Piloting a Health and Safety Clinic Model to Address Precarious Worker Concerns

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Abstract

Precarious work, work that differs from the typical model of standard full-time, year-round employment, exposes its workers to adverse occupational health and safety outcomes such as increased occupational injury rates, higher hazardous exposures, and inadequate safety training and resources. Industries such as agriculture, custodial, food-service, housekeeping, and warehouse work are connected to precarious work. Minorities, migrant workers, and small-business workers make up a large proportion of precarious workers and minimal research has been done to minimize the occupational risks this population face. Building off an existing state-funded grant to educate low-wage workers about workplace safety hazards, this project developed, implemented, and evaluated a series of health and safety problem-solving clinics for vulnerable precarious workers. Transfer of health and safety knowledge and resources occurred during three 2-hour clinics. All clinics were pilot clinics that provided professional support to precarious workers as they identified their primary health and safety problems. The goal was for workers to empower one another through collaboration to address their concerns with the support of health and safety experts. To test the effectiveness of this model, follow-up interviews were conducted with clinic participants in order to determine the utility of the information and resources provided and its impact it may have had at a worker's jobsite. Worker concerns such as occupational injury, filing a worker's compensation claim, workplace conflict, and harassment were commonplace across the different occupations at each clinic. Workers stated that the clinics were helpful in getting their voice heard on the issues they face but they need additional support to follow up on the resources given to them. By bringing the health and safety experts to the workers, the clinics provide an opportunity to minimize the adverse occupational health and safety outcomes precarious workers face.

Precarious Work

The definition of precarious work is ambiguous. In the globalized flexible job market, precarious work is defined as poorly paid work that is incapable of sustaining a household and differs from the typical model of standard employment where a worker is employed by a single employer at full-time, year-round employment (Fudge, 2006). The International Labor Organization (ILO) states that precarious work occurs when employers shift their risks and responsibilities on to workers through actions such as uncertain employment durations, multiple employers with volatile relationships, lack of worker benefits, low pay, and barriers preventing the worker from joining a union (Quinlan, 2015). Precarious work is also commonly referred to as contingent, atypical, or non-standard work (Kalleberg, 2009). Having an ambiguous definition means that it is harder to understand who the workers are in precarious work and their concerns. While there is no universally agreed upon definition of precarious work, common themes of worker exploitation and adverse health and safety risks are connected to each definition.

The key aspect that makes a job precarious is the work arrangement. Aspects of each work arrangement add additional stressors onto the job that make the worker live on a day-to-day basis (Kiersztyn, 2017). Some worker arrangements that can increase precarity are long hours, few or no benefits, fixed-term contracts, and part-time or temporary employment (Kiersztyn, 2017). Research shows that because of these arrangements, precarious non-standard work exposes workers to adverse occupational health and safety outcomes such as increased occupational injury rates, higher hazardous exposures, and inadequate safety training and resources (Quinlan, 2015).

Precarious work typically has minimal job qualifications and requirements that attract workers lacking higher education experience, migrant workers with little-to-no English literacy,

and workers whose need for money outweigh the potential health risks (Work Rights Centre, 2018). A wide variety of industries including food service, housekeeping, retail, custodial, agricultural work, and home healthcare are connected to precarious work arrangements and many of the vulnerable workers in these industries are over-represented by people from minority communities and small businesses (David, 2013; Work Rights Centre, 2018; Zoeckler, 2018). Many precarious workers, especially racial and ethnic minorities and non-English speaking individuals, do not speak up about their concerns or about the problems they face due to fear of losing their job over conflict with a supervisor, lack of access and knowledge to health and safety information from their employer, and little training on how to recognize or address risks encountered at work (de Castro, 2006). With few other options for work, precarious workers face the injustices at their job despite the overwhelming risk to their health and well-being.

Measuring precarious work is difficult to accomplish and not much research on injury rates or number of workers among this group has been examined (Riley, 2015, Leigh, 2016, Kiersztyn, 2017). Precarious work has no single statistical category that it can call its own due to employment variation among its many job sectors (Kalleberg, 2014). Taking statistics from the smaller job sectors within precarious work to examine it as a whole is not an accurate way to measure workers. Caveats to consider include part time yet stable work or self-employed individuals (Kalleberg, 2014). A lack of authentic statistics for an assumed sizable workforce in the United States is alarming. Advocating for improved health and safety knowledge for precarious workers and ways for them to empower themselves and others like themselves at work is a possible solution to minimize the inherent dangers they face.

Previous Work

The Low-Wage Workers Health Project was an initiative created by Jeanette Zoeckler in Syracuse, NY (Zoeckler, 2014). This project occurred over three phases that each built upon what was learned in the previous phase. Phase one conducted a survey of 275 low-wage workers. Jeanette utilized community-based organizations (CBOs) to connect to these workers and conduct the survey. The survey focused on details of low-wage work such as wages, hours worked, and their health and safety conditions. Phase two built upon what was learned through the survey and used popular education methods such as body mapping and workplace hazard mapping to form conversation groups amongst workers. The conversation groups addressed specific problems raised by workers. Phase three continued what worked well and improved other aspects from the previous phases. The study found that group discussion amongst low-wage workers fostered a boost in their morale. It allowed the workers to share stories on what they faced, how they overcame challenges, and whether or not other workers could do what they did as well. Reading Ms. Zoeckler's reports as well as talking with her through a video chat conference helped our study team design a model and content for our clinics.

For the current study, the Fair Work Center (FWC), alongside sub-contractor University of Washington Department of Environmental and Occupational Health Sciences (DEOHS), has been working on a Washington State Department of Labor & Industries Safety and Health Investments Projects (SHIP) grant to reach and train precarious workers in the Seattle area about workplace health and safety risks. The initial grant involved multiple phases and goals over the course of two years. The overall grant goals were to:

A. Address the health and safety needs of low wage workers

B. Increase the organizational capacity and effectiveness of CBOs in addressing workplace health and safety issues in their communities
C. Develop a curriculum, methods, and other materials to enhance health and safety knowledge, hazards recognition, and skills among vulnerable populations, and raise the bar for workplace safety to reduce injuries and illnesses

Multiple phases in the grant were executed alongside a consortium of community-based organizations (CBOs) affiliated with the Fair Work Center. There are many CBOs in the state of Washington. Each CBO works with a different population of workers and has the experience needed to tackle that specific populations needs while advocating for improvements in their rights. Many of the CBO staff either have experience interacting with these workers in their community or are perceived as trustworthy leaders in their community that workers can come to for guidance. Utilizing CBOs addresses the health challenge of connecting to hard-to-reach workers about their workplace safety. It also gives these workers a platform to discuss their concerns with people they can trust. The deliverable goal of the grant was the one-hour health and safety awareness curriculum, which CBO staff delivered to their constituents. The curriculum was designed for flexible delivery in many settings to provide precarious workers a basic understanding of health hazards in the workplace, their rights, and strategies to reduce risk. Flexibility was an essential factor due to the various populations and languages of the target precarious worker population, and the time constraints of the CBOs and workers. The 10-hour "train-the-trainer" workshop on health and safety principles and resources preceded the one-hour health and safety awareness curriculum. The workshop described curriculum ideas and

techniques that CBO staff could modify according their presentation style and abilities. It built a foundation-training outline needed for the deliverable goal of the grant.

The final goal of this grant was the creation and implementation of a problem-solving and empowerment clinic model focused on addressing worker health and safety concerns. Since the 1-hour trainings focused on flexibility and brevity, it was assumed that workers may either have more questions and concerns that need to be answered. It was also important to empower workers to seek more information on their workplace safety and health and to advocate for their safety needs. The 2-hour clinic builds upon the basic information discussed in the 1-hour training and creates solutions tailored to each worker. By bringing workers to a group of health and safety professionals, the workers would be getting expert advice on their problems that they would not get in the 1-hour trainings and would be able to expand their knowledge on hazards they may face at work. The workers would discuss ways to solve their problems amongst themselves and the experts would be there to facilitate discussion and provide insight on knowledge they would not know.

