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Caring for the Worker in Migrant Health:

Occupational Medicine Brings Healthcare Justice to the Front Lines

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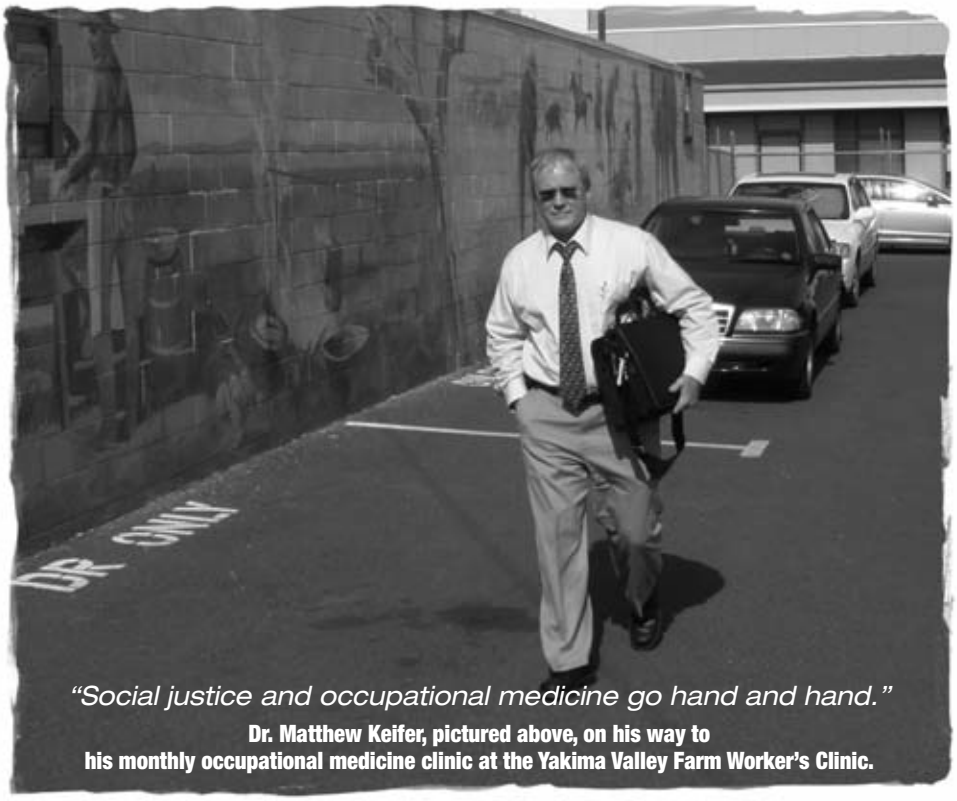
Editor's Note: This article showcases an occupational medicine model for migrant health that MCN is trying to replicate in Migrant and Community Health Centers across the country. If you are interested in building this type of activity into your practice, either as a primary care clinician/clinic or as an occupational medicine specialist, please contact Amy Liebman, at aliebman@migrantclinician.org or 410.860.9850.

Each time Hector Garcia* tried to return to work at the local fruit packing plant, his asthma worsened. Just the smell of the packing house made his breathing difficult. Struggling more and more in his attempts to go back to work, Hector sought treatment at a local health clinic in Washington State. Because his asthma had begun following a mass poisoning with carbon monoxide, he was diagnosed with work-related asthma. Despite the best clinical efforts to help Hector manage his asthma, nothing seemed to improve his condition. Neither his bronchodilator inhaler nor inhaled steroids made a difference. Hector's physician referred him to Dr. Matthew Keifer, an occupational medicine specialist from the University of Washington.

Each month for the last 13 years, Dr. Keifer has flown from Seattle to Toppenish, the heart of Washington's agricultural region, where he runs a half day occupational clinic at the Yakima Valley Farm Workers Clinic. Dr. Keifer deals with the complicated cases regarding work related injuries and exposures, cases no longer manageable in the primary care setting.

Hector's symptoms did present like asthma. But something was off. "It just didn't add up," comments Dr. Keifer. "He also suffered from depression and prolonged anxiety. But the immediacy of symptoms such as shortness of breath in response to auditory stimuli suggested it wasn't asthma."



"Social justice and occupational medicine go hand and hand."
Dr. Matthew Keifer, pictured above, on his way to his monthly occupational medicine clinic at the Yakima Valley Farm Worker's Clinic.

Dr. Keifer reviewed Hector's case. He interviewed and examined him and went over all of his symptoms in detail, delving into potential triggers to his shortness of breath. He ordered a methacholine challenge test, which was negative. Dr. Keifer had seen several similar cases and finally concluded that Hector suffered from Post Traumatic Stress Disorder related to the mass poisoning from carbon monoxide.

