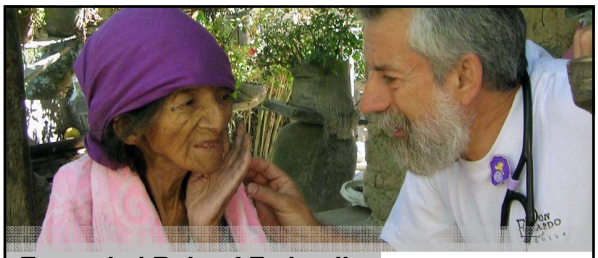

Expanded Role of Federally Qualified Health Centers

TB Intensive Workshop
October 5, 2012
Ed Zuroweste, MD, CMO
Migrant Clinicians Network

MCN

A force for justice in healthcare for the mobile poor

Welcome to the World of Federally Qualified Health Centers

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

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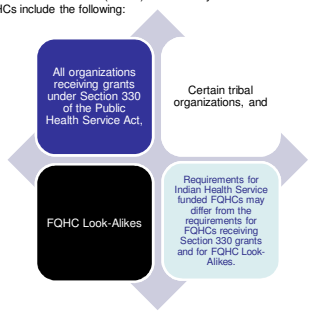
FQHCs: Federally Qualified Health Centers

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



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:

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

Part One

Public Health Section 330 Programs

Section	Program
330 (e)	Community Health Center
330 (g)	Migrant Health Center and Voucher Programs
330 (h)	Health Care for the Homeless
330 (i)	Public Housing

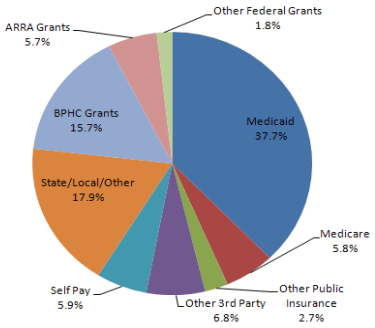
So what is a 330? A CHC?

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

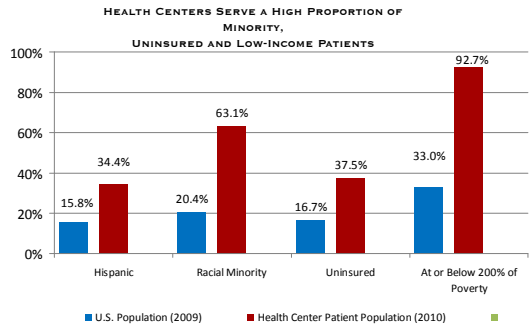
http://www.hrsa.gov/about/news/2012tables/healthcentersacafactsheet.pdf

Health Center Revenue Sources



Source: Uniform Data System, 2010

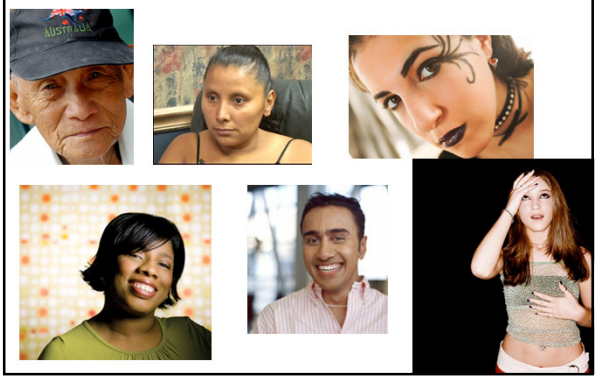
Health Center Program Overview
National Impact



SOURCE: *HEALTH CENTER DATA:* UNIFORM DATA SYSTEM, 2010. *NATIONAL DATA:* U.S. CENSUS BUREAU, 2010 CURRENT POPULATION REPORTS AND CURRENT POPULATION SURVEY.

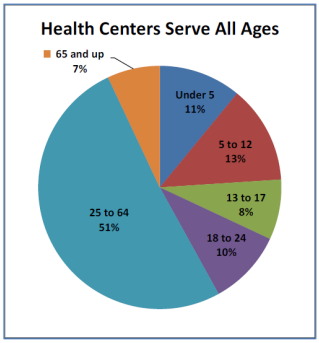
Health Center Program
National Presence

Who do you see in the clinic?



