

# streamline

## Children in the fields: Profile of Melissa Bailey

by Claire Hutkins Seda, Writer, Migrant Clinicians Network, and Managing Editor, *Streamline*

*[Editor's Note: In 2015, Migrant Clinicians Network is celebrating its 30th year of working to create practical solutions at the intersection of poverty, migration, and health. To commemorate our 30th anniversary, we launched 30 Clinicians Making a Difference, in which we celebrate the work of 30 individuals who have dedicated their lives to migrant health. The following profile is a part of this project, as is the profile on page eight. View all 30 profiles at [www.migrantclinician.org/30-clinicians-making-a-difference](http://www.migrantclinician.org/30-clinicians-making-a-difference).]*

**A**round 2009, Melissa Bailey started noticing a large increase in the number of children she encountered working in tobacco, fruit, and vegetable fields across North Carolina, where she was a recruiter for the state's Migrant Education Program. "We had always seen children on farms, but we had never seen them in great numbers. We began seeing work crews entirely under the age of 18 and as young as 10," Bailey explained. "We noticed a serious lack of oversight."

She discovered that tobacco fields' contractors were operating without accountability; they were often sub-contracted by a manager, who in turn was working for a grower. "A grower... cannot hope to see every crew coming in there on thousands of acres," she explained.

Child workers on these farms are encountering a myriad of potential health and safety hazards, from chemical and nicotine exposure, to lack of access to shade, bathroom facilities, and fresh water, to sexual harassment, said Bailey. Workers, in turn, have trouble reporting labor abuses when unable to pinpoint their location among the thousands of acres of crops.

Bailey's shock turned to action. She began working with a few contractors in the field, ensuring water, shade, breaks, safety from harassment, and promised pay. Then, she turned to the community. Later, when approached by the Children in the Fields Campaign, she joined other outreach profes-



sionals in organizing child workers and their parents. "We started building leadership in the community among the child workers themselves, so they could start sharing their experiences to raise awareness," Bailey said. The work became the backbone of the grassroots non-profit, NC FIELD, which she co-founded and eventually led. NC FIELD — short for North Carolina Focus on Increasing Education Leadership and Dignity — quickly gained relevance in the community, providing immigrants with education on their rights and tools to better their lives, and a community to celebrate their lives and their goals, while simultaneously calling for an end to the injustices by exposing them to the rest of the nation.

The spike in child labor was a result of a number of factors. The downturn in the economy left many families hungry. "Food prices had gone up a lot, and migrant farmworkers are not eligible for emergency food assistance in North Carolina," Bailey explained. The state's restrictions on immi-

grants and driver's licenses meant many people lost their ability to drive to work. "Once mobility was gone, [workers] had to rely on contractors. We started seeing more wide-scale issues, with the way they were treated. There was no reason to treat [workers] well anymore," because their ability to quit and move to a new job was stifled. A tobacco buyout program starting from 2004 — in which government funds went to help tobacco farms diversify and move away from tobacco, to assist growers after the government dropped tobacco price supports — resulted in farmers buying up more acres to grow more tobacco, said Bailey. Larger farms meant more subcontractors, and less oversight on hiring practices. "The chain of accountability is so convoluted," Bailey explained, saying that "there continues to be no accountability" for child laborers on farms. She said that she has not seen a reduction in child labor since that initial



# Mobile Populations Navigating the HIV Treatment Cascade

by Claire Hutkins Seda, Writer, Migrant Clinicians Network, and Managing Editor, *Streamline*

**P**eople move. At times, people have to move often – for work, for better living conditions, to survive. But the need to migrate should not be an impediment to care.

Over the course of two years, a young HIV-positive woman moved four times. She returned from the US East Coast to her home country of South Africa for seven months, and then moved to a new US state. She then moved two more times, to two other US states. Each location had varying care structures, with differences in eligibility requirements for safety net services. Luckily, one of her clinicians enrolled her in Health Network, MCN's bridge case management system providing linguistically and culturally competent coordination of care. A Health Network associate maintained contact with the patient throughout the two years, and set up care for her before she arrived at each of her new destinations, assuring that she

could continue her treatment, despite her frequent moves. A case study outlining the many steps Health Network took to maintain her care follows this article.

Mobile patients like this young woman encounter numerous barriers to health care, including limited information about a new community's resources, language and cultural barriers to accessing that information, immigration status concerns, lack of insurance, and transportation difficulties. As a result, regular check-ups and non-acute care may be limited for mobile patients, removing opportunities to screen for HIV.

If an HIV+ patient does seek care, it is often for an acute co-infection. Most of Health Network's HIV cases – including the accompanying case study – were identified when they were under treatment for tuberculosis.

When a patient is diagnosed with HIV,

what happens next is critically important. Clinicians tending to mobile populations like migratory agricultural workers often only have a narrow window with a patient; a few minutes may be all that clinician will ever see of the patient before he or she moves again. Yet, new research, plus a new Health Resources and Services Administration (HRSA) clinical measure, emphasizes the need to assure mobile patients with HIV are able to continue care as they move.

## The Big Picture

More than 1.2 million people are estimated to be living with HIV in the United States; almost one in seven of those infected are unaware of their infection.<sup>1</sup> The figure is high, and troublesome: those unaware of their infection don't know that they can

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# Communication in coordinating health care: A case study

By Alexandra Smith, Health Network Representative, Migrant Clinicians Network

**H**ealth Network has been managing HIV cases since 2007, with a total of 163 cases to date. This case study exemplifies the amount of time and effort Health Network associates provide to mobile patients, particularly in a case where the patient is suffering from a coinfection. Of those 163 HIV cases that have been managed, 96 cases presented a coinfection of tuberculosis and HIV. The majority of HIV cases enrolled with Health Network were originally TB cases, demonstrating HIV+ patients' higher susceptibility to TB infection. TB is one of the leading causes of death for people living with HIV.<sup>1</sup>

Health Network began to receive funding specifically for HIV cases in 2012 from the Elton John AIDS Foundation to support coordination of care for patients after incarceration or during immigration deportation. The Health Resources and Services Administration (HRSA) also contributes to Health Network's HIV services, because they fund Health Network to help coordinate care for mobile populations, and HIV falls under the umbrella of funding that HRSA gives to Health Network. Coinfection of HIV and TB is not only common, but also can be detrimental without the proper care. The case study that follows specifically emphasizes the need to give attention to this coinfection in mobile populations, and the diligent work that goes into coordinating care for these patients by Health Network associates through case management.

In August 2012, Naomi\* an African woman in her late twenties residing in the Northeast, tested positive for tuberculosis, and was started on treatment shortly thereafter. Naomi brought herself to an emergency room and was admitted into the hospital with a fever and cough. She was then tested for HIV due to the symptoms she had when she presented to the hospital, and was found to be HIV+. After being diagnosed with HIV, Naomi was also diagnosed with a secondary condition called Immune Reconstitution Syndrome (IRIS). This commonly occurs when a patient is being treated simultaneously for TB and HIV and his/her immune system begins to respond to the antiretroviral treatment for HIV. Due to this new diagnosis of IRIS, Naomi was continued on antiretroviral medications and

stopped her TB treatment for several days, then resumed it with one medication at a time. The patient was released from the hospital with one month of TB treatment and three months of antiretrovirals for her HIV. This is a common practice for hospitals when a patient is staying in the same area for a long period of time, which was what the hospital thought was the case for this specific patient. However, Naomi was planning to move back to her country of origin, in east Africa.

