North Carolina Institute of Medicine

North Carolina Healthcare Safety Net Task Force Report:

April 2005

Funded by The Kate B. Reynolds Charitable Trust

health policy

North Carolina Institute of Medicine

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North Carolina Institute of Medicine
5501 Fortunes Ridge Drive, Suite E
Durham, NC 27713
919.401.6599

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NC IOM Healthcare Safety Net Task Force

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NC IOM Healthcare Safety Net

Task Force Steering Committee NC IOM Staff

Task Force

The Honorable Carmen Hooker Odom
Co-Chair of the Task Force
Secretary
NC Department of Health and Human Services

Sherwood H. Smith, Jr.
Co-Chair of the Task Force
Chairman Emeritus
Carolina Power & Light

Carolyn C. Allison
CEO
Metrolina Comprehensive Health Center, Inc.

Thomas J. Bacon, DrPH
Executive Associate Dean & Director
NC Area Health Education Centers Program
UNC-CH School of Medicine

Gillian Baker, MHA
Director
Appalachian Healthcare Project

Andrea Bazan-Manson, MSW, MPH
Executive Director
El Pueblo, Inc.

James Bernstein, MHA
President
NC Foundation for Advanced Health Programs, Inc.

George F. Bond, Jr., MPH
Health Director
Buncombe County Health Department

Sonya Bruton, MPA
Executive Director
NC Community Health Center Association

Moses Carey, JD, MPH
County Commissioner
Orange County
Executive Director, Retired
Piedmont Health Systems

Mike Cinoman, MD
Director, Pediatric Critical Care WakeMed
Executive Director
WakeMed Faculty Physicians
Executive Director
Wake AHEC
Associate Professor Pediatrics
UNC-Chapel Hill

Lawrence M. Cutchin, MD
President & CEO
Health Care Savings, Inc.

Richard L. Daugherty
Vice President, Retired
IBM

Leah M. Devlin, DDS, MPH
State Health Director
Division Director
Division of Public Health
NC Department of Health and Human Services

L. Allen Dobson, MD
President/CEO
Cabarrus Family Medicine
Director of Graduate Medical Education
Northeast Medical Center

Brian Ellerby, MSPH, CMPE
Executive Director
Guilford Child Health, Inc.
Guilford Adult Health, Inc.

Margaret P. Elliott, MPA
Executive Director
Crisis Control Ministry, Inc.

Bobby England, MD
Representative
NC General Assembly

John H. Estes
Healthcare Consultant
Office of Research, Demonstrations and Rural Health Development
NC Department of Health and Human Services

Robert J. Fitzgerald
Director
Division of Facility Services
NC Department of Health and Human Services

Olivia Fleming, MA
Clinic Director
Open Door Clinic
Urban Ministries of Wake County

Gary Fuquay
Former Director
Division of Medical Assistance
NC Department of Health and Human Services

Rick Gilstrap
President
Halifax Regional Medical Center

John Graeter
Executive Director
Hot Springs Health Program

Robert G. Greer
Chairman
New Hanover County Commissioners

Paul Harrison
Executive Director
Wake County Medical Society

Fletcher Hartsell
NC Senate

Andy Hartsfield, JD
Vice President
Public Policy and Advocacy
GlaxoSmithKline

M. Anita P. Holmes, JD, MPH
Executive Director
Center for Health and Healing
General Baptist State Convention of NC

Thomas G. Irons, MD
Professor of Pediatrics
Associate Vice Chancellor
Brody School of Medicine

Johanna S. Irving DDS, MPH
Dental Health Director
Wake County Human Services

Howard Lee
Chair
North Carolina State Board of Education

Alan McKenzie
CEO
Buncombe County Medical Society

G. Earl Marett, MSW
Director
Johnston County Department of Social Services

John O. McNairy
President
Harvey Enterprises and Affiliates

John Mills, CAE
Executive Director
NC Association of Free Clinics

Richard H. Parks
Chief Executive Officer
Cape Fear Valley Health System

Burnie Patterson
Rural Health Group, Retired

William Pully, JD
President
NC Hospital Association

William R. Purcell, MD
Senator
NC General Assembly

Wanda Sandelé
Health Director
Craven County Health Department

Adam Searing, JD
Project Director
NC Health Access Coalition

Shirley Faison Sims
Wayne County Board of Education
Wayne Initiative for School Health

Stephen T. Smith, JD
Program Associate
NC Council of Churches

John Sullivan
Senior Vice President, Regional Facilities
Carolinas Healthcare System

Doug Yarbrough
President & CEO
Duplin General Hospital, Inc.

Steering Committee

Sonya Bruton, MPA
Executive Director
NC Community Health Center Association

Thomas J. Bacon, DrPH
Executive Associate Dean & Director
NC Area Health Education Centers Program
UNC-CH, School of Medicine

John H. Estes
Healthcare Consultant
Office of Research, Demonstrations and Rural Health Development
NC Department of Health and Human Services

Dennis E. Harrington, MPH
Deputy Director
Division of Public Health
NC Department of Health and Human Services

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

Alan McKenzie
CEO
Buncombe County Medical Society

John Mills, CAE
Executive Director
NC Association of Free Clinics

Ben Money, MPH
Associate Director
NC Community Health Center Association

Andrea D. Radford
Primary Care Consultant
Office of Research, Demonstrations and Rural Health Development
NC Department of Health and Human Services

Thomas C. Ricketts, III, PhD, MPH
Deputy Director
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill

Jeff Spade, MHA, CHE
Executive Director
NC Rural Health Center
NC Hospital Association

Torlen Wade
Director
Office of Research, Demonstrations and Rural Health Development
NC Department of Health and Human Services

Aimee Wall, JD, MPH
Institute of Government
University of North Carolina at Chapel Hill

Tom Wroth, MD, MPH
Department of Social Medicine
University of North Carolina at Chapel Hill

NC IOM Staff

Pam C. Silberman, JD, DrPH
(Report Director)
Vice President
NC Institute of Medicine

Gordon H. DeFriese, PhD
President and CEO
NC Institute of Medicine

Kristen L. Dubay, MPP
Project Director
NC Institute of Medicine

Thalia S. Fuller
Administrative Assistant
NC Institute of Medicine

Adrienne R. Parker
Director of Administrative Operations
NC Institute of Medicine

Kristie Weisner Thompson, MA
Assistant Vice President
NC Institute of Medicine

NC Institute of Medicine
Woodcroft Professional Center
5501 Fortunes Ridge Drive, Suite E
Durham, NC 27713
919-401-6599
Fax: 919-401-6899

Executive Summary

NC IOM Healthcare Safety Net Task Force

North Carolina is in the midst of a quiet, but growing, healthcare crisis. The number of uninsured residents is rising at an alarming pace, and as healthcare costs continue to increase, there is little chance of an immediate respite. Between 2000 and 2003, North Carolina's uninsured population experienced one of the largest percentage increases of all the US states. Approximately 1.4 million people in North Carolina under the age of 65 are uninsured, a growth of more than 300,000 people (31%) since 2000. One-year estimates from the Current Population Survey suggest that almost one out of every five non-elderly person in the state (19.4%) lacked health insurance coverage in 2003. North Carolina has been harder hit than many states due to the loss of manufacturing and textile jobs that resulted from trade relocation. The rising cost of health insurance, coupled with the downturn in the economy, is making it more difficult for people to afford coverage.

Currently, almost one out of every five non-elderly North Carolinians is uninsured. Most of the uninsured in North Carolina (62%) have incomes less than 200% of the federal poverty guidelines. This makes it challenging for the uninsured to pay for their healthcare needs out of pocket. Difficulty paying for needed healthcare is not limited to the uninsured, but the effects on this population are more acute. Approximately 15% of North Carolinians reported in 2003 that there was a time in the last 12 months when they needed to see a physician but could not because of the cost. The uninsured were far more likely to report access barriers (41.2%), than were people with insurance coverage (9.5%). Further, 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. When they do seek care, they are generally sicker than the insured population and as a consequence, experience worse health outcomes.

Clearly, the lack of health insurance coverage affects the uninsured person and his or her family, but it also has a broader societal impact. Lack of health insurance coverage decreases worker productivity; negatively affects the health of children and, thus, their ability to learn; and has unfavorable financial implications for healthcare providers. The latter is particularly true for safety net providers. Safety net organizations have a mission (and in some cases a legal mandate) to: offer services to patients regardless of their ability to pay; provide services for free or on a sliding-fee scale basis (or otherwise help make services financially affordable); and deliver a significant amount of care to the uninsured, Medicaid, or other vulnerable populations. Safety net providers strive to meet the healthcare needs of the uninsured, but this has become increasingly difficult as the number of uninsured has risen without commensurate program funding increases.

Some of the uninsured access non-emergent healthcare services in hospital emergency departments, yet this is neither a cost-effective nor desirable way to address non-emergency healthcare needs. Preferably, the uninsured would have an established relationship with a primary care provider who can provide comprehensive, coordinated, and continuous care. In many communities across the state, there are safety net services available to meet the primary care needs of the uninsured, but these services are not available in every community; and even where they do exist, they are not sufficient to meet the healthcare needs of all of the uninsured. Private providers also help provide services to the uninsured, but the extent to which this occurs in each community is unknown. In recent years, the number of physicians who report providing charity care nationally has declined. It is unknown whether the same trend is occurring in North Carolina.

Overview of North Carolina Safety Net Organizations

In North Carolina, the safety net consists of federally qualified health centers (e.g., community and migrant health centers), state-funded rural health centers, local health departments, free clinics, Project Access or Healthy Community Access Programs, school-based or school-linked health centers, hospitals, and other organizations that have a central goal of providing care to patients

regardless of their ability to pay. Many private physicians provide care to the uninsured, albeit not always on a sliding scale basis. While some safety net resources exist in most communities, they are not always sufficient to meet the many healthcare needs of the uninsured. ***Only about 25% of the uninsured in this state received primary care services through these safety net organizations.*** Some communities have multiple safety net organizations, but the system of care is fragmented. Others have a basic capacity to provide primary care services, but cannot meet the need for specialty consults or referrals, prescription medications, or more complex care. Still other communities lack even the capacity to meet the basic primary care needs of the uninsured.

Federally Qualified Health Centers (FQHCs): Federally qualified health centers are public or private non-profit organizations that receive federal funds to provide healthcare services to underserved populations. FQHCs, often referred to as community or migrant health centers, provide comprehensive primary care services as well as health education, preventive care, chronic disease management, oral, and behavioral health services. Services are provided to the uninsured on a sliding-fee scale basis. In addition to traditional health services, FQHCs also provide "enabling" services, such as case management, transportation services, outreach, and interpreter services to help their low-income, chronically ill, or immigrant populations access health and social services. In 2003, there were 24 federally-funded grantees with a total of 74 service delivery sites, serving more than 272,000 patients in 54 NC counties. Of these, 122,457 were uninsured. Health center patients are more likely to be low-income, ethnic minorities, uninsured, or covered by Medicaid than patients in private physicians' offices. North Carolina health centers serve a higher proportion of uninsured than other centers nationally. Further, the numbers of uninsured patients seen in NC centers have risen more rapidly than other paying patients in the last five years (32% increase in uninsured compared to a 22% increase in patient population overall). While the number of uninsured patients has risen, the federal funds used to support this patient population have not increased commensurately.

State-Funded Rural Health Centers (RHCs): The NC Office of Research, Demonstrations and Rural Health Development (ORDRHD, formerly the Office of Rural Health), helped establish 81 rural health centers throughout the state. These are private, not-for-profit organizations located in geographic areas that lack sufficient primary care resources to meet the needs of their communities. State-established rural health centers must provide primary care services, and must have the capacity to arrange for inpatient care and specialty referrals. However, RHCs are not required to provide dental, behavioral health, or enabling services, which are required of FQHCs. Thirty-two rural health centers receive ongoing support from the state for the care of the uninsured. Centers are paid $68 per visit for services provided to the uninsured with incomes below 200% of the federal poverty guidelines (These payments are called Medical Access Plan (MAP) reimbursements). In 2003, the state-funded rural health centers served 21,252 uninsured, low-income patients who received MAP reimbursement. The state-funded rural health centers tend to be located in the eastern and far western parts of the state, and range from single nurse practitioner sites in very remote areas to multiple practitioner sites serving multiple counties.

Local health departments: There are currently 85 local health departments covering all 100 counties: 79 that represent single counties and six district health departments. Over the years, NC public health has expanded its mission from the fundamental responsibilities of infectious disease control, food and water sanitation and safety, and data gathering to include a variety of programs and initiatives, such as maternal and child health programs; universal childhood immunizations; family planning; environmental sanitation; fluoridation of drinking water; and injury prevention and workplace safety. Recently, public health has dedicated more resources to health promotion and disease prevention activities to reduce the incidence of certain chronic diseases, including asthma, diabetes, hypertension, heart disease, and stroke. In addition to health promotion and targeted clinical services, some health departments offer comprehensive primary care and dental services. Health departments typically serve as providers of last resort for these services—providing these services only when community members are unable to access them elsewhere. As a result, the array of services varies by community, depending on residents' needs and the availability of other community resources. In 2003, local health departments provided services to 641,601 unduplicated patients, of which 260,603 (41%) were uninsured. Most of the uninsured were seen for specific clinical services (such as Pap smears or cholesterol screenings, well-child check-ups

or developmental evaluations, prenatal care, family planning, immunizations, or investigation of certain reportable diseases). Data are not collected on the number of patients who use health departments as their primary care provider. In most communities, an increasing number of uninsured patients are seeking care in local health departments. Health departments receive some funding for the traditional public health services provided to the uninsured, but this funding is not sufficient to meet growing needs.

Free clinics: Free clinics are non-profit organizations designed to meet the healthcare needs of the low-income uninsured in their communities, by drawing on local healthcare resources and volunteers. Free clinics tap into the willingness of the healthcare community (physicians, nurse practitioners, physician assistants, social workers, pharmacists, dentists, mental health providers, and chiropractors) and other members of the community to volunteer their time to provide healthcare to the uninsured. There are currently 60 free clinics or pharmacies in the state, serving 48 communities. Hours and the array of services vary among the clinics. Most free clinics are open one or two evenings a week, and serve patients on a first-come, first-served basis. Free clinics generally offer basic primary care, prevention services, and some pharmaceutical services (often through donated medications) needed to serve their uninsured patients. Although most of the free clinics are not able to guarantee continuous, comprehensive primary care services, some of the larger, more established free clinics have been able to offer chronic care clinics where patients can establish relationships with the same providers over time. In 2003, NC free clinics served 69,320 low-income patients, 59,840 patients in clinics providing primary care and medical services; and 9,480 in specialized clinics providing only pharmaceutical assistance or behavioral health services. Free clinics are generally supported through foundations, in-kind and cash donations, and local fundraising events. Free clinics are also seeing an increased number of uninsured patients seeking services.

Project Access or Healthy Communities Access Programs (HCAP): Project Access and Healthy Communities Access Programs help link the services of traditional safety net providers to healthcare services offered by private providers in the community. Project Access models help to fill gaps in the healthcare services available to meet the healthcare needs of the uninsured (e.g., by linking uninsured patients to specialists who agree to serve Project Access clients for free). Access systems involve local primary care physicians and specialists providing care to the uninsured. Many Access projects also have funds available to help purchase medications when needed medications are not available through the pharmaceutical assistance programs or other sources. Hospitals provide diagnostic services as well as outpatient and inpatient services. Project Access systems vary, depending on the community needs and resources. While these models are typically not able to provide all healthcare services needed by the uninsured (e.g., dental, behavioral health, or physical therapy services), they do help to provide more comprehensive services than are traditionally available in the community. The Project Access model has been implemented in nine NC communities: Asheville (Buncombe County), Boone (Watauga-Avery Counties), Charlotte (Mecklenburg County), Concord (Cabarrus County), Mitchell-Yancey Counties, Greensboro (Guilford County), Greenville (Pitt County), Henderson (Vance-Warren Counties), and Raleigh (Wake County). Five other communities (Sylva, Rutherforton, Winston-Salem, Durham, and Jacksonville) are exploring or in the process of implementing Project Access models.

School-Based or School-Linked Health Centers: Children are not always able to access comprehensive and coordinated systems of care. This is particularly problematic for adolescents, who have the lowest utilization of healthcare services of any age group. One way to ensure that children receive appropriate health services is to provide health services in the schools. There were approximately 1.3 million children attending 2,158 public schools and 93 charter schools in North Carolina for state fiscal year (SFY) 2003-2004. Nurses are available in most school districts, albeit on a limited basis. School nurses provide important health services to children and adolescents at school including counseling, chronic disease management, administration of medications or other healthcare procedures, and emergency services for injuries. In addition, school nurses oversee the care provided to medically fragile children who require one-on-one support. More comprehensive primary care and mental health services are provided in school-based or school-linked health centers. The actual services offered by school-based or school-linked centers vary, but generally include medical care, preventive health services, mental health assessment and treatment, chronic disease

management, laboratory testing, health education and promotion, social services, nutritional services, and other specialty services. Centers are generally not allowed to offer treatment for sexually transmitted diseases or family planning. State funds help support 31 school-based and three school-linked health centers, which provided services to approximately 28,000 students. There are 22 other centers across the state that do not receive state-funds and are generally not as comprehensive as the state-funded centers. School-based and school-linked centers struggle financially, because most do not have a source of guaranteed funding to sustain these programs.

Private Physicians: National studies suggest that the uninsured usually obtain health services from private physicians; although care provided through private physicians' offices is not always financially affordable. A 2001 study of households reported that nearly two-thirds of the uninsured reported a physician as their usual source of care, and half receive care in a physician's office. Some of this care is provided at no charge or at a reduced rate (charity care), and some of this care is provided with the expectation that the uninsured person will ultimately pay for the services. This distinction is important, as people with outstanding medical bills are much more likely to report having an unmet medical need or delaying care because of costs. Nationally, physicians were less likely to provide charity care in 2001 than they were in 1997. In 1997, approximately 76% of physicians reported that they provided charity care; in 2001, that number dropped to 71%. There has not been a formal study of NC practitioners as it relates to uninsured, underinsured, and charity care practices, so it is difficult to quantify how much charity care is being provided by NC physicians. However, private physicians clearly play an important role in caring for the uninsured.

Area Health Education Centers (AHEC) Program: AHEC's mission is to meet the state's health and health workforce needs by providing educational programs for healthcare professionals in partnership with academic institutions, healthcare agencies, and other organizations. As part of this mission, AHEC 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. These residency programs provide a significant amount of services to the uninsured. In 2003-2004, AHEC residency programs provided outpatient services to an estimated 35,427 uninsured patients.

Hospitals: Hospitals are an integral part of the North Carolina's safety net because almost all of them operate emergency departments that provide some services to everyone who comes to their door. There are 130 general acute care hospitals in North Carolina, 109 of which operate emergency rooms. The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals that participate in Medicare to screen anyone who requests treatment at the emergency room, regardless of ability to pay. If the person has a medical emergency, the hospital must treat them in order to stabilize the condition or transfer the patient to another hospital. Hospitals are the providers of last resort in communities where there are not enough other safety net providers to address the primary care or specialty needs of the uninsured. When uninsured or low-income patients are unable to obtain affordable care elsewhere, they sometimes turn to hospital emergency departments. In fact, some safety net providers refer patients to hospital emergency departments for specialty services when specialists in private practice are unable or unwilling to make these services available in their private practices. The state does not currently collect data on outpatient visits that do not result in inpatient hospitalizations. However, a 2003 survey of NC Hospital Association members found the uninsured accounted for 10% of outpatient visits (1,234,426 of 12,344,256 visits), and of those, 22% were uninsured patients making emergency room visits (672,799 out of 3,058,176). In addition to services provided to the uninsured in the emergency department, some hospitals run or help support outpatient ambulatory care clinics. These clinics provide a wide array of primary care services to the uninsured or other underserved populations. Generally, hospitals face the same financial problems as other safety net organizations—increasing numbers of uninsured patients seeking care, without a commensurate increase in funds to care for the uninsured.

Prescription Drug Programs: There are limited resources available to help the uninsured and those with limited healthcare coverage to obtain necessary medications. These resources, like other safety net programs, are limited and do not meet all of the medication needs of the uninsured. The largest source of free medications is through patient assistance programs (PAPs) offered by pharmaceutical companies. The PAP programs vary substantially from one another in terms of the medications offered, eligibility requirements, and application processes. The PAP programs do not

cover every medication or every uninsured person. Many require that physicians complete the application on behalf of their patients. Some of the safety net providers also offer free or low-cost medications (or assist patients in filling out the necessary forms to obtain the free drugs through the patient assistance programs). In addition, a few communities have organized local pharmacy assistance programs to help low-income uninsured patients obtain needed medications. Low-income Medicare recipients have other sources of assistance—either through the Medicare sponsored pharmacy discount cards and/or the Senior Care program. While these programs are a huge benefit to thousands of uninsured in our state, they are not sufficient to meet all of the medication needs of the uninsured.

Availability of Safety Net Services Throughout the State

As noted earlier, few communities have sufficient safety net resources to meet the healthcare needs of all of the uninsured. Yet, some communities have fewer safety net resources than others. The Task Force collected data on the number of uninsured residents receiving care in existing safety net institutions and compared this to the estimated numbers of the uninsured in each county. The difference was the number and percentage of uninsured for whom there was no identified source of primary care. Based on these analyses, the Task Force was only able to determine that about 25% of all the non-elderly uninsured received primary care services from safety net organizations. Yet, this percentage varied widely across the state. In some counties, it appears that all or most of the uninsured have been able to access safety net services; while in others there are no known safety net organizations available to meet the primary care needs of the uninsured. The Task Force identified 28 communities that have the fewest safety net resources to meet the primary care needs of the uninsured. Thirteen of these counties also had lower than average primary care provider-to-population ratios, suggesting that, at least in these communities, it would be difficult for the private providers to meet the unmet primary care needs of the uninsured. Further, most communities lack the full array of services necessary to meet the healthcare needs of the uninsured. Access to pharmaceuticals, specialty care, behavioral health, and dental services is still a problem in many communities, including those that have adequate primary care capacity.

Few communities have fully-integrated systems of care to address the entire range of healthcare services needed by the uninsured. Most communities have fragmented systems of care for the uninsured. This is due, in part, to the difficulties in sharing patient information across providers, turf issues, and/or the need to compete for paying patients to help cover the costs of caring for the uninsured.

Recommendations

The NC IOM Healthcare Safety Net Task Force spent almost a year studying this issue (March 2004-January 2005) and offered 28 recommendations (listed below) that could help strengthen and expand the existing safety net to better meet the healthcare needs of North Carolina's uninsured. These recommendations propose a number of different actions, including: legislative action and/or additional funding, policy changes within the NC Department of Health and Human Services (NC DHHS), action and/or collaboration between safety net organizations, and targeted grant-making within foundations. Of these 28 recommendations, ten are considered the top priority, which, if implemented, will have the greatest likelihood of expanding care to the uninsured. The priority recommendations are highlighted (shaded) in the list below. These "top priority" recommendations are indicated by shading in the following table.

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
Chapter 2: Uninsured					
2.1. The NC General Assembly should take steps to make health insurance coverage more affordable and to expand health insurance coverage to more uninsured individuals. (PRIORITY)	✓				

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
Chapter 3: Safety Net Defined					
3.1. The Office of the Secretary of the NC Department of Health and Human Services should continue its efforts to monitor access to behavioral health services for the uninsured and other underserved populations. The Office of the Secretary should examine access to services both for the priority (target) populations and for those with less severe behavioral health problems and should seek input from a wide variety of stakeholders including, but not limited to, publicly funded local management entities, children's development services agencies, behavioral health providers, primary care providers, safety net organizations, and representatives of consumer groups.		✓	✓		✓ Other health professionals
3.2. The Office of the Secretary should work with the NC Pediatric Society, NC Academy of Family Physicians, NC Chapter of the American College of Physicians, NC Psychiatric Association, other interested professional associations, and NC Area Health Education Centers program to examine ways to expand the capacity of primary care providers to address some of the behavioral health needs of the uninsured and/or underserved populations. Information on this initiative should be reported to the NC Commission for Mental Health, Developmental Disabilities and Substance Abuse Services.		✓	✓		✓ Other health professionals
Chapter 4: Availability of Safety Net Services					
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.	✓	✓	✓	✓	✓ Sheps Center, UNC-CH

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
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 foundations, 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. (PRIORITY)					
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. (PRIORITY)		✓	✓		✓ Local Community
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.			✓		

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
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 NC 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. (PRIORITY)			✓		
Chapter 5: Prescription Drugs					
5.1. The NC Office of Research, Demonstrations and Rural Health Development and other safety net organizations should create a workgroup to meet with pharmaceutical companies to discuss: a) Simplifying and streamlining the Patient Assistance Programs, including the application forms, verification requirements, and eligibility requirements; and b) Creating bulk replenishment programs and other ways the pharmaceutical industry could help provide medications to safety net organizations. Information should be disseminated to safety net organizations and private physician practices about the best way to access existing pharmaceutical resources.		✓	✓		
5.2. The NC General Assembly should support the Health and Wellness Trust Fund's efforts to support and expand prescription assistance programs, including, but not limited to, expanding the availability of Medical Access and Review Program Medication and Access Review Program (MARP) and medication assistance programs.	✓			✓	
5.3. North Carolina private foundations should consider three-year start-up funding at $180,000 per year to the NC Office of Research, Demonstrations and Rural Health Development to create a bulk medication replacement system. (PRIORITY)		✓		✓	
5.4. The NC Office of Research, Demonstrations and Rural Health Development should explore opportunities to expand 340B drug discount prices to low-income patients of other safety net organizations.		✓	✓		
Chapter 6: Coorination and Integration of Services					
6.1. The NC General Assembly should enact legislation that clarifies existing state confidentiality laws to ensure that safety net providers are allowed to share identifiable health information with each other when providing care to the same patients, consistent with applicable federal law. The legislation should include heightened protections for particularly sensitive information, such as mental health and communicable disease information.	✓				

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
6.2. The NC Office of Research, Demonstrations and Rural Health Development should collect and disseminate descriptions of various models of collaboration and integration found to work well in particular communities.		✓			
6.3. In addition to healthcare providers, local safety net collaborations should encourage the participation of business and industry, colleges and universities, faith-based organizations, social service agencies, non-profits, and other interested groups in community collaborations to provide care to the uninsured.			✓		✓ Universities Business Others
6.4. North Carolina foundations should help convene a best practices summit of safety net organizations that will focus on collaboration and integration. This summit would help local communities identify ways to build and strengthen their capacity to meet the healthcare needs of the growing uninsured population, and to reduce barriers to interagency collaboration and integration. Summit participants should include representatives of existing safety net organizations at the state and local levels. One of the outgrowths of this summit would be to develop clearer and measurable criteria of collaboration to guide future decisions for safety net program support by public and private funding agencies. (PRIORITY)			✓	✓	
6.5. Hospitals should take the lead to develop collaborations with local safety net organizations to help ensure that the uninsured have appropriate medical homes and after-hours care for persons requiring non-emergent attention.			✓		
6.6. The NC Institute of Medicine should create an on-going state-level Safety Net Advisory Council that can encourage state-level and local safety net collaborations and can help monitor the implementation of the Safety Net Task Force's recommendations. The group should include the full array of existing safety net organizations, including health departments, federally qualified health centers, free clinics, hospitals, medical societies, Project Access and Healthy Communities Access Programs, medication assistance programs, and other non-profit agencies providing care to the uninsured. (PRIORITY)			✓		✓ NC IOM
Chapter 7: Financing Safety Net Services					
7.1. The NC Department of Health and Human Services, NC Community Health Center Association, NC Association of Free Clinics, NC Health Directors Association, NC Hospital Association, NC Medical Society, and other safety net organizations should work with the NC congressional delegation to support NC safety net organizations. a) The NC congressional delegation should oppose any efforts to create a Medicaid block grant or otherwise limit the availability of federal Medicaid funds to the states. b) In order to ensure that North Carolina receives its fair share of federal funding for federally qualified health centers (FQHCs), the NC congressional delegation should work to ensure that priority for new FQHC funding should be given to		✓	✓		✓ Congress

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
states that have higher than average proportions of uninsured, racial disparities, and/or a lower than average receipt of federal FQHC funds per low-income person. c) The NC congressional delegation should also work to ensure that North Carolina receives its fair share of federal State Children's Health Insurance Program (SCHIP) and Ryan White CARE funds, and that Congress continues funding the Special AIDS Drug Assistance Program (ADAP) Initiative. d) The NC congressional delegation should work to expand the 340B program to include free clinics, local health departments, and other non-profit or governmental agencies with a mission to serve low-income uninsured patients. (PRIORITY)					
7.2. The NC Health Directors Association should develop a legislative proposal to amend state laws to enable local boards of public health to create governance structures that would make them eligible to participate in additional federal programs through which funding is available to support care for the uninsured.			✓		
7.3. The NC health foundations should consider additional funding to meet the capital and infrastructure needs of healthcare safety net organizations.				✓	
7.4. The NC General Assembly should appropriate, on a recurring basis, $6 million to be used for federally qualified health centers and those health centers that meet the criteria for federally qualified health centers, and $5 million to be used for state-designated rural health centers, public health departments, and other non-profit healthcare organizations with a mission to serve the uninsured and other medically underserved populations. The funds shall be used to: a) Increase access to preventive and primary care services by uninsured or medically indigent patients in existing or new health center locations; b) Establish health center services in counties where no such services exist; c) Expand the NC Office of Research, Demonstrations and Rural Health Development's Medical Access Program (MAP) to safety net providers who currently receive no financial support for indigent care and who are located in high-needs counties; d) Create new services or augment existing services provided to uninsured or medically indigent patients, including primary care and preventive medical services, dental services, pharmacy, and behavioral health; e) Increase capacity necessary to serve the uninsured by enhancing or replacing facilities, equipment, or technologies; and f) Create or augment community collaborations or integrated delivery systems that have the capacity to expand health services to the uninsured or medically indigent patients.	✓	✓	✓		

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
Of the $5 million appropriated to state-designated rural health centers, public health departments, and other non-profit healthcare organizations, $140,000 shall be provided to the Office of Research, Demonstrations and Rural Health Development to develop planning packages for local communities interested in developing safety net programs, provide technical assistance, and collect data on the capacity of the existing safety net to meet the needs of the uninsured and medically indigent. (PRIORITY)					
7.5. The NC General Assembly should appropriate $11.35 million in SFY 2005-2006 and $25.95 million in SFY 2006-2007 to expand the number of school health nurses with the goal of fully implementing the school health nurse initiative over the next five years. (PRIORITY)	✓		✓		
7.6. The NC Division of Medical Assistance should explore different Medicaid payment rules that would provide higher reimbursement to FQHCs, FQHC look-alikes, and rural health clinics (RHCs) that serve a disproportionately high percentage of uninsured. New funds should be used to support and expand care to the uninsured.		✓	✓		
7.7. The NC Division of Medical Assistance should assure that reimbursement to local health departments for Medicaid services will be at actual cost (same as for FQHCs, RHCs, and CHCs). Rates should be adjusted annually to account for the full cost to provide services or the annual cost settlement payment should include the full share (county, state, and federal) of Medicaid payments. New funds should be targeted to providing care to the uninsured (comprehensive primary care, population-based services, or other more targeted clinical services).		✓	✓		
7.8. The NC General Assembly, NC Division of Medical Assistance, and NC State Employees Health Plan should consider options to enhance payments to hospitals that serve high proportions of uninsured patients or that meet identified health shortage needs by providing other critical health services. a) Options may include, but are not limited to, increasing Medicaid or other reimbursement to achieve this goal or exploring whether Disproportionate Share Hospital-related supplemental payments can be used for this purpose. b) The General Assembly should appropriate new funds for this purpose. c) In distributing new funds, the state should recognize other funds the hospitals receive to serve the uninsured. d) New funds should be targeted to expanding care to the uninsured.	✓	✓	✓		✓ State Employees Health Plan
7.9. The NC Division of Medical Assistance should explore the possibility of creating a system of "shared savings" with regional Community Care of North Carolina (CCNC) networks. Savings that are retained by regional networks should be used to provide similar health services to the uninsured.			✓		

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
7.10. The NC Division of Medical Assistance (DMA) should ensure that the federal Medicaid spend-down rules that allow applicants to use the value of healthcare services paid by state and county programs in meeting their spend-downs are fully implemented. In so doing, the DMA should: a) Explore which programs are eligible for this deduction, including, but not limited to, Division of Public Health purchase of care programs, AIDS Drug Assistance Program (ADAP), mental health, and MAP programs. b) Work with the other state agencies that administer these programs to develop cost of care statements, and, ultimately, develop systems to facilitate the exchange of information about the value of services provided across programs to simplify the spend-down process for applicants.		✓			
7.11. The NC Division of Medical Assistance should continue its work to simplify the Medicaid application process for parents, people with disabilities, and older adults. Specifically, the Division should: a) Create a simplified application form, b) Extend the length of time for recertification, and c) Explore the possibility of eliminating the assets test for families with children.		✓	✓		

Chapter One Introduction

Between 2000 and 2003, North Carolina's uninsured population experienced one of the largest percentage increases in the country. Approximately 1.4 million people in North Carolina under the age of 65 are uninsured, a growth of more than 300,000 people (31%) since 2000.[1,2] One-year estimates from the Current Population Survey suggest that almost one out of every five non-elderly persons in the state (19.4%) lacked health insurance coverage in 2003. North Carolina has been harder hit than many states due to the loss of manufacturing and textile jobs that resulted from trade relocation. The rising cost of health insurance, coupled with the downturn in the economy, is making it more difficult for people to afford coverage.

Lack of insurance coverage creates great barriers obtaining needed health services. Individuals without coverage are less likely to have a regular source of care. In North Carolina, 51% of the uninsured reported that they had no one whom they consider to be their personal physician or healthcare provider in 2003. In contrast, only 12% of people with insurance coverage had no regular source of care. The uninsured are also more likely to delay or forgo needed care and are less likely to receive preventive care. When they do seek care, they are generally sicker than the insured population and experience poorer health outcomes.

Most of the uninsured in North Carolina (62%) have incomes less than 200% of the federal poverty guidelines.[3] This makes it challenging for the uninsured to pay for their healthcare needs out of pocket. Difficulty paying for needed healthcare is not limited to the uninsured, but the effects on this population are more acute. Approximately 15% of North Carolinians reported in 2003 that there was a time in the last 12 months when they needed to see a healthcare provider but could not because of the cost.[4] The uninsured were far more likely to report access barriers (41.2%), than were people with insurance coverage (9.5%).

In some parts of the state, the uninsured can access safety net organizations for some or all of their healthcare needs. Safety net organizations are defined as:

> "Providers that organize and deliver a significant level of healthcare and other health-related services to uninsured, Medicaid, and other vulnerable populations."[5]
>
> Core safety net providers "have two distinguishing characteristics: (1) by legal mandate or explicitly adopted mission they maintain an "open door," offering access to services to patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients."[5]

In North Carolina, the safety net consists of federally qualified health centers (e.g., community and migrant health centers), state-funded rural health centers, local health departments, free clinics, Project Access or Healthy Community Access Programs, school-based or school-linked health centers, hospitals, and other organizations that have a central goal of providing care to patients regardless of their ability to pay. (A list of safety net organizations by county is included in Appendix A.) In addition, private physicians often provide care to the uninsured; albeit not always on a sliding scale basis. While some safety net resources exist in most communities, they are not always sufficient in meeting the healthcare needs of the uninsured. Some communities have multiple safety net organizations, but the system of care is fragmented. Others have a basic capacity to provide primary care services, but cannot meet the need for specialty consults or referrals, prescription medications, or more complex care. Still other communities lack even the capacity to meet the basic primary care needs of the uninsured.

Existing safety net organizations are experiencing an increased demand for their services without a corresponding increase in revenues to meet this need. The state and federal funding sources available to meet the healthcare needs of the uninsured are not keeping pace with the growing needs. The increased numbers of uninsured and inability to raise revenues from third party payers or other sources is creating significant

financial strains for many of these organizations. Without these institutions, the capacity to provide healthcare services for the uninsured and other underserved groups would be seriously undermined.

The NC Institute of Medicine Healthcare Safety Net Task Force was established to examine the adequacy of the existing safety net structure. The Task Force was chaired by the Honorable Carmen Hooker Odom, Secretary for the NC Department of Health and Human Services, and Sherwood Smith, JD, Chairman Emeritus of Progress Energy, and included 46 other members, including representatives of safety net organizations and provider associations, state and local elected officials and agency staff, non-profits and advocacy organizations (See page 3 for full list of Healthcare Safety Net Task Force and Steering Committee members). The goal of the Task Force was to develop a plan to better coordinate and integrate existing safety net institutions, identify communities with inadequate systems to care for the uninsured and underinsured, ascertain possible funding sources (nationally and locally) that can be used to expand care to the uninsured, and ultimately to expand and strengthen the capacity of healthcare providers and safety net institutions to care for underserved populations.

This report is divided into eight chapters. Chapter 2 describes characteristics of the uninsured in the state in more detail and the consequences of being uninsured. Chapter 3 provides an overview of the existing safety net system, including a description of the different types of safety net organizations, their locations, the services provided, the types of patients served, and financing. Chapter 4 identifies areas in the state with the greatest unmet needs and proposes a set of recommendations for how these needs can be addressed. Chapter 5 describes the existing ways to help the uninsured or people with inadequate coverage to obtain affordable medications (including pharmacy assistance programs and the 340B Drug Pricing Program) and includes recommendations on how the availability of affordable medications can be expanded to more low-income uninsured or underinsured patients. Chapter 6 begins with a description of some of the barriers preventing efforts to better coordinate safety net resources and concludes with a series of recommendations based on best-practices and strategies to promote collaboration and integration among organizations. Chapter 7 focuses specifically on financing options, with a more detailed description of how existing safety net organizations are financed and recommendations of options to expand financial support to enable these organizations to provide additional care to the uninsured. Chapter 8 is a summary of the Task Force recommendations.

References

1 Historical Health Insurance Tables, Table HI-6. Health Insurance Coverage Status and Type of Coverage by State—People Under 65: 1987 to 2003. Washington, DC: US Census Bureau, Current Population Survey, 1988 to 2004 Annual Social and Economic Supplements, Last revised September 2004. (Accessed September 21, 2004, at: http://www.census.gov/hhes/hlthins/historic/hihistt6.html). This report focuses on the non-elderly uninsured, as most older adults (65 or older) have Medicare or other health insurance coverage. In North Carolina, only 1% of older adults are uninsured.

2 Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2003. Washington, DC: US Census Bureau. Current Population Survey, 2004 Annual Social and Economic Supplement, Last revised September, 2004. (Accessed September 21, 2004, at http://ferret.bls.census.gov/macro/032004/ health/h05_000.htm).

3 200% of federal poverty guidelines in 2004 amounted to $18,620 for a single person and $47,140 for a family of four.

4 2003 BRFSS Survey Results: North Carolina. NC State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS).

5 Lewin ME, Altman S, eds. America's Health Care Safety Net: Intact but Endangered. Washington, DC: Institute of Medicine, 2000.

