This session will:

• Provide an overview of Federally Qualified Health Centers (FQHC) in the US
• Review the impact of FQHC
• Highlight the major challenges experienced by FQHC patients
• Describe an innovative program developed in collaboration with public health and community health centers to improve the health care delivery to migrants undergoing treatment for TB

At the end of this presentation, participants will be able to:

• Describe the federally qualified health center system
• Understand health center success in improving access to primary care
• Describe access issues for mobile patients
• Effectively utilize the FQHC system as a referral resource when appropriate

The Federally Qualified Health Center’s Mission

Improve the health of the Nation’s underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services
The Ultimate Goal…

Improving health status (i.e., patient health outcomes) of all populations in the target area served by a health center, especially the underserved

PIN-96-23

FQHCs: Federally Qualified Health Centers

A federally qualified health center (FQHC) is defined by the Medicare and Medicaid statutes. FQHCs include the following:

- All organizations receiving grants under Section 330 of the Public Health Service Act.
- Certain Indian organizations, and
- Requirements for Indian Health Service (IHS) funded FQHCs differ from the requirements for FQHCs receiving Section 330 grants and for FQHC Look-Alikes.

Benefits of being a Federally Qualified Health Center

For health centers that are PHS 330 grant recipients, the biggest benefit is grant funding. Other benefits include:

- Enhanced Medicare and Medicaid reimbursement
- Access to Vaccine for Children program
- Eligibility for various other federal programs and grants
- Medical residents participating through Federal Teaching Programs
- Enroll in National Health Service Corps

NOTE: Not all of these benefits are extended to FQHC Look-Alikes. The funding for new starts - up to $650,000 - is not available to FQHC Look-Alikes.

So what is a 330? A CHC?

Health Center Program Overview Calendar Year 2011

- 1,314 Organizations with 8,100 sites
- 20.2 Million Patients
- 80 Million Patient Visits
- 50% rural
- 93% Below 200% poverty
- 36.4% Uninsured
- 62.2% Racial/Ethnic Minorities
- 1,087,000 Homeless Individuals
- 863,000 Migrant/Seasonal Farmworkers
- 173,000 Residents of Public Housing
- Over 131,000 Staff
- 9,936 Physicians
- 6,933 NPs, PAs, & CNMs

Health Center Revenue Sources

Source: Uniform Data System, 2010

Health Center Program Overview

National Impact

Health Centers Serve a High Proportion of Minority, Uninsured and Low-Income Patients


Health Centers Serve a High Proportion of Minority, Uninsured and Low-Income Patients

Part One

Health Center Patients by Age Group

Health Center Patients by Insurance

Who do you see in the clinic?

Health Center Program National Presence

Health Centers and Sites September 2010

Part One

Health Center Patients by Age Group

Health Centers Serve All Ages


Health Center Patients by Insurance

Insurance Source of Health Center Patients

FQHC’s have 3 distinct differences which set them apart from all other health center programs

- The first is that the Health Center must be a not for profit corporation
- The second and most important criteria is that the health center must represent the community
- The third distinction is that a FQHC must provide access to care to a patient regardless of their ability to pay

Challenges for Health Centers

- Making it financially
- Follow-up: chronic, acute, preventive
- Screenings (i.e. PPD, Pap, Mammograms) & Referrals
- Realistic appointment schedules and no show rates
- Medications: US, Mexican, Canadian
- Finding specialty care

Challenges for Patients

- Language differences
- Unreliable transportation
- Unfamiliarity with local resources
- Legal status / fear
- Limited formal education
- Fear of costs involved with treatment and lack of funds
- No health insurance, no disability / worker’s comp
- Limited access to Medicaid
- Not understanding the treatment

Special Population Challenges for Community Health Centers

- Unequal Access to Prevention, Health Education and Screening
- Food Security
- Migration
- A whole person orientation
- The constant need for Innovation

Unequal Access to Prevention, Health Education and Screening

- Immigrants use 55% fewer health care dollars than non-immigrants
- 74% fewer dollars spent on immigrant children
- Foreign born adults 3 times more likely to be uninsured
- Average immigrant pays $1800 more in taxes than they use in services

"Unequal Access: Immigrants and US Health Care" S Mohanty
Food Security: a North Carolina Study

- 47% households surveyed were food insecure
- 10% with moderate hunger
- 5% with severe hunger
- More food insecurity in households with children (56%)
- Almost twice as much food insecurity in households with low educational attainment as with higher (primary v. secondary)


Migration

Migration causes discontinuity of care and loss of familiarity with health care systems, as well as special needs related to traveling long distances.

Patients on the Move Need...

- To know service location
- Extended hours
- Transportation
- Affordable care
- Access to their medical records
- Culturally competent care

Whole Person Orientation

- Value for and understanding of the life of the patient resulting in integration and inclusion or selection of services to better support the patient, their family in the reality of their life

Innovation: A Medical Home

- The provision of medical homes may allow better access to health care,
- increase satisfaction with care, and
- improve health

The Medical Home is really not so new

- The concept of the medical home was introduced by the American Academy of Pediatrics in 1967
- Later expanded to mean that health care services should be “accessible, accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians”
So let’s review the concept of a Medical Home

- Medical home, also known as Patient-Centered Medical Home (PCMH), is defined as:
  - an approach to providing comprehensive primary care...
  - that facilitates partnerships between individual patients, and their personal providers

Medical Home

- Medical homes are associated with better health,
- Lower overall costs of care, and
- Reductions in disparities in health

But a Mobile Medical Home?

