

**COMMUNITY HEALTH
CENTER BASED
TOBACCO CESSATION
TREATMENT FOR LOW-
INCOME TOBACCO
USERS IN IOWA**

**Promising Practices: Achieving Health and Social
Equity in Tobacco Control Conference**

April 28, 2010

LEARNING OBJECTIVES AND TOPICS ADDRESSED

○ Learning Objectives

- Participants will understand the tobacco cessation program in place in Iowa's Federally Qualified Community Health centers.
- Participants will be able to describe how outcomes data is tracked using i2i, a disease management registry, and by an independent evaluator.

○ Topics Addressed

- About the Iowa/Nebraska Primary Care Association (IA/NEPCA) and Iowa Community Health Centers (CHCs)
- Iowa CHC Patient Demographics
- Tobacco Cessation Program Highlights and Outcomes



The background is a dark olive green. On the left side, there are several vertical stripes of varying widths and shades of green and grey. To the right of these stripes, there are several circles of different sizes, also in shades of green, arranged in a vertical line.

ABOUT IA/NEPCA AND IOWA CHCs

ABOUT IA/NEPCA

- Membership association for Community Health Centers in Iowa and Nebraska
- PCAs in every state (some multi-state)
- Federally funded to provide services to member CHCs
 - Health Resources and Services Administration
 - Bureau of Primary Health Care



WHAT IS A COMMUNITY HEALTH CENTER?

- Not-for-profit corporations (consumer led boards)
- Provide comprehensive primary health care to medically underserved populations regardless of ability to pay
- Created by Section 330 of the Public Health Service Act in 1965
- Federally designated and funded
- Receive funds from other sources, as well



HOW CHCs DIFFER FROM PRIVATE PRACTICE

- Health centers remove common barriers to care by serving communities that otherwise confront financial, geographic, language, cultural, and other barriers. They:
 - Are located in high-need areas
 - Are open to all residents
 - Offer enabling services
 - Tailor their services to fit the special needs and priorities of their communities, and provide services in a linguistically and culturally appropriate setting.



HOW CHCs DIFFER FROM PRIVATE PRACTICE, CONT.

- Offer a sliding fee scale to patients at 200% of the federal poverty level and below.
- Have a responsibility to address broader public health needs.
- For many patients, the health center may be the only source of health care services available.



WHO CHCs SERVE

Health Centers care for:

- 17.1 million people in the United States
- 1 in 18 people in the United States
- 92% below 200% of the federal poverty level
- 70% below 100% of the federal poverty level
- 33% of all patients are best served in languages other than English and nearly 100% of patients report their clinician speaks the same language they do.

At a cost of:

- \$588 average annual cost per patient
- \$129 average cost per visit



OUTCOMES

- Effective management of chronic illness
 - The Institute of Medicine and Government Accountability Office recognize health centers as models for screening, diagnosing, and managing chronic conditions.
 - Have improved health outcomes while lowering the cost of treating
- Increased access to primary and preventive care
 - Low income, uninsured health center patients more like to have usual source of care than uninsured nationally
 - Those living in close proximity are less likely to have an unmet medical need, less likely to visit the emergency department or have a hospital stay, and more likely to have had a general medical visit compared to uninsured nationally



OUTCOMES

- High patient satisfaction
 - More than 99% of nationally surveyed patients report they were satisfied with services received at health centers
- Disparities in health status do not exist among health center patients, even after controlling for socio-demographic factors. Moreover, as more of a state's low income population is served by health centers, racial and ethnic health disparities in key areas are reduced across the state.



OUTCOMES

- Provide high quality care
 - Equal to or greater than the quality of care provided elsewhere
- Improve birth outcomes
 - Infant mortality rates 10% lower than comparable communities without a center
- Create jobs and stimulate economic growth
 - Overall economic impact reaches \$12.6 billion annually
 - 143,000 jobs in some of the country's most economically deprived neighborhoods



OUTCOMES

- Several studies show that CHCs:
 - Save the Medicaid program around 30% in annual spending for health center Medicaid beneficiaries
 - Generate savings for the entire health care system of up to \$17.6 billion a year
 - Results in less costly specialty, inpatient, and emergency room care
 - If avoidable visits to the emergency rooms were redirected to health centers, over \$18 billion in annual health care costs could be saved nationally

