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A GOVERNMENT PERSPECTIVE II

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Over the past two days I have been sitting in the audience and hearing talks from people who are able to report vast experiences with agriculture and farming. So it is with some trepidation that I got up here. I reminded myself, "Hey, Gene, you have more than 35 years of experience as an end-user of agricultural products and that is it." But I do know what it is like, briefly, to be a practicing physician, seeing agricultural injuries, and—when I recognize them—illnesses. Frequently, I did not know where to go for preventive as opposed to curative or palliative help.

Nurses have a long history of public health care. They are in immunization programs, in tuberculosis control, women, infant, and children programs, STD programs—virtually all aspects of public health. What I want to do now, with these few minutes, is describe what we are doing. We are calling it the Nurses' Project, which will extend that model of public health nursing into the agricultural-occupational arena. I will try to fit this program into what I have heard from other talks.

It is still developing. It is already a program that will act locally and, I believe, has national impact.

May I go to that first slide with the map of our projects (Figure 1). The Nurses' Project is the green triangles. I think I will center the world on Iowa today and do an Iowa-centered perspective. You can see that we have the Nurses' Project located in Iowa, Minnesota, and North Dakota. New projects have just been awarded starting in July in Ohio and Kentucky. The project is also in California, Georgia, New York, Maine, and North Carolina.

Each project has three to five nurses. They will be, for the most part, regionally located. That varies from state to state. They are all in state health departments, but they will be based in districts, counties, or quadrants of the state, depending on the state and its population and the differences that each applicant engineered into its programs.

The important part is that each of these nurses is expected to become involved with the target communities. That means getting to know health-care providers of all types, getting involved with the Extension Service, land-grant universities, educational institutions, the Farm Bureau, the Grange, or whatever is important in taking care of the health and safety of the population, which they will be helping.

I think of the program as providing a public health infrastructure. It does that with three functions. Two of them are part of the surveillance, intervention, and research triad—surveillance and intervention. Those are enabled by what I expect to be the nurses' ability to forge links between their efforts, their health department's efforts, and other efforts and resources from