Chapter Two

The Uninsured in North Carolina

Over the last four years (2000-2003), North Carolina experienced an increase in the number and percentage of non-elderly uninsured, which was more than double the rate of increase nationally.[i] During that period, the percentage of the state's population under age 65 who lacked insurance coverage increased from 15.3% to 19.4% (or a 4.1 percentage point increase), whereas at the national level, the percentage of uninsured increased from 16.1% to 17.6% (a 1.5 percentage point increase). Most of the increase in the uninsured is attributable to the decline in employer-sponsored insurance. Between 2000-2003, the percentage of North Carolina's non-elderly population with employer-based coverage declined from 67.4% to 58.5%, an 8.9 percentage point difference. There was also a drop in employer-based insurance at the national level, but this decline was less than half the decline experienced in North Carolina. Nationally, 67.7% of the non-elderly population had employer-sponsored insurance in 2000. This declined to 63.8% by 2003, a 3.9 percentage point drop in employer-based coverage.[1]

The number of uninsured would have been even larger in North Carolina had there not been an increase in the percentage of people covered by Medicaid and who purchased non-group insurance. The percentage of the state's non-elderly population covered by Medicaid grew 2.8 percentage points (compared to 2.1 percentage points nationally), while the percentage of people with non-group private coverage grew 2.4 percentage points (compared to a 0.1 percentage point increase nationally).

Certain groups have higher risks of being uninsured than others. Family income (e.g., poverty status); race, ethnicity, and country of origin; age; employment status and, if employed, the industry and firm size; and geographic location all factor into a person's likelihood of being uninsured. As a general rule, low-income families, those who are non-white or non-citizens, 20-30 year olds, unemployed, or those working for small firms or certain industries (e.g., construction, hospitality, or agriculture) are more likely to lack insurance coverage. The rising cost of health insurance also affects the ability of individuals and families to afford coverage. Obtaining needed medical care can cause great financial difficulty to families. Individuals without coverage are more likely to delay or forgo needed care. When they do seek care, they are generally sicker than the insured population and experience worse health outcomes. Each of these factors is discussed in more detail below.

Low-income families are more likely to be uninsured: North Carolina residents have been more deeply affected by the downturn in the economy than people in other states. The sluggish economy has led to increases in the state's poverty rates. North Carolina experienced the fourth largest increase in the percentage of the population with incomes below 100% of the federal poverty guidelines (FPG). Between 2001-2002 and 2002-2003 this percentage grew from 13.4% of the state's population (2001-2002) to 15.0% of the state's population (2002-2003).[2] Not surprisingly, those living in poverty have a greater chance of being uninsured and are less likely to have employer-based coverage than individuals with higher incomes (Table 2.1). More than one-third of the people living in poverty (35.6%) are uninsured as are 31.6% of the near poor (incomes between 100-200% FPG).

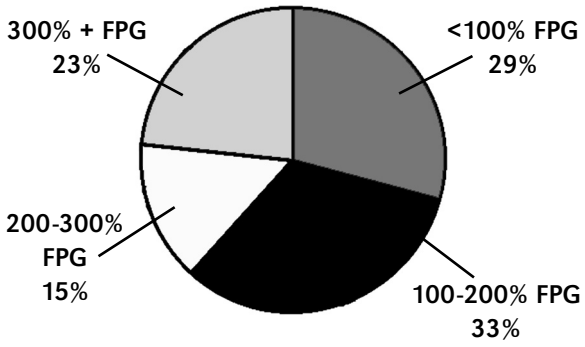
Overall, 62% of all uninsured have incomes below 200% of the federal poverty guidelines (see Chart 2.1 on page 22).

i Because most older adults, age 65 or older, have Medicare, the discussion of the uninsured is limited to non-elderly individuals (younger than age 65). Only about 1% of individuals age 65 or older lacked any type of health insurance coverage.

Table 2.1.[3,ii]
Insurance Coverage by Poverty Status—Under Age 65 North Carolina Population (2001-2003)

Insurance Type	<100% FPG	100-200% FPG	200-300% FPG	300% + FPG	Total
Employer	12.7%	30.5%	61.3%	80.8%	57.0%
Medicaid	36.6%	19.6%	8.2%	2.0%	11.9%
Medicare	6.6%	6.3%	3.4%	1.4%	3.5%
Private (non-group)	8.5%	12.1%	10.8%	6.6%	8.7%
Uninsured	35.6%	31.6%	16.3%	9.2%	18.9%
Total	100%	100%	100%	100%	100%

Chart 2.1.[4,ii]
Poverty Status of Uninsured—Under Age 65 North Carolina Population (2001-2003)



Racial and ethnic minorities and non-citizens are more likely to be uninsured than whites: One out of every five African American, non-Latinos under the age of 65 (19.9%), and 55.7% of the Latinos were uninsured, compared to only 14% of white, non-Latinos. North Carolina Latinos are more likely to be recent immigrants who were born outside of the United States, thus, they are disproportionately likely to be uninsured. Latinos born in the United States are similar in percentage uninsured to non-Latino, non-whites (24.9%); however, Latinos born outside the United States are much more likely to be uninsured (45.1%), and those that are non-citizens are most likely to be uninsured (68.4%). Latinos are more likely to be uninsured because they work in low-wage jobs, in industries that do not offer health insurance coverage (construction, hospitality), and because they are not eligible for publicly-subsidized coverage. More than half (58.3%) of the Latinos living in North Carolina are immigrants, and many are recent immigrants who arrived in the United States within the last five years. Federal immigration laws, passed in 1996, made it more difficult for Latinos and other recent immigrants to qualify for certain federally-funded programs, including Medicaid and NC Health Choice (SCHIP).[5]

Young adults are more likely to lack insurance coverage: Insurance status also varies by age, with older adults most likely to be insured. Only 1% of individuals 65 or older are uninsured, compared to 36.2% of young adults age 20-24, or 33.2% of adults age 25-29. Aside from the elderly, those least likely to be uninsured are children under age five (9.8%), or adults between the ages of 55-59 (9.9%). National studies suggest that the reason young adults are more likely to lack insurance coverage is that they are more likely to work in low-wage jobs or not-qualify for employer-sponsored insurance.[6]

Individuals working for small firms or in certain industries are more likely to be uninsured: Most of the uninsured are in families with some connection to the workforce. Families with two or more full-time workers comprise 17.9% of all uninsured, and families with one full-time worker comprise another 50.2% of all uninsured. Together, over

ii The 2004 data was weighted more heavily. Survey data reports insurance status as of the year prior to the date of the survey. In 2003, the federal poverty guidelines for a family of four was $18,400. Analysis using a weighted average from the 2002, 2003, and 2004 Current Population Survey of the US Census Bureau.

two-thirds of uninsured are in a family with at least one full-time worker. Another 12.4% of the uninsured are in a family where someone works part-time. Less than one-fifth of all uninsured (19.5%) have no connection to the workforce.

However, having a connection to the workforce—even a full-time job—does not guarantee health insurance coverage. For example, most of the uninsured *adults* are employed, with 47.2% being employed full-time and 16.5% employed part-time. The likelihood of having health insurance coverage depends, in part, on the size of the employer and the type of industry. North Carolina employees working for small companies (those employing fewer than 25 employees) have a much higher risk of being uninsured (34.2%) compared to those working for very large employers with 1,000 or more employees (11.2%). Nonetheless, approximately one-quarter of the uninsured (23%) works for very large employers. The industry of employment also affects insurance coverage. Agriculture, construction and hospitality industries are less likely to offer health insurance coverage than government, health and education, or finance jobs.

Coverage varies across geographic areas of the state, with people in rural areas more likely to be uninsured: Rural residents are more likely than urban residents to be uninsured (24% vs. 17%, respectively), but because there are more people living in urban areas, a larger percentage of the overall uninsured live in urban areas.

The Cecil G. Sheps Center for Health Services Research (Sheps Center) at the University of North Carolina at Chapel Hill (UNC-CH) developed county-level estimates of the number of uninsured individuals under age 65.[iii] Socioeconomic factors, such as race, ethnicity, age, sex, poverty, educational attainment, employment sector, and employment status of the county population, were used in developing estimates of the uninsured. The county-level estimates ranged from a low of 16.5% (Dare County) to a high of 27.0% (Duplin County) in 2003.[7] (See Chapter 4 and Appendix B for county-level estimates of the uninsured).

The rising cost of health insurance, coupled with the downturn in the economy, has made it more difficult for people to afford coverage: Nationally, health insurance premiums rose 11.2% between 2003-2004, far faster than the 2.2% increase in workers' hourly wages. North Carolina employees are generally required to pay a greater amount for health insurance premiums than other employees nationally; despite the fact that North Carolina's median income is lower than the national average.[iv,8] On average, NC employees paid $575 for single coverage and $2,110 for family coverage in 2002, compared to national average employee costs of $565 and $1,987, respectively.[9] This creates very real problems related to affordability of coverage.

Lack of health insurance affects access to care: The uninsured have much greater difficulties accessing health services. Two recent studies of low-income uninsured children in North Carolina shed light on the access barriers experienced by uninsured lower-income families. In 2001, North Carolina froze enrollment in the NC Health Choice program (North Carolina's State Children's Health Insurance Program). The Sheps Center conducted six focus groups with parents of children who were placed on the waiting list during the enrollment cap.[10] Few parents were able to afford coverage for their children so most children on the waiting list were uninsured during the freeze. Parents reported delaying needed care or using the emergency room to obtain needed services. Even when they were able to obtain care for their children, it was often at great financial cost. Parents reported juggling payments, incurring late fees, and receiving calls from creditors. Many had outstanding health bills they were trying to pay months after services were provided. Another study examined changes in access to health services for children newly enrolled in NC Health Choice. It found that children who were previously uninsured were significantly less likely to report having a regular doctor or receiving a check-up and significantly more likely to report unmet medical

iii Because most surveys (such as the Current Population Survey) are not large enough to support *direct* estimates of small areas (that is, estimates computed directly from survey responses) with ample precision, Sheps Center staff used small area estimation methods to develop *indirect* estimates of the rate of uninsured at the county level. Sheps Center staff used socioeconomic characteristics of the county, including race, ethnicity, age, sex, poverty, educational attainment, employment sector, and employment status of the county population to develop estimates of the uninsured.

iv In 2003, North Carolina's median household income was $38,234. The median US household income was $43,564.

needs than those with insurance coverage.[11]

As reported in Chapter 1, Behavioral Risk Factor Surveillance System (BRFSS) data also provide some information about ability to obtain healthcare services among NC uninsured adults.[12] Approximately 15% of respondents reported in 2003 that in the last 12 months there was a time when they needed to see a doctor but could not because of the cost. The uninsured were far more likely to report access barriers (41.2%) than were people with insurance coverage (9.5%). Similarly 35.2% of uninsured diabetics reported that there were times in the past 12 months when they were unable to obtain testing supplies and diabetes medicines due to costs (compared to 8.8% of people with insurance). The uninsured are far more likely than those with insurance to report that they have no person whom they consider to be their personal doctor or regular healthcare provider (50.7% compared to 12.4%, respectively).

More recent data on the costs of healthcare are available from a state-supplement to the BRFSS. The NC Department of Health and Human Services added questions to the 2004 BRFSS asking about adequacy of insurance coverage and out-of-pocket expenses. Preliminary data are available from 3,300 adult respondents contacted during the first three months of the 2004 BRFSS survey (January-March).[v] Of these respondents, 21% of all respondents (44% of the uninsured vs. 17% of those with insurance) reported that someone in the household had problems paying medical bills; and 18% (36% of uninsured vs. 15% of the insured) reported being contacted by a collection agency to pay past medical bills. Twenty-nine percent of the uninsured and 18% of the insured reported that they had to cut back on living expenses, including food, clothing, utilities, housing, and/or transportation, to pay for needed healthcare costs.[13]

Latinos and other immigrant populations have additional access problems related to language and cultural barriers. People who come from other countries are accustomed to different healthcare systems, financing mechanisms, and types of healthcare providers. They may also have different understandings of what affects health. These varying cultural beliefs and healthcare expectations can create barriers to the effective use of the US healthcare system. These barriers are then compounded for approximately half of all Latinos in North Carolina who report that they are unable to speak English very well.

Lack of health insurance affects health: National studies have shown that lack of health insurance affects a person's health status.[14] The uninsured receive less preventive care (e.g., they are less likely to have had a recent mammogram, Pap smear, prostate exam, or colon cancer screening). As a result, numerous studies have shown that the uninsured are more likely to be diagnosed with late-stage cancer, including late-stage melanoma, colorectal, breast, prostate, and cervical cancer. The chances of surviving cancer are much lower when the disease is diagnosed at a later stage of progression. Preventive screenings for elevated cholesterol and hypertension are also less common among the uninsured. Further, uninsured individuals with chronic illnesses are less likely to receive the care needed to manage their health conditions.[15]

Studies have shown that the uninsured are less likely to receive major interventions than those with insurance after being admitted to the hospital. A national study of 330,000 patients with myocardial infarction (heart attack) showed that uninsured patients were less likely to receive cardiac catheterization and revascularization procedures than those with insurance. This may be due, at least in part, to differences in the hospital where patients go to seek care. Treatment differences between people based on insurance status have also been found in people with diabetes, kidney disease, liver disease, pneumonia, and cystic fibrosis. Medical care also has been found to differ for trauma patients.

The uninsured use fewer services and delay care, which makes them more likely to be hospitalized for conditions that could have been prevented if they received adequate primary care. Middle-aged people who were continuously uninsured over a four-year time period were 60% more likely to have a major health decline (including death) than those with continuous insurance coverage. Other studies also show that the uninsured are approximately 25% more likely to die prematurely than people with insurance coverage. The Institute of Medicine of the National Academies found that there were 18,000 excess deaths among people younger than age 65 due to lack of health

v These data are unweighted and do not represent the state as a whole. Weighted data for the entire year (2004) will be available in April, 2005.

insurance coverage.[16] This is similar to the number of people who die prematurely due to diabetes or stroke within the same age group.

Not only does lack of insurance coverage affect health status, it also can indirectly affect labor force participation. People in poor health are less likely to work, or may work fewer hours, and as a result, their annual earnings from work are generally less than people in better health. Some studies suggest that poor health reduced annual earnings by 15-30%, and that poor health affects educational attainment.[17]

As will be evident in the following chapters, high uninsurance rates in communities can also have a spillover effect on healthcare institutions, including those providing services to people with insurance coverage. Hospitals and other healthcare organizations that serve a high proportion of uninsured patients have less ability to cover their costs.[18] This financial stress not only affects care for the uninsured, but also the ability to provide care to the larger community.

The Task Force recognized that the primary barrier the uninsured face in obtaining needed health services is lack of insurance coverage. Therefore, the Task Force recommends:

Rec. 2.1: The NC General Assembly should take steps to make health insurance coverage more affordable and to expand health insurance coverage to more uninsured individuals.

Ideally, everyone in North Carolina and in the nation should have affordable health insurance coverage that meets their basic healthcare needs. Providing such coverage would reduce the need for safety net providers; although providers who are experienced in addressing the education, transportation, and other non-financial barriers of low-income or underserved populations will always be needed.

Until the uninsured have coverage, the Task Force recognized the importance of supporting and expanding existing safety net capacity to be able to meet more of the healthcare needs of the uninsured.

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Chapter Three

Safety Net Programs in North Carolina

On the surface, North Carolina appears to have many safety net organizations with a mission to provide services to the uninsured. While safety net organizations exist throughout the state, they do not exist in every community, and many provide a limited array of services. Thus, these institutions are not always able to meet the full healthcare needs of the growing uninsured population.

This chapter provides an overview of the major safety net organizations in the state, including federally qualified health centers, rural health clinics, state-funded rural health centers, local health departments, free clinics, Project Access, school-based and school-linked health centers, private practitioners, Area Health Education Centers (AHEC) teaching clinics, hospital outpatient clinics, and emergency departments (A county-based list of safety net organizations is included in Appendix A). An overview of each of the safety net providers is given along with more detailed information on services offered, the number of uninsured patients served, patient eligibility requirements for the services (if any), financing, and current challenges the safety net organizations are facing in providing care to underserved populations. State-level information is provided as well as a national comparison, when available.

Federally Qualified Health Centers (FQHCs)

Overview: The federal health center program began in 1965 as a demonstration project from the Office of Economic Opportunity. The program has grown nationally from 150 centers in 1973 to 890 centers, which provided services to 12.4 million people in 2003. These centers served approximately 4.8 million uninsured users (11% of the nation's uninsured) in 2003.[1]

Federally qualified health centers are public or private non-profit organizations that receive funds from the Bureau of Primary Health Care in the Health Resources and Services Administration of the US Department of Health and Human Services. FQHCs are authorized under Section 330 of the Public Health Service Act and include the following type of organizations:

- Community health centers (CHCs),
- Migrant health centers,
- Health Care for the Homeless,
- Public Housing Primary Care, and
- Healthy Schools, Healthy Communities.[i]

In 2003, there were 24 FQHC grantees with a total of 74 service delivery sites serving patients in 54 NC counties. These centers employed more than 1,200 full-time employees, including physicians, nurse practitioners, physician assistants, dentists, nurses, and other medical staff. While most grantees are traditional community health centers, there are also eight migrant health centers, two Health Care for the Homeless programs, and four Healthy Schools, Healthy Communities programs (including one that is a school-based subrecipient of a community health center). In addition, the NC Farmworker Health program, operated through the Office of Research, Demonstrations and Rural Health Development (ORDRHD) also receives federal funding under this program.[ii] Most of the FQHCs in North Carolina are stand alone centers, but there are six grantees that have five or more service delivery sites. FQHCs are spread geographically throughout the state; however, there are lower concentrations of centers in the eastern and western portions of the state.

Health centers must satisfy certain basic criteria in

i 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).

ii The Farmworker Health Program is a voucher (contracted fee-for-service) program and does not provide any direct services.

order to be designated as a FQHC and receive federal funding. Health centers must:

- Serve a medically underserved area or population based on poverty and population health indicators;
- Provide comprehensive primary and preventive healthcare services, either directly or by contract, regardless of ability to pay;
- Provide enabling and support services to facilitate access to health and social services (e.g., case management, outreach, transportation, and interpreters);
- Have a schedule of charges consistent with locally prevailing rates;
- Apply a sliding-fee scale based on a patient's income and family size; and
- Have a community-based board of directors where the majority of the board are active users of the center services.[2]

Health centers that do not receive federal grant funding can be designated as an FQHC look-alike, if they demonstrate that they are serving those most in need within their service area; and meet other Section 330 program requirements. There were two FQHC look-alikes in 2003, located in Asheville and Reidsville. While FQHC look-alikes do not receive federal funds, they do receive some other benefits from that designation (discussed below).

Services: FQHCs must provide comprehensive primary care services as well as health education, preventive care, chronic disease management, oral health, and behavioral health services. If the health center lacks the capacity to provide the services, then it must assure that quality specialty medical, diagnostic, and therapeutic services are available to patients through organized referral arrangements. Health centers must coordinate and oversee the care provided to patients, whether provided directly or through referrals. To make services more accessible, health centers must have a system for 24 hours a day, 7 days a week coverage, as well as offer clinic hours outside the normal 9:00 am-5:00 pm work schedule.

Specifically, health centers must provide in-house or through referrals, the following services:

- Preventive services;
- Immunizations;
- Primary medical care;
- Diagnostic laboratory;
- Prenatal, perinatal, and well-child services (including eye, ear, and dental screenings for children);
- Cancer and other disease screenings;
- Screening for elevated blood lead levels;
- Diagnosis and treatment of communicable diseases;
- Family planning services;
- Preventive dental services;
- Emergency medical and dental service;
- Pharmacy services;
- Substance abuse and mental health services;
- Enabling services including outreach, transportation, interpreters, and case management services;
- Services to help the health center's patients gain financial support for health and social services; and
- Referrals to other providers of medical and health-related services.

North Carolina health centers are slightly less likely to directly provide prenatal care, mental health services, substance abuse treatment, and a pharmacy with a registered pharmacist than are other centers throughout the country (Table 3.1). However, they are more likely to provide other services, such as: hospital care, dental care, lab services, and a pharmacy with a dispensing physician.

Historically, enabling services have set community

Table 3.1.
Services Provided by North Carolina Health Centers[3]

Direct Services	Primary Care	Follow Hospitalized Patients	Prenatal Care	Dental Services	Mental Health Services	Substance Abuse Treatment	Pharmacy with Registered Pharmacist	Pharmacy with Dispensing MD	Lab Services
NC FQHC	100%	88%	48%	80%	64%	48%	32%	64%	96%
US FQHC	99%	79%	72%	74%	70%	50%	34%	62%	82%

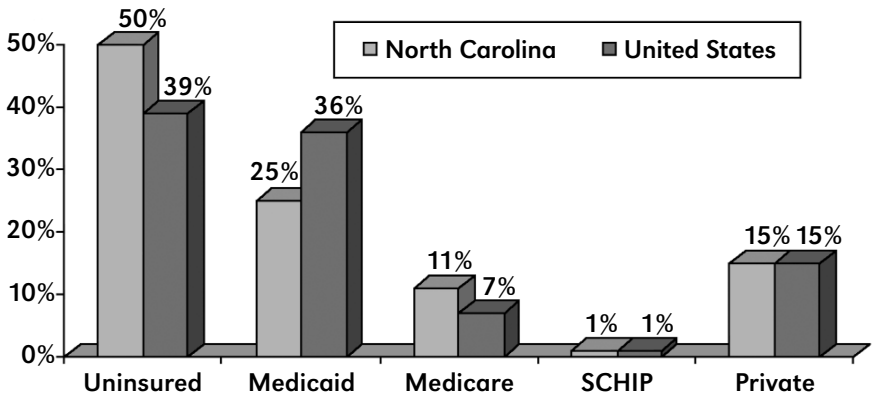
Table 3.2
Enabling Services of North Carolina Health Centers[5]

Enabling Services	Case Management	Eligibility Assistance	Interpreter Services	Outreach	Transportation	WIC Services
NC FQHC	92%	80%	96%	88%	60%	20%
US FQHC	90%	87%	85%	91%	57%	29%

health centers apart from other types of healthcare providers. These services—including case management, transportation services, outreach, and interpreter services—facilitate access to health and social services, particularly among low-income, chronically ill, and/or immigrant populations. North Carolina health centers spent $7.7 million on enabling services in 2003, accounting for 10% of FQHC costs. In North Carolina, all of the health centers provided some level of enabling services.[4] (see Table 3.2)

Centers have many different methods to meet the medication needs of their patients. Ten of the centers participate in 340B discount drug program (either through an in-house pharmacy or contracting with a community pharmacy) (See Chapter 5). Some FQHCs provide samples, participate in the pharmaceutical manufacturers' pharmacy assistance programs, have in-house pharmacies that offer medications on a sliding scale, or have other arrangements with community pharmacists.

Chart 3.1.
Insurance Coverage of Patients (NC, US, 2003)[6]



Patient population: Although the health centers in North Carolina all have their unique characteristics, the users of health centers share several attributes. Health center patients tend to be low-income, ethnic minorities, and uninsured or covered by Medicaid. In 2003, these centers served 272,314 users including 122,457 uninsured patients, 34,862 migrant or seasonal farmworkers, 2,063 homeless individuals, 5,799 prenatal patients, 7,044 children under age two years, and 75,142 Latinos. Patients make, on average, 3.2 visits per year to their health centers.

Compared to other community health centers in the country, NC health centers cared for more uninsured and fewer Medicaid patients in 2003. Fifty percent of NC health center users were uninsured compared with 39% in other US health centers (See Chart 3.1 below). Twenty five percent were Medicaid recipients compared with 36% nationally. Eleven percent were covered by Medicare, 15% by private insurance, and 1% by NC Health Choice (the State Children's Health Insurance Program, or SCHIP). The larger proportion of uninsured and the smaller percentage of Medicaid users have important financial implications for NC health centers. As will be discussed later, Medicaid is the most important non-grant financing mechanism for health centers. Because they serve a larger proportion of uninsured patients and fewer Medicaid recipients, NC health centers must rely more heavily on grant sources and collection from self-pay users.

Over the last five years, the number of community health center patients in North Carolina increased by 22% and the number of visits increased by 27%. There was an even larger increase in the number of uninsured patients (32% increase).

The average income level of NC health center patients is similar to other US health centers. Ninety percent of users had incomes below 200% of the federal poverty guidelines (FPG) ($36,800 a year for a family of four in 2004); and 70% had incomes below 100% of the federal poverty guidelines ($18,400/year for a family of four in 2004).[7]

Like other US health centers, the majority of NC health center users (73%) are from racial and ethnic minorities. North Carolina health centers, however, have a slightly different mix of patients than do other centers nationally; NC users are more likely to be African American (41% vs. 24%), and less likely to be white (26% vs. 36%) or Latino (28% vs. 35%) than other centers nationally. While Latinos are a smaller percentage of the NC FQHC patient population than in other centers nationally, the number of Latino users is growing rapidly. North Carolina health centers have seen a 25% increase in Latino users since 2000. This growth has required centers to provide translation services now that 26% of users are best served in a language other than English. Language and cultural barriers also pose a challenge in coordination of care and case management.

While most of the users of health centers in North Carolina are young, there is a trend toward serving an increasing number of older adults. Thirty three percent of users were under age 20 years, 59% were working age adults, and 8% were over age 65 years.[8] The age and gender of users in North Carolina are similar to users in other US health centers. The elderly comprise an increasing proportion of health center users. From 1990 to 2000, elderly users of health centers grew by 55% nationally.[9] Elderly patients tend to have more chronic medical problems and often require more intensive services.

The most common presenting diagnoses at health centers include: hypertension (39%), diabetes (27%), mental disorders (13%), and asthma (10%). Other diagnoses include heart disease (7%) and HIV/AIDS (2%).

Special funding rules: In addition to the federal grants that FQHC receive to support the costs of uncompensated primary and preventive healthcare, FQHC qualify for other special benefits. For example, FQHC can obtain federal grants to plan and develop networks and federal loan guarantees. Grantees are protected by the Federal Tort Claims Act, which provides coverage for most malpractice claims—thereby reducing their need to purchase private malpractice insurance coverage. Both FQHC and FQHC look-alikes can participate in the Section 340B drug pricing discounts (see Chapter 5 on Medication Assistance), receive no-cost vaccines for children, and have access to medical providers through National Health Service Corps (if located in a Health Professional Shortage Area). In addition, FQHC, FQHC look-alikes, and rural health centers (RHCs) receive special Medicaid and Medicare reimbursement. Congress, as part of the Benefits Improvement and Protection Act of 2000 (BIPA), changed Medicaid reimbursement to RHCs and FQHCs to a prospective payment system (PPS). A base rate per visit is calculated for each center (using the center's state fiscal year (SFY) 1999 and 2000 costs), which is then inflated each year using the primary care component of the Medicare Economic Index. The per visit rate may be adjusted based on changes in covered services. Under BIPA, states have the authority to use a different payment methodology, as long as it is agreed to by the FQHCs and RHCs and provides as much or more reimbursement than under the PPS system. Currently, North Carolina offers each center the option of using the PPS system or the Medicare "cost-based system" that was in effect prior to BIPA.[iii]

Piedmont Health System: Serving the Growing Latino Community

Serving the growing Latino population has created new challenges for health centers. In some clinical sites, Latinos account for 50-75% of the patients served. Almost three-quarters of the patients (70%) in the Siler City office of Piedmont Health System are Latino. A majority of the Latino population is uninsured; and many have limited English proficiency.

In order to serve this population, health centers are reaching out to hire bilingual providers. About half of the providers and 25% of the administrative staff at Piedmont Health System can speak Spanish. Piedmont is one of the state's leaders in ensuring that its staff can meet the cultural and linguistic needs of the patients and many other centers are also making great strides.

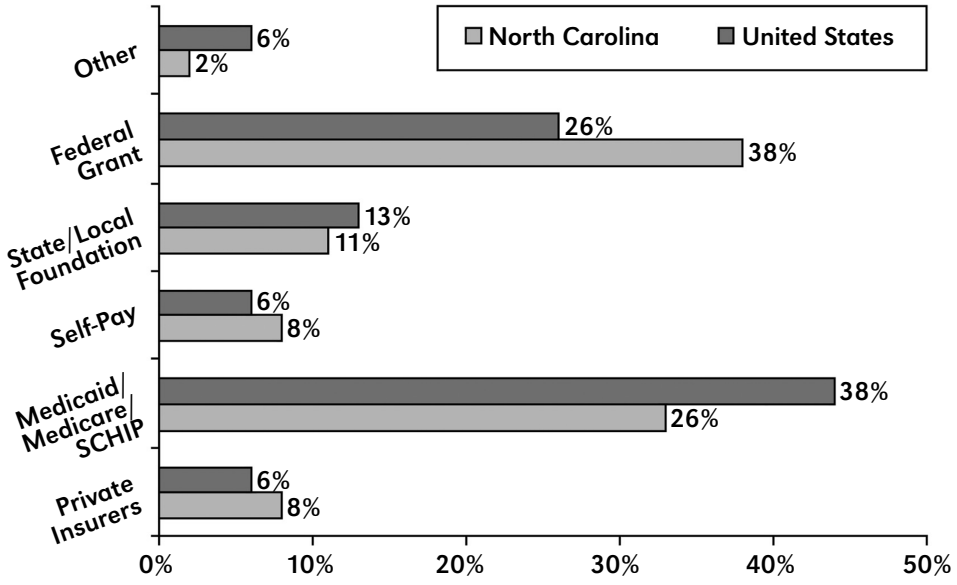
iii The old cost-based reimbursement system was subject to a federal cap; in calendar year 2004, the rate could not exceed $68.65 for RHCs, $91.64 in rural FQHCs, and $106.58 in urban FQHCs. The caps are adjusted annually based on the Medicare Economic Index (MEI).

Revenues: Community health centers in North Carolina are funded through a combination of Bureau of Primary Health Care grants; state, local, and foundation funds; public and private insurance payments; and patient payments. Aggregate fiscal data from 2003 showed a $2.5 million profit (3%) for NC health centers, which compared to an aggregate 0% profit for US health centers.[iv,10] While there was an aggregate profit for health centers in North Carolina, their financial strength varies widely. The surplus or deficit as a percentage of total costs ranged from an 11% deficit in one center to a 13% profit in another.

Important differences in the revenue mix of NC health centers may help to explain why some centers are experiencing financial stress. Health centers with more Medicaid, Medicare, and private insurance users tend to be financially stronger than those serving larger percentages of uninsured people. A 2000 analysis of national Uniform Data System data indicated that centers that cared for larger shares of uninsured patients had larger revenue deficits and tended to be worse off.[11] Health centers that serve a higher proportion of uninsured tend to be more reliant on sliding scale payments (self-pay collections). Typically, these payments do not cover the full costs of care. Thus, these centers must rely more heavily on federal grants and other revenues to make up the difference, and federal grants are not adjusted to adequately reflect differences among centers in the proportion of the patient population that is uninsured. On average, half (50%) of NC health centers' patients are uninsured, but this varies widely by center. In some centers, more than 70% of their patient population is uninsured, while in others, fewer than 25% of the patients are uninsured. The percentage of a health center's patients who are on Medicaid varies from a high of 52% in some centers to a low of 9%.

In the past, NC health centers received proportionately less revenue from state and local sources than other health centers in the United States and more from the Bureau of Primary Health Care (BPHC) grants (Chart 3.2).[v] Other states tended to receive more from state indigent care programs and other revenue including fund raising and interest income.[vi] However, the NC General Assembly recently appropriated $5.0 million in non-recurring funding (SFY 2005)

Chart 3.2.
Revenue Sources of FQHC (NC, US, 2003)[12]



iv FQHC profits go into reserves to cover unforeseen shortfalls and/or growth and expansion of programs and services.

v In the past, FQHCs received state funding to perform specific services (for example, some FQHCs received funds from the Division of Public Health to operate WIC programs or adult health screening programs). Until the recent $5 million appropriation in SFY 2005, the only state "grants" received were to newly established FQHCs transitioning from the state MAP program (see Section on Rural Health Centers) or participating in the Farmworker Health program (fee-for-service voucher program). FQHCs did not receive general state support until the recent state appropriations.

vi State indigent care programs subsidize care to the uninsured through various funding sources other than state budgetary appropriations directed to health centers. If the state appropriates funds directly to health centers it is considered a state grant.

to help support and expand the services provided by FQHCs. This non-federal grant revenue is especially important when North Carolina grantees are applying for BPHC funding (see Chapter 7 on Financing). In order to be competitive for BPHC grants, health centers must demonstrate an ability to match federal grant funds with state and local funding.

Quality: National studies of Medicaid patients served by FQHCs have found that Medicaid patients served by health centers are less likely to use the emergency room, have fewer preventable hospitalizations (i.e., for ambulatory sensitive conditions such as asthma or diabetes), and cost less than Medicaid patients receiving care elsewhere.[13,14,15,16] While North Carolina-specific data on health outcomes are not available, other quality indicators are. Currently, nine of the 25 centers are accredited by the Joint Commission on Accreditation of Healthcare Organizations, and more are likely to become accredited in the future, as the BPHC encourages accreditation. In addition, 13 centers in North Carolina are participating in the National Health Disparities Collaborative; and 14 centers participate as primary care providers in the Community Care of North Carolina program. Both of these initiatives focus on providing disease management and care coordination to chronically ill patients.

Challenges: While community health centers can provide quality primary care services to the uninsured, there are still major barriers to obtaining specialty care, diagnostic tests, behavioral health services, and prescription drugs. In a 2002 national survey, medical directors and executive directors of community health centers reported that they could address the primary healthcare needs of their patient population, but had a harder time ensuring access to services such as specialty care, diagnostic tests, and behavioral health services.[17] Medical directors stated that while insurance status did not affect the quality of care that patients received on site, lack of insurance was a problem when they tried to arrange referrals for other health services, which many patients were unable to access because of their costs. Poor access to specialty care was also emphasized in a 2002 evaluation of the safety net in five medium-sized cities.[18] Respondents reported that patients often had to wait for months for appointments and only some of the services were provided for reduced fees. Poor access to behavioral health services and to prescription drugs has also been well documented for community health center patients across the country and anecdotal evidence indicates similar problems exist in NC centers.

In addition, there is quantitative and anecdotal evidence that FQHCs in NC are under significant financial stress, perhaps more than other centers in the Southeast. With increasing health insurance premiums, significant erosion of employer-based insurance, and job losses in the manufacturing industries, many health centers are caring for more uninsured and disadvantaged populations than ever, without a commensurate increase in federal grants to pay for the additional costs of caring for the uninsured. The new one-time state appropriation will help; but funds need to be reallocated in following years. Furthermore, while the funds will help centers provide care to *additional* uninsured users, these funds were not intended to help centers serve their existing uninsured population. As noted previously, some centers serve a much higher proportion of uninsured than others; and federal grants are not always sufficient to meet the costs of serving these uninsured patients. The new state funds do not directly address this issue.

Rural Health Centers (RHCs)

Overview: Since 1973, the NC Office of Research, Demonstrations, and Rural Health Development (ORDRHD, formerly the Office of Rural Health) helped establish 81 rural health centers throughout the state. These centers are private not-for-profit organizations. The ORDRHD worked to develop these resources in geographic areas that lacked primary care resources, but had a community committed to supporting a center. Local communities had to match state capital funds on a five-to-one state-to-local community match. The ORDRHD's goal was to provide initial program funding for three-to-five years until the centers could become self-sufficient.

Over the years, the state's rural health center program has been augmented by two developments: the creation of the federal Rural Health Clinics Act and state-funding of certain rural health centers for the provision of indigent care. In 1977, Congress created the Rural Health Clinics Act, P.L. 95-210, as a means of expanding care into rural underserved areas through the use of physician extenders.[19] Nationally in 1999, there were nearly 3,500 federally-designated rural health clinics; 97% were located in health professional shortage areas. Most (53%) were independent practices

and 47% were provider based (i.e., owned by a hospital or nursing facility).

There are currently 108 *federally-certified rural health clinics* in North Carolina. Most, but not all, of the 81 state-established rural health centers also qualify as federally-certified rural health clinics. Federally-certified RHCs receive cost-based reimbursement from Medicare and Medicaid (described in more detail in Chapter 7). In return, federally-certified RHCs must provide care to Medicaid and Medicare recipients. There are no federal requirements regarding care provided to the uninsured.

Some of the conditions that rural health clinics must meet to be federally certified include:[20]

- Exist in a Health Professional Shortage Area or Medically Underserved Area (this requirement can be fulfilled by Governor's designation);
- Employ a physician assistant, nurse practitioner, or certified nurse midwife at least 50% of the time the clinic is open;
- Be under the medical direction of a physician;
- Provide primary care;
- Provide commonly furnished diagnostic and therapeutic services, including basic laboratory services;
- Meet Medicare and Medicaid regulations on health and safety requirements;
- Have arrangements with providers and suppliers participating in the Medicare and Medicaid programs to furnish medically necessary services such as inpatient hospital care, physician services, and additional or specialized laboratory services not available at the clinic; and
- Comply with all applicable state, local, and federal requirements.

While most rural health centers established with assistance from the ORDRHD have become self-sufficient (through enhanced Medicare and Medicaid reimbursement, and/or other third-party reimbursement), there have been a subset of centers that has needed ongoing state support. These centers typically serve a higher proportion of uninsured patients, and therefore have more difficulty covering operational costs. The ORDRHD helps fund 32 of the 81 state-established rural health centers on an ongoing basis ("*state-funded rural health centers*"). The state-funded rural health centers tend to be located in the eastern and far western parts of the state, and range from single nurse practitioner sites in very remote areas to multiple practitioner sites serving multiple counties. Some, but not all, of these centers are federally-certified rural health clinics.

State-funded rural health centers must be non-profit, 501(c)(3) organizations, with a local board of directors (i.e., community residents). These centers do not have the same requirement as FQHCs for board composition (i.e., the boards do not need to comprise 51% consumers/users of the centers). State funding is provided as a last resort to offset operational shortfalls and costs for care to the uninsured. In the past, the state awarded centers money solely to underwrite their operational budget. However, by the end of the 1990s, the ORDRHD shifted its funding process so that centers had to "earn" their state funds by seeing indigent patients. This new funding process is called the Medical Access Plan, or MAP program. Today, more than two-thirds of the state funding is used to support care to uninsured patients who meet the MAP eligibility requirements. MAP eligibility requires that patients are NC residents, uninsured, under 200% of the federal poverty level, and not eligible for Medicaid or NC Health Choice. Patients are required to pay a copay, ranging from $5-$20 per visit, based on their family income. Centers are paid $68 each visit, which is roughly the Medicare rural health clinic cost-based reimbursement rate, less the copayment.

Most centers receive a combination of MAP funds and some ongoing non-targeted operational funds. However, the ORDRHD is moving more of the state funds into the MAP program. Currently 68.5% of the state funds are distributed through MAP, and the goal is to increase this level to 85%. The remaining 15% would be held for new developments and to address crisis situations.

Services: As noted previously, both federally certified rural health clinics and state-established rural health centers must provide primary care services and must have the capacity to arrange for inpatient care and specialty referrals. However, these RHCs are not required to provide dental, behavioral health, or enabling services, which are required of FQHCs.

While not legally obligated to do so, some of the state-funded RHCs provide supplemental services in addition to primary care. For example, three have dental clinics and others provide assistance for their uninsured patients in accessing pharmaceutical company prescription assistance plans. None of the rural health centers have in-house pharmacies with a pharmacist. One grantee has a full-time clinical social worker who provides

some behavioral health services, but most of the RHCs refer patients with behavioral health problems to other providers or agencies.

