

streamline

The Migrant Health News Source

Get the Lead Out!

Resources for Prevention and Treatment of Lead Exposure in Migrant Workers and Families

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Lead has recently re-emerged as a public health concern in connection with the presence of lead in children's toys. Another story behind those headlines, however, is that groups such as migrant workers and their families experience exposures to lead and other toxins that are not as well known. While lead poisoning has decreased significantly in the US in recent years, continued vigilance is warranted for those who may live and work in conditions that place them at higher risk. Exposure can be either environmental, such as from imported foods, cooking utensils, or medications; or occupa-

tional. Table 1 lists occupations associated with lead exposure, including construction, factory work and activities associated with work in agriculture. (Source: *Indecent Exposure: Lead Puts Workers and Families at Risk* by Holly Brown-Williams, Joan Lichterman, and Michael Kosnett; Health Research for Action Perspectives, March 2009, vol. 4, no. 1, p. 3.)

As highlighted in the article *Multiple Risk Factors for Lead Poisoning in Hispanic Sub-Populations: A Review* by Ray Brown and Thomas Longoria, excerpted beginning on page 3, there is evidence that Hispanic sub-

populations such as those served in migrant health settings are at increased risk of exposure to lead and the consequences of lead poisoning. The Migrant Clinicians Network (MCN), in partnership with Texas Tech University, Texas State University and Motivation Education & Training, Inc., has developed a set of resources for primary care clinicians and health educators to address this need. This project, funded by the Environmental Protection Agency (EPA), responds with practical tools to an environ-

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mental and occupational health risk which impacts uniquely on the migrant population. Products developed through the project include.

Clinician Training Resources

- Clinical guidelines have been developed for the recognition and management of lead exposure for migrant patients in the primary care setting. There are separate guidelines addressing the unique features of:
 - Migrant children
 - Adult workers engaged in agriculture, construction and housing rehabilitation
 - Pregnant migrant women.
- A one-hour training module for clinicians entitled “Grasshoppers, Dust and Salsa - An Old Toxin in a New Setting: A Fresh Look at Lead Poisoning in Migrant Populations” that includes:
 - Risk and consequences of lead exposure
 - Sources of exposure
 - Routes of exposure
 - Taking environmental/occupational exposure histories
 - Symptoms of lead poisoning
 - Testing, diagnosis and management
 - Cultural competency issues related to lead exposure in vulnerable populations

The training was piloted initially at the Community Health Center of Lubbock and was then presented by webcast to a national audience. The webcast is archived by the Clinical Directors Network (CDN) and can be accessed at <http://www.cdnetwork.org/NewCDN/LibraryView.aspx?ID=cdn521>. Continuing education credits are available through CDN at no charge after viewing the presentation.

Additional Resources

- In addition to the products described above, a wide range of lead-related materials have been posted to a section of MCN’s Environmental and Occupational Health web pages (see http://www.migrantclinician.org/clinical_topics/lead.html) including:
- Research and news articles relevant to lead exposure in migrant populations
 - Patient education materials for children, pregnant women and adults
 - Promotora environmental training curriculum
 - Screening and exposure history forms

All resources are available free of charge to any who are able to use them. For additional information or technical assistance on this topic, please contact Amy Liebman at aliebman@migrantclinician.org. ■

Table 1.
Occupations Associated with Lead Exposure

<p>Manufacturing</p> <ul style="list-style-type: none"> ■ Batteries ■ Radiators ■ Steelworks, blast furnaces ■ Iron foundries ■ Smelting and casting of brass, copper, and lead (including ammunition, solder, weights) ■ Paint for industrial use ■ Ceramics, tile, glass ■ Machining and grinding lead alloys ■ Plastics <p>Mining</p> <ul style="list-style-type: none"> ■ Lead ■ Copper 	<p>Construction</p> <ul style="list-style-type: none"> ■ Bridges and tunnels ■ Welding and cutting painted steel ■ Paint removal and sanding ■ Lead abatement ■ Renovation/remodeling ■ Wrecking and demolition <p>Other</p> <ul style="list-style-type: none"> ■ Recycling (batteries, scrap metal, cable, electronics) ■ Radiator repair ■ Cutting and soldering wire cable; cable splicing ■ Indoor firing ranges ■ Stained glass
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Table 2.
Some Common Non-occupational and Environmental Sources of Lead Exposure

