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A Needs Assessment of Access to the Poison and Drug Information Center

The Deaf, Hard-of-Hearing, and Migrant Worker Populations

Prepared for:

Finger Lakes Regional Poison and Drug Information Center

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Summary

CGR (The Center for Governmental Research) was asked to participate with the Finger Lakes Regional Poison and Drug Information Center (hereafter the "Poison Center") as a partner in its Maternal and Child Health Bureau Stabilization and Enhancement grant. CGR's role over the course of the three-year grant is as follows: In Year One, CGR has conducted a multi-county needs assessment of the deaf or hard-of-hearing population, and the migrant worker population. This report details the findings of the needs assessment and includes recommendations for change to be implemented by the Poison Center during Year Two. In Year Two, CGR's role is to set up an evaluation of any changes the Poison Center opts to make based on the Year One findings. Continuing into Year Three, CGR will continue to evaluate the changes implemented, and will develop a final evaluation report to be presented to the Poison Center at the end of Year Three.

For both populations, CGR began by interviewing several local experts in agencies that provide services to one or both populations. We also had contact with County Health Departments in all twelve counties in the Poison Center's region. We used our expert contacts for help in arranging focus groups with both populations. In addition to learning from experts in

service agencies, we also wanted to be sure to communicate with persons who could directly represent the populations of interest in this assessment. The focus groups were designed to inform us about what kinds of services and outreach individuals in each population would recommend for consideration by the Poison Center.

The deaf and hard-of-hearing communities are not monolithic; in fact, within each community there is great diversity. Therefore, no one strategy or approach will reach everyone. Rather, the Poison Center should undertake a variety of methods to reach as many people as possible. CGR recommends focusing on three broad areas: internal reforms, opportunities for partnership with existing agencies, and a media campaign.

The Poison Center should consider a four-tiered educational approach for migrant workers in the region. The approach should include two- way education between the migrant service agencies and the Poison Center, education of the health care community about the Poison Center, utilization of the service agencies for educational material development and for outreach to migrants, and a media campaign.

CGR believes the Poison Center should take the recommendations made in this report, and move forward to work with agencies that serve both special populations. The Poison Center should share the results of this report with the agencies interviewed in the process, and proceed to meet with them to discuss ways of working together to meet the needs of the deaf or hard-of-hearing population and the migrant population.

Once the Poison Center evaluates its options and selects changes to incorporate, it should develop a specific, step-by-step workplan to implement change in the next year.

The agencies interviewed for this needs assessment were consistently impressed with the Poison Center's desire to improve services to the deaf population and the migrant worker population. With no exceptions, agencies are excited to participate in this effort, and they welcome the next steps in the process.

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We would also like to thank all the persons listed in the Appendix who gave of their time, and put much thought into our interviews. Finally, thanks to all the focus group participants for giving of their time to this important assessment.

TABLE OF CONTENTS

Summary i

Acknowledgements iii

Table of Contents iv

Introduction 1

- Poison Center Background 1
- Current Daily Functioning of the Center 2
- Project Background 3

Needs Assessment Methodology 5

- Interviews 5
  - Deaf or Hard-of-Hearing Population 5
  - Migrant Worker Population 5
- Focus Groups 5

Findings and Recommendations 6

- Deaf or Hard-of-Hearing Population 6
  - Methods of Communication 7
    - Pagers and Text Messaging 8
    - Internet and Email 8
    - Relay Service 8
    - American Sign Language (ASL) 9
  - Health Care Provision 10
  - Outreach and Educational Opportunities 12
  - Advertising Opportunities 15
    - Interactive Web page 16
    - Physician Brochures 16
    - Methods of Advertising 17
- Suggested Poison Center Strategy for the Deaf and Hard-of-Hearing Communities 18
  - Internal Reforms for the Poison Center to Undertake 18
  - Opportunities for Partnership 19
  - Media Campaign 20
- Migrant Workers 21

Health Care Access for Migrant Workers 22
County Health Department Interaction with Migrants 22
Other Health Care Access 23
Hospitals Used By Migrant Workers 23
Migrant Workers and 911 24
Lack of Knowledge Among Health Care Staff 24
Barriers to Health Care Access 25
Lack of phone access 25
Lack of money 26
Unwillingness to Address Pesticide Dangers 26
Inaccessible work camps 26
Sources of Information for Health Care and Other Services 26
Poison and Drug Concerns 27
Accidents 27
Drugs or Alcohol 28
Traditional and Other Medicines 28
Carbon Monoxide 29
Pesticides 29
Worker Protection Standard 30
Current Use of the Poison Center 32
Outreach and Education Opportunities 33
Culturally-Relevant Examples 33
Best Time and Place for Education 33
Preferred Type of Education Materials 35
Migrant Liaisons to Community 36
Cultural Variations 36
Suggested Poison Center Strategy for Educational Approach with Migrants 36
Four-tiered Educational Approach 37
Education for the Migrant Service Agencies 37
Education for the Health Care Community 38
Educate the Migrant Workers 41
Use Available Media Outlets 43
Strategy to Track, Monitor, and Measure Progress 44
Current Tracking Activities 45
Tracking Use by Migrant Workers 45
Collect Race and Ethnicity Data 45
Make the Data Available to the Community 46
Participate in HealthAction Report Cards 46
Cultural Awareness is Critical to Quality Care 46
Tracking Progress on Educational Efforts 47
Tracking Use by Deaf or Hard-of-Hearing Populations 49
Conclusions 50

References **53**

Appendix A: List Of Interviews **54**

Migrant Service Agencies 54
Deaf or Hard-of-Hearing Service Agencies 55
County Public Health Departments 55
Other Health Care Providers 57

INTRODUCTION

CGR (The Center for Governmental Research) was asked to participate with the Finger Lakes Regional Poison and Drug Information Center (hereafter the "Poison Center") as a partner in its Maternal and Child Health Bureau Stabilization and Enhancement grant. CGR's role over the course of the three-year grant is as follows: In Year One, CGR has conducted a multi-county needs assessment of the deaf or hard-of-hearing population, and the migrant worker population. This report details the findings of the needs assessment and includes recommendations for change to be implemented by the Poison Center during Year Two. In Year Two, CGR's role is to set up an evaluation of any changes the Poison Center opts to make based on the Year One findings. Continuing into Year Three, CGR will continue to evaluate the changes implemented, and will develop a final evaluation report to be presented to the Poison Center at the end of Year Three.

Poison Center Background

The Finger Lakes Poison Center was founded in 1955, and is the second-oldest poison center in the United States. The Poison Center is located at the University of Rochester Medical Center/ Strong Memorial Hospital, and is staffed by physicians with specialties in clinical toxicology, as well as by nurses and pharmacists with special training in poison information.

The Poison Center provides poison and drug information, education, and treatment services to twelve counties: Monroe, Wayne, Seneca, Livingston, Chemung, Schuyler, Steuben, Ontario, Yates, Cayuga, Tompkins, and Tioga. Public education and outreach are important services of the Center, in its quest to reduce the number and severity of poison and drug exposures.

The Poison Center has expertise in medications, both in overdose situations and general information; drugs of abuse; use of drugs during lactation; industrial and household chemicals; environmental toxins; nuclear, biological and chemical substances of terrorism; poisonous plants and mushrooms; snake bites, bee stings, spider bites, and other envenomations; and food poisoning.

The Poison Center collaborates with a number of agencies in its public education efforts - including the American Red Cross, Monroe County Women, Infants and Children (WIC) program, Cornell Cooperative Extension, Catholic Family Center Refugee Program, and the Arnot Ogden Volunteer Program. In 2000, the Center also began a new educational program in conjunction with Head Start Schools in the Rochester area. The program includes a puppet story presentation to teach young children the importance of asking first before they eat or drink anything. Information is also sent home for parents to discuss with their children.

In 2000 the Poison Center participated in 54 fairs and 93 lectures for public education purposes. In addition, the Center distributed thousands of materials such as stickers, posters, and brochures.

Professional education is another important component of the education process. In 2000, the Center sent mailings to pharmacists and day care centers, gave 18 lectures to health professionals, completed a series of student trainings, and a series of staff trainings.

Current Daily Functioning of the Center

Calls come in to the Poison Center from a variety of sources, including internal staff at Strong Hospital, 911 operators, medical staff from medical facilities in the 12-county area, Lifeline, and from individuals in the community. Late afternoon and early evening are the busiest times of day, generally speaking. Specialists in Poison Information (SPI) call on the Toxicologists on staff when very serious substances (such as antifreeze) or unusual situations are involved. Center staff use a variety of databases with product and patient management information. To supplement this information the staff use texts, journals, and community consultants. For each incoming call to the Center, the staff determines the treatment needed, after careful evaluation of the patient and the severity of the exposure, and makes recommendations over the phone to the person calling.

By American Association of Poison Control Center criteria, the Center must follow-up with health care facility patients until the patient is out of danger or medically cleared. The required follow-up applies whether the patient is treated at home or at a health care facility. For persons admitted to the hospital because of a

poisoning, the Center will follow up until the person has been released.

In 1998, the Center handled 26,000 calls, or an average of 71 calls per day. The SPIs are available by phone 24 hours a day, year-round. Four in five calls are handled over the phone, while the remainder require the person to seek treatment at a health care facility in consultation with the Poison Center.

If a Spanish-speaking person (or any other non-English speaking person) calls into the Poison Center hotline, the SPI will call a phone translation service to serve as an intermediary. Consistent with most Poison Centers throughout the country, the Finger Lakes Poison Center does not have any Spanish-speaking SPIs. The American Association of Poison Control Centers conducted a survey in 2000 of all U.S. Poison Centers, 69 in total, to characterize operations, services, staffing, and public education activities. The survey found that only three of the 66 Centers responding to the survey (4.5%) provide 24-hour bilingual staff. Three-quarters of the responding centers (74.2%) provide line translation services, paid for by the Center (AAPCC, 2000).

For deaf callers, the Center has a working TTY (Tele-typewriter) machine, with a separate phone line. The SPI can then interact by typing responses and questions into the TTY. All staff are trained on the use of the TTY.

Project Background

In preparation for the grant application to the HRSA (Health Resources and Services Administration) Maternal and Child Health Bureau Stabilization and Enhancement Project, the Poison Center worked to identify populations in the Rochester and Finger Lakes region that are not accessing the Poison Center with a volume of calls in proportion to the size of the population. The Poison Center discovered, for example, that the number of calls they receive through their TTY system from the deaf population has decreased in recent years.

The Poison Center and CGR recognize that persons with hearing loss include both those who are deaf and have total hearing loss, as well as those who are hard-of-hearing. For the purpose of this study, the Center has chosen to evaluate the needs of both the

deaf and the hard-of-hearing populations, with a particular emphasis on the deaf.

For a city its size, Rochester has twice the national average population of deaf persons under the age of 65 (3,617), due to the presence of the National Technical Institute for the Deaf (NTID) and the Rochester School for the Deaf (RSD). In fact, Rochester is known to have one of the highest deaf populations per capita in the nation. The Finger Lakes Poison Center was the first Poison Center in the United States to adapt its phone system for the deaf and had the original teletype adapted to its phone systems in 1970. Due to lack of resources, however, the Center has been unable to promote its services specifically to the deaf community.

