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Continuity of Care for TB Patients Around the World

Ricardo Garay and Ed Zuroweste, MD

"In the past six years of working for the TB Program of Health Service Region 8, TBNet has proven to be a valuable weapon in that battle against the spread of TB. The patients have and are now receiving the continuity of care that was lacking in those earlier years. Thank you for being a reliable resource."

Hope V. Alvarado, R.N., B.S.N., Department of State Health Services, Health Service Region 8

Continuity of care is one of the greatest challenges of providing healthcare services; that challenge is greatly increased when caring for patients who move during treatment. TBNet was created by The Migrant Clinicians Network (MCN) as a component of the larger Health Network, to address the need to create an effective system for the continuity of care for mobile TB patients. TBNet is a global patient navigation/bridge case-management and medical records transfer program that serves as a medical home for patients that are undergoing TB treatment. Its goal is to achieve effective and timely care for TB patients around the world.

History

In its 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% completion rate for its enrolled patients. Relationships with National Tuberculosis Programs (NTPs) in Mexico, Honduras, Guatemala, El Salvador, and others have created a Continuity of Care For TB Patients around the World atmosphere of cooperation, which facilitates information flow. In 2010 TBNet was recognized by the U.S.-México Border Health Commission with the Border Models of Excellence in

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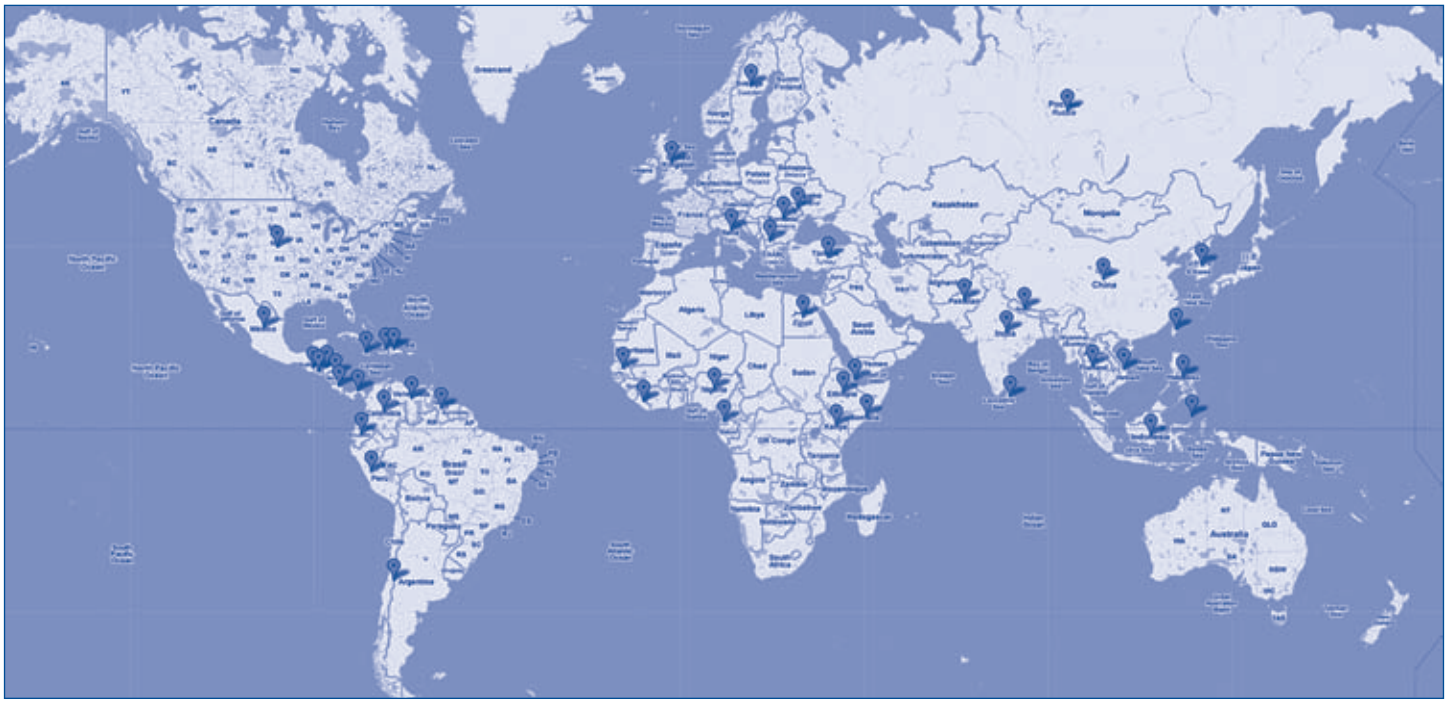
Countries That Have Worked with TBNet, 2005-2010



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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.

