

# streamline

The Migrant Health News Source

## Impact of Clinic Environment: The HepTalk Project

**P**atient-Provider communication as a predictor of patient satisfaction is very much in the news. A recent New York Times article said that "while 'difficult doctors... have always been a part of medicine, medical organizations fear that they are increasingly common.' [Dr.] Howard Beckman says, 'there is a common thread to difficult doctors: most have problems talking to or listening to patients.'" (NYT, *When the Doctor Is In, But you Wish He Wasn't*, November 30, 2005) Dr. Beckman was also a participant in research on which the Migrant Clinicians Network's (MCN) HepTalk initiative is based. HepTalk is applying current research on emotionally charged discussion as well as clinic systems strategies to help clinics serving the mobile poor efficiently address communicable disease screening and prevention.

The role of good communication in accurate risk assessment and risk prevention education has for the most part been discussed in the context of HIV/AIDS education. Taking a lesson from this work, MCN has undertaken a five-year study of risk communication. Because hepatitis is currently a newsworthy health topic as well as a disease of increasing concern to clinicians, MCN is applying research on health communication and clinic systems to this arena. In addition, prevention of hepatitis A, B, and C encompasses the need to discuss risk factors common to other communicable diseases, so this work has potentially broad application.

The HepTalk Project is now in the training-development phase. This project will continue to push current strategies from research to front-line practice by incorporating Standardized Patient Instructors, or SPIs, into the training. SPIs will visit the sites and provide one-on-one training on patient communication and risk assessment. This technique is often used in medical school training, and is more recent to practice-based training.

### The HepTalk Project

The HepTalk Project is a practice-based research project conducted by MCN with the support of Community Health Education Concepts (CHEC) and clinic sites involved in providing primary care and public health services to migrant and mobile underserved patients. The primary goal of the HepTalk Project is to promote productive communication about Hepatitis A, B, and C infection risks and prevention between primary care providers and patients who migrate for purposes of work or family unification.

The project is currently in its third year and will be piloting interventions based on site visit results from the past two years. This article reports on some of the initial findings of the site visit phase of the project which included 27 baseline visits which helped achieve a snapshot of the realities of communicable disease prevention and screening in clinics today.

Some of the tools used in the study were adapted from the work of Epstein, et al. designed to capture clinician-patient productive discussion of emotionally-charged personal health behaviors. Other tools were based on those used in a previous CHEC study on integration of HIV prevention into family planning clinic systems ("Awkward Moments in Patient-Physician Communication about HIV Risk," *Annals of Internal Medicine*, 15 March 1998, Volume 128, No. 6, 435-442. Ronald M. Epstein, MD; Diane S. Morse, MD; Richard M. Frankel, PhD; Lisabeth Frarey, BA; Kathryn Anderson, MA; and Howard B. Beckman, MD).

### Twenty Seven HepTalk Sites

The HepTalk project has engaged in a series of site visits to gather baseline data to inform future training and resource development. The site visits consisted of day-long observations at each of the 27 partici-

**HepTalk Project Hypothesis:** patients will engage in a discussion of the emotionally charged issues that surround discussion of 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.

pating clinic sites located in five regions through the United States. The five regions are experiencing changes in migration patterns—new types of migrant work, new patterns of settlement, new ethnic or regional immigrant groups, etc. Within those regions, pairs of Community and Migrant Health Centers and local Health Departments were chosen randomly and asked to participate.

During the site visit, two members of the HepTalk team interviewed staff, shadowed clients, and made observations about the clinic's functioning, patient-provider interaction, and overall layout. At least one person on each HepTalk team was bilingual.

Perhaps the most interesting and data-rich part of the baseline visits were client shadows. Observers followed clients from the front desk check-in to check-out. For these shadows, HepTalk obtained consent forms from both clinicians and clients.

A battery of baseline data collection tools reflected the amount of information gathered as well as the conscious attempts of the

**Baseline Site Visit Tallies**

Clinics visited . . . . .	27
Staff interviewed . . . . .	172
Patients shadowed . . . . .	60
Patients exit-interviewed . . . . .	52
Knowledge surveys returned . . . . .	234

HepTalk team to triangulate the data — to obtain both quantitative and qualitative data on the same measures when possible, to corroborate what was seen and found.

The health center visits yielded a large amount of data on many different aspects of clinic function and risk assessment strategies. The HepTalk team is using this information to create site-specific training for the participating clinics. This article shares some of the findings related to clinic environment that may be useful for other sites and clinicians in designing and maintaining clinic systems. MCN will share more information from the project, including specifics on patient-provider communication in future *Streamline* issues.

