

# streamline



## Mobile Patients and Opioids

By Laszlo Madaras, MD, MPH, Co-Chief Medical Officer, Migrant Clinicians Network

*Francisco, a 26-year-old with chronic back pain, is a new patient at your health center. He says he injured his back three years ago falling off an orchard ladder at work, and that he recently moved to your community for farm-work. He shows an almost empty prescription medication bottle: high dosage opioids.*

**M**obile patients with chronic pain are sometimes trapped in the midst of a nationwide opioid addiction crisis. Without a medical history, clinicians must start from scratch. And with thousands of addicted patients around the country, and many others selling prescriptions on the streets, it can be hard to assess what patients really need: you don't want to over-dose them, or undertreat them if they are truly in a lot of pain. If you cut them off altogether, they may go into opioid withdrawal. As a hospitalist also trained in primary care in a Pennsylvania hospital, I have watched as the opioid epidemic has raged on, cutting across racial, ethnic, and socio-economic

boundaries; no demographic has been spared. But, as with other health concerns, those starting with fewer resources and more barriers to care may need special attention. Just like with the general population, I begin by assessing the mobile patient's pain needs to determine what he or she needs to get into control.

### Conversations in the Exam Room

Bringing a culturally and linguistically appropriate strategy to how you talk about opioids and how patients can reduce their suffering is critical. Empathy for a patient's situation can be one of the most important tools a clinician can use. Team-Based Opioid Management (at [www.improvingopioid-care.org](http://www.improvingopioid-care.org)), a project to improve safe prescribing of chronic opioid medication in rural clinics in Washington and Idaho, offers language suggestions when discussing opioid risks and safety, many of which are particularly relevant to a mobile population where time-intensive addiction treatment options

may be unrealistic. Some of the tips focus specifically on redirecting clinical encounters to focus on what patients are able to do to improve their quality of life, like having patients define treatment goals without using the word "pain," asking the patient what he or she would be doing if they had less pain, and helping patients address barriers to physical activities that could reduce suffering. Reframing the use of opioids can have a lasting impact on patients: "Emphasize the potentially temporary nature of pain relief from opioids, but the permanent dependence on opioids to avoid withdrawal symptoms."

### Prescribing Opioids

Mobile patients require the same level of care as all patients when prescribing opioids. The Centers for Disease Control and Prevention's Guideline for Prescribing Opioids for Chronic Pain provides specific

# Clinical Management of Diabetes as an Occupational Health Concern

By Amy K. Liebman, MA, MPA, Director of Environmental and Occupational Health, Migrant Clinicians Network

Last year, Honesto Silvo Ibarra, 28, was working in blueberry fields through an H-2A guestworker visa in Washington State near the Canadian border when he fell ill. He died days later in a nearby hospital after suffering cardiac arrest. Ibarra's death sparked protests by fellow workers of poor treatment, and led to state and federal investigations and a recently filed federal lawsuit. The King County Medical Examiner determined Silva's cause of death was related to complications from diabetes.<sup>1</sup>

Many occupational hazards may have factored into Ibarra's death. Ibarra and dozens of other workers on the farm that week were working in poor air quality, listed as "unhealthy," as a result of smoke from distant wildfires. Temperatures were soaring, fields were in full sun, and workers were putting in 12-hour shifts. The federal lawsuit claims that H-2A workers on the farm were not supplied adequate water or given shade and that several workers were suffering from heat stress. Additionally, the lawsuit states that the workers were provided with "inadequate and unhealthy food."<sup>2</sup>

Ibarra's untimely and unnecessary death is a stark and tragic reminder that diabetes is an occupational health concern among agricultural workers. Excessive heat and/or long hours in a hot work environment may affect blood glucose levels or affect the absorption of some diabetic medications. Additionally, poor air quality from particulate matter like smoke increases the risk of cardiovascular problems among people with diabetes.<sup>3</sup>

In H-2A or other agricultural worker situations, food, housing, and other lifestyle factors are often provided, increasing the occupational risks for workers suffering diabetes. Insufficient or the wrong type of food, and housing that continues a worker's exposure to high heat or humidity after work ends, may each contribute to hyper- or hypoglycemic episodes. Improper storage of medications may affect their efficacy.