Specific Aims

A. Facilitate the transfer of health and safety knowledge and resources during three 2-hour clinics. This includes providing support to workers as they identify their primary health and safety concerns, documenting resources and expert advice that happens during the clinics, and ensuring that workers receive the resources in an accessible format
B. Evaluate the feasibility and effectiveness of the clinic model as implemented here by process evaluation on the development and implementation of the clinics and through

follow-up interviews with clinic participants to determine the utility of the information and resources provided and its impact it may have had at the worker's jobsite

Methods

This project went through Institutional Review Board (IRB) protocol to determine the method ethics of the project. IRB determined that this project is exempt from IRB criteria and was able to continue recruitment. Worker recruitment is first done through CBO leaders. The CBO leaders are members of the community that know the workers and are familiar with the concerns these workers face at work. CBO leaders invite workers to attend the 1-hour general health and safety hazard awareness presentation. CBO leaders conduct the presentation in a way that caters to the workers understanding and language. At the completion of the 1-hour training, workers that have specific occupational concerns that need further discussion express interest and are invited to attend the 2-hour clinic.

Demographic information such as occupation and any concerns the worker experiences on the job are documented by the CBO prior to the clinic and sent to UW to allow for preparation of resources given out at the clinic. The organizers contact experts in the fields of occupational safety and health, industrial hygiene, occupational medicine, occupational nursing, and legal support to ask them to volunteer in the clinic. Interpreters for Somali or Spanish speaking workers are also recruited as needed for each clinic. The accumulation of this planning are the 2-hour pilot clinics that connects the workers with the expertise that they are normally are not exposed to.

Approximately 8-12 workers attend each pilot clinic. UW staff and CBO leaders introduce the project and purpose of the clinic to workers in attendance at every clinic. Workers

are first joined together as a group where each person describes their occupation, their working conditions, and their primary reason for attendance to experts and other workers. After each worker shares their list of work concerns, they collaborate amongst one another to propose solutions to the problems based on past experience or critical thinking. Experts contribute to discussion on problems that are too difficult for workers to resolve. Workers are also provided the opportunity to meet one-on-one with experts and discuss private worker issues. Demographic data such as race/ethnicity and gender were determined by visually assessing every worker instead of asking each worker to keep anonymity.

At the conclusion of each clinic, workers completed a brief clinic evaluation form. The evaluation was developed for workers to quickly assess the clinic and provide recommendations for improvement. The evaluations resembled program development evaluations because of limited research methodology on evaluating precarious work. Brevity was emphasized to make sure that workers are comfortable when answering questions. The evaluation for clinic one was structured through recommendations made by the FWC so that it would be simple for workers. This evaluation led to many one-word answers. The evaluation for clinic two was improved so that more detail could be discussed by workers. Clinic three evaluations continued with even more detailed questions to compensate for no worker interviews. Each pilot clinic evaluation evolved over time by building on what was learned and how workers responded to the evaluation. Clinic organizers also contacted workers several weeks after the clinic for a phone interview. Clinic one and two were the only clinics to have conducted interviews. Clinic three did not conduct interviews due to time constraints of the project. Both the evaluation form and the interview are conducted to assess the overall clinic model and if the answers to worker concerns had been applied at work.

Clinics one, two, and three all were modified to cater to the worker preference as well as to build upon what was learned at the previous clinic. The first clinic was hosted at the FWC and hosted multiple industry workers. Workers at this clinic favored meeting with experts privately over discussing amongst others. The second clinic was in collaboration with Working Washington (WW) to focus on agricultural workers. Workers shared similar jobs with one another and preferred to discuss their problems as a group before moving on to one-on-one time. The last clinic was concentrated on the SEIU Local 6 union and the janitorial workers they represent. This clinic incorporated the one-hour hazard awareness into the methods to train a larger number of anticipated attendees. Every modification was done to keep workers comfortable with the flow of the clinic in a way that benefits them the most and to assess alternative modes of delivery of these services.

Clinic Descriptions

Process of the Clinic

Clinic 1

The first clinic was held on Saturday, September 30, 2017 at the FWC office in Seattle, WA. The clinic was held mid-day from 12:00-2:00 pm to accommodate worker schedules, although the start time was delayed. Five workers, two interpreters, two FWC staff, and four health and safety experts attended in addition to program staff and family members of the workers. The four experts were volunteers from the University of Washington (UW) and are professionals in the fields of industrial hygiene, occupational safety, occupational medicine, and occupational nursing. The Spanish interpreter accompanied the Spanish-speaking worker and the Somali interpreter accompanied the Somali-speaking worker through the duration of the clinic.

The clinic began with a brief overview of the purpose and the structure of the clinic. Workers were given the choice on the style of the clinic, whether it be an open discussion, allowing workers to talk about their problems amongst one another and with experts, or individual discussions between one worker and panel of experts. The majority of workers preferred the individual discussion format to the group discussion format. Experts moved one building over and prepared a private room for the individual meetings. As workers met individually with the experts, other workers were provided lunch.

The course of action was to have each worker come to the panel of experts, give a five-minute introduction on their problem and receive an initial solution to their problem. The expert panel would then determine what information and resources were needed for each worker and present their solutions in detail later. Each worker ended up spending approximately 10 minutes during the introduction discussion due to time needed for interpreters to speak, time for more detailed description of their job and problems, and time for experts to dissect and understand each situation. Some workers described concerns brought up in the pre-clinic information while other workers brought up new concerns and were in different occupations. Experts divided workers into two groups based on the types of concerns that the worker raised. One group focused on workers compensation system concerns (filing an occupational injury claim, physician second opinions, worker's compensation) and the other group focused on worker mistreatment and harassment.

Clinic 2

The second clinic was held on Saturday, March 10, 2018 at the Working Washington Office in Yakima, WA. The clinic was held in the late afternoon from 4:00 – 6:00 pm. 12

workers, three interpreters, four experts, and two clinic organizers attended the clinic, totaling 21 people. All of the workers came from an agricultural occupation but had different specific jobs such as warehouse packer, driver, and harvester. Three health and safety experts volunteered from the UW and one legal support expert volunteered from the FWC. The three health and safety experts had professional backgrounds in occupational medicine, occupational nursing, and industrial hygiene. One Spanish interpreter officiated through the entire clinic while the other two interpreters provided individual support when needed.

The clinic two group discussion format differed from the clinic one individual discussion format. The clinic began with worker introduction, which included their name, occupation, and the health and safety concerns they had. Once each worker described their concerns, the experts addressed the concerns that were common amongst all workers. Discussion between experts and workers about their concerns and possible solutions to their concerns occurred for a majority of the clinic. A plan to break up into smaller groups for further discussion on medical or legal concerns was cancelled because all workers enjoyed the large discussion format and felt that they share multiple concerns. Group discussion ended at 6:00 pm. Workers stayed past the 6:00 end time to talk individually about their concerns with the experts. Before workers left, they completed a short evaluation on the clinic and some volunteered to be contacted at a later date for an interview.

Clinic 3

The third clinic was held on Saturday, May 12, 2018 at the Service Employees International Union (SEIU) Local 6 offices in Seattle, WA. The clinic was held mid-day from 12:30-3:30 pm but the start time was delayed to 12:45. Seventeen workers, two interpreters, four

experts, one FWC employee, and two clinic organizers attended the clinic. All workers serve as janitorial service workers and are represented by their local janitorial union, SEIU Local 6. Three health and safety experts volunteered from the UW and one legal support expert volunteered from the FWC. The UW experts had professional backgrounds in industrial hygiene and occupational medicine. The union provided six Spanish speaking workers interpretation devices. A Spanish speaking union leader provided interpretation through the devices the entire clinic. Another union leader provided Somali interpretation for two Somali speaking workers.

