Health Care Services for the Uninsured and Other Underserved Populations

A Technical Assistance Manual to Help Communities Create or Expand Health Care Safety Net Services

The North Carolina Institute of Medicine serves as a nonpolitical source of analysis and advice on issues of relevance to the health and healthcare of North Carolina's population. The Institute is a convenor of persons and organizations with health-relevant expertise, a provider of carefully conducted studies of complex and often controversial health and healthcare issues, and a source of advice regarding available options and approaches for problem solutions.

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Developed with the generous support of the Blue Cross and Blue Shield of North Carolina Foundation, who through its focus on serving the health of vulnerable populations is partnering with leading experts and organizations across the state to help find solutions to, and meet the needs of, the uninsured.

Dedication

This manual is dedicated to the memory of James Bernstein (1942-2005) who devoted his professional life to improving access to health care services for underserved populations in North Carolina. Jim Bernstein created the first Office of Rural Health in the NC Department of Health and Human Services (1973) and ran it until he became the Assistant Secretary of Health and Human Services (2000). While his special focus was on care for underserved populations and communities, Jim Bernstein was a passionate leader who worked tirelessly to improve access to and quality of health care services for all North Carolinians.

Acknowledgements

This manual was written to help community groups interested in developing or expanding health care services for the uninsured and other underserved populations. It was developed by the NC Safety Net Advisory Council (NC SNAC) with the support of the Blue Cross and Blue Shield of North Carolina Foundation. NC SNAC grew out of a North Carolina Institute of Medicine (NC IOM) task force that examined the availability and financial stability of safety net organizations across the state.[1] NC SNAC includes representatives from the NC IOM, community and migrant health centers, state-funded rural health centers, local health departments, free clinics, Project Access models, the NC Hospital Association, the NC Medical Society Foundation, the NC Area Health Education Centers Program, the NC Office of Rural Health and Community Care, the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, and the NC Foundation for Advanced Health Programs. NC SNAC meets on a regular basis to identify strategies to address the unmet health care needs of the uninsured and other underserved populations.

1 North Carolina Institute of Medicine. North Carolina Healthcare Safety Net Task Force Report: April 2005. http://www.nciom.org/projects/SafetyNet/safetynetreport.html. Accessed June 4, 2007.

We would like to extend a special thanks to Morgan Jones and Aaron Augustino who were Jim Bernstein scholars at the NC Institute of Medicine and who helped write the manual. We would also like to thank Phyllis Blackwell, editorial assistant for the NC Institute of Medicine, and Kimberly Alexander-Bratcher for their assistance in writing and editing the manual. Andrea Radford, NC Office of Rural Health and Community Care, provided invaluable writing and editorial assistance. Several other members of the NC SNAC and other organizations contributed to the manual including Ben Money and Sonya Bruton, NC Community Health Center Association; Allen Feezor, John Graeter, and Torlen (Tork) Wade, NC Foundation for Advanced Health Programs; Anne Braswell, John Price and Michael Keough, NC Office of Rural Health and Community Care; Jeff Spade, NC Hospital Association; Pam Highsmith and Maggie Sauer, NC Medical Society Foundation; Dennis Harrington and Rick Mumford, NC Division of Public Health; Mike Darrow, NC Association of Free Clinics; Linda Kinney, Buncombe County Medical Society and NC Association of Healthcare Access; Linwood Hollowell, III, The Duke Endowment; and Paul Harrison, Wake County Medical Society. This manual would not have been possible without the generous support of the Blue Cross and Blue Shield of North Carolina Foundation, which provided the funding for the Jim Bernstein scholars program and helped underwrite some of the NC SNAC work.

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Introduction

This manual is intended to help communities develop or expand health care safety net services. **Safety net organizations have a mission or legal obligation to provide health care and other related services to uninsured and underserved populations.** Often these organizations provide services for free or on a reduced cost basis. Safety net organizations include federally qualified health centers, free clinics, state-funded rural health centers, public health departments, and school-based or school-linked health services. Other health care organizations such as federally certified rural health clinics, nonprofits, hospital outpatient departments, Project Access models or other community collaborations, and other community-based initiatives may also function as safety net organizations.

This manual provides information on how to identify unmet health care needs in your community. It then offers options on how to expand your community's safety net capacity. Specifically, the guide describes key elements in a successful safety net initiative: needs assessment, leadership, garnering community support, financial considerations, collaboration, possible funding sources, and where to turn for technical assistance. The manual also provides explanations of various types of safety net organizations and how they differ.

According to the US Census Bureau, more than 1.4 million nonelderly people in North Carolina (over one-sixth of the state's population) were uninsured during 2005-2006.[1] This was an increase of more than 33% over the prior five years. North Carolina experienced a larger increase in the percentage of people who were uninsured than most states in the nation. Being uninsured can lead to adverse health consequences. Uninsured people are less likely to visit a doctor or fill a prescription due to the expense. Because they delay getting the care they need, the uninsured are more likely to have serious illnesses when they do seek services.[2]

There are many safety net organizations across the state dedicated to providing services to the uninsured and other underserved populations. However, these organizations do not have sufficient capacity to meet all of the outstanding needs. The North Carolina Institute of Medicine studied the state's health care safety net in the 2005 *NC Healthcare Safety Net Task Force Report*.[3] The Task Force estimated that only 25% of the uninsured received primary care services through safety net organizations. Many communities provide services to meet some of the health care needs of the uninsured. However, few communities are able to meet all their health care needs. These needs include access to primary care, specialty care, prescription drugs, dental services, and mental and behavioral health services.

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1 US Census Bureau, Housing and Household Economic Statistics Division. Table HIA-6. Health Insurance Coverage Status and Type of Coverage by State—Persons Under 65: 1999 to 2006. Available at http://www.census.gov/hhes/www/hlthins/historic/hihistt6.html. Accessed 11 Sep 2007.

2 North Carolina Institute of Medicine. *Expanding Health Insurance Coverage to More North Carolinians: North Carolina Task Force on Covering the Uninsured: April 2006*. http://www.nciom.org/projects/uninsured/uninsured.html. Accessed on September 12, 2006.

3 North Carolina Institute of Medicine. *North Carolina Healthcare Safety Net Task Force Report: April 2005*. http://www.nciom.org/projects/SafetyNet/safetynetreport.html. Accessed on September 12, 2006.

The Safety Net Advisory Council (NC SNAC) is a group of state agencies, nonprofits, and safety net organizations that meets on an ongoing basis. Its goal is to identify unmet health care needs and develop strategies to address gaps in services. NC SNAC members developed this guide to help communities expand health care services to the uninsured. Many state-level groups are available to provide more in-depth expertise if further assistance or information is needed. These groups are listed in Appendix A.

Information for this manual was taken from the following sources:

- North Carolina Institute of Medicine. *Healthcare Safety Net Task Force Report: 2005.* Available at: http://www.nciom.org/projects/SafetyNet/safetynetreport.html.
- Communities in Charge. *Improving Access to Health Care: Building a Community-Based Program*. 2005. Available at: http://www.communitiesincharge.org/manual.pdf.
- Goldin GL and Hanson SH (2002). *Starting a Free Clinic: A Volunteers in Health Care Guide*. Pawtucket, RI: Volunteers in Health Care.
- *Increasing Access to Dental Care for the Uninsured. Volunteers in Health Care*. 1999.
- Romm CE, Martell MW, Murphy MY. *Building Access to Community Health Services*. Available at: http://www.futurehealth.ucsf.edu/pdf_files/Electronic%20Toolkit.pdf.
- The University of Kansas Online Community Tool Box. Available at: http://ctb.ku.edu/en/
- Walton, JM. (2002,2004). *Starting a Pharmaceutical Access Program: A Volunteers in Health Care Guide*. Pawtucket, RI: Volunteers in Health Care. Available at: http://www.rxassist.org/docs/starting-pap-manual.pdf.

Identifying Need

Who do you want to serve and why? What are the greatest unmet needs? What resources already exist to address those needs? What services do you want to provide?

Identifying Need

Existing Community Needs Assessments

Before beginning any safety net initiative, you will need to identify the unmet needs in your community. This is commonly done through a community needs assessment. However, before undertaking a new needs assessment, find out whether other groups have already conducted one. You can review several sources of data before conducting your own community needs assessment. Many of the sources listed here also refer to other existing resources.

- *Local public health departments*. By law, local health departments are required to conduct a community health assessment every four years. This assessment may include information about county demographic, socioeconomic, educational, and environmental factors that affect health. It will also have data about the health status of the community. Links to individual health departments are available at http://www.ncalhd.org/county.htm.
- NC *State Center for Health Statistics*. County health data and vital statistics are available through the State Center for Health Statistics. General information is available at http://www.schs.state.nc.us/SCHS/data/databook.
- *North Carolina Institute for Public Health*. The NCIPH helps local health departments assemble data on demographics, leading health problems, and existing health resources. These data can be accessed at http://www.sph.unc.edu/nciph.

- *Healthy Carolinians*. Many counties have a local Healthy Carolinians partnership that focuses on improving the health of communities. Each partnership includes community and business leaders and representatives of public and private health providers. Information about local Healthy Carolinians collaboratives and their work can be found at http://www.healthycarolinians.org.
- *Additional sources of community information.* Other organizations, including the local United Way and the Chamber of Commerce, may have also conducted community assessments. Information for local United Way chapters is available at http://www.unitedwaync.org/localuw/volunteer.html.

Many guides are available to help you conduct a community needs assessment if you do not have enough existing data to identify the target population and unmet needs. (See Community Analysis Guides sidebar.) A community analysis will:

- Identify the target population.
- Identify the geographic area you want to serve.
- Identify the greatest unmet health needs.
- Evaluate the capacity of the existing health care system to address these needs.
- Determine community support for a safety net initiative.

Each of these factors is discussed below.

Community Analysis Guides

NC Department of Health and Human Services *Community Assessment Guide Book*
Provides a step-by-step description of assessing community health. It is a comprehensive resource document or toolkit for county public health departments and other community agencies.
http://www.healthycarolinians.org/pdfs/02Guidebook.pdf

US Agency for Healthcare Research and Quality *Safety Net Monitoring*
Provides data on the demand for safety net services (including percent uninsured, percent below poverty and percent with disabilities), structure of the safety net (including inpatient and ambulatory care), health care delivery system (including physician supply per 100,000 and inpatient beds per 1,000), socio-demographic factors, and certain access related outcome measures.
http://www.ahrq.gov/data/safetynet

Community Tool Box
Provides over 6,000 pages of practical skill-building information on over 250 different topics. Topic sections include step-by-step instructions, examples, check-lists, and related resources.
http://ctb.ku.edu/en/

Identify the Target Population

Some groups are more likely to experience barriers to health care access than others. These groups include the uninsured, people with low incomes, racial and ethnic minorities, and people with limited English proficiency. A needs assessment can help you identify your target population.

It is important to start your needs assessment by obtaining information about your county's population. This should include the number of people that reside in the county, the number of uninsured individuals, the number of people in poverty, and the number of residents who qualify for publicly-subsidized health insurance (Medicaid, Medicare, or NC HealthChoice). You should also collect data on the racial and ethnic composition of your community. Also try to identify the number of people that have limited English proficiency. You can use this information to identify the groups likely to have the most unmet needs. Are there a large number of children who are uninsured and not covered by NC HealthChoice or Medicaid? Are there a growing number of immigrants who have language barriers? Your demographic analysis can help you define the size, characteristics, and possible needs of your target population.

In addition to general demographic factors, consider these additional factors when identifying the target population:

- *Current size and projected trends of the population.* You can obtain county-level population data from the NC State Demographics office. (See Resources for Demographic Information Specific to North Carolina sidebar.) The demographer's office also provides information about future population trends in your community. This information will help provide a better estimate of the current and future needs of the target population.
- *Socioeconomic factors*. How many people live in poverty in your county? Are there any groups that are more likely to live in poverty (eg, age, racial, or ethnic groups)? These data are available from the US Census Bureau. (See Resources for Demographic Information Specific to North Carolina sidebar.)

- *Insurance coverage*. How many uninsured people live in your county? The Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill provides county-level estimates of the numbers of nonelderly uninsured individuals. Uninsured individuals typically experience more barriers to obtaining needed health services. One option to address the needs of the uninsured is to identify people who may be eligible for, but are not enrolled in, publicly-funded health insurance programs (eg, Medicaid or NC HealthChoice). You can then help them enroll in available programs. Look at the percentage of your county's population that is poor. Compare this to the percentage enrolled in NC HealthChoice or Medicaid. If there is a large difference, this might indicate a need for additional outreach to target individuals or families who might be eligible for publicly-subsidized health insurance.

- *Racial and ethnic health disparities*. This information may help identify populations with the greatest unmet needs. In addition, it can help you identify the need for culturally appropriate approaches to serving the target population. Information on racial and ethnic disparities is available from the State Center for Health Statistics or the Office of Minority Health and Health Disparities. (See Resources for Demographic Information Specific to North Carolina sidebar.)

- *Language barriers*. North Carolina has a rapidly growing immigrant population. Many immigrants do not speak English well. They may not know how to obtain needed services. They also may have different cultural beliefs regarding health and health care. The 2000 Census contains information on the number of people in your county that do not speak English well. This can help you identify groups that may have language or cultural barriers to accessing health services.

- *Special populations such as the homeless, migrant or seasonal agricultural workers, residents of public housing, at-risk children, or people with mental health, developmental disabilities, or substance abuse problems*. There are some safety net programs and organizations that target specific populations. Working with these organizations can help you identify the health care needs of special populations.

Resources for Demographic Information Specific to North Carolina

Population Projections

NC State Demographics

Provides estimated projections of the population.

http://demog.state.nc.us

Age, Gender, Race, Ethnicity, Language

NC State Data Center

Provides information specific to North Carolina using US Census data.

http://sdc.state.nc.us

US Census Bureau

Census 2000 Summary File 1 contains county-level information on population size, race, ethnicity, and age.

Census 2000 Summary File 3 contains information on income, earnings, poverty (by race and ethnicity), language spoken at home, ability to speak English, and place of birth for foreign born residents.

Census 2000 Summary File 4 contains other sex, age, and socioeconomic data.

