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

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REBECCA RAMON
NATIONAL CENTER FOR FARMWORKER HEALTH
1770 FM 967
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calendar

National Farmworkers Health Conference
May 8-9, 2013
San Diego, CA
National Association of Community Health Centers
www.nachc.com

National Worker Health and Safety Conference
December 11-12, 2013
Baltimore, MD
National Council for Occupational Safety and Health
www.coshnetwork.org

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Clinician Orientation to Migration Health Series
Migrant Clinicians Network

Patient Centered Medical Home for Patients on the Move
June 12th, 2013 1-2pm EST

Women's Health and Migration
July 17th, 2013 1-2pm EST

Quality and Meaningful Use in Migration Health
August 7th, 2013 1-2pm EST

To register for one or all of these go to
http://www.migrantclinician.org/orientation

MCN **streamline**
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The Migrant Health News Source

Where have all the clinicians gone?

Candace Kugel, FNP, CNM, MS

One of the most persistent struggles encountered by Health Center Program grantees is the effort to find and keep good clinicians. In working with grantees, Migrant Clinicians Network hears concerns about the difficulty of attracting well-trained clinicians who are compassionate and passionate. We also monitor trends that contribute to the challenges of recruitment and retention of primary care clinicians. MCN has developed tools and resources that support grantees in maintaining their clinician staffing goals. This article discusses current challenges and strategies in clinician recruitment and retention, highlighting valuable resources that can be used by health center program grantees.

THE CHALLENGE

While many clinicians actively seek work with underserved patient populations, it can be difficult to recruit to a setting that is remote, understaffed, and clinically challenging. HRSA-funded health centers have always competed with hospital systems, private practices, training programs and other settings to attract clinicians to their locations. Other factors in the ever-changing healthcare landscape which contribute to persistent clinician vacancies include the following:

- Some research points to increased vacancies for physicians, nurse practitioners,

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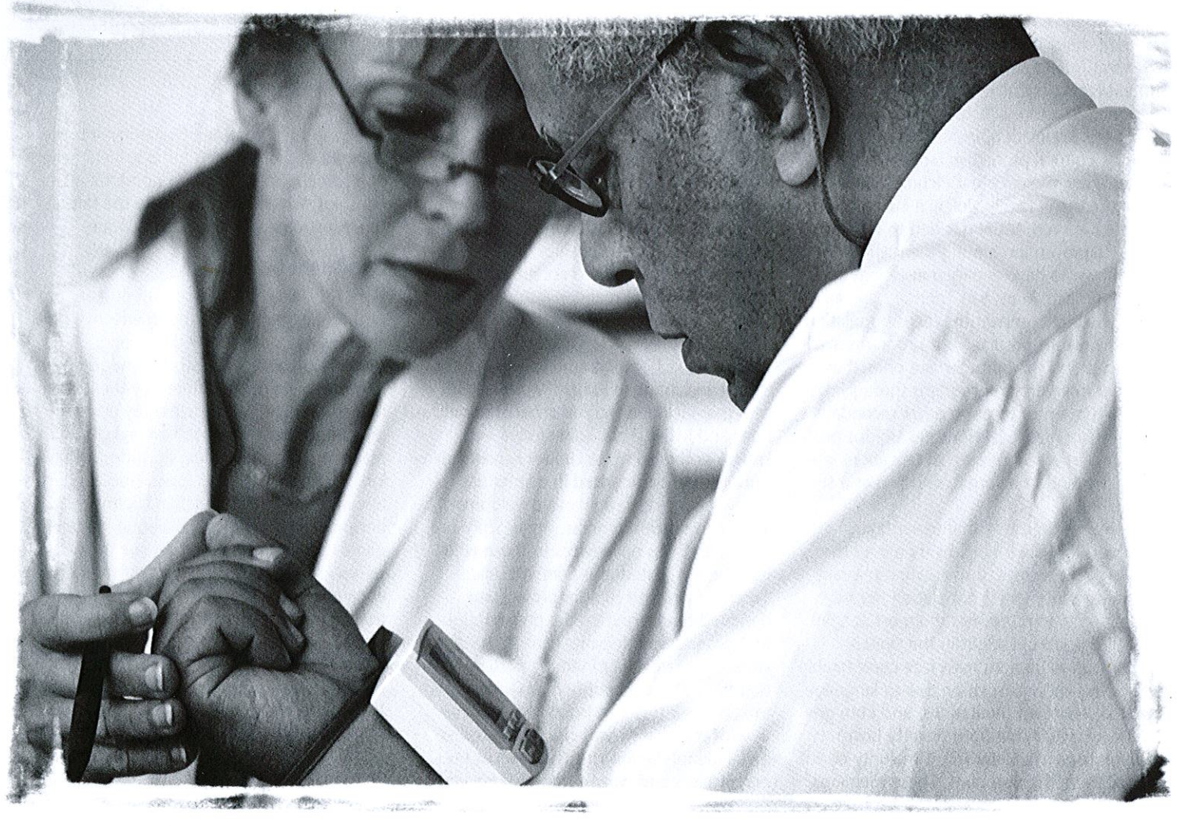
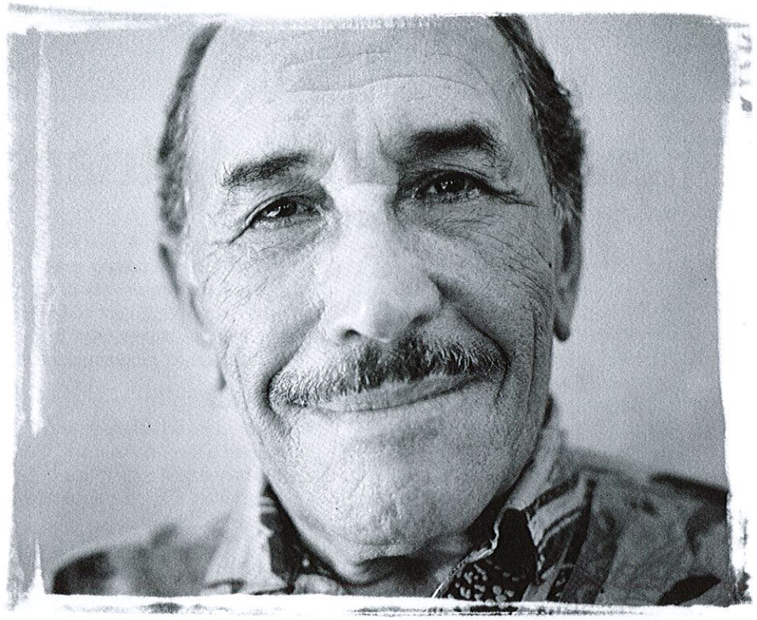


