

streamline

The Migrant Health News Source

A Shot of Quality Improvement!

Jennie McLaurin, MD

All health care delivery organizations are required to have quality assurance and quality improvement programs, but it is often difficult to make these efforts really meaningful in the everyday practice of serving clients. This article suggests a number of immunization quality measurements that you can adapt to your local setting. MCN's Quality Improvement (QI) Immunization program has found from our site visits that many of you really struggle with understanding who is getting immunized, who is missed, and what the root causes are for the gap between your goal of full immunization and the present reality at your center. Additionally, immunization data gathering is often very time consuming, often duplicated several times over for various outside agencies, and often not in step with the ways changes are made in other parts of your organization. Here are a few ideas from us, and we welcome feedback from you in order to continually improve immunization practices.

Addressing the Big Four

Our four quality improvement (QI) topics will cover:

- Immunization reminder systems
- Audits of baseline immunization rate audits
- Measuring success
- Client self-management in record retrieval

Immunization Reminder Systems

Why do our dentists and veterinarians do a better job at keeping our teeth clean and our pets vaccinated than we do at identifying who is in need of an immunization? My doctor doesn't tell us when our children need shots, but my dog's vet sends three different reminders ahead of time. There are several answers. First, privacy rules don't apply to vets. But they do apply to dentists, so it's not all about problems with privacy and recall systems. Second, human immunizations have complex schedules and are on a larger scale than dental care and pet

care. Third, vets and dentists are used to recall systems. So—our reminder systems must be able to protect privacy concerns, respond to complex schedules, and be able to deal with a large scale population. Where do we begin?

- Measure what you are doing. Your Quality Improvement (QI) should start with the question of whether you have a recall system for immunizations. Follow-up questions include:
 - Is it prospective or retrospective or both? That is, does it only trigger a call if an immunization is missed, or does it remind the person in advance of the actual needed vaccine?
 - Is it working? What is the relationship between the recall system and when people come in for an immunization? Do you know how to measure this? If you haven't, simply ask the next 25 people who come in how they knew to come. Then you have done a QI audit!
- Make improvements. You can start small scale but go deep. Have every client who gets a vaccine fill out a postcard to be self-addressed that tells them it's time to come in for their next vaccine. Figure out when that actually is. Put the card in a file sorted by month of the year. Put it in the month prior to the actual need. Then every month, mail the postcards for that month. Track your success.
- Address privacy concerns. Immunizations are a public health matter and don't require record privacy. So call or email with reminders. Train staff and clients on need for openness regarding immunization records.
- Target everyone if you don't have good data on subgroups. Send every client a card or a call that requests a response about the status of their immunizations. Track how big a response you get if you do this twice a year.
- Set up a Facebook page for your health center and let people be fans. Send out



updates on when different groups need immunizations.

- Decide to target a particular at risk subgroup such as teens. Get really good with a recall system for the neediest group, and then spread it to other groups. Need more help with designing a recall system? Just ask! And have fun! Try to design a recall system that fits your population and that is manageable by you. Build in rewards for staff and clients as the recall system is found to be effective.

Find Your Baseline

- Define "fully immunized" for your clinic.
- Use standard groups: measure two year olds, twelve year olds, and adults. Pick another age group that you are concerned about, such as 20-30 year olds. Look at gender differences, ethnic differences, and insurance/self-pay differences as you look at baseline rates. Consider

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Quality Improvement in Action: An Immunization Case Study

Carolyn Shepherd, MD

Clinica Family Health Services is a four site Federally Qualified Health Center (FQHC) in Colorado serving just under 40,000 clients in the north Denver metropolitan area. We provide full family practice model care including integrated behavioral health, dental and pharmacy services. We have collected data on clinical outcomes since 1990.

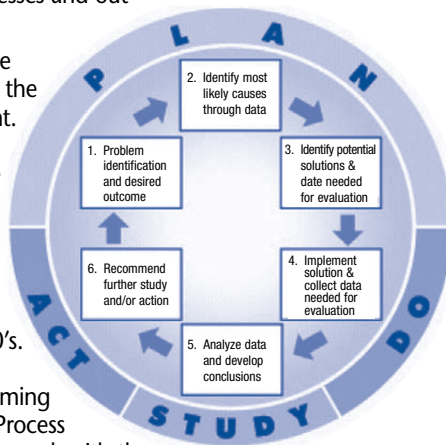
We began redesigning our processes for administering immunizations for children in 1993. We used the chronic care model to focus on improving delivery system design, information systems, decision support and client activation strategies to improve our outcomes. Our outcomes were gathered over the years by doing a sample audit (200 charts) of our one and two year olds. The audits were done by outside staff from the Colorado Primary Care Association (CPCA). We were provided a sampled list of our clients and staff would gather the paper charts for CPCA to audit. We were audited only once or twice a year so we had large gaps before getting any feedback on how we were doing. We were happy with the gains we had made in immunization rates.