These data sets are available at the county, state, and national levels.

http://factfinder.census.gov/servlet/DatasetMainPageServlet?_ds_name=DEC_2000_SF1_U&_program=DEC&_lang=en

Uninsured Data

Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill

Provides county-level estimates for the number of uninsured in North Carolina.

http://www.schsr.unc.edu/publications/NorthCarolinaUninsured2005.pdf

North Carolina Institute of Medicine ***Expanding Health Insurance Coverage to More North Carolinians***

Provides information about the uninsured in North Carolina.

http://www.nciom.org/projects/uninsured/uninsured.html

Additional information is available through the NC Health Data section.

http://www.nciom.org/data.html

Enrollment in Medicaid and NC HealthChoice
NC Department of Heath and Human Services
Provides county-level data on the number of individuals eligible for Medicaid and State Children's Health Insurance Program (SCHIP).
http://www.dhhs.state.nc.us/dma/elig/elig.html

Economic Indicators
NC Rural Economic Development Center
Includes the poverty rate for different ethnic, gender, and age groups.
http://www.ncruralcenter.org/databank/search.asp

Log Into North Carolina (LINC)
Uses census data to determine rates of poverty for several groups.
http://data.osbm.state.nc.us/pls/linc/dyn_linc_main.show

Racial Disparities
NC State Center for Health Statistics
Shows county-level racial and ethnic disparities for birth and mortality.
http://www.schs.state.nc.us/SCHS/data/query.html
http://www.schs.state.nc.us/SCHS/pubs/direct.cfm?dir=minority

NC Office of Minority Health and Health Disparities
Provides statewide data on health disparities.
http://www.ncminorityhealth.org/omhhd/index.html

US Agency for Healthcare Research and Quality
Provides data on racial and economic disparities.
http://www.ahrq.gov/data/safetynet/databooks/v2_sec09_06.htm

Determine the Service Area

In most communities, there is a greater need for safety net resources than there are resources to meet the needs. Therefore, it may be necessary to limit services to a particular geographic area or a special population. The location of the targeted population may influence the type of safety net organization you want to develop. Certain types of safety net organizations have requirements that limit their service areas. For example, a federally qualified health center must be located in an area that is designated as a health professional shortage area (HPSA) or medically underserved area (MUA). They are also required to serve a medically underserved population (MUP). These designations are made by the federal Health Resources Service Administration (HRSA). (See the Resources by Geographic Location sidebar.) Rural health centers must be located in nonurban areas as defined by the US Census.

Resources by Geographic Location

US Bureau of Primary Health Service
Lists all HPSAs, MUAs, and MUPs by county or region.
http://muafind.hrsa.gov/index.aspx

NC Department of Commerce
Provides individual county descriptions including county maps with geographic barriers.
http://www.nccommerce.com/en/AboutDOC/PublicationsReports/CountyProfiles.htm

Identify Greatest Unmet Needs

It is important to collect health status indicators for the population you want to serve. Uninsured individuals are less likely to receive preventive care. They are also more likely to delay needed health care. As a result, the uninsured are often diagnosed with more severe health problems than those with insurance coverage. Identifying the major health problems of the target population may guide your decisions about what type of safety net organization to develop or what types of services to provide.

Health status data may be required when requesting funds from federal, state, and local governments, and private foundations. Health status data can also be used as benchmarks in measuring improvements in community health over time. Some of the health status indicators that could be examined include:

- Birth rates
- Mortality rates
- Infant mortality rates
- Rates of low birth weight
- Entry into prenatal care
- Leading causes of death
- Rates of chronic diseases such as AIDS, asthma, hypertension, and diabetes
- Other areas of care such as oral health, child nutrition, behavioral health, and infectious disease

County health data and vital statistics are available through the NC State Center for Health Statistics at http://www.schs.state.nc.us/SCHS/data/databook. Information may be available at the county level to help evaluate the health care needs of different racial or ethnic populations.

Evaluate the Capacity of the Existing Health Care System

Before creating a new safety net organization, it is important to know what health care resources already exist in the community. It is also important to know the capacity, availability, and accessibility of these resources. This information will help show any gaps in services. You can then determine whether it will be possible to expand existing resources to address unmet needs.

Identify the health care resources that exist in your community and the services they provide including:

- Physicians
- Hospitals
- Health departments
- Federally qualified health centers
- Free clinics
- Rural health centers
- Project Access
- Community Care of North Carolina
- Local management entities that help arrange mental and behavioral health services

Preliminary data have been collected about safety net organizations throughout the state by the NC Institute of Medicine Safety Net Task Force. Updated information on safety net organizations, hours of operation, and services offered will be available in 2008. http://www.nciom.org

Information About the Current Health Care System

North Carolina Institute of Medicine Health Care Safety Net Organizations
Provides a list of all safety net organizations by county.
http://www.nciom.org/projects/SafetyNet/NCsafetynetorglist.html
Additional information on services offered, location, and patient eligibility requirements (if any) will be available at http://www.nciom.org

North Carolina Health Professions Data System
Cecil G. Sheps Center for Health Services Research University of North Carolina
Provides reliable data on selected health professionals in North Carolina.
http://www.shepscenter.unc.edu/data/nchpds/ncptoc.html

US Agency on Healthcare Research and Quality (AHRQ) Safety Net Profile Tool
Has 118 indices measuring information about safety nets including inpatient care, inpatient uncompensated care, ambulatory care, and outcome measures.
http://www.ahrq.gov/data/safetynet/profile.htm

US Bureau of Primary Health Care
Provides information about federally qualified health centers that deliver primary care to underserved populations.
http://ask.hrsa.gov/pc

The University of North Carolina and the National Library of Medicine
Provides a comprehensive list of health care providers by county.
http://www.nchealthinfo.org

Putting It All Together

After collecting the community needs information, you should be able to answer the following questions:

1. What is your target population?

What specific group in your community do you want to serve? _____

_____

What age range?_____

What race/ethnicity? _____

What neighborhood or county?_____

What language? _____

What specific health care needs? _____

_____

_____

What insurance status? _____

2. What services are currently available to your target population? _____

_____

_____

Who offers these services? _____

_____

_____

3. What limitations or gaps exist in services available to this population? _____

_____

_____

4. What services do you want to provide your target population? _____

_____

_____

Leadership

Who is going to initiate, sustain, and ultimately lead the development of the project to address health care needs? Who is going to champion this project? Who else can you involve in the planning and development process?

Strong Community Leadership

Strong community leadership is important to the development of any health care safety net initiative. Therefore, it is important to identify leaders who will champion the effort. Can you identify community and health care leaders who are willing to assume leadership of the project? The leader or leaders may be health care professionals, community or business leaders, or people in the faith community. They must be respected within the community in order to unite health care professionals, business and community leaders, and other stakeholders needed for the success of the safety net initiative. The leaders will serve as the public face of the initiative, requiring them to be well-spoken and well-educated on the aims of the initiative.

Community leaders must have a clear understanding of the goals of the initiative, a thorough knowledge of their community, and ideas on how to achieve those goals within the community. They should be able to identify those individuals or organizations that need to be involved in the initiative. The leaders will need to create and nurture the enthusiasm and energy needed to sustain the effort over a period of time. Leaders often need strong interpersonal, motivational, and organizational skills in order to facilitate the work of many individuals and groups. They also need to be good problem solvers in order to identify strategies to overcome any barriers that may arise.

Steering Committee to Guide the Work

While strong leadership is critical to the success of any community-based initiative, successful community-based projects also involve the work of many other key individuals. Community-based projects are often guided by a working steering committee comprised of representatives of key constituencies. Involving different stakeholders in the development of the initiative will help create a sense of ownership in the project. The steering committee may include health care and business leaders, health and human service providers, members of the faith community, and representatives of the underserved community who are likely to use the new safety net organization. Bringing together members with different backgrounds and varying perspectives will help to identify the unmet health care needs of the community as well as the resources that can be garnered to support the project. Can you identify the other people or groups that need to be actively involved in the steering committee?

One of the first jobs of the leader will be to educate other steering committee members about the aims of the safety net initiative and gain their support. The leader will need to create a climate where everyone's perspective is heard and valued in order to build trust among the diverse steering committee members. While diversity among the committee members can create some initial challenges, it can ultimately help strengthen the project. Diverse membership creates a wider range of skills, knowledge, and abilities to improve the effectiveness of the initiative. The steering committee can help the leaders identify tasks that need to be accomplished in order to successfully implement the initiative. Steering committee members will help coordinate the work of the initiative and help develop more broad-based community support. In addition, individual members or subgroups can be assigned to work on specific tasks, increasing the productivity of the group.

Key Questions About Leadership

Being able to answer "yes" to these questions increases the likelihood of having a successful project:

1. Is there is a key community or health care champion who will lead this effort in your community? _____

_____

_____

2. Is this person respected and viewed as a leader in the community? _____

_____

_____

3. Do you have staff that can support the champion? _____

_____

_____

4. Are the right organizations partnering in the collaboration? _____

_____

_____

5. Will the political and fiscal environment support both the short- and long-term efforts?

_____

_____

6. Do leaders agree on what they want to accomplish? _____

_____

_____

7. Do you really know what it's going to take to get a program up and running, and do you have the resources to carry out the planning and program development? _____

_____

_____

8. Do you have a small group of people who will help plan and implement the project?

_____

_____

Community Support for Safety Net Efforts

How will community factors affect the success of the project? Do you have support for your initiative? What community resources are available to help support the project?

Once you've identified a leader (or leaders), your target population, and the services you want to provide, you also need to understand other community factors that could affect the success of your project. These factors include the support of health care providers in the community (health care factors), the political and economic environment of your community, and the community resources that may be available to support your initiative.[1]

Health Care Factors

Consider how community physicians and others will respond to your project. Will they be supportive? What are the relationships like among providers in your community? Is there competition? Have any providers worked together in the past to provide care to the uninsured? It is important to identify the primary care and specialty services that already exist in your community. You can then determine whether these providers already provide care to the uninsured. Do the physicians belong to a local medical society? If so, you may want to involve the medical society in your work. Are there existing safety net organizations in your community? You can interview key health care providers and safety net organizations to learn which services are actually being offered, which services are needed, and whether existing health care providers will support or oppose the new initiative.

Political Environment

Political factors will also affect the program design, implementation, and continuation of new or expanded safety net capacity. Will the local government support your efforts to assist the underserved? You will want to work with elected officials to ask for their feedback and ideas. You will need to determine if they are supportive of the endeavor. You can also involve other community leaders or groups that can positively influence local political leaders to support the effort.

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1 Communities in Charge. *Improving Access to Health Care: Building a Community-Based Program*. January 2005. http://www.communitiesincharge.org/manual.pdf. Accessed July 25, 2006.

Financial Resources

Consider the financial resources of the community. You may need to seek financial support from local government, organizations, or businesses. Therefore, it is important to learn about the fiscal priorities of your local government. United Way, community foundations, or other local philanthropies may support a safety net initiative. Large employers may offer philanthropic support in the community. Small employers may be willing to provide financial support in order to provide health care services to their workers. You should also explore whether the hospital would support a safety net initiative. A hospital may be willing to contribute either in-kind or direct financial support, especially if the safety net initiative will reduce unnecessary use of the emergency department. It is important to determine if these funding sources are available for long-term support or limited to start-up funding. If financial resources are very limited, it may be difficult to develop new or expanded services and continue them over the long term. Consider other successful community initiatives. Where did they get their financial support? Do they charge for their services? Did they receive community donations? Did they have the political and financial support of local government?

Economic Factors

Even with the support of the local community, the economic health of the area can also affect the success of new or expanded services. You should research the economic trends in your community such as unemployment rates, status of large employers, and recent trends in local industry. Economic downturns may increase the demand for services and the support for a community initiative, but it can also decrease the amount of community funding. On the other hand, if the local economy is strong, you may be able to obtain more financial support, particularly from county government or local companies that support community organizations.

Key Questions About Community Support

Being able to answer these questions will help you identify other factors in your community that may influence the success of your project:

1. Which local providers are supportive? _____

_____

_____

2. Is there competition or other issues between providers or local agencies that might affect your project? _____

_____

_____

3. Are you seeking support and/or funding from local government? _____

_____

_____

4. Who are your advocates or supporters within local government? _____

_____

_____

5. How does your project fit into current fiscal priorities of your local government? ___

_____

_____

_____

6. Are there other sources of funding to help support your project over the long-term?

_____

_____

_____

7. How will the community's economic health affect your project? _____

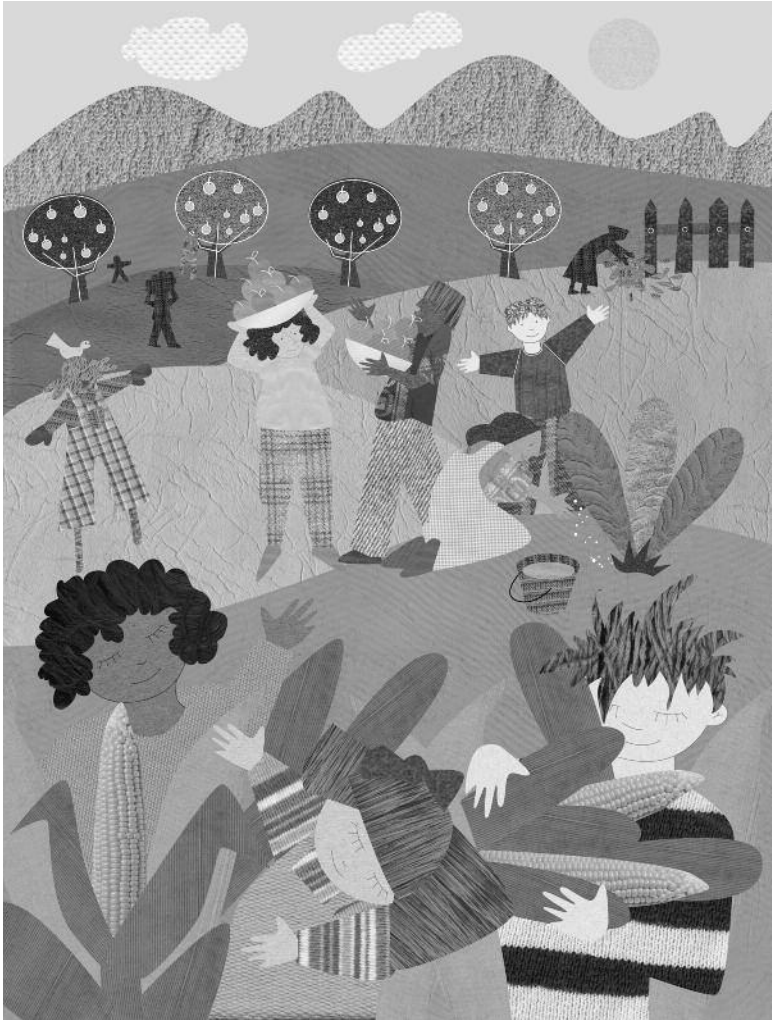
_____

_____

_____

Types of Health Care Safety Net Organizations

What type of safety net organization best fits your community? What services should be provided? What hours of operation are needed to meet the unmet health needs in the community?