Hombres Unidos Provides Critical Primary Prevention Services

Adrian Velasquez; Candace Kugel, CRNP, CNM; Jillian Hopewell, MPA, MA and Deliana Garcia, MA



Since 1990 MCN has developed a strong foundation of work in family violence prevention. Early programs focused on educating and empowering women to confront this issue. Materials for clinicians to use in screening for domestic violence and identifying services for women who may be in danger were also developed by MCN. After a number of years in this field, it became apparent that there was a paucity of resources for working directly with migrant men to prevent violence.

Beginning in 2005, MCN discovered, through field research with migrant men at various locations throughout the United States, that approximately 60% thought rape was a big problem in their community and 67% thought partner abuse was a big problem; 77% of the men surveyed stated they would like to help prevent rape and partner abuse in their community.[1]

Over the next year MCN worked with experts across the country to design an intervention strategy specifically targeting migrant men. The intervention, called *Hombres Unidos Contra la Violencia Familiar (Men United Against Family Violence)*, was designed to address factors that most often affect this population, including: language, literacy, cultural protective factors and importantly, the risks that victims face.

Unlike many family violence interventions directed at men, MCN decided to focus on violence prevention among men who were not known to have engaged in violent acts. This approach, known as "primary prevention," is able to impact the focus population before violence occurs. Most programs available to Latino migrant men are offered as batterer intervention programs through the judicial system or through other secondary and tertiary methods. Hombres Unidos provides a safe space for men to talk about violence prevention before it is known as a serious issue.

Hombres Unidos is an intervention designed for Latino migrant men over the age of 17. It focuses on the Latino migrant and recent immigrant population because this population represents the most socially isolated group of Latinos in the United States. Latino migrant men face considerable social and cultural isolation due to language barriers, economic limitations, and immigration concerns. Aside from poverty being a predominant characteristic, a majority of this population is foreign born. These men are adapting to a migration (mobile) lifestyle as well as trying to assimilate into a U.S. lifestyle. This suggests that many internalized norms and values from their countries of origin persist while in this country, such as male-dominated relationships, and the socialization that women accept or tolerate abuse as a form of male privilege and that abuse is thus not recognized as a grave act.[2]

Hombres Unidos was designed through an intensive collaboration among experts in the Sexual and Intimate Partner Violence (S/IPV) field that included victims' services organizations and MCN. This collaborative body, known as the Hombres Unidos Leadership Consortium, participated in a literature review, program design and development, and an evaluation process. While S/IPV projects often focus on services to those who have been violated, the *Hombres Unidos Contra la Violencia Familiar* project was designed to incorporate the presumption that program participants have no history of violence in familial or intimate partner relationships. This presumption allows the men to keep their focus on building a positive view of masculinity and gaining a positive social identity amongst their peers as non-perpetrators and worthy contributors and leaders in their community. Participants are not criticized or shamed for long-held beliefs or past behaviors regarding domestic relationships, which helps to create the safe space instrumental to group dialogue.

PROGRAM DESIGN:

Hombres Unidos is a five-session primary prevention intervention. Through effective partnerships and community organizing, *Hombres Unidos* engages Latino migrant men in group dialogue, facilitated by their peers, to learn about S/IPV together. By using a peer educational approach wherein Latino males explore knowledge, attitudes, behaviors, and beliefs (KABB) about intimate partner violence (IPV) and define healthy relationships through group dialogue, participants take ownership of the issue themselves, gain the skills and vocabulary to encourage others to develop healthy relationships, and become advocates against IPV. The *Hombres Unidos* curriculum is the result of a five-year program focused on *Preventing Sexual and Intimate Partner Violence within Racial/Ethnic Minority Communities*, initiated by the Centers for

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Disease Control and Prevention.

Men are recruited to the program by male health *promotores* (community health workers). These *promotores* are familiar with the local population and are known in their communities for their knowledge of education on other health issues. Viewed as peers and community members, the *promotores* recruit 10-15 men per workshop. Taking the geographic and social isolation of Latino migrant men into consideration, the program usually takes place in participant living quarters or community gathering areas where access to the location is easy and reliable transportation is not needed. Confidentiality is discussed and agreed upon and 'house rules' established to create an appropriate environment for emotionally charged topics. Participant retention is encouraged by having the workshop participants decide upon a meeting time.

Hombres Unidos was developed to incorporate protective factors against violence perpetration present within the Latino culture. Hoffman[3] cites many of them, including placing family needs above one's own, cooperating with others through teamwork, respecting authority figures, and valuing interpersonal relationships more than material gain or status. *Hombres Unidos* goes beyond this, incorporating language and literacy considerations in its design. It is dialogue-based with few printed materials. Literacy is not presumed. The printed materials, including evaluation tools, incorporate images and color schemes to minimize any discomfort by low-literacy participants.