"In order for injectable diabetic medication like insulin to be effective, it has to be stored refrigerated," noted Laszlo Madaras, MD, MPH, Co-Chief Medical Officer at MCN. "This may be a challenge to mobile populations who work in the heat, since even a short disruption in the cold chain could jeopardize their insulin effectiveness."

Additionally, long work hours, fear of retaliation from the workplace, and, for the mobile workers, unfamiliarity with the community, may result in poor access to health care, which may lead workers to ignore critical health cues or miss prescription refills.



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"Diabetes is becoming a very common condition among agricultural workers in the US," explained Ed Zuroweste, MD, Migrant Clinicians Network's Co-Chief Medical Officer. "Primary care providers can play an important role by recognizing that work, particularly in high risk industries, where matching energy expended with carbohydrate intake and appropriate adjustment of medication has a toll on the patient's ability to manage their diabetes."

In 2016, a group of researchers set out to determine how to support primary care providers to better evaluate work-related triggers to common concerns like diabetes. The group published its findings at the end of 2017. One study that came out of the research concluded that, while primary care providers recognized the impact that work could have on patients' health, they lacked "accessible knowledge at the right time." The study explored Clinical Decision Support (CDS) to assist clinicians. Examples provided in the study, which when integrated into electronic health records (EHRs) would prompt the clinician to ask about occupation and potential exposures, were found to be useful, but providers were still concerned about time constraints and "a perceived inability to act on the findings."

"When a primary care clinician is working with a patient with a chronic illness like diabetes, even just one or two minutes checking in on occupational stressors can lead to better glucose control and ultimately better long-term outcomes," noted Dr. Zuroweste. "Even minimal inclusion of worker health in the primary

## How Does Diabetes Interact With Extreme Heat?

- 1 High body temperatures can lower blood sugar.
- 2 Sunburn can raise blood sugar.
- 3 Warm skin absorbs insulin faster, while dehydrated skin absorbs insulin more slowly. It is important to keep the insulin injection site at normal temperature and hydration.
- 4 Dehydration from sweating can raise blood sugar and can lead to heat exhaustion. People with diabetes are more likely than others to be admitted to the hospital for dehydration and heat exhaustion, and to die from it. Also, high glucose levels lead to urinating more, which increases risk for dehydration.
- 5 Heat can damage insulin, other medications, and test strips. Extreme heat or cold can affect test results and degrade diabetes drugs, making it difficult for an agricultural worker to manage his/her diabetes.
- 6 Insulin pumps and continuous glucose monitors should function in hot weather if they are not exposed to direct sun for long; they need to be covered and protected in order to function properly.
- 7 Perspiration can loosen adhesives on continuous glucose monitors and insulin pumps. These need to be checked during work.

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# Diabetes Affects Work: Health Network Case Study

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

**A**t the Ventanilla de Salud (VdS) in Austin, Texas, Health Network Associate Leslie Diaz, LMSW, provides health information and resources to those who come to the Mexican Consulate for legal or other documentation concerns. Diaz links visitors with local health resources, and coordinates local health events and trainings in topics like nutrition and exercise. When a visitor to the VdS is moving or planning to move and has an ongoing health condition, Diaz enrolls him or her in Health Network, MCN's bridge case management system, to transfer records and help them get into care at their next destination. In August, Juan Delgado\* came to Diaz interested in a recently implemented nutrition class series at the VdS. Delgado, a construction worker in his 30s, told Diaz that he was at the Consulate to renew his passport, when he overheard her presentation in the waiting area on VdS services and for the class. He explained that he hadn't been feeling well in recent months, and was trying to eat more healthfully, but it hadn't yet made an impact. He was interested in the nutrition class to see how he could improve his health. Diaz asked additional questions on his health concerns, and discovered that Delgado was occa-



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sionally missing work at the construction site because he was too lethargic to get out of bed on some mornings. Even on days when Delgado did go to work, he felt tired and worn out.