Part One

Health Center Patients by Age Group



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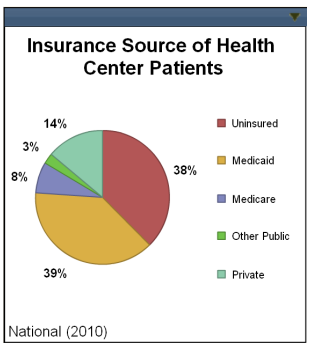
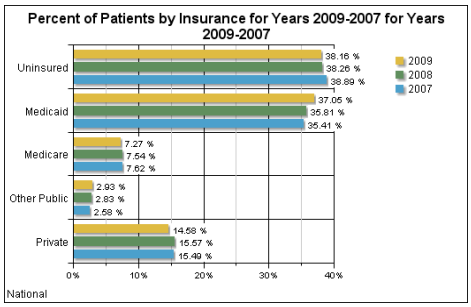
Health Center Patients by Insurance



http://bphc.hrsa.gov/uds/view.aspx?q=s&year=2010



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

Photo: Eduardo Moreno

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

Photo: Eduardo Moreno

Outreach workers doing glucose checks by flashlight in a migrant camp "after hours".

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)
  - Quandt, Arcury, Tapia, Early, Davis. "Hunger and Food Insecurity Among Latino Migrant and Seasonal Farmworkers in NC". Proceedings of the 2002-03 Migrant Stream Forums.

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?

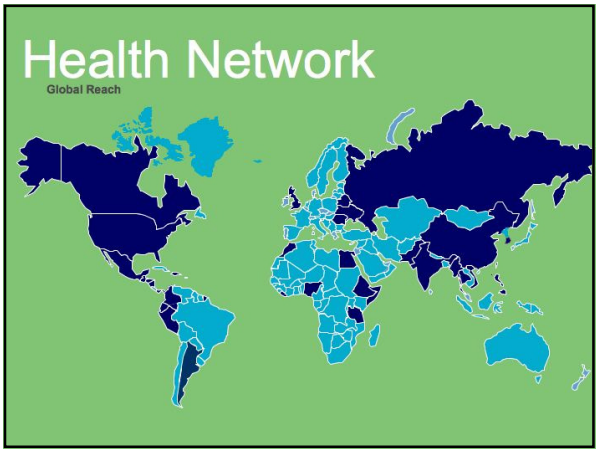
- Health Network staff will verify contact information
- Health Network staff will identify a treatment provider in the new location
- Health Network will maintain contact with the provider AND the patient for the duration of treatment

How Does it Work?

- Health Network will inform the enrolling provider of the treatment outcome
- Should the patient fail to present or discontinue treatment, Health Network will communicate with all known contacts to bring the patient back into care

Benefits of Bridge Case Management

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



The IMPACT of TBNet

- Managed over 5,000 patients to more then 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	Total contacts	Total contacts per pt
805	7,742	**Aver. 9.9**	25,683	**Aver. 32.9**	33,425	**Aver. 42.8**

Nationality TBNet 2005-2010

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

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

- TBNet case manager called “coyote” on the West Coast
- Spoke to patient and explained culture results and need for treatment
- Immediately after call TBNet contacted ICE, initiated human trafficking investigation
- June 11, 2010 patient contacted TBNet was released by “coyote” and now on the East Coast
- Appointment made/medical records sent to local health department
- Patient started on 4 drug regimen DOT

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

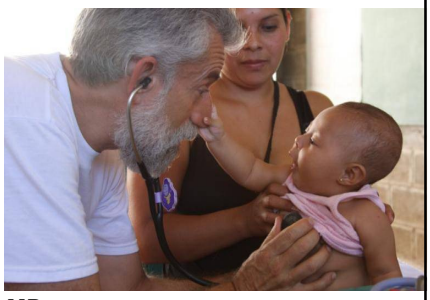
TBNet Successes

- 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

Contact:



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