As part of this needs assessment process, the Poison Center is hoping to learn enough to be able to develop educational resources specifically designed for the deaf or hard-of-hearing populations.

The second target population, migrant workers, represents a challenging group of individuals who often move in and out of our community with the seasons. According to the Oak Orchard Clinic in Monroe County, the migrant worker population numbers approximately 2,000 to 3,000 in Monroe County alone. Meanwhile, Wayne County has the highest number of migrant workers of any county in the state (nearly 5,000 (FLHSA, 1999)), according to the Finger Lakes Migrant Health Center. The 12-county area served by the Poison Center therefore includes several thousand migrant workers. The Poison Center has made selected efforts to reach migrant workers. For example, the managing director of the Poison Center is fluent in Spanish and has initiated contacts with the Monroe County Health Department and a community health clinic with outreach services to the migrant worker population. However, resources have been insufficient to expand the efforts and have been insufficient to add a Spanish-speaking component, especially Spanish printed materials.

Needs Assessment Methodology

The needs assessment for both target populations, the deaf population and migrant worker population, followed the same general protocol.

Interviews

For both populations, CGR began by interviewing, either in-person or by telephone, several local experts in agencies that provide services to one or both populations. We tapped into these experts' experience for suggestions on other persons to interview, as well as for information on how the Poison Center might better serve these populations. Such interviews provide the insights of experts knowledgeable about services to both adults and children.

Deaf or Hard-of-Hearing Population

For the assessment of the deaf population, we were able to take advantage of the Rochester area's extraordinary array of experts on the needs of this population. Agencies interviewed included, among others, the Rochester-based National Technical Institute for the Deaf, the Rochester Hearing and Speech Center, Self-Help for Hard-of-Hearing People (SHHH) and the Monroe County Association for the Hearing Impaired (MCAHI) at the Health Association. We also interviewed representatives of county health departments, and selected medical providers who would be familiar with poison and drug-related incidents affecting the deaf population, and how such incidents might be avoided in the future. A full list of agencies interviewed can be found in the Appendix.

Migrant Worker Population

For the assessment of the migrant worker population, we tapped into the numerous knowledgeable and insightful community leaders and service providers familiar with the needs and sensitivities of this population. Agency interviews included the BOCES Geneseo Migrant Center, Migrant Education Outreach Program in Brockport, Finger Lakes Migrant Health Center in Rushville, Rural Opportunities, and others (see Appendix for a full list).

Focus Groups

We used our expert contacts for help in setting up focus groups with both populations. In addition to learning from experts in service agencies, we also wanted to be sure to communicate with

persons who could directly represent the populations of interest in this assessment. The focus groups were designed to inform us about what kinds of services and outreach individuals in each population would recommend for consideration by the Poison Center.

To reach the migrant population, we held two focus groups, one arranged through the Brockport Migrant Education Outreach Program in the village of Brockport, and one arranged through the Rushville Migrant Health Clinic in Rushville, Yates County. The Brockport focus group was designed for 12 parents, primarily mothers, but only three mothers were able to attend and participate in the session. The Rushville focus group included 12 participants, 11 men and one woman.

To reach the deaf population, we held a session with two ASL (American Sign Language) instructors who work through MCAHI and use ASL as their primary language. SHHH, a support group for the hard-of-hearing, has offered to hold a focus group in September or October 2002.

FINDINGS AND RECOMMENDATIONS

Deaf or Hard-of-Hearing Population

The population with hearing difficulty includes a range of sub-populations with varying degrees and types of difficulties. The two primary groups are (1) hard-of-hearing individuals, and (2) deaf individuals. *Hard-of-hearing individuals*, with or without hearing aids, depend primarily on their hearing, supplemented by vision to perceive speech. By contrast, *deaf individuals*, with or without hearing aids, rely primarily on their vision to communicate, supplemented by hearing (with assistance devices) to perceive speech.

Nationally, there are more than 28 million hard-of-hearing people. In Rochester, there are more than 90,000. One in ten people in the general population is hard-of-hearing, and one in three people over 65 years of age experience some degree of hearing loss. Hard-of-hearing people face particular challenges in rooms with poor acoustics – hard surfaces, no carpets or drapes, and no

acoustic ceiling or walls. They also face challenges when confronted with excessive background noise, speakers with foreign accents, moustaches or beards or people who talk softly or with their back to the listener.

The deaf population includes persons who have no, or extremely little, hearing ability. Within the deaf population, there are two primary sub-populations: (a) the "academic" deaf, who focus in academics on proper English, and (b) the general deaf population, or "culturally deaf," which relies much more heavily on American Sign Language (ASL), which is not a direct conversion from English. The "academic" deaf are more likely to understand the grammar and vocabulary of written English than are the "cultural" deaf, whose English grammar and vocabulary are likely to be much more limited. The challenges of text or relay service communication between a deaf person who relies primarily on sign language and a hearing person unfamiliar with sign language are described in greater detail later in the report.

In contrast, some deaf people, including those who lost their hearing later in life after learning to speak, and hard-of-hearing people use speech and identify with the hearing community. The hard-of-hearing population generally includes persons with good speaking ability and the ability to hear selectively with amplification technologies, including hearing aids. The "late-deafened adult" population includes those persons who lost their hearing later in life, and who may be resistant to changing their usual method of communication. Finally, the speech-impaired population includes individuals who have experienced stroke, cerebral palsy, or some other health condition that may leave their hearing intact, but their ability to speak clearly is limited.

Methods of Communication

The different populations described above communicate through very different methods. Hard-of-hearing people use assistive devices such as amplified telephones, telephones with telecoils, induction loop amplification systems, hearing aids and one-to-one communicators.

Deaf persons communicate through the eyes, using ASL, lip reading, pager systems, email, Instant Messaging, TTY, and closed captioning on the television. There is no single dominant method of communication within the deaf community. *Thus, any agency*

working with deaf people must be open to using a combination of communications systems.

Traditional methods of communication, such as lip reading and ASL, have several obvious limitations. To lip read, one must be able to see another person's face and the speaker must enunciate clearly. To communicate via ASL, both people in the conversation must be fluent in sign language. Captioning on television often does not capture all dialogue, and often completely ignores other aural context (tone of voice, atmospheric noises such as a door slamming or birds chirping). TTY phone calls are cumbersome due to the time it takes to type messages.

Pagers and Text Messaging

More modern methods of communication provide additional options to both the deaf and hard-of-hearing communities, but also have disadvantages. Pager systems offer more readily available access to communication, but one must still be near a tower to receive a signal. In addition, many pager systems can only accept a limited amount of text. Finally, pagers are relatively expensive in relation to their limitations.

A pager device made by Win-tel is used by some deaf persons for text messaging. The device allows users to send and receive text messages to and from other pagers and email addresses.

Internet and Email

Email and Instant Messaging, especially the latter, are gaining favor in both the deaf and hard-of-hearing communities. Instant Messaging allows communication in "real time" and a greater feeling of a two-way conversation. The fact that many deaf households do not have a phone, but rather rely on a computer for communication, is indicative of how important and convenient these newer methods of communication have become. However, a disadvantage is that both more modern methods of communication require access to a fairly expensive computer. Further, the focus group participants indicated that the internet and instant messaging are favored by the younger generation, and are not as commonly used among middle aged and older deaf persons.

Relay Service

Many hard-of-hearing people communicate using induction loops, amplification devices, hearing aids, and special services such as the "relay service." Relay service provides telephone accessibility to

people who are deaf, hard-of-hearing, or speech-impaired. The operator serves as the "ears" or the "voice" as necessary. A hearing person can use the relay service to call someone with a TTY, for example. Relay service includes VCO (voice carry over), and HCO (hearing carry over). Voice carry over allows a hard-of-hearing or deaf person to speak directly to their caller, but to read a typed response. Hearing carry over permits speech-impaired users with hearing to listen to the person they are calling, but to type in their responses. The major disadvantages of relay are the time it takes for the message to be relayed from one person, through the relay operator, to the other person, and the lack of privacy, given that a stranger serves as an intermediary.

According to the focus group participants, relay service is used extensively for making phone calls to hearing persons. However, with low levels of English proficiency, some deaf persons have trouble communicating with the relay person. Further, it's not possible to know if the relay person made a mistake in the conversion of text to spoken language, or vice versa. Also, the focus group participants have the impression that hearing persons do not like to use the relay service.

American Sign Language (ASL)

True American Sign Language (ASL) is a different language from English—different grammar and different syntax. In fact, ASL has more in common with Japanese than English. ASL is not an international language, and sign languages are different in other countries. Interestingly enough, American Sign Language is more similar to the sign language used in France than to that used in Great Britain. In addition, there are regional variations and "accents" in ASL.

Because ASL is a different language from English, translation can be difficult. If a hearing person is not familiar with ASL, the word order and vocabulary that a deaf person may use in written text can be confusing. For example, the literal translation of the sentence "The bird sat on the fence" into ASL would be "fence the bird sat." As one respondent explained, ASL paints a scene and then adds action, as opposed to English where the verb is often in the middle of a sentence.

In addition, due to the late diagnosis of hearing impairments and the substantial differences between ASL and English*, many deaf*

people have approximately a third-grade reading level. As a result, they may not understand complex written text or words. Anyone wishing to communicate with deaf people must be aware of these issues.

While many deaf and hearing people may sign, not all of them use American Sign Language. In many cases, they will use Signed Exact English or Pidgin Sign English, which are efforts to directly convert the English language into sign. These two approaches rely more heavily on finger-spelling for ideas. As a result, signing in this way can be a cumbersome way to communicate, especially for those accustomed to speech. More abstract concepts may lack a sign in this more limited form. In addition, due to the limitations of creating a different sign for each word, there is often not a separate sign for slight variations in meaning. Subtle nuances are lost when the same sign is employed for similar words.

Health Care Provision

The quality of provision of health care services to both the deaf and hard-of-hearing populations is mixed. Larger providers, including hospitals in the Rochester metropolitan area, provide good services to the deaf population, due in part to the efforts of the many deaf advocates and service agencies in the region. However, at least one advocacy agency expressed concern that some interpreters are not well-qualified, making diagnosis and communication between doctor and patient even more difficult. In addition, some deaf people express concern about the lack of privacy and confidentiality available in medical offices. In a waiting room, signing or use of an interpreter allows anyone within sight to know what is being conveyed. *Health care providers should be sure to provide private rooms or areas for communication.* If an interpreter is involved, a third person is privy to all medical information. This is a more difficult barrier; encouraging more deaf persons to pursue medical training, and encouraging providers to become fluent in sign language, are among the ways to provide one-on-one care with the best form of communication.

Smaller health care providers are even less consistent in providing communication aids to deaf or hard-of-hearing patients. For example, a smaller health care provider may feel it can simply use written communication with the patient. However, a deaf person who relies primarily on ASL may not be able to properly interpret

the written English. Further, written communication takes much longer, and may mean that a doctor or other health care provider does not provide the level of detail necessary. While hiring an interpreter would be the ideal solution, smaller providers of health care generally do not want or cannot afford to absorb the accompanying expense.

