streamline

Keeping Hypertension Under Control While Migrating: Health Network Case Study

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

Health Network, Migrant Clinicians Network's virtual case management system, has served thousands of patients across the US and around the world. Many published Health Network case studies showcase dramatic and complicated case management: a patient with multidrug-resistant tuberculosis who travels to a rural hometown out of the country; a patient whose pregnancy is high risk, yet who moves every three weeks for work; a young family crossing the US-Mexico border on foot. Yet, Health Network is available for any health concern a mobile patient may face. Patients may be signed up to ensure that a pap smear or blood test result is communicated after the patient moves out of the service area. Or, a patient may be enrolled to ensure that a new diabetes diagnosis is followed up with a nutrition class in a new hometown.

Another common concern for which Health Network is utilized is hypertension. Last fall, Renata Gomez*, a 66-year-old mobile agricultural worker, was at a routine appointment for hypertension at a community health center in Florida. Her hyperten-sion was under control but required regular follow-up appointments and prescription refills. She was planning to move to another state further north, so the clinician enrolled Gomez in Health Network, Migrant Clinicians Network's virtual case management system. Alma Colmenero, a Health Network Associate, received the enrollment form. Because the enrollment form came without medical records, Colmenero started by requesting medical records from the health center. Several calls and three weeks later, Colmenero received the records, and

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* Patient's name has been changed to protect patient identity.

then reached out to Gomez directly.

"I tried to contact the patient: I called her, left voicemails, sent texts," she recalled. About a month after receiving the medical records, Colmenero finally managed to catch Gomez on the phone. "She said she's going to the clinic and is under care," Colmenero found. The health center had enrolled Gomez, anticipating her move, but she hadn't yet left Florida. The health center had written on the enrollment form the recommended schedule of appointments for Gomez. Gomez confirmed that she was following the schedule, and had attended another appointment in Florida since enrollment, so Colmenero followed up with the health center once more to receive updated medical records.

Hypertension is a common concern among agricultural workers. Data from 174 migrant health centers in 2017 show that almost 12 percent of patients had a diagnosis of hypertension; of the 875,142 patients served at migrant health centers, 101,535 had hypertension.[1] Hypertension was the most common diagnosis among the reported health concerns. While fewer agricultural worker patients have a diagnosis of hypertension than the overall US population, foreign-born agricultural workers may be at risk related to acculturation, wherein the length of time spent in the US is associated with a higher risk of hypertension.[2]

Mobility, particularly among agricultural workers, whose work is unstable and often unpredictable, complicates care for chronic conditions like hypertension. Gomez's health center took the extra time to enroll Gomez, despite an uncertain date of migration, as an anticipatory step to assure that, whenever she's ready to move, Gomez will be able to continue her care and keep her hypertension under control. Colmenero will continue to keep up regular communication with Gomez, and, when she needs to move, Colmenero will help her find a new clinic, set up an appointment to keep her recommended schedule of appointments, and transfer her medical records.

This case highlights Health Network's wide lens of care, and one of the many ways health centers utilize Health Network to anticipate patients' mobility and assure continuity of care. While some of the case management had to slow down as Colmenero waited for medical records from the enrolling clinic, and waited to hear back

from the patient, the high-touch and personal case management provided by Health Network is essential for keeping mobile patients in care, for any ongoing health concern, including hypertension – and, without such case management, patients like Gomez might fall through the cracks.

To learn more about Health Network or to schedule a training for your clinic on how to use Health Network, contact Theressa Lyons-Clampitt, MCN's Senior Program Manager and *Training and Technical Assistance Coordinator, at tlyons@migrantclinician.org.* ■

Hypertension Resources

In the spring of 2019, MCN offered a Project ECHO series for Community Health Workers in Spanish about hypertension. Project ECHO is a "hub-and-spoke" webinar educational model that allows for expert-led conversations, networking, and knowledge sharing by participants. Here are a few of the popular resources from the ECHO series.

Patient education comic books on hypertension: https://bit.ly/2WGfScc

"Control de la presión arterial," ("Blood pressure control") from the Centers for Disease Control and Prevention, features infographics for clinicians on blood pressure including incidence by region, state, and race and ethnicity: https://bit.ly/2LG2dla

"Cómo tomar la presión arterial correctamente" ("How to correctly take blood pressure") is an infographic offered up by AXA Health Keeper. https://bit.ly/2E6jcXD

"Desmintiendo 7 mitos del sodio" ("Busting 7 myths about sodium"), from the American Heart Association, is one of several sodium-related infographics in Spanish, available at: https://bit.ly/2vVkxMz

The American Heart Association has numerous additional resources in English and Spanish: https://www.heart.org/en/health-topics/high-blood-pressure

Visit MCN's Resources and Toolbox for extensive resources on hypertension for patients experiencing vulnerability: https://www.migrantclinician.org/tools-and-resources.html

References

[1] "Table 6A - Selected Diagnoses and Services Rendered." 2017 National Migrant Health Centers Program Grantee Data. Health Resources and Services Administration. Available at: https://bit.ly/2XJJabo.

