MCN streamline
Volume 12, Issue 4
July / August 2006
The Migrant Health News Source

The Role of Patient-Provider Interaction in Facilitating Discussions about Risk

The role of good communication in accurate risk assessment and risk prevention education has of been examined by researchers in the context of HIV/AIDS education. Learning from this work, MCN and Community Health Education Concepts (CHEC) have undertaken a five-year project (HepTalk) to study hepatitis risk communication with migrant/mobile underserved populations. MCN is providing clinical tools and training based on the research findings to to improve health communication and clinic systems. This work, being piloted in 27 health centers and clinics throughout the country, has potential for broad application for preventing and treating Hepatitis A, B, and C.

The HepTalk project hypothesizes that patients will engage in a discussion of the emotionally charged issues that surround Hepatitis A, B, and C infection risks and prevention if the clinic health care environment includes:

1. Access to information for patients on hepatitis, consistent with CDC Guidelines, and opportunities to discuss emotionally-charged personal health topics, including hepatitis risk factors, and
2. Clinicians able to anticipate, recognize the need for, encourage, and participate in discussion of emotionally charged personal health topics.

In the January-February, 2006 issue of *Streamline* we presented some of the observations from the initial 27 HepTalk clinic site visits. That article discussed the role of the clinic environment and patient education material in facilitating good discussions about risk. This article continues with a discussion of observations of patient-provider communication, and how that communication can facilitate or deter good discussion of risks.

HepTalk team site visitors shadowed 60 adult clients at 27 community and migrant health centers and local health departments around the US that serve mobile poor clients and recent immigrants from Latin America. Site visitors also interviewed clinic staff and clients. The majority of clients shadowed and interviewed presented at the clinic for symptoms or illnesses not related to hepatitis, though a few were seen for concerns about sexually transmitted diseases. The observations were compiled to assist the team in developing training materials based on real situations and demonstrated needs. These observations were also shared with participating clinic staffs.

Beginning the Discussion: Health Histories

A good discussion of health risks often takes place in the context of a thorough, yet concise health history.

Sexual history taking

Not all of the client visits observed included sexual history taking. When they did, practices varied widely from clinic to clinic, and sometimes from provider to provider. Those visits that included the most complete sexual history taking usually included one or more of the following question types: questions about partners, partners' partners, partners' gender, and type of sexual interaction. Questions such as a history of STDs, or concerns about HIV were more common.

The majority of questions asked about partners elicited information about number of partners. Observers saw few (<5) instances of questions being asked that elicited information about partner's drug use or "new partners since last visit," or length of time with current partner." Gender of partners was mentioned only three times in observers' notes. Site visitors observed at least five times when the risk question related to partners was equivalent to "are you married?" and few or no other questions were asked if the answer was yes.

Notable instances of good communication practices also occurred. One question, "as far as you know, is this a mutually monogamous relationship" stands out from observation

continued on page 2

notes as being concise, focused and sensitive. Providers sometimes followed up questions about partners with an explanation about why the number of partners was important: "the more partners you have, the greater your risk," and "if either she or her partner had other partners, they could get STDs." Providers occasionally advised clients that communicating with partners was an important way of understanding and preventing risk.

Often, however, observers noted the lack of follow-up after sexual history taking. There were few instances, following the elicitation of number of partners, of staff or clinicians explaining why that question was being asked, or what meaning the patient's answer might hold for the provider. Of interest to the project team is what the implied messages of asking risk questions might be when the clinician does not respond to the answer. For example, what, if anything, is implied if a patient, responding to a question about condom use, says "sometimes," and the provider moves on to the next question? Does the client assume that there is no meaning to the answer and that he/she does not need to consider behavior change, or that the clinician hasn't heard or doesn't care what the answer was? The HepTalk training will include a discussion of how agenda-setting might help clarify expectations: "I'm going to ask you a series of questions, and we'll talk about your answers when I'm done. Is that okay?"

Also of interest is information about what number of partners triggers a follow-up response, both within clinic systems and for individual providers. This number seems to vary widely. It also necessarily depends on the disease focus. For example, hepatitis C is far less efficiently transmitted sexually than hepatitis B. One state, South Carolina, has determined that it is cost effective to test for hepatitis C only if the number of partners is greater than 50. For hepatitis B, and other more common STIs, the number of concern is lower — CDC recommends testing of anyone who has more than one partner in the previous six months.