Immigration should be recognized as an environmental risk: Asia, Mexico and Central America have particularly high levels of lead still available in everyday products. Industrial pollution in Asia is a well-known source. Other sources include:

- Remodeling or painting pre-1978 housing
- Peeling paint
- Ethnic medicines or folk remedies (e.g., azarcón, greta, pay-loo-ah, kandu, some Ayurvedics)
- Ethnic Foods such as fried grasshoppers, self-imported spices, and candies. The wrappers of these foods may also contain lead, as has been shown with candies.
- Pica (ingestion of lead-containing nonfood items, e.g., soil or ceramics, plaster, or paint chips)
- Retained lead bullet or fragments
- Melting lead for fishing weights, bullets, or toys
- Lead solder in stained-glass artwork
- Lead-soldered cans
- Lead-contaminated candies
- Backyard scrap metal recycling
- Moonshine (liquor from a homemade still)
- Antique pewter plates, mugs, utensils, toys Imported brass or bronze kettles, cookware
- Lead-glazed tableware or cooking vessels
- Leaded crystal tableware
- Mine tailings
- Beauty products such as kohl eye make-up, certain hair dyes
- Imported toys
- Imported vinyl miniblinds
- Recreational target shooting
- Lead-contaminated drinking water supply
- Using lead glazes for ceramics, food dishes, and cookware. Acidic foods like salsa can leach even more lead from these containers
- Painting/stripping cars, boats, bicycles

Multiple Risk Factors for Lead Poisoning in Hispanic Sub-Populations: A Review

Add authors, Ray Brown and Thomas Longoria

[Editor's Note: The following has been excerpted with permission from the *Journal of Immigrant and Minority Health*, March, 2009, Springer. For the full article including references go to <http://www.springer.com/public+health/journal/10903>]

As a result of recent media attention to lead (Pb) in consumer products, Pb exposure and toxicity to children has been placed back on the national agenda. This review presents the current literature on sources of Pb in Hispanic sub-populations in the broader context of national lead poisoning trends, sources, and exposure pathways. Pb poisoning among Hispanics is a multi-dimensional issue that is far more complex than for the general population in terms of environmental, cultural, and social dimensions. As a result, a higher percentage of Hispanic children have elevated blood lead levels compared to the general population.

Overview of Blood Pb Concentrations in Hispanic Children in the US

The evaluation of blood Pb concentrations in Hispanic children began in the 1970s. Health disparities in Pb exposure were first noticed as soon as data began to be collected based on ethnicity. For example, a study conducted in New York City found that geometric means for blood Pb concentrations were different for different ethnic groups.

Three National Health and Nutrition Examination Surveys (NHANES) along with a survey targeting three Hispanic groups (The Hispanic Health and Nutrition Examination Survey: HHANES1982-84) have been conducted since 1970 (1971-75, 1976-80, 1988-94). Continuous NHANES data collections have occurred since 1999. These studies have documented factors related to the health and nutritional status of children including increasing consideration of environmental health. Data is collected from thousands of in-home interviews and medical tests using mobile examination centers. These studies constitute the most comprehensive assessment of child health nationally and have documented health disparities between Hispanic and non-Hispanic children including disparities in blood Pb concentrations.

The first NHANES study did not collect

blood Pb data. While NHANES II did include this data, ethnic determination of children tested was limited to black versus white. The HHANES data revealed blood Pb differences among Mexican-American, Puerto Rican and Cuban children and disparities between Hispanic and white children. In an assessment of the NHANES III (1988-1994) study, it was reported that 1% of 1-2 year old Mexican-American children had greater than 25 lg/dl blood Pb, twice that of non-Hispanic whites. In another evaluation of the third NHANES study data, ethnic groups were compared revealing that 28% of Mexican American children had BLLs greater than 5 lg/dl compared with 19% of non-Hispanic white children.

