MIGRANT CLINICIANS NETWORK
MCN
streamline
Volume 29, Issue 3
Fall 2023

The Myriad Health & Safety Risks for Cannabis Workers

By Claire Hutkins Seda, Associate Director of Communications, Migrant Clinicians Network

In the remote forests of the far northwestern corner of California, dubbed the Emerald Triangle, the cannabis trimming season is underway. From September to December, migrant farmworkers from around the world cut the psychoactive flower buds from the cannabis plant for processing.

Cannabis in California is like no other agricultural product. The market has grown substantially since its legalization for recreational use in 2016. Market pressures and competition resulted in $5.3 billion in legal sales in 2022 – 8% lower than sales in 2021, yet still indicative of an agricultural powerhouse.[1] The health issues that arise for the workers who tend to and process the plants are different from other crops. "The fact that it's an illegal commodity at the federal level changes the landscape" for the health and safety of cannabis farmworkers, suggested Marc Schenker, MD, MPH, a longtime researcher on farmworker health with the University of California, Davis, and a member of Migrant Clinicians Network's Board of Directors. Cannabis farmworkers contend with stigmatization, deeply remote locations, frequent utilization of firearms on-site for security, a vastly different farmworker profile, temporary and unconventional living conditions, physiological exposures, structural violence, race- and gender-based discrimination, and wage theft. Earlier this year, Dr. Schenker joined Xochitl Castañeda, PhD, Founding Director of Health Initiative of the

continued on page 2

The Myriad Health & Safety Risks for Cannabis Workers continued from page 1

Americas (HIA) at the School of Public Health, University of California, Berkeley and also a member of MCN's Board of Directors, along with lead author Stella Beckman, PhD, MPH, and other authors, to publish a set of research articles based on interviews with cannabis workers, exploring these many issues that they confront. Here, we present some of the health concerns highlighted in their articles and in a recent interview with Drs. Schenker and Castañeda.

Physiological concerns: Cannabis workers have unique dermatologic, respiratory, and ergonomic issues. Cannabis is an allergen, and farmworkers experience contact dermatitis or, in more severe cases, systemic response. Like other farmworkers, they are routinely exposed to pesticides and other chemicals used during the growing and processing stages, and they suffer from ergonomic challenges like stooping and bending and working with pruners and scissors. High dust levels and air contaminants like mold contribute to respiratory issues among many workers. Much of the product is processed into oils, which requires a high-pressure volatile extraction, which can also be dangerous for workers if improperly performed or ventilated.

Work limits and training: Workers who were interviewed reported working long hours – sometimes "13 hours a day for six to seven days a week, for three months," Dr. Schenker noted – increasing the risk of physical injury and psychological stress. To prevent injury and preserve well-being, "you need a shorter workday, and you [shouldn't] work seven days a week, and yet none of those controls exist," he added. Further, workers are eager for increased hours to make more money, and many embody a viewpoint that their bodies can handle it. "Health and safety regulations should apply to these workers, like mandatory rest breaks and limits [on] the hours per day or days per week, and health and safety training," Dr. Schenker emphasized. "None of our subjects reported getting any training in health and safety."

Farmworker profile: "Ten years ago, [cannabis workers] tended to be more hippies, more Europeans. Now, there are waves of Latinos," in addition to other ethnic groups, including Hmongs and Thais, noted Dr. Castañeda. With few training opportunities in place, it is unlikely that culturally and linguistically appropriate communications and accommodations are available, which may limit workers' ability to communicate with supervisors, over issues such as health, safety, rights, and wages. It may also lead to misuse of tools and pesticides when communication on use and labeling is not in their preferred language.

Living conditions: Many workers live in their cars or in tents, unprotected from the elements. In the fall, large uncontrolled wildfires often bring smoke to the growing region, with most farmworkers not getting reprieve from smoke inhalation even at night after work. As climate change progresses, said Dr. Castañeda, this danger will occur more frequently. In the winter, workers lack heating, and inhale fumes from kerosene or propane heaters used in place of cleaner indoor heaters.

Firearms and concertina wire: More than half of cannabis cultivation is still conducted illegally despite legalization. Farms that are operating legally may still "work in the gray, or even in the black markets," noted Dr. Castañeda. Coupled with its very high value, this explains some of the defense efforts that some farms undertake, which may increase injury risk for workers. It also instills fear in the workers, who may decline to speak up about workplace conditions or wage discrepancies.

