MCN streamline
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The Migrant Health News Source

Celebrating Twenty Years of Exemplary Service to the Mobile Poor

In the summer of 1987 Karen Mountain responded to a job announcement for a "creative/motivated person experienced in health care to migrants" to "develop, implement, and monitor activities to expand clinical technical assistance to migrant health centers". With her wealth of experience, Karen was soon hired as the first Director of the Migrant Clinicians Network. In the subsequent twenty years Karen has served MCN with calm, intelligent and focused energy. During her time with MCN the organization has grown to a mature, international organization that has always remained grounded in its roots as a force for social justice in health care for the mobile poor.

We asked those who have known and worked with Karen over the past twenty years to send us their thoughts and recollections. Many responded to this request, just a few are quoted here:

"(Karen) has always had faith in what we as clinicians do for others. I hope you convey to her the absolute greatness of her actions." Sylvia Corral, MD, former MCN Board Chair

"I find it very hard to say any single thing about Karen. She is an inspiring, passionate, creative and visionary leader yet also a very grounded, pragmatic, and caring person that has always known how to be a compassionate listener." Larry Li, MD

"I have always felt so honored to work with Karen. Her innovative mind and deep commitment to the underserved has been a career long inspiration for me." Matt King, MD

"It has been my pleasure to watch MCN grow and on occasion be associated with it on a formal or informal basis. I applaud Karen for all she has accomplished and look forward to what is to come." Alice Larson, PhD

Please join us in congratulating Karen on the excellence of her service these past twenty years and in celebrating the exciting times still to come! ■

Karen Mountain

We are a force for justice in healthcare for the mobile poor!

Twenty- two years ago the Migrant Clinicians Network was founded by three dedicated frontline clinicians with a vision for a national network supportive of providers dedicated to quality health care for migrant farmworkers.
While MCN has grown significantly we remain true to our original vision. In recognition of our strong commitment to clinicians and the mobile poor as well as the global nature of our work with migrants, MCN is proud to unveil our new logo and mission statement. As an organization MCN is committed to social justice, global health and to clinicians caring for migrants from all parts of the world as they move to survive.

As a part of our expanded services we invite you to join your colleagues in a cutting edge conversation about the issues facing clinicians and migrants on our new blog, www.migrantclinician.org/blog. Current issues include the question "Are Social Security numbers required for health care?" as well as an expanded look at emergency preparedness for mobile populations.

New Patient Education and Clinicial Resources from MCN!

LO QUE BIEN EMPIEZA...BIEN ACABA: Consejos para las mujeres para prevenir daños a la salud y a sus bebés causados por pesticidas.
This full color, educational comic book in Spanish helps women of reproductive age and pregnant women understand the risks associated with pesticide exposure and ways to minimize exposure. The comic book targets women in rural and urban areas and women in various occupations. It also addresses various pesticide exposures: occupational, para-occupational exposures (take home) and in-home.

MCN produced this resource in response to the numerous requests for patient educational materials to help pregnant women living and working around pesticides.

Funding for this project came from the Paso del Norte Health Foundation and the American Academy of Nurse Practitioners Foundation.

