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Pilot Study

HIV Risk Assessment Tool with a Sample of Migrant Farmworkers in the Napa Valley

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Recent changes in HIV testing and new screening recommendations being issued by the CDC [see editorial below] are likely to alter HIV screening and testing practices at Migrant and Community Health Centers (M/CHC). Like many other M/CHCs, Clinic Ole, in California's Napa Valley, is exploring the best mechanisms to screen and test migrant farmworkers for HIV in this new environment. In the Fall of 2006, the clinic began a pilot process to develop a succinct HIV risk assessment tool to determine who would most benefit from receiving the new rapid HIV test at migrant health fairs. The intent is to incorporate the HIV screening tool into an existing health fair screening questionnaire which currently covers topics ranging from TB to mental health to substance use. This article explores the issue of HIV/AIDs risk among farmworkers as well as describes the pilot risk assessment results.

HIV/AIDS Risk and Knowledge in Migrant Populations—Literature Review

Migrant farmworkers are at increased risk of acquiring HIV due to limited knowledge about the virus, high-risk sexual behavior, limited access to health care, poverty, and the injection of both illicit and non-illicit drugs (antibiotics and vitamins) (UNIDOS Network, 2004). Education efforts are crucial in order to control the spread of HIV among this population. Unfortunately, mobility, language, illiteracy, traditional customs, and limited access to health care all present substantial barriers to HIV prevention efforts (UNIDOS Network, 2004). Studies have shown that using promotores de salud (lay health educators) can be effective in disseminating information in a culturally and linguistically competent manner. One study presented at the 1999 National HIV Prevention Conference, utilized promotores in two communities on the U.S.-Mexico border to bring the HIV prevention message to farmworker families (Davis & Gonzalez, 1999). The promotores went into the fields, to homes, churches, community centers, and schools to educate farmworkers and their families about HIV transmission and prevention. Over an 8-month period, the promotores educated more than 3,700 farmworkers and family members and obtained 1,227 pre-training questionnaires indicating that farmworkers lack basic knowledge about HIV transmission and often use ineffective prevention methods (Davis & Gonzalez, 1999). Davis & Gonzalez determined that well-trained peer educators can reach hard-to-find farmworkers and deliver an effective HIV prevention message.

Organista, Organista & Soloff (1998) conducted a survey which demonstrated that while farmworkers possessed some accurate

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EDITOR'S NOTE

In September 2006, the CDC issued revised recommendations for HIV testing which serve as an update to the previous recommendations that have guided us since 2001. The "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings" (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm) includes some major revisions, moving us in the direction of universal screening of adults and adolescents. Those recommendations are:

- In all health-care settings, screening for HIV infection should be performed routinely for all patients aged 13-64 years. Health-care providers should initiate screening unless prevalence of undiagnosed HIV infection in their patients has been documented to be <0.1%. In the absence of existing data for HIV prevalence, health-care providers should initiate voluntary HIV screening until they establish that the diagnostic yield is <1 per 1,000 patients screened, at which point such screening is no longer warranted.
- All patients initiating treatment for TB should be screened routinely for HIV infection.
- All patients seeking treatment for STDs, including all patients attending STD clinics, should be screened routinely for HIV during each visit for a new complaint, regardless of whether the patient is known or suspected to have specific behavior risks for HIV infection.

Patients must be informed of testing and may opt out of testing, but prevention counseling and written consent for testing would not be required components of screening. There are additional recommendations related to intervals of repeat testing, communicating results, testing of pregnant women and newborns, and provision of care for those testing positive.

These recommendations have not been adopted in all settings, but many healthcare entities are considering revisions to their practice. Familiarity with the guidelines is recommended.

