: Promote and advance quality of care

- According to the 2016 Uniform Data System, the percentage of health center patients with controlled diabetes and hypertension is higher than the national average
- One in seven center health centers met or exceeded Million Hearts Initiative goals for aspirin therapy, blood pressure control, and tobacco counseling
- Medicaid enrollees seen at health centers have lower total spending, fewer visits, lower spending on specialty care, fewer inpatient admissions, and lower spending on inpatient care compared to those seen at non-health center settings.
- As of September 30, 2017, 67 percent of health centers are recognized as a patient-centered medical home (PCMH).
- Strategic Goal 3: Optimize BPHC Operations
 - Uniform Data System (UDS) Modernization Project: Will provide additional time and support for preparation and submission; reduce the reporting burden; improve data quality; and expand data usage to improve health center clinical care and operations.
 - A new Compliance Manual provides basic guidance for health centers by consolidating all Program Assistance Letters (PALs), Policy Information Notices (PINs), and Program Requirement Summaries in one place.

BPHC resources to support the Health Center Program include the BPHC website (www.bphc.hrsa.gov), a weekly e-newsletter, a BPHC Helpline, the BPHC project officers, technical assistance provided through the National Cooperative Agreements (NCA), and a Primary Care Association (PCA) in each state.

Discussion

- Ms. Andrés-Paulson commented that the new compliance manual makes it easier for board members to understand what their health center needs to do to be in compliance.
- Mr. Morgan stated that local law enforcement is concerned that the focus on opioids does not reflect the nature of the substance abuse problem in his community in Pennsylvania.
- Ms. Andrés-Paulson expressed concern about the lack of culturally competent mental health and substance abuse services, especially for pediatric patients.
- Fr. LaBarge stated that the State of Maryland does not reimburse for telemedicine for mental health services. This creates a challenge for rural areas.
- Ms. Phillips Martinez pointed out that telehealth also requires grant-funded services to bring patients to the location.
- Ms. Andrés-Paulson noted that reimbursement is a national issue, but decisions are made state-by-state.

National Association of Community Health Centers (NACHC) Update

Joseph Gallegos, Senior Vice President for Western Operations, NACHC

Mr. Gallegos provided updates on the impact of federal policies on health centers and the status of the Ag Worker Access 2020 campaign.

Health Center Funding

- The Community Health Center (CHC) Fund Extension expired on September 30, resulting in a 70 percent cut in funding. The National Health Service Corps (NHSC), Teaching Health Centers Graduate Medical Education (THCGME), the Children’s Health Insurance Program (CHIP), and other programs expired at the same time. The House held a hearing on CHIP/CHCs in June.
- Congress passed a continuing resolution that maintains short-term funding for discretionary programs through December 8, 2017.

- HRSA is disbursing CHC funds on a month-to-month basis until funds run out, which creates financial challenges for CHCs.
- If Congress does not restore the funding, nine million patients will lose access to primary and preventive care, more than 51,000 providers and staff will lose their jobs, and 2,800 health center sites will close.
- CHCs have broad, bi-partisan support in Congress. The House passed legislation on November 3 that would avert the funding cliff and extend several other key programs, but the Senate has not introduced a bill. NACHC is working closely with the leadership of both houses, with a goal of fixing the funding cliff for five years.

Affordable Care Act (ACA) and Medicaid expansion

- Repeated efforts to repeal the ACA have failed. NACHC remains concerned about the impact on CHCs if Medicaid funding is given to states as block grants.
- The debate has elevated the visibility of the Medicaid program and increased support.
- NACHC policy resources are available online (www.nachc.com).

Ag Worker Access 2020 Campaign

- The goal of the campaign is to serve two million MSAW patients by 2020
- The number of MSAW patients increased from 790,226 in 2013 to 957,529 in 2016, despite a challenging policy climate.
- New campaign strategies include:
 - Broaden the campaign beyond the health center network to local community-based organizations, churches and synagogues, and farmers/growers
 - Develop MOUs to promote partnerships and collaborations (e.g., MSHS, migrant education, farmworker housing units,
 - Broaden and diversify the role and composition of the campaign task force
 - Continue to train patient registration staff on migrant health definitions
 - Work with BPHC on administrative policy and service delivery models and tools (e.g., voucher programs, mobile teams/vans, co-location with farmworker housing units, face-to-face encounters, rural telehealth).
- The 2017 Midwest Migrant Stream Forum identified a wide range of innovations to increase access, such as board resolutions to make increased access for MSAWs a priority.
- The task force has four recommendations for HRSA:
 - Clarify the level of flexibility for MHCs to institute an expedited Scope of Project review and approval process for health centers and voucher programs that want to mobilize health teams and co-locate with area partners to increase access.
 - Revise the definition of a “user” and an “encounter.”
 - Work with the Centers for Medicare and Medicaid Services (CMS) to legitimize telehealth as a billable and reimbursable service under Medicare and Medicaid.
 - Incentivize and orient CHCs to more deliberately identify, serve, properly register, and record in their UDS all special populations served, even if the CHC is not funded to serve a specific special population.

