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streamline

Integrated Team-Based Approach to Hypertension at Virginia Garcia

By Claire Hutkins Seda, Writer, Migrant Clinicians Network, and Managing Editor, *Streamline*

Four years ago, the providers at Virginia Garcia Memorial Health Center, a Community Health Center in Oregon, took a hard look at how they managed patients with hypertension. Nationwide, this chronic disease is affecting one in three adults, and increasing those patients' risk for cardiovascular disease, the number one killer in the US.[1] Since then, Virginia Garcia has increased the number of patients with controlled hypertension by a small but notable three percent. Eva Galvez, MD, physician at Virginia Garcia and a member of Migrant Clinicians Network's Board of Directors, credits the increase in blood pressure control to Virginia Garcia's hypertension registry, the increased frequency of patient visits for those with hypertension, a team-based treatment plan, strong links to providers to address social determinants of health and mental health concerns, and a "big picture" approach to provider-patient communication around hypertension.

"Hypertension can be so difficult to control," Dr. Galvez admitted. "Our patients are working. They're busy. It takes everything they have to get to their [provider] visits," but Virginia Garcia has stepped up to the challenge to meet patients where they are, make health care work for them, and make a lasting impact on patients' health.

The first change was to better identify patients with hypertension. Often, hypertension is newly identified when patients are attending an appointment for another health concern. To make sure sufficient time and focus are given to the new diagnosis, they are placed on a registry that sets into motion the layered approach that Virginia Garcia has developed.

"From diagnosis, we are actively reaching out to them to try to get them in," for a follow-up appointment with a registered nurse, just two weeks after diagnosis, Dr. Galvez noted. The nurse assesses how the patient is adapting to the treatment plan, and, under Dr. Galvez's supervision, can adjust medications if needed. It's also a chance for the nurse to dive deeper into lifestyle changes and possible barriers to change. The frequency of visits remains high until the patient gets on track and doesn't require medication adjustments.

"Can they afford medications? What are their goals? We identify barriers to achieve

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Oregon's Alternative Payment Methodology At Work

At Virginia Garcia, the frequent nurse visits at the heart of this strategy are at no cost to patients. That's because Virginia Garcia, like several other Oregon Community Health Centers, is a coordinated care organization (CCO) that has bucked the fee-for-service norm, receiving instead a set amount for panel of patients, per period of time, regardless of how many or which people from that panel seek care. Oregon adopted a coordinated care approach in 2012 to improve the quality of health care and limit the growth in health care spending. There are now 15 CCOs in Oregon, providing care for roughly one million Oregonians.

To determine the amount per panel, Virginia Garcia looks at how often each patient in the panel came for visits in previous years, and the resulting payment the health center received. The health center then averages the entire panel's payments, and then spreads it out over the course of the year, giving the health center a lot of flexibility in how the payments are spent. "We have a large number of uninsured patients, but the lump sum we receive every six months for managing this panel has been a great incentive to us" to creatively determine how to improve care for everyone on the panel, Dr. Galvez shared. "This payment structure allows for frequent nurse visits and the funding of care team members like the CHW, nutritionist, and behavioral health practitioner," Dr. Galvez added.

Photo courtesy of Virginia Garcia Memorial Health Center

1 "High Blood Pressure." Centers for Disease Control and Prevention. https://www.cdc.gov/bloodpressure/index.htm. Accessed June 5, 2018.

Patient History: Still The Best Tool for Accurate Diagnosis

By Ed Zuroweste, MD, Co-Chief Medical Officer, MCN

Patients are increasingly mobile. From an agricultural worker who moves with the seasons, to a businessperson who visits clients around the globe, to a recent immigrant, to a young woman who recently returned from a honeymoon abroad, the next patient in the exam room is highly likely to have recently experienced some level of mobility, or will in the near future. Mobility complicates care — but it doesn't need to interrupt it. The most valuable and powerful diagnostic tool in our current medical toolbox to bring us to the correct diagnosis for our increasingly global patient populations is one of the most basic: the taking of a patient's medical history.