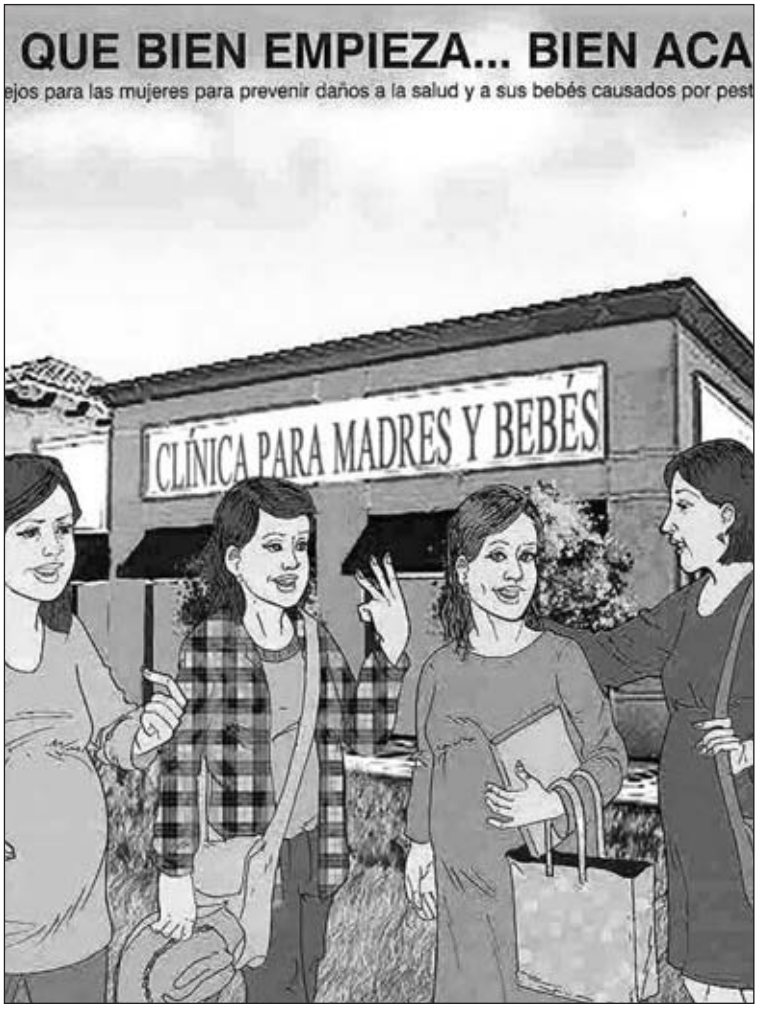
Copies are available to download from the MCN website under the clinical excellence section dealing with environmental and occupational health. You may place orders for FREE hard copies of this comic book on our website. Minimum order is 100 copies while supplies last!

Las Historias de Melesio
With funding from the EPA Region III, MCN partnered with Rural Family Development of the Virginia Council of Churches to produce **five radio novellas** (Las Historias de Melesio) **in Spanish** to promote environmental health information. You can download all of these novelas for your own use from our website.

1) Getting Rid of Pests /Acabando con las plagas (Inhome Pest Control)
2) Protecting Yourself from Pesticides/Protegiéndose de los pesticidas
3) Be Careful with Water and Lead/Cuidado con el agua y el plomo (Water, Sanitation, Hygiene and Lead)
4) Protecting Kids from Pesticides/Protegiendo a sus niños de los pesticidas
5) Respiratory Problems/Los problemas respiratorios (Improving Indoor Air Quality)

Back by popular demand!...
***Aun que Cerca...Sano* Comic Book in English and Spanish**
This 16-page, full color comic book targets migrant and seasonal farmworker families and helps educate parents about children's risks to pesticide exposure and ways to minimize these risks. It was developed in 2003 by Migrant Clinician Network (MCN) and Farm Safety 4 Just Kids (FS4JK) and funded by the National Children's Center for Rural and Agricultural Health and Safety (NCC).

Free copies now available again due to overwhelming requests for additional booklets.. Copies are available to download from the MCN website under the clinical excellence section dealing with environmental and occupational health. You may place orders for FREE hard copies of this comic book on our website. Minimum order is 100 copies while supplies last!



Clinical Materials

In addition to our clinical guidelines for pesticides, MCN's website houses numerous pesticide resources and links for the clinician. We've listed several resources here. Visit our website to find many more resources – click on the clinical excellence section dealing with environmental and occupational health and pesticides.

A Migrant Farmworker Occupational Health Reference Manual for Clinicians – Produced by NYCAMH and MCN, offers information for the diagnosis and treatment of occupational injuries. This online resource provides information on farmworker crop profiles, diagnosis and treatment, patient education, cultural competency, and much more.