The hospital staff treating Naomi for HIV and TB learned of her intentions to move in the beginning of December. Her doctors wanted her to be reevaluated by an infectious disease doctor once she was back in Africa, so they decided to take action to ensure the patient received care after she had moved. The hospital informed the Centers for Disease Control and Prevention (CDC) of the patient's intentions to move out of the country, and the CDC enrolled her with Health Network. After Health Network was contacted, the CDC was able to have the patient released to Africa, since Health Network was the third party that would be coordinating care for the patient as she moved.

Three months after her hospitalization Naomi had arrived in Africa and was undergoing treatment for both her TB and HIV at a local clinic and a hospital in her area. This treatment plan was put in place before Health Network was able to contact the patient, since the patient was already in the process of moving when she was enrolled. Later on that month, Jessica, the Health Network case manager for Naomi, was informed by the patient that the hospital where she was being treated for HIV was not willing to send her information to Health Network due to confidentiality concerns. Jessica informed the patient that her signed consent form does allow Health Network access to the patient's medical records, and that she should inform the hospital of this. Three weeks later, Naomi was informed by the hospital that the only way Health Network can have access to the records is if they were present at the hospital with her. Jessica tried to obtain the contact information for the hospital where the HIV treatment was taking place from Naomi to talk to them personally about Health Network, and the services it provides for mobile patients. Naomi did not know the information, but would ask at her appointment the following month.

Naomi underwent nine months of treat-

ment for her TB due to her sputum results that were taken in Africa. She completed treatment in June 2013, at the TB clinic in Africa. When Health Network tried to obtain these records, the TB clinic stated they needed to contact her treating physician who was at a hospital nearby in order to obtain the records. Shortly after completing treatment, in December 2013, Naomi moved back to the United States. Health Network learned this when Jessica called Naomi's mother, who informed Jessica that Naomi had moved back to the US, and gave her a phone number for her daughter. Jessica called Naomi, and was informed that she was planning to stay in the US for a long time, and admitted to doing well.

She brought a summary of her HIV treatment with her to the US along with two months' worth of HIV treatment medication from her African clinic, but she did not have a current clinic to go to in the US. Jessica then got into contact with a clinic near Naomi that treats HIV and also has individual case managers to keep up with the patient. Health Network was able to send medical records to the clinic to get Naomi enrolled, and she was able to set up an appointment at the clinic for January 2014, one month after the patient had arrived back in the US.

Health Network needed documentation of the TB treatment completion to close out the TB portion of the case. When Health Network contacted the African clinic to obtain treatment completion records, the treating physician in Africa requested Naomi's TB card; the card has a specific identification number needed to access the patient's completion records since the African clinic did not have an electronic medical records system. Jessica contacted Naomi about the TB card, but she reported that she had left it in Africa. Naomi then contacted her mother in Africa, and had her send the TB card to the US. In June 2014, Naomi sent the card to Health Network. The TB portion of this case was closed in July by MCN's Chief Medical Officer, and the HIV portion currently remains open.

When Jessica checked in on Naomi again in May 2014, she said that she had another appointment set up at her current clinic the following month. She also said she was planning to move to another state to find work and to go to school, because her current location was turning out to be a place where she was not getting enough support from those around her. By July, Naomi had moved,

1. Centers for Disease Control and Prevention (CDC). Tuberculosis (TB). <http://www.cdc.gov/tb/topic/tbhivcoinfection/default.htm>. Accessed June 1, 2015.

\* The patient's name, country of origin, and all dates have been changed to protect her identity.

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# New Haven Farms: Linking health center patients directly to the farm, for nutrition education and access to healthy foods

by Claire Hutkins Seda, Writer, Migrant Clinicians Network, and Managing Editor, *Streamline*

*Once we got the health center going, we started stocking food in the center pharmacy and distributing food — like drugs — to the people. A variety of officials got very nervous and said, 'You can't do that.' We said, 'Why not?' They said, 'It's a health center pharmacy, and it's supposed to carry drugs for the treatment of disease.' And we said, 'The last time we looked in the book, the specific therapy for malnutrition was food.'*

**Geiger, Jack. *The Unsteady March. Perspectives in Biology and Medicine*, 48, 1-9.**

In 2009, Carmen Gomez\* of New Haven, Connecticut was diagnosed with diabetes. But, because she was diagnosed at Fair Haven Community Health Center (FHCHC), what happened next was far from typical: Gomez was prescribed food — plus time on the farm for growing food and attending nutrition and cooking classes. She was contacted a week after her diagnosis by Rebecca Kline, then with FHCHC's diabetes prevention program (DPP), who brought her out to New Haven Farms, an urban farm with educational components down the street from FHCHC. "I would water the plants, and do some weeding. I would work with cilantro, onions, kale, cherry tomatoes, big tomatoes... I would typically spend a couple of hours there," several times a week, Gomez said. Six years later, she's still an active participant. Every Monday, Gomez and others enrolled in the DPP receive cooking and nutrition education on the farm, after an hour or more of farming. The instruction includes seasonally-adjusted cooking strategies, and nutrition and lifestyle education. The patients' entire families are invited. After the hour-long educational component, participants eat the meal they prepared together, and then bring home enough servings of vegetables and fruit from the farm for every member of their household for the week — meaning, lots of produce — plus, recipes for the harvest.

"I feel that my life has changed in many ways. I am more active and have not increased in weight," Gomez states. Not only is her diabetes stable, "it's gone," she exclaims. She also says she's seen a huge difference in her family, who are also invited out to the farm, to work, learn, cook, and eat.

\* The patient's name has been changed to protect her privacy.



Photo courtesy of Fair Haven Farms

"They have seen their mom stay active and eat better and be happy," she said. She is eating more vegetables now, and, she says. "I believe I am passing on a better diet to my family."

## It's access plus education

In 1965, Jack Geiger, the father of the health center movement, began 'prescribing' food from a local cooperative farm in the Mississippi Delta to his patients suffering from malnutrition. Fifty years later, the approach still has advocates. Many of the health problems that plague the underserved populations of the US — diabetes, obesity, high cholesterol, some cancers — can be traced to a lack of availability of healthy foods and a dearth of nutrition and cooking education. And yet, FHCHC may be one of the country's few health centers — perhaps the only health center — currently 'prescribing' food by having direct, concrete links between the health center and a local farm.

Now, new research signals that the approach may be more than just novel. Two new studies on food deserts — urban areas where it's difficult to purchase healthy, fresh food — show that providing access to healthy foods like fresh fruits and vegetables did not significantly affect consumption of healthy foods, meaning, although a market in the community finally featured cucumbers and apples, the nearby residents didn't end up buying more vegetables or fruit than they normally did. Their food buying habits stayed the same. In a New York Times article about the studies, Jessie Handbury, an author of one of the papers, concluded that "improving people's diets will require both making food

accessible and affordable and also changing people's perceptions and habits about diet and health."<sup>1</sup>

## A haven for healthy food

Over at New Haven Farms, in the Fair Haven neighborhood of New Haven, Connecticut, Rebecca Kline, who is now the Executive Director of the project, responded to the article with glee. "The article describes exactly why, at New Haven Farms, we provide both access to [healthy] foods and [to] education," she said. New Haven Farms' main site is located in a food desert, but the program provides more than just access to produce, Kline contends. This is how it works: Practitioners at FHCHC prescribe time at the farm for a medical condition by filling out a referral form within the electronic medical record of the patient. Patients are brought out to the farm to participate in food growing and harvesting, which is matched with nutrition and lifestyle education, to equip patients of FHCHC and their families to better their food behaviors. The two innovations — connection to the health center, and the inclusion of education — are the key difference between New Haven Farms and other community farm projects, says Kline. The resulting robust program is a model for community health centers looking for an alternative method to combat diet-related health issues like diabetes and high cholesterol.