According to one service agency, there are very few deaf services in rural areas. In fact, it generally seems that services for the deaf and hard-of-hearing populations are less available in rural communities. Many rural public health services indicated that they believed everyone in their communities was underserved and that they did not make any special outreach efforts to the deaf community.

Not all households with a deaf person have a TTY machine, and some who do have one do not have a very good one. The machines can be expensive, especially the newer ones. Many deaf households that have computer access rely on email and do not have a phone line. As a result, phone-based services would not be available to these people in their homes. Nonetheless, the focus group participants indicated that most deaf persons do have TTY in their home (and they prefer the term "TTY" to "TDD").

During the focus group with deaf participants, one participant who admits his English is good but not great, called the TTY. It took a while for someone to answer and get connected, and the caller almost hung up. But once the Poison Center SPI indicated they were on line, they did well. The SPI typed fast, and was friendly. The SPI warned the caller that it would take a few minutes to get the requested information and not to hang up.

The main suggestion from the participants was to keep the language very simple. For example, the SPI said "there are no direct interactions" and then went on to talk about possible side effects and suggestions for spacing doses. The SPI also said "...so as not to have a possible additive effect." That language might be too high-level, and a deaf person might be embarrassed to admit it.

Recommendations: When answering TTY calls, try to answer more quickly (and type something so the caller knows you have answered), and try to use simple language.

The Tompkins County EMS agency Director indicated that he does not recall his agency ever receiving a call through their TTY system. Similarly, while the Yates, Cayuga and Tioga County EMS all have a TTY line, the dispatchers there indicated that they rarely receive calls on the line.

When asked if they would call 911 in an emergency, the focus group participants gave mixed responses. Two said that they would use 911, but the third participant said absolutely not. He once called on a TTY and was asked to hold so that they could figure out the TTY. Once you have an experience like that, the participants explained, it is difficult to trust a service again.

Using hearing family members is an option, but family members do not serve as full interpreters, and may leave out important information in the interpretation process.

Outreach and Educational Opportunities

There are several ways in which Poison Center staff could be educated to improve their outreach and communications efforts with the deaf and hard-of-hearing populations. The National Technical Institute for the Deaf offers classes for hearing people interested in working with the deaf population. The Institute offers training to improve communication skills between the two groups and to raise the sensitivity of hearing workers to the needs of their deaf colleagues and customers.

The Health Association also offers classes in ASL, which teaches not only basic signs, but also the basic grammar of ASL. For example, the statement "I am fine today but my molar hurts" would translate into ASL as "Today me fine but m-o-l-a-r pain-in-mouth."

Recommendation: The Poison Center should consider sending staff to an educational workshop at NTID designed to improve their skills in interacting with the deaf and hard-of-hearing populations, or to an ASL class at the Health Association.

There are many other opportunities for the Poison Center to improve its outreach and education services to the deaf community. Many of the deaf service agencies we interviewed indicated that they would be willing to work with the Poison

Center to educate their clients about poison and drug information. For example, BOCES offered to allow the Poison Center to send information home to parents, and the Rochester School for the Deaf encouraged the Poison Center to contact their community outreach worker to discuss specific ways to collaborate. The Regional Center for Independent Living (RCIL) offered their building as a place to hold workshops or undertake other outreach efforts. In addition, RCIL is sponsoring booths at Eastview Mall for Deaf Awareness Week this year in September. This event is an opportunity for groups to advertise services they offer to the deaf community specifically, and the general population. Almost all the organizations we interviewed (NTID, Rochester School for the Deaf, Relay service, etc.) employ outreach workers or other staff whose main role is to facilitate interaction and connections in the community. These workers would be willing to work with the Poison Center to help educate the deaf population about the services available. Many would also be willing to send written material to the people on their mailing lists.

To reach out to the hard-of-hearing community, Self-Help for Hard-of-Hearing people (SHHH) has indicated an interest in having a Poison Center staff member offer a lecture or educational presentation at one of their evening general meetings.

Recommendation: The Poison Center should pursue connections with existing organizations, such as BOCES, RCIL, SHHH and the School for the Deaf, to find ways to collaborate on outreach efforts. Some of these organizations have standing workshops in place, and some are willing to include Poison Center information in ongoing mailings.

A number of agencies working with the deaf population also recommended that the Poison Center consider adding a deaf person to its board and/or forming an advisory board of deaf and hard-of-hearing people who could make recommendations on improving outreach efforts. One agency representative recommended that the Poison Center consider hiring a deaf person as an SPI. Whether adding a person to the board, creating an advisory board and/or hiring a deaf person, pursuing any of these approaches would make use of people who already have connections in the community that would facilitate outreach

efforts. Including them from the beginning would indicate to the deaf and hard-of-hearing communities a strong commitment to the outreach efforts. The people we interviewed indicated that they or others in their organizations would be willing to serve in this capacity as volunteers.

Recommendation: The Poison Center should consider adding a deaf or hard-of-hearing person to the Board and/or form an ad-hoc Advisory Board consisting of deaf and hard-of-hearing individuals (remember to hire an interpreter for meetings). NTID students looking for internships might also provide a supply of persons who could volunteer with the Poison Center. The Poison Center should consider the feasibility of hiring a deaf SPI.

SHHH publishes a monthly newsletter with a circulation of nearly 600 for hard-of-hearing people in the Rochester community. Likewise, for the deaf population, *The Deaf Rochester News* includes a listing of a number of social and recreational clubs for deaf people. According to people we interviewed, the Rochester Recreational Club for the Deaf is quite active in the community and would be a good contact for distributing information about the Poison Center informally in the community. A long-standing group, Deaf Women of Rochester, and a group that was only formed recently, the Rochester Deaf Mothers Club, both consist of deaf women with children. The person we interviewed indicated that the Rochester Deaf Mothers Club in particular is a group of deaf women with young children who meet occasionally to socialize and discuss general issues of childcare. This is an ideal group for the Poison Center to contact to get across basic information about safety issues for children.

Recommendation: The Poison Center should investigate opportunities to expand outreach through informal or more structured social and recreational clubs for deaf people.

September 22-28th is Deaf Awareness week in Rochester, and will be kicked off with a Deaf Fiesta at the Henrietta Dome Center on September 21st. Events such as these are excellent opportunities to reach out to the deaf or hard-of-hearing community.

Recommendation: Take advantage of the Deaf Awareness Week and the Deaf Fiesta to conduct outreach.

Advertising Opportunities

In order to advertise the Poison Center's phone and TTY numbers to the deaf population, the traditional method of the phone book may not be ideal. The deaf community does not rely on the phone book as much as the hearing population. Further, while there used to be a TTY phone book published in the Rochester area, it has not been updated in recent years. However, although these books may not be heavily used they should certainly still be updated with the Poison Center's information.

Recommendation: Be sure the telephone book and the TTY phone book are both regularly updated with the Poison Center's phone and TTY numbers.

Opportunities for advertising the Center's TTY number to the deaf population include the *Deaf Rochester News* magazine, the *Deaf Times*, news bulletins, and a deaf listserv currently in existence. To reach the hard-of-hearing population can in many ways be even more challenging, because members of this population may be in denial about their hearing loss, still trying to cope in the hearing world, but encountering difficulties as a result. Public Service Announcements (PSAs) should always include captioning. Open captioning, which appears on all television screens automatically, is preferable to closed captioning, which requires a specially-equipped television and must be turned on (i.e. the difference between CNN's scroll bars at the bottom of the screen that are viewed on all TVs, and the text dialogue that people might see on TVs in a showroom or at the gym when the sound is off).

When using captioning, the text must remain on the screen long enough for the reader to process the information. Many hard-of-hearing individuals are elderly and may be slower in processing information than they were in their youth. It would also be helpful to use relatively simple vocabulary, as many deaf people who rely on ASL have a more limited English vocabulary.

Recommendation: The Poison Center should consider advertising in both traditional media (such as deaf newspapers) and more contemporary outlets (such as deaf listservs and websites). Any video advertising should include

open captioning rather than closed captioning. Language should be simple, concise and remain on the screen for a long period of time.

The Poison Center is listed in the MCAHI's Community Resource Handbook for Deaf, Hard of Hearing, and Hearing People. However, the new 800 number is not yet listed.

Interactive Web page

The people we interviewed indicated that the deaf population is increasingly making use of the internet and would benefit greatly from an up-to-date and informative web page. In fact, if people could contact the Poison Center via email through the web page, that would be particularly useful. The focus group participants agreed that a web page is a good idea, but suggested it be kept as simple as possible. Further, a link to the Poison Center's website should be listed on the www.deafrochester.com website.

Recommendation: The Poison Center should develop an interactive web page, with the opportunity for deaf, hard-of-hearing, or other persons to ask questions via email. The Poison Center should have a link from the www.deafrochester.com website.

Physician Brochures

One agency encouraged the Poison Center to work with pediatricians and obstetricians in encouraging them to tell their patients about the Poison Center and the services it provides. In addition, written information in doctors' offices would be very helpful. Deaf people would benefit from having a written brochure to use as a reference. Brochures and other printed material allow people to read and understand at their own pace. Patients in pediatricians' and obstetricians' offices would be particularly sensitive to poison issues for young children and would be a receptive audience for the Poison Center's message.

It is necessary to keep in mind with written material that many deaf people have a third-grade reading level (according to interviewed service agencies), so language and concepts must be kept fairly simple. Graphics would be particularly useful.

Recommendation: If it has not already done so, the Poison Center should develop brochures, ideally specifically for the deaf and hard-of-hearing communities, that use simple,

concise sentences and graphics to illustrate concepts. These brochures should then be distributed to medical offices and agencies that serve the deaf and hard-of-hearing communities.

Methods of Advertising

The media used by the deaf and hard-of-hearing populations vary somewhat. Both the deaf and the hard-of-hearing tend to rely on the following mass media sources:

- ***Newspapers and flyers.*** The advantage of this approach is that it is a visual media that allows a person to read at his or her own pace.
- ***Online services and the internet.*** Again, these are visual media that allow a person to read at his or her own pace. Deaf people are increasingly using computers to communicate and to obtain information.
- ***Television.*** Programs must have captioning or focus on peoples' faces to allow lip reading. News shows that primarily display an anchorperson who clearly enunciates words are a model for television programs geared to the hard-of-hearing. Deaf people are more likely to rely on captioning than lip reading. Captioning should be displayed long enough for people to read and absorb the text.
- ***Presentations*** with slides, overheads or other visual images, supplemented with some form of assisted listening devices. For deaf people, the presenter should be accompanied by a sign language interpreter.

For the *hard-of-hearing* only:

- ***Radio***, especially news and talk shows where clear speech is used.

Recommendation: The Poison Center should make use of several different media to advertise to the deaf and hard-of-hearing communities. A multi-tiered approach is discussed below.

Suggested Poison Center Strategy for the Deaf and Hard-of-Hearing Communities

The deaf and hard-of-hearing communities are not monolithic; in fact, within each community there is great diversity. Therefore, no one strategy or approach will reach everyone. Rather, the Poison Center should undertake a variety of methods to reach as many people as possible. CGR recommends focusing on three broad areas: internal reforms, opportunities for partnership, and a media campaign.

