

**Safety Net Task Force
Minutes
April 14, 2004**

Members present: Carmen Hooker Odom (Co-Chair), Sherwood Smith (Co-Chair), Carolyn Allison, Gillian Baker, George Bond, Sonya Bruton, Moses Carey, Mike Cinoman, Larry Cutchin, Leah Devlin, Brian Ellerby, Margaret Elliott, John Estes, Bob Fitzgerald, Olivia Fleming, Gary Fuquay, Rick Gilstrap, John Graeter, Andy Hartsfield, Tom Irons, Alan McKenzie, John Mills, Burnie Patterson, Adam Searing, Shirley Sims, Steve Smith, John Sullivan, Doug Yarborough.

Staff present: Gordon DeFriese, Thalia Fuller, Dennis Harrington, Mark Holmes, Adrienne Parker, Andrea Radford, Tom Ricketts, Pam Silberman, Jeff Spade, Tork Wade, Kristie Weisner, Tom Wroth.

Others: Jordan Parker, Stephanie Triantifillou, Marty Wolf.

Introductions and Welcomes

Gordon DeFriese introduced members, and thanked everyone for agreeing to serve.

**Community and Migrant Health Centers
President's Initiative for Health Center Growth and Expansion**

Sonya Bruton, MPA

Executive Director

NC Primary Health Care Association

Federally Qualified Health Centers Overview

Federally Qualified Health Centers (FQHC) are public or private non-profit, charitable, tax-exempt organizations that: receive funding (directly or as a sub-recipient) under Section 330 of the Public Health Service Act; or are determined by DHHS to meet the requirements to receive funding without receiving a grant (i.e. FQHC look-alikes).

FQHCs must:

- serve a medically underserved area (MUA) or population (MUP);
- be governed by a Board of Directors made up of a majority of patients and that represents the demographics of the service area;
- provide (directly or by contract) a comprehensive scope of preventive and primary health services, including outreach, case management, interpretation, transportation and other support services, regardless of ability to pay;
- have a schedule of charges designed to cover the reasonable costs of operation and are consistent with locally prevailing rates; and
- apply a sliding fee scale based on a patient's income and family size.

Section 330 Health Center Programs include: Community Health Centers (CHC)(Sec. 330(e)), Migrant Health Centers (MHC)(Sec. 330(g)); Health Care for the Homeless (HCH)(Sec. 330(h)); Public Housing Primary Care (PHPC)(Sec. 330(i)); and Healthy Schools, Healthy Communities (HSHC).

The legislation for FQHCs allows 5% of the federal funds to be allocated to public agencies, usually a health department. The public agencies must still meet the other FQHC requirements, including a governing board that is reflective of the community (racially and ethnically), and which is comprised of at least 51% users of the center. There are no publicly-funded FQHCs in the southeast because of the board requirements.

Federally Qualified Health Centers are expected to:

- assess the full health care needs of their target populations;
- form a comprehensive system of care incorporating appropriate health and social services;
- manage the care of their patients throughout the system; maintain ongoing referral arrangements with one or more hospitals;
- retain admitting privileges and hospital staff membership for clinicians at their referral hospital(s);
- assure that quality specialty medical, diagnostic and therapeutic services are available to patients through organized referral arrangements;
- form or join integrated delivery systems;
- provide comprehensive/continuous care that includes care during hours in which the health center is closed (nights/weekends) as well as clinic hours outside the normal 9-5 work schedule; and
- educate patients and the community regarding the availability and appropriate use of health services.

The FQHC model for comprehensive primary care provides a medical home for patients across all life cycles, regardless of ability to pay. Comprehensive care includes, but is not limited to, health maintenance, preventive care, oral care, acute care, chronic disease management, and behavioral health care.

Federally funded health centers provide health services to underserved populations. This includes people who may have difficulty paying for services, or have language or cultural differences. FQHC also serve communities with an insufficient number of health professionals/resources available in their community, or with health disparities. FQHCs serve culturally and linguistically diverse communities, and must ensure cultural competency. For example, in North Carolina approximately 25% of patient population seen by FQHC are Latinos, 40% are African-American, 27% white, 3% American Indian, 1% Asian/Pacific Islander, and 4% are unreported. Serving the growing Latino population has created new challenges for health centers. In some clinical sites, Latinos are between 50-75% of the patients served. Almost three-quarters of the patients (70%) in the Siler City office of Piedmont Health System are Latinos. A majority of the Latino population is uninsured; and many have limited English proficiency. In order to address

this population, health centers are reaching out to hire bilingual providers. About half of the providers and 25% of the administrative staff at Piedmont Health System can speak Spanish. Piedmont is one of the state's leaders in ensuring that his staff can meet the cultural and linguistic needs of the patients, but many other centers are also making great strides. Some centers are giving bilingual providers and staff preferences in the hiring process, creating bilingual health education materials, and providing cultural competency training for their growing Latino population. Center staff also try to meet the cultural needs of their non-Latino populations (including blacks, Native Americans, and white patients).

FQHC Look-Alikes: Health centers that do not receive federal grant funding can be designated as a FQHC Look-Alike, if they demonstrate that they are serving those most in need within the service area; and meet the statutory, regulatory and program requirements for grantees supported under section 330 of the PHS Act. FQHC Look-Alikes must be public or a private nonprofit entities and serve, in whole or in part, a federally designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP). These organizations must justify the need for FQHC Look-Alike designation by documenting the lack of sufficient health care resources in the service area to meet the primary health care needs of the target population. Applicants may not be owned, controlled or operated by another entity. Applicants for FQHC Look-Alike designation must be operational at the time of application and must re-certify their status annually.

The Bureau of Primary Health Care (BPHC) receives and reviews FQHC Look-Alike applications for compliance with Section 330 requirements. BPHC forwards recommended applications to the Centers for Medicare and Medicaid Services Central Office (CMS CO). Only CMS CO has the authority to designate FQHC Look-Alikes. The CMS CO notifies the state Medicaid office of the applicants pending FQHC-Look-Alike status. The state Medicaid office then has 14 days to comment on the application for designation. The state may request up to 60 days to investigate any issues prior to CMS awarding the designation.

Aside from the receipt of federal grant funds, FQHC Look-Alikes qualify for many of the same benefits (described below) as other FQHC. North Carolina has two Look-Alikes—one in Buncombe County and one Reidsville. A center can still be an FQHC if they do not offer the full range of services and meet all the requirements; thus, Look-Alike status is a good first step if you trying to become an FQHC.

Benefits of being a FQHC or FQHC Look-Alike: Section 330 FQHC grantees receive federal grants to support the costs of uncompensated primary and preventive health care. Aside from this direct federal grant, both FQHC and FQHC look-alikes can: obtain federal grants to plan and develop networks and federal loan guarantees; participate in the Section 340B Drug Pricing discounts; receive no-cost vaccines for children; receive special Medicaid and Medicare reimbursement (including the Prospective Payment System (PPS)); and have access to medical providers through National Health Service Corps (if in a HPSA). Grantees and look-alikes are protected by the Federal Tort Claims

Act (FTCA) in lieu of purchasing malpractice insurance. In addition, grantees and look-alikes outstation Medicaid workers, can waive Medicare deductibles, and can waive health center co-payments for patients with incomes below 200% of the FPL (i.e., the minimum health center charge for low-income patients).

