Briana Stevens (BS): Hi! Welcome to the Harris Podcast! I'm Briana
Vivi Santana Bueno (VSB): I'm Vivi
Adie Ramirez (AR): And I'm Adie! And on today's episode we're going to be discussing the Farm Workers and the covid-19 pandemic. We're going to be taking a deep dive into the history of farm working both in the US and in North Carolina. We're going to be looking at the various factors that impact farmworker such as being undocumented, housing, language barriers, and having a limited access healthcare. Then we're going to hear from an amazing Physician, Dr. Modjulie Moore who is working to change the outlook for farm workers both within the pandemic and beyond

BS: So we wanted to start off the podcast today by giving a quick overview of the history of farm-working in the United States. Farm-working has a really long and controversial history in our country. Dating back to the 1800s, farm working has often relied on immigrant labor. Farm workers come from all over. From Mexico, China, Japan, the Philippines and many other countries. Well, how did that come to be? So, in the 19th century, farms were usually small and had limited number of workers. But as Americans began moving from rural to urban areas and industrialization took off in the late 19th century, smaller farms died out and were absorbed into these larger conglomerates. And at the same time, farming itself was becoming more advanced with new, faster technology. And so there was this chain reaction where a new technology increased the cost of farming, which then increased the need for a migrant seasonal labor force. Then World War one started, which further increased the need for agricultural workers. So in 1917, Congress passed the Immigration and Nationality Act, which imported around 70,000 workers, more or less, from Mexico to the US. Also, again, we saw a similar pattern occur when World War Two began. Agricultural demand rose again.

Finally, Congress passed the Bracero Act in 1943, and the Bracero Act was basically an agreement between the US and Mexican government to bring Mexican immigrants to the United States to work on farms. The program continued until 1964, ultimately bringing in more than 5 million Mexican farm workers. As a number of farm workers grew, there was increasing concern over the poor living conditions farm workers were subjected to. There were high levels of poverty, poor education, harsh working conditions and violence. Workers could not organize or form unions to protect themselves. The exploitation of farm workers led to the publishing of an eye opening documentary, Harvest of Shame, by journalist Edward R Murrow. And this documentary was especially important because it exposed how bad conditions were for migrant farm workers. And once the public saw how bad things were, there was a bit of progress made. The National Farm Workers Association was established and also the Migrant Health Act was passed in 1962, and the Migrant Health Act helped to expand services and clinics for farm workers across the country. And all of this sounds great, but still, here we are 60 years later, and farm workers are still negatively impacted by many social determinants of health.

AR: And listener if you hadn't had the chance to watch The Harvest of Shame, it is definitely a watch! They really did travel out to the farms and really exposed a lot of the conditions that farm workers were living in and showed things like that America did not know about the treatment and working conditions of farm workers. It was super super impactful because it was aired after Thanksgiving Day. So while people were sitting at their tables and having leftovers and stuff, food that at Farmworkers likely picked, they were exposed to all this information. And they did a follow up documentary that was what 50 years later? And what was impactful about that one is that they noticed that nothing has really changed within those fifty years. Which I think speaks volumes to the lack of federal support that there is for farmworkers. Some of the language and images are difficult to see and hear, so please proceed with caution.