Although screening for risk status is not necessarily a component of testing under universal screening guidelines, risk assessment such as discussed in this article can continue to serve several valuable purposes. Risk screening provides:

- education to patients regarding behaviors and practices that increase risk of HIV infection and feedback regarding the patient's individual risk status,
- guidelines for the clinician to determine those who require more frequent testing, and
- general information to the healthcare entity about the risk status of its patient population

knowledge regarding HIV/AIDS transmission, misinformation was common. Nearly half thought mosquitoes could transmit HIV, while 37.5% believed transmission was possible via public bathrooms or kissing (Organista et al., 1998). This study found that a quarter of the sample felt AIDS was solely a concern for homosexuals and drug addicts. One fifth of the farmworkers surveyed thought that they could determine whether someone was infected by physical appearance (Organista et al., 1998). Ford et al. (2001) conducted a similar study in order to investigate HIV/AIDS knowledge among Latino adolescent and adult migrant farmworkers in Michigan. In general, the sample seemed knowledgeable about sexual modes of HIV transmission, however casual contact, through kissing or attending work or school with an infected individual, was also viewed as a possible route to infection by some (Ford et al., 2001). Thirty-five percent agreed that condoms are only for use with prostitutes and 54% agreed that condoms are only for gay men (Ford et al., 2001).

Mexican migrants may engage in high-risk sexual practices when moving to the U.S. due to the fact that they are lonely and isolated, more liberated from sociocultural controls on behavior, and may feel compelled to exchange sexual services for food, lodging, or money (Sanchez et al., 2004). The patronage of prostitutes along with inconsistent and incorrect condom usage escalates risk substantially among this population. Organista et al. (1997) found that 44% of the 342 male Mexican migrant laborers surveyed had sex with prostitutes and that married men were less likely than single men to use condoms in these situations, thus putting their wives at risk (Organista et al., 1997).

In 2006, the California Department of Health Services and the Office of AIDS, together with the City of Berkeley Health Department completed a comprehensive HIV risk assessment of migrant Latino day laborers residing in the cities of Oakland, Berkeley and Richmond. This DHS study utilized bilingual community health workers to recruit and interview 291 male Latino day laborers using a 70-item questionnaire (Ehrlich, Tholandi & Martinez, 2006). The survey collected information on sociodemographic characteristics, perceptions of risk for HIV infection, histories of testing for HIV and sexually transmitted infections (STIs) , behaviors that may place day laborers at risk for HIV or other STIs, and preferences for receiving STI prevention information and HIV testing services. Of the day laborers surveyed, 73.8% were between 20 and 39 years of age. Sixty seven percent had less than a high school education, and 55% were married or had a common law wife (Ehrlich et al., 2006). Thirty-six percent of the sample reported exchanging food, shelter, drugs, or money for sex with a woman. Eight point six percent said they had had sex with a man, and about one third indicated they had been high on alcohol during sex within the past six months (Ehrlich et al., 2006). Less than a third of the sample had received previous HIV testing. Ehrlich et al. found that the study participants preferred the rapid HIV test and group-based STI/HIV educational sessions; the authors suggest that these preferences should be considered when developing HIV intervention programs targeted at a similar population.

Until recently, the prevalence of HIV in Mexico and among Mexican migrants in California has been stable and relatively low; however, recent studies suggest that the HIV epidemic may expand more aggressively among this vulnerable population in the coming years (Sanchez et al., 2004). According to the UNIDOS Network, "Major factors contributing to the risk of HIV/AIDS for migrant farmworkers include: cultural taboos against frank discussion of sexual matters between partners or parents and children; widespread social acceptance of males having multiple sex partners; heavy use of alcohol during sexual encounters; use of syringes to inject antibiotics and vitamins (from Mexico) as well as illegal drugs; unprotected sex with sex workers; and men having unprotected sex with men (many of whom do not identify as gay)" (UNIDOS Network, 2004).

Migrant Farmworker Risk Assessment at Clinic Ole

The pilot HIV risk assessment tool for Clinic Ole consisted of eleven questions. All participants remained anonymous although certain demographic characteristics were collected. All data was collected in the form of face-to-face interviews conducted in Spanish so as to avoid any problems with literacy.