Participation in *Hombres Unidos* is offered to Latino migrant men of any sexual orientation. The content of the curriculum and the discussion environment allow groups to have unrestricted discussions about any intimate partner relationship. Confidentiality agreements and house rules agreed to by all participating group members facilitate a safe space for open discussion without the pressure of disclosing relationship status.

Each session lasts two hours, with activities and discussion in which each participant has the opportunity to contribute. Each participant attends every session and is given a certificate for completion during the fifth session as well as a small gift (usually a $10 gift card) to celebrate his achievement with family members.

Each session presents new topics and information for the participants. Session one broadly covers the topic, "Male Socialization." During session two, "Defining Violence and Abuse," men discuss different forms of violence. Session three, "Power and Violence," guides the men in understanding the role that power, or the lack of power, has in contributing to violence and abuse. During session four, "Developing Tools and Skills to Prevent and Respond to Violence," each participant collaborates with his fellow workshop participants to develop techniques to prevent violence at a personal level and within their community. For session five, "Promise & Celebration," participants are asked to invite guests to celebrate their completion of the workshop. During this final session, men are asked to make a public promise to not condone or tolerate violence in their community.

CREATING THE PROGRAM:

The initial development of the program operated on the presumption that men would be unwilling to engage in a frank discussion of interpersonal behavior. A second potential barrier was the expectation that it would be difficult to find male *promotores de salud* willing and able to engage peers on these issues while retaining the participants for five sessions. To address both of these potential barriers, MCN selected project sites that had functional male *promotores* already recognized and trusted by the men of the community and who had basic training in health promotion and group education. This strategy allowed the program to focus on content and evaluation. Small incentives for participation were offered (snacks during the sessions and a $10 phone card for completion).

Funding from the Centers for Disease Control and Prevention (CDC) in 2005 made initial implementation possible. Three locations capable of field testing the male *promotores* training model were identified and selected as implementation sites for *Hombres Unidos*. Staff from these sites formed an Advisory Council to inform staff and the Leadership Consortium about the realities of the program occurring on-site. The sites identified local resources for in-kind gifts of space and equipment as well as sources for snacks and beverages for participants.

After the initial launch, ongoing implementation has been made possible by support from the Office on Violence Against Women and by organizations that approached MCN for replication. The most current iteration of the curriculum is being implemented in New Mexico, Pennsylvania, Texas and Washington. Further collaborations are part of MCN's strategic communications plan and funding sources are being sought for expanded curriculum implementation.

EVALUATION

MCN has used several methods to evaluate the intervention and outcomes using both process and outcomes evaluation. In 2010, the Robert Wood Johnson Foundation selected *Hombres Unidos* for RWJ's "Strengthening What Works Initiative," to strengthen the evaluation of program activities that focus on prevention of intimate partner violence in immigrant and refugee communities in the United States. MCN has improved the evaluation capacity of the *Hombres Unidos* curriculum and has a strong understanding of the successes as measured by quantitative and qualitative data.

After every session, facilitators fill out a facilitator survey form. This analysis tool provides an understanding of participant involvement during each activity. Facilitators are asked to identify and describe activities that were the most and least successful. Observations on participant behavior and behavioral change are also measured using this survey.

A pre- and post-session survey instrument is incorporated as an activity during the first and fourth sessions. The survey is read aloud to the participants as literacy levels are unknown and not assumed. Participants mark their responses on individual surveys using color schemes to assist with possible literacy limitations. For example, the answer options are a green oval marked "Yes" for agreement and a red oval marked "No" for disagreement in response to the idea or situation that is read to them. Using this level of evaluation, MCN is able to analyze and measure changes in participants' KABB. From 2007 to 2010, each workshop reflected statistically significant KABB change in the positive direction for participants. From the original 12-question survey one question asked "If your friend was hitting his partner, would you tell him that this was unacceptable behavior?" Out of 309 overall participants, 56.63% said that they would intervene when surveyed prior to participating in *Hombres Unidos*, while 79.29% said they would speak up after the *Hombres Unidos* intervention, demonstrating significant change.

Beginning in 2012, MCN conducted follow-up interviews in which MCN spoke with previous workshop participants, facilitators and facilitator supervisors. During one of those interviews, Susan Bauer, the Executive Director at Community Health Partners in Illinois, a 2007-2010 implementation site, stated, *"One of our current Board members was a facilitator for Hombres Unidos when he was a promotor. He would always talk about how transformational it was. Not just for the participants but for him. It's such a great program!"*

Sandra Ortsman at Enlace Comunitario in

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Access to Healthcare for Immigrant Youth

Alexis Guild, Farmworker Justice

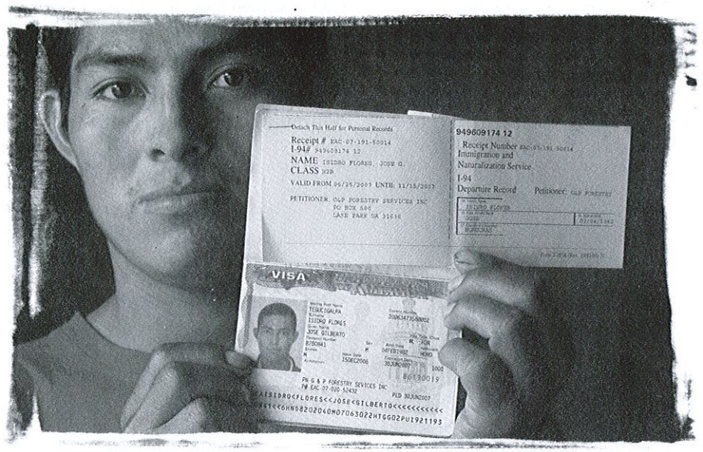

Photo courtesy of Earl Dotter

On June 15, 2012, the Obama administration announced an initiative known as Deferred Action for Childhood Arrivals (DACA). Deferred action will give certain undocumented youth temporary permission to remain in the United States for two years and to apply for work authorization. Although it neither provides a path to citizenship nor confers legal status, DACA can have a positive impact on access to healthcare for eligible farmworker youth.