Wage theft: Dr. Castañeda shared that workers take on the risk of the market, which may reduce or eliminate their wages. "If the owner doesn't sell the crop at the price they thought because they are competing with others, the workers have to absorb [it]," explained Dr. Castañeda, a situation that the researchers found on some farms. If the owner sells at a higher price, however, those profits are not distributed to the workers. "What can they do? There are guns — you are not paid," she said. "When we asked, what is your biggest fear working in this industry? Two things: not being paid and being deported."

Gender- and race-based discrimination: The fear of deportation emphasizes the immigration-status power dynamic that exists on farms. "There's a lot of racial discrimination that has been documented in other parts of the country [that] also grow cannabis," she said. "The owners are white – they live in the facilities, and the trimmers and other workers live in tents," she added, by way of example. Dr. Castañeda also noted that facilities can be inappropriate or unsafe for women. As in many agricultural settings, women experience sexual harassment and/or feel unsafe in the environment. They additionally face challenges addressing their basic needs: "There is no running water, so they were saying, 'I'm on my period. When am I going to take a real shower?'" she recounted.

Remote locations: Should any worker wish to seek treatment, they cannot, as

continued on page 7

Dictionary of Terms

Cannabis: Any part of the *Cannabis sativa* or *C. indica* plants

Marijuana: There are varying definitions of the word, leading researchers to prefer the clearer term "cannabis." "Marijuana" is often used synonymously with the term "cannabis." The term is also used to refer to the psychoactive parts of the *Cannabis sativa* or *C. indica* plants that contain high levels of THC, namely, the flower buds and leaves.

Cannabinoid: The chemical components found in cannabis. THC and CBD are the two primary cannabinoids. Data indicate that cannabinoids may help certain "rare forms" of epilepsy, reduce nausea in cancer patients, and reduce appetite loss and weight loss in patients with HIV/AIDS. There is some evidence it may help with chronic pain and multiple sclerosis symptoms. Read more on this National Institute of Health page: https://www.nccih.nih.gov/health/cannabis-marijuana-and-cannabinoids-what-you-need-to-know

THC: Tetrahydrocannabinol, the cannabinoid in cannabis that causes a "high."

CBD: Cannabidiol, a cannabinoid in cannabis that has been used therapeutically, but without the altered mental state of THC.

Hemp: *Cannabis sativa* plants with very low levels of THC. These plants are federally legal.

Addressing Adverse Childhood Experiences (ACEs) and Toxic Stress

By Pamela Secada-Sayles, MPH, Program Manager of Witness to Witness, Migrant Clinicians Network

Childhood is a crucial period of development, shaping an individual's physical and mental health throughout their life. However, for some children and adults, their early years have been harmed by adverse childhood experiences (ACEs). ACEs encompass a range of traumatic events during childhood, such as abuse, neglect, household dysfunction, and other forms of adversity. Research has shown that children who have experienced a high number of ACEs and do not have secure, trusting relationships with parents or caregivers to help buffer these experiences are at an elevated risk of developing chronic physical and mental health conditions, including depression. When the effects of ACEs add up over time throughout life, individuals can develop toxic stress. It is important to highlight that not all stress is bad. Stress is a natural response, and it signals our bodies to prepare for a perceived threat. However, when a child experiences prolonged, strong, and frequent adversities, toxic stress occurs. Toxic stress from ACEs can change the brain's stress response system and have lasting negative effects on health and well-being well into adulthood.

Research shows that some groups are more likely to experience ACEs than others. Black and Latinx youth experience greater numbers of ACEs compared to white youth.[1] Agricultural worker communities also face unique challenges that may increase the risk of ACEs, including low wages, long working hours, exposure to harmful pesticides, and lack of access to health care and education.[2] Unfortunately, ACEs are common, and the effects of these events can add up over time. The CDC reports that about 64% of US adults report having at least one type of ACE before the age of 18.[3] As the number of ACEs increases, the risk for negative health outcomes also increases. The need for early screening and intervention is evident and opportunities to mitigate the effects of ACEs do exist. Since depression often stems from ACEs, depression screening alongside ACEs screening can provide additional insight into a patient's well-being.

Screening for ACEs can mitigate toxic stress and improve health outcomes.