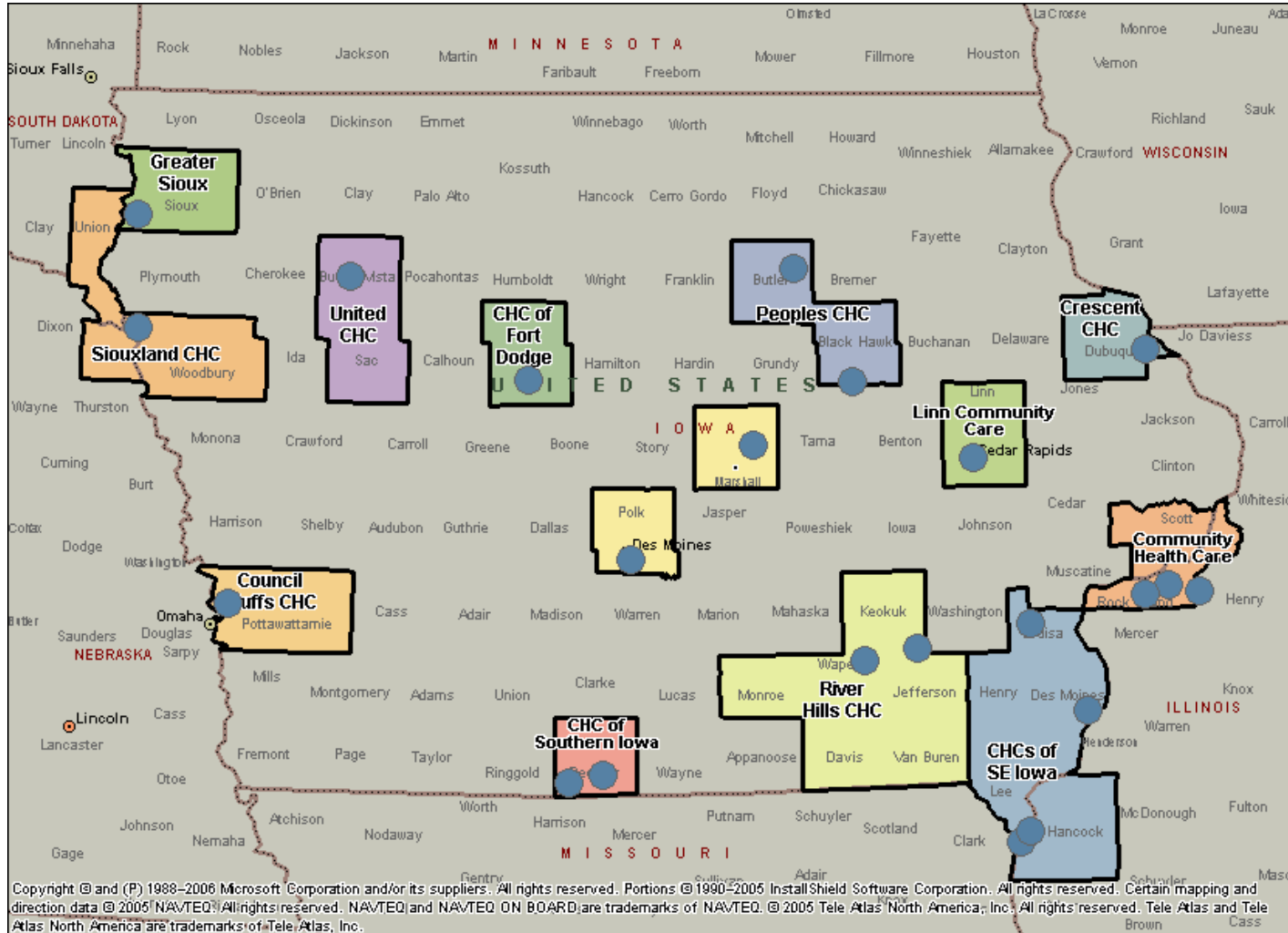


CONTINUED FEDERAL SUPPORT

- Former President Bush doubled the number of FQHCs
- President Obama – unprecedented support in the American Recovery and Reinvestment Act of 2009
 - Workforce
 - Increased demand for services
 - Construction
 - Health Information Technology
- Health Reform Legislation
 - Beginning FY11, \$11 billion in new funding over 5 years for FQHCs
 - 20 million new patients



IOWA CHC SERVICE AREA



IOWA COMMUNITY HEALTH CENTERS

- 13 CHCs (main sites)
 - Burlington (dental in Burlington and Columbus Junction)
 - Cedar Rapids
 - Council Bluffs (dental)
 - Davenport (dental)
 - Des Moines (dental in Des Moines and Marshalltown) – 2 CHCs
 - Dubuque (dental)
 - Fort Dodge (dental)
 - Leon
 - Ottumwa (dental in Ottumwa and Richland)
 - Sioux City (dental)
 - Storm Lake (dental)
 - Waterloo (dental in Waterloo and Clarksville)
- 1 FQHC Look Alike
 - Sioux Center
- 20 primary delivery sites; 74 total delivery sites across the state





**IOWA CHC PATIENT
DEMOGRAPHICS**

IOWA DEMOGRAPHICS

2008

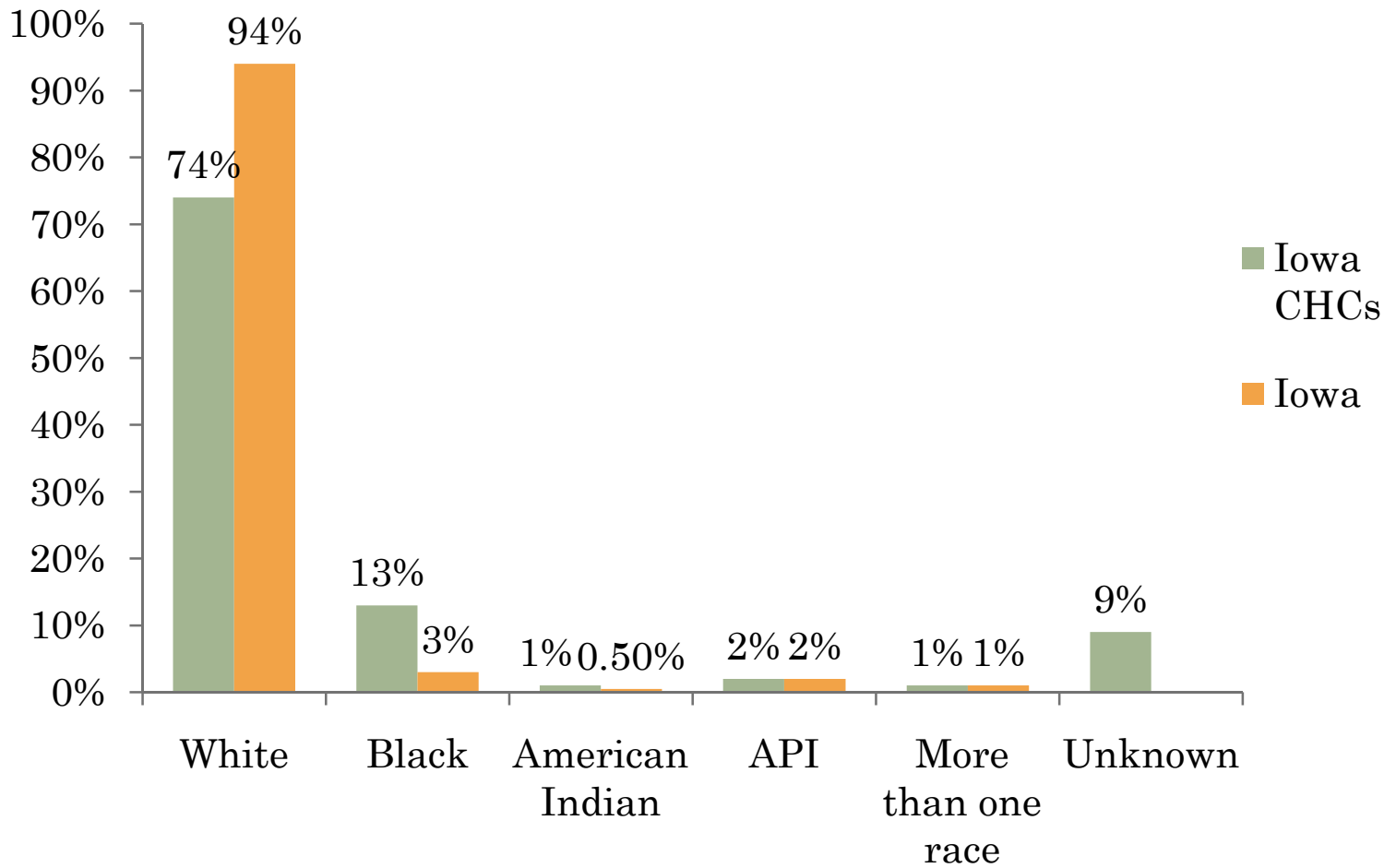
- 137,830 unique patients
- 488,598 total visits
- 13% best served in a language other than English

