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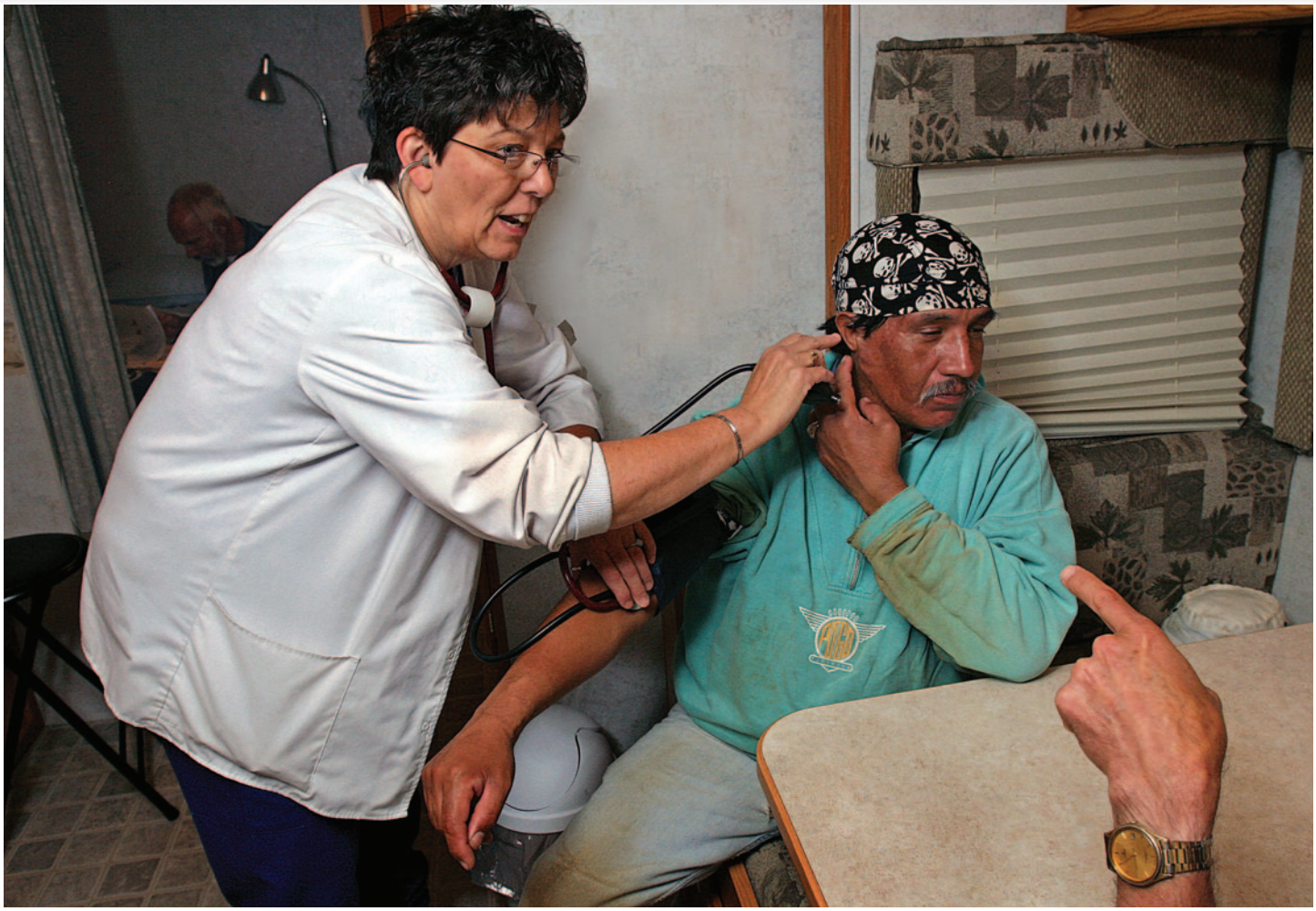


Best Practices in Interpretation

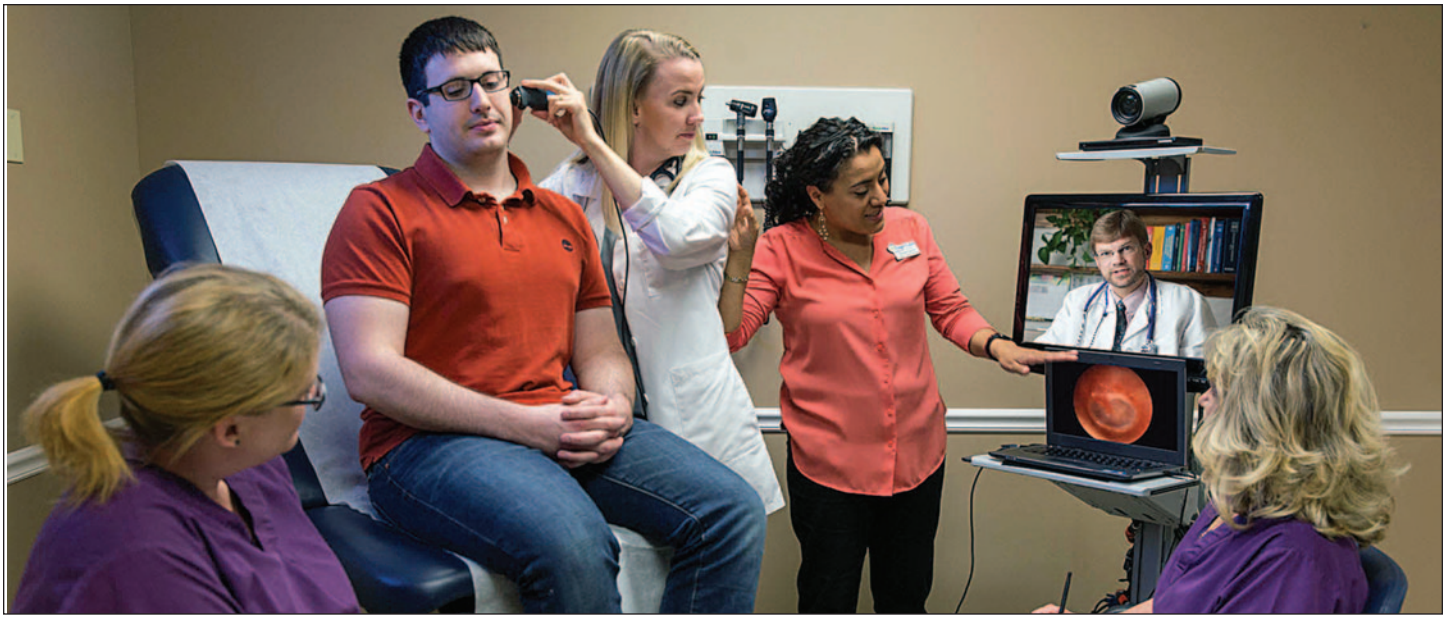
By Ed Zuroweste, MD, Founding Medical Director, Migrant Clinicians Network