Participants

Participants in this pilot study included 18 of the 30 farmworkers residing at a migrant camp in Napa Valley at the time of the study. All participants were male, Latino vineyard workers. The age of participants ranged from 17 to 54, with the majority in their 30s and 40s. Participants originated from the Mexican states of Michoacan, Hidalgo, Queretaro, Guanajuato, Jalisco, and Oaxaca. Education levels ranged from two years of elementary school to finishing high school; most participants had received an elementary school education. Exactly half of the participants were married and the other half identified as single.

Results

Overall, the survey results indicated that the group was fairly low risk with respect to HIV transmission however, 7 of the 18 participants admitted to having had sex with a prostitute. No one identified as "a man who has sex with other men" and no one indicated IV drug use. Condom use was fairly consistent when participants had sex with someone other than their spouse but compliance was not 100%. Interestingly, 5 participants reported being high on a substance during sex; most with alcohol but one man had used crystal meth. The number of lifetime partners ranged from 1 to 80 though most reported a total average of 10 partners. Very few (n=2) reported ever having an STI. aOnly 6 of the 18 participants had ever received an HIV test and virtually all of those had been tested through Clinic Ole.

Discussion

One major weakness of this pilot study is the very small sample size (n=18). Part of the difficulty of subject recruitment may have been due to the small window of time available to

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Helping Health Centers Identify Migrant and Homeless Patients

The Health Care for the Homeless (HCH) Clinicians' Network and **Migrant Clinicians Network (MCN)** serve as National Partners to the HRSA Health Disparities Collaboratives. One of the critical roles for both organizations is helping health centers identify their migrant and homeless patients. Both organizations share a commitment to the principal that **mobility should not be a barrier for health care access or continuity of care**. What follows is a set of succinct and helpful suggestions for how to better identify homeless and migrant patients in your practice.

Identifying Homelessness:[1]

There are a number of ways to identify someone as homeless. Some of these are more obvious then others. The following list provides a good overview of the different ways in which a person and his or her dependents can be classified as homeless.

- Patient self-defines
- Patient lives place-to-place
- Patient lives with family or friends because there is no other option
- Patient is staying in a place that restricts number of nights they can stay (including pays rent by day or week)
- Patient is in housing that is based on illegal or unwanted acts (e.g. prostitution)
- Patient separated from family members because of limited housing choice

Signs of Instability:

We know that a key to identifying homelessness includes recognition of **instability**. Persons experiencing homelessness can move through a variety of housing environments.

- Does the person know where she will stay in the foreseeable future? Is it stable?
- Is there a place the person inhabits legally (leases or owns)?
- Is there a safe place for the person's belongings?
- Is there a history of frequent moves?
- Does the person desire to escape danger in current housing?

Use the following list to have patients self select their current housing, anticipated housing and past housing.

Unsheltered: streets, bridges, cars, abandoned buildings, tents, woods or racetracks.

Emergency Sheltered: homeless shelters, domestic violence shelters.

Doubled Up: family, friends, and acquaintances.

Transiently Housed: hospitals, jails, motels, respite care and treatment programs.

Housed: house or apartment (own or lease)

Identifying Migrant Patients:[2]

The following are the key questions for verifying migrant or seasonal farmworker status[3]

1. Have you or a member of your family, as a primary source of income, ever worked as an agricultural laborer, planting, tilling or harvesting crops grown on the land such as fruits and vegetables?

A "**Yes**" to this question **establishes them as an agricultural worker and you should ask questions 2-4**.

If the answer is "**No**", there is **no need to complete questions 2 and 3**

2. Have you or a member of your family, moved in the past two years to another area (established a temporary home) in order to perform agricultural labor?

A "**Yes**" to this question **qualifies them as *migrant* farmworkers**

3. Have you or a member of your family, worked in the past two years in agriculture, without the need to move away from your home?