Patients: The state does not collect data on the number of patients seen by all of the federally-certified rural health clinics in the state. They must submit cost-reports to Medicare and Medicaid to obtain their cost-based reimbursement, but are not required to collect data on the numbers of uninsured they treat or the services provided. Therefore, there is no information on the number or type of patients served or the utilization of services. However, a national survey of rural health clinics in 1999 showed that approximately 56% of patient visits were attributable to Medicaid and Medicare patients.[21] Federally-certified rural health clinics are not legally obligated to serve the uninsured, but many choose to do so. Uninsured patients receiving services on a sliding-fee scale accounted for 8% of all visits to federally-certified rural health clinics nationwide.[22]

While data are not available for *all* of the federally-certified rural health clinics in North Carolina, the state does collect data for the 32 state-funded RHCs. Of the 101,648 total users seen by state-funded RHCs in SFY 2003:

- 21,252 (21%) were uninsured (7,963 participated in MAP)
- 21,820 (21%) were on Medicaid
- 28,165 (28%) were receiving Medicare
- 30,411 (30%) had other forms of insurance

The percentage of uninsured users seen by health centers varies from approximately 65% in one center to approximately 7% in another.

Revenues: Nationally, in 1999, 54% of the patient revenues of federally-certified rural health clinics were from Medicare and Medicaid. Thirty percent of the revenues were from commercial or private insurance, 15% from self-pay, and 4% from other sources. Information limited to NC federally-certified rural health clinics is not available.

The ORDRHD collects more information about state-funded rural health centers. In SFY 2004, 32 centers received state funding. The state funds ($2,359,673) represent 8.5% of the centers' combined annual operational budgets ($27.68 million). The majority of a center's revenue is derived from Medicare, Medicaid, and commercial insurance.

Challenges: RHCs, like other safety net organizations, are facing financial pressures in trying to serve the uninsured. There are more uninsured seeking care and not enough funds to help underwrite the costs. Many of the centers have aging facilities and infrastructure because they were built in the 1970s or 1980s. Few sources of capital funding exist to replace equipment and most centers lack sufficient revenues to cover the costs of capital improvements. On average, rural practices are behind their urban counterparts with information technology and the ability to tap into evidence-based medicine through personal digital assistants. Some also have problems recruiting and retaining skilled managers/administrators. There are four NC RHCs in serious financial distress, and the problems seem to be getting worse rather than better.

Public Health

Overview: The NC General Assembly created the first state board of health in 1877. Two years later, local boards of health were developed throughout the state, and the first local health department was established in Guilford County in 1911. By 1950, all 100 counties were covered by health departments. This year (2004), there are currently 85 local health departments—79 single-county health departments and six district health departments.[vii] In North Carolina, most health departments are units of local government and are governed by 11-member boards of health appointed by the county commissioners.[viii]

Over the last century, public health has played a significant role in improving the public's well-being and reducing morbidity and mortality rates across the country. While public health cannot be credited with all of this improvement, it has played a major role through provision of services and raising public awareness of health-related issues. Between 1950 and 2002, the national infant mortality rate dropped from 29.2 per 1,000 to 7.0 per 1,000; and life expectancy grew from 47 years to 77 years.[23] The federal and state

vii There are a few variations on the single-county health department model. There is one public health authority (Hertford County), one hospital authority (Cabarrus County), and one consolidated human services agency (Wake County).

governments are critical components of the nation's public health system, but much of the responsibility for the delivery of public health services rests with the local health departments. The first local health departments were initially created to control outbreaks of disease and to collect health-related data. Now, there are approximately 2,500 local health departments throughout the country,[24] and they offer a wide range of public health and personal healthcare services.

Over the years, NC public health has expanded its mission from the fundamental responsibilities of infectious disease control and data gathering to include a variety of programs and initiatives such as maternal and child health programs, universal childhood immunizations, family planning, environmental sanitation, water and food safety, fluoridation of drinking water, and injury prevention and workplace safety. Over this century of public health development, the infant mortality rate in North Carolina dropped from 78.7 per 1,000 in 1925 to 8.2 in 2003; and life expectancy grew from 55 years in 1925 to 76 years in 2000. Recently, public health has dedicated more resources to health promotion and disease prevention activities to reduce the incidence of certain chronic diseases, including asthma, diabetes, hypertension, heart disease, and stroke. For example, state and local public health officials have engaged in public education campaigns to increase exercise and to reduce obesity and tobacco use.

With the exception of prenatal and child health services, many local health departments throughout the country do not offer personal healthcare services. However, health departments in the southeastern United States generally play a larger role in the delivery of personal healthcare services than others around the country. This is certainly the case in North Carolina where the rural nature of the state and other barriers to care make local health departments an integral source of access in many communities.

Services provided: Local health departments can provide a wide range of services. They are required by state law to provide certain categories of core public health services, including communicable disease control (including sexually transmitted disease (STD) testing and treatment), environmental health services, and vital records registration. Local health departments are also required to either provide or contract for certain clinical safety net services if the services are not otherwise available in the jurisdiction.[25] These clinical services include:

- Child health (including immunizations and well-child care)
- Adult health (including chronic disease prevention and detection)
- Maternal health (including pregnancy testing and prenatal care)
- Family planning (including provision of information on contraceptives)
- Home health

In addition to these mandated services, some health departments offer other clinical services, including the full range of primary care services and dental health services. Health departments typically serve as providers of last resort for these services, meaning that they provide services only if residents are unable to access them elsewhere. Therefore, the array of services varies by community, depending on local needs and the availability of other community resources.

Many local health departments provide valuable care for the uninsured through the provision of clinical safety net services. Some health departments have full-time providers on staff who provide check-ups, health maintenance, prenatal care, dental care, and sick visits for patients. Other health departments offer few clinical services other than immunizations, flu shots, and testing and counseling for sexually transmitted diseases, tuberculosis, and HIV/AIDS. Most health departments fall somewhere in between; offering some but not all of the available services, such as primary care for children (but not adults) or dental care to children with Medicaid or who are uninsured. However, all local health departments provide health education and promotion programs for individuals needing disease management and healthy living services.

As public policies and the market environment have changed over time, some of the clinical services tradi-

viii Local boards must have 11 members, eight of which are designated slots (a medical doctor, dentist, registered nurse (RN), optometrist, veterinarian, pharmacist, engineer, and county commissioner) and three at large community members. N.C.G.S. §130A et. seq.

tionally offered by local health departments, such as childhood immunizations, well-child visits, and care for Medicaid recipients, have shifted in whole or in part from health departments to the private sector. In other cases, clinical services have moved from private providers back to public health. For example, when private providers leave the community or decide to stop providing care to a subset of the population.

Compared to other health departments across the country, local health departments in North Carolina provide more clinical services, making them an essential part of the safety net. (Table 3.3).

Table 3.3.
Services Provided by Health Departments (NC, US)[26,27]

Services	Percent of Health Departments Providing Services: NC (2003)	Percent of Health Departments Providing Services: US (2000)
School health	68%	46%
Home health	43%	36%
Primary care	58%	18%
Dental treatment	50%	30%
Case management	100%	67%
Prenatal care	92%	41%
Family planning	100%	58%
Nutrition	94%	NA
HIV/AIDS testing and counseling	100%	64%
STD testing and counseling	100%	65%
Diabetes screening	87%	57%
Well child care	93%	59%
TB testing	100%	88%
Adult influenza vaccines	100%	91%
Childhood immunizations	100%	89%

The breadth of health department responsibilities and services require local health departments to employ many types of professional staff, including health professionals (physicians, nurses, nurse practitioners, physician assistants, dentists, and pharmacists), epidemiologists, social workers, engineers, veterinarians, and professional administrators. The NC public health system statewide currently employs approximately 10,000 full-time equivalent staff, including 2,300 registered nurses, 900 environmental health specialists, 600 social workers, and 400 nutritionists.

Numbers of uninsured patients served: Local health departments are required to report the number of patients seen in each public health clinic and the source of payment. Using these data, it was determined that health departments provided services to 641,601 unduplicated patients in SFY 2003 (Appendix B). Of these, 260,603 (41%) were uninsured. Specifically, health departments provided services to the uninsured in the following clinical settings:

- **Adult health clinics:** 36,657 uninsured patients (54% of all patients seen in adult health clinics). Adult health clinics provide a variety of screening tests (e.g., Pap smears and cholesterol screening), as well as monitoring and managing chronic diseases. Some, but not all health departments also provide comprehensive primary care services to adults in their adult health clinics;
- **Child health clinics:** 27,745 uninsured patients (23% of all patients). Child health clinics provide well-child services, developmental evaluations, child health coordination, and treatment of minor acute illnesses such as otitis media and upper respiratory infections. Some, but not all, health departments provide comprehensive primary care services to children in their child health clinics;
- **Maternity health clinics:** 21,126 uninsured patients (31% of all patients). Maternity clinics provide prenatal care, maternity care coordination, and a few provide prenatal care for high-risk women. Many local health departments provide the initial comprehensive prenatal services and routine care up to a specific point in the pregnancy and then refer to a private provider in the community at an agreed upon time (e.g., seven months). Health departments served approximately 40% of the pregnant women enrolled in Medicaid and 40% of all pregnant Latinos in 2002.[28] Some also provide primary care

services to the women they are treating in their maternity care clinics;

- **Dental clinics:** 2,364 uninsured patients (5% of all patients). Dental services vary by health departments. Some are limited to routine check-ups, cleanings, x-rays, and fillings, while others provide comprehensive dental services (including extractions, root canals, etc.);
- **Epidemiology:** 60,849 uninsured patients (56% of all patients). State law requires health departments to collect data on approximately 65 reportable diseases and conditions. Last year, local health departments investigated 6,500 cases of gonorrhea, 3,000 cases of foodborne illnesses, more than 1,000 cases of hepatitis B, and 125 cases of hepatitis A. Health departments are required to conduct investigations and intervene when necessary to assure compliance with control measures, even if treatment and/or coverage is provided in the private sector;
- **Family planning:** 66,259 uninsured patients (50% of all patients);
- **Immunizations:** 81,053 uninsured patients (42% of all patients). Immunizations include both childhood immunizations as well as immunizations provided to adults (such as flu shots or pneumococcal vaccinations); and
- **Nutrition:** The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) served an average of 210,000 clients per month.

Aside from the clinical and nutritional services provided by *local* health departments, the *state* Division of Public Health also provides clinical and nutritional services to thousands of North Carolinians. These services are typically, although not exclusively, targeted to low-income populations. For example, the Division operates or has responsibility for:

- The state laboratory, which provides certain clinical laboratory services including newborn screenings, Pap smears, and HIV tests.
- Children's developmental services agencies, which provide early intervention programs to 10,420 infants and toddlers who have or are at risk for developmental delays.
- Child and adult congregate feeding programs, which feed approximately 130,500 people two meals and a snack each day.
- Summer food supplement program, which provides meals to 33,645 children in the summer to replace the free and reduced school lunch program.

The Division of Public Health also purchases certain medical services directly from local health providers for individuals with special health problems (See Table 3.4). All of the clients served in these programs are uninsured or have limited insurance which does not cover the services paid for by this program.

While health departments are a major source of healthcare services to the uninsured, they do not all provide comprehensive primary care. Unfortunately, there are no consistent data indicating whether a health department provides primary care services, or how many uninsured patients are served. For example, in a state survey of local health departments (SFY 2003), health departments covering 60 counties reported providing primary care either to adults, children, or both.[30] However, a more accurate assessment of whether the health department serves as a person's medical home is whether the health department serves as a primary care provider for the Medicaid Carolina Access or Community Care of North Carolina programs. Health departments covering 41 counties participate as primary care providers for these Medicaid programs. Only 39 counties are listed both as primary care providers in the state survey and in the Medicaid database. The confusion about the number of health departments that provide primary

Table 3.4
Public Health Direct Purchase of Services[29]

Program	Total expended	Number clients	Average cost/client
Children with Special Health Services	$2,519,156	2,126	$1,185
Assistive Technology	$423,444	305	$1,388
Cystic Fibrosis	$107,890	18	$5,994
Cancer Diagnosis	$718,968	1,171	$614
Cancer Treatment	$1,304,125	436	$2,991
Kidney	$307,239	1,848	$166
Sickle Cell	$521,019	202	$2,579
HIV-ADAP (AIDS Drug Assistance Program)	$20,584,596	2,899	$7,101

care services may be a definitional one, because to be listed as a primary care provider for the Medicaid program, the health department must commit to providing comprehensive services (preventive and acute or "sick" care), and be available 24 hours a day, 7 days a week (through back-up coverage). No definition of primary care was given in the state survey. Furthermore, data is not available on the number of primary care visits, clients, or payment source for these visits because the state's current Health Services Information System (HSIS) does not gather this information from local health departments.[ix]

In addition to the direct provision of services, public health departments collect and analyze data that are used by safety net and other health providers, local communities, and state and local policy makers, including vital records; birth, cancer and immunization registries; Pregnancy Risk Assessment Monitoring System; the Behavioral Risk Factor Surveillance Survey (BRFSS); the Youth Risk Behavior Survey; and the community diagnosis. The state also maintains a critical alert surveillance system.

Financing: The total budget for state and local public health departments was $593 million in SFY 2004. Federal grants comprise 40% of the funding, local government provides more than one-third (38%), state funds comprise 12%, and other receipts (including Medicaid) account for approximately 10%. The General Assembly appropriates $23 million to local health departments, of which the majority of funds are categorical (i.e., designated for a specific program or purpose). Only about $5 million of state funds are provided in general aid to the counties (i.e., flexible funds to help support health departments).

Challenges: In most communities, an increasing number of uninsured patients are seeking care in local health departments. A 1999 survey of health departments found that 40% reported client overcrowding, with patients waiting and obstructing the hallways.[31] Some of the clients seeking care at health departments need comprehensive primary care services because of a dearth of other safety net providers in the community, while others seek more traditional health department services. Health departments receive some funding for the traditional public health services provided to the uninsured, but this funding is not sufficient to meet growing needs. For example, local health departments receive Medicaid reimbursement (for Medicaid-eligible pregnant women), and can use Maternal and Child Health (MCH) block grant funds to help pay for prenatal care services to the uninsured. However, Medicaid reimbursement does not cover the full costs of treating Medicaid patients (See Financing chapter, 7), and the federal MCH funds are insufficient to cover the healthcare needs of all uninsured women and children accessing health department services. The funding gap forced health departments to provide an estimated $10.3 million in uncompensated prenatal care in 2003 (a 25% increase since 2001). In 2003, uncompensated prenatal care spending in health departments averaged 21% and reached as high as 69% in some counties.

Like FQHCs, local health departments are seeing an increasing number of Latinos. Health departments are trying to respond to this new population by adding bilingual staff, providing educational and informational materials in Spanish, and providing outreach services to the non-English speaking communities. Approximately three-fourths (74%) of health departments have staff-designated interpreters, but more resources are needed to ensure that patients and providers can communicate effectively.

Free Clinics

Overview: The first free clinics in North Carolina began serving patients in 1969, when the Christian Medical Society of Bowman Gray School of Medicine opened four volunteer clinics in Winston-Salem.[32] These clinics closed five years later and there were no free clinics until 1985 when the Open Door Clinic opened in Raleigh as the only free clinic in the state. The number of free clinics has increased rapidly since 1985, and as of 2004, North Carolina had more than 60 clinics and/or pharmacies serving 48 communities. The largest part of the growth was during the mid-to-late 1990s. Nationally, there are 850 free clinics. North Carolina leads the nation in the numbers of free clinics and free pharmacies. Free clinics serve an important function, even in communities with other

ix The state is in the process of updating the HSIS system, the first major update in 30 years. Once the new system is operational, it will collect information about the number of primary care patients and visits, along with insurance coverage (if any).

safety net resources. In a study reviewing the safety net of five major US cities, researchers found that free clinics provided an alternative for patients who are unsuccessful or simply not comfortable seeking care from other providers, including other safety net providers.[33] The study questioned why someone would feel more comfortable at a free clinic and respondents explained that "the large size and busy feel of the major safety net hospital that provides much of the care in that city can be intimidating for some residents... [and] free clinics provide a comfortable environment for undocumented residents."[34] The existence of a free clinic provides an alternative for the uninsured healthcare consumer.

There is not one specific free clinic model, although most follow certain patterns. Free clinics are non-profit, usually 501(c)(3), organizations governed by local boards of directors. They are designed to meet the healthcare needs of the low-income uninsured in their communities by drawing on local healthcare resources and volunteers. Volunteers are the cornerstones of the free clinic movement. Free clinics tap into the willingness of the healthcare community (doctors, nurse practitioners, physician assistants, social workers, pharmacists, dentists, mental health, and chiropractors), and other members of the community to volunteer their time. In 2003, more than 8,000 volunteers helped staff the NC free clinics, including 2,000 physicians, 1,500 nurses, 350 dentists, 325 pharmacists, and 3,000 lay people. Thirty NC hospitals provide financial support and in-kind services. The use of volunteers and donated materials lowers the free clinics' overhead.

While the majority of free clinics rely heavily on volunteers, many have some paid staff. The average clinic has two full-time employees and 150 volunteers, but this varies from 0-12 full-time and part-time employees. Free clinic budgets range from $5,000 to $850,000 a year.

Services: Clinic hours and the array of services vary across clinics. Most free clinics are open one or two evenings a week, and serve patients on a first-come, first-serve basis. In addition to conventional community-based primary care and preventive services, some clinics provide a broader spectrum of supportive services, such as health education, case management, and nutrition counseling. The majority of free clinics in North Carolina offer some pharmaceutical services, which are necessary to meet the healthcare needs of an uninsured population. Free clinics provide basic primary care services to their uninsured patients, but they are not always able to guarantee continuous, comprehensive primary care services, including the ability to establish a medical home with a specific provider. Most have very limited hours of operation, and are unable to provide patients with 24 hours a day, 7 days a week coverage.

Depending on the resources in the community, some free clinics are able to provide chronic and specialty care. A few of the larger clinics are able to offer chronic care clinics where patients can establish a relationship with a provider over time. If volunteer providers are willing to take free patients in private practice, then the patient is referred. However, not every clinic has relationships with the specialists in their community.

Free clinics dispensed 450,000 prescription medications in 2003. There are 33 licensed pharmacies operating in NC free clinics (either free standing or in the clinic). Most of the free clinics tap into pharmaceutical assistance programs to meet the prescription drug needs of their low-income uninsured patients. In addition, some clinics provide medications to those on Medicare.

Dental care is one of the most highly demanded services in free clinics. Statewide, 300 dentists volunteer at free clinics. Nonetheless, the availability of dental services is limited. Only 22 of the programs (37%) offer dental services, and the services that are provided are generally limited to extractions. The costs and time involved in restorative care make it prohibitive for most free clinics to offer.

Patients: Free clinics provide services to the uninsured who typically have incomes below 200% of the federal poverty guidelines (although the income eligibility guidelines vary across centers-some are as low as 150% of FPG, and others as high as 225%).[35] Free clinics do not generally provide care to people with insurance—including Medicaid or Medicare—because they can go to other community providers. Patients who might be eligible for Medicaid are referred to the local Departments of Social Services. In 2003, NC free clinics served 69,320 low-income patients: 59,840 patients in clinics providing primary care and medical services and 9,480 in specialized clinics providing only pharmaceutical assistance or behavioral health services.

The typical client served by a free clinic is between 18-64 years old. Most clients are working and many have multiple jobs. The most common diagnoses include diabetes, hypertension, and mental health problems. Free clinics serve few children because most

low-income children are eligible for either Medicaid or NC Health Choice (North Carolina's SCHIP program). Since 2003, free clinics have experienced a rise in the number of college-educated individuals seeking care. Many of these people have been laid off and cannot afford COBRA (Consolidated Omnibus Budget Reconciliation Act, 1986) continuation coverage. The number of uninsured older adults, ages 65 years or older, seeking services in free clinics has also increased. This population is often characterized by immigrants who cannot qualify for Medicare.

Revenues: Clinics raise revenue from individual donations, fundraising events, in-kind donations, foundation grants, faith-based organizations, and businesses. The Duke Endowment and Kate B. Reynolds Charitable Trust have been very supportive of free clinics. Physicians, hospitals, nursing homes, and pharmaceutical companies also support the clinics by donating equipment, medications, and other needed supplies. Unlike free clinics in Virginia, West Virginia, and Vermont, NC clinics do not receive any direct appropriations from the state legislature. However, NC free clinics do occasionally benefit from settlements that the state obtains with pharmaceutical companies. Free clinics do not generally charge for their services, although some clinics accept donations or have an application fee at the first visit. Some pharmacy programs have small copays for prescriptions. In 2003, NC free clinics received $13 million in funding from the private sector, but were able to provide $85 million in healthcare services. Nationally, free clinics delivered over $1 billion in healthcare services in 2002.

Early in 2004, Blue Cross Blue Shield of North Carolina (BCBSNC) Foundation awarded a five year, $10 million grant to the NC Association of Free Clinics to support existing NC free clinics and establish new clinics.[36] Each free clinic received a $15,000 unrestricted base grant and an additional $1,000 for the purchase of influenza vaccines. Free clinics can apply for additional funding for specific needs of up to $40,000; however, these funds are competitive. Other grant funds may be available to support innovation, use of technology, and the elimination of racial/ethnic health disparities.

Foundation funds are also going to be used to help develop new clinics: up to $5,000 can be awarded for planning grants (for needs assessment, focus groups, surveys of other means of determining the potential success of a new free clinic) and $5,000 can be sought for infrastructure grants (to be used upon completion of the planning process if the decision is made to create a free clinic). The infrastructure grants can also be used to pay for the creation of the non-profit entity, filing for tax-exemption and articles of incorporation, and to purchase office/computer hardware software. New clinics can access $25,000 in start-up funds to begin providing services or to secure a clinic location, hire an executive director, and purchase equipment; and an additional $25,000 is available to match dollars raised in the community in support of the new free clinic. These funds will help ensure the long-term sustainability of new clinics.

Challenges: Free clinics face a number of unique challenges. Free clinics' reliance on volunteer health professionals to deliver services makes it difficult to establish these clinics in health professional shortage areas. Communities need a core of supportive health professionals willing to donate their time in order to establish a free clinic. Even in communities with vibrant free clinics there are challenges meeting the healthcare needs of the uninsured. Since free clinics depend on volunteers who may have irregular schedules, it is more difficult to establish a relationship between the provider and patient. Therefore, free clinics are less able to offer continuity of care since patients are likely to see different providers over time. Furthermore, as with other safety net providers, it is difficult in many communities to find specialists willing to treat the uninsured.

While the use of volunteers dramatically reduces overhead costs, free clinics still need funds to pay for overhead and other expenses. Free clinics need sustainable funding because they receive no third-party reimbursement for their services. Despite the recent BCBSNC Foundation grant, free clinics need to constantly raise more funds to cover operating expenses. Free clinics vary tremendously in the level of support they are able to obtain from their communities. For example, Forsyth County, a relatively affluent county that is rich in healthcare resources, can support a 9,000 square foot free clinic with seventeen exams rooms and a specialty clinic. The clinic pays Novant Health Systems $1 a year to lease the space. In contrast, other communities provide less support to free clinics that are unable to afford stand-alone clinical space. In these communities, free clinics may need to borrow space from other healthcare providers, such as health departments or FQHCs. It is often those communities most in need of safety net resources (i.e., communities

that have been most heavily hit by job losses and a downturn in the economy) that are the least able to provide the financial resources needed to adequately support a free clinic.

Prescription drug costs are the single largest line item in most of the free clinic budgets. While free clinics sometimes receive donated drugs from local physicians or access the pharmaceutical assistance programs offered by manufacturers, they still need to purchase some medications to meet the healthcare needs of their patients. Unfortunately, free clinics do not currently qualify for discounted prices—for example, those offered through the 340B drug discount pricing program (see Chapter 5) or purchased under the state contract. Because of the high pharmaceutical costs, purchasing the full array of needed medications can be cost-prohibitive.

Malpractice coverage is also a problem for some of the volunteer physicians. The NC Good Samaritan Laws were amended to ensure volunteers are protected by the statute, but this only provides protection against monetary liability.[37] The statute does not cover the costs of defending the lawsuit in which the Good Samaritan defense might be asserted. Retired physicians can get volunteer coverage for the costs of the defense for only $100 per year (from NC Medical Mutual), but this limited coverage does not cover physicians in active practice. Some active physicians are discouraged from volunteering at free clinics because their regular malpractice coverage is not portable outside their own offices (or the hospital). Thus far, there has not been a medical malpractice suit against a provider in a NC free clinic; however, the fear of malpractice suits has discouraged some physicians from volunteering.

The influx of Latinos and non-English speaking patients is also challenging. Free clinics have seen a large increase in the percentage of Spanish-speaking patients over the last five years. Patients and providers often struggle to overcome the language barriers. Immigrant care in free clinics has worked better in urban areas because there are more resources to address language problems.

Project Access Systems

Overview: Project Access began in Asheville, NC in 1994 with a grant from The Robert Wood Johnson Foundation. It was designed to help link the services of traditional safety net providers to healthcare services offered by private providers in the community. The result is a community-based healthcare system that is able to provide a continuum of healthcare services, including primary care, specialty referrals, lab and x-ray, medications, and hospital services at reduced or no cost to low-income uninsured.

Historically, the local health department, FQHC look-alike, AHEC teaching clinic, and other non-profit community clinics were able to meet the primary care needs of most of the uninsured in Buncombe County. Each of these clinics provided some medication assistance. Private physicians who wanted to volunteer their time usually did so through free clinics. Few saw significant numbers of uninsured patients in their private offices. Safety net organizations often had difficulty obtaining specialty referrals and providing ancillary care. The uninsured patients who were seen by specialists regularly had problems paying for their prescriptions, and could have difficulties scheduling non-urgent hospital procedures. Those who were hospitalized could be faced with large outstanding bills that negatively impacted their credit ratings.

Project Access helps to address some of these problems, by organizing the private medical community to augment services already being provided by existing safety net organizations. Private providers had been reluctant to offer services to the uninsured because they were afraid that they would be inundated with requests. Some were also concerned that they had no way of knowing which patients needed free or reduced cost services, and which patients could afford to pay. Some providers were hesitant to offer their services because they could not ensure that the uninsured patients would obtain needed medications or diagnostic services. Project Access eases some of these concerns by verifying patient need and distributing patient referrals among many different providers. This helps spread the burden and risks of caring for the uninsured. In addition, Project Access makes reminder phone calls to reduce no-shows and helps ensure that patients can obtain specialty and ancillary services and needed medications.

The Project Access model has been implemented in eight NC communities—Asheville (Buncombe County), Boone (Watauga-Avery Counties), Charlotte (Mecklenburg County), Concord (Cabarrus County), Mitchell-Yancey Counties, Greensboro (Guilford County), Greenville (Pitt County), Henderson (Vance-Warren Counties), and Raleigh (Wake County), although the program varies depending on the community needs and resources.

Five other communities (Sylva, Rutherforton, Winston-Salem, Durham, and Jacksonville) are exploring or are in the process of implementing Project Access models. Project Access models are also operating in other states. There are more than 30 communities in other states that have operational community-based systems modeled after the Buncombe County Medical Society Project Access, with 70 more in the implementation or exploratory stages.

Services: Project Access models help to fill gaps in the healthcare services available to meet the healthcare needs of the uninsured. Access systems involve local physicians, both primary care and specialists, in providing care to the uninsured. Many Access projects also have funds available to help purchase medications when needed medications are not available through the pharmaceutical assistance programs or other sources. Hospitals provide diagnostic services as well as outpatient and inpatient services. While Project Access systems may not be able to provide all needed healthcare services (for example, dental, behavioral health, or therapy services), they do help to provide more comprehensive services than are traditionally available in the community.

Private physicians can participate in one of two ways: (1) they can commit to serve patients at one of the safety net organizations, or (2) agree to see a certain number of patients in their office per year. In Buncombe County, 80% of the physicians in private practice have agreed to participate in the program. Primary care providers agree to see 10 uninsured low-income patients, and specialists agree to see 20 patients per year. Local hospitals donate all lab tests and inpatient and outpatient services. Patients who visit a specialist (or a primary care doctor in their private office) can obtain their medications through a county-funded medication assistance program. All of Buncombe County's 44 pharmacies provide medications at cost, waiving counseling and dispensing fees.

One example of how Project Access helps augment services provided by existing safety net providers is through its specialty referral system. By referring specialty care patients to private physicians, primary care providers spend less time trying to address specialty needs, thereby freeing up time to serve more patients. In Buncombe County, the average number of physician visits at the local health department decreased from 5.0 visits per year per patient in 1995 to 2.5 visits per year per patient in 2003. The average length of each visit also declined from 45 minutes per visit to 20 minutes per visit. During that time frame, the Buncombe County Health Center made major changes in its organization and placed a heavy emphasis on production. However, the improvements could in no way have occurred without the presence of Project Access. Clinicians in the Health Center had previously spent untold minutes and hours seeing the same patients repeatedly for unresolved specialty care needs and trying to make referrals to specialists in the community. Project Access opened the door to those specialty referrals and enabled the Health Department to discontinue handling unresolved specialty care needs and focus on vastly improving its primary care service. The health department is now more able to focus on reducing no-shows and arranging transportation and other ancillary services. In addition, the time donated by private physicians in the clinics also helps expand the number of clients served.

The Buncombe County Medical Society administers Project Access and its role includes recruiting providers to volunteer, enrolling patients, and keeping track of referrals and appointments. The Medical Society makes patient appointment reminder calls 24 hours before each appointment. In addition, the Society processes standard insurance claims forms voluntarily submitted by physicians, hospitals, and pharmacies to document which services were provided and the value of the services.

Patients served: To qualify for Project Access services in Buncombe County, a person must:

- Be between ages 18-64 years
- Not have any medical insurance
- Have a gross household income of less than 200% of the federal poverty guidelines
- Not be receiving Medicaid or Medicare

The health department, community clinics, and private physicians refer patients into the program. Medicaid eligibility workers are outstationed at community clinics and screen individuals for Medicaid eligibility or help them enroll in Project Access. Patients referred by private physicians have their eligibility determined through the Buncombe County Medical Society. The average enrollment is approximately six months, but this varies based on the patient's needs and length of time that he or she is uninsured. Patients are responsible for keeping their appointments. After three missed

appointments patients are dropped from the program.

The number of patients actually seen by Project Access in Buncombe County for specialty care is approximately one-quarter the number seen by safety net providers for primary care. Patients seen exclusively in the safety net clinics continue to receive their care and medications through that system and are not screened or "counted" as Project Access patients. The only patients who are screened for Project Access eligibility are those who are seen by private physicians in their private offices (primary care providers or specialists), or who need hospital services. In 2003, for example, traditional safety net providers saw 20,500 uninsured low-income patients; primary care providers in their private offices treated 1,000 Project Access patients, and 3,500 received specialty referrals (See Table 3.5).

Financing: Project Access models across the state rely on different funding sources to support the systems. The services donated by the private providers and healthcare institutions create the core of the support for Project Access models. In Buncombe County, for example, physicians donated approximately $4 million and hospitals donated approximately $3.2 million in services in 2003. A local durable medical equipment provider donates approximately $100,000 per year of durable medical equipment supplies such as diabetic test strips. Additional funding is needed to support the infrastructure, including eligibility determinations, recruiting providers, purchasing medications, scheduling referrals and tracking the value of donated services. In Buncombe County, local county funds help pay for medications and the Medical Society's administrative costs. Pharmacists accept deeply discounted rates for their medications. Safety net clinics pay the non-federal share (50%) of Medicaid eligibility workers, who are outstationed and help determine eligibility for Medicaid and Project Access.

North Carolina Project Access programs across the state have received funding from a variety of sources, including national, state, and local foundations and charitable organizations; United Way; the federal government (Bureau of Primary Health Care and the Appalachian Regional Commission); county government; and local hospitals. North Carolina Project Access systems have also benefited from settlements that the NC Attorney General reached with vitamin manufacturers.

Challenges: Implementing Project Access models may be challenging in some communities. It is generally easier to create Project Access models in communities with existing primary care safety net capacity. In Buncombe County, for example, there were already several non-profit, faith-based, or governmental organizations that provided primary care services and offered prescription medications to the uninsured. It is more difficult to create a similar system in communities where these safety net resources did not already exist, although the Project Access system in Boone, NC, demonstrates that it is possible.

Project Access models rely on physician and provider volunteers, much like free clinics. Again, this is generally more difficult in rural and medically-underserved communities where there are fewer providers. Additionally, Project Access models are dependent on physician leaders and an "organizing entity." Physician leaders assist by enlisting colleagues and broader provider support, while the "organizing entity" is responsible for making all eligibility determinations and tracking referrals and utilization. One of the reasons for the underlying success in Buncombe County was the leadership shown by the Buncombe County Medical Society and existing physician leaders. This model would be harder to implement without a medical society or other physician-directed organization that had the support of the broader healthcare community.

Table 3.5
Buncombe County Integrated Delivery Healthcare System for Uninsured Project Access[38]

	1995	2003
Patient population	190,000	210,000
Uninsured patients (estimate below 200% federal poverty guidelines)	15,000	23,000
Primary care patients served in: -Existing safety net clinics -Private physicians offices -Hospital emergency department	 7,300 ? high-use	 20,500 1,000 low-use
Specialty patients served in private physician offices	?	3,500
Access to pharmacy (specialists)	Low	High
Hospital services billed to patient	Yes	No
Uninsured patient population with primary care	50%	90%

Outcomes: The health of the uninsured in Project Access communities has improved. According to 1998 survey of Buncombe County Project Access enrollees, 80% reported that their health was better or much better after enrolling in Project Access.[39,40] One-quarter (25%) of the patients reported that the healthcare services they received helped them return to work or do a better job. Thirteen percent of patients surveyed reported reduced absenteeism, and 25% reported increased productivity. In addition, local hospitals were able to report a $2-3 million reduction of projected charity care expenses.

School-Based or School-Linked Health Centers

Overview: Children are not always able to access comprehensive, coordinated, and culturally-competent systems of care. Many children are uninsured: 11.9% of children in North Carolina lacked health insurance coverage in 2003.[41] Despite the availability of Medicaid and NC Health Choice, 19% of children with family incomes below 200% of the federal poverty guidelines lacked coverage over a three-year period (SFYs 2001, 2002, and 2003).[42] Lack of insurance makes it difficult for some families to afford needed healthcare services. In addition to financial barriers, other barriers exist which prevent some children from seeking care. Adolescents have the lowest utilization of healthcare services of any age group.[43] Some of the reasons why adolescents do not seek out available care include concern about confidentiality, lack of knowledge of available services, and lack of culturally appropriate services. Another provider-related barrier includes a greater focus on the needs of younger children or adults.[44]

There were approximately 1.3 million children attending 2,158 public schools and 93 charter schools in North Carolina for SFY 2003-2004.[45] Nurses are available in most school districts, albeit on a limited basis. The average school nurse/student ratio was 1:1,897 in North Carolina for SFY 2003-2004, although national standards suggest that there be at least one school nurse for every 750 students. In 2004, the NC State Board of Education adopted the national recommendation to have one school nurse for every 750 students, and the General Assembly appropriated funds to support an additional 80 permanent school nurse positions and 65 time-limited (two-year) positions. This will reduce the nurse-to-student ratio to 1:1,436, assuming no increase in the number of students. Adding the additional school nursing positions will increase the number of school systems meeting the 1:750 ratio from 10 to 24. School nurses provide important health services to children and adolescents at school, including: counseling, chronic disease management, administration of medications or other healthcare procedures, and emergency services for injuries. In addition, school nurses oversee the care provided to medically fragile children who require one-on-one support.

Comprehensive primary care services are provided in school-based or school-linked health centers.

Appalachian Healthcare Project: A Rural Model

While the Project Access model is easier to establish in communities with large provider bases and existing safety net providers, Project Access models have been established in less resource rich environments. The first rural Project Access program, the Appalachian Healthcare Project, serves Watauga and Avery Counties. Watauga County has a population of 42,857 people with 25 primary care providers and 60 specialists. Avery County has a population of 17,610 with 17 primary care providers and two specialists.

In the spring of 2000, the only place for low-income uninsured patients to receive care was the hospital emergency department. There were no safety net organizations or free clinics providing comprehensive primary care. This project was made possible by the commitment of the medical communities in these two counties. Each provider pledged to see anywhere from 12 to 24 patients per year. In addition, the local hospitals offered inpatient, outpatient and diagnostic services to Appalachian Healthcare Project patients. The medical community's commitment allows the patient load to be equitably distributed among the physicians.

Since the project was implemented in April 2001, approximately 600 people have been served. On average, there are about 200 active patients at any time. In 2003, the healthcare community provided more than $2 million in free care and medications to Appalachian Healthcare Project patients.

School-based health centers (SBHCs) bring healthcare services to schools, where young people spend a great deal of their time. School-linked health centers (SLHCs) are located near, but not on, school grounds. SBHCs and SLHCs provide age-appropriate health and mental health services and health education to students with parental consent. They are designed to eliminate or diminish barriers to care for students[46] and to help address the unmet physical and emotional health needs of children and adolescents. In addition, these centers help keep students in school by removing physical and emotional barriers to learning. By providing healthcare services at or near the schools, these centers also provide assistance to working parents who can avoid taking time off from work to take their children to the doctor.

State funds for SFY 2004-2005 help support organizations or providers that sponsor 18 credentialed school-based or school-linked health centers and 16 non-credentialed centers.[47] "Credentialed" centers meet higher standards through an accreditation type review by the Division of Public Health/Women's and Children's Health.[x] Of these sites, 31 are school-based and three are school-linked. All state-funded centers have advisory councils composed of parents, students, providers, business, clergy, and other community leaders. Almost half of the 16 state-funded SBHCs are in middle schools, 38% (14) are in high schools, 3% (1) is in a middle/high school, 3% (1) is in a middle/elementary school, and 3% (1) is in an elementary school. In addition to the school-based or school-linked centers supported by state funds, there are other SBHCs or SLHCs in the state that do not receive state funds. The NC School-Based and School-Linked Health Center Association reported 56 centers statewide, but it is unclear whether each of these centers offer the same array of services as the state-funded centers.

Services: Services offered through school-based or school-linked health centers vary across the state. All state-funded sites offer a comprehensive array of services; other centers may offer fewer services. Services may include: medical care, preventive health services, mental health assessment and treatment, chronic disease management, laboratory testing, health education and promotion, social services, nutritional services, and other specialty services such as dental care and well-baby care for students with children. Services are provided directly at the site or, if not available on-site, through a referral to a local care provider. Most SBHCs are not allowed by local education authorities to offer STD or family planning services.

Staffing at SBHCs and SLHCs may vary, but state-funded credentialed centers are similarly staffed to

Wayne Initiative for School Health

Wayne Initiative for School Health (WISH) is a nonprofit school-based health program providing affordable, accessible physical and mental health services to over 2,000 adolescents in Wayne County. WISH addresses a broad range of needs, such as: basic health care, mental health issues, alcohol/drug use, teen pregnancy, communicable diseases, nutritional education, immunizations and preventive health services. WISH is a community effort with the local hospital, health department, department of social services, public school system, Communities In School, and local physicians.