We finished implementing an Electronic Health Record (EHR) in July 2007. Beginning in 2008 we had a robust amount of data and began switching measures to 100% audits out of the EMR database. Originally we used Excel and Crystal reporting tools on our EHR

What is the PDSA Cycle?

The Plan-Do-Study-Act (PDSA) is an integral component of the he Model for Improvement developed by the Institute for Health Improvement. This model has been used very successfully by hundreds of health care organizations in many countries to improve many different health care processes and outcomes.

The PDSA cycle guides the tests of a change to see if the change is an improvement. The origins of the improvement PDSA Cycle can be traced back as early as 1939 to Walter A. Shewhart. W.E. Deming utilized the Shewhart model in his work in Japan in the 1950's. In Japan the model then became known as the Deming Cycle. The Associates in Process Improvement built on this work with the Model for Improvement, which includes the PDSA cycle.



The PDSA cycle is a method to test a change or group of changes on a small scale to see if they result in improvement. If they do result in improvement the model then allows participants to expand the tests and gradually incorporate larger and larger samples until there is confidence that the changes should be adopted more widely. A team learns from the test — What worked and what didn't work? What should be kept, changed, or abandoned? — and uses the new knowledge to plan the next test. The team continues linking tests in this way, refining the change until it is ready for broader implementation.

At times it seems a waste of time to test. However, people are far more willing to test a change when they know that changes can and will be modified as needed. Linking small tests of change helps overcome an organization's natural resistance to change and ensure buy-in.

database, but have upgraded to a Business Intelligence tool to be able to look at data over time.

We were dismayed to find that once we were looking at 100% of our eligible children we had immunization rates much lower than we had reported using the sampling of charts. Figure 1 shows the immunization rates Clinica reported prior to 2008 and then after 2008 when 100% of the clients were included. Our immunization rates went from a reported high of over 90% to rates between 30% and 40% at the lowest.

We have had the "opportunity" to go back and work on improving our immunizations rates now that we have complete data and

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Figure 1. Clinica Campesina – All Sites 2 Year Old Immunization Rates
Goal: 90% of 2 Year Olds Immunized

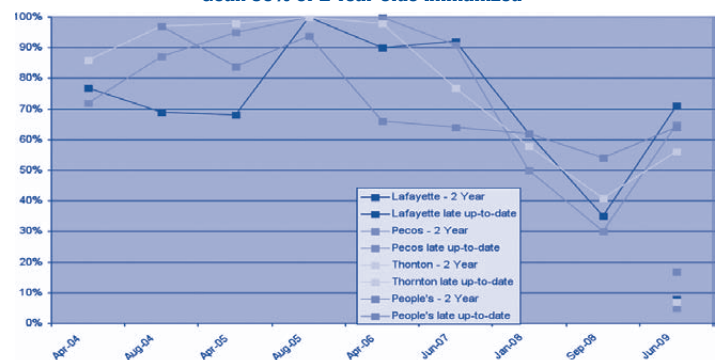


Figure 2.

