

streamline

Support: Health Network Rises to Meet Needs of Diverse Mobile Patients

Health Network's Internal Support System

Claire Hutkins Seda, Writer, Migrant Clinicians Network, Managing Editor, *Streamline*

[Editor's note: In this issue, we explore how Health Network Associates provide support beyond basic case management to mobile patients. This piece dives deeper into how Migrant Clinicians Network ensures that the Associates themselves get enough emotional support and practical tools to provide a consistent high level of care.]

A young mother with tuberculosis who can't find a clinician. A diabetic father who is deported, while his wife and children remain in the US. A young asylum seeker with cancer who is scared and has no one to confide in. A patient who is lost to follow-up. A patient who, despite all the care, dies from his condition. These are profiles of some of the agricultural workers and other underserved and mobile patients that MCN's Health Network Associates speak with every day. Our five Health Network Associates spend most of the week engaged in their critical and at times high stress jobs to ensure that patients can continue their treatment even if they have to move. Supported by Ricardo Garay, Health Network Manager and Deliana Garcia, Director of International Projects, Research, and Development, the Associates handle thousands of cases a year. The Associates have their own physical and emotional responses to their work, so Migrant Clinicians Network has increased the resources and support for Associates in order to best serve our Health Network patients by providing emotional and practical support to our Associates.

Last year, the Health Network team initiated a weekly session to discuss difficult cases. "Every Friday for about a year, we have had a case review, with the idea that if you have a tough case that week, you can get it off your chest and let it go," explained Garay. Associates find the regular session to be a time to renew their dedication to the cause, strengthen their relationships with the team,



and explore practical and novel ways to assist patients in continuing their treatment.

"Case review helps us generate new solutions for cases and allows us to express how we are feeling after a hard week," said Olivia Hayes, Health Network Associate. "I feel this meeting plays an important role in maintaining good self-care."

Once a month, the weekly session is augmented by a visit from Mitch Sudolsky, MSSW, LCSW, Professor at the School of Social Work, University of Texas, Austin, and a friend of Garcia.

"I knew Mitch from earlier in his professional career and when he went into academia he told me that he wanted to do some volunteer work so that he could keep his hand in direct care," explained Garcia. "I told him that I had just the program for him to work with."

Sudolsky's time with the Associates is sometimes didactic, wherein he teaches

counseling skills or other communication techniques like motivational interviewing. At other times, Sudolsky facilitates a deeper conversation with Associates about the struggles inherent to their work. In addition, Sudolsky has assisted Associates in mourning the loss of two Health Network Associates, Homero Segovia, who tragically died in 2015, and Ricardo Guerrero, who passed away in 2016. Sudolsky's inclusion in the team's rhythm has assisted Associates in recognizing and addressing the emotional toll of such losses while still trying to maintain a full workload.

By building an empathic team and encouraging opportunities for Associates to process difficult cases and their own emotional responses through the weekly session, Health Network Associates are more prepared to provide high quality, compassionate care that can lead to greater rapport with patients and better treatment results. ■



Support: Health Network Rises to Meet Needs of Diverse Mobile Patients

Expecting a Baby, Experiencing Depression: Health Network Case Study

By Olivia Garcia, Health Network Associate

Maya*, an agricultural worker, had a one-month-old healthy newborn when I first spoke with her. Her previous case manager at Health Network, Alma, had gone on maternity leave, so I took Maya's case. It's clear that Maya and her previous case manager had bonded over their pregnancies, but Maya was very grateful for the continued assistance after the birth of her baby boy.

A clinic in a Southern US state had originally enrolled Maya in Health Network in September 2015, to help her continue to get prenatal care as she moved regularly to keep up with the harvests throughout the Eastern Seaboard. Alma called Maya right after she received the enrollment forms, to

introduce herself and Health Network. Maya was responsive from the very beginning. She told us she was moving to another state in the South in two weeks. Like most agricultural workers, she didn't have the address of the farm on hand. Even after she moved, she wasn't able to give us the address of where she was working. We had to wait a few weeks before the farm managers gave her the address. Alma got Maya her first appointment shortly after getting the address.

After that initial move, Maya moved three more times, every three weeks, to different farms within that same state. Each time she moved, Alma assisted in finding and contacting a new clinic, moving her health records, and communicating closely with Maya. The third time that Maya moved, Alma encountered issues with the local county health

department. They didn't want to send Health Network Maya's medical records — so they printed them out and gave them to Maya. She took them on her own to the next clinic. It took multiple calls on Alma's part to get the medical records sent to the next place properly.

Shortly after her first appointment, Maya confided in Alma that she was struggling with depression. Alma encouraged her to seek treatment, and helped her find a therapist. Maya visited a mental health specialist at one of the clinics — but she did not like the experience, telling Alma that she felt like the providers weren't listening to her. Alma continued to encourage her to seek treatment, but Maya refused. Alma made sure that Maya spoke about these issues with her

* All names, locations, and dates have been changed to protect the identity of the patient.

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Support: Health Network Rises to Meet Needs of Diverse Mobile Patients

Serving Patients with Diabetes, Limited Resources, and Lives on the Move

By Jeremy Leake, Social Work Intern, Health Network

[Editor's Note: This article is part of our ongoing series to provide a platform for our interns to share their experiences and perspectives about MCN programs and services. Jeremy Leake, who interned with Health Network for the fall 2016 semester, is a senior at The University of Texas at Austin, majoring in Social Work.]

As a social work intern, I began working for Migrant Clinicians Network's Health Network from a learner's standpoint – to educate myself on the agricultural worker population as a whole, and how I could help to bridge the gap in meeting their health needs. My perspective in serving these individuals has been enhanced by sixteen years of living as a diabetic, and offers a different approach in providing care through case management.

