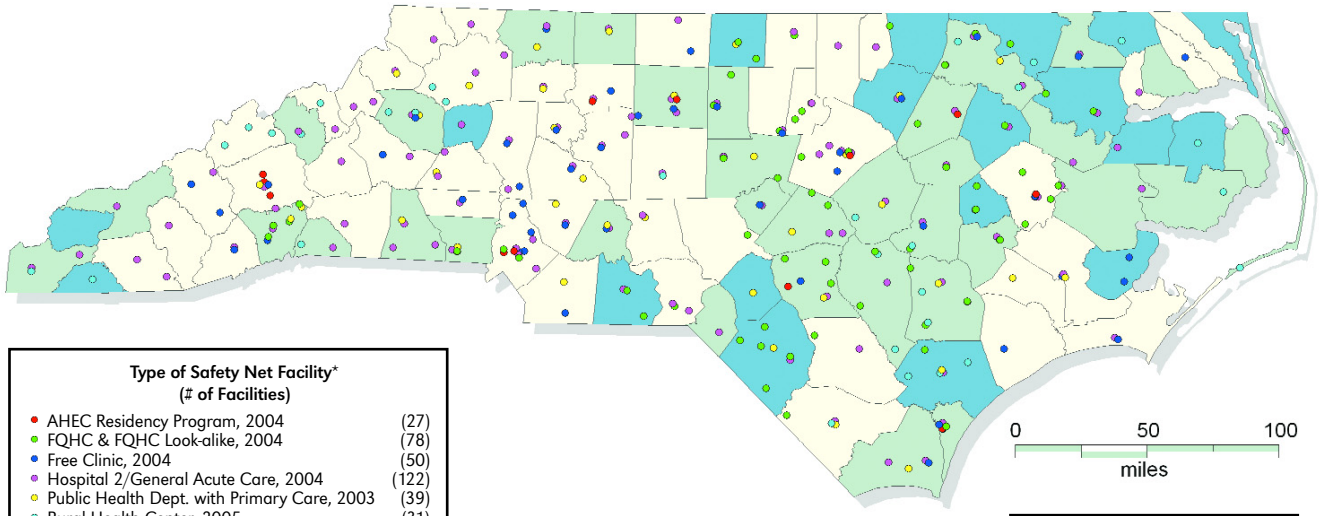
Chapter Four

Availability of Safety Net Providers

Access to safety net providers is not consistent throughout the North Carolina. The map below (Map 4.1) illustrates the location of the state's FQHC and FQHC look-alikes, free clinics, local health departments offering primary care services, state-funded rural health centers, AHEC residency clinics, and general acute care hospitals. The map also shows primary care Health Professional Shortage Areas (HPSAs). Primary care HPSAs are counties, or portions of counties, that have too few primary care physicians to meet the needs of the population.[i]

In some communities, there are multiple safety net organizations available to provide services to the uninsured, but in others, there are no known safety

Map 4.1.
Safety Net Providers—North Carolina 2003-2005



Produced by: NC Rural Health Research Program, Cecil G. Sheps Center for Health Services Research, UNC-CH.

Sources: NC Association of Free Clinics, 2004; NC Division of Facilities Services, 2004; NC Community Health Center Association, 2004; North Carolina AHEC, 2004; Office of Research, Demonstrations and Rural Health Development, 2005; NC Institute of Medicine, 2005; NC Division of Public Health, NC Division of Medical Assistance, 2003; Area Resource File, 2003.

i The federal government designates areas and populations as Health Professional Shortage Areas (HPSAs) in order to qualify communities to be eligible for assistance programs. To be eligible for designation, the area or population must have fewer than one full-time primary care physician for 3,500 people. If there are high levels of poverty, infant mortality or a high proportion of elderly, then that threshold is lowered to 1:3,000. The most common designation is a county since most counties represent the service area for a primary care practice; these are termed full- or whole-county HPSAs. When counties are too large, portions of a county or a specific population in a county, for example Medicaid eligibles, may be designated a HPSA. In those cases, the designation is termed a part-county or population HPSA.

net organizations. Many communities have *some* capacity to provide primary care services to some of the uninsured, but few communities have sufficient capacity to meet the primary care needs of all of the uninsured. Tables 4.1 and 4.2 of this chapter identify counties with the greatest unmet need. Furthermore, even in those communities with adequate primary care capacity, there is often insufficient access to specialty, diagnostic, or ancillary services.