The length and structure of clinic three differed from the previous clinics. Clinic three had two segments, a one-hour hazard awareness training and a two-hour problem-solving clinic. The training segment immediately preceded the clinic segment. The training segment was added to the clinic because of the possibility of over 40 attending janitorial workers. Awareness training is deliverable to larger groups of workers compared to the smaller personable clinics. The concept is that all attending workers would learn the basic hazard awareness training material that can be applied at their occupations. Workers with specific health concerns that needed expert advice would stay for the subsequent clinic while other workers leave. Combining the two segments into one entity allowed for more worker presence while still solving specific individual problems.

The training segment began with worker introduction, which included their name and the janitorial company they work for. Training was divided into four presentation sections: worker rights, identifying hazards on the job, understanding safety strategies, and taking action. The worker rights section focused on presenting nine rights each worker has to keep themselves safe. The identifying job hazards section presented four types of hazards on the job: physical, biological, chemical, and social. Workers were encouraged to identify specific hazards that they

encounter and place them into one of the categories. The understanding safety strategies section introduced a modified hierarchy of controls to the workers. Workers were tasked with taking a hazard that they face and thinking of different ways that they can control the hazard. The taking action section utilized a specific scenario and had the workers actively come up with ways on taking action to manage a hazard. The understanding safety strategies and taking action sections blended together during presentation.

Clinic organizers stated that all specific individual concerns were to be saved and shared only during the clinic segment of the presentation. During the training segment, a majority of workers had specific questions related to their individual rights and the presentation evolved into a clinic discussion. Many workers participated in the training using personal situations rather than holistic scenarios that other workers could relate and discuss with. Only eight of the seventeen workers actively participated in the training section and a majority of the participating workers were Caucasian males. The training section ran an hour longer than anticipated. Workers were free to leave at the end of the training segment and encouraged to stay for the clinic portion if they felt they wanted further health and safety discussion for individual concerns.

Nine janitorial workers and two union workers remained for the clinic segment. The clinic began with worker re-introduction that included specific concerns that workers raised. Discussion between experts and workers highlighted issues that all workers shared. Experts proposed solutions and worker empowerment opportunities for the workers and the union to collectively take. Workers slowly left the discussion over time. Four workers stayed for the entirety of group discussion which ended at 3:30 pm. Before workers left, they completed a short

evaluation of the clinic. Worker interviews for were not arranged for the third clinic because of time limitations of data collection.

Concerns and Solutions

Clinic 1

Information on number of workers and worker concerns were gathered prior to the clinic. The data focused primarily on worker concerns and occupation while demographic data such as age, language spoken, or race/ethnicity was not obtained at the time. The collected information stated that the five workers came from different occupational backgrounds that include orchard worker, warehouse packer, homecare worker, and custodian. The general concerns gathered before the clinic were worker mistreatment, improper and aggressive work practices, wage theft, and occupational injury. The intent was to have the clinic experts review the occupation and concern information prior to the clinic so that resources could be prepared for workers. However, due to delayed collection of worker information, experts had a limited time to review and compile printed resources.

Five workers attended the clinic. Of the five workers that were in attendance, two had submitted their concerns as a part of the pre-clinic collected information. The other three workers were from different occupations than those anticipated. Despite each worker sharing a different work experience, the general health and safety concerns were similar to the collected concerns. The general concerns that the workers expressed were difficulty filing occupational injury claims, finding physician second opinions, the worker's compensation system, and worker mistreatment. Based on the general concerns above, workers were divided into two groups during solution discussion.

Table 1: Worker Demographics for Clinic One

WORKER	Industry	Gender	Language	Race/Ethnicity
1	Warehouse	Male	Somali	Somali
2	Agriculture	Female	Spanish	Chicana
3	Custodial	Female	English	Somali
4	Gas Station Attendant, Housekeeping	Female	English	Somali
5	Retail	Female	English	Somali

Each worker presented their issues and concerns individually to the expert panel. The first worker was a Somali male in his 40s. He only spoke Somali so interpretation was needed throughout the discussion. He works two jobs in the warehouse and service industries but was not currently at work due to an occupational injury sustained in 2016. He sustained a groin injury while at work that has required him to miss significant time. He reported his injury, received medical care, and was recommended surgery. The worker wanted to seek a second opinion on his injury to avoid surgery but fears that if he were to seek another doctor, he would lose his workers compensation medical benefits. The occupational medicine expert recommended that he see an occupational physician. An occupational physician would be better equipped to understand his workplace injury and act accordingly compared to a normal physician. He was reassured that every worker has the right to a different doctor and that his medical benefits would not be lost in the process. Experts provided the worker printed resources on the worker's compensation claim system and a list of occupational physicians in the Seattle area.

The second worker is a Chicana female in her 50s who had many concerns ranging from sexual harassment to worker mistreatment. She only spoke Spanish and interpretation was needed throughout the discussion. She has been working for more than 20 years in the agricultural industry, both as a field worker and as a warehouse worker. She informed the experts

that many women at her workplace endure suffer sexual harassment from employers and that the women do not have a voice to stop it from happening. She described that in 2014, the Pacific Northwest Agricultural Safety and Health Center (PNASH), a UW DEOHS agricultural health and safety center, conducted a study that provided training and educational clinics on sexual harassment in agriculture. She and her fellow workers felt that those clinics were very beneficial in protecting the workers. She also described mistreatment on the jobsite involving workers continuing work despite injury. She also did not believe Washington State Labor & Industries (L&I) is doing all that they can to help her and her fellow workers. Her concern is that L&I has not provided solutions or talked to employers about prevent further injury and that her voice is not being heard. The occupational nurse expert responded to her concerns in the worker mistreatment discussion. The expert, who is also a member of PNASH, connected her to the director of community engagement at PNASH. The director of PNASH had previously worked with the worker in a previous study. The expert explained that continuing the partnership between PNASH and the workers would educate them more about their rights and on how to handle sexual harassment and mistreatment at the workplace.

The third worker was a Somali female in her 50s who spoke both Somali and English. She had been working as a custodian at a local university for many years and has had a debilitating back injury for quite some time. She first injured her back in 2008 while cleaning a bathroom stall and that her pain had gotten worse over time. In 2016, the pain in her back had become unbearable and she brought it to the attention of her employer. The employer provided workers compensation and physical therapy that later got put on hold. A doctor diagnosis informed her that she has a reoccurring bulging disc in her lower back that requires surgery. She was hesitant to take the surgery because the doctor told her there is a chance she would be

confined to a wheelchair. The occupational physician recommended during the solution discussion that the worker see an occupational physician who would be more qualified to understand the situation and handle the injury. The occupational physician provided the worker with a printed list of occupational physicians in the city of Seattle who could look at her case.

The fourth worker attended the clinic for a friend that was unable to attend the clinic. Demographic data on the friend was not obtained but the worker that did attend the clinic was a Somali female in her 20s who spoke both Somali and English. The woman explained that her friend worked two jobs, one at a gas station and another as a housekeeper. Her friend was injured one month prior to the clinic when an object fell on him at one of his jobs. The injured body part was not specified but he is getting worker compensation for his injury. The friend was interested in knowing more about general health and safety in the workplace to prevent future occupational injury. The occupational safety expert and the industrial hygiene expert provided general health and safety information regarding workers compensation and workplace hazards to this woman to relay back to her injured friend.

The final worker was a Somali female in her 30s who spoke both Somali and English. She had worked at a major retail company as a customer service representative for 15 years. In the past year, she had experienced a major workplace harassment issue led to her temporary termination from the company. The incident that led to her termination involved a co-worker reporting her for workplace misconduct. She filed a complaint with the FWC's help and eventually got her job back. The worker attended the clinic to understand and gather more information about worker's rights so that she may support others that have faced similar issues. The worker briefly discussed she had foot pain in the past from her job but did not go into detail

on that issue. The expert panel provided information and contacts that specialize in worker's rights.

