

streamline

The Migrant Health News Source

New Developments in State Immigration Legislation

Virginia Ruiz, JD

The recent passage of state immigration laws has caused concern in immigrant communities and in some cases has resulted in fewer people accessing services. This article offers a brief overview of three state immigration laws and highlights the basic rights of immigrant workers and their families.

Following the path of Arizona, states eager to crack down on illegal immigration have begun passing their own anti-immigrant legislation that includes provisions mandating electronic verification of employment authorization and targeting undocumented immigrants by using state and local officials to inquire about their immigration status. This year Alabama and Georgia passed nearly identical legislation that would require all or most employers to enroll in the federal employment verification program and authorize local law enforcement to inquire about the immigration status of anyone they stop in the course of routine police work.

Highlights of New Immigration Laws

Specifically, Arizona's E-Verify law (HB 2779) became effective on January 1, 2008, with two key features. First, it authorizes the imposition of a business license penalty against any employer who knowingly or intentionally hires unauthorized employees after January 1, 2008. Second, the law requires all Arizona employers to enroll in the federal government's E-Verify program to confirm the work eligibility of all new hires. Arizona's SB1070 law requires law enforcement to verify the immigration status of any person arrested prior to their release, among other provisions. While the Supreme Court has found Arizona's E-Verify legislation constitutional, a federal court has halted core SB 1070 provisions.

Georgia's tough new immigration enforcement measure combines an Arizona-style policing measure with an E-Verify mandate, in this case for all but the smallest businesses in the state. Georgia's HB 87 requires



public and private employers with more than ten employees to enroll in E-Verify – they will not be issued state, county or municipal business licenses unless they do. As written, the policing provisions of HB 87 give local law enforcement officers authority to question anyone they stop who cannot provide identification proving his or her immigration status. In June 2011, however, a U.S. District Judge issued a preliminary injunction against two of the bill's provisions: the section that would require police to check the immigration status of suspects who cannot provide identification and the section criminalizing persons who provide transportation or housing to someone without legal immigration status.

The strictest immigration law came out of Alabama (HB26) and combines aggressive employer sanctions with policing measures. The bill contains many provisions similar to the Arizona legislation, such as mandatory employment verification for employers (it includes loopholes for domestic workers and employers using independent contractors) and requirements that local law enforcement verify immigration status during traffic stops. However, the bill goes even further by including requirements that public schools determine the immigration status of enrolled children and report it to state offi-

cial (federal law protects the right of all children to attend elementary and secondary schools) and a prohibition on undocumented youth attending post-secondary institutions. The police may also charge anyone "harboring" or "transporting" an undocumented immigrant with a crime. On September 28, a federal judge in Alabama allowed many parts of the law to go into effect, including provisions requiring school officials to verify the immigration status of enrolling children and their parents; allowing police to demand papers demonstrating immigration status or citizenship during routine traffic stops; and prohibiting the enforcement of contracts, such as rental agreements and child support arrangements, if any participant is undocumented, among others. Some significant provisions were temporarily blocked by the court's ruling, including those that would have criminalized the transportation of undocumented friends and family. The law is having an immediate impact on the state's residents with numerous reports of decreased school enrollment.

Immigration advocacy organizations have appealed the district court's decision.

Human Rights of Workers

In the wake of these immigration laws it is important to highlight the basic rights shared by all workers and their families:

- All workers are covered by wage and hour laws and are entitled to be paid for all hours worked
- All workers are covered by occupational health and safety law and are entitled to a safe workplace
- Any person in the U.S. is covered by emergency Medicaid, regardless of immigration status
- Without a warrant or your consent, law enforcement may only enter into a public area of a health clinic to question people they believe to be undocumented (see a fact sheet on the issue by the National Immigration Law Center, http://www.nilc.org/ce/nilc/imm_enfrmt_know_patient_rts.pdf) ■

Immigration, Access, and State Law: Clinics Describe New Barriers

By Jennie McLaurin, MD MPH and Andrew Provan, MSIII*

As MCN clinicians conduct training and technical assistance projects around the country, we have opportunities to discuss local challenges faced by our fellow clinicians. In June, Dr. McLaurin taught several Hispanic health workshops in Alabama and Florida. The news of the moment was the passage of Alabama's restrictive immigration legislation, making it a crime to transport, house, or employ undocumented immigrants. Despite Supreme Court rulings that assure all children a public education, regardless of immigrant status, Alabama's law calls for documenting the immigration status of all children, which has had the effect of frightening many parents into keeping their children out of school altogether.

Clinicians at those June trainings were overwhelmingly in favor of treating all people who needed care without regard to immigrant status. However, they were unaware of supports and protections already in place for their clients, such as the regulations prohibiting immigration enforcement agents on healthcare facility grounds, assuring children a right to education, and allowing victims to report violence or abuse without fear of immigration enforcement. All clinicians requested assistance with patient education that would convey that health centers were safe havens.

In order to better understand the impact of some of the immigration policies on the provision of migrant health care, we asked personnel at fifteen migrant health clinics in the states of Alabama, Arizona, and Georgia to confidentially respond to a brief on-line questionnaire. Seven centers responded with all three states represented. Questions are listed here:

1. What is your position at the center?
2. How long have you been at this center?
3. What state are you in?
4. What education has center staff received on immigration laws and health?
5. What has your center done to assure immigrants of care?
6. Do you ask patients for a Social security number?
7. Do you ask patients for documentation status?
8. Have you encountered specific examples of patient care being affected by immigration laws in your state?

The questionnaire was introduced to the center personnel through email contact by Andrew Provan, a third year medical student doing elective work in migration health. Though we asked for respondents to be clinicians, the administrative personnel receive-

ing the email generally answered the questions and did not forward the questionnaire. All seven respondents desired further assistance in assuring health access to immigrant patients and expressed concerns over present obstacles faced by their clients.

Respondents averaged ten years of experience at their sites. Only one center had any formal training for staff related to immigration and health care. All but one site noted a decrease in healthcare access by migrant and seasonal workers in their area. They attributed the decrease to fear, a sudden exodus of workers due to new immigration laws, stress on the families, and increasing difficulty in providing transportation. For example, a Georgia center stated it now only transports six passengers in its fifteen passenger van so that it avoids the possibility of being subject to immigration documentation requirements of commercial carriers. Another Georgia site completely ended transportation services. Church and social service vans are facing similar restrictions.

Outreach is increasing in all respondent sites as a mechanism to assure services. Mobile dental and medical units are used in the community and in camps. Outreach workers report that people are waiting longer to seek care and they are also intermittently leaving the state to seek care in neighboring states. Georgia personnel reported that migrant and seasonal farm workers have resorted to living in the woods in order to avoid immigration authorities. Local churches have been providing food and support to these hidden families.