2009

- 154,020 unique patients
- 556,862 total visits
- 12% best served in a language other than English

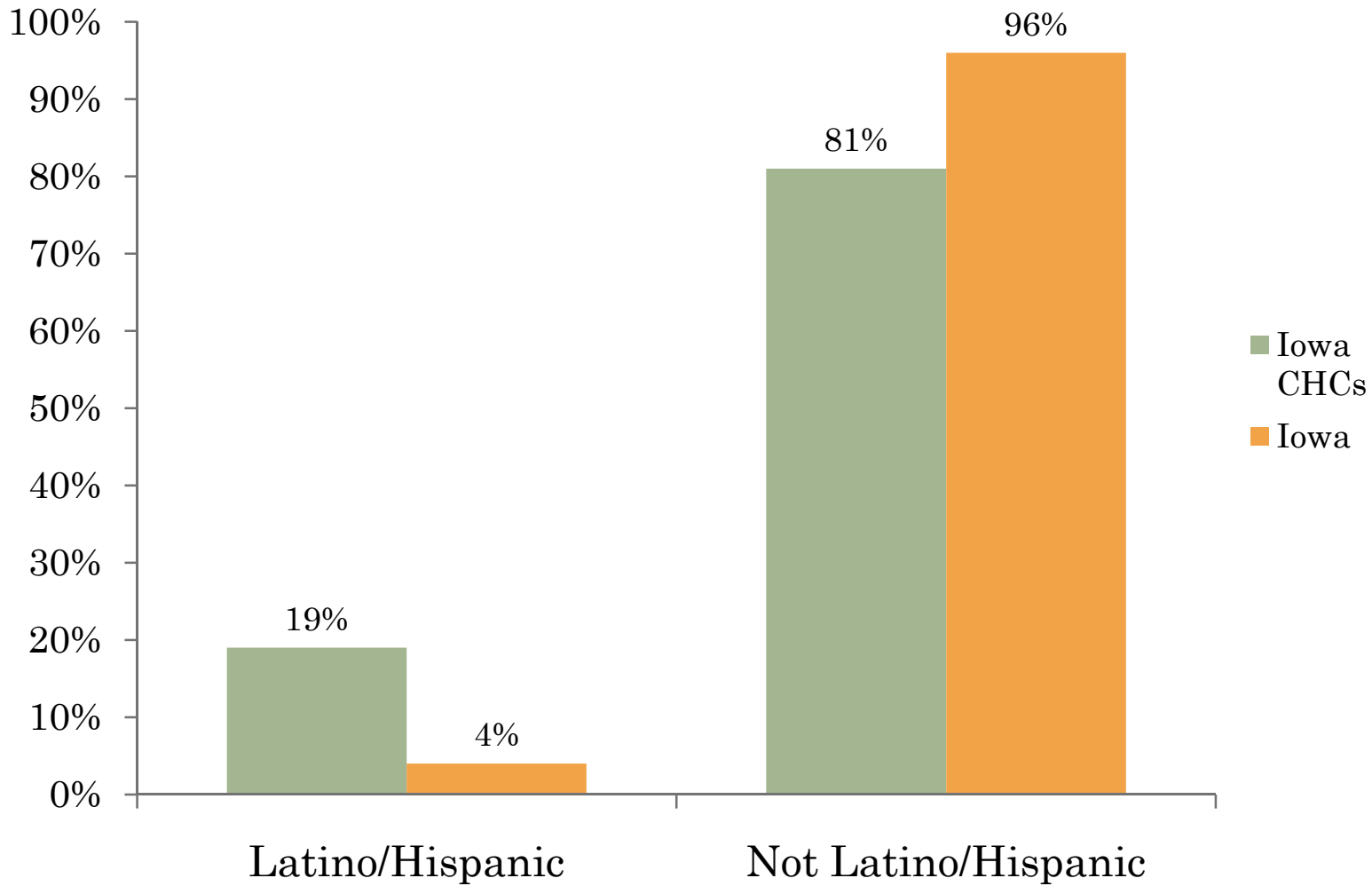
* Source: 2008, 2009 Uniform Data System (UDS)