Internal Reforms for the Poison Center to Undertake

Certain components of both the deaf and hard-of-hearing communities are close-knit and somewhat isolated. For these groups, it is important that the Poison Center demonstrate an obvious and overt interest in reaching out specifically to these communities. This effort to show seriousness of purpose and long-term commitment can take several different forms.

Poison Center staff should enroll in classes or workshops to improve their understanding of, and sensitivity to the deaf and hard-of-hearing communities. As mentioned above, NTID offers such classes for hearing people interested in learning more about the deaf community and deaf culture. These classes will also aid in understanding the writing of a deaf person attempting to translate ASL verbatim into English.

The Poison Center should create a deaf and hard-of-hearing Advisory Board and/or add deaf and hard-of-hearing people to the existing Board. Members of the Board would provide a direct link to the deaf and hard-of-hearing communities. They would also add a sense of legitimacy to the Poison Center's outreach efforts. Finally, they would be well-informed on the best ways to reach out to the deaf and hard-of-hearing communities, especially to make use of informal social groups within each community.

The Poison Center should consider hiring a deaf SPI. Hiring a deaf SPI would show commitment to reaching out to the deaf community. In addition, many deaf people may feel more comfortable communicating with another deaf person than with a hearing person.

The Poison Center should consider answering emergency information requests via email. Some deaf and hard-of-hearing people do not have phones in their homes and many are more

accustomed to using email than TTY or the relay service. Email would offer an additional, and perhaps more convenient, way for deaf and hard-of-hearing people to contact the Poison Center.

Opportunities for Partnership

There are a number of existing organizations in the Poison Center's service area that offer opportunities for partnership and collaboration. These organizations indicated during interviews that they would be willing to help the Poison Center disseminate information, to host workshops, and to offer their expertise. CGR identified four main groups available for partnership and collaboration.

The Poison Center should initiate contact with existing agencies that serve the deaf and hard-of-hearing communities. Many of the organizations we interviewed indicated that they would be willing to host workshops and presentations at their offices; disseminate information through their existing mailing lists, newsletters and outreach staff; or help link Poison Center staff to appropriate groups and organizations in the community.

The Poison Center should reach out to informal social clubs. There are a number of informal social clubs, especially within the deaf community, that offer opportunities for the Poison Center to get its message to a target audience. For example, the Rochester Deaf Mothers Club would provide the opportunity to meet with a target audience of women with young children.

The Poison Center should distribute brochures through doctors' offices. During the interviews, it became clear that many people are unaware of the other services that the Poison Center offers in addition to the Hotline. The information about the similarities between certain drugs and candies, drug interactions and what drugs are expressed in breast milk were of particular interest. Many interviewees thought that it would be useful if these services were advertised in obstetricians' and pediatricians' offices--and also in other physician offices as well—especially to reach older hard-of-hearing persons.

For the service area outside Monroe County, the Poison Center should work with Public Health Departments. Each county has its own Public Health Department, and many of these

agencies do not make any particular efforts to reach the deaf and hard-of-hearing communities, with the exception of interaction with some deaf children ages 0-2, through their Early Intervention program. In addition, the Health Departments often coordinate access to services for children ages 0-21 diagnosed with hearing loss (ensuring they have adequate services at school, receive appropriate treatment, etc.). However, the Health Departments typically do not provide direct services to the deaf or hard-of-hearing outside of the Early Intervention program. With few, if any, service organizations located in these counties dedicated to the deaf and hard-of-hearing communities, deaf and hard-of-hearing people may be underserved. The Poison Center can work with the Public Health Departments to expand outreach to the deaf and hard-of-hearing communities. *Health educators and/or health outreach workers on staff in all county health departments are eager to work with any service agency, such as the Poison Center, to conduct in-service with staff on health-related issues, and to discuss methods of improved communication and education to underserved populations.*

Media Campaign

A successful media campaign will need to take advantage of a number of approaches to reach the largest proportion of the deaf and hard-of-hearing communities. CGR recommends a multi-pronged approach.

The Poison Center should advertise through traditional media in a "deaf and hard-of-hearing-friendly" manner. This approach can take the form of television advertisements with open captioning; making ample use of graphics, brochures and flyers with simple language and graphics; and traditional newspaper advertisements.

The Poison Center should also target deaf and hard-of-hearing-specific publications. *The Deaf Rochester News*, publications by MCAHI, and participation in Deaf Awareness Week in the fall all provide opportunities to target the Poison Center's message specifically to the deaf and hard-of-hearing communities.

The Poison Center should make use of more modern media. Members of both the deaf and hard-of-hearing communities are embracing technology to improve the ease of communication among each other and with the hearing world. The Poison Center

also should take advantage of the advances in communication options. The Poison Center could advertise on deaf websites (DeafTimes.com), and/or through deaf listservs. The Poison Center could create its own webpage and answer inquiries via email.

Undertaking a combination of these approaches will increase the likelihood that the Poison Center will reach the largest audience and the greatest proportion of the deaf and hard-of-hearing people in its 12-county service area. Also, opportunities for partnership will relieve some of the expense and time-commitment from the Poison Center and will provide easier access to the target populations.

Migrant Workers

The migrant worker population in the Finger Lakes region numbers in the thousands, with about 350 migrant housing sites, including about 200 licensed camps, according to the Brockport Migrant Education Outreach Program. Farmworkers Legal Aid estimates that 150 to 200 camps or housing sites exist in Wayne County alone, although they vary substantially in size. Wayne County has the most migrants of any county in the state of New York, with nearly 5,000 in the peak harvest period (FLHSA, 1999). An additional estimated 3,500 migrant workers reside in western Monroe, Orleans, and Genesee counties (FLHSA, 1999). Turnover among the migrant worker population is estimated at 40% on an annual basis, according to the Farmworkers Legal Aid Society.

Migrant workers fall roughly into four categories:

1. Migrants who come and go each season, and may be legal or undocumented. These migrants often come from Texas, Florida, Central America, Puerto Rico, or Mexico, and make their way up the east coast with the planting and harvesting cycles;

2. "H2A contract workers." H2A is a subsection of the 1986 immigration law that allows growers to bring contract help in if they can prove a lack of labor supply in the area;

3. "Seasonal workers" who are often legal, and have decided to remain in the area, but only work during the agricultural season; and

4. "Settled out workers," who are in the area full time, year round. These workers may have previously worked in agriculture, but many no longer do.

According to one service agency, the migrant worker population is getting younger, with youth ages 13 to 15 working in the fields with falsified identification showing them to be 17 or 18.

Health Care Access for Migrant Workers

According to the Hispanic Health Study conducted by the Finger Lakes Health Systems Agency (FLHSA), there are approximately 45 Hispanic physicians in the Finger Lakes region, with most in Monroe County. This is a low ratio of Hispanic physicians, with fewer than 10 Hispanic physicians for every 10,000 Hispanics, compared to 24.7 total physicians per 10,000 total population nationwide. Most migrant workers in the Finger Lakes region are of Hispanic origin.

Further, there is a shortage of bilingual and bicultural health care providers. While translation services exist at many health sites, availability and quality vary. In one focus group, participants indicated that a major barrier to accessing health care was the need to communicate in English. While most of the focus group participants indicated that they are able to read and write Spanish, very few said they could communicate in the same fashion in English.

County Health Department Interaction with Migrants

Most of the County Health Departments interviewed reported that they do not have much direct contact with migrant workers and their families. Rather, they rely on the service agencies such as the Rushville Migrant Health Center, Oak Orchard, etc., to provide services to this special population. Focus group participants supported this statement. When asked where they go for health care, Rushville Focus Group participants indicated that they only go to the Migrant Health Center and do not access health care anywhere else.

The Monroe County HD works through its Department of Communicable Disease Control to access migrants for provision

of immunizations, and for Tuberculosis testing. The County hires students to go into the work camps and other areas where the migrants reside. For communication purposes, the HD relies on a telephone translator service when persons speaking any language other than English are provided direct services (immunizations, pre-natal care, etc.). Even though the non-English speaker is there in person, the HD personnel will call the telephone translator service and use that translator to carry on the in-person conversation.

Cayuga County is one that provides direct services, including a public health nurse working in the field to provide services to migrant workers.

The undocumented population is constantly fearful of doing something that might expose them to public authorities, so it may well be that a county role in provision of services to this population is not the best route.

Other Health Care Access

One agency indicated that migrants will generally go to Rural Opportunities field offices, Oak Orchard clinic, or the Sodus clinic for health care. Migrants find information about health care from these locations, by word of mouth, and on bulletin boards posted in grocery stores, laundromats and other locations the migrant population frequents.

Many migrants in the Finger Lakes region access health care at various sites reimbursed with federal vouchers provided through Finger Lakes Migrant Health, or at community health centers such as Oak Orchard. Migrants traditionally choose to see a doctor only when they are extremely ill, and unable to work.

Hours during which health services are offered can be a challenge. Migrant workers cannot take time out of their workday, which often includes Mondays through Saturdays, to make a physician visit. Evening hours often work best for farm workers, but many clinics close at 5pm.

Hospitals Used By Migrant Workers

The Brockport focus group reported that they primarily utilize the Oak Orchard Clinic and Strong Hospital for health care services. They use Lakeside Hospital to a lesser extent. One service agency that serves a multi-county area reported that migrant workers also

utilize Sodus Hospital and Newark Hospital for emergency services.

Migrant Workers and 911

When they experience emergencies, migrants typically do not call 911. They reported that the primary reason for not calling 911 is because of an anticipated language barrier. One EMS agency Director reported that he did not recall ever receiving a non-English speaking 911 call at their center. He reported that if they did encounter someone who spoke another language they would contact the local university for help with interpretation. Other County EMS staff indicated that they often have someone on staff who knows a few words of Spanish or another foreign language and can communicate basic information. Otherwise, these EMS programs indicated that they would use a telephone translation service, although they cautioned that the service is expensive and they did not know who would pay. The Yates County EMS Coordinator indicated that the migrant population is growing in that county, and they do have some EMTs who speak Spanish. However, if a non-English speaking call comes into the 911 center, they use a telephone translation service line for translation. One service agency indicated that having a Spanish statement immediately following an English statement used in answering incoming calls can be very helpful for Spanish-speaking callers.

Migrant workers indicated that if they show up in person in the emergency room, they can communicate better face-to-face than by phone. They can communicate, albeit in limited amounts, with limited ability to write words in English (though they stated an inability to communicate the same words verbally). However, their preference is to make contact with a Spanish-speaking provider or to utilize individuals they know to be bilingual such as the staff at the Brockport Migrant Education Outreach Program. Focus group participants indicated that they use Outreach Program staff *especially* in an emergency situation.

Lack of Knowledge Among Health Care Staff

One service agency explained that physicians and clinics do not appear to be well educated on occupational health issues, including pesticides and other potential poisons. They do not know what types of symptoms to look for. Migrant focus group participants stated that their greatest interest was for information on how to protect themselves from pesticide exposure and how to treat exposure. Participants

wished that their doctors were more knowledgeable and proactive about pesticide exposure. They said that often a doctor would not recognize the symptoms or did not ask them about their work exposure to pesticides. This could provide an opportunity for the Poison Center to conduct some education efforts.