"**Yes**" to this question **qualifies them as *seasonal* farmworkers**

4. Have you or a member of your family stopped traveling to work in agriculture because of disability or old age?

A "**Yes**" to question **qualifies them as aged/disabled farmworkers**

How Farmworkers Identify Themselves:[4]

Sometimes the words that providers may use to ask about farmwork are not the ones that farmworkers use to describe themselves. It is important to be aware of the following list of terms that can serve as clues to identify someone as a farmworker.

Terms Used to Describe Farmwork

By the name of the crop

En el fríjol *In the beans*
En la cebolla *In the onions*
En el empaque de *In packing*
En el algodón *In the cotton*

By the pace of agriculture

En la labor *In the field*
En una nurseria *In the nursery*
Con un contratista *With the contractor*
Con un ranchero *With the farmer*

By the name of the agricultural activity

Soy amarrador *I fasten the plants*
Soy Pizcandor *I am a picker*
Trabajo en el plástico *I work laying plastic*
En maquina pizcadora *In harvesting machine*
En el azadón *I work with a hoe*
En el desahije de *I work thinning the… or Thinning the…*

By the geographic location

Me voy pa Michigan *I go to Michigan*
Voy a los trabajos *I follow the work*
Me voy pa los trabajos *I follow the crops*
Me voy con el troquero *I go with the contractor*
Sigo las corridas de *I follow the crops*
Me voy pal norte *I go to the north*

Remember! *Dependents* are classified according to their head of household for both Migrant and Homeless Patients

How long is someone Homeless or Migrant?

- The official designation for migrant and homeless often changes
- It is important to remember that the designation identifies that person as at risk for adverse health access and outcomes.
- For purposes of medical records and reporting:
  - If person has been "**migrant**" at any time in **previous 24 months**, he/she is STILL designated as migrant
  - If person has been "**non-housed**" in any of the homeless designations in **past 12 months**, he/she is STILL designated as homeless

Questions that Lead to Solutions

The following questions allow you to think about your current system for identifying migrant and homeless patients. You can use these questions to guide changes in your health center policies. For those of you in the health disparities collaboratives, these are good examples of PDSAs you can explore.

- How are patients presently defined as migrant or homeless in your medical records and/or intake forms?
- How often is this classification updated?
- Are providers aware of homeless/migrant status of patients?
- Are patients aware of homeless/migrant status in the records?
- What is the breakdown by ethnicity/race, gender, and age in your patient population?
- What are the outcomes for special populations in your registries (or medical records) as compared to "non-special" patient population?

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Migrant Clinicians Occupational Health Reference Manual

A new resource is available for primary care clinicians to help address occupational injuries and exposures in migrant and seasonal farmworkers. The New York Center for Agricultural Medicine and Health/ Northeast Center (NYCAMH/NEC) developed a 250-page reference manual covering: the agricultural workplace, culturally competent health care, the basics of occupational health exams and history methods, trilingual patient education materials, and information on Worker's Compensation.

NYCAMH/NEC developed *A Migrant Farmworker Occupational Health Reference Manual* for clinicians in response to research conducted in collaboration with federally funded migrant and community health centers and hospital emergency departments in the northeast. This research indicated that approximately 15% of all adult medical visits to migrant health centers were related to an occupational health problem. (See July/August 2004 *Streamline* for further discussion of this study.) Moreover, MCN clinician survey data indicated that close to 50% of primary care clinicians working with migrants never had any training in occupational or environmental health (May/June 2001 *Streamline*). This data suggested that support for occupational health care for this population was greatly needed.