Diaz recommended that he visit a health center to rule out common health concerns that may be responsible for his lethargy, including diabetes. She enrolled him in Health Network to track him as he traveled back to his hometown in another part of Texas, where she would find him an appointment and also look for nutrition classes for him. She found that the closest health center permitted walk-in appointments, and she quickly followed up with Delgado to encourage him to make time to go to the health center. Meanwhile, Diaz contacted her colleagues focused on nutrition educa-

tion to find a group that offered classes in Delgado's town.

Delgado went to the health center, and his clinician determined he had a hemoglobin A1C of 10. Although Delgado was hesitant to start medicine — he preferred a natural, non-medicated approach — he was prescribed medication that he began taking shortly thereafter. When Diaz called to follow up with Delgado, he told her that he was feeling better, and had consequently cut his medication back. Diaz explained the importance of maintaining consistency with his medication and encouraged him to stay at the prescribed dosage; Delgado recalled his doctor saying the same thing. He said he had a lot more energy and that he was no longer missing work. He also said that although the medication costs were large for him, at roughly \$80 per month, he felt he could afford it. During a recent follow-up call, Diaz learned that Delgado has brought his A1c down to within a safe range. Delgado's case demonstrates how Health Network's case management reinforces important messages to empower patients to self-manage diabetes. ■

\* Names, locations, and details have been altered to protect the patient's identity.

## ■ Clinical Management of Diabetes as an Occupational Health Concern continued from page 2

care encounter can alter the decisions of the clinician — and can make the difference in his or her patient's diabetes being in or out of control."

In a second study, the researchers developed CDS systems on work and asthma, work and diabetes, and return-to-work guidelines. The diabetes CDS system focused on identification of work that may impact diabetes control, and patient education. The goals of the system were: 1) to improve management of diabetes when a patient has workplace factors that can affect blood sugar; 2) to understand how impairment of physical or mental function from hypoglycemia may impact patient or public safety; and 3) to provide guidance for work restrictions.

A clinician seeing patients with a hemoglobin A1c at or above eight or with reported episodes of hypoglycemia is guided by the CDS. The clinician is prompted to ask patients about specific features of the workplace that could impact diabetes management, like shift work, the ability to take breaks, exposure to heat or temperature extremes, the ability to eat, drink, or take medication, and the level of

physical activity. If the patient answers "yes" to any of the features, then the CDS populates educational material options that the clinician can choose and print, the study notes. The researchers emphasized that the clinician must always be aware of any cultural, linguistic, or literacy barriers for the individual patient and adapt these materials appropriately.

According to the researchers, while low-literacy and culturally appropriate materials would still need to be developed, such a basic prompt could not only prevent complications among patients with diabetes due to their work environment, but also assure that workers in "safety sensitive" jobs can prevent a low blood sugar episode that could result in injury for himself/herself or others — for example, ensuring that a forklift operator has sufficient breaks to take insulin medication before operating heavy machinery.

Learn more by watching our recent archived webinar, Diabetes and Environmental and Occupational Health, at <https://www.migrantclinician.org/archived-webinars.html>. ■

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# Trauma-Informed Care: Lessons from Serving Asylum Seekers

By Kate Sugarman, MD

A woman came to the exam room with irregular and heavy periods, during which she says she was passing blood clots. She also experienced menstrual cramping. For a typical patient, these symptoms might not have been enough to even go to the doctor. But for a recent immigrant who is seeking asylum and who had been sexually assaulted in her country of origin, these symptoms are traumatic. They also present an opportunity to help her work through her trauma. With just ibuprofen and a few months of birth control, her symptoms lessened, became manageable. After certain screenings, we could also tell her that she did not have any STDs, and she was on the path to healing from her trauma as she began to feel more control over her body and her situation.

Fifteen years ago, I saw my first patient who was an asylum seeker. The patient had been referred to me by chance, but I soon discovered there was enormous need for scar documentation among this population, and I found the work incredibly satisfying. I soon began seeing survivors of torture in the Washington, DC metro area, offering my services as a doctor for free to the clients, survivors from Cameroon, Eritrea, Ethiopia, from other parts of Africa, and from South Asia as well. Almost all had been beaten, tortured, and imprisoned for their political views, their sexual orientation, or other difference, in their home country. Some of them had been detained by the US immigration system as well. All were now seeking asylum, and needed care.