Medical history-taking is an art form, and nowhere does it require so much skill and dexterity as with a patient from another culture, who may be more comfortable in a language other than the clinician's, or who has been recently mobile. Each of those aspects — culture, language, and mobility — require careful consideration while taking a medical history.

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Culture

"Cultural humility" or "cultural sensitivity" continue to be important components for clinicians to embody in the exam room. But what do they entail? They start with a basic understanding that we come to the clinic with our own ideas, experiences, and biases which may be different or at odds with our patients'. Our ideas and biases could potentially lead us in the wrong direction when we take a history. Make sure you go through all the steps without assumptions — don't let your preconceptions make the diagnosis.

Clinicians can learn some of the cultural characteristics, history, values, belief systems, and behaviors of the more common ethnic groups among the clinician's community to develop sensitivity to their needs. This doesn't mean expert level understanding or full integration — just basic familiarity. One clinician serving a large Ethiopian refugee community commented that just saying a few key phrases of greeting in her patients' language sets her patients at ease, as they recognize the clinician reaching out to the patient — even if they don't share the same language. On my trips to rural Guatemala and Honduras, I found it a bit strange when new patients would ask me, the clinician, personal questions at the start of an exam, such as if I had a wife or children at home, until I saw that having a basic level of understanding of my lifestyle and value system opened a level of trust that I didn't have with them when they first arrived, and helped the patients connect with me across cultures, which made easier the next step of taking a patient history. I recognized the cultural cue instead of brushing it off. Don't dismiss one culture's norms; if a traditional healer's approach is not detrimental to my treatment strategy, I won't discourage the patient from going to the healer as well.

I have learned to treat patients the way they wish to be treated, not the way that I wish to be treated. Such careful attention to the patient allows a clinician to successfully navigate many different cultures even without extensive background in each one. Another part of cultural sensitivity is understanding that, even with familiarity, there is cultural diversity between and within cultures. Again, self-awareness that our assumptions should not be the main guide will help us assure that the patients are the guide.

Learning to read the situation, listening, and asking more open-ended questions if confused can expose culture-related conflicts or help you catch cultural cues you may have otherwise missed. Listening includes reading body language. If you see hesitancy or annoyance, you may be running into a intercultural misunderstanding. The best reaction may be to pause and simply ask the patient if they are worried or concerned about something. Ask questions to understand what things mean in their culture. Open-ended questions allow the patient time and space to tell their story, in their own words. Here are some example questions:

What do you think is causing your illness?

Do you have an explanation for why it started when it did?

What have you done to treat this?

What does your sickness do to you — how does it work?

Have you asked anyone else to help you?

What kind of treatment do you think you should receive?

Language

Asking such questions can be challenging if the patient doesn't speak the clinician's primary language well. Interpreters are a must in a clinic, either an on-staff interpreter that is available for the appointment or interpreters through a phone-based interpretation service. Here are some interpretation tips:

- Family members – and especially children – should never be used for interpretation.
- Avoid slang or jargon and speak directly to the patient, not to the interpreter or phone.
- If you have an interpreter in the room, start with some ground rules. Ask the interpreter to repeat back everything the patient says, and if the interpreter would like to add any cultural interpretation, to do so after repeating word-for-word what the patient said.
- Pay attention to how a patient responds to a question — body language, force of words, other non-verbal cues — by always focusing your attention on the patient.
- Have the interpreter sit next to and a bit behind the patient, so that the path between you and the patient is clear.
- Make sure you look ahead at your schedule at least one day (or much longer for a less common or an American Sign Language interpreter) to assure that you have the interpreters on hand for the appointment.
- Ask patients to repeat your treatment instructions. If they use the same words, they may not have fully understood. Rephrase, and ask them to restate the instructions.

Remember that even if you have a brochure in the patient's preferred language, the patient may not be able to read it, or read it well. Literacy level is another consideration as you navigate global patients.