**The Clinic Environment**

The HepTalk project includes careful consideration of the clinic environment as part of hepatitis prevention—how the setting supports discussion of risk reduction strategies and testing. A supportive atmosphere can include things such as chart forms that include good risk assessment questions, well-designed and displayed patient education posters, a comfortable waiting area, and efficient patient flow and staffing patterns.

The physical environment is significant in terms of risk assessment practices because it often sets the mood: a well-designed waiting room can give a client the impression that he or she is important to the staff at the clinic. More concretely, the presence of educational materials on topics that can be difficult to bring up (i.e. condom use, drug use, sexual activity) can give a signal to clients that the staff of this clinic is comfortable with these conversations and considers the information important to good health.

**Patient Education Materials: Placement, Use and Language**

**Placement and use**

HepTalk observers noted when and where clients looked at educational materials. Clients were most likely to pick up and look

For more information about Hepatitis please visit MCN's website at [www.migrantclinician.org/excellence](http://www.migrantclinician.org/excellence)

at brochures when they were displayed neatly and placed within arm's reach of seating areas in waiting rooms and in exam rooms. One clinic had good parent-teen communication information that included sexuality topics on big posters near the exam tables.

Observers found that patient education posters are most likely to be seen or looked at if they were attractive, provided a clear message, were not cluttered on the walls, and were bilingual. Posters need not be confined to the waiting or exam rooms—team members observed several good placements of prevention messages in other locations such as restrooms.

Those waiting rooms and hallways that had cluttered pamphlet racks and poster displays appeared to have had little thought put into the topics displayed: often disorganized displays were filled with educational materials provided by pharmaceutical companies (notably, even sites that were somewhat reluctant to have sexuality messages in waiting rooms for families did have Viagra pamphlets). Clinics came up with creative strategies to combat the clutter: One clinic had neat racks of low literacy brochures on topics relevant to clients in both English and Spanish. They also had a few good and well-placed posters. This clinic had one nurse assigned to be the patient education materials person and she was responsible for ordering all of their supplies.

Many sites adapted creatively to their space and the needs of their clients. One STD clinic site, for instance, had a variety of bilingual adult patient education materials attractively displayed as well as children's videos playing on the television so that adults would have opportunities to fill out paperwork and read materials.

Several sites had brochures in exam and education rooms that were to be given to clients by staff. Some clinicians and educators made good use of materials to add more information or reiterate important points. Posters conveyed topic areas that clinicians and staff were open to discuss, especially potentially emotionally-charged issues. One clinic reported that after displaying a hepatitis poster in the waiting room, a client asked to be tested and was found to be positive for hepatitis C. The medical director stated that this client would not have been screened had he not asked.

This table shows the locations of patient education materials observed during the site visits. Most "Other" places were either hallway displays or areas kept for access by staff in an office or cabinet.

Please see the accompanying article in this issue of *Streamline*: "Best Uses of Patient Education Materials" for further information.

**Language**

Educational materials and signage in Spanish show obvious concern for and inclusion of Spanish-speaking clientele. All of the sites visited said they wanted and needed more

**Clinics with low literacy materials by language of materials**

	Available N=24		Low literacy N=19, 18*	
	N	%	N	%
English materials	23	95.8	14	73.7
Spanish materials	22	91.7	8	44.4

\* valid data available from 19 clinics for English materials and 18 for Spanish materials

good patient education materials that are low literacy and also in Spanish. This table shows the percentage of clinics that had patient education available in English and Spanish as well as low literacy. Only one clinic had materials in Haitian Creole.

**Condom availability**

While condoms are clearly more than an educational tool, their ready availability in a clinic conveys the message that the clinic sees condom usage as an important health protective behavior and is open to discussion about issues surrounding sexuality and safer sex practices. One way some clinics make condoms available is to put them in a bowl or basket that clients can access. Site visitors noted that condoms were out and available at three of the clinics visited, but not readily available at 20 clinics.

Many sites offered free condoms if clients

**Condoms available in a basket or bowl, N=24**

	N	%
Not available	20	83.3
Available	3	12.5
Unclear*	1	4.2
<b>Total</b>	<b>24</b>	<b>100.0</b>

\* rater disagreement

**Placement of materials N=26\***

Location of materials	N	%
Waiting room	13	50.0
Exam rooms	14	53.8
Bathrooms	4	15.4
Laboratory	1	3.8
Other Places	13	50.0

\* Materials may be located in various places; column does not add up to 26

continued on page 3

asked, but often the place and time to ask for them was not obvious to observers.