Patients who have experienced trauma — from life-threatening torture in their homeland, to sexual assault during a long migration, to traumatic events within the US's own immigration system — require a trauma-informed care model. A clinician following such an approach recognizes the widespread impact of trauma on health and identifies the signs and symptoms of trauma, while providing care that adheres to the basic principles of serving people with trauma (See sidebar). As providers, we can reframe the exam room experience, help the patient work toward achievable health goals, and refrain from re-traumatizing the patient. Many of the following tactics are applicable for migrant patients who may have recently arrived at your own clinic, and may be harboring traumatic experiences from their home country or during migration, even if advanced torture isn't present. Our careful consideration of their unique health needs can lead to better results and stronger trust relationships.

## 1. Uncover health concerns while giving the patient some control.

When patients arrive in the US, they often



have long-ignored medical health concerns, some of which may have already been diagnosed. While every moment in the exam room is already overtaxed, a review of the medical history can help a provider drill down on the best and quickest steps the patient can take with the provider's support to make health improvements. If a patient arrives in the clinic with stomach pain and dizziness, it would be helpful to already know she suffers from hypertension and hasn't used any medication since her arrival. It may seem obvious, but backing up a moment to see what we already know can save valuable time in the exam room.

Some common health concerns may be diagnosed for the first time in your clinic. This can be an opportunity to lead not just to quick health turnarounds but also to a strengthening of the patient-provider relationship. Seeing a responsive, knowledgeable, and culturally competent provider, the patient feels the provider understands what they've been through — and will be more willing to try a medication for the newly diagnosed diabetes or to begin taking in a new HIV diagnosis and thinking through a treatment plan. Patients recovering from trauma often have experienced prolonged loss of control. I try to allow the patient to be in control as much as possible. I also make sure I'm providing eye contact, warmth, and a kind demeanor. I often learn some greeting in the language of

my patients, which goes quite far at putting people at ease.

In my exam room, questions about assault are not asked unless symptoms are suggestive. I ask quietly and with eye contact, "Why are you here today?" I allow them to make the choice of what they want to talk about. I never ask about sexual assault, but I maintain space for patients to bring it up if they feel comfortable. Headaches are often a common ailment, so I may feel driven to ask of there's a history of head trauma, a common history among asylum seekers.

For either newly diagnosed or previously diagnosed concerns, we may be able to make considerable health progress in a short amount of time. Such a health win can mean a great deal to a patient who has struggled for a long time and, in his or her new position as an asylum seeker, feels powerless and stuck in other parts of his or her life. By pinpointing a health problem and establishing a plan together wherein the patient can make measurable progress, the patient can feel more in control and hopeful.

## 2. Make the basic tests routine at the first visit.

With all new clients, I screen for Hepatitis B and C, HIV, and diabetes, and other conditions as indicated. Most patients like my approach during which we "check for everything," because they feel well cared for and often find comfort in the results. Some patients are reluctant, claiming they have not engaged in behavior that would result in some of the health concerns for which I am screening. I assure them that I screen all new patients — this is not a special test just for this patient — and often, because it's billed as a routine new patient check, this satisfies any concerns. Of course, the final say is up to the patient. Among traumatized patients like asylum seekers who have survived torture, I emphasize to patients that they are ultimately in charge of their bodies, and I am there to support their health. This can run contrary to our medical training, but can go a long way in building the trust relationship and in avoiding re-traumatizing the patient. For a patient who rejects an HIV test, I tell them to just tell me when they are ready.

For those who have experienced sexual assault, knowing the results of the tests — positive or negative — can provide some much-needed relief so they can begin to move on. One patient from West Africa came to me, severely depressed and suicidal. The key to moving him toward recovery was his first visit to the doctor. I checked him for everything, with his consent. To his relief, he

was HIV negative. He had a mild case of Hepatitis B that did not require treatment and he did not have liver damage. After we talked about his results, he was able to open up, about being raped, about torture. Immediately, upon getting a better understanding of his health — in fact, getting a better bill of health than he expected — he could begin to envision a path forward to healing.