Often, to connect with interpretation services, a clinician must call the interpretation line, provide name and service contract number, and wait for connection. Those three or four minutes that it takes to connect with the interpreter could be used for other work with the patient – but it's worth the wait, because medical interpretation shouldn't be left for family and friends, if at all possible.

For example, a patient came into the ER who had just moved to my community from a nearby state and had secured employment in the kitchen of a local restaurant. He had been quite ill, with a cough, weight loss, and persistent fever. One day, he passed out in the kitchen, and his new friend who also worked in the restaurant took him to the ER. This patient was from Guatemala, and he did not speak English well, but his friend, who was from Mexico, spoke fair English. The doctor in the ER asked if the friend could interpret for him, and he said yes.

The ER doctor asked a number of questions. He asked, "Have you ever been exposed to TB?" The friend interpreted this question to the patient. Perhaps because of stigma, this patient decided to answer "no," because he did not want his new friend to know about his past TB exposure. The patient was admitted to the ICU, where he was treated for a severe pneumonia; one lung was a total whiteout. After three days, they discharged him. A few days after that, results returned that he had active tuberculosis. When I called him, I spoke to him in

continued on page 10



Courtesy of Finger Lakes Community Health

The Virtual Medical Home at Finger Lakes Community Health

By Claire Hutkins Seda, Associate Director of Communications, Migrant Clinicians Network

In rural upstate New York, a farmworker heads to the nearby primary care clinic. After check-in, a medical assistant helps him log in with his psychiatrist in the exam room. While the clinic can't afford to have specialty care in-house, they are able to provide it via telehealth. Instead of driving 45 minutes to get to his appointment, he could reach the provider just a few minutes from his house. And with the cover of the primary care clinic, he can avoid the stigma he was concerned about, around access of mental health care.

A family couldn't bring a child in to the pediatric neurologist because of the time off from work and school required to drive for regular appointments, so the neurologist came to them – virtually, in their home. After the medication adjustment made during an after-school appointment, the school reported that the child is doing better academically.

Virtual care via telehealth was given a significant boost during COVID, but some community health centers have embraced telehealth more than others. At Finger Lakes Community Health, the virtual medical home has been a key aspect of their care for over a decade, as the health center's administration pushed forward telehealth options years before most health centers considered the approach – serving hundreds of patients like the farmworker needing mental health care, and a local child in connecting with a neurologist.

"We saw the virtual health center as an additional site to offer services for our patients," explained Mary Zelazny, Chief Executive Officer at Finger Lakes, so as early as 2008, she and her team pushed forward specialty care telehealth at their rural clinics, wherein patients could enter the clinic but be seen by a specialty care clinician, who may be hours away in another clinic, through the clinic's telehealth equipment.

She saw that private practices could bill for telehealth, but community health centers could not – and started to push back. While some limited services were covered, telehealth services were limited by location. After long-time dedicated advocacy, in February 2019, New York State changes its rules, allowing the health center system to bill for telehealth regardless of where the patient was. Finger Lakes clinicians went immediately to work linking rural patients to specialty care that they would otherwise forgo – and the efforts proved particularly beneficial for agricultural workers who had trouble getting to clinical sites.

Then COVID hit.

"We were in good shape because we'd been doing it," Zelazny said. "We already had developed our programs. We were using a HIPAA-compliant platform. We

Data Collection and QI/QA

"We're going to continue this work – so we need to be able to document everything correctly, and be able to show our payers… and show legislators, that this is the impact that we are [making]," Garcia said. Finger Lakes closely monitors its telehealth outcomes to ensure providers are following compliance requirements, correct codes are used, etc. For their policy push in New York, Finger Lakes tracked their patients with HPV using telehealth versus in-person services, to demonstrate impact and saved costs. "Each telehealth program at Finger Lakes Community Health (FLCH) has a registry of quality metrics based on clinical standards of care," Zelazny said. "By tracking each element or metric around particular chronic disease or condition, FLCH is able to test the benefits of using technology to address those barriers that a patient might encounter that impedes improved outcomes."

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weren't just willy-nilly turning on the camera – we were very careful from day one." Even with their telehealth head start, there were hiccups, as providers settled in to providing care at home, and some patients struggled to download the app for their virtual care platform. With subtle differences in the platform depending on how the patient accessed the appointment, whether by cell phone, tablet, or laptop, clinicians struggled on their own to direct patients through. Finger Lakes developed a support team of telehealth specialists – two IT employees, one manager, and one nurse – to support clinicians, and to call patients before their appointment to get their tech in good shape before the provider logged on.

With this COVID-necessitated telehealth revamp, migrant agricultural workers weren't left behind – in fact, they were ahead of the curve, Zelazny insisted. Providers told her that "the ag workers were a lot more comfortable with video. We think that's because people were already using Snapchat and WhatsApp to talk to people from home," Zelazny noted. "They already knew not to move the camera around – they just had a bit more etiquette with the video component. The providers loved having video calls with them because they didn't get motion sick!"

As COVID funding wanes and clinics return to regular in-person appointments, some health centers have scaled back their virtual operations. That's a mistake, says Sirene Garcia, Finger Lakes' Chief Innovation Officer. She sees telehealth as an important way to advance the patient-centered medical home, by bringing primary and specialty care into the same virtual room, for patients who otherwise could struggle to access both. She gives the example of an HIV patient.