## Beginnings

New Haven Farms was born out of a partnership between FHCHC and Chabaso Bakery, a large East Coast artisan bakery with a New Haven commercial bakery. The owner of

Chabaso, Charles Negaro and his wife, Nancy Dennett turned an adjacent vacant lot on the bakery's grounds into a community garden for employees about ten years ago — but it went underutilized. At the same time, FHCHC was launching a new DPP for their low-income, mostly Hispanic patient population. The program was translated from the National Institutes of Health's Diabetes Prevention Program curriculum, after which FHCHC added innovative components like cooking classes and family-based interventions, said Kline.

Just as FHCHC was developing their DPP, Negaro and Dennett approached FHCHC to see if they would like to utilize the garden, which by then was fully operational and ready to use with irrigation systems and compost-amended soil, for free. FHCHC agreed. They hired Kline to join their DPP team, and one of her tasks was to run the gardening component for the clinic's patient population. The position became a staff person shared by both FHCHC and New Haven Farms. "I had never heard of urban farms or gardens existing to impact this particular population's health and food security. It was at the time —and still is— a pretty unique mission," Kline states.

Soon after the collaboration began between FHCHC and New Haven Farms, the program became hugely popular with patients and their families, Kline said, and garnered national press including a New York Times article. Most importantly, it helped people connect the dots between their DPP education and their daily eating habits. "It filled a gap for people," Kline explained. "At the DPP, they're learning cooking and nutrition, [and] behavior change concepts, but people don't necessarily have the tools to [implement] the things they're learning — tools being access to fresh fruits and vegetables. This fills that gap."

Since then, New Haven Farms has expanded into its own 501(c)3 nonprofit, adding new community farms in other low-income areas of New Haven. They're now planning to partner with other health centers beyond FHCHC, addressing food security and education for low-income patients with diabetes throughout New Haven.

### The nitty gritty: Staff, IT, and funding

Kline says that the partnership wasn't onerous to set up because of the timing: the farm was ready to be used, resulting in minimal start-up costs, and the health center was in the process of setting up their DPP, meaning there was flexibility to add a new component. FHCHC's IT team easily set up the new referral form in the EMR.

"The last simple thing was orienting the clinicians so they knew about the program and knew how to make the referral when they were in people's charts — that's why this shared staff member is so critical," explained

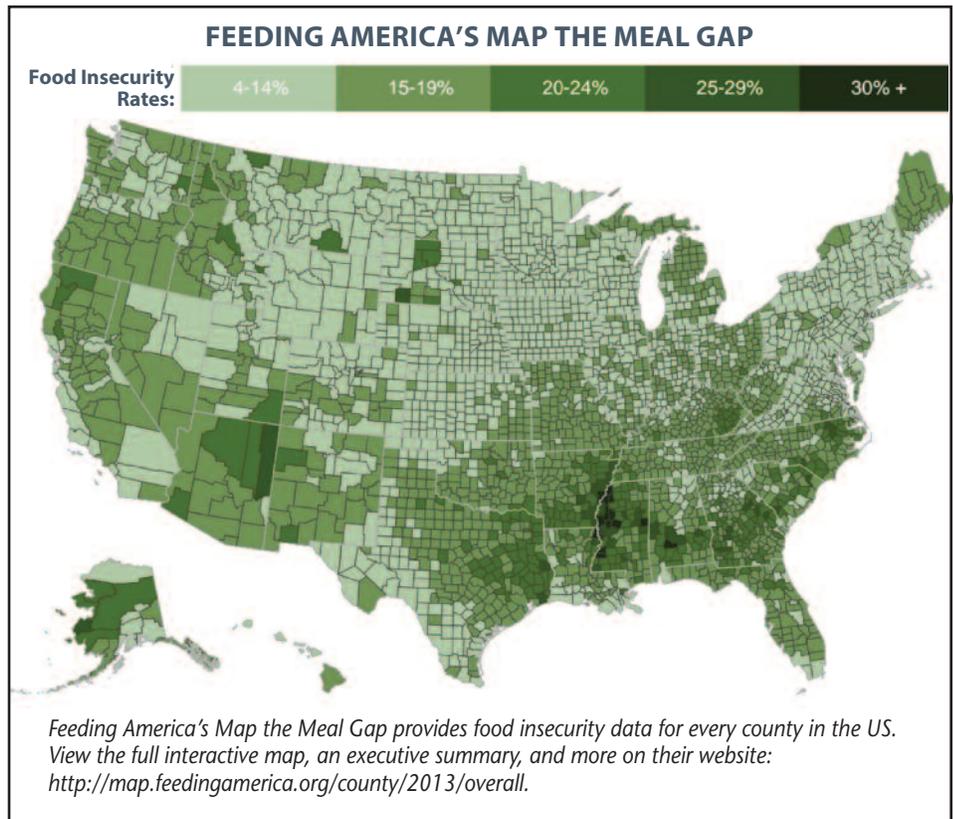


Photo courtesy of Fair Haven Farms

Kline. "That person not only knows the IT system but they know the clinicians." As that staff person, Kline would provide orientation to new clinicians and assist current clinicians in navigating the program. "If we're not hitting our targets for referrals," says Kline, the staff person can knock on the clinicians' doors to check in. Kline notes that there are few incentives for clinicians to refer their patients; clinicians make referrals simply "because they're excited about the program," she said.

As they expand, New Haven Farms is shifting its funding strategy. As a nonprofit, New Haven Farms is now charging the medical centers who wish to partner with them. Their new partner, Cornell Scott Hill Health Center, found some of the needed funds in its current operating budget; they also wrote New Haven Farms in as a sub-grantee in a related grant. They're additionally asking for employee donations to help subsidize the cost of their patients' participation. In other words, health centers wishing to participate in the program must be willing to do the often hard work of finding the funding.

### Results

Initial data from the program is encouraging but not jaw-dropping. In 2013, there was a 20 percent decrease in food insecurity among participants and a notable increase of one serving per day of fruits and vegetables. There were not significant changes in BMI or blood pressure. New Haven Farms is incorporating the new data into their strategy. "We didn't focus a lot that year on decreasing consumption of junk food," noted Kline, instead focusing on increasing healthy food; they plan to change that. They will also increase on-the-farm exercise education, beyond the physical element of farming itself. "We've moved more toward the behavior change model," in an attempt to affect BMI numbers. "We're not a weight loss program, but we know that BMI is... associated with diet and related chronic disease risks," Kline said. "So, some change in BMI would be nice... But the big things are food security, and fruit and vegetable intake, and those are things we definitely know we're impacting, and it's what our program is specifically designed to impact." ■

### RESOURCES:

Learn more about New Haven Farms on their website, <http://www.newhavenfarms.org>.

More on FHCHC's DPP can be found at: <http://www.fhchc.org/diabetes-prevention>.

1. Giving the Poor Easy Access to Healthy Food Doesn't Mean They'll Buy It. New York Times. [http://www.nytimes.com/2015/05/09/upshot/giving-the-poor-easy-access-to-healthy-food-doesnt-mean-theyll-buy-it.html?smid=tw-nytimes&\\_r=1&abt=0002&abg=1](http://www.nytimes.com/2015/05/09/upshot/giving-the-poor-easy-access-to-healthy-food-doesnt-mean-theyll-buy-it.html?smid=tw-nytimes&_r=1&abt=0002&abg=1). Accessed June 2, 2015.

influx, six years ago — just that some of the children got older and reached adulthood. Many have continued to work the fields.