Program Structure

TBNet is one arm of MCN's Health Network, which provides similar bridge case management services to patients under care for a wide range of primary care conditions including diabetes, cancer screening and pregnancy. The program has incorporated relevant protocols to serve all of its stakeholders. Enrolling a patient into TBNet is simple, giving sites the option of filling out the patient enrollment packets themselves or having a TBNet representative interview the patient over the phone. With the latter option, an individual Patient Information Sheet is automatically generated through Health Network software and immediately sent to the enrolling clinic. Speaking directly with the patient enables the TBNet team to inform both the patient and the clinician about the steps necessary to ensure continuity of care. Once a patient is enrolled the case manager makes periodic contacts with both the patient and the treating clinician. Before a case can be closed, MCN's Chief Medical Officer reviews every record for accuracy and completion. Treatment must be finished within a year to be considered successful. Establishing continuity of care as soon and as effectively as possible is a top priority and a performance measure for TBNet.

TBNet is committed to rigorous quality control measures including quarterly case audits and periodic satisfaction interviews with both facilities and patients. The chart audit process ensures that a random sampling of patient records is reviewed quarterly for compliance according to 13 different criteria established for medical recordkeeping and documentation of patient and provider communications.

Total Number Enrolled in TBNET

Since inception a total of 5,799 individuals have been enrolled in all Health Network Programs. Since the inception of TBNet in 1996, a total of 4,441 individuals have been enrolled.

For more information about TBNet services contact:
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The Numbers 2005-2009

Class 3 (Active Tuberculosis)

	2005	2006	2007	2008	2009	Total	%
Deceased	1	2	0	2	0	5	0.6%
Lost to Follow Up	17	16	19	17	14	83	10.3%
Refuses Treatment	3	7	3	3	1	17	2.1%
Treatment not recommended	4	9	7	4	0	24	3.0%
Stopped on own	0	10	3	1	3	17	2.1%
Treatment Completed	63	203	186	106	101	659	81.9%
Total	**88**	**247**	**218**	**133**	**119**	**805**	**100%**

Notes:

1. These cases were all smear/culture negative and the receiving country determined that these patients did not have an active case of TB and therefore they decided not to continue TB treatment.
2. An in depth analysis of part of this data has been accepted for publication in Sept. 2011 in the "Journal of Immigrant and Refugee Studies"

Summary of TBNet Results, 2005-2009

Total 805
Deceased 5
Treatment not recommended 24
Total TBNet Case Managed 776
Total treatment Completed 659
% of Total Rx Completed 84.9%

This is very time intensive work with a large number of both patient and clinic contacts required to assure access to as well as continuity of care. Between 2005-2009 TBNet associates made the following number of contacts by telephone and email with both enrolling and referral clinics and patients.

TBNet Patient and Clinic Contacts: 2005-2009

Year	Total Patients	Patient contacts	Contacts per patient	Clinic contacts	Contacts per patient	Total contacts	Total contacts per patient
2005	88	632	7.2	3679	41.8	4311	49
2006	247	1058	4.3	6752	27.3	7810	31.6
2007	218	2883	13.2	7354	33.7	10237	46.9
2008	133	2333	17.5	5534	41.6	7867	59.1
2009	118	836	7.1	2364	20.0	3200	27.1
Total/Avr	**805**	**7742**	**Aver. 9.9**	**25683**	**Aver. 32.9**	**33425**	**Aver. 42.8**

Number of Active TB patients by Country Served by TBNet in 2005-2009 (Total # Countries 56)

Country	2005	2006	2007	2008	2009	Total	% of total
Honduras	36	110	92	47	29	314	39%
Guatemala	18	38	34	18	20	128	15.9%
Mexico	19	27	27	24	28	125	15.5%
El Salvador	4	34	29	14	7	88	10.9%
Nicaragua	1	7	7	2	4	21	2.6%
China		3	2	3	8	16	2.0%
Ecuador	1	2	2	4	5	14	1.7%
Peru	1	5	4	2	1	13	1.6%
Brazil	2	2	3	1	1	9	1.1%
Haiti		3	2	2	1	8	1.0%

81.3 % of all cases from four Countries: Honduras; Guatemala; México; El Salvador
Countries with Patients served by TBNet

Photo courtesy of Bertha Almendariz

CASE STUDY: TBNet in Practice

The following case study is a good example of collaboration among TBNet, ICE and multiple Health Departments that resulted in a positive outcome. The patient was enrolled at an ICE facility in the south on March 4th, 2010. The patient had negative smears, an x-ray showing RUL nodular consolidation with mild volume loss and a TST test showing 20mm for a skin reaction. The patient was deported to Central America the next day. At that point, cultures were pending and the patient had not been started on treatment.