Uniform Data System (UDS) Two Year Old Immunizations

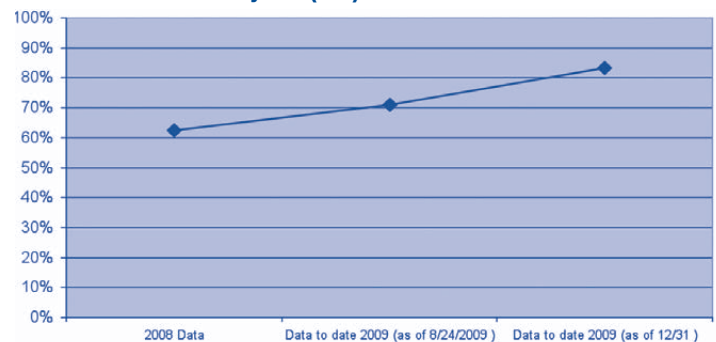
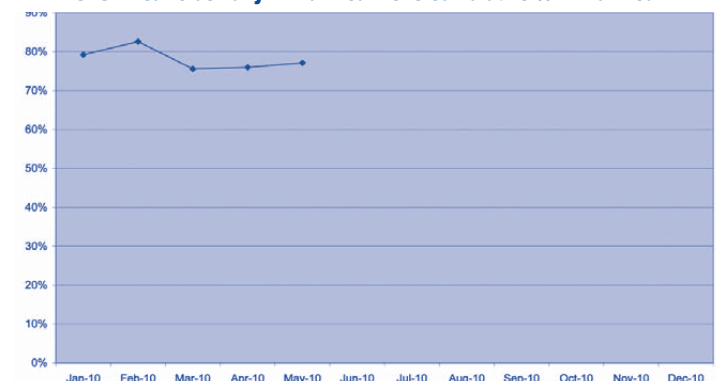


Figure 3.

UDS 2 Year Olds Fully Immunized. 2010 Cumulative % Immunized



■ A Shot of Quality Improvement! continued from page 1

- other distinctions within your population.
- Design a schedule for your audits, like two year olds in October, twelve year olds in January and adults in May. Then you will have time to design interventions that target each group.
 - Plan your audit. Decide who will be involved. The more providers, the better, as their involvement in the audit contributes to understanding and improvement.
 - Make the audit fun. Don't cram it into a full day. Provide refreshments or some nice touch. If five people do five charts each, it isn't a big deal, whereas one person with 25 charts at the end of a day is tedious.
 - Have a uniform audit sheet. Sample audit sheets are available on MCN's website, www.migrantclinician.org. We have provided a sample above. Have a place to record age, gender, special population (migrant, homeless, immigrant, etc.). Note language spoken. Note whether they are fully immunized by a specific date you have chosen. Decide what counts as your record: electronic record, paper chart, or registry. If you have the time, it's great to also note what immunizations are getting missed.
 - Pull sample charts, paper or electronic. Look at enough records to have confidence in outcome. Usually 5-10% of your strata group is good. You may need to over represent particularly at-risk or minority clients.
 - Determine yes or no, whether the record shows the client is fully immunized (based on definition set above). Take no prisoners: keep it clean and just do yes/no. You can find out more when you revisit the "no's" but a lot of audits fail because people get wrapped up in the why and ignore the fact of the percentage actually reached.
 - Calculate baseline rates based on audit findings.
 - Contact a nearby university health sciences center for assistance with your audit. Schools of Nursing and Public Health often require community service projects and this could be a "win-win" situation for both parties.

Reporting for Improvement

There is no point in doing audits if they aren't linked to rapid change possibilities. But too often we try to change everything at once. Do your audits twice a year and use the information. Is your rate lower than you thought? Find out why. Find at least two or three reasons why. How? Do a QA cycle looking at client satisfaction related to vaccines. Ask 3-5 questions, such as: "I know

when my child needs his next vaccine" – yes/no. "I find it easy to keep my immunizations up to date" – yes/no. "The main reason I/my child can't get immunized on time is: _____ (give several choices like cost, transportation, forgot, don't like side effects, worried about vaccine safety, sick, etc.).

Then devise a quick intervention related to your findings. Don't make all your efforts conform to a one-year grant cycle plan. Make small changes frequently, and measure success.

- Ask your staff for ideas. Show them the results and ask them to identify three problems and three strategies. Let everyone pick a strategy and try it for a month. Measure to see whether it works the next month. You don't need to pull lots of charts to do this, just the ones seen in the last month related to your improvement strategy. This can make QA interesting!
- Try to streamline data entry. Any time someone enters data, figure out how to use that data in your QA plan. Don't enter useless data! Often, forms get added but nothing gets deleted. Part of QA is purging old stuff. Do you ask about Social Security numbers on forms? It's not needed—delete it! Do you ask place of business? Why? What do you really need? Then collection is quicker and retrieval is quicker. One month of a QA activity could just be to review forms for things that could be deleted or streamlined.
- Celebrate success. Did rates go up by a significant margin? Do something about that to celebrate! Make a poster for your clinic,

announce it to staff, tell the world. Good job! Set goals for continued improvement.