Who is eligible for DACA?[1]

Not all undocumented youth are eligible for DACA. Applicants must be at least 15 years old (with an exception for youth who are in deportation proceedings or have a removal order), have arrived in the U.S. before they turned 16 years old, and be under age 31 as of June 15, 2012. They also need to have resided in the U.S. continuously for the five years prior to June 15, 2012, and must undergo a background check. In addition, applicants must either meet an education requirement (have graduated or obtained a certificate of completion from high school; obtained a GED; or currently be in school, which includes traditional secondary and post-secondary education and adult education and vocational education) or be "an honorably discharged veteran of the Coast Guard or Armed Forces of the United States."

How will it impact access to healthcare?

In general, DACA will positively impact farmworkers' access to healthcare. Immigrants granted deferred action, who previously avoided medical care due to their fear of revealing their undocumented status or fear of detention by law enforcement, may now be more willing to access healthcare for emergency or preventative care. Also, with valid work authorization and without the threat of deportation looming over them, farmworkers will be better able to avoid dangerous living and working conditions which contribute to poor health outcomes.

On August 30, 2012, shortly after the US Citizenship and Immigration Services (USCIS) began accepting applications for DACA, the US Department of Health and Human Services announced that DACA recipients will not be eligible for enrollment in Medicaid/CHIP or the Pre-Existing Conditions Insurance Program (PCIP),[2] the temporary government sponsored high risk insurance pool. Because DACA recipients are not eligible for PCIP, they will not be eligible to enroll in the state health insurance exchanges in 2014. DACA recipients are also not eligible for Medicaid/CHIP coverage under CHIPRA (Child Health Insurance Program Reauthorization Act of 2009), which allows states to provide coverage to expanded categories of children and/or pregnant women.[3] Due to these limitations in insurance coverage, those granted deferred action may continue to rely on health care providers who serve the uninsured as a primary source of preventative healthcare.

DACA and farmworkers

While the impact of DACA on farmworkers is not yet fully known, data from the National Agricultural Workers Survey suggest that an estimated 54,000 farmworkers could potentially qualify.[4] Even though many farmworkers have heard about DACA, there is a lot of misinformation about application costs and the application process itself. There are several challenges that may deter eligible farmworkers and their family members from applying for deferred action under DACA.

- *Proof of Continuous Residency:* As part of the application process, applicants must show that they have continuously resided in the US from June 15, 2007 to June 15, 2012. Although USCIS states that an applicant does not need to show proof for every month, obtaining documented proof for a five year period can prove challenging for farmworkers who may migrate with the harvest and have a limited paper trail.
- *Education:* The education requirement of DACA may be difficult for many farmworkers to achieve. Despite migrant education programs, farmworkers often lack access to educational resources. Frequent mobility, high poverty levels, and limited English proficiency as well as the limited number of adult education programs in rural areas make it difficult for farmworkers to obtain the minimum education requirements of a high school diploma or GED certificate.
- *Cost of Application:* The $465 fee for the DACA and work permit application is a significant financial investment for many farmworkers and their families. Few fee exemptions will be granted to applicants. To qualify for a fee exemption, the applicant must have an income less than 150% of the federal poverty level AND either (a) be under age 18 and homeless or without parental support, (b) have accrued $25,000 in medical expenses during the last year, or (c) have a serious chronic disability.

For more information about Deferred Action for Childhood Arrivals, please contact Alexis Guild at *aguild@farmworkerjustice.org*. You can also visit the websites of U.S. Citizenship and Immigration Services at *www.uscis.gov/childhoodarrivals* or Farmworker Justice at *www.farmworkerjustice.org*. ■

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Where have all the clinicians gone? continued from page 1

physician assistants and nurses as a result of the expansion of health centers under the Affordable Care Act.[1] Estimates are that the expansion of healthcare services under the Affordable Care Act has created a 38% increase in the need for primary care physicians from 2000 to 2020.[2]

- The supply of primary care providers in the United States, especially physicians, grows more limited as increasing numbers of specialists are trained.[3, 4]
- Primary care providers typically do not stay in the same position for the long term, so that staff turnover creates a need for health centers to be constantly recruiting.

RECRUITMENT AND RETENTION RESOURCES

While the real solutions to these challenges may lie beyond the domain of the individual grantee, their pressing task is providing services to a vulnerable and underserved population. To assist with that objective, following is a collection of resources and strategies that are new, recently revised or time-honored.

Recruitment and Retention Planning Tools:

Recruitment and retention of clinicians is typically overseen by the organization's Chief Medical Officer (CMO), with the assistance of the Chief Executive Officer (CEO), Human Resources Department and others. The Board of Directors needs to be kept informed of clinical staffing needs and plans.

- Start by taking MCN's online *Recruitment and Retention Self-Assessment Survey* at http://www.migrantclinician.org/survey/fillsurvey.php?sid=4. This brief questionnaire, revised in 2012, serves as a quick self-assessment for health center leadership to determine readiness for effective recruitment and retention of clinical staff and provides a score indicating the level of preparation.
- For more in-depth planning, use the MCN *Recruitment and Retention Review Tool*, online at http://www.migrantclinician.org/files/MCN-R&Rreviewtool_2012_0.pdf. This recently revised tool provides a roadmap for evaluating aspects of the organization that relate to clinician recruitment and retention and the development of an improvement plan. It includes the self-assessment survey mentioned above, as well as a Clinician Retention Interview tool.
- As part of self-assessment, the *National Health Service Corps Retention Calculator* at http://nhsc.hrsa.gov/currentmembers/membersites/retainproviders/ can determine retention rates within an organization.
- The National Association of Community Health Centers' *Recruitment and Retention Toolkit* is another guide for health centers to use in finding and keeping strong clinical staff. See http://www.nachc.com/client/documents/CLINICAL%20RECRUITMENT%20AND%20RETENTION%20TOOLKIT_final1.6.11.pdf
- Develop an organizational *Recruitment and Retention Plan* to define the need, goals and actions that will be undertaken. Sample plans can be found in MCN's Tool Box http://www.migrantclinician.org/toolsource/94/recruitment-and-retention/index.html, "Recruitment and Retention" under the "Human Resources" heading.

