

streamline

The Migrant Health News Source

CAN-track—Bridging Care for Mobile Patients; Saving Community Health Centers Time and Money

Maria Rodriguez Galván* is a 47 year old migrant and seasonal farmworker from Central America. She picks vegetables and lives temporarily in various states along the east coast, moving from harvest to harvest. Last autumn, while she was picking tomatoes in Maryland, Maria participated in a breast cancer prevention outreach program organized by a local health department where she had a routine mammogram.

The health department wanted to make sure Maria received her test results and got the necessary follow-up care. The health department understood Maria's migratory life style and signed her up for the Migrant Clinician Network (MCN) program, CAN-track. CAN-track is part of the MCN Health Network, an initiative to provide bridge case management and continuity of care to mobile patients. Maria completed the two forms necessary to enroll her into CAN-track, one dealing with HIPAA consent and the other with contact information. The contact form always asks for the number of a relative or friend who is likely to know how to reach the patient. Maria received a plastic, wallet size MCN Health Network card and the outreach worker explained how the program worked.

Three weeks later MCN staff attempted to call Maria to see if she received her results and if she needed any follow-up care but her phone had been disconnected. MCN staff then called Maria's daughter, the contact person listed on the MCN Health Network form, to try to get a message to Maria.

When MCN staff called the daughter, Maria was there visiting. MCN staff asked Maria if she had received her results. She had and she told MCN staff that she was concerned because she did not understand them.

Maria's results were inconclusive and she needed another mammogram. MCN staff explained the results and stressed the importance of getting another mammogram. Maria said she knew she needed to make an appointment but did not know where to go. The town where she was staying with her daughter was very isolated. To help Maria MCN staff did the following:

- Located the nearest migrant community health center and made an appointment for Maria.
- Found transportation services to help Maria to the health center.
- Requested a copy of Maria's records from the Maryland Hospital, where she had the mammogram, and sent it to the health center. The first attempt to obtain the

records from the hospital failed because they had misspelled the Maria's last name. Using other identifying data on the MCN Health Network Consent Form, MCN staff helped the hospital locate the records.

- Reported back to the local Maryland health department that Maria received follow-up care. The health department needed this information to report to the CDC, as the department is participating in a program to minimize the number of patients they lose to follow-up.

All of MCN efforts for CAN-track were free of charge to the health department in Maryland and the health center in Florida. How much money does CAN-track save the health center and the health department? How much time would your clinic have spent if they had to find Maria and find her records? Would Maria have received her second mammogram? Would Maria have been another patient lost to follow-up? ■

Editor's Note

*MCN has assembled all three tracking programs, TBNET, Track II and CAN-track, under one umbrella called the **MCN Health Network**. This will allow clinics to participate in all three tracking programs by using standard forms and one time training. The **MCN Health Network** has developed an interactive Training CD in all three programs that allows clinics to download patient consent forms, HIPPA agreements and other material necessary to participate in any of the three programs. The Training CD also will allow clinics to train several providers at the same time and as a resource to be used for their new providers. There is no cost for the Training CD, and MCN staff will provide Technical Assistance to help providers design an effective implantation of the programs in their clinic.*

***MCN Health Network services and resources are available at no charge;** you may request resources, technical assistance or schedule a free training at any time by calling 512-327-2017 or e-mailing Andrea Kauffold (akauffold@migrantclinician.org).*

*Name is fictitious.

Tuberculosis on the Border and Beyond

By Jeanne Laswell, RN — TBNet Project Manager

MCN staff often get calls from clinicians asking what it is exactly that TBNet does, sometimes followed by, "But I thought that is what Cure TB does." And occasionally, "What about the Binational Card?" The answer to these questions is that TBNet, CureTB and the Binational TB Card are linked programs with the same goal: To assist mobile patients in treatment for tuberculosis to continue their treatment with each move they may make until they complete their course of therapy.

The need for programs that work with migrant patients is evidenced in the latest figures from the CDC. *Tuberculosis in the United States, 2003*, reported that although the number of TB cases decreased, there are still alarming trends. Fifty-three percent of all TB cases in the U.S. are foreign-born and the case rate among these persons is eight times greater than the rate of U.S.-born persons. In 2003, death rates from tuberculosis increased for the first time since 1989. (Kenneth Castro, MD, CDC)

Mobile patients are diagnosed with TB in a variety of different settings including migrant/community health centers, county health departments, immigration service processing centers, and homeless shelters. Once a patient has been identified as being someone who might move in the course of treatment, s/he should be enrolled in one of the three programs depending on where that patient is likely to migrant next. Cure TB is designed for patients moving to the interior of Mexico from any state except Texas. The Binational Card Project targets patients from the designated pilot sites in the United States or Mexico. While TBNet is for patients moving within the United States, to countries other than Mexico, or initiating treatment in Texas and moving to Mexico.