There are many different types of safety net organizations. The most common organizations are described below, but communities can develop customized models to address their specific health care needs. Some models offer comprehensive services, while others are more limited in scope. Some organizations are open during regular business hours, some may have after-hours or weekend services, and others may be limited to one or two days a week. Some organizations partner with private physician practices, so services are provided during practice hours. Some organizations have paid staff and providers while others are run through volunteer networks.

Different types of safety net services and safety net organizations are described below. This information is organized into four sections: primary care, behavioral health services, prescription drug assistance, and dental care. A comparison chart follows the short descriptions. More detailed descriptions of these organizational types are included in Appendix C.

Primary Care

Federally Qualified Health Centers (FQHCs)

Federally qualified health centers are public or private nonprofit organizations that receive federal grant funds from the US Bureau of Primary Health Care.[1] There are different types of federally funded FQHCs. These include community health centers, migrant health centers, and health care for the homeless centers. Some FQHCs also receive federal funding for school-based centers. FQHCs must be located in a medically underserved area (MUA) or serve a medically underserved population (MUP). FQHCs must have a community-based board of directors where the majority of board members are active users of the health center. FQHCs are required to provide comprehensive preventive and primary care, preventive dental services, and pharmaceutical services. They also provide enabling services such as transportation, interpreters, and case management. Services to the uninsured are charged on a sliding fee scale based on a patient's income and family size.

FQHCs receive higher Medicaid and Medicare reimbursement than most other primary care providers. They can also obtain discounted medications through the 340B federal prescription drug discount program (see Pharmacy section).

Grants from the US Bureau of Primary Health Care are highly competitive. They also require reapplication every three to five years. In 2007 there were 23 FQHCs in North Carolina with 104 delivery sites.

1 The grants (called 330 grants) are administered through the US Bureau of Primary Health Care within the US Department of Health and Human Services.

Federally Qualified Health Center Look-Alikes (FQHC-LAs)

FQHC look-alikes are public or private nonprofit organizations that meet the program requirements and structure of an FQHC. They do not, however, receive grant funding from the US Bureau of Primary Health Care. These centers must serve in a designated MUA or MUP. They must provide primary health care and support services. Although FQHC-LAs do not receive federal grant funds, they do receive other benefits. They are eligible for enhanced Medicaid and Medicare reimbursement. They can participate in the federal prescription drug discount program (340B). (See Pharmacy section.) The Look-Alike designation requires an annual recertification from the US Bureau of Primary Health Care and the Centers for Medicaid and Medicare Services (CMS). Due to restricted funds and the competitiveness of FQHC grants, designation as an FQHC Look-Alike may provide some of the benefits of an FQHC while helping the organization prepare a successful application for federal grant funding. In 2007 there were 4 FQHC-LAs within North Carolina.

Federally Certified Rural Health Clinics (RHCs)

Federally certified rural health clinics provide primary care services in rural communities. These clinics can also arrange for inpatient care and specialty referrals. They are legally required to provide services to Medicaid and Medicare recipients. Federally certified RHCs are not required to serve the uninsured, but many do so. RHCs also qualify for enhanced reimbursement from Medicare and Medicaid. The center must be located in a HPSA or MUA. It must employ a physician assistant, nurse practitioner, or certified nurse midwife for at least 50% of the time the clinic is open. There were 110 federally certified RHCs in North Carolina in 2007.

State-Funded Rural Health Centers

State-funded rural health centers are located in geographic areas that do not have enough primary care resources to meet the needs of their communities. State-funded rural health centers must be nonprofit 501(c)(3) organizations with a local board of directors (ie, community residents). These centers do not have the same requirement as FQHCs for board composition (ie, a majority of board members do not have to be users of the centers). Limited state funding is available to help pay for services to the uninsured. The state funding is provided through the Medical Access Plan. State funds help pay for services to low-income uninsured people with incomes up to 200% of the Federal Poverty Guidelines (FPG). Unfortunately, state funds are limited. They are not available for every center seeking to expand services to the uninsured. There were 85 rural health centers initially established by the Office of Rural Health, but in 2007 only 30 of them received state funds.

Free Clinics

Free clinics are nonprofit, usually 501(c)(3), organizations governed by local boards of directors. There is not one specific free clinic model, although most follow certain patterns. They are designed to meet the health care needs of the low-income uninsured in their communities. They draw on local health care resources and volunteers. Free clinics provide basic primary care and preventive services to their uninsured patients. Some clinics provide a broader range of supportive services such as health education, case management, and nutrition counseling. The majority of free clinics in North Carolina offer some pharmaceutical services through either an on-site pharmacy or a voucher system with local pharmacies. Some provide dental services that depend on volunteer dentists.

Volunteers are the cornerstones of the free clinic movement. Free clinics rely on the willingness of health care providers (doctors, nurse practitioners, physician assistants, social workers, pharmacists, dentists, mental health providers, and chiropractors) and other community members to volunteer their time. Cash and in-kind donations are received from a number of sources. These may include individual contributions, churches, businesses, hospitals, the United Way, and foundations.

Free clinics vary from being open one or two evenings a week to having multiple day and night clinics. Some serve patients on a first-come, first-serve basis, and others require appointments. Although free clinics offer primary care, they are not always able to guarantee continuous, comprehensive services such as the ability to establish a medical home with a specific provider. There were 69 free clinics in North Carolina in 2007.

Public Health Departments

Local health departments provide a wide range of services. They are required by state law to provide certain core public health services. These services include communicable disease control, environmental health services, and vital records registration. Almost all health departments provide prenatal care, immunizations, and family planning. Health departments are a major source of health care for the uninsured. However, most do not provide comprehensive primary care services to all populations. Some health departments offer comprehensive primary care services to children, but not adults. Others offer comprehensive primary care services to some adults, but not children. Many do not offer any comprehensive primary care services. There were 79 single-county health departments and 6 district health departments in North Carolina that cover all 100 counties in 2007.

School-Based or School-Linked Health Centers (SBHCs and SLHCs)

School-based and school-linked health centers are designed to eliminate or reduce barriers to care for students.[2] SBHCs and SLHCs offer services to meet the unmet physical and behavioral health needs of children and adolescents. In addition, these centers help keep students in school by removing physical and emotional barriers to learning. School-based health centers bring health care services into the schools. School-linked health centers are located near, but not on, school grounds. SBHCs and SLHCs provide comprehensive primary care including physical and mental health services, acute and chronic disease management, immunizations, treatment of minor injuries, and prescription for or administration of medications. They provide emergency services for injuries and other health care procedures. They also offer health education to students with parental consent on a variety of age appropriate topics. The North Carolina Association of School-Based and School-Linked Health Centers reports 53 centers across the state in 2007.

In addition to SBHCs and SLHCs, most school districts employ nurses. School nurses are responsible for triage of student conditions and oversee the care provided to medically fragile children. School nurses may work collaboratively with school-based or school-linked health centers.

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2 The Center for Health and Health Care in Schools. School of Public Health and Health Services, The George Washington University Medical Center. http://www.healthinschools.org. Accessed September 2004.

Hospital Emergency Rooms and Outpatient Clinics

Hospitals are an important part of the North Carolina safety net. Almost all hospitals operate emergency departments that provide services to everyone who comes to their door. The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to screen anyone who requests treatment at the emergency room regardless of his or her ability to pay. If the person has a medical emergency, the hospital must treat the patient to stabilize the condition or transfer the patient to another hospital if the person's condition is stable. Medical emergencies are defined as acute, severe conditions that could place the person's health (or the health of an unborn child) in serious danger if the person does not receive immediate medical attention. Hospitals are often the most available health care provider in communities where there are not enough other safety net providers. When patients are unable to obtain affordable primary care elsewhere, they sometimes turn to hospital emergency departments for care. Many hospitals and health systems in North Carolina also offer primary care clinics and outpatient centers with a community focus. These clinics and centers operate in a similar fashion to private physician practices. Hospitals may offer these services through rural health clinics, outpatient centers, urgent care clinics, primary care practices, and hospital-based health clinics. Academic medical centers with primary care residency training programs also support a wide range of outpatient clinics and services.

HealthNet

HealthNet is an initiative funded through a one-time appropriation from the NC General Assembly. The primary focus of HealthNet is making a medical home available to uninsured adults. Secondarily, HealthNet helps with care coordination, medication assistance, and other needed services including specialty care, and outpatient and inpatient services by developing and coordinating the network of care among the existing safety net providers within a community.

Specialty Services

Care+Share

Care+Share is an initiative funded by The Duke Endowment to support community collaborations for low-income uninsured. Similar to Project Access, the goal of Care+Share is a coordinated system of care that includes specialty services, diagnostic services, hospitalizations, primary care, medications, behavioral health services, and dental care. Primary care services are often provided by existing safety net organizations (such as FQHCs or free clinics). Other services may be offered on a volunteer basis by private providers or donated by other organizations. A local hospital must be involved in the community collaboration to qualify for Care+Share funding.

Hospital Emergency Rooms and Outpatient Clinics

In addition to primary care clinics, some hospitals and Area Health Education Centers (AHEC) residency programs offer specialty clinics. Some, but not all, of these clinics offer services to the uninsured on a sliding scale basis.

Project Access

Project Access was developed in Asheville, North Carolina, in 1996 to fill some of the gaps in health care services available to the uninsured. Project Access organizes primary care and specialty providers in the private medical community to increase services being provided to the uninsured. Typically, Project Access programs help organize the private medical community to provide primary and specialty care, diagnostic services, hospitalization, and some medications to low-income uninsured patients depending on the community services. Services will be provided for free, or for a small fee. The Project Access model has been implemented in 10 North Carolina communities as of 2007.

Mental Health, Developmental Disabilities, and Substance Abuse Services

Local Management Entities (LMEs)

LMEs are local agencies that manage the provision of mental health, developmental disabilities, and substance abuse services to people in their service area. Some LMEs cover one county (generally the larger counties) but most LMEs cover several counties. LMEs are required to screen individuals, provide crisis services, and help consumers obtain ongoing services. They develop networks of community providers. LMEs also handle consumer complaints and grievances. Because of limited funding, LMEs target public resources to assist individuals with the most severe problems. Contact your LME for a list of mental health, developmental disabilities, and substance abuse providers and services available in your area. A directory of LMEs and counties served is available at http://www.dhhs.state.nc.us/mhddsas/lmedirectory.htm.

Pharmaceuticals

Almost half of all Americans take at least one prescription drug, and 17% take three.[3] Many North Carolinian's have trouble affording prescription drugs because they either have too little health insurance or no health insurance at all. While a number of programs exist to provide low-cost or free prescription drugs to low-income individuals, accessing these programs is often very difficult.

Many safety net organizations and nonprofit groups help low-income uninsured people obtain needed medications. For example, some organizations help people obtain free or discounted medicines offered by pharmaceutical manufacturers (called "patient assistance programs"). Other safety net providers offer free drug samples donated by private providers or provide discounted medicines. Some safety net organizations use several methods to help patients obtain needed medicines or supplies.

Pharmaceutical Patient Assistance Programs (PAPs)

Different pharmaceutical companies offer a large number of patient assistance programs which provide free or discounted medications for low-income or uninsured individuals. However, patients often need help applying for the free medications. Each company has different forms and eligibility requirements. In addition, the covered medications or eligibility requirements may change over time. Many companies require that the form be completed by the patient's provider. (See Additional Resources for Pharmaceutical Assistance Program sidebar.)

Medication Assistance Program (MAP)

To help people access needed medications, the NC Health and Wellness Trust Fund (HWTF) funds a network of medication assistance programs (MAP services) to serve North Carolina's under- and uninsured. The HWTF initiated MAP in January 2003 and has awarded more than $17.8 million to 84 organizations providing MAP services.

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3 Prescription Drugs: More than 40% of US Residents Take at Least One Prescription Drug Report Says. Daily Health Policy Report. Washington, DC: Kaiser Family Foundation, December 3, 2004. Accessed January 3, 2008, at: http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=27058.

MAP grantees help low-income individuals and seniors with gaps in their prescription coverage identify and apply for free or low-cost prescription drugs. MAP offers a single point of access to 138 public and private patient pharmaceutical assistance programs, which provide almost 3,000 different medications. To connect people with the lowest-cost programs providing the appropriate medication, HWTF gives funds to MAP grantees for computers, specialized software, and a prescription assistance coordinator to help patients identify which programs can provide the needed medication at the lowest cost. The specialized software includes a database of available programs and eligibility requirements, the capacity to generate completed applications and renewal forms, and it eliminates the need for multiple applications by automatically transferring the patient's demographic data when they need a new medication or a refill. MAP grantees also help seniors optimize their Medicare Part D choices. MAP grantees across the state represent many organizational types including: local agencies on aging, senior centers, health departments, hospitals, community health centers, and health clinics. MAP grantee sites provided $122 million in free medications to more than 87,000 patients between January 2003 to December 2007.

The NC Foundation for Advanced Health Programs, with technical support provided by the Office of Rural Health and Community Care and funding from The Duke Endowment, has developed software to help identify appropriate PAPs. This software is called the Medication Access and Review Program (MARP). The basic MARP software allows a patient or provider to fill out information once. It then provides information on all available PAPs, identifies appropriate PAPs for the individual patient, and lists eligibility requirements and application forms. A more sophisticated version of MARP known as the "Medication Management Program" helps identify possible drug interactions, provides patient and provider education, and offers counseling on alternative therapies. The MARP program is free. Training is provided by the Office of Rural Health and Community Care. In 2007, more than 137 sites in North Carolina used MARP software. These sites included FQHCs, rural health centers, free clinics, health departments, and other programs.

Donated Medications

Safety net organizations may be able to obtain donated medications. Sometimes private providers donate the free drug samples they receive from pharmaceutical representatives. Pharmaceutical representatives may also be willing to donate drug samples directly. In addition, local nursing facilities may be willing to donate medications that would otherwise have to be discarded after a resident dies.

340B Drug Discount Programs

Certain safety net organizations can obtain deeply discounted pharmaceuticals through the federal 340B drug discount program. Drug purchasing prices under the federal 340B drug program are discounted 20% or more compared to the pricing available through other purchasing arrangements. The 340B drug program provides discounts to the following safety net organizations: FQHCs, FQHC Look-Alikes, AIDS clinics and AIDS drug assistance programs, hemophilia treatment centers, and public health agencies. (The discounts available to public health agencies only cover medications for family planning services or treatment of sexually transmitted diseases or tuberculosis.) Certain hospitals that serve a large number of Medicaid and low-income patients (called disproportionate share hospitals) can qualify through the 340B drug program to fill prescriptions for patients who receive outpatient services. Organizations can only provide 340B discounted medications to established patients of their organization (ie, people cannot become patients solely to receive discounted medicines).