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Photo courtesy of CSM

Mobility

Travel history is too often left out of a patient history. With our globalized world, a patient may arrive in your office just days after being in a rural part of the other side of the world. During the Ebola crisis, we had signs put up in all of our clinics asking patients to tell us if they had recently been to West Africa; during the Zika crisis, the signs asked about the Caribbean. Most of these signs have come down, but we still need to know where patients have been. Ask patients if they have recently traveled, if they plan to travel, and if anyone in their household has had recent illness as well, to determine if someone else's travel may have affected your patient. The patient may have contracted his disease in transit, as well, so be sure to understand the method and route of travel. Occupation can uncover additional details that may lead you to a diagnosis; mobile agricultural workers, for example, often work out-of-doors during the day, with limited to no health education, access to preventative care or even basics that can help prevent illness like water, shade, insect repellent, window screens, or sunscreen. A patient who is a truck driver might say he has not been traveling, as he associates "traveling" with "vacation," not with his daily grind.

Simple awareness, good questions, and lots of attention to the patient can oftentimes bring a correct diagnosis just from the medical history — and it doesn't have to be costly. Although it may require a few more minutes of a clinician's time, it is significantly less expensive than an MRI or other expensive diagnostic test. With a good medical history, the clinician should have the ability to construct a reasonable differential diagnosis list that then can limit the number of diagnostic tests needed to confirm or rule out each diagnosis entertained. As our world continues to shrink, and technology has made movement faster and easier, the least technologically advanced tool — a patient history — has become all the more important.

Learn more at MCN's archived webinar, "Treating Global Health At Your Doorstep Starts with a Good Patient History," at https://goo.gl/hiqRKW.

CONFHER Model

The CONFHER model is a cultural assessment tool to guide clinicians to gather the most pertinent information during patient intake. Here's a brief summary of the questions one could ask when using the model.

Communication: What is her preferred language in which to communicate? What non-verbal cues is she using, like eye contact or body language?

Orientation: What is the patient's ethnic identity? When asked, where does he consider home?

Nutrition: What kinds of foods does the patient prefer, and do they have any effect on treatment? For example, the patient may have gastrointestinal distress, and only eats spicy foods.

Family relationships: Does the patient have control over treatment decisions? Does another member of the family make medical decisions for the patient?

Health beliefs: How is the patient experiencing her illness? How does it affect her life? Does the patient's religion or culture inform how the patient responds to or communicates about her illness? For example, in some cultures, illness may be seen as a punishment that the patient must suffer through due to past transgressions.

Education: What is the patient's education level? If the patient is no- or low-literacy, what health education may he need? For example, an agricultural worker may apply pesticides but not be able to read warning labels.

Religion: How do the patient's religious or spiritual beliefs or preferences affect her life and her relationship to Western medicine?

MCN's New Resource on Patient-Centered Medical Home

By Theressa Lyons-Clampitt, Training and Technical Assistance Coordinator, MCN

Patient Centered Medical Home (PCMH) continues to be a dominant model at health centers around the US. Through PCMH, health centers are providing comprehensive, quality care from a team of providers working together for the patient's whole body health. A mobile patient like an agricultural worker presents a big challenge in successfully executing PCMH because the patient may be in the service area for a very limited time and may encounter numerous other barriers to health care due to mobility, poverty, language, culture, and more. MCN's new PCMH resource helps clinicians walk through resources that may streamline or augment PCMH processes to better serve the needs of a mobile patient. Learn more about PCMH for mobile patients and access the new resource on our PCMH page: https://www.migrantclinician.org/pcmh.

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Are Patients Clear on the Cost?

MCN Project Tracks Conversations Between Patients and Providers on the Cost of Care

By Claire Hutkins Seda, Writer, Migrant Clinicians Network, and Managing Editor, *Streamline*

For the last year, Deliana Garcia, MA, MCN's Director of International Projects and Emerging Issues, has spent time as part of a research team at four Community Health Centers (CHCs) in Texas, Puerto Rico, and Pennsylvania to better understand whether clinicians have conversations with their patients about the cost of care (CoC), and whether those conversations are effective. With funding from the Robert Wood Johnson Foundation, the research, spearheaded by Douglas D. Bradham, DrPH, MA, MPH, Health Economist and Principal Investigator, and aided by Alma Galván, MHC, MCN's Senior Program Manager and Corey Erb, Research Assistant and Executive Associate, showed a wide spectrum of conversations and an even more diverse set of patient reactions to the conversations.