Drug and alcohol related risks

Most of these questions about drug and alcohol use were general, typically a yes/no choice to "do you use drugs?" Observers noted eight times when questioners specifically asked about IV drug use. In client interviews following unobserved visits, 12 clients (25%) responded yes to a question about whether or not anyone had discussed drug use.

Hygiene issues

There were only two recorded observations of risk discussions that included questions about hygiene. Both included discussions of food-washing, and one included good hand-washing practices. In client interviews, clients responded "yes" to a question about whether or not hand washing was discussed 14 times or 29%, and food handling 9 times or 19%.

Risk Assessment Skills

The HepTalk observers rated each patient-provider interaction using the following list of risk assessment skills:

1. General Interviewing Skills
   a. Helping the patient tell the story
   b. Relationship-building
   c. Organizing the interview
2. Process Skills
   a. Opening the inquiry into hepatitis risk
   b. Facilitating further discussion of hepatitis risk
   c. Using clear language
   d. Negotiating potentially awkward moments
   e. Facilitating behavior change
   f. Using the client's primary language

The following is a synopsis of notable findings. Again, this information was gathered to assess what skills were most present, and which techniques would be most helpful in a training package.

Encouraging communication

Helping the patient tell their story, relationship building, and organizing the interview

Across the board, staff members were generally positive, friendly, warm and compassionate, providing a sound basis for helping the patients to tell their stories. At the same time, site visitors noticed that specific communication skills did not always accompany the positive attitude, as in the example of an observer's comment that a provider was "pleasant and friendly, but didn't ask any open-ended questions." Skills that were often noted as missing were skills in organizing the interview or agenda setting. These include phrases that help to frame the conversation while engaging in it, like "I'm going to ask you a few more questions and then we'll come back to your back pain." They also include expressions that direct the client towards what the staff person is thinking, like "I'm concerned for your health," or "the reason I'm asking this is..."

Observers also noted that during physical exams, agenda setting skills, or explanations of what would happen next were common ("I'm going to do this next," or "you'll feel my hand here"). However, during risk discussions, agenda setting techniques were used less frequently. There were few explanations of why the provider moved from one topic to another, few examples of providers offering follow-up responses to answers to risk assessment questions, few reassurances from provider that he or she would return to topics that were not fully addressed or conversations that were interrupted, or few explanations of why questions were asked.

Initiating, Organizing, and Sustaining a Difficult Conversation

Facilitating discussion

Skills that help to facilitate good discussion, such as eye contact, the use of pauses and silences, humor, and open-ended questions, were common. Others included positive feedback, expressions of concern, encouragement and reassurance, and facilitating access to provider via business cards or phone numbers

Initiating the risk assessment

Observers noted a few times when rationales were provided for asking risk questions, such as "some of these questions are a bit heavy, but we ask everyone, because this is your first visit," or "since I've not seen you before, I want to ask you some other questions." However, this skill was not as common as good eye contact and warm, friendly voice tone.

Sustaining the Conversation

Probing and getting enough information to have an adequate risk assessment included the use of repetition and restatement of questions ("Do you use IV Drugs? Needles? Never?"), as well as persistence in the face of miscommunication, and asking follow-up questions ("Why?" "What are the situations when you don't use condoms?"). However, these skills were not commonly observed.

Materials, including videos and brochures, were also used to facilitate discussion, though rarely. In some cases, materials were provided to clients, but clients had little opportunity to discuss those materials with clinic staff.

Using clear language

Most difficulties with language happened in the context of interpretation (see below). There were sporadic but notable instances of clear concise questions, like "As far as you know, is this relationship mutually monogamous?," "Do you have sex with men or women or both?" or "What are the situations where you don't use condoms?" One conversation included a remarkably clear, simple and matter-of-fact interpretation of the question "do you have oral or anal sex" for a client who was mentally disabled.

continued on page 3

The Role of Patient-Provider Interaction continued from page 2

Language and translation challenges

In clinics with no bilingual staff at hand, there were often language and interpretation challenges. Though every clinic had some provision for providing service to non-English speaking clients, they were not always adequate. Observers noted instances where clients brought friends who did not understand medical terminology, interpreters who "interpreted" both patient and provider, and staff with little experience in using an interpreter. . A common occurrence was for staff to talk to or address questions to the interpreter instead of to the patient. Occasionally, patient flow was affected by the need to wait for the interpreter to finish with another patient. This was particularly true when the interpreter had other duties in the clinic besides interpretation. Observers also noted one instance when a form was not in Spanish, and the Spanish-speaking client signed it anyway, though no one had gone over the form with her in her own language. Agencies that lacked Spanish-speaking staff and/or interpreters saw this at least as an impediment to efficiency or patient flow, and most recognized it as the quality of care issue.