Other Discount Programs

Safety net organizations may also obtain reduced-charge medicines through an arrangement with a local pharmacy. The participating pharmacy may waive dispensing fees or limit charges to the cost of the medication. In addition, organizations that can dispense medications may be able to work with the pharmeceutical companies to arrange for bulk donated or discounted medications.

Additional Resources for Pharmaceutical Assistance Programs

Volunteers in Medicine
Provides information on starting a free clinic.
http://www.vimi.org/starting.shtml

Partnership for Prescription Assistance (PPA)
Offers a single point of access to more than 475 public and private patient assistance programs, including more than 180 programs offered by pharmaceutical companies. The partnership provides help with access to free or reduced medication and a link for different organizations that help with insurance premiums and co-pays to financially and medically eligible people.
https://www.pparx.org/Intro.php

Pharmacy Affairs and 340B Drug Pricing Program (HRSA)
Administers the 340B program. The Disproportionate Share Hospitals and 340B link specifies the eligibility criteria, outlines the application process and required certifications, and includes frequently asked questions (FAQs), databases, and sample forms and letters.
http://www.hrsa.gov/opa

Pharmacy Services Support Center (HRSA)
Provides information to help entities use the 340B program. Most of the program materials on the Pharmacy Affairs site are here as well. Includes presentations, links, FAQs, forms, certifications, databases, policy briefs, and program requirements.
http://pssc.aphanet.org

Pharmacy Technical Assistance (HRSA)
Provides onsite technical consultation after a hospital is ruled eligible by the Office of Pharmacy Affairs. Contact PharmTA to arrange a consultation.
http://www.pharmta.net

340B Prime Vendor Program
Provides a process for obtaining 340B drugs. The original 340B legislation contained a special requirement mandating establishment of a "prime vendor" for negotiation of pharmaceutical pricing below the 340B price as well as improving access to affordable medications by establishing a distribution network for pharmaceuticals. Benefits of the 340B Prime Vendor Program include familiarity with subtleties of the Section 340B program, value-added service, and sub-340B prices.
http://www.340bpvp.com/home.asp

Safety Net Hospitals for Pharmaceutical Access (formerly Public Pharmacy Coalition) Monitors, educates, and serves as an advocate on issues related to drug pricing and other pharmacy matters affecting safety net providers. The 340B Resources link provides detailed information on the 340B discount drug program and sample enrollment letters for disproportionate share hospitals.
http://www.safetynetrx.org/public/index.cfm

Dental Care

North Carolina communities have tried to address the shortage of dental services for the uninsured or Medicaid populations in a variety of ways.

Dental Safety Net Clinics

FQHCs may be able to obtain federal funding to create or expand safety net dental capacity. Some health departments in North Carolina have developed safety net dental capacity to serve children, adults, or both. In addition, free clinics may offer limited dental services (eg, tooth extractions). Other nonprofit organizations have created stand-alone dental clinics.

In addition to dental clinics, some community organizations have purchased mobile dental vans to provide services to children in schools, older adults or people with disabilities in institutional or group settings, or people in rural communities.

School-Based Dental Screenings

The NC Oral Health Section, Division of Public Health, provides preventive dental screenings for children in public schools (focus on Grades K and 5th). The dental professionals will help arrange dental services with local providers for children with suspected dental cavities.

Private Dental Clinics

Some private dentists have established dental clinics to serve children receiving Medicaid or NC HealthChoice benefits.

Private Dental Services

Some Project Access models include dental services provided in dentists' offices.

Additional Information on Dental Care

Safety Net Dental Clinic Manual
Provides information about starting a dental program.
http://www.dentalclinicmanual.com

Oral Health Section, NC Division of Public Health
Provides prevention and education services on dental health specifically for children.
919-707-5480 or http://www.communityhealth.dhhs.state.nc.us/dental

Wake Smiles
Uses the Project Access model to provide dental services.
919-250-2952 or http://www.rwcds.com/wake

Overview of Major Health Care Safety Net Organizations

	Federally Qualified Health Centers	Federally Funded Rural Health Centers	State-Funded Rural Health Centers
Target Population	■ MUP ■ Uninsured	■ Medicaid and Medicare recipients	■ Medicaid and Medicare recipients ■ Uninsured
Geographic Location	■ MUA	■ MUA ■ HPSA	■ Nonurban
Services Provided: Comprehensive primary care, specialty care, hospitalizations, some provide dental.	■ Comprehensive primary care ■ Mental health services ■ Dental services	■ Basic primary care	■ Basic primary care
Organizational Type	■ Nonprofit ■ Public entity	■ For-profit ■ Nonprofit ■ Public entity	■ Nonprofit
Primary Funding	■ Federal grant ■ Medicaid and Medicare reimbursement	■ Medicaid and Medicare reimbursement ■ Private insurance	■ Medicaid and Medicare reimbursement ■ State funds for operating subsidy
Number of Sites in North Carolina	■ 23 sites	■ 108 sites	■ 81 sites

Free Clinics	Public Health Departments	Project Access	School Based/ School Linked Health Centers
■ Uninsured	■ General public ■ Low-income or other special populations	■ Uninsured ■ Ages 18 to 64 ■ Incomes below 200%of FPG	■ Children and adolescents
■ Any location	■ Statewide		■ On or near a school campus
■ Varies but usually limited to primary care	■ Varies but generally provides child and maternal health services ■ Some but not all provide comprehensive primary care	■ Varies but primarily fills gaps in health care services	■ Comprehensive primary care ■ Mental health ■ Health education
■ Nonprofit	■ Public entity	■ Public/Private partnership	■ Public entity ■ Nonprofit
■ Cash and in-kind contributions	■ Medicaid and NC HealthChoice	■ Donations from private suppliers ■ National/state/ local foundations ■ Hospitals	■ State revenues ■ Federal funds ■ Institutional sponsorship ■ Local grant funding ■ In-kind support
■ 71 sites	■ 79 single-county health centers 6 district health centers	■ 10 NC communities	

Financial Considerations

How will this project be funded? How much money and in-kind support will be required for implementation and start-up? Will the project require ongoing financial support or will it be self-sustaining?

It is important to develop a working budget and to determine what financial resources are available to support the initiative. Depending on what type of safety net model you plan, different financial resources will be available. It may be helpful to develop one funding plan for the implementation or start-up period and a separate plan for ongoing operations. Appendix B provides a list of potential private funding. Appendix C includes information on types of funding and reimbursement available to different safety net providers.

Implementation

Significant expenses can occur during the start-up period. These will need to be met through cash reserves, financing arrangements (debt), or in-kind donations. Typical expenses incurred during the start-up period include:

- Acquiring and/or renovating space
- Furnishing space (furniture, examination room, and medical equipment)
- Stocking inventory (medical, pharmaceutical, and office supplies)
- Setting up the IT system (computers, printers, Internet access, medical office software, and electronic medical records)
- Marketing and/or conducting community outreach
- Soliciting grants and in-kind donations to fund implementation and start-up expenses

Ongoing Operations

The level of ongoing operating expenses will vary significantly depending on the safety net model you choose to implement. A free clinic model that relies mostly on volunteers and sees patients two or three nights a week will have lower costs. An FQHC that requires more paid staff to support full-time operation will have higher costs. Some of the ongoing operating expenses you should consider as you develop your budget include:

- Personnel (salaries, fringe benefits, paid versus volunteer)
- Facility expenses (utilities, cleaning, maintenance, mortgage/rent)
- Insurance (malpractice, bonding, directors and officers)
- Communications (telephones, cell phones, Internet access)
- Supplies (medical, dental, pharmaceutical or other health care supplies, and office supplies)
- Contracts (medical office software fees, equipment rental, maintenance agreements)
- Legal & Accounting
- Security

Sources of operating revenue will also vary significantly depending on the safety net model. A free clinic model will rely heavily on fundraising, in-kind donations of time and supplies, and private foundation grants. An FQHC will rely on patient revenue (Medicare and Medicaid) and a federal government grant. (See Appendix C for additional details.)

Cash reserves may be needed to fund operations during the first few months you are open and providing care. This will especially be true if you rely on patient revenue to cover a large amount of your operating expenses. It may take several weeks to receive your provider billing numbers, as well as to build up a steady level of productivity.

Key Questions About Financial Considerations

1. How much will it cost to start your project? _____

_____

_____

2. How much of your start-up costs will be covered through the following sources?

Grant funds_____

In-kind donations_____

Community fund-raising _____

_____

3. How much will it cost to operate your project on an ongoing basis?_____

_____

4. How much of your ongoing expenses will be covered through the following sources?

Patient revenues (patient and/or insurance company billing) _____

_____

In-kind donations or volunteers_____

Grant funds_____

Community fund-raising _____

_____

_____

Choosing a Type of Safety Net Organization

What services do you want to provide? How many and what type of providers are found in your community? What is your geographical area? What resources already exist?

There are a number of factors to consider when identifying the appropriate type of safety net organization for your community.

Services Provided

Certain safety net organizations may be more or less appropriate depending on the types of services you want to provide. For example, RHCs, free clinics, or public health departments may provide basic primary care services. FQHCs or FQHC-LAs may provide more comprehensive primary care. Working with a local health department or FQHC may be the best option if you are interested in providing comprehensive dental services.

Number of Providers

The number of medical providers within a community will affect the choice of safety net organizations you consider. Free clinics and the Project Access systems depend largely on the services of volunteer providers. Therefore a community must have adequate numbers of providers willing to volunteer in order to select these models.

Geographic Location

The designation of a service area as rural or urban will influence eligibility for certain safety net programs. Federally certified RHCs must be located in areas not designated as "urbanized" by the US Census. FQHCs or FQHC-LAs must serve MUAs and MUPs. MUAs can be in either rural or urban areas, but must meet certain federal criteria that establish a lack of primary care providers to meet the health needs of the population.

Existing Safety Net Organizations

Before creating a new organization, you should explore whether an existing safety net organization could address the community's unmet health care needs. It is often easier to expand existing organizations than to create new ones. Even if you are unable to address the community's unmet health care needs through an existing safety net organization, working collaboratively with existing organizations can help increase the likelihood of success. (See Collaboration section.)

Other factors to consider in choosing the right safety net organization for your community include:

- Community support
- Funding (start-up and continuing)
- Provider recruitment
- Facility needs

Key Questions About Choosing a Type of Safety Net Organization

1. What type of services do you want to provide? basic or comprehensive primary care, dental, etc. _____

_____

_____

2. What type of providers and how many in your community may be willing to support the safety net organization? _____

_____

_____

3. What type of geographic area is your community? _____

_____

_____

4. What safety net resources already exist within your community? _____

_____

_____

_____

_____

Collaboration

Who already provides safety net services in your community? Who serves the populations you want to target? What groups or organizations may be interested in partnering with you to achieve a similar goal?

Communities that develop broad-based collaborations to address the health care needs of the uninsured may be more successful because they are able to provide more services.[1] Funders may be reluctant to fund a new organization if they believe it duplicates or competes with existing resources. Despite its advantages, developing collaborative partnerships can be difficult and time-consuming. Long-standing conflicts may need to be resolved. Trust may need to be built among collaborating organizations. However, the payoff in developing a community collaboration is generally worth the effort. Collaborations of existing health care organizations and community, business, and faith leaders can:

- Identify unmet health care needs.
- Identify available resources to meet those needs.
- Achieve greater buy-in from existing health care and community leaders.
- Provide increased access to policy makers and funders.
- Create greater community support.
- Expand networking opportunities.

Before creating a new group, examine existing collaborations in your community. Identify the ones that could be used to address unmet safety net needs. Many communities have Healthy Carolinians initiatives. In addition, almost every county has a Community Care of North Carolina program. Community Care organizes networks of health care providers to deliver care to the Medicaid population. (See Appendix C.)[2] These groups are important resources for individuals or organizations that want to expand the safety net in their community. They may also have an interest in ongoing efforts to address the unmet health care needs of the uninsured or underserved populations.

1 Work Group on Health Promotion and Community Development. Community Tool Box: Creating and Maintaining Coalitions and Partnerships. University of Kansas at Lawrence. http://ctb.ku.edu/tools/coalitions/expand/index.jsp Accessed July 25, 2006.

2 Community Care of North Carolina is a network of local primary care physicians that manages the health care needs of Medicaid enrollees and provides referrals for specialty care.

If there are no other community collaborations interested in addressing unmet safety net needs, consider organizing a new partnership. To achieve a broad-based collaboration, look for partners from the following groups:

- Health care organizations and providers who already serve this population as well as other leaders in the health care community
- Consumer representatives from the community who are likely to use the new services (to ensure that the services are best designed to meet their needs)
- Business leaders
- Community and faith leaders who could help identify resources and generate community support
- Local and state political leaders and policy makers

As you develop your community collaboration remember to:

- Identify key organizations you want to involve in the collaboration.
- Assemble a core group of individuals who are involved with the issue.
- Recruit members to the collaborative partnership.
- Plan and hold regular meetings.
- Identify roles for partners.
- Develop accountability and evaluation plans.
- Identify ways to recognize organizations and individuals for the work they may already do to address the health care needs of the community.

Additional Information on Community Collaboration

Healthy Carolinians
Provides information on health objectives and their certification process.
http://www.healthycarolinians.org

Community Care of North Carolina (CCNC)
Provides information on CCNC programs and initiatives.
http://www.communitycarenc.com

Key Questions About Collaboration

1. Are there any existing partnerships or collaborations with an interest in safety net issues?

_____

_____

_____

2. If collaborations exist, are they interested in or willing to serve the target population and address the service needs you have identified?_____

_____

_____

_____

3. If a collaboration does not exist, who are the key people and agencies that should be involved in creating a broad-based collaboration?_____

_____

_____

_____

4. What topics, services, or joint activities are likely to attract existing service programs to a collaborative initiative? _____

_____

_____

_____

Conclusion

The Safety Net Advisory Council (NC SNAC) developed this technical assistance manual to help communities that want to expand health care services and improve access to care for underserved populations. North Carolina's uninsured population continues to increase at a faster rate than other states in the nation. In 2006, more than 1.5 million nonelderly people in North Carolina were uninsured.[1] This was one-sixth of the state's population. Although numerous safety net organizations across the state are dedicated to providing services to the uninsured and other underserved populations, they are insufficient to meet the growing need.

Rather than wait for the federal or state governments to act, many North Carolina communities have developed creative local strategies to address some of the health care needs of the uninsured. This manual provides guidance on the key elements in the development and implementation of a successful safety net initiative: leadership, needs assessment, safety net options, community support and collaboration, technical assistance, and funding. With proper information and leadership, other communities can make similar headway in addressing the health care needs of the uninsured.