[2] Boggess B and HO Bogue. The health of US agricultural worker families: A descriptive study of over 790,000 migratory and seasonal agricultural workers and dependents. J Health Care Poor Underserved. 2016;27(2):778-92. doi: 10.1353/hpu.2016.0089.

2019 FHN Key Resources for Agricultural Health

By Theressa Lyons-Clampitt, Senior Program Manager and Training and Technical Assistance Coordinator, Migrant Clinicians Network

In May, the Farmworker Health Network (FHN) released its updated Key Resources for Agricultural Worker Health, which provide best practices and field-tested models for health center staff and board members serving agricultural workers. The FHN, a coalition of six HRSA-funded National Cooperative Agreement (NCA) organizations, provides training and technical assistance to health centers with a focus specifically designed to enhance care to agricultural workers and their families. The FHN members, comprised of Migrant Clinicians Network, MHP Salud, Farmworker Justice, National Center for Farmworker Health, Health Outreach Partners, and the National Association of Community Health Centers, contribute critical resources on topics relevant to agricultural worker health.

Here are a few topics covered in the new Key Resources list:

- Health center board membership toolkit;
- Bilingual digital stories on various health topics, including agricultural worker identification;
- Health policy bulletin related to recent developments in policy and research;
- Diabetes materials for agricultural worker patients;
- Transportation and health access quality improvement toolkit;
- Outreach reference manual;
- Guide to develop easy-to-understand materials;
- Community Health Workers and social determinants of health resources;
- Hypertension and heart-health guide for Community Health Workers;
- Continuity of care services for mobile patients;
- Clinical education materials.

FHN FARMWORKER HEALTH NETWORK

Key Resources for Agricultural Worker Health

The Farmworker Health Network (FHN) is comprised of six National Cooperative Agreements in agricultural worker health funded through the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) to provide training and technical assistance to current and potential Health Centers. The FHN is committed to supporting the development of leadership within the community and health centers and increasing access to care for the agricultural worker population. We function as a trusted resource to health center staff and boards, helping them to fulfill their capacity building needs, and to incorporate services delivery options that are designed to enhance care to agricultural workers and their families. Collaboration among FHN members includes a team approach to addressing health center needs and bringing multiple areas of expertise to bear in problem solving. The FHN works to assure the visibility of agricultural worker health within HRSA, and other governmental and private organizations through the articulation of issues, analysis and comment 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. Attached are key resources from each of the FHN members, which highlight best practices and field-tested models.

MHP Salud
956-968-3600
http://mhpsalud.org/

FARMWORKER JUSTICE
(202) 293-5420
https://www.farmworkerjustice.org/

NCFH
National Center for Farmworker Health, Inc.
(512) 312-2700
http://www.ncfh.org/

MIGRANT CLINICIANS NETWORK
MCN
(512) 327-2017
http://www.migrantclinician.org/

Health Outreach Partners
(510) 268-0091
http://outreach-partners.org/

NATIONAL ASSOCIATION OF Community Health Centers
(301) 347-0400
http://www.nachc.org/

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To access the complete guide, visit https://bit.ly/2w0g2QM.

Complex Conversations on Cost

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

"We suspected that clinicians in Federally Qualified Health Centers assumed their patients were covered and their out-of-pocket costs were affordable," said Dr. Bradham. "Neither assumption is supported in independently-collected observations of primary care as well as specialty encounters in 2016."

How many clinicians hold a conversation with patients around the potential costs of the proposed care devised for the patient? For low-income patients, who have little to no savings, the fear of paying for a health crisis increases the anxiety and stress around the diagnosis itself, including a chronic condition like diabetes. And yet, according to a paper published this week in the Annals of Internal Medicine, discussion around cost of care occurred during less than half of observed patient encounters, and only 11.9 percent of physician-patient encounters included a discussion of the cost of treatment plans. The Robert Wood Johnson Foundation-funded research was conducted by Douglas D. Bradham, DrPH, MA, MPH, a health economist and policy expert, and Principal Investigator of Migrant Clinicians Network's "Clear on the Cost" study; Deliana Garcia, MA, MCN's Director of International Projects and Emerging Issues; Alma Galván, MCH, MCN's Senior Program Manager; and Corey Erb, MCN's former Research Assistant and Executive Associate.