Recruitment Resources

- MCN has gathered links to a wide variety of recruitment resources in our Tool Box under the heading of "Professional Practice and Development." These include profession-specific (nurse practitioners, pediatricians, family physicians, etc.) job banks and recruitment services that relate to specific work settings (rural, regional, etc.).
- *The National Health Service Corps (NHSC)*, one of the primary recruitment resources for Health Center Program grantees, now allows recruiting sites to register online and conducts Virtual Job Fairs. For eligibility information and to register go to http://nhsc.hrsa.gov/corpsexperience/virtualjobfair/.
- Similar to NHSC, the *NURSE Corps Loan Repayment and Scholarship Programs* provides assistance to Registered Nurses and advanced practice nurses who work at Critical Shortage Facilities. For more information, see http://www.hrsa.gov/loanscholarships/nursecorps/index.html.
- Develop partnerships with clinician training programs to provide a ready pool of potential recruits. Serving as a clinical rotation site for students and partnering with residency programs through HRSA's *Teaching Health Center Graduate Medical Education Program* are examples of "pipeline" approaches to recruitment.
- Consult State or regional *Primary Care Associations* for information about other recruitment avenues such as state loan repayment programs or international medical graduates (*J-1 Visa Waiver Program*).

Retention Resources

- Focus on keeping your current clinical staff by monitoring their satisfaction. MCN's *Clinician Retention Interview* tool mentioned earlier can be used for that purpose. A similar tool is the *Stay Interview*,[5] which asks employees questions like "What do you like most about working here?" and "On a scale of 1 to 10, how would you rate your intention to leave?"
- Based on the needs and career goals of clinical staff, provide them with opportunities to teach, conduct a support group for patients, take unpaid leave to work internationally, job share, exercise midday, or work part-time. Remember that not everyone will be motivated by the same incentives or rewards.
- Cultivate an organizational culture and practice environment that reflects the organization's mission and quality healthcare. Clinicians who have strong leadership and a voice in decision-making are more likely to feel ownership in the organization and pride in their association with it.

While this article has focused on the challenges and difficulties associated with recruitment and retention of clinicians, HRSA-funded health centers have much to offer to dedicated clinicians who are interested in meaningful work. By seeking out those who are interested in working with multicultural underserved patients and providing them with the resources that they need to provide quality care, the organization, clinicians and patients will all benefit.

In this document, unless otherwise noted, the term "grantees" is used to refer to organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service Act, as amended. It does not refer to FQHC Look-Alikes or clinics that are sponsored by tribal or Urban Indian Health Organizations, except for those that receive Health Center Program grants. ■

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Border Health Innovations in Tuberculosis Management

Bertha Armendariz, MD

In 2005, an increase in the incidence of tuberculosis (TB) was noted in the northern Mexico state of Chihuahua. A total of 500 new cases were reported. This was reflected in an increase of Multi-Drug-Resistant TB in the neighboring U.S. state of New Mexico. This compelled the health authorities of both countries to initiate a binational health agreement.

Early in 2007, the New Mexico Office of Border Health (NM OBH) noted the importance of TB, which had for some time been affecting the residents of the border areas of Luna County, New Mexico, and Palomas, Chihuahua.

In that same year, NM-OBH with funding from the United States-Mexico Border Health Commission, initiated a three-year strategic plan titled "Public Health Plan for the County of Luna and Palomas, Chihuahua," focused on nine health topics of which tuberculosis was a priority.

This resulted in the signing of a bilateral agreement between the health authorities of Chihuahua and New Mexico to address issues of mutual concern.

In response to the strategic plan, the New Mexico Office of Border Health convened a meeting of decision makers from both sides of the border and various agencies interested in fighting TB. This meeting resulted in the establishment of the Binational Committee on Tuberculosis. The Committee held several meetings to develop the *Binational Pilot Project for the Monitoring and Control of Tuberculosis in the Border Region of New Mexico-Chihuahua.*

The proposal was sent to the United States-Mexico Border Health Commission to request funding. The commission funded the project, using Migrant Clinicians Network as the financial and technical agency in 2009.

MCN recently completed a summary of three years of activity for the *Binational Pilot Project for the Monitoring and Control of Tuberculosis in the Border Region of New Mexico-Chihuahua* for the period September 1, 2009 to August 31, 2012.

This project took place in the state of Chihuahua, Mexico, an area that is 100% rural, hard to access, geographically extensive with communities distant from each other and where the incidence of tuberculosis is high. The health infrastructure is limited and migration is high due to proximity to the United States' border along New Mexico.

During three years of intensive work, the project established its own infrastructure and coordination with the hiring of a local coordinator, the acquisition of computer equipment, the search for office space within Chihuahua's Jurisdiction No. 5, and the strengthening of the communication between the project and key public health officials of the State of Chihuahua. The training of the coordinator and staff, as well as the creation of a memorandum of understanding between the authorities of both countries, was an integral part of the initial work.

Promotional billboard to educate the border population about TB.

A technical committee was formed, and included the director of the Sanitary District No 5, the Chief of Epidemiology, the Project Coordinator, the Director of the Office of Border Health in New Mexico and Chihuahua, and MCN.