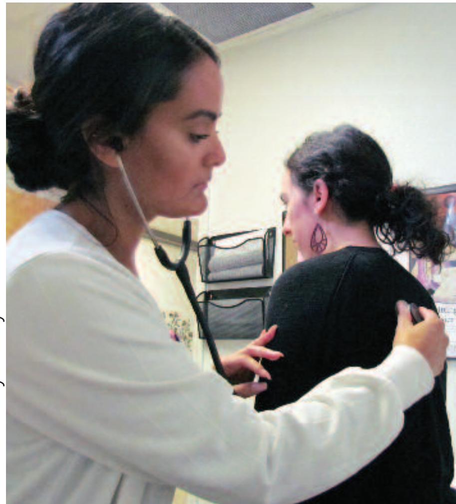

Photo courtesy of Tiffy Daud

"When question about 'how sensitive' discussions of personal finances and the ability to pay for health care with their health care provider felt, 50 percent indicated that they were 'not sensitive,'" Garcia said. "However, nearly a quarter of respondents said these discussions were 'highly sensitive,' indicating that health care providers need to approach the topic carefully, with no expectations as to the openness of the patient to a conversation around cost.

Based on previous MCN research on highly charged conversations, the researchers posited that a cost of care conversation — one in which the clinician lays out the treatment options with their associated financial implications — will be most successful when the clinic environment includes:

- Access to language-appropriate information materials on possible out-of-pocket costs;
- An expectation that a routine part of the exam room encounter includes the discussion of emotionally-charged financial topics, including an outline of items that the clinician would cover; and,
- Clinicians and staff who are provided trainings to know how to anticipate and encourage meaningful CoC discussions.

Research efforts aimed to view the conversation around CoC from different perspectives. Health Network team members Tanya Snyder Salgado, Olivia Hayes, Sophia Galewsky, and Rob Corona assisted the researchers in data collection, completing bilingual interviews of 85 low- and mid-income patients whose age makeup reflected the overall distribution of ages in the 2016 data inputted by CHCs to the Uniform Data System (UDS). A total of 67 patients then agreed to be shadowed by a researcher-observer during their visit. To get another view of the conversation around costs, clinicians' impressions on the encounters were also reviewed.

The results of the observed interactions suggest that a majority of the patients interviewed rated their clinician very high on trust determinants. Additionally, almost half (48.8%) of the patients were encouraged to ask cost of care questions, but 18.6% say they were not encouraged.

While few clinicians responded to the survey that captured their own perspective on what was covered in the conversation and how patients responded, it was, nonetheless, determined that having clinicians engage in a cost of care conversations with their patients can help one in ten patients to make more informed decisions around health care, knowing the potential out-of-pocket costs. This is based on a review of the literature that indicated that ten percent of patients delay or avoid medical intervention because of cost, and a conversation that sought solutions would help these individuals potentially achieve a different outcome.

Watch MCN's archived webinar about Clear on the Cost to learn more: https://www.migrantclinician.org/archived-webinars.html.

Accessing Behavioral Health Services: Health Network Case Study

By Claire Hutkins Seda, Writer, Migrant Clinicians Network, and Managing Editor, *Streamline*

In 2017, Jorge Gonzalez*, a 32-year-old warehouse worker from Central Texas, approached Leslie Diaz, LMSW, Health Network Associate at the Ventanilla de Salud. Diaz was providing information and sign-ups at a health fair at the Ventanilla, a program of the Mexican government designed to give Mexicans and other Latinos in the United States greater access to health information and needed health services. He asked her if she knew of any mental health resources.

"He had done lots of navigation himself, and his English was quite good, but he wasn't happy because the providers he was able to access had emphasized medications — he said he saw an overuse of medications — and the side effects were making him feel like he was spinning his wheels," Diaz recalled. As Gonzalez was visiting for several weeks from out of the area, Diaz signed him up with Health Network, Migrant Clinicians Network's bridge case management program, to assist him in finding ongoing mental health care while he was in Austin, and then in his hometown when he returned.