Response to Risk

Once risk has been determined, what happens next? Observers noted instances when follow-up to risk assessments did occur. But more commonly they noticed that there was no response to determined risk. Observers noted both openings in the conversation suggesting risk was present, either patient or staff initiated, which did not continue past the initial remark, or answers to a risk assessment question indicating that risk was present which received no response.

One of the positive follow-up responses recorded was to hepatitis risk. (Other positive observations included conversations about other STIs, smoking, breast self-exam, and alcohol use). The following interview demonstrates some of the complexities faced by clinical staff in routine risk assessment situations. It includes moments during the interview when follow-up occurred as well as times when it did not.

> One staff person, a nurse, completed a detailed risk assessment. In response to a question about unprotected sex, the client indicated that he felt he knew "if something was wrong." This was somewhat vague, and the nurse did not clarify, though she did offer condoms. She also pressed for more information in other circumstances. For example, in response to a question about how much alcohol he drank, the client said, "You don't want to know." The observer noted that: "Nurse very pleasant and friendly, but tough and followed up with 'Yes I do.' Looked straight at the patient."

The interview also included the question "do you know what hepatitis is," and a follow-up, a brief explanation of symptoms, when the client responded that he did not know. The patient was then asked if he'd ever had these symptoms and he said no. However, presumably because of significant risk factors, including unprotected sex with multiple partners and lack of adequate information about partners, the nurse followed up her risk assessment by asking the client if he wanted to receive hepatitis B vaccinations. She pressed the client for information about his current and past living situation, so she could help him figure out how he would be able to finish the series if he started it, since he was a migrant, and apt to be moving soon.

By the end of the visit, however, the offer of immunization was not followed up. The patient had two other urgent conditions that required immediate attention. In addition, it was the nurse who addressed the topic of hepatitis. (In client interviews, the people most likely to talk to the client about any of these topics were the nurse or the physician, nurse practitioner, or physican assistant.) She noted in the chart that the patient "would like to start Hep B im." She also advised the patient to mention it to the doctor, and he did not. The doctor addressed the two complex presenting complaints (one of which necessitated a discussion about workers' compensation papers) and did not return to the topic of hepatitis. The patient left without beginning the immunization series, nor was there any plan made to return to the topic at subsequent visits.

Encouraging behavior change

One response to perceived risk is encouraging behavior change. Observers noted several different types of opportunities for behavior change.

Encouraging clients to use condoms is a frequently discussed behavior change. A little more than a third of the time that team members noted a discussion of condoms, they also noted that condoms were directly offered to clients. Discussions of condoms commonly included information about providing protection against STIs. Observers recorded one condom demonstration and one offer to demonstrate that was refused by the client.

Substance abuse (including alcohol) counseling

Observers noted only a few interviews in which clients admitted substance abuse, and these were primarily related to alcohol abuse.

In one case, the patient had already been in rehab, and in one other, the patient was being treated for alcohol withdrawal.

Testing/immunization

Encouraging clients to protect themselves against hepatitis via immunizations is another response to risk. Offers to vaccinate were rare in these observations, as were questions about hepatitis immunization history. As noted in the interview above, some clinics did offer immunization to patients discovered to be at risk. In another instance, Hepatitis B immunization was offered to a patient whose risk assessment revealed that she had been in treatment for substance abuse (though not IV drugs) and that she had had unprotected sex with multiple partners. (This patient declined the immunization series because she didn't want to keep coming back to the clinic.) There were other barriers in addition to missed opportunities and the need for returning to the clinic. Some clinics stated that they hesitated to talk about immunizations if there were cost factors for patients, and commented on the necessity for and lack of funding for clinics to provide free or low-cost immunization for adults. Those STD clinics that did offer the hepatitis B immunization at no cost to clients generally did ask routinely about immunization history.