"We encourage our providers to sit in on those [specialty care] visits," she said. The providers share their concerns and talk through the patient's care plan with each other. "Where else could you have primary and specialty care happening at the same time? And we're able to pull in [support] for other diseases, like not just HIV but [if the patient] is diabetic as well, [we can] bring all of the folks together and look as a team… to better support" the patient, Garcia said. Of course, reimbursement for such simultaneous encounters can be tricky, but a value-based care model enables clinicians to prioritize the virtual team approach, even when the team is spread out across clinics.

This approach doesn't just serve the patient – it can lead to growing clinician competence. For example, HIV care was initially not incorporated into primary care. "Fast forward a few years, and it is [now] done in primary care. But when that came about, our providers said, 'that's great, I'll just take a few courses and I'm comfortable' – because they had been sitting in on those visits… because they were the hands and ears for those specialists," during telehealth visits.

It's also an important retention tool. "It's a career builder, to help our providers have connection with others. Some of our health centers are very small – it can be just one provider. Here, we're building space for them to talk" with other providers.

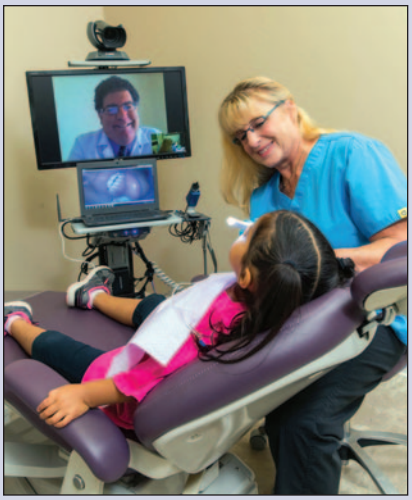
Retention is achieved not just at the provider level, but across the clinics. Finger Lakes now employs people in five states – because many don't need to be in the brick-and-mortar clinic. "We're increasing our workforce catchment area," by offering work-from-home opportunities, Garcia noted. "People have moved and we tell them, you can still work for us," Zelazny says. Finger Lakes is expanding these efforts, with a virtual receptionist program in the works.

With the myriad benefits for patient, provider, and support staff at the clinic, Garcia envisions a growing virtual health center offering, with "one-click access to our health center." She also envisions not just providers but the entire team working virtually – including financial advocacy and social support for concerns like housing. She'd also like to see more offerings to patients in the home, like increased home visits and shipments of home monitoring equipment like glucometers or blood pressure cuffs. Newer technology can improve home monitoring and make such equipment easier to use for patients.

Garcia believes that with this model, Finger Lakes will best serve patients like agricultural workers who have trouble accessing care otherwise. Her ultimate goal: to "keep pushing the bar, to see how much we can replicate via video that's done in person," so that the clinic comes to the patient, rather than the other way around.

Visit Finger Lakes Community Health: https://www.flhealth.org/

Telehealth Policy



Courtesy of Finger Lakes Community Health

Mary Zelazny, Sirene Garcia, and their team at Finger Lakes pushed New York State for better policy to enable telehealth reimbursements at New York community health centers. Each state has unique rules around telehealth including around payment, Medicaid, school-based telehealth, and more. The Center for Connected Health Policy (CCHP) monitors the telehealth policy landscape state by state, and acts as the National Telehealth Policy Resource Center funded by the Health Resources and Services Administration (HRSA). Under that designation, they provide technical assistance to twelve regional Telehealth Resource Centers, state and federal policy makers, and health systems developing or expanding their own telehealth capacities.

Mei Wa Kwong, JD, Executive Director of CCHP, has been watching telehealth initiatives coast to coast as COVID's temporary telehealth waivers expire. Will health centers still have the same telehealth opportunities? "It's a mixed bag for clinics," Kwong said. "They have to consider: are their patients covered by Medicare, Medicaid, out-of-pocket, or a commercial payer?" Each insurance provider will provide different – or no – payments for telehealth. For example, if a state's Medicaid program does not currently reimburse for telehealth-delivered services, a clinic that has primarily Medicaid patients may have difficulty funding a telehealth program. But clinics with patients with a diversity of payment structures, and clinics especially motivated to provide telehealth due to their patient population, can make it work financially, especially as more policies around telehealth reimbursement are adopted. Each state has its own rules, and many states are presently considering legislation on advancing telehealth. CCHP has tools on its website to find those rules, and track pending regulation and legislation.

Center for Connected Health Policy provides primers on and tracks telehealth policy: https://www.cchpca.org/

National Consortium of Telehealth Resource Centers can direct you to a local resource center: https://telehealthresourcecenter.org/

Pain Management and Opioids

A Migrant Clinician's Perspective

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

Purdue Pharma introduced Oxycontin in 1996, the year that I graduated from my Family Medicine residency. At the time, drug representatives visited our hospitals and clinics frequently to update us on the latest pharmaceuticals. Our new crop of doctors was given the marketed information that this sustained oxycodone preparation was less addictive than traditional opioids, in fact almost non-addictive compared to then-available short-acting narcotic pain medications. It was originally targeting cancer pain, and I admit that it was very helpful in that regard as metastatic disease from various cancers can cause terrible pain. The marketing was successful for Oxycontin and sales for 1996 were about $48 million, and by 2000 about $1.1 billion as the indication for use of Oxycontin expanded to cover many types of non-cancer pain, even minor pains which once were handled by such medications as acetaminophen/codeine and ibuprofen. A wider audience learned of strong effective and "safe" synthetic opioid medications such as Oxycontin and later fentanyl for chronic pain and more direct consumer advertising bypassed the physician's office as social media allowed more targeted advertising to groups formed with specific disease interests.

Unfortunately, the marketing materials were wrong. These highly addictive synthetic opioids are now the center of an ongoing drug addiction epidemic.

Since 2013, drug overdoses involving synthetic opioids, particularly fentanyl, have skyrocketed. The CDC estimates that in the United States, 187 people die every day from an opioid overdose, including prescribed and illicit opioids.