FQHCs are unique in that they are required to offer evening or weekend hours, enabling services (such as transportation, translation, and case management), services in response to demographic, epidemiological, resource and marketplace factors; and have an autonomous community-based Board of Directors.

In 2003, North Carolina had 23 Health Center Grantees serving 73 clinical service sites. There were eight Migrant Health Center Grantees, three Healthy Schools/Healthy Community Grantees, two Homeless Health Care Grantees, and two Federally Qualified Health Center Look-alikes. These centers employed 120 physicians, 52 nurse practitioners/physician assistants, 32 dentists, and 302 nurses and other medical staff (more than 1,200 full-time employees).

Q: Why don't we have any public housing centers?

A: North Carolina is not as competitive as other states in obtaining public housing center grants, because our public housing units generally don't house as many people as in some of the larger urban communities. We don't have the same numbers of people that can be seen because there are not a lot of high-rise public housing units.

Q: Is that something we should look at?

A: The only interest in this is from Asheville. It's an opportunity for us, but we are competing nationally with some of the larger centers that have many people. We have to have the initiative at the local level to write the proposal and have local support.

Comment: In Charlotte, we are looking at trying to partner with a center that serves public housing. We are trying to do this through a Healthy Communities Access Program (HCAP) grant to integrate safety-net resources. Public housing is close to our health center, so if we tried to get new FQHC funds, they would ask why people don't just go to the health center.

Comment: North Carolina has elevated housing issues as a key component of any type of health and human service issues. DHHS is trying to foster low-income housing for seniors and people with disabilities. There is not a comprehensive housing policy for the state. There are great opportunities to integrate public housing and service delivery. DHHS is working with the federal government to try to increase Section 8 and other services. This might be an area where we can look at housing as part of the safety-net.

Services: FQHCs must provide primary medical care; diagnostic laboratory; radiology services; preventive services (including prenatal, perinatal & well child services); cancer and other disease screenings; immunizations; screening for elevated blood lead levels, communicable diseases and cholesterol; eye, ear and dental screening for children; family planning services; preventive dental services; emergency medical and dental services; pharmacy services; outreach, transportation, interpretive, and case management services; services to assist the health center's patients gain financial support for health and social services; referrals to other providers of medical and health-related services; and substance abuse and mental health services. While centers have to provide similar services, each FQHC is unique and operates differently than others.

FQHCs provide most of the services in-house, but may outsource some of the care when the health care needs of the patients exceed the scope of practice of the CHC providers. Thus, for example, if a CHC has a client with diabetes that needs a more intensive eye exam, they may refer the patient to an ophthalmologist. To meet the federal requirements, the FQHC would need to first ensure that the referral doctor will take the patient and that the services are financially accessible (i.e., FQHC must make up the difference if the ophthalmologist won't take a discounted rate).

FQHCs are required to either provide services directly or help patients access services that are not on site. Centers may not need to provide services directly when there are other community resources available where patients can be referred. For example, diagnostic laboratory services may be provided via a referral arrangement with a local hospital or a contract with LabCorp for reference laboratories. Likewise, diagnostic X-ray procedures may be provided via a referral arrangement with a local hospital. Optometry is almost always going to be provided through referrals; 20 of the NC centers refer patients for optometry. Obstetrical and gynecological care, such as prenatal care, may also be provided through referral arrangement with a local hospital or health department or through established referral relationships with private providers in the community. Centers are also training mid-level providers to deliver prenatal care services on-site. Some centers have rented office space to a local obstetrician. Twelve of North Carolina centers refer patients to other providers for obstetrics and 12 for mammograms. Mental health and substance abuse services may be provided through screening and referral to the Area Mental Health/Developmental Disabilities and Substance Abuse Programs. Mental health treatment may also be provided through relationships and referral arrangements for homeless patients. Six of the health centers refer patients for mental health and substance abuse services. Oral healthcare is provided in some centers, but it is also provided via referrals to local dentists or to the UNC-Chapel Hill School of Dentistry; four of the centers refer for dental care. Generally, if the needed health care services are not available in the community, then the FQHC may have to offer the services on site.

Centers have many different ways to meet the medication needs of their patients. Ten of the centers participate in 340B reduced drug pricing (either through an in-house pharmacy or contracting with a community pharmacy). FQHCs may also provide samples, participate in the pharmaceutical manufacturers pharmacy assistance programs,

have in-house pharmacies (that offer medications on a sliding scale), or have some other arrangement with another community pharmacist. Nine of 23 centers are JCAHO accredited, although more are likely to become accredited in the future (as the BPHC encourages accreditation).

Q: Why are there some CHCs that don't participate in 340B (the federal program that allows discount purchasing of drugs)

A: In the past, this program has been cumbersome to operate. A lot of the program rules have been changed to reduce the barriers, but this information hasn't been widely disseminated. Therefore, some centers lack current information about the program. The NC Primary Care Association is putting together a program to help the centers understand how to start the 340 b program. It is mostly an educational issue.

Q: Do you have to have an on-site pharmacy to participate in the 340 b program?

A: No. It's available to any CHC regardless of whether you have a pharmacy on site. You can work with retail pharmacists to provide services through 340B.

Comment: 340b has gotten less complex. Programs can use a "virtual inventory" which has simplified stocking problems. The landscape is changing quickly. These are very heavily discounted drugs and the program may not last so CHCs that can sign up should do it fast. This should not be confused with the Pfizer Share-the-Care program. Both are great programs, but you must have a licensed pharmacist to have Share-the-Care.

Patients. Community and migrant health centers provided care to 261,197 patients (2003 unaudited data). Almost half (48%) or 124,320 patients were uninsured, and most were low or moderate income (72% of users had incomes below 200% of the federal poverty level and 54% had incomes below 100% of the FPL). Less than ten percent (8%) had incomes in excess of 200% of the federal poverty level; 20% of the patients did not provide income information. More than two-thirds (71%) of the users are women. Most of the CHC users are adults over the age of 24. Approximately one-quarter (24%) of the users are on Medicaid, 3% are on NC Health Choice, 11% on Medicare, and 15% have private insurance. Approximately 10% (26,963) are migrant and seasonal agricultural workers. The patients of the community and migrant health centers had 833,839 visits in 2003, or approximately 3.2 visits per user.

Over the last five years, community health center patients increased by 22% and the number of visits increased by 27%. There was an even larger increase in the number of uninsured patients (32% increase). NC community and migrant health centers provide cost-effective care, serving Medicaid, Medicare, the working poor, and uninsured patients for only \$1.10 per day per patient. (This is based on total cost per user—including medical, dental and other charges—and dividing it by 365 days/user).

The most common presenting diagnoses include: hypertension (39%), diabetes (27%), mental disorders (13%) and asthma (10%). Other diagnoses include heart disease (7%), HIV/AIDs (2%), abnormal breast (1%) or cervical (1%).

Income and revenues: On average, approximately one-third of health center income (32.4%) comes from BPHC 330 grants, 49% from patient revenues, and 15% from other sources. However, this varies across centers, with some centers much more reliant on BPHC grants.