Centers were evenly divided on whether they required Social Security numbers of their patients. While banks advise all Americans to avoid supplying Social Security numbers to non-employers, the practice is widespread and often linked to medical record requirements. Digital photos of patients are also on the rise and may be problematic in terms of trust.

This article outlines the new barriers reported by a few personnel at migrant health center clinics in key states where immigration laws have been implemented. It confirms our concerns that state-level immigration issues are impacting health center care in multiple and negative ways. Patients avoid care when they are unsure of their rights to access and when enabling services such as transportation are withdrawn. Health center personnel are well intentioned but lack clear guidelines, resources, and staff education about how to provide care in a

socially oppressive culture. Much of the community advocacy work that set migrant and community health centers in motion in the 1960's must be relearned by today's health center boards and staff in order to promote social justice for the mobile and immigrant populations.

Going Forward

Despite current restrictions impacting care, clinicians may improve access in a number of ways. Here are several suggestions for centers to begin a quality improvement process related to patient access concerns:

- Provide posters and signage assuring community members that all people are welcome regardless of immigration status, national origin, language, ethnicity, or ability to pay.
- Provide formal training to all staff on current issues affecting patient access and ensure staff know that health centers are not required to ask about immigration status, should not require Social Security numbers for any type of record keeping, are considered off-limits for any immigration enforcement activities, and may in fact be serving a number of legal residents who qualify for Medicaid, Medicare, or CHIP under the new Affordable Care Act.
- Provide safe outreach activities that assist patients in applying for benefits for which they are eligible. Immigrants underuse social benefits such as Food Stamps and WIC.
- Address alternate transportation initiatives with patients and staff in order to safeguard this enabling service.
- Exercise citizen rights through clinician professional organizations, individual corresponsibility, and other legal mechanisms available for advocacy without breaching lobbying restrictions of the clinic.
- Collect and document all situations of health compromise directly or indirectly related to restrictive social pressures. This includes unnecessary emergency department visits, complications of simple diseases or wellness in pregnancy, adverse developmental conditions for children, and behavioral health impacts on families. Data are needed in order to make economic and bioethical arguments for change.
- Share your work with MCN so we can promote it as a promising practice, assist you with further development, and advocate with you for health justice. ■

* Third year medical student, UBC, Vancouver, Canada

Integration of Lifestyle Medicine into Primary Care

Jillian Hopewell, MPA, MA

Chronic diseases – such as cardio vascular disease, cancer, diabetes, and osteoarthritis – are among the most common, costly, and preventable of all health problems in the U.S. Many chronic diseases are either caused or exacerbated by issues such as poor nutrition, lack of exercise, excess stress, alcohol abuse, and tobacco use. The practice of Lifestyle Medicine is specifically geared toward working with patients to address these issues in a clinical setting. As stated by the American College of Lifestyle Medicine, “although the practice of Lifestyle Medicine incorporates many public health approaches, it remains primarily a clinical discipline... A growing body of scientific evidence has demonstrated that lifestyle intervention is an essential component in the treatment of chronic disease that can be as effective as medication, but without the risks and unwanted side effects.” (www.lifestylemedicine.org)

Health care practitioners are well versed on the impact that lifestyle choices have on health care and yet often find themselves challenged to address these issues in the typical clinical setting. Family HealthCare Center, a Community Health Center in Fargo, ND, has accepted this challenge and is actively



engaged in incorporating Lifestyle Medicine into their primary care services. This effort has been spearheaded by Dr. Mary Larson, a licensed registered dietician, clinical diabetes educator and community health education specialist.

As a result of the ongoing effort to incorporate Lifestyle Medicine into primary care, Dr. Larson received a 2011 Bush Fellowship. The Bush Fellowship provides an opportunity for

individuals to increase their leadership capacity to more effectively work with others to solve tough problems in their communities.

Dr. Larson is particularly interested in bringing the practice of Lifestyle Medicine to people who have few economic resources. While she recognizes that lifestyle health concerns should be addressed with all patients regardless of age, race, or gender, individuals who have lower levels of education and fewer economic resources often have limited access to health care and therefore suffer the consequences of lifestyle health conditions at significantly higher rates than their counterparts. At the same time, the healthcare systems provide acute and episodic care to these individuals rather than additionally focusing on the factors that are foundational to good health. Dr. Larson's vision “is to serve this particular community by engaging partners within primary health care settings to integrate lifestyle medicine into every visit and to work with individuals and organizations in the community to foster healthy choices by creating healthier living environments.”

On page 4, Dr. Larson's explores some thoughts about the process of incorporating Lifestyle Medicine into primary care. ■

Preventing Partner Violence in Refugee and Immigrant Communities

Greta Uehling, Alberto Bouroncle, Carter Roeber, Nathaniel Tashima and Cathleen Crain

[Editor's Note: This article has been reprinted with permission from *Forced Migration Review* #38, <http://www.fmreview.org>]

For many refugees and other forced migrants, sexual and gender-based violence does not necessarily stop after resettlement; for some, that may be when it begins.

Although some research suggests that domestic or intimate partner violence (IPV) is no more or less prevalent among minority groups in the United States than in the general population, refugees and immigrants face special barriers to receiving appropriate services. The causes of violence are multiple and complex but the intense stress associated with adjustment to a new life can create tension and conflict that may make IPV more likely. In the US, changes involving greater female empowerment or independence may disrupt a previously established balance of power within a family and precipitate forms of emotional, psychological or physical abuse. It has also been argued that the psychological effects of experiencing the nor-

malization of violence in countries at war may be contributing factors for intimate partner violence.

Although there is no universally accepted definition of IPV, it is generally understood as actual or threatened acts of physical, sexual, psychological, financial and verbal harm, including stalking. Intimate partners include current or former spouses (including common law partners), boyfriends, girlfriends and persons wishing to be in a romantic relationship. They may or may not be cohabiting.

Over the past decade, a growing body of research suggests that there is not one but several types of violence that occurs in intimate relationships and that these different types require different kinds of interventions. What is not yet known is the extent to which IPV as experienced by refugees and immigrants falls into the same types.

Addressing IPV in refugee and immigrant communities is complicated by a number of factors. The domestic violence prevention community in the US is largely organized around separating perpetrators and victims.

The assumption is that violence occurs in a cycle and that separating the perpetrator and victim is the best and most long-lasting solution. However, for cultural reasons and due to the vulnerability created by migration, separating a refugee or immigrant IPV survivor from her or his family may not be the most advisable course of action; many refugees prefer to find remedies within their relationships. As one service provider put it, “Over the last decade, I've learned that the priority [among refugee clients], rather than safety, is family preservation.”

