

streamline

Up to the Challenges: Profile of Sue Hagie, NP

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

[Editor's Note: In 2015, Migrant Clinicians Network celebrated 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 two profiles are a part of this project. View all 30 profiles at www.migrantclinician.org/30-clinicians-making-a-difference.]

Summers on the Eastern Shore of Maryland are busy for Sue Hagie, NP. Until recently, she was the only nurse practitioner providing health care on the farms and at seafood houses for three counties, while the Choptank Community Health team with which she works had two and a half additional nurse practitioner positions for the migrant program that sat unfilled. Between June and August, she heads out, with an interpreter and sometimes a support staffer, to the camps to provide care for migrant workers across Maryland. "I cover 21 seafood houses, a couple of nurseries, a cannery, and the farms," she said, providing care for 39 sites in all. Including the driving—the northern camps require her to drive about 160 miles a day—she clocks in about 10 hours a day. "Then, I go home and I work on the scripts and complete the documentation." She then inputs all the information into the electronic medical record, as internet access is limited at the camps: "It's a long day."

EARLY EXPERIENCES

For the last several years, Hagie has tried to do the work that was once done by several providers. The lack of support, in the field and sometimes financially, is not new to Hagie. Previous to moving to Maryland, Hagie worked for the National Health Service Corps in a community health clinic located



in the Blue Ridge Mountains of Virginia, until a loss of clinic funding forced the clinic to downsize. That action nearly eliminated the community-based program. "Our staff... dropped from more than 20 workers to three. It was a wonderful clinic and they gave excellent care, but you need to have money to keep health care programs operating," she admitted.

The high level of need and the challenges in providing care are part of the appeal for Hagie. In speaking about the need for more migrant health care providers at Choptank, she notes, "If folks gave it a chance, I think they'd really love it. There's just no work I can think of where you can find more challenges than working with the migrant population. One just needs to enjoy variety and be flexible."

FARM OWNERS MAKE A DIFFERENCE

One of her biggest challenges is the issue of denied access to camps. One farm does not give Hagie and her team access to its camp at all, instead permitting the farm's workers to attend an off-site clinic which occurs once or twice a summer. Numerous attempts to provide transportation, and to work with the farm owner in advance to assure agricultural worker attendance, have resulted in limited success, she says. "Unfortunately, these are sites where there are older agricultural workers and ones having numerous chronic care issues, such as hypertension, heart disease, diabetes, asthma, hepatitis, and other chronic conditions," she said.

The schedule is hard on the workers. The workers arrive several hours late to the clinic, but have to return to the camp shortly thereafter—the owner requires them to be back by 9pm. "The workers start at 5 o'clock in the morning, and they haven't eaten by the time they arrive at 7:30 at night," Hagie explained. "We always provide food for them there, and it's a nice air-conditioned clinic, but they're dead tired. They fall asleep in the waiting room."

Additionally troubling is Hagie's inability to fit everything into the short time that she has. "You have almost an hour and a half to see 10 or 11 people with several chronic issues, acute issues, a bag full of pill bottles, they need blood work—it makes it very difficult," she admitted.

Continuing care is even more difficult. "If the patient needs blood work done, I am denied access to that worker by the farm owner to discuss his lab results and how to take any of the needed medications. It's a difficult situation that prevents the workers from receiving needed medical care," Hagie stated. "This is an ongoing issue where we have not had a very successful outcome. It's the type of occurrence that one would have

Dental Health with John McFarland, DDS

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

John McFarland, DDS was a young dentist preparing to open his first private dental practice in the early 1970s when he first heard about a job at a health center, housed in an old onion warehouse in the South Platte Valley region of Colorado. He took the job at the community health center, now called Salud Family Health Centers, thinking he'd work there for a few years, grow their program, and then begin his own practice. The dental clinic in the new center was serving a large migratory agricultural worker community with just one chair, two dental assistants, and Dr. McFarland. "About all you could do was provide emergency and acute services," he admitted. Forty-two years later, he's still there, a witness to the vast changes in his community and the responses of the health center. Now, he's the Director of Dental Services, and, under his leadership, the dental program has ballooned to 60 dental chairs, housed in nine different sites, with 15 dentists and 12 hygienists, serving 20,000 dental patients.

EARLY YEARS AND FIRST ENCOUNTERS WITH MIGRANT HEALTH

His middle class upbringing in Denver was followed by dental school at Northwestern in Chicago. After time in the military and a few years of travel, Dr. McFarland returned to Colorado. He had no experience with the migratory and seasonal agricultural workers living in his home state when he took the job at Salud. Shortly after being hired, he took a trip out to the fields, along with the medical director, to better understand the day-to-day lives of the clientele of the health center. At the time, the South Platte Valley was home to a thriving sugar beet industry, and, consequently, the vast majority of the health center's patients were migratory and seasonal agricultural workers from the beet fields. He and the medical director used the standard long pick with a short handle, the beet thinner's tool, bending over clumps of beets in the hot sun.

"The medical director and I lasted about an hour, because it was such demanding work. It was hot and it was difficult," Dr. McFarland explained. "Here were all these migrant and seasonal farmworkers, who were working very hard, contributing to the economy, all the things that we talk about in a cliché manner of putting food on the table, and really getting nothing from it in terms of basic services including education, health care, etc. When I saw that, I thought, 'This isn't right'... I was shocked."

Dr. McFarland calls it a sentinel moment:



Photo courtesy of Plan de Salud del Valle

"Where did I miss all of this, when I grew up in my middle class world?"

His patients and their everyday reality provided inspiration to Dr. McFarland, but he finds it difficult to single out one motivating patient story, over his long career. "There are so many stories of people in similar situations, living in horrible conditions and really just barely getting the basic necessities—including health care," Dr. McFarland said.

PROGRAMS AND PROGRESS

In 1972, the Colorado Health Department started a new program to have dental students join the health center during the summer. Over the years, the program has grown. "Virtually every student from the University of Colorado [School of Dentistry] rotates through us. We have a lot of students—plus we have the residency program," both of which expose dentists early into their career to the world of health centers, helping to break stereotypes about health center facilities and their patients.

Dr. McFarland chaired MCN's board from 1987 to 1991, and he saw the need to have a similar network for dentists and hygienists. In 1991, he founded the National Network for Oral Health Access (NNOHA), which he says he based off of MCN's structure. He chaired NNOHA's board until two years ago. "It's somewhat similar to MCN. It's a group that represents and supports oral health clinicians," Dr. McFarland said. "In the early days, we were just in the hundreds," of oral health clinicians focused on the underserved. Now, NNOHA counts around 3,500 dentists

and 1,500 hygienists in community health centers across the nation. There are roughly 5,000,000 community health center dental patients today.

MOVING FORWARD

Yet, those 5,000,000 dental patients are just 22 percent of the patients visiting community health centers. "We all have to be pleased with how much health centers have grown over these last 45 years," said Dr. McFarland, but he is frustrated that dental lags so far behind medical. Dr. McFarland's goal has been "to ensure that oral health is a part of the health center primary care model," he explained. "My idea of primary care done correctly is comprehensive care that includes medical, dental, and behavioral health."

Funding has stymied expansion of services. "Medical drives the bus," Dr. McFarland said. "Dental finds itself in the position where we have to fight and advocate to try to improve access to oral health care services."

Yet, he continues his work, embarking on his final years before retirement. He finds inspiration in his fellow health center workers, who share a common mission. "We're here because there's something that we think is worthwhile, and that is improving the health status of a lot of people, that if we weren't here, it wouldn't happen," he noted. "I am so lucky to have been involved with the wonderful people that I've been involved with in migrant and community health. I am proud of what we've achieved, but, boy, we sure have a long way to go."