VSB: And on the topic of, you know, housing, I kind of want to talk more about the housing options for farm workers or better yet, the lack of adequate housing for farm workers. Farm workers have three options for housing. First, being grower owned or privately rented or government housing. By law, growers are required to provide housing to H-2A workers. However, H-2A workers only account for 10% of the nation's workforce. If you're not an H-2A worker and live in grower owned housing, rent is deducted from your paycheck. Although growers are mandated to provide housing to H-2A workers, there are few standards which are rarely enforced for the housing. Barriers to adequate housing, including these regulations. For example, the North Carolina Migrant Housing Act requires only one toilet for every 15 people and only one laundry tub for 30 people. And this is a laundry tub not a laundry machine. Additionally, the low number of inspectors makes it easy for these minimal living standards to be enforced. Here is a quote from a study that highlights this issue. And the largest and most comprehensive, comprehensive study of farmworker housing conducted in the southeast. Researchers at Wake Forest School of Medicine found multiple violations of state and federal housing standards in every camp they studied. Farm workers also may fear reporting these poor living standards because they fear repercussions. And the second option is that farm workers may opt for privately rented housing in isolated rural areas with limited housing options. Their owners can have a monopoly on available housing, which allows them to overcharge for rent. The last option isn't really an option for most farm workers. In order to qualify for government housing, one must be documented. At least six out of ten farm workers are undocumented. This kind of ties into your topic, Adie, of documentation status in farmworker communities.

AR: Yeah, this is one of the topics that I really wanted to focus in on because as you mentioned, the vast majority of farm workers are undocumented. I kind of want to take a step back and see what access to healthcare looks like for undocumented peoples in general. Because they lack documentation, undocumented immigrants are ineligible for any federal aid and that includes Medicaid, Medicare and CHIP, which is the children's health insurance program. If you think of what that looks like, it basically means that federally they do not qualify for any type of health insurance and are ineligible for insurance through the ACA. Meaning they can't even but

insurance from the federal government at the Marketplace. That leaves people with two options which is to purchase insurance privately which can gets really really expensive or getting insurance through their employer. If you don't have health insurance, this means you are likely not receiving primary care and the main point of access is through the emergency room, there are other but it's mainly the emergency room In order to have the emergency room covered, you have to truly be in dire circumstances to qualify for something called emergency medicaid. which is for when you are coming into the emergency room and it's a life-saving procedure that you need to get done. That's why you would qualify, which is terrible

Undocumented immigrants make up the largest group of uninsured individuals in the US with an estimated between 45 percent to 71 percent of undocumented peoples lacking sny type of Health Care coverage and the number range from state-to-state because certain states do open up a little bit more of aid such a California and New York. The way that most undocumented immigrants do receive Primary Care is through one of 1,400 federally qualified Health Care Centers that they were designated because the government understood that we can't let people fall through the cracks in Healthcare. These primary care centers are dedicated to serving low income and underserved areas, and see unhoused and undocumented people's as well.

What I found really interesting was some of the numbers behind Medicaid and specifically numbers for undocumented peoples in terms of expenditure. According to Medicaid data, in 2016 the federal government spent 974 million in total Emergency life-saving services for undocumented immigrants but that only represents 0.2% of all of the Medicaid expenditure. Overall, within the same year, what the government spent on Medicaid 565 billion dollars. What was crazier to me was that, because i really truly do hate making things about the numbers, when they're talking about a generating wealth and income taxes, in 2018 undocumented immigrants contributed 20.1 billion in federal taxes and 11.8 billion in state and income taxes. Further, between 2000 and 2011 undocumented immigrants generated 35.1 billion dollars in surplus for the Medicare Trust Fund. So why did bring up all these numbers? Basically it means that undocumented immigrants funding and paying for these programs that they do not have access to. Which to me is incredibly heartbreaking to me.

What I also found really important I think that we have to share and talk about was that, about 73% of farm workers are born outside of the US. About 50% of them are going to be undocumented and having these issues and barring them from access to healthcare specifically based on status, is going to be one of the huge impediments to having an overall well health. Being undocumented is therefore is one of those social determinants of health and one of those barriers to accessing health. H2A itself, like we talked about earlier, it doesn't provide any type of status, it's only temporary. It's one of those things that you can keep on reapplying for but it doesn't grant you any protection, it doesn't give you a pathway to citizenship, it doesn't protect you from low wages and it doesn't protect you from being taken advantage of, it doesn't protect you from overcrowding and unsafe housing, it doesn't protect you from lack of healthcare and is truly is one of those things where you're still suffering from anxiety because you can still get arrested and you can still get deported. It just adds another layer to chronic health outcomes.