The manual is largely designed for migrant clinicians caring for farmworkers working with crops that are grown in northeastern agriculture (e.g. apples and blue berries). Nonetheless there are many common topics that are relevant regardless of geographic location. Manual sections are tabbed for easy reference. The manual begins with an in depth section on cultural competency with discussions on Mexican, Haitian, Jamaican, and Native American farmworkers. The next section deals with commodity profiles, with useful explanations of the crops or commodity and common injuries and exposures. The third part of the manual deals with diagnosis and treatment and offers three training modules developed by occupational medicine specialists. The fourth section provides easily reproduced patient education material in Spanish, Haitian-Creole, and English. Lastly, there is a section on worker's compensation. Prototypes of the manual were extensively pre-tested with clinicians at several migrant health centers in the Northeast region over a 12-month period.

This manual is now available on the MCN website. MCN has partnered with NYCAMH/NEC to compile the manual in a user friendly, searchable web format. (Please see the environmental/occupational web page that is part MCN's section on clinical excellence at www.migrantclincian.org.) Future plans include the development of additional crop worksite descriptions, as well as additional training modules on different common health problems. ■

Profile of the New York Center for Agricultural Medicine and Health

The New York State Legislature established the New York Center for Agricultural Medicine and Health in 1988. Recognizing the unacceptably high rates of occupational injury and illness in New York's largest industry, the legislature has charged NYCAMH to provide:

- Research into the causes and prevention of agricultural injury and illness
- Education and prevention activities within the farm community
- Education of professionals serving the farm community
- Clinical help for farm-related health problems

In addition to its state mandate, the National Institute for Occupational Safety and Health (NIOSH) has designated NYCAMH as one of nine agricultural centers across the country, the Northeast Center for Agricultural and Occupational Health (NEC). Serving a thirteen-state region from Maine through Virginia, NEC promotes farm health and safety research, education, and prevention activities.

NEC's specific objectives are to:

- Focus efforts of research, education, and prevention on issues epidemiologically identified as high risk in the northeast region, including the following:
  - Mechanical hazards, particularly tractors, powered implements, and PTO/drivelines
  - Another mechanical hazard, noise, which has generated an epidemic of hearing loss in the farm population
  - The health problems of noise-induced hearing loss, musculoskeletal and soft-tissue disorders, respiratory disorders—especially asthma—emotional distress, and skin cancer
- Address populations known or suspected to be facing increased risk, including the older farmer (65 years and older), migrants, children and women.
- Serve the entire northeast region's farm community by reaching out to regional resources in agricultural health and safety, occupational health, engineering, education, public health, communications, public policy, medicine, and other areas.
- Work with NIOSH and other occupational resources, both regionally and nationally.
- Enhance networking and sharing of regional resources.
- Train health professionals, teachers, engineers, and others. It also involves active outreach programs to the health community, agricultural colleges, and others.

NYCAMH/NEC has numerous patient education materials in Spanish and recently published the *Migrant Farmworker Occupational Health Reference Manual* for clinicians. To access these resources or for more information visit — *www.nycamh.com* ■

calendar

10th Anniversary Health Education Advocacy Summit
March 3-5, 2007
Washington, DC
Society for Public Health Educators
http://www.healtheducationadvocate.org/

National Farmworker Health Conference
May 9-12, 2007
Newport Beach, CA
National Association of Community Health Centers
(301) 347-0400
http://www.nachc.com/ela/listing.asp

The American College of Nurse Midwives Annual Meeting & Exhibit
May 25- 31, 2007
Chicago, Illinois
240-485-1800
http://www.acnm.org/education.cfm?id=841

New Online Clinical Education Available

The Migrant Clinicians Network Continuing Education Program

MCN is committed to providing high quality continuing education to health care providers serving migrants. To this end, we have recnelty developed a series of online courses to tackle issues pivotal to health care providers committed to serving migrants, and other mobile, underserved populations.

What MCN's Distance Education Program will Do for You

MCN's Clinical Distance Education Program is designed to develop excellence in clinical practice, clinical leadership, cultural competence and your working knowledge in the physical, mental, and environmental health of migrant farmworkers and other mobile, underserved populations. Each course provides free continuing education for nurses and health educators and physicians.