The initial incident struck Hector and his coworkers almost a year earlier at the fruit packing plant. The carbon monoxide poisoning, not uncommon in Washington State agriculture, resulted from forklifts being used in a relatively tightly sealed workplace. Trying to keep insects out of the packed fruit, packing houses often limit ventilation and close doors and other openings that might provide natural ventilation. This can become dangerous when gas powered forklifts and other petroleum or natural gas powered equipment are used.

In Hector's case, several workers fell to the floor unconscious. Others made it out, some collapsing once outside the ware-

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house. The workers awoke amidst the screeching of sirens as ambulances and personal vehicles rushed to the scene to take sickened workers the hospital. The residual fear and trauma of the event caused Hector to suffer anxiety attacks resulting in shortness of breath and other symptoms. These were all related to the terrifying, life threatening episode he endured and witnessed.

Dr. Keifer's occupational clinic has helped numerous workers injured on the job. In addition to problems related to the residuals of carbon monoxide poisoning, he sees a wide variety of worker injuries and illnesses ranging from pesticide exposures to falls and trauma to chronic pain from dangerous or repetitive workplace tasks. He also offers expertise in dealing with the workers' compensation system and helps the workers, the clinicians and the clinic navigate an often bureaucratic maze. Because Dr. Keifer regularly deals with workers' compensation he is rarely thwarted by what others perceive as a complicated and at times insurmountable system.

Dr. Paul Monahan, an internist at the Yakima Valley Farm Workers Clinic, says about Dr. Keifer, "It's nice to have someone to fall back on. He helps us with the complex cases. Without him some of these cases would be stuck in limbo. There are lots of other specialists that just don't want to get involved with these kinds of cases. "

Standing up for workers in the legal, regulatory arena is part of the expertise that an occupational medicine specialist brings to the table. While supporting the worker is first and foremost on the mind of Dr. Keifer as an occupational medicine specialist, he must also maintain credibility with growers and employers. Dr. Monahan feels this is a particular strength of Dr. Keifer. "He's very well respected by employers. He's a thoughtful and deliberate physician who makes good clinical judgments. He knows a tremendous amount about the agricultural workplace. Growers know this. At the same time, he takes patient problems seriously. Even when patients can't get any benefits, they realize they've been heard."

As a specialist, Dr. Keifer spends more time with patients. New patient visits are generally an hour and follow-up visits about 20 minutes. He volunteers his time and the clinic pays for his travel and expenses. Malpractice insurance is covered under his clinical duties at the University of Washington. As a fluent Spanish speaker, he does not require the use of an interpreter to provide care.

The extra time Dr. Keifer spends evaluating patients makes a difference. Dr. Monahan finds that there are just some things that the primary care clinician can't address in their 15 minute encounters. "In your busy day when you think you've covered all your bases you just might miss the occupational end of things. (Dr. Keifer) is there to bring it all together. It's really quite extraordinary what he does," notes Dr. Monahan.

Yakima Valley Farm Workers Clinic Executive Director, Carlos Olivares, feels that offering an occupational medicine clinic on site in a migrant and community health center is critical to quality care and stresses the need to expand this model across the country. "If your mission is truly focused on improving the health of the worker, having an occupational medicine clinic is a no-brainer," says Mr. Olivares. "Migrant health is generally thought of only from a primary care perspective, but occupational health is almost as critical. Can you imagine how the injured patient feels, knowing that specialty care is needed and having to go to a major metropolitan area for treatment? And how do you think the family doctor feels making this referral? The chances of the patient actually getting the treatment are almost zero. It's not good care. And it's certainly not cost effective. We need specialists like Dr. Keifer who can leave the university and come to the workers."

Mr. Olivares adds that the expertise of occupational specialists is also needed to maneuver through the workers' compensation system. "Labor and Industry feels quite comfortable contesting the family practitioner, but they rarely deny a claim that carries the weight and expertise of a specialist like Dr. Keifer."

From a risk management perspective, Mr. Olivares comments that an onsite occupational medicine specialist decreases the risk of malpractice. "It diminishes the margin of error. Our clinicians take much comfort in working within a medical treatment plan when an occupational medicine specialist is involved."

The benefits of conducting an occupational clinic in a migrant health center go far beyond the patient. Dr. Keifer and referring primary care clinicians enjoy an ongoing collegial exchange of medical knowledge and expertise. Dr. Keifer learns first hand patient care issues presenting in frontline, primary care medicine. His colleagues at Yakima Valley Farm Workers Clinic share with him their successes and lessons learned in offering culturally competent care to foreign, non-English speaking patients.