He had felt that he was healthy, until he got into a car accident, six months earlier. "The accident triggered a lot of emotions that he thought he had already worked through," Diaz said, including the trauma of his migration from Mexico, years before, and violence in his birth town, where he witnessed a friend's death. After the accident, he began to suffer from back pain, which affected his ability to work. He was now negotiating legal proceedings around the car accident, which was generating significant stress in Gonzalez's daily life. He suffered from depression.

"He's a bit of an anomaly, because he had the resources to be able to find a mental health professional on his own," Diaz noted. Because of his inability to work, he had qualified for a medical assistance program that covered some specialty care. Over the next few weeks, while in Austin, Gonzalez returned to the Consulate offices seeking to meet with the psychologist while she provided occasional office hours at the Ventanilla, but each time, the psychologist was unavailable. Diaz, as a licensed social worker, provided motivational listening during these drop-ins. "I explained to him that we weren't treating him, just giving him active listening as social workers are trained to do, until we were able to connect him with a psychologist here." An early attempt at a telemedicine

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Disasters, Mental Health, and Puerto Rico: Interview with Dr. Lorena Torres

By Alma Galvan, Senior Program Manager, Migrant Clinicians Network

[Editor's note: This interview has been edited for brevity and clarity.]

Photo courtesy of CSM

In September, 2017, Hurricane Maria slammed into Puerto Rico in what is called the strongest hurricane to ever hit the island. The devastation was widespread and long-lasting — both to local infrastructure and to residents' health. Many months later, power outages occur less often and water systems are largely back online, and the communities are beginning the long path to rebuilding. Within those rebounding communities, however, mental health concerns continue to be on the rise and health centers are still struggling to work at capacity. In April, Lorena Torres, PhD, from Corporación de Servicios Médicos, a Community Health Center in Hatillo, Puerto Rico, joined several other leading experts for MCN's on-the-ground workshop, "Learning from the Past and Looking to the Future: Natural Disasters and Our Patients." Dr. Torres' clinic serves patients from numerous vulnerable populations including agricultural workers, homeless patients, substance users, and single mothers. Here, Dr. Torres describes her perspective on disaster preparation, clinician burnout after a disaster, and plans for the future.

Why is it important for clinicians to pay attention to vulnerable populations when working on disaster preparedness plans in regards to mental health?

The process of preparing for a disaster depends largely on how emotionally stable and how educated the person is. Vulnerable populations do not have access to a lot of resources, so the clinician plays a vital role in educating patients about proper health management and identifying patients who need specialized mental health services to assure they can receive adequate services and can weather the disaster.

What reactions do you remember from the first days after Maria, and what does it say about the mental health needs of your population?

After Hurricane Maria, reactions were of frustration, helplessness, and uncertainty. The reality was that we were not prepared for an event like this — not individually, not governmentally and not organizationally. We must remember that what we are experiencing is the result of many factors. At that historic moment [when Hurricane Maria struck], Puerto Rico was already going through a bankruptcy that affected access to services and increased uncertainty. On top of that, we have a high level of high school dropouts, a high rate of chronic conditions, and one of the highest poverty levels in North America. What [has now] shifted on my island is this increase in a range of mental health conditions after the disaster, so our need for education and services is enormous — and the work is titanic.

What patients do you remember the most — do you have one story to share?

After the hurricane, I remember listening to a patient whose access to his home was destroyed. He had to wade across a river every day to get to work and make that effort. Now, seven months after the hurricane, his situation remains the same. These types of situations continue.

What did your health center do to prepare for the increase in mental health concerns, and what would you do differently?

It actually wasn't something that was thought through officially [beforehand]. The hurricane [touched down on a] Wednesday, and I anticipated that the worst cases would present to the clinic on Monday, and the clinic would receive patients as always, with perhaps some kind of disruption of electricity, but nothing more. The reality was otherwise. My home is well constructed and designed for hurricane-force winds. During the hurricane, when water started to leak through the doors and windows, and the winds blew my garage door off and threatened to destroy the entryway, I then understood that this was something much more powerful than we had thought and that our lives would be changed forever — and they were. Immediately, after I assured the basic safety of my family and home, and after waiting in line for seven hours to get $20 of gasoline, I got to work and, with my colleagues, I began visiting shelters and our communities [directly].