Other factors that complicate prevention include the use by perpetrators, victims or service providers of ‘tradition’ or ‘culture’ to justify abusive behavior. Some service providers engage in a process of questioning destructive or unhealthy practices and use a human rights or social justice framework to communicate the fact that – regardless of the way a person may have been treated in the past – every individual is entitled to specific rights and freedoms

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Reflections from the Field

Mary Larson, PhD, MPH, LRD, CDE, CHES

What does it mean to integrate “Lifestyle Medicine” into primary care? In our healthcare system it is now the cultural norm to expediently diagnose and treat. Patients accept it, Chief Financial Officers demand it, and insurance companies pay for it. I am asking that health care providers postpone their narrow focus of diagnosing and treating symptoms for 2 minutes— 120 seconds—to address key preventive lifestyle choices. I am asking that at every visit we address lifestyle factors which have been determined to be foundational for good health. Even treating a sore throat or a sprained ankle should include lifestyle medicine. There are four behaviors and one lifestyle health condition that account for the leading causes of chronic illness and death and which escalate the cost of health care and deflate human productivity and quality of life. We can emphasize these five areas of lifestyle medicine by encouraging patients to 1) eat a well-balanced, low fat, high fiber diet, 2) get more exercise, 3) engage in low risk alcohol consumption, 4) cease using tobacco products, and 5) maintain a healthy weight. This paradigm shift requires an adaptation in the normative behaviors and expectations in our current primary care culture.

All medical providers are familiar with lifestyle behaviors, though more education and training is devoted to treating illness and disease than is spent learning about preventing disease and the art and science of influencing behavior change. People seeking health care also have some knowledge about lifestyle behaviors but many people do not live in environments supportive of good health. When people become ill, they have come to expect a quick fix by their health-care providers.

When I ask health care providers to integrate foundational, preventive health into their practices, I am asking them to navigate often uncharted territory. We cannot afford

to continue providing reactionary health care. People who use health care also need to change their expectation that a pill is the answer to every healthcare problem. We have some common ground—people want to feel better, healthcare providers want to help their patients feel better, and healthcare payers want to control spending by reducing the number and complexity of patient visits. Health care can be part of the solution by integrating a lifestyle medicine plan that is designed to keep people healthier.

I realize that I am also asking for a systems change. Sometimes it takes a major health event like a cardiac arrest before we are motivated to engage in necessary changes. Metaphorically, our healthcare system is experiencing a “CODE BLUE.” Who are the first responders (stakeholders)? Who has the most to gain from changing the system to one that addresses lifestyle change? Who has the most to lose from the integration of lifestyle medicine? What systematic changes are needed? What policy changes are needed? These are the questions that I hope to answer through the process of engaging primary care providers and staff, medical school leaders, payer system decision makers, and health care system users in discussions of how to transform primary care.

My networking skills are called into action as I work on facilitating these adaptive changes. Much of the work I am doing to build lifestyle health indicators into primary care practice is challenging deeply held values, beliefs, and attitudes of providers of health care and the patients accessing health care. One example of this work to transform primary health care systems is illustrated in the collection of height and weight data for every patient. In order to integrate lifestyle medicine we need to move from a system that simply collects height, weight, and body mass index (BMI), to one that utilizes BMI information as a risk factor for the prevention of chronic con-

ditions by addressing BMI with every patient at every visit. Patients who have BMIs in a healthy range are encouraged to maintain their weight and patients who have BMIs outside of their healthy range are provided support to manage their weight. Conversations about weight maintenance or management will likely involve nutrition and physical activity as these lifestyle factors are all interconnected. Addressing these lifestyle health factors at every visit is not part of our current health care system. Making systematic changes of this nature and magnitude requires adaptations by healthcare providers and patients.

Currently a discrepancy exists between the vision of an effective Lifestyle Medicine practice and what is underway due to the adaptations required by systems and people. So, much of “the work” at this stage is creating awareness and closing the gap between what is needed from primary health care and what primary health care is providing. This article is a fine example of communicating a vision of what might be, creating awareness about the discrepancy that exists, and building a foundation of support to enact change. ■

For more information about the field of Lifestyle Medicine go to:

Harvard Medical School,
The Institute of Lifestyle Medicine
<http://www.instituteoflifestylemedicine.org/index.php>

The American College
of Lifestyle Medicine
<http://lifestylemedicine.org>

Institute for Clinical Systems
Improvement (which also has a
series of clinical guidelines that align
with Lifestyle Medicine)
<http://www.icsi.org/>

under US law. However, traditional norms and cultural practices can also be protective, as well as contributing factors to IPV.

Many prefer to keep partner violence private and seeking help may be seen as a form of betrayal. Privacy is also sought to avoid inciting discrimination and stigmatization from the host community. This reluctance to disclose violence underlines the importance of creating an environment in which refugees and immigrants can address the issues themselves within their own families and communities.

Tolerance thresholds and definitions of abuse are far from universal. One advocate told the story of a Somali refugee who requested and was offered shelter when her husband left her without food and electricity to provide for another wife. She insisted she had not been abused but was merely destitute. During her stay in the shelter, the provider said, "She started to understand that her husband hitting her is violence. Only when she started to understand more about IPV did she begin to talk about the violence she had experienced from her husband."



Good practice?

There is a significant gap in knowledge about the most effective psychosocial interventions and prevention strategies for refugees who are either at risk of or are experiencing IPV. A new three year initiative entitled 'Preventing Partner Violence in Immigrant Communities: Strengthening What Works' aims to generate practice based evidence to fill this gap, enabling the organizations involved to identify, strengthen and promote creative and innovative approaches.

The eight organizations working on the programme have seen some success in embedding IPV education in other services such as English language teaching, sessions about US law in general and even financial literacy workshops. Meanwhile, they are evaluating potentially promising practices to address IPV, including the following:

- **Engaging young people whose attitudes are still forming to speak about IPV among their peers.** For example, Asian Task Force Against Domestic Violence believes that overlapping forms of racial, ethnic and gender inequality are the root cause of violence. They suggest that by teaching youth to recognize and address these inequalities, healthy relationships and communities can be built. In 2010 refugee youth and US-born children of refugees and immigrants created an electronic magazine with anti-violence content including photographs, poetry and articles.
- **Engaging spiritual and community leaders to target unhealthy traditional or**

religious practices. Spiritual leaders are often instrumental in helping their communities to examine the values, norms and beliefs that can be used by some to justify violence.