© earldotter.com

California has been at the forefront of ACEs screening and response and has been actively pushing clinicians to educate and screen for ACEs. However, for those who have been historically marginalized, disclosing childhood adversity and traumatic events can be difficult, making it critical for community health centers (CHCs) to be safe and non-judgmental spaces.

Migrant Clinicians Network served as an evaluation partner for the community-based portion of *Project NACES: Addressing ACEs and Toxic Stress in Farmworker Communities*. For the project, MCN partnered with Futures Without Violence, *Alianza Nacional de Campesinas, Líderes Campesinas*, and RAND, with funding from California's ACEs Aware initiative through the UCLA-UCSF ACEs Aware Family Resilience Network (UCAAN) pilot program. The aim of the project was to collaborate with agricultural worker leaders and two community health centers to address the health impact of ACEs and toxic stress in agricultural worker communities in California through ACEs education, screening, and response. This project underscored the significance of community-based organizations' (CBOs) involvement in educational outreach efforts that included working together with the community to build educational materials and resources. Trust in the health care system is crucial to address sensitive topics like ACEs and toxic stress. The agricultural worker leaders of this project played an important role in initiating trust with CHCs. As trusted members of the community, the agricultural worker leaders engaged in conversations and shared their knowledge about ACEs that acknowledged the community's culture, practices, and lived experiences. In non-agricultural worker communities, community health workers (CHWs) can engage their communities in the same way. CHWs are embedded in their communities, understand the challenges faced, and with training can be well equipped to engage in sensitive discussions around ACEs, which will lay the foundation for CHCs to continue the conversation and facilitate ACEs screening.

ACEs screening can help clinicians assess the risk of toxic stress and potentially reduce negative health outcomes. Utilizing CHWs and CBOs to build educational materials and resources can transform the way communities think of ACEs. Resources to aid clinicians in understanding, screening, and managing ACEs include the Centers for Disease Control and Prevention (CDC) and the California's ACEs Aware Initiative. ■

Resources:

To learn more about ACEs, please visit https://www.cdc.gov/violenceprevention/aces/index.html

To read more about California's ACEs Aware Initiative, please visit https://www.acesaware.org/

References:

1 Liu SR, Kia-Keating M, Nylund-Gibson K, Barnett ML. Co-Occurring Youth Profiles of Adverse Childhood Experiences and Protective Factors: Associations with Health, Resilience, and Racial Disparities. Am J Community Psychol. 2020;65(1-2):173-186. doi:10.1002/ajcp.12387

2 University of California, Merced and California Department of Public Health. Farmworker Health in California: Health in a Time of Contagion, Drought, and Climate Change. https://clc.ucmerced.edu/sites/clc.ucmerced.edu/files/page/documents/fwhs_report_2.2.2383.pdf

3 Centers for Disease Control and Prevention. Violence Prevention. Fast Facts: What are adverse childhood experiences? https://www.cdc.gov/violenceprevention/aces/fastfact.html

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,204,180.00 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Experts, Community, and Case Studies

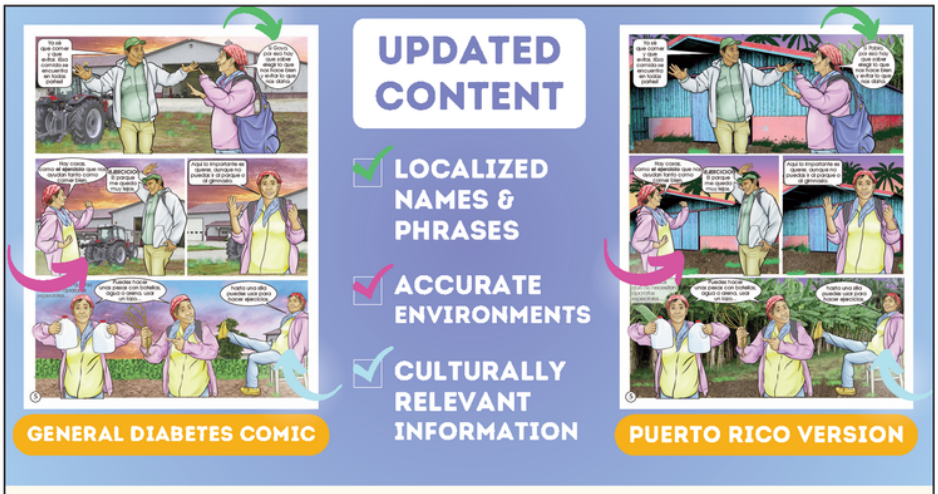
MCN's Diabetes ECHO Reduces Diabetes Burden by Supporting Community Health Workers