Charting

(See following training materials on charting suggestions)

Charts offered another opportunity for follow-up if the providers recorded topics that were broached but not fully addressed.

continued on page 7

Chart Forms:

Some basic recommendationsfor effective hepatitis risk assessment with adult clients

- You do not need separate hepatitis risk list—these risk factors overlap with many other communicable diseases!*
- If you are mentioning other diseases, do mention hepatitis (for example, if you list HIV or other STIs, list hepatitis B as well).
- Nurse or medical assistant can look over history/risk assessment to see if client hascompleted the form or has questions, and flag concerns for clinician to save clinician time.
- ***The sample questions below are examples of clear, efficient wording to obtain basic information needed for assessing hepatitis risk.***

hygiene

- Ask about washing food and clean food preparation.
- Ask about access to clean drinking water.
- Ask about handwashing.

Sample questions:

Are you always able to wash fruit and vegetables before eating?
☐ Yes ☐ No

Are you able to wash hands often during the day (after using the rest room, after changing a diaper, before eating, before and after sexual contact)?
☐ Yes ☐ No

Do you have clean water to drink and use for cooking?
☐ Yes ☐ No

If lack of clean water or hygiene practices put client and family at risk of hepatitis A and other communicable diseases, follow up with education.

drug/alcohol/needle use

- Ask about IV drugs, even one time use.
- Ask about number of drinks of alcohol per week.
- Ask about other types of injections outside a clinic—vitamins, antibiotics, etc.?

Sample questions:

Have you ever used injection (IV) drugs (even one time)?
☐ Yes ☐ No

If yes, are you using IV drugs now? ☐ Yes ☐ No

How many drinks of alcohol (beer, wine, liquor) do you drink a week? _____

Do you use needles for any kind of injection at all outside a clinic—vitamins, antibiotics, or anything else?
☐ Yes ☐ No

If client has EVER used injection drugs or might have shared needles for any other reason, follow up with education and encourage hepatitis C testing and hepatitis B vaccination.

sexual risk

- Ask about number of partners lifetime/past six months.
- Ask if partner has other partners.
- Ask about partner's IV drug use.
- Ask about condom use—including how often.
- Ask if client has sex with men/women/both?

Sample questions:

How many people have you had sex with in your life? _____

How many sexual partners have you had in the last six months? _____

Do you have sex with ☐ Men ☐ Women ☐ Both men and women? ☐ I have never had sex.

Are you sexually active now? ☐ Yes ☐ No

If yes, does your partner have other partners? ☐ Yes ☐ No

Does your partner use injection (IV) drugs? ☐ Yes ☐ No

Do you use condoms? ☐ Yes ☐ No

If yes, how often?
☐ Every time I have sex. ☐ Sometimes ☐ Never

If client has more than one sexual partner in the last six months, if they have multiple partners and do not use condoms, or if they are unsure of whether partner has other partners or uses IV drugs, follow up with education and encourage hepatitis B immunization. If client has more than 50 lifetime partners, encourage hepatitis C testing.

medical history

- Include history of hepatitis and liver disease in standard list/checklist. (Family history is not crucial.)
- Ask about immunization history for hepatitis B.
- Ask about blood transfusion and organ transplants.
- Ask about work related exposure to blood.
- Ask country of origin and migration history.

Sample questions:

Have you ever had hepatitis or liver disease?
☐ Yes ☐ No If yes, when? _____
If yes, do you know what type of liver disease? _____

Have you received immunization (3 shots) for hepatitis B?
☐ Yes ☐ No

Have you ever had a blood transfusion or received blood?
☐ Yes ☐ No If yes, when? _____

Does your work ever expose you to accidental needlesticks or require you to handle situations where you might be exposed to another person's blood? ☐ Yes ☐ No

Were you born in the United States? ☐ Yes ☐ No
If no, where were you born? _____
How old were you when you moved to the U.S.? _____
How long have you been here (in this town)? _____

If client received blood clotting factor before 1987 or blood transfusion before July 1992 in the U.S. (or anytime in another country, if you are uncertain about the safety of the blood supply), encourage hepatitis C testing. If client was born in a country with high or intermediate rates of hepatitis B (including Asia, Africa, Amazon Basin, Eastern Europe, Middle East, as well as Haiti, Dominican Republic, El Salvador, Honduras, and Guatemala), encourage hepatitis B testing.