Dr. Keifer works with the clinicians to help them understand occupational medicine. One key component that primary care providers often overlook is the determination of cause in occupational medicine. While the medical condition is diagnosed with the same certainty applied to any medical condition, the determination of the cause of the condition, whether it is in fact attributable to the workplace, is made on a "more probable than not" basis. In other words, clinicians only need to be more than 50 percent certain that the illness or injury is work related in order to file a claim. Documenting charts to satisfy both the medical and legal systems becomes critical for the patient's as well as the clinic's success in obtaining benefits from the worker compensation system.

For Dr. Keifer, his monthly clinics have helped him tremendously in designing relevant, applicable research projects, and more importantly, in gaining access to both the clinicians and the community to be able to do the research. Dr. Keifer is a renowned scholar regarding pesticide health effects and has published extensively in the peer reviewed literature on this topic. Most recently, his research has focused on cholinesterase monitoring of pesticide applicators in Washington and some of his efforts involve community based participatory research. "When I do work in the community, I have first hand knowledge of what their health concerns and problems are," says Dr. Keifer. "They know me and trust me. Having credibility is fundamental to doing any kind of research in the community."

The clinicians in Yakima also have confidence that Dr. Keifer's research efforts are going to be worthwhile. He feels his work with the health center has helped break down the perception of the "Ivory Tower" as his clinical activities have a track record of benefiting farmworkers. "They (the clinicians) know what they see. They know I know what they see. They know this guy's out here in the trenches with them." When he proposes research projects, the clinic tends to be very supportive of his work.

In the end, Dr. Keifer feels his monthly trips to the Yakima Valley have been as beneficial to him as to the patients he cares for. "It's much more than volunteering. It's about really doing the work I was trained to do. It's motivating and it's interesting. It keeps my Spanish in great shape. More than anything else, it's my constant reminder that social justice and occupational medicine go hand and hand." ■

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* *The particular medical case discussed in this article has been modified to protect the patient's privacy. It builds on several similar cases and incidents surrounding Post Traumatic Stress Disorder and carbon monoxide poisoning. Hector Garcia is a fictitious name.*

Cancer Patient Navigation Systems and Mobile Clients

Andrea Caracostis, MD, MPH, Carmen Retzlaff, MPH, Jillian Hopewell, MPA and Kathryn Anderson

Editors Note: This article is excerpted from a longer article that compares four different cancer patient navigation programs. To read the full article go to MCN's website: www.migrantclinician.org and search for "cancer navigation."

Photo – www.earldotter.com

Health disparities among different racial, ethnic and socioeconomic groups continue to concern health professionals. Many health disparities are evident in cancer rates in the United States, with some racial and ethnic groups exhibiting disproportionate rates of incidence and deaths from different cancers. Reasons for disparities in healthcare are complex. Some of these disparities are linked to late diagnosis resulting from lower screening rates. Some patients are also being lost to follow up—times between obtaining an abnormal screening test and diagnosis, between diagnosis and start of treatment, and from treatment to resolution are longer for some groups than others. As a result, cancers in some disadvantaged groups are being diagnosed and treated at more advanced stages. Migrant workers represent some of the most disadvantaged groups in the United States. They are part of a larger underserved population—mobile persons who travel frequently for work and other reasons.

In addition to lack of insurance and inadequate access to medical care, the lack of a medical home is often identified as a significant barrier to quality care.(1) The continuity of a relationship between clinician and patient is linked to improved preventive care and reduced hospitalization.(2) Simply locating the appropriate medical care facility in a new community is often challenging, especially if language barriers exist. Frequent moves are therefore one barrier to consistent medical care for many poor clients.

Patient navigation is one strategy that can help cancer clients access timely and appropriate health care. By design, most patient navigation systems work within the existing local healthcare system. Patient navigators can help clients connect to healthcare systems and establish a medical home, if the client stays in that system, city or region. This raises challenges for mobile clients.

Background

The patient navigation model is attributed to Harold Freeman, MD, who instituted the use of patient navigators in 1990 at Harlem Hospital Center in New York City because he was concerned about the number of poor African American clients he saw initiating cancer treatment at late stages of the disease. His program demonstrated increases in early detection and decreases in late-stage detection at his hospital.(3)

Freeman's Harlem model informed national legislation on patient navigation. In 2005 the US Congress approved the Patient Navigator Outreach and Chronic Disease Prevention Act, authorizing the National Cancer Institute, Health Resources and Services Administration and the Indian Health Services to award grants for model programs that provide prevention, early detection, treatment, and appropriate follow-up care services for individuals from populations with health disparities who have or are at risk for cancer and other chronic diseases. Other patient navigation systems have also been developed outside this federally funded pilot group in other settings and communities.

Patient navigation systems for cancer care are intended to provide support and guidance in accessing the cancer care system and overcoming barriers to quality, standard care from the time of an abnormal finding, through diagnostic tests to completion of cancer treatment.