Self-Management

Over and over again we find that the best way to know if a migrating client is up to date on their vaccines is through client self-reporting. Those who are given accurate records and explained to carry them and show them at each health center, actually do this over 90% of the time.

- Do you have a system for giving clients up to date vaccine records?
- Is it working well? Audit this and see. Just check the next 30 clients for a self-carried record.
- Collect samples of portable records.
- Pick one.
- Use it on everyone who gets a vaccine.
- Consider an incentive for the clients who keep it, like updating the card with a new digital photo of the child before each shot. This is easy with today's technology! You can have an electronic record, take a web photo, and then print the record with the new photo.
- Check the percentage of clients using your portable record in two months time. You can use a Worksheet for Tracking Change to keep track of your work. Samples can be found on MCN's website, www.migrantclinician.org
- Be creative!

Collaborate as much as possible with parents, clients, and staff. Be creative and engaged and your performance will go way up! ■

■ An Immunization Case Study continued from page 2

don't have the previous sampling errors showing a falsely elevated immunization rate. The drop in the two year old rates below was multifactorial—looking at 100% of children, adding in the ability with the EHR dates to factor the appropriateness of the intervals the vaccines were given, and using reports from our statewide immunization registry that were loaded from our EHR. All of these factors are impacted by having our immunization data pulled from the EHR. By way of comparison, our diabetes outcomes had always been done on 100% of our diabetes clients. We had no significant change in our outcomes for diabetes when we switched to the EHR based outcomes. Our lesson learned: the EHR gives us the opportunity to revisit improvement strategies for populations that have been evaluated using sampling protocols.

The EHR gives us real time and actionable

data, allowing us to "re-fix" the system problems with our immunizations without any confounding sampling errors. In our experience the best approach is having access to real time data. We have it set up now so that we develop reports to look at last week's missed opportunities and use that information to correct defects and educate staff. We also look at the kids due for vaccines next week so we can call them and get them scheduled. Figure 3 shows a running report we now have looking at kids who are turning two years old each month. This granularity of data allows us to know whether our PDSAs (See "What is the PDSA Cycle?" on previous page) are impacting our rates as we work to improve the outcomes. Figure 2 shows the steady improvements we have made since 2008 in our actual immunization rates as a result of the quality improvement strategies we have implemented. ■

Survey of Residents of Northwest Orchard Community Shows High Levels of Perceived Pesticide Risk and Lack of Pesticide Training

Elliot Hohn, Oregon Health & Science University

Many residents of agricultural communities live or work in close proximity to the farming operations that surround them, creating a situation in which all community members, both farmworkers and non-farm workers, have reason to be concerned about the potential effects of pesticide exposure on health and the environment.

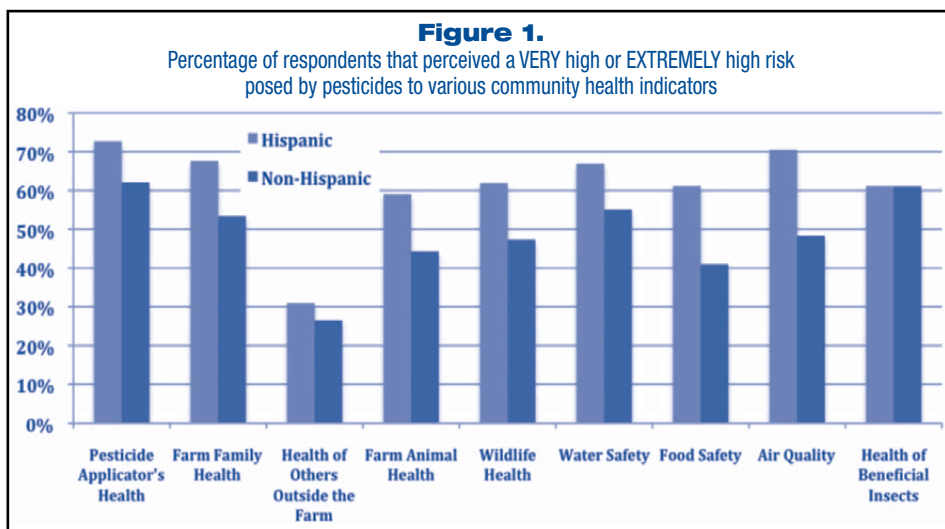
Many of these communities also include large numbers of seasonal and migrant farm workers, a population that is particularly vulnerable to pesticide-related health effects because of poverty, substandard living conditions, language and cultural barriers, and limited access to healthcare (Hanson & Donohoe, 2003). Many of these workers may come in contact with pesticides through occupational exposure and from living in housing located near growing fields. Furthermore, children in these communities that are living with parents who work with agricultural pesticides, or who live in proximity to pesticide-treated farmland, have been shown to have higher levels of pesticide exposure than do other children living in the same community (Lu, Fenske, Simcox, and Kalman, 2000).

