

APPENDIX B

DESCRIPTION OF SAFETY NET ORGANIZATIONS

This appendix describes many but not all types of safety net organizations in the North Carolina. Those included here participated in the Safety Net Workgroup or were referred to in safety net provisions of the ACA.

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.^a In order to be designated as an FQHC and receive federal funding, FQHCs must meet certain basic criteria. They must be located in a medically underserved area (MUA) or serve a medically underserved population (MUP) based on poverty and population health indicators. FQHCs must provide comprehensive primary and preventive health care services either directly or by contract regardless of a person's ability to pay. They must provide enabling and support services to improve access to health and social services (eg, case management, outreach, transportation, and interpretation and translation). FQHCs must have a community-based board of directors with a majority of board members who are active users of center services. They must have a schedule of fees similar to local health rates and apply a sliding fee scale based on patient income and family size. FQHCs must provide 24-hour/7-day coverage and offer clinic hours outside the typical 9 to 5 work schedule. Finally, they must have a quality assurance program and other program criteria.¹ FQHCs receive higher Medicaid and Medicare reimbursements than most primary care providers and can obtain discounted medications through the 340B federal prescription drug discount program (see 340B program expansion section). FQHCs include community and migrant health centers, health centers for the homeless, public housing primary care, and school-based health centers.

In 2011, there were 28 FQHCs in North Carolina delivering care at 150 different sites. There were also three FQHC look-alikes providing services at three clinical sites^b and a Migrant Voucher program that provides grants and reimbursement for clinical and outreach services. FQHCs provided services to 409,709 patients, 52% of whom were uninsured. Ninety-five percent of North Carolina FQHC patients have incomes below 200% of the federal poverty level (FPL), and nearly 75% of them have Medicaid or no insurance. In addition to serving more low income populations, North Carolina FQHCs also serve patients who are more racially and ethnically diverse than the state population.² Compared to other states, North Carolina FQHCs serve a higher proportion of the uninsured (52% NC, 38% US). They also rely more heavily on federal funding and self-pay than FQHCs in other states.^{3,4}

FQHCs in North Carolina are cost-saving. The total cost per FQHC patient was \$490 in 2010. Medical visits are provided at an average cost of \$122 per visit and just \$170 per dental visit compared to \$569 for a hospital emergency department visit. FQHCs brought \$56 million federal

^a Health Centers Consolidation Act of 1996, Pub L 104-299, amending Sec. 330 of the Public Health Service Act, 42 USC 254b.

^b FQHC look-alikes are organizations granted status by the Bureau of Primary Health Care (BPHC) for conforming to the structure and services of an FQHC. They receive no Section 330 grant funding but do receive FQHC Medicaid reimbursement rates and other benefits. Look-alikes do not report their service statistics to the BPHC and their data is not reflected in federal funds brought into the state.

dollars into the state of North Carolina. Health centers have been found to improve health outcomes, reduce health disparities, and lower the cost of treating patients with chronic illnesses.²

Local Health Departments

Public health departments are local government entities required by state law to provide certain core public health services. These services include communicable disease control, environmental health services, and vital records registration. They are a major source of care to the uninsured, but do not provide comprehensive primary care to all populations.¹

There are 85 local public health departments in North Carolina. Of those, 79 are single county health departments while 6 multi-county district health departments cover the other 21 counties. All local public health departments provide child and adult immunizations, STD and HIV/AIDS testing and counseling, TB testing, family planning, and case management. Almost all health departments provide child health clinics, prenatal care, and nutrition services. Half of them provide dental services.⁵ Health departments in North Carolina are more likely to provide clinical services than health departments in other states.⁵⁶ There are 39 local health departments that serve as primary care medical homes and 36 that offer adult primary care services.^c Local health departments are funded largely through county funds, federal grants or Medicaid and NC Health Choice, and state funds. There is an accreditation process to ensure quality and consistency across the state. As of December 2011, 64 local health departments have been accredited.⁷

Free Clinics

Free clinics are nonprofit, usually 501(c)(3), organizations that are governed by local boards of directors. There is not one specific free clinic model, rather they are designed to meet the health care needs of the low-income uninsured in their local communities. Most free clinics offer primary care services and preventive services. The majority of free clinics offer pharmaceutical services through either an on-site pharmacy or a voucher system with local pharmacies. Some free clinics offer limited dental services. Others offer a broader range of supportive services including health education, case management, and nutritional counseling.¹

Volunteers are the cornerstone of the free clinic movement. Health care providers and staff volunteer their time to provide services and support to patients. Services are provided for free to the uninsured with incomes below a certain income threshold; others may be charged on a sliding fee scale. Free clinics generally have more limited hours of operation than regular health clinics. They vary from being open one or two evenings a week to having multiple day and night clinics.¹

There are 79 free clinics in communities across North Carolina. Free clinics served approximately 79,500 patients in 2009, 87,000 patients in 2010, and 94,000 patients in 2011. Primary support for free clinics is through voluntary (donated) professional services and supplies, community fund raising, and the Blue Cross and Blue Shield of North Carolina Foundation. The Blue Cross and Blue Shield of North Carolina Foundation provided \$18 million

^c Reed, J. North Carolina Division of Public Health. Written (email) communication. April 19, 2011.