NHANES 1999-2002 collections showed persistent disparities. For example non-Hispanic black and Mexican American children \1 year had higher percentages of elevated BLLs (1.4% and 1.5%, respectively) than non-Hispanic whites (0.5%). It is important to mention along with these disparity descriptions that blood Pb levels for Hispanics were also declining overall. It was reported that blood Pb levels among Mexican Americans declined from 2.96 to 1.86 lg/dl in comparing the NHANES III and NHANES (1999-2002) data.

Pb exposure to all children in the United States has been greatly reduced as a result of banning Pb-based paint and leaded gasoline. It is now estimated that fewer than 2% of US preschoolers overall have a blood-Pb level greater than 10 lg/dl. Disparities among different ethnic groups, however, still persist.

Explanations for continued disparities are likely a combination of environmental factors (e.g., condition of housing, proximity to busy highways and intersections) as well as unique cultural and behavioral dimensions within different Hispanic subpopulations.

Where People Live: Pb Exposure as a Function of Location

Immigration and Pb Poisoning

For Hispanic immigrants, blood Pb levels may be a reflection of prior exposure in their country of origin where environmental risks are greater. Evidence of increased risk to environmental Pb concentrations and

exposures in Latin American countries has been documented in numerous review articles and research studies.

The consequences of inaction in battling diseases linked to environmental health in Latin American countries have been discussed along with suggestions on how to address these environmental health issues.

Whether and how developing countries address environmental contamination is important because their policies are having an impact on health indicators in the US. Immigrants bring with them their physiological burden of Pb stored in bone. In addition, they bring distinctive cultural and dietary practices that can result in the significant exposure to Pb discussed in the following sections.

Unfortunately, very few studies have been conducted on the Pb burden of newly arrived immigrants. One study found a greater percentage (20%) of Mexican-born Hispanic children had blood Pb levels greater than 10 lg/dl than did US-born Hispanic children (7%). 12% of immigrant children arriving at the Miami-Dade County Health Department from 1999 to 2001 had elevated blood Pb levels, a rate 5.5 times the general population at the time. In Massachusetts, the percentage of recently arrived refugee children with elevated blood Pb levels was more than twice that of US-born children, leading the authors to suggest that clinicians should consider nativity as a risk factor.

Pb, once absorbed into the body, is stored in bone and slowly leeches into the blood over the course of a lifetime—a process that accelerates during pregnancy. Pb absorbed into bone while in the native country accounted for blood Pb levels among immigrant women in samples taken in the US. In another study, 1,428 pregnant immigrants in South-Central Los Angeles had a significantly higher blood Pb level mean of 2.3 lg/dl compared to 1.9 of 504 pregnant non-immigrants. Blood Pb levels of immigrants were related to time spent in the US with each natural log increase in years translated to a 19% decrease in blood Pb. Generation status has been shown to affect blood Pb concentrations in immigrant families.

First-generation Mexican-American children had higher BLLs than third-generation

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children. In brief, these findings document the impact of nativity and prior environmental exposure. Addressing the economic losses associated with elevated blood Pb levels for these new Americans and their children should be a public health priority. This can be done by focusing on testing immigrant children and women of child-bearing age and developing programs to minimize the negative effects of Pb through nutrition and education programs.

National Origin Differences

Generalizations regarding the environmental health of different national origin groups are difficult to make due to the confounding effects of differences in environmental and socio/behavioral risk factors. Health disparities, however, do exist among national-origin subpopulations and ignoring race and ethnicity can lead to an underestimation of health disparities, for example as seen in the case of asthma.

In an examination of Hispanic subpopulation differences in Pb concentrations, Puerto Rican children presented the highest mean blood Pb levels (11.5 lg/dl), followed by Mexican-American children (10.4 lg/dl) and Cuban children (8.6 lg/dl). Puerto Rican children had the highest percent of elevated blood Pb defined as greater than 25 lg/dl (2.7%) as compared to 1.6% of Mexican-American children and less than 1% (0.9%) of Cuban children.