Recommendation: The Poison Center may wish to pursue an exchange of information with the Finger Lakes Occupational Health Services organization to learn more about the relationship between occupational health and poison and drug exposures. The Poison Center may also wish to consider developing educational materials and in-service training sessions about pesticide exposure and its symptoms to share with health care providers throughout the region.

Barriers to Health Care Access

A local survey conducted in 1992 among 314 Hispanic rural residents found that the top four reported barriers to health care include unemployment, lack of transportation, language barriers, and the lack of health insurance or resources to pay for care (FLHSA, 1999).

The FLHSA Hispanic Health Study emphasizes important characteristics of interpreters as not only translators of two languages, but also as communicators of subtle signs and cues, and of language and terms that might not be easily translated and which might be driven by different cultural context. In the health care field, interpreters must be familiar with biomedical terminology and concepts. *Health care interpreters must also understand the importance of the provider-patient encounter, and their own limits as an interpreter.*

Lack of phone access

A lack of phones is a frequent problem, but some work sites have pay phones, and some workers have cell phones. At the Rushville focus group, only three of 11 participants indicated that they had a phone at home. The crew boss has a cell phone, however, and they would have access to the cell phone in an emergency. Services traditionally accessed by telephone are not particularly popular with migrants. The concept of calling a stranger is not common in their culture and can be considered very intimidating.

Nonetheless, one agency thinks that cell phones would help with connectivity. All participants in the Brockport focus group reported that they have a phone in their homes.

Lack of money

Brockport Migrant Education Outreach Program focus group participants unanimously agreed that money is a primary barrier to care.

Unwillingness to Address Pesticide Dangers

One service agency indicated that migrant workers certainly are interested in gaining improved access to health care, but that they are not interested in hearing about the dangers of pesticides, nor are they willing to leave the fields; this is their livelihood. However, as indicated later in the report, participants in both focus groups described great concerns about pesticide poisoning.

Inaccessible work camps

Some of the growers or crew bosses will post signs at the camps that indicate the land is private property, to ward off visitors. This may intimidate some health providers from making needed visits to the camps. However, the migrant workers have a legal right to have visitors, so if someone wants to drive into the camps, they may legally do so. According to one service agency, some crew leaders may resort to violence to keep visitors off their property; while this is not frequent, it is important to be aware of such a possibility if the Poison Center were to consider making work camp visits.

Recommendation: Some of these barriers are outside the purview of the Poison Center's activities. However, the reluctance to address pesticide dangers may be an area where the Poison Center can have an impact. Any educational materials or presentations surrounding pesticides should take into account the possible reluctance on the part of migrant workers to address pesticides as a poison.

Sources of Information for Health Care and Other Services

One Brockport focus group participant indicated that she uses the phone book to find new information. Others indicated that friends and family are their primary sources of information. Most of the Rushville focus group participants indicated that they would rely primarily on informal methods of communication, such as talking among friends or asking people they knew had lived in the area longer. They stated that they would also use the phone book

as a secondary source of information, especially if advertising were printed in Spanish. Participants indicated that a growing number of Spanish-speaking individuals work in various agencies, so they are building an increasing network of Spanish phone lists.

Agencies consistently reported that they are used by migrant workers as clearinghouses for information. Brockport Migrant Education and Outreach Program, Farmworkers Legal Aid, and the Finger Lakes Migrant Health Center all receive regular phone calls from migrant workers looking for information on a variety of issues.

Farmworkers Legal Aid visits the larger camps in the area two to three times per year, to provide a variety of information on legal issues, as well as on any other outreach and education they have been contracted to work on.

The service agencies interviewed for this project are in regular contact with migrants and have built a trusting relationship with them. The agencies are often a first point of contact when a migrant has an emergency. *If the agency staff are aware of the Poison Center, they will then know to contact the Center for information.* For example, the staff persons who answer the 800 number at the Rushville Migrant Health Center are trained to probe callers regarding health issues. They could surely benefit from training from the Poison Center on the types of questions to ask regarding Poison and Drug issues.

Recommendation: The Poison Center should consider utilizing existing service agencies as a point of access to the migrant workers. This is discussed in more detail later in the report.

Poison and Drug Concerns

When asked what they think of when they hear the word "poison," Brockport focus group participants said "something serious," "pesticide," and "cleaning/household products." Rushville participants also thought of "pesticides" as well as "danger." When asked if they consider prescription drugs to be a potential poison, they said, "yes, if a child can get into it" and also "yes, if you take too much."

Accidents

Accidents (which include poisonings) cause Hispanic deaths two and one-half times as often as among the general population. Ten

percent of deaths in the 0-15 age category among Hispanics in the 6-county Rochester region in 1991-1995 were caused by accidents. This proportion increases to 25% of deaths in the 15-24 age group, and 15% of the 25-44 age group (FLHSA, 1999). Since the majority of migrant workers are of Hispanic ethnicity, these data are worth attention.

Drugs or Alcohol

The 1997 Monroe County Health Department Youth Risk Behavior Survey found that 16.5% of Hispanic youth reported that they had "used any other type of illegal drug such as LSD, PCP, ecstasy, mushrooms, speed, ice, heroine, or pills a doctor prescribed in their lifetime" (excludes marijuana and cocaine). While this percentage was not statistically higher than the total Monroe County sample, it was higher than the African-American sample (6.4%).

The Youth Behavior Survey found that 20.9% of Hispanic youth reported they had drunk five or more drinks in a row within a few hours, on one or more occasions in the last 30 days. This percentage was not statistically different from the full Monroe County sample.

One provider agency reported "tremendous" drug and alcohol abuse among migrant workers, attributed to their distance from home, and from family and friends.

Traditional and Other Medicines

According to multiple service agencies, migrant workers rely often on traditional medicines, such as herbs and teas. The migrant workers may not identify these medicines as drugs that could interact with over-the-counter medication or with prescription medications. The risk for dangerous interactions is therefore present. *The health care community, including the Poison Center staff, may not be aware to ask migrant worker callers about their use of traditional medications.* Mixing prescription medications, and sharing medications among friends or family members, is also a possible concern, as it is among any low-income population.

The Brockport focus group participants indicated that while herbal traditional medicine is common in their country of origin, they are often unable to identify the herbs sold at the grocery store because of the language barrier. Therefore, they don't use them, and they don't know anyone in their circle of friends and family who uses

them here. Nonetheless, migrants from different cultures might have different experiences. Rushville focus group participants stated they had no poisoning concerns about traditional medicines because they are "natural." They did not believe these natural medicines would cause poisonings, even when taken along with prescription drugs.

One service agency mentioned that the over-the-counter drugs people can purchase in Mexico are often highly potent and are different from those available for purchase in the United States. The Poison Center should be aware that migrant workers should be educated about the risks of over-the-counter medications, and should also know to ask migrant workers about such substances if they call in to the hotline.

Recommendation: SPIs should be aware that migrant workers may have in their belongings medications, both prescription and over-the-counter, from outside the United States. This risk should be built into any Drug and Poison educational materials.

Carbon Monoxide

Some migrant workers spend time in packing houses and in greenhouses, especially in the colder winter months. The workers often use machinery with combustion engines in these conditions, which can lead to carbon monoxide poisoning.

Recommendations: SPIs should be aware of migrant workers' potential exposure to carbon monoxide. This risk should be built into any Drug and Poison educational materials.

Pesticides

Agencies report that on occasion pesticides may cause skin rashes, and the migrant workers will go to the health clinic for treatment. The pesticides may make the workers feel dizzy, but the migrants are unsure whether it's really the pesticides or if their dizziness has another cause, such as a long period of time since they last ate.

One agency that provides substantial outreach and spends significant time in the camps reported that migrants use empty pesticide cans for storage, subjecting their storage items to pesticide residue. However, participants in both focus groups indicated that they do not use pesticide cans for storage. The

camps often consist of rooms where 5 or 6 people reside, with few storage spaces for dangerous cleaning solutions or other potential poisons. Therefore children are likely to be within reach of such substances. Even if children are not exposed directly to pesticides, Rushville focus group participants expressed concern that adults will bring pesticide residue home on their clothes and skin. Children will be exposed to the pesticides through the adults' clothing or contact with their skin. Participants were concerned about this indirect pesticide exposure for their children.

Depending on the type of agriculture, different substances will be found at the camps. While apple orchards will have pesticides for their crops, dairy farms will have cleaning products and medications for the cows, with which the migrant workers may come into contact. Dairy farms also use pesticides on corn or other crops they grow for feed. One agency indicated that the dairy farms, located primarily in Steuben, Livingston and Yates counties, have been more thoughtful about their use of pesticides and poisons, and are more responsive to suggestions from agencies that serve migrant workers.

Recommendation: The Poison Center should develop a component in its educational materials that addresses steps migrants can take to minimize their exposure to pesticide-related dangers.

Worker Protection Standard

The 1992 Federal Worker Protection Standard (WPS) was issued by the Environmental Protection Agency (EPA) and requires that anyone who employs workers exposed to pesticides be given (1) information about exposure to pesticides; (2) protections against such exposures; and (3) ways to mitigate exposures to pesticides.

As part of the WPS, employers must display certain EPA information in a central location, including (1) an application list of the type of pesticide to be applied, and the time and date the pesticide will be applied, (2) emergency information, including the name, number, and address of the nearest emergency medical facility, and (3) a pesticide safety poster.

As part of WPS, employers must be sure their workers are trained by an EPA-approved trainer. Since the growers are required by law to provide such training, the growers invite Rural Opportunities, Inc. (ROI), a local trainer, to visit their farms. ROI uses the WPS requirement to access agricultural workers, to provide both the EPA-required educational information, and additional information on health care-related topics. For example, ROI has developed a coloring book designed to teach children about the dangers of pesticides and other poisons. They plan to re-design the book in the near future and would welcome input from the Poison Center in that process.

Recommendation: The Poison Center should take advantage of the opportunity to work with Rural Opportunities to re-design their coloring book to teach children of the dangers of poisons. This will also reach adults who color with or read to their children.

One service agency pointed out that if an agricultural worker were to call the Poison Center, the Center should be sure to ask about the labels on the container of pesticide.[1]

Pesticides are a concern of the Brockport focus group participants. When the growers spray, they spray right over the participants' homes, with no warning as to the time the spraying will occur. Rushville focus group participants stated that they were not always notified when pesticides were applied. If they were given advanced notice of pesticide spraying, they were often working in adjoining fields. As a result, they were exposed to the pesticide cloud if it drifted from the sprayed field to nearby areas. One focus group participant said that she is more concerned about the effects on her children, and does not know what symptoms to look for. She is concerned that the children will not know how to tell her what is wrong or how they are feeling.

Recommendation: When developing materials that describe actions migrants can take to avoid exposure to pesticides, be aware of these sources of exposure.

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[1] The New York Center for Agricultural Medicine and Health conducts inventories of toxins on the farm, and helps with disposal.

Current Use of the Poison Center

Migrants are thought by the service agencies to be unaware of the issues surrounding poisonings, and to be unaware of the Poison Center itself.