For several months, I served patients enrolled in Health Network for their various health needs, including tuberculosis, diabetes, and general health care. My curiosity in working with diabetic patients comes from a place of empathy in understanding the daily challenge involved in managing this condition. It is a full time job in itself. Aside from ensuring that these individuals have the education and medication that is vital to their health, there is much to say about the psychological and emotional health that can pose barriers to staying engaged in the changes in lifestyle that are necessary to effectively manage diabetes. "Diabetes burnout" is a construct that can be defined as occurring "when an individual with diabetes has the information (education) necessary to manage diabetes well, yet his or her psychological and emotional state(s) have become barriers to adequately engaging in the behavior necessary to effectively manage" the health condition.¹ The possibility of burnout among diabetic patients is concerning, and should be kept in mind when working with individuals facing any change that functions as an obstacle to living a normal life.

In addition to learning from my MCN co-workers about how we can continue to



Photo courtesy of Abigail Peka-Stansberry

improve our efforts to extend care to patients, I utilized theories and frameworks that I have learned throughout my coursework as a social work undergraduate student with my patients to begin to assess the extent to which patients' basic needs are being met. These needs include food, shelter, safety, and the presence of strong support systems, with their health only being a fraction of need. In order to check in about patients' needs, I referenced Maslow's hierarchy of needs, which places basic human needs into five different tiers. The base of the hierarchy pyramid is an individual's physiological well-being (food, water, shelter), followed by consecutive tiers of needs including safety, sense of self-belonging and love, self-esteem, and self-actualization.² I incorporated prior knowledge of the patient's background information (age, location, race, health, culture) and used motivational interviewing techniques to encourage them to feel comfortable in dis-

cussing any concerns or issues that might be present, including how we can help the patients help themselves. These tools that I learned, and have been able to use from my university coursework, complement the Health Network training that I received. Another quick, yet very efficient assessment tool that I began to use later in my internship was introduced to me and the rest of Health Network staff by my Field Instructor, Mitch Sudolsky, a clinical professor at the University of Texas and social work consultant with MCN. Ideas, Concerns, Expectations (ICE)³ assists case managers in understanding the patient's needs, through learning their thoughts relating to what is going on with their body/health condition, what the patient's biggest worry is (which may differ from the case manager's), and what the patients are hoping that the case manager can do for them based on their

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Go With the Flow: How One Collaborative Aims to Improve Clinical Flow at FQHCs

Claire Hutkins Seda, Writer, Migrant Clinicians Network, Managing Editor, *Streamline*

Primarily care is in crisis. With fewer health care professionals choosing primary care and with a growing demand for primary care services, millions of people around the United States find that they simply can't go to a clinician when they're sick. The problem is amplified for underserved patients like agricultural workers, who often haven't established a relationship with a local clinic due to barriers like their mobility, language differences, cultural sensitivities, and poverty. Some clinics are taking time out for meetings to address this shortage. Through a new collaborative, clinics across the US meet to generate and implement plans to improve their workflow, in hopes of providing higher quality health care and more efficient appointments for their patients.

On a recent Monday, Seenamma Machireddy, MD took time away from her busy primary care schedule, seeing patients at Cherry Health in Grand Rapids, Michigan, to join her staff for a weekly hour-long meeting to check in on improvements to workflow they have implemented. In addition, every week, a team from Dr. Machireddy's clinic, consisting of a nurse, supervisor, and site managers, logs into a two-hour virtual meeting with other clinics from around the country. The two weekly meetings are a regular feature of Cherry Health's time commitment for the Improving Clinical Flow collaborative, which Cherry Health has been participating in for over a year.

"It's been a learning experience — and we've seen a lot of changes," Dr. Machireddy noted. "Definitely, we were able to improve a lot of our quality measures." When Cherry Health began the ECHO project, a primary goal was to decrease patient cycle times. The baseline cycle time was 69 minutes. "Now it's been consistently staying around 50 to 55," she said, providing new time for more patients. Such a goal improves accessibility of care for agricultural workers and other underserved patients who struggle to get appointments, by increasing the number of patients served, thereby increasing their likelihood of getting an appointment when they need it, and avoiding the emergency room when care is put off. "This definitely impacts patient satisfaction, of course, too," Dr. Machireddy added, as patients with appointments spend less time in the waiting room. After just a year, the additional hours spent in the collaborative meetings has already paid off.

Two Approaches, One Collaborative

The new 12-month program fuses the Institute for Healthcare Improvement's Breakthrough Series Collaborative with Project ECHO's teleECHO clinics to give Federally Qualified Health Centers (FQHCs) like Cherry Health the tools and support they need to make significant changes in their workflow to improve quality of care for patients. The project is a test run, supported by the GE Foundation's Developing Health US Program, to see how the two forms can complement each other.

The Institute for Healthcare Improvement (IHI) has been putting its Breakthrough Series Collaborative (BTS) model to work for two decades. "IHI takes these known changes that people have tried all over the country, and puts them into a 'change package,'" explained Cory Sevin, RN, MSN, NP, Director of IHI. With the 'package,' the BTS model presents to its participants the system of changes that seem to help other organizations get better results in the target area. For this collaborative, the change package is mostly focused on creating and optimizing the care team, improving work flow, and removing waste.

IHI augments the 'package' with a suite of data tools that provides the participating clinic with updated information every month to map their progress over the course of the collaborative — the tools that Dr. Machireddy and her team used to see how their cycle times dropped. The improvement team must upload data related to the clinic's goal to the IHI system at minimum once a month. IHI cuts and pastes the data so changes over time are visible, and compares the data with sets from other collaborative teams. "Being able to put that data along with the change package in front of [the participants] every week for a long period of time — that seems to help... the level of sophistication of the teams and how they're able to talk about the data, understand the system changes over time," Sevin noted. Dr. Machireddy found the data to be key. "Having baseline numbers on all the measures helped a lot, to gauge where we are, if we're improving. If there's not significant improvement, we look for a new alternative," she said.