- **Overcoming shame and stigma, and drawing on informal networks of support.** The Asian Women's Shelter was finding that survivors of abuse in the Asian and Pacific Islander lesbian, gay and transgender community were hesitant to access services due to fears of sexism, racism and homophobia. They developed the 'Chai Chat' programme, providing a space to meet and explore issues of relationships, sexuality and safety from violence.
- **Including men and women in programming.** As part of an effort to challenge community norms that support IPV, Migrant Clinicians Network in Austin, Texas, has designed a project called Hombres Unidos Contra la Violencia (Men united against violence) that uses role-playing to provide men with skills to prevent episodes of IPV.
- **Building community capacity or 'social capital'.** Early on it became clear that organizations serving refugees and immigrants recognized the complexity of issues surrounding IPV in their communities, and that strengthening formal and informal social networks, creating links between organizations and decreasing people's sense of isolation are all important features of a community-level response to IPV. Building

community capacity or social capital may contribute to IPV prevention through mechanisms such as dissemination of information about healthy and unhealthy relationships and about healthy norms of behavior. This parallels discoveries within the humanitarian community that the response to sexual and gender-based violence must engage refugees, be multisectoral, and rebuild family and community support networks.

Conclusion

IPV is both a human rights issue and a public health concern. Many lessons have been learned about preventing and responding to sexual and gender-based violence in complex humanitarian emergencies and camp-based settings. Sexual and gender based violence is now a common (although many would say as yet insufficient) part of international humanitarian monitoring and evaluation efforts. It is now time to link these efforts with those that can be made to protect refugees and immigrants after resettlement. The eight organizations in the programme are being supported in evaluating their practices with a view to creative and innovative approaches being identified, strengthened, and disseminated. ■

MCN has been honored to participate in the 3-year Strengthening What Works program, sponsored by the Robert Wood Johnson Foundation and aimed at assisting IPV service providers with evaluation of their projects.

TBNet in Action

Ricardo Garay and Gracie Castillo

TBNet is a multi-national tuberculosis patient tracking and referral project designed to work with mobile, underserved populations. It is one arm of MCN's bridge case management system Health Network. Treatment of these populations is complicated by the fact that many people, given the circumstances of their lives, are unable to remain in a given location long enough to complete the lengthy TB treatment regimen.

For more than 15 years, TBNet has expanded its reach to a total of 56 countries worldwide. This growth is a reflection of migration as a global phenomenon, far beyond the U.S.-Mexico border. TBNet has established a professional rapport and brand recognition among TB controllers around the world, which has facilitated the management of these international cases. The program currently boasts an 84% treatment completion rate for its enrolled patients. Relationships with National Tuberculosis Programs (NTPs) in Mexico, Honduras, Guatemala, El Salvador, and others have created an atmosphere of cooperation, which facilitates information flow. In 2010, TBNet was recognized by the U.S.-Mexico Border Health Commission with the Border Models of Excellence in Tuberculosis Surveillance and Control Award for its value, relevance, and effectiveness in that region. Using TBNet as a sole source for these referrals has also served to simplify, standardize, and streamline the documents used for international case transfers.

The following case provides a window into the effort required to manage multinational patients. The complexity of this case is illustrative of the challenges that TBNet associates tackle on a daily basis.



Carmen* was referred to TBNet in December, 2010 by an Immigration and Customs Enforcement (ICE) detention facility in a state located on the US/Mexico border. This referral was initiated as a precautionary measure triggered by an abnormal x-ray which showed a left upper lobe opacity. Three sputum samples were smear negative and there was no significant TST (tuberculin skin test) reaction. Carmen was born in Mexico and still had family living there which would facilitate continuity of care planning.

As is standard protocol, a phone interview was scheduled between the patient in the detention facility and a TBNet associate. During this interview, Carmen provided her contact information in Mexico and a U.S. tele-

phone number. She mentioned the possibility of being released on bond into the U.S. as opposed to being returned to Mexico. Carmen used her doctor in Mexico as an anchor contact (a person with whom consistent communication is maintained). She explained that the doctor was familiar with her family's situation as she participated in the TB treatment he had provided for one her brothers.

The TBNet associate was able to acquire the necessary information by explaining the program, its scope of support, and detailing the expected outcomes for the patient. The TBNet associate was able to establish a good rapport with Carmen in large part because of the extensive experience in effective patient interviewing, culturally competent care, and cross-border health systems.

Two weeks later, the patient was released on bond. Because of her abnormal x-ray, she remained a tuberculosis suspect and the detention facility assured TBNet that culture results would be sent to TBNet once they were available. Those same results, along with any recommendations for follow-up, would be communicated to the patient through TBNet. A plan for follow-up was set up in Mexico and in the U.S. so that whatever the outcome of her detention, continuity of care had been established for the patient.

A week later, TBNet received notification of positive culture results for *Mycobacterium tuberculosis* that were pan-sensitive to all first line treatment. These results were faxed to TBNet using a confidential number. An associate notified both the receiving clinician and the patient of the positive culture results and the need for treatment. In the interim Carmen had traveled back to Mexico. TBNet informed both the Mexican state health department and Carmen's doctor of these results in order to initiate treatment. TBNet received an official notification that treatment in Mexico was initiated later that week.

The following week, a routine follow up call was made to the patient. Her family in Mexico notified TBNet that the patient had returned to the U.S., and the number that she had previously provided was not functional. Multiple calls were made in an attempt to communicate with the patient and coordinate care. Three weeks later the patient's family in Mexico was able to provide a new secondary number in the U.S. Several attempts were made to reach the patient, but the person answering was not cooperative. The TBNet associate finally spoke with Carmen, obtained her new contact information in the U.S., and reiterated the importance of treatment adherence.

Carmen was provided with the direct number for the TBNet associate. The local U.S.

health department was contacted regarding the patient's arrival in the region and medical records including start dates in Mexico were forwarded. The patient re-initiated treatment under Directly Observed Treatment (DOT) beginning in March of 2011.

Follow-up for this case involved phone calls with both the patient and the health department to ensure that the patient was continuing treatment. Follow up calls are made monthly for every TB case enrolled in TBNet. If the patient does not answer, a message is left, but a case can only be pushed forward for contact the following month if there is confirmation from the clinic that the patient remains in care. In this particular case, the health department reported that Carmen remained in treatment for several months.

This ended in July 2011 when the county health department contacted TBNet to report that the patient was missing. The TBNet associate contacted the patient in Mexico, where the patient's family was screening all calls. It appeared that Carmen was involved in a very unstable domestic situation in the U.S., although the details were never fully disclosed to TBNet.

A week later the U.S. county health department sent medical records to TBNet noting negative sputum results with positive culture results. In a call to Mexico two days later, her family reported that she had returned to the United States.

TBNet contacted the health department that same day to notify them that the patient had returned to the U.S. Two weeks later, TBNet was informed that the patient was under treatment again at the same county health department. After receiving the call from the health department, the TBNet associate contacted Carmen and confirmed that she had returned to treatment. The importance of completing the full course of treatment was emphasized.