Mr. Gallegos closed with a quote from an MHC consumer board member: “We all need a lawyer at least once in our lifetime. We all need a doctor at least three times per year. We all need an agricultural worker at least three times per day.”

Discussion

- Ms. Phillips Martinez asked if NACHC has model board policies to increase access.
 - Mr. Gallegos offered to provide information on a health center in Chicago that developed a board resolution. The center is conducting a new needs assessment to determine their current penetration rate and identify strategies to increase access; they are also providing incentives for staff.
- Ms. Andrés-Paulson expressed concern that children whose parents are deported become unaccompanied minors and can no longer access services.
 - Mr. Gallegos stated that NACHC is working with the National Immigration Law Center to help parents create power of attorney documents in the event that they are deported. California Health Access does similar work for MSAWs in that state.
- Fr. LaBarge asked how many of the MSAWs served in 2016 were seen at MHCs.
 - Mr. Gallegos replied that the increase from 2013-2014 primarily reflected patients who were seen by non-MHCs. Overall, about 70 percent of MSAW patients are seen at MHCs.
- Mr. Paras stated that his center supports the Ag Worker Access campaign, but they only have one promotora.
 - Mr. Gallegos said the Task Force recognizes that enabling services are the essence of the MHC model, yet they are often the first things to be cut because they are not reimbursable. The PCMH model recognizes the role of the social determinants of health (SDOH). Going forward, reimbursement will be based on improved health status rather than clinician encounters. Promotoras and outreach workers will become more critical.
- Ms. Triantifillou asked if the number of MSAW patients would continue to increase, given the current immigration environment, and when the 2017 UDS data would be available.
 - Mr. Gallegos replied that 2017 UDS data would be available in July 2018. Efforts to increase the number of MSAW patients will be challenging until Congress establishes an immigration policy and a pathway to citizenship.

North Carolina Primary Care Association Update

*E. Benjamin Money, Jr., MPH, President & CEO, North Carolina Community Health Center Association
Elizabeth Freeman Lambar, MSW, MPH, Program Director, North Carolina Farmworker Health Program*

Mr. Money provided an overview of agricultural health worker health services in North Carolina:

- North Carolina has 11 MHCs and 10 Farmworker Health Programs that collectively operate more than 90 sites. The ACA helped expand the number of centers in the western part of the state.
- North Carolina has an estimated 83,723 agricultural workers. In 2016, 46,732 MSAWs and their dependents accessed enabling and medical services through agricultural worker health sites. The majority were adult male Latinos who were best served in a language other than English. Most were uninsured, with incomes below the Federal Poverty Level.
- The number of agricultural workers in North Carolina decreased by five percent from 2007 to 2016. The number of H-2A visa workers increased during that same period.

Ms. Lambar shared a poem, "The Farmworker," by Dr. Gayle Thomas, who is the medical director of the North Carolina Farmworker Health Program (<http://news.unhealthcare.org/news/2017/may/mobile-clinic-offers-care-to-farm-workers>).

Ms. Lambar provided an overview of farmworker health in North Carolina:

- Factors that influence farmworker health include demographics; migration/immigration status; type of worker (i.e., seasonal, migrant, H2A); accompanied or unaccompanied; level of control over one's life and environment; and working and living conditions.
- Farmworkers are employed in every county in the state, but access to care varies, largely due to the availability of enabling services.
- Working conditions include long work hours; physical strain of hand harvesting crops; rapid pace of work; lack of access to drinking water, bathroom facilities, or handwashing facilities; and significant occupational hazards.
- Living conditions include trailers, houses, barracks, shacks, cars, and tents. Housing is often provided by the grower. Air conditioning is rare, and substandard housing is common.
- The most common occupational illnesses include heat illness; pesticide exposure; injuries (e.g., musculoskeletal strains and fractures; cuts; eye trauma; vehicle and machinery accidents); dermatitis and pterygium; and Green Tobacco Sickness (GTS).
- Top reasons for medical visits are hypertension, diabetes, back pain, gastritis, acute upper respiratory infection and pterygium. Other common concerns include oral health and depression and anxiety.
- Barriers to care include isolation, frequent mobility, transportation, language, cost, and fear.