On March 2nd, 2010 TBNet was notified by the Infectious Control Officer at the ICE facility about the patient's positive culture results. TBNet contacted the patient to direct him to a clinic in his country. We were then informed by the patient's main contact that he was on his way back to the U.S. and he did not have a phone number where he could be reached. We received a call from his wife on May 4th, 2010 stating that he was back in the U.S. and would be contacting us soon.

The patient's wife then called us to let us know coyotes in the US were holding him, and needed help getting out. She was agitated and expressed a legitimate fear for her husband's safety. The patient provided the coyotes with our telephone number being the only U.S. contact he had. We informed the people holding him that the patient had tuberculosis and should be released immediately to receive urgent medical attention; we also urged everyone involved to get checked for TB. We requested their contact information to direct the patient to the nearest clinic, however they abstained from providing any details. We were then allowed to speak to the patient briefly to make sure that he was in fact being held, and to notify him of his culture results. The patient sounded distressed and mentioned that he was not being fed properly. Immediately after ending this conversation, TBNet contacted ICE to initiate a human trafficking investigation. The patient's wife in the Central American country was extremely worried because she too had lost communication with her husband. On June 11th, 2010 TBNet received a call from the patient stating that he was now in an East Coast State. He explained that he was allowed to leave because of TBNet's conversation with his captors and our explanation of the health hazards that detainment posed to him and others. It was clear that the patient was now aware of his condition and understood that he needed to start treatment immediately. The patient's new address and phone number were obtained, and the local Health Department was provided with a summary of the patient's situation. All of the patient's medical records were also transferred to the Health

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Creating a Patient Centered Medical Home for Patients on the Move

Ed Zuroweste, MD and Jillian Hopewell, MPA, MA

The Patient Centered Medical Home is a concept that was originally articulated in 1967 by the American Academy of Pediatrics. The idea has recently garnered a great deal more attention as sites struggle to find ways to best provide quality care to patients. According to the National Committee for Quality Assurance (NCQA), "the patient centered medical home is a model for care provided by primary care clinician practices that seeks to strengthen the clinician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship".

In many ways Federally Qualified Health Centers (FQHCs) are uniquely qualified for this vision of health care. FQHCs have been practicing variations of the Patient Centered Medical Home (PCMH) for years without the official recognition that is currently being recommended. To encourage the further development of PCMHs, the federal government has recently enacted several incentive programs that provide additional advantages to gaining official recognition of PCMH status. The most recent data from the Health Resources and Services Administration (HRSA) indicates that approximately 100 FQHCs, which include approximately 500 primary care sites, have applied for recognition by NCQA as PCMHs.

As more FQHCs work toward official PCMH recognition from NCQA it is important to discuss how to manage mobile patients within a PCMH model. MCN finds that some health centers are resistant to taking on migrant and mobile poor patients because of concerns that they will not be able to provide them with the services required of a medical home, and thus resist identifying them as a special population. Indeed, continuity of care is an ongoing challenge for all who work with homeless, migrant, or other mobile populations.

However, with some creative thinking and the utilization of key tools designed for mobile patients, MCN believes that Migrant and Community Health Centers are in an excellent position to open PCMHs to mobile patients.

Consider first the core principals of the PCMH as originally defined by the American Academy of Family Practice (AAFP), the American Academy of Pediatrics (AAP), American College of Physicians (ACOP) and American Osteopathic Association (AOA):

- **Personal physician***: each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Physician*** directed medical practice: The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation:** The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals.
- **Care is coordinated and/or integrated**

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Photo courtesy of Bertha Almendariz

Cancer Prevention and Research Institute of Texas

In 2007 Texas voters approved a constitutional amendment authorizing the state to issue $3 billion in bonds to fund cancer research and prevention in Texas. From this action the Cancer Prevention and Research Institute of Texas (CPRIT) was established. CPRIT's goal is to expedite innovation and commercialization in the cancer research and enhance access to evidence-based prevention programs and services throughout the state.

MCN received a grant awarded by CPRIT for MCN's Moving Against Cancer program. This grant will allow MCN to work with a selection of six Texas Federally Qualified Health Centers (FQHCs) and the Ventanilla de Saludes in close proximity to increase cancer prevention awareness and action among the Hispanic population in Texas.

Some facts to consider

Table 1. Overall Cancer Incidence and Death Rates

Racial/Ethnic Group	All Sites Incidence	Death
All	470.1	192.7
African American/Black	504.1	238.8
Asian/Pacific Islander	314.9	115.5
Hispanic/Latino	356.0	129.1
American Indian/Alaska Native	297.6	160.4
White	477.5	190.7

Statistics are for 2000-2004, age-adjusted to the 2000 U.S. standard million population, and represent the number of new cases of invasive cancer and deaths per year per 100,000 men and women.*

In the coming months MCN will be highlighting the progress of this program and sharing resources we hope you will find useful. ■

Visit the following website to view facts about your local area
http://www.cancer-rates.info/

Fall-related injuries on the farm

Can they be prevented?

by Virginia Ruiz, Farmworker Justice

Falls are among the leading causes of workplace fatalities and injuries in agriculture. Serious fall injuries occur throughout the range of agricultural work settings and occupations. Thousands of farmworkers are injured every year from falls and more than 20 die each year from fall-related accidents. Falls are common, for example, among orchard workers who work on ladders to pick tree fruits. Other farmworkers are injured as a result of falls from and into farm machinery, falls while working with animals, and falls while working on elevated farm structures.