* This form was developed to help assess risk for hepatitis A, B, and C. The risk factors for theses diseases are common to many other diseases transmitted via sexual contact, drug and needle use, inadequate hygiene and water safety. Communicable diseases not addressed in this handout include airborne diseases such as tuberculosis, influenza, etc.

Regulatory Changes in the EPA's Worker Protection Standard

More Protection for Farmworkers Needed

Shelley Davis, JD and Amy Liebman, MPA, MA

The Environmental Protection Agency (EPA) is proposing changes to the Worker Protection Standard (WPS), the agricultural worker regulation intended to provide basic workplace protection for millions of farmworkers. The purpose of the current regulation is to reduce the risk of illness and injury from occupational exposure to pesticides on farms and in forests, nurseries and greenhouses

The regulation originally was developed to provide agricultural workers with the same basic workplace protections that are provided to workers in industrial settings. The increased use of agricultural pesticides, especially the more acutely toxic organophosphate and carbamate pesticides, required a strengthening of the original (1974) agricultural worker protection regulation. A major change in the regulation was proposed and a strengthened regulation was issued in 1992 and went into full effect in 1995.

Despite the changes in the 1990s, the EPA believes the WPS needs additional changes to reduce risks to farmworkers, strengthen the program and make it more efficient.

Migrant Clinicians Network and Farmworker Justice are participating in an EPA work group to improve the WPS. The work group includes a broad range of stakeholders in addition to farmworker advocates.

MCN and Farmworker Justice along with other advocates have compiled a listing of recommendations to the EPA for better worker protection. The recommendations call for improvements for 1) farmworkers who may be exposed to pesticides after they are applied (e.g harvesters, pruners etc.); 2) farmworkers who handle and apply pesticides; 3) procedural protections; 4) broader coverage (e.g. landscape workers); and 5) protection from drift. Outlined below is a list of the problems that farmworker advocates believe need to be improved through regulatory change.

I. Post-Application Workers

Pesticide Training Is Inadequate

One short pesticide training session every five years offers virtually no protection to field workers and others who work in treated areas following a pesticide application. Workers often fail to understand the dangers associated with pesticide use and exposure to themselves or their family members, fail to recognize pesticide-related illnesses, are unaware of the chronic effects associated with pesticides, are not knowledgeable about their rights, do not know how or where to report illnesses or WPS violations, and do not know what steps they can take to reduce exposure to themselves and their children. Compared to farmworkers, workers in non-agricultural industries are entitled to much more extensive training and chemical exposure information under OSHA's Hazard Communication Standard.

Hazard Communication and Worker Notification of Applications Is both Limited and Ineffective

Workers do not know the names of the pesticides used at their worksites or the short- and long- term health effects associated with exposure to these products. Nor are workers adequately warned or notified about restricted entry intervals (REIs) applicable to the fields in which they labor (or must cross). The central pre-requirement has not proven to be an effective way to inform all workers about pesticide applications at their worksite because many fieldworkers do not congregate at central farm locations, and often growers merely keep the information in their offices. Central posting also lacks information about health effects and fails to provide information to offsite workers affected by pesticide drift (one of the principal causes of poisonings) and to drift-affected near-farm communities—many of which are low-income communities of color.

Early Entry Exceptions Should Be Strictly Limited

Workers engaged in hand labor activities prior to the expiration of an REI are at risk of overexposure and existing protections are inadequate. The required use of Personal Protective Equipment (PPE) is usually not practical for early entry workers, especially for those engaged in harvest or other piece rate activities, for workers who have not been adequately trained in proper use of PPE or when ambient temperatures are high (e.g., 90 degrees or above). Moreover, "no contact" exception, for example, is a myth because there may be inhalation exposure (which does not dissipate in four hours) and tractor drivers often get down from their equipment to make a repair in the middle of a treated field. As a consequence, early entry into areas under an REI should be prohibited except in true emergency situations (e.g., unexpected freeze.).

"Take Home" Exposure

Workers often return home from the farm with clothing and shoes that are contaminated with pesticides and then embrace their children. This leads to contamination of private vehicles and homes and ultimately to exposures to children and other family members. One way to reduce take home exposure is to require that workers have an area to change clothes, wash and store clothing. WPS must address the exposure of the workers' families.