Elizabeth Clewett, PhD, Senior Program Manager with Project ECHO, believes IHI's approach greatly enhances Project ECHO, a telementoring platform that has made significant strides in expanding primary care clini-

cians' tools and resources to battle a wide range of health concerns in their patient population. The popular virtual meeting program is defined by four pillars, Clewett said: using technology to overcome barriers like making an expert panel available to clinicians in a remote region; bringing in best practices; supporting case-based learning; and initiating a feedback loop, wherein participants are surveyed and the program offerings are adjusted to best serve the needs of the participants in real time. Participants are brought together through webcams and high-speed internet, the only requirements to participate in the highly interactive virtual meetings. With the new collaboration with IHI, Project ECHO brings the technology and the experts, and IHI brings the data crunching and the expertise in transforming work environments for the best, most efficient outcomes.

"The hope is for expanding reach and deepening interaction," Sevin explained. "This is a very early test to see what we can learn through the partnership and integration."

Nuts & Bolts of the Collaborative

Before the collaborative meetings began, each FQHC spent two months to develop their improvement teams and make sure their technology was up to the task of utilizing virtual meeting platforms and pulling and adding information to IHI databases. Next, they process-mapped their workflow to better understand their pre-collaborative state and provide baseline data. Then, faculty and improvement advisors stepped in to review the workflow and identify where improvements could happen. Finally, the collaborative officially kicked off, with a two-day, in-person learning session at ECHO headquarters in New Mexico.

Finally, the "Action Period" began, during which they tested out their first round of changes and measure their effects on work flow, Sevin said. A second virtual learning session was followed by a second round of action, to build on and spread successes from the first round, or back up and regroup, if the data weren't showing significant progress. During this phase, the FQHC teams come together weekly for a two-hour ECHO call where brief didactics from ECHO staff are paired with case studies and roundtable discussions so that the community can

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Privileging, Hospital-Style

Claire Hutkins Seda, Writer, Migrant Clinicians Network, Managing Editor, *Streamline*

Health centers aren't hospitals. Centers focused on outpatient care cannot be built exactly like centers focused on inpatient care. They have different funders, reporting requirements, supported specialties, services, and targeted patient populations. Accordingly, a health center's structure is different than a hospital's. However, sometimes a hospital construct can lead to a health center innovation. At SAC Health System (SACHS) in San Bernardino, California, the local hospital informed their own provider privileging processes — leading to a model that has promise in the health center world.

When SACHS first started as a grant-sponsored community clinic associated with Loma Linda University and Medical Center, the providers serving the clinic were also working in the medical center — and consequently went through credentialing and privileging (C&P) with the medical center, which included a hospital and research facilities. They continued having joint privileging systems as SACHS transitioned into a Health Center Program look-alike, on their path to becoming a federally funded health center. Finally, in 2013, SACHS became a Health Center Program award recipient under Section 330, the term to denote that SACHS was finally a federally funded health center. Despite the transition, they have maintained their hospital-style privileging — which has the health center leading the way to efficiently approach the important program requirement.

“Big hospital organizations establish a medical staff that runs through a lot of quality pieces. We are really mimicking that here — that's where our expertise comes from,” described Jane Atkins, Chief Officer of Quality and Compliance at SACHS.

The hospital supports privileging renewal through a computer-based analysis. The basis of the system is a computer program within the billing system that “pulls all the provider's procedures [conducted within] the last two years,” explained Angela Teresi, Credentialing Specialist for SACHS. The system tallies how many of each procedure the provider has completed. Then any claims history is matched to the procedures, which is red-flagged for reappointment time, she said. A service chief reviews the information and speaks directly with the clinician to determine what level of proctoring or monitoring, if any, is required as a result of any claims. “If they haven't done a procedure in the last two years, then they won't grant



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them that privilege,” Teresi noted. “If they want the privilege back, then they'll do a proctoring or mentoring [in which] they set up a plan and focus on that procedure,” which keeps providers up-to-date on newer techniques and eliminates paperwork and staff time to continue privileging tasks that go unused. It also ensures that providers' skills are closely matched up with what they're doing in the exam room.

The process also eliminates a health center's struggle to determine which procedures a provider should be privileged for, by only privileging the necessary skills and ensuring those skills are kept up-to-date through additional training when needed. Medical Directors that oversee each department within the health center including its specialty clinics have oversight over the process, and conduct privileging meetings with providers to make sure they are confident in their providers. “They vouch for the provider that they are competent in all the areas that they are requesting privileges for,” Atkins explained. “It's important.”

Atkins calls the system a “bonus” of working closely with Loma Linda — it's a process that is above and beyond the C&P basics required by section 330 but greatly enhances the privileging aspects of the C&P process. During the creation of the health center, medical staff “brought along with them the expertise, with the logging and the tracking,” to build the system that SACHS now uses, which was put into place with the help of a credentialing organization that SACHS contracts with. But Atkins states

that most health centers could develop their own tracking system to mimic the process but tailor it to what that particular health center needs — and the results would be worth it.