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expected a hundred years ago, but not in the present day.”

Hagie emphasizes that the majority of migrant employers are fully supportive of the services Choptank provides, and welcome her team to the camps. “We work around their variable schedules and visit where they live, not disrupting their work time,” she explained. Just as farmers are across the map in providing access, they are diverse in the quality of housing they provide. Hagie recalls her first trip to a migrant camp in Virginia, with the state’s health department, to do check-ups on new mothers and their infants. “There would be a house, and 20 people living in it, and there would be no refrigerator or furniture at all, except for maybe a mattress in one room...where the mom and baby would be,” Hagie recalled. In some camps, “they have nice facilities, where they have a place for people to eat, [provide] dorm rooms, and [offer resources for] English as a Second Language...But then you go to the other places, where there are holes in the roof, [and] very deplorable conditions. It runs the whole gamut,” Hagie said.

MIGRANT HEALTH PLAN MAKES ACCESS EASIER

Hagie praises Choptank’s migrant health program for its yearly program with

migrants. “Each year, we charge a 15-dollar flat fee, and that covers my on-site visits to provide medical care, and the clinic visits,” she explained. Processing of the lab work is provided by Shore Health, a local lab and medical facility. Her migrant team delivers the medications to the patients within about two days, because travel to pharmacies is difficult. Hagie likes the strong link between her on-site visits and the clinic option; she encourages workers to go to the clinic for services she can’t provide, like dental care, or for urgent care between her visits.

To help address the increased need due to fewer migrant health care providers in the field, one of Choptank’s clinics extended its hours an additional hour and a half, one or two times a week, to see migrant workers, Hagie noted. Additionally, the community program hired an assistant to input information into electronic medical records, as double documentation was labor intensive. “One of the exciting new additions that we are hoping to try this summer is providing on-site dental exams and cleanings with our dental hygienists and mobile dental equipment,” Hagie added. “Dental care is a much-needed offering and it is difficult for the worker who has variable hours to plan three weeks in advance to go to an appointment. When

we offer care on-site to where they live, they put their name on the list and we fit them into the time that we have.”

PREVENTION AND FAIR TREATMENT

Hagie likes to emphasize prevention with her patients. “Prevention and lifestyle changes are an integral part of improving one’s health. It’s very satisfying to see the worker attempt those changes to improve his or her health,” she said. She tries to do her part by providing fair treatment to each of her patients. “A personal goal for me each day that I go to the camps is to try to manage to have the same energy level and interest in the last patient of the day as I had with the first patient who was seen,” she said. “It is a deliberate effort to make that happen.”

ACCESS AFFECTS AGRICULTURAL WORKERS’ HEALTH

Hagie finds that the health of the workers who she serves varies greatly. The agricultural workers, she says, come to Maryland sicker than the seafood, nursery, or cannery workers. “The people who are in the worst physical condition are the agricultural workers. Being here only three months, they can only access our care for three months,” she

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Needs Assessments, Step-By-Step with Health Outreach Partners

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

For health centers, a solid needs assessment is required as one of the 19 program requirements for community health centers funded by Health Resources and Services Administration (HRSA). It's also far more than just a requirement.

Health centers serving the underserved want to ensure they are responsive to the needs of their patient populations, explained Sonia Lee, MPH, Project Manager with Health Outreach Partners (HOP). Needs assessments are a huge opportunity to better understand the community and increase the health center's value to that community, Lee states—"but it's a big undertaking."

To assist organizations in developing, executing, and evaluating a useful needs assessment, HOP launched a needs assessment toolkit earlier this year. The toolkit fits with the nonprofit's greater goal to provide training and technical assistance to health centers, primary care associations (PCAs), and other community-based organizations, in an effort to increase access to care and other support services for communities around the country, Lee explains. The toolkit, HOP's corresponding webinars, and in-person assessment support have been very popular. "There's been a lot of need that we've been finding—and lots of interest in [the toolkit]," she says. "Some people think, 'Let's just do a survey' but I don't know how effective that is...The toolkit... offers a lot of structure," adding that it also offers some information about the HRSA health center program requirements on needs assessments.

"The toolkit has step-by-step processes, how to organize it, what you need to think about, how to collect the data, and what kind of options you have," Lee explains. "But it's an ongoing process and health centers should always be doing something to assure that they are responding to the needs of their population, because needs change."

Goals

The first—and most important—step is

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Excerpt from

Health Outreach Partner's Community Health Needs Assessment Toolkit

ABOUT THE TOOLKIT

This toolkit guides you through each step of the needs assessment process. The toolkit is organized into five sections. The first section, "Understanding a Community Health Needs Assessment," is intended to provide a foundation by defining a needs assessment, delineating the benefits of conducting one, and outlining the key steps in the process. The next three sections are organized by the specific steps for implementing a needs assessment:

- 1 Planning Your Needs Assessment,
- 2 Developing Your Data Collection Tools, and
- 3 Collecting and Analyzing Your Data.

The final section covers the different ways to share and use the needs assessment findings. Each section provides detailed information about the topic area, along with tools and resources. Additionally, real life examples of health centers and their needs assessment efforts are highlighted throughout the toolkit. These examples are taken from HOP's Innovative Outreach Practices (IOP) Database.¹ Whether you are starting from scratch in conducting a needs assessment, or are looking for ways to improve your existing needs assessment process, this toolkit serves as a comprehensive resource for your organization. Any section can also be used on its own, according to your specific needs. Although the sections of the toolkit are presented in a linear fashion, please note that the needs assessment process is more fluid. Each section of this toolkit contains information that can help to supplement or expand details in other sections.

TOOLKIT SECTIONS

1. Understanding a Community Health Needs Assessment
2. Planning Your Needs Assessment
3. Developing Your Data Collection Tools



Photo courtesy of Health Outreach Partners

4. Collecting and Analyzing Your Data
5. What's Next: Sharing and Using Your Findings Needs Assessment Toolkit

WHO THE TOOLKIT IS INTENDED FOR

This toolkit is intended for organizations and agencies that are striving to improve the health of underserved populations. The concepts, methods, and tools presented in this toolkit can be used by your organization to better understand and respond to the health needs of your communities. The toolkit can be used by:

- Health Centers
- Nonprofit hospital organizations
- Free clinics and other safety net providers
- Head Start programs
- Local and state agencies
- Other community-based organizations

Reference

- 1 The Innovative Outreach Practices Database is a resource to showcase the outreach efforts of health centers, and share practical ways to implement strategies, programs, and activities that have been proven effective in the field. <http://outreach-partners.org/2012/07/01/innovative-outreach-practices-report/>

The material presented in this portion of *Streamline* is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number U30CS09742, Technical Assistance to Community and Migrant Health Centers and Homeless for \$1,344,709.00 with 0% of the total NCA project financed with non-federal sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

developing a goal for the needs assessment. Lee encourages health centers to ask themselves: “What are you trying to find out, how you are going to use what you found out, and how is this useful to you and helpful to the communities you serve?”

“It’s tempting for people to skip this step,” Lee admits, but without a complete understanding of the goals, the whole program can quickly get out of hand. Refining goals is just as important. “It’s a big undertaking to conduct the needs assessment, so [many health centers] see it as an opportunity to do lots of things,” and the goal can get convoluted. “Narrow the focus, and keep... on task with the project,” Lee recommends. “It’s always good to be more specific and more focused.” With the goal in mind, the health center must establish a core team that can both assist in the development of the assessment and do implementation. The team should be a diverse group across departments, and may include board and community members, Lee says.