Availability of Primary Care Services

The Task Force wanted to identify areas of greatest unmet needs so that future resources could be targeted toward those communities. To do this, the NC Institute of Medicine (IOM) collected data on where the uninsured currently received healthcare services, and compared this information to county-level estimates of the uninsured.[ii] The Task Force focused on organizations that provide primary care services to the uninsured, recognizing the importance of establishing a medical home with a healthcare provider who can address most of the person's healthcare needs. Ideally, an uninsured person should receive comprehensive, coordinated, and continuous care from their primary care provider, much like what is currently afforded Medicaid and other insured patients. The NC Division of Medical Assistance requires primary care providers to assure that they can provide the following services to Medicaid recipients in order to qualify as a primary care provider under the Access or Community Care of North Carolina programs:[iii]

- Provide medical care, including health promotion, identification of individuals at risk, early detection of serious disease, management of acute emergencies, render continuous care to chronically ill patients, and refer patients to another provider when necessary;
- Provide for or arrange for coverage of services, consultation or referral, and treatment for emergency conditions 24 hours a day, 7 days a week. Automatic referral to the hospital emergency room for services does not satisfy this requirement;
- Provide direct patient care for a minimum of 30-office hours per week; and
- Establish and maintain hospital admitting privileges or a formal arrangement for the management of inpatient hospital admissions.

Optimally, uninsured individuals would have access to primary care services that meet these requirements, but the reality is that many safety net organizations are not able to provide this level of care. Free clinics, for example, are generally open limited hours during the week and may not be able to arrange for after-hours coverage. Some health departments are able to provide only limited clinical services, for example, screenings or well-child care rather than acute care services. In identifying areas of greatest unmet needs, the Task Force focused on organizations that could meet the acute care needs as well as the preventive health services of the uninsured.

Methodology: The NC IOM collected information on the number of uninsured users seen in federally qualified health centers (FQHCs),[iv] free clinics,[v] and hospital

ii *County-level uninsurance data:* Estimates of the uninsured in each county are based on a model developed by the Cecil G. Sheps Center for Health Services Research, UNC-CH. They are based on statewide data from the Current Population Survey (CPS) of the US Census Bureau. County-level estimates were developed using: age, gender, race and ethnicity, employment status, industry, income, and education of the county population as predictors of uninsured status. The full report that describes the methodology used in developing county level estimates of the uninsured is available at: http://www.shepscenter.unc.edu/new/NorthCarolina Uninsured2002.pdf. Last accessed September 2004.

iii The definition of primary care provider taken from the NC Division of Medical Assistance primary care provider contract.

iv *Federally Qualified Health Centers:* Data on uninsured users were provided by NC Association of Community Health Centers. Health centers provided total numbers of uninsured users in UDS reports from 2003. Health centers also report the percentage of users in each county in the service area. County-level estimates of uninsured seen in FQHCs were obtained by multiplying the total of uninsured by the percentage of total users from a county.

v Free Clinics: Data was provided by the NC Association of Free Clinics from 2003. The total number of uninsured seen by free clinics (69,320) was lower than originally estimated (125,000), because some centers initially counted visits instead of users. There was no data on county of residence of all free clinic users. Users were assigned to the county where their free clinic was located.

outpatient clinics[vi] from their respective associations: NC Community Health Center Association, NC Association of Free Clinics, and NC Hospital Association (Appendix B). Information about the uninsured seen in state-funded rural health clinics,[vii] local health departments,[viii] and Area Health Education Centers (AHEC) residency clinics[ix] were provided by state agencies: the Office of Research, Demonstrations and Rural Health Development, Division of Public Health, and the Area Health Education Centers program. Other Task Force members were able to provide us with information on the numbers of uninsured seen in their communities.

There are several limitations with these data. First, they do not capture all of the care provided to the uninsured. There is no system for collecting information about the number of uninsured individuals seen in private doctors' offices. National data (2001) suggest that half of the uninsured receive care in a physician's office, and 71% of physicians reported providing some charity care (see Chapter 3 for a more complete description).[1,2] The NC IOM was also unable to obtain information on the uninsured who obtain care from other safety net organizations, such as rural health clinics that receive no state funding or Veterans Affairs clinics where uninsured veterans may receive care. Furthermore, the state Division of Public Health does not currently collect information on the number of people who receive comprehensive primary care services because the current data system is limited to numbers of people seen in specific types of healthcare clinics (e.g., child health or adult health clinics). Some health departments have the capacity to offer comprehensive primary care, while others limit the scope of services provided. To address this concern, the NC IOM only counted uninsured individuals who received adult health, maternal health, or child health services from a health department that had the capacity to provide comprehensive primary care services. This is an inexact count, as some of these individuals may consider the health department their primary care home, while others may be visiting the health department for a specific test or screening. Finally, some uninsured may receive care from more than one provider. Data from the NC Behavioral Risk Factor Surveillance Survey (BRFSS) indicate that approximately 11% of the uninsured who report a usual source of care reported two or more sources of care. Therefore, in estimating the numbers of unduplicated uninsured who received care in a community, the NC IOM counted all the individuals who received care from any source, and then reduced this number by 11%.