Recognition and Management of Pesticide Poisonings – This edition covers about 1,500 pesticide products in an easy-to-use format. Toxicology, signs and symptoms of poisoning, and treatment are covered in 19 chapters on major types of pesticides. It is edited by Dr. Routt Reigart and Dr. James Roberts, and is published by EPA's Office of Pesticide Programs. Both English and Spanish versions are available.

National Pesticide Practice Skills Guidelines for Medical & Nursing Practice
This NEETF publication outlines the knowledge and skills that health professionals need to have about pesticides. This document is part of a national initiative aimed at ensuring that pesticides issues become integral elements of education and practice of primary care providers.

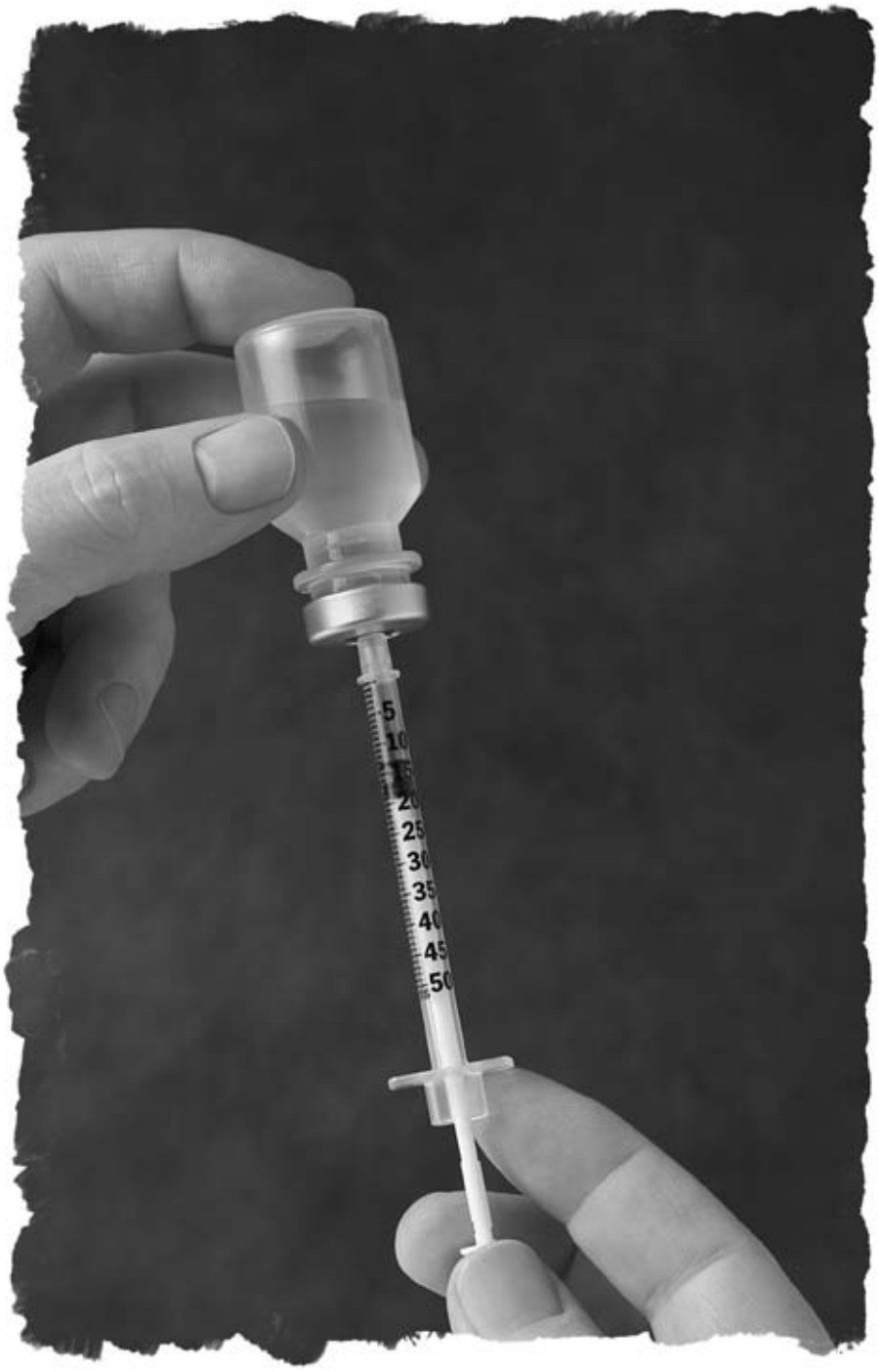
Links for clinicians

Links to even more great resources. On our pesticide page you will find easy links to other resources and organizations such as the National Pesticide Medical Monitoring Program – a program to help clinician diagnose and treat pesticide exposures and the **PAN Pesticide Data Base** a one-stop location to find out where to report pesticide exposures in your state. ■

www.migrantclinician.org

Influenza Vaccination for Health Care Providers

NOTE: The text below is taken directly from *Prevention & Control of Influenza - Recommendations of the Advisory Committee on Immunization Practices (ACIP)*. MMWR 2007 Jul 13;56(RR06):1-54.



Although annual vaccination is recommended for Health Care Professionals (HCP) and is a high priority for reducing morbidity associated with influenza in health-care settings and for expanding influenza vaccine use, national survey data demonstrated a vaccination coverage level of only 42% among HCP. Vaccination of HCP has been associated with reduced work absenteeism and with fewer deaths among nursing home patients and elderly hospitalized patients. Factors associated with a higher rate of influenza vaccination among HCP include older age, being a hospital employee, having employer provided healthcare insurance, having had pneumococcal or hepatitis B vaccination in the past, or having visited a health-care professional during the previous year. Non-Hispanic black HCP were less likely than non-Hispanic white HCP to be vaccinated.