Expenditures: On average, 44% of NC health center expenditures are for medical care, 28% for administration, 8% for dental services, 7% for enabling services, 6% for other health services, and 7% for the facility. CHCs employ on a FTE basis:

- Medical: 119.3 physicians, 51.2 PAs/NPs, 301.7 other medical staff,
- Dental: 31.3 dentists, 16.9 dental hygienists, 63.7 other dental staff,
- Behavioral Health: 9.8 mental health staff, 3.7 substance abuse staff
- Pharmacy: 25.8 pharmacy staff
- Other professional service staff: 1.3
- Enabling service staff: 165.2
- Administrative and facility staff: 569.2

Outcomes: National studies of Medicaid patients served by FQHCs have found that Medicaid patients served by health centers are less likely to use the emergency room, have less preventable hospitalizations (i.e., for ambulatory sensitive conditions such as asthma or diabetes), and cost less than Medicaid patients receiving care elsewhere.

President's Initiative for Health Center Growth

In 2001, the Bush administration established the President's Initiative for Health Center Growth and Expansion, which sought to increase the number of users by 6 million by creating 630 new health centers and expanding 570 existing centers. Eighty percent of the funds will go to existing grantees, leaving 20% for new centers. President Bush's FY 2004 budget proposed a \$122 million increase in the appropriations for the Health Center program. Of this, \$56 million would be available to support health center new access points (either new starts or satellites), \$26 million would be spent for expanded medical capacity at existing centers, approximately \$50 million is spent paying for the Federal Torts Claims Act (although this figure varies by year); and the remainder is spent on strengthening existing health centers (e.g., base adjustments).

Federally qualified health centers must satisfy certain basic criteria in order to receive federal funding. Funds must be used to expand to a new location, new population or to add services. Organizations must demonstrate that increased numbers of patients need to be served in order to justify funding.

Public or private nonprofit entities, including tribal, faith-based and community-based organizations, may apply for a grant for operational support of new access points under

the Consolidated Health Center Programs authorized under section 330 of the PHS Act. Applicants are expected to demonstrate compliance with the requirements for the specific type of health center (i.e., CHC, MHC, HCH, PHPC, SBHC) for which funding is requested. Applicants may target a subset of the population, for example services for homeless children and adolescents; or organizations applying for operational support for a school based health center targeting children and adolescents. Even when a population subset is targeted, services must also be made available to other community members.

New starts are available to organizations that do not currently receive 330 federal grant support. If approved, the new start applicants may receive funding for up to three years before seeking renewal.

Satellite operation: Centers that currently receive 330 grant funds can apply for a grant to open a satellite operation. Satellites must serve a new patient population. Centers can apply for satellite funds to open a new center in their existing service area if the satellite will serve a population/area that does not have access to care at the existing center or through other providers of care.

The maximum level of support for a new start or satellite is \$650,000 per year. Basically, the organization is limited to \$150 federal grant dollars per community user, or \$200 per user for migrant/seasonal farmworkers, homeless, public housing or school-based center patients. The organization may also request \$150,000 for one-time minor capital costs for equipment and/or alteration in Year One.

The BPHC will examine whether the applicant is able to begin operations within 120 days of when the grant is awarded, and will examine whether the applicant has a facility available and ready for occupancy, and whether the applicant has providers available to serve at the new site or satellite location.

Expanded Medical Capacity: Grants for expanded medical capacity are limited to currently funded 330 grantees. The intent is to increase access to primary health care services at existing service sites, for example, by expanding the array of services offered, adding new medical providers, expanding hours of operation or providing additional services through contractual relationships. To receive an expanded medical capacity grant, the center must show an anticipated increase in new users of 25% or 3,000 people (whichever is less) for CHCs, PHPCs, and SBHCs; or an increase in new users of 10% or 1,000 for HCH and MHC. Applicants participating in state-sponsored programs to expand capacity are required to meet only 50% of the minimum growth requirements to be eligible for funding. (This lower threshold only applies in the states that provide state appropriations to health centers to support expansion efforts). Applications for expanded medical capacity were due March 29, 2004.

The maximum request for an expanded medical capacity grant is \$600,000. Similar to new starts and satellites, the grantee can use up to \$150,000 of this for one-time capital projects to renovate or replace facilities or purchase equipment. The replacement site

(e.g., when a center closes an existing facility and opens a new facility) must be operational within six months of receiving an expanded medical capacity award.

Service expansion grants: Existing 330 grantees can also apply for service expansion grants to expand mental health and substance abuse services, oral health, or care management. Applications for these services expansion grants were due April 5, 2004.

- *MH/SA:* The BPHC is awarding 13 grants totaling \$2.0 million to establish MH/SA services at health center sites that lack these services or to expand services at sites that offer minimal services. The maximum award is \$150,000 for mental health and substance abuse awards; although grantees offering MH/SA services for the first time may request an additional \$10,000 for technical assistance and staff training activities.
- *Oral health:* The BPHC is awarding approximately four grants totaling \$1.0 million to establish new oral health services at a health center site that lacks these services or to establish new satellite sites to provide oral health services to a population that has lacked access to these services. The maximum award is \$250,000. In addition, BPHC is also providing 28 grants totaling \$4.2 million to expand service delivery capacity at existing oral health service sites. The maximum award for expansion of existing sites is \$150,000.
- *Health Disparities/Quality Care:* The BPHC also is awarding approximately 33 grants totaling \$1.3 million to support Phase 2 of the BPHC health disparities collaborative. Grantees can obtain up to \$40,000 in awards.

Healthy Communities Access Program (HCAP): In addition to the health centers grants, the BPHC also sponsors HCAP. The BPHC will award up to 35 new HCAP grants per year, with the possibility of funding for up to two additional years. The total funding available for HCAP awards is \$35 million. HCAP awards are used to develop or strengthen integrated community health care delivery systems that coordinate services for the uninsured or underinsured; and to develop or strengthen mechanisms to provide coordinated care for people with chronic conditions who are uninsured or underinsured. Applications were due April 5, 2004.

North Carolina Community Health Center Association (NCCHCA): NCCHCA offers services to 330 grantees throughout the state, including assistance with statewide strategic planning. In the current five-year strategic plan (2003), NCCHCA set a goal of obtaining: 10 new access points, 6 medical capacity expansions, 2 dental service expansions, 2 behavioral health expansions, and 2 pharmacy expansions. The plan proposes serving 82,000 new patients, and expanding capacity by hiring 83 medical and dental providers. The 5-year plan also identified a need for \$8.7 million in new capital projects, and \$15 million in operational costs.

North Carolina has had mixed success in obtaining grant awards. The NCCHCA has been told that North Carolina is doing better than most other states; although the state has not received a proportional “share” of grant awards. Most of the awards are given to a handful of states (including CA, NJ, MA). To date, North Carolina has received:

Opportunity	NC Applicants	# Funded	Total Amount
FY 2002			
New Access Point	7	2	\$1,159,358
Expanded Medical Capacity	9	5	\$3,165,245
Service Expansion	6	2	\$433,333
Total FY 2002			\$4,757,936 (2.9% of available federal funding)
FY 2003			
New Access Point	6	4	\$2,074,866
Expanded Medical Capacity	3	2	\$1,181,919
Service Expansion	6	1	\$200,000
Total FY 2003			\$3,456,785 (3.3% of available federal funding)

There are many challenges to obtaining federal funds:

- 1) Grant monies can only be used to support new patients. Many North Carolina centers need ongoing funding to support their existing client base, and are concerned about expanding without the assurance that they have sufficient funds to cover existing operations.
- 2) There are very limited capital funds. Centers need to obtain outside funding to meet capital needs; and need to coordinate other fundraising with potential BPHC grants.
- 3) Because grantees must be operational within a short-time frame (i.e., 120 days for new starts, satellites, or expanded medical capacity); this gives a competitive advantage to organizations that are functioning prior to the application.
- 4) One of the factors the BPHC considers in the grant award is the ability of the grantee to leverage other funds. North Carolina is disadvantaged compared to other states because it does not provide ongoing funding to health centers. Most other states provide some type of financial support to health centers (i.e., through indigent care funds).
- 5) Site expansions can strain existing operations until satellites are self-sustaining.
- 6) Applying for grant funds takes significant grant writing expertise and a financial investment.