Differences in blood Pb levels as a function of national origin may be linked to other factors. One researcher determined that working and housing conditions among poor workers were distributed based on nativity, citizenship, and indigenous background. Other findings have revealed discriminatory practices related to occupational safety and health issues for indigenous farm workers.

These findings suggest that national origin as a subpopulation criteria is limited and that considering both underlying class structure and immigration status issues may better account for understanding Pb exposures.

Border Populations and Pb

The US-Mexico border merits special attention with regard to environmental health and Hispanics. The highest poverty rates are found on the US-Mexico border. Gonzalez, et al. document that Pb is "a transborder problem which, if unaddressed, will lead to adverse long-term economic, social, and health consequences on both sides of the border". Proximity to Mexico affects residents in the US as some types of pollution and environmental contamination flow freely across the border. Many residents also

cross the border frequently, have family on the other side of the border, and maintain Mexican cultural traditions longer than Mexican immigrants away from the US-Mexico border.

A comparison study of blood Pb levels of children living directly on the US or Mexican sides of the border found mean BLLs were higher among children living on the Mexican side of the border (4.3 lg/dl) compared to those on the US side (2.2 lg/dl). In another example in Anapra, Mexico across the border from El Paso, Texas, Pb concentrations were found to be a function of distance from a smelter located in the US, which was closed in 1985. In an area closest to the border, 43% of children tested had blood Pb concentrations greater than 10 lg/dl. A decreasing percentage of children with blood Pb levels [10 lg/dl was found as a function of distance from the smelter.

Migratory Farmworkers

In 1989, there were 840,000 migrant farmworkers across the US with 409,000 children. In Texas alone, it was estimated that during the 2000–2001 school year, there were 71,656 migrant students in 223 school districts. Migratory farmworkers have been shown to live in crowded conditions in inadequate housing lacking basic facilities such as vacuum cleaners. Because of mobility, migratory farmworkers and their families face unique conditions that can potentially exacerbate health disparities including inconsistent health care and exposure to a constantly changing environment.

Schaffer and Kincaid found that children living in rental property and belonging to a family of migrant farmworkers were more likely to have elevated blood Pb levels. Children and adults moving from place-to-place into different substandard housing units as well as nutritional deficiencies caused by an inconsistent diet were likely factors.

What People Do: Pb Exposure as a Function of Activity

[Editor's Note: Tables 2 and 3 summarize the sources of Pb exposure from a variety of activities and/or products]

Discussion and Conclusions

Reducing childhood exposure to Pb is problematic. Proximity to a potential risk is not necessarily related to how individuals assess that risk. For example, risk judgments by people living near a metal processing plant were not a function of the actual risk present. Logically, risks from non-visible environ-

mental threats such as leaded dust would be of even less concern.

Most people do not understand sources of Pb in their environments and they do not take steps to prevent exposure to their children. Childhood exposure to leaded dust can be reduced by monitoring and encouraging hand washing and other behavioral changes. However, parents have limited awareness of their child's outdoor behaviors

Underestimated risk among minority and immigrant populations leads to increased health disparities. Many Hispanic immigrants come from areas that are far more contaminated with Pb and may perceive the US as a "cleaner" environment for their children thereby reducing their vigilance.

There is little doubt that Pb poisoning is a critical issue for Hispanic and immigrant health. A recent estimate determined that 310,000 children ages 1–5 in the US have blood Pb concentrations greater than 10 lg/dl and that Hispanic children 1 year old are 3 times more likely to have elevated blood Pb. The problem may be even worse due to evidence that would lower the definition of elevated blood Pb.

The Centers for Disease Control and Prevention has established guidelines for states in their development of screening plans with a focus on geography rather than population. While there are recommendations with regard to targeted screening as a function of family income and racial/ethnic background, the overwhelming message is that older housing (e.g., housing built before 1950), is the most significant source of Pb to children. An example provided to states in their development of screening plans even suggests determining whether to test children in an area according to whether 27% of housing is older than 1950.