**Risk Assessment Paperwork**

HepTalk observers recorded which clients were given risk assessment paperwork to fill out (most often, risk assessment questions were included in the medical history forms). Questions considered included: Did this happen for all new clients? Or for clients being seen for certain types of visits? For clients that had not been to the clinic for a certain length of time? Was medical history and risk assessment updated regularly?

Chart forms play a crucial role. The observers found that the questions that are on the forms are most often the questions that are asked. Good risk assessment questions on chart forms significantly contribute to good risk assessments being done.

Almost all of the clinics visited gave clients a medical history form to complete before being seen as an initial patient in the agency. The two exceptions to this were one site where the risk assessment was done orally (the client was given no forms), and another which did not have a form in place because they were transitioning to electronic medical records.

Most of the sites also gave the medical history paperwork to clients who had not been seen in the previous year at the clinic. This gives clients a chance to update contact information as well as medical history information. Some sites had a protocol in which the clinician was to review the medical history yearly. However, unless the form had a specific checklist or place to initial, this was done inconsistently. Observations indicated that the most effective risk assessment happened when clients had to fill out a current medical history form or clinicians had to document a review of each item of the history. Without this in place, clinicians asked a few questions on topics that they felt were most important, which varied widely by clinician.

**Clinic Flow**

The HepTalk project theorizes that the way clinics manage their daily business of seeing clients is critical to how risk assessment and prevention education are conducted. The flow of the clinic is often related to who does what portions of the risk assessment. In some cases, nurses or medical assistants go over the medical history and flag concerns for the clinician, while in other cases the clinician covers all of those topics.

Documentation of clinic flow also identifies places where risk assessment and prevention education can take place. After signing in and completing any paperwork in the reception area, most of the clients shadowed

(82%, N=60) were first seen by a staff person other than the clinician. This person was often a Medical Assistant (40%) or a nurse (22%), but could also be a registrar (10%) or other various clinic personnel (e.g. interpreter, Disease Intervention Specialist) (10%).

In situations where risk interview duties are split, observers looked at how concerns were conveyed to the next person in line: if a client brought up a concern, was that noted and passed along to the clinician? Observers noted several instances in which a client stated a concern to a clinic staff person that was not conveyed to the clinician.

The site that conducted oral medical history and risk assessment (a staff person read the questions to the patient—patients were given no paperwork) was concerned with literacy and language barriers. This approach certainly took more time, but also resulted in a thorough risk assessment. The systems that seemed to be most efficient and effective were those that had low-literacy (easy to read) bilingual forms and a staff member who reviewed the medical history carefully with the patient at the start of the visit.

At some sites, the clinician(s) reviewed the medical history and risk assessment. In others, a medical assistant or RN reviewed the paperwork with the client before the exam. Again, both systems had merit. When more staff were involved in interviewing the patient, there was potential for repetition of questions by staff. When the clinician did all of the history and risk assessment, this either took quite a bit of clinician time, or the interview tended to be very short and many items were not covered.

Those systems that seemed to HepTalk observers to work best had a nurse or medical assistant (or equivalent) review the paperwork with the client initially and flag potential risk issues for the clinician: this often guided the clinician interview quickly to the most important topics. This seemed to work well when the patient was aware that the MA would not be counseling or instructing, but making notes for the clinician on which to follow up.

In all cases where more than one staff was interviewing and/or provided education, it seemed to work best when the charts included explicit places to mark “education given.” This also worked for “immunizations and/or tests offered.” Approximately one third of the sites we visited included these sections on their chart forms. The majority relied on clinicians to make those notes on the exam form or progress notes. In these situations, types of education given were much less likely to be recorded.

Those sites that had the most efficient flow patterns in terms of client visit and wait

**Staff who reviewed medical history by clients shadowed, baseline, N=60**

Staff role	N*	%
Clinician	47	78.3
Medical Assistant	15	25.0
Other staff person	16	26.7

\* medical history may be reviewed by more than one staff person, column does not add up to 60

times were, not surprisingly, those that had done patient flow analyses in the recent past, and those that had evaluated their flow from a patient perspective. A few of these sites had moved to a system in which the client stayed in one room, and the staff rotated through (getting vitals, going over medical history, doing exam).