The need for comprehensive TB care is critical, particularly in the challenging environment of the border region. The U.S. and Mexico share 2000 linear miles of international boundary. According to the La Paz Agreement, the official border also extends 62.5 miles to the north and south of the actual boundary. It is the busiest crossing in the world with 43 ports of entry and 800,000 people crossing daily from Mexico to the US. There are four states on the U.S. side, six states on the Mexico side, and a combined population of 12 million people. Three of the ten poorest counties in the U.S. are on the border; the unemployment rate

along the U.S. side of Texas/Mexico is 250-300% higher than the rest of the country. Due to rapid industrialization, communities on the Mexican side of the border have decreased access to basic water and sanitation services than the rest of the nation. The health challenges in that area are enormous and include issues with funding, infrastructure, access, education, and environmental concerns.

So what do these border issues have to do with health facilities in Washington, Minnesota or Kansas? Because of the conditions of poverty, poor sanitation and crowding at border crossings, it is a breeding ground not only for garden-variety tuberculosis, but INH and multi-drug-resistant TB. Immigrants cross the border to seek economic opportunity that they don't have in their homeland and they rarely stay at the border. Most people move throughout the United States in the search for jobs. Infectious disease does not stop at the border.

TBNet, Cure TB and the Binational Card Project are designed to fit into this network of migration. An individual's "point of entry" into the health care system may be at an immigration service processing center near the border or at a county health department in Minnesota. Many people who cross the border and go north (or east or west) may



very well cross back while they are still in treatment to visit family or bring another family member across. Or they may join a migrating farmworker group and travel from state to state. Wherever their destination is, whether it is temporary or final, TBNet, Cure TB and the Binational Card Project are there to assist the patient in locating a clinic where they can continue treatment and have their medical records transferred.

For more information contact Jeanne Laswell at TBNet, 1-800-825-8205; Leticia Browning at the Binational Card Project, 619-692-8525; or Cure TB 619-542-4015. ■

National Women's Health Week

National Women's Health Week is May 8-14, 2005. In conjunction with this event, National Women's Check-Up Day will be held on May 9th to encourage women to use the many high-quality preventive care services available to them through the nation's health centers.

Many national, state and local organizations are getting involved. Front-line health care workers and communicators are uniquely positioned to play a key role in this important national health-awareness campaign. There are many ways to participate. You can host an event during the week of May 8-14 or become a Check-Up Day provider by offering women in your community free blood pressure checks, Pap tests and mammograms, diabetes and HIV/AIDS tests, and other critical preventive services

This event gives health care community yet another opportunity to increase direct health care services to all those most in need. Participating organizations will be listed on the National Women's Health Information Center Web site. Also free promotional and educational materials are available at <http://www.4woman.gov/whw> while supplies last.

National Women's Health Week was extremely successful last year, resulting in more than 1,000 events and health screenings in all 50 states. Please join again this year and help thousands of women take steps toward leading healthier lives.

Lead Poisoning Associated with Use of Litargirio – Rhode Island, 2003

Editor's Note: This article first appeared in the March 11, 2005 issue of MMWR Weekly (54(09);227-229)

Lead can damage the neurologic, hematologic, and renal systems.¹ Deteriorated leaded paint in older housing remains the most common source of lead exposure for children in the United States; however, other lead sources increasingly are recognized, particularly among certain racial/ethnic populations.² In 2003, the Rhode Island Department of Health (RIDOH) recognized litargirio (also known as litharge or lead monoxide), a yellow or peach-colored powder used as an antiperspirant/deodorant and a folk remedy in the Hispanic community, as a potential source of lead exposure for Hispanic children. This report summarizes a case investigation of elevated blood lead levels (BLLs >10 µg/dL) associated with litargirio use among two siblings in Rhode Island, the public health action taken, and a survey of

parents/guardians in three pediatric clinics in Providence, Rhode Island, to assess litargirio use. Findings underscore the importance of follow-up of elevated BLLs and thorough investigation to identify all lead sources.