Table 2: Individual Worker Concerns for Clinic One

WORKER	Individual Concern
1	Occupational Injury, Second Opinion on Surgery
2	Sexual Harassment, Unfair Work Practices, Lack of Response
3	Chronic Occupational Injury, Workers Compensation Claim
4	General Health and Safety Information, Injured Friend at Work
5	Unjust Firing, Harassment

Clinic 2

The CBO Working Washington gathered information on the number of attending workers and worker concerns three days prior to the clinic. Similar to clinic one, the collected data focused primarily on the worker concerns rather than demographic data. Eight workers confirmed their clinic attendance with the CBO. Four more workers stated that they may possibly attend the clinic but are not fully committed to showing up. All workers were within the agricultural industry but work at different locations and occupations. General worker concerns gathered include workplace accidents, physical occupational injury, chemicals, worker discrimination, and worker harassment. Working Washington stated that none of the workers had received previous hazard awareness training and needed Spanish interpretation throughout the clinic. Clinic organizers prepared an array of resources that cover worker concerns and other common hazards agricultural workers face. Resource topics include agricultural ladders, farm vehicle accidents, pesticides, musculoskeletal injuries, worker harassment, sexual harassment, and injury claims. All resources were placed on the discussion table and workers were free to take as many resources they wanted.

Twelve workers attended the clinic. All workers were Chicano and spoke Spanish. The general collective concerns that workers expressed were occupational injury, lack of trust and lack of worker representation. Occupational injury concerns were discussed in detail individually but the other two concerns took up a majority of the discussion. Workers conveyed a lack of trust and felt unrepresented by Yakima physicians, Yakima lawyers, and L&I. Many workers articulated instances with a physician where either they were rushed in and out of the hospital or the physician diagnosed physical injuries without touching the worker. Workers believe that the Yakima physicians do not represent the workers in any way and they are unresponsive with medical advice. The occupational physician expert pointed out that not all doctors are equipped to handle specific occupational concerns. While emergency room doctors prioritize severe injuries and illnesses, their goal is to get the patient in and out of the hospital as fast as possible. Occupational physicians are more equipped to operate around the worker's concerns and assist in creating an occupational claim based on their expertise. Experts provided workers with a list of nearby occupational physicians and experts recommended that workers communicate with one another about occupational physicians that have successfully helped them. Building trust for physicians would be more effective if workers can advocate for successful cases.

Trust and representation issues were also pointed at lawyers. Lawyers were labeled as "money hungry" and that they cannot be trusted since they do not have the best interest of the worker. Some workers stated that they have tried contacting lawyers for workers compensation cases but were denied help and were told that they do not qualify for help. The legal support expert explained that much like physicians, not all lawyers are equipped to deal with workplace injuries and worker's compensation. Workers that contact workers compensation lawyers will most likely qualify for help and will have capable lawyers representing them. Experts provided

workers with a lineup of organizations that specialize in helping underrepresented populations with legal issues. Organizations provided include the FWC, Columbia Legal Services, the Northwest Justice Project, and Project Help.

Workers constantly brought up issues with L&I during the clinic. Workers were well aware of L&I's authority over workplace safety but believed that they were doing a poor job of representing agricultural workers in Yakima. Workers stated that they feel like L&I does not hold the agricultural employers accountable for the risks and hazards they face on the job. Worker complaints sent to L&I would either be ignored completely or have no effect in eliminating the occupational hazards worker's face on the job. Employers moved workers to different jobs at a deduction of pay the moment the worker reports an injury to their supervisor. If an L&I inspection did occur, workers claimed that they experienced no change in workplace safety and their employers continued the same practices that workers fall victim to. Workers with occupational injury claims reported that L&I would close their case without notice or an explanation why. If L&I denies a worker's case, workers do not often appeal the decision. At this point in the process, workers are discouraged and believe appealing the decision is worthless since their concerns are not being heard. The experts detailed the workers compensation claim process to the workers and pointed out a few nuances that may have been reasons why complaints were ignored or why cases were dropped. In order for a worker's compensation claim to have a strong case, the claim must have evidence that the injury, illness, or exposure of concern is work related. If there is any doubt that concern is not work related or there is no evidence, the case no longer has weight to continue and L&I will dismiss the claim. Employers also have the ability to move workers to light duty work to avoid having to pay for time loss wages. Experts stressed the importance of filing an appeal and doing so on time. When filing an

appeal, the worker has 60 calendar days to do so since the notice of their decision and they must cite the specific law connected to the appeal. Experts reiterated that the legal support organizations could assist in finding evidence for an appeal and ensure that the worker has the strongest case possible.

Table 3: Worker Demographics of Clinic Two

WORKER	Occupation	Gender
1	Supply	Male
2	Fruit Picker	Female
3	Fruit Picker	Male
4	Construction	Male
5	Fruit Picker	Female
6	Warehouse	Male
7	Warehouse	Female
8	Warehouse	Female
9	Elderly Care	Female
10	Elderly Care	Female
11	Driver	Male
12	Warehouse	Female

Each worker had individual concerns that were presented to the discussion group or kept private until individual expert discussion. The first concerns shared in discussion were from a husband and wife couple in their mid 40s. The husband works primarily in construction while the wife works seasonal jobs picking fruit. The wife shared that she has lingering foot pain from an agricultural ladder fall while picking fruit. The pain does not deter her from working but it persists. She had seen a doctor for her foot pain and the doctor told her she is healthy. She feels misdiagnosed since the doctor only looked at her rather than assessing the ankle in detail. She also brought up a point regarding seasonal agricultural workers and workers compensation. She and other seasonal workers avoid filing for workers compensation because their job length is

short. She believes that going through the process would be a waste of time. The husband did not share any specific concerns regarding him. Experts responded to the wife's concerns by recommending an occupational physician for a better diagnosis. Resources and graphics on agricultural ladder safety were also provided. Experts recommended that seasonal workers should still file for workers compensation. Seasonal workers are entitled to the same workers compensation benefits as the standard worker. Specifics about worker coverage at the conclusion of the working season were not specified.

The next group of workers to share their individual concerns were a Chicano family of three. The family includes a father in his 50s, a mother in her 40s, and a son in his late teens. Each member of the family brought different concerns to the clinic. The father was suddenly dismissed from his field worker job of 25 years and the employer gave no reason why. He contacted a variety of lawyers for assistance but received no help. He stated he contacted some of the organizations provided by clinic organizers and that they were of no help to him. Experts recommended that the father contact other organizations on the provided resource list that he had yet to call. The other organizations may do a better job at handling his situation.

The mother is also a field worker and had an issue with chemical spray coming into contact with her skin. She filed a complaint but was told that she needed evidence of an overexposure. She does not know how to gather that evidence and is worried about the consequences of chemical contact. Experts recommended that she document in detail the chemical exposure incident to build up a claim. Pairing the detailed account of chemical exposure with an L&I complaint would be enough evidence to force a workplace compliance inspection. Resources and graphics on pesticide exposure were also provided.

The son worked a summer job and injured his back unloading pavers. He did not receive compensation support from the company and is undergoing physical therapy. The family is looking to find financial support for the physical therapy and ways to hold the company accountable. Experts referred him to the same resource list his father received that he can go to for workers compensation legal help during individual discussion.

An elderly couple shared their concerns of age discrimination at work. The husband and wife are both warehouse workers at the same company. Supervisors berate them for working at a slower pace than younger workers. They have complained to other managers within the company but are ignored. They believe that the supervisors look out for each other's best interest rather than holding themselves accountable. The couple's concerns were not addressed during the group discussion due to time constraints. Experts provided information on age discrimination solutions during individual discussion.