Among the Brockport focus group participants, one said she had heard of the Poison Center, one said she had not, and one said she had seen something about it on TV but did not understand what it was. At the Rushville group, no one had heard of the Poison Center prior to the focus group.

What the Migrant Workers Look For

When asked what types of things they would like the Poison Center to do for them, the participants responded with the following:

- Would like to be provided with information on the dangers of medications and other poisons;
- Would like to know what substances are considered dangerous;
- Would like to know what they should do if someone is poisoned;
- Would like to know what symptoms to look for;
- Would like to have information about the Poison Center posted in a place where everyone would see it, like inside the main door of the barn where they work, as well as in the phone book because some people do look there. The phone book listing will be more effective if it is in Spanish.

Recommendation: The Poison Center should take into account the specific requests of migrant workers listed above, as the Center designs any educational efforts for this population.

One agency indicated that it does not use the Poison Center because while the Center is useful for acute problems, it is not as helpful for chronic occupational toxic problems (such as farm exposures). Further, the agency has its own information on occupational toxicology.

Outreach and Education Opportunities

According to agencies that serve the migrant worker population, the best ways to conduct outreach with this population include peer education, and in-person conversations. Rushville focus group participants indicated that in-person contact is key, supplemented with a brochure that participants could take home. They indicated that it did not matter who presented the information (could be any race or either gender), but an interpreter is essential. Direct contact is critical, not just TV or radio ads, or just handing out literature, although those efforts can be supplemental.

Culturally-Relevant Examples

Educators must identify culturally-relevant examples the migrants can identify with. Because of the frequently low literacy level, visuals should be heavily used rather than large quantities of text. Videos reportedly work very well, as well as other visual aids. Nonetheless, several agencies as well as the migrant workers in the Brockport and Rushville focus groups reported that the workers like to have something to keep at the end of an educational program, such as a handout.

Participants in the Brockport focus group described an educational session that was unsuccessful, because the presenter read the information straight from a script, and did not hand out any materials. These participants indicated that they like to receive handouts with information they can keep. Rushville focus group participants also expressed a preference for a brochure or handout to accompany any presentation. The Poison Center can work in concert with agencies that currently serve the migrant population, or, if they have fluent Spanish speakers, could hold the session on their own.

Recommendation: The Poison Center should be sure to develop some type of handout, ideally printed in Spanish and English, for use in educational programs with migrant workers. Handouts should include culturally-relevant examples.

Best Time and Place for Education

The Farmworkers Legal Aid Society conducts most of its education and outreach in the evenings, on Saturdays (at soccer games, etc.) and on Sundays after Mass. The Society also conducts direct outreach in the camps, spends time at "clinic night" in Sodus, and spends time in Hispanic grocery stores, and in

churches with migrant worker parishioners. Farmworkers Legal Aid is also periodically invited to attend various English as a Second Language (ESL) classes in the region to provide educational programs.

The Brockport focus group participants indicated that they are more serious about an educational program if it's held outside of their workplace, but then it is more difficult for people to attend. They indicated that families fail to show up for educational programs for several reasons including (1) lack of interest, (2) no available time, and (3) transportation problems. The consensus was that holding informational sessions at their place of work will reach more people. Rushville focus group participants also indicated that offering informational sessions at the camp would reach more people. ***The Brockport group stated that Saturday afternoons are the best time of week to hold a session, which matches the Farmworkers Legal Aid Society's experience as a successful time.*** Rushville focus group participants indicated that early evening hours were the best time because it would catch people after work. ***Many migrants work on the weekends too, so even on Saturday or Sunday, an early evening time may be best for a presentation.***

It is difficult to encourage the men in the families to attend educational or health-related programs. The Brockport focus group participants did not have any suggestions for how to encourage the men to attend, and are frustrated at the men's unwillingness to participate. They explained that in the Hispanic culture, women generally make the health care decisions, so the men leave such issues to them. However, the Rushville focus group was disproportionately male and they seemed engaged in the discussion and interested in poison and pesticide-related concerns. Therefore, it is not clear that gender will be a barrier to disseminating health-related information.

An example of an opportunity to address a gathering of migrant workers is a monthly festival held by a dairy farmer in the southern part of the Finger Lakes region. Several local camps gather for dinner and games. Catholic Charities and the Geneseo Migrant Center both take advantage of this gathering for educational purposes.

Recommendation: If the Poison Center wishes to access the migrant worker population directly, it should be aware of natural gatherings of migrant workers that might serve as good opportunities. This would be useful both for direct presentations made by the Poison Center, and also for groups like Farmworkers Legal Aid Society that are trusted by migrants to use in their interactions with migrants.

Preferred Type of Education Materials

The focus group participants in Brockport and Rushville expressed substantial hesitation and concern over dialing a phone number if they are unsure whether someone on the answering end will speak Spanish. However, they indicated that they will make the call, if it's an important issue. When asked if they would like to participate in role-playing to practice making phone calls to unfamiliar organizations, they gave strong agreement that they would like that very much.

Recommendation: If the Poison Center makes presentations directly to migrants, they might consider doing a role-play as part of the session.

To advertise information to the migrant worker population and their families, service agencies suggested using posters (posted in places like laundromats and grocery stores frequented by the population), and brochures in the work camps. The Rushville Focus Group participants' crew boss has a poster at the camp, on which he puts important information, and on which he said he would be willing to post Poison Center information. Contacting the growers (farmers) directly is also a method of outreach.

Brockport and Rushville focus group participants indicated that if materials are written in Spanish, they are able to read them with no problems. In fact, they enjoy finding Spanish materials, because they so rarely exist. A service agency representative agreed that most migrants can read Spanish at an 8th grade level. Service agencies indicated that in addition to Spanish, several dialects are spoken as well as Creole and other languages; however, one agency estimated that 80% to 85% of the migrant workers communicate in Spanish.

Information in English can be read by some of the workers, but only if it's written extremely simply, not in long paragraphs.

However, they pointed out that some individuals who are truly migrant and are here only a short time will not have the time or incentive to learn how to read any English.

Recommendation: The Poison Center should remain aware that very simple English will be understood by some, but not all migrants. Materials written in Spanish will be understood by most migrants.

Migrant Liaisons to Community

Agencies interviewed indicated that the migrant worker population generally has one person in their social group who serves as a liaison to the English-speaking community. This might be someone who has lived in the United States for a longer period of time, can speak some English, and understands enough of the culture to serve in this role.

Another agency stated that if a migrant worker makes an emergency phone call to 911 or a Poison Center, the worker most likely speaks enough English to feel comfortable making the call.

Cultural Variations

According to the Finger Lakes Migrant Health Center, the two largest ethnic groups among migrant workers are Mexican and Haitian. In addition, some migrants are from smaller towns in Mexico, where the indigenous population speaks a language related, but not identical, to Spanish.

While 80%-85% of the migrant workers communicate in Spanish, as mentioned earlier, some dialects are included in this group. An individual who speaks Spanish can likely manage to converse with persons who speak various dialects, but the language used must be simple, and the converser must be patient and willing to listen to the "story" the migrant worker is telling. *Oral tradition is strong among migrant workers, and it can take time to elicit the true problem or point.*

Suggested Poison Center Strategy for Educational Approach with Migrants

Since the migrant population itself can be so difficult to access directly, ***we believe that the key to outreach is to conduct education and in-service training with existing service agencies that serve the migrant population***. It is unrealistic to expect that migrant workers who speak only Spanish will call into

It is Unlikely that Spanish-Speaking Migrant Workers will Call the Poison Hotline

a hotline when they have an emergency poison question and are in distress, or even when they simply have a question. Their preferred approach is to either be educated in advance about Poison and Drug issues, to contact a health clinic they are comfortable with, or to contact a migrant worker service agency they trust.

Nonetheless, ***the strong ongoing relationship between service agencies and the migrant workers can be beneficial to the Poison and Drug Information Center in two ways: (1) to help the Center gain direct access to the migrant workers for educational purposes, and (2) as a group that should be educated on Poison and Drug issues themselves, given their high levels of interaction with the migrant worker population.***

Four-tiered Educational Approach

The Finger Lakes Poison and Drug Information Center should consider a four-tiered educational approach for migrant workers in the 12-county region.

Education for the Migrant Service Agencies

1. **Educate the migrant service agencies**. All the migrant worker service agencies interviewed described their important function as a clearinghouse for information for the migrant workers with whom they come into contact, as well as for the workers who call them looking for information. All the agencies interviewed welcome opportunities for in-service training and education so that they can then provide better information and services to the migrant worker community.

   The Poison Center can choose to educate the agencies on a one-by-one basis, or might choose more efficiently to use one of the coalition groups to reach multiple agencies simultaneously. The "Working Together Coalition" involves several area migrant worker service agencies. The Coalition also has an annual meeting of 50 to 60 new outreach staff from the participating agencies, to provide the new outreach staff with information they might need in their work.

   Recommendation: The Poison Center should take advantage of gatherings of migrant workers service agency staff to educate them on drug and poison issues.

Education for the Health Care Community

2. **Educate the health care community**. In an emergency situation, the health care community is likely to be the initial point of face-to-face contact with the migrant worker community, whether it is a clinic or hospital emergency department. As mentioned earlier, the health care community may not be proficient at identifying occupational-related illness and injury, and may not recognize pesticide-related symptoms. If the Poison Center were to educate the health care community more fully about poisons and drugs that might be prevalent in the migrant worker community, it might lead to better diagnoses and treatment protocols.

   Staff at the Finger Lakes Occupational Health Services have conducted in-service trainings with physicians on how to recognize the signs and symptoms of chemical exposures. Physicians and other health care professionals do not always recognize the signs of such exposure, and likely need more training on the issue. Further, physicians and other health care professionals do not always ask the right questions to determine whether a chemical or other poisonous exposure may have occurred, such as asking workers if they were recently out in the field.

   A Finger Lakes Occupational Health Services staff person is conducting a study in which all western New York hospitals from Erie to Seneca counties are undergoing chart review to identify occupational injuries. Researchers periodically see a diagnosis of "ectopic dermatitis," with no follow-up questions regarding pesticide exposure. This may be because medical personnel would need to file paperwork with the NYS Pesticide Registry if they determine someone is harmed by pesticide exposure.

   Recommendation: The Poison Center should conduct in-service trainings with as many health care providers as possible, including physicians, hospital staff, front-line health care workers (EMTs, ambulance providers), clinic workers, and others.

   County Health Departments generally do not provide direct services to the migrant population. Nonetheless, all Health Departments have Health Educators or Outreach workers

who wish to remain aware of all public health threats and issues in their communities. Tompkins County, for example, has a Community Health Nurse assigned to coordinate in-service trainings for the staff. They would welcome an educational presentation from the Poison Center. The Tompkins County HD coordinates with the Head Start and school districts in the county, and would be able to coordinate a meeting with representatives from all of these organizations.

Similarly, Monroe County has a Senior Health Coordinator[2] who is available to coordinate an in-service with multiple units within the Health Department.

Recommendation: Work through County Health Departments to set up in-service training for HD staff and other collaborators.