### Early years

Bailey grew up in the Appalachian Mountains during the coal mine strikes, exposing her to the import of giving workers safe and meaningful work. Although the mountain culture is hardly similar to that of the migrant workers she now serves, she finds striking parallels. Her Appalachian childhood gave her “very good insight not just into poverty but into the culture of poverty. You’re pretty much ostracized from other regions,” she explained. Migrant workers in North Carolina “couldn’t communicate well, they didn’t know the rules socially, but they are a very important part of the economy” — which rung true for her coal mine family as well when they left their communities. Her recognition of these culture dynamics helped her better understand the migrants with whom she would work in the years to come, she said.

As a teen desperate to get out of Appalachia, she raised funds to send herself to Spain for a semester abroad. Her fluency in Spanish upon her return served her well when she eventually got the job at Migrant Education in 2001.

### From the FIELD

She stepped away briefly from Migrant Ed to work at NC FIELD in June, 2012, which gained its nonprofit status in 2011. As the Executive Director, Bailey enjoyed watching the non-profit take on significance in the community. “The fact that it’s been a stable presence in the community, I really see how necessary that is..., how that’s benefitted the community as a whole.” Bailey has watched child laborers return to school and attempt to better their lives as a result of the support and community provided by NC FIELD. She feels the infrastructure in this rural area is

what the youth need to “fulfill their own destinies, which in turn is helping the community move forward,” she said. “And I think that can happen on a much larger scale.”

### Continued needs

Bailey continues to see the need for support systems to help workers — children and adults — better understand how to navigate the world outside of farming. She says she sees people interested in doing other things, but they don’t know how to approach it. Workers need to understand “what they need to be successful in the larger society, outside of the bubble of agriculture... If you know you’re meant for greater things, but you have no clue how to do that, it can be frustrating and depressing,” she said.

She also believes mental and behavioral health services need to accompany basic health care for workers, some of whom have experienced abuse and harassment in the fields. “What do you do with a child who has been sexually harassed or molested in a field? What do you do with a child whose mother has had to [work as a] prostitute, in order to make ends meet?” asked Bailey. “We’re not doing a good job on a national level, so it’s hard to do it at a community level,” she explained, as the lack of infrastructure and funding leaves providers without support to address the issues, and children without sufficient care.

She commends the farmworker health services in eastern North Carolina for meeting the needs of the many marginalized people in her area, including large numbers of child refugees who have recently arrived from the border. She also recognizes, however, that parents who bring their children to the pediatrician are often not willing to disclose that their children are working in tobacco fields. Green tobacco sickness, resulting from nicotine absorption that occurs from handling tobacco plants, mimics

a stomach virus, said Bailey, making proper diagnosis difficult. “One of the challenges moving forward is simply getting the community to speak more freely” about their circumstances, including whether their children are working in the fields.

Another challenge is rural homelessness. When an adolescent refugee mother and her young child were suddenly not welcome in a home with relatives, Bailey was unable to find a local organization to take her in. The closest shelters in urban settings refused her as well, as she wasn’t within their service area.

### Taking care of ourselves

In 2013, Bailey stepped back from leadership and project coordination activities at NC FIELD due to health issues. She found herself exhausted. After several months off, she now recognizes the need for health workers and advocates to take care of themselves — and not just focus on the important goals at hand. “I thought I was taking care of myself, but I wasn’t, really,” she admitted. She hopes that personal health can be better built into the outreach worker model, which can so often take over an outreach worker’s private life, “because we have our own psychological fallout from things, and there really isn’t anywhere for us to go, or anywhere for us to admit that,” she said. After she fell ill, she also recognized that similar trainings were lacking in her own work with youth. “A lot of us spend time training youth as outreach workers and activists and community educators — but we’re not teaching them that [health piece] either, like when it’s okay to say ‘no.’” Bailey admits she wasn’t able to say ‘no’ herself, as her job is her life’s passion, and her work is heavily needed. She is now NC FIELD’s “volunteer-in-chief,” Bailey says with a laugh. With lessons learned on burnout and health, Bailey is on the rebound. “At this point, I’m getting ready to jump back in again now that I’m feeling better. Its model is so important.” ■

## ■ **Communication in coordinating health care: A case study** continued from page 3

and was referred by Health Network to a local hospital to treat her HIV. Jessica was able to coordinate care for the patient by sending previous HIV records to the new treatment facility. Jessica continued to stay in contact with the clinic and the patient throughout her treatment there. At the beginning of this year, Naomi moved again and Health Network was able to coordinate care for her by finding a clinic near her new home. Naomi is still in this location, and is under treatment at a clinic that Health Network found for her.

Currently, this case has resulted in 49 clin-

ic contacts and 42 patient contacts, and still remains an open case in Health Network. Without the communication that occurred on this case, and Health Network’s associates working diligently on the case, it is likely that Naomi’s care would not have been as cleanly executed. With serious coinfections like TB and HIV, treatment needs to be administered consistently over long periods of time; if Naomi had not been enrolled with Health Network, it is likely her treatment would not have continued due to her mobility, and the likelihood of developing drug

resistance to both her HIV and TB would have been increased. Despite moving between two countries and moving to three different states within the US, she was able to receive care. This demonstrates the importance of a constant flow of communication between all parties involving a mobile patient’s health, and that a case manager coordinating care, like an associate at Health Network, is essential to achieving competent care, especially when health care becomes as fluid as it does when interacting with mobile populations. ■

spread it. But, those with new diagnoses who do not continue treatment also contribute a high percentage of HIV transmissions.<sup>2</sup> A study co-authored by the Centers for Disease Control and Prevention (CDC) and published in *JAMA Internal Medicine* in April, 2015, found that people with an HIV diagnosis but who were not retained in medical care were responsible for 61.3 percent of HIV transmissions in 2009.<sup>2</sup> Those without a diagnosis were responsible for an additional 30.2 percent. Nine out of 10 new cases of HIV could therefore be prevented with effective medical care, by ensuring diagnosis and continued care.

### HIV Treatment Cascade

The researchers defined their research parameters based on the HIV treatment cascade, also called the care continuum, a system used by health care workers to better monitor HIV patients in medical care by grouping them according to their level of care. The first stage, those who have been diagnosed with HIV, made up 82 percent of all people living with HIV in 2012.<sup>3</sup> The next stages are cascading subsets of that original large group: those who are initially linked to care (66 percent), those who have been retained in care (37 percent), those who are prescribed anti-retroviral therapy (33 percent), and those whose HIV is virally suppressed (25 percent).<sup>3</sup> When a patient is on the move, often searching for work or improved living conditions, lack of access to care in new locations effectively shuts off the option to remain in care, which results in unchecked treatment and the increased likelihood of costly future complications, as well as increased likelihood to transmit the disease to others.

### Health Center Clinical Guidelines

The importance of continuity of care for patients with HIV was heightened last year when HRSA added a new Quality of Care clinical performance measure requiring health centers receiving funding from HRSA to report on continued care for newly diagnosed patients. The measure looks at how many newly diagnosed patients begin care within three months of diagnosis, which moves them to the second point on the treatment cascade – and lowers their risk of transmitting the disease. The new measure states:

*Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis.*

*Numerator: Number of patients in the denominator who had a medical visit for*

*HIV care within 90 days of first-ever HIV diagnosis.*

*Denominator: Number of patients first diagnosed with HIV between October 1 of the prior year through September 30th of the current measurement year.<sup>4</sup>*

Consequently, clinicians serving low-income and underserved populations have an additional reason to seek continuity of care for HIV patients – and to be certain that, if a patient is moving within 90 days after diagnosis, the patient is linked to care as he or she moves.