Mr. Money offered recommendations in seven areas:

- Data: Add ZIP codes of agricultural worker patients as a required field in UDS reporting.
 - These data are needed to reduce service area overlap; assess need; and strategically target expansion of services to areas with unmet need and help fulfill the goals of the Ag Worker 2020 Access Campaign.
- Medical-Legal Partnerships to address SDOH: Support the expansion of Medical-Legal Partnerships between MHCs/Voucher Program sites and civil legal aid organizations to address MSAWs' SDOH.
 - Considerations: Funding cuts to civil legal aid organizations at the state and federal levels.
 - Legal Services Corporation-funded organizations cannot represent non-US citizens, except for H-2A workers or "victims of battering, extreme cruelty, sexual assault or trafficking."
- Mental and behavioral health: Support the continued expansion of mental and behavioral health care services for agricultural workers, including:
 - Innovative models of care (e.g., mobile mental health services, telepsychiatry, and other technologies)
 - Night and weekend availability of providers
 - Implementation of CLAS standards at all agricultural worker health programs to address language and cultural needs of patients
 - Trauma-informed care.
- Transportation: Increase access to transportation for MSAWs. Support replication of transportation models that work while reducing need for travel.
- Occupational hazards: Support robust outreach, education, and training initiatives for agricultural workers, M/CHC and Voucher Program site staff, and farmers on occupational hazards and injuries impacting agricultural workers. Strengthen partnerships and collaboration with federal agencies, including the Occupational Safety and Health Administration (OSHA) and the Environmental Protection Agency (EPA), to identify and continue to address occupational hazards and injuries impacting agricultural workers

- Community Health Worker (CHW) Role on Clinical Care Teams: Support the integration of CHWs/Promotores(as) de Salud onto clinical care teams.
- Housing: Support the availability of safe and affordable housing for agricultural workers, including increased frequency of inspections by state agencies at labor camps and inclusion of agricultural workers in farm health and safety regulations that protect other workers.

Discussion

- Ms. Triantifillou asked for a description of GTS.
 - Ms. Lambar explained that occurs when workers are harvesting tobacco. Nicotine penetrates from damp tobacco leaves into the skin. Providers recommend wearing rain gear, but that is not realistic in the heat.
- Mr. Morgan asked about the ethnic background of the Latino population and the breakdown of crops in North Carolina.
 - Ms. Lambar replied that the primary crops are Christmas trees, strawberries, tomatoes, tobacco, sweet potatoes, and melons. Most of the labor is stoop labor. Most farmworkers in North Carolina are from Mexico, with a fair number from Guatemala and some from Nicaragua and Honduras. The demographics vary by region and by crop.
- Mr. Aguilar asked what farmers are doing to address GTS.
 - Ms. Lambar stated that her organization provides information to farmers during an annual Farm Safety Day. It is up to the farmers to follow the advice.
- Ms. Diaz asked how many MSAWs are minors.
 - Ms. Lambar replied that the number of MSAWs does not include dependents. There are no hard data on the number of minors working in agriculture, but the most common age is 16 or 17.

Testimonies

The Council heard testimonies from 16 MSAWs working in North Carolina regarding their experiences and needs related to mental health, substance abuse, intimate partner violence, and behavioral health and their awareness of Green Tobacco Sickness. Allison Lipscomb of the North Carolina Farmworker Health Program, Melinda Wiggins of Student Action for Farmworkers, and Christine Alvarado from East Coast Migrant Head Start helped to recruit the farmworkers and brought them to the meeting.

The farmworkers described the day-to-day challenges of working in the fields, and some said they began working as young as 12 years old. They shared stories of stressful experiences migrating from state to state or country to country. They testified that promotor/as from their communities are their first point of contact with the health care system and fulfill many needs, including helping them navigate the system, connecting them to community resources, and providing culturally and linguistically appropriate education and services for health and mental health. Many said they have to travel several hours to a health clinic. Some have seen several physicians, depending on their health conditions.

Ms. Phillips Martinez thanked the farmworkers and assured them that their testimonies would be a key component of the Council's understanding of the context and experience of MSAWs in North Carolina.

Discussion of Possible Recommendations

Council members reflected on the presentations and testimonies and identified key issues, adverse effects, and potential recommendations:

- Issues: Lack of access to health and mental health services due to rural nature of migrant communities. Lack of reimbursement for telemedicine/telehealth.
 - Adverse effects: Services are not available at the local health center. Dependence on grant funding is not a sustainable model. Lack of local/culturally competent mental health providers.
 - Potential recommendations: HRSA and CMS legitimize telehealth as a reimbursable service and scale up state models of reimbursement.
- Issue: MSAW populations are dispersed geographically.
 - Adverse effect: High levels of disconnect.
 - Potential recommendations: Continue to provide funding for enabling services (e.g., transportation, housing, CHWs, occupational hazards). Support medical-legal partnerships. Provide support and services for victims of domestic violence.
- Issue: Lack of training for front staff, lack of incentives and support for all CHCs to identify and track MSAWs.
 - Adverse effects: Undercounting the need for health services for MSAWs.
 - Potential recommendations: Identify MSAWs at the front desk of all CHCs, not just MHCs. Conduct community health needs assessments to identify MSAWs and determine where and how to direct services and where to locate new services and delivery points. Establish partnerships/collaboration between MHCs and MSHS to conduct community health needs assessments.
- Issue: No OSHA standards for occupational injuries of MSAWs.
 - Adverse effects: Musculoskeletal injuries.
 - Potential recommendations: Culturally appropriate prevention/education programs that have better uptake.
- Issue: MSAWs are not given water breaks, and water is not available in the field.
 - Adverse effects: High levels of dehydration.
 - Potential recommendations: Dehydration education/prevention.
- Issues: Lack of mental health providers in rural areas; high levels of stress, isolation, and unprogrammed time leads to depression and drinking.
 - Potential recommendations: Increase mental health services.