After the goal is laid out and a team is assembled, a complete and detailed timeline is developed, so the health center can lay out what kind of data they will collect, what methods they will use, and what tools they need to develop to collect that data. The center then needs to pilot their collection methods to make sure they are ready for use in the field.

Data collection

The second step is to get out into the community and collect data. Lee recommends creative approaches. In one health center’s needs assessment in which Lee assisted, the group interviewed the wife of a crew leader. “We hadn’t thought about speaking to the wife, but she’s the one that helps the agricultural workers with everyday stuff beyond work,” like helping agricultural workers get a bank account or buying a car. Lee also reminds health centers not to ignore secondary data, like previous needs assessments. “Don’t reinvent the wheel,” Lee advises. “If there is good information [in secondary data], don’t repeat it.”

For health centers who contract with HOP for in-person assistance, HOP requires high levels of engagement. “We as outsiders can’t go into the community to find who in the community to contact... It has to be someone on the ground. The health center has to use their community health workers, their outreach workers—they’re the ones really involved.”

Lee also warns that even with the best tools and outreach teams, data collection can be tough. “Imagine you’re out in the field all day and then we ask [you] to sit for an hour and do a focus group,” Lee offers. “It’s not impossible, we’ve done it—but it can be challenging to ask these groups for their time and participate in... focus groups, surveys, etc.”

Using the data

Lee estimates the average HOP-assisted needs assessment runs for about five months, but upon completion of the project, health centers then need to respond to the report. “The third step is what you do with your data,” Lee says. Here, once again, health centers may falter. “Lots of people do evaluations or assessments and they do these huge reports and then the report sits on the shelf, and that’s it,” Lee says. “Know how you’re going to use it—that needs to come into play at the very beginning. We have these goals, but what are we going to do with it afterward?” The resulting picture of needs in the community must inform the programs of the health center. If the health center is unable to adjust their programs to meet their community’s needs, Lee notes that the center can use the data as evidence of need when applying for grants or in other fundraising ventures.

Whether health centers contract with HOP for needs assessment assistance or just use their toolkit, Lee is confident that health centers can be successful, as long as they give it care and attention. “It’s a very dynamic and effective process, but you do have to plan it out,” Lee says. “Be intentional with what you’re doing.”

For the toolkit and additional HOP resources, visit <http://www.outreach-partners.org>. ■

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said. She finds the agricultural workers coming from Florida and Texas have more uncontrolled chronic health care needs. “They tell me that it costs more—they have to pay for their medications,” she noted. “If they have to pay for medications, many times they’re not going to get them,” even if care for a chronic condition requires regular medication. She suspects that many are coming from areas without an easily accessible community health center, and perhaps the combination of accessibility and transportation issues, with financial concerns, keeps these workers from care. Continuity of care is also a problem. “You’ll see these patients with two blood pressure medications of the same category, or they are taking other medications that should not be given together,” she noted, “because there is very little continuity” as they travel.

But such patients with overlapping issues are the most gratifying for Hagie, when she can make a difference. “I really like working

with the high-need patients, those who have several chronic conditions and acute problems. When you throw in the low income and the mobile status, that increases the

obstacles and makes it even more challenging,” Hagie admitted. “I like to see if we can make some positive outcomes occur—that’s very satisfying.” ■



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Trafficking and Migrant Agricultural Worker Women

Pennsylvania Migrant Health Outreach Workers Use Communication and Education to Combat Trafficking Ring

Earlier this year, one of the interpreters for migrants at Keystone Health Center's Migrant Health Program heard some disturbing rumors about migrant women being trafficked into prostitution. Mary Englerth, PA, the Pennsylvania State Director of the program and a Maryknoll Sister, was informed that these prostitution circles had been servicing the truckers at truck stops on the Pennsylvania Turnpike.

As Englerth dove deeper into the issue, she discovered that some of the prostitution circles have been coming to Pennsylvania migrant camps to offer their services to migratory agricultural workers. The majority of the prostitution circles coming to the camps, Englerth discovered, are from nearby states like New Jersey and Maryland.

Englerth was shocked. "I was [focused] so much on the farmworkers, I just wasn't aware of the extent of what is going on," she said. "It has dawned on us—we've all seen Maryland license plates in the camps," in previous years, even though none of the agricultural workers in the camps were from Maryland, she said. While a female sex worker offering services in the camps is not new, a more formalized and larger operation coming from out of state is a big shift, signifying a trafficking issue, said Englerth.

Partnering with local organizations

"I definitely wanted to do all that we could possibly do to help these women," Englerth emphasized. Keystone's large service area provides clinical care to thousands of migrant workers harvesting fruits, vegetables, and mushrooms, or working in packing houses, dairies, and poultry farms. But the migrant health staff hadn't done much in regards to the trafficking of the small population of women found in these agricultural settings—many of whom are not agricultural workers, but visitors. To better understand the breadth of the problem and to prepare to take action in her capacity as a program promoting health and well-being for migrants, she began to contact other organizations in the region.

She reached out to the Friends of Farmworkers in Philadelphia, which told her about a new partnership among several organizations working to secure a grant to address trafficking in Philadelphia, which is suspected to be the hub of trafficking circles in the region, said Englerth. She also met with Krista Hoffman, the YWCA Harrisburg's Human Trafficking Victim Services Coordinator at the time.

Hoffman provided Englerth with informational posters with phone numbers for women to call for help if involved in trafficking. "We use the turnpike a lot to go up to Erie," Englerth said. "We put those posters in bathrooms on the turnpike for the women to see."

She then began to get Keystone's staff informed on the issue. She invited Hoffman to present to the migrant health program staff in Adams and Franklin counties, as well as to other parts of the organization, like ER nurses and birthing staff. She participated in a number of meetings and coalitions focused on the issue in the region.

When summer rolled around and the migrant camps began to fill, Englerth and her staff stayed cognizant of the trafficking issues as they interacted with the few women they encounter on the farms. While they continue to provide the small population of female agricultural workers with domestic violence resources, they hope to add specific screening questions around trafficking in the future. For now, the staff has been asked to simply keep their eyes more open when visiting the camps, particularly for female visitors—not

just female agricultural workers—who may be victims. The staff members have a list of safehouses to provide to any women they encounter.

"We still haven't found the source of the [trafficking]," Englerth admitted, nor seen the out-of-state cars that may have belonged to the traffickers, but with apple harvest in full swing, new migrants have arrived and Englerth and her staff continue to watch.

"I think it's always been there, but I think it's more prevalent now," she concluded. With her staff's new attention to the issue, she says she is hoping to "make a good start to deal with these appalling situations." ■

Additional resources:

Trauma-Informed Care: Behavioral Health in the Primary Care Setting is MCN's webinar, archived from earlier this year: <http://goo.gl/8CeDJV>.

Rescue & Restore's Look Beneath the Surface is a valuable resource: <http://goo.gl/ZnjqbT>.

The National Human Trafficking Resource Center covers both sex and labor trafficking, and promotes their national hotline, 888-373-7888. <http://www.traffickingresourcecenter.org/>

Melissa Farley, of Prostitution Research, recommends reading their study of trafficked Native American women in Minnesota: <http://prostitutionresearch.com/2011/10/27/garden-of-truth-the-prostitution-and-trafficking-of-native-women-in-minnesota/>

The following is an excerpt from a presentation from Krista Hoffman, formerly of YWCA Harrisburg's Human Trafficking program, given to Englerth's team, to best serve migrant women and prevent human trafficking.