How are we possibly going to reconcile a dynamic population with a geographically static delivery system and then make it interface with the rest of our services? Or what happens when our TB patient moves back to North Korea?

Innovation with the future in mind

- Sixteen years ago confronted the perpetual problem of continuity of care for mobile patients
- Addressed a number of elements
  - Infectious disease
  - Chronic disease
  - Unrestrained geographic mobility
  - Limited English proficiency
  - Complexity of health care delivery system

Developing with the future in mind

- Created a system of virtual patient navigation and bridge case management that has assisted more than 5,000 mobile patients
- Health Network components
  - TBNet
  - Track II
  - Can-track
  - Prenatal care

An Innovative Public/Private Collaboration

- Immigration law allows detainees to be deported before treatment is complete
- Culture-confirmed case rate 2.5 times higher than other foreign-born individuals (STOP TB USA 2008)
- Detainees often return to countries where access to health care is limited, or fail to complete treatment due to mobility (Am J Prev Med 2007)
How Does it Work?

- Health Network staff will verify contact information
- Health Network staff will identify a treatment provider in the new location
- Health Network will maintain contact with the provider AND the patient for the duration of treatment

Benefits of Bridge Case Management

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Health Network Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtaining completion dates</td>
<td>Health Network relays providers with completion dates</td>
</tr>
<tr>
<td>Reluctance to test or screen for possible health issues, or start patients on treatment,</td>
<td>Health Network locates a clinic before a patient moves and tracks that patient through follow up and/or completion of treatment</td>
</tr>
<tr>
<td>Support for patients in treatment who are inclined to leave care</td>
<td>Health Network provides health education</td>
</tr>
<tr>
<td>Cost of maintaining patients in custody</td>
<td>Patients return to their countries faster</td>
</tr>
</tbody>
</table>

The IMPACT of TBNet

- Managed over 5,000 patients to more than 70 countries
- Bridge between patients and their providers
- In 2009, 84% of patients completed treatment for Active and/or Latent TB and only 8.4% of patients were lost to follow up
- Treatment completion reports provided to states
- Improved patient participation
Class 3 Active TB: TBNet Treatment Success (2005-2010)

- 937 Class 3 Active TB Cases Referred
  - 29 treatment not recommended by destination country
- 908 Treatment Recommended
  - 7 deceased
- 901 Followed by TBNet for Active TB
  - 95 lost to follow up
  - 49 refused treatment
- 757 Complete Treatment = 84%

TBNet 2005-2009

| TBNet Patient and Clinic Contacts: 2005-2009 |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| Total Patients  | Pt Contacts     | Contacts per pt | Clinic Contacts | Contacts per pt |
| 805             | 7,742           | Aver. 9.9       | 25,683          | Aver. 32.9      |
| Total contacts  | 33,425          | Aver. 42.8      |                 |                 |
|                  |                 |                 |                 |                 |

Nationality TBNet 2005-2010

<table>
<thead>
<tr>
<th>Country</th>
<th>Total Class 3 patients (937 total patients)</th>
<th>Percent of total patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honduras</td>
<td>345</td>
<td>36.8%</td>
</tr>
<tr>
<td>Mexico</td>
<td>161</td>
<td>17.2%</td>
</tr>
<tr>
<td>Guatemala</td>
<td>154</td>
<td>16.4%</td>
</tr>
<tr>
<td>El Salvador</td>
<td>103</td>
<td>11%</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>22</td>
<td>2.3%</td>
</tr>
<tr>
<td>Peru</td>
<td>18</td>
<td>1.9%</td>
</tr>
<tr>
<td>China</td>
<td>17</td>
<td>1.8%</td>
</tr>
<tr>
<td>Ecuador</td>
<td>16</td>
<td>1.7%</td>
</tr>
<tr>
<td>India</td>
<td>10</td>
<td>1.1%</td>
</tr>
<tr>
<td>Haiti</td>
<td>10</td>
<td>1.1%</td>
</tr>
<tr>
<td>Honduras; Mexico; Guatemala; El Salvador</td>
<td>763</td>
<td>81.4%</td>
</tr>
</tbody>
</table>

Case Study

- Feb. 2010 screened in ICE facility
- Negative smear, RUL consolidation, TST 20 mm, asymptomatic, medication not started
- Feb. 2010 enrolled TBNet and then deported
- March 2, 2010 TBNet notified positive culture
- Clinic identified in Central America and medical records sent
- Contacted family in Central America but patient had left for US
- May 4, 2010 wife called stating patient in US being held by “coyotes”

Case Study

- September 28, 2010 patient called - told TBNet he had moved to another East Coast State
- Clinic found, appointment made, medical records transferred from both previous clinics
- Patient resumed therapy per DOT
- Wife updated on patient’s treatment
- Treatment completed April 7, 2011
TBNet Successes

- Treatment equal to that among geographically stable populations
- Disease surveillance role
- Consistency between international protocols
- Policy recommendations – identify difficult to treat populations
- Model for management of other diseases in mobile populations

Conclusions

- Public Health and Primary Care have a huge mandate
- The need for access to low cost health care will continue to grow
- Providing that care will not get any easier
- Innovative programs which align public health and primary care components of the health care delivery system are the wave of the future

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