By Claire Hutkins Seda, Associate Director of Communications, Migrant Clinicians Network

Since 2018, Migrant Clinicians Network (MCN) has offered a Spanish-language series on Type 2 Diabetes for community health workers (CHWs), patient navigators, patient advocates, case managers, and outreach workers, who support the health of migrant and immigrant farmworkers, and factory, construction, and service industry workers. The six-session virtual series follows an ECHO model, a learning framework developed by the University of New Mexico that they call "all teach, all learn" – meaning, a highly participatory environment that invites the participants to share case studies and best practices, instead of leaning solely on an instructional, expert-centric approach. MCN's Diabetes ECHO was among the first Spanish-language ECHO in the nation, tailored to a critical member of the care team who frequently lacks access to expertise. "Most CHWs or *promotores* do their work within their communities, and rarely have the opportunity to speak with an expert, which may be even more true for those working in rural areas or in rural health centers," due to their remoteness, noted Martha Alvarado, Program Manager of Online Education and Evaluation for MCN. "To be able to access such expertise is really a gift that I'm sure a good majority would never be able to access with confidence and in the language that is most understood by them."

Just as critically, "the participants not only get to know MCN, but also each other," said Alvarado, who is the primary coordinator of the series and co-host alongside Lois Wessel, DNP, FNP-BC, an assistant professor at the Georgetown University School of Nursing and an active clinician serving migrants, immigrants, and refugees. "Let's say someone from a health center in Puerto Rico is struggling with a patient, we may have another *promotora* from Washington who is having the same issues. Participants compare notes and ask each other how to handle a situation or proceed with a patient." This collaborative learning process helps develop community and partnerships but also enables the spread of promising practices.

Additionally, Alvarado and Wessel, aided by expert guest speakers, provide participants with a deep clinical understanding of diabetes "so they can have that conversation with a clinician who is going to speak to them with [clinical] terms" in English, but also the duo gives them tools so they can talk plainly and



MCN's Diabetes Comic Book, Updated for Puerto Rico

Spanish speakers in the United States are not a monolith – and the population is changing. As of 2020, over 62 million people in the US identify as "Hispanic or Latino."[1] While people with Mexican heritage still account for more than half of this population, increases in immigration from Central and South America and the Caribbean have diversified communities around the country. For example, between 2000 and 2020, people of Venezuelan descent in the US grew 550%, a percentage that has continued to grow since then due to instability in that country. Over those 20 years, the number of people of Paraguayan, Honduran, and Guatemalan descent in the US each increased by over 300%.[2] An estimated 5.6 million people of Puerto Rican descent live in the US – compared to the 3.4 million living in Puerto Rico today.[3] This makes people of Puerto Rican descent the second largest population of Latinxs in the US, behind only people of Mexican descent.

Community health workers are tasked with building trust with and meeting the health needs of their diverse Spanish-speaking communities. Recognizing the need for more culturally attuned resources, Migrant Clinicians Network recently released a new version of the diabetes comic book, *Mi salud es mi tesoro* or My Health is My Treasure, redesigned to better reflect the culture and diet of Puerto Ricans.

Changes include name changes, emphasis on Puerto Rico activities and preferences, and brighter colors and Caribbean scenery throughout. Soccer is swapped out for dancing and basketball; a piñata is replaced with dominos; a coffee carafe becomes a moka pot preferred in the Caribbean. The food choices and sample menus have also been altered to reflect more typical Puerto Rican foods. Yucca, yams, and pumpkin are favored over corn tortillas; concha pastries become donuts.

"With the help of a cadre of Puerto Rican nutritionists and people living with diabetes, MCN carefully reviewed and adapted content and menus to reflect Puerto Rican conditions, language, and food practices so the comic book will be appropriate for people living with diabetes on the island. We aim for useful and resourceful educational materials, where the community feels identified and with concepts and words that make sense and are easy to follow," said Alma Galván, MHC, Director of Community Engagement and Worker Training for Migrant Clinicians Network, who oversaw the redesign along with Salvador Saenz, illustrator, Jose Rodriguez, MD, and MCN's Puerto Rico team. "Alianza Nacional de Centros de Salud Comunitaria, Inc. understands how useful this tool will be for CHWs in Puerto Rico — they will sponsor a printing so that all 12 health centers in Puerto Rico can use it. This will be a powerful tool for CHWs to help people better understand their diabetes and how to manage it."