What does this mean for agricultural worker patients? In San Bernardino, a more efficient privileging system means specialty clinicians are efficiently privileged for the tasks they routinely complete, and are not required to get privileges for tasks they never use. This means more time for patients like agricultural workers, who may struggle to get an appointment with the clinician they need — even more so than the general population. “Marginalized populations like agricultural workers often have enormous difficulty accessing specialty care,” noted MCN's Chief Medical Officer, Karen Mountain, MBA, MSN, RN. Agricultural workers, who have higher rates of occupational injury, may need higher access to occupational health, and their mobility limits their ability to accept an appointment scheduled four months out. “This model streamlines that process.” ■

Resources

Credentialing and privileging is outlined in the third of HRSA's 19 Health Center Program requirements. Read a short description here: <http://bphc.hrsa.gov/programrequirements/index.html#top>

MCN's online toolbox includes sample policies, procedures, and documents useful to health centers in performing credentialing and privileging: <http://www.migrantclinician.org/toolsource/85/credentialing-and-privileging/index.html>

discussion. This mutual understanding of patients' needs aided me to help them by calmly addressing their most pressing worry, and making them aware that they can receive help for their needs. Additionally, this could result in an increased willingness of the patients to discuss other issues that may be present in their life. By using theories, frameworks, and assessment tools, I was able to understand that when patients are anxious, they may not listen well and may not adequately problem solve. We problem solve with the patients over the phone to help alleviate their burden. Afterward, they are more inclined to listen to our input, plans for continuation of care, and efforts to help.

According to this frame of thought, some agricultural workers are more likely to show decreased motivation in caring for their conditions, should their most basic needs not be met. This reduced focus on health is worsened by the stress, depression, and grief that accompany the inability to provide these basic needs for one's self.⁴ Imagine a patient going to a clinic in hopes of obtaining care, and being informed that they must take a medication daily to keep themselves healthy. However, their anxieties and stress related to their inability to work or feed their child could be a more pressing need. By addressing and acknowledging the existence of a

diabetic patient's anxieties and stressors unrelated to their disease, the patient may feel heard and comforted by his or her case manager. As a result, the patient may be more likely to honestly disclose their struggles with diabetes management. Admittance to and disclosure of patients' health care adherence difficulties is critical. Building rapport with patients could be a simple fix to helping them get on the right track, diverting them from the path that leads to burnout.

Reflecting on my internship, I have come to learn how patients that are mobile and diabetic could face even greater challenges in managing their health condition, because of the impacts of social determinants of health. Pulling in my personal experience as a diabetic, and my experience gained through this internship, I now have a greater understanding of the importance of the role of an advocate in a Health Network Associate. Advocating for patients could actually be a determinant of whether or not they are able to maintain their strict diabetes (or other health care) regimens. Putting in the effort to assist patients in self-care relating to their health needs ultimately increases the likelihood that they can make it to work, and succeed at their jobs, which may enhance their overall quality of life. ■

Resources

Watch MCN's archived webinar in Spanish, "The Role of Community Health Workers and Diabetes," at <https://goo.gl/rZh2XC>.

MCN recently ran a blog post on Group Health Research Institute's diabetes self-management program, which dives into:

- Exploration of long-term solutions to continue trainings to serve the underserved patients with diabetes
- Community health advocate training
- Provision of diabetes self-management workshops in English and Spanish
- Skills to manage diabetes at home between clinic visits

Read the post on the MCN blog: <https://goo.gl/aaVmuo>.

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learn from each other and build on each other's successes. "The hierarchy of experts and teams and other clinicians is flattened in the belief that everyone has knowledge to provide," pointed out Clewett, an important — and effective — aspect of the ECHO model.

On the ground, this is the time during which FQHCs plan out, implement, and then evaluate improvements with a PDSA Cycle — "Plan, Do, Study, Act."

"Our staff who are involved in the ECHO project really got a good hold of how to run PDSAs and how to measure success, and how to tweak things if things are not working well," Dr. Machireddy said. Cherry Health's first PDSA was to ensure that emergency room (ER) records were ready for practitioners for patients who were at the clinic for an ER follow-up appointment. While the goal may not seem lofty, the planning, the intention, and especially the data assure such a basic improvement is done efficiently. "We now have records on almost 100 percent of the ER follow-ups, which makes the flow much easier, and the visit is just in and out," Dr. Machireddy noted.

Such efficiency improvements further assist agricultural workers by allowing for more time in the exam room with the patients. With higher rates of occupational injury, while combating various barriers like language, and with health issues rooted in the social determinants of health, agricultural worker patients can greatly benefit from even a few additional minutes with a clinician, who can dedicate time to a more detailed medical history, or can address a backlog of health concerns that an agricultural worker patient may have put off when not able to access care. Efficiency in the exam room may indeed benefit underserved patients the most.

High Level of Commitment from FQHCs

The collaborative requires a high degree of commitment from FQHC staff. A "day-to-day leader" is expected to assign up to 40 percent of his or her time toward the project. A "Clinical Champion" — a clinician — and a "Measurement and Data Leader" — ideally, an IT or administrative worker — are also designated. An Improvement Team is tasked to "test changes and drive the work." Finally,

an Executive Sponsor meets with other executives monthly for their own parallel track, that makes the business case for making the changes on the frontline and assures executive level buy-in and collaboration.

The collaborative goes beyond practical fixes to the workflow. "We've worked with the frontline teams to [help them] understand the changes they're making, and how [the project] relates to the financial vitality of their organization, because they care about it and they need to care about it," noted Sevin. "When you optimize your care team, when you... optimize the roles of a medical assistant or a nurse, or you get more people in, when you understand what it means to get rid of waste so you can see more people... [you bring] that financial understanding of the changes of how the frontline operates. I think it's a great innovation." ■

Learn more about IHI at www.ihl.org.

Learn about MCN's ECHO Clinic offerings here, <http://www.migrantclinician.org/project-echo>

Read about the GE Foundation at: www.GEFoundation.com.

MCN's IRB: Assuring Rights of Underserved During Research

Claire Hutkins Seda, Writer, Migrant Clinicians Network, Managing Editor, *Streamline*

How does exposure to pesticides affect the long-term health of agricultural workers? What are the health consequences when a workplace adheres strictly to federal regulations intended to protect workers? How much access does a given underserved group have to nutritious foods, physical activity, clean air, or health care services?

