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the ground" clinical experience designed the full-time, three-week, case-oriented "Arizona Course," Global Health : Clinical & Community Care, revised and conducted annually since 1982. The evolution of GH education preparing North American clinical professions students for short or career experiences abroad evolved, leading to the 1991 founding meeting in Tucson of the International Health Medical Education Consortium, which became Global Health Education Consortium a decade later, prior to its 2012 merger into CUGH.

Structure/Method/Design: Entering our 35th year, University Arizona and distinguished visiting faculty present this intensive 90-hour seminar in "flipped classroom" format, with daily breakouts into three mentor-led clinical/community problem-solving groups of ~8 participants each. Limited to ~ 24 participants, the "Arizona Course" now has 729 "graduates." While we now supply our extensive content via easily-portable "thumb drives," we maintain the real-time interactive dialogue and clinical procedure demonstrations possible only in this live seminar setting. As www.globalhealth.arizona.edu details, this content now forms the core of the College of Medicine's 5-element Global Health Distinction Track.

Outcome & Evaluation: In 1992 and 2009, we surveyed our graduates' careers, supplemented by annual updates on recent graduates' specialty choices and experiences in LMICs. Among the first 700 graduates [1982-2015], 239 [34%] were UArizona senior medical students; another 81 [11.5%] were other Arizona students or clinicians. The other 380 [54%] were from elsewhere, including medical schools in 32 states; 52 came from Canada. Over 60% are women. Of all 543 graduates surveyed in 2009, only 7 could not be located; 16% earned MPH degrees. Among the 322 physicians, 46% had entered family practice, 14% internal medicine and 14% pediatrics. Graduates have subsequently learned and served in 73 LMICs, including several with distinguished careers who return annually as faculty.

Going Forward: We welcome clinical students and faculty to this longest-running USA clinical global health course each October.

Source of Funding: We thank over 40 faculty who, other than the authors, have all been volunteers.

Abstract #: *2.036_HHR*

Cost Recovery and Service Usage in a Community Health Insurance Plan in Rural Uganda

***F. Pyarali**; University of Miami, Jackson Memorial Hospital, Miami, Florida, USA*

Background: Without a national health insurance system in Uganda, many areas have developed community health insurance initiatives (CHI). Although several studies examine the increased access to healthcare with CHI's, few studies investigate its sustainability at a hospital level. This study aims to find the differences in cost recovery and service usage between patients paying out of pocket (OOP) and those paying through the Kabale Diocese Community Health Insurance Scheme.

Methods: Accounting data on individual hospital visits from September 2011 to February 2012 was used. Data included services utilized, the department treating the patient, the total bill, and the amount paid. The CHI plan reimbursed the hospital using the flat rate based on the department treating the patient. Net deficits and percentage paid for each hospital visit were calculated and compared between the two patient groups.

Findings: A total of 4,279 hospital visits were recorded (n=3928 for CHI, n=351 for OOP). Two-proportion Z-tests demonstrated that a larger proportion of OOP patient visits used X-rays (19.7% OOP vs. 13.7% CHI, $p<0.05$), were administered medications (99.6% OOP vs. 95.7% CHI, $p<0.05$), involved operations (17.6% OOP vs. 9.1% CHI, $p<0.05$), and deliveries (25.9% OOP vs. 15.7% CHI). A larger percentage of CHI visits used laboratory services (62.7% CHI vs. 53.8% OOP, $p<0.05$). The total bill was larger for OOP visits ($23.77 OOP vs. $19.10 CHI, $p<0.05$). The percentage of the bill that was paid was higher for CHI visits (149.0% for CHI vs. 97.1% for OOP, $p<0.05$). The net deficit for each visit was higher for CHI patients ($1.45 CHI vs. $0.80 for OOP), but this was not significant ($p=0.18$). A 6-month aggregate of payments and costs showed lower cost recovery for CHI visits (84.6% vs 96.6%).

Interpretation: Patients with CHI generally used fewer services per hospital visit, and the total bill was larger for OOP visits. Percentage of bill payment was significantly higher for CHI visits, but there is some data to suggest that the hospital suffers a larger aggregate deficit with CHI patients. This suggests that changes need to be made in the CHI reimbursement schedule to make it more sustainable for the hospital without decreasing access.

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Abstract #: *2.037_HHR*

A Novel Telephone Triage Program for Hiv-Positive Children in Resource Poor Settings: Training Triage Coordinators in Chennai, India

***J. Radoc**[1], G. Odudu[2]; [1]University of California, Los Angeles, Los Angeles, USA, [2]David Geffen School of Medicine at UCLA, Los Angeles, USA*

Background: India is home to the world's third largest HIV-positive population. One particular sub-population- children living with HIV (CLHIV) -requires unique 'HIV triaging' to ensure patients at high risk receive priority interventions and treatment without delay. The International Alliance for the Prevention of AIDS (IAPA), an NGO in Chennai, India, supports 43 CLHIV by offering free once monthly medical visits and packages of nutritional supplements. Between once-a-month visits, all calls from patients are triaged by a single staff member. In Tamil, "uthavi," means help. The UTHAVI Project, a training curriculum and web-based telephone triage database, aims to help IAPA's CLHIV get the treatment they need between monthly visits. Specifically, the UTHAVI project's triage protocol trains community social workers and IAPA staff in triage categorization, evaluating trainees' knowledge and preparedness pre- and post-training.

Methods: In-depth Interviews with staff and physicians were conducted to assess program needs. The triage curriculum, 'The UTHAVI Project,' was adapted from the WHO's Integrated Management of Childhood Illness handbook. Using 25 CLHIV