### Recommended Clinician Guidelines

Mobile patients present with similar but slightly shifted risk factors, and require a different approach in the exam room. To assure care as the patient moves, MCN highly recommends enrollment in Health Network.

### Risk Factors

Mobile patients share the same risk factors for contracting HIV as the general population: sexual encounters, sharing needles or syringes, perinatal transmission and/or blood transfusions in a home country before universal precautions were in place. In the context of a mobile population, the same risk factors have a slightly different effect. With limited social networks and with families often left behind while migrants seek work, some turn to substance abuse or to sex workers to combat fear, stress, and loneliness. Stigma around condom use continues in some cultures and migrant populations. While on the move, often with few resources and limited communication with social networks, migrants are more likely to become victims of sex trafficking, sexual exploitation or sexual abuse.<sup>5,6,7</sup>

### Diagnosis

Because young, low-income men and women tend to present in clinics most commonly with acute illness or injury, clinicians are encouraged to screen all mobile patients for HIV risk factors at any visit, even if the patient is presenting with an unrelated complaint or injury. While taking a medical history from mobile patients, Migrant Clinicians Network recommends to:

- Ask about number of people with whom they have had sex in their lifetime/past six months;
- Ask if the person they have had sex with has sex with other people;
- Ask if they or the person/people they have had sex with uses IV drugs;
- Ask about condom use — including how often;

- Ask if the person has had sex with men/women/both.

### Enrollment in Health Network

In addition to these questions, and to assure continuity of care, ask the patient if he or she intends to move within the next year. Practitioners with mobile HIV patients are encouraged to enroll those patients in Health Network, MCN's bridge case management program, which assures continuity of care and treatment completion for mobile patients suffering from ongoing infectious or chronic diseases including HIV. Health Network provides comprehensive case management, medical records transfer, and follow-up services for the patient in his or her new destination. If your clinic is not currently utilizing Health Network for mobile patients, visit <http://www.migrantclinician.org/services/network.html> to learn more about how your clinic can begin enrolling mobile HIV patients in Health Network.

*Migrant Clinicians Network's webinar entitled "Structuring HIV Care for Mobile HIV Patients" from February, 2015 is archived on our website at <http://www.migrantclinician.org/toolsource/resource/webinar-structuring-hiv-care-mobile-hiv-patients.html>.* ■

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# Controlling Tuberculosis at the Border: Miguel Escobedo, MD, MPH

by Claire Hutkins Seda, Writer, Migrant Clinicians Network, and Managing Editor, *Streamline*

**M**iguel Escobedo, MD, MPH, is the Medical Officer for the US-Mexico Unit of the Division of Global Migration and Quarantine, a program of the Centers for Disease Control and Prevention (CDC). He's also an immigrant. Dr. Escobedo immigrated with his family from central Mexico to the Mesilla Valley, north of El Paso, TX, when he was eight years old. He has lived at the southern New Mexico and Texas border ever since. His father, a seasonal farmworker, worked in the local fields and orchards throughout the year: cotton, chili, alfalfa, pecans. His mother worked in the garment industry in El Paso. During the summers, "the children who had the means would go out and swim and go camping. My version of camping was going out and picking onions or hoeing cotton," said Dr. Escobedo. His earnings from summer farm work would go towards new clothes, shoes, a bicycle — things his parents couldn't afford. The experience was "part of my education," he explained.

## Early years in Texas

His early interests in biology, coupled with the encouragement of high school and university mentors, brought him on the path to medical school. He believes his upbringing encouraged him to find a profession that would serve the farmworker community: "I think being a physician has special significance because you feel you are able to ... help people directly. I can gain knowledge, and I can apply it, and I can cure people." As a child, his family would cross the border to the Mexican town of Ciudad Juárez any time health care was needed. "When I needed emergency surgery, we went across the border because care wasn't [accessible] here. It was routine that we didn't even think about it — we just went to Juárez," he said. When he grew up, he recognized that affordable and accessible care was still needed in his hometown. "People need help," he said. "What better way to [help than to] be a physician and to help people in a very direct manner?"

## A public health career: strong collaboration with Mexico

After his residency, he worked for a year at

[Support for the publication of this article was provided by the Elton John AIDS Foundation.]



local community health centers and soon discovered an interest in serving immigrants through the public health sector. He joined the El Paso City/County Health Department as the TB control officer and communicable diseases director, where he started a clinic for homeless patients, oversaw a clinic for sexually transmitted diseases, and provided HIV care at the beginning of the epidemic in the 80s through an HIV treatment clinic.

"At that time it became very obvious to me that it did no good to try to treat patients without having a system to communicate closely with Mexico," Dr. Escobedo said. He began his first binational project focused on TB when he collaborated with Mexican colleagues on a TB project called Juntos.

He also at that time began working with

Karen Mountain, MCN's CEO, and Del Garcia, MCN's Director of International Projects, Research, and Development, to conceive the first version of TBNET, MCN's tuberculosis patient tracking and referral program designed to keep mobile underserved populations in care, which was developed in the mid-nineties.

His collaboration with Mexico continues in his current job. Dr. Escobedo began work for the Centers for Disease Control and Prevention in 2005, and is now the US-Mexico Unit Medical Officer for the CDC's Division of Global Migration and Quarantine. His first task was to set up the El Paso quarantine station, one of 19 stations which respond to recent public health crises like Avian influenza and SARS. The El

continued on page 9



Photo courtesy of Bertha Almandariz

Paso unit teamed up with San Diego's quarantine unit to become the US-Mexico unit, where he works closely with Mexican colleagues to "prevent the introjection and transmission of infectious and communicable diseases from other countries into the US, which primarily focuses on Mexico," he said. "We don't just rely on doing our work on the US side, but we also set up surveillance systems trainings and special projects with Mexico." The team provides guidance to local customs officials in regards to illnesses of public health concern, assisting in the proper isolation and treatment of illnesses. Their active surveillance systems with Mexico ensure strong data sharing and collaboration even before diseases are detected, which assures public health preparedness in the case of emergencies: "We don't wait until diseases come to the border."

"Whenever we have public health emergencies, like H1N1, and now Ebola, we work closely with Mexico to set up mechanisms to exchange information, notification, commu-

nity prevention strategies," Dr. Escobedo noted.

#### **More collaboration for more information sharing**

Dr. Escobedo has recently partnered with MCN and others in Project ECHO, an innovative hub-and-spokes model of knowledge sharing through video conferencing, which Dr. Escobedo plans to utilize to enhance binational TB control efforts. Currently, his unit is setting up consultation services for complicated multi-drug-resistant tuberculosis (MDR-TB) cases using video conferencing technology, he said. The program is in line with the unit's goals: "We don't wait until people show up at the border with infectious TB, we actually set up programs in both countries to maximize collaboration [and] enhance surveillance," to help get people into treatment before more people are exposed.

#### **Public health concerns at the border**

Tuberculosis continues to be a huge issue, in

addition to illnesses of public concern like pertussis, measles, and even Dengue fever, which has recently been detected at the border.