Research on these topics and many more have illuminated the health concerns that face agricultural workers and other underserved patients in their daily lives. Such underserved populations — people experiencing homelessness, construction workers, agricultural workers — may differ from the general public in their work responsibilities, the need to move for work, lack of official identification or residence, levels of literacy, culture, and language. They may not be able to participate in research in the same ways that the general population can, and often require unique consent forms and research approaches tailored to these differences.

To review and help adapt research procedures to these underserved populations, Migrant Clinicians Network created an Institutional Review Board (IRB) in 1999. “The IRB guides researchers on how to best design their research to take into account the needs and concerns of underserved populations, and to ensure they are fully informed and protected as research subjects,” explained Maria de Jesus Diaz-Perez, PhD, Chair of MCN’s IRB. Today, MCN’s IRB is as relevant as ever and continues to advocate for research that attends to the rights, safety, and welfare of agricultural workers and other underserved research subjects.

“Being familiar with the population, we’re familiar with the risks that this population experiences,” noted Sara Quandt, PhD, a member of MCN’s IRB. All of the IRB members bring to their IRB work the added lens of working with hard-to-reach and underserved populations. “Research procedures commonly used with less vulnerable populations might actually endanger the rights of [certain] populations,” she noted. MCN’s IRB is uniquely qualified to review and recommend adjustments to advance research with this special population.

The research protocol reviews provided by the IRB vary greatly, covering research issues ranging from the best way to keep in contact with members of a mobile population over time, to the wording of consent forms. “If you don’t need their name, don’t ask for



it,” Dr. Quandt offered as an example, as a worker who lacks documentation may be intimidated and refuse to participate in the research and a researcher might hold unneeded information that could harm the participant if confidentiality is unintentionally compromised.

Dr. Quandt points out that because it is not affiliated with a university or other research institution, MCN’s IRB gets a wide range of researchers, many of whom come from nonprofit or community-based organization backgrounds. The IRB tailors its procedures to serve both experienced researchers and individuals and organizations who may be new to the research world.

“If there are procedures proposed that do not meet the usual requirements to protect research participants, we try to give concrete suggestions to applicants on what they need to do differently. That might include some of the research activities such as recruiting participants or storing data,” Dr. Quandt said, adding that such assistance might not be provided by IRBs associated with medical schools or universities, which typically engage only experienced researchers.

As the IRB continues its work, it strives to better serve new or less well-trained researchers. A newly streamlined application process has reduced the amount of content required from the applicant, and has improved the explanatory sections to allow applicants to

better understand what kind of information the IRB needs, according to Dr. Diaz-Perez.

“IRBs at universities are notorious for taking a long time to approve research projects,” Dr. Quandt admitted, and non-researchers applying may not be aware of the needed lead-time. MCN’s IRB recognizes that time is a particularly sensitive factor when working with mobile populations, which may be traveling by the time the IRB gives approval, so MCN’s IRB works efficiently, and provides upfront timelines to best communicate with applicants, to assure their research milestones aren’t thrown off track.

In 2012, MCN’s IRB received a Certificate of Merit for Best Practices from the Health Improvement Institute. In the intervening years, the IRB has enabled researchers to effectively recognize the health conundrums facing underserved populations while ensuring that research subjects’ unique needs, safety, and rights are a top priority. ■

MCN’s Institutional Review Board meets monthly to review submissions. The IRB is currently accepting new members, including non-researchers with expertise in underserved populations. For more information on the position or to learn more about submitting research to the IRB, please contact Theresa L. Lyons-Clampitt, MCN’s Training and Technical Assistance Coordinator at tlyons@migrantclinician.org.



A Stronger Worker Protection Standard is Now In Effect What Does It Mean for Workers?

Agricultural work is one of the most dangerous occupations in the US. This year, those who work in this important industry were afforded stronger protections. On January 2nd, the first wave of revisions to the Worker Protection Standard (WPS) went into effect, aiming to minimize the adverse health effects of pesticide exposure. The long-awaited implementation of the key new provisions to the WPS represents an important victory in farmworker health.

The WPS is the primary federal regulation to protect agricultural workers from pesticide exposure — and it hasn't been updated since its implementation in 1992. For years,

the Environmental Protection Agency (EPA) worked closely with stakeholders and advocacy organizations to revise the WPS and prepare for its implementation. The following revisions took effect on January 2nd. This summary is pulled from MCN and Farmworker Justice's Issue Brief on the revised WPS. (See Resources for the link to the brief, below.) A second wave of revisions will be implemented in January 2018.

As of January 2, 2017:

- Children under the age of 18 are prohibited from handling pesticides and from entering a pesticide-treated area before the restricted-entry interval (REI) has expired.

- Employers must post warning signs around pesticide treated areas in outdoor production when the product used has an REI greater than 48 hours.
- The posted information must include safety data sheets (SDS) for each pesticide used. SDSs contain essential information about a pesticide, including toxicity, health effects, first aid procedures, storage, disposal, and necessary protective equipment for handling.
- Workers who must enter a treated area during a REI receive detailed information about the pesticides used in the area

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CASE STUDY

Agricultural Workers Need Better Protections

[Editor's note: Why are the revisions to the Worker Protection Standard important? As clinicians, we recognize that simple, common-sense, and science-backed regulations can make a profound difference in the health of agricultural workers, a vulnerable and often exploited class of workers. The following is a case study illustrating how agricultural workers can often be at risk of exposure and may be in the dark about regulations. The newly implemented features of the revised WPS, if properly followed, will prevent this situation in the future.]

In 2015, a crew of 22 seasonal agricultural workers was working on a tobacco farm in a Southern US state.* All of the workers were Mexican nationals brought to the farm as a part of the H-2A temporary visa program. The workers were instructed by their supervisor to re-enter and begin work in a recently sprayed tobacco field before the restricted entry interval (REI) had expired. The field did not have warning signs posted alerting workers of the recent application, and the supervisor refrained from informing them about the REI.