While I do encourage most basic tests from the beginning, I do not do a pap smear during the first visit. For many women, this can feel too invasive, too foreign, and very traumatizing. I work up to pap smears. I only do a pap smear when a patient tells me she is ready and feels supported enough to do so. I make sure to tell her that she can stop at any time — she remains in charge of the encounter. It often takes many office visits before a patient is ready for the pap smear.

Conversations around contraception can be very difficult as well. Sexual abuse, relationships split by migration, and new relationships add many layers to the conversation. In my practice, I have seen vulnerable patients with precarious housing or work situations who were sexually harassed by a person of power. I try to address such concerns fully, which includes help with preventing unwanted pregnancy.

I remind myself that I cannot solve everything in a 15-minute visit, but I can show patients that the door is open for them. On a future visit, they can bring up contraception, or their back pain, or other concerns. Maybe the questions of sexual assault won't come up for the first five visits — and that's okay. I also try to ask questions. Most of my patients are from Africa. I recently had a new patient from India, and I had no idea what the conditions were like in his hometown, what he may have experienced, so I simply asked. Of course, I also make sure that new patients are linked to mental health providers as an essential next step for their care — another way of recognizing that not all can be completed during the primary care visit.

### 3. Document any physical or emotional scars you uncover.

At the very first visit, it is important to note any scars, wounds, depression, mismanaged medical conditions, or other evidence of torture-related injuries such as limited range of motion of joints and broken or missing teeth, as patients may need this documentation as evidence in the future. It only takes a few moments to make relevant notes on patients' charts about complaints of headaches that may be related to being beaten, or about the PTSD or other psychological concerns the patient exhibits. During future appointments, or by the time the patient has his or her asylum case hearing, some of this physical evi-

dence may have already faded, so it's important to do this early on. Such documentation can be important for any new migrant — those coming out of detention, newly arrived immigrants, or migrants who are passing through. It doesn't have to be extensive — just capture what it looks like that day: does the scar look like a cigarette burn? Was the patient crying?

### 4. Don't assume anything.

As part of giving the patient greater control over the patient-provider interaction, I try to ask very open-ended questions, allowing the space and time for patients to tell me why they are here. I don't barrage them with questions. In fact, I avoid even simple questions like, "Do you have a wife? Do you have children?" Such specific questions can be traumatizing for a patient who has left a

The Substance Abuse and Mental Health Services Administration outlines the six key principles, "rather than a prescribed set of practices or procedures," for a trauma-informed approach:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

family behind in a dangerous situation. I do not assume anything about patients. I cannot assume that what they tell their lawyers or their case manager is what they tell me as the provider. One client had visited several doctors, and didn't want to go back. After a long and open conversation, she revealed that she was raped and she never told any of her previous providers. This reinforced my careful approach to her care, wherein we only moved forward at a pace that she felt comfortable.

### 5. Long-term trauma-informed care means uncovering and treating the many layers of trauma, stress, and suffering.

Patients arrive with serious trauma from their home countries — but the story of trauma doesn't stop at the border. New trauma from their time in detention and from encounters with crime in their new US communities are not uncommon. Ongoing stress and serious life events, which can be upsetting and disruptive for all of us, may for a traumatized patient retrigger their symptoms. One patient's long-term recovery was going well, until she got into a minor car accident. While she didn't sustain any injuries, the accident brought to the surface the memories of torture that she was previously able to manage.

Another patient's mother died in Africa, and he was unable to be with his family, to grieve together. These type of events can manifest in the primary care office in their bodies — stomach aches, headaches. One man came in with back pain, but when trying to uncover the source, I learned that a family member had recently been abused as retaliation for him fleeing. Primary care is a not stigmatized as compared to mental health specialists' offices — and consequently many of these issues of trauma are presented in the primary care setting.

Primary care providers can play a tremendous role, not only in providing comprehensive primary care and documenting abuse and torture, but also by advocating for patients' needs and family. Patients who are seriously ill may be eligible for an expedited asylum hearing. I wrote a letter for a patient suffering severely from brittle diabetes and succeeded in moving up his hearing so he could focus on recovery. Similarly, if a family member of an asylum seeker is in jeopardy, I can write a letter to immigration to move things forward. A five-year-old deaf child of an asylum seeker had no access to services. Consequently, the child had no communication with his family, no special education, no hearing aid. I successfully argued that the family needed to be reunited so the child could get basic needed services to function in the world. A doctor's note can really make a difference.