[What the hurricane taught me was] you must train all personnel in handling the emotional [responses] of patients after a disaster and provide them with self-care strategies so that they can handle the situation.

How can clinicians really address the mental health needs of patients when they themselves have to deal with the disaster as well?

[The mental health needs after the hurricane demonstrate] the importance of advanced planning. For example, as professionals, we have more economic resources to access goods and services. But even for us, after the hurricane, we could spend a full day to complete a task that normally took an hour. The health center, in this case, could develop flexible scheduling for the professional staff [so that we] have time during the week to take the necessary steps to keep our families safe and [homes] well stocked. This approach would provide peace of mind to health professionals, so they can better work with their patients.

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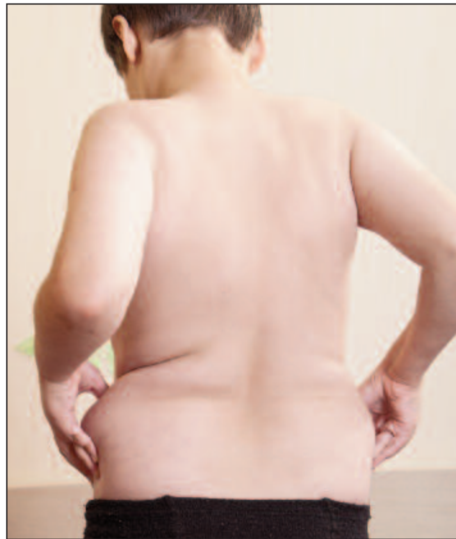
Tackling Childhood Obesity: Numbers On the Rise Again

By Claire Hutkins Seda, Writer, Migrant Clinicians Network, and Managing Editor, *Streamline*

A new study has found that childhood obesity is still rising.[1] Published in the March 2018 issue of *Pediatrics*, the research is in contrast to recent reports that have suggested that obesity among youth has recently plateaued or even decreased. The researchers also found that rates of obesity among Hispanic and black children continue to be significantly greater than that of their white and Asian counterparts.

Obesity during childhood increases the child's risk of developing type 2 diabetes, among a litany of other serious physiological, psychological, and social consequences. Children who have obesity are more likely to become adults with obesity — and the health risks continue and become more severe as they enter adulthood.

As a largely mobile poor population, agricultural worker children encounter many of the same health barriers as their parents, including linguistic and cultural differences, food insecurity, fewer opportunities or safe and accessible spaces for physical activity, exposures to pesticides, high levels of stress, and fewer health resources or access to health care. Additionally, low-income children are disproportionately exposed to advertising for fast food, sugary drinks, and other unhealthy products and habits. A recent review of literature found that estimates ranged from 15 to 37 percent of agricultural worker children have obesity.[2]



Health centers around the country are taking various approaches to reducing childhood obesity among agricultural worker children. Located in the agricultural worker city of Immokalee, Florida, the Healthy Me Florida project to address childhood obesity was developed by primary care psychologists and physicians from the Florida State University College of Medicine, Immokalee Health Education Site. The Healthy Me toolkit maps out behavioral interventions for adolescents based on the Transtheoretical Model of Behavior Change, which outlines the stages that one goes through to effectively change habits: precontemplation, contemplation, preparation, action, and maintenance. The toolkit presents tools for patients for each stage. In the preparation stage, the one-pager "Talking Down the Negative" enlists adolescents to respond to the negative thoughts around dietary changes with comebacks. The thought, "I'm tempted to eat" is matched with the comeback, "I can make it a group effort and help others eat better, too." The full program is available in English and Spanish at https://www.healthymeflorida.com.

Programs at school-based health centers (SBHCs) are another promising practice. SBHCs are ideal locations to provide medical management, offer ongoing support, and monitor progress over time, as students are more accessible for follow-ups or monitoring visits and peer groups are more easily formed and maintained. SBHCs are situated in predominantly low-income communities, where families struggle to access health care, serving populations that are at higher risk for obesity and related conditions like diabetes. The School-Based Health Alliance is offering a presentation on how telehealth can be integrated into SBHCs at their June convention. Learn more about SBHA's convention and access resources at: http://www.sbh4all.org/.