The opioid addiction crisis has only worsened over the course of the COVID-19 pandemic. Between 2015 and 2019, there were 13.7 opioid overdose deaths per 100,000 people on average each year, climbing slowly from 2015's 10.4 to 2019's 15.5 deaths per 100,000 people. The first year of the pandemic, however, saw 21.4 deaths per 100,000 people – a shocking 38% jump in overdoses from 2019.[1] Provisional data from 2021 indicates a 15% further increase in opioid overdose deaths from 2020.[2]

Social isolation increased the risk of addiction or relapse, as people found themselves cut off from support systems, both informal, like friends and family, and formal, like addiction recovery programs and facilities, or methadone and clean needle programs. Increased fear and anxiety — from social isolation, rapidly evolving economic and health situations, and the disruptions in everyday behaviors and routines – may also have contributed.

The connection between COVID and opioids, however, goes further. People with a current substance use disorder are eight times more likely to contract COVID than those without a substance use disorder. They are also more likely to be hospitalized or die from COVID.[3] Many factors may be influencing this increased risk. Opioid use may cause respiratory depression with every use.[4] People using opioids start a COVID infection, consequently, with potentially impaired lung function.

For migrant agricultural workers who may use opioids, this increased risk is further elevated by the social determinants of health which they face. Poor occupational protections and rights, fear of immigration status, poverty, and a lack of access to sources of low-literacy, culturally appropriate information on how to stay safe contribute to a higher risk of COVID infection.

Disparities in Pain Management Among Agricultural Workers

There is presently no clear evidence that opioid misuse is a concern among this population; however, repetitive use injuries and chronic pain are common among agricultural workers. Agricultural work continues to be one of the most dangerous occupations with very high rates of injury.[5] Clinicians serving migrants report that agricultural workers

often do not have their pain well managed. Cultural cues around gender and age may discourage some from reporting pain or seeking care. For those who wish to seek care, cultural or linguistic differences, lack of health insurance, poverty, lack of paid time off of work, and fear of exposing immigration status are just some of the barriers they may face to receiving care.

For those who attain care, racial disparities in pain treatment are well documented. One study of Emergency Medical Services in Oregon found that Hispanic patients were 21% less likely to receive a pain assessment procedure or receive pain medications compared to white patients. In fact, disparities in receipt of pain medications were observed for all non-white patients, compared to white patients.[6] One meta-analysis synthesized 20 years of studies to find that Black patients had the highest degree of disparities in pain care, and that Hispanic patients had disparities for management of "non-traumatic/nonsurgical pain."[7]

Solutions to Care Disparities and Substance Abuse

The recognition of unconscious bias by clinicians can be an important first step in its elimination, along with mentorship, cultural humility and curiosity, meaningful diversity trainings, and leadership commitment to culture change.[8] Such steps can reduce racial disparities in pain management.

Clinicians serving workers who are in pain may have little education on substance abuse. One national survey found that less than 20% of primary care physicians considered themselves "very prepared to identify alcohol or drug dependence."[9] One key solution to ensure that clinicians are responsibly addressing pain is culturally competent education for clinicians to develop a level of comfort in the treatment of substance abuse.

A team-based approach can enhance the patient's care, increasing opportunities for a patient to connect with a clinician, and providing a multifaceted approach to the patient's pain. The involvement of community-based organizations can further connect the patient to auxiliary services to better manage pain. For those with opioid abuse issues, these same approaches can expand access to programs specifically geared for those with substance use disorders.

Pain Management with Analgesics that Are Non-Opioid

It may be appropriate to prescribe opioids for acute pain under certain circumstances, but most situations call for the use of other analgesics including nonsteroidal anti-inflammatory drugs (NSAIDs), given our greater understanding of the addictive qualities of opioids. Clinicians should explore these opportunities with their patients. Many medical organizations have come out in support of such measures – the American College of Physicians supports the use of NSAIDs for the treatment of low back pain; the American Headache Society suggests using combination medicines such as acetaminophen (Tylenol) with aspirin and caffeine as a primary recommendation for reducing migraine pain and other symptoms; the American College of Rheumatology Osteoarthritis Guideline strongly recommends topical and oral NSAIDs to treat arthritis pain and it conditionally recommends against the use of opioids other than tramadol.[10]

Many opioid addictions start with a few weeks' supply of prescription opioids after dental surgery, with the first feelings of euphoria with analgesia ever experienced by an opioid-naïve patient. Non-opioid analgesics such as NSAID/acetaminophen combinations are safe and effective first-line options for managing acute dental pain according to the American Dental Association.

These are important factors for clinicians to consider when weighing the pros and cons of prescribing pain medications, in contrast to the past 25 years, when clinicians were taught to consider opioids as a first, effective, superior, and safe option for pain control. This could be an important step clinicians can take to help reduce the burden of suffering opioid addiction in our patients, and the cost to our nation's health.