On average for all clinics, the clients shadowed went through 3.75 stops with a median of 3.5 stops (N=58). The most stops included in a client visit were eight and the fewest was one. The longest visit was 3.58 hours and the shortest 17 minutes (visits shadowed were initial clinic visits or those in which the client had not been to the clinic for at least a year).

**Bilingual Staffing at Sites**

Site observers recorded the number of Spanish speaking staff available on the days of baseline visits as well as asking clinic staff the percentage of Spanish-speaking staff employed at the clinic. Some basic tallies from this sample of 27 M/CHCs and Heath Department clinics are as follows:

- 11 of 27 clinics had providers (clinicians—MD, PA, CNM, NP, or nurses qualified to do exams) who spoke Spanish well enough to conduct the exam in Spanish. One clinic had a bilingual English-Creole provider, and other Creole-speaking staff. This site was the only site in the project that sees significant numbers of Haitian Creole speakers.
- Three of the 27 clinics had no bilingual staff in the clinic the day they were visited. All of the sites we visited had some provision for the arrival of a monolingual Spanish speaking client if they did not have a bilingual staff person directly on hand. This included asking for help from another clinic within the agency (which might have been in the same building or in the next town, and often these clinics were themselves quite busy), calling a local translation service or other local agency that had translators interpreters, or calling some one from an administrative office who was known to speak Spanish).

Not surprisingly, bilingual needs were best met in the three sites in which every staff person was bilingual. The second best systems were those in which translation protocol was clearly determined: a Spanish-speaking nurse or MA was assigned to work specifically with each non-bilingual provider or one person had a specific role as a translator. Systems in which people in other roles translated as needed seemed effective as long as there were provisions for someone else filling in other duties when that person was translating. It was also usually clear to observers which translators and clinicians had been given training on proper translation techniques. In some clinics the Spanish of the clinician or other staff person was marginal. This worked relatively well so long as the staff person was clear about the point at which he or she did not understand the client and needed to repeat information or get a translator. Those clinics that had no Spanish speakers on staff on the particular day we visited typically had few or no Spanish-speaking clients, though all were in areas with Spanish speaking migrants and new immigrants. This seemed to indicate the role that word of mouth plays in people knowing where they can get bilingual services.

### Summary of Clinic Environment Findings

The patient experience at a clinic is influenced by a number of factors beyond the actual clinician-patient encounter. The observations made during the HepTalk site visits point to many important components of the patient experience including the physical space, placement of patient education materials, the patient flow process, and translation systems.

HepTalk observers found that:

**Clients do look at patient education materials if provided. They are more likely to do so if:**

- The materials are in their primary language.
- They are within arm's reach of seating areas in waiting and exam rooms.
- There are a few attractive materials rather than an overcrowded rack or wall.

**Chart forms make a difference.**

- Questions asked on medical history forms most often determine questions asked in risk assessment.
- If the chart includes a place to check education given, it is more likely to be given, and less likely to be duplicated.

**Clinic flow patterns can impact education given.**

- Longer visits were more likely to include duplicated educational information.

- When multiple people talked with the client about risk, communication systems were very important to ensure that patient concerns reached the next person in the flow.

**Bilingual staffing in clinics that serve migrants and recent immigrants vary widely.**

- Many clinics creatively address translation needs, but many are struggling.
- All of the clinics observed stated a need for more high quality Spanish-language patient education materials.

The HepTalk team is acutely aware of the fact that all clinics that serve indigent clients are pressed for time. By looking at clinic systems that support efficient risk assessment and education, the project hopes to help clinics take steps to more smoothly incorporate communicable disease prevention into the good work they already do, rather than adding yet another topic that "should" be discussed. Stay tuned to Streamline for updates on HepTalk training and how clinics and clients can benefit from this research. ■



## Best Uses of Patient Education Materials

*Carmen Retzlaff, MPH*

**Pick your messages carefully—a few important messages.** Don't stuff your racks with anything you find: decide what messages are most important to your clients and focus on a few conditions and behaviors.

**Remember to choose family planning methods information that includes sexually transmitted infection (STI) risk.** This is especially critical on information about hormonal methods.

**Avoid clutter.** Place posters and signs on uncluttered walls and doors. Avoid over-stuffed pamphlet racks.

**Choose low literacy messages.** Make sure everything is easy to read: nothing above a 6th grade reading level. No one, not even the best reader, likes or reads pages crammed full of text—limit text to a few important messages.

