North Carolina's Safety Net in the New World of Health Reform

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The Community Health Center Program is a 45-year-old federal initiative that receives bipartisan support and high marks for effectiveness from the White House Office of Management and Budget.[1] In the last 10 years, funding for the program has doubled and twice as many patients are being served.[2] Also known as federally qualified health centers (FQHCs), these patient-governed nonprofit primary care facilities offer medical services and, in many places, dental care, pharmacies, and an emerging behavioral health package of services in a medical home setting. Community health centers provide services on a sliding fee scale and accept Medicaid, Medicare, and private insurance.[3]

In 2008, the section of the Public Health Service Act that authorizes the centers, Section 330, provided $51.3 million to support the cost of primary medical, dental, pharmacy, and enabling services to uninsured patients served by North Carolina's FQHCs. This funding represented 30% of their total revenue and enabled North Carolina's health centers to serve 389,841 patients in the year, 93% of whom were medically indigent.[3] With awards of up to $650,000 annually, Section 330 grants provide substantial recurring support for primary care services in a comprehensive health care home. However, Section 330 health centers are only in 42 North Carolina counties, and no new Section 330 grants have been opened since 2007. While North Carolina represents 3.04% of the US population and 3.17% of the US uninsured,[4] our state received only 2.7% of the grant awards for new organizations or new sites of existing health centers during the 2002-2009 period of expansion. At present there are 27 FQHC and two FQHC look-alike organizations in North Carolina.

The passage of the health reform bill presents a unique opportunity to expand community health centers and create integrated medical homes in areas where safety net primary care is provided by local health departments, rural health centers, and free clinics.

Expanding Primary Care Access

The Patient Protection and Affordable Care Act permanently authorized the Community Health Center Program and created a Community Health Centers Trust Fund totaling $11 billion in new, dedicated funding for the Health Centers program over five years.[5] The majority ($9.5 billion) of this funding will allow health centers to expand their operational capacity to serve nearly 20 million new patients and to enhance their medical, oral, and behavioral health services.[6] This appropriation is in addition to existing funding of $2.19 billion in fiscal year 2010.

Anticipating the passage of this legislation, the Kate B. Reynolds Charitable Trust provided a grant of $400,000 in February 2010 to the North Carolina Community Health Center Association (NCCHCA) to prepare communities for the competitive application process for Section 330 funding. The North Carolina Health Center Development Incubator Program is an inclusive 18-month process bringing safety net providers including health departments, rural health centers, free clinics, hospitals, and existing health centers to the table for community-level planning and federal Section 330 application development. Assisting NCCHCA in these

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Health Reform's Effect on School-Based Health Centers

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Almost 2,000 school-based health centers (SBHCs) across the country, including 55 in North Carolina, provide access to high quality, comprehensive medical care, mental health services, preventive care, social services, and youth development to approximately 1.7 million children and adolescents in 44 states and the District of Columbia.[1] These services are provided without concern for students' ability to pay in a location that serves children and adolescents where they are much of the day: in or near schools.

In these SBHCs, developmentally appropriate health services are provided by qualified health professionals, incorporating the principles and practices of pediatric and adolescent health care recommended by the American Medical Association, the American Academy of Pediatrics, and the American Academy of Family Physicians. A recent longitudinal study showed that SBHCs have positive impacts on student achievement, including increasing grade point averages and attendance.[2]

Funding challenges have put many SBHC patients across the country at risk. Several centers in North Carolina are at risk of cutting services or even closing due to the current economic downturn due to staff layoffs or freezes, insufficient reimbursement for their mostly adolescent patient services, and reduced state, foundation, and/or local funding.