The following month TBNet was in communication with Carmen who said that she was continuing treatment. TBNet contacted the county health department to confirm that Carmen remained under treatment. Communication continued between TBNet staff and the county health department during the remainder of Carmen's treatment. In October, the county health department reported the patient successfully finished treatment.

In total, this case required 23 clinic contacts and 21 patient contacts. Due to the collaborative effort of ICE, multiple health departments, and TBNet, this case is an inspiring example of a successful outcome despite the arbitrary and frequent movement of the patient between countries. ■

* Not the patient's real name

Farmworkers in the Southeast

Alabama, Florida, Georgia, Mississippi

Erin Sologaistoa, MS

Editor's Note: The following is an excerpt from a new report issued from the Florida Association of Community Health Centers on the status of the farmworker population in the Southeast. This report is one of several regional reports on farmworkers. To access this full report as well as the profiles of farmworkers in other areas go to: www.ncfh.org. The full reports also feature recommendations for each regional area.

Introduction

This profile of Farmworkers in the Southeastern United States was prepared at the request of the Bureau of Primary Healthcare (BPHC), which funds the national migrant health program. The seven Regional Migrant Health Coordinators, also funded by the Bureau, were asked by the Office of Special Populations to research and report on issues related to farmworkers in their respective regions. The report covers information related to agricultural crops, farmworkers demographics, migration patterns, health needs and barriers to care as well as training and technical assistance needs at migrant health centers.

It can be difficult to find data on the farmworker population. Contributing factors include the migratory lifestyle many lead, their undocumented status, under-reporting by employers and general lack of priority put on the needs of this semi-invisible population. The profile is an attempt to fill in some of the gaps in information about Farmworkers in the Southeast. For the purposes of this profile, "The Southeast," includes the states of Alabama, Florida, Georgia and Mississippi.

In 2011, the Florida Association of Community Health Centers administered a questionnaire to farmworker organizations in the region. These included Federally Qualified Community Health Centers (FQHCs), Migrant Head Start, Migrant Education and Migrant Jobs Programs as well as community based organizations (CBOs) that work with the farmworker population. We received a total of thirty-five responses: twenty-seven from Florida, four from Alabama, three from Georgia and one from Mississippi.

Healthcare Use

According to the most recent NAWs data, forty-three percent (43%) of farmworkers interviewed indicated they had not used any healthcare services in the U.S. during the previous two years. This was down from fifty-seven percent (57%) in the previous five

FARMWORKER HEALTH

Health Prevalence

The following chart illustrates the responses by type of organization. FACHC SEMHQ respondents were asked to rank health conditions seen among farmworkers. Oral health ranked number one, followed by diabetes and substance abuse.

Farmworker Health Conditions

Health Condition	Rank
Poor Oral Health	1
Diabetes	2
Alcohol and Drug Abuse	3
Heart Disease	4
Pesticide Exposure	5
Late Entry Into Prenatal Care	6
Poor Mental Health	7
Infectious Disease	8
Asthma	9
Other Respiratory	10
Other Occupational Injury	11

Source: FACHC Southeast Migrant Health Questionnaire, 2011

Since such a high number of farmworkers are Hispanic it is worth taking note of the health disparities in that population. Factors that contribute to poor health outcomes among Hispanics include language and cultural barriers, lack of access to preventive care, and lack of health insurance.

Hispanic Leading Causes of Death

Cause of Death	Rank
Heart Disease	1
Cancer	2
Unintentional Injuries Stroke	3
Stroke	4
Diabetes	5
Chronic Liver Disease and Cirrhosis	6
Chronic Lower Respiratory Disease	7
Homicide	8
Prenatal Conditions	9
Influenza and Pneumonia	10

Source : CDC, 2007

year period. Use of federally qualified migrant health centers rose by nine percent (9%) and use of private doctors by six (6%) from 2004 and 2009. Use of federally qualified community (vs. migrant) health centers declined by three percent (3%).

Federally Qualified Health Centers

There were 99,207 farmworkers served in federally qualified migrant and community health centers in the Southeast in 2010. This was down six percent (6%) from 2008. The reason for the decline may be attributed to any number of factors. It could be a result of a decline in agricultural land corresponding with rapid population growth and suburban development in the region. It could be

attributed to poor data collection on this population on the part of health centers. Strong anti-immigration sentiments may play a significant role. The number of farmworker patients served at FQHCs in the Southeast since 2008 has increased in every state except for Florida, which saw a drop in farmworker numbers.

Barriers to Care

The farmworker population faces many barriers to accessing healthcare, particularly those that migrate. FACHC SEMHQ respondents indicated that finances and language were the greatest barriers to care for this population, followed very closely by trans-

portation. Fear was another important factor, which has been amplified recently by anti-immigrant laws passed in Alabama and Georgia and proposed in Florida. Health center and BPHC policies were not identified as critical barriers in the FACHC SEMHQ, however, anecdotal evidence from the region suggests that health center policies regarding income verification can create significant barriers to care for this population if a well thought out income verification process is not in place. Health centers whose policies do not take into consideration the wild fluctuations in income earned by farmworkers, and the fact that they may not be able to present the same type of documentation as other patients, make it difficult for agricultural workers to be placed at the appropriate place on their sliding fee schedule. Farmworker income can vary greatly from week to week, month to month, and year to year, and most farmworkers get paid in cash. Figure 1 reflects where FACHC SEMHQ respondents rated different barriers to care.

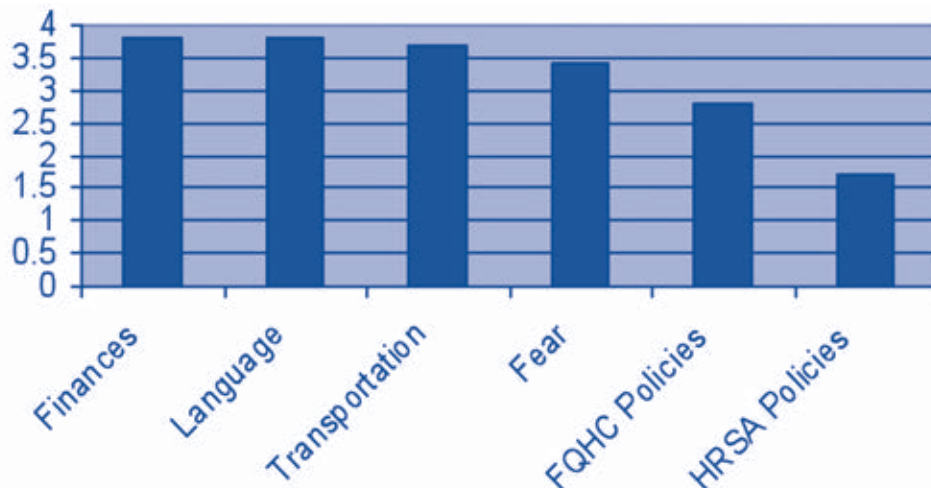
Insurance Status

In Figure 2, during the period between 2005 and 2009, twenty-eight percent (28%) of farmworkers interviewed for the NAWS indicated having had health insurance. Forty-one percent (41%) of spouses had insurance. Sixty-eight percent (68%) of respondents indicated that all the children in their household had insurance, while five percent (5%) indicated that only some of their children were insured.