After obtaining an estimate of the unduplicated

vi Hospital Outpatient Clinics. The NC Hospital Association provided information on uninsured seen in outpatient clinics.

vii *State Funded Rural Health Clinics:* Data on uninsured were provided by the Office of Research, Demonstrations, and Rural Health Development (ORDRHD) (2003 estimates). Numbers of uninsured users only include Medical Access Plan (MAP) eligible individuals i.e. individuals who are uninsured with incomes below 200% federal poverty guidelines (FPG). State-funded rural health centers also see other uninsured individuals that do not apply for or qualify for MAP.

viii *Local Public Health:* Data on uninsured users provided by the Division of Public Health is from the HSIS system. User information, such as adult health, child health, maternal health, was provided by service area. Not all of these service areas provide comprehensive primary care. For example, a child health clinic may provide well child checks and immunizations but not "sick" care. The Division of Public Health does not currently collect data for primary care visits. The Division of Public Health has provided a list of health departments that have identified themselves as providing primary care services (designated for adults, children, or both). The NC IOM also collected information from the Division of Medical Assistance that identifies health departments that are enrolled as providers for Carolina Access I or Community Care of North Carolina (CCNC). These practices are required to provide comprehensive primary care services. With these data limitations, to estimate the number of uninsured individuals seen by local health departments (LHDs), data was used for LHDs that identified themselves as primary care providers and were designated as Medicaid primary care providers (PCPs). We included all the uninsured users of adult health, child heath and maternity health clinics for the counties that self-reported that they provided primary care services to children and adults. We included all the uninsured users of child health clinics for those counties that self-reported that they provided primary care to children only. We included all the uninsured users of adult health and maternity clinics for the one county that reported that it provided primary care to adults only.

ix The NC AHEC program provided information on uninsured seen in AHEC outpatient residents' clinics. Generally, the teaching clinics reported the number of uninsured visits. The number of visits was divided by 3.2 to estimate the number of uninsured users.

Table 4.1
Indicators of County-Specific Categories of Need

	Explanation of Indicators				
	Uninsured Aged 0-64 (2003)		Uninsured with No Identified Source Primary Care		FTE Primary Care Provider-to-Population Ratio
	Number	Percent	Number	Percent	
★★ Quartile with fewest uninsured, least unmet needs accessing safety net providers, or highest ratio of primary care providers to population	887 - 4,375	16.5% - 19.0%	<3,188	<71.6%	10.77 - 6.02
★ Quartile with next to best access	4,424 - 8,572	19.0% - 20.6%	3,375 - 6,922	72.8% - 84.5%	5.77 - 4.53
⊘ Quartile with next-to-worst access	8,902 - 16,133	20.6% - 22.1%	7,022 - 11,928	84.7% - 94.0%	4.52 - 3.56
⊘⊘ Quartile with most uninsured, most unmet needs accessing safety net providers, or lowest ratio of primary care providers to population	16,174 - 119,717	22.1% - 27.0%	12,355 - 89,622	94.0% - 100%	3.56 - 0.84

numbers of uninsured in each county who received primary care services from one of the various safety net organizations listed above, the NC IOM compared this number to the estimate of uninsured in a particular county. This provided an estimate of the amount of unmet need (e.g., the numbers of uninsured who did not receive primary care services from safety net organizations). The Task Force calculated estimates of both the numbers and percentages of uninsured who did not receive primary care services from safety net organizations. The NC IOM also tried to develop a proxy measure to estimate a county's capacity to provide services to the uninsured through private providers, by examining the primary care provider to population ratio. Theoretically, those counties with higher numbers of primary care providers to population should have more capacity to provide healthcare services to the community.

These data were analyzed by quartiles to identify counties in greatest need. Counties with high numbers and high percentages of uninsured without identified primary care homes, and those communities with the lowest of full-time equivalent (FTE) primary care provider-to-population ratio, are the communities with the least capacity to address the needs of the uninsured (see Tables 4.1, 4.2). Table 4.1 shows the ranges among the different categories of need (by quartile).

Using this basis, 28 counties appear to have the greatest need for additional safety net resources, in that they fall within the lower half of counties in terms of the both the numbers and percentages of uninsured with no identified source of primary care (Table 4.2). Of these, 13 counties also have less private capacity to serve the uninsured, in that they have lower than statewide average number of FTE primary care providers to population ratio. These counties include: Brunswick, Columbus, Davidson, Edgecombe, Franklin, Granville, McDowell, Onslow, Randolph, Rockingham, Stanly, Vance, and Wilkes. As a general rule, urban areas tend to have higher numbers of uninsured without primary care homes, and rural areas tend to have higher percentages.