DEMOGRAPHICS: RACE



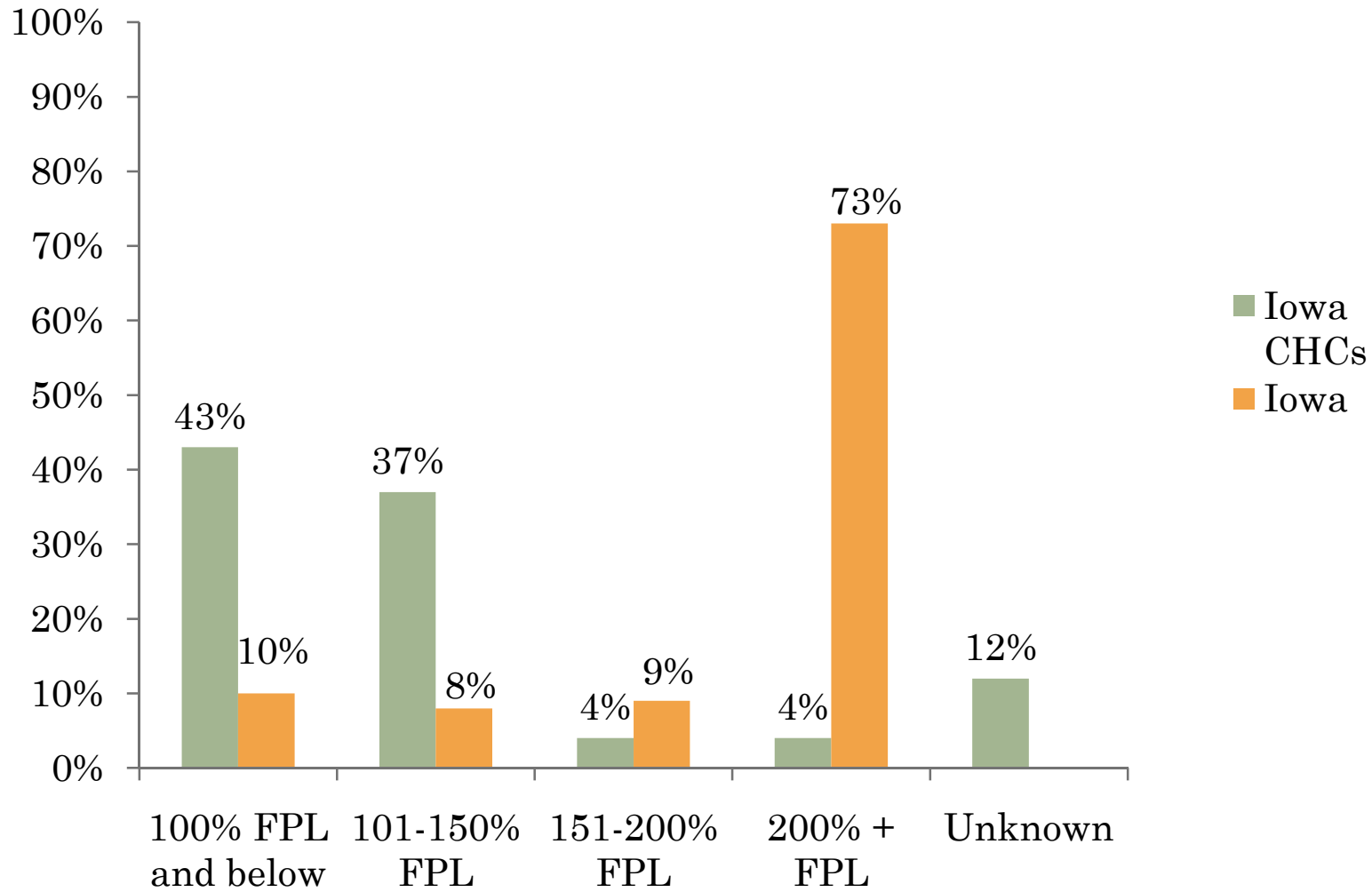
* Source: 2008 UDS

DEMOGRAPHICS: ETHNICITY

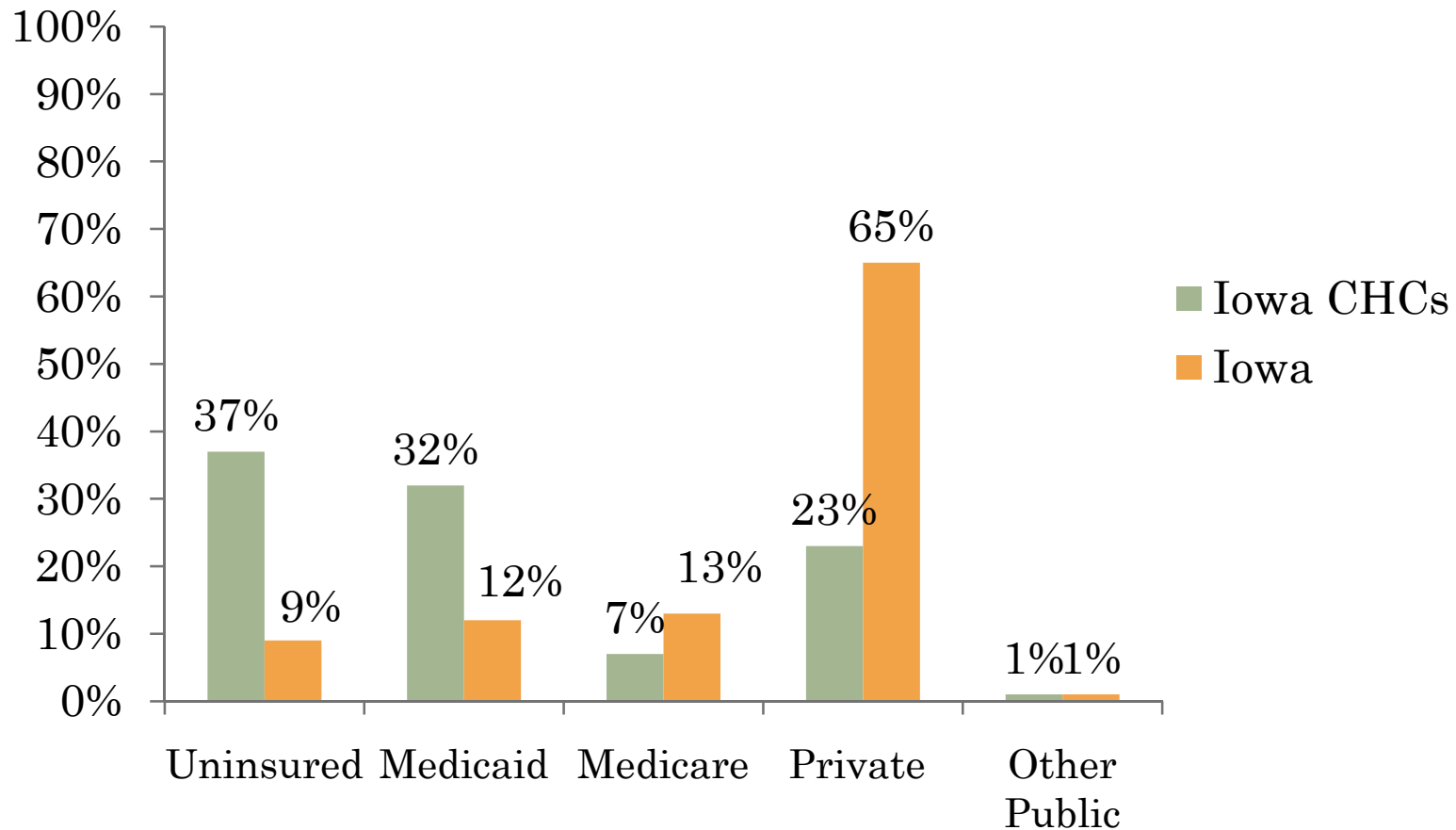


*Source 2008 UDS

IOWA CHC VS. STATE POPULATION BELOW FEDERAL POVERTY LEVEL, 2008



IOWA CHC VS. STATE POPULATION INSURANCE STATUS, 2008





**TOBACCO CESSATION
PROGRAM HIGHLIGHTS
AND OUTCOMES**

TOBACCO PROGRAM BACKGROUND

- Iowa Department of Public Health (IDPH) – Provides funding to Iowa CHCs for a tobacco cessation program targeted at low-income, uninsured patients.
- FY10 is the third year of the program (began February 2008).
- Independent evaluation of the program completed by the University of Northern Iowa Center for Social and Behavioral Research



PROGRAM OVERVIEW

- Eligibility – Iowans who are 18 and older, non-Medicaid, at any income level, and without private insurance providing cessation services
- Two Primary Goals
 - Provide free counseling and pharmacotherapy to CHC patients
 - Various counseling (individual, group, or referral to Quitline Iowa)
 - Various medications (Chantix, Bupropion, patches, gum, etc.)
 - Refer Medicaid patients to Medicaid cessation benefit
 - Screening – providers screen patients for tobacco use status
- Centers reimbursed per two-week course of treatment provided
 - Cost effective – 340b program