Healthcare Personnel (HCP) and Others Who Can Transmit Influenza to Those at High Risk

Healthy persons who are clinically or asymptomatically infected can transmit influenza virus to persons at higher risk for complications from influenza. In addition to HCP, groups that can transmit influenza to high-risk persons and that should be vaccinated include

- employees of assisted living and other residences for persons in groups at high risk;
- persons who provide home care to persons in groups at high risk; and
- household contacts (including children) of persons in groups at high risk.

In addition, because children aged <5 years are at increased risk for influenza-related hospitalization compared with older children, vaccination is recommended for their household contacts and out-of-home caregivers. Because influenza vaccines have not been approved by FDA for use among children aged <6 months, emphasis should be placed on vaccinating contacts of children aged <6 months. When vaccine supply is limited, priority for vaccination should be given to contacts of children aged <6 months.

Healthy persons aged 5–49 years in these groups who are not contacts of severely immunosuppressed persons (see Vaccination of Close Contacts of Immunocompromised Persons) may receive either LAIV or TIV. All other persons should receive TIV.

All HCP, as well as those in training for health-care professions, should be vaccinated annually against influenza. Persons working in health-care settings who should be vaccinated include physicians, nurses, and other workers in both hospital and outpatient-care settings, medical emergency-response workers (e.g., paramedics and emergency medical technicians), employees of nursing home and chronic-care facilities who have contact with patients or residents, and students in these professions who will have contact with patients.

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Improving Health Care Worker Vaccination Rates

NOTE: The text below comes from the Virginia State Health Deparment.

