MCN streamline
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The Migrant Health News Source

A Discussion of the Current Definition of Migrant Used in Migrant/Community Health Centers

Dear Colleagues:

Over the past year, MCN has engaged in many conversations with clinicians and other health center staff concerning the barriers faced in providing health care to migrants; a number of issues emerged. Among them was the difficulty of accurately applying the current PHS definition of migrant to the patient population being served. While this is perhaps one of many concerns, it is emblematic of systemic problems affecting the delivery of health care to the underserved.

Based on the various conversations we have had about this issue, it is clear that there is a significiant range of opinions. Some people feel very strongly that the definition should be revised, while others have articulated equally strong opinions that the definition must continue unchanged. With very few exceptions, everyone has expressed some degree of confusion about the definition particulary in light of the evolving demographics of migration.

In June, 2006, MCN conducted a brief survey concerning people's understanding of the definition and the sense of its applicability to the current health center patient population. While there are limitations to the number and variety of respondents, we feel that the results are representative of opinions voiced in the field. The results raised interesting issues for MCN in planning for future technical assistance to clinicians caring for migrants, and assume that this could be true for others serving this dynamic population. We present the findings here for your review and as a launch point for what we hope will be a robust discussion of an issue that affects the work of all of us.

Additionally, we are including an article written by Alice Larson, PhD that discusses issues confronted when attempting research with a migrant population. We believe that the article will assist in creating a better understanding of the matter and provoke a broad dialogue among the many segments of the migrant health community.

At intervals, MCN will publish additional articles from experts in the field. Hopefully, through a frank discussion and review of the possible implications of changing or maintaining the migrant definition, we will reach a better understanding of the many positions held within our community.

We welcome your thoughts and hope to share the responses we receive with everyone interested. I look forward to hearing from you.

Sincerely,

Karen Mountain, MBA, MSN, RN
Chief Executive Officer

Service Provider Survey Results

In order to have a clearer understanding of the opinions held by our colleagues regarding the current definition of "migrant", MCN initiated a survey to gather information **from individuals providing direct health services** about the possible strengths or weaknesses of the definition of migrant currently in use.

This was an internet based survey, notification of which went out to staff at 136 Migrant/Community Health Centers (M/CHC) and other sites serving migrants. MCN received 101 responses to this survey, 76% of those responding work in M/CHCs.

Sixteen percent of respondents were from Florida, 13% from North Carolina, 10% from Washington, 7% from Oregon, 6% from Texas and the remaining 64% were from 26 other states.

Twenty seven percent of respondents were adminstrative staff, 46% clinicians, 12% outreach workers, and 16% other.

When asked how many patients seen in clinic meet the HRSA definition of "migrant" 20.8% of respondents said that "Most" or "Many" of their patients fall into this category. Another 22.8% said that most of their patients fit the definition. Thirty two percent said that "Some" meet the criteria, and another 22.8% said that "Few" patients met the HRSA definition of "migrant".

Respondents were then presented with the following statement: "In many communities, there are individuals who are mobile but do not meet the criteria for migratory agricultural worker as defined

continued on page 2

Service Provider Survey Results continued from page 1

by HRSA. Such mobile individuals can include (but are not limited to): day laborers who are intermittently unemployed and move to find work; day workers who are employed but mobile due to homelessness; and unemployed and mobile, such as elderly or disabled individuals who move to live with various family members."
When asked how many of their patients fit into this definition of mobile, 14.9% said "Most" or "Many", 30.7% said "Some" and 49% said "Few".

Of those who do see mobile patients that do not fit the HRSA definition, the following highlights the type of work being done in order of reported frequency: Construction or Landscaping, Service industry (hotels, restaurants, sanitation, child care), Canning and processing produce, Meat processing (poultry, beef, pork), Factory work, Unemployed, Dairy, Cotton Gin labor, Horse racing/track workers, Forest Service, Smoke Jumper, Ski Area, River Guide, Transport/Driving, Domestic labor, Roofing, Waitress, Day labor, Pick brush, Crab workers, and the Fern industry.

Of those who responded, 32.7% said that HRSA's definition does not limit their ability to provide services. Thirty three percent said it "somewhat" limits their ability to provide services, and 10.9% said their services are limited "a lot". Twenty two percent were unsure.

Respondents gave the following answers when asked if HRSA was to expand the definition of migrant, how would an expanded definition increase their ability to provide services (respondents could pick more than one): increase funding opportunities (57.4%); increase identification and reporting of migrants seen (55.4%); increase ability to cover the costs of health care services (49.5%); increase number of migrants seen at clinic (44.6%); it would not increase our ability to provide services (8.9%). ■

Figure 1

Approximately how many patients seen in your clinic meet the current HRSA definition of migrant?