New York State has Regional Emergency Medical Services Councils. The Councils are responsible to plan, implement, and monitor the regional EMS system development in their multi-county area (defined in Article 30, Section 3003-a of the NYS Public Health Law). Several Councils cover the twelve counties served by the Poison Center:

- Southern Tier Regional Emergency Medical Services Council (STREMS, INC.): Chemung, Schuyler, Steuben.
- Central New York EMS (CYNEMS): Cayuga, Tompkins, [Cortland, Oswego, and Onondaga].
- Monroe-Livingston Regional EMS Council: Monroe and Livingston.
- Finger Lakes Regional EMS Council: Ontario, Wayne, Yates, and Seneca.
- Susquehanna Regional EMS Council: Tioga, [Broome, Chenango].

[2] John Ritchie, Senior Health Coordinator

The Councils could be a good source of contact for EMS on a regional basis, rather than contacting each of the twelve counties individually for in-service trainings. For example, Bill Little is the Wayne EMS Coordinator, but he also coordinates all in-service trainings for the Finger Lakes Regional EMS Council, which covers four of the counties served by the Poison Center. Similarly, Lee Shurtleff from the Tompkins County EMS stated that the Poison Center should work both with the individual county EMS agencies, as well as with the regional councils. The Central New York Poison Control Center is located in Syracuse, and is co-located in the same building with the Central New York Regional EMS Council. There may be a potential to co-host an in-service training session or in other ways work in conjunction with the Central New York Poison Control Center to collaborate on educational outreach in these counties. Pat Paddock, the Yates County EMS Coordinator, indicated that she would be the primary contact for training or in-service for Yates EMS staff. Sharon Chiumento indicated that the Monroe-Livingston Regional EMS Council coordinates all training for both counties.

The regional councils each have an advisory committee comprised of physicians in the region. The advisory committee develops protocols for the EMS agencies to follow, and the Poison Center may wish to work with the advisory councils to complete a Poison and Drug protocol for working with deaf persons or migrant workers.

Recommendation: The Poison Center should work through the Regional EMS Councils to coordinate in-service training for EMS workers.

Recommendation: The Poison Center should work through the medical advisory committee of each of the Regional EMS Councils to develop protocols for 911 calls related to Poisons or Drugs.

The Poison Center may also wish to use clinics, emergency departments and other health care facilities frequented by migrant workers as location for Spanish-language brochures, posters, or other written materials.

Recommendation: Take advantage of health care locations for placement of Spanish-language written materials regarding the dangers of drugs and poisons.

The Poison Center is involved in the Health Alert Network (HAN), a web-based notification system that allows the Health Department to communicate with the community via the Internet.[3] Since the Poison Center frequently looks for patterns and clusters in poisonings, and because of the new awareness of bioterrorism, the Poison Center's involvement with HAN is important.

Educate the Migrant Workers

3. **Utilize the migrant service agencies to gain access to the migrant workers**. In addition to educating the agency staff and the health care community, the Poison Center should educate and provide outreach to the migrant worker population itself. CGR does not believe it is in the Center's best interest to contact the migrant workers directly, or to enter the camps on their own.

Recommendation: Instead, CGR suggests two reasonable options, and perhaps a blend of the two is ideal: (1) work in conjunction with service agencies to gain access to the migrant workers; and/or (2) contract with service agencies to provide outreach and education on behalf of the Poison Center.

The BOCES Geneseo Migrant Center has developed a number of "Health Sheets," each addressing a specific health care issue, that are distributed to the migrant worker population. The sheets are printed in English on one side, and in Spanish on the other side. Selected Health Sheets that address Poison-related topics include: skin rashes, poisons and pills, pesticides, pesticides on clothing, medicine chest, keeping children safe, food poisoning, drugs, crack, breastfeeding, birth control, being careful with medicine, and alcohol. The Migrant Center would like to revise the sheets to ensure they are written at an appropriate educational level, and would welcome the Poison Center's involvement in this effort. The sheets are passed out

[3] Kurt Mast at the new Safety Building on Scottsville Road is the Monroe County contact.

in ESL classes and to the general population the Migrant Center interacts with.

Recommendation: Work with the BOCES Geneseo Migrant Center to revise Health Sheets that address drug and poison-related topics.

The Geneseo Migrant Center has contracts with many organizations to help with educational material development, and to develop curriculum for use with the migrant population. In addition, Rural Opportunities and Farmworkers Legal Aid both contract with organizations to provide education and outreach to migrant workers.

The Farmworkers Legal Aid Society currently contracts with the Finger Lakes Migrant Health Center to provide education and outreach on AIDS, domestic violence, and pesticides. In addition to presenting the material, the Society can also develop the curriculum. Since the outreach workers are so familiar with the workers, and what they are likely to respond to, they are in good stead to design the most user-friendly materials.

Recommendation: The Poison Center might consider working formally with the Geneseo Migrant Center, Rural Opportunities, and/or Farmworkers Legal Aid for help in developing educational materials, and in providing outreach to migrant workers.

One agency, which offered to work with the Poison Center to take its educational message to migrant workers, also offered this caveat. While some information can be appropriately dispensed by partnering agencies, other information may only be appropriately presented by persons trained in Drug and Poison control issues. The Poison Center should think carefully about the types of educational information it feels comfortable relinquishing to other agencies, and what types of information it feels it may not be able to pass to another agency and must convey directly.

Recommendation: Evaluate the type of educational materials the Poison Center could pass to another agency

to distribute and explain, versus the information that only Poison Center staff should disseminate. For the latter, Center staff should meet with migrant service agencies to determine the best way to gain access to migrants.

If the Poison Center were to determine that it would prefer to have its own staff conducting educational efforts directly with migrant workers in the camps, Rural Opportunities conducts "train the trainer" sessions to train staff from other agencies on how to best go about such efforts. Other agencies, such as the Geneseo Migrant Center, were also somewhat willing to help the Poison Center gain direct access to the camps. However, as described earlier, CGR does not believe that gaining direct access to the camps is the best way for the Poison Center to take its message to the migrant population. Thus, any direct Poison Center involvement with migrants should be carried out in conjunction with agencies such as Rural Opportunities, Geneseo Migrant Center, etc.

Use Available Media Outlets

4. **Conduct a Media Campaign**. Migrant service agencies indicated that typical TV and radio advertising will not be effective with the migrant worker population. However, a substantial Hispanic Media exists in the Rochester area. The following Hispanic media listing was collected by the Finger Lakes Health Systems Agency in 1999:

    a. **Print**—Swing Informativo (printed every 15 days, free, distributed at selected sites and through mail subscriptions).

    b. **Radio**—

        i. WGMC Super 90 (90.1FM) Domingo Martinez Sat. 12-7:30 pm; Sun 12-4:30 pm.

        ii. WRUR (88.5 FM) William Santiago Sat. 6-8pm.

        iii. Radio La Raza 950AM, weekdays 7-9pm.

    c. **Television—**

        i. R-News, ch 9, Que Pasa, 8:30 pm, Saturday and Sunday, Benjamin Herrera

ii. Cable

1. Telemundo, ch 17, national Spanish-speaking general and entertainment network.

2. Univision, ch 42, national Spanish television network.

iii. WXXI "Que Pasa Rochester," Friday 5:30pm, Benjamin Herrera.

The Poison Center could certainly take advantage of print media, especially given the migrant worker focus group participants who indicated that they enjoy reading printed materials in Spanish.

Recommendation: Advertise the Poison Center in all Hispanic printed media.

With a bilingual Director, the Poison Center could commit to participating in radio interviews on a regular basis.

Recommendation: Pursue radio interviews on Spanish-speaking radio shows.

R-News, Cable stations 17 and 42, and WXXI all provide an excellent media outlet for the Spanish-speaking population. While we recognize that many migrant workers will not have direct access to television, persons who work in migrant service agencies would be likely to gain exposure through Hispanic-oriented television, and some migrant workers live in residences outside of the traditional farm camps.

Recommendation: Pursue regular interviews with the various television Hispanic media outlets.

Strategy to Track, Monitor, and Measure Progress

An important first step in setting up a tracking or monitoring process is determining the questions of interest. Poison Centers

traditionally use "penetration rates" to measure their impact in a community. In addition, the Finger Lakes Poison Center tracks the number of educational seminars they hold each year.

Current Tracking Activities

Currently, the Poison Center participates in three primary data collection and monitoring activities:

1. The Poison Center utilizes the TOXICALL data collection form for documentation of all exposure and information calls. The SPIs collect information at the time a call is received. These data are archived on a monthly basis, with error checks made at that time. The data are then sent to the American Association of Poison Control Centers (AAPCC) semi-annually.

2. The Poison Center submits statistical and descriptive data to the NYS Department of Health for inclusion in the Annual Report of the New York Poison Center Network.

3. The managing director reviews cases on a daily basis to look for unusual cases or clusters. If a cluster of cases is discovered, the staff identify whether an educational outreach would be useful for a particular target population.

Tracking Use by Migrant Workers

In order to track the Center's utilization by migrant workers, a first step would be to monitor the Center's utilization by persons of Hispanic ethnicity.

Collect Race and Ethnicity Data

By the end of 1999, the FLHSA Hispanic Task Force (now called the Hispanic Health Coalition) planned to develop a statement on how local health care providers should collect information on ethnicity for data collection purposes. The Hispanic Health Coalition decided to adopt the Office of Management and Budget (OMB) federal data standard that was incorporated into the 2000 Census, and which will be required of providers in filling out birth and death certificates as of January 2003 (FLHSA, 2002).

Recommendation: The Poison Center should begin to collect, and track over time, ethnicity data from callers, in the manner described by the OMB. To collect race and ethnicity

data properly, SPIs must be trained on how to best elicit this information from a caller.

While information on race and ethnicity is a first step, ideally the SPIs would try to collect information on the caller's occupation to determine if the caller is a migrant worker. Migrant workers may refer to themselves as farmworkers, or agricultural workers.

Recommendation: Consider whether the SPIs can begin to collect and track occupational information from callers.

Make the Data Available to the Community

The FLHSA maintains a repository of Hispanic health statistics, with information on health status, health services utilization, and health care resources (FLHSA, 1999). If the Poison Center were to begin to collect data on the use of the Center or interactions of Center staff with the migrant workers population, such information might be included in the HSA's repository.

Recommendation: Submit any data collected on the Hispanic population to the FLHSA's data repository.

*Participate in Health*Action *Report Cards*

Health*Action*, formed in 1995, is a partnership of twelve Monroe County health care and planning organizations formed in 1995. The partnership generates community report cards monitoring community progress against specific health status goals, with the objective of improving the health status of the community. By 1999, five report cards had been issued: (1) mothers and children, (2) adolescents, (3) adults, (4) older adults, and (5) the environment. As the report cards are updated over time, the Poison Center may wish to include indicators on use of the Center by the Hispanic population.

Recommendation: Pursue a Hispanic* Poisonings *indicator for inclusion in the Monroe County HealthAction report cards.

Cultural Awareness is Critical to Quality Care

Nuestra Salud! [4] encouraged all health care organizations to commit to cultural competency, including programs and values which promote cultural competency and diversity. Health care organization leadership should recognize that cultural awareness is

[4] This report was written by the Finger Lakes Health Systems Agency (FLHSA).

critical to quality care. The report also encourages partnerships between Hispanic community-based agencies, such as those interviewed by CGR, and health care provider organizations.