Case Report

In May 2003, RIDOH and the Health & Education Leadership for Providence (HELP) Lead Safe Center investigated unexplained increases in BLLs in twin Hispanic boys aged 7 years (twins A and B). Annual BLL screenings for the twins since age 9 months were not elevated until June 2001, when twins A and B had elevated BLLs of 14 µg/dL and 15 µg/dL, respectively. Twin A's BLL increased to 42 µg/dL in May 2003, despite completed remediation of interior lead paint hazards in their home in June 2002 and of exterior lead hazards in May 2003, and provision of parental education about lead poisoning. Similarly, twin B's BLL increased to 26 µg/dL during the same period. In contrast, their younger brother's initial elevated BLL of 17

µg/dL in August 2001, at age 9 months, decreased to 8 µg/dL by November 2002.

In May 2003, RIDOH and HELP Lead Safe Center staff conducted a home inspection, which detected litargirio in a small glass jar in the bedroom of the twins, who used the substance as an antiperspirant/deodorant. The youngest brother did not use litargirio and had a separate bedroom. After the litargirio tested positive for lead by a sodium rhodizonate field test, all litargirio was removed from the home, and a sample was sent to the state laboratory for confirmatory lead testing. The litargirio sample contained 790,000 parts per million (ppm) (79%) lead. Follow-up BLLs decreased for twin A (27 µg/dL in June, 22 µg/dL in August, and 13 µg/dL in November) and twin B (22 µg/dL in June, 17 µg/dL in August, and 9 µg/dL in November).

The twins' visiting grandmother from the Dominican Republic had introduced litargirio into their home and also had

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Editor's Note

Litargirio is used in the manufacture of batteries, glass, and ceramics; in the vulcanizing of rubber; and as a paint pigment (3–5). Dominicans, particularly those from rural areas, use it as an antiperspirant/deodorant and as a traditional remedy for burns and fungal infections of the feet. This report, the first to describe lead poisoning associated with use of litargirio, demonstrates how a thorough investigation of elevated BLLs led to the discovery of litargirio, a previously unreported source of lead exposure.

Although deteriorated leaded paint in older housing remains the main source of childhood lead exposures, other sources should be considered, particularly when a child's elevated BLL does not respond to remediation of residential lead paint hazards. As described in this report, the BLLs of the twins' youngest brother decreased after residential lead paint hazards were remediated, but the twins' BLLs continued to increase, suggesting exposure to a different lead source. BLL elevations during or immediately after remediation or abatement are uncommon in Rhode Island because of strict control of the process.

Certain racial/ethnic populations at risk for lead exposure through use of traditional or folk remedies (6–9) might fail to disclose use of these products when asked about use of "traditional or folk remedies," rather than by product name. In this report, the twins' mother repeatedly denied use of "traditional or folk remedies" because she considered litargirio an ordinary product (i.e., deodorant), not a remedy. RIDOH now inquires specifically about use of litargirio when visiting Hispanic families of children with elevated BLLs.

Data regarding dermal absorption of inorganic lead compounds in humans is limited but reportedly substantially lower than absorption through inhalation or ingestion (1). Although litargirio was applied to the skin of these children, most of the product probably was ingested through hand-to-mouth behavior after contact with the product or with contaminated surfaces. Twin A, who had the higher BLL, sucked his thumb, supporting this premise.

The findings from the convenience survey are subject to at least two limitations. First, the survey sampled only persons seeking pediatric care at the three pediatric clinics; therefore, the results might not be generalizable to all Hispanic communities in Rhode Island. Second, health warnings about the use of litargirio might have biased participant responses and underestimated the prevalence of litargirio use. However, to minimize participant bias, Hispanic interviewers conducted the survey and collected no identifiers.

The survey results suggest that the prevalence of litargirio use in Rhode Island was minimal. Later attempts by RIDOH staff to purchase litargirio from botanicas or bodegas failed to locate any litargirio. Because of these findings, RIDOH took no further action. Conversely, in New York City (NYC), the NYC Department of Health and Mental Hygiene was able to purchase litargirio from five of eight botanicas visited in NYC after learning about the Rhode Island litargirio cases. One of the five litargirio samples tested contained lead (430,000 ppm [43%] lead). A public warning was issued, and botanica owners were required to remove all litargirio from their stores.