WEDNESDAY, NOVEMBER 8, 2017

Recap from Previous Day

Fr. Christopher LaBarge, Vice-Chair, NACMH

Fr. LaBarge opened the meeting and provided a summary of the presentations, testimonies, and discussions of the first day.

Green Tobacco Sickness: Impact on Migrant and Seasonal Agricultural Worker Health

Thomas Arcury, PHD, Professor, Department of Family & Community Medicine, Wake Forest School of Medicine, NC

Dr. Arcury provided an overview of Green Tobacco Sickness (GTS) and offered recommendations ...

- GTS is acute nicotine poisoning resulting from the transdermal absorption of nicotine from direct contact with the tobacco plant or contact with water on the plant. Nicotine is a naturally occurring alkaloid that is water and lipid soluble.
- The major symptoms of GTS are headache and vomiting, insomnia, and anorexia. Symptoms resolve within a day after contact with tobacco, but farmworkers seldom have the option of taking a day off from work.
- There is no established clinical case definition for GTS and no established level of nicotine poisoning. The definition that Dr. Arcury developed for his research includes three criteria: nausea or vomiting; headache or dizziness; and worked with tobacco in the past 48 hours.
- In the short-term GTS is unpleasant, it exacerbates heat stress and dehydration, it interferes with sleep, and it results in lost work time. The long-term effects are unknown. The potential effects on children are greater than for adults.
- Published information on GTS prior to 2000 is limited, and there have been few studies since 2003. Dr. Arcury's epidemiological research from 1998 to 2002 found that at least one in four workers get GTS; workers are sick two days for every 100 days they work; and workers are sick four days for every 100 days they pick tobacco. He also found that non-smoking farmworkers had the same level of cotinine in their saliva at the end of the season as smokers had at the beginning of the season. International studies verify what has been reported in the U.S.
- Harvesting and topping tobacco, working in wet clothing or conditions, and limited work experience increase the risk of GTS. Tobacco use and years worked in tobacco reduce the risk of GTS (but smokers still get GTS).
- GTS can be prevented, or the risk reduced, by reducing contact of workers with tobacco plants and the water on tobacco plants.
- A study of Connecticut tobacco workers highlights the importance of changing the organization of work to reduce or eliminate the risk of GTS.

Gaps and unmet needs include:

- Epidemiology on the long-term effects of nicotine exposure and effects on children working in tobacco
- Effective personal protective equipment (PPE) that eliminates contact with nicotine and does not increase the risk of heat stress.

Dr. Arcury outlined a hierarchy of controls to reduce farmworker contact with tobacco plants:

1. Elimination or substitution: Stop growing tobacco
2. Engineering: Use mechanical harvesting
3. Administrative: Change the organization of work; enforce current field sanitation and housing regulations; educate workers, health care providers, and employers about GTS
4. PPE: Provide waterproof clothing for workers; provide work uniforms; allow workers to change from wet clothing.

Dr. Arcury offered the following recommendations:

- Enforce current field sanitation and housing regulations (i.e., U.S. Department of Labor Field Sanitation Standard, MSAW Protection Act)
- Ensure clinic and outreach staff have training and materials to educate workers about the cause of GTS and practical and safe means to reduce exposure and dissuade them from using unsafe methods (e.g., tobacco consumption, milk, and other traditional remedies).
- Conduct outreach and education that helps farmworkers prevent GTS.

- Train physicians, physician assistants, nurse practitioners, and nurses to recognize, diagnose, and treat GTS.
- Educate employers using materials developed for MSAWs. Emphasize the hazards of GTS, worker well-being, and the impact of GTS on productivity.

Dr. Arcury provided examples of educational materials for MSAWs, including a brochure, telenovela, and educational video (https://www.youtube.com/playlist?list=PLUUComy3lcllxRoPB_oIH9USB6c0SPuG). He noted that workers need waterproof gear, changes of clothes, and washing machines to implement that education.

Dr. Arcury presented the outline of a GTS workshop for healthcare providers.

Dr. Arcury stressed that one in four people who work with tobacco are getting sick for doing their work properly, yet there is no regulation.

Discussion

- Ms. Andrés-Poulson asked if there was information that would support an economic argument.
 - Dr. Arcury replied that there are regulations on exposure to pesticides, but none on GTS. Child labor regulations that were proposed by the previous administration included a reference to GTS, but they were not adopted.
 - Dr. Quandt pointed out that growers do not see the impact of GTS, because the symptoms appear several hours after exposure.
- Ms. Naqvi asked if a specific diagnostic code for GTS would support efforts to reduce exposure.
 - Dr. Arcury stated that most physicians are unlikely to see GTS. Providers who work in tobacco growing areas should be trained to diagnosis it, even without a code.
- Ms. Andrés-Paulson asked if there were any data on long-term effects of GTS.
 - Dr. Arcury said there was no research to date on the long-term effects of GTS, but the effects of nicotine on the neurological system are well known.