USE OF PATIENT POPULATION HEALTH MANAGEMENT SYSTEM TO TRACK OUTCOMES

- First used PECS in 2002
- Implemented a more robust system in 2007 (i2iTracks)
- Software interfaces to Practice Management System
 - Brings over demographics, CPT, and ICD-9 codes
- Some centers have additional interfaces such as lab
- Used in conjunction with
 - Tobacco Cessation Program
 - Health Disparity Collaboratives
 - Other center specific initiatives

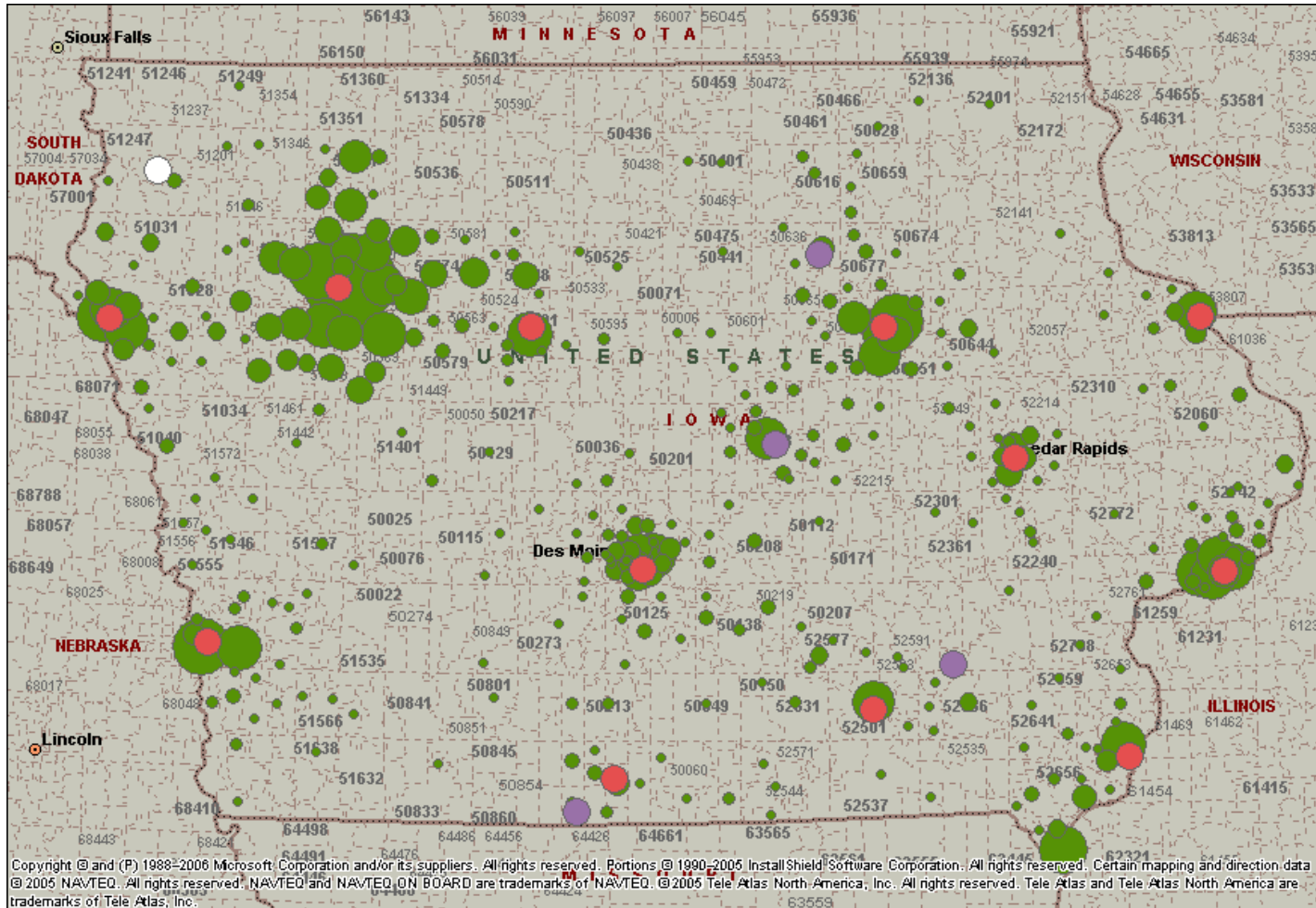


PROGRAM ACTIVITY

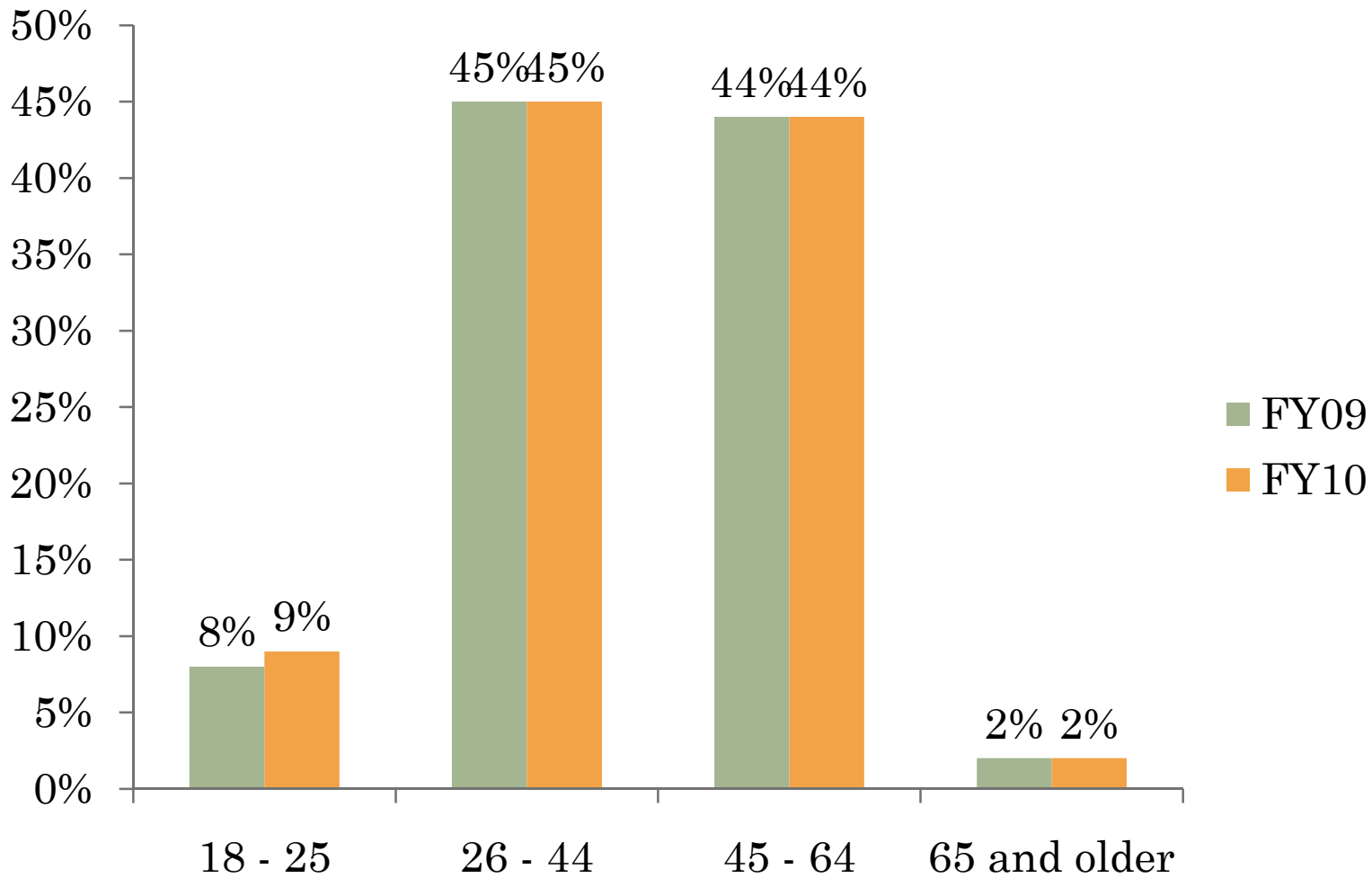
- Number of Patients Enrolled in the Program
 - FY10 – 1,560 (143 return patients from FY09)
 - FY09 – 3,265 (68 return patients from FY08)
 - Since Program Inception – 6,106
- Number of Two-Week Courses of Treatment Provided
 - FY10 – 5,759
 - FY09 – 10,884
 - Since Program Inception – 18,568
- Number of Patients Referred to the Medicaid Cessation Program
 - FY10 – 364
 - FY09 – 603
 - Since Program Inception – 1,204