CDC recommends that all health care workers receive an annual influenza vaccination to prevent transmission to patients. Influenza immunization rates among health care workers remain low, with only 36%-40% of health care workers reporting influenza vaccination each year. Influenza vaccination is an important patient safety issue because unvaccinated staff can spread influenza to patients, coworkers, and family members, leading to influenza-related illness and death. When health care workers become ill with influenza, absenteeism and disruption of care may result. When health care workers transmit influenza to patients, some of them may experience serious, even life-threatening complications or secondary pneumonias. When promoting vaccination among health care workers, emphasize the reasons to get the influenza vaccine:

- Prevents death
- Prevents severe illness
- Protects patients
- Protects families
- Protects you and your coworkers
- Decreases use of sick leave

Successful Campaigns for Vaccinating Health Care Workers

- Sending a letter, postcard or email to employees prior to the start of the vaccine season reminding them of the importance of vaccination, where and when they will be able to get the flu vaccine.
- Writing something in the employee newsletter or posting information on staff bulletin boards and providing fact sheets with pay stubs to dispel misconceptions and increase acceptance.
- Increasing the number of sites where the vaccine is given. Use mobile carts to transport to different clinic areas, service meetings, grand rounds or near cafeteria entrances. This approach can minimize inconvenience as well as means to advertise the vaccine availability. Carts should be stocked with vaccine, safety syringes, vaccine information statements, sharps disposal containers, alcohol hand rub, alcohol wipes, adhesive bandages, documentation forms, and injectable epinephrine with orders for administration in the event of an acute hypersensitivity reaction.
- Making appointments with services to attend service meetings. A schedule should be posted or email sent to those in the service announcing that the vaccine is available at the staff meeting.
- If your occupational health unit has a website, adding information to the website regarding flu shot locations and times.
- In late November identifying employees not yet vaccinated and reminding them by email or a phone call that the flu vaccine is available.

  Working closely with Pharmacy to get your supply of vaccine for employees.
- Modifying education materials from CDC and elsewhere to address risks to employees if they are not vaccinated.
- Encouraging the facility director, service chiefs, and other managers to lead the way by getting their vaccine and encouraging their staff to get vaccinated.
- Giving out buttons or stickers to all staff who are vaccinated showing that they have been vaccinated. It is an additional advertising strategy for both employees and patients to be vaccinated against influenza.
- Sponsoring a kick off event.
- Adding an influenza reminder to occupational health's telephone recording. When employees call they can automatically be reminded about the availability of the vaccine. If the recording capacity exists, add specific information regarding dates, times and locations for flu shots as well as any other pertinent information. These reminders should begin September 15 and conclude after the flu season has peaked, which usually occurs in February or March.
- Extending hours that the vaccine is available to staff to include all shifts and days of the week. Plans must be made to have additional staff available during the extended hours of the clinic or available during off tours.
- If there is a vaccine shortage, using additional strategies if necessary to ensure those who are identified as needing the vaccine are targeted. If the shortage resolves, there also should be a mechanism in place to remind those not vaccinated that it is not too late to get the vaccinated.

Obstacles - Individual Beliefs

Some health care workers have misperceptions and misunderstandings about influenza vaccine. The scientific literature suggests several reasons for low immunization rates among health care workers including: concern about side effects or vaccine safety, perception of low personal risk of illness, inconvenience, ignorance of CDC recommendations, and dislike of needles. Therefore, there should be continuous and ongoing vaccine education updates emphasizing the seriousness of influenza and addressing employee misconceptions about influenza and the vaccine. Common misconceptions must be addressed (the flushot does NOT give you influenza). Examples of notices that might be posted include:

You know that the influenza shot works, so why don't more people get vaccinated?

Some people are concerned about side effects. They think that the influenza shot will make them sick. However, mild soreness of the arm at the injection site is the most common side effect. The shot itself will NOT give you influenza. Influenza vaccination is the best protection against the influenza. Protect VA patients, yourself, your co-workers and your family. Get vaccinated. Check with your supervisor for information on how to get your influenza shot.

Did you get your influenza shot last year?

If you didn't, you may have harmed the health of some of our patients, your coworkers and family members. You can spread influenza to patients, putting them at risk for influenza and its complications. Studies show that vaccination of health care workers is associated with decreased mortality among nursing home patients. Protect yourself and your patients—get a shot. Ask your supervisor about information on how to get a flu shot.

"I don't need to get a flu shot." Is this you?