Within an hour, 12 out of 22 workers were unable to continue working due to illness as a result of pesticide exposure. Symptoms included nausea, headache, dizziness, stomach pain, muscle cramping, difficulty breathing, and extreme perspiration. The workers had not received any pesticide safety training. They were largely unaware of their rights, including their right to medical attention.

Because they were unable to continue working, the crew members alerted their supervisor and requested him to transport them to a nearby hospital. The supervisor denied the request.

The ill workers who did not return to work immediately were sent home to Mexico at their own expense and without medical attention.

Miguel, one of the ill workers who was sent home to Mexico, contacted a legal aid organization in the state where the tobacco farm was located. Miguel lived in a rural Mexican village and did not have a home telephone, fax machine, email address, or viable mailing address. Miguel did not have a treating physician and needed assistance with location, coordination with, and transportation to a medical specialist in a different part of Mexico to determine diagnosis and

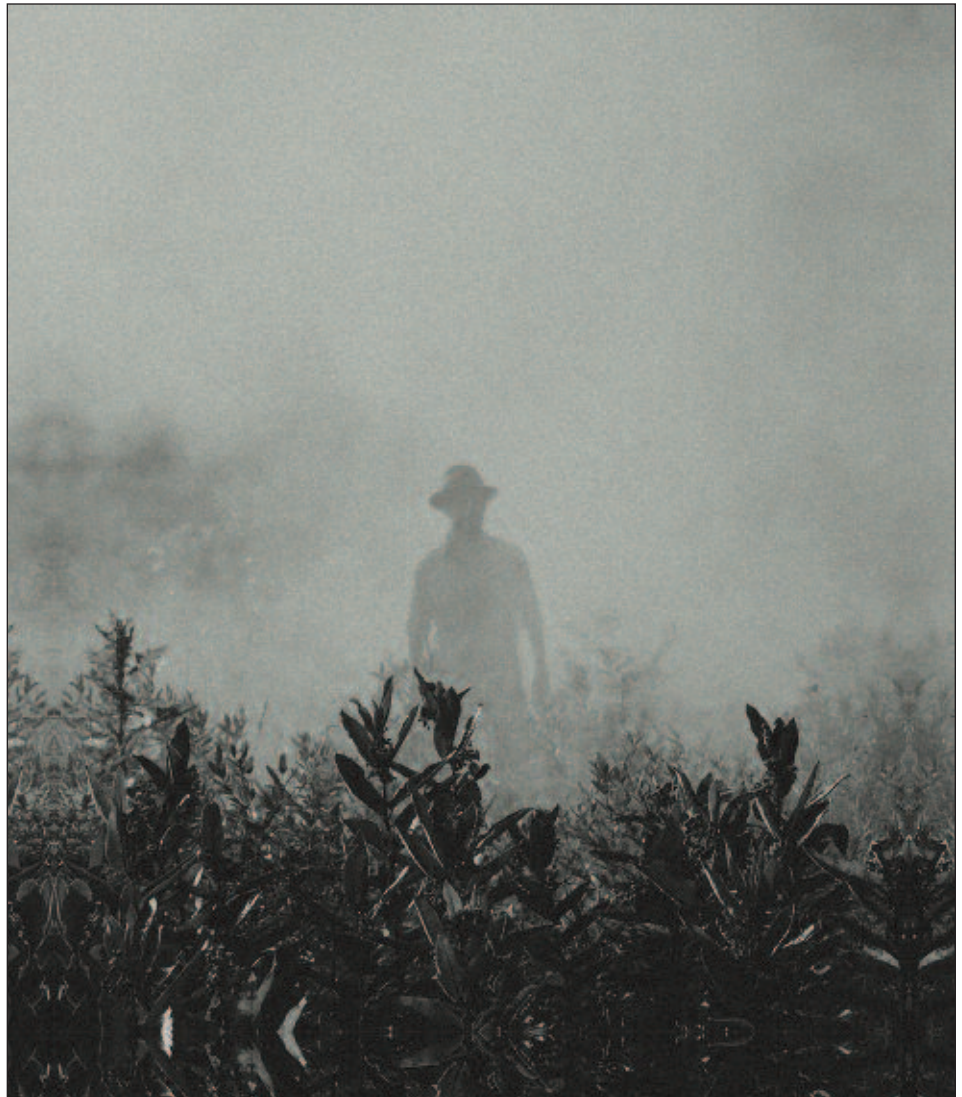
an appropriate course of treatment. His attorney requested from Miguel's employer a list of pesticides that had been applied to the fields in which he worked during the time that he became ill. The employer refused to provide this information for weeks, thereby impeding Miguel's diagnosis and treatment.

This case underscores important aspects of the support workers need to protect them from pesticide exposure. For clinicians, treatment of pesticide exposure can be challenging, and prevention is critical. Under the new, stronger WPS, many pesticide poisonings will be prevented. Several new prevention measures in particular may prevent such a case from occurring again: While safety training has always been obligatory, it is now required every year as opposed to the previous every five years. Workers must be trained

before they start work; there is no longer a grace period for training. Additionally, workers must be notified about REIs and a sign must be posted if the REI is greater than 48 hours for outdoor applications and four hours for indoor applications.

When exposed to pesticides, workers under the stronger WPS are allowed to designate a third party representative to obtain information about the exposure. The employer may no longer refuse such a request. This is an important piece of the new WPS since workers often encounter barriers to accessing this information, including language difference and fear of job loss. ■

* Names, dates, and other identifying information have been changed to protect the identity of the workers.