Partnerships and collaborations: Many health centers around the state are working in collaboration and partnership with other safety-net or community organizations in order to address the health access needs and improve the health of the underserved people in their communities. All communities benefit when different partners share their experiences, resources, vision and ideas. Some of the health center collaborations include:

- *Services for Seniors:* The Northampton County Office on Aging and the Northampton County Health Department contract with Rural Health Group's

Senior Center to coordinate home delivered meals. The Senior Center also operates two congregate nutrition sites in Northampton County. Seniors come to the nutrition sites for lunch as well as socialization and information sessions related to health and nutrition. Northampton County Home Health Agency transportation services are coordinated through the Senior Center. Roanoke Valley Adult Day Center refers clients for respite services at the senior center. Staff provides assessments for congregate and home-delivered meals, group respite, transportation and housing repairs for the Northampton County Office on Aging. Staff also provides activities for local mental health patients referred by Roanoke Chowan Human Services.

- *Metrolina Mammography Screening program*: Metrolina Comprehensive Health Center, Inc., Mobile Health Outreach and Our Lady of Guadalupe Church collaborate to provide breast health screening and education to Hispanic women at the health center and Our Lady of Guadalupe Church. A bilingual health educator teaches breast cancer prevention and early detection classes. Mobile Health Outreach provides comprehensive mammography services via a mobile van at Our Lady of Guadalupe Church and the health center.
- *Health Assist (Healthy Communities Access Program)*: Health Assist, a locally developed program of health, education and social support services for the uninsured has been working with Greene County Health Care (GCHC) to meet the health care needs of the uninsured in Greenville. The two organizations provide joint staffing at three Health Assist community resource centers. GCHC provides NP's/ PA's, medical office assistance and Latino outreach workers. Team members are assigned full time to the centers in the communities of Grifton, Grimesland, and Pactolus (all in Pitt County). HealthAssist provides nurse case managers, health educators, center managers, and volunteer coordinators.

Questions and Comments:

Q: Are there geographic limitations on applying and obtaining a 330 award—for example, if there is already one center in an area, can organization apply?

A: Two entities in the same area can't apply to serve the same patients, because it shows they aren't working collaboratively together.

Q: Does the federal tort claims act cover all providers?

A: The Federal Tort Claims Act (FTCA) covers all primary care providers and all employees. FTCA also covers contract employees if in the primary care practice (which includes OBs). However, contract providers must work for a center for a certain number of hours in order for FTCA to apply. Centers have to apply for FTCA coverage, it is not automatic. Center must apply each time they submit or resubmit their grant applications. If covered by FTCA, health center providers do not have to carry their own malpractice insurance.

Q: The President's initiative focuses on expanding sites or services, but not on supporting existing centers. If health centers were going to get more money from

the federal government, would they prefer funds for stabilization to existing centers?

A: In the President's initiative, there is a pot of money that will be divided equally to all the CHCs in the country. (This amounted to approximately \$20,000 per center in North Carolina). There was some discussion about whether to give more to health centers that need more (i.e., more uninsured, or environmental problems that forced them to lose days); however the funds will be distributed on a per capita basis. I'd like to see existing centers to get some money to support their existing clientele.

Q. How can we address some of the challenges in order to become more competitive in applying for federal funds?

A. We don't have state-funding or a conversion foundation in North Carolina that supports health centers, but we do have other foundation support, such as the Kate B. Reynolds Foundation (that helps with capital and other funding needs). Communities could also use help with grant writing, which might be offered through universities or other organizations. There are ways to help improve our competitiveness in applying for grants. In addition, better partnerships and collaborations (things that should grow out of the Task Force) would also help make us more competitive. Some of the other grants are amazing in terms of community collaborations. For example, some have collaborations where you can see the referral agreements spelled out; others have stronger partnerships with local hospitals; others have collaborations among local providers in recruiting and retention of health care providers. Some health centers around the country have agreements with local community colleges to grow their own management; others have joint staffing from other agencies, like social services or community mental health.

Comment: The NCCHCA has been lobbying hard for state appropriations targeted at centers that serve a high proportion of uninsured. Once a center reaches a certain threshold of uninsured users, it's hard to support center operations with other patient revenues. This is a big problem for dental clinics, but is also a problem for some of the health centers for their primary care services. Medicaid patients are being wooed to other health providers, so centers don't always get a lot of Medicaid revenues. Health centers need state appropriations to help support ongoing services; and need other community and foundation support to get new centers built. Grant applications need to have realistic income projections to be considered seriously. Staffing is also crucial to successful operations.

Comment: On average North Carolina health centers are doing well, but in some areas, the health centers are struggling. We need to figure out a way to subsidize and equalize those that are taking a higher proportion of the uninsured. We commissioned an outside group to examine the financial status of the health centers. We hope the Task Force will recommend a state appropriation to support health centers.

Comment: How many health centers take after-hours call, have after-hour coverage. Do we know what centers are offering in terms of extended hours? All centers either do at least one late day (evening), and about half provide services on two late nights and/or a Saturday morning. It would be helpful to see if CHCs can help reduce the unnecessary use of emergency rooms for primary care needs. We would like to think about how hospitals and CHCs could work together more collaboratively. Also, there is some need to formalize coverage arrangements for CHC patients who show up at the hospital.

Comment: We operate a collaboration with Moses Cone and High Point Regional and the county (in Guilford County) that operates much like a FQHC, but we don't get federal funding. We shouldn't forget about other types of safety-net providers that don't receive 330B funds. For example, 60% of our adult health clinic patients are uninsured; only about 2% of the children are uninsured (there aren't many uninsured children because of Medicaid and NC Health Choice). 45% of our patient population is Latino, but we also have Hmong and Urdu. We have providers who speak Spanish and Urdu.

Rural Health Clinics and State Supported Rural Health Centers

Tork Wade

Director

NC Office of Research, Demonstrations, and Rural Health Development

The Office of Research, Demonstrations and Rural Health Development (ORDRHD) assists underserved communities and populations to develop innovative strategies to improve access, quality and cost-effectiveness of care. The ORDRHD philosophy is to develop partnerships between the state and local communities, to improve the ability of communities to meet the health needs of underserved residents. Ownership of local health organizations is vested in community partnerships. ORDRHD provides in-depth technical assistance on an on-going basis.

ORDRHD operates a number of different programs, including: rural health centers program, primary care technical assistance, medical and dental placement services, prescription assistance program, senior care, critical access hospital program, farmworker health program, and demonstration programs.