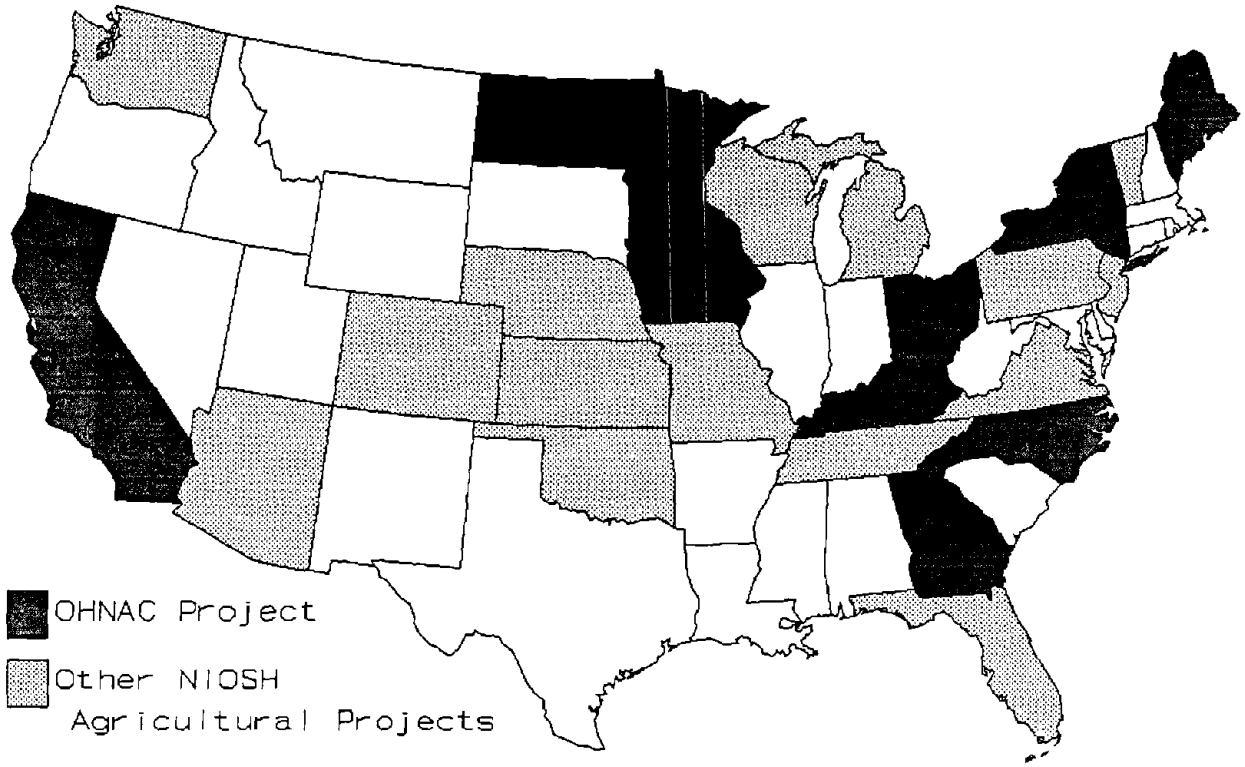

Figure 1. States with NIOSH Projects.

NIOSH projects, such as the Farm Family Health and Hazard Survey (FFHHS) that Todd just described, to all the groups I have mentioned, extension, educational groups, and the like.

I want to use Bill Halperin's surveillance topology from yesterday to help think through the surveillance aspects of this program. Inasmuch as the nurses, through their interactions with providers, can do case surveillance, they can help with the recognition of problems that may not be identified in the community.

For example, they may hear from a physician about a case of diagnosed or suspected organic dust toxic syndrome. They can identify that as a problem and trigger efforts to prevent it from happening again. Since they will be located in their own regions, they will often be able to identify all cases of a given condition, tractor rollovers or power take-off injuries. They can identify the scope of those problems, use that information to target intervention efforts, and after intervention efforts, evaluate how effective they have been.

The case surveillance also can work for targeting efforts in and of itself. An identified case of a sentinel event, which should not happen, such as a child injured from falling off a tractor on a farm, could trigger educational campaigns, press releases, on whatever would be appropriate in the community. This is active surveillance for these conditions because they will be there.

The other function is intervention. There are a number of ways to intervene.

Some are education (not just by going to schools and talking, which is something the nurses could do); giving presentations (sometimes it is very helpful to have someone who is a health professional provide that information); and also working with the already considerable efforts of the Extension Service. Another intervention is educating providers by giving them lists of reportable or desired reportable conditions or putting them in touch with contacts in the academic community, or referral sources that they are aware of.

Another educational intervention, which I think has the potential to be very powerful, is the dissemination of surveillance and research results. If they can show a community that these problems are real and happening to their neighbors, I think they can have an impact on people's behavior. Again, they can be links to other resources.

The Extension service have people who know how to retrofit tractors with rollover protection, if that is something someone wants to do. We at NIOSH have quite a lot of expertise in doing health hazard evaluations. That is an intervention that, when appropriate, could be performed.

By having some utility to providers in the community—and this brings things full circle—they can have an influence on surveillance. If you are asked to contribute to surveillance, you as a provider or an individual in the community are asked to contribute to something you perceive as useful. You, therefore, are going to be more likely to contribute.

That is the outline of the infrastructure, which with variations through our 10 cooperative agreement partners is being implemented. We have got a number of challenges ahead of us. We have work to do in terms of defining the most appropriate target conditions for this project.

I think injury clearly has much potential. Physicians are able to identify it. Some of the work on illness remains to be seen.

I believe that there are physicians and other providers out there who, as I have done, would—with a structure to support them in their interest in doing public health efforts—be eager to report. They would be eager to get their patients and their communities plugged into a public health system to prevent illness and injury.

There is plenty of work to be done in designing interventions. Of course, evaluating and identifying are the most successful elements of the varied projects that are part of this program. All these tasks need to be taken in concert with those at the local level that these people will be working with, the farmers, the Extension Service, the providers. All of these have a stake and a potential contribution.□

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