Access the diabetes comic book's three versions, English, Spanish general, and Spanish Puerto Rico, on our diabetes comic book page: https://www.migrantclinician.org/resource/my-health-my-treasure-guide-living-well-diabetes-comic.html

effectively with neighbors and community members in Spanish, Alvarado said. The series presents strategies, information, and resources to bolster efforts to prevent diabetes, recognize cases, and support newly diagnosed patients. Topics include motivational interviewing, diet and lifestyle, diabetes among children and adolescents, diabetes and mental health, self-management of diabetes, diabetes during a disaster, and more, incorporating up-to-date research and strategies that are culturally relevant for and applicable to the wide range of Spanish-speaking communities across the country.

This year's ECHO Diabetes Series featured the most diverse group of participants yet, in terms of country of origin. Seven countries, along with the US and Puerto Rico, were represented by the 24 participants who provided information. In previous years, the participants were mostly from Mexico; this year, for the first time, Mexicans made up less than half. "I believe it's a reflection of the communities they serve," and a growth of the CHW model into more and more communities, said Alvarado. "Now, their communities have someone with knowledge, who can say, 'this is what you're experiencing, it could be this or that.'" Latin America is diverse; many communities have distinctive cultural and even linguistic differences over short distances, Alvarado added. To successfully engage a community in changing habits to improve health, she added, trust is critical. "And if you have someone who looks like you and talks like you, it will be easier to break through."

To match the diversity of participants, the ECHO series seeks a diversity of experts. Every week, the session includes experts from universities, government agencies, community organizations, health centers, or elsewhere, to answer questions, provide fresh perspectives and approaches, and complement the conversations of participants around the many aspects of diabetes affecting their community's health. MCN is seeking to expand its panel of diabetes experts. Please contact Martha Alvarado, malvarado@migrantclinician.org, to learn more about the opportunity to share your expertise during our 2024 Diabetes ECHO series.

Diabetes & Mental Health

Migrant Clinicians Network's Diabetes ECHO has one session exclusively dedicated to mental health. "Especially since COVID, I think many of [the CHW participants] have felt the weight of having to deal with the pandemic on top of the already difficult job of providing education and care to their communities," Alvarado said. Consequently, the session addresses not just mental health and well-being for their patients, but also for themselves. The session provides numerous resources and basic education, but also, a needed outlet, "to let them get all that off their minds in a healthy way that allows them to reflect and understand the emotions they are feeling and how to best address them," Alvarado said. Some of the key areas discussed:

Diabetes Distress: Anxiety, fear, frustration, sadness, exhaustion, and stress around the daily management of diabetes has its own name – diabetes distress. These emotions may arise when a patient has been trying to manage their diabetes but isn't seeing results or feels limited in life by their illness. Many factors may bring on diabetes distress: changing food choices, taking medicines daily, checking blood sugar levels, clinical check-ups, and shame are called out in the 2023 Diabetes ECHO training. The CDC estimates that during any 18-month period, 33 to 55% of people with diabetes will experience diabetes distress.[4] People experiencing this distress may turn to a CHW or outreach worker who is accessible to the patients, trusted by the community, able to speak in the language of the patient, and familiar with and considerate of cultural aspects of these health concerns, so these clinicians must be well equipped to respond with empathy and encouragement – and an action plan.

Two-Way Relationship: Depression, stress, and anxiety may impact an individual's ability to keep up with their diabetes management. Simultaneously, diabetes and related health issues and risks may increase anxiety and stress or worsen depression, leading to a two-way relationship between the two conditions. Additionally, the profile of people with diabetes who may struggle with depression is different from the overall population. About 17% of people of Latin American origin have diabetes in the United States, compared to just 8% of the white population. Certain heritages within the "Hispanic" umbrella are at even more risk. Puerto Ricans, for example, have significantly higher rates of diabetes.[5] While fewer people of Latin American origin report symptoms of depression compared to the overall population, depression is on the rise, particularly among young people of Latin American origin.[6] Factors relating to culture, immigration status, and acclimation may further increase risk of depression. Stigma exists around both depression and diabetes in many of these communities.[7]

Referring Patients for More Care: Participants are instructed to refer the patient to a mental health professional if:
1) There is any possibility of the patient harming oneself or others; 2) The patient ignores their diabetes self-management; 3) Stress is affecting the work-life-health balance; 4) Severe mental illness is apparent; and 5) There are signs of an eating disorder.