In 2016, the National Collaborative on Childhood Obesity Research evaluated numerous programs offered by health centers to determine best practices and effective strategies in addressing childhood obesity. Their white paper, "Evaluating Community-Clinical Engagement to Address Childhood Obesity: Implications, and Recommendations for the Field," is available on their website at https://goo.gl/JJvBMM. NCCOR has numerous toolkits and resources for health centers at https://www.nccor.org/nccor-tools/. ■

1 Skinner AC, Ravenbakht SN, Skelton JA, et al. Prevalence of Obesity and Severe Obesity in US Children, 1999–2016. Pediatrics. Feb 2018, e20173459; doi: 10.1542/peds.2017-3459.

2 Lim YM, Song S, Song WO. Prevalence and Determinants of Overweight and Obesity in Children and Adolescents from Migrant and Seasonal Farmworker Families in the United States—A Systematic Review and Qualitative Assessment. Nutrients. 2017;9(3):188. doi:10.3390/nu9030188.

MCN is a member of the Farmworker Health Network (FHN)

The Farmworker Health Network (FHN) is comprised of six National Cooperative Agreements in migrant health funded through the US Department of Health and Human Services (HHS) to provide training and technical assistance to current and potential Migrant Health Center Programs. FHN members collaborate as a team to address health center needs and bring multiple areas of expertise to bear in problem-solving. The FHN works to provide high-quality, relevant training and technical assistance to health care providers of agricultural worker populations through the articulation of issues; analysis and comments on proposed policy and procedural documents; dissemination of population-specific information; and provision of technical assistance services to address the need for information, training, and education. Included in the following link are key resources from each of the FHN members that highlight best practices and field-tested models: https://www.migrantclinician.org/toolsource/ resource/fhn-key-resources-migrant-health.html. ■

■ Accessing Behavioral Health Services continued from page 4

appointment was unsuccessful, as Gonzalez felt uncomfortable with the set-up. It took several weeks until he finally managed to connect with the psychologist in person. This case emphasizes that Health Network's bridge case management is comprehensive: Health Network Associates do not just provide records transfer and appointment services but work to address the full health needs of the patient, connecting regularly with the patient as he or she navigates the health system and incorporates the prescribed health plan into his or her migratory lifestyle.

After he returned home, Gonzalez requested that Diaz keep the case open until he had his depression under control. She agreed to contact his primary care provider to determine if a therapeutic course could be started, in addition to the medication he had already received from his primary care provider. The case continues to be open, with Diaz contacting him to review his progress over regular intervals.

Learn more about Health Network at: https://www.migrantclinician.org/services/network.html. Visit the Ventanilla de Salud website at: http://ventanillas.org. ■

* *The name of the patient and details of his story have been altered to protect patient identity.*

those goals — and then give a warm hand-off to those who can help address them," Dr. Galvez said. If a patient is smoking, for example, a nurse might uncover that the patient smokes because she is suffering from high levels of stress. She may then be introduced to the Community Health Worker (CHW), who has a stronger focus on social determinants.

"It's hard to focus on eating healthy if you're stressed, depressed, or worried about your family being deported. Through our team-based approach, we can address some of the stressors they have. That can remove some of the huge barriers," Dr. Galvez emphasized.

"I had a patient who was trying to [get his hypertension under control] but was also dealing with moving — and was worried that he was going to end up homeless. Our CHWs were identifying the barriers and providing resources, and our nurse was reporting back to me as the provider. In a different clinic, you wouldn't know for three months down the road [until the next visit] what was going on with that patient," but in this situation, Dr. Galvez explained, the health center intervened early to help the patient manage a stressful situation and get back on the track to health. The team also includes a clinical pharmacist, who may also make prescription adjustments under the supervision of Dr. Galvez. "The clinical pharmacist or a registered nurse can get 20 or 30 minutes to sit down and talk with the patient," when Dr. Galvez's time is too limited to provide that much time. Additionally, Dr. Galvez's clinic has on staff a nutritionist providing popular classes in Spanish and English, as well as behavioral health providers. Each is ready for a warm handoff. Group visits are another key aspect to care. "The patients learn from each other," and feel less isolated in their struggles, she said.