Some of the common barriers faced by cancer patients in underserved groups include system barriers (fragmentation of care), financial barriers (lack of insurance or underinsurance), physical barriers, information and education barriers (both provider- and patient-related), issues of culture and

Individual case stories of mobile clients served by CAN-track help illustrate the services provided by the program (actual names of clients are not used).

Case Study #1: Rosa, Tennessee: In November of 2005, the American Cancer Society requested assistance obtaining services for a woman with cervical cancer who was pregnant, did not have insurance and who was not receiving prenatal care. After her cancer diagnosis, her medical provider discontinued Depo Provera without counseling about alternatives, and Rosa became pregnant. She could not receive cancer treatment during her pregnancy. Because of her high-risk status as a cancer patient, Rosa could not receive prenatal care at the local health department or community health center, and she was having trouble finding an obstetrician who would take on a high-risk client without insurance. Rosa's family income is $2500 per month for a family of four— too much for Medicaid and not enough to pay for insurance. CAN-track helped locate an obstetrician who would see Rosa for a set fee, and helped her find funding to pay for her prenatal care (Harvest of Hope, a local church, and an anonymous donor). CAN-track staff worked with a local social worker to arrange delivery of clothing and food to the family and enrollment into WIC. Rosa delivered a healthy baby, and CAN-track scheduled follow-up appointments with a surgeon to evaluate the cancer.

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Disaster Relief Programs for US Citizens and Immigrants

Shelley Davis, Esq, Farmworker Justice, Washington, DC

What Benefits Are Available to Farmworkers in the Event of a Disaster?

In a natural or manmade disaster, farmworkers' homes may be damaged or destroyed, their jobs may be lost, and food, clothing, household items or supplies may be spoiled or irreparably damaged. Once an event has been declared an official disaster by federal or state authorities, a variety of programs become available to disaster victims. Benefit programs can provide funds to repair or replace housing, home furnishings, tools or clothing; provide groceries or food stamps to purchase food; and pay unemployment compensation while workers cannot work due to the disaster. In many instances, eligibility for disaster relief depends on immigration status. Most programs are limited to US citizens or certain categories of legal immigrants.

I. BENEFITS AVAILABLE TO ALL REGARDLESS OF IMMIGRATION STATUS

Everyone, including undocumented workers and their families has access to certain immediate, short-term benefits. They include:

- Soup kitchens, which provide hot meals
- Food pantries, which provide groceries
- Emergency overnight shelters (many of which must be vacated in the daytime)
- Migrant and community health centers
- Crisis Counseling
- Battered women's shelters
- Some private charities

Check with your nearest One-Stop Center, migrant clinic, or other migrant service provider to find out the local emergency services available.

States may also provide food stamps for up to one month to disaster victims, regardless of their immigration status. When a state decides to grant such benefits, it need not require proof of immigration status or financial necessity. Generally, however, more extensive benefits are reserved for US citizens and persons who are lawfully present in the United States.

II. BENEFITS AVAILABLE TO US CITIZENS AND SOME CATEGORIES OF LEGAL IMMIGRANTS

A. Federal Emergency Management Agency Programs

The Federal Emergency Management Agency (FEMA) coordinates state and federal government benefits for disaster victims. Two of its programs, Temporary Housing Assistance (THA) and Individual and Family Grants (IFG), provide funds for repair or replacement of housing and/or home furnishings. A third program, Disaster Unemployment Assistance (DUA), provides funds for workers or self-employed individuals who lose income as a result of the disaster.

An application for FEMA benefits must be submitted within 60 days of the occurrence of the disaster. Persons who qualify can apply for themselves and their family members, even if not all family members are eligible. If more than one individual in a household applies, FEMA may attempt to recover the money from the person who applied later.

To apply for benefits from FEMA, call 1-800-621-3362 (FEMA); TTY: 1-800-462-7585 (for the speech and hearing impaired). The FEMA Help Line is available from 7:00 a.m. to 7:00 p.m. Eastern Standard Time from Monday to Friday. It operates in both English and Spanish. If the line is busy, try to call in the evening after 6:00 p.m. when call volumes tend to be lighter.

An applicant should receive written confirmation from FEMA soon after contacting the agency. If no written confirmation is received, the applicant should call FEMA or seek assistance from an attorney.

B. Temporary Housing Assistance

Owners or renters of homes that have been damaged or destroyed in a disaster can apply for Temporary Housing Assistance (THA). To be eligible, applicants must show that the housing is unlivable or that they are no longer living there because of the disaster. Persons who have insurance must first make reasonable efforts to secure these benefits. To secure Temporary Housing Assistance (THA), they must then provide evidence that they have been unsuccessful in obtaining insurance benefits. They must also agree to repay FEMA to the extent that they later receive insurance benefits.