Issues Impacting Care

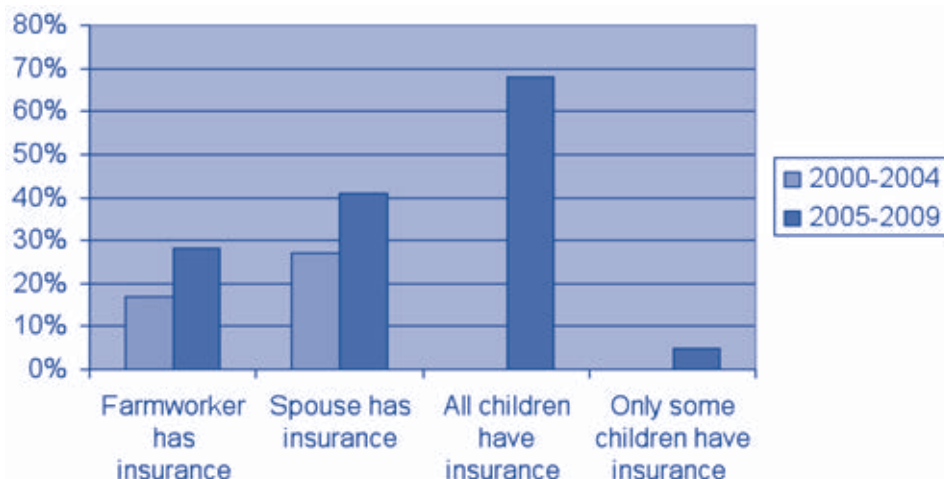
Anti-immigrant sentiment has grown throughout the Southeast in recent years. Both Georgia and Alabama have passed restrictive immigrant laws and a similar law was narrowly defeated in Florida during the 2011 legislative session. As a result immigrant farmworkers are more fearful than ever about accessing healthcare services and are generally limiting their mobility for fear of being picked up by law enforcement. There have been credible reports of road blocks and raids near health clinics, giving farmworkers good reason to be afraid. Eighty-two percent (82%) of IILSS respondents indicated that in the past year there have been incidents of farmworkers or immigrants in their area being arrested or intercepted in the process of accessing healthcare services. Not surprisingly, immigration was identified by FACHC SEMHQ respondents as the greatest issue currently impacting farmworkers in the region, followed by the economy (Figure 3). ■

Figure 1. Barriers to Healthcare



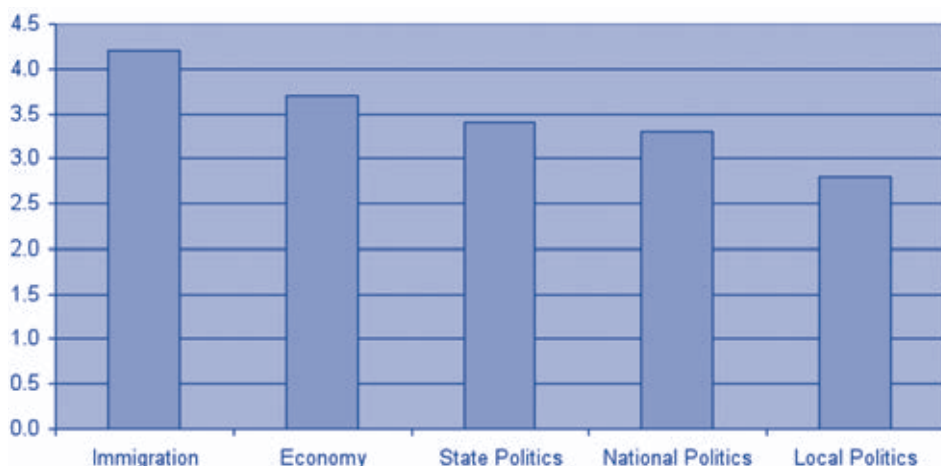
Source: FACHC Southeast Migrant Health Questionnaire, 2011

Figure 2. Insurance Status



Source: National Agricultural Workers Survey: Southeast Region, 2000-2009

Figure 3. Issues Impacting Farmworkers



Source: FACHC Southeast Migrant Health Questionnaire, 2011

A Guide to EPA's Worker Protection Standard For Migrant-Serving Clinicians

Virginia Ruiz, JD

The EPA's Worker Protection Standard (WPS) is a federal regulation aimed at protecting agricultural workers from the health risks associated with pesticides.¹ The WPS requires agricultural employers to comply with minimum safety precautions when using pesticides on farms, and in nurseries, greenhouses or forests. Requirements include training of workers handling pesticides or working in treated areas, provision of adequate personal protective equipment, communication of information about work areas recently treated with pesticides and when it is safe to re-enter these areas, and in case of emergency, availability of decontamination facilities and provision of medical assistance.

Health Effects of Pesticides

Studies show that farmworkers suffer serious short and long-term health risks from pesticide exposure. Short-term acute effects may include stinging eyes, rashes, blisters, blindness, nausea, dizziness, and diarrhea.² Exposure to pesticides over the long term can lead to chronic health effects such as cancer, infertility, birth defects, endocrine disruption, neurological damage and even death. Studies have also found that children exposed to pesticides are at a higher risk for asthma, cancer, and neuro-developmental problems.³

According to the National Institute for Occupational Safety and Health, U.S. farmworkers suffer pesticide poisoning at a rate 39 times higher than workers in all other industries combined.⁴ Workers can become exposed through spills, splashes, defective, missing or inadequate protective equipment, direct spray, drift or contact with pesticide residues on the crops or soil. Families can also be injured when farmworker children play in treated fields, when workers inadvertently take home pesticide residues on their hair, skin or clothing or when pesticides drift onto outdoor play areas and gets tracked into homes, etc.