The cost of care and time away from work are issues for patients, including Virginia Garcia's patients. To better meet patients' needs and address these concerns, Virginia Garcia has reimagined their services. Patients who aren't able to come in with such frequency can complete a visit over the phone, with nurses guiding the patients through how to take their blood pressure from home.

Dr. Galvez emphasizes that a critical part of a successful approach must encompass the way clinicians communicate to patients about hypertension. In most health centers, the provider explains that hypertension is a serious chronic condition and requires medication, and that the patient should focus on exercise and diet changes to get the condition under control — and the conversation ends there. "Most of our patients want to be healthy and live a long time. If we, as clinicians, make time to sit down with the patient and explain what the ultimate goal is — to decrease death from cardiovascular disease — I think most people get engaged," she said. "We get so caught up in talking about blood pressure numbers and medications, we forget what the big picture is. Why does my blood pressure have to be 140/80? When I tell a patient, 'long term, high blood pressure is damaging your kidneys and your heart and your brain, and you're at risk of dying from a heart attack or stroke,' most people pay attention. This is where we have to do the work — not just with moving the numbers. Most people want to be around for their grandkids." With Virginia Garcia's hypertension interventions, more patients will be able to do just that.

RESOURCES

In April, Dr. Galvez joined MCN for the first session of our Hypertension ECHO series, which brought top experts and the latest data on hypertension directly to frontline workers at health centers around the country. Here is a selection of resources provided to our Hypertension ECHO participants during that introductory session.

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, from the National Institutes of Health's National Heart, Lung, and Blood Institute, is available in English at https://goo.gl/yAt8hH and in Spanish at https://goo.gl/cxnk71.

National Heart, Lung, and Blood Institute's High Blood Pressure page reviews all the basics for patients in English at https://goo.gl/vaPSTg and in Spanish at https://goo.gl/sbH2k1.

"Do You Have High Blood Pressure?" is a low-literacy one-page resource from the CDC for patients, available in English at https://goo.gl/1K5LHV and in Spanish at https://goo.gl/jj3YQ2.

Read more about Alternative Payment Methodology in the Winter 2016 issue of Streamline: https://goo.gl/pokLEp.

Learn more about Virginia Garcia's programs: http://virginiagarcia.org.

Caring for Mental Health Response Teams After a Disaster

Dr. Torres' presentation on disasters and mental health included a number of best practices and lessons learned after Hurricane Maria. Here are her tips on how health centers can best serve their mental health response teams to assure their effectiveness and avoid burnout:

The health center should:

- Provide their mental health practitioners with as much information as possible about what has happened.
- Have providers work in pairs while they're in the community. Each partner in the pair is encouraged to remind the other to take rests and to eat.
- Make space for providers to share emotions or concerns at end-of-shift meetings.
- Maintain open communication channels with the team to determine if it is necessary to make adjustments to the schedule, provide additional time off, or change assigned tasks to accommodate employees who were strongly affected by the disaster.
- Mental health response team leaders should:
- Report regularly to team members about the status of their families and their location.
- Meet regularly with each clinical team to check in.
- Mental health response team members should:
- Be given time and space to have regular telephone contact (when possible) with family and friends.
- Be given time off to protect their health.
- Conduct walks together away from the work area.
- Be able to contact an assigned mental health provider for their own needs.

How do you address post-disaster burnout?

We need to talk about our thoughts and emotions, set agendas and take time for self-care activities, enjoy the people we love. Good nutrition and physical activity should also be a part of the process.

What part of your presentation do you think is the most critical?

Strategies to establish a system of support and protection of mental health response teams. [See text box, left.]

What is your next step — what will you be doing in the clinic for the next six months?

My plan is to continue providing quality mental health services and to educate the population so that the experience of Hurricane Maria has not been in vain and we are better prepared for the next disaster.

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