Dr. Escobedo finds tuberculosis a "fascinating disease". "We can have great effectiveness if we can educate people, [and] if we can use the limited resources wisely, to prevent a lot of disease and suffering for people," he said. "You add the binational component and it makes it even more interesting."

Currently, between 75,000 and 80,000 new legal permanent residents immigrate to the US from Mexico per year (the number is down from the 100,000 of recent years, he said). "Of those, four to five percent have TB conditions that require follow-up," Dr. Escobedo said, whether those conditions are an abnormal X-ray, a positive TB test, or TB exposure that requires follow-up. "We make sure that all of those medical records are forwarded to the local health departments so the immigrants get the follow-up that they

continued on page 10

need," he said. His unit operates a number of tools to assure infectious TB patients at the border are identified and given treatment. One tool is Do not Board/Border Look Out list, which focuses on TB patients who are lost to follow-up, or who left the country before follow-up could be arranged, and focuses on travel restrictions. Dr. Escobedo passes some cases on to Ricardo Garay, MCN's Health Network Manager, to follow patients who are crossing the border who need to continue care when they return to their country of origin. Garay then links those patients with care as they travel, for example facilitating a "meet and greet" at the US-Mexico border, a coordination effort between MCN, CDC, and the binational TB staff from the border state's health services department. In such a "meet and greet," Garay and his US colleagues work with Mexican health workers to prepare for an incoming patient needing care, so the Mexican health workers can arrange to assist that person once he or she has crossed the border.

Dr. Escobedo assists in a wide range of TB cases. A recent example is a teen who started treatment for MDR-TB in Houston, TX, who suddenly disappeared; it became apparent that the teen had travelled to Ciudad Juárez for his appointment to secure his permanent residency card, an appointment that includes a medical examination. "I quickly reached out to the panel physician," one of the physicians tasked with providing medical examinations to new immigrants, in Ciudad Juárez. "We worked with the binational TB control... and MCN. We facilitated the exchange of information and managed to get him treated in Juárez," Dr. Escobedo said. They also paid for laboratory support and second-line drugs that weren't available in Mexico. "As a result of our quick intervention and collaboration, linking all the parties, the young man got treated, he was rendered non-infectious, and eventually got his green card." They also managed to secure him a waiver to enter



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sooner than expected upon completion of treatment, Dr. Escobedo said.

### Continued struggles

Dr. Escobedo's main concern is "keeping up with new public health challenges," he said. Despite the strong focus on collaboration, crises at the border can cripple fast action, as was the case with the thousands of unaccompanied children that arrived at the border in summer, 2014. Politics in Washington, as well as "mindsets that are hostile to immigrants," slowed down the movement of resources. Normally untenable ideas not based on science, like the idea of quarantining the children for two months, began to be raised frequently in policy dialogue. But, soon resources were flowing and the children began to be admitted. "Eventually, it got done, and it got done well, but it took a long time,"

Dr. Escobedo admitted.

"Ebola," despite no cases along the border, "is consuming a lot of resources," Dr. Escobedo said, noting that several colleagues have been deployed to Africa to assist in readiness and exit screening. But the ongoing issue of note at the border is the decline in funding.

"I think we have been pretty successful," managing diseases of public health significance at the border, he said, "but the lack of support is sad to see. I think sometimes federal government priorities change. We could use more support, both financially and staffing-wise."

Dr. Escobedo noted that the level of government support, compared to just ten years ago, has waned significantly. "I think we're falling into complacency," he warned. "Even though we've been effective, TB could come back and haunt us." ■

## Summer Resources: MCN Has You Covered

**M**CN's website hosts numerous resources to assist you in serving your mobile populations in the clinic or out in the field. The summer farming season is now in full swing; can your clinic use some of these resources?

Is your clinic identifying all of the migratory or seasonal agricultural workers? Use MCN's algorithm in Spanish and English to find out: <http://www.migrantclinician.org/toolsource/tool-box/algorithm-identification-migrant-and-seasonal-farmworkers.html>

American Academy of Dermatology's SpotMe program helps Spanish-speaking clients understand the importance of skin cancer: [http://www.migrantclinician.org/files/CCP\\_Spanish\\_SpotMe.pdf](http://www.migrantclinician.org/files/CCP_Spanish_SpotMe.pdf)

MCN's archived webinar series Orientation in Migrant Health focused on Patient-Centered Medical Homes for a mobile population: [http://www.migrantclinician.org/files/\\_pdfs/2013Orientation\\_5PCMH.pdf](http://www.migrantclinician.org/files/_pdfs/2013Orientation_5PCMH.pdf)

MCN and Migrant Health Promotions rec-

ommend strategies for increasing clinician involvement in consumer board member recruitment: <http://www.migrantclinician.org/toolsource/tool-box/what-are-clinicians-role-recruiting-consumer-board-members.html>

MCN also offers tools to increase agricultural worker participation in Health Center boards: <http://www.migrantclinician.org/toolsource/resource/poster-solicit-migrantseasonal-farmworker-participation-health-center-boards.htm> ■

# World Health Organization classifies glyphosate as “probably carcinogenic:” Excerpt from “Carcinogenicity of tetrachlorvinphos, parathion, malathion, diazinon, and glyphosate”

Reprinted with permission from Elsevier. Guyton K, Loomis D, Grosse Y, et al; for the International Agency for Research on Cancer Monograph Working Group. Carcinogenicity of tetrachlorvinphos, parathion, malathion, diazinon, and glyphosate. *Lancet Oncol.* 2015;16(5):490-491. doi: 10.1016/S1470-2045(15)70134-8. [http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(15\)70134-8/abstract](http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(15)70134-8/abstract). Accessed June 15 2015.

*[Editor's Note: In May, 2015, the International Agency for Research on Cancer (IARC), the specialized cancer agency of the World Health Organization (WHO), classified glyphosate as “probably carcinogenic to humans (Group 2A).” An IARC Working Group had evaluated the carcinogenicity of five organophosphate pesticides, including the widely used herbicide glyphosate, which is sold commercially in the US under multiple brand names including Roundup (Monsanto), Rodeo (Dow AgroSciences LLC), Touchdown (Syngenta), and Accord (Dow AgroSciences LLC). The following is an excerpt from their summary of results, published in The Lancet Oncology. For the complete results, including the evaluations of the organophosphates malathion, diazinon, tetrachlorvinphos, and parathion, please read the full article, which is available on the Lancet's website at [bit.ly/1AQzmcW](http://bit.ly/1AQzmcW).]*

In March, 2015, 17 experts from 11 countries met at the International Agency for Research on Cancer (IARC; Lyon, France) to assess the carcinogenicity of the organophosphate pesticides tetrachlorvinphos, parathion, malathion, diazinon, and glyphosate (table). These assessments will be published as volume 112 of the IARC Monographs.<sup>1</sup>

Glyphosate is a broad-spectrum herbicide, currently with the highest production volumes of all herbicides. It is used in more than 750 different products for agriculture, forestry, urban, and home applications. Its use has increased sharply with the development of genetically modified glyphosate-resistant crop varieties. Glyphosate has been



detected in air during spraying, in water, and in food. There was limited evidence in humans for the carcinogenicity of glyphosate. Case-control studies of occupational exposure in the USA,<sup>2</sup> Canada,<sup>3</sup> and Sweden<sup>4</sup> reported increased risks for non-Hodgkin lymphoma that persisted after adjustment for other pesticides. The AHS cohort did not show a significantly increased risk of non-Hodgkin lymphoma. In male CD-1 mice, glyphosate induced a positive trend in the incidence of a rare tumour, renal tubule carcinoma. A second study reported a positive trend for haemangiosarcoma in male mice.<sup>5</sup> Glyphosate increased pancreatic islet-cell adenoma in male rats in two studies. A glyphosate formulation promoted skin tumours in an initiation-promotion study in mice.