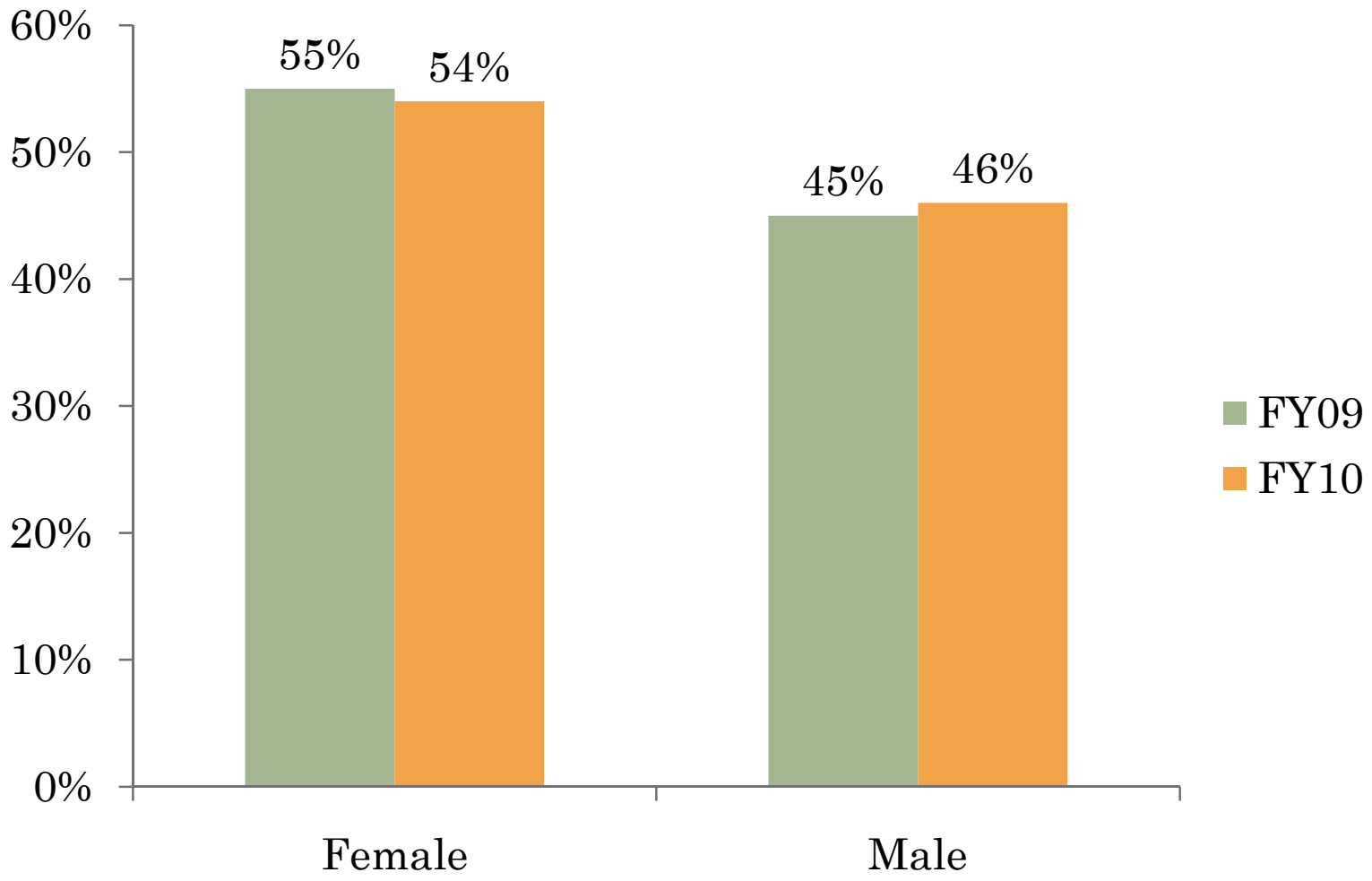
PATIENT ZIP CODES



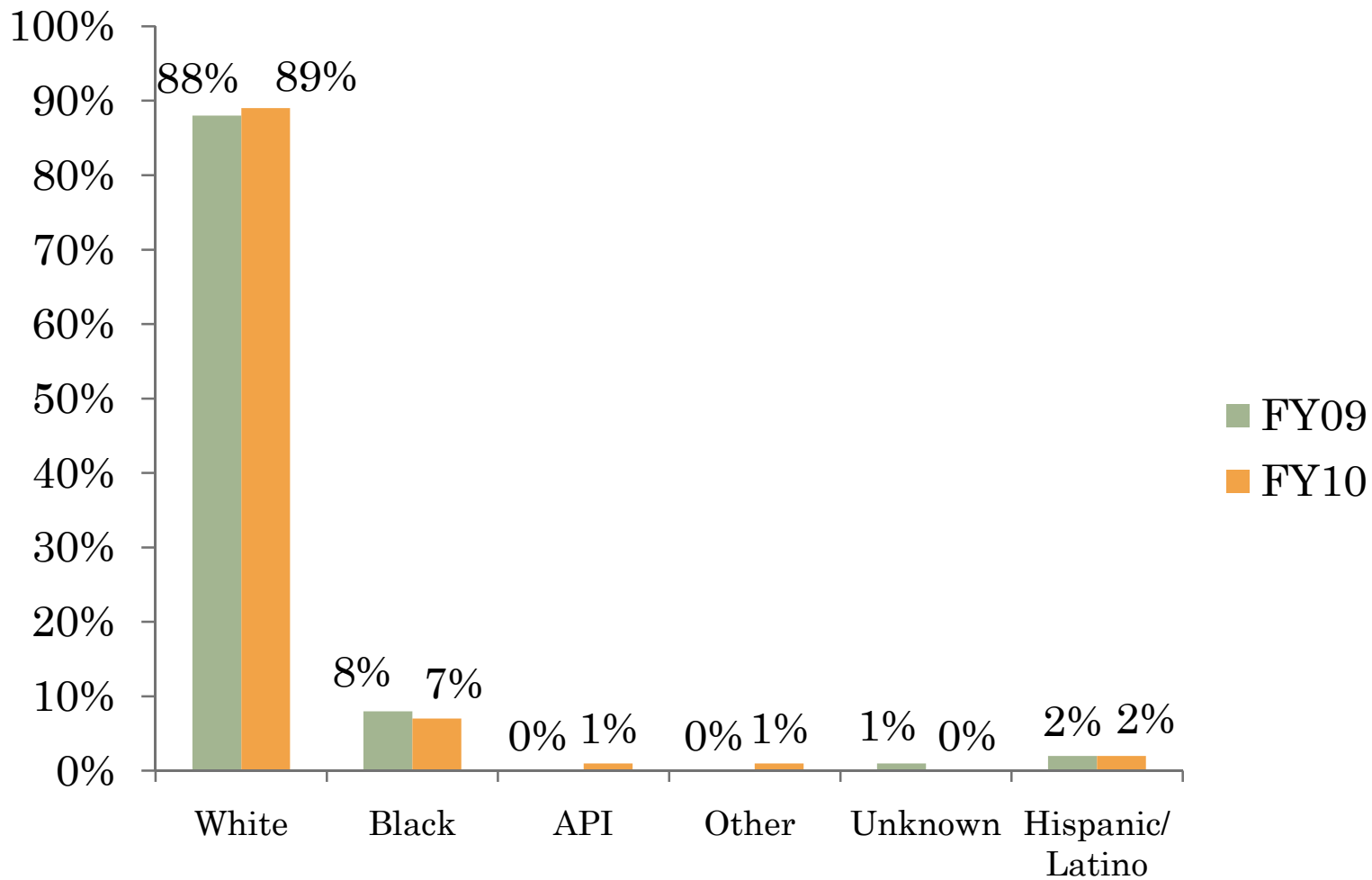
FY09 AND FY10 AGE DEMOGRAPHICS



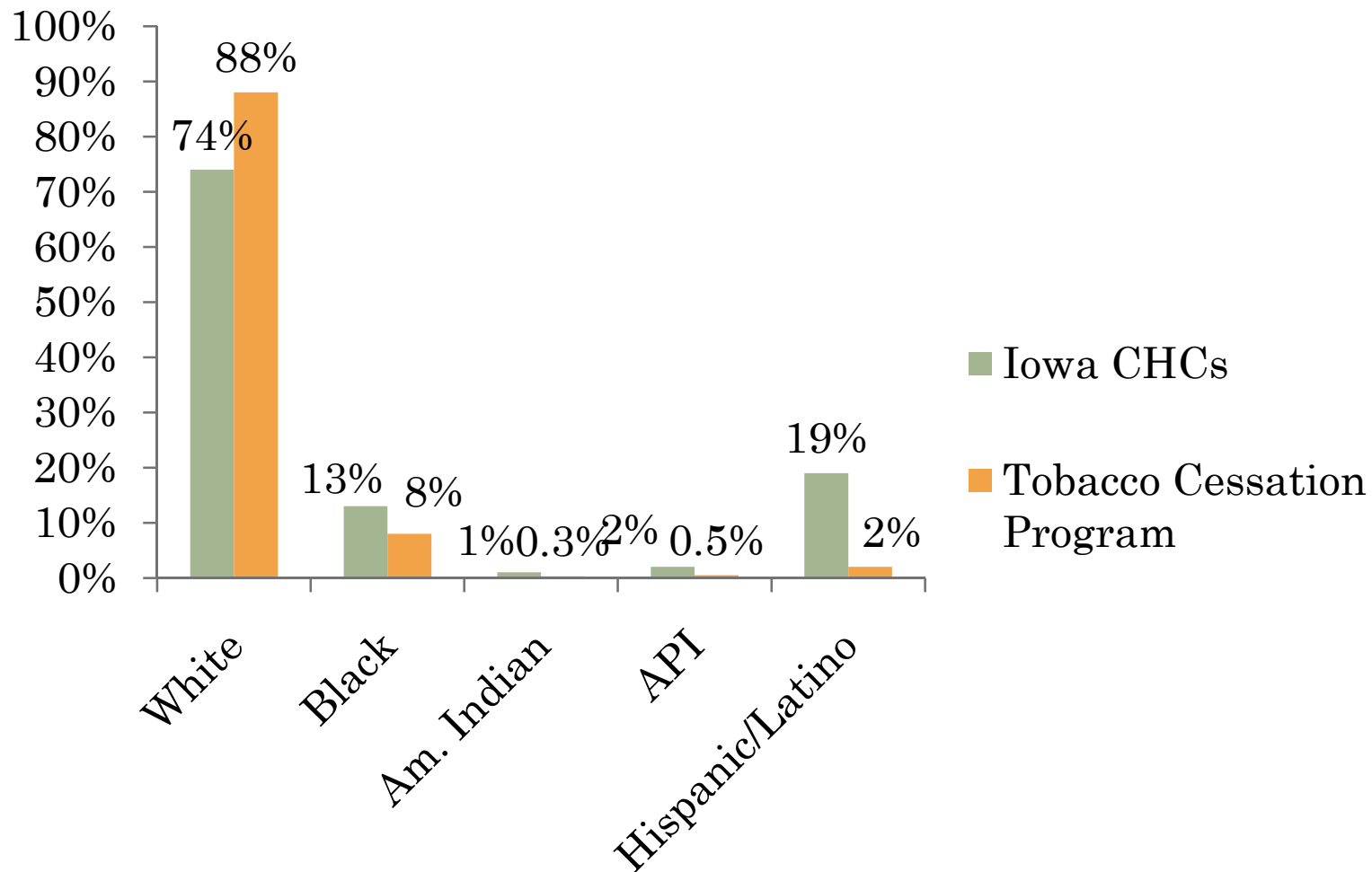
FY09 AND FY10 SEX DEMOGRAPHICS



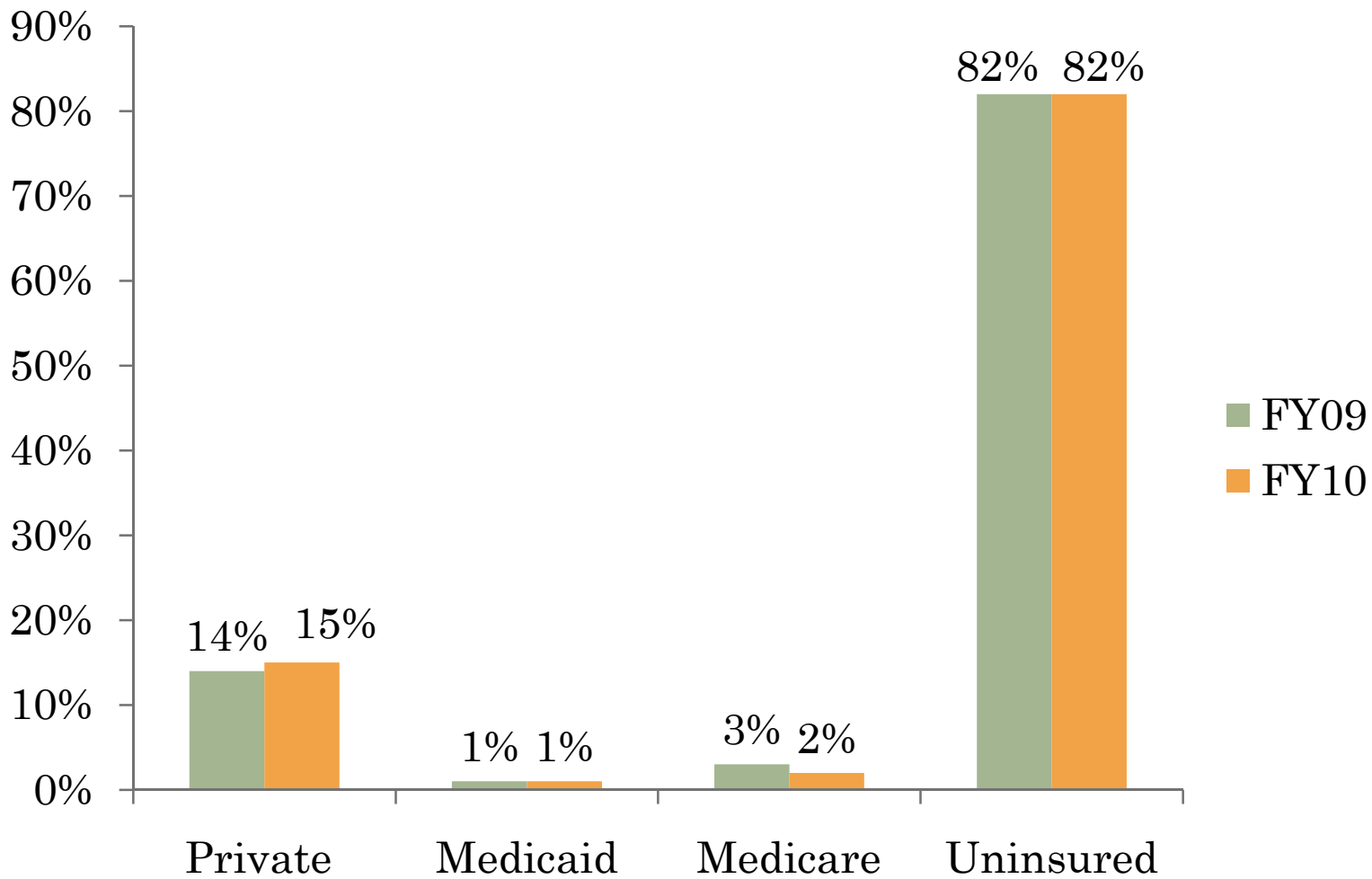
FY09 AND FY10 RACE/ETHNICITY DEMOGRAPHICS



CHCs vs. TOBACCO PROGRAM RACE AND ETHNICITY



FY09 AND FY10 INSURANCE STATUS DEMOGRAPHICS



CHALLENGES TO PROVIDING CARE TO UNINSURED

- Challenges faced by the uninsured compared to those with public or private insurance
 - 75% have gone without coverage for more than one year.
 - More likely to be unable to afford prescription drugs, to go without needed care due to cost, lack access to preventive care, and have no usual source of care.
 - Also more likely have to have difficulties paying basic monthly expenses such as rent, food, and utilities.