There was some confusion at the last meeting between federally certified rural health clinics (under P.L. 95-210), state designated rural health clinics, and state funded clinics. The ORDRHD helped local communities develop 81 rural health clinics over the last 31 years. Most (but not all) of these have also received federal certification as a rural health clinic under 95-210. In addition, there are other rural health clinics that have been certified that were not initiated with the ORDRHD assistance. Currently, there are 108 federally certified rural health clinics. ORDRHD also helps fund 32 rural health clinics on an ongoing basis, some of which are federally certified, some of which are not. (Note:

the 32 state-funded rural health clinics are a subset of the 81 that ORDRHD initially helped develop. These are clinics that receive some ongoing operational funding, primarily to serve the uninsured).

Federally Certified Rural Health Clinics (P.L. 95-210): Federally certified rural health clinics must be licensed by the Division of Facility Services and located in a rural underserved area. Federally certified RHCs must employ a PA or NP for 50% of the time the RHC is open. These centers must accept Medicaid and Medicare patients, but are not required to accept uninsured and/or indigent patients or offer their services on a sliding fee scale. They can be public, private not-for-profit, or for-profit. RHCs that are federally certified are reimbursed on a “cost-basis” for Medicare and Medicaid. They must submit cost-reports to obtain their cost-based reimbursement, but do not need to collect data on the numbers of uninsured they treat or the services provided, so there is no information on utilization or number/type of patients served.

Rural Health Centers Program: The state rural health centers program was started in 1973. ORDRHD helps assist underserved rural communities provide accessible primary medical services for all persons regardless of their ability to pay. In the past, ORDRHD focused this program on building capacity in geographic areas that lacked primary care resources. In recent years, ORDRHD has focused more closely on ensuring that centers provide primary care services to underserved populations.

In determining areas of need, ORDRHD looks at three criteria: 1) health professional shortage area (critical shortages of primary care and dental care); 2) the existence of safety-net providers; and 3) location of poverty and near poverty populations. In addition, there has to be a commitment from the local community to help sustain a center.

State-funded rural health centers must be non-profit (501(c)(3)) and community owned with local board of directors (comprised of community residents). These centers do not have the same requirement as FQHC for board composition (e.g., the Boards do not need to be comprised of 51% consumers/users of the centers). The centers must focus on essential primary care services, which include after-hours, inpatient and referrals, but not the full array of enhanced services provided by FQHCs. State funding is provided as a last resort, to help pick up the operational shortfalls. The initial goal of the rural health centers program was to provide initial program funding for 3-5 years until the centers could become self-sufficient; but the centers that serve a large underserved/uninsured population may never be fully self-sufficient. As a result, the state has focused ongoing operational funding on helping to cover the costs of treating the uninsured. The state offers some limited capital funding, money is awarded on a 5:1 state-to-local match. Usually state funds are not enough to meet a center’s capital needs (e.g., building a new center), so the state funds are combined with funding from KBR or other source of funds. ORDRHD provides the technical assistance to the centers to help develop a source of funding. These centers range from single nurse practitioner sites in very remote areas to multiple practitioner sites serving multiple counties.

ORDRHD can offer extensive technical assistance in the areas of: market analysis, organizational analysis, practice development, practice management, architectural and graphic design. These services are also provided to other health providers (including FQHCs, health departments, etc.) as staff time and other resources permit.

ORDRHD has developed a series of performance measures to ensure that the state gets value for the money invested. The operational team examines these performance measures in determining funding levels. The performance measures include:

Area	Measure
Provider productivity	Greater than or equal to 5,500 visits per adjusted full time equivalent
Unadjusted collection ratio	Greater than or equal to 80%
Variable costs	Less than \$5.50 per patient visit
Support staff to provider ratio	Less than 3.25 to 1
Salary increases	Less than 2% (over SFY 03)
Operational subsidy (non-MAP)	Less than SFY 03 final approved

The ORDRHD has helped establish 81 rural health centers since 1973. In SFY 04, 32 centers received state fund. The state funds (\$2,359,673) represents 8.5% of the centers combined annual operational budgets (\$27.68 million). Most of the state funding (68.5%) is used to support care for uninsured patients below 200% of the federal poverty guidelines. Annually, these centers served 101,648 patients, or 261,477 total patient encounters.

Most of the state funded centers are in the east and far west. There is a new center opening in Hyde county in June.

Q: What happened to other rural health centers, those that are no longer receiving state funds?

A: Some became private, some are community owned, some became FQHCs. Two closed operations. Centers that serve a large proportion of uninsured continue to receive some state funding.

Medical Access Plan (MAP)—In the past, the state gave centers money to underwrite their operational budget. About 5-6 years ago, ORDRHD shifted the budget so that centers had to “earn” their state funds by seeing indigent patients. Centers are paid \$67/visit (which is roughly the Medicare rural health clinic cost-based reimbursement rate). Centers are eligible to receive this reimbursement for the uninsured patients they treat that meet the MAP eligibility requirements, i.e., patients must be NC residents, uninsured, under 200% of the federal poverty level, and not eligible for Medicaid or NC Health Choice. Patients are required to pay a small copay based on their family income (copays range from \$5-\$20/visit).

Most centers receive a combination of MAP funds and some ongoing non-targeted operational funds. However, the ORDRHD is moving more of the state funds into the

MAP program. Currently 68.5% of the state funds are distributed through MAP, the goal is to spend 85% of these funds through MAP. The remaining 15% would be held for new developments and to address crisis situations.

Of the 101,648 total users seen by state-funded RHCs in SFY 2003:

- 21,252 (21%) were uninsured (7,963 participated in MAP)
- 21,820 (21%) were on Medicaid
- 28,165 (28%) were receiving Medicare
- 30,411 (30%) had other forms of insurance

The percentage of uninsured users seen by health centers varies from approximately 65% in one center to approximately 7% in another. However, as previously noted—not all of the uninsured are MAP patients. To be eligible for MAP, uninsured individuals must have their family income assessed to determine if they have incomes less than 200% of the federal poverty guidelines.

Availability of supplemental services: Some of the RHCs provide supplemental services in addition to primary care. For example, three provide dental clinics (other sites also provide dental varnishes under Medicaid). Some of the centers provide assistance for their uninsured patients in accessing pharmaceutical company prescription assistance plans, but none of the centers have their own pharmacies (with a pharmacist). One grantee has a full-time clinical social worker who provides some behavioral health services. Most of the RHCs refer patients with behavioral health problems to other providers or agencies.

Collaboration and partnerships: Some of the RHCs participate in Community Care of North Carolina (CCNC). In these communities, they are part of the community collaboration to provide case management and disease management to Medicaid recipients. RHCs also participate in local Healthy Carolinians initiatives, some participate in joint ventures with community hospitals (e.g., the physicians of one center staff the emergency room of the nearby critical access hospital and another rural health center is supported and managed by its community hospital); and some provide training sites for residents, medical and allied health students.

Challenges facing RHCs: RHCs, like other safety-net organizations, are facing financial pressures in trying to serve the uninsured. Because so many of the centers were built in the 1970s or 1980s, many have aging facilities and infrastructure. Replacing equipment is a challenge with limits on capital funding. On average, rural practices are behind urban counterparts with information technology and the ability to tap into evidence based medicine through PDAs. Some also have problems recruiting and retaining skilled managers/administrators. There are four centers in the state experiencing serious financial problems, and the problems seem to be getting worse rather than better. Replacing equipment is a challenge with limits on capital funding.