Sex trafficking:

- A person victimized through sex trafficking is a victim of sexual abuse.
- In order for it to be sex trafficking, the victim must have been abused in exchange for money, goods, debt forgiveness, or something else of value.
- Force, fraud, or coercion must be present unless the victim is a minor.

In the exam room:

- Patient needs to be examined alone.
- Always convey nonjudgment.
- Refrain from acting like you do not believe the patient.
- Talk to him/her about your concerns for her/his well-being.
 - ◆ "I have the feeling you might be in a situation that you don't have control of/ are being controlled."
 - ◆ "I can get you in touch with people who can help you."
 - Here is the number.
 - We can call them now if you would like.
 - I can give you a number.

Rescue & Restore, part of the US Office of Refugee Resettlement, suggests the following screening questions:

- Can you leave your job or situation if you want?
- Can you come and go as you please?
- Have you been threatened if you try to leave?
- Have you been physically harmed in any way?
- What are your working or living conditions like?
- Where do you sleep and eat?
- Do you sleep in a bed, on a cot, or on the floor?
- Have you ever been deprived of food, water, sleep, or medical care?
- Do you have to ask permission to eat, sleep, or go to the bathroom?
- Are there locks on your doors and windows so you cannot get out?
- Has anyone threatened your family?
- Has your identification or documentation been taken from you?
- Is anyone forcing you to do anything that you do not want to do?

Taking Care to a Higher Level: Integration of Behavioral Health

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

Not long ago, Scott Needle, MD, a pediatrician and the Chief Medical Officer at Healthcare Network of Southwest Florida, was doing a routine checkup on a teenager. “Things were good—it looked like he had a good relationship with the mother, he was doing okay in school,” and the teen appeared in good health, he noted. When the parent stepped out of the room for the physical exam, and the doctor and teen were alone, the teen asked, “Hey doc—did you get a chance to look at the questionnaire I filled out?”

Several years ago, Healthcare Network, headquartered in Immokalee, Florida introduced integrated care into their model. They decided to implement routine depression screening—which included that teen’s questionnaire. They also brought psychologists into the health clinic as part of the care team. Both changes were sought to better serve patients through more comprehensive care—and resulted in this teen’s appointment changing into something far from routine. When Dr. Needle reviewed the teen’s questionnaire, he found that “all of his responses were in the moderate to severe categories. [The questionnaire] asks things like, have you been feeling down? Have you been having trouble concentrating? Have you had trouble with sleep? And suicidal ideations as well,” Dr. Needle said. “Looking at him, talking with him—you would have never suspected.... We asked it, and that gave him permission to discuss something that may normally be considered ‘off limits.’”

At the conclusion of the physical, “we had him see the psychologist that day, right then and there, and we started a plan,” Dr. Needle continued. As part of the behavioral health revamp, psychologists are available in the health clinic for any patient who a provider feels could benefit from psychological care. Often, the provider can walk the patient right to the psychologist’s office for a “warm handoff.” The program identifies many children like the teen patient who need behavioral health care, and gets them into care, quickly: “If we hadn’t asked, we always wonder—what would have happened?”

Origins in academia, growth through community

Just five years ago, Healthcare Network’s behavioral health team was limited to one psychologist, Javier Rosado, PhD, from Florida State University, who focused specifically on



Photo courtesy of Healthcare Network of Southwest Florida

the migratory agricultural worker population. (About 22 percent of Healthcare Network’s patients are migrants.) “As the community became aware of the service and the need grew, clinic administrators realized the need for a chief psychologist to expand the program,” explained Emily Ptaszek, PsyD, ABPP, Healthcare Network’s Vice President of Operations and Director of Behavioral Health. Dr. Ptaszek initially took that role. Shortly thereafter, Healthcare Network was one of several partners in their community to share a three-year, three-million-dollar grant entitled the Beautiful Minds Initiative, aiming to increase access to mental health services for children in their community. The Naples Children and Education Foundation (NCEF) had recognized a dearth in behavioral health care for children in the community and sought to address it through the initiative. “Their funding has allowed us [the] several years that we have needed to figure out if

and how we can bill for services, [and] to get people on staff that can help us figure that out,” Dr. Ptaszek iterated. The goal isn’t focused on recouping expenses through billing, she said, but “to show sustainability via improved health outcomes, improved provider and patient satisfaction, and increased overall efficiency.” The funding focused on pediatrics, fitting with NCEF’s mission. In that first year, Healthcare Network also received a grant for integrated care expansion from Health Resources and Services Administration (HRSA).

Strong administrative support for the program complemented academia’s initial groundwork and NCEF’s and HRSA’s substantial injections of funds. Now, FSU runs the postdoctoral fellowship program; the fellows provide needed care to Healthcare Network patients, and are now also joined by five full time staff psychologists employed by Healthcare Network, said Ptaszek, adding that “they serve patients across Healthcare Network’s 19 sites and the program is fully supported and championed by the entire administrative team at Healthcare Network, which is so critical to its success.” The next step is determining how to make the program sustainable in the long run, when community funding ends. As Dr. Needle pointed out, “it’s constantly evolving.”

Integration at work in the clinic

Both Dr. Ptaszek and Dr. Needle happily report that the transition was virtually seamless, because staff recognized the import of the integration. “There were some growing pains—people are always being asked to do more with less—but it has been so glaringly apparent that this has been needed and is effective, that there really has been no push-back,” Dr. Ptaszek affirmed.

Dr. Needle contends that the model breaks the traditional mold of psychological care—for the benefit of the patient. Historically, a pediatrician may refer a young patient to a psychologist outside of the office, but not receive word on the patient’s progress. Did the patient end up taking the referral? How is the patient responding to treatment? Now, all questions are answered. “We can follow through. We routinely bounce things off of each other, and give each other new possibilities for care, particularly if things aren’t moving in the right direction for that child,” Dr. Needle

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Affordable Care Act: Assessing Agricultural Worker Access to Health Care

Alexis Guild, MPP, Farmworker Justice

[Editor's Note: Migrant Clinicians Network supports the advances in health justice that have resulted from the Affordable Care Act, which has increased the affordability of basic health care for many low-income Americans. However, as this article from Farmworker Justice's Alexis Guild points out, some of our most vulnerable populations continue to be shut out.]

As we enter the third open enrollment period (November 1, 2015 through January 31, 2016), the impact of the Affordable Care Act (ACA) on agricultural worker access to health care remains unclear. When asked about the ACA at a recent focus group in California, the *promotores de salud* in attendance had mixed reactions. Some praised the ACA for enhancing access to health insurance that many did not previously have. Others were disappointed that health care remained unaffordable even with health insurance due to high co-pays and deductibles.

During the summer, Farmworker Justice conducted focus groups with agricultural workers, *promotores de salud*, and community organizations to assess barriers to health care access in agricultural worker communities and the impact of the Affordable Care Act. The sentiments expressed by the *promotores* in California were echoed by numerous focus group participants across the country. At a focus group with workers in New York, a participant enrolled in a health insurance plan through the New York Marketplace noted the high co-pays, especially for prescription medications. A legal services organization in California expressed frustration about the complexity of applying for health insurance, especially for migrant and seasonal workers. Many workers who live near the border in California and Arizona prefer seeking medical care in Mexico, even though many have US health insurance.