The second thing I wanted to highlight was language barriers. I think it goes without saying that if you do not speak the language of your patients, as a provider you are not able to provide adequate care. Under Title IV of the Civil Rights Act, federally funded institutions must provide an interpreter for patients. This is not always enforced and sometimes funding is simply not enough for these centers. But as we have seen through our studies and personal experience, when patients are not provided an interpreter, patients are less satisfied with their care, they are more likely to not follow up with their provider or not have a great relationship with their provider. A 2002 Literature Review for Journal of Midwifery Womens Health confirmed all of this and found that miscommunication can subject patients to expensive tests and unnecessary procedures. Language serves as a barrier for farm workers specifically because as we have seen, most are traveling from outside of the US. This is why it's important for providers such as Dr. Moore, who we're gonna hear from a little later, that they continue to work on bilingual care and make healthcare more accessible.

Vivi: And now that we have provided some information about farmworkers and the various barriers they face we want to introduce to our listeners a doctor that worked closely with farmworkers throughout the pandemic, Dr. Modjulie Moore. Dr. Moore graduated from Virginia Commonwealth University School of Medicine in 2011. She completed her family medicine residency at Greater Lawrence Family Health Center and began her medical career in rural eastern North Carolina at a community health center. This experience combined with her interest in immigrant health led her to become the Medical Director for the North Carolina Department Of Health And Human Services Farmworker Health Program. And now let's chat with Dr. Moore.

Vivi: So to start, can you just tell us a little bit more about how you got involved with farm workers or possibly more about your background?

Dr. Moore: Yeah, sure. So I'm Dr. Modjulie Moore and I'm in the family medicine department, and I am so happy to spend time with you because we work together in the field too. And so my history with caring for farm workers started in North Carolina and a little bit before that as well in Massachusetts, but really significantly in the northeastern part of the state. I went from medical training right into a federally qualified health center who received federal migrant dollars to take care of migrant and seasonal farm workers, and so was basically a doctor on call and felt like I could reach out to this community because I can communicate in Spanish. So that was helpful, making sure that people feel well heard and kind of putting that language justice like to the top of the list and making sure that health care is excellent quality from the start of the entry to the door to the... to the care plan. And so northeast North Carolina is in, and all throughout the northeast, is in a really big high volume center for our migrant workers, who are usually H-2A visa workers. And I think we've all on this kind of conversation interacted with

them as well. And they're coming in through Mexico, usually March through April, and then they're leaving actually now because we have lots of departures going on right now. So that northeastern part of the state sees a lot of those, a lot of need for care.

And as we all know, it's hard for farm workers to access care because they're working until like seven, six or seven at night and clinics close at five. And so the system as we know it doesn't help that much in terms of like providing space to have health needs addressed. And so I found that rewarding as kind of an early practitioner on my new license after residency to really try and say like, how do you extend the care to the communities? And so a lot of that has to do had to do with like going out to the camps with a mobile clinic or actually bringing people in when they needed us and not not being incredibly strict with like, "Oh, I'm already booked, I don't have room" and realizing how difficult it is to actually bring a farm worker into a clinic because a lot of times that means you are out of work, you're not getting paid and you might have, you have a health concern that is impairing your ability to do your work, which is like your first priority. And so that was kind of my initial experience and so had a really positive time with that. And then also bridged into seasonal family relationships where we were seeing people over time and caring for kids and realizing that this really helps us to step back and think about social determinants of health for our agricultural workers and how so much more complex that is.