While other sources of Pb are mentioned, a recent broadcast by the CDC again emphasized Pb-based paint being the major source of exposure for Pb for US children. Not only are there other sources of available Pb just as important as paint, but a long list of myriad sources that non-universal (targeted) screening plans will ultimately miss.

This review article reveals that cultural and behavioral factors unique to Hispanic populations may be as important as age of housing and exposure to leaded paint for thousands of Hispanic children. The CDC recommends universal screening for states without a state-specific plan. For states that do not have universal screening plans, we strongly recommend that these states designate children with Hispanic origin as high risk. ■

New Research Explores Heavy Metal Exposures among Mexican Farmworkers

Summary by Lacey Saborido

In the first study to examine indicators of farmworker body burdens of metals, researchers compared creatinine-adjusted urine level of metals among farmworkers with the general US population and examined their associations with a series of relevant personal and occupational characteristics. The study analyzed data on metals found in urine of 258 farmworkers in eastern North Carolina in 2007 and concluded that farmworkers exceed the US population in levels of arsenic and lead, are similar for mercury, and are lower for cadmium.

The study specifically targeted four metals: arsenic (As), lead (Pb), mercury (Hg) and cadmium (Cd) in which growing evidence suggests that negative health effects from cumulative, lower level exposure. Chronic exposure to arsenic is associated with, increased risk of reproductive problems, including miscarriage, stillbirth, preterm cancer and diabetes. As a neurotoxin, lead has serious detrimental effects on child development and recent research has documents the cumulative adverse effect of lead on cognitive function in adults as



well. Mercury's neurotoxic effects are well-established for child development, and for adults effects include impaired concentration and performance of neuromotor function and parathesia.

The researchers point out that migrant and seasonal farmworkers from Mexico represent a population at a higher risk of exposure to these metals through environmental,

occupational and cultural sources. Mexico is a leading producer of lead, and the process of refining produces dust that contaminates the environment, including water sources. Lead is also found in traditional home remedies used throughout Mexico, as well as in candies, food products produced there, and

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[Editor's Note: This is part two of an article that first appeared in MCN's Immu-News listserv. The first part of this article appeared in the September-October, 2009 issue of Streamline. The Immunization Initiative is funded by the Centers for Disease Control and Prevention. The Immu-News Listserv is a support service for clinics participating in the project. If you would like to be on the listserv, or if you have questions about the listserv or resources listed here please contact Kathryn Anderson, listserv administrator at kath@healthletter.com or Kate Bero, MCN's Immunization Initiative Manager at kbero@migrantclinician.org.]

Vaccine-Hesitant Patients – What's a Provider to Do?

Part Two

Two recent articles in the medical literature point to the importance of providing patients and parents with science-based information about vaccines, including communicating with parents about the serious consequences of choosing not to vaccinate their children. According to a recent article in the May 2009 issue of BMC Public Health, when parents scored well on a test of vaccine knowledge, their children were more likely to be on schedule with their immunizations, which suggested to the researchers that if doctors do more to inform parents about vaccine effectiveness and safety, they will be more likely to keep their children on the recommended schedule. Also, in the June issue of Pediatrics, researchers found that parental refusal of pertussis vaccination is associated with an increased risk of pertussis infection in children. They found that the unvaccinated children were about 23 times more likely than vaccinated children to get whooping cough.

Adult Clients – what are the barriers and what are the strategies for providers when it comes to adult clients?

The reasons adults have for not getting vaccinated may be different from parents' hesitation on the part of their children. Our clinics have reported on some of the barriers they have heard from their adult patients:

- Resistance due to cost.
- Needle opposition.
- "If I don't have to get the shot [for work] then I don't want it."
- Unwillingness to miss work
- Pain avoidance
- Lack of knowledge about adult vaccines
- More hesitation among adult Hispanic male patients.