1 North Carolina Institute of Medicine. *Expanding Health Insurance Coverage to More North Carolinians: North Carolina Task Force on Covering the Uninsured: April 2006*. http://www.nciom.org/projects/uninsured/uninsured.html. Accessed on September 12, 2006.

Appendix A
Technical Assistance

Technical assistance is available when you are ready to consider the different types of safety net models that can address the needs of your community. The North Carolina Office of Rural Health and Community Care is a state agency that can provide assistance with a range of safety net options. The state or trade associations listed below tend to focus on one specific type of safety net organization.

The North Carolina Association of Free Clinics
1342 Ashley Square
Winston-Salem, NC 27103
(336) 251-1111
http://www.ncfreeclinics.org/mc/page.do
Services: Provides information on different ways to organize free clinics, how to develop the volunteer network, and obtain needed funding.

North Carolina Association for Healthcare Access
304 Summit Street
Asheville, NC 28803
(828) 274-9337
http://www.ncahaccess.org
Services: Provides information on how to create a Project Access model in a community.

North Carolina Community Health Center Association
2500 Gateway Centre, Suite 100
Morrisville, NC 27560
(919) 469-5701
http://www.ncchca.org
Services: Provides technical assistance in developing or expanding an FQHC or FQHC Look-Alike. Can also provide information on developing 340B discounted drug capacity for FQHCs or FQHC Look-Alikes.

North Carolina Office of Rural Health and Community Care
2009 Mail Service Center
Raleigh, North Carolina 27699-2009
(919) 733-2040
http://www.ncruralhealth.org/index.html
http://www.communitycarenc.com
Services: Provides information on provider recruitment, rural health centers, pharmaceutical assistance programs, farm worker health services, dental clinics, HPSA/MUA/MUP designations, FQHCs, and other types of safety net organizations.

North Carolina Hospital Association
2400 Weston Parkway
Cary, NC 27513-5519
(919) 677-2400
http://www.ncha.org
Services: Provides information on hospital-based outpatient clinics and primary care centers, 340B drug program, emergency care, critical access hospitals, community collaboration, rural health grants and funding, and Community Care of North Carolina.

North Carolina Medical Society Foundation
PO Box 27167
Raleigh, NC 27611
(919) 833-3836
http://www.ncmedsoc.org
Services: Provides help to recruit physicians, physician assistants, and family nurse practitioners into medically underserved areas. Can also provide general practice management technical assistance and practice management education through web resources, webinars, and seminars.

North Carolina Division of Public Health
NC Department of Health and Human Services
1931 Mail Service Center
Raleigh, North Carolina 27699
(919) 707-5000
http://www.ncpublichealth.com
Services: Provides technical assistance on health and health services data, indicators, and measures. Provides health indicators for most NC population groups. Can also provide guidance to communities on health promotion and disease prevention best or promising practices.

Healthy Carolinians
5605 Six Forks Road, 2nd Floor
1916 Mail Service Center
Raleigh, NC 27699
(919) 707-5150
http://www.healthycarolinians.org
Services: Provides assistance with community collaboration, health planning, disease management strategies, and improving the healthcare safety net.

Appendix B
Sources of Private Funding

Many philanthropic organizations provide funding to safety net organizations. Each has a slightly different mission. For example, some provide capital funding and others focus more on program funding. Few provide long-term operational support.

Three categories of funders are identified:

- State philanthropies with a health care focus and/or a mission of serving underserved populations. These foundations have provided significant funding to safety net organizations in North Carolina.
- State philanthropies or other funders with health and/or underserved populations as one of their focus areas. These foundations may cover limited geographic areas of the state.
- National foundations that focus on health care grantmaking.

State Philanthropies that Have Provided Significant Funding to North Carolina Safety Net Organizations

Blue Cross and Blue Shield of North Carolina (BCBSNC) Foundation

Grants from the BCBSNC Foundation focus on improving the health of vulnerable populations, promoting healthy active communities and improving the capacity of nonprofit organizations. The priorities within the Health of Vulnerable Populations focus area are to increase the supply of and access to health care, increase the number and availability of health care providers serving underserved populations, and increase the appropriate use of health care resources. The BCBSNC Foundation also works to increase the coordination and continuity of care among safety net organizations.
http://www.bcbsncfoundation.org

Community Health Grant Program

The North Carolina General Assembly created the Community Health Center grants program, which provides limited funding to federally qualified health centers, state-designated rural health centers, free clinics, public health departments, school-based health centers and other nonprofit organizations that provide health services to uninsured patients. The NC Office of Rural Health and Community Care administers the state funds, and makes them available to eligible health care organizations on a competitive basis. In the past, funds have been allocated to increase access to preventive and primary care services, dental services, pharmacy and behavioral health, and to increase the capacity to serve the uninsured by enhancing or replacing facilities, equipment or technologies. For more information contact: NC Office of Rural Health and Community Care at: 919-733-2040.

The Duke Endowment

The Health Care Division of The Duke Endowment helps fund nonprofit health care organizations in North and South Carolina. It focuses on improving the quality and safety of health care, expanding prevention and early intervention programs, and expanding access to care. Areas of interest include care for the underserved or uninsured, increased access to mental health services, and reduction of racial disparities.

http://www.dukeendowment.org

Kate B. Reynolds (KBR) Charitable Trust

The Health Care Division of the Trust provides grants to meet health care and wellness needs in the state. Grants also seek to improve the health of financially needy residents. Priority is given to projects that serve the vulnerable populations of the uninsured and underinsured, children and youth, the frail and elderly, or rural populations. The Trust also invests in programs that promote integrated care, community-based services, or system change.

http://www.kbr.org

North Carolina Health and Wellness Trust Fund

The NC Health and Wellness Trust Fund is one of three organizations created by the NC General Assembly from the North Carolina portion of the Tobacco Master Settlement Agreement. Grants are offered in four major areas: obesity prevention for youth, tobacco cessation and prevention, health disparities, and medication assistance for low-income individuals and seniors. The last program area provides grants to communities to (a) fund pharmacists to help seniors or low-income individuals with medication management or (b) provide software and training to help nonprofit or government programs locate public and private medication assistance programs for the target population.

http://www.healthwellnc.com/

Other North Carolina Philanthropies or Other Funders That May Provide Resources to Safety Net Organizations

A.J. Fletcher Foundation

The Foundation is flexible in its funding. It supports a broad range of causes and serves as an advocate for human services.

http://www.ajf.org

The Belk Foundation

Grants are offered in five areas including medicine. Grants tend to favor capital campaigns rather than ongoing operations. Foundation gifts are primarily concentrated in North Carolina, but also include the southeast region of the United States.

http://www.belk.com/main/belk_foundation.jsp

The Cannon Foundation

Health care, higher education, and community service are the primary fields of interest. Grants are made for capital improvements, project support, or special programs. Funds for operational support are not generally provided. Cabarrus County is the primary geographic area of interest, although grants are made throughout North Carolina, especially in rural areas.

http://www.thecannonfoundationinc.org

D. Michael Warner Foundation

The Foundation's goal is to improve the quality of life for low-income individuals and communities within North Carolina.

http://www.thewarnerfoundation.org

The Dell Foundation

The Foundation supports initiatives that provide health care services to children who are newborn to 18 years of age. Grant partners must be located in Guilford or Forsyth counties.

http://www.dell.com/content/topics/global.aspx/corp/foundation/en/index?c=us&l=en&s=corp

Foundation For The Carolinas

The Foundation offers competitive grants and grantmaking programs. Grants are made only to these North Carolina counties: Cabarrus, Cleveland, Davidson, Iredell, Lincoln, Lexington, Mecklenburg, Richmond, Rowan, Stanly, and Union.

http://www.fftc.org

Gladys Brooks Foundation

The Gladys Brooks Foundation was created to provide for the intellectual, moral, and physical welfare of the people of the United States. It establishes and supports nonprofit libraries, educational institutions, hospitals, and clinics. North Carolina is one of 17 states and the District of Columbia that are regularly funded by the Foundation.

http://www.gladysbrooksfoundation.org

Golden LEAF Foundation

The Golden LEAF Foundation receives one half of the funds coming to North Carolina from the Tobacco Master Settlement Agreement. Priority for grants is given to tobacco-dependent and economically distressed counties. Golden LEAF supports programs to improve health care and other social services needed to maintain the stability of tobacco-dependent communities.

http://goldenleaf.org

Mary Reynolds Babcock Foundation

The Foundation places special emphasis on community-building that seeks to assure the well-being of children, youth, and families. It supports programs that bridge the fault lines of race and class and that invest in communities' human and natural resources over the long term.

http://www.mrbf.org

North Carolina Community Foundation (NCCF)

NCCF operates at a grass-roots level through a network of affiliates active in 64 counties across the state. Affiliates work within their communities to establish their own endowment funds to support a broad range of charitable needs including health and human services. The Foundation also makes grants from multiple funds.
http://nccommunityfoundation.org/index.php

Examples of NCCF member affiliates are included below. A complete list of affiliates is available at http://www.nccommunityfoundation.org/04__affiliates.php.

Community Foundation of Greater Greensboro

Grants are awarded in areas including community development and health and human services. They are determined based on the merit of the program and its potential impact. Grants vary in size, duration, and frequency. They usually range in size from a few hundred dollars up to $10,000. Larger grants may be considered on rare occasions.
http://www.cfgg.org

Community Foundation of Western North Carolina

The Foundation helps develop local funds that address changing needs and opportunities in the 18 counties of Western North Carolina.
http://www.cfwnc.org

Triangle Community Foundation

The Foundation is a publicly supported nonprofit organization serving Wake, Durham, Orange, and Chatham counties. It assists donors in creating personal charitable funds to meet the needs of the community.
http://www.trianglecf.org

North Carolina GlaxoSmithKline Foundation

The Foundation supports activities in North Carolina that help meet current and future educational and health needs. It does not generally provide funds to programs that benefit a limited geographical region, but may make an exception when a program has the potential to be duplicated on a larger scale.

http://us.gsk.com/html/community/community-grants-foundation.html

North Carolina Healthy Start Foundation

Healthy Start is funded by the NC General Assembly in partnership with the North Carolina Department of Health and Human Services. Healthy Start conducts statewide efforts to decrease infant mortality by promoting healthy pregnancies and child health.

http://www.nchealthystart.org

North Carolina Medical Society Foundation

The Foundation is the philanthropic arm of the North Carolina Medical Society. The Foundation works to locate primary care practitioners in North Carolina's rural and underserved communities, improve the health care infrastructure of needy communities, and lower the cost of health care while improving quality.

http://www.ncmsfoundation.org

Community Practitioner Program (CPP)

The CPP assists local communities, state agencies, and other health care organizations in recruiting talented primary care practitioners. The program provides assistance to physicians, physician assistants, and family nurse practitioners in return for service in an underserved community. This assistance may include partial relief for educational debts, practice management assistance, and other incentives.

PractEssentials

PractEssentials provides technical assistance to CPP professionals to support and improve their practice. The goal is to improve the practices' quality, efficiency, and finances so that practitioners can continue to serve underserved populations.

Sisters of Mercy North Carolina Foundation

The Foundation supports the work of selected nonprofit health care, educational, and social service organizations. It seeks to assist projects designed to improve the quality of life for women, children, the elderly, and the poor. Special attention is focused on promoting system change.

http://www.somncfdn.org

United Way of North Carolina

United Way of North Carolina is a statewide organization providing member support services to 63 local and independent United Ways covering 85 counties in North Carolina. United Ways are autonomous independent nonprofit organizations that are governed by local volunteers. United Ways have similar missions to solicit local resources and develop community partnerships to support nonprofit organizations that make a measurable difference in people's lives. The goal of local United Way organizations is to help solve community problems. Details of local resources can be found on the web site.

www.unitedwaync.org

Wachovia Foundation

The Wachovia Foundation makes grants in North Carolina. One of the secondary focus areas of the Foundation is the support of health and human services that help build strong and vibrant communities. As part of this health care focus, the Wachovia Foundation will consider grants that ensure access to quality health care or health education programs.

http://www.wachovia.com/inside/page/0,,139_414_430,00.html

Warner Foundation

Strong preference is given to applicants and projects that provide new opportunities for economic independence for disadvantaged populations. It also supports projects which create partnerships between people of different ethnicities and economic classes. Projects should focus on self-sufficiency, encourage mutual problem-solving, demonstrate a long-term commitment to a particular community, and provide measurable indicators of success.

http://www.thewarnerfoundation.org

Winston-Salem Foundation

The Winston-Salem Foundation provides grants to charitable organizations serving the greater Forsyth County area. Grants may focus on children and families, education, health and well-being, arts and culture, and community improvement.

http://www.wsfoundation.org

Z. Smith Reynolds Foundation

The Z. Smith Reynolds Foundation is a private, general purpose foundation with the mission of improving the quality of life of the people of North Carolina. The Foundation focuses on programs or organizations that accomplish progressive policy change and/or systemic reform, especially those that have multi-county or statewide impact. The Foundation also focuses on innovative, community-based projects within the Foundation's focus areas, with an emphasis on reaching low-resource and/or rural regions in the state and low-income populations. Although health is not a specific area of focus, the Foundation will consider requests that among other targets, help to ensure equal access to government and community services, reduce adolescent pregnancy, and benefit the people of the state of North Carolina.

http://www.zsr.org

National Philanthropies that Focus on Health Care Grantmaking

Aetna Foundation

The independent philanthropic arm of the Aetna Company, the Foundation helps build healthy communities by encouraging volunteerism, forming partnerships, and funding initiatives that improve the quality of life where Aetna employees and customers live and work.

http://www.aetna.com/foundation

Bank of America Foundation

The Foundation's main funding priorities in North Carolina are for programs concerned with health and human services with an emphasis on United Way support. http://www.bankofamerica.com/foundation/index.cfm

Cisco Foundation

The Cisco Foundation funds organizations in the community that provide education, organize community service, or meet basic human needs. The Foundation focuses on programs that develop new ideas and try to make lasting positive change. A grant provides networking products and technology to eligible nonprofit organizations.

http://www.cisco.com/web/about/ac48/about_cisco_cisco_foundation.html

The Commonwealth Fund

The mission of the Commonwealth Fund is to promote a high-performing health care system. Such a system will achieve better access, improved quality, and greater efficiency. Target populations include people with low incomes, the uninsured, minority Americans, young children, people with disabilities, and the elderly.

http://www.cmwf.org/programsgrants/programsgrants.htm

Eli Lilly Foundation

The Eli Lilly Foundation provides funding that focuses on public policy research, health and human services in designated areas, and academic relations. Their health and human services funding generally supports groups that work in the areas of mental illness (particularly depression and schizophrenia), endocrinology (particularly diabetes and osteoporosis), oncology, cardiovascular care, infectious diseases, and postmenopausal women's health.

http://www.lilly.com/products/access/foundation.html

The Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation is the largest philanthropic organization devoted to improving health and health care. It supports training, education, research, and projects that achieve effective delivery of health care services. Rather than paying for individual care, the Foundation concentrates on health care systems and the conditions that promote better health. Their funding priorities include vulnerable populations, health insurance coverage, quality health care, reduction of disparities, and public health.

http://www.rwjf.org

The W.K. Kellogg Foundation

The Foundation's health programming focuses on supporting a strong health care safety net, improving the quality of health and the quality of health care services provided to vulnerable people and communities, and building health leadership in diverse populations.

http://www.wkkf.org

Appendix C
Detailed Descriptions of Safety Net Provider Types

Care+Share NC
Community Care of North Carolina
Federally Certified Rural Health Clinics
Federally Qualified Health Centers
Federally Qualified Health Center Look-Alikes
Free Clinics
HealthNet
Hospital Outpatient Clinics and Centers
Project Access
Public Health Departments
School-Based or School-Linked Health Centers
State-Funded Rural Health Centers

Care+Share

The Duke Endowment established Care+Share in 2007 to support community collaborations that expand health care services for low-income uninsured individuals.[1] Care+Share projects should offer primary care, specialty services, ancillary services, hospitalization, medications, care management, and disease management for low-income individuals. Both Care+Share and HealthNet funding will be used to support community-based collaborations that are similar to Project Access models (see Project Access). However, Care+Share funding is limited to community collaborations that involve local hospitals.