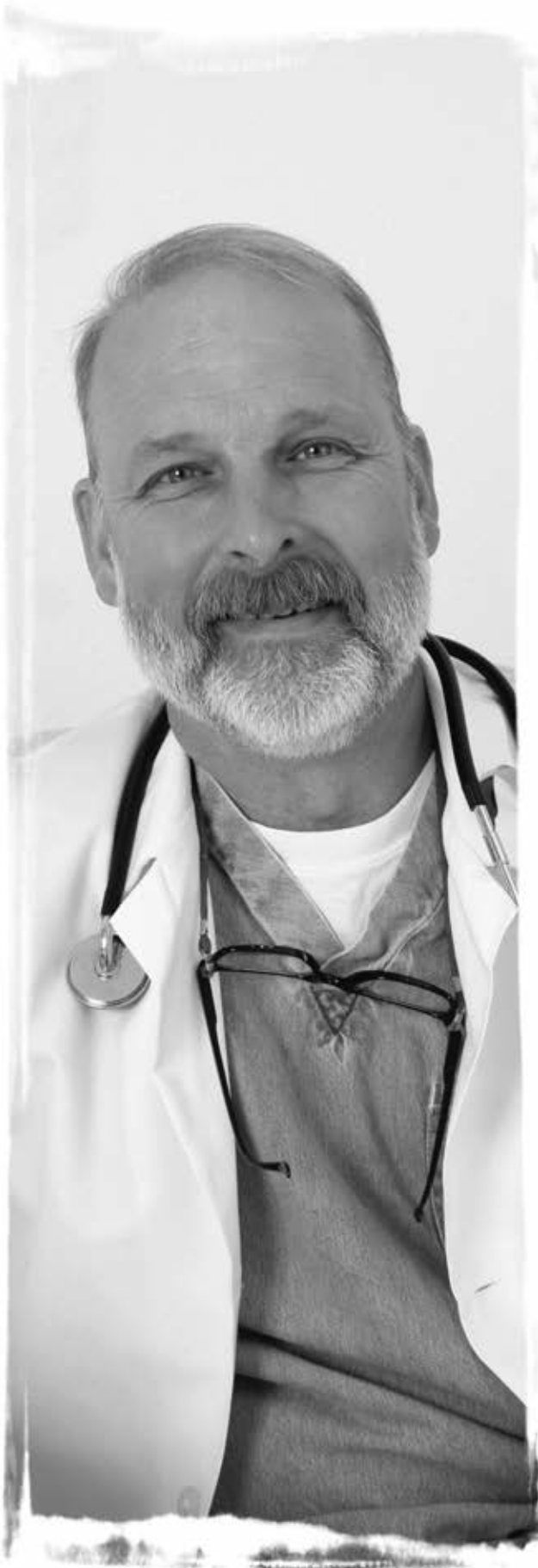
Basic Protections of the WPS

The WPS was enacted with the goal of providing basic protections to farmworkers in order to minimize the harmful effects of pesticide exposure to both workers and their families. The law applies both to workers who are involved in the production of crops, and to "handlers," who mix, load, or apply pesticides. The WPS requires agricultural employers to take the following steps:

- Provide pesticide safety training and posters
- Inform workers about where and when pesticides have been sprayed
- Keep workers out of pesticide treatment areas during application and until re-entry into these areas is deemed safe
- Provide protective equipment for all workers coming into contact with pesticides or pesticide-treated areas within the time periods when re-entry is restricted
- Provide facilities for decontamination (including clean water, soap, and towels)
- Facilitate emergency medical treatment if necessary

Pesticide Safety Trainings

Employers must provide training on pesticide safety to all workers and handlers who will enter a field treated with pesticides within the past 30 days or a field that has been under a restricted entry interval (or "REI") within the last 30 days. An employer must provide this training for his workers at least once every 5 years. Workers must be trained before they have worked six separate days in such a field. All early-entry workers must receive pesticide training before entering affected areas.



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■ A Guide to EPA's Worker Protection Standard continued from page 9

Employers must also display in a central location a poster with basic safety information and the name and address of a nearby health facility.

Information about Recent Pesticide Applications

Employers must inform workers about where and when pesticides were sprayed to avoid accidental exposures. The pesticide label will indicate if these notifications must be either written or oral, or both. If both written and oral notification is required, employers must post warning signs around the field, informing people not to enter. Oral notifications should include the location of the treated area, and the length of the REI. The WPS also requires employers to post information about recent pesticide applications (including name of the pesticide, location of field, and REI) in an easily seen central location.

Protections during Applications and during Restricted Entry Intervals

The WPS prohibits application of pesticides in a way that will expose workers or other persons. Workers must be excluded from areas while pesticides are being applied and they cannot enter a pesticide treated area during the REI unless they are given protective equipment. An REI can last anywhere between 4 hours and 30 days, depending on the crop, the pesticide used, and the location. Information about REIs are found on pesticide labels, and employers should also post REIs in a central location accessible to all workers.

Personal Protective Equipment

An employer must provide and maintain personal protective equipment (PPE) for handlers and workers who work in treated areas before the REI has ended. PPE includes clothing and equipment that must be used to protect a worker from contact with pesticides, such as gloves, respirators or coveralls.

Decontamination Supplies

Handlers and workers must have enough water, soap, and towels to wash their hands on a regular basis and to wash themselves in case of an accidental exposure to pesticides. Handlers must be provided with enough water for washing their entire body in case of an emergency and a clean change of clothing to dress in after the contaminated clothing has been removed.



Emergency Medical Assistance

If a farmworker becomes ill due to pesticide exposure, the employer must make available transportation (which can include calling an emergency vehicle) to a medical facility and provide information about the pesticide to which the person may have been exposed. This information could include the product name, EPA registration number, active ingredients, antidote or other emergency information from product labeling, description of the way the pesticide was used and the circumstances of the worker's exposure to the pesticide.

Retaliation

No worker may be prevented or even discouraged from complying or attempting to comply with the WPS. Workers who complain or exercise their rights under the WPS cannot be targeted by employers for discipline or termination.

Enforcement

The WPS is enforced by state agencies under cooperative agreements with the federal EPA. Agencies and inspectors responsible for WPS enforcement will conduct routine WPS inspections to monitor employer compliance with the regulations, as well as some "for cause" inspections that are usually initiated in response to a complaint, damage report, referral or tip following a pesticide application.⁵

Important Considerations for Migrant Clinicians

Farmworkers may be unaware that health effects or symptoms they are experiencing may be related to exposure to pesticides. They may not initiate a discussion regarding their occupational exposures with their

healthcare provider. For this reason, it is important for clinicians to ask patients about their occupation and to ask farmworkers about pesticide-related symptoms. MCN has a simple screening tool to quickly ascertain occupational and environmental exposures.

Additionally, workers often do not know the names of the pesticides they have been exposed to at work. Even though the WPS requires that this information be accessible to workers in a central location, workers often do not know where this information is and are reluctant or unable due to language barriers, to ask their employer for the information. And in the case of an emergency, they may not remember to seek out this information before obtaining medical care. Under the WPS, employers have a responsibility to provide clinicians and patients with information on any product whose use they suspect may have led to poisoning. Clinicians can and should call employers to ask for pesticide use information in order to make accurate diagnoses and plan treatment.