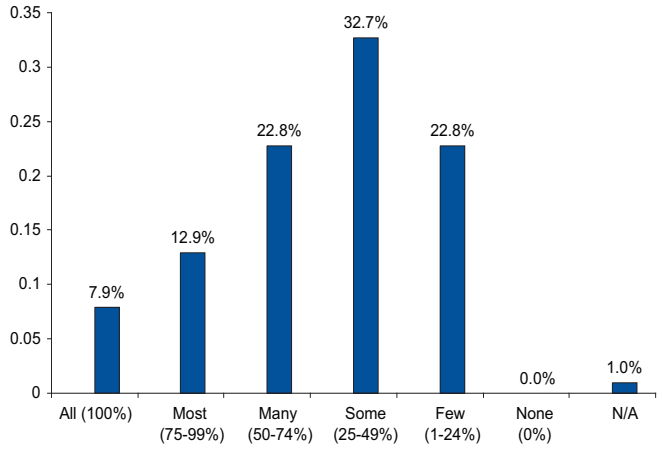


Figure 2

How many of the patients seen in your clinic are mobile but do not fall under the HRSA definition of migrant agricultural worker?

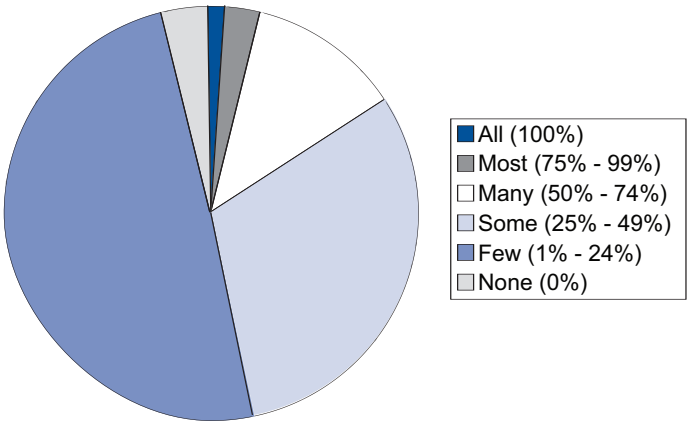
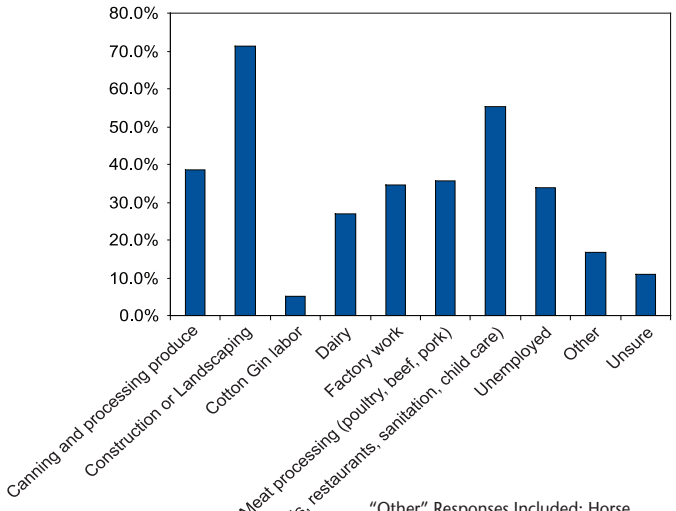


Figure 3

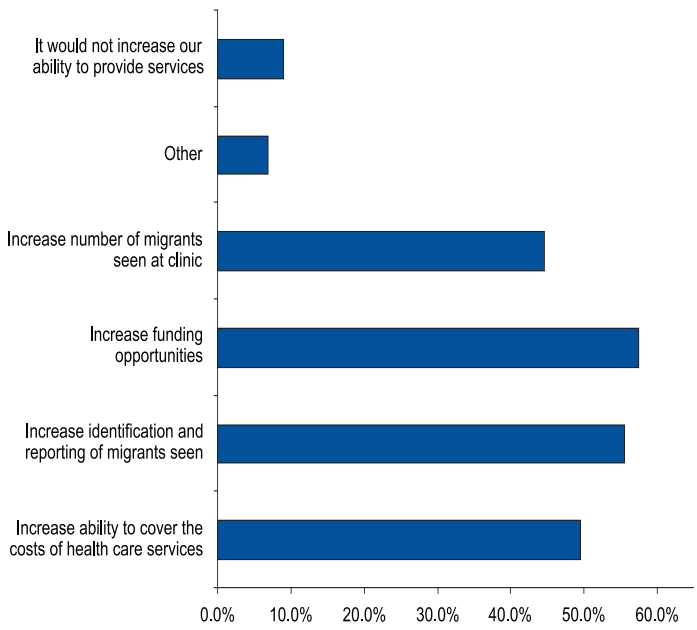
If there are mobile patients seen at your clinic, what types of work are they doing? (Respondents could check more than one)