Panel Presentation and Discussion: Stress, Mental Health and Substance Abuse, Intimate Partner Violence in Migrant and Seasonal Agricultural Workers, and the Need for Trauma-Informed Care as a Standard of Practice

Stress in MSAWs

Sara A. Quandt, PhD, Professor, Epidemiology & Prevention, Department of Public Health Sciences, Wake Forest University School of Medicine, NC

Dr. Quandt reviewed a model of stressors and distress for MSAWs, presented data on mental health outcomes in MSAWs, identified factors that seem to regulate distress, presented UDS data for mental health visits, and proposed recommendations related to mental health.

Dr. Quandt's model of stressors and distress for MSAWs includes four components:

- Structural stressors (affect many people): Discrimination, acculturation, documentation status, poverty/obligations
- Situational stressors (vary among individuals): Family separation, social marginalization, housing conditions, working conditions, weather, work demands, wage theft/income.
- Negative coping behaviors (amplify stress): Binge drinking drug use, aggressive behavior, intimate partner violence (IPV).

- Positive coping behaviors (protective factors): Contact with family, socializing, sports, gardening, church, music, seeking help.

Tools that have been used to measure stress in MSAWs include Cohen’s Perceived Stress Scale (developed for the general population) and Hovey’s Migrant Farmworker Stress Inventory (MFWSI).

Different cultures define distress in different ways. Respondents in studies conducted in California, Texas, and along the U.S.-Mexico border reported folk mental health conditions such as “nervios”, “latidos” (heart palpitations), and “susto” (fright).

The prevalence of depressive symptoms is elevated among MSAWs compared to the general population, but it varies among MSAW populations. It is highest among dairy workers in New Hampshire and women in farmworker families in North Carolina. The prevalence of anxiety among migrant men in North Carolina is similar to that of the U.S. population.

When asked about alcohol consumption in the last three months, 34 percent of MSAWs in North Carolina said they abstained, 19 percent said they had less than one drink per month, 22 percent said they drank monthly, and 25 percent said they drank weekly. About half did not participate in heavy episodic drinking (five or more drinks at one time), about a quarter said they did it seldom, and about a quarter reported weekly binge drinking. About 39 percent of male and female MSAWs consistently score at a level that indicates alcohol dependence.

Predictive factors for distress among MSAWs include:

- Gender: Depression is somewhat more prevalent among women than men.
- Time of agricultural season: Depressive symptoms are highest early and late in the season.
- Psychological work demands: Those with high work demands are 2.64 times more likely to have elevated depressive symptoms.

2016 UDS data show that the most prevalent mental health and substance abuse diagnoses for MSAWs were depression and other mood disorders (30,246 patients); anxiety disorders, including PTSD (29,439 patients), and other mental disorders, excluding drug or alcohol dependence (25,840). Other diagnoses included tobacco use disorders (8,845 patients), attention deficit and disruptive behavior disorders (5,224 patients), alcohol-related disorders (4,269 patients), and other substance-related disorders (3,229 patients). The National Agricultural Worker Survey (NAWS) found that workers with depression were four times more likely to seek healthcare than those without depression.

Dr. Quandt offered the following recommendations:

- Clinic personnel, including outreach workers, should be trained on the sources of stress unique to farmworkers.
- All clinic patients should be screened for depressive symptoms.
- All clinic patients should be screened for substance abuse, particularly alcohol.
- Clinics should employ sufficient mental health professionals so immediate hand-offs are possible.
- Outreach workers’ presentations should include mental health and resources for help (e.g., suicide hot lines, alcohol and drug counseling services).
- Clinics should foster relationships with local resources for mental health referrals.

- Clinics should work with communities to sponsor positive coping opportunities (e.g., farmworker festivals, music events, community gardens, other social events).

Discussion

- Ms. Naqvi asked how time affects workers' ability to attend social events, etc.
 - Dr. Quandt replied that workers have time on Sundays for personal pursuits, such as church and recreation. She emphasized the need to document the extent to which social activities conducted by lay workers reduce symptoms of anxiety or depression.
 - Dr. Arcury noted that a recent study on integrative medicine included questions about how workers deal with stress. The report from that study is forthcoming.
- Ms. Andrés-Poulson noted that the farmworkers' testimonies identified challenges of accessing mental health services and highlighted the need for culturally appropriate outreach.
 - Dr. Quandt stated that there are more community resources than in the past. Support groups are effective, but evidence is needed to support the case for funding.

Measuring and Addressing Trauma with Latino Farmworkers

Josh Hinson, MSW, LCSW, Clinical Assistant Professor, School of Social Work & Program Director, Refugee Mental Health and Wellness Initiative, University of North Carolina

Mr. Hinson discussed the mental health effects of migration, mental health needs of Latino farmworkers, and key components of culturally appropriate, trauma-informed services.