Questions and comments:

Q: Is medical malpractice a challenge?

A: It is an allowed expense within the centers operating budgets, so to the extent we are able to assist with operating shortfalls we help cover malpractice costs, but funds to cover operating shortfalls are limited.

Q: Can there be more than one safety-net organization in the same area?

A: Yes. The entire state funding for this program is only \$2.4 million. This isn't a lot of money. The program is more about bringing people together and facilitating health services to meet community needs; not about funding.

Q: One of your identified problem areas was recruitment and retention—but one of your performance measures was keeping salary increases to only 2%. Isn't that a problem?

A: That's a new performance measure based on the current state budget crisis—we felt like we couldn't ask the state government to fund large salary increases when the state was cutting budgets and state employees weren't getting salary increases.

Comment: Since part of the Task Force is focused on the financial survivability of safety-net organization, it seems like the MAP program is a gem because it helps insure that providers care for the uninsured. If we are looking at requesting additional monies to fund care for the uninsured provided through safety-net organizations, it seems like this is one area for a potential recommendation.

Comment: We have \$1.6 million going into MAP (of \$2.4 million funding to RHC). Field staff work with a state-funded RHC to determine how many uninsured they can see. ORDRHD commits funds based on this estimate and then centers can draw on this funding (with a cap based on the estimate of uninsured). The program doesn't cover everyone who is uninsured below 200% FPG.

Comment: Hot Springs Health Program is both a federally certified rural health center and a state-funded rural health center. Hot Springs Health Program has four medical centers, and employs the only providers in the community. But we struggle to break even. Hot Springs Health Program wouldn't be able to serve the uninsured without this program.

Q: Do you have to be a citizen to be served under this program?

A: No. The patient has to be NC resident, but doesn't have to be a citizen. Centers in eastern part of the state see undocumented immigrants. Part of the MAP application attempts to determine if people might be eligible for Medicaid or NC Health Choice. The application is fairly user friendly. Still there are some centers that are struggling to get people covered by MAP; they have a patient population that is reluctant to bring in their income to verify eligibility. The state continues to help these centers because they know they are serving uninsured.

Q: Is the MAP program available to urban areas?

A: No, the program is limited to rural areas now, because of limited funding.

Comment: We need to look at economic benefits of having these providers in the community. A reasonably small investment by the state has generated a lot in terms of economic impact in the community. For example, Hot Springs Health Center is one of the largest employers in the community. Sustaining health care services is also an economic development engine in many communities. Need to get an economist to look at this. Hot Springs Health Center's total budget including pharmacy is \$14 million. The centers help the community in many ways (aside from jobs and providing health care).

Comment: There are other rural communities around the state with similar need characteristics. We should look at whether similar models can be built in other rural communities in need. Most rural counties have to start with what they have, create collaborations, identify needs and develop services and programs based on this.

Medicaid Reimbursement Policies to FQHC and RHCs

Andrea Radford

NC Office of Research, Demonstrations and Rural Health Development

Federally Qualified Health Centers (FQHCs) are federally-funded Community Health Centers and "look-alikes." Rural Health Clinics (RHCs) are health centers certified under P.L.95-210, the Rural Health Clinics Act.

Congress, as part of the Benefits Improvement and Protection Act of 2000 (BIPA), changed Medicaid reimbursement to RHC and FQHC to a prospective payment system (PPS). States have the authority to use a different payment methodology, as long as it is agreed to by the FQHCs and RHCs and provides as much or more reimbursement than under the PPS system. North Carolina offers FQHCs and RHCs the choice of PPS or remaining with the traditional cost-based model. Seventy percent of the FQHCs and 93% of the RHCs use the traditional cost-based system. Thus, only 30% of FQHCs (7 centers) and 7% of RHCs (8 centers) opted to use the newer prospective payment system (PPS).

Traditional Cost-Based Payment System. Centers that select the traditional cost-based payment system are subject to different payment methodologies, depending on whether the service provided is a "core service" or other ambulatory service. Core Services include "face-to-face" patient encounters with a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist*¹, or clinical social worker. To be considered core services, services must be provided at a health center or a patient's residence. Core services include:

¹ Reimbursed at 62.5% of cost-based rate

- Physician services, including required physician supervision of nurse practitioners, physician assistants, and certified nurse midwives;
- Services and supplies furnished as “incident to” a physician’s professional services;
- Services of physician assistants, nurse practitioners, and certified nurse midwives;
- Services and supplies furnished as “incident to” services provided by nurse practitioners, physician assistants, and certified nurse midwives;
- Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies);
- Services of clinical psychologist (OBRA 1987) and clinical social workers (OBRA 1989); and
- Services and supplies furnished as “incident to” services provided by the clinical psychologists and clinical social workers.
- In addition, FQHC core services also include preventive primary care services (e.g., annual physicals). The costs of certain enabling services (such as transportation, translation, case management and nutrition counseling) are built into the costs used to determine the cost-based payment.

Medicaid pays FQHCs and RHCs that select the traditional cost-based reimbursement system an *adjusted cost-based rate* for each “core service” visit. The adjusted cost-based rate is calculated by dividing the adjusted costs by the adjusted visits. Adjusted costs are the total costs for the core services plus a percentage of the organization’s overhead expenses. Adjusted visits are the total visits minus the visits for any non-core service. The adjusted cost-based rate is calculated annually through the Medicare cost reporting process and is center specific. In addition, this rate is subject to a federal cap; in calendar year 2004, the rate cannot exceed \$68.65 for RHCs, \$91.64 in rural FQHCs, and \$106.58 in urban FQHCs. The caps are adjusted annually based on the Medicare Economic Index (MEI).

Other ambulatory services that are not considered “core services” include Health Check (EPSDT), Norplant and other family planning, child services coordination, maternity care coordination, dental, pharmacy, DME, home health, hospital, and diagnostic radiology costs. These costs are reimbursed separately using the Medicaid Physician Fee Schedule (fee-for-service) and with the exception of hospital and diagnostic testing, are reconciled to cost at the end of the year on the Medicaid cost-report (if the center remained with traditional cost-based). This is complicated for the billing staff.

Comment: We should fight this urban/rural differential.

Q: Services provided by clinical pharmacists can do more to reduce medication costs, why doesn’t the list include clinical pharmacists or certified diabetes educators?

A: The legislation is restrictive in its list of who is covered; however, Medicaid does have the option of adding to the services reimbursed under the program. Clinical pharmacy services could be reimbursed.

Q: What is the rationale for giving reduced reimbursement to mental health workers? Is it less expensive to offer these services?

A: Their salaries are lower than physician providers. It could be a budget balancing issue.