WISH was founded as a direct result of an identified need for easy access to adolescent health care in this rural and economically depressed county. WISH centers are located in highly populated, low-income areas. WISH has instituted a comprehensive health program with amazing results. In schools that house WISH school-based health centers, pregnancy rates have decreased by 75%, school attendance has increased by 4%, and disciplinary actions have decreased by 5%. There continues to be broad support among diverse groups committed to continuing their support for promoting wellness among Wayne County adolescents.

x Typically, Medicaid recipients must obtain prior approval from their primary care provider (PCP) before seeing another provider. However, Medicaid recipients can obtain care from credentialed school-based health centers without prior approval. To obtain credentialing, SBHCs must communicate with the PCP in a timely manner regarding the care and co-management of those students.

ensure that a comprehensive array of services is available to students. Services may be provided by certified nurse practitioners, physician assistants, physicians, registered nurses, licensed and/or credentialed mental health professionals and registered dietitians. Typically, SBHC staff are employees of sponsoring organizations, such as health departments, community health centers, private not-for-profit agencies, or hospitals, rather than employees of the school district. Sometimes, health professionals from other community agencies and organizations provide services at the centers through an interagency agreement or contract. Pediatricians or other physicians from a community practice, clinic, or from the public health sector frequently serve as medical directors.

Services at state-funded health centers are offered every school day; at other non-state-funded centers, the availability of services may be more limited. In these centers, a local provider office or clinic may visit the school site for a limited time each week. Because SBHCs are located in schools, their hours of operation are limited to the days and hours when schools are open; however, some SBHCs are able to provide 24 hour, 7 days a week coverage through their sponsor organization (i.e., health department, community health center, hospital, non-profit agency or local physicians' office).

Children served: Data are not maintained on the number of children seen in *all* the school-based or school-linked centers throughout the state. However, in 2002-2003, state supported SBHCs and SLHCs provided access to comprehensive services for approximately 28,000 students.

Financing: In general, it takes $150,000-$200,000 per year to run the average SBHC in North Carolina, but budgets vary based on the size of the center and scope of services.[48] Funding for SBHCs comes from a variety of sources, including state general revenues, federal monies, institutional sponsorships, third-party payers, local grant funding, and in-kind support. The state appropriated $1.5 million in SFY 2004-2005 to sponsors of 18 credentialed school-based or school-linked health centers and 16 non-credentialed centers. Other funders have included the Bureau of Primary Health Care, Duke University, First Health of the Carolinas, and the Kate B. Reynolds Foundation. Across the state, local health departments, hospitals, community health centers, physician practices, and non-profit organizations help sponsor school-based health centers. Insurance payments from Medicaid, NC Health Choice, and commercial plans have been a small but growing revenue stream for school-based health centers. In addition, local SBHCs seek grants to supplement their funding.

Outcomes: While state-funded centers are expected to report on selected performance, or outcome, measures in relation to services provided, general data on the health and academic impact of SBHCs on NC students are not available. For example, state-funded SBHCs report on the percentage of students with up-to-date well-child exams and appropriate child immunizations. In addition, centers are required to report the percentage of students who are overweight or at risk for overweight with documentation of their body mass index, risk status, treatment plan and who have participated in counseling, and the percentage of enrolled students with documented communication between staff andparents/guardians. Centers also choose from a list of mental health measures to include in their Continuous Quality Improvement initiative, such as attention-deficit disorder/attention-deficit hyperactivity disorder, depression or anxiety, or students with inappropriate, violent, or aggressive behaviors. Many of these measures are new to the centers, so data about outcomes in this state are not available.

While state-level outcome data are not available, national studies show that the increased access to care for adolescents served by SBHCs leads to higher visit rates (especially among minorities), decreases emergency room visits,[49] and improves utilization of mental health services for hard-to-reach populations.[50]

Challenges: SBHCs have a unique opportunity to meet student needs and an ability to implement broad-based community or school outreach and prevention activities because of their strategic location in schools. However, because of their unique set-up, SBHCs also face challenges not common among traditional healthcare providers. Centers located in schools often have more limited hours of operation; for example, SBHCs may only be open during school hours, and not in the summer or during school breaks. As a result, it is more difficult to assure continuity of care.

Additionally, SBHCs face some of the same challenges as other safety net providers. Most struggle daily with financial sustainability because unstable funding streams make it difficult to sustain these programs. Funding sources are not reliable and state funds have

not been increased for several years. Third party reimbursements make up a small part of revenues, in part because reimbursement rates are low or non-existent for many needed services provided to adolescents. For example, third-party insurers do not usually reimburse for health education, nursing, or case management services. The majority of SBHCs in North Carolina are located in medically underserved areas of the state. It is often difficult to attract health professionals to practice in these areas, which means that staffing for these centers is an ongoing issue.

Private Physicians

Overview: National studies suggest that the uninsured usually obtain health services from private physicians, although care provided through private physicians' offices is not always financially affordable. A 1994 national study found that 82.3% of primary care visits by uninsured patients occurred in physicians offices, 11.8% occurred in hospital outpatient departments, and 10% occur in community health centers.[51] Medicaid patients followed a somewhat similar pattern, although fewer of their primary care visits were in private physicians' offices (69.2%), and more were in hospital outpatient departments (17.3%) and in community health centers (13.5%). A 2001 study of households reported that nearly two-thirds of the uninsured reported a physician was their usual source of care, and half receive care in a physician's office.[52] Some of this care is provided at no charge or at a reduced rate (charity care), and some of this care is provided with the expectation that the uninsured person will ultimately pay for the services. This distinction is important, as people with outstanding medical bills are much more likely to report having an unmet medical need or delaying care because of costs.[53] The uninsured in families with outstanding medical bills are particularly likely to report access barriers: 29.1% reported an unmet medical need in the past year due to cost, 49.1% reported delaying care in the past year due to costs, and 47.5% reported not obtaining filled prescriptions due to costs.

Patients served: Nationally, most *primary care physicians* reported spending approximately two hours per month on charity care in 2001; *other physicians* reported spending about four hours per month on charity care.[54] The amount of charity care reported varies by specialty; the median amount of time spent ranged from a high of five hours per month for surgical specialties and psychiatry to two hours per month for internal medicine and pediatrics. There has not been a formal study of NC practitioners as it relates to uninsured, underinsured, and charity care practices.[xi,55]

In a national study of internists, the median amount of time reported on charity care was four hours per month, approximately three-fourths of which was provided in their private offices.[56] Approximately two-thirds of these internists (65%) reported that they would reduce or waive their fees for patients who were uninsured and had problems paying their bills, but 35% would continue to charge their customary amounts. More than half (55%) required some or all payment at the time of the visit. Slightly more than half of the internists (52%) reported that they limited their provision of charity care to those uninsured who were previous patients, 10% reported treating a mixture of new and old patients, 33% reported that their patients were mostly new, 2% report only seeing uninsured patients referred by their colleagues or uninsured relatives of existing patients, and 3% reported seeing no uninsured patients.

Physicians were less likely to provide charity care in 2001 than they were in 1997.[57] In 1997, approximately 76% of physicians provided charity care; in 2001, that number dropped to 71%. The number of physicians spending a lot of time on charity care (i.e., those that spend 5% or more of their time on charity care) also decreased (from 33.5% to 29.8%). Furthermore, approximately 16% of physicians reported that they would not accept any new uninsured patients, and 21% reported that they would not accept any new Medicaid patients.[58] In contrast, only 3-5% of physicians were no longer accepting new Medicare or privately insured patients.

With the exception of pediatrics, the provision of

xi The NC Medical Society conducted an informal survey of its members in 2003 and found that 60% of physicians reported providing charity care, and that on average, 2% of charges were attributable to indigent or charity care. However, the survey only had a 10% usable response rate, so it is unclear how reflective these responses are for the state's physician population as a whole.

charity care has decreased across all types of physician providers.[59] Pediatrics maintained its level of charity between 1997 and 2001 at approximately 65%. Solo or small group practices were most likely to provide charity care. Medical schools, substantial providers of charity care in the past, have experienced a decline in the provision of charity care. In 1997, 74.1% of medical schools provided charity care, whereas in 2001, the proportion dropped to 63.8%.[60]

Challenges: A number of factors have been suggested as possible reasons for the decline in charity care. These include reduced third-party payments, which reduce physicians' ability to cross-subsidize care they provide to uninsured patients.[61] The change in physician practices, from ownership to employee status, has also been suggested as a reason for the decline in charity care.[62] Physicians in solo or small group practice are more likely to provide charity care than physicians who are employees because the former have more control over decisions such as whether to offer charity care and how much to provide.

The decline in the number of private physicians treating uninsured patients, coupled with the difficulty that the traditional safety net organizations have in meeting the healthcare needs of the growing uninsured, may be leading to increased access barriers for the uninsured. Nationally, the percentage of uninsured individuals with a usual source of care decreased from 68.6% in 1997 to 64.2% in 2001.[63] The uninsured are much less likely than others with insurance to have a usual source of care. For example, 90.6% of Medicaid enrollees reported a usual source of care in 2001, a slight drop from 92.9% in 1997. Furthermore, the percentage of uninsured who reported that they saw a physician in the last year declined from 51.5% (1997) to 46.6% (2001). Uninsured individuals are far less likely to have seen a physician, compared with Medicaid enrollees (83.3% in 2001) or privately insured individuals (80.6% in 2001).

Area Health Education Center Teaching Clinics as Safety Net Providers

Overview: The Area Health Education Centers (AHEC) program began in 1972 at the University of North Carolina (UNC) School of Medicine. Initially, the program was funded with federal AHEC funds to support centers in three regions of the state. By 1974, the NC General Assembly approved and funded a UNC School of Medicine plan to create a statewide network of nine AHEC regions, which were operational by 1975. The legislative plan also called for the establishment of 300 new primary care medical residencies and the regular rotation of health science students to off-campus sites.

AHEC's mission is to meet the state's healthcare and healthcare workforce needs by providing educational programs for healthcare professionals in partnership with academic institutions, healthcare agencies, and other organizations. To accomplish this, AHEC offers academic and teaching programs and services targeted to:

- Improve the distribution and retention of healthcare providers, with a special emphasis on primary care and prevention. For example, AHEC supports clinical rotations for health professional students in hospitals, community health centers, health departments, private practitioners' offices, and other community settings. AHEC also helps support primary care residency training programs in family medicine, pediatrics, internal medicine, and obstetrics/gynecology, as well as in other shortage specialties (such as surgery and general medicine subspecialties).
- Increase the representation of minorities and disadvantaged populations in all health disciplines. AHEC helps to recruit underrepresented youth and adults into health careers, and provides continuing education courses on cultural competency and linguistic accessibility.
- Enhance quality of care and improve healthcare outcomes. AHEC offers continuing education courses for healthcare professionals around a variety of healthcare topics and offers specific coursework on practice improvement, disease prevention, and evidence-based medicine.
- Address the healthcare needs of underserved communities and populations. AHEC residency clinics and clinical training sites provide services to underserved populations as part of their core teaching mission.

Medical center residency and teaching programs provide a significant amount of safety net care throughout the state. AHEC 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. These programs employ 260 full-time faculty and 285 residents, which is about 12-15% of the total number of residency trainees in the state.

Patients served: Six AHECs have various mixes of primary care residency programs. They are located in Asheville, Charlotte, Greensboro, Wilmington, Raleigh, and Fayetteville.[xii] These programs provided 454,734 outpatient visits and 184,782 inpatient visits in 2003-2004 (Table 3.6). Approximately 98,400 of the outpatient visits were for uninsured (or "self-funded" patients). Other uninsured patients were seen in the rural family medicine programs and in the primary care residency programs in the four teaching hospitals.

AHEC also helps support primary care residencies at the four medical schools (Duke University, University of North Carolina, Wake Forest University, and East Carolina University). In addition AHEC has three rural family medicine programs. These programs are located in Cabarrus, Union, and Henderson Counties.

The payer mix varies among the AHECs. Some of the difference is driven by the specialties provided at each AHEC. For example, family medicine programs are required by their accrediting body to have a broad mix of patients—so these programs typically have a broader payer mix. Seven to 28% of the patients seen in the AHECs are self-pay (i.e., the proxy measure for the uninsured).

Table 3.6
NC AHEC Clinical Services Provided in 2003-2004[xiii]

AHEC site	Outpatient	Inpatient
Asheville (Mountain)	69,868	14,328
Charlotte	203,091	58,099
Fayetteville (Southern Regional)	25,677	1,665
Greensboro	40,223	14,953
Raleigh (Wake)	77,954	65,964
Wilmington (Coastal)	37,921	20,773
Total	454,734	184,782

Challenges: As with other safety net providers, there is an increasing number of uninsured patients seeking care at all the AHEC residencies. Although there has been an increased need for charity care, funding to support it has decreased. The AHEC programs have been affected by state budget cuts over the last four years. The state covers less than 20% of total AHEC costs, and less than 10% of the residency programs. Federal grant support via Health Resources Services Administration's Bureau of Health Professions has also declined in recent years, and has been targeted for elimination by the current administration. To compound the problem, AHECs are spending more money on rising malpractice premiums and hiring teaching faculty. The increase in malpractice premiums has caused problems for some programs, particularly those focusing on obstetrics and surgery. In the past, community physicians have volunteered their time to serve as faculty to the residents; however, private physicians are now less willing to give up their private clinic hours to teach residents and/or to take hospital call coverage for uninsured patients. As a result, AHECs have been forced to hire faculty and/or pay providers higher compensation to serve as teaching faculty.

Recruiting residents into primary care residencies is a growing problem nationally. The interest in primary care has dropped for five years in a row. Pediatrics has held steady, but there have been declines in family medicine, general internal medicine, and obstetrics and gynecology. North Carolina is still able to fill the primary care residencies with high quality physicians, but this is counter to the national trend. If North Carolina starts following the national trend, this may lead to primary care provider shortages. Furthermore, when residency programs lose residents, they also lose federal Medicare Graduate Medical Education

xii Asheville (Mountain AHEC) operates residencies in family medicine and OB/GYN. Charlotte operates residency programs in family medicine, internal medicine, pediatrics, OB/GYN, and surgery. Fayetteville (Southern Regional AHEC) operates a residency program in family medicine only. Greensboro operates residency programs in family medicine and internal medicine. Raleigh (Wake AHEC) is a major site of UNC residency training for internal medicine, pediatrics, OB/GYN and surgery, but does not have its own independent residencies. Wilmington (Coastal AHEC) operates family medicine, internal medicine, OB/GYN and surgery residency programs.

xiii Data reported are from six AHECs and does not include data from the four university medical centers or the rural programs.

funds, which will further reduce support for these teaching clinics.

Table 3.7
Payer Mix among AHECs[64]

	Self-Pay	Medicare	Medicaid	Commercial	Other
Asheville	14%	7%	45%	34%	—
Charlotte	27%*	12%	47%	13%	1%
Fayetteville	7%	13%	19%	60%	1%
Greensboro	13%	24%	31%	28%	4%
Raleigh	28%	12%	29%	29%	2%
Wilmington	13%	15%	49%	23%	—

**Includes self-pay and sliding-fee scale*

Hospitals as Safety Net Providers

Overview: There are 154 hospitals in North Carolina: 130 are general acute care, 15 are psychiatric, seven are specialty, and two are rehabilitation hospitals. Thirty-five of the hospitals are owned by local government, 11 are owned by the state, and nine are federal hospitals. The rest are community hospitals, of which 122 are not-for-profit and eight hospitals are investor owned.

Hospitals are an integral part of the North Carolina's safety net because almost all of them operate emergency departments that provide some services to everyone who comes to their door. The federal Emergency Medical Treatment and Active Labor Act (EMTALA, 1985) requires hospitals that participate in Medicare to screen anyone who requests treatment at the emergency room, regardless of ability to pay. If the person has a medical emergency, the hospital must treat them to stabilize the condition or transfer the patient to another hospital. Emergencies are defined as medical problems with acute, severe conditions that could reasonably place the person's health (or the health of an unborn child) in serious jeopardy if the person does not receive immediate medical attention. A woman who is having contractions is considered to have an emergency if there is not sufficient time to safely transfer her to another hospital before delivery, or if a transfer would pose a danger to the woman or unborn child.

While most of the NC hospitals provide some services to the uninsured, there are some hospitals that serve a higher proportion of the uninsured and/or Medicaid patients. These hospitals tend to share certain characteristics. For example, they:

- Are more likely to be located in low-income areas
- Have a special mission to serve poor and vulnerable populations (e.g., teaching hospitals, public hospitals)
- Have higher than average use of emergency services by the uninsured and higher use of the emergency room for non-emergency care

Services: All of the general acute-care hospitals provide inpatient services, and almost all (109) operate emergency departments. Aside from these similarities, hospitals vary in terms of the level of technology and types of services that are available. For example, smaller rural hospitals have fewer beds, and are less likely to do deliveries or offer intensive care services than larger hospitals. By comparison, larger teaching hospitals are likely to have sophisticated diagnostic equipment and offer a full range of services, including open-heart surgery, transplants, and/or brain surgery. Larger teaching hospitals are also more likely to have trauma units and/or neonatal intensive care units. Some hospitals also provide primary care services through rural health clinics or special clinics created to serve underserved communities.

Hospitals are the providers of last resort in communities where there are not enough other safety net providers to address the primary care or specialty needs of the uninsured. When uninsured or low-income patients are unable to obtain affordable care elsewhere, they sometimes turn to the hospital emergency departments. In fact, some safety net providers refer patients to hospital emergency departments for specialty services when specialists in private practice are unable or unwilling to make these services available in their private practices.

Patient served: On average, Medicare patients accounted for 39.2% of all patient discharges in 2003.[65] Medicaid accounted for 18.6%, commercially insured patients for 30.0%, the uninsured (self-pay) for 5.7%, other government for 3.8% and other categories of patients for 2.7% of patient discharges. The percentage of patient discharges attributable to Medicaid and the uninsured varied widely across general acute hospitals:

- Medicaid: The percent of Medicaid discharges varied from a high of more than 30% in five hospitals to a low of less than 5% in seven hospitals.
- Uninsured (self-pay): The percent of discharges attributable to the uninsured varied from a high of more than 10% in nine hospitals to a low of less than 2% in 14 hospitals.
- Medicaid/Uninsured: Total discharges attributable to both Medicaid and the uninsured varied from a high of more than 35% in nine hospitals to a low of less than 10% in 10 hospitals.

The state does not currently collect data on outpatient visits that do not result in inpatient hospitalizations. However, a 2003 survey of NC Hospital Association members found the uninsured accounted for 10% of outpatient visits (1,234,426 of 12,344,256 visits),[66] and of those, 22% were uninsured patients making emergency room visits (672,799 out of 3,058,176).[67]

National data show a wide variation in the proportion of emergency department patients who are uninsured or on Medicaid.[68] Thirty-six percent of all hospitals had a high safety net burden (defined as having Medicaid patients or uninsured comprise 30% of their emergency department patients separately, or 40% combined). More than half of the patients seen in 13% of hospitals are Medicaid and/or uninsured. High burden emergency departments are more likely to be located in the South and in communities with lower per capita income and higher unemployment.

National data showed a 16% increase in the number of visits to emergency rooms between 1996-97 and 2000-01.[69] Surprisingly, two-thirds of the increase came from privately insured and Medicare beneficiaries. The number of visits by uninsured patients increased only 10%, and visits among Medicaid patients did not change. The increase in emergency room use among the insured and Medicare beneficiaries parallels a general increase in ambulatory care visits to other providers. The percentage of emergency room visits as a proportion of all ambulatory visits remained relatively constant at a little less than 8% for these two groups. However, just the opposite was true for Medicaid patients and the uninsured. While their number of visits did not significantly increase, the reliance on the emergency department as their source of care did. Between 1996-97 and 2000-01,

WakeMed Teaching Clinics

Wake AHEC, located at WakeMed, serves as a training site for residents from UNC, Duke and East Carolina Universities. WakeMed helps train residents in: internal medicine, pediatrics, obstetrics and gynecology, and surgery. Until three years ago, WakeMed also provided clinical ambulatory services in cardiology, neurology, rheumatology, gastrointestinal, and ophthalmology, but those clinics were eliminated due to overwhelming demand for general medical care. WakeMed is also the largest provider of emergency services to community residents in Wake County.

In the past, community physicians volunteered to teach residents. Residents would care for unassigned, generally uninsured, patients. If there were more patients than the residents could treat, the community physicians would share in the call coverage. This is no longer the case. Physicians have pressures to generate income; as a result, fewer community physicians are willing to teach residents or to care for hospitalized patients (either their own or the unassigned patients). As the number of volunteer physicians has decreased, WakeMed has had to increase its own staff to serve as faculty and to hire hospitalists to admit the unassigned patients. Some of the WakeMed residency programs are having problems meeting the needs of a growing uninsured population. The ambulatory indigent adult clinic faces an especially dire situation, operating at a $2 million loss because of a poor payer mix. The clinic has been effectively "closed" to new patients for years, only seeing patients for follow-up care after hospitalization. Other clinics continue to operate and accept new uninsured patients, but costs for these programs have grown because of the need to hire faculty to teach in the clinical programs and staff to help with the overflow of uninsured patients admitted to the hospital.

Including both the AHEC teaching clinics and inpatient services, WakeMed is projected to provide $44 million in charity care to the uninsured in SFY 2004, up from $13.1 million in SFY 2002. The provision of charity care has been achieved through the support of other profitable programs, including its cardiology program. Despite an ongoing commitment to care for the uninsured, there is a question of whether WakeMed will be able to continue to cover these costs in the future. This will depend on the extent of the need, and other sources of revenues to subsidize charity care.

visits to the emergency room as a percentage of all ambulatory visits increased from 15.9% to 17.5% for Medicaid beneficiaries, and from 17.0% to 25.2% for the uninsured. These data indicate that patients had less access to physicians in private offices and became more reliant on emergency departments as their source of care. Thus, it is clear that emergency departments play a significant role in meeting the healthcare needs of both Medicaid and uninsured patients.

A few hospitals in North Carolina have taken a leadership role in trying to provide primary care services to their communities. In rural areas some hospitals have helped establish rural health clinics (see section on rural health centers). Many of these clinics provide services to the uninsured on a sliding-fee scale basis. In addition, some of the teaching hospitals have AHEC residency programs, which serve the uninsured in the outpatient teaching clinics (see AHEC section). A few of the larger hospitals have also created non-teaching primary care clinics for uninsured and/or Medicaid patients.

Financing: Medicare and Medicaid account for 58% of gross revenues for *all* hospital services, including both inpatient and outpatient services. Medicare accounts for almost half (45%) of patient revenues, Medicaid (13%), commercial payers (31%), other (4%), and uninsured (7%).[70] High-burden safety net hospitals treat more Medicaid and uninsured patients.

North Carolina hospitals are dependent on commercial/private payers in order to offset losses from government payers and the uninsured. Medicare and Medicaid are fixed payments that do not pay the full cost of providing care to these patients. Safety net hospitals that are heavily dependent on fixed payment reimbursement (Medicare and Medicaid), and that serve large numbers or percentage of uninsured patients have less ability to cost-shift the costs of covering the uninsured onto other third party payers.

Certain safety net hospitals receive additional funding to help them pay for the care provided to Medicaid patients and the uninsured. These payment mechanisms include the Medicaid and Medicare Disproportionate Share Hospital (DSH) payment systems and cost-based reimbursement available to Critical Access Hospitals under Medicaid and Medicare (See Chapter 7 on Financing).[xiv] In addition, Medicare recently increased reimbursement to rural hospitals. However, while these extra funds generally help cover the full costs of caring for Medicaid and Medicare patients, they are not sufficient in covering all of the care provided to the uninsured.

Duplin General Hospital

Duplin County is primarily agricultural and has a population of 50,000 people. Approximately 19% of the county is Latino, and one-fourth of the population lacks health insurance coverage. Duplin is one of the poorer counties in the state, with a county median income of $28,890 compared to the statewide average median income of $39,184 (1999 US Census data).

Duplin General Hospital is a 101 bed hospital. It performs more than 600 births each year (50% are to Latino mothers), and 48,000 outpatient visits. The uninsured account for approximately one-fourth of the 15,000 emergency department visits per year. Over the last two years, the percentage of commercially insured patients decreased (from 22.7% in 2001 to 20.3% in 2004), while the percentage of Medicaid and uninsured increased (from 23.0% to 24.3% for Medicaid patients, and 6.3% to 9.7% for the uninsured). Covering the costs of services to the uninsured has become a major problem. Duplin General collects, on average, less than 5% of the self-pay charges. The increase in the number of uninsured and decrease in commercially insured populations treated at the hospital has affected the hospital's bottom-line. Duplin General has gone from a $1.6 million profit in 2000, to an estimated deficit of more than $2.2 million in 2004. Bad debt and charity care has increased from $4.2 million in 2000 to a projected $7.0 million or more in 2004.

xiv Congress created the Critical Access Hospital (CAH) program in 1997, to provide financial support for small rural hospitals. To qualify, hospitals may have no more than 25 acute care beds, provide 24-hour emergency room services, have an average length of stay of 96-hours or less, and meet certain other criteria to show that they are a necessary community provider. CAHs receive cost-based reimbursement from Medicare. Some state's Medicaid programs, such as North Carolina, also pay CAHs on a cost-basis.

Challenges: Hospitals have also seen an increase in the numbers of uninsured that they serve. Between 2001-2003, the number of self-pay discharges increased from 52,599 (2001) to 60,308 (2003) or a 15% increase.[71] The amount of hospital inpatient charges attributable to self-pay increased from $435.7 million (2001) to $617.3 million, or a 41.7% increase. This is a particular problem in communities that have large Latino populations because close to 60% of all Latinos in the state are uninsured. Hospitals pay for the care they provide to the uninsured, in part by shifting these costs onto other payer sources. Medicaid payments were frozen in SFY 2003 and 2004,[xv] and the state recently reduced hospital payments under the State Employees Health Plan and the NC Health Choice program. The adequacy of third-party payments, and the continuation of the Medicare and Medicaid special reimbursement mechanisms, has a direct impact on the ability of hospitals to pay for care provided to the uninsured.

While many of the payments to hospitals have remained stagnant; hospital costs have increased. Malpractice premiums, which increased, on average, 181% over the last two years, contributed to rising costs.[72] Increased labor costs have also become a factor. Hospitals must offer higher wages to retain nurses and other staff, and hospitals in many communities are hiring hospitalists to take call coverage for unassigned cases.

Behavioral Health Services for the Uninsured

While not focusing on behavioral health safety net systems, the Task Force recognized that many uninsured or otherwise underserved groups have a critical need for behavioral health services. Lower-income individuals often have a greater need for these services because they more often live with financial stress and may have problems with depression, substance abuse, and/or homelessness. The uninsured and low-income may not have the resources to obtain services from private providers; therefore, the publicly funded behavioral health system is critical to these groups.

The Task Force did not focus on the role of area mental health, developmental disabilities, and substance abuse programs as safety net providers in this report because the state's public behavioral health system is in the midst of a major transformation.[73,74] Area programs will become Local Management Entities, which will contract with private non-profit and for-profit organizations for the delivery of behavioral health services, but will not generally provide clinical services directly. Because the state is in the midst of a comprehensive behavioral health system reform, it was difficult for the Task Force to include these providers as part of its overall analysis of the safety net system. However, the Task Force members recognize the need to examine this issue once the state has completed its restructuring. The Secretary of the NC Department of Health and Human Services is monitoring the implementation of the plan and how well it is meeting the behavioral health needs of all North Carolinians who need services, including, but not limited to, the needs of the uninsured. Therefore, the Task Force recommends:

Rec. 3.1: The Office of the Secretary of the NC Department of Health and Human Services should continue its efforts to monitor access to behavioral health services for the uninsured and other underserved populations. The Office of the Secretary should examine access to services for both the priority (target) populations and for those with less severe behavioral health problems and should seek input from a wide variety of stakeholders including, but not limited to, publicly funded local management entities, children's development services agencies, behavioral health providers, primary care providers, safety net organizations, and representatives of consumer groups.

Rec. 3.2: The Office of the Secretary should work with the NC Pediatric Society, NC Academy of Family Physicians, NC Chapter of the American College of Physicians, NC Psychiatric Association, other interested professional associations, and NC Area Health Education Centers program to examine ways to expand the capacity of primary care providers to address some of the behavioral health needs of the uninsured and/or underserved populations. Information on this initiative should be reported to the NC Commission for Mental Health, Developmental Disabilities and Substance Abuse Services.

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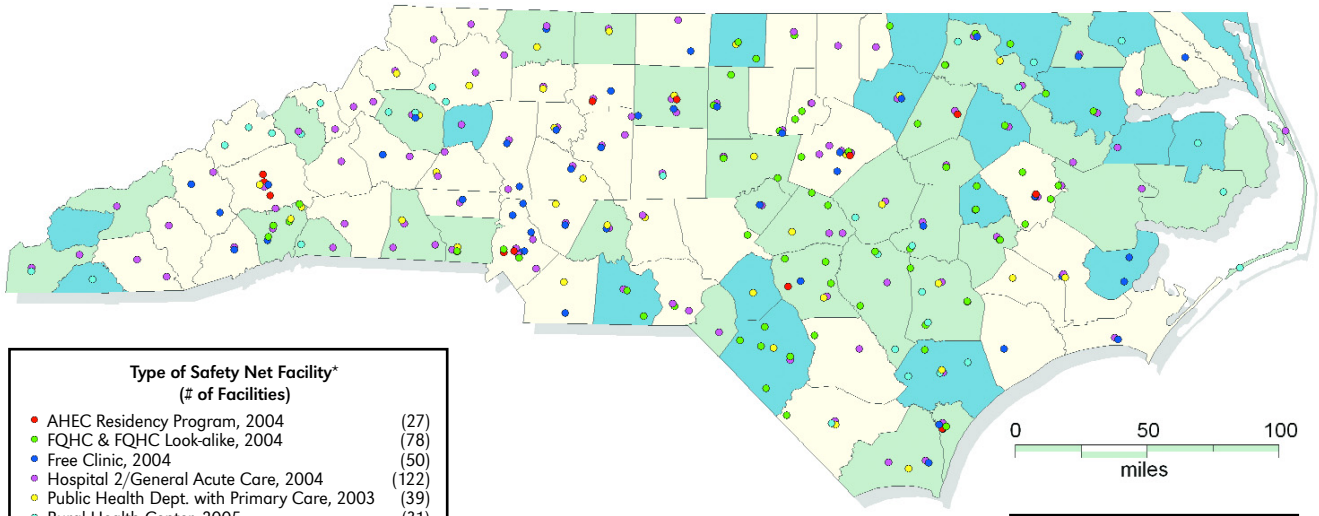
Chapter Four

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.

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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.

Chapter Five

Prescription Drugs

Prescription drugs are a critical component of healthcare. More than 40% of all Americans take at least one prescription drug, and 17% take three.[1] Yet many people lack the necessary means to purchase needed medications. Nationally, 23% of non-elderly Americans lacked drug coverage in 1996 (most recent data available); 36% of Medicare recipients lacked coverage in 2001.[2] Medicare Part D—to be implemented in January 2006—should make drug coverage more available to Medicare recipients, particularly those with low incomes who can qualify for Medicare Part D with little or no cost-sharing. However, the uninsured, as well as some with private health insurance, lack coverage for prescription drugs. Lack of insurance coverage often translates into difficulty purchasing medications. A 2003 Kaiser health insurance survey found that 37% of the uninsured said that they did not fill a prescription because of costs, compared to 13% of people with insurance coverage.[3] Lack of prescription drug coverage is a particular problem for people with chronic illnesses, and thus they have an ongoing need for medications to manage their health problems, but the problem is not limited to this population. The health of any individual may be compromised by the inability to obtain needed medications.

There are some limited resources available to the uninsured (or others who lack prescription drug coverage), but like other safety net services, these resources are not available in every community. The largest source of free medications is through patient assistance programs, offered by pharmaceutical companies. Each manufacturer determines which drugs will be offered through their program and sets specific eligibility requirements. Thus, the uninsured are not always assured medications through these programs. Some of the safety net providers also offer free or low-cost medications (or assist patients in filling out the necessary forms to obtain the free drugs through the patient assistance programs). In addition, a few communities have organized local pharmacy assistance programs, to help low-income uninsured patients obtain needed medications. Low-income Medicare recipients have other sources of assistance—either through the Medicare—sponsored pharmacy discount cards and/or the Senior Care program. These programs are described more fully below.

Patient Assistance Programs (PAP)

Patient Assistance Programs (PAPs) are programs offered through pharmaceutical manufacturing companies that provide free or low-cost medications to certain low-income individuals.[4] In 2004, there were 75 company-sponsored programs that covered approximately 1,200 different medications.[5] According to the Pharmaceutical Research and Manufacturers of America (PhRMA), the PAP programs helped 6.2 million uninsured or underinsured individuals obtain more than 17.8 million prescriptions nationally in 2003. In the same year, 270,516 North Carolinians accessed medications through these programs.[6,7]

The PAP programs vary substantially from one another in terms of the medications offered, eligibility requirements, and application process. Some require eligible individuals to reapply each month; others will accept one application to cover medications for longer periods of time. All PAPs have income requirements and exclude individuals with healthcare insurance coverage, unless the individual lacks prescription drug coverage (for example, some of the PAPs will provide assistance to people with Medicare if they do not have supplemental coverage that covers medications). Some PAPs are limited to persons with certain diseases, while others are broader in scope. The application process can be laborious. Most of the programs require extensive documentation of financial resources (some require that a patient provide copies of their tax returns), and many require that the patient exhaust other alternatives for prescription drug coverage (i.e., they must first apply for Medicaid). For some, the application is available online, but others require an interested party to request an application by phone or fax. Typically, the programs require a healthcare provider or a social worker to initiate the application process, and most

require the physician's signature on the application. Some of the companies will ship bulk prescriptions to safety net organizations so that they have medications on-hand to meet the immediate prescription drug needs of their patients, others require that medications be shipped individually to the provider and/or the patient. Furthermore, the programs are not always consistent because pharmaceutical companies sometimes vary the drugs covered, eligibility requirements, or application process.

In light of these challenges, the Task Force recommends:

Rec. 5.1. The NC Office of Research, Demonstrations and Rural Health Development and other safety net organizations should create a workgroup to meet with pharmaceutical companies to discuss:

a) Simplifying and streamlining the Patient Assistance Programs, including the application forms, verification requirements, and eligibility requirements; and

b) Creating bulk replenishment programs and other ways the pharmaceutical industry could help provide medications to safety net organizations.

Information should be disseminated to safety net organizations and private physician practices about the best way to access existing pharmaceutical resources.

As just noted, the variation in these programs makes it very difficult and time-consuming to identify helpful programs and apply for them. It is often difficult for private physicians' offices as well as some smaller safety net programs to take advantage of these free medications, because of the program complexity. There are several programs available to help providers, advocates, and patients access PAP medications. For example, Pharmaceutical Research Manufacturers of America has its own internet-accessible computer system to help providers and patients determine eligibility for medications provided by PAPs.[8] The NC Foundation for Advanced Health Programs, Inc., with funding from The Duke Endowment, also developed software to assist providers and advocates in accessing appropriate PAP programs. The Medication Access and Review Program (MARP) is software being used in about 80 sites in North Carolina, including federally qualified health centers (FQHCs), rural health centers, health departments, free clinics, Area Agencies on Aging, senior centers, hospitals, non-profit pharmacy assistance programs, and Healthy Carolinian projects. The Office of Research, Demonstrations, and Rural Heath Development (ORDRHD) provides technical assistance to support communities in using the MARP software. MARP supports two programs: the basic program that identifies appropriate PAPs and a more sophisticated program known as 'medication management programs,' which involves pharmacotherapy review. The basic program includes information on all current PAP programs, their eligibility requirements, and application forms. Once patient information is entered into the system, the computer will self-populate all the appropriate fields so that the same information need not be re-entered every time the patient needs a new medication or refill. The medication management pro-

Crisis Control Ministry Pharmacy (CCMP)

Crisis Control Ministry is a non-profit organization in Forsyth County that offers a pharmacy assistance program. Crisis Control Ministry Pharmacy (CCMP) is staffed by one full-time pharmacist, a pharmacy technician, a pharmacy assistant, and more than 150 volunteers. To qualify for medications people must lack income to pay for their medications. CCMP served 2,600 people and dispensed 31,351 prescriptions in 2003 (totaling more than $2.0 million in medications). The staff helps clients apply for the pharmacy assistance programs offered by pharmaceutical companies. Medications for eligible clients are shipped to CCMP where the patients receive the medications and prescription drug counseling. Some pharmaceutical manufacturers also provide bulk shipments to CCMP for a group of patients (which is easier administratively than applying for and receiving separate medications). CCMP also receives donated pharmaceuticals from local physicians and nursing homes. Volunteers help to repackage the medications into larger bottles, so that they can be dispensed by the pharmacist. CCMP has limited funds to purchase medications that are not available through PAPs or donations. In 2003, CCMP spent $200,000 to buy needed medications. CCMP is not eligible for 340B discounted drug prices.

gram requires coordination with at least one area pharmacist and helps assess possible drug interactions, provides patient and provider education, and offers counseling on alternative therapies.

The MARP system has helped providers and non-profit agencies access patient assistance programs, but some organizations have been unable to use this software. The primary obstacle is that many of the sites lack adequate technology or personnel to operate the software.

The software itself is free to sites, and training on how to use the program is also provided free of charge by the ORDRHD. Furthermore, the software is fairly easy to navigate and can be operated by a staff person who has been trained as a prescription assistance coordinator (PAC). However, the site must have a computer with Windows 2000 or XP, Office 2000 (or a more current version), a good printer, networking capability, and a compatible server to run MARP. In some sites, firewalls have prevented the software from operating correctly because the security protections prevent essential update downloads on the drug discount programs.

To address this barrier, the NC Health and Wellness Trust Fund Commission (HWTFC) provided funding to the ORDRHD to help fund and provide technical assistance to community agencies to create or expand existing medication assistance programs and provide funds to purchase the necessary hardware. Since 2002, 69 grants were awarded (through a request for proposals process) to sites serving 95 counties, to implement the software and to establish medication assistance programs that extend pharmacist-provided drug management to patients.[9] These grants provide start-up funding to recipients for up to three years while sustainability is established. The UNC School of Pharmacy provides assistance to the remaining counties through telephone consults.

Some of these programs, like Senior PharmAssist in Durham, were initially created to assist seniors. Other programs provide assistance to low-income individuals of all ages who lack prescription drug coverage. In addition, those that were initially established to serve older adults are being encouraged to expand their scope of services to the population under age 65 years because most low-income seniors will soon be covered by Medicare Part D. While these programs provide critical services, they are unable to help every low-income uninsured patient. Between January 1 and November 30, 2004, the MARP software was used to help 24,973 patients access PAPs. Staff in different organizations helped patients submit 64,796 new requests for medications and 55,116 reorders.

Currently, funding from the HWTFC is sufficient to support the existing programs through 2008 and to provide for modest expansion. However, in the past, the NC General Assembly has taken some of the funding from the HWTFC to support other healthcare initiatives. Funding for local medication assistance programs and support of the MARP system may be insufficient if the HWTFC has inadequate funds to support these programs. Therefore, the Task Force recommends:

Rec. 5.2. The NC General Assembly should support the Health and Wellness Trust Fund's efforts to support and expand prescription assistance programs, including, but not limited to, expanding the availability of Medication Access and Review Program (MARP) and medication assistance programs.

In addition to the existing PAPs, in January 2005, ten major pharmaceutical companies announced a new prescription drug discount card, called Together Rx Access™ for certain individuals who lack prescription drug coverage.[10] To qualify, an individual must:

- Be under age 65 years and not otherwise eligible for Medicare,
- Have no other public or private prescription drug coverage,
- Have an income that is equal to or less than 300% of the federal poverty guidelines, and
- Be a documented US resident.

Together Rx Access™ promises savings of between 25-40% on more than 275 brand-name medicines and other generic products. While these savings are important, many uninsured individuals will still need access to the PAP programs, as the discounted price of certain medications may still be unaffordable. The new discount program promises to notify individuals if they would be eligible for free or further discounted medications through the PAPs.