The "triple-trauma" paradigm developed by the Harvard Refugee Trauma Program recognizes that a trauma narrative includes trauma from the country of origin, trauma in flight, and trauma in the new country. An individual's trauma story includes social, physical, spiritual, and psychological components.

Migration is one of the most stressful life experiences. Trauma can occur at any point in the process. Understanding the trauma story is fundamental to understanding the clinical needs of MSAWs. Providers and outreach workers should be trained to ask questions that will elicit those stories.

Many MSAWs have symptoms of post-traumatic stress disorder (PTSD), such as invasive memories, thoughts, dreams, feelings, or flashbacks; emotional numbing or detachment to avoid reminders of the trauma; and physiological changes (e.g., sleep disturbance, difficulty concentrating, hypervigilance, or startle response). Symptoms can present differently due to culture or socio-economic status or among individuals who suffer chronic trauma, such as MSAWs, refugees, or victims of human trafficking.

The Patient Health Questionnaire-9 (PHQ9) screening tool for depression, which is commonly used in MHCs, may miss indicators of traumatic stress. Outreach workers should be trained to recognize them.

The Harvard Refugee Trauma Program developed a conceptual model for trauma-informed care that integrates treatment for physical health and mental health, including PTSD and depression. The model recognizes that physical symptoms presented by MSAW patients may be the direct result of traumatic experiences or the indirect results of the mental health effects of those experiences.

Mental health providers who work with MSAWs must understand culturally-bound illnesses (e.g., *susto*, *nervios*, *panicos*, *mal de ojo*, *mal aire*, and *caliente/frio*). Definitions of those conditions can vary across nationalities, socio-economic status, or education. Providers should develop trust and ask appropriate questions to elicit health beliefs.

Finding an appropriate referral can be challenging. It is important to understand what the client needs (i.e., outpatient mental health and/or substance abuse treatment, inpatient hospitalization), who can see the client, what services they can provide, and barriers to access.

Latinos' treatment experiences are impacted by stigma, fear of involuntary hospitalization or medication, a belief that they can deal with it through will power ("pura fuerza de voluntad"), belief in "juramento"), and a storefront model of Alcoholics Anonymous.

Pathways to Wellness developed a Refugee Health Screener (RHS-15) to determine a refugee's level of emotional distress and trains providers to use it. Some MHCs have used the tool with farmworkers. Health workers who administer the tool are trained to inform clients that their health visit will include questions about how they are doing in both their body and mind, and to let them know that many farmworkers find it stressful to come to a new country. The screener uses a visual five-point rating scale to rate the client's experience of various symptoms and their ability to cope and a thermometer graphic to indicate how much distress the client experienced in the past week. The provider scores the questionnaire with the client and discusses the results, using a script that normalizes the client's experience, explains the role of a counselor or therapist, and requests permission to make a referral.

Pathways to Wellness developed an eight-week Community Adjustment Support Group curriculum for use with refugees. The program could be modified for farmworkers.

Mr. Hinson made the following recommendations:

- Use a trauma-focused screening instrument
- Assess local resources
- Advocate for communities and providers to build capacity (e.g., offer Community Adjustment Support Groups)
- Advocate for clients (e.g., educate providers on culture and symptoms; develop new resources)
- Advocate for compliance with Title VI of the Civil Rights Act
- Have outreach workers assume the role of Care Manager
- Follow up with MSAW patients at one week regarding medications, therapy, self-management, and/or education materials.

Discussion

- Ms. Phillips Martinez asked Council members if their clinics had discussed building capacity to deliver trauma-informed care.
 - Ms. Andrés-Paulson replied that her health center was training its providers and outreach workers in trauma-informed care. A behavioral health grant from HRSA helped them hire providers. The San Diego County school district provides training in trauma-informed care for staff who work with families.
- Ms. Phillips Martinez asked about barriers to providing trauma-informed care for MSAWs.
 - Mr. Hinson replied that the primary barriers are the lack of providers of bilingual, culturally appropriate care and the need for integrated primary health and mental health care, with a warm handoff between providers. The barriers to accessing in-patient substance abuse treatment in Spanish are even greater.

- Ms. Andrés-Paulson noted that her clinic has a partnership with a school of social work that provides social work interns who conduct initial assessments and help to ensure appropriate referrals for MSAWs and their families.
- Fr. LaBarge commented that a small group approach is an essential part of a recovery program, because it breaks down the sense of isolation.

Intimate Partner Violence (IPV) in Migrant and Seasonal Agricultural Workers and the Need for Trauma-Informed Care as a Standard of Practice

Alison Bartel, MD, Associate Medical Director, Rural Health Group, NC

Dr. Bartel discussed the scope of IPV among MSAWs, barriers to obtaining services, limitations faced by service providers, elements of trauma-informed care, screening mechanisms used in health care settings, clinical interventions, recommendations for health care clinics, and the importance of community partnerships.