Criteria

To be eligible for funding, the program/community should meet the following requirements:

- Targeted to communities with the greatest unmet needs.
- Collaboration must include the local hospital.
- Care+Share grant funds may not be used to supplant other funding sources for current program operations.
- The program should cover uninsured people with incomes under 200% of the Federal Poverty Guidelines. Uninsured individuals must first be screened to determine if they are eligible for Medicaid or NC Health Choice.
- The collaborative must provide enrolled individuals access to a primary care medical home as well as needed specialty care, ancillary services (x-ray labs), hospital care, and pharmacy services. Primary care services may be offered through an existing safety net organization.

1 The name of this initiative – Care+Share – may be changed in the future.

- The collaborative must provide access to care/disease management services to help patients with chronic illnesses manage their health problems.
- The collaborative must engage in a quality improvement effort using evidence-based care.
- The collaborative must be patient and family centered.
- Care+Share grantees must submit periodic reports to the program office.
- Care+Share grantees must have a business plan for long-term sustainability after grant funds run out.

Services

- Primary care, including preventive health services
- Specialty services
- Ancillary services (including lab and x-ray)
- Hospitalization
- Pharmacy services
- Disease and care management

Governance

The governance structure should include representatives from primary care providers, specialty care providers, local health department, free clinics and safety net providers, local hospitals, department(s) of social services, dentists, medication assistance programs, and the local management entity (LME).The governance structure is encouraged to include representatives from schools, religious groups, community organizations, Area Health Education Centers (AHEC) Programs, Healthy Carolinians, and the uninsured.

Structure

Care+Share grantees must include the active participation of at least one local hospital. There are no other requirements on how Care+Share programs have to be structured.

Funding

Care+Share is funded through The Duke Endowment. Initially, grants will be administered through the North Carolina Hospital Association (NCHA) and the NC Foundation for Advanced Health Programs (NCFAHP). In future years, a portion of The Duke Endowment funds will be used to create a new program office that will offer technical assistance to support community-based systems of care for low-income uninsured individuals.

Advantages/Disadvantages

Advantages	Disadvantages
■ Uses existing health care assets and resources	■ Service area must have enough providers willing to volunteer
■ Provides coordination to ensure volunteer services go to those most in need	■ Program must have a system to provide pharmaceuticals for the uninsured seen by private providers
■ Helps meet health care needs that existing safety net organizations are unable to address (eg, specialty referrals)	■ Funding may be needed to pay administrative costs or buy medications

Additional Information

- NC Foundation for Advanced Health Programs: call 919-821-0485 or contact Allen Feezor (allen.feezor@ncfahp.org) or Tork Wade (torlen.wade@ncfahp.org)
- NC Hospital Association: contact Jeff Spade at 919-677-4223 or jspade@ncha.org

Community Care of North Carolina

Community Care of North Carolina (CCNC) is a program that began in July 1998. The program was created to help manage the care of the Medicaid population. CCNC helps identify patients with chronic or high-cost health conditions. It provides these patients with services and supports to help them manage their health problems. CCNC has helped reduce the need for high-cost interventions for people with chronic health problems. Providers work together to develop the care management systems and supports needed to deliver improved quality, access, and cost-effective care. Many communities use the local CCNC network as the framework to implement programs that improve access to health care services for the uninsured population. There are 14 CCNC networks that cover the entire state.

Criteria

The CCNC program has the following features:

- *Partnership.* A network of community physicians, hospitals, health departments, and social services departments work together to meet the health needs of local Medicaid patients. The program is a state/local partnership in which the state provides resources, information, and technical support to help CCNC networks deliver and manage patient care.
- *Population Health Management Approach.* Under a population health management approach, networks address the overall health of patients by proactively managing their care. Tools such as risk stratification, disease management, case management, and access management are used to set up the care management systems and support services needed to improve patient care.
- *Accountability.* All CCNC networks work together and with the state to define, track, and report performance measures that evaluate the effectiveness of participating networks in achieving quality, utilization, and cost objectives.

Services

Providers are expected to manage the care of the patient population. They provide preventive services, case management, and patient education.

All networks in CCNC participate in the following initiatives:

- Asthma Disease Management
- Diabetes Disease Management
- Emergency Department Initiative (seeks to decrease nonurgent emergency department visits)
- Pharmacy Initiative (improves quality and reduces costs of medication)
- High-Cost/High-Risk Patients Initiative (identifies and manages care of this Medicaid population)
- Heart Failure Management

In addition, some networks have chosen to implement special initiatives based upon the needs of their local population. These initiatives include:

- Assuring Better Child Development (identifies and refers children ages 0-5 with developmental delays for early intervention)
- Chronic Obstructive Pulmonary Disease Management
- Gastroenteritis Initiative (addresses gastrointestial management in children)
- Otitis Media Initiative (educates parents on appropriate treatment options for ear infections)
- Projects with Public Health (current projects seek to decrease the rate of low birth weight infants and improve self-management efforts for people with diabetes)
- Diabetes Disparities Project (seeks to improve care of diabetic patients in minority populations)
- Medical Home and Emergency Department Communication Initiative (promotes the medical home concept and seeks to reduce emergency department use for pediatric patients)

Governance

Each local CCNC network is a separate non-profit 501(c)(3) organization.

CCNC is supported by the Office of Rural Health and Community Care and the Division of Medical Assistance, within the NC Department of Health and Human Services. The NC Foundation for Advanced Health Programs and Office of Rural Health and Community Care help provide direction, administration, and technical assistance to local networks.

Structure

CCNC operates through networks of community providers who work together to improve care for their patient population. At a minimum, each CCNC network must include primary care providers, safety net organizations, local hospital(s), social services departments, and public health departments.

Funding

Medicaid pays providers $2.50 per member per month to serve as the medical home for the Medicaid patients. In addition, networks receive an additional $3.00 per member per month to provide disease management and case management services for people with chronic or high-cost health problems.

Staffing

CCNC networks are community partnerships involving physicians, safety net organizations, hospitals, social services departments, public health departments, and other community providers.

Advantages/Disadvantages

Advantages	Disadvantages
■ Coordinated network of health providers and social services agencies focus on the healthcare needs of low-income underserved populations ■ CCNC networks cover the entire state, including rural communities which lack healthcare providers ■ Focused on quality improvement and managing the care of patients with chronic health problems	■ CCNC networks are primarily focused on improving care to Medicare recipients, and do not have as many resources to expand care to the uninsured.

Additional Information

- Community Care of North Carolina: http://www.communitycarenc.com

Federally Certified Rural Health Clinics

Federally certified rural health clinics (RHCs) provide primary care services for Medicaid and Medicare patients in rural communities. There are no federal requirements regarding care to the uninsured.

Criteria

To be federally certified, rural health clinics must:

- Serve a HPSA or MUA
- Be located in a nonurban area
- Be under the medical direction of a physician who is required to be on-site once every two weeks
- Provide a minimum of six basic lab tests on-site
- Must serve Medicare and Medicaid recipients
- Meet Medicare and Medicaid regulations for health and safety requirements
- Comply with all applicable state, local, and federal requirements

Services

Federally certified RHCs must offer the following services:

- Primary care
- Routine diagnostic and therapeutic services including basic laboratory services
- Referrals to providers and suppliers participating in the Medicare and Medicaid programs for medically necessary services that the RHC does not provide (eg, inpatient hospital care, specialty services, additional laboratory services)

Governance

There are no specific requirements.

Structure

Federally certified RHCs may be private, for-profit, nonprofit, or publicly owned.

Funding

Federally certified RHCs receive enhanced Medicaid and Medicaid funding. These payments are generally higher than what private providers receive for the same services. However, unlike FQHCs or state-funded rural health clinics, federally certified RHCs receive no additional funds to help pay for services to the uninsured. Like private physician practices, most federally certified RHCs rely on reimbursement from commercial insurers, Medicare, and Medicaid to fund clinic operations.

Staffing

Federally certified RHCs must be staffed by at least one nurse practitioner, physician assistant, or certified nurse midwife for 50% of the time the clinic is open.

Advantages/Disadvantages[2]

Advantages	Disadvantages
■ No competitive grant process ■ Ownership can be private, public, or nonprofit ■ Can be certified as an RHC at any time ■ Receives enhanced reimbursement for Medicare and Medicaid covered services	■ No federal grant money for uninsured patients or operational expenses ■ The Medicare RHC cap (maximum rate per visit) is lower than the FQHC rural cap ■ RHCs do not receive the enhanced reimbursement rate for Medicare beneficiaries enrolled in a Medicare Advantage Plan

Additional Information

- Rural Health Center see *Starting a Rural Health Clinic: A How-To Manual* at ftp://ftp.hrsa.gov/ruralhealth/RHCmanual1.pdf
- National Association of Rural Health Centers: http://www.narhc.org

2 Romm C, Martell M, Murphy M. Building access to community health services. The Center for the Health Professions, University of California at San Francisco. http://www.futurehealth.ucsf.edu/pdf_files/Electronic%20Toolkit.pdf. Accessed July 12, 2006.

Federally Qualified Health Centers

Federally qualified health centers (FQHCs) are public or private nonprofit organizations that receive funds from the US Bureau of Primary Health Care under section 330 of the Public Health Services Act.[3] FQHCs include the following type of organizations:

- Community health centers (23 in NC in 2007)
- Migranthealth centers (7 in NC)
- Health care for the homeless (4 in NC)
- Public housing primary care
- Healthy schools, healthy communities (3 in NC)

An FQHC can also be operated as part of a government agency such as a local health department. However, they must still meet all the other FQHC criteria (see below).

3 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) (Consolidated Health Centers Act of 1996).

Criteria

Health centers must satisfy certain basic criteria in order to be designated as an FQHC and receive federal funding. Health centers must:

- Serve a MUA or MUP based on poverty and population health indicators
- Provide comprehensive primary and preventive health care services either directly or by contract regardless of ability to pay
- Provide enabling and support services to improve access to health and social services (eg, case management, outreach, transportation, interpreters)
- Have a community-based board of directors with a majority of board members active users of center services
- Have a schedule of fees similar to local health care rates
- Apply a sliding fee scale based on patient income and family size
- Provide 24-hour/7-day coverage and offer clinic hours outside the 9 to 5 work schedule
- Have a quality assurance program

Services

FQHCs are required by federal statute to provide:[4]

- Primary medical care
- Diagnostic laboratory and radiological services
- Preventive services including prenatal, perinatal, and well-child services
- Cancer and other disease screening
- 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
- Pharmaceutical services
- Enabling services such as case management, translation, or transportation

4 North Carolina Community Health Center Association. Federally qualified health centers. http://www.ncchca.org/files/legislative-advocacy/chcs%20at%20a%20glance%202006_mar06.pdf. Published April 26, 2006. Accessed .

Governance

A majority of the board of directors (at least 51%) must be registered users of the health center. This requirement helps ensure that the FQHC meets the health care needs of the community.[5] The board must meet at least once a month.

Structure

FQHCs are public or private nonprofit 501(c)(3) organizations.

Support for Start-up Costs

Up to $650,000 can be requested under PHS 330 for a start-up clinic.

Annual Budget

The range is between $300,000 to $4.5 million.

Funding

FQHCs receive federal grant funding from the US Bureau of Primary Health Care. They also qualify for enhanced reimbursement from Medicaid and Medicare, which is higher reimbursement than other private providers receive for the same services. In North Carolina, federal grants account for 32% of total revenue, Medicaid accounts for 27%, and Medicare accounts for 14% of total revenue.

Staffing

FQHCs are required to have a core staff of full-time providers, but no definition of core staff is provided. A staffing level that allows for between 4,200-6,000 visits per year for each full-time equivalent health care provider is recommended.

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5 Rural Assistance Center. FQHC frequently asked questions. http://www.raconline.org/info_guides/clinics/fqhcfaq.php#staffing. Revised July 12, 2006. Accessed .

Advantages/Disadvantages[6]

Advantages	Disadvantages
■ Receives federal funding to expand access to health care services to underserved populations	■ Highly competitive, complicated grant application process
■ Receives cost-based reimbursement for services provided to Medicare patients and enhanced reimbursement for Medicaid patients	■ Competitive grant reapplication every 3-5 years
■ Can participate in the Public Health Service Act Section 340B Drug Pricing Program (which offers significantly reduced pharmacy costs)	■ Annual Financial Status Report (FSR) required
■ Can access free medical malpractice insurance under the Federal Tort Claims Act (FTCA)	■ Performance review conducted by the US Bureau of Primary Health Care at least every five years
■ Has access to US Bureau of Primary Health Care technical assistance	■ Higher level of staffing, both clinical and administrative, necessary to meet requirements
■ Can access the federal Vaccines for Children Program	■ Board must be comprised of at least 51% users of the clinics
■ Can request up to $650,000 start-up funding	■ No opportunity to adjust federal grant award to meet increased demands

6 Romm C, Martell M, Murphy M. Building access to community health services. The Center for the Health Professions, University of California at San Francisco. http://www.futurehealth.ucsf.edu/pdf_files/Electronic%20Toolkit.pdf. Accessed July 12, 2006.