There's also a big role for providers to help those who are detained in the US and denied medical care. I'm currently working on a case of a man with inadequately treated seizures who is in ICE custody. Shockingly, many detainees have serious and unmet health needs, in facilities in our homestates. To me, this is intolerable — and I'm looking forward to working more on this issue and helping more people access the care they need.

Trauma-informed care means providing comprehensive and compassionate care, and many of our patients need this approach — not just asylum-seekers, but many recent immigrants or migrants in our communities.

Read more at SAMHSA's Trauma-Informed Approach page: <https://www.samhsa.gov/ntic/trauma-interventions>.

### Resources:

Read MCN's Behavioral Health page at: <http://www.migrantclinician.org/issues/behavioral-health.html>.

Watch Migrant Clinicians Network's Archived Webinars on Behavioral Health:

Trauma-Informed Care: Behavioral Health in the Primary Care Setting,

<http://www.migrantclinician.org/toolsource/resource/trauma-informed-care>.

Learn more at [www.HealTorture.org](http://www.HealTorture.org).

# Chemical Safety on the Job

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

Shortly after Marta began her job cleaning hotel rooms around two years ago, she began having trouble breathing. She assumed it was part of getting older, and perhaps because she didn't exercise, and ignored it, until recently, when cleaning even just one hotel room made her short of breath. When her primary care provider diagnosed her with chronic obstructive pulmonary disease, she was shocked — her grandfather, who smoked daily, had COPD. She had never smoked. With no training on chemical safety and limited access to protective equipment like face masks, Marta did not know she was at risk for respiratory illnesses from the cleaning products she used that contain substances such as irritant aerosols and bleaching agents.

Maintenance and cleaning workers are one group of workers that is regularly exposed to chemicals on the job, and those workers' health is at risk without proper training and protection. Earlier this year, Alma Galván, MCH, Senior Program Manager for MCN joined co-facilitator Leslie Diaz, LMSW, MCN's Health Network Associate and Coordinator of the Austin, Texas Ventanilla de Salud, to train Austin-area community health workers on chemical safety and workers' rights and responsibilities among specific groups of workers, including hotel cleaners, as part of MCN's Chemical Hazards and Hazard Communication in the Workplace project.

"There are lot of different factors that can lead to illness and injury from chemicals in the workplace," Galván noted. "Workers are often not trained. They may also not feel they need to wear personal protective equipment — like gloves and masks — because it interferes with their ability to do the work fast." Hotel cleaners, for example, are under pressure to clean a set of rooms over a specific period of time, leading workers to increase their speed and, at times, also increase their risk. Such work pressures, lack of chemical safety communication, and lack of protective equipment are common among restaurant employees, farmworkers, landscapers, and construction workers as well. Compounding the risk are language barriers and cultural divides.

MCN's new wide-ranging and geographically diverse project, supported by the Susan Harwood Training Grant Program of the Occupational Safety and Health Administration (OSHA), seeks to equip workers like Marta to prevent work-related chemical illness and injury. Minority workers, particularly Latinos, are overrepresented in high hazard



industries like agriculture and construction. Many of these hard-to-reach workers encounter occupational risks. Many have not received health and safety training and have fewer workplace protections than workers in other industries. This project addresses chemical safety and hazard communication to alleviate some of that risk among those who use chemicals like cleaning agents and pesticides.

## Far-Reaching Effort

MCN is utilizing our nationwide network of Community Health Workers, our partnership with the Ventanilla de Salud, and our longstanding relationships with Puerto Rican health centers to assure a broad reach throughout the country. Galván and Diaz's first in-person training took place at Austin's Ventanilla de Salud, a program housed within Consulates General of Mexico in each of the 50 states that provides health resources, counseling, and referrals to local health services. That training came shortly after a nationwide webinar in which Galván and Diaz provided a virtual chemical safety training for health promoters at Ventanilla offices around the US. In April, MCN headed to Dallas for a national meeting of Ventanilla coordinators, where they elaborated on topics first covered in the January webinar.