**Make use of pictures.** Everyone is more attracted to and interested by posters and pamphlets that are attractive. Illustrations can help make the point and serve as memory aids. They can also help very low literacy clients understand the message.

**Place materials thoughtfully.** Put posters

and signs where patients will see them: at eye level when standing or sitting. Consider interesting placements: bathrooms, across from the lab chair, above the scale, next to the exam table, on the ceiling! Put pamphlets where patients can reach them from waiting room chairs and where they can peruse them with some privacy. Consider placing a few good pamphlets on key issues in the exam room within reach of exam table.

**Use simple signs.** Simple signs can be very effective and are easy to make.

Examples could include the following:

- "We offer hepatitis B vaccinations here. Ask if you should get one." (possibly placed in lab)
- "If you need condoms today, ask at the front desk." (possibly placed in restroom)
- "What you say to us is confidential." (in exam room)

**Make it multilingual.** Provide materials in the languages your clients speak.

**Identify yourselves.** Put your clinic name and contact information on brochures so clients can call or return with questions.

# Patient Education Resources

Some materials in use at participating HepTalk clinics

In 2004, the HepTalk team visited 28 clinics (including a pilot site) that serve indigent, migrant and recent immigrant clients around the country to gather resource and training needs information for the Migrant Clinicians Network HepTalk project. This list includes some sources of patient education materials used in participating health departments and community and migrant health centers. Included are low-literacy materials that

addressed many of the hepatitis risk factors or behaviors (including IV drug use, hand washing and hygiene, using condoms, getting immunizations, etc.), whether or not they said the word “hepatitis” specifically. (Note: NOT included here are several excellent materials produced by state health departments in the 18 states visited. HepTalk will continue to work to get reproduction permission for the best of those state-produced materials, and share

them in subsequent phases of the project.)

This is a list of the sources of some of the useful hepatitis-related patient education materials the HepTalk team found in clinic visits. Please look at their websites to see the different products they offer. This list does not constitute endorsement of all of the educational products or policies of these organizations by the HepTalk project or the Migrant Clinicians Network. ■

## Centers for Disease Control and Prevention, Division of Viral Hepatitis

<http://www.cdc.gov/ncidod/diseases/hepatitis/resource/index.htm>  
Order free educational materials on hepatitis A, B and C. Materials in Spanish.

## Immunization Action Coalition

<http://www.immunize.org>  
Vaccine information statements in a variety of languages, as well as many easy-to-reproduce patient education materials.

## California Family Health Council

<http://www.cfhc.org/>  
Patient educational materials for purchase include a hepatitis B brochure in Spanish and English. Products feature culturally-diverse photos.

## Channing-Bete

<http://www.channing-bete.com>  
Patient educational materials for purchase, including EveryReader series low-literacy booklets on a variety of topics, including STDs and hepatitis. Materials in Spanish.

## ETR Associates

<http://pub.etr.org/>  
Patient educational materials for purchase, including “Hepatitis A B C’s” pamphlet in English and Spanish.

## Planned Parenthood

<http://store.ppfastore.org>  
Patient educational materials for purchase, including “Hepatitis-Questions and Answers” pamphlet, and other STD prevention materials.

## American Social Health Association

<http://www.ashastd.org>  
([http://www.ashastd.org/publications/publications\\_org.cfm](http://www.ashastd.org/publications/publications_org.cfm))  
Patient educational materials for purchase, including Protección Es Vida (Protection is Life) Tabloid, developed in Spanish, translated to English, and other low-literacy materials on STDs, hepatitis, and safe sex.

## Agency for Healthcare Research and Quality

<http://www.ahrq.gov>  
Patient educational materials for downloading and printing on being an active healthcare consumer, including a pamphlet on “Quick Tips—Talking with Your Doctor,” as well as preventive health and screening checklists.

## Hepatitis C Support Project

<http://hcvadvocate.org>  
(<http://hcvadvocate.org/hepatitis/materials.asp>)  
Brochures and booklets on hepatitis C that you can download and print, including “African Americans and hepatitis C—the basics,” “The Liver—the basics” (which has information on keeping the liver healthy) and “Needle Exchange.”

## National Digestive Disease Information Clearinghouse, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health

<http://www.niddk.nih.gov/>  
(<http://digestive.niddk.nih.gov/ddiseases/pubs/hepatitis/index.htm>)  
Patient educational materials to download and print, including “What I need to know about hepatitis A,” “B,” and “C,” in English and Spanish.