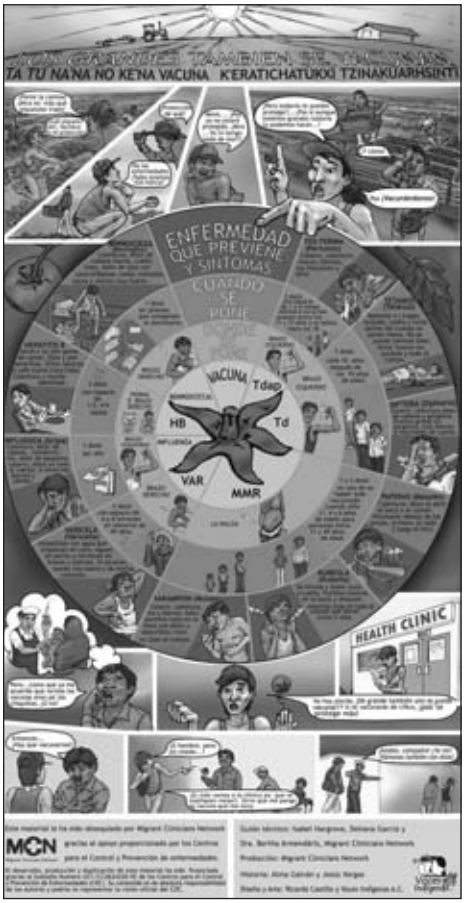
Current Courses

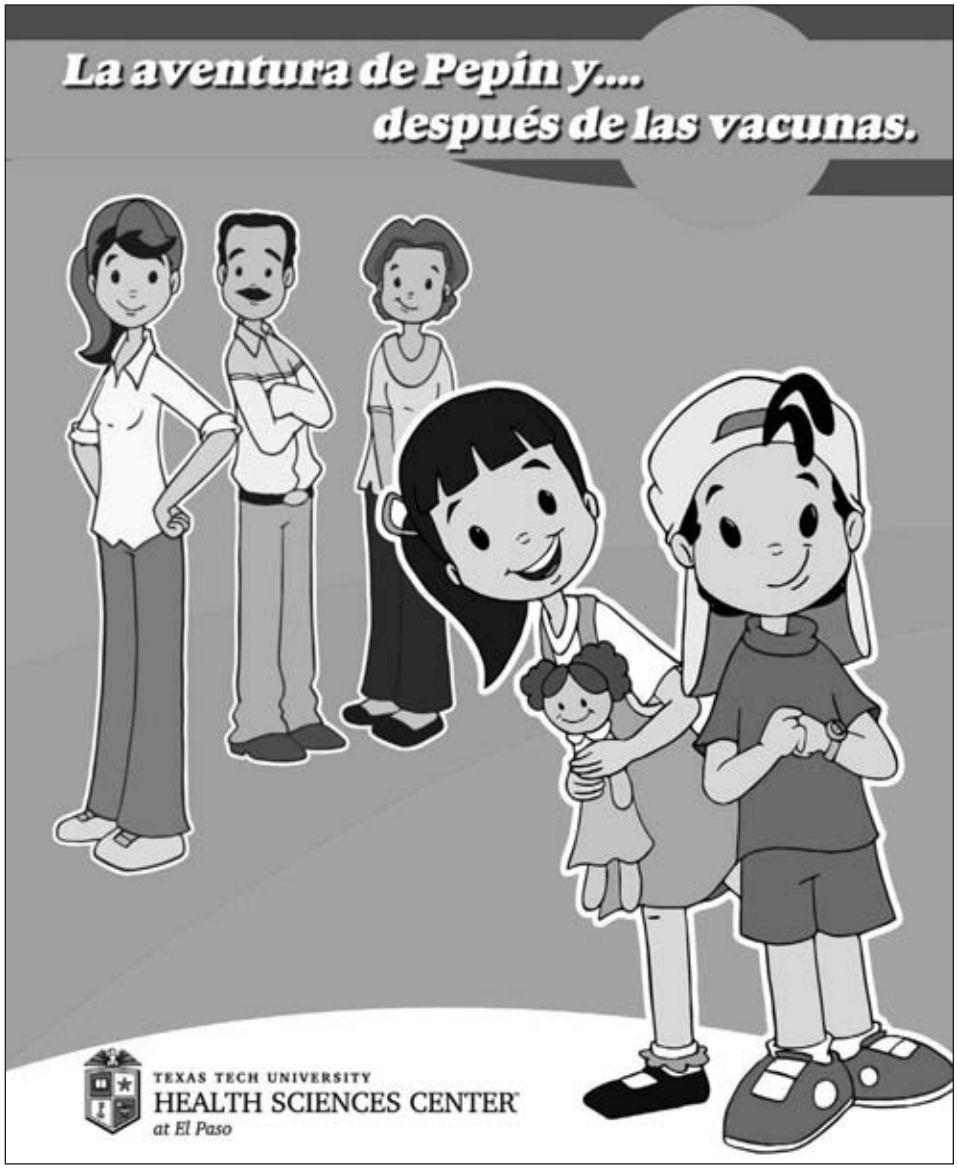
1. **"The Immunization Series"** is a 6 part foundation course designed to provide you with relevant information related to working with migrants to provide consistent child and adult vaccinations. This course discusses the rationale for vaccines and the status and barriers to immunization faced by migrant Latino children in the US. The modules will explore the latest information about vaccine preventable diseases, how to best educate non-English speaking parents, reasons whythe migrant population is at greater risk for vaccine preventible issness, the barriers to immunization for this population, and some of the next steps to address these issues with a migrant population.
2. **"Adolescent Farmworkers at Risk"** is a five-module distance learning offering that provides a comprehensive overview of the adolescent farmworker population and the environmental hazards they face. The offering is designed to raise health care provider's index of suspicion reagarding environmental causes of disease and injury among adolescent farmworkers while also providing physicians with tools and resources needed to address environmental and occupational concerns.
3. **"Tuberculosis and Migration"** is a 3-part course offered to help clinic staff serving migrant and recent immigrant populations increase their knowledge of tuberculosis. This course will provide staff with a knowledge basis from which they can initiate and engage in conversations with clients about tuberculosis awareness and prevention. The modules will explore the Importance of TB Care to the Migrant Population. Key characteristics that contribute to the spread of the disease in the US migrant population. The differences between the health care system of the US and other countries, primarily Mexico. and finally, testing, diagnosis and treatment with resources for more information about special populations.