Table 4.2
Uninsured Access to Safety Net Services, by County

	Uninsured Aged 0-64 (2003)		Uninsured with No Identified Source Primary Care		FTE Primary Care Provider-to-Population Ratio
County	Number	Percent	Number	Percent	
Alamance	22,978	19.7%	⊘⊘	★	⊘
Alexander	5,727	19.1%	★	⊘⊘	⊘⊘
Alleghany	2,107	23.5%	★★	★★	★★
Anson	4,693	21.8%	★	★	⊘
Ashe	4,789	22.8%	★	★★	★
Avery	3,542	23.0%	★	⊘⊘	★★
Beaufort	8,339	21.6%	⊘	⊘	★
Bertie	3,926	23.6%	★★	★★	⊘
Bladen	6,523	23.4%	★	★	⊘
Brunswick	14,057	20.2%	⊘⊘	⊘	⊘
Buncombex	32,143	17.8%	★★	★★	★
Burke	14,427	18.9%	⊘⊘	⊘	★
Cabarrus	21,914	17.5%	⊘⊘	⊘	★
Caldwell	12,513	18.6%	⊘	★	⊘
Camden	1,258	18.5%	★★	⊘⊘	⊘⊘
Carteret	8,902	17.5%	⊘	⊘	★
Caswell	4,269	20.9%	★★	★★	⊘⊘
Catawba	23,717	18.7%	⊘⊘	⊘	★
Chatham	9,534	20.8%	⊘	★	⊘
Cherokee	4,498	21.4%	★	⊘	★★
Chowan	2,387	20.0%	★★	⊘⊘	★★
Clay	1,569	20.4%	★★	⊘	⊘⊘
Cleveland	16,174	19.3%	⊘⊘	⊘	★
Columbus	10,830	23.2%	⊘	⊘	⊘⊘
Craven	14,611	18.3%	⊘	★	★
Cumberlandx	52,404	19.2%	⊘⊘	⊘	★
Currituck	3,751	20.9%	★	⊘⊘	⊘⊘
Dare	4,767	16.5%	★	⊘⊘	★
Davidson	24,855	19.0%	⊘⊘	⊘	⊘⊘
Davie	5,913	18.5%	★	⊘	⊘⊘

x Veteran Affairs (VA) clinics, which serve uninsured veterans, are located in these counties, but data are not available on the number of uninsured patients they serve. Therefore, these data may underestimate the number of uninsured patients receiving primary care in these counties.

	Uninsured Aged 0-64 (2003)		Uninsured with No Identified Source Primary Care		FTE Primary Care Provider-to-Population Ratio
County	Number	Percent	Number	Percent	
Davie	5,913	18.5%	★	⊘	⊘⊘
Duplin	11,800	27.0%	★	★★	⊘
Durham[x,xi]	40,154	19.3%	★★	★★	★★
Edgecombe	10,441	22.5%	⊘	⊘⊘	⊘⊘
Forsyth	48,279	17.6%	⊘⊘	★	★★
Franklin	9,611	21.3%	⊘	⊘	⊘⊘
Gaston	29,188	17.7%	⊘⊘	★	★
Gates	1,794	19.4%	★★	⊘	⊘⊘
Graham	1,615	24.1%	★★	⊘⊘	⊘
Granville	9,076	19.9%	⊘	⊘⊘	⊘
Greene	4,279	24.9%	★★	★★	⊘⊘
Guilford	66,747	17.8%	⊘⊘	⊘	★
Halifax	10,818	22.5%	⊘	★★	⊘
Harnett	18,682	21.8%	⊘⊘	★	⊘⊘
Haywood	8,383	18.1%	⊘	★	★★
Henderson	14,148	18.2%	⊘	★★	★★
Hertford	4,424	22.1%	★	⊘⊘	★★
Hoke	7,266	22.1%	★	⊘⊘	⊘⊘
Hyde	1,130	23.5%	★★	★★	⊘⊘
Iredell	20,745	18.0%	⊘⊘	⊘	★
Jackson	6,149	20.5%	★	⊘⊘	★★
Johnston	25,362	21.1%	⊘⊘	★★	⊘
Jones	1,915	22.2%	★★	★	★★
Lee	9,358	21.8%	⊘	★	★★
Lenoir	10,226	20.5%	⊘	★★	★
Lincoln	11,609	19.8%	⊘	⊘⊘	★
Macon	5,275	20.5%	★	⊘⊘	★★
Madison	3,498	20.6%	★★	★★	⊘
Martin	4,627	22.1%	★	⊘⊘	★
McDowell	7,674	20.8%	⊘	⊘⊘	⊘

x VA clinics, which serve uninsured veterans, are located in these counties; but data are not available on the number of uninsured patients they serve. Therefore, these data may underestimate the number of uninsured patients receiving primary care in these counties.

xi It is likely that the large hospitals in these counties serve uninsured residents from outlying counties, as well. Therefore, these data may overstate the availability of care in these counties.