The U.S. Occupational Safety and Health Administration (OSHA) is currently revising its regulations that are meant to prevent falls at the workplace. Though farmworkers remain excluded under the proposed revisions, Farmworker Justice is currently working with OSHA to provide the agency with information on the extent of fall-related injuries in agriculture and the feasibility of preventing them. The inclusion of farmworkers under the revised fall protection standards could prevent countless unnecessary injuries and deaths.

Consider the case of "Martin," a farmworker with ten years of experience at a North Carolina hog farm. One day, Martin was given the task of oiling and maintaining the pulley mechanism on a 16-foot high hog chute, designed to transport hogs between a truck and the hog house. Without being provided a harness, he climbed up on the top side rails of the chute, reached up using one hand to oil the hoist/pulley mechanism, and used the other hand to balance himself on the crossbar below. He was an experienced worker and had probably completed this task more than 100 times. But on this occasion, one of the two chains supporting the chute broke and that side of the chute dropped to the ground, throwing Martin off. The fall resulted in immediate paraplegia.

Had he been working in nearly any other industry doing the same maintenance work, Martin would have been covered by OSHA's fall protection standards, and his employer would have been required to provide him with equipment to prevent fall injuries. But Martin worked in agriculture, and Martin's employer could not be held responsible for the fall under OSHA's current regulations.

Sadly, Martin's story is not unique. As a clinician, you have probably treated many farmworkers injured from falls. Anecdotal and statistical information from migrant clinics and clinicians about fall injuries could help to inform OSHA on the extent and characteristics of such incidents. How many farmworker falls do migrant clinicians see every year? What are the most common causes and locations of falls? What are some successful strategies that employers have implemented to mitigate the risk of falling on the farm? Any and all information about farmworker falls would be helpful, including individual stories and anecdotes.

If you have any information or data to share, please contact Etan Newman, Farmworker Justice Fellow at *enewman@ farmworkerjustice.org*. Workers' names and personal information will not be shared. ■

Bilingual Pesticide Labels

A Common Sense Approach to Worker Safety

Virginia Ruiz, Farmworker Justice and Amy K. Liebman, Migrant Clinicians Network

According to the National Agricultural Worker Survey (NAWS), 81% of farmworkers reported Spanish as their native language, and 53% of farmworkers said they cannot speak, read, or write English. Despite the prevalence of the Spanish language in the fields, currently pesticide labels are only required to be printed in English. Spanish-speaking applicators are directed to get the label translated themselves.[1] Pesticide labels communicate important safety information, including warnings and precautionary statements, first aid information, personal protective equipment, directions for safe use, and emergency decontamination instructions. Thousands of pesticide applicators are at risk of injury or illness as a result of not being able to read the pesticide label. In a recent study of pesticide handlers in Washington State, only 29% reported being able to read in English but nearly all of the participants were able to read in Spanish to at least some degree.[2] Further, researchers have found that pesticide handlers who were not able to read English had significantly higher cholinesterase inhibition – a marker of pesticide exposure – than handlers who could read English to some degree.[3]

In 2009, Migrant Clinicians Network (MCN), Farmworker Justice (FJ), and other farmworker groups, petitioned the Environmental Protection Agency (EPA) to require pesticide manufacturers to translate their pesticide labels into Spanish. In response to the petition, the EPA recently asked for public comments to determine the need for Spanish labels, whether bilingual labels would ensure meaningful access for those with limited English proficiency, and the costs involved in translation and agency oversight. In comments submitted, FJ, MCN and other advocates urged the EPA to require Spanish translations of essential safety and environmental information on pesticide labels.

The immediate impetus for this petition came directly from the requests for assistance from a Community and Migrant Health Center in Puerto Rico, Hospital General Castañer. This health center is an MCN Environmental and Occupational Health Center of Excellence. MCN's partnership with Hospital General Castañer has allowed them to incorporate a greater focus on worker and community environmental and occupational health into their clinical practices. Under the direction of its Medical Director, Dr. Jose Rodriguez, Hospital General Castañer has fostered relationships with local farmers to establish worker education programs and devote appropriate clinical resources to ensure farmworkers are provided with relevant care. Both farm owners and their workers have asked Hospital General Castañer for help with translation of the information on provided on labels. Dr. Rodriguez's efforts and request for assistance on bilingual pesticide labeling is aimed at helping workers minimize exposure to and misuse of pesticides, both of which can result in adverse health effects.