over eight years to expand and support free clinics through the North Carolina Association of Free Clinics.^{d8}

Rural Health Clinics

State-funded rural health clinics are nonprofit 501(c)(3) organizations with local boards of directors. They are located in geographic areas that do not have enough primary care resources to meet the needs of their communities. Rural health clinics provide primary care and routine diagnostic and therapeutic care, including basic laboratory services, and referrals for medically necessary and specialty services they do not provide. Some rural health clinics also provide dental and behavioral health services or enabling services. They are required to treat Medicaid and Medicare patients and receive cost-based reimbursements. While rural health clinics are not required to treat the uninsured, many of them do provide services to the uninsured.¹

There are 86 certified rural health clinics in North Carolina. Of those, 28 rural health service delivery sites receive state funding from the Office of Rural Health and Community Care to help pay for indigent care. The funding is called the Medical Access Plan (MAP) for indigent patients. In order to receive MAP funding, rural health clinics must have a community board, agree to see the uninsured on a sliding scale basis, and be located in either a health professional shortage area (HPSA) or medically underserved area (MUA). The MAP funding is linked to uninsured patients with incomes below 200% FPL. Almost 65% of rural health clinic patients in North Carolina are uninsured.^e

School-based or School-linked Health Centers

School-based and school-linked health centers are designed to eliminate or reduce barriers to care for students.⁹ A school-based health center is a medical office located on a school campus. A school-linked health center is a free-standing health care center affiliated with schools in the community. School health centers may provide primary care, mental health, acute and chronic disease management, immunizations, medical exams, sports physicals, nutritional counseling, health education, prescriptions, and medication administration. Like other safety net organizations, not all health centers provide each of these services.¹ All centers require parents to sign written consents for their children to receive the full scope of services offered. Centers are monitored by advisory committees to ensure compliance with standards, to evaluate services offered, and to make policy recommendations.¹⁰

There are 55 school health centers serving 22 counties in North Carolina. Most of these are school-based health centers, several are school-linked health centers, and a few health centers operate from traveling vans or buses to serve several schools. They are sponsored by health care organizations such as hospitals, health departments, universities, community health centers, and other non-profit health care organizations. School health centers are also partially funded by the School Health Center Unit in the Children and Youth Branch of the North Carolina Division of

^d The Blue Cross and Blue Shield of North Carolina Foundation funding provides less than \$30,000/year on average to free clinics, which is not enough to pay for one-full time administrative staff.

^e Gilbert R. Primary Care Systems Specialist, Office of Rural Health and Community Care, Department of Health and Human Services. Oral communication. April 12, 2012

Public Health. Like health departments, there is a state credentialing process to provide standards for centers. As of April 2012, 22 school health centers have been credentialed.^f

Other Safety Net Organizations

There are many other organizations that comprise the primary care safety net. Other communities have created non-profit safety net organizations to serve the needs of the uninsured. Examples include Guilford Child Health, Guilford Adult Health, and Alliance Medical Ministries. These organizations often work in partnership or are supported through local medical societies or hospitals. The North Carolina Medical Society Foundation recruits physicians, physician assistants, and nurse practitioners to underserved areas through the Community Practitioner Program. Participating providers must offer primary care services to uninsured patients on a sliding fee scale. The program is funded by the Blue Cross and Blue Shield of North Carolina Foundation, Kate B. Reynolds Charitable Trust, The Duke Endowment, Golden Leaf Foundation, and other private donations. There are currently 41 private providers participating in the Community Practitioner Program in 30 communities across the state.

Specialty Care Referral Management Networks (Project Access Model)

Specialty care is often difficult for uninsured and underserved populations to access. Project Access organizes private providers and hospitals to expand the health care services that are available to low-income uninsured populations. The services offered vary across communities, but most focus on linking patients to volunteer primary care providers, specialists, and other services that are not available through existing primary care safety net providers. Services are typically provided for free or for a small fee. Project Access is financed primarily through donated services and goods, foundations, and other private funding sources. Safety net organizations and private providers often refer patients to the program in their communities. The Project Access model was developed in Asheville in 1996 and spread to 15 communities across the state.¹

Care Share Health Alliance

Created in 2009, the Care Share Health Alliance works with state and local partners to facilitate and foster Collaborative Networks that improve the health of underserved people in North Carolina. A Collaborative Network is an entity comprised of multiple local partners who integrate medical, preventative, community, social, and economic resources to achieve collective outcomes through a coordinated system of care. The network has a shared vision and purpose, and priorities, strategies, and objectives are aligned to improve the health of the underserved.

Care Share's statewide technical assistance services help communities improve health by: 1) leveraging new and existing resources; 2) increasing the number of physician volunteers donating care; 3) increasing access to care and other health services; 4) developing common referral networks all providers can use; 5) expanding the continuum of care in local communities; 6) helping networks create efficient systems and become financially stronger; and 7) identifying new grant opportunities for the safety net.⁸

^f Garson-Angert, D. School Health Center Program Consultant, Children and Youth Branch, Women and Children's Health Section, NC DHHS, April 12, 2012

⁸ Chapin, K. Executive Director, Care Share Health Alliance. Written (email) communication. March 1, 2012.

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