■ What Does It Mean for Workers? continued from page 8

- where they will work and the personal protective equipment (PPE) required by the labeling.
- During pesticide application in outdoor areas, only properly trained and equipped pesticide handlers involved in the application may enter areas up to 100 feet around the application equipment (known as an application exclusion zone or “AEZ”). An applicator must suspend application if a worker or other person is in the AEZ.
- Employers must comply with OSHA-equivalent standards on medical evaluation, fit testing, and training for pesticide handlers whenever a respirator is required by the labeling.
- In an emergency situation, an employer must promptly provide (even without being requested) the SDS, product information (name, EPA registration number and active ingredient) and circumstances of exposure to treating medical personnel.
- Workers may designate another individual to access information about the pesticides used in their worksites. This is important in the event a worker is fearful or otherwise incapacitated.

- Clinicians may request information. When an agricultural worker seeks medical assistance due to pesticide exposure, employers must promptly make available SDSs, product information, and application information to medical personnel upon request to better facilitate diagnosis and treatment.

These hard-fought revisions if implemented and enforced accordingly will help reduce pesticide exposure in agricultural workers, which prevents pesticide-related illness and injury. Years in the making, the revised WPS is a stronger standard. While not eliminating the risk of pesticide exposure, the standard provides important safeguards that are long overdue. We at Migrant Clinicians Network celebrate its implementation and continue to stand steadfast in ensuring its important provisions are followed in the fields. We look forward to the remaining revisions coming into effect next year. ■

Clinicians Are Key

Clinicians play an important role in recognizing and preventing pesticide-related illness and injury.

Clinicians are encouraged to better understand the key provisions outlined above, to best serve agricultural worker patients and advocate for their health needs.

Learn more about the WPS, the revisions, and its effect on agricultural workers with the following resources:

RESOURCES

Read MCN and Farmworker Justice’s Issue Brief overviewing the major WPS revisions that are particularly relevant for clinicians: <https://goo.gl/jnSV93>

Visit MCN and Farmworker Justice’s Pesticide Reporting Map to see state-by-state pesticide regulations and how to report pesticide exposures: <https://goo.gl/W6QhZK>

Order a free copy of the EPA book, *Recognition and Management of Pesticide Poisonings*, 6th edition: <https://goo.gl/yr53qj>

Explore more from the clinician’s point of view, with the *Clinician’s Guide to the WPS*, by MCN and Farmworker Justice: <https://goo.gl/rqST5e>

Gain access to other resources at MCN’s Worker Protection Standard page: <https://goo.gl/rLjupl>

More resources are at the Pesticide Educational Resources Collaborative at www.pesticideresources.org

See the EPA’s WPS page, with charts comparing the new to old versions: <https://goo.gl/q2Z6i3>

■ Expecting a Baby, Experiencing Depression: Health Network Case Study continued from page 2

clinician during her prenatal appointments. Maya missed several appointments due to her depression, and told Alma that she just didn’t feel motivated to go.

During her sixth month of pregnancy, Maya called Alma to express her fear that her baby wasn’t moving. Alma encouraged her to get to the clinic immediately. Luckily, the baby was healthy. Maya confessed to Alma that she had fears about her baby’s health because she lost a child several years before. She was not motivated to eat enough, she said, but she knew she should for the baby.

Maya moved again, to a third state along the Eastern Seaboard. She stayed one month in her next location, but she refused to go to the clinic against Alma’s advice. She wanted to establish herself in the hospital at her next location in the same state where she planned to have the baby. She had lived there before, and had developed a relationship with the local clinic; she also had friends in the community for postpartum support.

After six moves in a few months, Maya gave birth to a healthy baby. Typically, for prenatal cases in Health Network, the case is closed after the mother gives birth — but Alma recognized that Maya had significant

mental health issues that required further attention. Her case was shifted into the general health category. Shortly thereafter, I took over the case.

Maya was appreciative that we were keeping the case open. After birth, her Medicaid coverage expired, and she wanted more information on sliding scale fees for health care in her location. She talked to me about her problems, how she was feeling, and her sadness. But she never thought that she needed help for her depression. She didn’t think she needed counseling or medication. Because of her poor experience with the mental health clinician in her previous state, she was disheartened by the situation. We talked about her problems and accessing care repeatedly. I told her there were different options, like group counseling for families battling the grief of losing a child. Mostly, I think she just enjoyed talking to me on a regular basis — someone caring for her, checking up on her.

I continued the monthly check-in. I found her a clinic to visit for her depression, but she turned down the appointment because she thought the sliding fee scale was too high. After the baby was a few months old,

Maya reported to me that her depression had improved. She wasn’t working, but staying home to care for her baby, who was healthy and growing fast.

At the end of August, Maya called me to inform me that she was moving back to her hometown in Central America. Two months later, I called her to check in with her for the last time. She had moved in with her mom and was feeling a lot better. She said she didn’t think she was going to move back to the States and she felt like she was in a good place for herself and for her child. I let her know that if she moved back, we could work with a clinic in her country or in the US to get her re-enrolled if she had any ongoing health issues. She was happy with all the time we had spent helping her. Although Maya refused the mental health services that we strongly recommended, she was able to confide in Health Network Associates to talk through some of her issues, showing that sometimes having a person who will listen and care goes a long way. Maya was no longer moving. I closed her case confident that she had better control of her depression and was in a place where she could best care for her baby with less worry. ■

Edging Toward a Ban, Chlorpyrifos is Once Again Demonstrated to be Dangerous to Human Health

Chlorpyrifos is a neurotoxin that is used as an insecticide on millions of acres across the US. It's also the subject of a newly updated Environmental Protection Agency (EPA) assessment, released at the end of last year, which concludes that the current safety standards are not sufficient to protect anyone exposed — including the consumers of contaminated food and water, the rural residents adjacent to treated fields, and the pesticide handlers — from the myriad of health concerns that result from even very low levels of exposure.