Glyphosate has been detected in the blood and urine of agricultural workers, indicating absorption. Soil microbes degrade glyphosate to aminomethylphosphoric acid (AMPA). Blood AMPA detection after poisonings suggests intestinal microbial metabolism in humans. Glyphosate and glyphosate formulations induced DNA and chromosomal damage in mammals, and in human and animal cells in vitro. One study reported increases in blood markers of chromosomal damage (micronuclei) in residents of several communities after spraying of glyphosate formulations.<sup>6</sup> Bacterial mutagenesis tests

were negative. Glyphosate, glyphosate formulations, and AMPA induced oxidative stress in rodents and in vitro. The Working Group classified glyphosate as “probably carcinogenic to humans” (Group 2A). ■

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## Tribute to Dr. Joseph Fortuna

On June 16, Joseph Fortuna, MD, MACOEM, from the American College of Occupational and Environmental Medicine (ACOEM) passed away in New Orleans, LA. Dr. Fortuna was a steadfast supporter of Migrant Clinicians Network and a longtime advocate of worker safety and health. He strived to place farmworker health at the center of occupational and environmental medicine in the US in his work at ACOEM.

Dr. Fortuna was the Chief Executive Officer at PRISM of New Orleans, LA, and Clinical Assistant Professor, Division of OEM, Department of Family Practice, at Wayne State University School of Medicine in Detroit, MI.

MCN knew him best for his work at ACOEM as founder and Chair Emeritus of the Special Interest Section for Underserved Occupational Populations. At ACOEM, he welcomed Migrant Clinicians Network's expertise in farmworker health, and actively advocated for risks of injury and illness among agricultural workers to be addressed in environmental and occupational health.

"Joe was a brilliant guy with a big heart," recalled Ed Zuroweste, MD, Chief Medical Officer for Migrant Clinicians Network. He praised Dr. Fortuna for the hundreds of hours that he dedicated to farmworker health, on his own time. Dr. Zuroweste credits Dr. Fortuna with helping MCN build networks and key connections that contributed to the creation of our own Environmental and Occupational Health programs, saying, "He was a great friend of MCN and a deep



supporter of our work on migrant health, putting farmwork front and center" of occupational health.

Scott Morris, MD, a colleague of Dr. Fortuna at ACOEM, recalled Dr. Fortuna's multi-year commitment to bringing ACOEM conference goes out into the field, to better illustrate the health care needs of farmworkers. His work "not only [helped] raise aware-

ness of the unique problems faced by underserved workers and their families but also [helped] to create meaningful change that would improve their health and safety," long-term, said Dr. Morris. "The legacy he established and the lives he influenced will continue to live, thrive, and remain committed to justice for [the] health and safety of all workers everywhere." ■

### Call for Community Health Center Partners:

## Migrant Clinicians Network invites health centers to participate in Workers and Health program

Immigrant and migrant populations work in some of the riskiest industries in the country including agriculture, forestry, fishing, and construction. One of these workers may arrive in the exam room with a work-related injury, like pesticide exposure. Are the workers' health providers prepared to address it?

Migrant Clinicians Network's Workers and Health program provides training and expert technical support to integrate environmental and occupational health into the primary care setting. Through the program, clinicians gain valuable and applicable expertise in recognizing, managing, and preventing work-

related injuries and illnesses. Health centers utilizing the program are at the forefront of environmental justice and occupational health, assuring that their most vulnerable populations get the resources they need to stay safe from environmental hazards like pesticides.

Given the competing demands and severe time constraints in primary care, clinicians struggle with ways to incorporate occupational medicine into their day-to-day efforts. With support from the Environmental Protection Agency, MCN's Workers and Health program partners with Federally Qualified Health Centers across the country

to establish Centers of Excellence in Environmental and Occupational Health.

The guide on page 13, based on our award-winning poster, outlines the objectives and methods of our Workers and Health program, along with the results of implementation of the program at Blue Ridge Community Health Services in North Carolina.

Please contact Kerry Brennan, Environmental and Occupational Health Associate, at [kbrennan@migrantclinician.org](mailto:kbrennan@migrantclinician.org) or 512-579-4536 to learn more on how your health center can participate in Workers and Health. ■

Workers and Health:

# Community Health Centers Making a Difference in the Protection of Migrant Workers and their Families

Kerry Brennan<sup>1</sup> • Amy K Liebman, MPA, MA<sup>1</sup> • Shannon Dowler, MD<sup>2</sup> • Lee Homan<sup>2</sup> • Milton Butterworth<sup>2</sup>  
<sup>1</sup>Migrant Clinicians Network, Salisbury, MD • <sup>2</sup>Blue Ridge Community Health Services, Henderson, NC

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## Objectives

1. Increase clinical knowledge and improve clinical practices to recognize, manage and prevent environmental and occupational health injuries, illnesses, and exposures
2. Contribute to sustainable improvements in health and environmental justice for communities at risk for overexposure to pesticides
3. Increase clinician reporting to pesticide surveillance systems in order to contribute broader public health understanding of pesticide exposures, ultimately helping to protect communities and better inform public policy and regulation actions. acceptability of model among workers, employers and popular educators

## Methods

MCN partners with health centers across the country to establish Centers of Excellence in Environmental and Occupational Health. In a year year-long collaboration to improve the recognition and management of work-related injuries, illnesses, and exposures for migrant and underserved populations, MCN provides:

- On-site training and expert technical assistance to stakeholders and clinicians
- Support to outreach staff and community health workers to facilitate patient education about the risks associated with pesticide exposure and ways to minimize these risks
- Clinical resources that increase awareness, accurate diagnosis, and surveillance of work-related exposures to support clinicians
- Linkages between the health center and occupational medicine specialists, departments of health, and other community partners to assist in educating, diagnosing and reporting environmental and occupational health conditions



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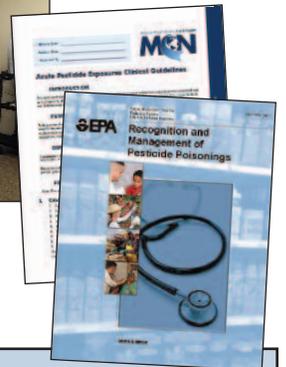
## Results since 2006

Over 5,000 clinicians and stakeholders trained via onsite workshops, national webinars and national and regional conferences



585,000 patient education resources distributed

128,000 clinical resources distributed



14 Centers of Excellence in Environmental & Occupational Health



## Blue Ridge Community Health Services

Blue Ridge Community Health Services (BRCHS) began its partnership with MCN in 2012. BRCHS strategies for the Workers and Health program included:

- Improved identification of their migrant and seasonal farmworker patients
- Didactic trainings
- Changes in the electronic health records
- Inclusion of worker health in outreach efforts
- Patient Centered Medical Home approaches such as team huddles to ensure identification of farmworker patients and trends in diagnoses





## Health and Safety Concerns with Immigrant Nail Salon Workers

Claire Hutkins Seda, Writer, Migrant Clinicians Network, Managing Editor, *Streamline*

In May, the *New York Times* ran a pair of exposés on the working conditions of nail salon workers in New York City. Two articles published on the front page of the paper detailed the labor abuses and environmental hazards faced by the largely immigrant workforce. Within days, New York State government launched an investigation and organized a Nail Salon Day of Action to alert workers of their rights. In June, the New York State legislature passed regulations providing legal protections for nail salon workers, particularly for unlicensed workers.