The Jurisdiction and the Mycobacteria Program of the State of Chihuahua worked jointly in the intensive search of active cases and contact investigation, using purified protein derivative PPD, chest X-Rays, and sputum samples to perform bacilloscopies and cultures. All of these were done according to the Mexican treatment protocols. Once an active case was identified, the project followed the patient with MCN's TBNet program and with home visits for the administration of treatment in conjunction of the DOT nursing network (Directly Observed Therapy).

A total of 47 cases were supervised by the project, starting with 16 patients in treatment and reaching 31 patients in the last year. A total of 2,231 home visits were done.

New adherence strategies were implemented for patients with high risk of abandoning treatment, Multi-Drug Resistance, and Co-morbidities. The first strategy was the use of food incentives, which not only contributed to better nutrition for the patient but put the responsibility of taking the medications on the patient, who had to comply in order to receive the food.

Another strategy was the implementation of home visits. Home visit nurses gave personal attention to the patient and established a warmer and closer relationship that was an important factor in the patient's willingness to continue and finish the treatment.

A significant component of the program was to provide education about tuberculosis to three target groups: patients, clinicians and the general public. The following summarizes the educational approaches taken with each of these three groups:

- **Patients:** Through lectures in strategic places like rehabilitation centers, nursing homes, health fairs, and individual visits, instructions were provided to patients and relatives. Emphasis was placed on prevention and transmission of the disease. A total of 17 such lectures were held.
- **Health Personnel:** There were two training sessions for medical and nursing personnel in the areas of Ciudad Juárez and Nuevo Casas Grandes in Chihuahua, with the participation of 150 doctors and nurses interested and dedicated to the area of Tuberculosis. Included in these sessions were specialists from the United States and Mexico.
- **General Public:** Installation of three billboards (two in Ciudad Juárez and one in Nuevo Casas Grandes) highlighted the importance of going to the doctor and identifying the symptoms of Tuberculosis.

Through coordination and education on matters of tuberculosis, communication was strengthened with other health entities in the area, such as Social Security and the Department of National Defense, with the objective of working jointly in the intensive search for active cases of TB.

The infrastructure created by this project provides the basis for true binational cooperation in TB care and serves as a foundation for future joint work to address this public health concern effectively on both sides of the border. ■

Hombres Unidos Provides Critical Primary Prevention Services continued from page <None>

New Mexico stated that a participant involved in their first workshop is now a facilitator for *Hombres Unidos*. This is the first documented case of a participant who later facilitated the program. Additionally, interviewed participants have shared with us the lessons learned and applications taken from the intervention.

Gabriel, a participant during a 2008 implementation in Pennsylvania, recalled using a skill he had learned from an activity during an argument he was having with his wife over the phone. He mentioned that emotions were escalating during the argument and although he doesn't consider himself violent, he told his wife that he was getting angry and needed to step away from the situation before he would say something he would regret. At that moment, he hung up the phone and returned her call at a later time.

SPREAD

Migrant Health Promotion and Enlace Comunitario became the first organizations to replicate *Hombres Unidos* without MCN oversight, but with MCN-led training and technical assistance to retain program fidelity. Migrant Health Promotion aims to improve health in border and farmworker communities by implementing health outreach education to community members. Enlace Comunitario is a domestic violence victims services organization dedicated to improving the lives of the immigrant community in Albuquerque, New Mexico. Both organizations were selected as implementation sites because of their outreach experience and their partnership with victims services organizations (Enlace Comunitario is a direct service provider).

Experience has shown that *Hombres Unidos* is a program which can be replicated in any area of the country where a migrant population is present. The recruitment and implementation methodology is very specific to the population and should be maintained during replication.

The program has reached nearly 300 participants over the past year in programs run by organizations other than MCN. Although the outcomes of the intervention at Enlace and Migrant Health Promotion have yet to be formally evaluated, anecdotal evidence provided by these sites indicates successful curriculum replication. As *Hombres Unidos* is culturally specific to Latino migrant men, the program could also be replicated with migrant men in work environments other than farm work.

One of the participants in *Hombres Unidos* had the following to say about the program:

> *The* Hombres Unidos *workshop was a very good experience for everyone involved. We all learned to calm ourselves in tense situations. For example, they stressed the importance of counting to ten before reacting to any sort of conflict. As a result of the Hombres Unidos workshops we all learned how to control our emotions. Furthermore this workshop served as a base to help others who have problems with their anger; for example, I was recently in Mexico and I was in a situation where a companion of mine was being very loud and a bit violent. I intervened and explained to him that he should not take his problems out in the open in such a loud and disrespectful way. I told him that he has to take care of his problems at a personal level and not out in public. Thanks to the* Hombres Unidos *workshop I had some guidance in counseling this man in how to deal with his emotions.*

For more information about *Hombres Unidos*, including what is required to replicate the program at your site, please contact Adrian Velasquez at avelasquez@migrantclinician.org or 512-579-4505. ■

MCN

MEN UNITED AGAINST FAMILY VIOLENCE
POST-SURVEY

#

a. Age range: 15-20 ☐ 21-25 ☐ 26-35 ☐ 36-45 ☐ 46-55 ☐ 56-65 ☐ 66+ ☐
b. Do you live in different places during the year because of your work? Yes ☐ No ☐
c. Marital status: Married ☐ Have partner ☐ Widow ☐ Divorced/separated ☐ Single ☐
d. Do you have children? Yes ☐ No ☐

1. Do you think men should make the decisions in a relationship?
   Yes No ?
2. Do you think that women have the right to say "no" if they don't want to have sex with their partner?
   Yes No ?
3. Do you believe that if a man apologizes to his partner for being violent, it means that he will not be violent again?
   Yes No ?
4. Do you think that when a man hits his partner, it can be her fault for provoking it?
   Yes No ?
5. If your friend was hitting his partner, would you tell him that this was unacceptable behavior?
   Yes No ?