"The Ventanilla is such a key point of information dissemination for the Spanish-speaking community, as many consider consulates an extension of their homes," Diaz explained. Diaz will continue to bring chemical safety to the Austin Ventanilla, providing ongoing trainings in the coming months directly to local workers and

employers. "These employees are what keep our infrastructure going. This is why it is so necessary that we work to keep important safety information in their hands," Diaz emphasized. "We are one part of a system that helps them maintain their health for themselves and for the community at large."

Concurrent with the Ventanilla trainings, Amy K. Liebman, MA, MCN's Director of Environmental and Occupational Health, joined Galván for in-person trainings in Puerto Rico. Using a "train-the-trainer" model, 20 community health workers were provided with similar in-depth trainings on chemical safety and communication to then go and train workers across the island.

"Our work in Puerto Rico and our commitment to the island's workforce builds on MCN's deep partnerships with community health centers and groups across the island," Liebman said.

At our partner Ventanilla de Salud in Austin and with our partner health center, Hospital General Castañer, in Puerto Rico, outreach workers and CHWs will offer area workers health and safety trainings. In all, MCN plans to reach a total of 800 CHWs and workers this year, strengthening skills to negotiate risk in the workplace, minimize chemical exposures and stay safer on the job.

## Communicating the Risk: What We Share With Community Health Workers

MCN focuses on how CHWs can communicate the risk and help workers minimize their

continued on the next page

exposure. Part of the challenge for workers is identifying the risks. There is a wide range of chemicals, each of which may come in a variety of forms (gas, liquid, or solid). The routes of exposure to chemicals vary. Additionally, each worker will have a different level of risk based on their body size, age, and gender. A woman of childbearing age or a child whose brain is still developing are more susceptible to chemical exposure, and a female or young worker — or a worker who may bring chemicals on their clothing back to a family member of this sort — may need greater protection to avoid health consequences of exposure.

MCN trainers discuss the hierarchy of controls for occupational safety when explaining ways minimize the risk of exposure. The most effective way to minimize risk is to eliminate it, rarely an immediate option for workers. Substituting the chemical for one

that is less toxic, emphasizing engineering controls to avoid exposures, and offering administrative controls such as access to safety data sheets and worker safety training are part of the hierarchy. Use of personal protective equipment is also stressed.

“In many workplaces, the total elimination of chemicals is rarely a possibility, but exposure can be minimized with safety training and proper and regular use of PPE,” Liebman said.

The MCN training also covers rights and responsibilities for both employees and employers. Part of the CHW training is to help workers understand what their employers are required to provide in terms of chemical safety. Throughout the trainings, an emphasis is placed on empowerment of the worker. “Employees in all industries have ‘the right to know’ — to know about the chemical risks in the workplace,

with information provided in their language,” Galván asserted. ■

## Resources:

MCN’s recent webinar, “It’s Your Right to Know! Helping Community Health Workers Promote Chemical Safety on the Job” is archived:

In English: <https://goo.gl/FYNJmu>  
In Spanish: <https://goo.gl/y18E2a>

MCN’s Bilingual Picture Dictionary, “Seguridad en Palabras/ Safety in Words,” illustrates workplace hazards and best practices for health and safety in agriculture is available at <http://bit.ly/2lwtEk5>.

MCN’s numerous environmental and occupational health resources are available at <https://goo.gl/PpNXu7>.

Ventanilla de Salud’s website is <http://ventanillas.org>.

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recommendations. The guideline addresses: 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. The Guideline is downloadable online at <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>.

### Avoiding Repeat Prescriptions Across County Lines

Some regions have implemented Prescription Drug Monitoring Programs (PDMPs). I use Pennsylvania’s PDMP to assure I make clinically appropriate decisions. Pennsylvania’s system was recently expanded to include Maryland and Delaware prescriptions, which is particularly relevant for mobile patients who may have last seen a doctor in another state. Some evidence indicates that the use of PDMPs helps reduce “doctor shopping.” Each state’s PDMP may differ, but use of the PDMP is important for mobile patients. According to the Prescription Drug Monitoring Program Training and Technical Assistance Center, 49 states, the District of Columbia, and Guam all have operational PDMPs. Their maps, state profiles, and FAQs can assist clinicians further in understanding how the PDMP works in their states: <http://www.pdmpassist.org>.