"Other" Responses Included: Horse racing/track workers (6 responses), Forest Service, Smoke Jumper, Ski Area, River Guide, Transport/Driving, Domestic labor, Roofing, Waitress, Day labor, Pick brush, Crab workers, Fern industry

Figure 4

If HRSA was to expand the definition of migrant, how would an expanded definition increase your ability to provide services (Respondents could pick more than one)?



Serving All in Need of "Migrant Health"

White Paper Developed By Alice C. Larson, Ph.D., Larson Assistance Services
Contact: las@wolfenet.com, 206-463-9000 (voice), 206-463-9400 (fax)

INTRODUCTION

With the likelihood of a new immigration policy looming that could have a major effect on the agricultural work force, this is a good time to examine the population covered under what we call "migrant health" to assure inclusion of all in need of care. This review should be accomplished in light of the changing definition of who is considered a migrant or seasonal farmworker (MSFW), the complexity of seasonal agricultural employment, the characteristics of those who perform this work, and gaps within the overall health care system to provide care for targeted populations in need.

It is hoped this paper might prove a starting place for such discussions by reviewing the background of the Migrant Health Program, examining the current target population definition in light of population health care needs, and presenting service options.

ISSUES FOR CONSIDERATION

Migrant Health Program Purpose and Structure

The primary point of the Migrant Health Program has been to serve migrant and seasonal farmworkers (MSFWs) in need of health care who, due to numerous barriers, are unable to obtain assistance. This can include inability to find health care providers who speak their language, care systems with little understanding of cultural norms and practices, few resources to pay for care and/or prescriptions, no transportation with which to reach facilities, lack of awareness of the availability of health care resources, fear of authorities, and health care operations not open evenings or weekends when workers have time to use them. The seasonality of their employment results in lack of work-based health insurance with low annual wages putting their income below or near the poverty level. Movement across state lines often excludes MSFWs and their family members from Medicaid eligibility.

"Migrant health clinics" were first launched under the "Migrant Health Act" in 1962. Grants were authorized to partially pay for establishing and maintaining services. Minimal funding delayed functional operation of the Program until 1966 when "Community Health Center [CHC] and Migrant Health Center [MHC] programs were launched." (U.S. Department of Health and Human Services, "Historical Highlights" www.households.gov/about/hhshist.html)

Structurally, there was a separate budget for MHCs within the Public Health Services Act, and program operations paralleled those of CHCs. In 1996, reauthorization of the Migrant Health Program placed it within the Health Centers Consolidation Act and under the broad umbrella of CHCs. Migrant Health was no longer a separate program.

Migrant Health Program Definition

> A *seasonal farmworker* is: "An individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months."
>
> A *migrant farmworker* meets the same definition but "establishes for the purposes of such employment a temporary abode." (U.S. Code, Public Health Services Act, "Migrant Health")

The Migrant Health Program definition is composed of three parts. It encompasses the only target population description, under the Health Centers Consolidation Act, based on occupation – in this case employment in agriculture. The two other components of the definition require movement and employment seasonality.

Within the industrial definition, the scope of "agriculture" is not all inclusive. It covers only field agriculture, nursery/greenhouse operations, food processing, and reforestation. It excludes all livestock, dairy, poultry, fisheries, meat or poultry processing, driving farm equipment or transporting produce, and agricultural services.

The definition of mobility has changed through the years. At first, Migrant Health only served "domestic migrant farmworkers" who worked in seasonal agriculture. Non-migrant seasonal farmworkers were added in 1968, the argument being that they, although not hampered by constantly changing residences, also suffered lack of health care due to the agricultural industry in which they were employed. Similar to migrant workers, they share movement in relation to work, in their case seasonal jobs requiring movement among different employers. However, for individuals today, these distinctions are not as clear. Both migrant and seasonal farmworkers may have a single employer – a labor contractor – who in turn works for a number of farmers.

Seasonality was formerly easy to define. It meant someone hired for harvest activities when the task required a great number of workers engaged for a limited period of time. Today, again this line has blurred. In a state like California, year-around agricultural production is possible. An individual can work in "seasonal demand jobs" (e.g., harvesting, pruning, thinning) almost twelve months a year.