Some states have additional protections for farmworkers and requirements regarding pesticides.

Medical Monitoring

To prevent overexposure to organophosphate and carbamate insecticides by pesticide mixers, loaders and applicators, **California** and **Washington** require employers to pay for blood tests that monitor pesticide handlers' exposure to these types of pesticides.⁶ When the tests show that the worker is overexposed, he/she must be removed from handling activities to prevent injury. In Washington, the handler must be paid while he/she recovers from the pesticide overexposure.

Incidence Reporting

Currently, thirty states have laws that require healthcare professionals to report suspected or confirmed pesticide-related illnesses and injuries. Twelve states (Arizona, California, Florida, Iowa, Louisiana, Michigan, New Mexico, New York, North Carolina, Oregon, Texas and Washington) participate in the Sentinel Event Notification System for Occupational Risk (SENSOR) program, which establishes formal reporting and investigation systems. MCN has developed a *reporting tool* (<http://www.migrantclinician.org/issues/occupational-health/pesticides/>)

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Focus on Work-Related Asthma

California Department of Health

A 37-year-old teacher developed new asthma at her workplace. She worked in an area where custodians used cleaning products at full strength instead of mixing them with water, as the label required. She now has asthma symptoms made worse by many different chemicals.

A 43-year-old high school custodian started having breathing problems when he used chemicals to clean the bathrooms and strip floor wax at work. It took a year for him to be diagnosed with asthma. He finally had to leave his job because of it.

These are just two of the many workers whose asthma was caused or made worse by cleaning products. Cleaning products are used in all workplaces and can cause or trigger work-related asthma. The California Department of Public Health (CDPH) has found that one in 10 workers reporting work-related asthma associate their symptoms with cleaning products.

Work-related asthma can have serious consequences. The CDPH Work-Related Asthma Prevention Program (<http://www.cdph.ca.gov/programs/ohsep/Pages/Asthma.aspx>) has produced educational materials about using safer products and cleaning methods. They include guidance on how to select safer cleaning products and to avoid 'green-washed' products falsely marketed as safe. ■



■ A Guide to EPA's Worker Protection Standard continued from page 10

reporting-illnesses.html) for information on reporting requirements and resources.

EPA relies heavily on clinicians to report possible pesticide poisonings in order to understand and prevent future pesticide misuse. In the past, clinician reporting has led to tighter regulation and even banning of some pesticides.⁷ ■

Notes

- 1 The WPS can be found at 40 CFR § 170 et seq. (online at: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title40/40cfr170_main_02.tpl) and FIFRA is at 7 U.S.C. § 136 et seq (summary online at: <http://www.epa.gov/lawsregs/laws/fifra.html>).
- 2 Calvert GM, Karnik J, Mehler L, Beckman J, Morrissey B, Sievert J, Barrett R, Lackovic M, Mabee L, Schwartz A, Mitchell Y, Moraga-McHaley S. 2008. Acute Pesticide Poisoning Among Agricultural Workers in the United States, 1998-2005. *Am. J. Industrial Medicine* 51(12): 883-898; see also Moses M. 1995. Designer Poisons: How to Protect

Your Health and Home from Toxic Pesticides. San Francisco: Pesticide Education Center.

- 3 For example, see Mills, P. 2001. Cancer Incidence in the United Farmworkers of America 1987-1997. *Am J. of Ind. Med.* 40:596-603; McCauley LA, Anger KW, Keifer M, Langley R, Robson MG, Rohlman D. 2006. Studying Health Outcomes in Farmworker Populations Exposed to Pesticides. *Environmental Health Perspectives* 114(6):953-960. Infante-Rivard, C. & S. Weichenthal. 2007. Pesticides and Childhood Cancer: An Update of Zahm and Ward's 1998 Review. *Journal of Toxicology and Environmental Health, Part B* 10(81). Bouchard MF, Chevrier J, Harley KG, Kogut K, Vedar M, Calderon N, Trujillo C, Johnson C, Bradman A, Barr DB, Eskenazi B. 2011. Prenatal Exposure to Organophosphate Pesticides and IQ in 7-Year Old Children. *Environmental Health Perspectives* 119(8): 1189-1195. For a comprehensive review of academic literature on health risks associated with pesticides, see Sanborn, et al, Pesticides Literature Review, Ontario College of Family Physicians (Toronto 2004), online at <http://www.bvsde.paho.org/bvstox/fulltext/rpesticides.pdf>
- 4 Calvert GM, Karnik J, Mehler L, Beckman J, Morrissey B, Sievert J, Barrett R, Lackovic M,

Mabee L, Schwartz A, Mitchell Y, Moraga-McHaley S. 2008. Acute Pesticide Poisoning Among Agricultural Workers in the United States, 1998-2005. *American Journal of Industrial Medicine* 51(12): 883-898. See also, Das R, Steege A, Baron S, Beckman J, Harrison R. 2001. Pesticide-related illness among migrant farm workers in the United States. *International Journal of Occupational and Environmental Health* 7:303-312.

- 5 For more information on WPS enforcement, see www.epa.gov/compliance/monitoring/programs/fifra/wps.html. See attached chart for contact information for the enforcement agency in each state.
- 6 These pesticides depress the level of the blood enzyme acetylcholinesterase which plays a vital role in the central and peripheral nervous system. Exposure can be detected through plasma or red blood cell cholinesterase tests taken within 24-48 hours. Without baseline levels, however, the test must be repeated weekly for about 6 weeks to see if levels rise.
- 7 See also the American Public Health Association policy statement "Requiring Clinical Diagnostic Tools and Biomonitoring of Exposures to Pesticides," available at <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1400>



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calendar

Western Migrant Stream Forum

February 15-17, 2012
Portland, Oregon
Northwest Regional Primary Care Association
www.nwrpca.org

2012 Annual Conference of the Association of Maternal & Child Health Programs (AMCHP)

February 11-14, 2012
Washington, DC
Association of Maternal and Child Health Programs
<http://www.amchp.org/>

National Health Policy Conference

February 13-14, 2012
Washington, DC
Academy Health
<http://academyhealth.org>

Public Health Preparedness Summit 2012

February 21-24, 2012
Anaheim, CA
<http://www.phprep.org/2012>

Preventive Medicine 2012

February 22-25, 2012
Orlando, FL
American College of Preventive Medicine
<http://www.preventivemedicine2012.org>

National Health Promotion Summit

April 10-11, 2012
Washington, DC
<http://www.aptrweb.org/2012summit.html>