THA is usually provided in the form of a check to cover the cost of rent, mortgage or essential home repairs. Persons can apply for rent or mortgage assistance if they have received a written notice of eviction for nonpayment of rent or mortgage. This assistance may be provided for up to 18 months for homeowners or up to three months for renters.

Money for home repairs is available to quickly repair or restore the essential livability of the dwelling. Housing must be able to be made livable within 30 days.

Citizenship or Immigration Status Requirements: Persons eligible for THA include:

- US citizens
- Lawful Permanent Residents (green card holders)
- Refugees
- Asylees
- Parolees for at least one year
- Cuban / Haitian entrants
- A person whose deportation has been withheld
- Victims of domestic violence

C. Individual and Family Grants to Secure Funds for Housing, Furnishings, Tools & Clothing

Individual and Family Grants (IFG) are available to individuals and families who have disaster-related necessary expenses or serious needs, and who did not receive adequate assistance from other sources, such as insurance.

IFG grants cover essential items or services to:

- Repair, replace or rebuild owner-occupied housing
- Provide clothing, household items, furnishings, and appliances, tools and equipment required as a condition of employment
- Replace or repair vehicles or provide public transportation
- Pay for funeral expenses

IFG benefits may not be counted either as income or resources in determining eligibility for any income-tested programs supported by the federal government, such as Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Medicaid, or food stamps.

IFG benefits cannot be taken by any creditor. They also cannot be assigned or transferred away from the recipient to someone else.

Citizenship or Immigration Status Requirements: Persons eligible for THA and IFG programs include:

- US citizens
- Lawful Permanent Residents (green card holders)

- Refugees
- Asylees
- Parolees for at least one year
- Cuban / Haitian entrants
- A person whose deportation has been withheld
- Victims of domestic violence

D. Disaster Unemployment Assistance

FEMA's Disaster Unemployment Assistance (DUA) program provides money for workers who lose income from their jobs due to a disaster, but who might not be eligible for regular unemployment compensation (described below).

Citizenship or Immigration Status Requirements: Persons eligible for DUA include:

- US citizens
- Persons with valid work authorization
- Refugees
- Asylees
- Cuban/Haitian entrants
- Parolees for one year or more
- Conditional entrants
- Victims of domestic violence
- Persons who have been granted withholding of deportation

For DUA, a person also must meet ALL of the following requirements:

- File of a DUA claim within 30 days of the disaster
- Unemployment as a result of a disaster
- Register for work with the Agency for Workforce Innovation
- Be able to work and available for work unless injured as a result of the disaster; or self-employed before the disaster; or remain unemployed to get a business back in order
- Meet certain wage requirements

Applicants who are denied DUA benefits have the right to appeal within 20 days from the date of the Notice of Determination. After an appeal is filed, the individual will get a notice explaining appeal rights. An interpreter should be requested in advance if needed. At the hearing an opportunity will be provided to explain to the appeals referee why DUA should be granted. Appellants may bring witnesses or documents to prove their case.

Persons denied DUA benefits may contact the nearest legal services agency or a private attorney for further assistance. Referrals may be obtained from a migrant health center or other migrant-serving agency in the area.

III. REPLACEMENT OR EXPEDITED FOOD STAMPS

Replacement Food Stamps: When food stamp recipients' food is lost or spoiled in a disaster, they can apply for replacement food stamps. Replacement food stamps can be obtained by contacting the local Food Stamp agency.

Expedited Food Stamps: Very needy people can obtain expedited food stamps within seven days of application. These benefits may also be helpful to disaster victims who have lost income or resources. The expedited request is part of the regular food stamp application process.

To be eligible for expedited food stamps, applicants must show one of the following:

- Individuals or their households have no more than $150 in monthly income before taxes **and** $100 or less in cash or in their bank accounts
- Basic shelter and utility expenses are greater than present income and resources combined

To secure expedited food stamps, an applicant can establish his/her identity by either:

- showing documents bearing his/her name, or
- having someone say they know him/her

Successful applicants for expedited food stamps should receive these benefits within seven days of applying even if all required verification efforts have not yet been completed. Those who do not qualify for expedited food stamps may still be entitled to regular food stamps; the application will be processed to make that determination.

Citizenship or Immigration Status Requirements: Persons eligible for regular, replacement, or expedited food stamps include:

- US citizens
- Refugees
- Asylees
- Cuban/Haitian entrants
- Green card holders (lawful permanent residents) who have 40 quarters of Social Security credit in the US (from their own work or that of a spouse or parent)
- Members of federally recognized Indian tribes
- Veterans
- Members of the armed services

Applicants for regular food stamps must also provide documentation for all of the following:

- A valid Social Security number
- Income
- The extent of expenses at the time of application

Within 30 days, applicants will receive a written decision as to whether they are eligible for regular food stamps and the amount of benefits to be provided. If the applicant is denied benefits, the decision can be appealed.