Characteristics of Those Served by Migrant Health

The racial/ethnic composition of the migrant and seasonal farmworker (MSFW) population served within the Migrant Health Program has slowly shifted. Historically, the predominant racial/ethnic groups working in the fields on a seasonal basis were White, African-American and Asian. Through the years, often under government contractual arrangements or by way of an influx of refugees, the following groups have also appeared: British West Indians, Jamaicans, Haitians, Hmong, and Vietnamese.

But it is Hispanics who have become the vast majority of seasonal agricultural laborers today. Driven by the Bracero program of the 1940s, Mexican workers were allowed to enter the country in large numbers to replace U.S. agricultural laborers who were fighting in World War II. Today the National Agricultural Workers Survey estimates Hispanics make up at least 83% of the nation-wide seasonal agricultural population. (U.S. Department of Labor, Employment and Training Administration, *Findings from the National Agricultural Workers Survey (NAWS) 2001-2002*, Washington, D.C. 2005.) The vast majority of these individuals are from Mexico, but Hispanics also represent Puerto Rico, and Central American countries such as: El Salvador, Guatemala and Honduras. In recent years, indigenous workers from Mexico as well as other countries are beginning to wend their way into temporary agricultural jobs in the United States.

Populations "Like MSFWs"

In the past, most of the jobs open to such immigrants were in seasonal agricultural labor. Today, these individuals are employed in other facets of agriculture including those jobs formerly held by local White or African American workers in meat and poultry production and processing, in dairy operations, in fishing and fish processing, in logging, and in many other categories within broadly defined agriculture. Outside of agriculture, these same individuals also fill slots in a variety of industries including: restaurants, hotels, housekeeping, construction, home repair and remodeling, mining, and manufacturing.

These new jobs, similar to seasonal agriculture, pay little, offer few if any benefits

continued on page 4

and can be located in isolated rural areas. This employment is often short-term or casual, although the task itself might not be seasonal.

Individuals who are not working in seasonal agriculture, face the same barriers to health care as MSFWs. However, because they do not meet the present definition for Migrant Health services, these "Like MSFWs" are not targeted for care by MHCs.

"Like MSFWs" Receipt of Care at CHCs

This new group of "Like MSFWs" is clearly eligible for services from CHCs, however, the question might be are most CHCs set up to adequately assist them? It has been shown that MSFWs who work in agriculture often require targeted outreach services to encourage comfort with and use of health care facilities. Health care providers need to speak Spanish, or arrange for quality translation assistance, adequate communication is now an issue with newly seen indigenous workers who speak neither English nor Spanish. The hours of CHC service, similar to MHCs, need to be set to accommodate their daytime work needs. Recognition and incorporation of cultural differences are key to provision and acceptance of health care. Working and living in isolated rural areas may mean transportation to medical facilities is not available.

Many CHCs are busy with the general low income population in their service areas and do not have the resources, staffing, cultural awareness, or facilities to reach out to this new and needy group. MHCs are far better geared to serve the population and are generally thought of as providers of care for Hispanics.

QUESTIONS TO BE CONSIDERED

The issue then can be summarized as a very large group of individuals clearly in need of health care services provided under the Consolidated Health Centers Act who are not being effectively assisted. They do not meet the Migrant Health definition, and so are not targets for MHCs. Yet these facilities might be described as the ones best equipped to serve them.

In considering the adequacy of the Migrant Health Program in meeting the needs of all of those employed in agriculture and underserved/unserved "Like MSFWs," the following summarizes some of the questions facing Migrant Health as it looks toward the future:

1. Should "agriculture," "seasonality," and "mobility" continue to be the primary elements that define Migrant Health eligibility?
2. Might the Migrant Health definition be changed to encompass more categories within "agriculture."?
3. Should the Migrant Health definition include other individuals who are "Like MSFWs" in regard to demographics and health care access barriers, but who do not work in agriculture?
4. Should CHCs be adjusted to better target and serve these like populations who do not work in agriculture?
5. Might there be some other means to assist this underserved/unserved "Like MSFWs" group?

WHAT MIGHT BE DONE?

The following presents three options that could be considered to address these issues.

Option One: Change the Migrant Health definition to encompass a wider "agriculture" classification.

Pro: This would allow assistance to the broader group that does work in agriculture who are not currently covered by the Migrant Health Program definition. It would keep to the spirit of Migrant Health – a program targeting employment in a particular industry. It would be possible to define this enlarged category using the North America Industry Classification System coding scheme.

Con: The second primary characteristic of Migrant Health, seasonality, would become confused. Most of these additional agricultural categories do not involve seasonal work. For example, dairy, livestock and poultry operations occur year-around and are dependent on economic and life cycle seasonality for any peaks and valleys within employment. Additionally, expanding the definition of Migrant Health without increasing the funding base for associated Centers would simply create more demand in a program estimated to serve only a small portion of those currently eligible for care.

