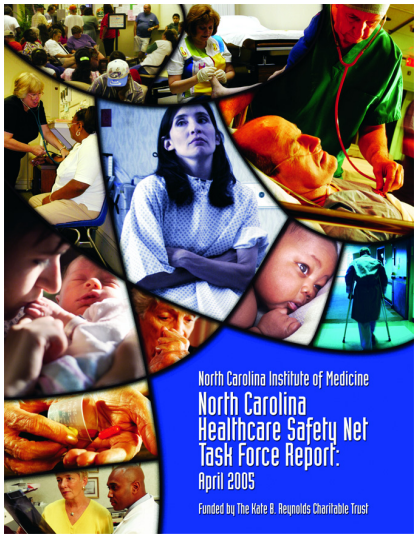
# Issue Brief | North Carolina Healthcare Safety Net Task Force Report: April 2005[1] North Carolina Institute of Medicine

## North Carolina is in the Midst of a Quiet, but Growing, Healthcare Crisis

Approximately one in five people under the age of 65, or 1.4 million people, lacked health insurance in 2003. The uninsured are far more likely than the insured to report facing barriers to accessing health services. This poses a serious problem for North Carolina because healthcare is critical to the productivity and well-being of the population.

The uninsured are less likely to have a regular source of care and are more likely to delay or forgo needed care than people with insurance coverage. As a result, when they do seek care, the uninsured are generally sicker than the insured population and experience worse health outcomes. This results in lower worker productivity and poorer health status for children, which makes learning more challenging.




Fortunately, there are some providers who offer care to the uninsured regardless of their ability to pay. They include federally qualified health centers (FQHCs), state-funded rural health centers, local health departments, free clinics, Project Access and Healthy Communities Access Programs, school-based and school-linked health centers, private physician volunteers, teaching clinics, hospital outpatient and emergency departments, and prescription drug programs. These organizations—often called *safety net institutions*—have a mission to provide services to the uninsured, and often provide services for free or on a sliding-fee scale.

In January 2004, the Kate B. Reynolds Charitable Trust awarded funding to the North Carolina Institute of Medicine (NC IOM) to convene a Task Force to study the adequacy and financial viability of the current healthcare safety net and to develop models to better integrate existing resources.[2] The Task Force met for close to a year, and developed 28 recommendations, which, if implemented, would improve access to health services for the uninsured. The recommendations highlighted in this document reflect the Task Force's highest priority recommendations.

## Lack of Insurance Coverage Is the Primary Barrier the Uninsured Face in Obtaining Needed Health Services

Not only does lack of coverage affect the ability of individuals to access needed services, but it also affects a person's health status. To address this issue, ***the Task Force recommended that the NC General Assembly take steps to make health insurance coverage more affordable and to expand health insurance coverage to more individuals and families who are currently uninsured.***

## The Healthcare Safety Net Should Be Expanded to Address the Needs of the Growing Numbers of Uninsured

On the surface, it appears that North Carolina has a wide array of safety net organizations located throughout the state. However, the Task Force determined that only 25% of all the uninsured receive primary care services from safety net organizations. This fact, combined with other studies showing that the uninsured are less likely to have a regular healthcare provider, and they are more likely to report access barriers, suggests that the healthcare safety net is not sufficient to meet the needs of the uninsured.

The percentage of uninsured served by safety net organizations varies widely across the state; in some counties there are multiple safety net organizations available to provide primary care services to the uninsured, but in others there are none. Further, even in those counties with adequate primary care capacity, there is often insufficient access to pharmaceuticals, specialty care, behavioral health, and dental services.

Because there is not unlimited funding or resources to support new or expanded safety net services across the state, the Task Force attempted to identify those communities or counties with the greatest unmet needs. The Task Force was able to collect data from some safety net providers about the number of uninsured people who received primary care services in the prior year, but

these data were not uniformly available from all safety net providers. The Task Force recognized the importance of collecting these data, in order to target new resources to the communities most in need and to monitor the capacity of the safety net. ***The Task Force recommended that the NC Office of Research, Demonstrations and Rural Health Development collect data from public and private safety net providers about the number of uninsured patients served, and that it work with other safety net organizations to develop a planning package and provide technical assistance to communities interested in expanding their safety net capacity.***

The Task Force also recognized that there are barriers in existing laws that discourage some private practitioners from volunteering their time to serve the uninsured. Some private providers have expressed concern that they may be subject to a lawsuit for a bad health outcome if they provide services to the uninsured. Although North Carolina already has a Good Samaritan statute that protects volunteer physicians against monetary liability, it does not currently shelter providers from the cost (either financially or emotionally) of having to defend a lawsuit. ***The Task Force identified a need to make the act of volunteering to serve the uninsured less of a burden, and recommended that the NC Free Clinic Association work with the NC Medical Society and other safety net providers to explore other ways of reducing the barrier that potential malpractice claims create to encouraging private practitioners from volunteering to serve the uninsured.***