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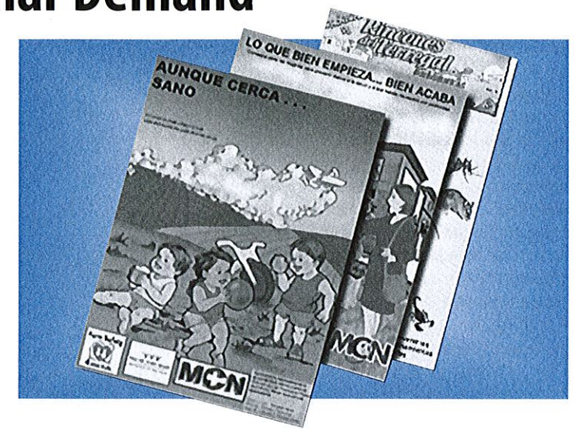
Comic Books Back by Popular Demand



The Migrant Clinicians Network (MCN) and the National Association of State Departments of Agriculture (NASDA) Research Foundation announce the availability of three pesticide educational comic books in Spanish. These full color publications are available free of charge and can be ordered via http://www.migrantclinician.org/orderpesticidecomics.

The comics include the following titles:

1. ***Aunque Cerca... Sano*** educates parents about children's risks to pesticide exposure and ways to minimize these risks.
2. ***Lo Que Bien Empieza... Bien Acaba*** helps women of reproductive age and pregnant women in rural and urban areas understand the risks associated with pesticide exposure and ways to minimize exposure.
3. ***Poco Veneno... ¿No Mata?*** offers family-based information on what pesticides are, why one should be concerned about pesticide exposures, how to minimize pesticide exposures and how to respond to a pesticide poisoning.

The comic books were developed by MCN and partners to help educate farmworkers and their families as well as other Spanish-speaking populations about pesticides and ways to minimize exposures. They offer protective concepts through illustration and conversation-style text and are an effective way to disseminate health information to populations with limited formal education.

These MCN comic books are printed and distributed by the NASDA Research Foundation under Cooperative Agreement X8-83456201, awarded by the U.S. Environmental Protection Agency. ■

New Pesticide Resources Available

Migrant Clinicians Network is pleased to announce the availability of our new clinical guidelines for acute pesticide exposure and accompanying exposure assessment form. These resources are critical for use in health centers that care for farmworkers, the population most overexposed to pesticides. The tools were adapted from guidelines drafted by Dennis Penzell, DO, MS, a former medical director at a federally funded health center in Florida. Dr. Penzell treated and managed farmworker patients who were poisoned in one of the largest pesticide poisoning incidents in the United States. The new tools include a listing for data collection for acute pesticide exposed patients. The contents of the data collection were adapted from a resource created by Matthew Keifer, MD, MPH, director of the National Farm Medicine Center and an occupational medicine specialist renowned for his research and clinical work with farmworkers and pesticides. This data collection listing will be included in the forthcoming Recognition and Management of Pesticide Poisonings, 6th ed. These tools were reviewed by MCN's expert advisory committee on environmental and occupational health.

From the Field to the Exam Room:

Blue Ridge Community Health Center Partners with MCN to Improve Care for Migrant Patients

Michael Piorunski

In the southwest corner of North Carolina, Blue Ridge Community Health Services (BRCHS) is taking steps to improve access to and quality of care for migrant patients.

Migrant Clinicians Network (MCN) and BRCHS began a year-long collaboration in November 2012 to establish the health center as an Environmental and Occupational Health Center of Excellence, focusing on improving the health of the region's agricultural workers and their families in the primary care setting. The health center partnership program is the cornerstone of MCN's Environmental and Occupational Health (EOH) program initiative and is supported through a cooperative agreement with the U.S. Environmental Protection Agency (EPA), Office of Pesticide Programs as part of the National Strategies for Healthcare Providers: Pesticide Initiative.

Blue Ridge Community Health Services

Based in Hendersonville, NC, with satellite locations in Brevard and four school-based clinics, BRCHS has served the residents of Henderson and Transylvania counties for more than 50 years. The center was the first federally-funded migrant health center in the country. It now serves patients from the surrounding counties of Buncombe, Polk, and other western North Carolina counties.

Residents in the region face a shortage of primary care providers. Henderson County is designated as a Health Professional Shortage Area for primary care, dental care, and mental health care. In addition, the low-income and farmworker populations are designated as Medically Underserved Populations. BRCHS offers adult and pediatric primary care, dental, pharmacy and behavioral health care. In addition to these services, the center provides community health education and outreach to migrant labor camps during the growing season.

With more patients expected to access care under the Affordable Care Act (ACA), the need for primary care providers in the region will increase. BRCHS is taking a proactive approach to address the expected growth in their patient population, partnering with the Mountain Area Health Education Center (MAHEC), Pardee Hospital and the MAHEC Hendersonville Family Medicine Residency Program to increase the number of newly graduated doctors entering the family residency program in Hendersonville. Made possible through a grant under the ACA "Teaching Health Center" program, BRCHS will assume operations of the MAHEC outpatient clinical site. More doctors participating in the MAHEC family residency program will mean increased access for patients who face barriers to accessing healthcare.

The North Carolina Employment Security Commission estimated close to 4,000 migrant and seasonal farmworkers (MSFWs) worked in Henderson and Transylvania counties in 2011. Including dependents, an estimated 11,300 farmworker family members are present..[1] Apples and Christmas tree production are the main source of work for

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IN MEMORIAM

Remembering a Tireless Community Advocate

MCN staff was greatly saddened to hear of the recent death of Ana Alexandra Oviedo Medina, a Community Outreach Coordinator for Blue Ridge Community Health Services, and former Henderson County Educational System immigrant advocate and ESL Parent Liaison.