Farmworker Justice has conducted extensive policy analysis to prepare a response to the EPA's request for comments. Their analysis and research has involved extensive interviews with pesticide handlers and applicators, pesticide safety trainers, pesticide safety researchers, and growers. These interviews revealed overwhelming support for translation of essential information on the pesticide label. As noted previously, pesticides in the two most toxic categories must include a statement in Spanish advising workers that if they cannot understand the label, they should find someone to explain it in detail. This approach is inadequate to protect workers from the risks of mishandling the pesticide and places a tremendous burden on employers and supervisors. Translation of specific label information can be challenging, even for people who are bilingual. Most growers and supervisors are not sufficiently bilingual to be able to translate all of the important information on the label. According to pesticide safety trainers FJ spoke to, supervisors generally explain the required protective equipment and directions for use, but they often do not go through all of the label material, such as symptoms of exposure. Workers need to know what symptoms indicate exposure and when they should seek medical attention. Under the current system, there is no guarantee that all workers and handlers have access to all relevant label information. Furthermore, in the event of an accident, a worker needs to be able to read the first aid instructions immediately, rather than waiting to find someone who can read and provide a reliable translation. Including Spanish translations on the labels would ensure that this information can be quickly and accurately explained by supervisors and accessed by workers who have questions.

MCN and FJ have reached out to clinicians and other individuals and organizations concerned with farmworker health and safety to explain EPA's request for comments. Both MCN and FJ recognize that the current labeling system is grossly inadequate and does not promote risk management and occupational safety. Without the benefit of a label in a language they understand, farmworkers are ill-equipped to protect themselves, others, or the environment. Providing the most critical label sections in Spanish would improve farmworkers' health and prevent environmental contamination by ensuring that all workers have access to this information. ■

1 The following statement appears buried in the labels of the two most toxic categories of pesticides: "Si Usted no entiende la etiqueta, busque a alguien para que se la explique a Usted en detalle. [If you do not understand the label, find someone to explain it to you in detail.]" 40 CFR 156.206(e)

2 Hofmann J, Checkoway H, Borges O, Servin F, Fenske R, Keifer M. (2010). Development of a computer-based survey instrument for organophosphate and N-methyl-carbamate exposure assessment among agricultural pesticide handlers. Annals of Occupational Hygiene. 54(6):640-50.

3 In a study of 154 pesticide handlers who participated in the Washington State cholinesterase monitoring program in 2006 or 2007, researchers examined cholinesterase (BuChE) inhibition, a marker of pesticide exposure, by English literacy status. Researchers found that pesticide handlers who were not able to read English had significantly greater BuChE inhibition than handlers who could read English at least to some degree after adjustment for other factors that might influence BuChE activity (on average 5.2% greater BuChE inhibition among subjects who could not read English; P=0.01). (Hofmann, J. Letter to US EPA – Docket ID EPA-HQ-OPP-2011-0014. June 2011).

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across specialists, hospital, home health agencies and nursing homes.

- **Quality and safety** are assured by a care planning process, evidence-based medicine; clinical decision-support tools, performance measurement, and active participation of patients in decision making.
- **Enhanced access to care** is available (i.e. via open scheduling, expanded hours and new options for communication)
- **Payment** that recognizes the added value provided to patients who have a patient centered medical home (i.e. payment reflects the value of work that falls outside of the face-to-face visit)

While each of these elements is critically important, they do not address some of the particular challenges that arise when working with a mobile population. Mobile patients must contend with a broader set of challenges including not knowing where services are located in new sites, access to transportation, inability to access payment mechanisms, lack of access to medical records, and interactions with a health care environment that may not share the same cultural understandings. Given these challenges and after extensive experience working with a number of clinic sites, MCN has developed a set of recommendations around the core elements of a PCMH for patients on the move:

1. In order to effectively work with migrant patients, the focus on a personal physician must be shifted to working with a personal provider or clinician to include the vital work of Nurse Practitioners, Physician Assistants and Certified Nurse Midwives. NCQA has already recognized this and adjusted their guidelines in January 2011 to include other primary care clinicians. However, the original professional organizations involved (AAP, AAFP, ACOP, and AOA) have not yet changed their guidelines.
2. It is unrealistic to expect that a migrant patient will establish a relationship with only one provider. To effectively build a PCMH for migrant patients, we must change the concept to include a team of providers in various locations who can be virtually connected.
3. The whole person orientation emphasized by a PCMH has been an important component of migrant health for many years. The new emphasis on PCMH provides FQHCs with both an incentive to increase services that focus on the whole person as well as a mechanism to gain recognition for the work that has already been done in this area. In particular, the work of migrant voucher programs which coordinate care for migrants among a great variety of care providers is ideally suited for this type of approach to health care.
4. The BPHC sponsored Health Disparities Collaboratives provided an excellent foundation for many FQHCs to build upon, particularly in the areas of quality and safety. The Collaboratives' emphasis on patient self management of chronic disease is particularly important to build into PCMHs for mobile patients. With more patient education and extensive patient self management skill provided to mobile patients there is a higher probability of improved long term outcomes for chronic diseases.
5. Migrant health providers have experimented over time with different methods of expanding access to care for this particularly difficult to reach population. Strategies such as extended hours, cultural competency training for all staff, and effective translation of patient materials should be continued and strengthened for a strong PCMH for mobile patients.
6. Migrant Heath Centers' emphasis on quality outreach services is a critical element of creating a solid PCMH for mobile patients. The incorporation of outreach and *promotoras* should no longer be considered an "add-on or enabling" service. These services are absolutely critical to the success of PCMHs, particularly for a mobile population, and in the future should be incorporated as an essential clinical component to the PCMH.
7. Many of the needed elements of a PCMH that includes mobile patients are not possible without the overlay of a bridge case management and patient navigation system that allows for communication across state and national borders. Bridge case management creates a multi-pronged heath care team for mobile patients, allows for data transfer, and provides a virtual medical home for patients on the move. MCN's Health Network provides free bridge case management services for any mobile patient and is an excellent addition to any site hoping to expand the PCMH to all of its patient population.

Fundamentally the PCMH provides FQHCs with some profound opportunities to shift health care practices in ways that benefit quality patient care. Sites that serve migrants are in a unique position to share best practices that have been learned over many years of providing care to one of the more difficult to reach populations. At the same time, tools such as MCN's Health Network open up the possibility of providing even better care to migrant patients within the context of a PCMH. MCN welcomes the opportunity to work with sites across the country to expand access to care for migrants by helping to ensure that health centers have the knowledge and tools needed to bring migrant patients into PCMHs.

For more information about how MCN can work with your site visit our website at www.migrantclinician.org or call our toll free Health Network number at 800-981-6353. ■

Announcements

MCN's Candace Kugel has been selected as a fellow for Reach the Decision Makers (REACH), a project of the UCSF Program on Reproductive Health and the Environment, which provides a year-long innovative science and policy training opportunity that aims to increase the number of scientists, community-based leaders, public health and health care professionals who are actively involved in informing the US Environmental Protection Agency (USEPA) of current and relevant scientific findings impacting their decisions in setting policy. REACH intends to help translate science into meaningful public policy that can protect reproductive health. Kugel has worked with MCN since 2001 with a focus on clinical systems and women's health issues and projects. Prior to joining MCN she worked as a Family Nurse Practitioner and Certified Nurse-Midwife in various rural and migrant health settings.

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Department. TBNet followed up on the patient and found that he initiated treatment shortly afterwards. A couple of weeks after starting treatment, the patient informed us that he was not being compliant due to his irregular work schedule and the side effects of treatment; the local Health Department corroborated this and mentioned that it was very difficult to set up DOT appointments with him. The patient stated that his priority was to work because he had no money for food and that he might be moving to look for a job elsewhere. After that conversation, TBNet was unable to get in touch with the patient. We tried to contact him directly and via his wife for months with no success. The patient called TBNet on September 28th, 2010 to let us know that he was now in a different East Coast State. TBNet then stressed the importance of his compliance TBNet and local health authorities, reinforcing the idea that if he moved again he should first contact us. We also passed on the news of this new whereabouts to his wife. The local Health Department in the patient's new location was contacted to alert them about this patient. The patient re-initiated treatment on September 28th, 2010. During his time in his new location, both the patient and the clinic were contacted on a regular basis to ensure he remained compliant. In the end, the patient successfully finished treatment on April 7th, 2011. This case required a total of 24 clinic contacts and 26 patient contacts. ■

Photo courtesy of Bertha Almendariz

California's 2011 Heat Illness Prevention Campaign

Cal/OSHA is once again launching a multi-faceted approach to protecting California's outdoor workers from heat illness that includes a combination of media, education, outreach and enforcement efforts. To help extend this effort throughout communities in the state, they are seeking the support of local organizations that can help reach workers and employers. Last year, a variety of organizations helped Cal/OSHA reach thousands of workers during the summer.

Materials are available in five languages – Spanish, Hmong, Punjabi, Mixteco and English. Strategically targeting the most underserved population of outdoor workers, the campaign addresses heat safety precautions and worker rights. The materials are effective educational materials for workers outside of California as well.

To find out more about this year's effort and to preview all materials, visit Cal/OSHA's bilingual English/Spanish website at www.99calor.org.