Overview

Data conclusively shows that the national uninsurance rate has dropped in the past two years. Among Latinos, the uninsurance rate declined by 12.4 percentage points since 2013.¹ Yet the ACA's impact in agricultural worker communities is harder to decipher. The most recent insurance data for agricultural workers is from the 2012 National Agricultural Workers Survey (NAWS), prior to ACA implementation. According to the 2012 NAWS, 34 percent of agricultural workers had health insurance.² Future NAWS data should provide an

insight into the effect of the ACA on health insurance status. However, the NAWS is limited in its reach. Most notably, the NAWS does not survey H-2A workers, who are eligible to purchase health insurance in the Marketplaces and are liable under the ACA's individual mandate.

For now, the best picture of the ACA's impact in agricultural worker communities can be gleaned from observations on the ground. Over the past two years, Farmworker Justice has had numerous conversations with agricultural workers, *promotores de salud*, navigators, community stakeholders, and others about the ACA. Many agricultural workers will not be able to access health insurance due to immigration status, affordability, or exemptions for seasonal work under the employer mandates. Under the employer mandate, employers with at least 50 employees are required to offer affordable, comprehensive health insurance to full-time employees. However, there is an exception for large employers whose workforce is largely seasonal called the seasonal worker exception. More information about the employer mandate and the seasonal worker exception can be found on the IRS website.³ However, there is some good news. Some agricultural workers are enrolling in health insurance, many for the first time. The vast majority of those enrolled qualified for subsidies that greatly reduced the cost of health insurance. Anecdotally, many H-2A workers who enroll in health insurance, for example, pay less than \$25 a month toward their premium.

Enrollment barriers

Health centers, community organizations, and others have undertaken vast efforts to educate agricultural workers in their communities about the ACA, their rights and responsibilities, and the benefits of health insurance. Yet despite these successes, numerous challenges remain, both pre- and post-enrollment. Perhaps one of the greatest challenges is the application itself. Though envisioned as a simple and *streamlined* application, in reality the application is lengthy and complicated, especially for noncitizen applicants. Noncitizen applicants must provide verification of their lawful present status (i.e. green card or I-94 card). For those who do not have a US credit history, the only options to apply for coverage are by phone or through paper application. Some seasonal agricultural workers in the US on H-2A visas ("H-2A workers") have had to con-

tend with delays in coverage due to incorrect eligibility determinations based on their income and immigration status.

Due to its complexity, the best and most effective way to apply for health insurance is with the help of an assister. According to a recent Kaiser Family Foundation report, there were an estimated 30,400 assisters during the second open enrollment period. Community health center programs, which accounted for an estimated 25 percent of all assister programs, provided application support to 31 percent of Marketplace consumers.⁴ Unfortunately, there are not enough in-person assisters to help everyone eligible for enrollment, especially in rural agricultural worker communities. This is especially true outside of open enrollment in areas with large numbers of H-2A and migrant workers, who tend to arrive at different times throughout the year. These workers qualify for a 60-day Special Enrollment Period but educating and enrolling all of the recently arrived eligible workers is sometimes beyond the capacity of the health center's assister program.

Once enrolled, barriers continue

For those who successfully enroll in health insurance, navigating the US health care system can be difficult. Approximately 20 percent of agricultural workers and their families sought care at a community or migrant health center in 2014.⁵ Based on discussions with workers and *promotores de salud*, narrow provider networks, high co-pays and deductibles, and lack of familiarity with the US health care system discourage some agricultural workers from using their health insurance.

Migrants may not understand that, with health insurance, they may still be eligible for a sliding fee discount. In 2014, the Bureau of Primary Health Care released a Policy Information Notice (PIN) on the Sliding Fee Discount Program that clarified that patients with health insurance may qualify for the sliding fee discount if the amount they would qualify for under the sliding fee discount is less than their health insurance out-of-pocket cost.⁶ This policy is especially important for migrant workers who may be enrolled in health insurance.

Migrant workers enrolled in health insurance are less likely to utilize their health insurance due to the lack of health insurance

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explained. He may have insight into other medical conditions the child is struggling with, or the psychologist may have more information on the child's sleep habits. "That's the best part about this, that it really takes the care to a higher level than from two separate providers [who] weren't communicating," Dr. Needle enthusiastically concluded.

The program's attempt to integrate behavioral health into all areas of the clinic is unique—and critical, says Dr. Ptaszek. "None of us can do our job completely unless we're looking at the whole of the patient," admitted Dr. Needle. "If you're physically ill, it's going to impact your emotional state, and if you're having emotional distress, that's going to have physical effects on you. The two are intimately tied." But health care has traditionally split the two. With the integration, Dr. Needle finds that "we start to apply behavioral health to all aspects of care," going beyond the basic diagnosis and into "aspects of coping, stress, and outlook on life"—a more holistic approach. Dr. Ptaszek added that such an approach "seeks to focus on prevention with culturally appropriate intervention and education. FSU's research has been key, because it immediately translates into practice."

Dr. Needle pointed to Healthcare Network's behavioral health efforts for dentists. While outsiders might find the connection strange, dentists "might notice signs of abuse, or eating disorders, and they might not know what do with [certain informa-



Courtesy of Healthcare Network of Southwest Florida

tion], who to go to," noted Dr. Ptaszek. In addition to acting as an ongoing resource, behavioral health staff provided training to the dental providers on motivational interviewing, which was well received, she said.

Health benefits for patients and community

The benefits of greater integration, prevention, and early intervention are well documented, say both doctors. "Symptoms can cause biological changes, increasing subsequent risk," Dr. Ptaszek said. "But prevention does not just refer to prevention of subsequent episodes of an illness due to early identification and treatment; it also refers to identification of biopsychosocial factors that put that person, that community, that entire group of people at increased risk of poor health outcomes,

not just mental health outcomes."

From a public health perspective, "you are communicating to a population of people that these are the things we care about at this health care center, and it's safe to come and to expect all of these needs to be addressed," Dr. Ptaszek noted. "This prevention—it's not just lip service; it's key." ■

RESOURCES

Visit Healthcare Network of Southwest Florida's website at <http://www.healthcareswfl.org>.

Watch MCN's archived webinar, Trauma-Informed Care: Behavioral Health in the Primary Care Setting, and access further resources at <http://goo.gl/8CeDJV>.

Learn more about Naples Children and Education Fund's mission and model at <http://www.napleswinefestival.com>.

View health integration resources at the SAMHSA-HRSA Center for Integrated Health Solutions: <http://www.integration.samhsa.gov/>

■ Affordable Care Act: Assessing Agricultural Worker Access to Health Care

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portability. Few health insurance plans have in-network providers across state lines. Even within a state, the health insurance network may only be limited to a certain area or county. Anecdotally, few workers disenroll and reenroll in health insurance as they migrate with the harvest.

Looking ahead, these challenges may take years to resolve and new challenges will likely arise, especially with full implementation of the employer mandate in 2016. Fortunately, the dedication of health centers and community organizations to educate and enroll agricultural workers and their families remains strong. To support their efforts, Farmworker Justice developed materials including fact sheets for workers and service providers on the ACA, available in Spanish, English, and Haitian Creole. We also continue to work with agencies at the federal level to better facilitate agricultural worker access to health insurance and health care. The link to Farmworker Justice's fact sheets as well as other national resources can be

found below. For more information, contact Alexis Guild at aguild@farmworkerjustice.org.

Resources

Federal Health Insurance Marketplace: www.healthcare.gov. Resources can be found at marketplace.cms.gov.

Enroll America: www.enrollamerica.org

Get Covered America: www.getcoveredamerica.org

Center on Budget and Policy Priorities' Health Reform: Beyond the Basics: www.healthreformbeyondthebasics.org

Farmworker Justice: <http://farmworkerjustice.org/content/access-healthcare-0> ■

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MCN Celebrates a Stronger Worker Protection Standard

We are celebrating: The Environmental Protection Agency (EPA) has at long last revised the Worker Protection Standard (WPS), fortifying the rules that protect farmworkers in fields across the US. The newly released regulation, revised for the first time since 1992, will help reduce worker exposures to pesticides.