This new MCN publication joins a growing body of research and popular press articles detailing the complexity around having a cost-of-care conversation. A recent New York Times article, entitled, "They Want It to Be Secret: How a Common Blood Test Can Cost $11 or Almost $1,000," dove into the complexity of medical costs,

using the routine metabolic blood panel as the example: "Some insurance companies provide consumers with tools to help steer them away from the $450 test, but in many cases you won't know the price your insurance company agreed to until you get the bill." Patient costs may be surprising to both patient and clinician.

Discrepancies in health care costs can change over time, tangling an already intricate picture of health coverage and patient responsibility differences, options in procedures and prescriptions, and in- and out-of-network care. Most patients who need to have cost-of-care conversations are not well and may be adjusting to the realities of new prescription regimens, long-term care needs, and procedures, and their impacts on day-to-day living, or the "indirect" costs of care, like loss of work or transportation costs. Additionally, clinicians and clinic staff have a limited patient encounter window, during which diagnosis and treatment must be fully discussed, in addition to the related cost of care.

In their study, MCN researchers observed clinical encounters, from check-in through discharge, and then conducted patient interviews and provided the clinicians with post-visit surveys, at two multi-site health centers in Texas and Pennsylvania. Of the 67 encounters with complete data, 38 of them (or 56.7 percent) had no mention of cost by clinic staff, clinicians, or patients. Indirect costs of care were mentioned in just 2.9 percent of visits.

"The nation's largest network of primary care providers could serve as a fulcrum to enhance transparency and clarity about all costs of care," concluded Bradham. "There are implications that these costs may reduce patients' compliance with recommended care and lower providers' positive outcomes, although these connections were not part of this current study."

In response to the research findings, Migrant Clinicians Network developed a policy template for use by health centers to implement and change policy and practice around cost-of-care conversations; it is currently being tested with two health center sites. Additionally, MCN is developing patient education materials, on issues including co-pay, out-of-pocket, annual deductible, and lifetime maximum. Such concepts can easily cause confusion among patients whose insurance coverage may change frequently, and with it, the cost of coverage. Watch MCN's blog for updates on the release of those materials and other initiatives to improve cost-of-care conversations: https://www.migrantclinician.org/community/blog.html. Read the full research article on cost-of-care conversations at the Annals of Internal Medicine website: https://annals.org/aim. ◼

Project Catalyst:
Evidence-Based IPV and Trafficking Engagement

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

Juana* had been in an abusive relationship for years. For the last two years, she'd been working with the behavioral health clinician at her local community health center in Arkansas. The previous year, as part of a new statewide initiative called Project Catalyst, the health center had partnered closely with a domestic violence agency and shelter, and the clinician had discussed the shelter as an option for the woman during recent visits. After many years in an abusive relationship, the woman was now ready to make the leap. After her appointment, she visited the shelter's thrift store — a less intimidating entry into the shelter's space, and a location that the clinician had offered as a place to learn more about her options — and was guided successfully through the process of obtaining a protection order. The clinicians at Juana's health center had been trained on intimate partner violence (IPV) and the center had partnered with a local shelter as part of Project Catalyst, a project that seeks to improve the health and safety outcomes for survivors of IPV and human trafficking (HT) and to promote prevention by building partnerships between community health centers and domestic violence agencies. A project of Futures Without Violence, a national non-profit focused on ending IPV, Project Catalyst is supported through a unique collaboration within the US Department of Health and Human Services partners, including the Administration for Children and Families' Family and Youth Services Bureau, HRSA's Bureau of Primary Health Care, and HRSA's Office of Women's Health. Project Catalyst's two-part model works locally with health centers while also addressing state- and territory-wide policies around IPV and HT, with the ultimate goal of preventing IPV and HT and increasing access to health and safety supports for survivors.

At the state/territory level, Project Catalyst brings together leadership from throughout the state/territory to promote policy and systems changes that support an integrated and improved response to IPV and HT at community health centers. Through a competitive application process, Project Catalyst identifies states/territories with which to partner. During its first phase, running from 2016 to 2017, Project Catalyst was imple-

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*   Patient's name and locations have been changed to protect patient identity.

mented in four states; last year, they launched their second phase with three more states and a US territory, expanding efforts to include leadership from state/territory Primary Care Associations, Domestic Violence Coalitions, Departments of Public Health, and Departments of Health, to build expertise in those key state and territory leaders.

Locally, staff at each participating community health center receives training and technical assistance on IPV assessment and response from Futures Without Violence based on evidence-based strategies. They also build strong relationships with a local community-based organization focused on IPV, like a shelter or advocacy nonprofit, to improve community connections and assure a warm handoff for patients to access both health and community resources as part of the strategy.