Although previous studies have examined farm workers' knowledge and beliefs about pesticides, little is known about the knowledge and beliefs of agricultural communities.

Community Perception

In order to learn more about the community's pesticide-related beliefs and perceptions, a survey was given to adults recruited at a county fair in an agricultural region in the Pacific Northwest. Approximately half of the 477 people that completed the survey reported having current or previous agricultural experience. The average age of the respondents was 40 years and approximately one fourth of the respondents were Hispanic.

Residents reported a number of concerns about the risk that pesticides pose to their health and the health of the community. The majority of participants thought that pesticides posed a very high to extremely high risk to the health of their community and to their personal health. Notably, in all community health categories surveyed, Hispanic

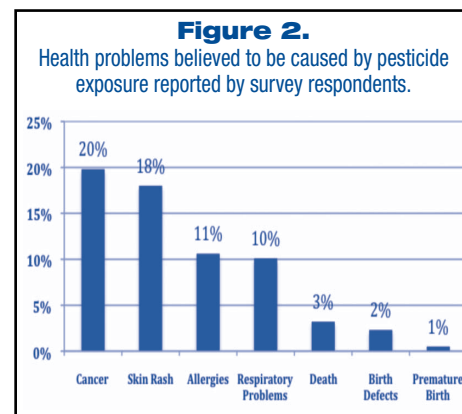


respondents were more likely to report being worried about the effects of pesticides than Non-Hispanics (Figure 1).

Hispanic respondents were also more likely to report having health problems they believed to be caused by pesticides (24%), or knowing someone who has had health problems that they associated with pesticides (42%), than non-Hispanic respondents (15% and 22%, respectively). The most common types of health problems reported were cancer, skin rash, allergies, and respiratory problems. Among the more extreme responses were reports of death, birth defects and premature birth (Figure 2).

Health and Safety Training in the Agricultural Workplace

Specific questions about workplace safety training were targeted to community members who work in agriculture which indicated a lack of training and knowledge about pesticides. The US Environmental Protection Agency's revisions to the Worker Protection Standard, promulgated in 1992 and made effective in 1995, made it mandatory for employers to provide workers with pesticide safety training. Even so, according to our survey, only 31% of all current or former agricultural workers that identified pesticide use in their jobs report "ever receiving pesticide safety training," with lower percentages



of Hispanic workers reporting training (27%) than non-Hispanic workers (33%). Studies have shown that, even when training is provided, many factors can make the training difficult to understand, including limited vocabulary and information provided in English to non-English speakers. Many workers also believe their immigration status (lack of documentation) places them in a powerless position, making the employer feel less compelled to provide pesticide education (Salazar, Napolitano, Scherer & McCauley, 2004). This lack of control over pesticide use was also seen in responses to our survey; few of the Hispanic agricultural workers felt like they had any control over the use of pesti-

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EPA settles lawsuit challenging rules allowing pesticide tests on people

Agency to propose new standards that bar unethical and unscientific research

WASHINGTON (June 17, 2010) – Pesticide experiments using people as test subjects will have stricter federal rules to follow under a new agreement reached today between the Environmental Protection Agency (EPA) and public health groups, farmworker advocates and environmental organizations.

“People should never have been used as lab rats for testing pesticides,” said National Resources Defense Council (NRDC) senior attorney Michael Wall. “Under today’s settlement, EPA will propose far stronger safeguards to prevent unethical and unscientific pesticide research on humans.”

In 2006, a coalition of health and environmental advocates and farmworker protection groups led by NRDC filed a lawsuit against EPA, claiming EPA’s recent rule violated a law Congress passed in 2005 requiring strict ethical and scientific protections for pesticide testing on humans. EPA’s 2006 rule lifted a ban on human testing put in place by Congress.

