Community and Migrant Health Centers: Providing Vital Access

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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 in the US.
- Review the impact of Federally Qualified Health Centers
- 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
DO NOT
FLUSH
PAPER TOWELS,
NEWSPAPER,
WRAPPING PAPER
RAGS, DISPOSABLE
DIAPERS, SANITARY
NAPKINS,
TAMPONS
PLASTIC, STICKS,
ETC., DOWN
TOILET.
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,
- FQHC Look-Alikes,
- Requirements for Indian Health Service funded FQHCs may 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:

Eligibility for various other federal grants and programs
Enhanced Medicare and Medicaid reimbursement
Access to Vaccine for Children program
Medical malpractice coverage through Federal Tort Claims Act
Access to National Health Service Corps
Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through 340B Drug Pricing Program

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**

<table>
<thead>
<tr>
<th>Section</th>
<th>Program</th>
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<tbody>
<tr>
<td>330 (e)</td>
<td>Community Health Center</td>
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<tr>
<td>330 (g)</td>
<td>Migrant Health Center and Voucher Programs</td>
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<td>330 (h)</td>
<td>Health Care for the Homeless</td>
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<td>330 (i)</td>
<td>Public Housing</td>
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So what is a 330? A CHC?

Community and Migrant Health Centers, Homeless Health Centers, Public Housing Health Centers, and School-Based health Centers are specially designated FQHCs.

Usually, in the “health center world”, we speak of community health centers and mean any of these subtypes.
Health Center Program Overview
Calendar Year 2010

• 1,314 Organizations with 8,100 sites
• 19.5 Million Patients
• 77 Million Patient Visits
• 50% rural
• 93% Below 200% poverty
• 38% Uninsured
• 62% Racial/Ethnic Minorities
• 1,052,000 Homeless Individuals
• 863,000 Migrant/Seasonal Farmworkers
• 173,000 Residents of Public Housing
• Over 131,000 Staff
• 9,592 Physicians
• 6,362 NPs, PAs, & CNMs
Health Center Revenue Sources

- Medicaid: 37.7%
- Other Public Insurance: 2.7%
- Other 3rd Party: 6.8%
- Self Pay: 5.9%
- State/Local/Other: 17.9%
- BPHC Grants: 15.7%
- ARRA Grants: 5.7%
- Other Federal Grants: 1.8%

Source: Uniform Data System, 2010
Health Centers Serve a High Proportion of Minority, Uninsured and Low-Income Patients

- Hispanic: 15.8%
- Racial Minority: 63.1%
- Uninsured: 34.4%
- At or Below 200% of Poverty: 92.7%

Who do you see in the clinic?
Part One

Health Center Patients by Age Group

- 65 and up: 7%
- Under 5: 12%
- 5 to 12: 13%
- 13 to 24: 19%
- 25 to 44: 28%
- 45 to 64: 21%
Health Center Patients by Insurance

Insurance Source of Health Center Patients

- Uninsured: 15%
- Medicaid: 37%
- Medicare: 7%
- Other Public: 3%
- Private: 38%

National (2009)
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

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
- Immigrant children with 74% fewer dollars spent on them
- 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

Fourteen 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
  - TBNNet
  - 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)
Virtual Case Management

- Patient Navigation
- Medical Record Transfer
- Bridge Case-Management Program
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**

- 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 Solutions**

- 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
Migrant Clinicians Network's International Reach Health Network (TBNet) has established and maintained relationships with various National Health Programs around the world.
The IMPACT of TB Net

• Managed over 5,000 patients to more than 60 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
TBNet 2005-2009

- Total: 805
- Deceased: 5
- Treatment not recommended: 24
- Total TBNet Case Managed: 776
- Total treatment Completed: 659
- % of Total Rx Completed: 84.9%
# TBNet 2005-2009

**TBNet Patient and Clinic Contacts: 2005-2009**

<table>
<thead>
<tr>
<th>Total Patients</th>
<th>Pt Contacts</th>
<th>Contacts per pt</th>
<th>Clinic contacts</th>
<th>Contacts per pt</th>
<th>Total contacts</th>
<th>Contacts per pt</th>
</tr>
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<tbody>
<tr>
<td>805</td>
<td>7,742</td>
<td><strong>Aver. 9.9</strong></td>
<td>25,683</td>
<td><strong>Aver. 32.9</strong></td>
<td>33,425</td>
<td><strong>Aver. 42.8</strong></td>
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</table>
## TBNNet 2005-2009

<table>
<thead>
<tr>
<th>Country</th>
<th>Total</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honduras</td>
<td>314</td>
<td>39%</td>
</tr>
<tr>
<td>Guatemala</td>
<td>128</td>
<td>15.9%</td>
</tr>
<tr>
<td>Mexico</td>
<td>125</td>
<td>15.5%</td>
</tr>
<tr>
<td>El Salvador</td>
<td>88</td>
<td>10.9%</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>21</td>
<td>2.6%</td>
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<tr>
<td>China</td>
<td>16</td>
<td>2.0%</td>
</tr>
<tr>
<td>Ecuador</td>
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</tr>
<tr>
<td>Peru</td>
<td>13</td>
<td>1.6%</td>
</tr>
<tr>
<td>Brazil</td>
<td>9</td>
<td>1.1%</td>
</tr>
<tr>
<td>Haiti</td>
<td>8</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

81.3% from four countries: Honduras; Guatemala; Mexico; El Salvador
TBNet Case Study #1

• Case 08-0179 (Vietnam)

• Need for Care
  – Patient Returning to Vietnam

• Course of Navigation
  – Smears reverted to positive / HIV positive
  – Patient took one dose in U.S., went to Vietnam and returned to U.S.
  – High priority case for ICE
  – Public figure in Vietnam, very concerned about personal information
TBNet Case Study #1

• Case 08-0179

• Course of Navigation (continued)
  – NTP/Harvard Partnership was contacted for clinic referral
  – Clinic found, patient preferred a private clinic-Provided name of doctor and clinic name
  – Contact established with clinic, updated on case, clinic referral was sent out
  – Recommendation made to have patient take copies of med records (information relayed to detention facility)
  – Contacted clinic and patient on patient status
  – Patient completed treatment on 10/21/2009
Case Study #2

• Case 07-0288

• Need for Care
  – Patient Returning to El Salvador

• Course of Navigation
  – Patient under custody negative AFB smears / positive cultures after deportation
  – Patient referred to clinic in his town, records sent and NTP notified of his condition
  – Patient arrives and continues treatment
Case Study #2

• Case 07-0288

• Course of Navigation
  – TBNet finds out the patient has decided to return to the U.S.
  – Family provides us with the patient’s address (after confidentiality is assured)
  – Patient contacted, address in U.S. verified
  – Health Department contacted notified
  – Records from El Salvador were translated and sent to Health Department
  – Patient finished treatment in the U.S. on 2/8/2008
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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