According to Anna Marjavi, the Health Program Director at Futures Without Violence, health centers outside of the states and territories participating in the initiative can still benefit, via the online toolkit. Available at https://ipvhealthpartners.org, the toolkit assists health centers in building a "comprehensive and sustainable response" to IPV and human trafficking. "We direct people to learn the promising practices from the sites that have implemented [Project Catalyst resources]. The site offers actionable tools for people to create their own local partnerships between community health centers and domestic violence programs," Marjavi said.

The toolkit, which offers five steps for health centers to implement, guides clinicians away from the formerly widespread use of a yes/no screening tool. "What we've learned is that people don't always feel comfortable or safe disclosing that information — but we do feel that health care providers are the right people to bring it up," Marjavi said, noting that fears over immigration status, systems involvement, confidentiality, and privacy, and other concerns, may prevent patients from speaking honestly or directly. The toolkit helps clinicians shift from disclosure-driven practice and to universal education. "You can still ask a pointed question — 'could something like this be going on for you?' — but we're not reliant on getting that 'yes,'" Marjavi noted.

The intervention is organized around the four steps represented in the acronym "CUES": confidentiality, universal education and empowerment, and support.

Confidentiality: Patients should be seen one-on-one. "That can be a pretty big systems shift for some clinics," Marjavi admitted, as many health centers do not have a policy specifying that patients are to be seen alone, but seeing the patient alone for even

part of the visit is key. The clinician must also disclose the limits of confidentiality before discussing IPV or HT, Marjavi added.

Universal Education and Empowerment: The toolkit's simple safety card helps guide the conversation on IPV and HT, and is provided to all patients. Clinicians can cover what constitutes an unhealthy relationship, and the health effects of IPV and HT. Clinicians are encouraged to give patients two safety cards — one for the patient, and one that the patient can give to a friend. "This normalizes the exchange, and it empowers people to be seen as helpers," Marjavi said.

Support: By offering a referral to the community organizations with which the health center has partnered, clinicians help patients envision the next step, opening a pathway out of their present situation. "The heart of the intervention is the partnership with the community-based organization," Marjavi maintained. Patients are also given information on 24-hour hotlines and other resources. Clinicians can give language around future support as well, "like how to reach them, or that they can always come back, or 'I always have an open door,'" Marjavi offered.

The project goes beyond IPV and HT. "At the state/territory-wide level, we're thinking about opportunities for state/territory policy change, thinking of ways to embed it and sustain it in the long run in the state or territory [that is engaged in the initiative]," Marjavi noted. In the exam room, clinicians are connecting the dots

between IPV, HT, and overall health: "Can the patient even pick up a prescription? [The patient] is in a smoking cessation program, but is she going to let go of smoking, given the other things going on in life?... IPV and trafficking are so connected to a whole host of health issues, and to social determinants of health, so we want programs thinking about and incorporating partnerships" around issues outside of IPV and trafficking as well, Marjavi said. ■

Resources:

Access the toolkit and the five-step implementation program for health centers at: https://ipvhealthpartners.org/

Learn more about the issue and their approach at: https://ipvhealth.org/

Futures Without Violence has developed several versions of the safety card:

- Reproductive Health Safety Card (in English and Spanish): https://bit.ly/2JrpZ1A
- Adolescent Health Safety Card (in English and Spanish): https://bit.ly/2PSCZ1s
- General Health Safety Card (in English, Spanish, Chinese, or Tagalog): https://bit.ly/2JjTWSr

Learn more about Project Catalyst at: Project Catalyst web page: https://www.futureswithoutviolence.org/health/project-catalyst/

Additional resources from Futures Without Violence are available at: https://www.futureswithoutviolence.org/health

As part of Project Catalyst, clinicians hand out two safety cards in the patient's preferred language: one for the patient, and one to give to a friend.

MCN

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calendar

July 10
MCN Maryland Office Open House
Salisbury, Maryland

July 10 - 13
Summer Institute on Migration and Global Health
Oakland and Berkeley, CA
http://www.migrationandglobalhealth.org

August 7 - 9
Western Agriculture Safety and Health Conference – Cultivating Collaborations
Seattle, WA
https://deohs.washington.edu/pnash/west-ag-safety-conf

August 18 - 20
NACHC Community Health Institute & Expo
Chicago, IL
http://www.nachc.org/conferences/chi/

September 25 - 27
Midwest Stream Forum
Denver, CO
http://www.ncfh.org/midwest-stream-forum

October 9 - 11
East Coast Migrant Stream Forum
San Juan, Puerto Rico
https://bit.ly/2R5hQlb

MCN Open Houses

MCN will host two open houses this year.

The first, in the Salisbury, Maryland office, will take place on July 10th.

The second, celebrating our new office in Puerto Rico, will take place concurrently with the East Coast Migrant Stream Forum in October in San Juan.

Contact Edith Rodriguez at erodriguez@migrantclinician.org for more information.