### The Uninsured also Need Access to Needed Medications in order to Follow Recommended Treatment Regimens

While there are some resources available to provide needed medications through the pharmaceutical companies' Patient Assistance Programs (PAPs), or through local safety net organizations, the current resources are insufficient to ensure that the uninsured can obtain necessary medications. There is also a federal program that allows certain safety net organizations to negotiate for highly discounted medication prices (called the 340B program). However, federal law restricts the 340B drug discount program to certain safety net organizations, including FQHCs, public health, and some hospitals. The deeply discounted prices are not available to free clinics, state-funded rural health centers, or other non-profit safety net organizations. ***The Task Force recommended that Congress expand the 340B drug discount program to include more safety net organizations. In addition, the Task Force recommended that state philanthropic organizations provide funding to help the NC Department of Health and Human Services establish a bulk purchasing program that would help negotiate volume discounts from pharmaceutical companies for safety net organizations around the state.***

### Safety Net Providers

***Area Health Education Centers (AHEC) program:*** The AHEC program provides educational programs for healthcare professionals and supports five residency programs in family medicine, three in rural family medicine, four in internal medicine, four in obstetrics/ gynecology, three in pediatrics, and three in surgery. In 2003-4, these programs provided services to 35,427 uninsured patients.

***Federally Qualified Health Centers (FQHCs):*** FQHCs receive federal funds to provide healthcare services to underserved populations. They provide comprehensive primary care services and health education, preventive care, chronic disease management, oral, and behavioral health services on a sliding scale basis. There are 24 FQHCs in NC with a total of 74 delivery sites, serving more than 122,000 uninsured patients in 54 counties in 2003.

***Free clinics:*** Free clinics are non-profit organizations that serve the low-income and uninsured by drawing on local healthcare resources and volunteers. Free clinics generally offer basic primary care, prevention services, and some pharmaceutical services. There are currently 60 free clinics or pharmacies in 48 NC communities, which served 69,320 low-income patients in 2003.

***Hospitals:*** Hospital emergency rooms provide services regardless of ability to pay and act as provider of last resort. There are 109 general acute care hospitals in North Carolina with emergency departments. In 2003, the uninsured represent 10% of all hospital outpatient visits. Of these, 22% (672,799 patients) were uninsured patients of the emergency departments. Some hospitals also support outpatient ambulatory care clinics providing wide array of primary care services to the uninsured.

### Counties that Have Established Collaborative and Integrated Safety Net Efforts Are Generally More Successful in Meeting the Healthcare Needs of the Uninsured

The patchwork of services, programs, and organizations serving the uninsured is being stretched in a number of directions as the demand for care among the uninsured has increased. Few counties have been able to meet all the needs of the uninsured, regardless of how many

safety net providers there are. The Task Force identified the need for increased levels of collaboration and, in some cases, integration of services and organizations to more effectively meet the needs of those served by safety net providers. Some counties have been able to successfully develop collaborations to expand the array of services available to the uninsured, but others have experienced challenges. Turf issues, competition for limited funding, and medical confidentiality issues are sometimes cited as obstacles to collaboration across safety net organizations.

***The Task Force recognized the need to create an ongoing state-level Safety Net Advisory Council (SNAC) that can help implement the recommendations of the Task Force and encourage state-level and local safety net collaborations and integration efforts.*** The SNAC would be charged with collecting and disseminating "best practices" and models for service organization and delivery. Additionally, the SNAC should work with NC foundations to help convene a best practices summit that would help local communities identify ways to build and strengthen their capacity to meet the healthcare needs of the growing uninsured population and reduce barriers to interagency collaboration and integration.

### The Increased Numbers of Uninsured and Inability to Raise Revenues from other Third-Party Sources Are Creating Significant Financial Strains on Many Safety Net Organizations

Safety net organizations receive financing from multiple sources, including Medicaid, Medicare, NC Health Choice (the State Children's Health Insurance Program), private third-party insurance, out-of-pocket payments, and charitable donations. The federal government also provides funding to support operational costs for FQHCs, and the state provides support to help pay for state-funded rural health centers. Despite these resources, there is not sufficient funding to cover the costs of care to the uninsured, and revenue is not well-targeted to those safety net organizations that provide the most free or subsidized care.

Although the Task Force spent considerable time trying to identify new sources of funding, the Task Force's highest recommendation was to maintain the state's major safety net funding source: Medicaid. The numbers of uninsured would be much larger if the 1.5 million people served by Medicaid lost their source of coverage. There is currently some discussion at the federal level about turning Medicaid into a block-grant program. This could be devastating to the state, safety net providers, and to low-income North Carolinians who rely on Medicaid to cover their healthcare needs. In addition, Task Force members felt strongly that the state was not getting its fair share of existing federal funds through the State Children's Health Insurance Program (NC Health Choice), the President's Initiative for Health Center Growth (which funds FQHC health center expansion), Ryan White CARE funds for people with HIV/AIDS, or the Special AIDS Drug Assistance Program. ***Therefore, the Task Force recommended that the NC Department of Health and Human Services and other safety net organizations work with the NC Congressional delegation to: (1) oppose efforts to limit the availability of federal Medicaid funds and (2) ensure that the state receive its fair share of other funds available to underwrite health services for the uninsured.***