IPV is a pattern of assaultive, coercive behaviors intended to establish control by a person who was, is, or wishes to be in an intimate relationship with the victim. It includes physical, psychological, or economic abuse, sexual assault, and stalking. IPV is experienced by one in three women, across all groups. Although women are six times more likely than men to be victimized, one in seven men experience severe physical violence.

Rates of IPV in immigrant communities appear to be the same or even lower than in the general population. However, the homicide rate of immigrant victims is much higher, possibly due to the difficulty in obtaining assistance. Half of Latinas who experience abuse never report it to an authority. Non-immigrant Latina survivors, or those who immigrated less recently, contact services more often.

Barriers to obtaining services for IPV include fear of reporting due to the risk of deportation or loss of children; language and cultural barriers in service providers; lack of awareness of social services or legal rights; and deliberate silencing.

Barriers to providing care for women experiencing IPV include difficulty hiring bilingual/bicultural staff; denial of service to women who lack official identification; lack of transportation services; lack of experienced legal professionals to help clients navigate the court system; real or perceived anti-immigrant sentiment in the community; and lack of funding.

Trauma-informed care is the recognition that traumatic experiences, including adverse childhood experiences (ACE), affect all areas of life.

- ACE include physical, sexual, emotional abuse; physical or emotional neglect; exposure to IPV, substance abuse, mental illness in household; and loss of a parent or caregiver due to divorce, separation, or incarceration. Dr. Vincent Felitti's ACE study found that the life expectancy for individuals who experience six or more ACE is two decades shorter than those with no ACE.
- A significant percentage of individuals in substance abuse treatment and the public mental health system report a history of trauma, usually from childhood. Children from homes with IPV have higher rates of PTSD/psychological problems and learning disabilities and lower IQ scores; they also show premature aging of their DNA by seven to 10 years.
- Risk factors for IPV include depression, substance abuse, poverty, and criminal activity. About one-third of those who are abused as children go on to become abusers, and those exposed to IPV are 74 percent more likely to commit a violent crime.

- Studies of ongoing trauma related to ACE and prevention of future trauma demonstrate that screening for IPV is essential and should be part of every health care visit. The RHS-15 may be a more sensitive screening tool for trauma than the PHS-9.

Interventions for clinicians include:

- Woman-centered care, including support with confidentiality, validation, and acceptance of patient's stage of change, and assessment of immediate safety with formation of a safety plan.
- Medication Assisted Treatment geared to specific symptoms, including treatment for injuries or treatment for concurrent depression/anxiety/PTSD.

Dr. Bartel made the following recommendations for health centers:

- Language capacity and training for cultural competency (for all mainstream service providers)
- Mandatory screening for abuse at all health care visits
- Culturally sensitive discussion in the patient's native language to clarify positive screening results
- Confidential counseling and safety planning
- Survivor empowerment without judgment
- Case management services (e.g., referral network for temporary shelter for victims and dependents; vocational rehab programs for training and job placement; housing options; services for children, including school supports and counseling for trauma).

Dr. Bartel made the following recommendations for community partnerships:

- Education for agencies about the justice system and legal services
- Legal aid regarding the U visa for victims of certain crimes who have suffered mental or physical abuse and the T visa for victims of human trafficking
- Ongoing advocacy and education about extended community service supports, with the goal of eventual self-sufficiency
- Coordination between health care entities, police, government agencies, and academic centers to gather data that can guide policy and prevention strategies.

Discussion

- Ms. Phillips Martinez asked what factors affect provider's ability to screen for ACE.
 - Dr. Bartel replied that the ACE survey is difficult to use with MSAW populations because it is a lengthy tool with highly sensitive questions. Her program is looking at ways to address those barriers.
- Ms. Naqvi asked what percent of abusers were abused as children.
 - Dr. Bartel said she did not have statistics on the percentage of perpetrators who were abused as children, but rates are high among those who witnessed IPV. Because legal systems vary, MHCs must be aware of statutes in their state and form partnerships with the justice system and police so they can inform patients about their options.
- Mr. Aguilar asked how law enforcement could be engaged in addressing IPV.
 - Dr. Bartel noted that some communities are providing crisis-informed training (CIT) to prepare law enforcement officers and emergency medical teams to respond to emotionally complex situations.
 - Ms. Diaz described her work to educate the sheriff's departments in 17 counties in New York about IPV. She emphasized that direct, personal communication with individual officers is the most effective approach.
 - Dr. Bartel stressed the importance of building community relationships.