This Option would not assist the other "Like MSFWs" group who have characteristics similar to and face health care barriers the same as to MSFWs although they do not work in agriculture.

Option Two: Encourage CHCs to outreach to and better assist those groups not now adequately served.

Pro: All of the individuals described as "Like MSFWs" or employed in broader agricultural categories are clearly eligible for assistance at CHCs where they can receive care on a sliding fee scale. CHCs have more resources than MHCs and therefore might be better able to include this underserved/unserved group. Unlike MHCs, most CHCs are located in urban areas where many "Like MSFWs" in service jobs, construction and other industries reside.

Con: CHCs often have their hands full serving the general population in their target area. Outreach to identify and encourage additional patients is not currently as much of a priority in CHCs as in MHCs. Enough patients will come to the Centers without prodding.

While the location of CHCs might assist "Like MSFWs" in cities, many of these individuals live and work in rural areas. MHCs are more plentiful in these locations, particularly where agriculture is the predominant industry.

Many CHCs are not currently staffed or set up to overcome health care barriers of this "Like MSFWs" population including language, culture, hours of operation, and fear. Staffing and operational changes would be necessary for CHCs to provide adequate assistance.

Option Three: Establish a new "special population" group under the Health Centers Consolidation Act (similar to homeless and school-based health) to meet the health care needs of "Like MSFWs."

Pro: Such a category would allow both

continued on page 7

Select References

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Sanders, Michael, "40 Years of Migrant Health," National Center for Farmworker Health, Austin, Texas, 2002.

United States Code, "Title 42, The Public Health and Welfare, Chapter 6A, Public Health Service, Public Health Service Act, Title III, Part D, Section 330, Migrant Health."

The following article originally appeared in the Sacramento Bee, September 22, 2006

Spray sickens farm crew: Potent pesticide sends dozens to hospital

By Susan Ferriss, Pamela Martineau and Edie Lau - Bee Staff Writers

About 45 farmworkers in San Joaquin Delta fruit orchards were exposed Thursday to an extremely toxic pesticide sprayed by a nearby aircraft.

Workers said they noticed a small plane spraying a nearby asparagus field, and their throats and eyes began to burn when a foul odor — like a skunk's spray, they said — wafted through an apple orchard on Grand Island near Walnut Grove.

Some of the workers said they left the orchard right away and showered at a nearby labor camp, then drove in groups to Methodist Hospital in Sacramento.

They went to the hospital to seek medical attention under orders of a company foreman following state law.

At Methodist, the workers complained of nausea and skin irritation — classic signs of intoxication by the organophosphate pesticide Di-Syston, which the Sacramento County Agricultural Commissioner's Office identified as the substance sprayed over the asparagus field.

Five workers who hadn't showered and a hospital nurse who became ill after touching them had to be placed in a decontamination tent erected outside Methodist in a parking lot. They stripped off their clothing, and were washed with copious amounts of water, said Sacramento Fire Department officials.

Hospital spokeswoman Adriane Varozza said 34 workers in total showed up at the hospital - at different times - and were examined by staff doctors who decided it was not necessary to admit anyone.

No one complained of respiratory distress, which signals a potentially lethal dosage of the farm chemical. No blood tests to measure traces of the pesticide were taken.

"We don't know yet if there were violations," by the pesticide applicator, said county Agricultural Commissioner Frank Carl. "Was it OK? No, it wasn't OK because the workers were affected and we don't want workers to be affected."

Carl, who visited the site of the incident, said that some workers sought private medical examinations. He said the affected workers seemed to be at least 600 feet away from the aerial spraying, which is more than the required 300-foot safety buffer.

"We suspected that they reacted to the odor," Carl said, "rather than the toxicity of the product."

Nevertheless, his office will be investigating, with plans to interview every affected worker, the growers and the pesticide application company, Alexander Ag Flying Service, Inc.

He said the pilot, who owns the company, is cooperating with the investigation.

An application company is responsible for determining if weather conditions are proper for spraying and for not causing harm to workers or anyone else. Wind can cause a pesticide to drift.

"These kinds of things absolutely should not happen," said Veda Federighi, spokeswoman for the California Department of Pesticide Regulation. She said the agency will take samples from fields and from workers' clothing to determine if there was drift of the pesticide.

None of the workers who sought exams at Methodist Hospital appeared ill by midafternoon. They stood outside waiting for a few others to be released.

All Spanish speakers, some said they were most concerned about the possibility of not getting paid for the day.