Registration

Registration is simple. Go to *http://courses.migrantclinician.org* to begin the process. If you have any questions or concerns please contact Jillian Hopewell at *jhopewell@migrantclinician.org* or 530-345-4806. ■

Three New Immunization Popular Education Resources Available at No Cost!





Immunization poster-size calendars 2007 to educate Hispanic indigenous migrant men. NEW!

Are you serving Latin American indigenous populations?

Latin American indigenous migration has increased in the past years in much of the U.S. In the past indigenous migrants lived primarily in the U.S.-Mexico border region, but more recently indigenous migrants have created smaller communities in towns and communities in the interior regions of the U.S. Many clinics and health providers are unprepared for the challenge of working with this unique population. Very few have the resources to hire and use an interpreter of an indigenous dialect to assist them in the outreach and care provision to non - English and non- Spanish speaking patients. There is also a dearth of popular education resources and tools for use in communicating health messages to this population.

To begin to address this need, MCN announces the availability of the 2007 immunization poster-size calendar. This low-literacy popular education resource uses primarily images to convey information about vaccine preventable. The resource is targeted at Latin American indigenous migrant males between the ages of 15 and 36 years.

Immunization comic book "La aventura de Pepin y después de las vacunas" (what to do after the shot) and the short films "Hepatitis A and Td vaccines"

MCN announces the availability of the comic book "La aventura de Pepin y después de las vacunas". This low literate popular education material in SPANISH was developed to help clinicians educate Hispanic migrant parents on what to do after their children get vaccinated.