And one of the things the state program does is we really think about digital inclusion because and this is perfect, like we're on Zoom right now, like being able to be on Zoom and such. We're so grateful for that because we have Internet, we have computers, we know how to log on. We have a Zoom account. When we think about farm workers, it's like like you all have seen. We have to bring the hot spots. We have to bring everything and make sure everybody is like having that same access. So I think I got off topic, but that I went in a different direction. But I think, yeah, I'm just like so energized by delivering care outside of our traditional models and that really allows us to take care of our most vulnerable population, and unfortunately we have those. We have significant amount. The tally or the kind of population of farmworkers in the state this year I think was 72,000. This state program only touches about 11,000. So we have so much work and there is a huge volume in the northeast of the state. We've got the mountains. It's Christmas tree time. So everybody's actually kind of transferring over to the mountains now. So really interesting interactions for us as health care providers to really try and figure out like how to meet the needs of those essential workers.

Vivi: Thank you for sharing. I guess my question is, why do you think we only reach like one-seventh of all farmworkers?

Dr. Moore: Yeah, awesome question. So I think if we have... so we get a HRSA grant through the state and that's been in existence since the early nineties, which is really exciting that the state had prioritized that. I mean, it makes total sense because the economy coming in through

agriculture for North Carolina is incredibly significant. Those numbers just keep climbing. The... the thing about it is that is only a small amount of funding. And so like the state program only funds eight centers around the state, which is great. I mean, we're so grateful we have that. But I think we need even more expanded infrastructure. And so we are trying and I think actually, let's bring it to COVID, which is really relevant to this conversation. But COVID had allowed us, has allowed us to connect even more. So previously, we were probably seeing maybe like 9000 people. We've expanded that significantly amongst those eight sites, even through the pandemic, which you would think people were more out of care. But actually just because of how amazing the outreach teams are and that's how the state program functions, it's a very much a public health system of community health workers. That model had... had allowed us to reach farmworkers better and actually try to increase numbers. So I think, you know, it takes a while. If you look at federally qualified health centers, the requirement is you need to be accessing more patients and you need to increase your growth. You need to grow your population of patients, and we're doing that, but it takes time and it takes money, unfortunately. So.

Adie: And I know you touched on a little bit about this earlier when you were talking about language barriers and kind of the social determinants of health. What in your experience have been the biggest barriers to health care for farmworkers? And second to that, how has COVID 19 really kind of blown this up or really just changed the way they look?

Dr. Moore: Yeah, Yeah. So barriers, definitely language tends to be a problem in rural North Carolina because we are we are lucky to be in a place where there are more bilingual speakers and that's in more like kind of urban metropolitan centers. In the rural areas, you tend to have communities of like seasonal families who will kind of stay together. But when they interact with the health system, a lot of times they'll bring like health advocates with them. Maybe one of the ten people that goes in is maybe fluent in both languages, but the majority of people are Spanish speaking only, which makes sense, especially if you're kind of coming back and forth. And it tends to be in our hospital systems and in our rural clinics. We don't have that great of language support. There's interpreters, there's like the video interpreter kind of services. But as we all know, that falls short. I think an in-person interpreter is much better to really help connect. So that's a big barrier. The other barrier is access, like we were talking about. So farmworkers can't come in from 8 to 5, as neither can doctors like where everybody's working. So I think or just like all of our working population. So just in terms of how the clinic hours are set up, that's a huge barrier. So we talk a lot about access with the state program. And so a lot of the clinics that serve farmworker populations are going to be clinics that have extended hours. So like Johnston County with Dr. Maynard and the Benson Area Medical Center, they have their Thursday night, and we try to do the mobile clinic on Tuesday nights. And we see in our mountain sites at Vecinos, they have like definitely mobile clinics in the evenings and then they go and they have a free standing clinic access that advanced access hours. And so that is a barrier. And I think the program tries to attend to that because we know we need to see people when they're available.

The other thing is probably if we're thinking about just health literacy, and I think sometimes when we think about that, we think about like, oh, you don't maybe have educational level to to understand health. But I think there's so many dynamics because we have amazing experience in our farmworker population, Like we have people who are coming with graduate degrees. We have people who are professional athletes, like we have a lot of really skilled workers who are also amazingly skilled in agriculture and we have so much to learn from them as well. But when I think about health literacy with farmworkers, I think more about system navigation because like if we we were going to work in agriculture in Mexico, it would be a totally different system. And it's like you rely on people to help you navigate that. So there's barriers because I think sometimes we skip those steps. And so that tends to be really difficult. And for that, we saw very, very, very prominently with COVID, because COVID was like, okay, vaccines, and you might need to seek health care. And it's like you become dependent on the system.