Medications Available through Safety Net Providers

Many of the safety net providers discussed in Chapter 3 also help their patients obtain prescribed

medications. Most safety net programs assist uninsured patients in obtaining free or reduced cost pharmaceuticals through the PAPs. However, PAPs do not cover the medication needs of all of the uninsured. Even when medications are available through a PAP, the safety net provider may need to provide an immediate short-term supply until the patient's PAP application is approved, and medications are sent in the mail. As a result, some safety net organizations have developed systems to assist patients in obtaining medications when they are unable to do so through the PAP. These systems vary, depending on the type of provider and available resources. For example, smaller free clinics are typically more limited in the types of medications they can offer because they may rely on donated medications from local physicians' offices and/or nursing homes. Ten communities in the state have created free pharmacies—similar to free clinics—that focus exclusively on meeting the medication needs of low-income uninsured residents. The free pharmacy clinics generally have a larger array of available medications than smaller free clinics, and may purchase some medications in addition to the medicines dispensed through donations or received through the PAPs. However, these organizations typically have limited ability to purchase medications due to the high cost of pharmaceuticals. Hospitals and some of the larger FQHCs and health departments provide medications through in-house pharmacies.

Private physicians' offices and rural health centers do not always have the staff needed to fill out PAP applications. Many communities have non-profit organizations that help people access the PAPs and provide medication counseling.

The 340B Drug Discount Program

Some of the safety net organizations have access to deeply discounted medications through the 340B program. The 340B program is a federal program that provides eligible safety net programs with discounts on drugs.[i] The program originated as Section 602 of the Veteran's Health Care Act of 1992. The 340B program (also known as the 602 program) was enacted to ensure that federal purchasers (i.e., Department of Veterans Affairs, Department of Defense, Public Health Service, and Coast Guard) were not at a disadvantage in negotiating discounts from pharmaceutical companies after Congress passed the Medicaid Rebate Program in 1990. The Medicaid Rebate Program established a mechanism for states to receive the "best price" for drugs for Medicaid recipients and the concern was that there was a disincentive for pharmaceutical manufacturers to negotiate discounts with other federal purchasers of drugs because those discounts would have to be passed along to state Medicaid programs through the formulas used to calculate "best price." The Veterans Health Care Act exempts prices negotiated by

The Cumberland County Medical Assistance Program (CCMAP)

CCMAP is a collaboration between the Cape Fear Valley Health System, Cumberland County Health Department and Department of Social Services, The CARE Clinic, and the Cumberland County Health Care Council. CCMAP assists eligible residents obtain free life-saving medications and works to enhance compliance and management of chronic diseases. It is supported by grants from The Duke Endowment, Kate B. Reynolds Charitable Trust, the NC Health and Wellness Trust Fund Commission, and donations from collaborating organizations. Low-income residents of Cumberland, Harnett, and Sampson Counties are eligible if they are on a stabilized dosage of medication, do not have insurance coverage for outpatient prescription drugs, do not qualify for government or third-party programs, and have incomes below 200% of the federal poverty guidelines. CCMAP began seeing patients in July 2002 and currently has 1,980 active patients with a waiting list of 575 applicants. CCMAP helps patients apply for the PAPs, dispenses some donated medications, and purchases other medications. CCMAP also provides prescription counseling to the patients. The average CCMAP patient receives about $1,800 in medications each year.

i The 340B program is administered by the Pharmacy Affairs Branch (PAB) of the Bureau of Primary Health Care (BPHC) in the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services.

certain other federal purchasers from being included in calculations for Medicaid best price. This Act was later expanded to include certain other health programs under section 340B of the Public Health Service Act.

Potentially eligible organizations include:[11]

- Community health centers,
- Federally qualified health center look-alikes,
- Migrant health centers,
- Health centers for public housing,
- Health centers for the homeless,
- School-based programs (Healthy Schools, Healthy Communities),
- AIDS clinics and AIDS Drug Assistance Program (ADAP programs),
- Hemophilia treatment centers,
- Black lung clinics,
- Certain disproportionate share hospitals, and
- Public health agencies can also obtain 340B drug discounts for medications dispensed in certain clinics, including family planning (Title X only), sexually transmitted diseases, and tuberculosis.

In the past, 340B drug discounts were limited to outpatient drugs, but the Medicare Modernization Act (2003) extended this provision to inpatient drugs at eligible public hospitals.[ii,12] Participating facilities receive an average savings of 25-50% off the average wholesale price (AWP) for covered drugs. Savings may be used to reduce the price of drugs for patients or to expand the healthcare facility's resources (e.g., increase revenue and allow them to treat more patients, offer more services, etc.). Many facilities adopt a sliding-fee scale that allows them to cover the entire medication cost for the neediest patients, pass the 340B savings on to some patients, and charge regular pharmacy prices to the highest income patients and those with good insurance coverage.[13]

The 340B program covers outpatient drugs that are prescribed for eligible patients of covered entities. Eligible "patients" are those who receive healthcare services from a covered entity. The patient is not eligible if medication services are the only services received from the covered entity (except for coverage of AIDS drugs through the AIDS Drug Assistance Program). Not all eligible organizations participate in the 340B drug discount program. For example, in 2003, only 13 of the 23 FQHCs in the state participated. Program requirements, including certain paperwork and accounting requirements, make it difficult for some organizations to participate.[iii]

The ORDRHD, Division of Public Health, NC Hospital Association, and NC Community Health Center Association are all working with potentially eligible safety net organizations to encourage them to participate in the 340B drug program, and have begun to see good results. Of the 56 rural hospitals nationally that were enrolled in the 340B program in the July 1, 2004 enrollment period, 16 were from North Carolina. More have enrolled since then. In addition to enrolling more of the potentially eligible organizations into the 340B drug discount program, the Task Force thought it would be important to amend the federal statute to make more organizations eligible to participate. Currently, safety net organizations including free clinics, Project Access models, or state-funded rural health clinics are ineligible to participate in the program. As a result, these organizations must pay much higher prices if they purchase medications for their low-income uninsured patients. To provide the same benefits to the

ii The Medicare Prescription Drug Bill exempts inpatient drugs purchased by 340B participating hospitals from manufacturers' best price calculations. Previously, the 340B Drug Pricing Program only related to outpatient drugs for disproportionate share (DSH) hospitals. Public Hospital Pharmacy Coalition. Opportunities for Pharmaceutical Manufacturers to Offer Deeper Discounts on Brand Name Inpatient Drugs for 340B Hospitals. National Association of Public Hospitals and Health Systems. Washington, DC: June 2004.

iii Drugs that will receive a Medicaid rebate cannot also be covered under the 340B Program discount because that would subject them to two layers of discounted prices. In order to prevent this from happening, covered entities that serve Medicaid patients must submit their Medicaid provider numbers during the registration process so that billing for drugs purchased through the 340B Program will not be included in the Medicaid rebate. Furthermore, eligible organizations that do not have in-house pharmacies can contract with community pharmacies. While contracts have helped many covered entities participate, they bring additional conditions that have to be met, including the development of tracking systems for the drugs that are purchased under the 340B Program and participation in audits to assure that drugs are being used for patients of the covered entity.

low-income uninsured patients of these organizations, the Task Force recommended that the NC Department of Health and Human Services, NC Community Health Center Association, and NC Free Clinic Association work with the NC Congressional delegation to amend the 340B statute so that other non-profit organizations with a mission to serve low-income uninsured patients can also obtain the benefits of this program. (see recommendation 7.1 in Chapter 7.)

Senior Care and Medicare Part D

Senior Care: NC Senior Care provides assistance in purchasing medications for certain low- and moderate-income seniors who are Medicare recipients. The program, which began in 2002, is funded by the Health and Wellness Trust Fund. It is being administered through the ORDHRD. Older adults (age 65 years or older) who are residents of North Carolina, with incomes below 250% of the federal poverty guidelines, are eligible for assistance with medications if they have no other source of prescription drug coverage. NC Senior Care works in conjunction with Community Care Rx, a Medicare-certified prescription drug discount plan. Together, eligible individuals are entitled to $1,200 per year in subsidies to help purchase medications and additional discounts on medications after the subsidy is exhausted. Seniors pay a copayment of 5% or 10% (depending on their income). This $1,200 per year subsidy is limited to older adults; it is not offered to people with disabilities who are also Medicare eligible (although the disabled may be eligible for a more limited subsidy of $600 per year through the Medicare prescription drug discount cards).

Medicare Part D: North Carolina Senior Care and the Community Care Rx drug discount cards are scheduled to end on December 31, 2005, immediately prior to the implementation of the new Medicare prescription drug program. Medicare Part D is scheduled to begin on January 1, 2006. It is voluntary among Medicare beneficiaries, but individuals who do not choose to participate when first eligible may be subject to a penalty (increased premium) if they later sign

Table 5.1
Medicare Part D Cost Sharing and Drug Coverage

Part D Coverage	Full Medicaid (dual enrollees)	<135% FPG	135-150% FPG	Above 150% FPG
Asset Test	No	$6,000/individual $9,000/couple	$10,000/individual $20,000/couple	No
Premium*	No	No	Sliding scale	~$35/month
Deductible*	No	No	$50	$250
Recipient costs for drug expenses up to $250	Covered	Covered	Covered	$250
Recipient costs for drug expenses between $250-$2,250 (preferred/ brand copay)	$1/$3 (<100%FPG) $2/$5 (above 100% FPG)	$2/$5	15% costs	25% costs
Recipient costs for drug expenses between $2,250-$5,100 (donut hole)	No gap, Part D pays all but copay above	No gap, Part D pays all but copay above	No gap, Part D pays all but copay above	100% of costs
Recipient costs for drug expenses over $5,100 (Catastrophic coverage)	No copay	No copay	$2/$5	Greater of 5% of $2/$5

** The premium and deductible level are indexed and will increase in future years.*

up for coverage. Individuals will be offered a choice of at least two prescription drug plans, e.g., Medicare Advantage plans (HMOs or PPOs) or stand-alone prescription drug plans (PDP).

Most individuals who participate in the new Medicare Part D program will have to pay a monthly premium and a $250 deductible (Table 5.1). Once the deductible is met, the prescription drug plan will pay 80% of the costs of covered medications until the person's drug expenses reach $2,250. At that point, Medicare Part D stops paying for prescription drug coverage until the person's drug expenses reach a "catastrophic" limit (currently $5,100). This is commonly referred to as the "donut hole," because Medicare pays nothing for drug expenses between $2,250 and $5,100. Medicare prescription drug plans will pay for all of the costs (minus certain allowable coinsurance or copay), once the individual's drug bill reaches the catastrophic threshold. In general, lower-income individuals (with incomes below 150% of the federal poverty guidelines) will have access to more complete coverage and lower cost-sharing than those with higher incomes. Once Medicare Part D is implemented, dual-eligible Medicaid recipients (i.e., those receiving both Medicaid and Medicare) will get their drug coverage exclusively through Medicare Part D.

Other State Programs

While there are some programs available to help low-income uninsured people obtain necessary medications and additional assistance available to low-income Medicare recipients, many low-income North Carolinians are still unable to obtain necessary medications. Other communities and states have developed innovative approaches to expand the availability of low-cost medications. The Task Force considered efforts of other states to expand the availability of low-cost prescription drugs, including: bulk purchasing programs, efforts to expand the availability of 340B drug discount programs or to obtain better drug prices for existing 340B eligible organizations, and programs that assist patients in purchasing lower cost medications from other countries.[14]

Bulk patient assistance program coordination efforts: In the bulk purchasing model of patient assistance programs, agreements are negotiated that allow an organization to screen for eligibility and get bulk product shipments, so neither the pharmaceutical company nor the provider has to deal with all of the applications. This is also advantageous because the bulk products are available when the patient is on-site, rather than requiring approval into the patient assistance program and for the medication to arrive by mail. Some bulk patient assistance program coordination efforts include:

- ***Health Kentucky:*** Health Kentucky is a nonprofit organization that has provided free healthcare to more than 250,000 patients since its inception in 1984. Eligibility for the program requires that an applicant is a Kentucky resident between the ages of 19-64 years; has no health insurance (including Medicaid, Medicare, Kentucky Children's Health Insurance Program, or Social Security Disability Insurance); and has an income level at or below federal poverty guidelines. As a part of Health Kentucky, members receive free covered medications under the Kentucky Pharmacy Providers Program. As many as 525 hospital and retail pharmacies donate their services to fill prescriptions for eligible patients at no cost. The medications themselves are donated by the following pharmaceutical companies: Abbott Laboratories, AstraZenca, Bristol-Myers Squibb, Eli Lilly and Company, Johnson & Johnson, Novo Nordisk Pharmaceuticals, Pfizer, and Pharmacia Corporation. Pharmacies get reimbursed by Anthem Prescription Management (APM) through a replenishment of the supply of dispensed medications.[15]

- ***Communicare (South Carolina):*** Communicare provides healthcare services to South Carolinians who have no other form of health insurance, including Medicaid, Medicare, and Veteran's benefits. Eligible participants have an income between 100% and 165% of the federal poverty guidelines and must be able to document one of the following conditions: currently employed, receiving unemployment compensation, receiving Social Security Retirement benefits, or receiving Social Security Disability benefits or Workman's Compensation. The Communicare benefits include the provision of a formulary of over 260 drugs, which are donated in bulk by pharmaceutical companies. Participating manufacturers include Abbott Laboratories, AstraZeneca, Bristol-Myers Squibb, Eli Lilly, GlaxoSmithKline, Johnson & Johnson, Pfizer, and TAP Pharmaceutical Products. The process works through a mail order facility, which sends 80% of the medications to physicians'

offices or clinics and 20% directly to patients' homes. Communicare partners with the South Carolina Free Clinic Association and provides 17 clinics with more than 135 different medications. Initially, Communicare patients received medications at no charge, but a $20 annual fee has recently been instituted. The program receives about $20 million worth of donated medications annually, and Pfizer drugs represent about 50% of those donations.[16,17]

- ***Georgia Partnership for Caring Foundation:*** The Georgia Partnership for Caring Foundation (GPCF) is a "private, non-profit organization comprised of healthcare providers who donate their time and products to provide non-emergency healthcare services for Georgia's low-income uninsured persons who are living below the federal poverty level." Residents of Georgia qualify for GPCF programs if they are uninsured and have a family income at or below 125% of the federal poverty guidelines. The prescription assistance program available through GPCF provides certain donated medications to participants free of charge. Medications are donated by Pfizer, Inc., Johnson & Johnson, Abbott Laboratories, and Novo Nordisk. Most participating pharmacies also waive their dispensing fees.[18]

- ***Virginia Rx Partnership:*** The Rx Partnership (RxP) in Virginia is increasing access to free medications for the uninsured by serving as a broker for the state in soliciting bulk medication donations from pharmaceutical companies and facilitating the distribution of those drugs to affiliate organizations. RxP licenses, credentials, and monitors affiliate pharmacies, which are typically operated by free clinics and community health centers. RxP negotiates with pharmaceutical companies for lower-cost and donated medications on behalf of these free clinics and community health centers. The program began working with 18 free clinics and four community health centers and, to date, is receiving medications from GlaxoSmithKline, Pfizer Pharmaceuticals, Wyeth Pharmaceuticals, and AstraZeneca.[19]

- ***Arkansas Health Care Access Foundation:*** The Arkansas Health Care Access Foundation (AHCAF) was established in 1989 as a volunteer-based medical referral program providing donated or low-cost medical care to low-income, medically-uninsured residents through a statewide network of volunteer medical professionals. Eligible residents have no other source of health insurance, including Medicare and Medicaid, and have an income below the Federal Poverty Guidelines. A statewide network of 345 pharmacies fills prescriptions at no charge to AHCAF patients. The medications are donated by Pfizer, GlaxoSmithKline, and Johnson & Johnson.[20]

The Task Force was very supportive of the effort to develop a bulk purchasing and centralized dispensing program and recommended that such a program be developed within the ORDRHD. The ORDRHD could help negotiate with the different pharmaceutical companies for bulk shipment of medications available through patient assistance programs. Participating safety net organizations, such as free clinics, medication assistance programs, and other non-profit safety net organizations, could determine eligibility for the PAPs. The medications could be shipped to a central warehouse and then redistributed to the participating safety net organizations to be distributed to the patients. This would enable safety net organizations to provide prescription counseling to their patients.

To accomplish this, the Task Force recommends that:

Rec. 5.3. North Carolina private foundations should consider three-year start-up funding at $180,000 per year to the NC Office of Research, Demonstrations and Rural Health Development to create a bulk medication replacement system.

Expanding the 340B Pricing Program or create larger purchasing alliances to obtain discounted prices: There have been some efforts to expand the use of 340B pricing. States are encouraging the creation of FQHCs, providing loans to health centers to start a pharmacy or partner with an existing community pharmacy, and encouraging referral relationships between organizations that allow them to make expanded use of 340B pricing. Some states have also created statewide bulk purchasing cooperatives that include 340B and/or non-340B entities. Some of these models include:

- ***Coordinated Care Network, (CCN), Pittsburgh, PA:*** CCN arranges for federally qualified healthcare centers to provide case management and pharmacy services to Medicaid patients in southwestern

Pennsylvania so they can access medications at 340B prices. CCN has "a central pharmacy and mail order facility that provides 340B [c]overed [e]ntities with on-site physician dispensing systems, prepackaged medications, and centralized refill, administrative, financial and regulatory reporting services."[21] CCN earns revenue from dispensing fees for its contracted pharmacy services. The program also provides 340B Poly-Pharmacy Member Case Management Services, which identify and provide persons with high pharmaceutical costs with case management services at a covered entity. Poly-pharmacy members are allowed to transfer prescriptions to the covered entity's 340B pharmacy (CCN), which provides them with free home delivery, refill reminders, and other services.[22]

- ***Safety Net Provider Purchasing Alliance (Alliance), California:*** The Alliance is a statewide bulk-purchasing cooperative that includes both 340B and non-340B entities. The Alliance leverages the purchasing power of community-based clinics, county clinics and hospitals, and academic medical institutions during negotiations with pharmaceutical manufacturers. In California, the program established a Pharmacy and Therapeutics Committee, which developed a preferred drug list for more competitive prices. The Alliance combines the 340B drug discount program with the Prime Vendor group purchasing organization to maximize cost-savings and has a two-tiered pricing structure to negotiate the best possible prices for both 340B and non-340B entities.[23]

- ***Texas Association of Community Health Centers:*** The Texas Association of Community Health Centers/ Cardinal Health offers a 340Better℠ pharmacy purchasing program, which provides sub-340B pricing on drugs to participating health centers through contracts with pharmaceutical manufacturers. The program targets high-cost, high-volume pharmaceuticals and uses the high-bulk purchasing needs of the participating health centers to negotiate very low pricing. The 340Better℠ is open to health centers throughout the United States, regardless of size or location.[24]

The Wake County Medical Society has tried to develop a system similar to the Coordinated Care Network of Pittsburgh to cover more low-income Medicaid and uninsured patients under the 340B drug discount program. The idea would be to extend WakeMed's 340B privileges to 29,000 Medicaid enrollees participating in Community Care of North Carolina (CCNC), as well as to other uninsured low-income people receiving care from primary care safety net clinics. The concept is to create a new corporation that includes all the safety net organizations in Wake County, including both 340B and non-340B organizations. The corporation would include WakeMed (a large 340B participating hospital), the Wake County Medical Society, Wake Health Services (an eligible 340B entity), Wake Human Services (which includes the health department), the Open Door Clinic (free clinic), and 30 private physicians' offices that participate in Community Care of North Carolina. Patients would receive case management services (e.g., disease management) through the Wake Community Care program under contract through Wake Med (a 340B entity). This would make all these patients eligible clients of a 340B participating organization. To accomplish this, Wake County would need to get a waiver from the Pharmacy Affairs Branch of the Bureau of Primary Health Care, within the US Health Resources and Services Administration, which administers the 340B program. This model should translate into lower medication costs for the Medicaid program, as well as the availability of deeply discounted medications for other safety net organizations. In addition, the program would help improve patient care by providing enhanced disease management and increasing the scope and nature of the drug utilization review process (DUR) to assess prescribed medications for appropriateness and potential drug interaction.

The Task Force was supportive of this effort as a means of extending 340B drug discount prices to additional safety net organizations. However, the project would require a separate agreement with the NC Division of Medical Assistance to cover Medicaid recipients under this initiative; the Division of Medical Assistance was unable to pursue this immediately because it is in the process of converting its Medicaid Management Information System (MMIS) to a new vendor (scheduled to be operational by January 1, 2006). Another complication recently emerged. The US Office of Pharmacy Services has become reluctant to grant waivers to expand the availability of 340B drug discount prices to other safety net organizations through coordinated networks. The Task Force is still supportive of pursuing these initiatives to extend

340B drug discount prices to additional safety net organizations, if the opportunity presents itself. Therefore, the Task Force recommends that:

Rec. 5.4. The NC Office of Research, Demonstrations and Rural Health Development should explore opportunities to expand 340B drug discount prices to low-income patients of other safety net organizations.

Programs to facilitate purchasing medications from other countries: Medications in Canada, Ireland, and the United Kingdom are, on average, between 25-50% lower than similar medications in the United States.[25] Currently, it is illegal to import medications from other countries. Despite the current prohibition on import of foreign drugs, some states have helped facilitate the purchase of lower-cost medications from these countries. Illinois, Wisconsin, and Missouri are currently supporting such a program; The I-Save-Rx program in Illinois has a contract to refill prescriptions with CanaRx, a Canadian pharmaceutical benefit manager. Participating patients must get the initial prescription filled in the US, but can get three-month supply refills from Canadian pharmacies. The participating pharmacies have been inspected by Illinois officials, and the program offers 100 of the most commonly prescribed brand name medications. However, the FDA issued letters of warning against CanaRx that their practices of importing prescription drugs from foreign countries are illegal, and that they could not provide the same assurances of drug safety as provided under the regulatory structure in the United States.[26,27] The Task Force decided not to pursue this option, given the current laws prohibiting foreign import of pharmaceuticals.

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Chapter Six

The Potential for Safety Net Collaboration and Integration

As the numbers of uninsured increase, the patchwork delivery system through which the uninsured access basic healthcare services is being pulled and stretched beyond its capacity. Few communities in our state are able to meet the primary care needs of all of the uninsured, regardless of how many or how few safety net organizations they have. To provide the care needed by the low-income and uninsured population, safety net organizations will need to work together to maximize the use of these resources to maintain and, hopefully, expand care to the uninsured. Nonetheless, there are barriers to collaboration and integration of safety net services in some communities. The Task Force identified these potential problems in order to identify models and incentives, which could encourage these relationships and promote effective collaboration and integration.

It is surprising to some that issues related to collaboration and integration would arise in the course of a Task Force on the healthcare safety net, but many members felt that these were important issues, especially for some communities. However, it is important to recognize that collaboration and integration issues do not arise in every community, and are much less likely in communities with few or no safety net providers. These issues are most relevant in areas where a number of different organizations and agencies have made a public commitment to address the needs of the uninsured and underserved. In these areas, there are questions of resource allocation and effectiveness.

What Is Meant by "Collaboration" and "Integration" within the Healthcare Safety Net?

The Task Force discussed numerous ways in which healthcare safety net organizations could collaborate. These include everything from periodic meetings (to identify gaps, needs, and ways to address these problems), to more elaborate inter-organizational agreements and the merging of clinical and other services. In general, the models could be categorized into two broader concepts: collaboration and integration models. Each is described more fully below, and the chapter includes additional examples of successful collaboration or integration models:

Collaboration models include:

- Convening groups of stakeholders to identify gaps, needs, and ways to address these problems (e.g., community planning efforts),
- Joint projects with joint funding,
- One safety net organization funding another,
- Co-location of services, and
- Best practices or pilot programs.

Integration models include:

- Healthy Communities Access Program (HCAP) models with integrated information systems and referral networks,
- Project Access models that integrate primary care, specialty referrals, hospitalizations, and have a source of payment for medications (discussed more fully in Chapter 3), and
- Creation of a unified health system for the uninsured.

In these discussions, it became clear that the word "collaboration" is far more acceptable as a term referring to efforts to have safety net organizations work together effectively in meeting the needs of the uninsured and

Healthy Carolinians

Healthy Carolinians is an example of a convening, collaboration model. The Healthy Carolinians group acts as a neutral convener, to bring together everyone with a stake in healthcare issues. Healthy Carolinians groups meet to examine local health statistics and develop plans to improve the health of the community by focusing on health promotion and disease prevention. The goal of Healthy Carolinians is to get the various stakeholders to work collaboratively to address community health needs.

underserved. The term "integration" can involve a much more extensive and formal set of relationships among stakeholder groups. It refers not just to integrating providers, but also the integration of patient populations as well. Integration also raises questions of ownership, which makes some organizations uneasy. Hence, in most circumstances where efforts are being made to achieve greater coordination among the programs and services of interest to this Task Force, it is "collaboration," and not "integration" of services, that is of focal interest and intent.

Problem Definition and Validation

The Task Force identified a number of problems related to the prospect of collaborative or integrative initiatives among safety net providers including, but not limited to, the following. Each is discussed in more detail below:

- Information sharing and confidentiality laws,
- Inclusiveness (or absence of a sense of shared responsibility),
- Feelings of relative advantage,
- Professional economics,
- Political factors,
- Fear of the unknown,
- Physician representation,
- Convener legitimacy,
- Trust,
- Competition for non-economic resources,
- Lack of recognition, and
- Payment versus cost avoidance.

Information Sharing & Confidentiality Laws

When safety net providers attempt to share information as part of collaborations designed to provide seamless and efficient care to shared patients, medical confidentiality laws are often seen as obstacles. While confidentiality laws present challenges for all healthcare providers, the challenges are sometimes greater for providers caring for uninsured patients because the patients often seek care from multiple providers. According to North Carolina data from the Behavioral Risk Factor Surveillance Survey (BRFSS), the uninsured are less likely to report a usual source of care than those with insurance coverage. Only 38.3% of the uninsured report that they have one usual source of care; others report either seeking multiple sources of care, or no usual provider (which may also indicate that they seek care from different sources when they do seek care). In contrast, 68.7% of those with insurance coverage report a usual source of care.[1] In order to provide more efficient and better quality care to the uninsured, safety net providers need to find ways to share information with each other and collaborate on developing a system of care. Innovative safety net collaborations, however, are often stymied by concerns about compliance with confidentiality laws.

Healthcare providers must comply with complex confidentiality laws at both the federal and state levels. The federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulation actually facilitates information-sharing for healthcare's core functions—treatment, payment, and healthcare operations—by allowing

Cabarrus Community Care Plan

CCCP was developed in 2001 as a non-profit organization working to improve service provision to the uninsured in Cabarrus County. The local medical society, Northeast Medical Center, the Community Free Clinic, the Cabarrus Health Alliance (local public health department), the Cabarrus Department of Social Services, the Piedmont Mental Health Center, Healthy Cabarrus (the affiliate of Healthy Carolinians), and other types of healthcare providers participate in CCCP. A federal Healthy Communities Access Program (HCAP) grant supports the initiative. CCCP staff screen individuals to determine financial eligibility for the program, which is limited to uninsured individuals and families with incomes below 125% of the federal poverty guidelines. Participants are asked to provide CCCP with permission to share financial information needed to determine eligibility, and health information necessary for case management, among participating organizations. This information-sharing assists CCCP in linking eligible individuals with primary care providers, providing needed medications, arranging for specialty referrals, and covering the costs of hospitalizations. CCCP helps spread the burden of caring for the uninsured population among all the providers in the community. In addition, CCCP staff offer diabetes and asthma disease management services and help coordinate the care of children with ADHD in the Cabarrus County schools.

providers to share information relatively freely with one another for those three purposes *without* the patient's written permission. The US Department of Health and Human Services (DHHS) explained that "given public expectations with respect to the use or disclosure of information for [treatment, payment and healthcare operations] and so as not to interfere with an individual's access to quality healthcare or the efficient payment for such healthcare, the Department's goal is, and has always been, to permit these activities to occur with little or no restriction."[i] The Privacy Regulation builds in other measures to protect the confidentiality of that information in the hands of each of the providers, such as requiring providers to distribute notices of privacy practices and establish written privacy policies and procedures. Taken as a whole, the Privacy Regulation allows providers to share information for basic healthcare activities without onerous administrative burdens, but ensures a baseline level of privacy protection for that information outside of the healthcare delivery context.

In addition to complying with the HIPAA Privacy Regulation, providers must comply with any state law that is more protective of patient privacy than the federal law. Unfortunately, North Carolina's law is not clear regarding the ability of providers—including safety net providers—to share information for the core purposes of treatment, payment, and healthcare operations without the patient's written permission. North Carolina's patchwork of confidentiality laws raises a variety of difficult legal and interpretive issues. For example, some healthcare providers and their attorneys believe that the state's physician-patient privilege law[ii] requires patient permission or a court order for almost all disclosures of health information. Others argue that the privilege is an evidentiary rule only and, therefore, only applies in the context of court proceedings. Two other NC laws allow disclosure of certain information (communicable disease and emergency medical service-related information) for most treatment purposes without patient permission, but limit disclosures necessary for payment and healthcare operations purposes.[iii] Some argue that the limitations in these two laws should extend to all health information because it is difficult to differentiate between types of information in a medical record. There are many other NC statutes and regulations that raise similar issues and questions.

Healthcare providers are committed to protecting the privacy of their patient's health information, particularly sensitive information such as mental health, substance abuse, and communicable disease information. They want to comply with all applicable laws, but are struggling to understand the full scope of North Carolina's law. As a result, providers are interpreting and applying state law rather haphazardly. Some communities, such as Cabarrus County, have developed integrated systems of care that allow information-sharing across agencies for common patients, but other communities are much more cautious in their approach, fearing litigation or other legal repercussions. The current situation is confusing for patients as they try to understand their privacy rights and for providers as they try to better serve uninsured patients. Legislation is needed to clarify state law to ensure that safety net providers are able to share information as part of collaborations designed to provide more seamless care to uninsured patients. Any new legislation should not conflict with the HIPAA Privacy Regulations and should incorporate more heightened privacy protections for particularly sensitive information.

Absence of a Sense of Shared Responsibility

In considering community-wide initiatives to meet the needs of the uninsured and underserved, the Task Force emphasized the importance of involvement and participation by all key stakeholders. Certain stakeholders in community-wide safety net efforts may not be invited to, or may chose not to attend, discussions related to collaboration efforts. The Task Force heard claims that, in some communities, there is a lack of shared responsibility, trust, and commitment to serving the uninsured. Task Force members expressed the view that the NC DHHS should encourage safety net providers receiving state funding to participate in community-based collaborative efforts.

One critical element of the healthcare safety net that would not be captured by NC DHHS encouragement is the network of private physicians that could, and do, provide care to the uninsured. The Task Force noted the importance of physician participation and involvement in community-wide efforts to address issues related to assuring healthcare services for the uninsured. Many physicians offer uncompensated services with some reg-

i 67 Fed. Reg. 53,182, 53,208 (Aug. 14, 2002)

ii NCGS § 8-53

iii NCGS §§ 130A-143 and -518

Community Care of North Carolina (CCNC)

CCNC is built around local networks of primary care providers, hospitals, health departments, social services, and other agencies that coordinate prevention, treatment, and referral services for Medicaid recipients. CCNC provides additional funds to help pay for case management and disease management services for Medicaid recipients with high-cost, chronic, or complex health conditions. The statewide and local disease management initiatives are based on evidence-based best practices that are developed by a statewide team of primary care physicians representing each network (so that there is local buy-in and a local physician champion from each community). CCNC currently operates in 68 counties, serving approximately 550,000 Medicaid recipients; but the goal is to have the program operate statewide by the end of 2005. While the CCNC networks currently focus on improving the care for Medicaid recipients, these groups may be an appropriate vehicle to develop collaborative models to expand care to the uninsured.

ularity through their private offices, even though they may not participate officially as part of more organized safety net programs. Individual physicians are often "the missing link" and the most fractured piece of local safety net planning efforts. However, many communities still struggle to get private physicians to provide services to the uninsured. One barrier to physician participation is that there frequently is no designated or valid *representative* of physicians as a group to meet with other potential collaborative partners. Leadership plays an important role in recruiting physician volunteers and provision of services by private providers. A representative of local physicians should preferably be a person clearly accountable to local physicians as a group. Organized local medical societies, to the extent they exist and have staff, can serve in this capacity. In addition, communities may be able to work through local CCNC networks to involve local physicians in the provision of care to the uninsured.

Feelings of Relative Advantage

One of the reasons collaboration and/or integration of safety net services may prove to be difficult in a given setting is that some organizations are seen by other safety net providers as having a clear advantage with regard to funding or reimbursement. The perception that some organizations have a relative advantage in terms of reimbursement for care provided to the uninsured, while others shoulder a larger share of the burden, opens the door to turf and political arguments. Safety net organizations receiving funding or reimbursement include some hospitals (particularly teaching hospitals) receiving Medicare Graduate Medical Education (GME) funds and/or Medicaid Disproportionate Share (DSH) payments in recognition of their teaching responsibilities and the provision of care to uninsured patients. Moreover, hospitals are seen as having the facility to "cost-shift" from one part of their overall system to another (or from one type of service or type of insured patient to another). FQHCs receive some federal funds to care for the uninsured, and local health departments also benefit from federal block grant funds that can be used to provide some clinical services. The varying amount of reimbursement for uninsured patients becomes a stumbling block, as safety net organizations are often forced to compete for the same group of paying patients to help cover the costs of caring for the uninsured.

Individual Professional Economics

Economic competition interferes with inter-professional collaboration and coordination. Providers are often competing for patients, especially insured patients who can pay for the services they receive. Time spent providing free or reduced-fee services is time that cannot be devoted to the care of insured patients and could cause delays in appointment times and in the performance of procedures. The Task Force is sensitive to the professional economics of healthcare providers who lend their services to community-based efforts to address the problems of caring for the uninsured. For this reason, in some communities, a special effort has been made to distribute the healthcare needs of uncompensated patients so that a small group of providers is not undertaking a disproportionate share of the burden.

Political Factors

There are many political issues involved with a decision to collaborate in community-wide initiatives to serve the uninsured. The perception of ownership of a safety net provider/service and the perceived need for credit for having a given service or program can be important to some stakeholders. These perceptions may keep some organizations from joining collaborative initiatives if they

Guilford Child Health, Inc. (GCH)

Guilford Child Health, Inc. (GCH) is a public-private partnership organized to provide health-care services to low-income children in Guilford County. GCH provides primary care and specialty services to 30,000 children, 95% of whom have health coverage through Medicaid, a third-party payer, or NC Health Choice. The uninsured population visiting GCH is heavily comprised of Hispanics. GCH receives significant financial support from the Guilford County government. Moses Cone Health System and High Point Regional Health Systems are the two owners of the organization, and three members from each organization comprise the GCH board of directors. Three clinic sites are available to patients in Guilford County and care is provided at no charge or on a sliding-fee scale.

In addition to GCH, many of these same partners collaborate to provide care to the uninsured through Guilford Adult Health, Inc. Guilford Adult Health is the medical home to 13,000 patients. Approximately 60% of the patients seen at Guilford Adult Health's two medical offices are uninsured. Moses Cone Health System, High Point Regional Health System, and Guilford County government are major financial contributors to these initiatives. Each member organization appoints a specific number of members to the Guilford Adult Health, Inc. board of directors.

perceive that doing so would require them to relinquish their ownership or decrease the credit their organization would receive. There is also competition for resources that are not necessarily paid by the patients (e.g., donations, volunteers, community goodwill, etc.). Many fear sharing ownership of a local safety net effort might jeopardize these resources and some organizations' identities as key safety net providers within the community.

Fear of the Unknown

Various facets of potential collaborative relationships are not clearly delineated and may be a source of uncertainty for some organizations that are hesitant to either give up or take on responsibility for a safety net service. Some organizations may also have concerns about regulatory requirements when one agency or provider takes a leadership responsibility for a particular service. In these situations, a special effort is required to dispel these fears, to share the experiences of collaborating organizations in other safety net communities, and to formalize policies through open and transparent dialogue involving all stakeholders.

Convener Legitimacy

There are often issues with the legitimacy of the individual(s) or the organization acting as the convener for collaborative efforts among safety net providers. For example, it was reported that it took years for Pitt County to establish enough trust to develop effective partnerships among safety net provider organizations, but these relationships are now strong and effective. Developing partnerships requires the creation of a vision for the future that assures each stakeholder a place in the overall structure and process—this should include a specification of how the various assets in a community can inter-relate more effectively. The leadership for such efforts must rely on local knowledge and the personal credibility of the leader. An outside person could help to facilitate a conversation among local stakeholders, but the group has to be convened by someone well-known and trusted.

Recognition

One of the first steps toward collaboration is to fully recognize the efforts of all safety net providers, regardless of type or category, and to make them aware of their interdependence in helping the community achieve 100% access to the full continuum of care for all citizens, regardless of ability to pay. Failure to recognize the contribution of each of the players can be a detriment to further exploration of collaboration avenues among safety net providers. Most physicians are not really interested in individual recognition, but their combined contributions to meeting the overall burden of caring for the uninsured and underserved often go without recognition.

Payment versus Cost-Avoidance

Task Force members expressed disappointment that, too often, *payment* for services has become a far more important driver of actions within some safety net organizations than merely the *avoidance of cost*. Many felt that efforts should be made to explore alternative views that are not driven by units of service. The safety net system could be a great area in which to demonstrate how we can be driven by health promotion—using quality and health status as the drivers.

Each player in the continuum of care is being asked for a contribution in exchange for a certain benefit (e.g., recognition as a group/profession). Being able to articulate the return on investment (ROI) in terms of community health to everyone is important. (See the information on Project Access in Chapter 3). The drivers toward assuring the availability of a continuum of care for all stakeholders include: building a business case for participation in safety net service provision, equity (groups needing to feel there is shared responsibility), patient accountability (e.g., patients keeping their appointments), clinics (tracking provided services—prescription medications and treatment), and recognition.

Efforts to Encourage Collaboration

In its analysis of the barriers to collaboration (e.g., competition for paying patients may make existing safety net organizations less financially stable; regulatory barriers; lack of community leadership or commitment to collaboration, etc.), the Task Force investigated ideas that might encourage collaboration. These ideas included:

- *Community-wide, safety net planning groups.* Community planning efforts can start by focusing on needs or gaps and on identifying the safety net organization in the community best able to address the needs with the least amount of duplication. Community wide efforts should be broadly representative of the community and include healthcare providers, businesses, colleges and universities, faith-based organizations, social service agencies, non-profits, and other interested groups.
- *Best practices or pilot programs.* Best practices in community collaborations or integration models could be disseminated through the NC Community Health Center Association (NCCHCA), the Public Health Directors' Association, NC Medical Society meetings, NC Hospital Association meetings, Area Health Education Centers programs (AHEC), and other appropriate forums.
- *Incentives to collaborate.* Foundations or state agencies could require greater evidence of collaboration, such as by requiring an economic impact statement with grant proposals. These statements could detail how the new or expanded organization will affect existing safety net resources.
- *Shared funding or other resources.* Multiple organizations could apply for grant funds that could be shared across agencies. For example, health department buildings could be used for free clinics after hours.
- *Cross-subsidization of safety net activities.* Hospitals could fund safety net organizations to offer after-hours primary care coverage to reduce the use of the emergency departments, or could help hire staff in safety net organizations who could provide unassigned call coverage in the hospital.
- *Other creative ideas to eliminate barriers.* With regard to FQHC regulatory barriers—there was some consideration of potential efforts to expand local health boards to meet the FQHC's 51% consumer/user requirement, while still meeting state statutory prescribed positions on these boards. It is not clear that this would either be possible or, by itself, would do much to enable local public health departments to qualify as neighborhood health centers.