## GLMA Gay and Lesbian Medical Association

<http://www.glma.org> (<http://www.glma.org/hepatitis/index.shtml>)  
Posters and brochures about hepatitis aimed at men who have sex with men. E-mail to order.

## RWHP Rural Women’s Health Project

<http://www.rwhp.org> (<http://www.rwhp.org/novelas.html>)  
Photonovelas, posters and brochures for purchase on HIV/STI prevention topics, including condom use.

## Provider Resource:

### Hepatitis Resource Network

<http://www.h-r-n.org>  
Management algorithm cards for hepatitis B and C treatment. Free download or order free laminated cards.

# Report from the Field

Rosa Luna, PA-C

[Editor's Note: Rosa Luna is one of the 2005 MCN Migrant Health Practicum New Providers. The Practicum is a program that provides for a four-month working and learning experience in a migrant health center for new health care professionals. New Providers are nurse practitioners, physician assistants, nurse-midwives, and dental hygienists, who have completed the training program for their profession and have an interest in working with migrants. The purpose of the program is to increase the sensitivity and understanding of migrant health care issues for the New Providers as they consider careers working with underserved



populations. If you are interested in hosting a New Provider or participating as a new graduate, you can find more information at [www.migrantclinician.org](http://www.migrantclinician.org) or by contacting Candace Kugel at 814-238-6566.]

Ever since I can remember my parents have worked in the fields. We moved around a few times following the harvest. It was hard making new friends at the new school. It was a while before my dad found a stable job that kept him working year round.

My parents didn't make much money and couldn't afford daycare for all five of us kids, so they did what they could to provide us with childcare. They befriended the neighbor and she became our babysitter. The neighbor was a small framed Mexican lady who wore her long black hair in two braids and around her head like a crown. Her name was Doña Angelita. She always made sure we ate, bathed and made it to school on time.

One day things changed. My dad had a new job and we had to move again. We never saw Doña Angelita again.

As a PA student I decided to go back to

my hometown to do my clinical rotation. I wanted to go back and serve my people and provide healthcare to those who really needed it. One day as I worked as a PA-S I walked into an exam room and I saw a little old Mexican lady sitting in the chair with long grey hair in two braids and around her head. As I stared at her trying to recall where I knew her from she turned to look at me and that's when I knew it was her, Doña Angelita. The lady that once took care of me was now being taken care of by me.

Going back to my hometown has brought back many wonderful memories. It has allowed me to see people that meant so much to me. Most importantly it has reminded me of where I come from and why I have struggled and worked so hard to be where I am today. ■

## calendar

### Annual Minority Health Conference

February 24, 2006  
The University of North Carolina at Chapel Hill  
Chapel Hill, NC  
919-966-4032  
<http://www.minority.unc.edu/sph/min-conf/2006/agenda.cfm>

### Cancer, Culture & Literacy: Solutions for Addressing Health Disparities through Community Partnerships

May 18-20, 2006  
Sheraton Sand Key Resort  
Clearwater Beach, FL  
Moffitt Cancer Center  
813-745-1445  
[http://www.moffitt.usf.edu/about\\_moffitt/calendar/events/200605.asp](http://www.moffitt.usf.edu/about_moffitt/calendar/events/200605.asp)

### 2006 National Farmworker Health Conference

May 20-24, 2006  
San Antonio, TX  
National Association of Community Health Centers  
301-347-0400  
[www.nachc.com](http://www.nachc.com)

### National Rural Health Association's 2006 Annual Conference

May 15-19, 2006  
Reno, NV  
National Rural Health Association  
703-519-7910  
<http://www.nrharural.org/conferences/sub/AnnConf.html>

### The National Institute for Farm Safety, 2006 Annual Conference

June 25 - 30, 2006  
Blue Harbor Resort  
Sheboygan, WI  
National Farm Medicine Center  
800-662-6900  
<http://www.marshfieldclinic.org/nfmc/>  
and click on "Education and Training."

## Join the Effort to Reduce Cervical Cancer among Latinas

Did you know that each year, over 2,000 Latinas are diagnosed with cervical cancer? And many of these women will die of the disease. Cervical cancer can be prevented with regular Pap tests—at least once every three years. While most Latinas get a Pap test at some point in their lives, many do not return for regular Pap tests or follow-up treatment. As a result, they are often diagnosed with advanced cervical cancer at higher rates than non-Latinas, reducing their chances for survival.