EPA’s 2006 rule allows experiments in which people are intentionally dosed with pesticides to assess the chemicals’ toxicity and allows EPA to use such experiments to set allowable exposure standards. In such experiments, people have been paid to eat or drink pesticides, to enter pesticide vapor “chambers,” and to have pesticides sprayed into their eyes or rubbed onto their skin. The pesticide industry has used such experiments to argue for weaker regulation of harmful chemicals.

“EPA’s 2006 rule allows pesticide companies to use intentional tests on humans to justify weaker restrictions on pesticides,” said Dr. Margaret Reeves, a senior staff scientist with Pesticide Action Network. “Pesticide companies should not be allowed to take advantage of vulnerable populations by enticing people to serve as human laboratory rats.” The coalition that challenged the regulation argued in U.S. Court of Appeals for the Second Circuit that the rule ignores scientific criteria proposed by the National Academy of Sciences, did not prohibit testing on pregnant women and children, and even violated the most basic elements of the Nuremberg Code, including fully informed consent. The Nuremberg Code, a set of standards governing medical experiments on humans, was put in place after World War II following criminal medical experiments performed by Nazi doctors.

“Unethical testing of pesticides on

humans is wrong and has to be stopped,” said Jan Hasselman, an attorney with Earthjustice involved in the case. “EPA made the right decision to improve its rules to prevent the ethical abuses and unscientific experiments used in the past to justify weaker regulation.”

“We hope that improved regulations will result in greater protections for those who are most exposed to pesticides, particularly farmworkers and their families,” said Bruce Goldstein, Executive Director of Farmworker Justice.

Through the settlement announced today, EPA has agreed to propose a new rule that would significantly strengthen scientific and ethical protections for tests of pesticides on humans. Under this agreement, a proposed rule must be issued for public comment by January 2011. The settlement still requires court action to become effective.

The lawsuit was filed by a coalition of advocacy groups including the Farm Labor Organizing Committee, Migrant Clinicians Network, NRDC, Pesticide Action Network North America, United Farm Workers, Pinosos y Campesinos Unidos del Noroeste (Northwest



Treeplanters and Farmworkers United) and the San Francisco Bay Area Physicians for Social Responsibility. Attorneys with NRDC, Earthjustice, and Farmworker Justice served as legal counsel for the coalition. ■

■ A Survey of Residents continued from page 4

cides (27%), or the method used to apply those pesticides (26%).

Risk Reduction Through Education

High levels of risk perceived by the community, combined with a large percentage of respondents claiming to know someone who has had health problems that they believed to be a result of pesticide exposure is cause for concern. Steps to minimize exposure in farm workers and their families, and to thereby decrease the prevalence of pesticide-related illnesses, must continue to be taken, helping to assuage some of the fears and beliefs held by members of the community. These steps should be particularly focused on the migrant farm worker community, with culturally competent and easily accessed education and safety material as a primary goal.

In addition to education for community members, pesticide safety training in the workplace remains important. Many workplace training efforts can be accomplished through a partnership between employees

and the employers (Wallerstein & Rubenstein, 1993). This partnership cannot be effective if workers feel marginalized and powerless, and are therefore unwilling or unable to approach a supervisor with questions or concerns about pesticide safety. Increased emphasis on worker safety and communication between employees and employers might be a good place to start. ■

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Contracts and Cooperative Arrangements for Specialty Care

Farmworker Justice

Note: This memo offers general guidelines on developing contracts and cooperative arrangements. Health Centers should seek the advice of an attorney to address their specific situations and needs.

BACKGROUND

Health Centers frequently collaborate and coordinate with other individuals and organizations in their community to provide health services, both primary care services and any additional / specialty services needed to provide quality health care, to farmworkers and their families. These collaborative relationships are usually formalized through written contracts or cooperative arrangements. In order to ensure that all parties are clear on their roles and responsibilities, and to protect the rights of the Health Center and its clients, contracts or cooperative arrangements should address a number of specific issues.

For more detailed information on contracts and cooperative arrangements, including Memoranda of Understanding and Memoranda of Agreement, see Farmworker Justice's article, "Entering Contracts or Cooperative Agreements for Specialty Care" – download a copy at <http://www.fwjustice.org/Health&Safety/resources1.htm>.