Migrant Clinicians Network has advocated for over 20 years for stronger worker protections and we commend the EPA for the much-needed and long-overdue revisions. We look forward to working with the EPA and our health justice advocates to assure speedy implementation and strong enforcement of the rule.

The strengthened Worker Protection Standard now includes:

- **Annual Training:** The EPA now requires yearly safety training for workers and pesticide handlers, rather than the previous five-year training cycle.
- **Expanded Training:** The training topics have expanded to include workers' rights, emergency assistance, and paraoccupational exposure prevention.
- **Grace Period Elimination:** Previously, a newly hired worker could begin work before being trained. We commend the EPA for eliminating this grace period, recognizing the occupational dangers of work without proper safety training.
- **Minimum Age for Pesticide Handling:** The EPA recognizes that children should not be applying pesticides and sets 18 as the minimum age for pesticide handling and early entry into restricted areas.
- **Worker Access to Information:** Notification of pesticide application must be posted in a central location. Importantly, workers can now designate another individual to access information about the pesticides used in their worksites.
- **Clinician Access to Information:** When an agricultural worker seeks medical assistance due to pesticide exposure, employers must promptly make available safety data sheets (SDS), product information and application information to medical personnel upon request to better facilitate diagnosis and treatment. In an emergency situation, an employer must promptly provide the SDS, product information (name, EPA registration number and active ingredient) and circumstances of exposure to treating medical personnel.
- **Respirator Fit-testing and Medical Evaluation:** Under the strengthened WPS, employers are required to comply with



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- **OSHA-equivalent standards on medical evaluation, fit testing, and training** whenever a respirator is required by the labeling.
- **Emergency Decontamination:** The new rules clarify the quantities of water that employers must provide for on-site hand and eye-washing stations for emergency decontamination after pesticide exposure.

What's missing

- **Medical Monitoring:** MCN is disappointed that the new WPS lacks medical monitoring requirements. We strongly contend that medical monitoring of pesticide handlers who mix, load, or apply Toxicity Category I or II organophosphates or N-methyl carbamates is an essential preventative measure. Monitoring programs have been successfully implemented for 40 years in California and over 10 years in Washington State. Moreover, the US Department of Agriculture requires medical monitoring of USDA staff dealing with organophosphates or N-methyl carbamates and the Department of Defense requires monitoring for personnel assigned to work in areas involving potential exposure to nerve agents. Medical monitoring is common in other industries and OSHA has promulgated over 25 specific standards for medical screening of workers exposed to hazardous substances.¹ Pesticide handlers deserve the same protections that are afforded to workers in other industries. MCN is concerned with the EPA's disregard for well-documented public health practices in the EPA's decision not to implement such a program nationwide. Medical monitoring programs are essential preventative measures. When

implemented accordingly, medical monitoring can stop handlers from being over-exposed by identifying subclinical evidence of exposure, prompting review of primary prevention practices.

- **Emergency assistance:** The EPA declined to clarify that providing 'prompt' transportation to a medical facility means that upon learning of an injury, employers should take immediate steps to obtain medical assistance.
- **Showers:** The EPA considered but decided against adding a requirement for handler employers to provide shower facilities onsite. "Take home" exposures could be reduced by requiring employers to provide their workers with onsite shower facilities and an area to change and store clothes.

Next steps

Now, we shift our focus toward the critical implementation and enforcement of these new rules through partnerships with the EPA and other organizations focused on health justice and farmworker rights. We look forward to working closely with the EPA to assure that farmworker and their families workers are protected from pesticide exposure.

Read the new WPS at the EPA's site: <http://www.epa.gov/agriculture/twor.html>.

Visit MCN's WPS page for more: <http://goo.gl/yY7E2v>.

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Excerpt from

Longitudinal Assessment of Blood Cholinesterase Activities Over Two Consecutive Years Among Latino Nonfarmworkers and Pesticide-Exposed Farmworkers in North Carolina

[Editor's Note: The following excerpt is from newly released research examining the effects of pesticide exposure over two growing seasons on agricultural workers who are not pesticide applicators. The researchers compared the agricultural workers' blood samples with those of workers in other industries who are not in contact with pesticides. The research is particularly notable because the two studied groups are relatively homogenous, outside of their profession. Additionally, very few longitudinal studies exist that examine pesticide exposure over two full growing seasons. The researchers found that "for total cholinesterase, farmworkers had almost fourfold greater odds of depressed cholinesterase activity in August, and one and a half greater odds overall, compared with nonfarmworkers." Cholinesterase-inhibiting pesticides may result in short- and long-term effects on the brain and nervous system. Please see the complete article for the authors' methods, including data collection and analysis.]

The following has been excerpted with permission from American College of Occupational and Environmental Medicine/Journal of Occupational and Environmental Medicine.

Quandt SA, Pope CN, Chen H, Summers P, Arcury TA. Longitudinal Assessment of Blood Cholinesterase Activities Over 2 Consecutive Years Among Latino Nonfarmworkers and Pesticide-Exposed Farmworkers in North Carolina. *J Occup Environ Med.* 2015; 57(8):851-7. PubMed ID: 26247638.]

SUMMARY

Objective: This study (1) describes patterns of whole blood total cholinesterase, acetylcholinesterase, and butyrylcholinesterase activities across the agricultural season, comparing farmworkers and nonfarmworkers; and (2) explores differences between farmworkers' and nonfarmworkers' likelihood of cholinesterase depression. **Methods:** Blood samples from 210 Latino male farmworkers and 163 Latino workers with no occupational pesticide exposure collected eight times across two agricultural seasons were analyzed. Mean cholinesterase activity levels and depressions 15 percent or more were compared by month. **Results:** Farmworkers had significantly lower total cholinesterase and

butyrylcholinesterase activities in July and August and lower acetylcholinesterase activity in August. Farmworkers had significantly greater likelihood of cholinesterase depression for each cholinesterase measure across the agricultural season. **Significance:** A repeated-measures design across two years with a nonexposed control group demonstrated anticholinesterase effects in farmworkers. Current regulations designed to prevent pesticide exposure are not effective.

INTRODUCTION

Exposures to cholinesterase-inhibiting pesticides, including organophosphorus and carbamate pesticides, place farmworkers at risk for immediate neurotoxic effects and may be linked to delayed effects, including neurodegenerative diseases and effects on children exposed in utero.¹ Although pesticide handlers are at the greatest risk for exposure and immediate health effects, field workers who do not routinely mix and apply pesticides are also at risk for exposure through drift and exposure to pesticide residues.²

Worker education as mandated by the US Environmental Protection Agency Worker Protection Standard (WPS) is designed to reduce pesticide exposures. Increasing use of pyrethroid and other pesticides that do not inhibit cholinesterase activities has been promoted. Despite these measures, studies of pesticide metabolites in farmworkers in the United States suggest that a significant number of workers are still exposed to cholinesterase-inhibiting pesticides.²⁻⁴ In addition to work-related exposure, most farmworkers live in substandard housing located near fields.⁵⁻⁷ Such housing has been found to contain residues of multiple pesticides that can further expose workers.⁸ These residues likely reflect drift or take-home pesticide pathways as workers bring pesticides into their residences, as well as the application of pesticides to try to control pest infestations.⁹

Monitoring cholinesterase activities of farmworkers can provide information on their exposure to organophosphorus and carbamate pesticides.^{10,11}

Currently, monitoring of cholinesterase activities is widely recommended for workers who mix, load, and apply pesticides. It is mandated in only a few states, such as Washington and California.¹⁰⁻¹⁴ There is no requirement to monitor agricultural workers who are not applicators.