Ana was 28 years old, a native of Torreon, Mexico, and the daughter of Pastor Alfredo Oviedo and Alejandra Oviedo. She attended the University of North Carolina at Charlotte where she majored in Political Science and Spanish.

Ana's obituary says, "Ana loved doing work for the community and advocating for those without a voice. Her favorite activities were going to church; her son's, nephews' and brother's soccer games; and shopping with her mother. Ana was intolerant of injustice and spoke up against it."

"Ana was a counselor to many. She always had time to listen to others and offer support. Ana liked to empower women and enjoyed being lovable to babies and children."

MCN staff worked with Ana to help bring environmental and occupational health services to Blue Ridge Community Health Center and to provide ongoing continuity of care to Blue Ridge patients through the use of MCN's Health Network.

MCN staff who worked with Ana say that she was "full of life and this is a huge loss for her family and the community of Blue Ridge. We feel lucky to have known her and will miss her as we continue to work on behalf of the patients she served."

From the Field to the Exam Room continued from page 9

farmworkers in the region. Workers also harvest strawberries, bell peppers and grapes.

Integrating Environmental and Occupational Health (EOH) into Primary Care

MCN's EOH program focuses on developing simple, practical adaptations to partner centers' clinical systems to support the integration of EOH into the primary care setting, based on the unique needs and conditions at each individual health center.

For BRCHS, an immediate need was improvement in the identification of migrant patients. In recent years, BRCHS and other migrant health centers have seen a decline in their migrant patient populations, partly due to a climate of fear among immigrant populations in North Carolina and other states.[2]

Together, BRCHS and MCN established the improvement of identifying migrant patients as a primary goal of the partnership.

"MCN helped us come up with a realistic work plan," said Milton Butterworth, Director of Community Engagement at BRCHS. Butterworth and Medical Director Shannon Dowler, MD, played key roles in identifying and supporting the achievement of improvement goals.

The identification of migrant and farmworker patients is important from an environmental and occupational health angle. MCN's Chief Medical Officer (CMO), Ed Zuroweste, MD, says that it's important for clinicians to utilize this information to think differently about potential causes and management of illness and injury. In his role as CMO, Dr. Zuroweste oversees the clinical content of MCN's EOH program. He also participated in an MCN site visit to BRCHS in November 2012.

"It was important for us to improve our rates of identification of MSFW at our gateways, the organization's front desks, and seamlessly make the provider aware of the patient's occupation," Butterworth said.

Agricultural work is among the most hazardous occupations, with farmworkers being the population most overexposed to pesticides. During the three-year period from 2008-2010, hired farmworkers were five times more likely to suffer fatal occupational injuries than were workers in all civilian industries combined.[3]

"Making the clinician aware that a patient or a member of the patient's family works in agriculture and is a migrant is the fundamental first step in providing quality care," Zuroweste said.

BRCHS will focus on improving documentation of migrant patients in their Electronic Health Records (EHR) as part of this effort.

Alongside this goal MCN and BRCHS will work together to integrate EOH throughout the medical practice, incorporating measures and guidelines to identify and document patients' EOH concerns. MCN will aid BRCHS during the next year to incorporate MCN's Pesticide Exposure Clinical Guidelines and EOH screening tools into the clinical practice.

"During this process MCN has helped us identify for ourselves some ways we could integrate what we learned about EOH issues faced by our mobile [patients]," Butterworth said.

Butterworth says that improving the identification of EOH risks[?] in the clinic setting as well as integrating components of the EOH guidelines into the EHR will enable BRCHS to better address the full range of issues in treating migrant and seasonal farmworkers in the long term.

Training

In November and February, MCN provided on-site clinical trainings for all BRCHS staff facilitated by expert faculty in migration health, EOH and pesticides. These trainings provided the clinical foundation for improvement of clinicians' skills in the recognition and treatment of EOH problems, with an emphasis on pesticide exposure. Expert clinical faculty included MCN's Zuroweste and James Roberts, MD, MPH – one of the nation's leading experts on pesticides and author of the EPA's forthcoming Recognition and Management of Pesticide Poisonings, 6th Edition. All clinical staff received continuing education units for their participation in the trainings and an overview of resources available to support the clinical and community treatment of patients' EOH problems.

Outreach

As a critical component of care for migrant populations, MCN and BRCHS will jointly develop guidelines for outreach staff to aid in the identification of migrant patients and the documentation of EOH risks during outreach encounters. BRCHS boasts a robust outreach program. To support the center's outreach efforts, MCN provided 2,000 copies of each of three Spanish-language pesticide comic books. The comics educate farmworkers and their families about pesticides and ways to minimize pesticide exposure.

During the year-long EOH Program partnership MCN will assist BRCHS in assessing their progress in achieving their quality improvement goals. The work of BRCHS with MCN has helped to create a "culture of care [within the center] that focuses on the EOH needs of our patients," Butterworth said.

To learn more about MCN's EOH Program Initiative or to download MCN's EOH clinical tools and resources, please visit our website www.migrantclinician.org. ■

MCN Pesticide Exposure Clinical Guidelines, Assessment Form and Other Resources

MCN has a number of resoruces for primary care clinicians to better incorporate occupational health into their practices. All of these resources have been developed in conjunction with MCN's Environmental and Occupational Advisory Committee.

MCN Occupational and Environmental Health Screening Questions for Primary Care

http://www.migrantclinician.org/files/MCNConsensusQuestionsENG_SPA.pdf

MCN Acute Pesticide Exposure Guidelines:
http://www.migrantclinician.org/files/PesticideGuidelines_2013_website.pdf

MCN Pesticide Exposure Assessment Form:
http://www.migrantclinician.org/files/PesticideExpAssessment_Feb15.pdf

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3. Villarejo D. 2012. Health-related Inequities Among Hired Farm Workers and the Resurgence of Labor-intensive Agriculture. Kresge Foundation, Troy, MI, 78p.