CONSIDERATIONS:

- In general, the appropriate form of the agreement depends on whether the Center is employing and/or paying the service provider. Contracts are commonly used when payment or other compensation for the service is involved. A written cooperative arrangement, either a memorandum of understanding (MOU) or memorandum of agreement (MOA – also known as a "cooperative agreement") may be appropriate if no financial exchange is planned.
 - Normally, MOUs / MOAs / cooperative agreements are not legally binding, but they may be binding and enforceable in court if a judge determines that they meet the legal standards of a contract or that there is a contract implied in law.
 - If the parties do not intend a MOU / MOA / cooperative agreement relationship to be legally binding, a statement to that effect should be included.

Certain issues should be considered and/or included regardless of the specific type of agreement or relationship being created, e.g.:

- Detailed descriptions of the specific

- services to be provided by each party.
- The duration of the agreement, including the terms or conditions under which the agreement will terminate.
- Licensing and credentialing requirements for all providers and institutions.
- Quality assurance programs in accordance with state, Federal or JCAHO requirements.
- Malpractice coverage: Both parties should assess their coverage situation and if needed, obtain the appropriate type (private insurance, FTCA coverage) and level of coverage for the services included in the agreement.
- Limited English Proficiency (LEP) requirements: The agreement should spell out which party (the Center or the provider) will be responsible for meeting the Title IV requirements for working with LEP populations.
- Procedures for emergency contacts during evenings, weekends and other times that the Center is closed.
- Representatives for each party (who and how to contact).

Health Centers need to ensure that the service provider will provide services in a manner that is timely, accessible, and acceptable to the Center's target population. This may require that the provider agree to:

- Make appointments in a timely fashion and avoid unduly long periods of performance
- Provide the Center with a case summary on a timely basis detailing diagnosis, treatments, client instructions, and follow up care needs
- Provide third party billing information, if applicable, and encourage client application for other payment sources
- Contact the Center for follow up care on a timely basis
- Get client's consent for treatment and for releasing their info

The Center should reserve rights in the contract or agreement to conduct periodic assessments of the provider's services, including:

- The right to monitor and evaluate whether the provider and its personnel are performing satisfactorily and in compliance with applicable policies, procedures, and operational and professional standards, as specified by the provider's representations.
- The right to receive notification from the provider if it or any of its personnel fail to meet insurance or licensure requirements

- (or other criteria required by the Health Center) and/or engage in any actions that could result in the revocation, termination, suspension, limitation or restriction of such licensure, certification, or qualification to provide such services, and the right to require removal and replacement under such circumstances.
- To minimize liability for care given at the provider's facility, Centers could include a disclaimer in their contract or agreement stating: "The specialty care provider does not and is not authorized to act on behalf of the Health Center."

Health Centers also need to require that the service provider is currently and will remain in compliance with all applicable federal and state laws and regulations, such as:

- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Age Discrimination Act of 1975
- Title VI of the Civil Rights Act of 1964
- Section 504 of the Rehabilitation Act of 1973

If the relationship being established includes payment for services, the contract should establish a fee schedule. The following items should be considered and/or included:

- If the service is within the Center's scope of project, the fee schedule must also contain a corresponding schedule of discounts adjusted on the basis of clients' ability to pay.
- If the Center will be paying for part or all of the service with federal grant money, enter a contract that complies with all of the requirements of OMB Circular A 110.
- If the service is within the Center's scope of project and the Center is paying for part or all of the service with federal grant money, include a clause in the contract requiring the provider to bill the Center for the services.
- If the provider is prohibited by state Medicaid regulations from billing the Center for the services or it cannot or does not want to bill the Center for some other reason (or the Center cannot or does not want to be billed by the provider for some reason), then include a clause in the contract allowing the provider to bill the client or another third party but requiring the provider to report all billings to the Center and within a reasonable period of time transfer all funds received from

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Farmworker Immigration Law – Legislative and Regulatory Update

Adrienne DeVartanian, JD, Farmworker Justice

Immigration reform continues to be a critical need for our nation's farmworkers, the majority of whom are undocumented. The Agricultural Job Opportunities, Benefits and Security Act (AgJOBS), is a proposed immigration law that would address this need by providing agricultural employers with a stable, legal labor force while protecting farmworkers from exploitative working conditions. AgJOBS, a bipartisan bill, represents a major compromise between farmworker advocates (led by the United Farm Workers) and major agricultural employers to address the agricultural immigration crisis. If enacted, AgJOBS would (1) create an "earned adjustment" program, allowing many undocumented farmworkers and agricultural guestworkers to obtain temporary immigration status based on past work experience with the possibility of becoming permanent residents through continued agricultural work, and (2) would revise the existing agricultural guestworker program, the H-2A temporary foreign agricultural worker program.