We previously analyzed total cholinesterase activities obtained from dried whole blood samples in nonapplicator farmworkers in eastern North Carolina. We showed that cholinesterase activity was significantly lower later in the summer and that depressions in cholinesterase activity were related to the number of different organophosphorus and carbamate pesticide metabolites detected in urine.¹⁵ That study had several shortcomings, including cholinesterase data from just a single year; lack of a comparison group; no information on potential residential pesticide exposure; and cholinesterase obtained from dried whole blood samples, preventing differentiation of acetylcholinesterase and butyrylcholinesterase activities. This study was designed to remedy these shortcomings to more definitively assess evidence of work-related exposure to cholinesterase-inhibiting pesticides.

In this article we focus on data collected from Latino farmworkers in eastern North Carolina and a comparison group of Latino nonfarmworkers in occupations unlikely to expose them to pesticides. Blood samples were obtained through venipuncture across summers of 2012 and 2013, and self-reports of residential exposure sources were also obtained. Our objectives in this study were to (1) describe patterns of whole blood total cholinesterase, acetylcholinesterase, and butyrylcholinesterase activities across the agricultural season, comparing farmworkers and nonfarmworkers; and (2) explore the differences between farmworkers' and nonfarmworkers' likelihood of cholinesterase depression across the agricultural season, taking into account self-reported residential pesticide exposure.

DISCUSSION

Only a few studies of cholinesterase activities

The material presented in this portion of *Streamline* is supported by a grant from the Environmental Protection Agency, Office of Pesticide Programs, Grant # x8-83487601.

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in agricultural workers have included a control group; these studies are mostly conducted outside the United States and contain limited description of the inclusion criteria for controls.^{21,26} Choosing a suitable comparison group for Latino farmworkers in the United States is difficult. We attempted to find a comparison group that was unlikely to experience exposure by excluding workers in such industries as landscaping and by recruiting controls in a more urban area. Data were collected from these study participants on lifetime and current exposure using a published instrument.²⁷ The results establish that our intended differences in pesticide exposure between the groups are reflected in their reports of work and living environments.²⁸ Genetic variability may affect cholinesterase activities,²⁹ as well as pesticide metabolism.³⁰ Although measuring such variability was beyond the scope of this study, we included only individuals of Hispanic heritage from North, Central, or South America to try to reduce this unmeasured variability. The nonfarmworker group was more diverse in terms of country of origin. Recruiting controls from an urban nonagricultural area was an important consideration, as other research has shown that nonfarmworker controls recruited from the same rural villages as workers experience longitudinal patterns of cholinesterase activities similar to farmworkers, likely because of endemic pesticide exposure in the rural environment.²¹

Previous research by ourselves and others has shown that pesticide usage to control residential pests is high in the poor-quality housing inhabited by farmworkers, both grower-provided housing and that obtained in local housing markets.^{8,31,32} Although we did not measure pesticides in this housing, we used items that tapped both household and neighborhood exposure possibilities in the week before each blood sample collection. As expected, farmworkers, many of whom live adjacent to pesticide-treated fields, reported more potential exposure sources. Taking this into account attenuated some between-group differences in likelihood of cholinesterase depression, but some remained significant.

Farmworkers' risk of pesticide exposure is widely recognized, and the current WPS was published in 1992 to put in place measures to protect farmworkers and pesticide applicators. The WPS mandates training of farmworkers, so they understand pesticides they may encounter at work, the health risks pesticides present, and how to protect themselves from pesticide exposure through personal hygiene and use of personal protective

equipment which, for most field workers, consists of clean work clothes that cover extremities. The WPS also obligates growers to train workers, post information when pesticides are used, provide workers with access to field sanitation supplies (water, soap, and towels), and take steps to keep workers out of areas being treated with pesticides. The results of this study indicate that, despite the measures mandated by the WPS and some transition to nonanticholinesterase pesticides like pyrethroids, nonapplicator farmworkers are still being exposed to pesticides. This is corroborated by studies in farmworker populations throughout the United States documenting pesticide exposure through biomarkers,^{3,9,20} as well as studies that show that WPS training is not always provided to workers, that growers are often not in compliance with laundry and bathing facilities and provision of personal protective equipment for workers to be able to practice WPS-recommended protective measures, and that farmworkers' need to work leads them to accept such circumstances.³³⁻³⁷

Beyond laboratory analyses, the primary strength of this study is its design, which included repeated measures of cholinesterase activities over two growing seasons and inclusion of a control group residing in a nonagricultural area. Other studies have used repeated measures. Nevertheless, measures are sometimes taken at long intervals and many study participants have only a single measurement,¹¹ or the control group is likely also exposed to endemic agricultural pesticides.²¹

Neurotoxic cholinesterase-inhibiting pesticides continue to be used in agriculture, and farmworkers are exposed. Even low-level exposure may place individuals at risk for negative future health consequences. Farmworkers constitute a vulnerable population who, because of language barriers and economic pressure, may not understand their health risks or take steps to protect themselves. This study indicates that steps are needed to ensure farmworkers' workplace safety. ■

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Clinician Recommendations: Cholinesterase-inhibiting pesticide exposure

Clinicians may encounter agricultural workers who have been exposed to cholinesterase-inhibiting pesticides like organophosphates and n-methyl-carbamates. The following recommendations by Migrant Clinicians Network may assist clinicians in properly identifying and reporting exposures.

Know the pesticides

Organophosphate insecticides are some of the most toxic pesticides on the market.¹ They are used in agriculture, homes, gardens, and veterinary practices.² They have also been used to control mosquitos.³ N-methyl-arbamates work similarly to organophosphate insecticides in inhibiting cholinesterase enzymes; however, organophosphates have longer inhibitory persistence. Exposure to organophosphates or n-methyl-carbamates may occur as a result of inhalation, ingestion, or absorption from the skin.

Know the symptoms

Muscarinic symptoms include:

- Miosis
- Diaphoresis
- Salivation
- Lacrimation
- Urination
- Defecation

- Gastroenteric cramping
- Emesis
- Bronchospams and Bronchorrhea
- Bradycardia

Nicotinic symptoms include

- Diaphoresis
- Headaches
- Weakness
- Nausea
- Respiratory Paralysis
- Fasciculations

Resources for Clinicians

Cholinesterase Protocols and Algorithm

Migrant Clinicians Network, in association with AgriSafe and the National Farm Medicine Center, designed Cholinesterase Testing Protocols and Algorithm for Health Care Providers, located at <http://goo.gl/1Sh3HK>. We strongly recommend these two resources for clinicians in determining appropriate testing for their patients who apply cholinesterase-inhibiting pesticides.

Pesticide Exposure Reporting Tool

Clinicians are required to report confirmed or suspected cases of pesticide exposure in more than 30 states. Migrant Clinicians Network's Pesticide Reporting Map assists clinicians in reporting pesticide exposures.

Clinicians will find reporting requirements, contact information, and additional resources organized by state at <http://goo.gl/IgzHaP>.

MCN's archived webinars relevant to cholinesterase-inhibiting pesticides:

Nuts and Bolts of Cholinesterase Monitoring. <http://www.migrantclinician.org/nutsandboltsresources>

Pesticide Poisoning: Are you prepared? <http://goo.gl/3tDGXa>

The Environmental Protection Agency's Recognition and Management of Pesticide Poisonings Sixth Edition, available at <http://goo.gl/mDjSnR>.