The North Carolina School Community Health Alliance (NCSCHA), an affiliate of the National Assembly on School-Based Health Care (NASBHC), has represented the state's school health centers over the past decade. They join a growing national movement that views SBHCs as a vital part of health care and a key element of health care reform. After years of providing critical care to the nation's youth, SBHCs became an authorized federal program (Title IV, Subtitle B, Sec.4101 (b)) under the Patient Protection and Affordable Care Act. The health reform legislation allows eligible SBHCs to receive funds for:

- management and operation of programs;
- salaries for health care professionals and other personnel;
- purchase or lease of equipment;
- construction projects and purchase of trailers or manufactured buildings installed on school property; and
- training.

A second provision authorizing $200 million ($50 million per year over four years) to SBHCs is restricted to capital projects (Sec.4101(a)) although the original intent of Senator Debbie Stabenow (D-Michigan), who sponsored this section, was to provide emergency funds for centers in distress or facing possible closure.

Becoming a federally authorized program is a historic victory for SBHCs, as it recognizes them as part of the federally supported health care system that serves populations with reduced access, helps address national disasters, and serves vulnerable patient populations in times of economic downturn. However, the SBHC authorization must be followed by appropriations if the centers are to continue serving our nation's youth. Until funds are appropriated, only limited federal support exists for SBHC operations, leaving little hope for the expansion that is called for by US Department of Health and Human Services' Secretary, Kathleen Sebelius: "We are thrilled that part of the [health reform] legislation calls for an expanded footprint of school-based health clinics...I can't think of a better way to deliver primary and preventive care to not only students, but their families, than through school-based clinics."[3]

NASBHC and the NCSCHA are pushing for a $50 million Congressional appropriation to fund the SBHC authorization for federal fiscal year 2011. In the current economic climate, states such as North Carolina are struggling to maintain the limited amount of support for the centers they currently fund, much less expanded operations. Federal appropriations would keep hundreds of centers open—serving thousands of the nation's neediest young people. The school health center organizations are also expressing concern and requesting that operational funding be added to the $200 million now targeted for capital expenses. Some centers and communities do have a need for capital funds, but operational funds will offer flexible, critical resources to help keep centers open and to assist communities that desire to open health centers at their schools. Grant instructions for the $200 million are expected to be released in June, and centers in North Carolina are looking forward to the opportunity for funding, whether for staff support, operational expenses, or capital funds to provide needed resources, such as electronic health record systems.

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efforts are the North Carolina Office of Rural Health and Community Care, Health Net, and the Care Share Health Alliance.

Section 330 Community Health Center grants are awarded after an extremely competitive national application process.[7] The federal Bureau of Primary Health Care (BPHC) prioritizes grants to applicants that demonstrate the greatest likelihood for successful implementation and program compliance at the time of application. In addition, the BPHC requires funded organizations to be up and running 120 days after the issuance of grant funding. This has proven to be a major stumbling block for many new health centers.[8] The aim of the Incubator Program is not simply to prepare competitive applications, but to prepare organizations to be viable and successful FQHCs. NCCHCA will focus resources on communities with primary care access needs, organizations most ready to compete for the Section 330 grant, collaborating communities, and organizations that participate in Incubator Program activities. These activities will include group trainings and individual technical assistance to communities.

Fostering Collaboration Yields Returns

North Carolina is poised to take advantage of this unique opportunity because of the six year effort of the North Carolina Safety Net Advisory Council (SNAC). Formed as a result of the first Community Health Grant appropriation by the North Carolina General Assembly in 2004, SNAC initially served as a committee to establish an equitable grant process for all safety net providers. Established by the North Carolina Office of Rural Health and Community Care and facilitated by the North Carolina Institute of Medicine, SNAC evolved into a forum for safety net providers to gain mutual understanding, build trust, and partner to advance the interests of the patients they serve. An example of this is a symbiotic co-location and collaboration model established between several FQHCs and free clinics. This model is quickly being adopted to position communities to be strong candidates for new federal funding. In these arrangements an FQHC can lease facility space from the free clinic in preparation to establish a new site of the FQHC funded through Section 330. With the FQHC as a tenant, the free clinic has a consistent revenue stream to cover overhead and other facility expenses. The community has enhanced primary care services and a medical home for new and existing patients. The free clinic retains its 501(c)(3) organizational identity but focuses its attention on recruiting volunteers for specialty care services. Through its established relationships, the free clinic supports the FQHC in brokering discount services for indigent and sliding scale fee patients. The free clinic also continues existing relationships with local and philanthropic organizations to enhance services generating a greater impact in the community.