	Uninsured Aged 0-64 (2003)		Uninsured with No Identified Source Primary Care		FTE Primary Care Provider-to-Population Ratio
County	Number	Percent	Number	Percent	
Mecklenburg	119,717	18.0%	⊘⊘	★	★
Mitchell	2,851	21.5%	★★	★	★★
Montgomery	5,779	24.7%	★	⊘⊘	⊘
Moore	11,907	18.5%	⊘	★	★
Nash	15,394	19.9%	⊘⊘	★	★
New Hanover	25,457	17.4%	⊘⊘	⊘	★★
Northampton	4,282	23.6%	★★	★★	⊘⊘
Onslow	31,552	22.4%	⊘⊘	⊘⊘	⊘⊘
Orange[xi]	20,418	19.1%	★★	★★	★★
Pamlico	2,278	21.0%	★★	★	⊘
Pasquotank	6,185	19.9%	★	⊘	★★
Pender	8,075	21.4%	★	★★	⊘⊘
Perquimans	2,040	21.0%	★★	⊘⊘	⊘⊘
Person	6,249	19.7%	★	★★	⊘⊘
Pitt	25,339	20.8%	★	★★	★★
Polk	2,877	18.8%	★★	⊘	★
Randolph	23,848	20.4%	⊘⊘	⊘	⊘
Richmond	8,572	21.5%	⊘	⊘⊘	★★
Robeson	26,414	24.1%	⊘⊘	★	★
Rockingham	16,133	20.5%	⊘⊘	⊘	⊘
Rowan[x]	21,678	19.0%	⊘⊘	★	⊘
Rutherford	11,010	20.6%	⊘	⊘⊘	★
Sampson	13,473	25.1%	⊘	★★	⊘
Scotland	6,321	20.6%	★	★	★★
Stanly	9,705	19.2%	⊘	⊘	⊘
Stokes	7,507	19.0%	★	★	⊘⊘
Surry	13,658	22.4%	⊘	⊘	★★
Swain	2,397	21.2%	★★	⊘⊘	★★
Transylvania	4,375	18.1%	★	⊘	★
Tyrrell	887	24.7%	★★	★★	⊘⊘

x VA clinics, which serve uninsured veterans, are located in these counties; but data are not available on the number of uninsured patients they serve. Therefore, these data may underestimate the number of uninsured patients receiving primary care in these counties.

xi It is likely that the large hospitals in these counties serve uninsured residents from outlying counties, as well. Therefore, these data may overstate the availability of care in these counties.

	Uninsured Aged 0-64 (2003)		Uninsured with No Identified Source Primary Care		FTE Primary Care Provider-to-Population Ratio
County	Number	Percent	Number	Percent	
Union	23,526	18.4%	⊘⊘	⊘⊘	⊘⊘
Vance	8,555	22.7%	⊘	⊘⊘	⊘
Wake	103,612	16.6%	⊘⊘	★	★
Warren	3,944	23.4%	★★	★★	⊘⊘
Washington	2,492	21.9%	★★	⊘⊘	⊘⊘
Watauga	7,920	21.2%	★	★★	★
Wayne	19,877	20.1%	⊘⊘	★	★
Wilkes	11,857	20.7%	⊘	⊘	⊘
Wilson	14,448	22.2%	⊘	★★	⊘
Yadkin	6,619	21.0%	★	★	⊘
Yancey	3,388	22.6%	★★	★★	★

The data included in this chapter reflect the Task Force's best understanding of the capacity of existing safety net organizations to meet the healthcare needs of the uninsured, and which communities have the greatest unmet needs. These data should be shared with state policymakers and foundations and local communities to be used in deciding how to allocate scarce resources. However, there are limitations in these data, as noted above. The Task Force viewed these data as a starting point, with the goal of collecting and refining the data over time.