Self-Care: Participants are taught numerous tactics to relieve or manage stress that they can then share with their patients or use for themselves. Social support, community, and medication are strongly featured as key protective elements of mental health for patients with diabetes.

Diabetes during COVID: The series focused on the health needs of patients – but, necessarily, the mental health needs of the participants were also spotlighted. To be able

continued on page 6

References

1 Jones N, Marks R, Ramirez R, Ríos-Vargas M. Improved Race and Ethnicity measures Reveal U.S. Population Is Much More Multiracial. United States Census Bureau. 12 August 2021. https://www.census.gov/library/stories/2021/08/improved-race-ethnicity-measures-reveal-united-states-population-much-more-multiracial.html

2 Zong J. A Mosaic, Not a Monolith: A Profile of the U.S. Latino Population, 2000-2020. UCLA Latino Policy & Politics Institute. 26 October 2022. https://latino.ucla.edu/research/latino-population-2000-2020/

3 Noe-Bustamante L, Flores A, Shah S. Facts on Hispanics of Puerto Rican origin in the United States, 2017. Pew Research Center. 16 September 2019. https://www.pewresearch.org/hispanic/fact-sheet/u-s-hispanics-facts-on-puerto-rican-origin-latinos/

4 Centers for Disease Control and Prevention. Mental Health. Last reviewed 15 May 2023. https://www.cdc.gov/diabetes/managing/mental-health.html

5 Johnson JA, Cavanagh S, Jacelon CS, Chasan-Taber L. The Diabetes Disparity and Puerto Rican Identified Individuals. Diabetes Educ. 2017;43(2):153-162. doi:10.1177/0145721716687662 https://pubmed.ncbi.nlm.nih.gov/28112033/

6 Latinx/Hispanic Communities and Mental Health. Mental Health America. https://www.mhanational.org/issues/latinxhispanic-communities-and-mental-health

7 Washburn M, Brewer K, Gearing R, Leal R, Yu M, Torres L. Latinos' Conceptualization of Depression, Diabetes, and Mental Health-Related Stigma. J Racial Ethn Health Disparities. 2022;9(5):1912-1922. doi:10.1007/s40615-021-01129-x https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8432279/

Health Network Portal Seeks to Streamline the Enrollment Process

By Claire Hutkins Seda, Associate Director of Communications, Migrant Clinicians Network

Patients who will be moving before treatment completion can be enrolled by their clinician into Health Network to connect them with care at their next destination. Health Network provides virtual case management for migrating patients moving to any location in the world – but the first step is to enroll the patient.

Presently, to enroll a patient, clinicians complete a paper form and fax it to our Health Network team, followed by faxing medical records. Despite few advancements in the technology over the decades, fax machines continue to be the standard method of transfer of sensitive patient information because of its HIPAA compliance. Fax machines, however, have numerous downsides. Oftentimes, Health Network Associates report that faxes come through too dark or too light; only certain pages are transmitted; partial faxes are received; or the fax fails to transmit at all. Additionally, fax machines may be in public areas or areas not sufficiently protected from the public, which may lead to poor protection of patient information. Handwritten notes that are transmitted by fax are sometimes hard to decipher. E-faxes, while an improvement, have many of the same issues: "We still get phone calls saying, 'that fax didn't go through' – even if it's electronically sent," noted Saul Delgado, Migrant Clinicians Network's Health Network Data Specialist. "That's where the portal comes in." For the past three years, Delgado has turned his attention to building a HIPAA-compliant, easy-to-use interface for clinicians to enroll patients into Health Network that bypasses some of the problems with faxes. His efforts resulted in Migrant Clinicians Network's new Health Network Patient Portal.

Once a clinician creates an account, they can begin enrolling patients through the portal. "It's done through a workflow; it takes you step by step through what you need to fill out," Delgado said. Clinicians fill out a patient's information and complete the consent form, upload medical records, and then the process is complete. Clinicians have several options to submit the consent form. If the clinician would like to use a paper form, the portal guides the clinician to the Health Network webpage on MCN's website where they can download and print it. A photo of the completed form can be uploaded to the patient file. For those completing enrollment with the patient through the portal, the patient can e-sign the document within the portal, after which the clinician will upload the page into the patient's file. "When nurses go into the fields, they can take a tablet and enroll the patient through the tablet instead of a paper form that can get lost," added Delgado, increasing efficiency and reducing paper burden.