"This means we've lost a lot of work time," said Eduardo Diaz, 23. He said he agreed to go to the hospital to be examined, "so as not to have doubts" about the exposure.

Diaz and other workers said they received instructions to put their contaminated work clothes in a bag and wash them repeatedly without mixing them with other clothing.

Some of the workers had been given fact sheets in Spanish about the pesticide.

"It was a neighbor spraying. Nobody advised us it was happening," said Alfonso Castillas, a foreman for DH&P Orchards, whose owner called Castillas on his cellular phone after hearing a news radio report about the incident.

Staff of the Sacramento County Agricultural Commissioner's Office talked with workers in Spanish outside the hospital, and tried to persuade them to take urine tests to look for traces of the pesticide.

Some workers drove off before they could be stopped, and many seemed nervous about submitting to more exams. Only one worker volunteered.

Federighi said the agricultural commissioner can levy civil penalties of up to $5,000 a person if violations of pesticide spraying are found.

A major exposure of an organophosphate can affect the nervous system and even lead to death, according to information provided by Art Craigmill, a toxicology specialist at the University of California Cooperative Extension.

The incident occurred on the west side of Grand Island, southwest of River and Leary roads. ■

Learning Opportunities from the Reported Incident of Pesticide Poisoning

Editors' note: In reading about the pesticide incident described in the Sacramento Bee, several questions concerning the care provided arise. What procedures could have prevented an attending nurse from getting ill? What is the protocol for decontamination of workers? What types of tests are actually needed? What kind of follow-up care is necessary? How do clinicians properly handle this case in terms of workers compensation? The incident, as reported, demonstrates several learning opportunities for clinicians to improve the management of a pesticide poisoning incident. We are aware that this is a news story and that we may not have the entire picture of how the incident was handled. Nonetheless, we want to share some advice from our partner occupational medicine experts as to how this incident could be handled differently to better protect the clinicians serving the exposed farmworkers and strengthen the quality of care provided to the workers.

1. When you suspect a pesticide poisoning, try to get as much information about the pesticide as possible including, the name of the pesticide used, the pesticide label and/or the Material Safety Data Sheet for this pesticide. Try to talk directly to the farm manager, safety person, or the pesticide applicator to get this information in addition to a description of the incident itself. Employers are required to make the name of the pesticide and the label available to health providers and workers if it is requested. So you may have to ask for it.
2. If you have warning of incoming exposed patients, try to meet the first patients outside the hospital in order to make a determination about need for decontamination. Unless it seemed like an obvious case of group hysteria with no real exposure, create a private space in which each person can bag their clothes and don scrubs. If possible allow each person to shower. Every emergency department has a plan for decontamination. If there are many victims, this may require activating a "disaster" plan. If you know that there is a large group (as in this case with 45 workers), try to enlist the help of other clinic or hospital personnel.
3. Obtain a clothing sample from each worker, and put it in a plastic bag to prevent others from exposure and to preserve the specimens for subsequent analysis. In this reported case, there seems to have been a missed opportunity (prior to getting inside the emergency department) to get the workers out of their clothing, and to have their clothing bagged. It can be difficult to find appropriate clothing to sample after a worker has been instructed to go home and thoroughly wash their clothing. However, if most clothing has been washed, it is likely that a worker's hat or shoes would still be contaminated and available for analysis.
4. If an exposure seems likely, either based on the story or the clinical exam, get a urine sample for each worker and freeze it. This is not a lot of extra work. Once frozen, you can work out whether and where to send it later.
5. If the patient appears to have been exposed to an organophosphate or n-myethyl carbamate insecticide, order a cholinesterase blood test, both plasma and red blood cell, to determine the clinical level of cholinesterase activity. Some experts think blood testing in this situation is a good practice if you think any significant exposure has occurred regardless of a baseline test. In the absence of baseline cholinesterase testing, the results of post-exposure testing are likely to be difficult to interpret. In this instance, it is advisable to conduct periodic re-tests, until it appears that the cholinesterase level has returned to normal. Remember that cholinesterase testing will not provide meaningful information if the workers were reacting to a pesticide other than an organophosphate or n-methyl carbamate or if s/he were reacting to other ingredients in the OP or CB formulation (other than the Di-Syston). A "negative" cholinesterase (or results within the "reference range") could be misinterpreted by an employer or insurer to mean that no exposure occurred. Nonetheless, research has shown that you do not necessarily need a baseline before the exposure if you can determine post-esposure cholinesterase levels afterwards. The recovery rate for a depressed cholinesterase can be estimated to be about 1% per day. However, if a non-depressed cholinesterase is confirmed through follow-up, this may actually hurt the worker's case.
6. You may also want to seek advice from an expert. Everyone has their own favorite. For immediate help call the Poison Control Center at 1-800-222-1222. MCN's Pesticide Resource Section on the MCN website has a listing of clinical tools and contacts for dealing with pesticides. *http://www.migrantclinician.org/excellence/environmental/pesticides.*
7. Fill out a workers compensation report for everyone. This first evaluation should be covered by the workers compensation system in some states like California and Washington. The employer may have to cover the cost of care themselves if they do not have workers compensation insurance as it is optional in some states. Whether subsequent care is covered depends on the result of this evaluation and whether the claim is approved.
8. Before sending everyone home call the appropriate state government authority as designated by the EPA to investigate pesticide poisoning incidents. These agencies determine if there was any violation of the Worker Protection Standard. Find out if there is anything they require you to do that you haven't already done.
9. Some states view pesticide illness as a reportable condition and require health providers (e.g. physicians, hospitals and labs) to report these incidents (often to the state health department). Visit MCN's pesticide web page to find out the reporting requirements for your state and where to report an incident. *http://www.migrantclinician.org/excellence/environmental/pesticides.*
10. Make arrangements with the workers for follow-up appointments and for giving them their test results.
11. After the dust has cleared, inform everyone else who needs to know about the incident such as the workers compensation case manager and the employer in particular. (While you're at it, you may as well call the local paper; they'll find you sooner or later).
12. One of the important things to remember before treating the workers is that while the diagnosis in the emergency room for the purpose of treatment can be based on a group exposure, worker compensation systems generally deal with workers one at a time. It is important for the clinician to collect what is needed to document the exposure for each individual. While illness consistent with other members in a clearly sick group may be sufficient for the clinician facing an outbreak, it may not be sufficient "objective" information to convince a claims manager of the presence of a compensable event. ■