Where Are the Providers?

The experience with comprehensive health reform in Massachusetts is instructive in forecasting what may take place when federal reform is implemented. Community health centers in that state saw a dramatic increase in the number of patients seeking care as a result of their state's health reform.[9] All the plans to create new primary care access points are moot unless there is an adequate supply of providers selecting primary care residencies and willing to serve in shortage designated communities. Inequalities in salaries, coupled with an average indebtedness at graduation of $156,456,[10] result in fewer physicians electing primary care residencies, thus exacerbating the dearth of primary care providers.

The health reform package includes a total of $1.5 billion in new, dedicated funding for the National Health Service Corps over five years. This funding will enable an estimated 15,000 primary care physicians, dentists, and other critically needed providers to access loan repayment and scholarship opportunities in return for service in shortage areas across the country. Provisions come into effect in the later years of health reform to improve the reimbursement to primary care providers; however, much needs to occur now in order to assure the needed supply of providers. Plans to expand medical school classes at the University of North Carolina at Chapel Hill and East Carolina University have been on hold for two years due to limited state funding.

In the summer of 2009, the North Carolina Office of Rural Health and Community Care, North Carolina Area Health Education Centers (AHEC), Eastern AHEC, the Brody School of Medicine, and NCCHCA developed a successful application to create Student Experiences and Rotations in Community Health (SEARCH). This is a state-based program funded through the National Health Service Corps in the Health Resources and Services Administration and enables students and residents to serve clinical rotations on multidisciplinary health care teams in underserved communities across the United States and its territories. SEARCH was launched through Eastern AHEC in the fall of 2010.

Within the health reform bill are initiatives to expand the use and practice of mid-level providers in primary care. The transition in practices towards electronic medical records may bring greater acceptance to this approach. The health reform legislation also creates a new Section 340H of the Public Health Service Act and appropriates $230 million over five years to establish a Teaching Health Centers Program.[11] This new program will create primary care residency programs in ambulatory patient care centers, primarily FQHCs. To assure a management workforce prepared to lead complex FQHC organizations with their unique array of grant and reimbursement structures, a Health Center Management Certificate Program is being developed through the Brody School of Medicine.

Need Will Continue to Exist

Medicaid expansion and health insurance exchanges resulting from health reform will provide more Americans with access to affordable health insurance coverage. Many current health center patients will have health insurance for the first time. The quality of care, customer service, and established relationships will be key factors in retaining patients in the centers. Reimbursement rates and regulatory processes will be the major determinants of whether private primary care providers will accept former center patients. Poverty, health disparities, and disenfranchisement will not be eliminated through health reform. There will continue to be individuals and communities best served through high quality, culturally competent community health centers providing integrated services under one roof.

Improving the Health of the Community

The passage of the health reform bill presents a unique opportunity to expand community health centers and create integrated medical homes in areas where safety net primary care is provided by local health departments, rural health centers, and free clinics. Through collaboration and coordinated resource allocation, safety net providers can enhance what they do best and maximize the impact of available resources. In this new environment, rural health clinics would link administrative and clinical services as part of a regional primary care network with FQHCs; free clinics would leverage volunteer and philanthropic support to fill gaps in care for individuals; and health departments would be freed from the burden of providing personal care services and focus on community-based prevention efforts. It is only through a tightly integrated continuum of prevention, early intervention, and treatment that we will begin to make a positive impact on preventable chronic diseases and make North Carolina a healthier state. **NCMJ**

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