Based on this analysis, the Task Force recommends:

Rec. 4.1: The NC Office of Research Demonstrations and Rural Health Development (ORDRHD), in collaboration with the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, should assume responsibility for collecting data and monitoring the capacity of the safety net on an ongoing basis.

a) The data should include information on safety net organizations that provide the full array of primary care services, as well as those that provide dental, behavioral health, preventive services only, or a less comprehensive array of clinical services. In addition, data should be collected on the numbers uninsured who receive services through non-profit or public dental clinics, pharmacy clinics, or other specialty providers.

b) Safety net healthcare organizations that receive state funding (through Medicaid, the Division of Public Health, or Community Health Grant funds) should be required to report information to the ORDRHD on the unduplicated number and the total number of visits (encounters) for uninsured patients who receive comprehensive primary care, dental, behavioral health, or other clinical services. The ORDRHD should create a standardized reporting form to ensure that the data are collected consistently across healthcare organizations. Other organizations that do not receive any state funding, such as free clinics, should be encouraged to provide similar information.

c) The ORDRHD should share these data with local Community Care of North Carolina groups, Healthy Carolinian organizations, local health departments, the NC Association of Community Health Centers, the NC Hospital Association, the NC Medical Society, the NC Free Clinic Association, the NC Division of Facility Services, and local medical societies so that they can use these data to identify areas of unmet need. Similarly, the data should be shared with NC health founda-

tions, to help inform their grantmaking process.

d) The ORDRHD should report these data to the Secretary, Governor, General Assembly, and NC Association of County Commissioners on a yearly basis to help inform policymakers of areas of greatest unmet need.

The Task Force identified the ORDRHD as the most appropriate state agency to collect these data on an ongoing basis. One of the ORDRHD's core missions is to help communities develop primary care and dental capacity to serve medically underserved populations. In addition, the 2004 General Assembly charged the ORDRHD to report to the General Assembly on the number of new uninsured patients who have been treated in safety net organizations as a result of the $7 million Community Health Grants that the General Assembly appropriated. Thus, the ORDRHD has already begun collecting some of these data.

Task Force members understand that local health departments will also be collecting information on the health status of its residents, as part of its four-year community health assessments or annual updates. Some health departments may also collect information on the ability of residents to access care. In its data collection efforts, the ORDRHD should request information from local health departments to determine if they have data that can augment the other data collected about where the uninsured obtain care.

The data included in this chapter reflect our best understanding of the capacity of existing safety net organizations to meet the healthcare needs of the uninsured and which communities have the greatest unmet needs. However, there are limitations in these data, as noted previously in the chapter. For example, the dataset does not include every possible safety net organization; and it is difficult at this time to identify whether local health departments are providing comprehensive primary care services to the uninsured or a more limited array of clinical services. Therefore, the ORDRHD should use the NC IOM data as a starting point, but make modifications to the data requested and include other safety net organizations in the data as information becomes available.

One way of checking the accuracy of the data is to provide the data to local community groups. The local agencies can check the data and help identify other sources of care to the uninsured. More importantly, these data can be a catalyst for local communities to identify unmet needs and to encourage them to develop capacity to serve the uninsured or other medically indigent at free or reduced costs.

Foundations can use these data to identify communities that are in greatest need of new or expanded safety net capacity. The Task Force recommends that foundations use these data to identify communities with the greatest unmet needs—either in terms of the percentage of the uninsured who do not have an identified source of care or the number of uninsured who do not have an identified source of care—and give priority to these communities in the grantmaking process. In addition, the foundations should seek comparable data in their grant reporting. This will reinforce the need for safety net organizations to collect these data.

Rec. 4.2: The NC Office of Research, Demonstrations and Rural Health Development should take the lead in pulling together a statewide collaborative of safety net organizations to develop a planning package for communities interested in maintaining or expanding their safety net capacity.

a) The collaborative should include, but not be limited to: the Division of Public Health, the NC Community Health Center Association, the NC Hospital Association, the NC Medical Society, the NC Free Clinic Association, and the NC Area Health Education Centers (AHEC) program. These groups should collaborate to provide technical assistance to communities. Priority should be given to low-wealth, high-need communities to help them develop additional safety net capacity. Cross-county or regional approaches should be considered, particularly for smaller, less-populated, or resource-poor communities.

b) The planning package should include information on financial planning, possible funding sources, healthcare information systems, record access and confidentiality, federal and state laws and regulations affecting the provision of safety net services, and the organizational aspects of interagency cooperation with such issues as eligibility determination. Once developed, information about the availability of the planning package and technical assistance should be provided to county commissioners,

local healthcare providers, community collaboratives (such as Healthy Carolinians and Community Care of North Carolina networks), and other interested non-profit organizations.

The Task Force recognized that one approach to development of safety net capacity would not fit every community. The state-level technical assistance team should help local communities assess their needs and then provide information about a range of potentially appropriate options and the resources needed to make changes. Information about some organizations and foundation support that could potentially assist local communities in developing or expanding their safety net resources is available in Appendix C.