Health Network Associates receive an alert once an enrollment is submitted and can immediately call the patient to begin the work to connect that patient to care. If an enrollment is missing key information, Health Network Associates can also send out a request for patient records. "Once a nurse [or enrolling clinician] sees that request, they can go into the portal, look up that patient, and upload the records. They don't have to print out records or fax us – they can just get the notification, go in, and upload," Delgado said.

The Health Network Portal is currently in beta testing, with a small number of health center users, so Delgado can identify and correct any road bumps in enrollment. Currently, he is seeking clinicians who are willing to beta test the Health Network Portal with their patients. After gaining more users, Delgado plans to create training videos to further create a user-friendly experience for clinicians. If you would like to use the portal, please contact Saul Delgado for more information: sdelgado@migrantclinician.org.

Diabetes & Mental Health continued from page 5

A Honduran health worker uses MCN's diabetes comic book as an educational resource for patients.

to take care of patients, participants needed to take are of themselves. They reported that the COVID pandemic pressurized their work, with increased needs of patients; fears and reality of infection; the impact of the pandemic on the daily lives of community members from lockdowns, school closures, layoffs, and unsafe workplaces; the rapidly changing COVID situation matched by rampant misinformation among community members; and much more changed the dynamics of their relationships with community members and forced non-COVID health needs into the background. "It's been a struggle trying to do diabetes work within the dark shadow of the pandemic," Alvarado admitted, and COVID has necessarily been woven into the diabetes ECHO series. This was particularly apparent during the mental health session, where space was provided for participants to talk through frustrations around misinformation, patient denial, and the cutoff from patients during lockdown, Alvarado said.

Resources

The American Association of Diabetes Educators has numerous Spanish-language resources. Access all of them at:

https://www.diabeteseducator.org/living-with-diabetes/spanish-resources. Here are two provided during the training:

Diabetes y depression: Doble problema
https://bit.ly/3F6QQfb

Estrés: Un poquito para todos nosotros
https://bit.ly/3rFdulq

Health Network: Lost to Follow-Up

By Claire Hutkins Seda, Associate Director of Communications, Migrant Clinicians Network

Health Network Associates regularly provide case management that connects patients to needed and, at times, lifesaving care, that they otherwise would struggle to attain. Health Network Associates remove numerous barriers to care, finding and booking appointments for patients at health centers, helping them connect with services like sliding fee scales so they can afford their treatments, forwarding medical records to their new clinicians so their care can be continuous, arranging for transportation to the clinic, and more. Yet, at each step in the process, Health Network Associates encounter issues that, at times, result in a patient who is lost to follow-up.

Earlier this year, Norma Gonzalez, Health Network Associate, received enrollment forms from a health center on the East Coast for a 30-year-old Mexican migrant worker, Gabriela,* who had an abnormal pap smear. Gabriela's clinician on the East Coast had explained to her what her abnormal pap smear could mean, and the importance of getting follow-up care like a colposcopy. The clinician then filled out the enrollment form, including the consent form.

Unfortunately for Gabriela, the forms were incomplete. The forms had just one phone number for Gabriela and did not have additional contact details or an "anchor contact"— a relative or friend who is not migrating who can help get in touch with the patient should other contact attempts fail. The health center also failed to forward any medical records, which might have provided additional details on her whereabouts.

"I try to call, text, WhatsApp, and Google text," when patients are not responsive,

explained Gonzalez. WhatsApp, in particular, is a critical tool for making contact with patients. Some patients do not have a United States phone number; others do not have a data plan on their phone. WhatsApp circumvents some of those barriers. "That's where I get most of my contacts," she said. "Sometimes, since they have our information, we wait to get a message on WhatsApp. They might contact us with another number through WhatsApp," different from what is on the enrollment form. For Gabriela, however, the platform did not help. She did not respond to numerous calls or text messages on multiple platforms.

Gabriela's case emphasizes the importance of complete enrollment forms, particularly the anchor contact. Without an anchor contact or any additional information like a labor camp name or an emergency contact, Gonzalez was unable to do more for Gabriela. Her last step is to send Gabriela a final text message indicating that because she cannot get in contact with her, she is going to send the case to close.