The next worker to share concerns was the only worker to have attended clinic one and two. This worker is a Chicana woman in her 50s that brought up concerns on sexual harassment, worker mistreatment, and issues with L&I at the first clinic. At clinic two, she explained that she had been recently fired for refusing to do work. She refused work because of a previous occupational injury that was not fully healed. The exact injury was not specifically stated. Experts addressed her concerns during group discussion and recommended that she contact the legal support organizations in the resource list provided.

A single mother in her 30s who works at a nursing home shared her concerns regarding an occupational shoulder injury. The worker did not discuss the specific action that caused her shoulder injury. She reported her injury to her supervisor but was told that her injury is mental instead of physical. Her shoulder is still in pain and she is unsure whether or not to go to the

doctor. Experts responded during group discussion that she should see and occupational physician from the provided list to help her with her injury. During individual worker discussion, she stated that sexual harassment was another issue she faces at work. Experts emphasized that employers are required by a state statute to have a sexual harassment policy and must train employees on how to deal with sexual harassment in the workplace. Experts also provided resources on how to deal with sexual harassment and stressed the importance of documenting the issue for evidence.

Another female worker in her 30s that works in a nursing home shared an issue she continues to have with L&I. This worker injured her ankle at work and went to the hospital to get it evaluated. A physician diagnosed her injury as a sprain. Her pain persisted for weeks and she returned to the hospital for re-evaluation. The physician recommended surgery after an MRI revealed she had a torn ligament and a bone fracture. She brought her occupational injury case to L&I and was told to get a second opinion. The second opinion agreed and recommended surgery but L&I then asked for a third physician opinion. Throughout the process, the worker's foot is still injured. Experts recommended that for her third opinion, she see an occupational physician that can help her with her compensation claim. The worker also mentioned sexual harassment as an issue during individual discussion. Experts provided the same information and resources on sexual assault to this worker as they did to the previous worker.

A male truck driver in his 40s presented to the group that he has experienced mental health issues and fatigue from work. The worker has fourteen years of experience as a truck driver and his mental and physical health has deteriorated over time due to the long worker hours he deals with. He took a vacation to rest his body but his symptoms remained. He reported his issues to his employer and has since taken a lighter duty job that pays less. Despite the lighter

workload, his symptoms persist. Experts recommend that he visit an occupational physician to accurately diagnosis his condition and provide the proper treatment.

The last worker to address their individual concerns was a female warehouse worker in her 40s. The worker stated that her workplace had a strong ammonia smell one day and she began to feel light headed. She notified her supervisors but they ignored her concerns and told her to return to work. She doesn't believe the supervisors prioritize employee health and that they need to be held accountable. Experts recommended during group discussion that filing a chemical exposure complaint to L&I will elicit an immediate compliance inspection.

Table 4: Individual Worker Concerns from Clinic Two

WORKER	Concerns
1	Back Injury, Compensation Claim
2	Pesticides
3	Unjust Firing
4	Worker's rights, Chemicals
5	Occupational Injury
6	Age Discrimination
7	Age Discrimination
8	Occupational Injury, Mistreatment
9	Occupational Injury, Mistreatment
10	Occupational Injury, Workers Compensation
11	Long Hours, Mental Health Issues, Fatigue, Wage Theft
12	Chemicals, Respiratory Health

Clinic 3

Pre-clinic worker demographic information and concerns were not collected for clinic three. Concerns were brought up by workers throughout both the training and the clinic portions. The general concerns that workers shared were workload, sharps, blood borne pathogens, and the lack of worker voice.

Table 5: Worker Demographics from Clinic Three

WORKER	Gender	Language	Race/Ethnicity
1	Male	Spanish	Chicano
2	Female	Spanish	Chicana
3	Female	Spanish	Chicana
4	Male	English	Caucasian
5	Male	English	Somali
6	Male	Spanish	Chicano
7	Male	English	Chicano
8	Male	English	Caucasian
9	Male	English	Caucasian
10	Male	English	Caucasian
11	Female	Somali	Somali
12	Female	English	Somali
13	Female	English	Asian
14	Female	English	Asian
15	Female	Spanish	Chicana
16	Female	Spanish	Chicana
17	Male	English	Caucasian

All concerns are related to the contract between the janitorial company and the customer. Companies promise customers cleaner rooms at a faster rate to create an attractive bid, leaving heavy workloads for the janitors in a small amount of time. Janitorial workload issues stem from the amount of rooms that need cleaning, the size of the rooms, and how much time the worker has to clean. Each janitor has a required number of rooms to clean each shift. Room sizes range from a single office to an entire floor of a building. Different types of rooms also determine how much cleaning must be done. For example, surgery rooms require more detail and disinfection than an average office. Janitors were pressured by their employers to get the heavy workload done in time or risk losing the customer contract. Hidden sharps and blood borne pathogens are common problems janitors face while tackling the heavy workload. While rushing to clean

restrooms, workers reported contacting diabetic or drug needles hidden underneath paper towels or in unsuspecting places. Soiled toilet paper and feminine products are other items inappropriately handled by customers, leaving janitors exposed to these hazards. Janitors are prohibited from interacting with the customer which limits their ability to voice their concerns.

Workers and experts both agreed that there is no simple answer to the general concerns raised. Each issue stems from a systemic problem with the contract between employer and customer. The janitors are left out of this bargaining process and end up with the health and safety problems. Experts stressed the importance of self-advocation and unity. Workers themselves are their own best advocate to a safe workplace. Once the worker advocates for their personal health and safety, unifying with other self-advocating workers can show leadership that engineering and administrative controls must be done to reduce hazardous exposures and workload to the collective workforce. Experts also promoted the union as a great source to help make formal complaints, write letters to policy makers, and assist with approaching employers on contract workloads. Recommendations regarding customer protocol are difficult to achieve but provide alternative opportunities for reducing hazardous exposures. Customer safety training or visual signs on proper disposal of sharps and soiled products are methods that may be successful in reducing hidden hazards. Other specialized personal protective equipment such as needle specific gloves were recommended for workers if administrative controls were unsuccessful.

Two workers had private meetings with experts to discuss personal concerns that they needed help with. The first worker was Caucasian male in his 50s that advocates for occupational safety amongst his peers. He met with one of the occupational physicians and discussed filing a statute of limitation towards his employer. The occupational physician stated that the timeline to

file the statute depends on the situation and it is best to go to an occupational healthcare provider for assistance.

The second worker that held a private meeting was a Somali woman in her 30s. She met with an occupational physician and the legal support expert individually to discuss her concerns. She informed the occupational physician that she injured her back at work. She was having difficulty communicating with her primary care provider given a continued lack of interpreter services during her doctor visits and was looking for a new provider that she can properly communicate with as well as accurately treat her for occupational injury. The occupational physician provided her with the list of occupational medicine providers in the city of Seattle and talked her through the injury claims process. The legal support expert discussed employer provided reasonable accommodation. The expert recommended that the worker collaborate with the union to create a referral that may be brought to the employer during the collective bargaining agreement.

Interviews and Evaluation

Clinic 1

At the clinic, the UW provided workers with an anonymous post clinic evaluation. The questions addressed worker's feelings of empowerment and respect while attending the clinic. The survey also asked if workers were satisfied with what they learned at the clinic and if they plan on recommending it to colleagues at their occupation. All of the evaluations were printed in English and if a non-English speaking worker needed assistance with the evaluation, an interpreter would be there to help. One worker did not complete an evaluation because he/she left the clinic early.