Moderated Discussion

- Dr. Quandt identified cross-cutting themes from the presentations:
 - Sensitivity of the topic, resulting in reluctance of patients to acknowledge issues of mental health or IPV and/or reluctance on the part of practitioners to address it
 - Importance of seeing patients in their context
 - Advocacy for screening
 - Importance of culturally appropriate care that goes beyond interpretation services
 - Role of community partnerships in implementing care
 - Need for research-informed care.
- Fr. LaBarge asked what percentage of MHCs/CHCs do not have mental health services.
 - Dr. Quandt said she looked for that information, but could not find it.
- Ms. Castro noted that the definition of woman-centered care included acceptance of the patient's state of change. She emphasized the importance for providers to have that level of acceptance and relay it to the patient.
 - Dr. Bartel noted that the ACE study found that asking the question and being with the patient in a non-judgmental way was therapeutic.
 - Dr. Quandt noted that the stages of change approach is based on the principle that people do change, and change can go in both directions.
- Ms. Phillips Martinez referenced a potential HHS funding opportunity related to workforce development, occupational safety, clinical practice, and service delivery models and asked what approach would have the most impact.
 - Dr. Bartel replied that the Robert Wood Johnson Foundation considers the availability of language services to be the most effective strategy.
 - Dr. Quandt stated that translation services are the baseline. Culturally appropriate care must go beyond translation.
 - Mr. Hinson replied that funding for billable positions for mental health is critical. Student interns are not a system of care.
- Ms. Triantifillou asked how MHCs that received funding for behavioral health are planning to use the funds.
 - Ms. Andrés-Paulson stated that her health center was using the funding for training and promotoras. Their Behavioral Health Department will hire social workers who can provide a warm handoff.
 - Ms. Diaz replied that most outreach workers in her clinic are trained in recognizing victims of domestic violence.
- Mr. Morgan stated that programs are not effective without providers and emphasized the need for funding to support training of psychiatrists.

Formulation of the Letter of Recommendations to the Secretary of HHS

Council members identified and discussed new issues that emerged from the morning presentations:

- Need for enabling services and provider training to support victims of IPV
- Need for mental health services to address high levels of trauma among MSAWs, including the effects of migration
- Need to address issues related to GTS (e.g., unknown effects of long-term exposure; vulnerability of children and youth working in the field; workers do not seek treatment; lack of education for providers).

Council members reviewed the full list of issues from both days of the meeting and agreed to develop recommendations in four areas:

1. Mental health (HHS priority): Recommend that all health centers serving MSAWs strongly consider using trauma-informed care as a standard of practice. Recommend that all health centers integrate mental health programs into their scope of practice
2. Enabling services: Recommend that all centers providing care to MSAWs be reminded of the need and requirement to provide enabling services. Recommend continuing funding for enabling services.
3. Children and environmental toxicants: Recommend that centers providing care to MSAWs specifically screen children for environmental toxicants.
4. Innovative models of care: Recommend the provision of comprehensive care through innovative models of care, such as telehealth.

Closing – Wrap Up/Summary

Amanda Phillips Martinez, Chair, NACMH

Next steps

Council members discussed the need to compile data and background information to support the recommendations. They agreed on the following timeline to develop the letter:

WHAT	WHO	WHEN
Draft 1	Father Chris	November 10
Draft 2: Flesh out data and background and focus recommendation(s); send input to Amanda	<u>Trauma Informed Care:</u> Adriana <u>Environmental toxicants:</u> Stephanie <u>Enabling services:</u> Susana <u>Telehealth and tele-mental health:</u> Rogelio; Case example from Finger Lakes FQHC: Alina <u>Testimonies paragraph:</u> Daniel	November 17
Draft 3: Incorporate input, do first edit, and submit to full Council for comments	Amanda	November 29
Draft 4: Provide comments on the draft and submit to Amanda	All Council members	December 4
Draft 5: Incorporate feedback into a final draft; submit the final draft to HRSA	Amanda	December 15

Next meeting

Council members proposed to hold the next meeting on May 8-9, 2018. Proposed locations were Washington State, Oregon, and upstate New York. Proposed agenda topics were:

- Presentation on an occupational hazard that is prevalent in the meeting location
- Nutrition and relation to chronic illnesses
- Sexually transmitted diseases among MSAWs.

Council members requested that the presentation from the primary care association include issues that are unique to the state that is hosting the meeting.

Council members provided feedback on the meeting:

- The pace of the meeting was good, and it was helpful to have the testimonies on Day 1.
- The presentations and panel discussion on Day 2 tied issues together.
- It would be helpful to have an overview of crops in the state.
- The presentation by the PCA did not address the significant population of H-2A workers in North Carolina. That was a missed opportunity.
- The presentations were excellent.
- The agenda was structured well.
- The federal update was excellent.
- The testimonies provided valuable information.
- The travel logistics and hotel were good.

Closing

Council members commended Ms. Phillips Martinez on her leadership.

Council members and HRSA staff expressed their deep appreciation to Ms. Diaz for her contributions during her tenure on the Council.

Ms. Naqvi thanked the co-chairs for their leadership of the Council.

Ms. Phillips Martinez thanked the presenters for generously sharing their research and insights. She thanked the guests for describing their efforts in their home communities and their insights into farmworkers' experiences with health and health care, and she reiterated her thanks to those who helped to recruit and bring farmworkers to testify before the Council.

Reimbursement and Logistical Information

Priscilla Myles, Meeting Manager, NACMH

Ms. Myles provided guidance regarding the updated reimbursement policy and procedures, including the deadline for submitting the reimbursement form and receipts.

The meeting was adjourned at 5:00 p.m.