IV. UNEMPLOYMENT COMPENSATION

Workers who lose their jobs due to a disaster (e.g., a freeze) may apply for Unemployment Compensation (UC).

Citizenship or Immigration Status Requirements: Persons eligible for UC include:

- US citizens
- Someone with valid work authorization
- Green card holders (legal permanent resident)
- Immigrants permanently residing under color of law (i.e., persons who are residing in the US indefinitely with permission from the Department of Homeland Security)
- Refugees
- Asylees
- Cuban/Haitian entrants
- Parolees for one year or more
- Conditional entrants

To be eligible for unemployment compensation benefits, a person must also meet all of the following requirements:

- File a UC claim at a local One Stop Service Center
- Register for work at a local employment services office
- Be able and available for work
- Meet certain wage requirements
- Serve a one-week waiting period

Even those who meet the above requirements may be disqualified from receiving UC benefits if they did one or more of the following:

- Voluntarily quit work without good cause attributable to the employer
- Were terminated because of misconduct
- Refused employment without good cause

Applicants who are denied UC benefits have the right to appeal within 20 days from the date of the Notice of Determination. After an appeal is filed, the individual will get a notice explaining appeal rights. An interpreter should be requested in advance if needed. At the hearing an opportunity will be provided to explain to the Appeals Referee why UC should be granted. Appellants may bring witnesses or documents to prove their case.

Persons denied the benefits they seek should contact the nearest legal services agency. Referrals may be obtained from a migrant health center or other migrant-serving agency in the area. ■

FOR FURTHER INFORMATION

Farmworker Justice
202-293-5420
www.farmworkerjustice.org

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bias, and failure of providers to obtain patients' medical test or laboratory results in a timely manner.

Patient navigation programs are intended to prevent the cumulative effect of these barriers—unequal delivery of cancer prevention services and delays in detection, diagnosis, and quality treatment of cancers. Their goal is to facilitate timely access to quality, standard cancer care. Some of the common qualities of patient navigator programs are:[4]

- Ability to provide timely, accurate information in a supportive, culturally sensitive manner
- Knowledge of the health care delivery system that the cancer patient must depend on for care
- Knowledge of financial resources and financial alternatives available to the patient
- Acceptance within the health care system by administrators, physicians, and associated health care professionals and within the community as a caring, trustworthy health care resource[4]

While the barriers that contribute to the disconnect between development and delivery are similar for racial and ethnic minorities, people of lower socioeconomic status, residents of rural areas and mobile underserved populations, there are no clear provisions in most patient navigation programs to address movement across county, state and country lines.

MCN CAN-track Project

In 1996, MCN and partner organizations implemented a comprehensive tracking and referral network for mobile populations dealing with tuberculosis. TBNet provides a central location where the medical records of TB patients are stored and can be accessed by the provider treating the patient. It also provides a toll free number that patients can call to get assistance in finding a source for treatment or other needed supports. Since 1996, TBNet has worked with over 2,000 participants. TBNet has assisted patients who have stayed within the United States as well as those who have moved abroad, including across the Texas/Mexico border and other countries throughout Latin America and worldwide. TBNet has shown that providing complete TB treatment to migrant patients can be successful and that it is possible to provide continuity of care to mobile populations.

Following this initiative, in 2004, MCN initiated CAN-track, which works with patients who have been screened or need screening for breast, cervical or colon cancer. The project was created in response to the challenges clinicians face when trying to report screening results to patients who have moved away from the area. With CAN-track, clinicians can help ensure that their patients get re-screened or receive further diagnostic tests if the screening results are abnormal. Patients can call a toll free number and receive assistance navigating the health care system when treatment is needed, as well as accessing their cancer screening and follow-up records from any location.

The goal of CAN-track is to increase screening rates and reduce mortality from breast, cervical, and colon cancers among migrant workers by decreasing the number of patients lost-to-follow-up. CAN-track provides a records transfer system (via fax) and care coordination services (via a toll-free telephone number) to participating clinics and service providers from the CDC National Breast and Cervical Cancer Early Detection Program (NBCCEDP). CAN-track transfers medical records throughout the United States, Mexico and Central America, integrating the services provided in those countries with the United States health care system and allowing clinicians to develop long-term care plans for their patients.

To date the project has enrolled and assisted 94 mobile clients with abnormal screening results or cancer diagnoses. Clinical staff in 27 community health centers and seven health department sites in 32 states have been trained in how to enroll clients in CAN-track.