And so that was like a very big challenge. And one of the things that was really exciting is we were able to build local teams. So the local teams that were built in 100 counties in North Carolina, which is just amazing that this happened, but in 100 counties we had the health department have like a representative or like an advocate. We had the ag extension agent. So in each county there's actually an agricultural support person. So that person was part of the team. We invited any other health entity that would be helpful. So maybe like a health center or maybe like any anybody who is who is kind of navigating COVID and we're able to bring those people together. And then some of the high volume counties like Wake County or Lenoir County, the local teams were just like, fantastic communication was improved, access to farmworkers were improved in Sampson County. I just love looking at this data. But the uptake of vaccines in farmworkers was significantly higher because of these like approaches than the actual county itself. So like when you look at like who's vaccinated, like the farm workers were like all vaccinated, I think it was like over like 85% of farm workers. It was awesome. And that response, actually the whole farm worker team, COVID response received the Governor's award for that just a few weeks ago because of how well they could get like basically overcome challenges that were incredibly significant. So. I feel like I could go on.

Adie: That's incredible, because I think when we were kind of looking up a little bit about the topic and just kind of discussing what health care access looks like for farm workers, I think the COVID pandemic kind of really posed a great either threat or a great opportunity for growth. And it's so amazing to hear that it's been going really well in terms of increasing access.

Briana: So you've dedicated, oh sorry, you've dedicated so much of your practice to working with farmworkers, which is amazing. What changes do you hope to see with the farm working community as far as health care access goes?

Dr. Moore: Yeah, so this is actually this is a big conversation with the state program which runs

through the Office of Rural Health and Department of Health and Human Services. But we're trying to come up with our strategic priorities because we have been an emergency response so like so greatly for the last three years. So I think what we would love to see, especially from a clinical priority perspective, is like COVID integrated into chronic care management and really helping our farm workers to identify health risk. So, you know, like almost doing more pain management around our population. So we're identifying our patients with diabetics and our patients, our patients who have high blood pressure and people who fall into risk and then really trying to reach out for support in that respect. And that's a different level as opposed to just like kind of like vaccinate everyone. That's kind of your first level. And now we're really getting into more complex care because we do have people with like we have people with pretty significant health risk and we want to make sure that we are identifying that and responding to that and just supporting them through that. So that's kind of like a big topic. The other thing that is a high priority is the pandemic has opened virtual care to all of us.

Now you go into your doctor and it's like, do you want an in-person do you want a virtual do you want a phone? Like it's a menu of what do you want for your care? And so we're really hoping to expand telehealth because that allows different access to specialty care and to other services that might not have been in the rural areas. And that I'm kind of thinking of the program Echo, which I don't know if you've heard of, but the ECHO program was started with Hep Liver treatment in New Mexico. It's an amazing program that basically connects your specialists. So you have your hepatologist, for example, and then you're the provider in a... in a rural area, but your patient has hepatitis C, but you need a little bit more support. So I think I was just looking at their motto is like, deliver knowledge. Don't, don't. Or I think it's move knowledge, don't move the people. And so it's like community based care. And I think with COVID, we can really just like take– take this model to the next level and really attend to some of the risks that we see in our farm workers and their health priorities too.

Adie: That sounds incredible. I think that I feel like we had a lot of conversations. I think my follow up question to that, I think we talked about earlier how when we go to the rural clinics. Internet and access like that can be really difficult. What would kind of be that next step to increase that connection? Because that's something that's really important and vital to like telehealth.