Additionally, the Task Force acknowledged that the ORDRHD would face financial and labor costs related to the collection of data and development of safety net planning packages. Therefore, to minimize the burden of developing a data collection process, and to maintain ongoing collection and development of safety net planning packages, the Task Force recommends that the General Assembly provide financial support to the ORDRHD.

Encouraging Other Private Providers to Provide Services to the Uninsured

Private physicians are another major source of care to the uninsured. National studies suggest that most of the uninsured receive their care from private physicians. Private providers are particularly critical in communities that lack sufficient capacity to address the needs of the uninsured through safety net organizations. Unfortunately, studies also suggest that there is a growing reluctance among private providers to provide charity care. Nationally, the percentage of physicians who reported providing charity care fell from 76% to 71% between 1997 and 2001. Access to specialty care physicians is a particularly acute need. Even in communities that have sufficient primary care capacity, the uninsured have difficulties accessing specialty services.

The Task Force identified a number of factors that could discourage private providers from volunteering their time to serve the uninsured. Providers have limited time to volunteer because of the need to see enough paying patients to cover the costs of their practice. Some providers are reluctant to treat the uninsured for fear that they will be deluged with large numbers of uninsured seeking care. In addition, providers do not have the time to investigate whether an individual is truly needy—uninsured and unable to pay—or whether a person has the ability to pay for needed care. In the past, providers have also been reluctant to provide services if they thought that all of the patients' healthcare needs could not be met. For example, some providers were unwilling to provide services if their patient was unable to obtain the prescribed medications or other specialty referrals. And finally, some providers are afraid that they may be subject to a lawsuit for a bad health outcome; and the uninsured, particularly low-income uninsured, may be more prone to poor health outcomes because of the effects of poverty and lack of ongoing primary and preventive services. The Task Force developed a set of recommendations to remove these barriers in order to encourage more providers to provide services to the uninsured. Some of the recommendations support Project Access models or other "fair-share" systems that equitably divide care to the uninsured among multiple community providers, while other recommendations focus on the potential liability concerns.

Project Access or Fair-Share Systems: Project Access or other "fair-share" models have been successful in distributing care among primary care and specialists in the community, so that no particular provider feels overwhelmed with large numbers of uninsured patients. Another benefit of an organized system of care, such as a Project Access or Healthy Communities Access Program, is that the program can screen people to determine financial eligibility for free care, and may be able to help with scheduling and reminder phone calls to ensure that patients keep their medical appointments. Project Access models or other similar systems can also help arrange for necessary specialty care, and provide some access to medications. However, these models are not available in every community and need some financial support to help the ongoing administrative costs of running a program. Therefore, the Task Force recommends that the ORDRHD, in providing technical assistance to communities, explore the option of creating a Project Access, Healthy Communities Access Program look-alike or other fair-share system.

In addition, the Task Force acknowledged the importance of recognizing those providers who do volunteer significant amounts of time to care for the uninsured. One possible way to provide meaningful

recognition to the providers is to collect testimonials from patients who have been assisted by the provider. Therefore, the Task Force recommends:

Rec. 4.3. The NC Medical Society, local medical societies, free clinics, Project Access models, and other community initiatives that encourage private providers to donate their services to the uninsured should develop systems to recognize providers for their services. Recognition should be provided at both the local and state levels.

Malpractice: The Task Force learned that some healthcare providers are reluctant to provide care to the uninsured due to the fear of a malpractice suit. North Carolina laws already provide some protection to healthcare professionals who volunteer services to provide care to the uninsured without receiving compensation. The law protects providers who provide free care in local health departments, community health centers, or free clinics or who provide free services to patients referred by one of these organizations. The law protects providers from liability from damages as long as the damages were not the result of wanton conduct or intentional wrongdoing.[3]

As noted in Chapter 3, this Good Samaritan statute provides some protection against monetary liability, but does not cover the costs of having to defend a lawsuit. Retired physicians can get volunteer malpractice insurance that covers the costs of legal defense for $100 a year from Medical Mutual Insurance Company; but this same coverage is not available to providers who have active practices, and some private policies do not cover healthcare services provided outside the physician's office or hospital. There are no known lawsuits filed against NC volunteer physicians, and an earlier New York study suggested that the uninsured and low-income patients were significantly less likely to file malpractice suits after controlling for the severity of the injury.[4] Nonetheless, the fear of lawsuit (whether real or imagined) discourages some providers from volunteering to serve the uninsured. The Health Insurance Portability and Accountability Act of 1996 included provisions to extend the Federal Torts Claims Act to physicians who volunteer in free clinics; however, this provision was not implemented until recently.[5] It is unclear at this time how difficult it will be for volunteer physicians and free clinics or other community organizations that provide free care to qualify for this coverage. Therefore, the Task Force recommends:

Rec. 4.4. The NC Free Clinic Association should take the lead in pulling together a group of health professionals and safety net organizations, including, but not limited to, the North Carolina Medical Society and NC Project Access organizations to identify options to reduce the fear of and/or threat of malpractice lawsuits against providers who volunteer their time to serve the uninsured without compensation. At a minimum, the group should examine the existing Good Samaritan Law to determine if further changes are needed to provide protection to physicians and other healthcare professionals who volunteer to provide services to the uninsured upon referral from an organized system of care for low-income uninsured.