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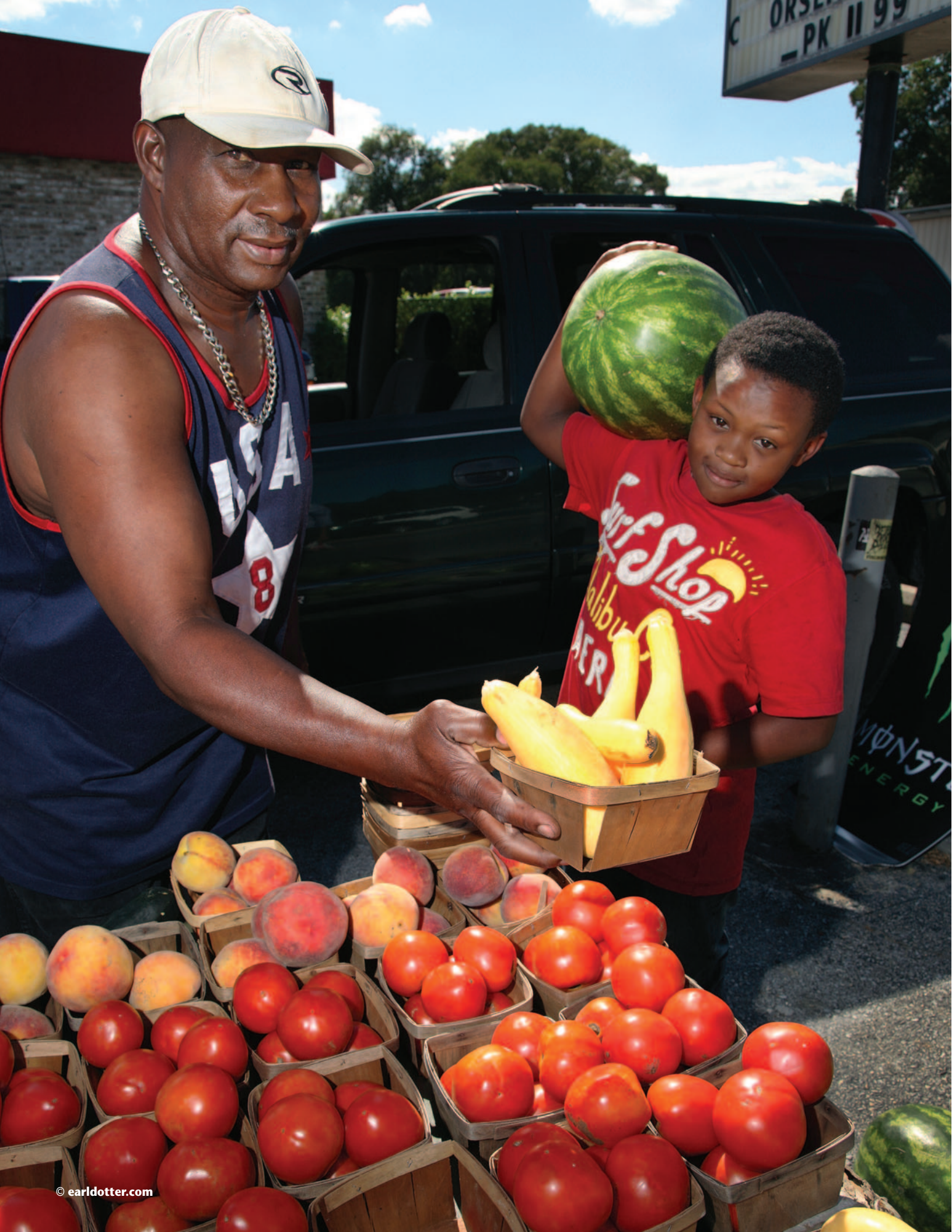
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Food Insecurity During COVID: A Perspective from WIC

By Claire Hutkins Seda, Associate Director of Communications, Migrant Clinicians Network

Food insecurity among migrant and immigrant agricultural worker families has grown in the last three years, as economic impacts and uncertainty, physical and social isolation, political rhetoric and policy, and a lack of a financial cushion left many unprepared to meet their families' food needs during the crisis. While numerous studies show that food insecurity increased in the pandemic's first years among the general population,[1] few studies examine the food insecurity specifically among migrant agricultural workers in the US. One study found that 37% of surveyed Californian farmworkers experienced food insecurity during the first year of the pandemic.[2] Of course, many of these families experienced food insecurity before COVID; a 2007 study of migrant and seasonal agricultural workers along the US-Mexico border found that 82% of surveyed households reported food insecurity.[3]

As most migrants to the US are from Mexico, the Caribbean, and Central and South America, Latinx families may serve as a proxy. Before COVID, Latinxs had the highest rate of food insecurity compared to other races and ethnicities.[4] Numerous studies have found that Latinx households were more vulnerable to the economic shocks of COVID than the general population, due to pre-existing economic, social, and health disparities.[5,6] Latinx households were disproportionately affected by COVID's economic stressors and consequently endured greater food insecurity.[7]

To address COVID-induced food insecurity, the federal government increased supplemental food benefits for low-income households and funded free lunches for all children. Some states like California are continuing the free-lunch funding, but many COVID programs are winding down. Yet, many of these programs proved effective in addressing the ongoing and worsening food insecurity issues among vulnerable people. The federal government is now stepping up outreach for its programs, such as the US Department of Agriculture (USDA) Food and Nutrition Service (FNS)'s Special Supplemental Nutrition Program for Women, Infants, and Children (WIC),[8] to address these issues.

WIC helps low-income pregnant and breastfeeding women, and their children

continued on page 8

Moving to Whole Grain

WIC influences grocery and convenience store practices, as tens of thousands of women use WIC benefits – and stores vie for their business. As a science-based nutrition program, WIC bases its "food packages" – what they call their food offerings, like bread, vegetables, and beans, that WIC participants can purchase — on studies that demonstrate that WIC will increase the nutrition of the low-income families that rely on the program. In 2017, in response to a congressional act, the National Academies of Science, Engineering, and Medicine (NASEM) completed a scientific review of WIC food packages, after which they presented recommendations to update the food package to bring it in line with nutritional science.

One of the recommendations was a transition to 100% whole grains for the breakfast cereals and other products that WIC recipients can purchase. Whole grain products contain more fiber and minerals than their processed equivalents. Fiber-rich and intact foods like whole grains, vegetables, and beans can help prevent and/or reverse numerous chronic diseases, including heart disease,[13,14] diabetes,[15] and cancer.[16] Since 2017, as a result of the NASEM recommendation and in anticipation of a possible change in WIC food requirements, many cereal companies have retooled their formulas to meet the 100% whole grain designation. A move to whole grains can support families in making healthy choices to reduce the chronic diseases that disproportionately affect Latinx communities. Proposed updates[17] to the WIC food packages based on the 2017 NASEM report will be shortly released by the USDA and open to public comment.

Read NASEM's 2017 recommendations:
https://nap.nationalacademies.org/resource/23655/WIC-highlights.pdf

 continued from page 7

under the age of five, to get high-nutrition foods and health care during these critical years in children's development.