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New publication highlights MCN's Clinical Assessment Tool

[Editor's Note: The following article recaps a *Journal of Agromedicine* article, online at <http://goo.gl/omDRRd>. Full citation:

Perla ME, Iman E, Campos L, et al. Agricultural occupational health and safety perspectives among Latino-American youth. *J Agromedicine*. 2015;20(2):167-77.]

Researchers evaluating Migrant Clinicians Network's Rapid Clinical Assessment Tool found the bilingual interactive tool addressing young workers and occupational-related conditions to be useful and effective. The findings, published in the August edition of the *Journal of Agromedicine*, and co-authored by MCN's Amy K. Liebman, MPA, MA, were based on surveys conducted with young, primarily acculturated Latino-American farmworkers in the Yakima Valley of Washington State.

MCN developed the assessment tool to help facilitate communication about agricultural hazards between clinicians and young workers. The tool features 20 illustrations depicting agricultural tasks that may result in occupational hazards, like lifting, climbing, and milking cows. The interactive tool's colorful illustrations are accompanied by the name of the task in English and Spanish. The user may hover over an illustration to prompt a short audio reading of the task in both languages; for example, hover over a picture of a man on a ladder picking an apple, and the tool vocalizes: "Cosechando fruta de arbol; harvesting tree fruit."

The majority of participants in the study found that the tool "made agricultural tasks easy to identify" (89 percent of respondents) and that "the overall tool was clear and easy to understand" (87 percent of respondents). Roughly three-quarters of respondents felt that the tool "made it easier to communicate with health professionals about work hazards, and that other workers would appreciate its use as well." The study's authors concluded that:

Although very few youth reported conversations about work with their clinical providers, a high proportion responded positively to ques-

tions regarding the use of the [clinical tool] for this purpose. Future activities to incorporate the [clinical tool] within a clinical setting are merited.

Migrant Clinicians Network offers the Rapid Clinical Assessment Tool as an interactive tool on the MCN website at <http://goo.gl/Rxn8S1>. Clinicians may also print the PDF version for use in the field at <http://goo.gl/a2BG8B>. ■



MCN Receives Susan Harwood Training Grant

This month, Migrant Clinicians Network (MCN) was awarded a Susan Harwood Training Grant for capacity building from the Occupational Safety and Health Administration (OSHA). MCN's project, Worker Safety and Health in Community Health Centers: A sustainable and integrative approach to immigrant safety and health, will target immigrant workers in hazardous industries, in both rural and urban areas.

Throughout the project, MCN will partner closely with health centers around the US and Puerto Rico to facilitate the integration of occupational health into the health center setting. MCN will utilize a train-the-trainer model to train community health workers (CHWs) to provide occupational health and safety education to immigrant workers. This

project will build capacity for occupational health at partner health centers and within MCN.

In year one, MCN looks forward to partnering with HOPE Clinic to serve nail salon, janitorial, and housekeeping workers in Houston, Texas, and with Hospital General Castañer to serve agricultural workers in Castañer, Puerto Rico.

The project will also launch a CHW webinar series that will kick off in March 2016. The series will highlight best practices in worker education for CHWs, on the topics of chemical safety, work-related asthma, and heat stress. The webinar series will also weave the theme of workers' rights into each lesson. In addition, MCN will offer a work-related asthma webinar designed

specifically for clinicians.

"This project offers an exciting opportunity for MCN to reach urban immigrant workers and we look forward to developing materials that are culturally appropriate and relevant for this rapidly growing population," said Juliana Simmons, MSPH, MCN's Environmental and Occupational Health Program Manager.

CONTACT

For more information on this project, contact Juliana Simmons, MSPH, Environmental and Occupational Health Program Manager, at jsimmons@migrantclinician.org or Kerry Brennan, Environmental and Occupational Health Program Associate, at kbrennan@migrantclinician.org. ■

Children Need Protection, Too: Celebrating National Farm Safety and Health Week

By Juliana Simmons

[Editor's Note: This article originally ran on MCN's blog to commemorate National Farm Safety and Health Week. Subscribe to our active blog to keep a pulse on the world of MCN, migrant health, health policies, current events, and issues on the horizon: <http://www.migrantclinician.org/community/blog.html>.]

September 20th to 26th was National Farm Safety and Health Week. While there is much to be celebrated in terms of advancements in farm safety, there is still much work to be done—particularly when over 100 children are killed each year on farms in the US from largely preventable incidents, as reported by the Childhood Agricultural Safety Network. Hundreds more are injured. These avoidable farm tragedies affect children and their families for life.

MCN is committed to improving the health and safety of agricultural workers and their families. Last year, in collaboration with the National Children's Center for Rural and Agricultural Health and Safety, MCN launched *Protecting Children While Parents Work*, a project which aims to engage agricultural employers, child care providers and farmworker parents to facilitate the availability of and access to services for children of migrant and immigrant agricultural workers. When affordable, high quality childcare options are available, farmworker parents are able to focus on the work at hand while knowing that their children are safe and cared for.

In a farm setting, both working and non-working children and adolescents are at risk for injury. Despite an overall decrease in agriculture-related injuries among youth, it is important to note that injuries among children under 10 years old continue to increase. For working youth under 16 years old, fatalities for youth working in agriculture remain higher than all other industries.¹

Cultivating a culture of safety is imperative when it comes to protecting youth who live, visit, or work on farms. Farm owners can play an important role in protecting their own children and the children of farmworkers. For example, they can connect farmworker parents with local resources, such as Migrant and Seasonal Head Start, to help keep farmworker children safe while



Courtesy of Healthcare Network of Southwest Florida

their parents work. Learn more about this project and all of MCN's environmental and occupational health initiatives at <http://goo.gl/OYiKyb>. ■

RESOURCES

Child Agricultural Injuries Fact Sheet, by the National Children's Center: <https://goo.gl/jNr7yD>.

Adolescent Worker Fact Sheet, by the National Children's Center: <https://goo.gl/y0JtYQ>.

Children and Safety on the Farm, by Penn State Extension: <http://goo.gl/o0sMQJ>.

The Children's Agricultural Safety Network: <http://www.childagsafety.org/>.

REFERENCE

- 1 National Children's Center for Rural and Agricultural Health and Safety. 2014 Fact Sheet: Childhood Agricultural Injuries in the US. https://www3.marshfieldclinic.org/proxy/MCRF-Centers-NFMC-NCCRAHS-2014_Child_Ag_Injury_FactSheet.1.pdf. Accessed September 23, 2015.



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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:

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calendar

February 24-26, 2016

2016 Western Forum for Migrant & Community Health

Portland Hilton – Portland, OR

<http://www.nwrcpa.org>

April 6-8, 2016

11th Annual Medical-Legal Partnership Summit

Hyatt Regency Indianapolis – Indianapolis, IN

<http://www.medical-legalpartnership.org>

April 21-24, 2016

20th Annual Conference

NHMA & Hispanic Dental Association

Renaissance Hotel – Washington, DC

<http://www.nhmamd.org>

April 29-30, 2016

LGBT Health Workforce Conference

Hunter College – New York, NY

<http://www.bngap.org>

May 10, 2016

21st Health Equity Conference

Hilton Minneapolis – Minneapolis, MN

<http://www.ruralhealthweb.org>

October 4-6, 2016

2016 Texas STD Conference

Renaissance Austin Hotel – Austin, TX

<http://www.dshs.state.tx.us>