■ Lead Poisoning Associated with Use of Litargirio continued from page 3

given it to the family of their two female cousins, aged 1 and 5 years. In June 2002, the older girl had a BLL of 24 µg/dL, and the younger girl had a BLL of 32 µg/dL. Previous annual BLL screenings for the older girl were not elevated. In July 2002, after a home inspection revealed lead paint hazards, their parents implemented lead hazard control measures. However, the girls' BLLs increased to 29 µg/dL and 44 µg/dL, respectively, by January 2003. The older sister used litargirio sporadically until the family ran out of the product in January 2003, after which her BLLs decreased to 20 µg/dL in March, 15 µg/dL in April, and 7 µg/dL in November. Although the younger girl had not used litargirio, she shared a bedroom with her older sister and likely ingested litargirio residue on various surfaces through hand-to-mouth activity. Her BLLs also decreased to 33 µg/dL in March, 29 µg/dL in April, and 16 µg/dL in November after her sister discontinued using litargirio.

Public Health Action

Litargirio is available locally in botanicas (i.e., shops selling herbs) and bodegas (i.e., grocery stores) located in Hispanic communities. It is manufactured and/or packaged by laboratories in the Dominican Republic and sold in small, clear, plastic packets labeled "litargirio" (Figure). A litargirio sample purchased by RIDOH staff from a local botanica contained 360,000 ppm (36%) lead.

RIDOH issued a statewide health alert on June 30, 2003, warning the public to stop using litargirio and advising pregnant and nursing women and children who used this product to obtain a BLL test. The media provided coverage in both English and Spanish. RIDOH notified CDC and the Food and Drug Administration (FDA) about the litargirio cases and, on October 2, FDA issued a warning to consumers about litargirio. RIDOH

FIGURE. Packages of litargirio, a yellow or peach-colored powder, used as an antiperspirant/deodorant and a folk remedy in the Hispanic community.



Photo/New York City Department of Health and Mental Hygiene

notified the Dominican Republic Secretary of Public Health about the high levels of lead in litargirio imported from the Dominican Republic.

Survey

To assess litargirio use in the Hispanic community in Providence, RIDOH and CDC conducted a convenience survey of parents/guardians in three hospital-based pediatric clinics over a 2-week period (weekdays) during January–February 2004. Hospital A (a pediatric clinic and pediatric dental clinic) was surveyed during January 5–9 and 12–16. Hospital B (a pediatric clinic) was surveyed during February 9–13 and 17–20. All parents/guardians were approached to determine whether they were eligible for the survey (i.e., considered themselves Hispanic, were a parent/guardian, lived with a child, and were aged >18 years). A screening questionnaire was administered to 1,025 persons; 599 (58%) were deemed eligible. Of those eligible, 584 (98%) participated in the survey. Among participants, 157 (27%) had heard about litargirio; of those, 134 (85%)

were Dominicans. Among the 134 Dominican participants who had heard about litargirio, the majority (104 [78%]) heard about it as a tradition from their country of origin. Of the 40 participants with a personal or family history of litargirio use, 38 (95%) were Dominicans who typically used the substance while growing up in the Dominican Republic.

No Dominican participants reported current or recent personal use of litargirio. Furthermore, no study participant reported using litargirio before or after the health alert. No additional cases of litargirio-associated lead poisoning have been reported to RIDOH or CDC.

Reported by: D Silva, Health & Education Leadership for Providence (HELP) Lead Safe Center; J Tourangeau, St Joseph's Hospital Lead Clinic & HELP Lead Safe Center, Providence; R Aglione, M Angeloni, MBA, C Brackett, W Dundulis, MS, Rhode Island Dept of Health, Div of Emergency and Environmental Health Svcs, National Center for Environmental Health; N Reyes, MD, EIS Officer, CDC.

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MCN Announces the 2005 Unsung Hero

"Every year we get amazing nominees for our Unsung Hero Award. To be chosen from this outstanding group speaks volumes about the quality of work and dedication of that individual," says Jillian Hopewell, Director of Education for MCN. "The people who work day in and day out for those who need medical attention and have no way to get it are rarely recognized for the incredible work they do. It is nice to be able to honor that kind of devotion," adds Hopewell.

The Migrant Clinicians Network, the nation's oldest and largest clinical networks dedicated to the mobile underserved, established the Annual Unsung Hero Award in 1990 as a way to honor unrecognized clinicians in the field of migrant health. MCN is leading the effort to identify the changing face of the immigrant worker.

This year's Winner is Jerry Lewis, a Physician Assistant who has worked for Golden Valley Health Centers (GVHC) for 30 years. Jerry is dedicated to improving the health of patients by providing quality, pri-

mary health care services to people regardless of language, financial or cultural barriers in a major agricultural area of the Central Valley of California.