 - More likely to be in poor health and low-income.



COMPLEXITY OF CHC TOBACCO PATIENTS

- Prevalence of chronic diseases among tobacco patients (heart, lung, diabetes, and arthritis-related conditions)
 - Approximately 40%
- Prevalence of mental health/substance abuse disorders (other than nicotine)
 - Approximately 37%
- 82% are uninsured



MOST RECENT EVALUATION FINDINGS

- Quit Rates
 - 3-month – 29%
 - 6-month – 27%
 - 12-month – 26%
 - Similar to national cessation rates of ~20%
- Harm Reduction
 - Baseline – 23 cigarettes per day
 - 3-month – 13
 - 6-month – 16
 - 12-month – 16
- Screening Evaluation Measure Exceeding IDPH Goal (70% in first two years) – 90% on average
 - 95% among participants in program
 - 84% among non-participants
- Across the Three Follow Up Cohorts
 - 94% would recommend the program to others
 - 81% were very satisfied or satisfied with the program



PATIENT SUCCESS STORIES

- A patient came in for a provider appointment and has been smoke-free for eight months. He used that success to drive himself forward to achieve other goals including losing 32 pounds over the last three months.
- A male smoker of over 30 years started the program at the beginning of June. He has been smoke-free using Chantix and counseling since June 3. His wife saw how successful her husband was and she signed up for the program in July. She has been smoke-free since July 8.
- “It has really helped me in maintaining my smoke-free status by talking with you bi-weekly. Thank you.” Patient was smoke-free at day seven after taking Chantix and has maintained a smoke-free status for five months.



Questions?

**For additional information, contact:
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