HealthAssist, Pitt County

HealthAssist is a community partnership developed in Pitt County to provide healthcare and other services to the indigent, uninsured population. It serves between 600 and 800 clients at any given time. The four areas of service include a quasi-insurance program, pharmaceutical assistance, healthcare and social/education services, and case management. To qualify for any of these services, an individual must be uninsured and have an income below 125% of the federal poverty guidelines. The HealthAssist insurance program provides free or reduced-cost outpatient primary care through volunteer local private physicians, the Greene County Health Care (FQHC), and the Brody School of Medicine at East Carolina University. Hospitalization is provided at no charge at Pitt County Memorial Hospital. Four Community Resource Centers (CRCs) serve as enrollment centers, provide space for examination rooms, and employ case managers who assist clients with healthcare and other social service needs. The prescription medication program makes generic and brand name medications available with small copays.

Recommendations

In its consideration of specific efforts to encourage collaboration among safety net providers and other stakeholders statewide, and particularly at the community level, the following recommendations are offered by the Task Force:

Confidentiality

North Carolina's law regarding the confidentiality of medical records is often seen as an obstacle when safety net providers attempt to share information as part of collaborations designed to provide seamless and efficient care to common patients. To clarify the law for safety net organizations so they can provide more continuous care for their shared patients, the Task Force recommends the following:

Rec. 6.1: The NC General Assembly should enact legislation that clarifies existing state confidentiality laws to ensure that safety net providers are allowed to share identifiable health information with each other when providing care to the same patients, consistent with applicable federal law. The legislation should include heightened protections for particularly sensitive information, such as mental health and communicable disease information.

Best Practice

In addition to the confusion over the laws for sharing medical records, most safety net organizations do not have the resources or staff time to devote to researching effective modes of collaboration. It would be helpful if descriptions of successful models were available in one location. Having access to descriptions of successful models may reduce some of the fears and initial barriers to creating partnerships. Funding will be integral to this process. North Carolina foundations could help the state-level Safety Net advisory council convene a best practices summit of safety net organizations to help communities identify ways to expand collaboration between safety net organizations and strengthen community capacity to meet the healthcare needs of their residents. To help communities and safety net organizations find and implement successful models of collaboration, the Task Force recommends:

Rec. 6.2. The NC Office of Research, Demonstrations and Rural Health Development should collect and disseminate descriptions of various models of collaboration and integration found to work well in particular communities.

Rec. 6.3. In addition to healthcare providers, local safety net collaborations should encourage the participation of business and industry, colleges and universities, faith-based organizations, social service agencies, non-profits, and other interested groups in community collaborations to provide care to the uninsured.

Rec. 6.4. North Carolina foundations should help convene a best practices summit of safety net organizations that will focus on collaboration and integration. This summit would help local communities identify ways to

Henderson County Collaboration: AHEC, Public Health, and Free Clinic

The Hendersonville Family Practice Residency Program (HFPRP), which is part of the Mountain Area Health Education Center, the local health department, and the free clinic, are working together to expand care to the uninsured. The HFPRP provided 38,000 outpatient visits, and 6,013 inpatient visits in 2003, many of which were to uninsured patients. The teaching faculty and residents also provide care to the uninsured at the health department and free clinic. One of the HFPRP faculty members serves as Medical Director for the local health department, providing much of the $550,000 in uncompensated care provided during the year. Another HFPRP faculty member serves as Medical Director for the free clinic. Furthermore, faculty and resident volunteers at the free clinic provided more than 300 volunteer hours and 1,400 patient visits in 2003. In addition, these groups, along with other community partners, formed a local health network to address the healthcare needs of the poor and uninsured in Henderson and Transylvania Counties. The Health Resources and Services Administration recently awarded a $900,000 Healthy Communities Access Program grant to further their efforts.

Duke University Health System (Duke) and Lincoln Community Health Center (Lincoln) Collaboration

Duke and Lincoln developed a joint initiative to provide two satellite health clinics in Durham. The first clinic, located in the Lyon Park Community Family Life and Recreation Center, was so successful that it has expanded space and clinic hours and spurred the development of the second clinic, near the Walltown neighborhood of Duke's East Campus. Duke Community Health, a division of the Department of Community and Family Medicine and the School of Nursing, administers and staffs the clinics under a contract with Lincoln. Lincoln receives cost-based reimbursement from Medicaid for the patients seen by contracted Duke providers. Lincoln, in turn, pays the providers the same rates they would have received directly from Medicaid if the patients were seen in Duke clinics. These local health clinics provide affordable healthcare to all patients, regardless of insurance status. Patients served under this collaborative have access to all of Lincoln's services, including pharmacy and enabling services, such as transportation, case management, nutrition counseling, and interpreter services.

build and strengthen their capacity to meet the healthcare needs of the growing uninsured population, and to reduce barriers to interagency collaboration and integration. Summit participants should include representatives of existing safety net organizations at the state and local levels. One of the outgrowths of this summit would be to develop clearer and measurable criteria of collaboration to guide future decisions for safety net program support by public and private funding agencies.

Hospital Collaborations

Hospitals continue to look for ways to reduce non-emergency use of their emergency departments. Many safety net providers are able to provide urgent care, which could take some of the burden away from hospitals. In Lee County, the hospital pays the health department to provide care to patients after normal business hours. Recommendation 6.5 is meant to encourage collaboration between hospitals and safety net providers for non-emergency medical needs.

Given the fact that hospitals in North Carolina have shouldered a tremendous burden of after-hours and non-emergency care for uninsured and underserved populations, the Task Force recommends:

Rec. 6.5: Hospitals should take the lead to develop collaborations with local safety net organizations to help ensure that the uninsured have appropriate medical homes and after-hours care for persons requiring non-emergent attention.

Ongoing State-Level Collaborations of Safety Net Organizations

Many of the safety net organizations need technical assistance and leadership as they consider collaborative efforts. In an effort to create a body that would continue state-level discussions of these issues and serve as an example of collaboration, the Task Force recommends:

Rec. 6.6: The NC Institute of Medicine should create an on-going state-level Safety Net Advisory Council that can encourage state-level and local safety net collaborations and can help monitor the implementation of the Safety Net Task Force's recommendations. The group should include the full array of existing safety net organizations, including health departments, federally qualified health centers, free clinics, hospitals, medical societies, Project Access and Healthy Communities Access Programs, medication assistance programs, and other non-profit agencies providing care to the uninsured.

References

1 Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: US Department of Health and Human Services, CDC, 2002.

Chapter Seven

Financing Options for Safety Net Organizations

Safety net organizations typically receive financing from multiple sources, including Medicaid, Medicare, private third-party insurance, out-of-pocket payments, and charitable donations. The funding sources vary depending on the type of organization. This chapter identifies existing and potential funding sources to support safety net organizations and expand the availability of services to the uninsured. Specifically, the Task Force identified four different types of funding opportunities: 1) ensuring that North Carolina receives its fair share of federal funding for safety-net programs, including funding from the President's Initiative for Health Center Growth and Expansion; 2) assisting safety net organizations with state funds; 3) enhancing Medicaid reimbursement for safety net organizations; and 4) ensuring that eligible individuals receive Medicaid in order to make more limited state funds available to serve uninsured individuals who cannot qualify for Medicaid.

As noted in Chapter 2, North Carolina currently has 1.4 million uninsured; 62% have incomes below 200% of the federal poverty guidelines. The numbers of uninsured would be much larger without the existence of Medicaid and the North Carolina Health Choice program (North Carolina's State Children's Health Insurance Program). In December 2004, Medicaid provided health insurance to more than 1.2 million low-income North Carolinians, and NC Health Choice covered more than 120,000 low-income children.[1] 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 the low-income citizens of our state who rely on Medicaid to cover their healthcare needs. Any efforts to significantly cut or limit Medicaid or NC Health Choice, at either the state or federal levels, would critically impair the state's ability to address the healthcare needs of the uninsured. The recommendations in this chapter are contingent on the state being able to draw down federal Medicaid funds to continue to provide healthcare coverage to low-income populations.

Federal Funding For Safety Net Programs

President's Initiative for Health Center Growth and Expansion

In 2001, the Bush Administration established the President's Initiative for Health Center Growth and Expansion, which sought to increase the number of federally qualified health centers (FQHC) users by six million by creating 630 new FQHCs and expanding 570 existing centers. These funds are available to expand the services available to the uninsured.

Federally qualified health centers must satisfy certain basic criteria in order to receive federal funding. Funds must be used to create new access points (new starts or satellite operations), expand to a new location (satellite operations), add new services (expanded medical capacity), or expand the availability of existing services (service expansion grants). Organizations must demonstrate that increased numbers of patients need to be served in order to justify funding. Most (80%) of the new funds are designated for existing grantees, leaving 20% for new centers.

- *New access points:* New starts are available to organizations that do not currently receive Section 330 federal grant support (as described in Chapter 3) from the US Bureau of Primary Health Care. They are typically awarded to communities that lack other FQHCs. Centers that currently receive Section 330 grant funds can apply for a grant to open a satellite operation, but to receive new funds, the satellite operation must serve new patients. Centers can apply for satellite funds to open a new center in their existing service area if the satellite will serve a population/area that does not have access to care at the existing center or through other providers of care. Health centers must be operational within 120 days of the date when the grant is awarded. The maximum level of support for a new start or satellite is $650,000 per year, calculated on the basis of $150 in grant funds per community user or $200 per user for migrant or

seasonal farmworkers, public housing, or school-based center patients.[i]

- *Expanded medical capacity:* Only currently-funded Section 330 grantees can apply for expanded medical capacity grants. These grants are intended to be used to increase access to primary healthcare services at existing service sites, for example, by expanding the array of services offered, adding new medical providers, expanding hours of operation, or providing additional services through contractual relationships. To receive an expanded medical capacity grant, the center must show an anticipated increase in new users that equals at least 25% of current users or 3,000 people (whichever is less) for community health centers (CHCs) and school-based health centers; or an increase in new users of 10% or 1,000 for free-standing migrant health centers or Health Care for the Homeless sites. The maximum request for an expanded medical capacity grant is $600,000.[ii]
- *Service expansion grants:* Existing Section 330 grantees can also apply for service expansion grants to expand mental health and substance abuse services, oral health, or care management. The maximum award depends on the service to be expanded, for example, in 2004, the maximum awards were $150,000 for mental health and substance abuse, $250,000 for oral health, and $40,000 for care management to reduce health disparities.

The Bureau of Primary Health Care (BPHC) awards these funds on a competitive basis. A certain amount of these funds is set aside for public FQHCs. However, public health departments in North Carolina are unable to apply for FQHC status and funding because of a conflict with state legislation. Under the federal regulations, FQHC board governance structure must be consumer-dominated (at least 51%). However, NC legislation requires local health departments to have 11-member boards whose compositions are defined by the General Assembly (for more information see Chapter 3). This legislation restricts local health departments in the state from applying for federal funds that are available to public FQHCs.

Aside from the public health department issue, to date, North Carolina has had mixed success in obtaining grant awards, receiving on average about 3% of the grant funds.[iii] North Carolina's uninsured comprises, on average, about 3% of the uninsured population nationally. Thus, it might appear that North Carolina is receiving a fair share of the new funding. However, North Carolina started with a lower health center penetration rate than in many other states—i.e., a smaller percentage of individuals with incomes below 200% of the federal poverty guidelines are served by FQHCs. In North Carolina, only 7.4% of low-income individuals are served by FQHCs. A higher proportion of low-income individuals were served by FQHCs in 28 other states and the District of Columbia.[2] The percentage of low-income individuals served by FQHCs ranged from a low of 1.9% to a high of 40% (the average among states was 11.0%). North Carolina's FQHCs could serve a higher percentage of low-income individuals if awarded a more equitable share of grant funding.

North Carolina Health Choice

North Carolina has historically used all or most of its State Children's Health Insurance Program (SCHIP) federal allocation, and is eligible for reallocated funds from other states. The federal SCHIP funds are allocated based on a formula using the annual March supplement

i Organizations may also request $150,000 for one-time minor capital costs for equipment and/or alteration in the first year of the three-year grant cycle.

ii Similar to new starts and satellites, the grantee can use up to $150,000 of this for one-time capital projects to renovate or replace facilities or purchase equipment.

iii In FFY 2002, North Carolina submitted seven new access point applications (two were funded), nine expanded medical capacity applications (five were funded), and six service expansion applications (two were funded). In all, the state received $4.7 million dollars, or 2.9% of available federal funding in FFY2002. In FFY 2003, NC applicants submitted six new access point applications (four were funded), three expanded medical capacity applications (two were funded), and six service expansion applications (one was funded). In all, North Carolina received $3.5 million, or 3.3% of available federal funding in FFY 2003. In FFY 2004, North Carolina submitted nine new access point applications (two were funded), four expanded medical capacity applications (one was funded), and four service expansion grants (three were funded). In all, North Carolina received $2.2 million, or 3.4% of available federal funding in FFY 2004.

to the Current Population Survey (CPS); although many experts who have examined these data have concluded that the use of these data has led to consistent over- or under-counting of children in different states.[3] Specifically, the CPS sample size in many states is not large enough to accurately predict the number of uninsured low-income children in a state. In North Carolina, for example, the CPS sample did not include enough families to be able to make reliable estimates of the number of uninsured children at different ages and income guidelines.[4] Other studies have examined the federal allocation and found that the state SCHIP allocations have varied significantly between 1999 and 2002; and that half of this variation is due to random error in the estimates used to determine the number of uninsured children in a state.[5]

The fact that North Carolina has consistently spent all or most of its federal SCHIP allocation, while other states have tremendous difficulty spending their allocation (even after expanding the SCHIP program to cover parents of children) suggests that the funding formula is biased against states like North Carolina. The funding allocation should be reexamined to ensure that states that consistently run out of federal funds receive a more appropriate federal allocation.

NC AIDS Drug Assistance Program (ADAP) and Ryan White Comprehensive AIDS Resource Emergency (CARE) Act Funding

North Carolina is currently at a disadvantage in how Ryan White CARE funds are allocated. The two largest components of the CARE Act are Title I, which provides funding to metropolitan areas where the AIDS epidemic was originally centered, and Title II, which provides resources to state government agencies to serve the entire state. Title I and II funds are generally allocated using a formula based on the estimated number of people living with AIDS, but the states that have one or more Title I cities end up receiving significantly more resources than states without Title I cities, on a case-by-case basis. This is because people with AIDS living in Title I qualified cities are counted both in the Title I allocations and in the Title II allocations. North Carolina does not qualify for Title I funds, and as a result, receives proportionately less than states with Title I cities. This is a current problem, but will be an even greater problem in the future as the HIV/AIDS epidemic has been increasing much more rapidly in states with significant rural, poor, and minority communities such as North Carolina.

North Carolina also had the largest AIDS Drug Assistance Program (ADAP) waiting list of any state in the country in the 2004 program year. On June 23, 2004, President Bush made available $20 million in emergency funds to pay for drug therapies for people with HIV/AIDS. North Carolina was one of ten states that qualified for this program because of its large waiting list. Special funding for this initiative was expected for two years. For the first year, medications were to be provided directly to clients under a contract the Health Resources and Services Administration (HRSA) entered into with a private mail-order pharmacy. For the second year, funds were to be provided as part of the state's regular Ryan White allocation. However, it appears that Congress did not include the $20 million or the special language required to continue this initiative in the Omnibus Budget Bill for FFY 2005. As a result, North Carolina stands to lose access to the special funding provided last year to support the ADAP program. It would be advantageous to North Carolina if our congressional delegation to the United States Congress worked to "adjust" the FFY 2005 budget in order to assure that both the funds and the language required to continue this Special ADAP Initiative are included.

The Task Force recommended that the NC Department of Health and Human Services and other safety net organizations work with the congressional delegation to describe the problems the state is facing meeting the healthcare needs of the uninsured, and the problems that would be created by limiting federal Medicaid funding through a block-grant or other mechanisms. Further, the delegation should be encouraged to ensure that North Carolina receives its fair share of federal safety net, SCHIP, and Ryan White funds. In addition, as noted in Chapter 5, the congressional delegation should work to change the 340B drug pricing law to allow other safety net providers to obtain medications at the discounted prices. Therefore, the Task Force recommends:

Rec. 7.1. The NC Department of Health and Human Services, NC Community Health Center Association, NC Association of Free Clinics, NC Health Directors Association, NC Hospital Association, NC Medical Society, and other safety net organizations should work with the NC congressional delegation to support NC safety net organizations.

a) The NC congressional delegation should

oppose any efforts to create a Medicaid block grant or otherwise limit the availability of federal Medicaid funds to the states.

b) **In order to ensure that North Carolina receives its fair share of federal funding for federally qualified health centers (FQHCs), the NC congressional delegation should work to ensure that priority for new FQHC funding should be given to states that have higher than average proportions of uninsured, racial disparities, and/or a lower than average receipt of federal FQHC funds per low-income person.**

c) **The NC congressional delegation should also work to ensure that North Carolina receives its fair share of federal State Children's Health Insurance Program (SCHIP) and Ryan White CARE funds, and that Congress continue funding the Special AIDS Drug Assistance Program (ADAP) Initiative.**

d) **The NC congressional delegation should work to expand the 340B program to include free clinics, local health departments, and other non-profit or governmental agencies with a mission to serve low-income uninsured patients.**

In addition to inequitable distribution of federal funds, the Task Force believes that it is important for North Carolina to remove state legislative barriers restricting public health departments in the state from qualifying for federal FQHC status and funding. To eliminate these barriers, the Task Force recommends:

Rec. 7.2. The NC Health Directors Association should develop a legislative proposal to amend state laws to enable local boards of public health to create governance structures that would make them eligible to participate in additional federal programs through which funding is available to support care for the uninsured.

There are many other challenges to obtaining federal funds under the President's Initiative for Health Center Growth:

1) It is difficult to establish new organizations or sites because grantees must be operational within 120 days of when the grants are awarded. In determining if a site can be operational in 120 days, the Bureau of Primary Health Care examines whether applicants have a facility available and ready for occupancy and whether the applicant has providers available to serve at the new site or satellite location. This gives a competitive advantage to organizations that are functioning prior to the application.
2) Grant monies can only be used to support new patients. Many NC centers need ongoing funding to support their existing client base, and are concerned about expanding without the assurance that they have sufficient funds to cover existing operations.
3) There are very limited capital funds. Centers need to obtain outside funding to meet capital needs and coordinate other fundraising with potential BPHC grants. Historically, The Kate B. Reynolds Charitable Trust and The Duke Endowment have helped to fill this need, but there are not enough capital funds to address large capital needs.
4) Applying for grant funds takes significant grant writing expertise and a financial investment. This is particularly problematic in low-wealth communities that may lack the capacity to complete the approximately 200-page application required to compete for these federal funds.
5) One of the other factors the BPHC considers is the ability of the grantee to leverage other funds.

In the past, the NC Community Health Center Association and the NC Office of Research, Demonstration, and Rural Health Development (ORDRHD) have provided technical assistance to new applicants in submitting their grant applications and in applying for grant funds from NC foundations to meet their capital needs. The Kate B. Reynolds Charitable Trust and The Duke Endowment have historically helped provide funding to address some of the capital and infrastructure needs of FQHCs, hospitals, and other safety net organizations. While foundation funding has been available, it has not always been sufficient to meet all the capital and infrastructure needs. To apply for federal funds under the President's Initiative for Health Center Growth, organizations must have the capacity to be operational within 120 days after the grant is awarded, which is extremely difficult for new starts.

Rec. 7.3. The NC health foundations should consider additional funding to meet the capital and infrastructure needs of healthcare safety net organizations.

In addition, the state has historically been at a competitive disadvantage compared to the states because it did not provide state funding to support health centers. Thirty-five other states provided funding to support FQHCs in 2003.[6] However, for the first time, the North Carolina General Assembly appropriated $5 million dollars in the 2004 legislative session to the Office of Research, Demonstrations and Rural Health Development in non-recurring funds to support and expand the services available to the uninsured and medically indigent through FQHCs or FQHC look-alikes.[7] These funds should help address several of the problems listed above. Some of the funds were allocated to new organizations, which will help them become operational so they can compete for the new start funds. Funds were also used to support and expand centers' existing operations. Moreover, these funds help make North Carolina applications more competitive, because they demonstrate another source of funds to provide care to the uninsured, meeting the "leveraging" requirement listed above.

State Funding to Support Safety Net Providers

FQHCs, Local Health Departments, State-Funded Rural Health Centers, and other Non-Profit Safety Net Organizations with a Mission to Serve Low Income Uninsured

In addition to the $5 million allocated to FQHCs or FQHC look-alikes, the North Carolina General Assembly also appropriated $2 million dollars to the ORDRHD to support care to the uninsured through state-funded rural health centers and local health departments. The funding for state-funded rural health centers is being used to expand the Medical Access Plan (MAP), which provides $68 per visit to pay for care to uninsured patients with incomes below 200% of the federal poverty guidelines (this program is described more fully in Chapter 3).

The Task Force recognized the importance of maintaining and expanding these state funds and of making similar funding available to other non-profit organizations that have a mission to serve low-income Medicaid and uninsured. To this end, the Task Force recommends that Section 10.3a of Session Law 2004-124 should be expanded and amended as follows:

> **Rec. 7.4. The NC General Assembly should appropriate, on a recurring basis, $6 million to be used for federally qualified health centers and those health centers that meet the criteria for federally qualified health centers, and $5 million to be used for state-designated rural health centers, public health departments, and other non-profit healthcare organizations with a mission to serve the indigent and other medically underserved populations. The funds shall be used to:**
> **a) Increase access to preventive and primary care services by uninsured or medically indigent patients in existing or new health center locations;**
> **b) Establish health center services in counties where no such services exist;**
> **c) Expand the Office of Research, Demonstrations, and Rural Health Development's Medical Access Program (MAP) to safety net providers who currently receive no financial support for indigent care and who are located in high-needs counties;**
> **d) Create new services or augment existing services provided to uninsured or medically indigent patients, including primary care and preventive medical services, dental services, pharmacy, and behavioral health;**
> **e) Increase capacity necessary to serve the uninsured by enhancing or replacing facilities, equipment, or technologies; and**
> **f) Create or augment community collaborations or integrated delivery systems that have the capacity to expand health services to the uninsured or medically indigent patients.**
>
> **Of the $5 million appropriated to state-designated rural health centers, public health departments, and other non-profit healthcare organizations, $140,000 shall be provided to the Office of Research, Demonstrations and Rural Health Development to develop planning packages for local communities interested in developing safety net programs, provide technical assistance, and collect data on the capacity of the existing safety net to meet the needs of the uninsured and medically indigent.**

School Nurses

North Carolina has a severe shortfall of school health nurses. School nurses help administer medications and perform clinical procedures for the growing number

of children with chronic illnesses and special health needs attending school.[iv] Nationally, the recommended ratio of school health nurses to student population is 1:750, but the North Carolina statewide average is 1:1,918 students. In 2002-2003, the nurse:student ratio varied from a high of one school nurse for every 473 students in one Local Education Authority (LEA) to a low of one nurse for every 7,082 students. Four LEAs had no school nursing at the time. The State Board of Education recommended that each LEA reach the 1:750 ratio within four years, and the 2004-2005 General Assembly responded by appropriating funding to fill 145 nursing positions (65 are time-limited). Even with the funding, there is still a need for 973 school nurses (without adjusting for increases in student enrollment) to achieve the 1:750 ratio. Therefore, the Task Force recommends that:

Rec. 7.5. The NC General Assembly should appropriate $11.35 million in SFY 2005-2006 and $25.95 million in SFY 2006-2007 to expand the number of school health nurses with the goal of fully implementing the school health nurse initiative over the next five years.

Medicaid Funding to Support Safety Net Organizations

The Medicaid program is a major payer for different safety net organizations, including FQHCs, FQHC look-alikes, rural health centers, local health departments, and hospitals. Generally, the state sets Medicaid provider reimbursement within certain upper payment limits established by the federal government. Under federal Medicaid law, certain providers are eligible for special payments and may or may not be subject to the general upper payment limits. For example, public organizations, such as local health departments or local management entities, are entitled to cost-based reimbursement for services provided to women and children.[8] FQHC, FQHC look-alikes, and federally-certified rural health centers (RHCs) are eligible for a modified cost-based reimbursement.[9] Hospitals that serve a disproportionate share of Medicaid and uninsured patients are eligible for higher reimbursement (called Disproportionate Share Hospital payments or "DSH").[10] These safety net organizations receive special payments because Congress recognized that they serve a high proportion of Medicaid and uninsured patients and are less able to cost-shift losses from serving these clients onto other payers.

The Task Force recognized the important role that Medicaid payments play in ensuring the financial viability of safety net organizations. Maximizing Medicaid reimbursement to these organizations is less expensive than spending 100% state funds for these purposes because the federal government pays approximately 62% of the costs of providing healthcare to Medicaid eligible patients. The Task Force was especially interested in enhancing Medicaid payments to those organizations that provide the most care to the uninsured, since these organizations have the most trouble finding other payer sources to cover these costs. The Task Force explored different ways of enhancing payments to FQHCs and RHCs, local health departments, and hospitals that serve a higher than average proportion of uninsured patients.

FQHCs and Rural Health Centers

In North Carolina, there is a wide variation in the percentage of health center patients who are uninsured. On average, 47.6% of the NC FQHC users in 2003 were uninsured, but this varied from more than 65% in five centers, to less than 30% in seven centers. The federal Section 330 grants paid to FQHCs are not directly tied to a center's number or proportion of uninsured users. Rather, an FQHC's base funding is determined by their initial estimate of the numbers of individuals in the center's target population that will be served by the center. The target population is a group of people who have barriers to care or health disparities based, for example, on income (below 200% of the federal poverty guidelines), being homeless, or migrant farmworker status. The target population does not need to be uninsured. Over the years, health centers have received small increases in their base grants, but this has not been tied to actual increases in the uninsured. Thus, health centers that have seen large increases in the uninsured have not received proportionally more

iv School health nurses help to provide nebulizer treatments, tube feedings, blood glucose monitoring, management of insulin pumps, and the development of emergency care plans. In addition, school nurses can help promote the physical, social, emotional, and educational growth and well-being of children.

money to address their increased numbers of uninsured. As a result, the current federal Section 330 grants paid to FQHCs are not directly tied to a center's number or proportion of uninsured users. Federal Section 330 grants averaged $254.12 per uninsured user, but the range per uninsured user varied from more than $500 per unisured user in four centers to less than $200 in five centers. Three of the five centers that had higher than average percentages of uninsured had lower than the state average of federal grants per uninsured user.

The percentage of uninsured patients seen in state-funded rural health centers also varies. For example, in 2003, more than 30% of patients were uninsured in four state-funded rural health centers, whereas less than 10% of patients were uninsured in two centers. The distribution between centers serving a high proportion of uninsured versus those serving a lower proportion is less divergent among the state-funded rural health centers compared to FQHCs because state-funded rural health centers receive less funding to serve the uninsured and, thus, have a greater mix of paying patients than do many FQHCs.

The Task Force recognized the importance of supporting institutions serving a disproportionate share of uninsured patients. Support is needed to ensure their financial ability to continue serving this population. Rather than seek 100% state funds for this purpose, the Task Force wanted to explore whether the state could enhance Medicaid reimbursement for these organizations.

Under the Benefits Improvement and Protection Act of 2000 (BIPA), state Medicaid agencies were required to use a prospective, cost-based reimbursement methodology to reimburse FQHC, FQHC-look alikes, and federally-certified rural health clinics (see Chapter 3 for a more complete description). This prospective, cost-based reimbursement was effectively the "floor;" states were required to use this reimbursement methodology but were free to develop an alternative payment system as long as it was *no less than* the BIPA methodology. Using this flexibility, the Task Force recommends that:

Rec. 7.6. The NC Division of Medical Assistance should explore different Medicaid payment rules that would provide higher reimbursement to FQHCs, FQHC look-alikes, and RHCs that serve a disproportionately high percentage of uninsured. New funds should be used to support and expand care to the uninsured.

Local Health Departments

Local health departments provide critical health services to Medicaid and other low-income uninsured patients. Some health departments are able to provide a comprehensive array of primary care services, while others provide more limited clinical services (such as immunizations, prenatal care, health screenings, and diagnoses and treatment of communicable or sexually transmitted diseases). Under federal Medicaid laws, public entities are entitled to cost-based reimbursement for their Medicaid services; however, under North Carolina's Medicaid reimbursement methodology, local health departments effectively receive less than full costs.

The state uses a two-step process to pay local health departments.[v] First, local health departments receive payments for services to Medicaid eligible patients. The amount of this payment is based on a fee established by the Division of Medical Assistance. This fee is based loosely on historical costs, but does not reflect actual current costs. Second, at the end of the year, the state "cost-settles" with local health departments. The fee-for-service payments are compared to the health department's actual costs. The health department then is entitled to the difference between Medicaid payments and actual costs as part of their year-end reconciliation. However, unlike other safety net providers who receive the full difference, local health departments are only paid the federal share of this difference (not the state or local share). In effect, local health departments only receive 62% of the difference between their interim payments and their true costs. As a result, public health departments have been paid between $10-$12 million less than their actual costs annually for a number of years.

Currently, local health departments must use local dollars and/or other federal funds to cover the uncompensated costs of treating Medicaid clients. The Task Force recommended that the Division revise this payment

v This payment methodology applies to both local health departments and the Children's Developmental Services Agencies (CDSA). CDSAs have been paid $2-4 million less than their actual costs annually.

methodology to ensure that local health departments receive their full costs of treating Medicaid patients. If health departments received full Medicaid reimbursement, then they would have more funds available to serve the uninsured. This is important, because the amount of care provided to the uninsured has increased in recent years, but the amount of federal or state funds that can be used to cover the costs of caring for these patients has not increased commensurately.

In addition, the Task Force discussed using performance-based contracting to ensure that all or a portion of the new funds are used to provide primary care services to the uninsured; and that other funds can be used to provide population-based or other clinical services to the uninsured.

Based on this, the Task Force recommends:

Rec. 7.7. The NC Division of Medical Assistance should assure that reimbursement to local health departments for Medicaid services will be at actual cost (same as for FQHCs, RHCs, and CHCs). Rates should be adjusted annually to account for the full cost to provide services or the annual cost settlement payment should include the full share (county, state, and federal) of Medicaid payments. New funds should be targeted to providing care to the uninsured (comprehensive primary care, population-based services, or other more targeted clinical services).

Hospitals

Hospitals that serve a disproportionate share of Medicaid and uninsured patients are eligible for enhanced payments called Disproportionate Share Hospital (DSH) payments. DSH payments help hospitals cover their Medicaid deficits, since Medicaid typically pays less than a hospital's actual costs (for example, Medicaid pays hospitals 80% of their costs for outpatient services provided to Medicaid patients). DSH payments, along with related supplemental payments, are also intended to help cover the costs of caring for the uninsured. States have flexibility in designing their DSH programs, as long as two basic federal requirements are met: at least 1% of the hospital's patients receive Medicaid and the hospital has two obstetricians on staff.

North Carolina has developed a number of different DSH payments that are targeted to certain types of hospitals. A major portion of DSH funds available to North Carolina are used by state-owned hospitals to cover cost deficits incurred in providing services to Medicaid and uninsured patients. Other DSH and related supplemental payments are intended for non-state hospitals, teaching hospitals, Critical Access Hospitals (CAH), rehabilitation hospitals, and hospitals that are Medicaid Health Maintenance Organization contractors. In general, these payments are proportional to deficits incurred in providing services to either Medicaid or uninsured patients. These payments have significantly improved Medicaid reimbursement to hospitals, but the net financial impact on recovering costs incurred for the unreimbursed, uninsured services is relatively modest.

The Task Force recommended that the Division of Medical Assistance explore options to provide additional support to those hospitals that have a high percentage of uninsured in their patient mix. Similar to other safety net organizations that serve a high percentage of uninsured patients, these institutions have less ability to recover their costs for uncompensated care. In addition, the Task Force recognized that there were other public policy reasons for enhancing payments to certain institutions, for example, if a hospital provides a critical healthcare service that is not readily available in the local area.

The Task Force recommended that the Division of Medical Assistance explore different payment methodologies to more effectively address the needs of these hospitals.

Rec. 7.8. The NC General Assembly, NC Division of Medical Assistance, and NC State Employees Health Plan should consider options to enhance payments to hospitals that serve high proportions of uninsured patients or that meet identified health shortage needs by providing other critical health services.

a) Options may include, but are not limited to, increasing Medicaid or other reimbursement to achieve this goal or exploring whether Disproportionate Share Hospital-related supplemental payments can be used for this purpose;

b) The General Assembly should appropriate new funds for this purpose;

c) In distributing new funds, the state should recognize other funds the hospitals receive to serve the uninsured; and

d) New funds should be targeted to expanding care to the uninsured.

Community Care of North Carolina

Approximately 70% of Medicaid recipients in North Carolina are enrolled in some form of managed care. Most are enrolled in a primary care case management program, either Carolina ACCESS or Community Care of North Carolina (CCNC). Carolina ACCESS, started in 1991, was a system that linked Medicaid recipients to a primary care provider who was paid a small monthly case management fee to help coordinate and manage all of the patient's care. CCNC builds on ACCESS by adding disease management and case management to the care of Medicaid patients. CCNC is built around local networks of providers, including primary care providers, the health department, social services, and a hospital. The networks provide additional education and support for individuals with certain chronic health conditions or high costs. CCNC currently operates in 68 counties and serves approximately 550,000 Medicaid recipients. The program is scheduled to operate on a statewide basis by the end of 2005.

The program began by focusing on managing the care of people with asthma and later expanded to cover diabetes. In addition to these two health problems, CCNC networks are also involved in managing high-cost cases, reducing the unnecessary use of the emergency room, and pharmacy management. Participating providers are expected to use evidence-based clinical practice guidelines to assess patients; develop treatment plans; help educate patients about how to manage their own care; and, when appropriate, use medical equipment (such as inhalers or glucose monitors). An early assessment of the program showed that it yielded modest cost savings primarily by reducing hospitalizations for people with asthma and diabetes.[11] In addition to the statewide disease management initiatives, local networks have also been involved in managing high-risk pregnancies, depression, attention deficit and hyperactivity disorder, sickle cell anemia, and gasteroenteritis. In the last legislative session, the General Assembly also directed the Department of Health and Human Services to:

> "... contract with a physician-owned and managed network that has demonstrated success in improving the cost-effectiveness of Medicaid services in at least one state other than North Carolina. The Department shall develop a payment methodology that may include sharing savings with contractors providing medical management services but the methodology shall not allow increased spending relative to current appropriations." (Sec. 10.11 of Session Law 2004-124).

Currently, any savings realized in CCNC is returned to the program. Local networks are not able to use any of the savings. In contrast, if the state contracts with a managed care organization (MCO), the MCO may be able to keep any savings realized from better care management or reduced hospitalizations. The Task Force was interested in exploring whether the state could develop a shared savings system with the local CCNC networks; with the requirement that any savings realized as a result of better care management would be used to expand services to the uninsured. Therefore, the Task Force recommends:

> **Rec. 7.9. The NC Division of Medical Assistance should explore the possibility of creating a system of "shared savings" with regional CCNC networks. Savings that are retained by regional networks should be used to provide similar health services to the uninsured.**

Ensuring Eligible People Are Enrolled in Medicaid

Medicaid, a publicly financed health insurance program, is limited to low- and moderate-income individuals who meet certain categorical, income, and resource requirements. For example, only certain types of people are eligible, including pregnant women, children (under the age of 21), families with dependent children, people with disabilities, and/or the elderly (age 65 or older). Childless adults who are not disabled and not elderly cannot qualify for Medicaid, regardless of how poor they are. In addition to these categorical restrictions, the state establishes certain income and resource limits for the different program categories.

Medically Needy Eligibility

The state has not fully implemented federal Medicaid rules that help certain individuals with high medical bills qualify for Medicaid. As noted above, Medicaid is typically limited to individuals with incomes below the Medicaid income limits. However, some individuals with higher incomes can also qualify. Otherwise eligible individuals can qualify if they have

medical bills equaling the difference between their countable income and the state's Medicaid medically needy income limits.

Example: Mrs. Jones is a 67-year-old widow, living on $842/month in Social Security retirement income. She currently meets the categorical eligibility requirements (she is 65 years or older), and meets the resource requirements (she has no more than $2,000 in countable resources). However, her income is too high to meet the general Medicaid income limits for older adults ($776/month). Mrs. Jones can still qualify if she incurs medical bills equaling the difference between her income and the state's Medicaid medically needy income limits (currently $242/month for an individual). This difference is called the "spend-down" or Medicaid deductible. This spend-down is generally calculated on a six-month basis. Medicaid will pay for any additional healthcare expenses over the amount of the spend-down for the rest of the six-month period; after which Mrs. Jones will have to incur new bills to meet another six-month deductible.

$842	—	*Mrs. Jones monthly income*
-242	—	*NC's Medicaid medically needy income limits*
$600	—	*spend-down or deductible*
x 6	—	*spend-down calculated on a six month basis*
$3,600	—	*Mrs. Jones will need to incur $3,600 of medical expenses before Medicaid begins covering additional healthcare expenses.*

Federal law limits the types of healthcare expenses that can be applied to the spend-down. Generally, individuals can only use healthcare bills that they have a liability to pay in meeting their spend-down. In other words, if someone else pays the bill, then the Medicaid applicant cannot use those expenses to meet the Medicaid spend-down.

There is one major exception to that rule. Federal law requires states to count the amount of free care provided by a state or local governmental program in the spend-down calculations.

"3628. When countable income exceeds the MNIL [Medically Needy Income Limit] for the budget period, deduct from that income certain medical and remedial care expenses incurred by an individual, family or financially responsible relative that are not subject to payment by a third party unless the third party is a public program of a State (or territory) or political subdivision of a State (or territory). ***Deduct incurred medical and remedial care expenses paid by a public program (other than a Medicaid program) of a State (or territory). (emphasis added)*** Once countable income is reduced (by applying these deductions) to an amount equal to the MNIL, the individual or family is income eligible.

3628.1 Expenses That Must Be Deducted.— Deduct from countable income the medical and remedial care expenses ...that are not subject to payment by a third party. ***(Such deductions are allowable even if the expenses are paid by a public program (other than the Medicaid program) of a State or territory if the program is financed by the State or territory.)***"

There are a number of state-funded health programs that provide, and pay for, services to potential Medicaid-eligible individuals. If these individuals were made eligible for Medicaid, then the state-only funds would be available to serve more uninsured individuals who do not qualify for Medicaid. Currently, the Division of Medical Assistance has identified nine state-funded programs that would meet these federal requirements, including cancer prevention and control, epilepsy medication, home health services, renal disease, school health funds, sickle cell anemia, medical/eye care, personal care services, and clozaril programs.[12] The Task Force identified other state-funded programs that might also meet these requirements, including the Aids Drug Assistance Program (ADAP), the MAP program, and state-funded mental health, developmental disabilities, and substance abuse services.