"It's a privilege working with someone so dedicated to his job and liked so well, not just by the patients but co-workers. We love him, and Golden Valley Health Centers is very fortunate to have someone like him working with the organization for so long," says Gloria Kohn, Medical Staff Coordinator Golden Valley Health Centers

Unsung Hero Award winners and nominees are distinguished by their demonstrated dedication to migrant health, participation in areas of migrant health care delivery, innovation in service delivery and prevention strategies, clinical leadership, and lack of previous recognition for their contributions to migrant health. Mr. Lewis will receive an all expense paid trip to the National Farmworker Health Conference in San Juan Puerto Rico, May 11 through 14th, 2005

For more information or a list of previous



Jerry Lewis

award winners please contact Jillian Hopewell at jhopewell@migrantclinician.org or 530-345-4806, or Michael Sullivan, CEO, Golden Valley Health Centers 888-484-2674 www.gvhc.org. ■

NEWSFLASHES

Clinicians Needed to Provide Input on the Links Between Chronic Disease and Environmental Exposures

Physicians for Social Responsibility, a national nonprofit education and advocacy organization, is working with CDC and Johns Hopkins University to talk to primary care doctors about their perspectives of the links between chronic disease and environmental exposures. Insight from physicians will be a helpful tool for the CDC as they work to develop and implement their Environmental Public Health Tracking Network (EPHTN). The EPHTN will be a national database that will offer the capability to compare non-infectious disease surveillance data with environmental quality data. Many of the links between the environment and human health are only vaguely understood, and the CDC hopes that the EPHTN will provide researchers, health care providers, and policy makers with the information to make our communities healthier. For more information

contact: Jenny B. Levy, Outreach Coordinator, Physicians for Social Responsibility, Environment and Health Program, (202) 587-5239, www.psr.org

FDA: Certain Soft Cheeses Create Health Risk

If you count Hispanics among your patients, make special note of a March 14 FDA health advisory: Certain soft cheeses made with raw milk are popular in the Hispanic community but can present a serious health risk to such high-risk groups as pregnant women, newborns, older adults and people with weakened immune systems. Raw-milk soft cheeses can cause infectious diseases such as listeriosis, brucellosis, salmonellosis and tuberculosis. Recent cases of tuberculosis in New York City have been linked to consumption of queso fresco-style cheeses either imported from or consumed in Mexico. The cheeses were contaminated with *Mycobacterium bovis*. FDA recommends that consumers not eat any unripened raw-

milk soft cheese from Mexico, Nicaragua or Honduras. "There is some risk of infection from a number of pathogenic bacteria for anyone who eats raw-milk soft cheese from any source," says the statement. Go to <http://www.fda.gov/bbs/topics/news/2005/NEW01165.html> to read the advisory.

Maternal and Child Health Library Services Available

The National Center for Education in Maternal and Child Health at Georgetown University has been awarded a cooperative agreement from the Maternal and Child Health Bureau, HRSA to continue its Maternal and Child Health Library (MCH Library) services. The MCH Library combines research and reference capacity with information technology to provide broad access to information about advances in MCH sciences and practice for health professionals, policymakers, program administrators, families, and educators. Visit their website at <http://www.mchlibrary.info>. ■



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calendar

National Farmworker Health Conference

May 12-14, 2005
San Juan, PR
National Association of Community Health Centers
301-347-0400
www.nachc.com

AAPA's 33rd Annual Physician Assistant Conference

May 28-June 2, 2005
Orlando, FL
American Academy of Physician Assistants
703-836-2272
www.aapa.org/annual-conf/index.html

Strengthening the Delivery of New Vaccines for Adolescents:

A National Stakeholders Meeting

June 2-3, 2005
Washington, D.C.
404-639-8209
egary@cdc.gov

Global Health Summit

June 5th, 2005
Philadelphia, PA
866-544-9677
www.globalhealthsummit.org

Health Equity and Diversity Conference

June 10-12, 2005
Toronto, ON
416-977-9871
www.healthequityanddiversity.com

American College of Nurse-Midwives' 50th Annual Meeting

June 10-12, 2005
Washington, DC
240-485-1800
www.midwife.org/meetings

2005 National HIV Prevention Conference

June 12-15, 2005
Atlanta, Georgia
787-876-8704
tsalud@caribe.net

Creating a Culture of Healthy Sexuality: Diversity and Dissemination

September 22-24, 2005
San Francisco, CA
770-541-9912
sash@sash.net

American Public Health Association

133rd Annual Meeting
November 5-9, 2005
New Orleans, Louisiana
(202) 777-2478
<http://www.apha.org/meetings>