"Sometimes they call us back" when that closing message is sent, Gonzalez said, who hopes this will be the case this time. "We provide all our information and contact numbers. Even if we close the case, we can reopen it if they contact us."

From January to August 2023, under 5% of cases were sent to close without an outcome. These cases may have lacked medical records, a signed consent form may have been missing, or the Health Network Associate did not receive sufficient response from the patient after multiple contact attempts. Health Network Associates pursue as many avenues of communication with the patient as possible, but even with culturally and linguistically attuned case management, technological advances, and the support of foundations and charities to remove barriers, some patients are still unable to continue their care. ■

Learn more about Health Network, access enrollment training videos, read other case studies, and explore Health Network programs: https://www.migrantclinician.org/our-work/health-network.html

* Names and identifying details may be generalized or altered to protect patient identity.

The Myriad Health & Safety Risks for Cannabis Workers continued from page 2

many of the farms are four to five hours from the nearest city. "Any emergency is hard to reach by medical care," Dr. Schenker added, noting that the remoteness multiplies the dangers. Cell service is limited or nonexistent, further isolating the farms. Some workers do not have their own vehicles, further complicating a timely and safe exit during an emergency.

The cannabis market is growing nationwide. Now, 23 states and the District of Columbia have legalized cannabis for recreational use, the latest being Delaware and Minnesota, which passed legislation earlier this year. With the growth of the legal market for cannabis, comes increased demand, which in turn may increase the number of workers experiencing these health and safety risks. Meanwhile, health research has not kept up. "Health and safety research is needed to understand the health risks and their prevention," Dr. Schenker said. ■

Read these recently published articles from Drs. Castañeda and Schenker on cannabis worker health:

Beckman S, Eastman Langer C, Schenker MB. A Pilot Study of Respiratory and Dermal Symptoms in California Cannabis Cultivation Workers. J Agromedicine. 2023;28(1):28-35. doi:10.1080/1059924X.2022.2141407

Beckman S, Castañeda X, Rivas L, Schenker MB. California cannabis cultivation and processing workers: A qualitative analysis of physiological exposures and health effects. Am J Ind Med. 2023;66(1):75-84. doi:10.1002/ajim.23442

Schenker MB, Beckman S. Cannabis Industry Worker Health and Safety: Time for Action. J Agromedicine. 2023;28(1):14-17. doi:10.1080/1059924X.2022.2148031

Beckman S, Castañeda X, del Rivero V, Chavez A, Schenker M. Experiences of structural violence and wage theft among immigrant workers in the California cannabis industry. J Agriculture, Food Systems, and Community Development. 2023;12(3), 127–140. https://doi.org/10.5304/jafscd.2023.123.014

References

Yakowicz W. California's Cannabis Sales Declined in 2022, The First Time Since Legalization. Forbes. 28 February 2023. https://www.forbes.com/sites/willyakowicz/2023/02/28/californias-cannabis-sales-declined-in-2022-the-first-time-since-legalization/?sh=391438077af9

Migrant Clinicians Network
P.O. Box 164285 • Austin, TX 78716

Non Profit Org.
U.S. Postage
PAID
PERMIT NO. 2625
Austin, TX

Acknowledgment: *Streamline* is published by Migrant Clinicians Network (MCN). This publication may be reproduced, with credit to MCN. Subscription information and submission of articles should be directed to:

Migrant Clinicians Network
P.O. Box 164285
Austin, Texas, 78716
Phone: (512) 327-2017
Fax (512) 327-0719
www.migrantclinician.org
E-mail: cseda@migrantclinician.org

calendar

November 13-15
PCA & HCCN Conference
Primary Care Association and
Health Center Controlled Network
Louisville, KY
https://www.nachc.org/conferences/pca-hccn-conference/

November 29 – December 1
East Coast Migrant Stream Forum
North Carolina Community Health Center Association
Winston-Salem, NC
https://bit.ly/3M2tPOv

December 6-8
COSHCON: National Conference on Worker Safety and Health
National Council for
Occupational Safety and Health
Baltimore, MD
https://nationalcosh.org/COSHCON2023

December 10-13
IHI Forum
Institute for Healthcare Improvement
Orlando, FL
https://events.ihi.org/forum-2023

December 14
Health Center Preparedness and Response Forum: Natural Disasters
National Training and Technical Assistance Partners, including MCN
Online Seminar Series
https://bit.ly/3RDtNjw