The Task Force also recommended continued and

## Safety Net Providers

***Local health departments (LHDs):*** Local health departments provide maternal and child health programs, universal childhood immunizations, family planning, environmental sanitation, fluoridation of drinking water, injury prevention and workplace safety. Some also offer health promotion, targeted clinical services, comprehensive primary care and/or dental services. There are currently 85 local health departments covering all 100 counties. These agencies provided clinical health services to 641,601 patients in 2003, of which 260,603 were uninsured

***Prescription Drug Programs:*** Some safety net providers offer free or low-cost medications and a few communities have local pharmacy assistance programs. However, patient assistance programs (PAPs) offered by pharmaceutical companies are the largest source of free or reduced cost medications. Each has unique eligibility requirements, application process, and medications offered.

***Private Physicians:*** Physicians in private practice are a major source of care to the uninsured; many of whom provide services for reduced fees or at no charge. No North Carolina specific data are available on the number of practitioners providing care to the uninsured, but a national 2001 study found that nearly two-thirds of the uninsured reported a physician as their usual source of care.

***Project Access or Healthy Communities Access Programs (HCAP):*** Project Access and HCAPs are local community initiatives to link the services of traditional safety net providers to healthcare services offered by private providers in the community. These models help provide more comprehensive services to uninsured patients and many help purchase medications. The Project Access model has been implemented in nine NC communities.

expanded state funding for safety net organizations. Last year, the NC General Assembly appropriated $7 million in one-time funds to expand the availability of healthcare services to the uninsured through new or existing safety net organizations: $5 million to FQHCs and $2 million for state-funded rural health centers and/or local health departments. ***The Task Force supported the NC General Assembly's efforts, and recommended that this funding be expanded to $11 million on a recurring basis: $6 million for FQHCs and $5 million for state-funded rural health centers, local health departments, or other non-profit safety net organizations with a mission of serving the uninsured.***

Another need that has surfaced in many policy discussions in recent years is the need for additional school health nurses. The Task Force was aware of the important role these nurses play in meeting the primary healthcare needs of children and adolescents in our public schools. For many children, and especially for adolescents, school nurses are the only healthcare professionals they see, yet North Carolina has a shortage of such personnel. ***The Task Force recommended an appropriation to support additional school health nurses.***

**North Carolina Can Improve the Health and Healthcare Access for the Uninsured by Implementing the Task Force's Recommendations.**

Safety net organizations are experiencing an increase in the number of patients seeking free or reduced-cost healthcare, because of the rising numbers of uninsured in the state. This increase in demand, coupled with dramatically rising healthcare costs, is putting a major strain on the organizations that make up North Carolina's safety net. The NC IOM Task Force on the NC Healthcare Safety Net found that most counties across the state lack the full array of services necessary to meet the healthcare needs of the uninsured. As a result, the uninsured are unable to access the care they need in a timely manner. Instead, they are more likely to delay care, use emergency departments for non-emergent care, and forego prescribed medications, all of which leads to the need for higher-cost care when they do access medical assistance.

Fortunately, the organizations that make up the NC safety net are dedicated to the improvement and expansion of services to the uninsured. Their participation on this Task Force contributed to the development of recommendations described in the Task Force report, which could significantly improve access to services for the uninsured.

*About the NC Institute of Medicine: The NC General Assembly chartered the NC IOM in 1983 to provide balanced, nonpartisan information on complex and often controversial health issues in our state. The NC IOM serves as a non-political source of health policy analysis and advice in North Carolina. Contact information: 5501 Fortunes Ridge Drive, Suite E, Durham, NC 27713. 919-401-6599. Website: www.nciom.org.*

## Safety Net Providers

***School-Based or School-Linked Health Centers (SBHCs or SLHCs):*** SBHCs and SLHCs augment the services provided by school nurses by offering more comprehensive primary care and mental health services, such as medical care, preventive health services, mental health assessment and treatment, chronic disease management, laboratory testing, health education and promotion, social services, and nutritional services. State funds support 31 SBHCs and three SLHCs providing services to approximately 28,000 students. There are 22 other centers across the state supported by non-state funds.

***State-Funded Rural Health Centers (RHCs):*** The North Carolina Office of Research, Demonstrations, and Rural Health Development in the North Carolina Department of Health and Human Services helped to establish 81 rural health centers throughout the state, with 32 of these receiving on-going support from the state. In return for the ongoing operational funds, these centers must agree to provide comprehensive primary care services to low-income uninsured individuals on a sliding-fee scale. These state-funded centers served 21,252 uninsured low-income patients in 2003.

1 The full report, North Carolina Healthcare Safety Net Task Force Report: April 2005, is available online at: www.nciom.org

2 The Honorable Carmen Hooker Odom, MA, Secretary for the North Carolina Department of Health and Human Services, and Sherwood Smith, JD, Chairman Emeritus of Progress Energy, chaired the 48-member Task Force, which included representatives of safety net organizations and provider associations, state and local elected officials and agency staff, non-profits, and advocacy organizations. The Task Force met once a month for nearly one year (March 2004-January 2005).