We theorize that some of the reason for the latter is that women receive vaccines as

adults when they are pregnant as well as postpartum. They are more familiar with the idea of adults getting vaccines, and the vaccine may have been introduced to them in the context of a concrete and tangible result: mothers will be protecting their children from illnesses that could have been carried into the household by the mothers

Tips from the field to increase adult vaccination rates

1. Know your clinic's policy regarding vaccine fees.
2. If your clinic doesn't provide vaccines, know where in your area your client can go for vaccines, especially if they are free. Provide clients with phone numbers and directions in Spanish.
3. An example from East Georgia Health

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[Editor's Note] Three years ago MCN and Farmworker Justice (FJ) embarked on a focused partnership to provide comprehensive, high quality capacity building assistance to Migrant Health Centers (MHC). Since the initiation of this effort, Farmworker Justice's expertise in legal and policy issues has proved invaluable. For the next six months MCN will be featuring articles and/or policy memos written by Farmworker Justice that address key legal and/or policy issues impacting clinical care at Migrant Health Centers. The following two risk management resources are a continuing part of this series. If you have further questions or comments about the content please contact Virginia Ruiz at Farmworker Justice (vruiuz@farmworkerjustice.org).

Care for Undocumented Patients: Risk Management Considerations

Farmworker Justice

Note: these are general risk management guidelines. Health Centers should seek the advice of an attorney to adopt specific risk management policies and procedures that address their unique needs.

BACKGROUND

Unlike providers of many other federally-funded services and benefits, Health Centers are permitted to serve undocumented patients, and are not required to ask about a patient's immigration status. Migrant Health Centers need to ensure that their policies protect patient privacy while complying with applicable laws on collection and disclosure of patient information.

CONSIDERATIONS

- The information that a Health Center gathers on a patient, including an undocumented immigrant, is generally protected under the Health Insurance Portability and Accountability Act (HIPAA).
- HIPAA states, however, that disclosure of a patient's health record may occur if required by another federal or state law. In some instances, a court may issue an order under another law to release a patient's medical record. It is possible in such a situation that information about immigration status could be revealed if it appears in the medical record.
- Health Centers may soon have certain responsibilities to establish systems to pre-

vent and detect perpetration of "identity theft," which could relate to some undocumented workers. The term "identity theft" means a "fraud" committed or attempted using the identifying information of another person without authority. However, the state of the law is unclear: The US Supreme Court has recently ruled that use of false documents to get a job is not necessarily "identity theft" under criminal law.

- In 2003, Congress ordered federal agencies that regulate credit to issue regulations requiring that non-profit and other entities that provide services for which they bill later implement programs to prevent identity theft. The FTC issued regulations known as "Red Flag Rules." The term "Red Flag" refers to a pattern, practice, or specific activity that indicates the possible existence of identity theft. Although the Rules became effective in late 2008, enforcement has been delayed several times, most recently until August 1, 2009.
- To determine if your Health Center must comply with and for additional details about Red Flag requirements, please see *Complying with the FTC's Red Flag Rules¹* and *FTC Red Flag Rule Considerations in Developing an Identity Theft Prevention Program.²*

The development and implementation of identity theft prevention programs in accordance with the Red Flag Rules is separate from the

Health Centers' legal obligations to meet the health care needs of eligible patients, which includes undocumented workers. The Red Flag Rules do not directly affect Health Centers' responsibilities to provide medical care.