Redlands Christian Migrant Association

A Best Practice in Services to Migrant Farmworkers

Amy K. Liebman, MPA, MA

MCN consistently searches among our community and migrant health center partners for examples of best practices including clinical care, outreach, health promotion, recruitment and retention among others. Recently, I visited the Redlands Christian Migrant Association, a model community development organization offering child care and other services to migrant families and children in Florida. While not a health center, Redlands offers us an outstanding example of best practices in numerous areas that are indeed applicable to the work we do in migrant health. It is the wide breadth of their mission and their unequivocal commitment to community empowerment that trickles throughout every tentacle of the organization that is so impressive, offering important examples from which to learn and to apply to our work in migrant health. What follows is a compilation of information from interviews with RCMA staff and the RCMA website and annual reports.

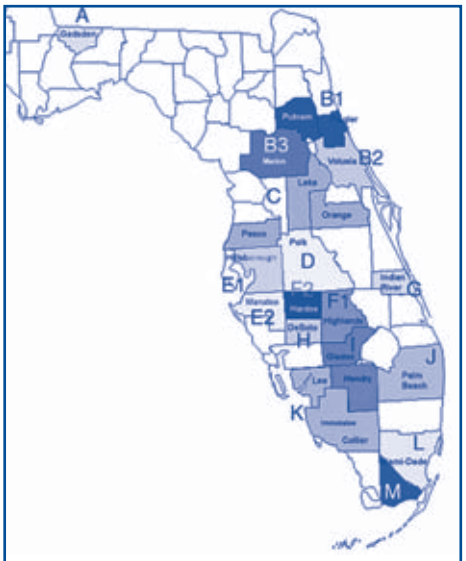
RCMA was founded Oct. 1, 1965, by Mennonite Church volunteers in the Redlands farming area of southern Miami-Dade County to provide a safe, nurturing environment for children while their parents worked in the fields. Initially RCMA began with three centers, serving approximately 75 children in the Homestead and Florida City area. In 2009-2010 RCMA served 8,184 children ages six weeks to 12 years in 87 centers/programs and two charter schools in 21 Florida counties. It is now the largest non-profit child-care provider in Florida and more than half of RCMA's child-care centers are nationally accredited. RCMA is also well-equipped to serve children with disabilities. In 2009-2010, RCMA assisted 458 children with disabilities to access special educational services and needed therapies. A non-sectarian association, RCMA is built on principles of incorporating the family into child development, health care and educational activities and hiring and training staff from the communities served.

It is important to view RCMA as more than a provider of childcare. Services to family and children are its underlying mission. However, it is the focus on community development that enables RCMA to serve as a model organization. Through its capacity building and investment in staff hired from the community, there is an important and positive impact not only on the staff hired, but on the families of the staff. Ultimately, this commitment to the community results in broader development and empowerment.

Overseeing RCMA is a volunteer Board of Directors (BOD), drawn from the geographic regions where RCMA operates and the constituencies served, including former parents, growers and other representatives from the agribusiness community. RCMA embraces the concept of shared governance and shared decision-making, which is also a requirement of Head Start programs.

RCMA takes part in an extensive needs assessment process to gather parent input, understand community concerns and obtain feedback on its services. Their strategic planning and expansion is based on the needs assessment results. Expansion is often a response to an immediate need or even a community tragedy. For instance, one RCMA center opened after the death of young child from agricultural-related accident. The BOD and executive staff participate in strategic planning process every three years. This time frame of three years is due to the rapidly changing funding environment.

RCMA staff represent the community it serves; 85% of staff are community members. Many are former farmworkers and parents that benefited from the childcare and family services offered by RCMA. There is enormous commitment to staff and staff tenure is impressive. Many of the staff have worked for RCMA for over ten years. RCMA invests in their staff by helping them achieve credentials required to provide child care ranging from a Childhood Development Associate (CDA) credential to an associate's degree to a bachelor's degree from a four year college. Many of the classroom teachers and family support workers start as entry staff that then receive professional development and are promoted to higher positions. In 2009-2010 RCMA celebrated the college graduations or professional development of 98 staff members.



RCMA's service area includes 21 Florida counties. RCMA serves over 8,000 low-income and rural children and operates 87 child development centers and two charter schools

Staff retention is particularly impressive as many centers close down for three to four months each year as workers migrate north to work in crop agriculture outside of Florida. Staff are eligible to receive unemployment benefits during this time. RCMA offers a token loyalty bonus to returning staff when centers reopen.

RCMA remains committed to a well educated, credentialed staff. However, RCMA staff commented that it is the underlying commitment to hiring community members who were farmworkers themselves that makes RCMA so successful. In fact, there have been moments in the organizations history when funders requested that RCMA reconsider the type of staff they hire and opt for already credentialed staff. RCMA refused to take this action.