Despite the use of such drug monitoring programs, there is very little information that passes to the primary care physician if their patient has recently overdosed. There are no mandates for EMS or police to provide a report to the primary doctor on the use of Narcan to reverse an overdose in the field or on the way to the hospital. The ER physician may get a verbal or written report, but often patients are revived outside a medical facility,

### The Other Opioid Crisis

A commission of The Lancet recently published their report on global use of opioids, which describes how just 0.03 percent of morphine-equivalent opioids distributed in the world each year go to low-income countries. The commission concludes that the lack of global access to pain relief and palliative care is a global crisis of its own: “The fact that most patients, poor patients in particular—including many poor people in high-income countries—are denied access to such an inexpensive and powerful intervention is a medical, public health, and moral failing.”<sup>1</sup>

1 Knaul F, P Farmer, E Krakauer, et al. Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: the Lancet Commission report. *Lancet*. 12 October 2017. DOI: [https://doi.org/10.1016/S0140-6736\(17\)32513-8](https://doi.org/10.1016/S0140-6736(17)32513-8).

### Encountering Addiction and Providing Treatment

Unfortunately, many patients with prescriptions for opioids may be addicted. Attempting to take into account the many challenges that opioid addiction may present in a patient’s life is difficult, and is why so many remain without sufficient support to beat addiction. Mobility brings more complications that a clinician should take into account. Being mobile and having in one’s possession a significant number of narcotic medications, even if legitimately obtained

through a clinician, may look suspicious when being questioned by police or immigration officials, and put the mobile poor at some real or imagined legal risk. With mobile patients who may be away from family and other emotional support for months at a time, behavioral health may be another concern to fold into the patient encounter. Indeed, many of the barriers that affect mobile patient care in other realms — language, lack of sufficient health care coverage, irregular appointments at new health centers after every move — complicate care for opioid addiction as well.

In managing opioid use disorder among mobile patients, clinicians in the exam room need to adjust their addiction strategies to take into account a patient with a mobile lifestyle, who may be unable to take part in outpatient programs or other counseling opportunities over time, as they may find themselves moving again before a program can make a lasting impact. Some successful strategies for addicted mobile patients include:

- Health Network: MCN’s bridge case management assures timely and accurate records transfer for mobile patients: <https://www.migrantclinician.org/services/network.html>
- SAMSHA’s Treatment Services Locator: The Substance Abuse and Mental Health Services Administration hosts three important search tools that allow clinicians to assure that a patient can continue treatment even if she or he has to move: <https://www.findtreatment.samhsa.gov/>
  - Buprenorphine Treatment Practitioner Locator
  - Methadone Treatment Program Locator
  - Behavioral Health Treatment Services Locator



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**calendar**

**May 18 - 20**  
**National Latino HIV and Hepatitis C Conference**  
San Antonio, TX  
<https://www.latinosandhiv.org/>

**May 30**  
**Webinar: Manejo del paciente con hipertensión durante emergencias: experiencia de Puerto Rico durante y después del huracán María**  
Migrant Clinicians Network  
<https://www.migrantclinician.org/webinars.html>

**June 7 - 9**  
**North American Refugee Health Conference**  
Portland, OR  
<http://nasrhp.org/north-american-refugee-health-conference-3>

**June 16 - 18**  
**North American Refugee Health Conference**  
Toronto, Canada  
<https://www.northamericanrefugeehealth.com/>

**June 18 - 21**  
**13th Summer Institute on Migration and Global Health**  
Oakland, CA  
<https://goo.gl/dKntP4>

**June 24 - 27**  
**School-Based Health Care Convention**  
Indianapolis, IN  
<http://www.sbh4all.org/>

**August 26 - 28**  
**NACHC Community Health Institute & Expo**  
Orlando, FL  
<http://www.nachc.org/conferences/chi/>