Table 6: Post Clinic One Worker Evaluation Answers

WORKER	Did this clinic empower you to advocate for health and safety at your workplace?	Do you feel you were respected today during the clinic? Were your concerns addressed?	Would you recommend this clinic to other workers?	Overall, how satisfied are you with this clinic?	Any other recommendations, comments, or concerns?
1	Yes	Yes	Yes	Yes	-
2	Yes	Yes I was respected, but not all my concerns were addressed	Of course	Yes, I'm satisfied	None
3	Yes	Yes	Yes	Good	-
4	Yes	Yes	Yes, if I see someone who needs help I'll send them to it	80% satisfied	It's nice to know about a safe workplace

Workers agreed to be contacted for post clinic follow up phone interviews. The first interview was done with the warehouse worker and part time driver. This worker is a 30-year-old Somali male that works in the city of Seattle. Somali interpretation was provided during the interview. When asked about how his concerns were addressed by the experts, the worker stated he was satisfied with the worker answers. When asked about what health and safety information he specifically remembers from the clinic, he responded with the process on receiving a second opinion from an occupational doctor and how to file a claim with LNI. When asked about how he used what he learned from the clinic at his occupation, we found out that this worker had not been at work since the clinic. The worker had lost the resource sheet provided and did not contact an occupational physician. The worker ended up having surgery as recommended by his

doctor and continues to have pain. When asked about his expectations on the clinic, he stated he had no expectations coming in and he felt comfortable with the information provided by experts.

The second interview done with the janitorial worker. This worker is a 53-year-old African Female that works in the City of Seattle. No translation was needed as this worker was proficient in English. Much like the previous interview, questions on how her concerns were addressed, what safety and health information does she remember, how she has used what she learned at work, her expectations coming into the clinic, and any recommendations she had were asked. This worker stated that while the clinic was helpful in providing discussion, she felt that more could have been done. She brought up points that other workers in her field do not have access to computers to file a claim with LNI so assistance at that would be needed. She remembered the process of contacting an occupational doctor for a second opinion and contacted some of those doctors. She stated that her case could not be picked up by the doctors due to some technicality and that is the extent that she has gone. She has not been at work since the clinic and refuses to take surgery that may put her ability to walk at risk. Despite her troubles, she believes that the clinic is a good start but more guidance must be provided, especially regarding legal advice for taking occupational injury cases.

Clinic 2

Workers were provided an anonymous post clinic evaluation to fill out. The evaluations were translated in Spanish for all the workers to understand. There were five questions that covered their thoughts on if the clinic addressed their concerns, their satisfaction with the support given and the clinic itself, any suggestions they would make to the clinic, and if they would recommend the clinic to others. Seven evaluations were filled out. All workers agreed that their

concerns were addressed and that they are satisfied with the expert support. Majority of workers were very satisfied with some concern on not having enough time for the clinic. Primary suggestions included added time to the clinic, provide more individual support to workers, and more communication with other workers during discussion.

Table 7: Clinic 2 Post Clinic Worker Evaluation Answers

WORKER	Did this clinic address your health and safety concern? Why or why not?	How satisfied were you with the support you received today?	Overall, how satisfied were you with this clinic?	What suggestions do you have for ways to improve this clinic?	Would you recommend this clinic to other workers? Why or why not?
1	Yes	I wanted more information	Not much because there was not enough time	More time and that it is individual	Yes, as long as there is more time available for each case individually
2	Yes because you gave us information	Very satisfied	I loved it	That will help the receive more information	Yes because they need information
3	Yes	Satisfied	Because they gave a lot of information	I would like it to be individual	Yes, so they can learn more
4	Yes it addressed by problem	Yes it helped	Satisfied	That it is individual	Yes
5	Yes because it addressed my doubts	Very satisfied	I liked it a lot	There was individual support	Yes because they give important information that can help more people
6	Yes only that we needed more time	Satisfied	Very well, we need more like this	Presentation of each person	Yes, it is always necessary for more people to be informed about the different topics
7	-	Very well	Very satisfied	More communication with other workers	Yes, I would recommend to other workers

Five workers agreed to be contacted for follow-up phone interviews at the end of the clinic. Of the five, only two responded to interview calls and another worker rescinded their consent for an interview. Spanish interpretation services were provided for both phone interviews. The first interview was done with the 50-year-old Chicano father from the family of three. He is a field worker in the city of Yakima and his concerns at the clinic revolved around chemical exposure to his wife, a back injury his son sustained at work, and his sudden firing from his job of 25 years. When asked about his concerns and how the experts addressed them, he stated that the experts did not give any useful answers to him. He was under the impression that someone would contact him after the clinic to specifically assist him with his job dismissal case. It is reasonable to assume that the worker mistook the follow up interview as providing professional follow up case help. When asked about the resources provided to him, he stated that he had previously contacted some of the resources and that they were of no help to him, specifically Project Help. He mentioned that he had contacted attorneys from Project Help for a consultation but nothing useful came from the visit. He did not contact any of the other resources because he felt it would be a waste of his time. When asked about any additional health and safety issues faced since the clinic, he responded by saying he avoids accidents to the best of his ability. When asked about any recommendations to improve the clinic, he proposed that an attorney attend the clinic to guide workers with all the health and safety cases that they have. With an attorney there to gather evidence and build up a defense, the workers would finally have their voices heard and have some of their cases go in their favor. The worker concluded the interview by asking if there is an attorney available to follow up with specific worker cases. I responded by pointing out that most attorney-based information was included in the resources given at the clinic. I also recommended that he contact the FWC because they provide legal

support to workers in need. He concluded the interview by saying that the clinic was a negative experience for him and that he believes more legal help should be provided.

The second phone interview was done with the 58-year-old Chicana worker who had attended both clinic one and clinic two. Her concerns ranged from sexual harassment and worker mistreatment in clinic one to L&I disputes in clinic two. Her biggest concern was her getting fired from her job of fourteen years. During the interview, she specifically talked about what led to her job termination. On February 14, she was told to pick some apples. She refused to do the work and explained to her employer that she had previously sustained shoulder and hand injures while cleaning tables on the job but was still let go. When asked about how her concerns were addressed by experts, she said that the experts explained her rights and gave her information on how to handle her issues but no lasting help was given. She was frustrated at both clinic one and clinic two because experts did not actively help her or other workers with specific cases. We followed up by asking her if she contacted any of the resources provided and she replied that she did not try contacting anyone. She said that after she was fired, she was depressed and that she focused on finding medical insurance because she was no longer covered and her medical issues make it hard for her to find adequate coverage. When asked if she is currently working following her termination, she replied that she is. She went to a counselor to seek advice and started a new job two days later. When asked what effect both clinic one and clinic two had on her, she stated that there were some positive effects from the clinic. Some positive effects include learning about health and safety information and sources of help to handle a health and safety problem. The only negative effect the clinic had was the lack of actual change following the clinic. For example, she knows that L&I does inspections following their complaints but nothing is done post inspection. She is frustrated because she faces the same hazards she encountered before the

inspection and the clinic told her to trust in L&I's authority over her company. When asked to compare and contrast the two clinics she attended, she felt that clinic two was much more involved and rewarding. She felt that the group conversation is superior to individual support because workers discuss their problems with one another and they get to hear the similar situations that they are in. She championed for group discussion in clinic one but no one else supported her. When asked on any recommendations for clinic improvement, she endorsed a few ideas. Her first proposition would be to provide quicker and more integrated follow up after the clinics. She said workers are left wondering what to do at the end of the clinic and are left waiting for more help. Her second proposition would be to take a worker's problem on at the clinic and show workers step by step what needs to be done. She thinks that would empower workers because they would physically see change working in their favor. Her last proposition would be to find a way to empower workers more at each clinic. When she confronts her employer about her rights, she is singled out as a trouble maker for the company and her fellow coworkers do not support her due to fear of being chastised. She enjoys the clinics but feels that more help needs to be given instead of information.

Clinic 3

Due to time constraints, worker follow up phone interviews were not scheduled. The anonymous post clinic evaluation was modified to accommodate the removed interviews. Evaluations were written in English and an interpreter was provided if workers needed assistance. The evaluations asked questions on addressing worker occupational concerns, their next steps using the clinic information, potential barriers in their way, would it be useful to other workers, their satisfaction with the clinic, and any recommendations they may have for

improvement. The evaluations were handed out at the end of the clinic to the remaining four workers. Three workers completed and returned the evaluations. Two of the evaluations were completed in full and provided useful commentary and feedback on clinic.