**But there is something you can do to help.** The National Cancer Institute, the Office of Minority Health, the National Alliance for Hispanic Health, Redes en Acción, and the Migrant Clinicians Network, invite you to join our nationwide outreach effort to increase awareness among Latinas about the importance of cervical cancer screening.

**What can you do? Distribute a new informational booklet "Cáncer cervical: Cómo puede protegerse" (Cervical Cancer: What You Can Do to Protect Yourself)** to help spread the word about regular Pap test screening. The booklet contains information in Spanish and English in a plain language, low literacy format. To order free copies, call 1-800-4-CANCER (1-800-422-6237) or go to [www.cancer.gov/publications](http://www.cancer.gov/publications).

**Spread the message about cervical cancer screening.** Promotional materials, including flyers, public service announcements, press releases, newsletter articles, and slideshows in English and Spanish are available online at <http://www.ncipoet.org/promotools.cfm>. We ask that you download these materials and integrate them into your health outreach efforts.

Thank you for your support.

Sincerely,

Laura Boyle, Consultant, National Cancer Institute  
Felicia Solomon, National Cancer Institute  
Amelie G. Ramirez, DrPH, Redes en Acción  
Guadalupe Pacheco, MSW, Office of Minority Health  
Andrea Kauffold, MD, Migrant Clinicians Network, Inc.  
Eliana Loveluck, National Alliance for Hispanic Health

# Recommendations for Adolescent use of Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis (Tdap) Vaccines

**A**cross the United States, workers conduct labor-intensive tasks that help our nation maintain its stature as a world leader in production agriculture and other related industries. Recent estimates indicate that among the nearly two million migrant and seasonal farm laborers, about 7% are between the ages of 14 and 17 years; and among these adolescents, a large and growing proportion of them are single males.

Many adolescent farmworkers are emancipated youth (minors are considered emancipated when they have left home, are removed from parental control, and supporting themselves, and are a minor between the age of 16 and 18) who are usually in the United States illegally. Others are part of farmworking families and are more likely to have been born in the United States, and therefore, have different citizenship and eligibility for US health and human services than do their parents.

Whether for adults or adolescents, there has been a spotty history in the U.S. of providing a consistent level of health care, housing, and sanitation for migrants. One very important concern is levels of immunization among adolescent migrants. Typically adolescents are outside of those cohorts regularly targeted for immunization projects. MCN is concerned about adolescent vaccination rates and is focusing on addressing issues of adolescent immunization in two current projects — HepTalk and the Immunization initiative.

For adolescents working in agricultural and other dangerous professions, tetanus is

a serious issue. In addition, younger workers living with older workers in large numbers and in small dwellings creates a good environment for transmission of infectious disease such as diphtheria and pertussis.

The purpose of this statement is to provide the rationale and recommendations for adolescent use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccines. Despite universal immunization of children with multiple doses of pediatric diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine, pertussis remains endemic with a steady increase in the number of reported cases. Two peaks in the incidence of pertussis occur in pediatric patients: infants younger than six months of age who are inadequately protected by the current immunization schedule and adolescents 11 through 18 years of age whose vaccine-induced immunity has waned. Significant medical and public health resources are being consumed in post-exposure management of adolescent cases, contacts, and outbreaks with little beneficial effect on individuals or the epidemiology of disease. Two Tdap products were licensed in 2005 for use in people 10 through 18 years of age (BOOSTRIX) and 11 through 64 years of age (ADACEL). The American Academy of Pediatrics (AAP) recommends the following:

1. Adolescents 11 to 18 years should receive a single dose of Tdap instead of tetanus and diphtheria toxoids (Td) vaccine for booster immunization. The preferred age for Tdap immunization is 11 to 12 years.
2. Adolescents 11 to 18 years of age who have received Td but not Tdap are encouraged to

receive a single dose of Tdap. An interval of at least five years between Td and Tdap is suggested to reduce the risk of local and systemic reactions; however, intervals less than five years can be used, particularly in settings of increased risk of acquiring pertussis, having complicated disease, or transmitting infection to vulnerable contacts. Data support acceptable safety with an interval as short as approximately two years.

3. Tdap and tetravalent meningococcal conjugate vaccine (MCV4 [Menactra]) should be administered during the same visit if both vaccines are indicated. If this is not feasible, MCV4 and Tdap can be administered using either sequence. When not administered simultaneously, the AAP suggests a minimum interval of one month between vaccines.