The strengths of MCN's CAN-track program include the ability to transfer medical records across state and country borders. This allows the project to serve a mobile population that is national and international in scope. CAN-track staff has been able to work directly with state breast and cervical cancer programs and strengthen their abilities to serve indigent mobile clients. The primary challenge to the project to date has been getting clients enrolled in the project. Because CAN-track is not based in a clinical facility, it has limited access to clients and must rely on staff at local health departments and community health centers to make time in their already busy routines to fill out the necessary forms and explain the program to the clients.

The concept of cancer patient navigators is still relatively new. As their use increases, those concerned about the care of the poor and underserved will look on with interest to see how variations of the model work in different communities and settings, as well as for mobile clients who do not stay settled in one community. Further research is needed on how clients who work with a patient navigator do on their own if they leave that system and must negotiate their own care in another city or location. ■

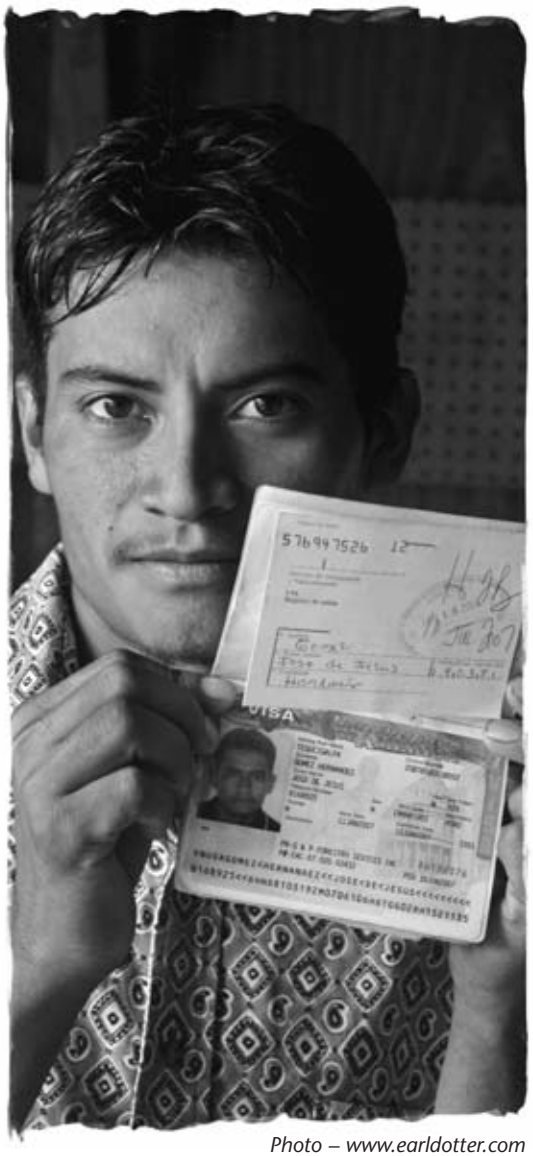

Photo – www.earldotter.com

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"A Community Guide to Environmental Health"

An Essential Tool Kit for Global Communities Tackling Environmental Problems

Written collaboratively with the help of 120 communities and issue specialists from over 33 countries, A Community Guide to Environmental Health published by the Hesperian Foudnation is a tool kit that instructs people how to tackle everything from improving access to safe drinking water to organizing against larger interests that may pollute water and land. The book is a collection of best practices from communities worldwide that address both the immediate symptoms of environmental threats as well as the root causes of environmental problems.

Like all of Hesperian's books, *A Community Guide to Environmental Health* is highly illustrated and contains numerous easy to follow actions and educational activities, ranging from the simple to the more complex based on a community's needs and resources.