Although the Division of Medical Assistance has policies to enable individuals to use the costs of state-funded programs to help them meet their Medicaid deductible, this is rarely, if ever applied. These state-funded health programs do not typically generate statements of the costs of the services. As a result, there is no way for a local Department of Social Services to know how much to apply toward the deductible. To address this issue, the Task Force recommended that state funded programs generate a statement of the cost of service, which can then be given to the local

Department of Social Services to use towards the deductible. In the longer term, as DHHS redesigns its Medicaid management information system, it should have the capacity to share information electronically about costs of state-funded services provided by other DHHS agencies.

To ensure that the federal Medicaid spend-down laws are implemented and that eligible individuals qualify for Medicaid, the Task Force recommends:

Rec. 7.10. The NC Division of Medical Assistance (DMA) should ensure that the federal Medicaid spend-down rules that allow applicants to use the value of healthcare services paid by state and county programs in meeting their spend-downs are fully implemented. In so doing, the DMA should:

a) Explore which programs are eligible for this deduction, including, but not limited to, Division of Public Health purchase of care programs, AIDS Drug Assistance Program (ADAP), mental health, and MAP programs.

b) Work with the other state agencies that administer these programs to develop cost of care statements, and, ultimately, develop systems to facilitate the exchange of information about the value of services provided across programs to simplify the spend-down process for applicants.

Streamlining the Eligibility Process

National data suggests that only 72% of eligible children and 51% of eligible non-elderly adults enroll in Medicaid.[13] Census data suggests that there were approximately 177,000 uninsured children in North Carolina with incomes below 200% of the federal poverty guidelines who were eligible for either NC Medicaid and/or NC Health Choice, but were not enrolled.[14] Many eligible individuals do not know that they are eligible for this coverage or are discouraged because of the stigma attached to applying for public programs. Others are discouraged because the application process is so difficult to complete. The state has made significant progress in simplifying the Medicaid and NC Health Choice application for children. North Carolina has a two-page application for both programs, and individuals can apply in person or by mail. In contrast, adults have to go into the local Department of Social Services to fill out a 10-page application. However, the Division of Medical Assistance is in the process of simplifying the application and allowing them to be mailed to local Departments of Social Services. The Division is pilot testing the new form and mail-in application process in Cleveland, Duplin, Granville, Guilford, Forsyth, Onslow, and Wake Counties and hopes to be able to implement the process statewide later in 2005.

In addition to a simplified application form, other states have done more to simplify the eligibility determination processes to make it easier for eligible people to qualify for assistance. For example, 37 states and the District of Columbia have a 12-month certification period for parents, whereas North Carolina requires families to reapply every six months. Twenty-one states have eliminated the asset test requirements for low-income families as a means of streamlining the eligibility process, improving the productivity of eligibility workers and reducing administrative costs, and making the enrollment process more accessible for families.[15] Eliminating the asset test was not found to be very expensive, because there are very few denials of Medicaid coverage for low-income families due to excess assets.[16] North Carolina still requires families to prove that their assets (e.g., savings accounts or other liquid assets) are below certain state-established thresholds.

Rec. 7.11. The NC Division of Medical Assistance should continue its work to simplify the Medicaid application process for parents, people with disabilities, and older adults. Specifically, the Division should:

a) Create a simplified application form,

b) Extend the length of time for recertification, and

c) Explore the possibility of eliminating the assets test for families with children.

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7 Section 10.3(a) of Session Law 2004-124.

8 42 C.F.R. §431.615(c)(4). State Medicaid agencies must pay local health departments and other Title V grantees for the cost of services furnished Medicaid recipients by or through the grantee.

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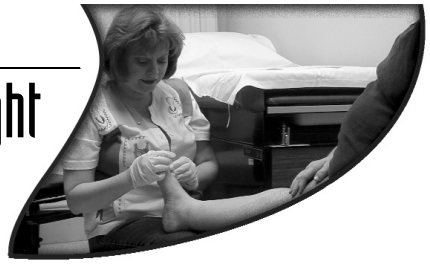
Chapter Eight Conclusion



North Carolina is in the midst of a quiet, but growing, healthcare crisis. The number of uninsured residents is rising at an alarming pace, and as healthcare costs continue to increase, there is little chance of an immediate respite (discussed in Chapter 2). Currently, almost one out of every five non-elderly North Carolinians is uninsured. Because of financial barriers caused by the lack of insurance coverage, the uninsured are more likely to delay care and, as a result, their health suffers. The uninsured are less likely to receive preventive health services, more likely to be diagnosed with more severe health problems, and more likely to die prematurely than those with insurance coverage.

Clearly, the lack of health insurance coverage affects the uninsured person and his or her family, but it also has a broader societal impact. Lack of health insurance coverage decreases worker productivity; negatively affects the health of children and, thus, their ability to learn; and has unfavorable financial implications for healthcare providers. The latter is particularly true for safety net providers, i.e., healthcare providers who serving a high percentage of uninsured, Medicaid, and other vulnerable patients. Safety net providers strive to meet the healthcare needs of the uninsured, but this has become increasingly difficult as the number of uninsured has risen without commensurate funding increases. Ideally, North Carolina would guarantee health insurance coverage to all residents to help them access needed healthcare services. However, this is a long-term goal; one that is unlikely to be met in the immediate future. A shorter-term goal, and the focus of this Task Force, is to ensure the availability and financial viability of the healthcare safety net.

Some of the uninsured access non-emergent healthcare services in hospital emergency rooms. This is not a cost-effective or desirable way to address non-emergency healthcare needs. Preferably, the uninsured would have an established relationship with a primary care provider who can provide comprehensive, coordinated, and continuous care. In many communities across the state, there are safety net services available to meet the primary care needs of the uninsured, including federally qualified health centers, state-funded rural health centers, local health departments, school-based health services, free clinics, Project Access or Healthy Communities Access programs, AHEC teaching residencies, and/or hospital outpatient clinics (safety net services are discussed in Chapter 3). However, these services are not available in every community; and even where they do exist, they may not be sufficient to meet the healthcare needs of all of the uninsured. Private providers also help provide services to the uninsured, but the extent to which this occurs in each community is unknown. In recent years, the number of doctors who report providing charity care nationally has declined; it is unknown whether the same trend is occurring in North Carolina.

The Task Force collected data on the number of uninsured residents receiving care in existing safety net institutions and compared this to the estimated number of the uninsured in each county (discussed in Chapter 4). The difference was the number (and percentage) of uninsured for whom there was no identified source of primary care. ***Based on these analyses, the Task Force was only able to determine that about 25% of all the non-elderly uninsured received primary care services from safety net organizations.*** This, combined with other studies showing that the uninsured in North Carolina are less likely to have a regular healthcare provider and 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, it appears that all or most of the uninsured have been able to access safety net services; while in others, there are no known safety net organizations available to meet the primary care needs of the uninsured. The Task Force identified 28 counties that have the fewest safety net resources to meet the primary care needs of the uninsured. Thirteen of these counties also had lower than average primary care provider-to-population ratios suggesting that, at least in these counties, it would be difficult for the private providers

to meet the unmet primary care needs of the uninsured. Furthermore, most communities across the state lack the full array of services necessary to meet the healthcare needs of the uninsured. Access to pharmaceuticals (discussed in Chapter 5), specialty care, behavioral health, and dental services is still a problem in many counties, including those with adequate primary care capacity.

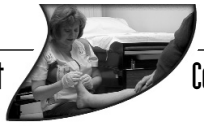
Few counties have fully-integrated systems of care to address the full range of healthcare services needed by the uninsured; most counties have fragmented systems of care for the uninsured (discussed in Chapter 6). This is due, in part, to the difficulties in sharing patient information across providers, turf issues, and/or the need to compete for paying patients to help cover the costs of caring for the uninsured.

The Task Force spent almost a year studying this issue and identified 28 recommendations (listed below) that could help strengthen and expand the existing safety net to better meet the healthcare needs of the uninsured. These recommendations propose a number of different actions, including: legislative action and/or additional funding, policy changes within the NC Department of Health and Human Services, action and/or collaboration between safety net organizations, and targeted grant making within foundations. Of these 28 recommendations, ten are considered the top priority and, if implemented, will have the greatest likelihood of expanding care to the uninsured. The priority recommendations are highlighted (shaded) in the table below:

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
Chapter 2: Uninsured					
2.1. The NC General Assembly should take steps to make health insurance coverage more affordable and to expand health insurance coverage to more uninsured individuals. (PRIORITY)	✓				
Chapter 3: Safety Net Defined					
3.1. The Office of the Secretary of the NC Department of Health and Human Services should continue its efforts to monitor access to behavioral health services for the uninsured and other underserved populations. The Office of the Secretary should examine access to services both for the priority (target) populations and for those with less severe behavioral health problems and should seek input from a wide variety of stakeholders including, but not limited to, publicly funded local management entities, children's development services agencies, behavioral health providers, primary care providers, safety net organizations, and representatives of consumer groups.		✓	✓		✓ Other health professionals
3.2. The Office of the Secretary should work with the NC Pediatric Society, NC Academy of Family Physicians, NC Chapter of the American College of Physicians, NC Psychiatric Association, other interested professional associations, and NC Area Health Education Centers program to examine ways to expand the capacity of primary care providers to address some of the behavioral health needs of the uninsured and/or underserved populations. Information on this initiative should be reported to the NC Commission for Mental Health, Developmental Disabilities and Substance Abuse Services.		✓	✓		✓ Other health professionals
Chapter 4: Availability of Safety Net Services					
4.1. The NC Office of Research, Demonstrations and Rural Health Development (ORDRHD), in collaboration with the Cecil G. Sheps Center for Health Services	✓	✓	✓	✓	✓ Sheps Center, UNC-CH

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
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 North Carolina health foundations, to help inform their grant-making 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. (PRIORITY)					
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		✓	✓		✓ Local Community

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
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. (PRIORITY)					
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.			✓		
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 NC 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. (PRIORITY)			✓		
Chapter 5: Prescription Drugs					
5.1. The NC Office of Research, Demonstrations and Rural Health Development and other safety net organizations should create a workgroup to meet with pharmaceutical companies to discuss: a) Simplifying and streamlining the Patient Assistance Programs, including the application forms, verification requirements, and eligibility requirements; and b) Creating bulk replenishment programs and other ways the pharmaceutical industry could help provide medications to safety net organizations. Information should be disseminated to safety net organizations and private physician practices about the best way to access existing pharmaceutical resources.		✓	✓		



RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
5.2. The NC General Assembly should support the Health and Wellness Trust Fund's efforts to support and expand prescription assistance programs, including, but not limited to, expanding the availability of Medication and Access Review Program (MARP) and medication assistance programs.	✓			✓	
5.3. North Carolina private foundations should consider three-year start-up funding at $180,000 per year to the NC Office of Research, Demonstrations and Rural Health Development to create a bulk medication replacement system. (PRIORITY)		✓		✓	
5.4. The NC Office of Research, Demonstrations and Rural Health Development should explore opportunities to expand 340B drug discount prices to low-income patients of other safety net organizations.		✓	✓		
Chapter 6: Coorination and Integration of Services					
6.1. The NC General Assembly should enact legislation that clarifies existing state confidentiality laws to ensure that safety net providers are allowed to share identifiable health information with each other when providing care to the same patients, consistent with applicable federal law. The legislation should include heightened protections for particularly sensitive information, such as mental health and communicable disease information.	✓				
6.2. The NC Office of Research, Demonstrations and Rural Health Development should collect and disseminate descriptions of various models of collaboration and integration found to work well in particular communities.		✓			
6.3. In addition to healthcare providers, local safety net collaborations should encourage the participation of business and industry, colleges and universities, faith-based organizations, social service agencies, non-profits, and other interested groups in community collaborations to provide care to the uninsured.			✓		✓ Universities Business Others
6.4. North Carolina foundations should help convene a best practices summit of safety net organizations that will focus on collaboration and integration. This summit would help local communities identify ways to build and strengthen their capacity to meet the healthcare needs of the growing uninsured population, and to reduce barriers to interagency collaboration and integration. Summit participants should include representatives of existing safety net organizations at the state and local levels. One of the outgrowths of this summit would be to develop clearer and measurable criteria of collaboration to guide future decisions for safety net program support by public and private funding agencies. (PRIORITY)			✓	✓	
6.5. Hospitals should take the lead to develop collaborations with local safety net organizations to help ensure that the uninsured have appropriate medical homes and after-hours care for persons requiring non-emergent attention.			✓		

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
6.6. The NC Institute of Medicine should create an on-going state-level Safety Net Advisory Council that can encourage state-level and local safety net collaborations and can help monitor the implementation of the Healthcare Safety Net Task Force's recommendations. The group should include the full array of existing safety net organizations, including health departments, federally qualified health centers, free clinics, hospitals, medical societies, Project Access and Healthy Communities Access Programs, medication assistance programs, and other non-profit agencies providing care to the uninsured. (PRIORITY)			✓		✓ NC IOM
Chapter 7: Financing Safety Net Services					
7.1. The NC Department of Health and Human Services, NC Community Health Center Association, NC Association of Free Clinics, NC Health Directors Association, NC Hospital Association, NC Medical Society, and other safety net organizations should work with the NC congressional delegation to support NC safety net organizations. a) The NC congressional delegation should oppose any efforts to create a Medicaid block grant or otherwise limit the availability of federal Medicaid funds to the states. b) In order to ensure that North Carolina receives its fair share of federal funding for federally qualified health centers (FQHCs), the NC congressional delegation should work to ensure that priority for new FQHC funding should be given to states that have higher than average proportions of uninsured, racial disparities, and/or a lower than average receipt of federal FQHC funds per low-income person. c) The NC congressional delegation should also work to ensure that North Carolina receives its fair share of federal State Children's Health Insurance Program (SCHIP) and Ryan White CARE funds, and that Congress continues funding the Special AIDS Drug Assistance Program (ADAP) Initiative. d) The NC congressional delegation should work to expand the 340B program to include free clinics, local health departments, and other non-profit or governmental agencies with a mission to serve low-income uninsured patients. (PRIORITY)		✓	✓		✓ Congress
7.2. The NC Health Directors Association should develop a legislative proposal to amend state laws to enable local boards of public health to create governance structures that would make them eligible to participate in additional federal programs through which funding is available to support care for the uninsured.			✓		
7.3. The NC health foundations should consider additional funding to meet the capital and infrastructure needs of healthcare safety net organizations.				✓	
7.4. The NC General Assembly should appropriate, on a recurring basis, $6 million to be used for federally qualified health centers and those health centers that	✓	✓	✓		

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
meet the criteria for federally qualified health centers, and $5 million to be used for state-designated rural health centers, public health departments, and other non-profit healthcare organizations with a mission to serve the uninsured and other medically underserved populations. The funds shall be used to: a) Increase access to preventive and primary care services by uninsured or medically indigent patients in existing or new health center locations; b) Establish health center services in counties where no such services exist; c) Expand the NC Office of Research, Demonstrations and Rural Health Development's Medical Access Program (MAP) to safety net providers who currently receive no financial support for indigent care and who are located in high-needs counties; d) Create new services or augment existing services provided to uninsured or medically indigent patients, including primary care and preventive medical services, dental services, pharmacy, and behavioral health; e) Increase capacity necessary to serve the uninsured by enhancing or replacing facilities, equipment, or technologies; and f) Create or augment community collaborations or integrated delivery systems that have the capacity to expand health services to the uninsured or medically indigent patients. Of the $5 million appropriated to state-designated rural health centers, public health departments, and other non-profit healthcare organizations, $140,000 shall be provided to the NC Office of Research, Demonstrations and Rural Health Development to: develop planning packages for local communities interested in developing safety net programs, provide technical assistance, and collect data on the capacity of the existing safety net to meet the needs of the uninsured and medically indigent. (PRIORITY)					
7.5. The NC General Assembly should appropriate $11.35 million in SFY 2005-2006 and $25.95 million in SFY 2006-2007 to expand the number of school health nurses with the goal of fully implementing the school health nurse initiative over the next five years. (PRIORITY)	✓		✓		
7.6. The NC Division of Medical Assistance should explore different Medicaid payment rules that would provide higher reimbursement to FQHCs, FQHC look-alikes, and rural health clinics (RHCs) that serve a disproportionately high percentage of uninsured. New funds should be used to support and expand care to the uninsured.		✓	✓		
7.7. The NC Division of Medical Assistance should assure that reimbursement to local health departments for Medicaid services will be at actual cost (same as for FQHCs, RHCs, and CHCs). Rates should be adjusted annually to account for the full cost to provide services or the annual cost settlement payment should		✓	✓		

RECOMMENDATIONS	Legislature	NC DHHS	Safety Net Organizations	Foundations	Other
include the full share (county, state, and federal) of Medicaid payments. New funds should be targeted to providing care to the uninsured (comprehensive primary care, population-based services, or other more targeted clinical services).					
7.8. The NC General Assembly, NC Division of Medical Assistance, and NC State Employees Health Plan should consider options to enhance payments to hospitals that serve high proportions of uninsured patients or that meet identified health shortage needs by providing other critical health services. a) Options may include, but are not limited to, increasing Medicaid or other reimbursement to achieve this goal or exploring whether Disproportionate Share Hospital-related supplemental payments can be used for this purpose. b) The NC General Assembly should appropriate new funds for this purpose. c) In distributing new funds, the state should recognize other funds the hospitals receive to serve the uninsured. d) New funds should be targeted to expanding care to the uninsured.	✓	✓	✓		✓ State Employees Health Plan
7.9. The NC Division of Medical Assistance should explore the possibility of creating a system of "shared savings" with regional Community Care of North Carolina (CCNC) networks. Savings that are retained by regional networks should be used to provide similar health services to the uninsured.			✓		
7.10. The NC Division of Medical Assistance (DMA) should ensure that the federal Medicaid spend-down rules that allow applicants to use the value of healthcare services paid by state and county programs in meeting their spend-downs are fully implemented. In so doing, the DMA should: a) Explore which programs are eligible for this deduction, including, but not limited to, Division of Public Health (DPH) purchase of care programs, AIDS Drug Assistance Program (ADAP), mental health, and MAP programs. b) Work with the other state agencies that administer these programs to develop cost of care statements, and, ultimately, develop systems to facilitate the exchange of information about the value of services provided across programs to simplify the spend-down process for applicants.		✓			
7.11. The NC Division of Medical Assistance should continue its work to simplify the Medicaid application process for parents, people with disabilities, and older adults. Specifically, the Division should: a) Create a simplified application form, b) Extend the length of time for recertification, and c) Explore the possibility of eliminating the assets test for families with children.		✓	✓		

Appendix A | North Carolina Healthcare Safety Net Organizations

The following list includes contact information for healthcare safety net organizations in North Carolina, including: federally qualified health centers, state-funded rural health centers, federally designated rural health clinics, free clinics (pharmacy only free clinics are noted), local health departments (those providing primary care to either adults children are noted), other non-profit safety net providers, Project Access programs, Healthy Communities Access Program (HCAP) grantees, hospital outpatient clinics, Area Health Education Center (AHEC) residency teaching clinics, hospitals, departments of social services (DSS), school-based and school-linked health centers, and local area mental health, developmental disabilities and substance abuse (MH/DD/SA) programs. A more complete description of safety net programs, typically offered services, and whether the organization provides services to the uninsured on a sliding-fee schedule is listed in Chapter 3.

These programs can change over time, so it is important to call the organization first to find out more about the availability of services, hours of operation, eligibility criteria (if any), and fee schedules.

Alamance County

Alamance-Caswell Area MH/DD/SA Authority
319 N Graham-Hopedale Road
Suite A
Burlington, NC 27215
Phone: 336-513-4200
Emergency Phone: 336-513-4444
Fax: 336-513-4203

Alamance County Department of Social Services
319 N Graham-Hopedale Road
Suite C
Burlington, NC 27217
Phone: 336-570-6532
Fax: 336-570-6538

Alamance County Health Department
319 N Graham-Hopedale Road
Suite B
Burlington, NC 27217
Phone: 336-227-0101

Alamance County Health Department - Dental Health Program
1914 McKinney Street
Burlington, NC 27217
Phone: 336-570-6415
Fax: 336-513-5572

Alamance Regional Medical Center
Hospital
PO Box 202
Burlington, NC 27216-0202
Phone: 336-538-7450
Fax: 336-538-7425

Charles Drew Community Health Center
Federally qualified health center
723 Edith Street
Burlington, NC 27215-3456
Phone: 336-570-3739

Open Door Clinic of Alamance County
Free clinic
221 N Graham-Hopedale Road
Burlington, NC 27215
Phone: 336-570-9800
Fax: 336-570-3376

Scott Clinic
Federally qualified health center
5270 Union Ridge Road
Burlington, NC 27217
Phone: 336-421-3247

Alexander County

Alexander County Department of Social Services
334 7th Street, NW
Taylorsville, NC 28681
Phone: 828-632-1080
Fax: 828-632-1092

Alexander County Health Department
322 First Avenue, SW
Taylorsville, NC 28681
Phone: 828-632-9704
Fax: 828-632-9008

Family Care Center
Rural health clinic
1668 NC Highway 16, South
Taylorsville, NC 28681
Phone: 828-632-9736

Foothills Area MH/DD/SA Program
306 S King Street
Morganton, NC 28655
Phone: 828-438-6230
Emergency Phone: 800-942-1797
Fax: 828-438-6238

Frye Regional Medical Center Alexander Campus
Hospital
226 NC Hwy 165
Taylorsville, NC 28681
Phone: 828-635-4200
Fax: 828-635-4059

Alleghany County

Alleghany County Department of Social Services
PO Box 247
Sparta, NC 28675
Phone: 336-372-2411
Fax: 336-372-2635

Alleghany Memorial Hospital
Primary care clinic
233 Doctors Street
PO Box 9
Sparta, NC 28675
Phone: 336-372-5511
Fax: 336-372-8451

Alleghany County Health Department
Part of the Appalachian District Health Department, primary care services available
157 Health Services Road
Sparta, NC 28675
Phone: 336-372-5641
Fax: 336-372-7793

New River Behavioral HealthCare
MH/DD/SA Services
895 State Farm Road, Suite 508
Boone, NC 28607-4996
Phone: 828-264-9007
Fax: 828-264-9468

Anson County

Anson Community Hospital
500 Morven Road
Wadesboro, NC 28170
Phone: 704-694-5131
Fax: 704-694-3900

Anson County Department of Social Services
118 N Washington Street
Wadesboro, NC 28170
Phone: 704-694-9351
Fax: 704-695-1608

Anson Family Medicine
Rural health clinic
510 Morven Road
Wadesboro, NC 28170
Phone: 704-694-9440

Anson County Health Department
Primary care services available
110 Ashe Street
PO Box 473
Wadesboro, NC 28710
Phone: 704-694-5188
Fax: 704-694-9067

Anson Regional Medical Services, Inc.
Federally qualified health center
Highway 52, South
Morven, NC 28119
Phone: 704-851-9331

Anson Regional Medical Services, Inc.
Federally qualified health center
203 Salisbury Street
PO Box 192
Wadesboro, NC 28170
Phone: 704-694-6700

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Emergency Phone: 800-256-2452
Fax: 910-673-6202

West Anson Medical Clinic
Rural health clinic
Highway 74
PO Box 68
Polkton, NC 28135
Phone: 704-272-8321

Ashe County

Ashe County Department of Social Services
PO Box 298
Jefferson, NC 28640
Phone: 336-219-2700
Fax: 336-219-2762

Ashe County Health Department
Part of the Appalachian District Health Department, primary care services available
413 McConnell
PO Box 208
Jefferson, NC 28640
Phone: 336-246-9449
Fax: 336-246-8163

Ashe Memorial Hospital, Inc.
200 Hospital Avenue
Jefferson, NC 28640
Phone: 336-246-7101
Fax: 336-246-0746

New River Behavioral HealthCare
MH/DD/SA Services
895 State Farm Road, Suite 508
Boone, NC 28607-4996
Phone: 828-264-9007
Fax: 828-264-9468

Top Dog Clinic, Ashe Middle School
School-based health center
PO Box 178
Warrensville, NC 28693
Phone: 336-384-1625
Fax: 336-384-1626
Sponsor: Appalachian District Health Department

Avery County

Appalachian HealthCare Project
Hospital outpatient clinic, Project Access program
155 Furman Road, Suite 7
Boone, NC 28607
Phone: 828-263-9493

Avery County Department of Social Services
PO Box 309
Newland, NC 28657
Phone: 828-733-8230
Fax: 828-733-8245

Charles A. Cannon, Jr. Memorial Hospital, Inc.
PO Box 767
Linville, NC 28646
Phone: 828-737-7000
Fax: 828-737-7709

New River Behavioral HealthCare
MH/DD/SA Services
895 State Farm Road, Suite 508
Boone, NC 28607-4996
Phone: 828-264-9007
Fax: 828-264-9468

Toe River District Health Department
861 Greenwood Road
Spruce Pine, NC 28777
Phone: 828-765-2239
Fax: 828-765-9082

Beaufort County

Aurora Medical Center
Rural health clinic
151 Third Street
Aurora, NC 27806
Phone: 252-322-4021

Beaufort County Department of Social Services
PO Box 1358
Washington, NC 27889
Phone: 252-975-5500
Fax: 252-975-5555

Beaufort County Hospital
628 East Twelfth Street
Washington, NC 27889
Phone: 252-975-4100
Fax: 252-948-4800

Beaufort County Health Department
1436 Highland Drive
PO Box 579
Washington, NC 27889
Phone: 252-946-1902, Ext 226
Fax: 252-946-8430

Metropolitan (Agape) Community Health Services, Inc.
Federally qualified health center, HCAP grantee
118 W Martin Luther King Boulevard
PO Box 1886
Washington, NC 27889
Phone: 252-948-0710

Pungo District Hospital Corporation
202 East Water Street
Belhaven, NC 27810
Phone: 252-943-2111
Fax: 252-944-2236

Tideland Mental Health Center
1308 Highland Drive
Washington, NC 27889-3494
Phone: 252-946-8061
Emergency Phone: 800-682-0767
Fax: 252-946-1537

Bertie County

Bertie County Department of Social Services
PO Box 627
Windsor, NC 27983
Phone: 252-794-5320
Fax: 252-794-5344

Bertie County Health Department
102 Rhodes Avenue
PO Box 586
Windsor, NC 27983
Phone: 252-794-5332
Fax: 252-794-5321

Bertie Memorial Hospital
PO Box 40
Windsor, NC 27983
Phone: 252-794-6600
Fax: 252-794-6605

Cashie Medical Center
Rural health clinic, hospital outpatient clinic
1403 South King Street
PO Box 509
Windsor, NC 27983
Phone: 252-794-6775

Eastern Carolina Family Practice
Rural health clinic
105 Commerce Street
Powellsville, NC 27967
Phone: 252-332-6484

Lewiston-Woodville Family Medical Center
Federally qualified health center
307 South Main Street
PO Box 39
Lewiston, NC 27849
Phone: 252-348-2545

Medical Clinic of Colerain
Rural health clinic
109 West River Street
Colerain, NC 27924
Phone: 252-356-2404

Roanoke-Chowan Human Services Center
MH/DD/SA Services
144 Community College Road
Ahoskie, NC 27910-9320
Phone: 252-332-4137
Emergency Phone: 252-332-4442
Fax: 252-332-8457

Windsor Medical Center
Federally qualified health center
306 Winston Lane
PO Box 628
Windsor, NC 27983
Phone: 252-794-3042

Bladen County

Bladen County Department of Social Services
PO Box 365
Elizabethtown, NC 28337
Phone: 910-862-6800
Fax: 910-862-6801

Bladen County Hospital
PO Box 398
Elizabethtown, NC 28337
Phone: 910-862-5179
Fax: 910-862-5129

Bladen East Medical Center
Rural health clinic
PO Box 398
Elizabethtown, NC 28337
Phone: 910-669-2225

Bladen Lakes Community Health Center
Federally qualified health center
6777 Albert Street
Dublin, NC 28332
Phone: 910-879-1020

Bladen Medical Associates
Rural health clinic, hospital outpatient clinic
211 4th Street
Bladenboro, NC 28320
Phone: 910-863-3138

Bladen Medical Associates
Rural health clinic, hospital outpatient clinic
88 East Green Street
PO Box 95
Clarkton, NC 28433
Phone: 910-647-0083

Bladen Medical Associates
Rural health clinic, hospital outpatient clinic
16 Third Street
PO Box 87
Dublin, NC 28332
Phone: 910-862-3528

Bladen Medical Associates
Rural health clinic, hospital outpatient clinic
300A East McKay Street
PO Box 517
Elizabethtown, NC 28337
Phone: 910-862-5500

Bladen County Health Department
300 Mercer Mill Road
PO Box 189
Elizabethtown, NC 28337
Phone: 910-862-6900
Fax: 910-862-6859

Bladen Urgent Care Center
Rural health clinic
601 South Cypress Street
Elizabethtown, NC 28337
Phone: 910-862-5100
Fax: 910-862-1241

Southeastern Regional MH/DD/SA Services
2003 Godwin Avenue
Lumberton, NC 28358-2901
Phone: 910-738-5261
Emergency Phone: 800-672-8255
Fax: 910-738-8230

Brunswick County

Bolivia Medical Center
Rural health clinic
3875 Business 17, East
Bolivia, NC 28422
Phone: 910-253-7990

Brunswick Community Hospital
PO Box 139
Supply, NC 28462
Phone: 910-755-8121
Fax: 910-755-1200

Brunswick County Department of Social Services
PO Box 219
Bolivia, NC 28422
Phone: 910-253-2077
Fax: 910-253-2071

Brunswick County Health Department
Primary care services available
25 Courthouse Drive
PO Box 9
Bolivia, NC 28422
Toll Free: 888-428-4429
Phone: 910-253-2250
Fax: 910-253-2387

Calabash Medical Center
Rural health clinic
10081 Beach Drive, SW
PO Box 4960
Calabash, NC 28467
Phone: 910-579-7971

Holden Beach Medical Center
Rural health clinic
2930 Holden Beach Road, SW
Supply, NC 28462
Phone: 910-842-5991

J. Arthur Dosher Memorial Hospital
924 Howe Street
Southport, NC 28461
Phone: 910-457-3800
Fax: 910-457-3908

New Hope Clinic
Free clinic
PO Box 10601
Southport, NC 28461
Phone: 910-457-6044

Seaside Medical Center, Inc.
Rural health clinic
710 Sunset Boulevard, N, Suite A
PO Box 7237
Sunset Beach, NC 28468
Phone: 910-575-3923

Shallotte Medical Center, Inc.
Rural health clinic
341 Whiteville Road
PO Box 2561
Shallotte, NC 28459
Phone: 910-754-8731

Southeastern Center for MH/DD/SAS
PO Box 1230
Wilmington, NC 28402-1230
Phone: 910-251-6440
Emergency Phone: 910-251-6551
Fax: 910-796-3133

Buncombe County

ABCCM Medical Ministry
Free clinic, hospital outpatient clinic
155 Livingston Street
Asheville, NC 28801
Phone: 828-259-5339

Asheville High School and Middle School
School-based health center
35 Woodfin Street
Asheville, NC 28801
Phone: 828-250-5056
Fax: 828-255-5319
Sponsor: Buncombe County Health Department

Asheville Specialty Hospital
428 Biltmore Avenue
Asheville, NC 28801
Phone: 815-727-3355

Barnardsville Medical Services
Hospital outpatient clinic
540 Dillingham Road
Barnardsville, NC 28709
Phone: 828-626-3965

Buncombe County Department of Social Services
PO Box 7408
Asheville, NC 28802
Phone: 828-250-5500
Fax: 828-255-5845

Buncombe County Health Department
Primary care services available
35 Woodfin Street
Asheville, NC 28801-3075
Phone: 828-250-5214
Fax: 828-255-5326

Buncombe County Medical Society
Project Access program
304 Summit Street
Asheville, NC 28803
Phone: 828-274-2267

Emma Family Resource Center
Hospital outpatient clinic
37 Brickyard Road
Asheville, NC 28806
Phone: 828-252-4810

Erwin Middle School
School-based health center
35 Woodfin Street
Asheville, NC 28801
Phone: 828-250-5056
Fax: 828-255-5319
Sponsor: Buncombe County Health Department

Health Partners - Today and Tomorrow, Inc.
HCAP grantee, other non-profit safety net provider
8 O. Henry Avenue
Wachovia Building, 1st floor
Asheville, NC 28801
PO Box 1463
Asheville, NC 28802
Phone: 828-253-8939
Fax: 828-253-3371

Minnie Jones Family Health Center
Hospital outpatient clinic
1 Granada Street
Asheville, NC 28806
Phone: 828-251-2455

Mission Hospitals, Inc.
509 Biltmore Avenue
Asheville, NC 28801
Phone: 828-213-1111
Fax: 828-213-1151

Mountain AHEC
501 Biltmore Avenue
Asheville, NC 28801-4686
Phone: 828-257-4400
Fax: 828-257-4768

Thoms Rehabilitation Hospital
PO Drawer 15025
Asheville, NC 28813-0025
Phone: 828-274-2400
Fax: 828-274-9452

Three Streams Family Health Center, Inc.
Hospital outpatient clinic
2 Sulpher Springs Road
Asheville, NC 28806
Phone: 828-285-9725

Western Highlands MH/DD/SAS
356 Biltmore Avenue
Asheville, NC 28801
Phone: 828-258-3500
Emergency Phone: 800-951-3792
Fax: 828-252-9584

WNCCHS Ridgelawn Health Center
Hospital outpatient clinic
10 Ridgelawn Road
Asheville, NC 28806
Phone: 828-285-0622

Burke County

Burke County Department of Social Services
PO Drawer 549
Morganton, NC 28655
Phone: 828-439-2144
Fax: 828-439-2137

Burke County Health Department
700 East Parker Road
PO Drawer 1266
Morganton, NC 28680-1266
Phone: 828-439-4413
Fax: 828-439-4444

Foothills Area MH/DD/SA Program
306 S King Street
Morganton, NC 28655
Phone: 828-438-6230
Emergency Phone: 800-942-1797
Fax: 828-438-6238

Good Samaritan Clinic
Free clinic
PO Box 3601
Morganton, NC 28680-3601
Phone: 828-439-9948

Grace Hospital, Inc.
2201 South Sterling Street
Morganton, NC 28655
Phone: 828-580-5000
Fax: 828-580-5509

Valdese General Hospital, Inc.
PO Box 700
Valdese, NC 28690
Phone: 828-874-2251
Fax: 828-879-7544

Cabarrus County

Cabarrus Community Care Plan, Inc.
HCAP grantee, Project Access program
845 Church Street, N
Suite 307
Concord, NC 28025
Phone: 704-783-1516
Fax: 704-783-1459

Cabarrus County Department of Social Services
PO Box 668
Concord, NC 28025
Phone: 704-920-1400
Fax: 704-920-1401

Cabarrus County Health Department
Primary care services available
1307 S Cannon Boulevard
Kannapolis, NC 28083
Phone: 704-920-1000
Fax: 704-933-3345

MedAssist of Mecklenburg
Free clinic (pharmacy only)
5516 Central Avenue
Charlotte, NC 28212
Phone: 704-536-9766

Mount Pleasant Family Physicians
Rural health clinic
8560 Cook Street
PO Box 1058
Mount Pleasant, NC 28124
Phone: 704-436-6521

NorthEast Medical Center
Hospital
920 Church Street, N
Concord, NC 28025
Phone: 704-783-3000
Fax: 704-783-1409

Piedmont Behavioral Healthcare
MH/DD/SA Services
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010

The Community Free Clinic
Free clinic
1018 Lee-Ann Drive, NE
Concord, NC 28025
Phone: 704-782-0650
Fax: 704-782-8638

Caldwell County

Caldwell County Department of Social Services
1966-H Morganton Boulevard, SW
Lenoir, NC 28645
Phone: 828-426-8256
Fax: 828-757-1189

Caldwell Memorial Hospital, Inc.
PO Box 1890
Lenoir, NC 28645
Phone: 828-757-5100
Fax: 828-757-9819

Caldwell County Health Department
Primary care services available
1966-B Morganton Boulevard, SW
Lenoir, NC 28645
Phone: 828-426-8415
Fax: 828-426-8450

Collettsville Medical Center
Rural health clinic, rural health center
4329 Collettsville Road
Collettsville, NC 28611
Phone: 828-754-2409

Foothills Area MH/DD/SA Program
306 S King Street
Morganton, NC 28655
Phone: 828-438-6230
Emergency Phone: 800-942-1797
Fax: 828-438-6238

Happy Valley Medical Center
State-funded rural health center
1345 Highway 268
PO Box 319
Patterson, NC 28645
Phone: 828-754-6850

Helping Hands Clinic of Caldwell County
Free clinic
PO Box 621
Lenoir, NC 28645
Phone: 828-754-8565

Camden County

Albemarle Mental Health Center & Development Disabilities and Substance Abuse Services
305 E Main Street
Elizabeth City, NC 27906
Phone: 252-335-0803
Emergency Phone: 888-627-4747
Fax: 252-335-9143

Camden County Department of Social Services
PO Box 70
Camden, NC 27921
Phone: 252-331-4787
Fax: 252-335-1009

Camden County Health Department
160 B US 158, E
PO Box 72
Camden, NC 27921
Phone: 252-338-4460
Fax: 252-338-4478

Carteret County

Broad Street Clinic Foundation
Free clinic
500 North 35th Street
Morehead City, NC 28557
Phone: 252-726-4562

Carteret County Department of Social Services
PO Box 779
Beaufort, NC 28516
Phone: 252-728-3181
Fax: 252-728-3631

Carteret Family Practice
Rural health clinic
2 Medical Park Penny Lane
Morehead City, NC 28557
Phone: 252-247-2464

Carteret General Hospital
PO Drawer 1619
Morehead City, NC 28557
Phone: 252-808-6000
Fax: 252-808-6985

Carteret County Health Department
3820 Bridges Street, Suite A
Morehead City, NC 28557
Phone: 252-728-8550
Fax: 252-222-7739

Emerald Isle Primary Care, PA
Rural health clinic
7901 Emerald Drive
Veranda Square, Suite 7
Emerald Isle, NC 28594
Phone: 252-354-6500

Med Center One
Rural health clinic
600 Atlantic Beach Causeway
Atlantic Beach, NC 28512
Phone: 252-247-2464

Neuse Center for MH/DD/SAS
PO Box 1636
New Bern, NC 28563-1636
Phone: 252-636-1510
Fax: 252-633-1237

Newport Family Practice
Rural health clinic
338 Howard Boulevard
PO Box 969
Newport, NC 28570
Phone: 252-223-5054

Caswell County

Alamance-Caswell Area MH/DD/SA Authority
319 N Graham-Hopedale Road
Suite A
Burlington, NC 27215
Phone: 336-513-4200
Emergency Phone: 336-513-4444
Fax: 336-513-4203

Caswell County Department of Social Services
Drawer S, PO Box 1538
Yanceyville, NC 27379
Phone: 336-694-4141
Fax: 336-694-1816

Caswell County Health Department
Primary care services available
189 County Park Road
PO Box 1238
Yanceyville, NC 27379
Phone: 336-694-4129, Ext 157
Fax: 336-694-7030

Caswell Family Medical Center
Federally qualified health center
439 US Highway 158, West
PO Box 1448
Yanceyville, NC 27379-2004
Phone: 336-694-9331

Prospect Hill Community Health Center
Federally qualified health center
140 Main Street
PO Box 4
Prospect Hill, NC 27314
Phone: 336-562-3311
Fax: 336-562-4444

Catawba County

Bethlehem Family Practice
Rural health clinic
1232 Shiloh Church Road
Hickory, NC 28601
Phone: 704-495-8226