Dr. Moore: Oh, my gosh. Yeah. Because without the Internet, you don't have telehealth. Exactly. So that is digital equity and inclusion. And for farm workers, it's so important. And also, like, just just fundamentally, like farm workers are like the H-2A kind of migrant worker is away from family, away from children or sick people or sick loved ones and things like that. And even just having cell phone access to get on WhatsApp and like communicate with family like improves emotional health. And so like the digital kind of inclusion and equity part has just like really come to the forefront in the state also and actually nationally, because even the federal

government has prioritized money for rural areas to try and really improve broadband infrastructure. So what the big ask from all agricultural communities is because it really is across the table, it's farm workers, it's farmers, it's everybody in the rural area. Like if we could have broadband throughout the state, we could enhance quite a bit and probably also enhance the economy and the educational experiences for our kids. And like, I think I think that it's a it's a big a big level move. But in the meantime, we're going to continue. We have a digital alliance that focuses on agricultural workers and that runs through NC State and ECU. It's multi... multi-center, collaborative, and they do amazing work to try and make sure information is accessible. And we bring hotspots out and not just for health delivery but for any kind of social determinants of health like need. And there's trainings, there's like digital literacy trainings and things like that. So pretty... that's something that I think us in our careers we'll just continue to hear because if you implement something like even the UNC MyChart and you don't have a smartphone or you can't or you don't have minutes on your smartphone and you don't know how to like connect the app or you don't have Internet. I mean, it's just like we -- it's wonderful for us to take those steps backwards and be like, wait a second, We have to think about like the ground up and we can't just like, skip to, oh, yeah, just go on MyChart, you know, kind of thing. So it's an exciting topic and I think it's something we all can have a voice and we can bring farm workers' voices and we can leverage that and we can really try to move towards that.

Adie: That's amazing. And I think what I really liked about the course that we took this semester was it was highlighting these things, right? Like, how can we highlight and find these social determinants of health or these gaps in care? And how do we change that? Because essentially what we want to do as future physicians is increase access and make sure that people are getting as much care as possible when they need it and before they really need it. Right? And so it's really incredible to hear all the work that y'all have been doing. And so it's really awesome. The last question I think we have for you is -- is there anything in general in terms of health care and working with farmworkers that you would like to highlight or you would like people to know about your practice?

Dr. Moore: Yeah, I think I think that I want, well, one, I want to thank everyone who has come out to the mobile clinic. I also am just appreciative that it is such a team effort because it really does take like a team to provide advanced access care, which means like going into a camp or bringing the mobile bus or wherever we're doing. And so that I think is really important to acknowledge that it's just really great to be surrounded by people who prioritize that. And then the other thing is like, I really think especially in medical training, we really need to push ourselves to grow in terms of being flexible because as you know, when we're out in the camps, like you got to make it work. So your priority is keeping your farm, the farm worker healthy and trying to get to this best like wellness and well being. But the process is very humbling because you've got to navigate like all these different things, whether it's like the environment where the clinic is built or put up, how are you going to get the medications, what language you're going to

communicate in. Like, I just feel like that flexibility is so, it's so rewarding to practice that way and to always be thinking like, "how can I maximize someone's health by myself stepping out of my comfort zones sometimes." And I think that is important. And I think it's such a great message for us as we're always lifelong learners of how to deliver care. So that should be a -- that's a good one.

Adie: That was the incredible Dr. Moore! We all had the opportunity to work with her and the farmworker healthcare team through the mobile clinic, where we travel out to the farms and see farm workers until 10-11 at night. It was so amazing to see all the ways they are working to increase the access for farm workers, specifically on how COVID-19 allowed them to increase broadband infrastructure, that is a total game changer! Thank you so much for tuning in and we hope that you were able to take in some of the history of farm working and note the various factors that impact farmworkers such as being undocumented, housing, language barriers, and having a limited access healthcare. I'm Adie, I'm Briana, I'm Vivi, and this is the Harris Podcast. Join us next time!