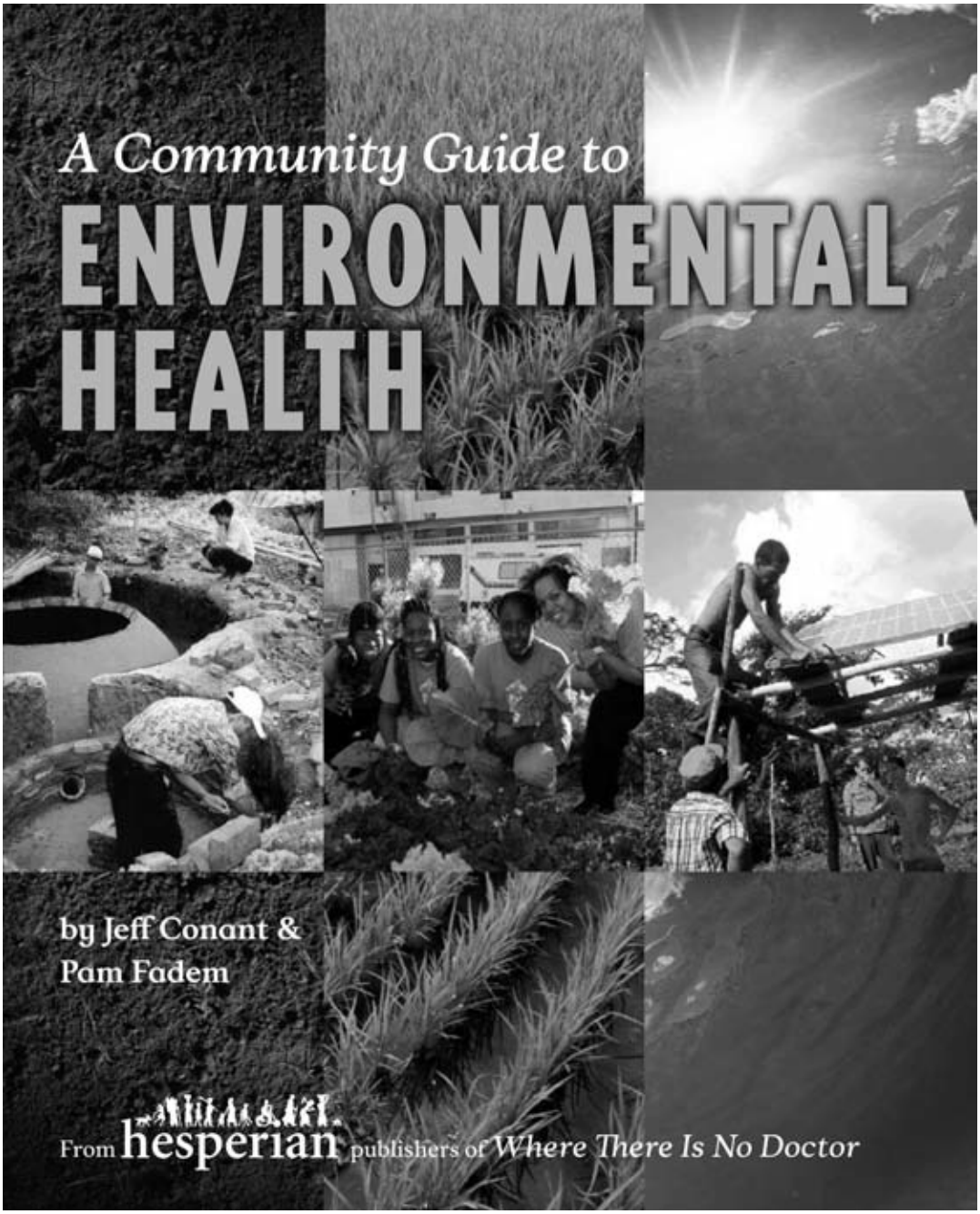
Topics covered in the book include: Preventing and Reducing Harm from Toxic Pollution; Protecting Community Water and Watersheds; Forestry - Restoring Land and Planting Trees; Food Security and Sustainable Farming; Solid Waste and Health Care Waste; and How to Reduce Harm from Mining and Oil Development. Throughout the book, the focus is on creating sustainable forms of development that promote local, community-based food security, clean energy and an overall healthy local environment.

Miriam Aschkenasy MD & MPH, a Public Health Specialist with Oxfam America, declares, "This timely guide is the Where There Is No Doctor of community water, sanitation and environmental health. It makes water, health and hygiene accessible to those who need it most. Focusing on the important intersection of public health and risk reduction at the community level FOR the community, this guide is literally a lifesaver."

Charlotte Brody, Director of Commonweal, a center for cancer research and treatment, states, "From the inside cover's encouragement to freely copy, reproduce and adapt this book, Hesperian's Community Guide to Environmental Heath is not your standard how-to manual. Instead it is a comprehensive and practical handbook on how to create transformational planetary change, one guided discussion, one community health walk, one rehydration drink, one flytrap, one tippy tap, one trench latrine, [and] one planted tree."

And contributor Feliciano dos Santos, 2008 Goldman Environmental Prize Winner and Director of ESTAMOS in Mozambique states, "Community work is more effective and efficient when we have tools that meet the needs and expectations of the communities. Hesperian produces materials so creative and communicative, and of such quality and precision, that they allow us to respond to the many common problems of communities while recognizing that each case is unique. The flexibility of these materials makes them useful in a wide variety of social and geographic contexts."

Hesperian is a non-profit publisher of books and educational materials that help people take the lead in their own health care and organize to improve health and environmental conditions in their communities. To learn more about Hesperian and A Community Guide to Environmental Health, please visit: www.hesperian.org. ■



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American Public Health Association Annual Meeting
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October 25-29, 2008
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New Orleans, Louisiana

Midwest Stream Farmworker Health Forum
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January 23-25, 2009
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