Alberto Gonzalez, Jr., Senior Advisor for External Engagement at FNS, shared that "more than half of all eligible [individuals] are not enrolled in WIC – there's an enrollment gap…WIC advances equity, because we don't all have access to healthy foods." Under WIC, mothers take part in nutrition screenings, and then are provided with a benefits card to purchase basic healthy items like whole grains, peanut butter, fruits, vegetables, and beans. WIC takes into account cultural preferences by defining food categories but not specifying the products required – for example, whole-corn corn tortillas may be purchased as a whole grain option under the program. "Providing more variety and choice accommodates the diverse needs of WIC participants, including different ethnic or cultural needs," specified 2018's WIC Food Package Policy and Guidance.[9]

In late September 2022, the White House Conference on Hunger, Nutrition, and Health convened for the first time since 1969. At the conference, the Biden Administration unveiled a blueprint to end hunger and to reduce diet-induced chronic disease. The blueprint calls for reestablishing free school meals nationwide, among other strategies.[10,11] Gonzalez believes that these federal initiatives will boost nutritious food intake and consequently increase health equity. "What's important is the work after that conference," Gonzalez stated. "There are opportunities to collaborate with different programs [with] equity as the focus." ■

Food Insecurity and Ultraprocessed Foods

Food insecurity does not equate to poor access to food. Oftentimes, families lack access to healthy, nutritious foods – either because they are unavailable or expensive compared to their ultraprocessed and nutrient-deficient counterparts. In rural areas, fresh food may be hard to purchase despite proximity to farms. Many agricultural workers shop at convenience stores that are located on the way to work and open during the late hours after work. Many foods like muffins, energy and granola bars, and sports drinks masquerade as healthy, but in fact contain numerous additives or preservatives. These ultraprocessed foods "hook our brains and overwhelm our biology because they contain unnatural combinations of fat and carbs along with sodium and other flavor enhancers," says one recent Washington Post article. As a result, consumers of ultraprocessed food in one study consumed more and gained weight, even though the ultraprocessed and unprocessed diets provided to study participants contained similar amounts of fat, sugar, sodium, and fiber, and everyone was allowed to eat until satisfied.[12] To properly address food security, healthy and unprocessed whole foods must be made available – and presented through culturally appropriate promotion.

Resources

Visit the National WIC Association for resources, advocacy, and events regarding the WIC program: https://www.nwica.org/

Read the National WIC Association's issue brief on "Closing Nutrition Disparities: Boosting Whole Grain Intake to Strengthen Health Equity" at https://s3.amazonaws.com/aws.upl/nwica.org/ whole-grain-rich.pdf

Read the Salud America! article, Advancing Health Equity for Latinos Through WIC, which features numerous resources specifically for Latinx communities: https://salud-america.org/advancing-health-equity-for-latinos-through-wic/

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Supporting Clinician Well-Being Through Comics

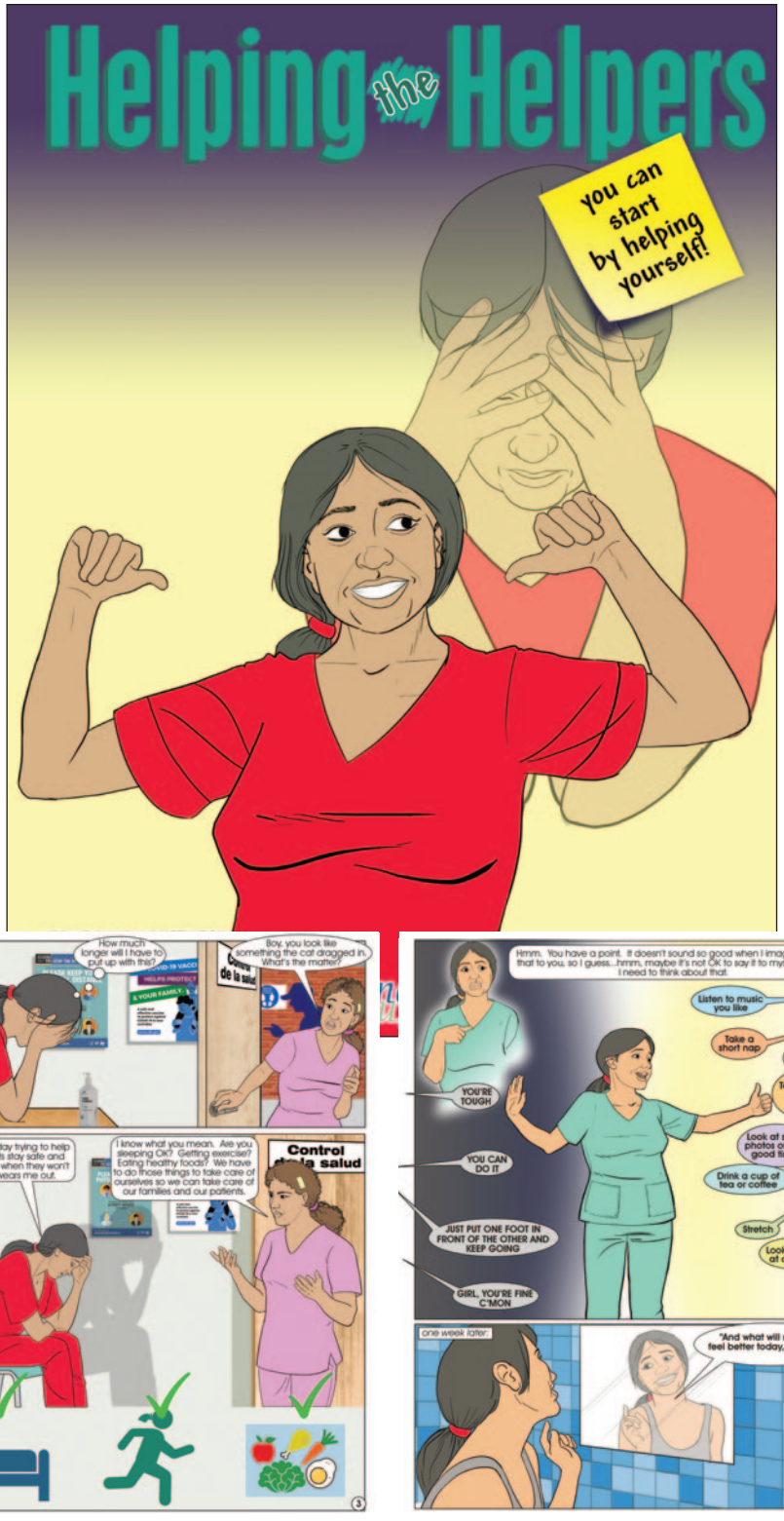
By Pamela Secada, MPH, Program Manager, Witness to Witness, Migrant Clinicians Network

Almost three years into the pandemic, clinicians continue to face challenges as they witness the hardships and trauma their migrant agricultural worker patients have endured, as the pandemic bared down hardest on those already facing health challenges and access issues.[1,2,3] Witnessing the preventable health disparities that these communities experience because of economic and social inequities, weighs heavily on these clinicians. But clinicians like community health workers — who have a strong connection to the communities they serve, including migrant agricultural worker communities – often lack resources to support their own well-being in the midst of the suffering they see daily.