Additional Information

- *So You Want to Start A Health Center…? A Practical Guide for Starting a Federally Qualified Health Center*:
  http://iweb.nachc.com/downloads/products/05_start_chc.pdf
- North Carolina Community Health Center Association:
  http://www.ncchca.org
- US Bureau of Primary Health Care:
  ftp://ftp.hrsa.gov/bphc/docs/1998PINS/PIN98-23.PDF

Federal Qualified Health Center Look-Alikes

Federal Qualified Health Center Look-Alikes (FQHC-LAs) are public or private nonprofit organizations that provide primary health care and support services. They have the same criteria, structure, and governance requirements of an FQHC (see above). However, they do not receive federal grant funding from the US Bureau of Primary Health Care. They are eligible for enhanced Medicaid and Medicare reimbursements, and may participate in the federal prescription drug discount program (340B). The Look-Alike designation requires an annual recertification from the Bureau of Primary Health Care and the Centers for Medicaid and Medicare Services. Due to restricted funds and competitiveness of the Section 330 grant process, a Look-Alike designation may provide some of the benefits of FQHCs while laying the foundation to successfully compete for federal funding.

Free Clinics

Free clinics are designed to meet the health care needs of the low-income uninsured. To be covered under the Free Clinics Federal Tort Claims Act, free clinics must rely on community support through volunteers and donations. Free clinics tap into the willingness of health care providers and other members of the community to volunteer their time and resources.

Services

Services provided by free clinics vary, but may include:

- Basic primary care
- Preventive services
- Health education
- Case management
- Nutrition counseling
- Chronic disease management (eg, diabetes and hypertension)
- Pharmaceutical services (on-site pharmacy or voucher system with local pharmacies)
- Dental services (dependent upon volunteer dentists)

Access to free clinics also varies:

- Most clinics have limited hours of operation. Some are open only one or two nights a week. Others offer multiple day and night clinics. Few free clinics provide 24 hour/7 day coverage.
- Some clinics provide services on a first-come, first-serve basis. Other require appointments.

Free clinics are generally unable to guarantee continuous and comprehensive primary care services or a medical home with a specific provider.

Governance

Free clinics have a volunteer board of directors that represent a broad cross-section of the community.

Structure

Free clinics are public or private nonprofit, usually 501(c)(3), organizations.

Funding

Free clinics receive no federal or state funding. They do not bill third-party payers such as insurance companies. Free clinics are supported primarily by cash and in-kind donations received from individuals, churches, businesses, hospitals, United Way, and foundations.[7]

Staffing

Free clinics rely on health professionals and other community members to volunteer their time and services. Health care providers may include doctors, nurse practitioners, physician assistants, social workers, pharmacists, dentists, mental health providers, chiropractors, and others.

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7 Fleming O, J Mills. Free clinics in North Carolina: a network of compassion , volunteerism, and quality care for those without health care options. *NCMedJ*. 2005;66(2):127-129. http://www.ncmedicaljournal.com/mar-apr-05/FlemingMills.pdf. Accessed July 9, 2007.

Advantages/Disadvantages

Advantages	Disadvantages
■ Custom designed by communities to meet identified health care needs ■ Uses existing community health care assets and resources	■ Typically offers limited services ■ Has limited hours of operation ■ Relies on volunteers and donations ■ Does not generally provide continuous and comprehensive primary care services ■ Is more difficult to organize in communities with a lack of health care

Additional Information

- North Carolina Association of Free Clinics: http://www.ncfreeclinics.org/mc/page.do
- Volunteers in Medicine: http://www.vimi.org/starting.shtml

HealthNet

The North Carolina General Assembly appropriated one-time funding in 2007 to establish HealthNet. Grant funding is available to help support local networks of health care providers that offer primary care, specialty services, ancillary services, hospitalization, medications, and care management and disease management for low-income, uninsured adults. Both HealthNet and Care+Share funding will be used to support community-based collaborations that are similar to Project Access models (see Project Access). HealthNet funding will be used to assist these community-based systems of care to perform core functions including enrollment, assignment to a primary medical home, and coordinated access and referral to services, as well as collaboratively sharing resources, skills, and expertise to improve the overall functioning of the safety net service delivery system.

Criteria

In order to qualify for HealthNet funding, the community collaborative must meet the following requirements:

- The community collaborative must include a Community Care of North Carolina (CCNC) primary care provider network and local indigent care program(s) with a track record of serving the uninsured population through a consortium of local safety net providers.
- HealthNet grant funds may not be used to supplant other funding sources for current program operations.
- The target population for HealthNet is uninsured adults aged 18-64 with incomes at or below 200% of the Federal Poverty Guidelines.

- The collaborative provides enrolled individuals access to a primary care medical home as well as needed specialty care, ancillary services (x-ray labs), hospital care, and pharmacy services.
- The collaborative provides access to care/disease management services to help patients with chronic illnesses manage their health problems.
- The collaborative should engage in quality improvement efforts using evidence-based care. These efforts may be coordinated with disease management and quality improvement efforts provided to the Medicaid population through the CCNC network.
- The collaborative should be patient- and family-centered.
- HealthNet grantees must submit periodic reports to the state.
- HealthNet grantees must have a business plan for long-term sustainability after grant funds run out.

Services

- Primary care, including preventive health services
- Specialty care
- Ancillary services (including lab and x-ray)
- Hospitalization
- Assistance with obtaining prescription medications
- Disease and care management

Governance

The governance structure should include representatives from primary care providers, specialty care providers, local health department, free clinics and safety net providers, local hospitals, department(s) of social services, dentists, medication assistance programs, and local management entity (LME). The governance structure is encouraged to include representatives from schools, religious groups, community organizations, Area Health Education Centers Programs (AHEC), Healthy Carolinians, and the uninsured.

Structure

HealthNet programs must include Community Care of North Carolina networks and existing indigent care program(s) within the community. There are no other requirements on how HealthNet programs have to be structured.

Funding

HealthNet is funded by the North Carolina General Assembly. Funds are administered through the NC Office of Rural Health and Community Care (NCORHCC).

Advantages/Disadvantages

Advantages	Disadvantages
■ Uses existing health care assets and resources	■ Service area must have enough providers willing to volunteer
■ Provides coordination to ensure volunteer services go to those most in need	■ Program must have a system to provide pharmaceuticals for the uninsured seen by private providers
■ Helps meet health care needs that existing safety net organizations are unable to address (eg, specialty referrals)	■ Funding may be needed to pay administrative costs or buy medications

The General Assembly appropriated one-time funding for HealthNet in 2007. Check with the Office of Rural Health and Community Care if your organization is interested in pursuing HealthNet funds.

Additional Information

- Contact Anne Braswell at 919-733-2040 or anne.braswell@ncmail.net

Hospital Outpatient Clinics and Centers

Many hospitals and health systems in North Carolina offer primary care clinics and outpatient centers that are intended to serve the local community. Hospitals may offer these services through rural health clinics, outpatient centers, urgent care clinics, primary care practices, and hospital-based health clinics. Many of these primary care centers and clinics operate in a similar fashion to private physician practices. Academic medical centers with primary care residency training programs also offer and support a wide range of outpatient services.

Criteria

Factors a hospital may consider in deciding whether to offer primary care services include:

- Location in a HPSA or MUA
- Location in a rural or urban setting
- Size of the hospital sponsoring the practice or clinic
- Availability of Medicare and Medicaid cost-based reimbursement
- Location of clinic and distance from main hospital
- Number of patients expected to use the clinic according to demographics, insurance coverage, and health status

Services

Services offered at a hospital sponsored primary care clinic may include:

- Primary care consultation and evaluation by a physician, physician assistant, or nurse practitioner
- Basic diagnostic services (eg, radiology and laboratory)
- Pharmaceutical care
- Screenings, immunizations, vaccinations, physical examinations, and health and wellness checkups
- Health education and disease management

Governance

Governance of hospital-sponsored primary care clinics and outpatient centers is under the control of the hospital's board of trustees. Administration of hospital-sponsored primary care clinics is vested in the hospital's management structure.

Structure

Characteristics of the community and the organization of the hospital are key factors in selecting a primary care clinic model.

Funding

Like private physician practices, most hospital-sponsored primary care clinics rely on reimbursement from insurers, Medicare, and Medicaid to fund clinic operations. In some instances, hospital charity care guidelines and policies may cover patients. Clinics with a special mission to serve certain disadvantaged or uninsured populations usually require special funding programs, grants, or other financial commitments to cover the costs of the clinics.

Staffing

Hospital outpatient services may have part-time or full-time staff to provide medical care. These health professionals may include physicians from various specialties, nurse practitioners, physician assistants, and others.

Advantages/Disadvantages

Advantages	Disadvantages
■ Locating primary care services at or near the hospital can help reduce unnecessary use of the emergency department ■ Hospital may underwrite some of the costs of providing care to the uninsured	■ Services are not always available on a sliding scale and may not be affordable to some uninsured

Additional Information

- The NC Rural Health Center: http://www.ncha.org/about/ (follow NC Rural Health Center link on left side of page).

Project Access

Project Access works with primary care and specialty providers and other health care organizations to increase the services available for low-income uninsured. Project Access models are based on the donation of services by physicians and other health care providers. Project Access staff or other community groups help determine eligibility (based on locally developed guidelines). Eligible individuals are referred to private providers for services that are not available through the traditional health care safety net. Services are most commonly provided for free. Some Project Access models may charge a small fee to help with the administrative expenses. Safety net organizations and private physicians refer patients to the program.

Criteria

Each community sets its own eligibility requirements. Project Access programs often limit coverage to uninsured individuals who meet the following eligibility requirements:

- Are between 18 to 64 years of age
- Have a gross household income that is less than 200% of FPG (some projects have lower income limits)
- Live within a certain county
- Are not eligible for or receiving Medicaid, Medicare, or NC Health Choice

Services

Project Access helps organize local health care providers to offer the following services to qualified individuals:

- Primary care
- Specialty care
- Ancillary services
- Diagnostic services
- Inpatient care
- Medication assistance

Project Access makes reminder phone calls to uninsured patients to reduce appointment no-shows.

Governance

There are no specific requirements, although many operate through the local medical society or hospital.

Structure

There are no specific requirements for how Project Access models are structured. However, many are housed within the local medical society and/or hospital.

Funding

Project Access is financed primarily through donated services and goods. Physicians volunteer their time while health care organizations such as hospitals donate medical services. In addition, some Project Access models receive local funding to support administrative operations and to purchase needed medications. New funding may be available through The Duke Endowment's Care+Share program or HealthNet.

Staffing

Many Project Access models have part-time or full-time staff who help recruit providers, determine patient eligibility, and arrange patient referrals. Some Project Access programs have bilingual staff to assist with language barriers. Providers generally donate their services.

Advantages/Disadvantages

See description of advantages and disadvantages under Care+Share or HealthNet.

Additional Information

- North Carolina Association for Healthcare Access: call 828-274-9337 or visit http://ncahaccess.org
- American Project Access Network (APAN): http://www.apanonline.org

Public Health Departments

Local public health departments provide a wide range of services. They are major sources of health care for the uninsured. However, most health departments do not provide comprehensive primary care.

Criteria

Public health departments must:

- Offer certain categories of core public health services as required by state law
- Provide communicable disease control
- Provide environmental health services
- Maintain vital records registration
- Provide mandated services at no cost to the client
- Provide or contract for certain safety net services if the services are not otherwise available in the community

Services[8]

Services offered by local health departments include (* indicates a mandated service):

General Population Services

- Tuberculosis screening and treatment*
- HIV screening and counseling*
- Sexually transmitted disease clinics*
- Communicable disease screening and treatment*
- Recording of birth and deaths
- Registration of communicable/reportable diseases
- Health education on various health concerns and issues
- Interpreter services available as needed
- Environmental health

8 North Carolina Public Health. *Local Health Department Services*. North Carolina Department of Health and Human Services. http://www.ncpublichealth.com/lhd/lhd.htm. Accessed July 9, 2007.

Maternal and Child Health Services

- Prenatal care (regular and high-risk)
- Maternity care coordination
- Prenatal and child birth classes
- Family planning
- Women, Infants and Children Program (WIC)*
- Immunizations*
- Child health screening
- Child service coordination (case management)

Other services available in some local health departments:

- Dental care for children
- Primary care for children

Adult Health Services

- Blood pressure and blood sugar screening
- Adult immunizations (tetanus, pneumonia, influenza)
- Health promotion and disease prevention activities

Other services available in some local health departments:

- Primary care for adults
- Home health and Medicare-certified skilled intermittent care including in-home registered nursing, home health aides, physical therapy, and occupational therapy
- Dental care

Governance

Under North Carolina laws, most health departments are governed by an 11-member Board of Health appointed by the county commissioners.

Funding

In North Carolina, federal grants represent 15% of public health funding. The state funds 5%. Local governments provide 80% of funding (48% local appropriations, 23% Medicaid revenues, and 29% fees and other revenues). No client is denied services based on ability to pay. However, health departments charge for many services using a sliding scale based on patient income.

Staffing

Health departments have health professional staff members who perform the various services. The health professionals may include doctors, nurse practitioners, physician assistants, social workers, pharmacists, dentists, epidemiologists, nurses, and health educators.

Advantages/Disadvantages

Advantages	Disadvantages
■ Public health departments cover every county in the state	■ Most do not provide comprehensive primary care services
■ Provide some clinical services and may have capacity to expand to cover additional services	■ May require financial support from county commissioners to expand services to the uninsured

Additional Information

- North Carolina Association of Local Health Directors: http://www.ncalhd.org/county.htm

School-Based or School-Linked Health Centers

School-based and school-linked health centers (SBHCs and SLHCs) are designed to eliminate or reduce barriers to health care for children and adolescents[9] by offering services on or near school grounds.

Criteria

School-based health centers must:[10]

- Establish organized relationships with the school, students, parents/guardians, collaborating agencies, primary care providers, and the community
- Provide services that are accessible to all enrolled students
- Provide comprehensive services to all enrolled students
- Provide a safe, accessible, effective, and efficient environment of care consistent with their mission, services, and laws/regulations

9 The Center for Health and Health Care in Schools. State Resources – North Carolina. Quality Standards for School-Based Health Centers in North Carolina, Access Standard I. School of Public Health and Health Services, The George Washington University Medical Center. http://www.healthinschools.org/sr/states/NC/NC-quality.asp. Accessed July 11, 2007.