On May 14, 2009, Senator Feinstein (D-California) and Representatives Berman (D-California) and Putnam (R-Florida) introduced AgJOBS in the Senate (S. 1038) and House of Representatives (H.R. 2414). AgJOBS is also part of the push for comprehensive immigration reform. AgJOBS is included in the House Comprehensive Immigration Reform bill, CIR ASAP, introduced by Rep. Luis Gutierrez (D-Illinois) and will likely be included in any comprehensive immigration reform bill that is introduced in the Senate.

The H-2A agricultural guestworker program has been the subject of much attention recently. On February 12, 2010, the Labor Department announced new regulations for the H-2A program that would largely undo changes to the program made by the outgoing Bush Administration over a year ago. The new rules took effect on March 15. Changes to the formula for calculating the adverse effect wage rate, recruitment requirements, transportation reimbursement provisions, preoccupancy inspection of farmworker housing, and other provisions have been restored to the regulations that existed prior to the Bush Administration's changes. In addition, the new regulations add provisions such as a surety bond for farm labor contractors, disclosure of job terms to guestworkers by the time they apply for a visa, online posting of H-2A applications so that US workers can learn about jobs; and a requirement that H-2A labor contractors specify each specific location where work will be performed, the name of the grower and the period of work. ■



Health Alert!

Mercury Poisoning Linked to Use of Face Lightening Cream

The California Department of Public Health (CDPH) is investigating several cases of mercury poisoning due to an unlabeled face cream from Mexico used for lightening the skin, fading freckles and age spots, and treating acne. The cream contained very high levels of mercury: 56,000 parts per million (ppm) or 5.6%. The U.S. Food and Drug Administration allows only trace levels of mercury (less than 1 ppm) in face cream products.

Signs and symptoms of mild to moderate toxicity due to inorganic mercury may include nervousness and irritability, difficulty with concentration, headache, tremors, memory loss, depression, insomnia, weight loss, and fatigue. Other symptoms may include numbness or tingling in hands, feet, or around the lips. Renal effects include proteinuria, nephrotic syndrome, and renal tubular acidosis. Gingivitis and excessive salivation may also occur. In children, prolonged exposure to inorganic mercury may also cause acrodynia, irritability, anorexia, and poor muscle tone. CDPH asks medical providers to alert their clients who may be using unlabeled, nonprescription face creams from Mexico for lightening the skin, fading freckles and age spots, and preventing acne that these products may be harmful to their health. Providers should urge their clients to immediately stop using any of these products.

■ Contracts and Cooperative Arrangements for Specialty Care continued from page 6

- the billing to the Center, after which the Center will reimburse the provider.
- If the Center is not paying for the services, include in the MOU / MOA / cooperative agreement provisions establishing rates and methods of payment that the provider will administer when billing the client or another third party.

The Center should reserve the right to terminate the contract or agreement in the event that the provider's performance is deemed unsatisfactory or not in compliance with applicable policies, procedures and/or standards, or the Center determines, in good faith, that the health, safety and welfare of clients may be jeopardized by the continuation of services. ■



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LIVESTRONG Conducts Survey for All People Affected by Cancer

LIVESTRONG is conducting an anonymous survey of all people who have been affected by cancer, including people who have ever been diagnosed with cancer and people who have a loved one who has ever been diagnosed with cancer.

The survey will provide valuable information that will help LIVESTRONG improve programs and resources for people who have been affected by cancer. Survey results will be available in late 2011.

If you qualify and would like to do so, take the survey at www.livestrong.org/survey2010.

If you have any questions about the survey, please contact Ruth Rechis at research@livestrong.org or (512) 236-8820.



calendar

National Summit of Clinicians for Healthcare Justice

September 23-25, 2010
Washington, DC
www.allclinicians.org

National Association for Healthcare Quality Educational Conference

September 30-October 3, 2010
Kansas City, MO
<http://www.nahq.org/conference/2010/details.html>

2010 East Coast Migrant Stream Forum

October 21-23, 2010
Charleston, South Carolina
<http://www.nchca.org/>

20th Annual Midwest Stream Farmworker Health Forum

November 17-20, 2010
Austin, TX
<http://www.ncfh.org/>