Finally, MCN announces the availability of the short films in Spanish and English, in VHS and DVD format addressing the topics Hepatitis A and Tetanus/Diphtheria vaccines. These low literate popular education videos of 10 minutes each were developed to help clinicians in educating and encouraging low literate patients get vaccinated and vaccinate their children.

Please complete the Immunization Education Materials Order Form and fax it to: Immunization Project at 512-327-0719. These resources are free of charge, and postage is also free as in the US! Recipients of these resources are asked to complete an evaluation of the materials. Supplies are limited and will be distributed on a first-come, first-serve basis. You may, order up to 50 of each comic book or poster-calendar. Order now! ■

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Immunizations Educational Materials Order Form

The development, production and duplication of these resources were supported by Grant Number U21/CCU624220-02 from the Centers of Disease Control and Prevention. These resources **are free of charge, and postage is free as well in the US!** Recipients of these resources are asked to complete an evaluation of the materials. Supplies are limited and will be distributed on a first-come, first-serve basis. **You may order 1 of each and up to 50 of each comic book or poster-calendar.**

Please check all that describe your patient population:

☐Pediatric ☐Adult ☐Adolescents ☐Prenatal ☐Migrant Farmworker ☐Immigrant
☐Uninsured ☐Mobile ☐Homeless ☐HIV ☐Chronically ill ☐School Health
☐Head Start ☐ Hispanics from indigenous origins

Estimation of the number of patients you serve monthly: _____

Dialects spoken by Hispanic Indigenous population serve:

☐ Mixtec ☐Zapotec ☐Triqui ☐Mam ☐Other (please specify which one)_____

Please indicate number of resources

- **2007 Poster-Calendar for Hispanic Indigenous men: _____ pieces**
- **Comic book in Spanish " Después de las vacunas" : _____ pieces**
- **Short films Hepatitis A and Td vaccines:**

	Spanish DVD	Spanish VHS	English VHS
Hepatitis A and Td vaccines			

Name of contact person:	
Position:	
Name of Organization:	
Address	
City, State and Zip Code	
Contact phone	
Fax number	
Email address	

Order by fax to: Attn: Immunization Project at Migrant Clinicians Network at Fax number: (512) 327-0719.

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HIV Risk Assessment Tool continued from page 2

interact with the farmworkers. A larger sample size could have been obtained either during the peak of summer when the camp census is closer to 60 or if the pilot study had been conducted over a longer period of time.

Although the sample surveyed indicated no injection drug use or receptive anal sex, other risk factors emerged such as sex with prostitutes, inconsistent condom use, and sex under the influence of alcohol or drugs. Given the low number of participants who had been tested for HIV, the group could benefit from having access to the new rapid oral test through the migrant health fairs. The hope is that the HIV risk assessment tool will be incorporated into Clinic Ole's migrant health fair screening questionnaire so as to more efficiently and accurately identify those farmworkers at risk and then be able to offer appropriate and cost-effective HIV testing on site. ■

Helping Health Centers Identify continued from page 3

- What is the percent inactive status of your special population patients?
- What are barriers to care for patients who miss appointments?
- What is the average amount of money your patients spend on medications per month? How does this break down by special population?
- For those of you in the health disparities collaboratives, is there an equitable distribution of providers and patients participating in spread as it promotes inclusion of special populations?

Some points to remember:

- This is just a start: The HRSA definitions of migrant and homeless identify a portion of our vulnerable population, but they are not exhaustive.
- Mobile patients, whether or not they meet these definitions, are also at risk.
- These special population measures can be a springboard to identifying other "at risk" patients. ■

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2. Migrant Clinician's Network
3. National Center for Farmworker Health, Inc.
4. Hilda Ochoa Bogue, RN, MS, CHES, National Center for Farmworker Health, Inc.

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