In meeting their obligations, Health Centers should be aware of the potential for misunderstandings regarding migrant workers' identities, particularly those who are immigrants, and attempt to prevent adverse effects on such workers. For example, a patient may supply personal identifying information that contains inconsistencies. However, there may be some circumstances where this would arise that are unconnected to identity theft. For example, in some Hispanic/Latin American cultures, naming traditions are different than in the United States and inconsistencies in the medical records may result. A patient may innocently provide one last name, and then at a later date, may provide multiple last names. Health Centers' policies and practices should continue to be sensitive to the special populations they are serving. ■

1 Available from the National Association of Community Health Centers at http://www.nachc.org/client/documents/Compliance_with_FTC_Red_Flag_Rules_Issue_Brief_2.10.09.pdf

2 Available from the National Association of Community Health Centers at [http://www.nachc.org/client/documents/FTC_Red_Flag_ITPP_IB_4_8_09\[1\].pdf](http://www.nachc.org/client/documents/FTC_Red_Flag_ITPP_IB_4_8_09[1].pdf)

■ Vaccine-Hesitant Patients continued from page 5

Care: provide outreach, if possible, to the workplace. EGHC, while it cannot provide vaccinations in the field, does send staff to workplaces, and the staff provides education about vaccines and information about where to go to get them.

4. Educate! Every conversation about immunizations may increase comfort level and familiarity with the idea of adult vaccinations, and can help increase the value to the tipping point of action. Be prepared with a couple of standard lines, such as the ones listed here, about why vaccines are important:

- "An hour of your time now could save you weeks of work. Instead of getting sick and having to stay home,

you will be able to work."

- "You can keep your family from getting sick as well, if you don't bring sickness home with you. By getting the vaccine yourself, you are providing some protection for your children."

The following articles discuss adult and/or pediatric vaccines and some of the barriers mentioned above.

Further Reading

1. *Parental Knowledge of Paediatric Vaccination* Borras E, et al. BMC Public Health. 2009 May 27;9:154. <http://www.ncbi.nlm.nih.gov/pubmed/19473498>
2. *Parental Refusal of Pertussis Vaccination Is Associated with an Increased Risk of Pertussis Infection in Children* Glanz JM, et al. Pediatrics 2009

Jun;123(6):1446-51

<http://www.ncbi.nlm.nih.gov/pubmed/19482753>

Please note: only the abstract is available unless you have a subscription to *Pediatrics*

3. *Vaccinations in Adults: Missed Opportunities* Editorial, Richard K. Zimmerman and Judith Ball, *American Family Physician*, September 15, 1998. <http://www.aafp.org/afp/980915ap/edit.html>
4. *Attitudes of US obstetricians toward a combined tetanus-diphtheria-acellular pertussis vaccine for adults.* Clark SJ *Infectious Diseases in Obstetrics and Gynecology* Volume 2006, Article ID 87040, Pages 1-5 <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1779616&camp;blobtype=pdf>
5. *Community and patient values for preventing herpes zoster.* Lieu TA, Ortega-Sanchez I, Ray GT, Rusinak D, Yih WK, Choo PW, Shui I, Kleinman K, Harpaz R, Prosser LA. *Pharmacoeconomics*. 2008;26(3):235-49. <http://www.ncbi.nlm.nih.gov/sites/entrez> Please note: only the abstract is available ■

Behavioral Health Care for Mobile Populations: Risk Management Considerations

Farmworker Justice

Note: these are general risk management considerations. Health Centers should seek the advice of an attorney to adopt specific risk management policies and procedures that address their unique needs.

BACKGROUND

In recognition of the importance of behavioral health as a component of quality health care delivery, HRSA requires health centers to provide these services to their patient population. These are services that are difficult for many MHCs to provide onsite so they often must be contracted to outside providers. Behavioral health services may include, but are not limited to, counseling for mental health issues (e.g., depression, anxiety) and substance abuse (e.g., alcohol, recreational drugs). Health centers need to be aware of the special requirements imposed by HIPAA on medical records generated by the provision of behavioral health services, and consider the impact on FTCA coverage of referring patients to outside and/or off-site providers.

CONSIDERATIONS

HIPAA Compliance: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created standards for the use and disclosure of patients' health information that have specific provisions for behavioral health care.