Unfortunately, there is often a substantial time lag before a FQHC or RHC receives full payment (based on the cost-based payment). Centers receive payment for services, but the rate at which they are paid may not reflect their current costs due to the lag time involved in submitting, processing, and settling cost reports. The payments can be adjusted through a cost-settlement process, so that the payments more accurately reflect the center’s costs. The cost-settlement process is delayed until the center’s cost-reports are submitted and tentatively settled. Medicare and Medicaid cost reports are due five months from the end of the center’s fiscal year-end. For example, an RHC with fiscal year-end of June 30, 2004 would have their cost report due by November 30, 2004. The RHC’s tentative settlement date is July 1, 2005. This would be the settlement for costs incurred in FY 2004 (July 1, 2003-June 30, 2004). This same “cost-based rate” would then be applied to services provided in 2005 (until these services have been cost-settled). FQHCs have generally shorter time frame for settling cost-report because they are processed “in-house” by the Division of Medical Assistance (DMA). RHC cost reports are submitted to and processed by an outside Medicare vendor so it takes more time.

The Prospective Payment System (PPS). Under this system, each RHC and FQHC that elects the PPS reimbursement option has an all-inclusive rate for all Medicaid core services provided. The core-services are the same as used in the traditional cost-based system. The rate is calculated by dividing all allowable and reasonable costs by the number of visits from FY1999 and 2000. The rate is automatically inflated each year by the primary care component of the Medicare Economic Index, and may be adjusted to account for changes in covered core services. PPS other ambulatory services are also the same as those in the traditional cost-based payment system and are reimbursed according to Medicaid fee schedule. PPS reconciles payments received for core services and other ambulatory services to the overall PPS rate annually. Depending on what the provider has been paid throughout the year, a provider may be owed money or may owe money back to Medicaid.

Cost-Based – PPS Comparison

Traditional Cost-Based	PPS
Center specific	Center specific
“Rebased” annually	Based on FY 1999 & FY 2000 data with MEI adjustments
Adjusted cost-based rate for core services	Core bill rate for core services
Fee schedule and settlement (if applicable) for other ambulatory	Fee schedule for other ambulatory services

services	
Annual cost report and settlement	Settlement to overall PPS rate

Comments and Questions

Q: Could we build in some reimbursement mechanism to help recognize those centers that serve high proportion of uninsured through the more flexible cost-based funding formula?

A: The state has flexibility in establishing an alternative payment methodology for FQHC and RHC, as long as the payment is not less than what the centers would have received under PPS. DMA can look into this.

Q: Do you know how centers have fared better—those with cost-based or PPS?

A: When we looked at this, most of the state-funded RHCs did better under cost-based not PPS (or only marginally better under PPS). It also depends on whether FQHC had high costs in 1999/2000. The PPS system rewards centers that had high cost-based rates in 1999/2000 (since that is their base year). If you can make money using the inflated 1999/2000 base payment, you are allowed to keep the differential. Also, some centers like PPS, because they get payment faster (which helps the cash-flow). Some of the centers switched to the PPS system because it is not subject to the federal cap. For FQHCs, the smaller centers are the ones who switched. You need a staff member looking at data and trying to make sure it works.

Comment: This is a huge amount of revenue for the safety-net system, and small changes can make a major difference. So, if the state were to recognize this as a high priority area with more outcomes-based or incentive-based cost-finding, we might have the chance to change it. We would need a strong and accurate argument with strong political support. It could improve the overall safety-net; although it appears to be focused on small number of beneficiaries.

Free Clinics

John Mills

Executive Director

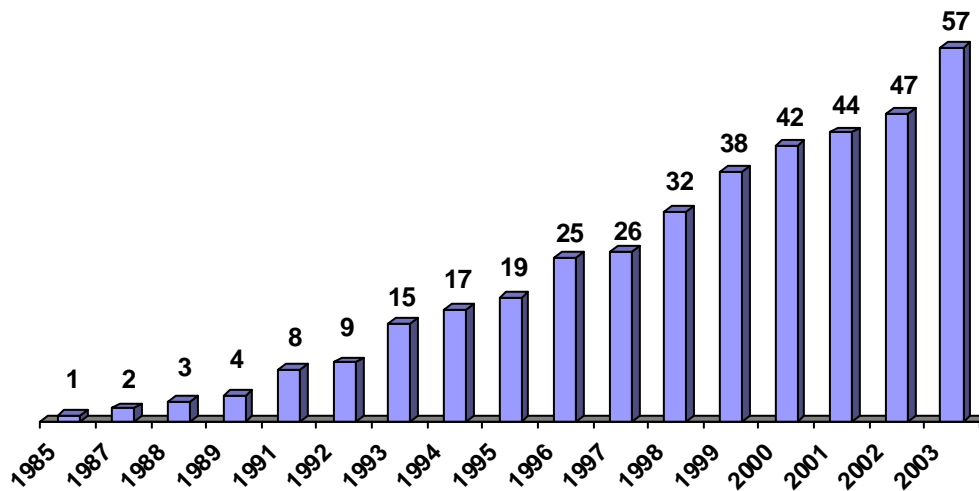
NC Association of Free Clinics

Mr. Mills opened his presentation with a quote from Dr. Martin Luther King, Jr. “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

The crisis of the uninsured is getting worse. According to the U.S. Census Bureau, 41.2 million Americans were without health insurance during all of 2001 (an increase of 2.5 million). Another source, Families USA, reported 2.2 million non-elderly North Carolinians were without health insurance for all or part of 2001-2002. The problems associated with being uninsured are extensively documented in the literature. A sluggish economy, rising health insurance premiums, and increased Latino immigration will only exacerbate the problem

Free clinics began in NC in 1969 when the Christian Medical Society of Bowman Gray School of Medicine opened four volunteer clinics in Winston-Salem. These clinics closed five years later in 1974. In 1985 the Open Door Clinic opened in Raleigh and was the only free clinic in North Carolina. By 2004, North Carolina had more than 60 clinics. The largest part of the growth was in mid-to-late 1990s. NC leads the nation in the numbers of free clinics and free pharmacies.

Growth in Free Clinics in North Carolina (1985-2003)



There is not one specific free clinic model. Basically, free clinics are community-based organizations custom-designed to meet identified healthcare needs using the community’s unique healthcare assets and resources. Free clinics work in collaboration with physicians in the community, hospitals, health department, etc.

Free clinics are non-profit, usually 501(c)(3). They depend on community support (churches, individuals, foundations) and receive no federal or state funding (except occasional settlements with pharmaceutical companies). Free clinics are governed by community boards of directors representing a broad-cross section of the community. There is no requirement or prohibition for having patients on the board or directors.

What separates free clinics from other safety-net providers is the use of volunteers. Volunteers are the cornerstone of the free clinic movement. Free clinics tap into the willingness of the healthcare community (doctors, nurse practitioners, physician assistants, social workers, pharmacists, dentists, mental health, chiropractics) and other members of the community to volunteer their time. Volunteers allow free clinics to keep overhead low. North Carolina free clinics benefit from the help of 8,000 volunteers (2,000 physicians, 1,500 nurses, 350 dentists, 325 pharmacists, and 3,000 lay people).

Free clinics provide services to the uninsured—people without Medicaid or Medicare with incomes below 200% FPG (although the income eligibility varies across centers,

some are 150% and some 225%). Free clinics turn away people with insurance because these people can go to other community providers. Free clinics screen patients to be sure that they are uninsured and meet the income criteria. Patients who might be eligible for Medicaid are referred to the local Departments of Social Services. Not a lot of children are being served by free clinics because most low-income children are eligible for either Medicaid or NC Health Choice (North Carolina's SCHIP program). The uninsured people served are generally between 18-64 years old. Many work multiple jobs. Recently, Free Clinics have seen more college educated individuals who have been laid off and cannot afford COBRA coverage. This is new in the last 18 months. Free clinics are also seeing a new demographic, the 65+ population who are undocumented and therefore cannot qualify for Medicare. Some free clinics have prescription assistance and may provide prescription assistance to the 65+ population.