The rationale for this strategy is to provide direct protection of immunized adolescents. With implementation of vaccine recommendations, indirect benefit also is likely to extend to unimmunized peers and other age groups. By preventing later disease, universal Tdap immunization at 11 to 12 years of age is a cost effective strategy. ■



## Using Human Subjects to Test Pesticides

### EPA proposes Rule for Conducting Intentional Dosing Human Studies

**T**he US Environmental Protection Agency Protection Agency (EPA) has controversial proposed regulations which will permit companies to test pesticides on human subjects in order to determine their toxicity and the adverse health effects they cause. These regulations will apply to intentional dosing of human subjects with pesticides. They do not apply to observational, epidemiological or other types of studies conducted by private parties without government support.

Farmworkers Justice Fund prepared comments and jointly submitted them with MCN and numerous other organizations. MCN's Institutional Review Board also submitted comments. The EPA is expected to

issue its final rule in February or March 2006.

Below is a brief summary of our comments. For the complete comments, please visit the MCN environmental and occupational health web page at [www.migrantclinician.org](http://www.migrantclinician.org).

- The EPA should not consider, for any purpose, studies involving the intentional, non-therapeutic dosing of human subjects with pesticides, whether conducted before or after the promulgation of this rule.
- The sole exception to this blanket prohibition should be to consider pesticide studies involving human subjects, conducted before the issuance of this rule, that would lead the EPA to set

- a lower No Observeable Adverse Effect Level, and therefore, afford greater protections to people. Previously conducted, small-scale studies, which find no effect should ever be accepted, because they are both unethical and scientifically deficient, (since they lack statistical power).
- The EPA's purported prohibition against conducting intentional dosing studies of pesticides involving pregnant women, fetuses, infants or children, is far too limited and may well result in the conduct of such studies.
- EPA's protections for children, especially abused and neglected children and prisoners, are also too limited. ■



**Migrant Clinicians Network**

P.O. Box 164285 • Austin, TX 78716

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

**Nominate the 2006 Unsung Hero!**

The Migrant Clinicians Networks invites you to nominate an unsung hero. MCN is the nation's oldest and largest networks dedicated to the mobile underserved and it wants to honor a clinician in the field of Migrant Health. "Last year, we recognized a Central Valley California physician's assistant who has tirelessly worked for more than 30 years, providing care to migrant workers and their families." says Jillian Hopewell Director of Education and Professional Development at MCN. "Since 1991, MCN has recognized a number of outstanding healthcare workers dedicated to laborers who may be sick or injured yet, work in our fields, our businesses and our homes. These same workers are often forgotten when it comes to their health." adds Hopewell.

Nominees are distinguished by their demonstrated dedication to migrant health. Qualifications may include innovation to service delivery or prevention strategies. Other attributes may include their leadership skills or contributions to the health of those who need it, but often do not get it.

The Migrants Clinician Network is in a unique position to look nationwide, to honor someone from your community. The unsung hero will receive an all expenses paid trip to the Annual Farm Worker Health Conference in San Antonio, Texas later this year. MCN will present the award in front of a professional audience of clinical peers. Please submit their names for consideration with a simple paragraph describing the nominee and why they embody the characteristics of the "2006 Unsung Hero Award." Email, call, or write to Jillian Hopewell, Migrant Clinicians Network, 1309 Orchard Way, Chico, CA 95928, (530) 345 4806 by February 28th 2006.

For more information on the "The Unsung Hero Award," changes in the migrant population or any of MCN's innovative programs caring for the mobile underserved in your area at please contact:

Jillian Hopewell at (530) 345-4806, [jhopewell@migrantclinician.org](mailto:jhopewell@migrantclinician.org) or Edward Zuroweste, MD, at (814)238-6566 [kugelzur@migrantclinician.org](mailto:kugelzur@migrantclinician.org).



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](mailto:jhopewell@migrantclinician.org)

**George Davis, MD**

Chair, MCN Board of Directors

**Karen Mountain, MBA, MSN, RN**

Executive Director

**Jillian Hopewell, MPA, MA**

Director of Education, Editor

*Editorial Board* — Marco Alberts, DMD, University of Washington, Harborview Medical Center, Seattle, WA; Matthew Keifer, MD, MPH, Harborview Occupational Medicine Clinic, Seattle, WA; Nikki Van Hightower, PhD, Department of Political Science, Texas A & M University