Serving children and families in 21 Florida counties, RCMA is headquartered in Immokalee, Florida at the State Office/Rollason Center, named after the RCMA founder Wendell Rollason. Each of the child development centers is overseen by a Center Coordinator. Staff may include an Early Childhood Specialist,

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Family Support Workers, Teachers Level 1, 2, 3, and Mentor Teacher and Cooks, Bus Drivers and a Food Transporter. Centers are grouped by geographic regions and overseen by Area Coordinators and supported by Program Coordinators, Health Specialists, Data Entry Specialists and Maintenance Workers.

Many of the centers are designed with extensive detail to physical space. At the Rollason Center that is based at the State Office in Immokalee, all of the administrative windows look out on playgrounds or gardens. Classrooms are open with windows to the outside and windows between each room.

The hours of operation of each center are determined with parental input. Some centers open as early as 6:30 am. The centers serving primarily migrant families are opened seven to eight months a year. Workers are temporarily laid off from RCMA when the center closes.

RCMA offers a number of programs for parents. RCMA provides English and literacy classes for parents as well as the opportunity to finish their education in both the Florida and Mexican school systems. Additionally, centers host monthly parent meetings in the evenings (this is a requirement of migrant head start). Food, childcare, interpretation services and transportation, as needed, are provided to facilitate parent attendance. The content and topics of these meetings vary and offer important opportunities to provide parents education and information pertaining to their health and safety as well as that of their children.

Most RCMA children are part of Head Start, Early Head Start and Migrant Head Start, comprehensive child-development programs that serve children from birth to age 5, pregnant women and their families. In addition to these federally funded programs RCMA maintains a unique, innovative and valuable partnership with the State of Florida in recognition of the association's experience and success with the unique needs of the farmworker population, with a contract designed to target the children of farmworker and former farmworker families wherever services are needed throughout the state. Voluntary pre-kindergarten is available to eligible 4 year olds in our programs

The programs strive to increase the school readiness of young children in low-income families. Head Start is a program within the Administration on Children, Youth and Families in the U.S. Department of Health and Human Services, which awards grants to RCMA to provide these services.

RCMA also has two charter schools with more than 350 students grades K-8.

RCMA uses the language of child's home primarily from birth to three. When the child turns three, RCMA incorporates more and more English. Staff speak various languages including English, Spanish and Creole. RCMA, like other organizations dealing with immigrant populations, is challenged by the changing demographics as different immigrant groups need services such as indigenous populations from Mexico and Central American and who speak numerous different dialects.

RCMA offers families other services. Each center includes one or two family support workers who offer case management to assist families in navigating social services and accessing health care. Transportation is also an important service offered by RCMA.

RCMA is funded by local, state and federal grants, as well as through the generosity of the United Way, agribusiness and other corporations, community foundations and individuals.

State and federal agencies represent over 85 percent of RCMA's funding. Florida growers, businesses, community foundations, social service agencies and concerned individuals provide land, buildings, services and expertise to help open doors to opportunities for farmworker families. Additionally, local school districts provide grants and reimbursements for certain programs and services provided by RCMA.

The United Way, community foundations, civic groups and corporate and individual donors provide vital support, as RCMA must raise $500,000 annually from local sources to qualify for certain grants. For every $1 donation, RCMA can receive up to $16 in matching funds. RCMA does not have a development director or any staff solely dedicated to fundraising. They also do not rely on revenue generating activities.

RCMA is unique in that members of its BOD as well as funders include substantial representation for the grower/producer community. In Florida, grower-worker relationships have a contentious history. While some in the farmworker community have criticized RCMA for these types of relationships, RCMA believes that if groups can align around their common mission and focus on children then the collaboration is important. RCMA staff reported that some of their grower partners engage with RCMA as they recognize the important service RCMA provides to their workers and the importance of having a safe place for children while parents work on their farm. Others, they reported, are not necessarily motivated by the benefit to their workers, but are simply motivated by an overall civic duty and desire to support a stellar organization. Additionally, RCMA staff underscored that their primary focus is children and families and will not hesitate to address the grower community to advocate for their families. ■

Photo courtesy of Amy Liebman

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calendar

Community Health Institute (CHI) & EXPO
August 26-30, 2011
San Diego, CA
National Association of Community Health Centers
www.nachc.com

American Public Health Association
139th Annual Meeting and Exposition
October 2-November 2, 2011
Washington, DC
American Public Health Association

24th Annual East Coast Migrant Stream Forum
October 20-22, 2011
West Palm Beach, FL
North Carolina Community Health Care Association
www.ncchca.org

21st Annual Midwest Migrant Stream Forum
November 10-12, 2011
Albuquerque, NM
National Center for Farmworker Health
www.ncfh.org
www.apha.org

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