Table 8: Clinic 3 Post Clinic Worker Evaluation Answers

	What were your occupational concerns coming in? Were they successfully addressed today?	**What are your next steps for using the information and resources given today? What are possible barriers preventing you from taking these next steps?**	**Would you recommend this clinic to fellow workers? What ways would it help them solve their workplace issues?**	**Overall, how satisfied are you with this clinic and the information given?**	**What recommendations do you have for us to improve this clinic?**
1	Blood, Feces, Other Biohazards	Unknown? Lobby to King County on work conditions?	Yes	A good place to vent	Bring in OSHA, WISHA, King County Health Reps, Union President to participate in the clinic
2	Lack of safety training at worksite, exposures to hazardous working conditions	Collecting statements from co-workers, compile the information and presenting it to government agencies. Barriers: government agencies underfunded and understaffed	Yes, it outlined the importance of self-advocacy	Very satisfied	Homework for follow up. Example: Go back to the work site and find 3 potential violations and report back. Do a worksite safety check list
3	To learn more about safety actions	To share what is heard with my coworkers	Yes	-	-

Worker responses for clinic three were of greater detail when compared to previous clinics. Worker one highlighted biological concerns such as blood and feces as the primary reason for attending the clinic. The worker is unsure of what next steps to take but believed that lobbying to King County would be a possible option. This worker would recommend the clinic to other workers and stated it is a great opportunity for precarious workers to vent their frustrations. This worker recommended that the following clinics include representatives from OSHA, WISHA, and King Country to hear worker concerns in person and understand the hazards they face. Worker two's concerns highlighted the lack of safety training and exposure to hazardous conditions while on the job. This worker pointed out that the next steps are to collect coworker statements of their health and safety concerns to bring forth to government agencies. This worker also addressed that the government agencies that handle these complaints are often understaffed and underfunded and this may prove to be a potential barrier impeding the next step following the clinic. This worker stressed the importance of self-advocacy and believes the clinics would be a great opportunity for other workers to participate in. This worker's recommendations focus on follow-up education for each worker through homework. The example given was to have each worker go back to their occupation, find three potential health and safety violations, and report back to the clinic to share what they found. Another example given would be for workers to complete a worksite safety checklist and assess their work environment. Worker three only answered three of the five evaluation questions. This worker's concern coming into the clinic was about learning more about workplace safety. This worker answered that they would share what was learned at the clinic and recommend it to their coworkers.

Clinic Comparison

Each clinic had a different structure. Clinic one focused on the individual discussion between the worker and experts. Individual discussion allowed for the experts to hear every worker's concerns in detail and provide thought-out resources. It was the best clinic structure for reserved and quiet workers that would hesitate to speak in group discussion. The lack of worker empowerment limits this clinic structure. Workers would only focus on their own concerns and not feel obliged to share what they learned with coworkers.

Clinic two structure focused primarily on group discussion with a little time for optional individual discussion at the end of the clinic. This clinic is the opposite of clinic one and fostered worker empowerment through the sharing of stories and solutions. Discussion blossomed because all workers came from the same community and industry sector. Workers felt connected to one another and fed ideas off of one another. While each worker shared problems that they face, the discussion became dominated by outspoken workers and the concerns of reserved workers were not discussed with the group. At the end of the clinic, the reserved workers had an opportunity to talk about their concerns but were limited by time.

Clinic three introduced the hazard awareness training to group discussion. Despite attempts by clinic organizers to differentiate the hazard awareness training with problem solving group discussion, workers did not understand the difference and the two portions blended throughout the entire clinic. It limited the effectiveness of how the experts presented the material and how much information workers absorbed. Much like clinic two, the discussion was dominated by a few outspoken individuals while others were unable to share their thoughts. The difference at this clinic was that the outspoken individuals were Caucasian males and individuals that had their voices diminished were ethnic females. When comparing different clinic structures,

we see that each has its own strengths and limitations. Workers may flourish under certain styles or feel dissatisfied with the clinic because their expectations are met. The ability to have a flexible clinic that can accommodate and satisfy all workers is ideal but difficult to achieve. Improvements can be made to the final clinic model by comparing the strengths and weaknesses of the three previous clinics.

Worker concerns varied from clinic to clinic. While some specific concerns such as finding an occupational physician or filing a compensation claim were shared at each clinic, it is hard to anticipate the types of concerns faced at each clinic, even with pre-clinic information. Workers share details in discussion that are not collected during the pre-clinic information. The details provide context to the situation and may lead to different resources needed. This adds stress to experts and clinic organizers to collect the right resources ahead of time. If the wrong resources are handed out, the worker would not solve their problems and workers would feel discouraged that another organization failed them. Another difference for worker concerns can be related to the use of the union. Workers without the union showed less knowledge of safety rules and regulations when talking with experts and had difficulties with the occupational claims process. The unionized workers of clinic three had concerns that related to things they cannot actively change without institutional support. These workers have the union on their side to teach them of their rights and help them through the occupational injury process while non-unionized workers are expected to know their rights without help from an outside source. The differences in concerns shared display the array of issues precarious workers face and the difficulty addressing them.

A majority of the worker evaluations at each clinic had positive feedback. Evaluations for clinic one was influenced by FWC requests. They requested that the evaluations remain very

simple so that the worker will not stress about completing it. Due to the way the questions were asked for clinic one, workers did not provide explanations for each question they answered and all answers were single word answers. We modified the evaluation for clinic two to ask for descriptions of answers and workers followed through. These workers also provided recommendations for improvement. All workers recommended that more time be added to the clinic for individual work with experts. Other recommendations include a better presentation of each person's concerns and more discussion between workers. Despite having the lowest number of evaluations, workers evaluations from clinic three were some of the most detailed and engaging. The evaluation was improved once again to ask for more detailed thoughts on the clinic. Workers clearly listed out the concerns they had coming in, what steps they plan to take next, the barriers they may face, their satisfaction with the clinic, and any recommendations they have to improve the clinic. The evaluations at each clinic show that the workers enjoy the clinic once it is completed. They appreciate it as a vehicle for them to vent their frustrations and to learn about their rights to a safe workplace.

When comparing evaluations clinic by clinic, we see and evolution of detailed answers. Answers became more detailed and worker explanations for their answers were more thought out. Improvements to the clinic evaluation may partly explain the enhanced worker responses. Another explanation would be the use of the union. The unionized workers have support on their side and exhibit better worker empowerment than other clinic workers. Their responses to the evaluations are more policy-based solutions than direct solutions. They know that they can go through their union to support them and advocate for institutional change. The evaluations provide context of the worker's initial thoughts of the clinic before they practice what they learned at their job.

Worker interviews had much different responses compared to the evaluations. While the evaluations were universally positive, all four interviews had less successful results. All interviews asked similar questions on topics such as what concerns were raised to the experts, how did the experts answer their problems, what information do they remember from the clinic, and what recommendations do they have to improve the clinic. Clinic one's first interviewed worker enjoyed the clinic because he had no expectations going in. He appreciated the information provided despite losing the resource list. The second interviewed worker from clinic one also enjoyed the clinic contents but felt more hands on help is needed. She pointed out that the information is nice to have but actual tangible support is needed, especially regarding legal support.

Clinic two interviewees expressed more frustrations than those from clinic one. The first interviewed worker from clinic two immediately stated that he felt the clinic provided him no help and that he was expecting better follow up. Even though he did not try contacting all resources provided to him, he wanted more hands-on assistance with his problems than just a list of places he can go for help. The second interviewed worker shared similar concerns with worker follow up and active use of clinic time. This worker wanted the clinic to take on a worker's case to physically show positive change. She believed that it would improve worker empowerment and build trust in the resources provided.