In the recently-published “Identifying Health and Safety Concerns in Southeast Asian Immigrant Nail Salon Workers,” in *Archives of Environmental and Occupational Health*, researchers in Oregon present data that confirm what the news articles purport: nail salon workers are exposed daily to dangerous and unregulated chemicals that may gravely affect their health.<sup>1</sup> Their research builds on several other studies on the occupational health hazards of nail salons<sup>4-7</sup>

The researchers noted that hazardous chemicals like formaldehyde, toluene, and dibutyl phthalate (the “Toxic Trio”) are known to be present in nail polish, acrylics, gels, and solvents, to which nail salon workers are regularly exposed. Studies have found a correlation between long-term occupational exposure to such chemicals and a

laundry list of self-reported health problems like respiratory and neuropsychological issues. Other potential exposure risks are unknown; 89% of the chemicals used in the cosmetics industry have not been required to be tested for safety.

The researchers surveyed 65 Vietnamese nail salon workers in Oregon on their health, their workplaces, and their access to health information. Self-reported health issues included nose irritation, allergies, and skin irritation. Two-thirds reported their health as “fair” or “poor.” Study participants also reported inadequate ventilation and inadequate use of personal protective equipment (PPE) which may result in higher chemical exposure. Almost 50% of study participants lacked access to health insurance, which may also be a result of their workplace, as many nail salons do not hire their workers as employees but as independent contractors, who do not receive employee benefits like health insurance.

Study participants who reported low access to information like Material Safety Data Sheets (MSDS) and health brochures also reported low levels of knowledge on the chemicals with which they work, compared to participants who reported better access to information. Almost half of study participants were not familiar with MSDSs. Another barrier to information access is language. An estimated 45% of nail salon workers in the US are

Vietnamese immigrants and refugees; all of the Oregon study’s participants spoke Vietnamese as the primary language at home. ■

### RESOURCES:

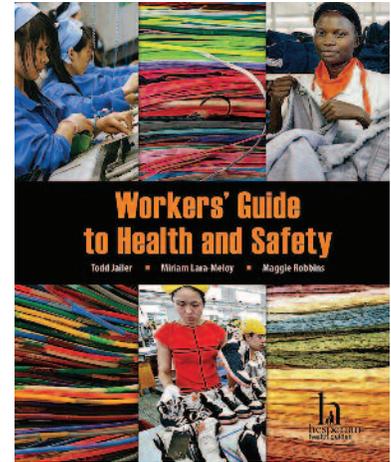
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## Hesperian Health Guides releases Workers' Guide to Health and Safety

In May, Hesperian released its latest resource, a 500-page guide for workers on occupational health and safety. The well-illustrated Workers' Guide to Health and Safety aims to empower workers in the garment industry, in electronics factories, and in other industries around the world, by providing easy-to-read information on electrical hazards, machine dangers, ergonomics, chemical use, fire, and more, along with information on "social hazards" like low wages, long hours, sexual harassment, and workplace violence. The book also covers specific illnesses that are common or exacerbated by factory conditions, such as tubercu-

losis and mental health. HIV in the context of worker health and safety is discussed as well. The guide features real-life stories, activities for workers to learn how to uncover and address workplace hazards, and an extensive chemical index to empower workers to better understand the risks of the chemicals they are handling.

"MCN is excited to see such a comprehensive resource on worker health and safety. It fills a very large gap in the popular education material addressing worker health," says Amy K. Liebman, MPA, MA, Director of Environmental and Occupational Health for MCN.



Visit Hesperian's website at [www.hesperian.org](http://www.hesperian.org) to learn more, view a sample chapter, purchase a book, or donate to have a book sent to a Workers' Center. ■

## US Worker Fatality Data Project expands understanding of workplace deaths

Claire Hutkins Seda, Writer, Migrant Clinicians Network, Managing Editor, Streamline

Worker fatalities happen every day. Workers in the US's most dangerous industries, like construction, fishing, and farming, account for a large percentage of the thousands of work-related deaths each year. But timely and updated information on these preventable fatalities is important for policy makers and health advocates to be able to quickly pinpoint trouble spots and promote policies to prevent future deaths. With this in mind, the National Council for Occupational Safety and Health (National COSH) has created the largest-ever open-access data set about US workplace fatalities — and they are calling for public participation in the project.

The US Worker Fatality Data Project website features an easy-to-use online form to report a workplace fatality in 2015, available in English and Spanish. It also has forms to report a death from work-related illness — a type of work-related fatality that often goes unreported. The group plans to offer form translations in Swahili and Portuguese soon. 2014's collected data is available for view as an interactive map, as a timeline, by industry or by state.

"The U.S. Worker Fatality Data Project is filling an important gap in our knowledge about workplace deaths," declared Mary Vogel, Executive Director of National COSH, in an email announcement earlier this month. "Our data is more current than the annual Census of Fatal Occupational Injuries released by the US Bureau of Labor Statistics

(BLS), which is now reporting deaths from calendar year 2013. Also, unlike BLS, our Data Project includes the names of workers who have died. This is a crucial step in telling the real story of the dangers inside US

workplaces, and making all of us safer in the future." ■

The database is viewable at <http://www.coshnetwork.org/fatality-database>.

MIGRANT CLINICIANS NETWORK



### Strengthen our collective voice.

As a network of clinicians and health advocates, Migrant Clinicians Network relies on interaction with our constituents to do our work. From *Principios de Salud Pública para Promotores*, our acclaimed webinar series, to Health Network, our bridge case management program, to publications like Streamline, we are working hard to assure that frontline clinicians are equipped to advance health justice for the mobile poor.

Please join the conversation and show your support.

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Migrant Clinicians Network  
P.O. Box 164285  
Austin, Texas, 78716  
Phone: (512) 327-2017  
Fax (512) 327-0719

E-mail: [jhopewell@migrantclinician.org](mailto:jhopewell@migrantclinician.org)

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## calendar

### September 1 APHA Webinar

Racism: The Silent Partner in High School Dropout and Health Disparities  
2 p.m. EDT  
[apha.org](http://apha.org)

### September 16 MCN Webinar: Fortaleciendo A Los Promotores de Salud Utilizando Tecnología De Información

<http://www.migrantclinician.org>

### October 14 MCN Webinar: Los Retos Futuros de la Salud Pública

<http://www.migrantclinician.org>

### October 15-17 2015 East Coast Migrant Stream Forum

Sheraton Memphis Downtown Hotel – Memphis, TN  
[www.ncchca.org](http://www.ncchca.org)

### October 23-24 4th Annual Rural HIV Research and Training Conference

Coastal Georgia Center, Savannah, GA  
[georgiasouthern.edu](http://georgiasouthern.edu)

### November 9-11 25th Annual Midwest Stream Farmworker Health Forum

Hotel Albuquerque – Albuquerque, NM  
[www.ncfh.org](http://www.ncfh.org)

### November 15-18 Interprofessional Collaboration to Improve Oral Health Access and Outcomes

Indianapolis Marriot Downtown, Indianapolis  
<http://www.nnoha.org>

### December 2-6 46th Union World Conference on Lung Health A New Agenda: Lung Health Beyond 2015

Cape Town, South Africa  
<http://capetown.worldlunghealth.org>

### February 24-26, 2016 2016 Western Forum for Migrant and Community Health

Portland Hilton – Portland, OR  
<http://www.nwrpca.org>