Influenza can cause serious illness and death even in young, healthy people. It's not just a

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Improving Health Care Worker Vaccination Rates continued from page 4

disease that affects the elderly. If you get influenza, you can spread it to your patients, putting them at risk for severe illness and complications from the flu. Protect yourself, your coworkers, and your patients—get a flu shot. Ask your supervisor for information on how to get vaccinated.

Key elements of a successful staff flu vaccination campaign include:

- informing employees about the availability of the vaccine and the plan (awareness),
- educating employees about its importance (marketing),
  making the vaccine convenient,
- notifying employees regarding the scheduling of administration and
- keeping track of who has been vaccinated.

Additional Measures to Take to Prevent the Spread of Influenza

Remind employees that although the influenza vaccination may be the best way to protect against the influenza, there are other measure that they should also take to protect themselves, their families, and patients.

- Stay at home when they are sick, especially if running a fever
- Keep tissues at their desk so that they can cough or sneeze into it – NOT into their hands
- Keep a trash can at their desk to dispose of used tissues
- Frequently wipe down their keyboard, mouse and phone with antibacterial wipes
- Wash their hands or wipe with hand sanitizer frequently, especially after using copy machines, fax machines, someone else's computer or phone, or after sneezing or other contact with their own secretions
- Avoid contact with people who are sick, except of course the patients they are here to help
- Wash their hands before eating food
- Wash their hands frequently with water and soap or alcohol-based rubs

Remember health care workers may also have health problems and conditions which put them at increased risk of complications from influenza. These include:

- Chronic cardiac or pulmonary disorders severe enough to require regular medical follow-up care.
- Being 65 and older.
- Chronic health conditions such as diabetes mellitus and other metabolic diseases, cancer, immunodeficiency, renal disease, anemia and hemoglobinopathy.
- Any conditions that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration.
- Pregnant women.

Immunization is the primary method to prevent influenza, limit transmission, and prevent complications from the flu. Trivalent inactivated influenza virus vaccine may be administered to all categories of health care workers unless there is a contraindication for the vaccine. Live attenuated influenza vaccine (FluMistTM) may also be administered to health care workers. It is a good option for those health care workers who are in good health, are not pregnant, those who have a dislike of needles, and meet the criteria for LAIV. ■

Influenza Vaccination for Health Care Providers continued from page 3

Facilities that employ HCP should provide vaccine to workers by using approaches that have been demonstrated to be effective in increasing vaccination coverage. Health-care administrators should consider the level of vaccination coverage among HCP to be one measure of a patient safety quality program and obtain signed declinations from personnel who decline influenza vaccination for reasons other than medical contraindications. Influenza vaccination rates among HCP within facilities should be regularly measured and reported, and ward-, unit-, and specialty-specific coverage rates should be provided to staff and administration. Studies have demonstrated that organized campaigns can attain higher rates of vaccination among HCP with moderate effort and using strategies that increase vaccine acceptance.

Efforts to increase vaccination coverage among HCP are supported by various national accrediting and professional organizations and in certain states by statute. The Joint Commission on Accreditation of Health-Care Organizations has approved an infection control standard that requires accredited organizations to offer influenza vaccinations to staff, including volunteers and licensed independent practitioners with close patient contact. The standard became an accreditation requirement beginning January 1, 2007. In addition, the Infectious Diseases Society of America recently recommended mandatory vaccination for HCP, with a provision for declination of vaccination based on religious or medical reasons. Fifteen states have regulations regarding vaccination of HCP in long-term–care facilities, three states require that health-care facilities offer influenza vaccination to HCP, and three states require that HCP either receive influenza vaccination or indicate a religious, medical, or philosophical reason for not being vaccinated. ■

Pesticide Exposure Clinical Guidelines

Amy Liebman, MPA, MA and Dennis Penzell, DO

In 1989 Dennis Penzell, DO was Medical Directors of Ruskin Community Health Center in Ruskin, Florida. At about 10am one normal morning, the call went out that there had been a pesticide incident at a local farm. The health center was forced to rapidly gear up to respond as farmworkers began to arrive in various states of distress. In the end Ruskin saw 80 farmworkers, 10 of which were hospitalized for issues related to their exposure to pesticides. The others were seen for issues related to respiratory distress, dermatological concerns, and nausea. There were no fatalities from this incident, but the impact on the health center was tremendous.