Visit **www.migrantclinician.org/excellence/environmental** for a more detailed review of the WPS and proposed detailed recommendations to improve WPS and to sign on to a letter detailing the specific recommendations to the EPA

II. Pesticide Handlers

Lack of Medical Monitoring to Help Protect Pesticide Handlers from Highly Toxic Organophosphate and N-methyl Carbamate Insecticides

Pesticide handlers should receive cholinesterase monitoring to provide for early detection of overexposure incidents from Toxicity Category 1 and 2 organophosphates and n-methyl carbamates. Exposure to these products causes both immediate and long-term adverse health effects. Cholinesterase monitoring programs have been implemented in California for over 20 years and Washington State for two years.

Lack of Label Specification for Respirators, Respirator Fit Testing and Medical Evaluation

Many pesticide labels, including labels for the Toxicity Category 2 organophosphate chlorpyrifos, include the statement: "Avoid breathing spray mist" rather than a specific requirement for use of a respirator. This results in workers being denied needed respiratory protection. In addition, under OSHA's standard, workers who are required to wear respirators must be "fit tested" using proscribed protocols to determine if the respirator fits properly. Workers must also complete a medical evaluation questionnaire which is reviewed by a physician to determine whether a worker has any medical condition which would make wearing a respirator unsafe. Pesticide handlers, using respirators, should have these same protections. When respirators do not fit properly, pesticides leak around the face seal and workers are not protected.

"Take Home" Exposure and Handlers Need for Showers and Clean Change Areas

Handlers get prolonged exposure to pesticides and may become ill or may expose their families because they cannot shower before leaving work.

continued on page 6

Over 280 Cancer Care Resources Just a Click Away

Gabriela is a 46 year old woman who recently learned her last mammogram was abnormal. She now needs a biopsy, but does not qualify for Medicaid or any other state assistance program. She is worried; her mother died of breast cancer a few years ago, but has no money to pay for her biopsy…Does this case sound familiar to you? Have you ever been faced with finding specialty care for a patient that has limited income to pay for services? Have you ever wanted to help a patient find services but did not have enough time to do so? You now have at your fingertips the opportunity to easily find the resource you need for your uninsured or underinsured patient. You will be able to save time and access new sources of care for your patients.

MCN has recently increased its database of cancer care resources for uninsured and underserved populations, linking you with over 280 organizations that provide diverse services to vulnerable populations. The database is also searchable by key word. Here you will find organizations that can help you get a wheel chair, organizations that can help your patient pay for her next mammogram or help a family pay for utilities while a family member goes through cancer treatment. You can now find different options for getting medications from pharmaceutical companies. You may also find links to free legal advice on what to do when your patients insurance will not pay for service, and many more practical services.

This database was made possible thanks to a grant from the Lance Armstrong Foundation. We hope you will take some time to explore this database, make it your home page and take advantage of this wonderful tool. If you do not have access to the web you can request a printed copy of the resources. Please feel free to contact us if you know of additional resources that should be added or if you have any comment about this database. You may contact us at acaracostis@migrantclinician.org or at 512-327-2017. ■

Cancer Care Resources for Vulnerable Populations

- Breast Cancer (29)
- Cancer Clinical Trials (21)
- Children (15)
- Education (6)
- Financial Assistance for Cancer Patients (42)
- General Cancer (46)
- Legal (9)
- Lung Cancer (3)
- Medial Supplies (5)
- Pharmaceuticals (14)
- State Cancer Programs (61)
- Transportation (6)

■ More Protection for Farmworkers Needed continued from page 5

Handlers' Need for Closed Mixing and Loading Systems

Pesticide handlers mixing and loading Toxicity Category 1 liquids and wettable powders are injured due to spills and splashes and blowing powder.

Handler Training and Information Is Inadequate

Handler training is also inadequate to ensure that handlers have the information they need to protect themselves, other people and the environment.

III. Expand Coverage of the WPS

WPS is currently limited to farms, nurseries, greenhouses and forests. WPS coverage of livestock operations is needed because of significant pesticide use and growing numbers of migrant and seasonal farmworkers employed in this sector. Pesticides for fly control, including DDVP are used frequently in enclosed or semi-enclosed areas. Sodium hypochlorite and other antimicrobials which are skin, eye and respiratory irritants are used to disinfect large areas. Antifungal foot treatments and other pesticides are used to treat problems in the animals.

WPS coverage should also be expanded to include maintenance gardeners and landscapers as this is a growing industry and workers use herbicides in hand-held and backpack sprayers.