Most free clinics believe that access to healthcare shouldn't depend on whether you can pay for it or not, but this is an ongoing debate within the free clinics. Free clinics do not generally charge for their services, although some clinics accept donations or have an application fee at the first visit. Some pharmacy programs have small copays for prescriptions.

Free clinics place strong emphasis on providing non-judgmental, compassionate care, respecting the dignity and self-worth of every patient. Patients may have to wait in line or in the waiting room, but when they reach the provider, the provider takes the time to listen and give compassionate care. Physicians who volunteer say they do it because it allows them to get back to practicing medicine—they don't have to worry about third-party billing.

There are more than 60 free clinics and pharmacies in both rural and urban areas serving 48 counties and cities in North Carolina (See end of meeting summary for the map of free clinics). These clinics received \$13 million in funding from the private sector, provided \$85 million in healthcare services provided in 2003—serving more than 125,000 patients.

The services provided at free clinics include primary care, dental, pharmacy, and sometimes chronic and specialty care (depending on the resources available in the community). If volunteer providers are willing to come to the clinic, specialty care can be provided onsite. If volunteer providers are willing to take free patients in private practice, then the patient is referred. However, not every clinic has a relationship with the specialists in their community. Thirty NC hospitals provide financial support and in-kind services.

Free clinics also dispensed 450,000 prescription medications in 2003. There are 33 licensed pharmacies (either free standing or in the clinic). Most of the free clinics tap into a pharmaceutical assistance program. The pharmaceutical industry is the largest contributor to free clinics based on free medications they donate. We need to streamline this process.

Dental care is one of the most highly demanded services. Dental providers are not as willing to volunteer in the free clinics as other health care providers. Only 22 of the programs offer dental services, which more often than not are extractions and not restorative care. Costs and time involved in restorative care make the number of patients a clinic can see much lower.

The average clinic has two full-time employees and 150 volunteers, but varies from 0-12 full-time and part-time employees. Budgets range from \$5,000-\$850,000. Clinics raise their annual budget from: individual donations, fund raising events, in-kind donations of employees and service from hospitals, foundation grants, faith-based organizations, and businesses. The Duke Endowment and Kate B. Reynolds Charitable Trust have been very supportive.

There are 850 free clinics in the United State. Three state legislatures support the operation of their free clinics (Virginia, West Virginia, and Vermont). Collectively, free clinics delivered over \$1 billion in healthcare services in 2002.

Free clinics face a number of challenges. Four of the most serious challenges are obtaining sustainable funding, a dependence on volunteers, rural and urban differences, and prescription drug costs. Volunteers are the core and that is a benefit and a liability. This free clinic model cannot be dropped into very rural counties because rural communities do not have the same infrastructure of doctors and pharmacists to draw upon. The portability of malpractice insurance is a problem for some of the doctors. The Good Samaritan laws were amended to ensure volunteers are protected by statute—but it doesn't pay for defense costs even though the provider won't have a liability. Thus far, there has not been a medical malpractice suit against a provider in a NC free clinic. Retired physicians can get medical malpractice coverage as a volunteer for \$100 from Medical Mutual.

Prescription drug costs are the single largest line-item in most of the free clinic budgets. The NC free clinics are exploring whether they can tap into the Minnesota multi-state contract alliance for pharmacy (a deeply discounted purchasing network for state and county supported pharmacies and hospitals). To take advantage of 340B drug pricing would require federal changes.

Mental health problems are the third most common diagnosis (diabetes, hypertension, and mental health). The influx of Latinos and non-English speaking patients is also challenging. Patients and providers have to overcome the language barriers. Immigrant care in free clinics has worked better in urban areas because there are more resources.

Specialty referrals are another challenge for some of the programs. It is often difficult to find the service if it is not provide it in the clinic. Since free clinics depend on volunteer providers who are often on irregular schedules, the continuity of care may be an issue since long-term patients will see different providers. Some clinics operate daytime hours and channel the chronic care patients into these clinics with full-time practitioner. If we

take the chronic-disease patient out of evening clinics and move to day-time clinic, then we are able to expand the number of new clients (or acute care clients) you can see.

For free clinics to be successful, they have to develop relationships the all of the healthcare providers in a community (medical societies, health departments, hospitals, Divisions of Social Services, churches, etc.). About half of the free clinics are faith-based. The lack of time and relationships are the greatest challenges to collaboration.

Free clinics could benefit from some legislative changes. Changing the state statute to enable Free Clinics to purchase medications and supplies from the NC state contract would help.

The NC Association of Free Clinics (NCAFC) was founded in 1998. There are 58 member programs. NCAFC conducts advocacy, public relations, resource development, training and technical assistance on behalf of its members and sponsors an annual Free Clinic Conference.

Early in 2004, Blue Cross Blue Shield of North Carolina (BCBSNC) awarded \$10 million in funding to NC free clinics for a five year period. Each NCAFC program will receive a \$15,000 unrestricted base grant. Free clinics can apply for additional funding via a competitive grant for specific needs—up to \$45,000. Some funds have been allocated for special programs. For instance, the BCBSNC Foundation Flu Shot Fund will provide \$1,000 to each clinic for the purchase of flu vaccines. BCBSNC will also award three \$10,000 grants at the 2005 NCAFC Annual Conference, in these categories: innovation, use of technology, and eliminating racial/ethnic health disparities

There is also funding for new clinic development. BCBSNC awards \$5,000 planning grants (for needs assessment, focus groups, surveys of other means of determining the potential success of a new free clinic) and \$5,000 infrastructure grants (to be used upon completion of the planning process if the decision is made to create a free clinic). The infrastructure grants can also be used to pay for the creation of the non-profit entity, filing for tax-exemption, and articles of incorporation, and to purchase office/computer hardware software.

The major BCBSNC funding includes two categories of \$25,000 grants. A \$25,000 start-up grant may be used to open new clinics and begin providing services or to secure a clinic location, hire an executive director, and purchase equipment. A \$25,000 matching grant will provide matching funds on dollars raised in the community in support of the free clinic. This will help ensure the long-term sustainability for new clinics.

Free clinics do not claim to be “*the answer*,” but rather an important part of the solution to the challenge of increasing access to health care for all North Carolinians.

Comments and Questions

Q: What are the NCAFC dues?

A: Dues are 1/10th of 1% of the cash operating budget or a minimum of \$200. Many of the member programs are United Way Agencies.

Comment: Free clinics have been able to find space. Some are in health departments, only a few are in churches. However, sometimes finding enough space is difficult. The Open Door Clinic has been at capacity for a while and can't expand because of the lack of space. The lack of adequate space prevents growth in other centers as well.

Comment: It is amazing how much you are able to do with free-clinics. We have patients with chronic conditions that would be in the emergency room. The average cost of visit including medication is \$89. The range for chronic patients is between 10-25 scripts per month.

NCAFC Member Clinics and Services