When looking at all four interviews, we see that all four workers did not use the resources given to them. The workers were expecting us to assist them step by step the entire way. Comparing the interviews and the evaluations shows how over time, the worker's opinion of the clinics changed. Once the clinic ended, workers were happy to share the stress they encounter each day. When asked to evaluate the clinic several weeks after, they realized that they had not

used what was given to them, leading to a negative response and request for more help. Something that was not explicitly pointed out by each worker was the potential barriers they may face when utilizing the resource list. Some potential barriers include lack of trust in the provided material, isolation from organizational help, or lack of evidence needed for a claim defense. It is our responsibility as experts to ensure the workers are comfortable and trust the material that we present them. Application of the given material, whether it be through homework, assisted problem solving, or regularly scheduled clinics, is needed. Sustained support is needed to make real change and to overcome the barriers that precarious workers face.

Discussion

Clinic participants represented and portrayed the same characteristics as the typical precarious worker. 85% (29 of 34) of the attended workers for all three clinics were ethnic minorities and 38% (11 of 29) of the minorities did not speak English. These workers are often misunderstood because of language barriers between them and employers (Brach, 2000). Exploitation occurs because of these barriers which create inherently dangerous work conditions that harm the worker but benefit the employer (Wright, 2007). Workers concerns included employers intimidating and harassing them to keep them from exercising their rights and ensure the company avoids lawsuits. Job insecurity, a common issue for the standard precarious worker, was brought up by multiple workers. Workers came from many industries that employ a high number of precarious workers including agriculture, janitorial, warehouse, and customer service. Many of the concerns raised by each worker were shared across industries. Each worker that participated in a clinic embodied a prototypical precarious worker and proved that their health and safety is exploited by their employers.

While the clinic model shows promise, improvements must be made for it to successfully impact a wide network of precarious workers. First, the clinic model must focus on setting a strong model structure that can be flexible to the workers needs while still providing the information in a supportive and sufficient manner. It is impossible to form the perfect clinic model that can address all worker needs at the same time. We learned from clinic one that having multiple workers from different industries makes it difficult to foster worker empowerment and it compounds stress of the clinic organizers. The workers preferred to remain private with their concerns instead of sharing in front of others who come from completely different industries. Clinic organizers must also anticipate the types of hazards that workers to collect the resources needed. Having many industries at one clinic multiplies the amount of resource collection.

Clinics two and three focused on one industry at a time. The workers from clinics two and three were much more open to collaboration when solving each other's problems because they all were from the same background and could understand the struggles that their peers faced. Clinic organizers were also more prepared with a wider array resources that cater to the industry specific hazards and concerns. While it is assumed that the workers in clinics two and three were more open to disclosing personal challenges faced because other workers came from similar work backgrounds, another explanation could be due to cultural beliefs. In clinic one, the workers voted between a discussion style or individual style. All workers that voted for individual discussion were Somali while the only worker who voted for group discussion was Chicana. Forwarding to clinic two, all workers were of Mexican descent and preferred to remain in group discussion over splitting into smaller discussion groups. While we do not know much about Somali and Chicana culture in detail and the sample size is small, it can be assumed that the differences in culture played a role in fostering worker empowerment.

An improvement to the name "clinics" needs to be made. The word clinic can have different meanings for many people, leading to different expectations on what actually happens at the clinic. While we advertised the clinics to be health and safety problem solving clinics, we did not anticipate the difference in interpretation. While we may understand health and safety to mean occupational safety and health, workers have a different understanding of health and safety to meaning diagnosis of disease and injury by a primary care provider. When evaluating the interviews, we begin to see the difference in worker expectation on the clinics. Workers one and two from clinic one had no expectation coming in and seemed to enjoy the clinic for the information. However, they both came in with occupational injury cases that wanted second opinions and it is assumed that their expectation was a doctor to provide that second opinion at the clinic. We see from clinic two interviews that worker expectation on the clinic was different. Their expectation was not revolved around diagnosing injury but around solving occupational claims cases. Providing detailed description of what actually will be held during the clinics or renaming the clinics as something else is needed to lessen the gap of expectations and understanding.

Another improvement that must be made to the clinic would be to provide more follow up following the clinics. Workers recommended this improvement in both evaluations and interviews. While we may provide the workers with useful and trustworthy resources, they are useless if workers ignore them. Workers continue to face barriers that possibly inhibit them from accessing the resources given and we should guarantee that they successfully solve their problems. One possibility for improved follow up would be to provide homework workers can actively participate with. With homework, workers could return to their jobs and focus on the hazards and problems they face to find a solution. We may not provide constant help all the way

through for every problem, especially if it requires attorney help, but we can make sure that the workers get to the source of help and are provided what they need without barriers discouraging them or preventing them the right solution.

We faced many limitations along the way, primarily involving the evaluation and interview process. During the first clinic, we were limited with the way we worded the evaluation. The FWC wanted to keep the questions simple for workers, resulting in one-word answers that are hard to evaluate. Another limitation we faced was the evaluation response rate. The response rate by percent of workers responding declined each clinic. Clinic one had four workers respond out of a total of five workers. Clinic two had seven workers respond out of a total of twelve. Clinic three had the worse response rate of three workers out of seventeen. We could have improved this by providing an incentive for workers to complete the evaluation. Lastly, our limitation is the number of interviews conducted. We had hoped to complete more interviews, especially for clinic two, but was unable to do so. We had at least six workers confirm for clinic two interviews but only three responded and one of them rescinded their consent for an interview. It was also difficult to set up interviews due to a lack of interpretation services at our disposal. We had to consult with an outside source to complete the interviews. We knew coming in connecting with these workers would be challenging and we got to experience it ourselves.

Another challenge we faced was communication between multiple stakeholders. In order to reach the workers, we had to connect with CBOs to set up the clinics. While initial set up and clinic execution was manageable, subsequent follow up was difficult. Reconnecting with the workers to complete interviews took longer than expected and made it difficult for clinic evaluation. This issue is difficult to solve, especially when working with CBOs that are also non-

profit. Non-profits deal with a great amount of worker turnover and that delayed our ability to connect with workers. Going forward, finding ways to improve communication amid unforeseen circumstances could result in more clinics and improved worker follow up.

A particular challenge we faced was the types of concerns that were brought up. We had hoped that workers would come to the clinics with physical concerns based around occupational health and safety. Answers to physical types of concerns such as chemical concerns or exposures are easy for the experts we brought in to answer. However, the clinics showed that most of the concerns brought up were psychosocial concerns that are difficult to provide direct answers to. Many of the answers revolve around institutional or policy-based change which often take lots of time to be put into place and see fruition. Legal experts were brought into clinics two and three to assist with these types of concerns but the feeling was that we were simply telling them how to do something rather than actively solving a problem. Going into future clinics, planning around expected psychosocial concerns and providing experts that can easily provide guidance on those issues is needed.

Looking at what we had done on this project, I believe that we achieved a sense of accomplishment. Workers stated through evaluations that the clinic provided them an opportunity to vent their frustrations. This in itself is an accomplishment in providing workers a type of service. We may not have envisioned it to be an accomplishment but it is an accomplishment nonetheless. Our major accomplishment of providing recommendations for all worker problems was not achieved. If we build upon what we learned from this project, we would eventually achieve that accomplishment.

The clinic model is not perfect but it shows promise as a way to reduce injury and illness in the precarious workplace. It provides workers the opportunity to express their health and

safety concerns to experts and other workers while possibly leading to collaborative solutions. It unites workers outside of work and provides the necessary resources needed to reduce their health and safety risks. Improved clinic description, structure, and follow up with workers are needed for the clinic to achieve its full intended potential. The pilot model is feasible to serve workers by CBOs in a way that no other model has previously done. While we did not achieve everything that we hoped for, the model is a step in the right direction towards helping a very important population of workers.

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