Because of the close connection, community health workers sometimes shoulder additional burdens. The fine line between their personal and professional life and the stress and heaviness of the work cause feelings of guilt when thinking of their own well-being.

Migrant Clinicians Network's Witness to Witness program provides culturally and linguistically appropriate resources to help clinicians cope during difficult and challenging times. Our latest resource is an eight-page comic that takes us through what clinicians like community health workers experience when they forget to take care of themselves. The comic is short and filled with bright colors, making it accessible and easy to read. The comic is currently available in English and Spanish at the Witness to Witness webpage: https://www.migrantclinician.org/resource/helping-helpers-comic-book.html.

This resource is one of many that Witness to Witness has developed specifically for clinicians during the pandemic. Access numerous resources, many in English and Spanish, at the main Witness to Witness webpage: https://www.migrantclinician.org/w2w.



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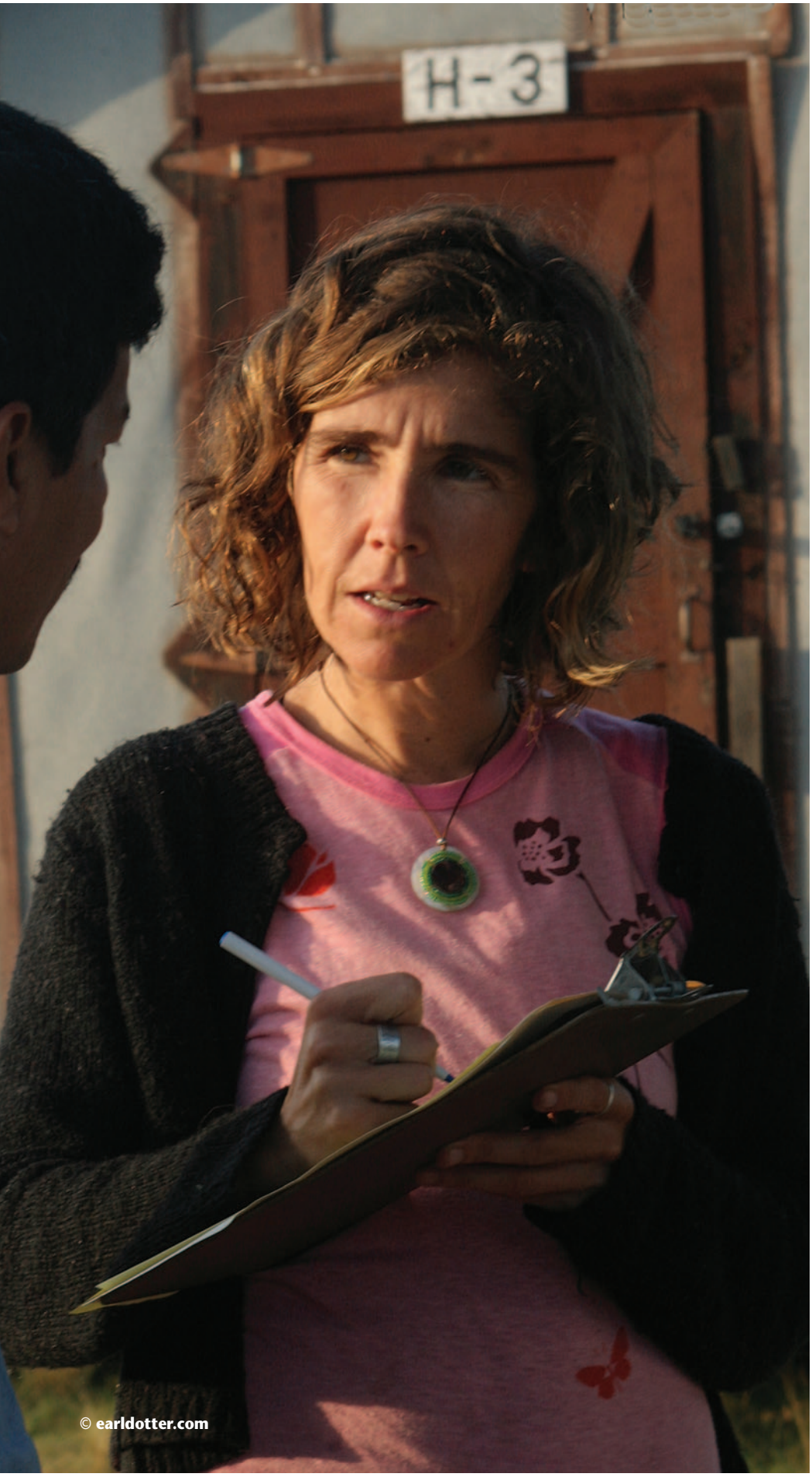

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Best Practices in Interpretation

continued from page 1

Spanish. I introduced myself as a doctor with the state's Department of Health and asked how he was doing.

The first thing he said to me was: "I hope I don't die of TB."

Upon further questioning, the patient confided that his uncle had died of TB the year before, and he had taken care of him before his death in Guatemala. Then, after he and his brother moved to the US, his brother had been diagnosed and treated for TB in another state.

I consulted his records; in the ICU, a pulmonologist noted, "history per ER interpreted." No other interpreted history had been taken than what the friend from his work had provided.

Situations like this one are all too common. Without official interpretation, the medical history may miss key components. When a daughter is interpreting for the patient, a gynecologist might not ask the same questions about sexual behavior and STIs, or the mother will not confide that the pregnancy was the result of rape. Or, the nuances of the question may be left out or misunderstood, when the interpreter's English or other language is not sufficiently strong.