A special thank you to our contributing Occupational Medicine Specialists:

Mike Rowland, MD, MPH, Medical Director, Maine Migrant Health Program, Advocacy Fellow, CMAP, Columbia University

Daniel L. Sudakin, MD, MPH, Oregon State University

Matthew C. Keifer MD, MPH, University of Washington

NIOSH Agricultural Centers

The National Institute for Occupational Health and Safety funds nine regional Agricultural Centers throughout the country for the purpose of protecting and improving the health and safety of the nation's farmers, farmworkers, and consumers. The NIOSH Agricultural Centers were established as part of a Centers for Disease Control and Prevention (CDC) / NIOSH Agricultural Health and Safety Initiative in 1990. The Centers were established by cooperative agreement to conduct research, education, and prevention projects. Geographically, the Centers are distributed throughout the nation to be responsive to the agricultural health and safety issues unique to the different regions. MCN will feature NIOSH centers and other institutions in subsequent Streamlines in order to open the door to clinicians to resources in agromedicine, environmental health an occupational medicine.

The Western Center for Agricultural Health and Safety

The Western Center for Agricultural Health and Safety is a comprehensive, multidisciplinary program dedicated to the understanding and prevention of illness and injury in Western agriculture. The Center is located at the University of California, Davis, with collocated Schools of Medicine and Veterinary Medicine, and a land grant College of Agriculture and Environmental Sciences. Director, Dr. Marc Schenker, heads up an interdisciplinary team of investigators who collaborate on scientific studies of the challenging aspects of agriculture affecting health and safety. Current areas of research and outreach include:

- Musculoskeletal Injury and Ergonomics
- Neurotoxicity and Pesticides
- Respiratory Diseases
- Industrial Hygiene and Exposure Assessment
- Socioeconomic Impacts on Health Behaviors
- Environmental Risk Assessment
- Evaluation and Biostatistics
- Costs and Financial Effects of Adverse Health Outcomes

For more information about the Western Center for Agricultural Health and Safety go to their website *http://agcenter.ucdavis.edu/.*

The Center benefits from collaborations with the Division of Agriculture and Natural Resources, various state agencies stakeholders and NGOs. The state capitol in Sacramento, 12 miles from Davis, is home to the state Departments of Health Services, Food and Agriculture, and Environmental Protection. This large, diverse, multidisciplinary expertise provides a wealth of resources and experience to the Center, and access to populations and contacts in the field. California and the other western states served by this Center are home to a number of types of farms, from family businesses to corporate megadairies, all of which employ family members, farmworkers and laborers from many countries and cultures. ■

calendar

The 16th Annual Midwest Stream Farmworker Health Forum
November 9-11, 2006
Hotel Albuquerque at Old Town
Albuquerque, New Mexico
(800) 531-5120
http://www.ncfh.org/00_clt_mwfsf.php