National organizations have generated materials on cultural awareness. For example, the American Medical Association (AMA) has developed a *Cultural Competence Compendium*, a "resource guide to help physicians and other health professionals communicate with patients and provide individualized, respectful, patient-centered care" (AMA, 2002). The Federal Public Health Service, Office of Minority Health has proposed draft national standard language to begin to move towards national consensus on cultural competence in health care. The OMH has drafted guidelines for providers, policymakers, accrediting agencies, purchasers, patients, advocates, educators, and the health care community in general (USDHHS, 2002).

Recommendation: Review the existing materials on cultural awareness to make Poison Center staff more aware of the issues.

Tracking Progress on Educational Efforts

Agencies interviewed for the needs assessment indicated that they generally measure their educational effort success in terms of the number of "contact hours" they have with their target population. They also keep track of the number of educational materials they distribute throughout the year, and how many staff at other agencies they train through in-service or other educational efforts.

Recommendation: Track the number of hours Poison Center staff spend in contact with migrant service agencies, conducting educational and outreach efforts. Also tract the number of service providers, health care workers, EMTs, etc., trained thru the Poison Center efforts.

An educational campaign could be an important part of an educational effort through the Hispanic media. If the Poison Center decides to conduct a media campaign, they would want to track the number of advertisements run in Hispanic media, as well as the number of migrant workers thought to be reached by such advertising.

Recommendation: If the Poison Center conducts an educational campaign, it should track the number of advertisements over time, and if possible, track an estimate of the number of migrant workers thought to be reached by the ads.

Recommendation: Also track the number of migrants trained or exposed to trainings or workshops given directly by Poison Center, or on a contract basis by Rural Opportunities, Farmworkers Legal Aid, etc.

Track calls from migrants and migrant service agencies

Ideally, the Poison Center would be able to track the number of calls they receive from migrant workers, as described earlier. However, since the Poison Center will be doing more education with service agencies, the Center should track the number of incoming calls from migrant service agencies as well. In addition, key agencies serving the migrant population should be asked to track, and report to the Poison Center, the number of poison-related calls and requests they receive directly.

The Poison Center should consider working with the Strong Memorial Emergency Department and others such as the Sodus Hospital and Lakeside Hospital Emergency Departments to monitor the number of ED visits made by migrants that are drug- or poison-related.

Recommendation: Work with Emergency Department personnel and other medical providers to monitor the number of poison and drug-related visits. Also, work with other service providers to monitor the number of poison-related calls and requests they receive from migrants.

The Poison Center could conduct focus groups with both migrants and migrant service agency staff, before and after the changes suggested in this report are made, to determine whether there is any increase in awareness about the Poison Center and the issues surrounding drugs and poisons.

Recommendation: To measure increased awareness, hold focus groups with migrants and migrant service agencies, or conduct brief surveys, both before and after the educational campaign.

Tracking Use by Deaf or Hard-of-Hearing Populations

Currently, the Poison Center tracks the number of calls received via TTY, and reports that there has been a decrease in TTY calls over the past few years. However, the Poison Center does not track relay calls. It is possible that at least a portion of the decrease in TTY calls is attributable to increased use of the relay call system.

Recommendation: The Poison Center should begin tracking relay calls separately as well as TTY calls. Also track email requests from deaf or hard-of-hearing persons.

The Poison Center should offer additional staff training to increase sensitivity to the specific needs of the deaf population and the hard-of-hearing population, recognizing that these are two broad and distinct groups, with subgroups within each.

Recommendation: The Poison Center should provide additional staff training to increase sensitivity to issues in the deaf and hard-of-hearing communities.

Monroe County has a vast array of resources and programs for deaf and hard-of-hearing people. In turn, these resources attract a large deaf population. The Poison Center should make use of the programs and services offered by such entities as the Rochester School for the Deaf, the National Technical Institute for the Deaf and the Folsom Center, among others.

In outlying areas, Health Departments in rural counties have reached out to the migrant population to a certain extent, but many rural public health departments do little if anything specifically targeted to the deaf population. Therefore, it would seem that the rural deaf and hard-of-hearing populations are particularly well-suited for outreach efforts by the Poison Center.

Recommendation: The Poison Center should make use of existing community resources, especially in the metropolitan Rochester area, to access the deaf and hard-of-hearing populations.

Recommendation: Track the number of hours Poison Center staff spend in contact with deaf and hard-of-hearing service agencies, conducting educational and outreach efforts.

Recommendation: If the Poison Center conducts an educational campaign, it should track the number of advertisements over time, and if possible, track an estimate of the number of deaf or hard-of-hearing persons thought to be reached by the ads.

Recommendation: Track the number of deaf or hard-of-hearing persons exposed to trainings or workshops given directly by Poison Center, or on a contract basis.

Recommendation: Work with Emergency Department personnel and other medical providers to monitor the number of poison and drug-related visits. Also, work with other service providers to monitor the number of poison-related calls and requests they receive from deaf or hard-of-hearing persons.

Recommendation: To measure increased awareness, hold focus groups with deaf or hard-of-hearing persons and service agencies, or conduct brief surveys, both before and after the educational campaign.

CONCLUSIONS

The network of service agencies in the Poison Center's 12-county region is strong. These agencies have direct, regular contact with the deaf population and the migrant worker population. The agencies are trusted by the populations they serve.

Poison Center has a Unique Opportunity

The health care community provides a somewhat more mixed level of service to the special populations. While selected County Health Departments provide direct services, the Counties' role is predominantly one of coordination of services, and of linking individuals with the service agencies interviewed for this report. ***The Poison Center has a unique opportunity to not only conduct outreach and education on Poison and Drug issues, but to make health care providers in all twelve counties more aware of communication difficulties faced by the deaf or hard-of-hearing, and the migrant populations.***

CGR believes the Poison Center should take the recommendations made in this report, and move forward to work with agencies that serve both special populations. The Poison Center should share the results of this report with the agencies interviewed in the process, and proceed to meet with them to discuss ways of working together to meet the needs of the deaf or hard-of-hearing population, and the migrant population.

The strategy to reach the deaf population and the hard-of-hearing population should include the following:

1. Internal reforms for the Poison Center, including increased staff education, addition of deaf and hard-of-hearing persons to the Board, creation of a deaf or hard-of-hearing advisory board, and creation of an interactive web site.

2. Explore opportunities for partnership with existing agencies, take advantage of existing informal social clubs for outreach, design and distribute brochures and other written materials, and work with Public Health Departments, particularly in the outlying counties.

3. Conduct a media campaign through the traditional media, through the deaf media, and through new technologies including the Internet.

The strategy to reach the migrant worker population should include the following:

1. Addition of migrant workers or migrant service agency staff persons to the Board, and creation of a migrant advisory board.

2. Exchange of educational information between migrant service agencies and the Poison Center. The agencies have the opportunity to educate the Poison Center on migrant-specific cultures, opportunities for education, etc. In turn, the Poison Center can educate the agencies on the services they provide so that the agencies know whom to contact on behalf of migrant workers, and so they can better educate their constituent groups about poison-related issues.

3. Education for the health care community. In addition to educating the service agencies about the Poison Center's services, other health care organizations should be educated as well. This includes physicians, hospital staff, county health department staff, emergency and EMS/EMT workers, clinic workers and others.

4. Utilize existing agencies as partners to help reach the migrant workers. The Poison Center may wish to contract with a service agency to both help in the development of educational materials, and also to conduct outreach to the migrant workers both in work camps and other living situations.

5. Conduct a media campaign. The Hispanic media is substantial in Rochester, and many Spanish-speaking TV, radio, and print materials exist. The Poison Center can take advantage of such outlets for a media campaign.

Once the Poison Center evaluates its options and selects changes to incorporate, it should develop a specific, step-by-step workplan to implement change in the next year.

The agencies interviewed for this needs assessment were consistently impressed with the Poison Center's desire to improve services to the deaf population and the migrant workers population. With no exceptions, agencies are excited to participate in this effort, and they welcome the next steps in the process.

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APPENDIX A: LIST OF INTERVIEWS

Migrant Service Agencies

Bob Lynch, Bill Cotton
BOCES Geneseo Migrant Center
Mt. Morris, NY

Sister Beverly Baker
Josefino Paz
Migrant Education Outreach Program
SUNY Brockport
Brockport, NY

James Schmidt
Farmworkers Legal Aid Society
Rochester, NY

Patricia Rios
Finger Lakes Migrant Health Center
Rushville, NY

William Beckett
Medical Director
Finger Lakes Occupational Health Services
Rochester, NY

Jane Boyd
Nurse
Finger Lakes Occupational Health Services

Michael Attia
Rural Opportunities
Rochester, NY

Deaf or Hard-of-Hearing Service Agencies

Matthew Starr
Monroe County Association for Hearing Impaired
Rochester, NY

Pat Pogue
BOCES
Fairport, NY

Cynthia Kesselring
Marion B. Folsom Center
Rochester, NY

Karen Black
Rochester National Technical Institute for the Dear
Rochester, NY

Becky Kindelberger
Rochester School for the Deaf
Rochester, NY

Dr. Larry Medwetsky
Rochester Hearing and Speech Center
Rochester, NY

Mary Beth Mothersell
New York Relay Service
Geneseo, NY

Susan Demers Postlethwait
Regional Center for Independent Living
Rochester, NY

Trish Pross
Self-Help for Hard-of-Hearing People
Rochester, NY

County Public Health Departments

Brenda Kelly, Migrant Program
Susan Barrette, Early Intervention
Cayuga County Health Department
Auburn, NY

Linda Swarthout
Chemung County Health Department
Elmira, NY

Michelle Walker, Health Outreach Worker
Livingston County Health Department
Mt. Morris, NY

Andrew Doniger, Director
Jennifer Leger, Director of Communicable Disease Control
Monroe County Health Department
Rochester, NY

Alice Robeson
Ontario County Health Department
Canandaigua, NY

Marsha Kasprzyk
Schuyler County Health Department
Watkins Glen, NY

Vicky Swinehart
Seneca County Health Department
Waterloo, NY

Margaret Sullivan
Health Educator
Tioga County Health Department
Owego, NY

Karen Bishop, Community Health Nurse Supervisor
Diane Olden, Community Health Nurse
Tompkins County Health Department
Ithaca, NY

Elizabeth Featherly, Coordinator of Migrant and Seasonal Farmworker Health
Wayne County Public Health Department
Lyons, NY

Lisa Roth
Wayne County Health Department
Lyons, NY

Lauren Snyder, Public Health Director
Cindy Hinkal, Special Education Coordinator
Yates County Health Department
Penn Yan, NY

Other Health Care Providers

Stephanie Schrader
Clinical Coordinator
Finger Lakes Regional EMS Council, Inc.
Canandaigua, NY

Lee Shurtleff, Director
Tompkins County Fire, Disaster, and EMS (911)
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Patricia Paddock
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Sharon Chiumento
Monroe-Livingston Regional EMS Council

Peggy Mach
Pat DeNono
Cayuga County EMS

Sandy Stoeckel
Susquehanna Regional EMS Council