To get the most out of interpretation, here are some best practices to follow:

1. Use interpretation – even when the patient speaks English fairly well. As you know, medical language requires nuance and vocabulary that an interpreter can easily provide. It's worth the extra minutes.
2. Don't forget that the friend who offers to interpret might not speak the second language as strongly as they suggest. Clinicians here in the US can generally quickly evaluate a patient's English language skills, but cannot evaluate a volunteer interpreter's command of the second language to be used in the exam room. This is another benefit of taking advantage of interpretation services.
3. Consider the culture. Interpretation can be difficult in cultures where certain personal health topics are not frequently broached or for which there is a strong stigma in that culture.
4. Encourage the entire team to use interpretation services. During intake and vitals, patients who are left without interpretation may feel that their care is not as high priority as for English-speaking patients. If the handoff between the team and the clinician is instantaneous,

continued onnext page

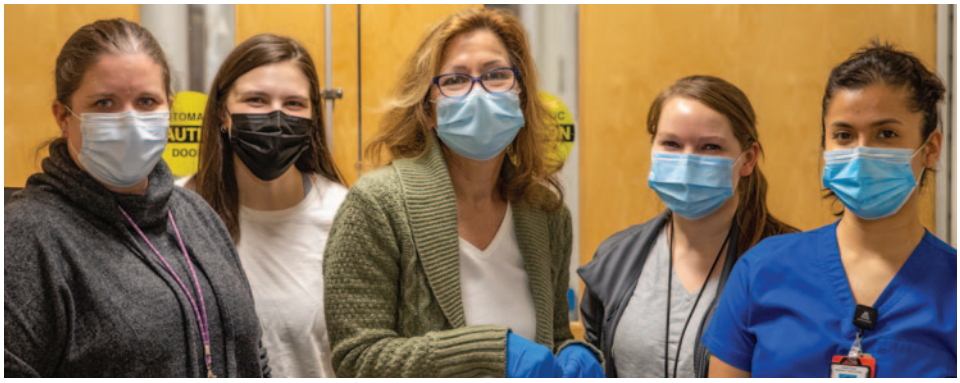
 continued from page 10

then the interpreter can stay on the line, saving the initial set-up minutes.

5. Talk to the patient, not the phone. When asking a question, make eye contact when culturally appropriate. This helps you build a relationship with the patient, who can register your friendly warm smile, or read your concerned body language. It will also encourage the patient to do the same, to look at the clinician instead of the phone when speaking.
6. Read the patient's body language. Similarly, when the interpreter is talking to the patient, the clinician can pick up very important communication – did the patient respond with a feeling of comfort and warmth? Did the patient begin to shake her head, cross her arms, furrow her brow? Then the clinician can follow up after that question and ask, "It appears that you were upset by that question. Why?" Or another question that takes into account their emotional response.
7. Use the "teach back" technique whenever possible. Follow up to make sure the patient understands by asking if they have questions and asking them to repeat back what you have shared. When using an interpreter, because of the extra time taken to have each sentence in two languages, this step can too often be left off when it is a critical step to ensure the patient understands.
8. Check in with family members. If there are others in the room, be sure to ask if they have questions as well, to weigh in on the patient's treatment and ensure full buy-in by everyone in attendance.
9. Break the rule when it may be to the patient's advantage. In an extreme emergency when vital history may be lifesaving, use whoever you can to get the necessary history. Or, on very rare occasions, a family member who offers to interpret may have recently completed treatment for the health concern that the patient is considering. In this case – while also taking into account culture, language level, and confidentiality – having the family member interpret may act as a selling point.
10. When stuck with non-professional interpretation, lay down the ground rules. In a refugee camp or in an emergency situation outside of the exam room, tell the person who has accepted interpreting duties to repeat exactly what is said. For example, start by saying, "Please introduce yourself to the patient and let them know you will say everything that I am going to say. Please let me know if there are things you feel uncomfortable translating and I can try to reword." Make extra sure, in this case, that your communications are clear and jargon-free.

Interpretation is only getting more complex. In one recent case, a nurse made a home visit, where she and the patient video conferenced with me as the doctor on one device, while calling the interpreter on a second device. But this four-way call was successful: the patient got the care she needed, in her language of choice, at home. As care gets more complicated, interpretation must be built into the changing workflows and technology platforms. It can be cumbersome and time-intensive – but it also lifesaving and ensures the patient gets the most out of their visit. ■

Call for Editorial Board Members



Migrant Clinicians Network is looking for new members for the editorial board of *Streamline*. Editorial board members support the Editor-in-Chief and Managing Editor by reviewing and providing content-related commentary on articles relevant to their expertise in each quarterly issue of *Streamline*. Editorial board members are given roughly 1.5 weeks for turnaround. Before delivery to the editorial board, *Streamline* is reviewed and copy edited internally at Migrant Clinicians Network.

The eligibility criteria for this appointment include the following:

1. Demonstrated scholarly expertise and leadership in any one of the subject areas pertinent to *Streamline*: migrant agricultural worker health; environmental and occupational health of migrant or other underserved workers; clinical services in health centers; emerging health issues in relation to marginalized populations; outreach and other non-clinical services to migrant, agricultural worker, or other marginalized populations.
2. Published work on relevant topics in a peer-reviewed journal.
3. A commitment to journalistic excellence which prioritizes the delivery of information and topics in a factual, unbiased manner.

Editorial board members commit to a two-year term, and may serve multiple two-year terms upon the approval of the Editor-in-Chief.

For a full description of the editorial board member position or to apply, please contact Claire Hutkins Seda at: cseda@migrantclinician.org or 512-579-4533.

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

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Migrant Clinicians Network
P.O. Box 164285
Austin, Texas, 78716
Phone: (512) 327-2017
Fax (512) 327-0719
E-mail: cseda@migrantclinician.org

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calendar

November 14-16, 2022
2022 PCA & HCCN Conference
Fort Lauderdale, FL
https://www.nachc.org/conferences/pca-hccn-conference/

November 17, 2022
Strategies to Address Health Inequities Exacerbated by the Climate Crisis
MCN Webinar – Virtual
https://www.migrantclinician.org/webinars/upcoming

November 17, 2022
National Diabetes Prevention Program (NDPP): Family Engagement in Public Housing Communities
Learning Collaborative Series
National Nurse-Led Care Consortium
https://bit.ly/3DMJJc5

November 18, 2022
Special & Vulnerable Populations COVID-19 Forum Series
National Training and Technical Assistance Partners
https://bit.ly/3DAzHuo

December 4-7, 2022
IHI Forum
Orlando, FL
https://www.ihi.org

December 6-8 and 13-15, 2022
COSHCON 2022
Virtual Conference
https://nationalcosh.org/COSHCON2022

December 13-15, 2022
IHI Forum
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