2006 International HIV/AIDS Meeting
November 17- 21, 2006
Baltimore, Maryland
Institute of Human Virology
410-706-8614
http://www.ihv.org

16th Annual Western Migrant Stream Forum
January 26-28, 2007
Sacramento, CA
Northwest Regional Primary Care Association
(206) 783-3004
http://www.nwrpca.org/conf/forum.php

National Farmworker Health Conference
May 9-12, 2007
Newport Beach, CA
National Association of Community Health Centers
(301) 347-0400
http://www.nachc.com/ela/listing.asp

■ Serving All in Need of "Migrant Health"

continued from page 4

CHCs and MHCs to apply for funding in accordance with their ability to provide care. Centers might be encouraged to adjust their delivery of services as they assess the population needs in their service area.

Con: Funding is the major issue. Would some other program under the Health Centers Consolidation Act have to be sacrificed in order to create this new special population group?

Defining this "special population" might prove difficult as its members are not all of one ethnicity nor do they all work in one industrial classification. ■

Notes from the Field

The New Provider Practicum in Migrant Health is a program that provides for a four-month working and learning experience in a migrant health center for new health care professionals. New Providers are **nurse practitioners, physician assistants, nurse-midwives, and dental hygienists**, who have completed the training program for their profession and have an interest in working with migrant farmworkers. The following is an excerpt from a blog written by Sarah Saalfield is a 2006 Practicum participant in Saltville, VA. In this excerpt Sarah honestly discusses some of the realities faced by new clinicians working in migrant health.

"I have wanted to do home visits since I started nursing school, to see what people eat, what the six surfaces of their rooms are covered in, what their lives smell like. There are fewer unfathomables when caring for a man in his own living room; he cannot have forgotten to bring his medications in to show me, if I chose to I could open his fridge and see just exactly what ingredients make up his diet. Yet now that I'm living the fantasy, I find myself uncomfortable with delivering healthcare to farmworkers in their homes or in the fields. Not having resources literally at hand, not having just one patient trapped, really, in the reassuring sameness of an exam room, forced to focus only on her own needs and my exploration of them. Not being able to draw blood or order an X-ray to pursue a hunch. Home visits force my attention back to the patient's history of present illness and the physical examination, upon which primary care should rely almost wholly but which are often skimmed over on the way to more elaborate diagnostics.

I shrink from advocacy. I have been here a month and just yesterday conjured the energy to call the ex-migrant health outreach coordinator at his new job in DC, to simply ask who I need to bother for the money to buy 4 new Polaroid cameras for health passport photos, and from whence do glucometer test strips issue. Glucometers are free, those intricate small pieces of sophisticated technology. It's the test strips that cost. In the first week of my practicum, I had the energy afforded by novelty and the chance at improving a small, broken system..."

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Newsflashes

New Test Measures Spanish-Speaking Patients' Understanding of Basic Medical Terminology

Researchers have developed an easy-to-use word-recognition test to assess Spanish speakers' comprehension of medical terms commonly used in clinics and community health programs. Low health literacy plays an important role in health disparities and may contribute to high health care cost, low quality of care, and even medical errors. The researchers evaluated the test-the Short Assessment of Health Literacy for Spanish-Speaking Adults or SAHLSA—on 201 Spanish-speaking clinic patients from various countries and found that it could reliably identify those with low health literacy. The test, which asks patients to identify words such as embarazo (pregnancy), microbios (germs), and infección (infection), found no major differences among the groups except that patients of South American origin scored higher. According to the study's leader, Shoou-Yih D. Lee, Ph.D., of the University of North Carolina School of Public Health, the new tool overcomes the problems encountered in translating word-recognition health literacy assessment into Spanish and can be used in clinics as well as in community health programs. The article, "Development of an Easy-to-Use Spanish Health Literacy Test," was published in the August issue of Health Services Research.

Varicella News

A combination MMR-Varicella vaccine is expected to be on the market soon, as it was licensed to ProQuad. Regardless of whether the varicella vaccine is given singly or in combination, the Advisory Committee on Immunization Practices (ACIP) has voted, along with the American Academy of Pediatrics (AAP), to give a second (booster) dose of varicella vaccine at ages 4-6, with a "catch-up" second dose advised for anyone older than 4-6 who has had the first dose and no varicella infection. This decision is because long term findings show that 15-20% of people who receive one dose of varicella vaccine are still susceptible to disease. It is unclear how much of this is due to vaccine failure or to waning immunity over time, but nonetheless, a second dose is needed to prevent outbreaks of varicella. VCF is expected to cover this second dose. ■

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