Since that time there have been other reported incidents of acute pesticide exposure issues, one of the most recent one occurring near Sacramento, CA. In that incident 45 farmworkers came to the hospital emergency room that was ill equipped to handle the cases stemming from the exposure. (See Streamline, Vol 12, Issue 5, September-October, 2006)

Using his experience with the pesticide exposure incident in 1989, Dennis Penzell created the following Pesticide Exposure Clinical Guidelines for primary care clinics. These guidelines have now been peer-reviewed by both primary care clinicians and occupational medicine specialists. In addition to pesticide exposure, these guidelines are very relevant for other biological and chemical exposures.

You can also download these guidelines in a PDF format from MCN's Tool Box on MCN website — www.migrantclinician.org

PESTICIDE EXPOSURES CLINICAL GUIDELINES

I. HISTORY

In each case of suspected pesticide exposure, the provider's note should address each of the following items:

- Name & place of employment
- Date, time and place of incident
- Other workers affected or witnessing incident
- Crop and type of work involved (mix, loader, applicator, picker, etc)
- Way in which exposure occurred
- Route of suspected pesticide exposure (skin, respiratory, ingestion, eyes, etc.)
- Signs & symptoms
- Onset & duration of symptoms
- Name of pesticide product (s), if known and EPA registration number, if known

II. PHYSICAL EXAM

In each case of suspected pesticide exposure, the provider should assess whether worker has undergone proper decontamination before coming to the clinic.

In each case of suspected pesticide exposure, the provider's note should document examination of the following area:

- Skin
- Eyes
- Mucous Membranes (esp. mouth, nose and throat)
- Lungs
- Heart (esp. rate and rhythm)
- Neurologic exam (specifically papillary response, distal sensory exam, motor exam and coordination)

III. LAB TESTS

The following lab tests are important in documenting toxic exposure to organophosphates (OP) and carbamates. These should be ordered in each case of suspected toxic exposure to these chemicals. They should also be ordered when the offending agent has not been identified.

A. PLASMA or RBC CHOLINESTERASE Determination.

- Cholinesterase is most useful in comparison to baseline. Baselines are recommended while the patient is not working, if this is possible.
- The normal range is wide, and a given individual may vary 20% from his own baseline even without exposure. A drop of >20% from the patient's own baseline reliably

indicates exposure.
- Patients may not become symptomatic until cholinesterase levels are depressed by >50%
- If no baseline is available, but OP exposure is clinically suspected, use reverse logic. Allow the worker to rebound to his own baseline by restricting from further potential exposure. Recheck cholinesterase levels weekly until baseline is achieved, and compare baselines.
- Other tests as indicated: Depending on the type of exposure and class of pesticide, blood tests such as CBC and liver function tests, may be indicated. Chest x-ray and pulmonary function tests would be appreciated in poisonings with paraquat.

B. TREATMENT & DECONTAMINATION
Decontamination refers to the process of rendering an object, person or area free of contaminating substance such as bacteria, poison or gas, or a radioactive material.

Immediate treatment involves the application of first aid measures dependent on source of contamination or poisoning.
- If swallowed:
  1. Call Poison Control 1-800-222-1222
- Skin Contamination:
  1. Remove clothes
  2. Rinse pesticide from hair, skin and clothes immediately
  3. Bag all clothes to prevent others from exposure
  4. Preserve specimen of clothing for analysis
- Eye Contamination:
  1. Rinse eyes immediately with clean water or an eye wash
- Inhalation:
  1. Remove from fumes and get victim in fresh air
  2. Check victim for breathing status

In all cases, seek further medical evaluation.