This group may also want to explore other ways to reduce the fear of and/or threat of malpractice lawsuits. Some of these ideas include:

- Collecting state and national information about the history of malpractice lawsuits brought against healthcare professionals who donate their time to provide charity services to the uninsured at free clinics, Project Access models, or in private offices. The information should then be distributed throughout the state to local medical societies and in risk-management seminars.
- Examining options to provide low-cost malpractice coverage to physicians and other health professionals to help them defend malpractice suits, similar to the limited policy offered by Medical Mutual to retired physicians who volunteer in free clinics.
- Creating a risk pool to help pay for some of the malpractice costs of volunteer physicians.
- Examining legislative options to provide financial support to providers to help offset the costs of malpractice insurance needed to cover the defense costs for providers who volunteer their time providing healthcare to the uninsured through free clinics, Project Access models, health departments, and/or federally qualified health centers.
- Exploring the Federal Torts Claims Act to determine if volunteer health professionals can obtain malpractice coverage, under Section 194 of the Health Insurance Portability and Accountability Act of 1996.

References

1 Reed MR, Cunningham PJ, Stoddard, J. Physicians Pulling Back from Charity Care. Washington, DC: Center for Studying Health System Change. Issue Brief No. 42, August 2001. (Accessed September 1, 2004, at: http://www.hschange.org/CONTENT/356/).

2 Cunningham PJ. Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001. Washington, DC: Center for Studying Health System Change. Tracking Report No.6, December 2002. (Accessed January 3, 2005, at: http://www.hschange.com/CONTENT/505/?topic=topic18).

3 The statute, N.C.G.S. §90-21.16 reads:
Volunteer healthcare professionals; liability limitation.
(a) This section applies as follows:
(1) Any volunteer medical or healthcare provider at a facility of a local health department or at a nonprofit community health center,
(2) Any volunteer medical or healthcare provider rendering services to a patient referred by a local health department as defined in G.S. 130A-2(5) or nonprofit community health center at the provider's place of employment,
(3) Any volunteer medical or healthcare provider serving as medical director of an emergency medical services (EMS) agency,
(4) Any retired physician holding a "Limited Volunteer License" under G.S. 90-12(d), or
(5) Any volunteer medical or healthcare provider licensed or certified in this State who provides services within the scope of the provider's license or certification at a free clinic facility, who receives no compensation for medical services or other related services rendered at the facility, center, agency, or clinic, or who neither charges nor receives a fee for medical services rendered to the patient referred by a local health department or nonprofit community health center at the provider's place of employment shall not be liable for damages for injuries or death alleged to have occurred by reason of an act or omission in the rendering of the services unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the person rendering the services. The free clinic, local health department facility, nonprofit community health center, or agency shall use due care in the selection of volunteer medical or healthcare providers, and this subsection shall not excuse the free clinic, health department facility, community health center, or agency for the failure of the volunteer medical or healthcare provider to use ordinary care in the provision of medical services to its patients.
(b) Nothing in this section shall be deemed or construed to relieve any person from liability for damages for injury or death caused by an act or omission on the part of such person while rendering healthcare services in the normal and ordinary course of his or her business or profession. Services provided by a medical or healthcare provider who receives no compensation for his or her services and who voluntarily renders such services at facilities of free clinics, local health departments as defined in G.S. 130A-2, nonprofit community health centers, or as a volunteer medical director of an emergency medical services (EMS) agency, are deemed not to be in the normal and ordinary course of the volunteer medical or healthcare provider's business or profession.
(c) As used in this section, a "free clinic" is a nonprofit, 501(c)(3) tax-exempt organization organized for the purpose of providing healthcare services without charge or for a minimum fee to cover administrative costs and that maintains liability insurance covering the acts and omissions of the free clinic and any liability pursuant to subsection (a) of this section.

4 Burstin HR, Johnson WG, Lipsitz SR, Brennan TA. Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status. JAMA. October 13, 1993;270(14):1697-1701.

5 See: http://www.bphc.hrsa.gov/freeclinicsftca/application.htm. Accessed January 5, 2005.