“We are concerned that safe levels of chlorpyrifos in the diet may be exceeded based on current chlorpyrifos uses,” the EPA’s assessment announcement page says. (Find a link to the assessment in Resources, below.) The full assessment notes: “The revised analysis indicates that expected residues of chlorpyrifos on most individual food crops exceed the ‘reasonable certainty of no harm’ safety standard under the Federal Food, Drug, and Cosmetic Act (FFDCA). In addition, the majority of estimated drinking water exposures from currently registered uses, including water exposures from non-food uses, continue to exceed safe levels even taking into account more refined drinking water exposures.” The assessment also concludes that agricultural workers who apply the chemical adhering to all safety and protective precautions are still exposed to chlorpyrifos at a level deemed unsafe by the EPA.

The assessment includes summaries of research indicating that very low-level prenatal exposure to chlorpyrifos is correlated with brain development disruption including a decrease in IQ, attention deficit disorders, working memory issues, and developmental delays. Chlorpyrifos is identified as an acetylcholinesterase inhibitor, which reduces the transmission of signals through the nervous system. The assessment summarizes some of the numerous studies on the health risks of exposure to chlorpyrifos, including epidemiology studies in mothers and children. Several scenarios are evaluated including dietary exposure via drinking water and via food, 21-day residential exposures for children, youth, and women, 21-day residential exposure for young children, and more. They outline real-life versions of the scenarios — for example, a golfer on treated turf might have exposure to chlorpyrifos for four hours each day.



The updated assessment comes on the eve of an expected ban on the chemical, the result of a decade-long effort in the courts. In 2001, the EPA banned chlorpyrifos for use in homes, citing developmental harm to children, but it continued to be used heavily in the fields. In 2007, Pesticide Action Network North America joined the Natural Resources Defense Council and Earthjustice to petition the EPA to ban all uses of chlorpyrifos, based on studies that demonstrated that very low level exposure had serious neurological consequences for children. In 2014, the EPA completed its initial health risk assessment, concluding that children were in fact at risk. It also covered the wide range of health concerns faced by agricultural workers and rural communities as a result of application, drift, and contaminated water. In 2015, the Ninth Circuit Court of Appeals directed the agency to act on the 2007 petition, which has resulted in this updated assessment and a proposal to ban chlorpyrifos. The EPA is expected to make a final decision in the coming months; the Ninth Circuit Court provided a deadline of March 31, 2017.

The chemical, banned for indoor use but still pervasive in agriculture, is used to control insects on a wide variety of food crops including aphids on soybeans, scale insects on citrus, mealybugs on wine grapes, twig borers and ants in almond orchards and codling moths in walnut orchards. It's also

used extensively on non-food crops like cotton and Christmas trees.

Chlorpyrifos is one of many pesticides used in agriculture that has been demonstrated to have serious human health effects. As clinicians, we treat agricultural workers or members of their families, a patient population that is the most overexposed population to pesticides. Signs of acute exposure such as headaches, nausea, and vomiting are easily misdiagnosed. (See the EPA’s manual entitled “Recognition and Management of Pesticide Poisonings, 6th ed.”, for more: <https://goo.gl/d2Cay8>.) Also, most clinicians are not aware that in most states they are required to report confirmed and suspected cases of pesticide exposure. Consistent reporting provides health authorities with important data on pesticide exposure trends. The interactive Pesticide Reporting Map, created by Migrant Clinicians Network and Farmworker Justice, gives state-by-state reporting requirements and how-tos: <https://goo.gl/ttknSD>. ■

Resources:

Access more of MCN’s pesticide resources, including our popular bilingual comic books and plenty of clinical tools, at <https://goo.gl/qxdLSL>.

Read the EPA’s updated assessment at: <https://goo.gl/OUVgxb>.

Learn more about the petition to ban chlorpyrifos at: <http://earthjustice.org/healthy-communities/toxic-chemicals/>



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calendar

April 26-27 **4th Annual Cultural Inclusion Institute**

Theme: Linking Social Determinants of Health to Health Disparities and Cultural Inclusion
Menger Hotel – San Antonio, TX
<https://ce.uthscsa.edu/browse/nursing/courses/4th-cultural-inclusion-conference#Headlink4>

April 29-May 2 **Spring Conference on Correctional Health Care**

Hyatt Regency Atlanta – Atlanta, GA
<http://www.ncchc.org/spring-conference-on-correctional-health-care-2017>

May 3-6 **10th Annual National Conference on Health Disparities**

JW Marriott – New Orleans, LA
<http://www.nationalhealthdisparities.com/2017/registration.php>

May 9 **NRHA's Health Equity Conference**

San Diego, CA
<https://www.ruralhealthweb.org/>

May 20-23 **2017 Spring Primary Care Conference & Annual Membership Meeting**

Spokane, WA
<http://www.nwrpca.org/>

May 22-24 **2017 Conference for Agricultural Worker Health**

Savannah Marriott Waterfront – Savannah, GA
<http://www.nachc.org/conferences/agricultural-worker-health/>

June 6-8 **8th Annual National Tribal Public Health Summit**

Together We Rise: Sustaining Tribal Public Health As a National Priority
Hilton Anchorage – Anchorage, AK
<http://www.cvent.com/events/8th-annual-national-tribal-public-health-summit/>

June 16-18 **North American Refugee Health Conference**

Sheraton Centre Toronto Hotel – Toronto, Canada
<http://www.northamericanrefugeehealth.com/>

July 8-11 **NCLR Health Summit**

Phoenix Convention Center – Phoenix, AZ
<http://healthsummit.nclr.org/>
September 7-9, 2017
2017 Philadelphia Trans Health Conference
<https://www.mazzonicenter.org/trans-health>