IV. Procedural Protections

Workers are afraid to file complaints for fear of retaliation. When complaints are filed, investigations often take place weeks later, when the worker may have moved on to another farm. In addition, complaint investigations are often inadequate and disputes between growers and workers are almost invariably resolved in favor of the grower. When violations are found, fines are too low, often because the state does not keep accurate records of repeat offenses.

V. Pesticide Drift

Growers, workers and their families, and rural, agricultural community members are often exposed to pesticides through drift. There are currently no regulatory guidelines to prevent drift in order to minimize human exposure. Moreover, there no regulations aimed at protecting workers in one field from being exposed to pesticides that are being applied in an adjacent or nearby field. Clearer labeling, improved training as well as infrastructural changes are needed to address the severe problem of pesticide drift. ■

MCN Statement of Commitment

In November of 1996, in response to changes in welfare legislation, MCN issued a statement affirming an obligation to the people served by our clinician members. In light of the current environment of rising anti-immigrant sentiment expressed throughout the country, we feel that the time has come to reissue our statement of commitment.

From this day forward, we at MCN proclaim that we will serve all people in need, providing comprehensive health care to farmworkers and their families and our communities regardless of race, religion, gender, nationality, immigration status or sexual orientation.

MCN Streamline Volume 2, Issue 6 November/December 1996

We have received numerous anecdotal reports of raids, ruses, and road blocks that have impeded many migrants and immigrants from receiving the health care services they need. This action has created an atmosphere of fear so wide-spread that critical health services, essential medications and food staples are neglected by many in need whether they are undocumented or not. MCN is saddened and angered that those who work so hard to meet our needs for food, service and infrastructure should be denied unfettered access to basic health care.

In an effort to more fully understand the magnitude of these actions, we ask that you tell us about activity in your community that bars migrants from clinics and other service providers. We know that Medicaid and CHIP are not available to undocumented immigrants. It is important to note however, that there is nothing in current law that denies access to health care services provided by a migrant and community health center to any person or group because of immigration status. Additionally, there is no affirmative requirement to report an undocumented person to federal immigration services who presents for care. Now more than ever it is critical that these services be provided to the most vulnerable. If you have questions about restrictions to or possible punishments for providing care, please contact MCN so that we may provide you with the most accurate information available.

Please take heart and stand firm in your commitment to provide quality health care to those in need. To contact us please call 512-327-2017 or email at dgarcia@migrantclinician.org.

Newsflashes

Farmworker Birth Defects: North Carolina Department of Health and Human Services Finds a Plausible Association between Possible Pesticide Exposure and Birth Defects

The May/June and November/December 2005 issues of *Streamline* each included articles about three severe birth defects in children born to farmworker women in Florida. When all three babies were conceived in 2004, the mothers lived within 200 feet of one another at the same Florida migrant labor camp. All of them are Mexicans who worked for Ag-Mart, picking tomatoes in the same field, where more than 20 different types of pesticides were used. All three women also worked for Ag-Mart in North Carolina. As a result, the North Carolina Division of Public Health, Occupational and Environmental Epidemiology Branch conducted an investigation and assessment of the pesticide exposures likely experienced by these women while in North Carolina. Their report released in May said pesticide exposure may have caused the defects, but stopped short of making a conclusive link. To view the report in its entirety visit the environmental and occupational health webpage on MCN's website – http://www.migrantclinician.org/excellence/environmental/research

The HPV Vaccine

Earlier this month, the Food and Drug Administration (FDA) licensed the first HPV vaccine for use in girls/women, ages 9-26 years. This vaccine protects against four types of HPV, including two that cause 70% of cervical cancers and two that cause 90% of genital warts.

There have been many questions raised by the public and by healthcare providers about this new vaccine, as well as about HPV infection and its link to cervical cancer. To address these important questions, CDC has developed a new set of HPV vaccine materials, including a new fact sheet for healthcare providers. The fact sheet, entitled ***HPV and HPV Vaccine—Information for Healthcare Providers***, is available at *www.cdc.gov/std/HPV/STDFact-HPV-vaccine-hcp.htm*. This fact sheet complements the *HPV Vaccine Q&A* for members of the general public, which is available at *www.cdc.gov/std/HPV/STDFact-HPV-vaccine.htm*. Please feel free to distribute these materials widely. CDC will be updating them as new information becomes available. ■

■ The Role of Patient-Provider Interaction continued from page 3

Notes in the chart indicated the need to continue with the topic the next time, or to continue the discussion with a different staff member. In the interview of the migrant worker above, for example, the nurse provided both opportunities: the provider had and will have access to the note in the chart which stated that the client wanted Hepatitis B shots. In addition, if charts included medical history or risk assessment forms that were filled out by the clients, their responses on these forms presented opportunities to respond to risks. Observers noted instances when a client marked down something that may have been a risk factor, which was *not* addressed in the interview.