IV. REPORTING

Every case of suspected pesticide exposure should be reported to a given state's reporting agency. Use the PANNA website to determine the reporting procedures for your state: *http://www.pesticideinfo.org/Search_Poisoning.jsp#Reporting*

A. Reporting of exposure should be documented in progress note on chart.
B. When reporting to the above agency, providers should be prepared to answer all questions found on the form entitled "Basic Information Needed to Report Pesticide-Related Poisoning or Health Problems"
C. Cases should be reported without naming or implicating the patient (guard the patient's anonymity as if you are guarding his/her job), or the patient's consent to report should be documented.
D. Pesticide exposure should always be recorded as a diagnosis on the encounter form in order to allow central tracking of data related to pesticide exposures.

V. DISASTER PLANNING

A. Immediate first aid measures. Establishing airways, breathing, and circulation.
B. DECONTAMINATION.
C. Identification and labeling of all patients and valuables. Record keeping.
D. Identify type of chemical, location and exposure.
E. SETTING UP TRIAGE AREAS.
F. Chain of Command.
G. STABILIZATION – MONITORING – EVACUATION
H. Alerting referral hospitals.
I. Linkages with specialists.
J. Coordination of transportation of non-critical patients and linking of families for retrieval of patients after discharge from hospital.
K. Reporting of incidents to appropriate officials.
L. Follow-up planning, retesting, etc.

* SEE DECONTAMINATION INFORMATION
** THESE RECOMMENDATIONS ARE NOT NECESSARILY FOLLOWED IN SEQUENCE. THEY MAY BE DONE SIMULTANEOUSLY.

VI. RESOURCES

A. Poison Control Center 1-800-222-1222
B. National Pesticide Medical Monitoring Program, Daniel L. Sudakin, MD, MPH, *sudakind@ace.orst.edu*, (541) 737-8969
C. *EPA's Recognition and Management of Pesticide Poisonings* i(5th ED, 1999)
D. Migrant Clinicians Network, Inc. *www.migrantclinician.org/environmental*

BASIC INFORMATION NEEDED TO REPORT SUSPECTED PESTICIDE-RELATED POISONING OR HEALTH PROBLEMS

1. **Name/Age/Sex**
2. **Name of Employer/Ranch**
3. **Date, time, location (exact) of incident**
4. **Number of other workers affected**
5. **Crop and type of work (job description) of the worker, e.g., Mixer/Loader/Applicator/Picker/Thinner, etc.**
6. **Way in which the exposure occurred:**
   - Spill, leak
   - Drift, over spray
   - Re-entry into treated fields
   - Other
7. **Type of Exposure:**
   - Dermal (skin)
   - Eye
   - Respiratory
   - Ingestion
   - Any combination (be specific)
8. **Name of the pesticide(s) if known, when applied.**
9. **Type of usage of pesticide if known.**
10. **Description of the incident – to include:**
    - Signs/Symptoms – time of onset and persistence
    - Management – tests ordered/results
11. **Medical attention – who/results**
12. **Disposition and follow-up – Reports sent to county/state**
13. **Name (Clearly printed or typed) of person reporting and date report was prepared**

Pesticide Clinical Guidelines: Originally created by Dennis H. Penzell, DO, MS (2001) and modified with permission by the Migrant Clinicians Network Inc, with input from Mike Rowland, MD, MPH and Daniel L. Sudakin, MD, MPH (2007). This form may be duplicated and used as needed. For more information contact MCN at 512.327.2017 or *www.migrantclinician.org.*

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calendar

Western Migrant Stream Forum
January 25 - 27, 2008
Spokane, WA 99201
http://www.nwrpca.org/
(206) 783-3004

National Farmworker Health Conference
May 6-8, 2008
San Juan, PR
http:/www.nachc.com
301-347-040

Rural Health Policy Institute
January 28-30, 2008
Washington, DC
National Rural Health Association
http://www.nrharural.org
816-756-3140

Policy and Issues Forum
March 12-17, 2008
Washington, DC
National Association of Community Health Centers
http://www.nachc.com
301-347-0400

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