- HIPAA regulation refers to the patient behavioral health information as "psychotherapy notes," which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private, group, joint, or family counseling session and that are separated from the rest of the individual's medical record.
- Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
- Normally, a Health Center must disclose health information to a patient at their request; however, a Health Center does not have to allow an individual to inspect and obtain a copy of his/her psychotherapy notes.
- A Health Center generally must obtain written authorization from the individual who received the counseling if someone other than the person who created the notes is going to use them or if their contents are going to be disclosed.
- However, a Health Center may use or disclose psychotherapy notes without authorization:
 - for training programs that allow students, trainees, or practitioners in mental health to learn to practice their skills in counseling;
 - to defend itself in a legal action or other proceeding brought by the person who is the subject of the notes;
 - to comply with an investigation by the Department of Health and Human Services;
 - when the use or disclosure is required by law;
 - when the information is used or disclosed for oversight of the person who created the notes;
 - to a coroner or medical examiner; or
 - to avert a serious threat to health or safety.
- For all other uses or disclosures, a Health Center must obtain written authorization. A Health Center must retain the authorization, or an electronic copy of it, for six years after the date when it was last in effect.
- Prior to use or disclosure of psychotherapy notes, the Health Center should ensure that the authorization's expiration date has not passed or the expiration event has not occurred. It should also ensure that the authorization has been completely filled out.
- A Health Center should have a procedure in place which ensures that when a revocation of authorization is received, no further uses or disclosures are made of the psychotherapy notes whose authorization was revoked.
- An authorization for the use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes, and not with any other type of authorization.

FTCA Coverage

- For behavioral health services to qualify for FTCA coverage, the provision of behavioral health services must have been approved in the annual grant application.
- For referrals to be entitled to FTCA coverage, they must be made pursuant to a formal written referral agreement under which the Health Center maintains responsibility for the patient's treatment plan and will be providing and/or paying or billing for appropriate follow-up care based on the outcome of the referral.
 - The formal written referral agreement should describe the manner by which the referral will be made and managed, and the process for referring patients back to the Health Center for follow-up care.

■ New Research Explores Heavy Metal Exposures among Mexican Farmworkers continued from page 5

ceramics. Arsenic is known to be concentrated in drinking water in numerous regions of Mexico, often in excess of established international standards. Arsenic has also been used extensively in agricultural pesticides, contaminating soils and plants grown in them. Mercury exposure results from eating contaminated seafood, as well as from cultural and religious practices like injecting mercury. Cadmium is found in soils where certain fertilizers have been used and in plants grown in such soils. Smoking tobacco is a major source of both arsenic and cadmium due to the plant's absorption of these metals in the soil from fertilizers.

The researchers also discussed the fact that the sources of farmworkers exposure to these metals is not clear, and is likely a combination of both exposure in their communities of origin as well as occupational exposures here in the US.

The exposure of farmworkers to metals is of interest because of their occupational exposures as well as their origins in areas where the potential for exposure to environmental sources is high. The article suggests that possible interaction of such toxic chemicals with pesticides to which farmworkers are routinely exposed puts them at risk for adverse health effects from his combined exposure.

Additionally, it points out that because farmworkers generally have fewer occupational health protections and limited access to medical care, they are a population for which additional exposures to metals is an issue of environmental and occupational justice.

Full Article: Quandt SA, Jones BT, Talton JW, Whalley LE, Galván L, Vallejos QM, Grzywacz JG, Chen H, Pharr KE, Isom S, Arcury A. (2009). Heavy metals exposures among Mexican farmworkers in eastern North Carolina. Environmental Research. In press and available at www.elsevier.com/locate/envres



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calendar

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January 27-28, 2010

Dallas, TX

Agricultural Health and Safety Council of America

<http://www.ashca.com/>

Western Migrant Stream Forum

February 12-14, 2010

Seattle, WA

Northwest Regional Primary Care Association

<http://www.nwrpca.org/migrant-health/western-migrant-stream-forum.html>

Cancer, Culture & Literacy - 7th Biennial Conference

May 20-22, 2010

Clearwater Beach, FL

Moffitt Cancer Center

<http://www.moffitt.org/cc>

National Farmworker Health Conference

May 5 - 7, 2010

San Diego, CA

National Association of Community Health Centers

<http://www.nachc.com>



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