(The chart recommendations information on page 4 is one of the materials used in the HepTalk training to help clinics look at their own forms and make decisions about risk questions to add or eliminate. Many of the sample questions were taken from forms of clinics visited. Trainers encourage clinic staff to make decisions about risk questions based on the needs of their clients and communities.)

Conclusions

Time is big issue in doing risk assessment and especially sexual history. Risk assessments may be curtailed or skipped in light of other pressing issues, or because of the number of other patients waiting to be seen—realities that clinic staff face daily. However, in a previous study, it was determined that "comprehensive assessment of patients with risk behaviors or concerns about HIV required an average of three minutes longer than incomplete assessments."[i] Although this study focused on HIV risk assessments, it is likely that generalizing for risk assessments that include other STIs would produce results not widely variant from these. In addition, say the authors of this study, "Care of HIV infected patients is expensive and cost-benefit analysis would probably justify the additional time that clinicians may have to spend to assess and modify risk for HIV infection." Like care for HIV patients, treatment and health maintenance of infected Hep B and C patients is expensive, as are complications such as liver cancer and cirrhosis that can occur as a result of chronic infections.

Another reason for doing risk assessments routinely—that is to say, at the moment patients are in the office—is that young male clients rarely access the health care system. They are especially unlikely to be seen for routine preventive care, the kind of visit during which risk assessment is commonly done. They are likely to come to the clinic only if they have symptoms that prevent them from working. "For these clients", says Dr. Edward Zuroweste, MCN's Chief Medical Officer, "we need to be thinking not only about their health today, the presenting problem, but what might cause trouble for the next five years."

HepTalk training is now underway. We are seeking not to add hepatitis to an already too-long list of diseases clinicians are supposed to ask about in their brief time with clients, but demonstrate and reinforce specific skills that are useful in efficiently addressing disease risk, and incorporating efficient risk assessment practices routinely into clinic systems. ■

References

[i] Epstein, RM *"**Awkward Moments in Patient-Physician Communication about HIV Risk**,"* Annals of Internal Medicine, 15 March 1998, Volume 128, No. 6, 435-442.

MCN
Migrant Clinicians Network
P.O. Box 164285 • Austin, TX 78716

Non Profit Org.
U.S. Postage
PAID
PERMIT NO. 2625
Austin, TX

calendar

19th Annual East Coast Migrant Stream Forum
October 19–21, 2006
Sheraton Myrtle Beach Convention Center Hotel
Myrtle Beach, South Carolina
(202) 347-7377
http://www.ncchca.org/East%20Coast%202006.htm

14th Annual HIV/AIDS Update and Border Health Summit
October 25 – 27, 2006
South Padre Island, Texas
Valley AIDS Council, Texas/Oklahoma AETC
(800) 333-SIDA
http://www.valleyaids.org

The 16th Annual Midwest Stream Farmworker Health Forum
November 9-11, 2006
Hotel Albuquerque at Old Town
Albuquerque, New Mexico
(800) 531-5120
http://www.ncfh.org/00_clt_mwfsf.php

2006 International HIV/AIDS Meeting
November 17- 21, 2006
Baltimore, Maryland
Institute of Human Virology
(410) 706-8614
http://www.ihv.org

16th Annual Western Migrant Stream Forum
January 26-28, 2007
Sacramento, CA
Northwest Regional Primary Care Association
(206) 783-3004
http://www.nwrpca.org/conf/forum.php

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

MCN

Acknowledgment: *Streamline* is published by the MCN and is made possible in part through grant number U31CS00220-09-00 from HRSA/Bureau of Primary Health Care. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA / BPHC. This publication may be reproduced, with credit to MCN. Subscription Information and submission of articles should be directed to the Migrant Clinicians Network, P.O. Box 164285, Austin, Texas, 78716. Phone: (512) 327-2017, Fax (512) 327-0719. E-mail: jhopewell@migrantclinician.org