10 National Assembly on School-based Health Care. North Carolina School-Based Health Centers Credentialing Standards and Evidence of Performance (abbreviated). http://www.nasbhc.org/APP/NC_Certification_Standards.htm. Accessed July 11, 2007

Services

Services may include:

- Medical care for acute illness
- Emergency services for injuries
- Preventive health services
- Mental/behavioral health evaluation and treatment
- Administration of medication
- Chronic disease management
- Laboratory testing
- Health education
- Nutrition services
- Dental care
- Special needs services
- Referrals to local providers

Governance

While there is no specific governance requirement, SBHCs have advisory boards. SLHCs have a separate board of directors. Suggested members of the advisory board include parents, students, school staff, clinic staff, community members, and representatives from the sponsoring organization.

Structure

SBHCs are sponsored by a variety of organizations including community health centers, health departments, hospitals, and nonprofit community-based organizations

Funding

SBHCs are eligible for Medicaid reimbursement and State Children's Health Insurance Program (SCHIP) payments as well as reimbursement from other third-party payers.

Staffing

Comprehensive services must be provided by a multi-disciplinary team of professionals. Recommended staff members include a registered nurse, nurse practitioner/physician assistant, mental health professional, health center manager, nutritionist, and clerical staff. Other staff positions may include health educator, community outreach coordinator, mental health supervisor, dentist, or dental hygienist. Physician back-up, as required by state law, must be available for mid-level practitioners.

Advantages/Disadvantages

Advantages	Disadvantages
■ Offers services where children are located ■ Services are targeted to meet the healthcare needs of children and adolescents ■ May help improve school performance by addressing children's underlying health needs	■ Services may be limited during nonschool hours or school vacations ■ Requires support of local schools ■ Some services may be unavailable in a school setting

Additional Information

- North Carolina section of the Center for Health and Health Care in Schools: http://www.healthinschools.org/sr/states/NC/NC-guidelines.asp

State-Funded Rural Health Centers

State-funded rural health centers (RHCs) provide much needed access for underserved populations who may not receive health care due to economic barriers. Funding is provided through the Medical Access Plan to offset the cost of services to low-income uninsured patients.

Services

State-funded rural health centers are required to offer:

- Primary care
- Routine diagnostic and therapeutic care including basic laboratory services
- Referrals to providers and suppliers participating in the Medicare and Medicaid programs for medically necessary services that the RHC does not provide (eg, inpatient hospital care, specialty services, additional laboratory services)

While not legally obligated to do so, some state-funded RHCs may provide include dental, behavioral health, or enabling services.

Governance

State-funded RHCs are non-profit organizations with a local board of directors. Unlike FQHCs, a majority of board members do not have to be users of the center.

Structure

State-funded rural health centers must be nonprofit 501(c)(3) organizations.

Funding

State funding may be provided through the Medical Access Plan (MAP) to help pay for services to uninsured patients with incomes less than 200% of Federal Poverty Guidelines (FPG). Patients pay a small co-payment based on income. State-funded RHCs with federal certification receive enhanced Medicare and Medicaid reimbursement.

Staffing

There are no special staffing requirements, unless the state-funded RHC is also seeking federal certification status. In that event, the state-funded RHC must meet the staffing requirements for federally certified RHCs.

Advantages/Disadvantages

Advantages	Disadvantages
■ Additional state funds are available to pay for services provided to low-income uninsured patients ■ Medicare and Medicaid enhanced reimbursement is available if the state-funded rural health center is federally certified	■ State funding is limited and may not be available to support new state-funded rural health centers or pay for all the care provided to the uninsured

Additional Information

- NC Office of Rural Health and Community Care: call 919-733-2040

Glossary

340B Drug Pricing Program: This federal program provides access to reduced price prescription medications. 340B discounted pharmacy pricing is limited to eligible safety net organizations and public health agencies.

Access: The ability of people to obtain needed health care services. Certain factors can impact whether a person can access needed services, such as office location and hours of operation, distance to needed services, availability of transportation, and the cost of services.

Acute care: Short-term health care services provided to treat an illness or injury. Acute care services are generally provided on an outpatient basis (eg, in a physician's office, clinic, or emergency department). Acute care is different than preventive services or chronic care (see definitions below).

Ancillary services: Supplemental health care services used in conjunction with medical or hospital care for the diagnosis and treatment of health conditions. Ancillary services may include services such as lab work, x-rays or other diagnostic imaging, and physical therapy or other forms of rehabilitation services.

Behavioral health services: Services provided for the evaluation, diagnosis, or treatment of mental health and substance abuse disorders.

Care+Share: A network of existing safety net organizations, local hospitals, and private providers who collaborate to provide primary care, specialty and diagnostic services, behavioral health services, hospitalizations, medications, and dental care to the low-income uninsured.

Case management: Services provided to help patients obtain and coordinate needed health services. Case managers may also help patients obtain enabling services (see definition below) or obtain other needed services in the community. Case management services are typically provided to individuals with complex or chronic health conditions or with high-cost health problems. Case management services may be provided directly by a health care provider or by a separately trained case manager.

Comprehensive services: Full range of health care services for the diagnosis, treatment, follow-up, and rehabilitation of patients. Some safety net organizations are able to provide a complete array of services including primary and specialty care, hospitalizations, pharmaceuticals, and access to enabling services. Other safety net organizations can offer less comprehensive primary care including preventive, acute, and chronic care management, but may not be able to offer specialty services or hospitalizations. Other safety net organizations offer more limited services, often restricted by hours of operation or by type of clinical service.

Chronic care: Health care and treatment for individuals with long-term, continuing health problems (eg, asthma, congestive heart disease, depression, diabetes, hypertension). Chronic care is delivered in both outpatient and inpatient settings. Chronic care services often include patient self-management, so that patients can learn to monitor and manage their own chronic health problems more effectively.

Community Care of North Carolina (CCNC): The CCNC program supports networks of physicians, hospitals, and public agencies that collaborate to meet the health care needs and improve the quality of health care provided to Medicaid recipients.

Cost-based reimbursement: Payments made by a health plan or insurer to providers based on the actual costs incurred in the delivery of care and services. Under federal law, Medicare and Medicaid must pay certain safety net providers including rural health clinics, federally qualified health centers, and critical access hospitals, a modified cost-based reimbursement. Most other insurers have stopped using cost-based reimbursement. More common reimbursement arrangements include prospective payments (for hospitals or nursing facilities), fee-for-service, or a fee schedule for health care professionals (see definitions below).

Emergency medical condition: A health problem that would place the person in serious jeopardy or cause serious impairment to bodily functions or bodily organs in the absence of immediate treatment. Labor and delivery is also considered an emergency medical condition. Under North Carolina law, the state uses a "prudent layperson" definition of an emergency medical condition. Thus, a health condition is considered an emergency medical condition if a reasonable person, possessing an average knowledge of health and medicine, thinks that the health problem would place the person in serious jeopardy absent immediate medical attention.

Emergency services: Health care services that are needed to screen for or treat an emergency medical condition until the condition is stabilized. Under federal law, all hospitals that participate in Medicare are required to screen any individual who comes to the emergency department requesting treatment for an emergency medical condition, regardless of ability to pay. If the hospital determines that the person does have an emergency medical condition, the hospital must treat the patient or stabilize the person and transfer the patient to another hospital.

Enabling services: Services that reduce barriers to health care by helping patients access needed services. Some of the more common enabling services include transportation (to help people travel to health providers), case management, interpreters, patient education, and outreach.

Environmental health services: Services that plan for, identify, and respond to potentially harmful environmental conditions that might impact the health of the general public or a specific patient subpopulation. Environmental health services include, but are not limited to, inspection of food or wells or public water systems, regulation of landfills, and monitoring of the discharge of certain pollutants into the environment.

Federal Poverty Guidelines (FPG): The FPG are issued annually by the US Department of Health and Human Services and are used to determine eligibility for certain federal programs. FPG vary by family size.

Federally Qualified Health Center (FQHC): Federally funded FQHCs provide comprehensive primary care, behavioral health services, and dental services to uninsured or medically underserved populations in medically underserved areas. Community health centers and migrant health centers are examples of FQHCs.

Federally Qualified Health Center Look-Alike (FQHC-LA): An FQHC-LA provides similar services to the same populations as an FQHC, but does not receive federal grant funding. An FQHC-LA does participate in other FQHC benefits.

Federally Funded Rural Health Clinic: Federally funded RHCs provide basic primary care to Medicaid and Medicare recipients in medically underserved areas or health professional shortage areas. Federally funded RHCs are not required to serve the uninsured population, but many do so.

Fee-for-service: Payments to providers based on the specific services rendered. Under a fee-for-service system, the provider is paid each time he or she provides a different service. Fee-for-service reimbursement schedules are often based on a percentage of the provider's charges.

Fee schedule: A provider reimbursement system that pays providers according to a fixed fee schedule established by an insurer, HMO, or government. Medicaid and Medicare typically pay health care professionals using a preestablished fee schedule.

Free Clinic: Free clinics provide basic primary care and preventive services to low-income uninsured people. Free clinics rely heavily on the willingness of health care providers and other community members to donate their time and services to meet the health care needs of the uninsured.

Health disparities: Differences in health status, service utilization, or quality of care that exist between specific groups within a larger population. Health disparities can exist based on gender, race, ethnicity, geography, socioeconomic status, or a combination of different factors.

Health indicators: Measures of individual behaviors and physical and social factors that affect the health of individuals or groups. Health indicators may include access measures (eg, the ability to obtain needed medical, pharmacy or dental services or the number of people admitted to a hospital with preventable health conditions), health risk measures (eg, percent of people who exercise regularly at least three times a week or percent of people who have smoked in the last 30 days), or health status measures (ie, percent of people with cancer, diabetes, or heart disease).

Health literacy: The ability of people to understand and communicate health information in order to make informed choices about medical care to reduce health risks and to improve quality of life.

Health Professional Shortage Area (HPSA): To qualify as a HPSA an area must have fewer than one full-time primary care physician for 3,500 people. In areas with high levels of poverty or infant mortality or with a high proportion of elderly, the threshold is lowered to one full-time primary care physician for 3,000 people.

Health Resources and Services Administration (HRSA): A federal agency, HRSA, seeks to improve public health and health care systems by improving access to health care for the uninsured, eliminating disparities in access to care, and improving quality of care and health outcomes.

HealthNet: A network of existing safety net organizations, local hospitals, and private providers who collaborate with Community Care of North Carolina to provide primary care, specialty and diagnostic services, behavioral health services, hospitalizations, medications, and dental care to the low-income uninsured.

Hospital Outpatient Services: Similar in operation to private physician practices, many hospital and health care systems provide primary care, diagnostic, preventive, and pharmaceutical services in site-based or remote primary care, community, or urgent care clinics.

Medicaid: A government-financed health insurance program that provides assistance with medical costs for certain low- and moderate-income individuals and families. The federal government sets broad guidelines for the program. The state then establishes the specific eligibility criteria and determines the covered services within the federal guidelines.

Medical Access Plan: The Medical Access Plan provides funding to state-funded rural health centers to cover the costs of primary care services provided to low-income uninsured patients.

Medically Underserved Area (MUA): An MUA is an urban or nonurban area with a quantifiable shortage of primary health care services as determined by the ratio of primary care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over.

Medically Underserved Population (MUP): An MUP is a population group that experiences economic barriers (low-income or Medicaid-eligible populations) or cultural and/or linguistic access barriers to primary health care services. MUP designation is determined by the ratio of primary care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over.

Medicare: A health insurance program for adults age 65 or older and disabled individuals who are eligible for Social Security, Railroad Retirement, or Disability benefits. Medicare has four parts: Part A is hospital insurance, Part B covers the costs of physicians and other providers, Part C expands the availability of managed care arrangements to Medicare recipients, and Part D offers prescription drug coverage.

Medication Access and Review Program (MARP): Used by Medical Assistance Program participants, MARP software connects patients to possible Patient Assistance Programs. A patient or provider enters demographic and health information into the MARP system. The software helps match the individual to potential programs, listing eligibility requirements and providing application forms.

Medication Assistance Program (MAP): MAP awards grants to organizations and agencies that help low-income and uninsured populations identify and apply for low-cost prescription medications through public and private prescription assistance programs.

NC Health Choice: A publicly-funded program that offers free or reduced-cost health insurance for uninsured children from birth through age 18. Uninsured children must have a family income that is equal to or less than 200% of the Federal Poverty Guidelines and must not qualify for Medicaid.

Patient Assistance Programs (PAP): Pharmaceutical companies offer a large number of PAPs which provide free or discounted medications for low-income or uninsured individuals. Eligibility requirements and covered medications vary, and forms are often difficult to complete.

Preventive care services: Services or clinical tests that are provided to reduce the chance of developing a particular health problem. Preventive services are provided to help prevent illnesses or to identify health problems early in the progression of the disease (ie, when it is easier to treat the health problem). Preventive services include, but are not limited to, annual physicals, immunizations, risk counseling, and screenings (to identify cancer, hypertension or other illness or chronic health problem).

Primary care: Comprehensive and coordinated health care provided by a provider who is trained to manage most of a person's health care needs. Primary care practitioners are most often trained in family medicine, general internal medicine, or general pediatrics. Physicians, nurse practitioners, physician assistants, and certified nurse midwives may serve as primary care providers.

Project Access: An initiative that helps organize private health care providers to provide primary care, and specialty and diagnostic services to low-income uninsured people.

Prospective Payment: Reimbursement system in which the rates are set *prior* to the delivery of health services. For example, Medicare and many private insurers pay hospitals using a diagnosis related grouping (DRG) payment. This is a prospective payment system based on the patient's diagnosis. The payment is set based on what the episode of care should cost, regardless of actual expenses incurred.

Provider: A licensed healthcare professional or institution providing health care to patients (eg, physicians, nurses, clinics, hospitals, pharmacies, nursing homes).

Public Health Department: Federal and state-funded health departments typically provide child and maternal health services to low-income and uninsured populations. Some, but not all, public health departments provide comprehensive primary care.

Safety net organizations: Health care organizations that have a mission or legal obligation to provide health care and other related services to the uninsured and underserved, regardless of their ability to pay.

School Based and School Linked Health Centers (SBHC, SLHC): Federal, state, and privately funded SBHCs and SLHCs provide comprehensive primary care, behavioral health services, and health education to children and adolescents on or near a school campus.

Specialty care: Diagnosis or treatment provided by a health care provider that focuses on a specific part or system of the body (eg, heart) or a specific type of disease (eg, diabetes). Specialist clinicians do not typically have first contact with patients; instead, patients are referred to specialists by primary care providers and, less commonly, through self-referral.

State-Funded Rural Health Center: State-funded RHCs provide basic primary care to Medicaid and Medicare recipients and to the uninsured population in nonurban locations. State-funded RHCs receive Medical Access Plan funds to help cover the costs of primary care services provided to low-income uninsured patients.

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