Catawba County Department of Social Services
PO Box 669
Newton, NC 28658
Phone: 828-695-5600
Fax: 828-695-2497

Catawba County Health Department
Primary care services available
3070 11th Avenue Drive, SE
Hickory, NC 28602
Phone: 828-695-5800
Fax: 828-695-4410

Catawba Valley Medical Center
Hospital
810 Fairgrove Church Road
Hickory, NC 28602
Phone: 828-326-3800
Fax: 828-326-3371

Cooperative Christian Ministries
Free clinic
31 First Street
Hickory, NC 28603
Phone: 828-345-0854

Frye Regional Medical Center
Hospital
420 North Center Street
Hickory, NC 28601
Phone: 828-322-6070
Fax: 828-324-0193

Hickory High School (Mobile Van)
School-based health center
3070 11th Avenue Drive, SE
Hickory, NC 28602
Phone: 828-302-8911
Sponsor: Catawba County Health Department

Mental Health Services of Catawba County
1985 Tate Boulevard, SE
Suite 529
Hickory, NC 28602
Phone: 828-327-2595
Fax: 828-325-9826

Totally Teens Health Center
School-linked health center
3070 11th Avenue Drive, SE
Hickory, NC 28602
Phone: 828-695-5168
Fax: 828-695-5156
Sponsor: Catawba County Health Department

Chatham County

Chatham County Department of Social Services
PO Box 489
Pittsboro, NC 27312
Phone: 919-542-2759
Fax: 919-542-6355

Chatham Hospital, Inc.
PO Box 649
Siler City, NC 27344
Phone: 919-663-2113
Fax: 919-663-2343

Chatham County Health Department
Primary care services available
80 East Street
PO Box 130
Pittsboro, NC 27312
Phone: 919-542-8215
Fax: 919-542-8227

Goldston Medical Center
Rural health clinic
Coal & Bellevue Street
PO Box 307
Goldston, NC 27252
Phone: 919-898-2256

Moncure Community Health Center
Federally qualified health center
7228 Moncure-Pittsboro Road
PO Box 319
Moncure, NC 27559
Phone: 919-542-4991

Orange-Person-Chatham MH/DD/SA Authority
100 Europa Drive, Suite 490
Chapel Hill, NC 27517
Phone: 919-913-4000
Fax: 919-913-4001
Emergency Phone: 800-233-6834

Siler City Health Center
Federally qualified health center
401-B N Ivey Avenue
Siler City, NC 27344
Phone: 919-663-1635

Cherokee County

Chatuge Family Practice
Rural health center
1251 Medical Parkway, F
Murphy, NC 28906
Phone: 828-389-6383
Fax: 828-389-6803

Cherokee County Department of Social Services
40 Peachtree Street, Suite 200
Murphy, NC 28906
Phone: 828-837-7455
Fax: 828-837-9789

Cherokee County Health Department
228 Hilton Street
Murphy, NC 28906
Phone: 828-837-7486
Fax: 828-837-3983

District Medical Center, Inc.
Hospital
415 Whitaker Lane
Andrews, NC 28901
Phone: 828-321-1291
Fax: 828-321-1276

Hiwassee Dam Union
School-based health center
215 Blue Eagle Circle
Murphy, NC 28906
Phone: 828-644-0775
Fax: 828-644-0486
Sponsor: Cherokee County Health Department

Murphy Medical Center, Inc.
Hospital
4130 US Hwy 64
Murphy, NC 28906
Phone: 828-837-8161
Fax: 828-835-7507

Peachtree Internal Medicine Clinic PA
Rural health clinic
4188 East US 64, Suite 1
PO Box 158
Murphy, NC 28906
Phone: 828-837-8131

Smoky Mountain Center for MH/DD/SAS
PO Box 127
Sylva, NC 28779
Phone: 828-586-5501
Emergency Phone: 800-849-6127
Fax: 828-586-3965

Chowan County

Albemarle Mental Health Center & Development Disabilities and Substance Abuse Services
305 E Main Street
Elizabeth City, NC 27906
Phone: 252-335-0803
Emergency Phone: 888-627-4747
Fax: 252-335-9143

Albemarle Regional Health Services
Multi-county health department
King Street
County Office Building
PO Box 808
Edenton, NC 27932
Phone: 252-482-6003
Fax: 252-482-6020

Chowan County Department of Social Services
PO Box 296
Edenton, NC 27932
Phone: 353-382-7441
Fax: 252-482-7041

Chowan Hospital
PO Box 629
Edenton, NC 27932
Phone: 252-482-6156
Fax: 252-482-6429

Clay County

Chatuge Family Health Center
Rural health center
Church Street
PO Box 1309
Hayesville, NC 28904
Phone: 828-389-6347

Clay County Department of Social Services
PO Box 147
Hayesville, NC 28904
Phone: 828-389-6301
Fax: 828-389-6427

Clay County Health Department
Riverside Circle
PO Box 55
Hayesville, NC 28904
Phone: 828-389-8052
Fax: 828-389-8533

Smoky Mountain Center for MH/DD/SAS
PO Box 127
Sylva, NC 28779
Phone: 828-586-5501
Emergency Phone: 800-849-6127
Fax: 828-586-3965

Cleveland County

Burns High School and Middle School
School-based health centers
315 Beaver Dam Church Road
Shelby, NC 28152
Phone: 704-484-5211
Fax: 704-484-5220
Sponsor: Cleveland County Health Department

Cleco Medical Center of Shelby
Rural health clinic
208 E Grover Street
Shelby, NC 28150
Phone: 704-480-9344

Cleveland County Department of Social Services
Drawer 9006
Shelby, NC 28150
Phone: 704-487-0661
Fax: 704-484-1051

Cleveland County Health Department
Primary care services available
315 East Grover Street
Shelby, NC 28150
Phone: 704-484-5200
Fax: 704-484-5220

Cleveland Regional Medical Center
Hospital
201 East Grover Street
Shelby, NC 28150
Phone: 704-487-3245
Fax: 704-487-3290

Crawley Memorial Hospital, Inc.
PO Box 996
Boiling Springs, NC 28017
Phone: 704-434-9466
Fax: 704-434-5376

Crest High School and Middle School
School-based health centers
315 Beaver Dam Church Road
Shelby, NC 28152
Phone: 704-484-5211
Fax: 704-484-5220
Sponsor: Cleveland County Health Department

Kings Mountain High School and Middle School
School-based health centers
315 Beaver Dam Church Road
Shelby, NC 28152
Phone: 704-484-5211
Fax: 704-484-5220
Sponsor: Cleveland County Health Department

Kings Mountain Hospital
706 West King Street
Kings Mountain, NC 28086
Phone: 704-739-3601
Fax: 704-739-0800

Kings Mountain Medical Center
Rural health clinic
812 W King Street
Kings Mountain, NC 28086
Phone: 704-739-5456

Pathways MH/DD/SA
901 S New Hope Road
Gastonia, NC 28054
Phone: 704-867-2361
Emergency Phone: 704-867-4357
Fax: 704-854-4809

Shelby High School and Middle School
School-based health centers
315 Beaver Dam Church Road
Shelby, NC 28152
Phone: 704-484-5211
Fax: 704-484-5220
Sponsor: Cleveland County Health Department

Upper Cleveland Medical Center
Rural health clinic
109 Ball Park Road
Lawndale, NC 28090
Phone: 704-538-8532

Columbus County

Chadbourn Family Practice Center
Rural health clinic
104 Seventh Avenue
Chadbourn, NC 28431
Phone: 910-654-3143

Columbus County Community Health Center
State-funded rural health center
209 W Virgil Street
PO Box 1330
Whitesville, NC 28472
Phone: 910-641-0202

Columbus County Department of Social Services
PO Box 397
Whiteville, NC 28472
Phone: 910-642-2800
Fax: 910-641-3970

Columbus County Health Department
Primary care services available
Miller Building
304 Jefferson Street
PO Box 810
Whiteville, NC 28472
Phone: 910-641-3914
Fax: 910-640-1088

Columbus County Hospital, Inc.
500 Jefferson Street
Whiteville, NC 28472
Phone: 910-642-8011
Fax: 910-642-9305

Cypress Village
Federally qualified health center
197 Orange Street
Fairbluff, NC 28439-9652
Phone: 910-649-7971

Delco Health Clinic
Rural health clinic
25478 Andrew Jackson Highway, East
PO Box 9
Delco, NC 28436
Phone: 910-655-4359

Lake Waccamaw Family Medical Practice
Rural health clinic
107 Church Street
Lake Waccamaw, NC 28450
Phone: 910-646-2132

Main Street Medical Clinic
Rural health clinic
110 N Brown Street
PO Box 325
Chadbourn, NC 28431
Phone: 910-654-1701

Riegelwood Medical Clinic
Rural health clinic
PO Box 118, Highway 87
Riegelwood, NC 28450
Phone: 910-655-0021

Southeastern Regional MH/DD/SA Services
2003 Godwin Avenue
Lumberton, NC 28358-2901
Phone: 910-738-5261
Emergency Phone: 800-672-8255
Fax: 910-738-8230

Tabor City Family Medicine Center
Rural health clinic
27 Pireway Road
PO Box 675
Tabor City, NC 28463
Phone: 910-653-2112

Whiteville Community Health Center, Inc.
Rural health clinic
144 1/2 Jefferson Street
Whiteville, NC 28472
Phone: 910-641-3914

Craven County

Beachcare Urgent Medical Care Center
Rural health clinic
1224 E Main Street
Havelock, NC 28532
Phone: 252-447-7474

Craven County Department of Social Services
PO Box 12039
New Bern, NC 28561
Phone: 252-636-4900
Fax: 252-636-4946

Craven County Health Department
Primary care services available
2818 Neuse Boulevard
PO Drawer 12610
New Bern, NC 28561
Phone: 252-636-4960
Fax: 252-636-4970

Craven Regional Medical Center
Hospital
PO Box 12157
New Bern, NC 28561-2157
Phone: 252-633-8880
Fax: 252-633-8939

MERCI Clinic
Free clinic
1315 Tatum Drive
PO Box 15254
New Bern, NC 28561-5254
Phone: 252-633-1599

Neuse Center for MH/DD/SAS
PO Box 1636
New Bern, NC 28563-1636
Phone: 252-636-1510
Fax: 252-633-1237

Senior Pharmacy Program
Free clinic
PO Box 826
New Bern, NC 28563
Phone: 252-638-3657

Cumberland County

Cape Fear Valley Medical Center
Hospital
PO Box 2000
Fayetteville, NC 28302-2000
Phone: 910-609-4000
Fax: 910-609-6160

Cumberland Area MH/DD/SA Program
PO Box 3069
Fayetteville, NC 28302-3069
Phone: 910-323-0601
Emergency Phone: 910-323-0601
Fax: 910-323-0096

Cumberland County Department of Social Services
PO Box 2429
Fayetteville, NC 28302
Phone: 910-323-1540

Cumberland County Health Department
Primary care services available
227 Fountainhead Lane
Fayetteville, NC 28301
Phone: 910-433-3700
Fax: 910-433-3659

Highsmith-Rainey Memorial Hospital
150 Robeson Street
Fayetteville, NC 28301-5570
Phone: 910-609-1434
Fax: 910-609-1456

Southern Regional AHEC
1601 Owen Drive
Fayetteville, NC 28304
Phone: 910-678-7230
Fax: 910-678-7279

Stedman Family Dental Center
Federally qualified health center
Highway 24, East
PO Box 368
Stedman, NC 28391
Phone: 910-483-3150

The CARE Clinic, Inc.
Free clinic
239 Robeson Street
PO Box 53438
Fayetteville, NC 28305
Phone: 919-485-0555

Wade Family Medical Center
Federally qualified health center
7118 Main Street
Wade, NC 28395
Phone: 910-483-6694

Currituck County

Albemarle Mental Health Center & Development Disabilities and Substance Abuse Services
305 E Main Street
Elizabeth City, NC 27906
Phone: 252-335-0803
Emergency Phone: 888-627-4747
Fax: 252-335-9143

Currituck County Health Department
Albemarle Regional Health Services
Highway 168
PO Box 26
Currituck, NC 27929
Phone: 252-232-2271
Fax: 252-232-2442

Currituck County Department of Social Services
PO Box 99
Currituck, NC 27929
Phone: 252-232-3083
Fax: 252-232-2167

Dare County

Albemarle Mental Health Center & Development Disabilities and Substance Abuse Services
305 E Main Street
Elizabeth City, NC 27906
Phone: 252-335-0803
Emergency Phone: 888-627-4747
Fax: 252-335-9143

Dare County Department of Social Services
PO Box 669
Manteo, NC 27954
Phone: 252-475-5500

Dare County Health Department
109 Exeter Street
Manteo, NC 27954
Phone: 252-475-5008
Fax: 252-473-5763

Healtheast Family Care
Rural health clinic
4810 S Croatan Highway, Suite 100
Nags Head, NC 27959
Phone: 252-441-3177

The Outer Banks Hospital, Inc.
4800 S Croatan Highway
Nags Head, NC 27959
Phone: 252-449-4500
Fax: 252-449-4555

Davidson County

Davidson County Department of Social Services
PO Box 788
Lexington, NC 27292
Phone: 336-242-2500,
Thomasville 336-474-2760
Fax: 336-249-1924,
Thomasville 336-472-6635

Davidson County Health Department
915 Greensboro Street
PO Box 439
Lexington, NC 27292-0439
Phone: 336-242-2300
Fax: 336-242-2485

Davidson Medical Ministries Clinic, Inc.
Free clinic
420 N Salisbury Street
PO Box 584
Lexington, NC 27293
Phone: 336-249-6215

Lexington Memorial Hospital
PO Box 1817
Lexington, NC 27293-1817
Phone: 336-248-5161
Fax: 336-248-2069

Piedmont Behavioral Healthcare
MH/DD/SA Services
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010

Thomasville Medical Center
Hospital
PO Box 789
Thomasville, NC 27360
Phone: 336-472-2000
Fax: 336-476-2534

Davie County

Carolina Primary & Urgent Care - Farmington Center
Rural health clinic
1503 East Broad Street
1590 Farmington Road
Mocksville, NC 27028
Phone: 336-998-6004

CenterPoint Human Services
MH/DD/SA services
4045 University Parkway
Winston-Salem, NC 27106
Phone: 336-714-9100
Emergency Phone: 888-581-9988
Fax: 336-714-9111

Davie County Department of Social Services
PO Box 517
Mocksville, NC 27028
Phone: 336-751-8800
Fax: 336-751-1639

Davie County Health Department
Primary care services available
210 Hospital Street
PO Box 848
Mocksville, NC 27028
Phone: 336-751-8700
Fax: 336-751-0335

Davie County Hospital
PO Box 1209
Mocksville, NC 27028
Phone: 336-751-8100
Fax: 336-751-8402

Storehouse for Jesus Free Medical Clinic
Free clinic
PO Box 216
Mocksville, NC 27028
Phone: 336-751-1060

Duplin County

Duplin County Department of Social Services
PO Box 969
Kenansville, NC 28349
Phone: 910-296-2200
Fax: 910-296-2323

Duplin County Health Department
Primary care services available
340 Seminary Street
PO Box 948
Kenansville, NC 28349
Phone: 910-296-2130
Fax: 910-296-2139

Duplin General Hospital, Inc.
401 North Main Street
Kenansville, NC 28349-0278
Phone: 910-296-2602
Fax: 910-296-1174

Eastpointe
MH/DD/SA services
117 Beasley Street
PO Box 599
Kenansville, NC 28349-0599
Phone: 910-296-1851
Emergency Phone: 800-513-4002
Fax: 910-296-1731

Goshen Medical Center-Beulaville
Federally qualified health center
119 Crossover Road
Beulaville, NC 28518-8801
Phone: 910-298-3125
Fax: 910-298-8101

Goshen Medical Center, Inc
Rural health clinic
444 South Center Street
PO Box 187
Faison, NC 28341
Phone: 910-267-0421
Fax: 910-267-0441

Goshen Medical Center-Plainview
Rural health clinic
360 East Charity Road
PO Box 237
Rose Hill, NC 28458
Phone: 910-289-3086
Fax: 910-289-3099

Plain View Health Services
Federally qualified health center
360 East Charity Road
Rose Hill, NC 28458
Phone: 910-289-3086

Rose Hill Medical Center
State-funded rural health center
4088 S US Highway 117
Rose Hill, NC 28458
Phone: 910-289-3027

Warsaw Medical Center
Rural health center
107 North Center Street
Warsaw, NC 28398
Phone: 910-293-3401

Durham County

The Durham Center
Managing Behavioral Health & Disability Services
200 N Mangum Street
Durham, NC 27701
Phone: 919-560-7100
Emergency Phone: 800-510-9132
Fax: 919-560-7216

Duke University Health System
Hospital outpatient clinic
Erwin Road
Durham, NC 27710
Phone: 919-684-8111

Durham County Department of Social Services
PO Box 810
Durham, NC 27702
Phone: 919-560-8000
Fax: 919-560-8102

Durham County Health Department
414 East Main Street
Durham, NC 27701
Phone: 919-560-7650
Fax: 919-560-7652

Durham Regional Hospital
3643 North Roxboro Road
Durham, NC 27704
Phone: 919-470-4000
Fax: 919-470-6147

GK Powe Elementary
School-based health center
913 Ninth Street
Durham, NC 27704
Phone: 919-560-9125
Sponsor: Duke Community Health

George Watts Elementary
School-based health center
800 Clayton Road
Durham, NC 27703
Phone: 919-560-2536
Fax: 919-560-2540
Sponsor: Duke Community Health

Glen Elementary
School-based health center
2415 East Geer Street
Durham, NC 27704
Phone: 919-560-2211
Sponsor: Duke Community Health

John H. Lucas, Jr. Wellness Center, Hillside High School
School-based health center
3727 Fayetteville Street
Durham, NC 27703
Phone: 919-956-4519
Fax: 919-688-3288
Sponsor: Lincoln Community Health Center

Local Access to Coordinated Health Care (LATCH)
HCAP grantee, other non-profit safety net provider
4321 Medical Park, Suite 102
Durham, NC 27704
Phone: 919-620-8034
Fax: 919-620-8014

Lincoln Community Health Center, Inc
Federally qualified health center
1301 Fayetteville Street
PO Box 52119
State-funded rural health center
Durham, NC 27717-2119
Phone: 919-956-4000

Lincoln Homeless Clinic
Federally qualified health center
412 Liberty Street
Durham, NC 27701-3408
Phone: 919-682-8734

North Carolina Specialty Hospital, LLC
PO Box 15819
Durham, NC 27704
Phone: 919-956-9300
Fax: 919-287-3237

Piedmont HIV Health Care Consortium
HCAP grantee, other non-profit safety net provider
331 West Main Street, 5th Floor
Durham, NC 27701
Phone: 919-682-3998
Phone: 800-272-9610
Fax: 919-682-3873

Select Specialty Hospital - Durham
3643 N Roxboro Road
Durham, NC 27704
Phone: 919-470-9011

Senior PHARMAssist
Free clinic (pharmacy only)
123 Market Street
Durham, NC 27701
Phone: 919-688-4772

Southern High School Wellness Center
School-based health center
800 Clayton Road
Durham, NC 27703
Phone: 919-560-2536
Fax: 919-560-2540
Sponsor: Duke Community Health

Edgecombe County

Edgecombe County Department of Social Services
3003 N Main Street
Tarboro, NC 27886
Phone: 252-641-7611, 252-985-4101
Fax: 252-641-7980, 252-985-1615

Edgecombe County Health Department
2909 Main Street
Tarboro, NC 27886
Phone: 252-641-7531
Fax: 252-641-7565

Edgecombe-Nash
MH/DD/SAS
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 252-937-8141
Emergency Phone: 888-893-8640
Fax: 252-443-9574

Heritage Hospital
111 Hospital Drive
Tarboro, NC 27886
Phone: 252-641-7700
Fax: 252-641-7484

Macclesfield Healthcare Center
Rural health clinic
201 W Edgecombe Street
PO Box 397
Macclesfield, NC 27852
Phone: 252-827-5231
Fax: 252-827-5775

Oakwood Medical Center
Rural health clinic
111 S Fairview Road
Rocky Mount, NC 27801
Phone: 252- 985-3546

Forsyth County

Ashley Elementary
School-based health center
4555 Ogburn Avenue
Winston Salem, NC 27105
Phone: 336-885-4092
Fax: 336-661-4954
Sponsor: School Health Alliance for Forsyth County

Atkins Middle School
School-based health center
4555 Ogburn Avenue
Winston Salem, NC 27105
Phone: 336-885-4092
Fax: 336-661-4954
Sponsor: School Health Alliance for Forsyth County

CenterPoint Human Services
MH/DD/SA services
4045 University Parkway
Winston-Salem, NC 27106
Phone: 336-714-9100
Emergency Phone: 888-581-9988
Fax: 336-714-9111

Community Care Center
Free clinic
2135 New Walkerton Road
Winston-Salem, NC 27101
Phone: 336-723-7904

Crisis Control Ministry Pharmacy
Free clinic (pharmacy only)
200 East 10th Street
Winston-Salem, NC 27101
Phone: 336-724-7875

Downtown Health Plaza, Wake Forest University Baptist Medical Center
Hospital outpatient clinic
1200 Martin Luther King, Jr. Drive
Winston-Salem, NC 27101
Phone: 336-713-9700

Forsyth County Department of Social Services
PO Box 999
Winston Salem, NC 27102
Phone: 336-703-3400
Fax: 336-727-2850

Forsyth Memorial Hospital
3333 Silas Creek Parkway
Winston Salem, NC 27103
Phone: 336-718-5000
Fax: 336-718-9250

Forsyth County Health Department
799 Highland Avenue
PO Box 686
Winston-Salem, NC 27102
Phone: 336-703-3101
Fax: 336-748-3292

Forsyth HealthCare, Inc.
Project Access program
501 N Cleveland Avenue
Winston-Salem, NC 27101
Phone: 336-723-6565

Medical Park Hospital, Inc.
1950 South Hawthorne Road
Winston Salem, NC 27103
Phone: 336-718-0600
Fax: 336-718-0384

Mineral Springs Elementary and Middle School
School-based health center
4555 Ogburn Avenue
Winston Salem, NC 27105
Phone: 336-885-4092
Fax: 336-661-4954
Sponsor: School Health Alliance for Forsyth County

N. Forsyth High School
School-based health center
4555 Ogburn Avenue
Winston Salem, NC 27105
Phone: 336-885-4092
Fax: 336-661-4954
Sponsor: School Health Alliance for Forsyth County

North Carolina Baptist Hospital
Medical Center Boulevard
Winston Salem, NC 27157
Phone: 336-716-4750
Fax: 336-716-2067

Northwest AHEC- Wake Forest University Health Sciences
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Phone: 336-713-7700
Fax: 336-713-7701

SemperCare Hospital of Winston-Salem, Inc.
3333 Silas Creek Parkway
Winston-Salem, NC 27103
Phone: 336-718-6500
Fax: 336-718-6510

Franklin County

Four County Health Network
Project Access program
511 Ruin Creek Road, Suite B-1
Henderson, NC 27536
Phone: 252-430-0360
Fax: 252-430-8980

Franklin County Department of Social Services
PO Box 669
Louisburg, NC 27549
Phone: 919-496-5721
Fax: 919-496-8137

Franklin County Health Department
Primary care services available
107 Industrial Drive, Suite C
Louisburg, NC 27549
Phone: 919-496-8110
Fax: 919-496-8126

Franklin County Volunteers in Medicine Clinic
Free clinic
108 Bickett Boulevard
PO Box 397
Louisburg, NC 27549
Phone: 919-496-0492

Franklin Regional Medical Center
Hospital
PO Box 609
Louisburg, NC 27549
Phone: 919-496-5131
Fax: 919-497-8018

Vance Granville Franklin Warren Area Authority
MH/DD/SA services
134 S Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Emergency Phone: 877-619-3761
Fax: 252-430-0909

Gaston County

Bessemer City Health Care Center
Federally qualified health center
520 ED Wilson Road
PO Box 486
Bessemer City, NC 20816
Phone: 704-629-3465

Gaston County Department of Social Services
330 N Marietta Street
Gastonia, NC 28052
Phone: 704-862-7500
Fax: 704-862-7885

Gaston County Health Department
Primary care services available
991 West Hudson Boulevard
Gastonia, NC 28052
Phone: 704-853-5262
Fax: 704-853-5252

Public Health Dental Clinic
Federally qualified health center
991 West Hudson Boulevard
Gastonia, NC 28052
Phone: 704-853-5262
Fax: 704-853-5252

Gaston Family Health Services Inc
Federally qualified health center
991 West Hudson Boulevard
Gastonia, NC 28052-6430
Phone: 704-853-5261

Gaston Family Health Services Pediatric Dental Clinic
Federally qualified health center
991 West Hudson Boulevard
Gastonia, NC 28052-6430
Phone: 704-853-5191

Gaston Memorial Hospital
PO Box 1747
Gastonia, NC 28053-1747
Phone: 704-834-2121
Fax: 704-834-2500

Pathways MH/DD/SAS
901 S New Hope Road
Gastonia, NC 28054
Phone: 704-867-2361
Emergency Phone: 704-867-4357
Fax: 704-854-4809

Gates County

Gates County Department of Social Services
PO Box 185
Gatesville, NC 27938
Phone: 252-357-0075
Fax: 252-357-2132

Gates County High School
School-based health center
PO Box 297
088 US Hwy 158 West
Gatesville, NC 27938
Phone: 252-357-1244
Fax: 252-357-1690
Sponsor: Gates County Medical Center

Gates County Regional Medical Center
Rural health center
501 Main Street
PO Box 297
Gatesville, NC 27938
Phone: 252-357-1226

Hertford Gates District Health Department
PO Box 246
Winton, NC 27986
Phone: 252-338-4404

Roanoke-Chowan Human Services Center
MH/DD/SA Services
144 Community College Road
Ahoskie, NC 27910-9320
Phone: 252-332-4137
Emergency Phone: 252-332-4442
Fax: 252-332-8457

Graham County

Graham County Department of Social Services
PO Box 1150
Robbinsville, NC 28771
Phone: 828-479-7911
Fax: 828-479-7928

Graham County Health Department
Moose Branch Road
PO Box 546
Robbinsville, NC 28771
Phone: 828-479-7900
Fax: 828-479-6956

Robbinsville High School and Robbinsville Middle School
School-based health center
PO Box 625
301 Sweetwater Road
Robbinsville, NC 28771
Phone: 828-479-9395
Fax: 828-479-4255
Sponsor: Graham County Health Department

Smoky Mountain Center for MH/DD/SAS
PO Box 127
Sylva, NC 28779
Phone: 828-586-5501
Emergency Phone: 800-849-6127
Fax: 828-586-3965

Granville County

Four County Health Network
Project Access program
511 Ruin Creek Road, Suite B-1
Henderson, NC 27536
Phone: 252-430-0360
Fax: 252-430-8980

Granville County Department of Social Services
PO Box 966
107 Lenoir Street
Oxford, NC 27565
Phone: 919-693-1511
Fax: 919-603-5090

Granville Family Medicine PA
Rural health clinic
1012 College Street
Oxford, NC 27565
Phone: 919-693-7108

Granville Medical Center
Hospital
PO Box 947
Oxford, NC 27565
Phone: 919-690-3000
Fax: 919-690-3400

Granville Vance District Health Department
101 Hunt Drive
PO Box 367
Oxford, NC 27565
Phone: 919-693-2141
Fax: 919-693-8517

South Granville Primary Care
Rural health clinic
317 Central Avenue
Butner, NC 27509
Phone: 919-575-6103

Stephen D Ertischek MD
Rural health clinic
1032 College Street
Oxford, NC 27565
Phone: 919-693-6541

Vance Granville Franklin Warren Area Authority
MH/DD/SA services
134 S Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Emergency Phone: 877-619-3761
Fax: 252-430-0909

Greene County

Adolescent Health Services
Federally qualified health center
Hwy 91, W
Snow Hill, NC 28580
Phone: 919-747-5841

Greene Central High School
School-based health center
PO Box 658
Snow Hill, NC 28580
Phone: 252-747-5841
Fax: 252-747-4916
Sponsor: Greene County Health Care, Inc.

Greene County Department of Social Services
229 Kingold Boulevard, Suite A
Snow Hill, NC 28580
Phone: 252-747-5932
Fax: 252-747-8654

Greene County Health Department
227 Kingold Boulevard, Suite B
Snow Hill, NC 28580
Phone: 252-747-8183
Fax: 252-747-4040

Grimesland Community Resource Center
Federally qualified health center
550 River Street
Grimesland, NC 27837
Phone: 252-752-1857

Kate B. Reynolds Medical Center
Federally qualified health center
205 Martin Luther King, Jr. Parkway
Snow Hill, NC 28580
Phone: 252-747-4199

Snow Hill Medical Center
Federally qualified health center
302 N Greene Street
Snow Hill, NC 28580
Phone: 252-747-2921

Walstonburg Medical Center
Federally qualified health center
PO Box 658
Snow Hill, NC 28580
Phone: 252-753-3771
Fax: 252-753-4814

Wilson-Greene Area MH/DD/SAS
1709 S Tarboro Street
PO Box 3756
Wilson, NC 27895-3756
Phone: 252-399-8021
Emergency Phone: 888-399-8021
Fax: 252-399-8151

Guilford County

Allen Middle School
School-based health center
Student Health Center
4015 W Wendover Terrace
Greensboro, NC 27407
Phone: 336-370-8118
Fax: 336-370-8002
Sponsor: Guilford School Health Alliance

Andrews High School
School-based health center
Student Health Center
4015 W Wendover Terrace
Greensboro, NC 27407
Phone: 336-370-8118
Fax: 336-370-8002
Sponsor: Guilford School Health Alliance

Community Clinic of High Point, Inc.
Free clinic
904 N Main Street
PO Box 5607
High Point, NC 27262
Phone: 336-841-7154

Greensboro AHEC - Moses Cone Health System
1200 N Elm Street
Greensboro, NC 27401-1020
Phone: 336-832-8025
Fax: 336-832-7591

Grimsley High School
School-based health center
Student Health Center
4015 W Wendover Terrace
Greensboro, NC 27407
Phone: 336-370-8118
Fax: 336-370-8002
Sponsor: Guilford School Health Alliance

Guilford Adult Health
Other non-profit safety net provider
1046 E Wendover Avenue
Greensboro, NC 27405
Phone: 336-641-3310

Guilford Child Health
HCAP grantee, other non-profit safety net provider
1046 E Wendover Avenue
Greensboro, NC 27405
Phone: 336-272-1050
Fax: 336-272-1110

Guilford County Area MH/DD/SA Program
232 N Edgeworth Street, 4th Floor
Greensboro, NC 27401-2221
Phone: 336-641-4981
Emergency Phone: 800-853-5163
Fax: 336-641-7761

Guilford County Department of Social Services
PO Box 3388
Greensboro, NC 27402
Phone: 336-641-3000
Fax: 336-641-6868

Guilford County Health Department
Primary care services available
232 N Edgeworth Street
PO Box 3508
Greensboro, NC 27401
Phone: 336-641-3288
Fax: 336-641-6971 (Greensboro)
Fax: 336-845-7987 (High Point)

HealthCare Sharing Initiative, Inc.
Project Access program
612 Pasteur Drive, Suite 309
Greensboro, NC 27403
Phone: 336-294-0778

Healthserve Ministy
Free clinic
1002 S Eugene Street
Greensboro, NC 27406
Phone: 336-271-5971

High Point Regional Adult Health Center
Hospital outpatient clinic
624 Quaker Lane, Suite 100C
High Point, NC 27260
Phone: 336-878-6027

High Point Regional Health System
Hospital
PO Box HP5
High Point, NC 27261
Phone: 336-878-6000
Fax: 336-878-6158

Jackson Middle School
School-based health center
Student Health Center
4015 W Wendover Terrace
Greensboro, NC 27407
Phone: 336-370-8118
Fax: 336-370-8002
Sponsor: Guilford School Health Alliance

Kindred Hospital - Greensboro
2401 Southside Boulevard
Greensboro, NC 27406
Phone: 336-271-2800
Fax: 336-271-2734

Medication Assistance Program
Free clinic (pharmacy only)
1100 E Wendover Avenue
Greensboro, NC 27401
Phone: 336-641-8030

Moses Cone Health System
Hospital
1200 N Elm Street
Greensboro, NC 27401-1020
Phone: 336-832-7000
Fax: 336-832-1742

Pen-Griffin Middle School
School-based health center
Student Health Center
4015 W Wendover Terrace
Greensboro, NC 27407
Phone: 336-370-8118
Fax: 336-370-8002
Sponsor: Guilford School Health Alliance

Smith High School
School-based health center
Student Health Center
4015 W Wendover Terrace
Greensboro, NC 27407
Phone: 336-370-8118
Fax: 336-370-8002
Sponsor: Guilford School Health Alliance

Halifax County

Family Practice Associates of Roanoke Amaranth Community Health Group
Rural health clinic
Highway 125
PO Box 848
Weldon, NC 27890
Phone: 252-536-5000

Halifax County Department of Social Services
PO Box 767
Halifax, NC 27839
Phone: 252-536-2511
Fax: 252-536-6539

Halifax County Health Department
Primary care services available
19 Dobbs Street
PO Box 10
Halifax, NC 27839
Phone: 252-583-5021
Fax: 252-583-2975

Halifax Regional Medical Center, Inc.
Hospital
PO Box 1089
Roanoke Rapids, NC 27870
Phone: 252-535-8011
Fax: 252-535-8466

Lake Gaston Medical Center
State-funded rural health center
201 N Mosby Avenue
PO Box 250
Littleton, NC 27850
Phone: 252-586-5411

Medical Clinic of Enfield
Rural health clinic
114 Market Street
Enfield, NC 27823
Phone: 252-445-2332

Our Community Hospital, Inc.
PO Box 405
Scotland Neck, NC 27874
Phone: 252-826-4144
Fax: 252-826-2181

Primecare Family Medical Center
Rural health clinic
1261 Julian Allsbrook Highway
Roanoke Rapids, NC 27870
Phone: 252-537-5600

RiverStone Counseling and Personal Development
MH/DD/SA services
210 Smith Church Road
PO Box 1199
Roanoke Rapids, NC 27870-1199
Phone: 252-537-6174
Emergency Phone: 252-537-2909
Fax: 252-533-2610

Roanoke Amaranth Community Health Group, Inc.
Federally qualified health center
2066 Highway 125
Roanoke Rapids, NC 27870
Phone: 252-534-1024

Roanoke Clinic
Rural health clinic
1385 Medical Center Drive
Roanoke Rapids, NC 27870
Phone: 252-537-9176

Roanoke Valley Medical Ministries Clinic
Free clinic
536 Jackson Street
PO Box 1344
Roanoke Rapids, NC 27870
Phone: 252-308-1261

Scotland Neck Family Medical Center
State-funded rural health center
919 Junior High School Road
PO Box 50
Scotland Neck, NC 27874
Phone: 252-826-3143
Fax: 252-826-3110

Twin County Dental Clinic
Federally qualified health center
204 Evans Road
PO Box 10
Hollister, NC 27844
Phone: 252-586-5151

Twin County Rural Health Center, Inc.
Federally qualified health center
204 Evans Road
PO Box 10
Hollister, NC 27844
Phone: 252-586-5151

Harnett County

Anderson Creek Dental Clinic
Federally qualified health center
6720 Overhills Road
Spring Lake, NC 28390
Phone: 910-436-3194

Anderson Creek Medical Center
Federally qualified health center
6750 Overhills Road
Spring Lake, NC 28390
Phone: 910-436-2900

Angier Medical Center
Federally qualified health center
84 Medical Drive
Angier, NC 27501
Phone: 919-639-2123

Benhaven Medical Center
Federally qualified health center
985 NC 87, South
Cameron, NC 28326
Phone: 919-499-9422

Betsy Johnson Regional Hospital
PO Drawer 1706
Dunn, NC 28335
Phone: 910-891-7161
Fax: 910-891-6030

Boone Trail Medical Center
Federally qualified health center
1000 Medica Center Road
Mamers, NC 27552
Phone: 910-893-3063

Good Hope Hospital, Inc.
410 Denim Drive
Erwin, NC 28339
Phone: 910-897-6151
Fax: 910-897-7822

Harnett County Department of Social Services
PO Box 669
Lillington, NC 27546
Phone: 910-893-7500
Fax: 910-893-6604

Harnett County Health Department
Primary care services available
307 Cornelius Harnett Boulevard
Lillington, NC 27546
Phone: 910-893-7550
Fax: 910-814-4060

Lee-Harnett Area MH/DD/SA Authority
130 Carbonton Road
Sanford, NC 27330-4009
Phone: 919-774-6521
Emergency Phone: 910-893-2118
Fax: 919-776-6179

Haywood County

Good Samaritan Clinic of Haywood County
Free clinic
112 Academy Street
Waynesville/Canton, NC 28716-4443
Phone: 828-648-8676

Haywood Christian Ministry
Free clinic
2489 Asheville Road
Waynesville, NC 28786
Phone: 828-456-4838

Haywood County Department of Social Services
Community Services Building
514 East Marshall Street
Waynesville, NC 28786
Phone: 828-452-6620

Haywood County Health Department
2177 Asheville Road
Waynesville, NC 28786
Phone: 828-452-6675
Fax: 828-452-6730

Haywood Regional Medical Center
Hospital
262 Leroy George Drive
Clyde, NC 28721
Phone: 828-456-7311
Fax: 828-452-8277

Lillington Family Medical Center
Rural health clinic
1406 S Main Street
PO Box 1687
Lillington, NC 27546
Phone: 910-893-2641
Fax: 910-893-3208

Smoky Mountain Center for MH/DD/SAS
PO Box 127
Sylva, NC 28779
Phone: 828-586-5501
Emergency Phone: 800-849-6127
Fax: 828-586-3965

Henderson County

Apple Valley Middle School Health Center
Federally qualified health center, school-based health center
43 Fruitland Road
Hendersonville, NC 28792
Phone: 828-697-6755
Fax: 828-697-7138
Sponsor: Blue Ridge Community Health Center

Blue Ridge Community Health Services, Inc.
Federally qualified health center
Howard Gap Road and
Highway 64 East
PO Box 5151
Hendersonville, NC 28793-5151
Phone: 828-696-826

Druid Hills Family Practice
Federally qualified health center
1801 Asheville Highway
Hendersonville, NC 28791
Phone: 828-696-0545

George Bond Memorial Health Center
Federally qualified health center
Highway 74-A
Bat Cave, NC 28710
Phone: 828-625-9141

Henderson County Department of Social Services
246 Second Avenue, East
Hendersonville, NC 28792
Phone: 828-697-5500

Henderson County Health Department
Primary care services available
1347 Spartanburg Highway
Hendersonville, NC 28792
Phone: 828-698-6019
Toll Free: 800-627-9513
Fax: 828-697-4709

Kate B. Reynolds Women and Children's Center
Federally qualified health center
US Hwy 64 & Howard Gap Road
Reynolds Building
PO Box 5151
Hendersonville, NC 28793-5151
Phone: 828-692-7057

Margaret R. Pardee Memorial Hospital
800 North Justice Street
Hendersonville, NC 28791-3518
Phone: 828-696-1000
Fax: 828-696-1128

Park Ridge Hospital
PO Box 1569
Fletcher, NC 28732
Phone: 828-684-8501
Fax: 828-687-0729

Partnership for Health, Inc.
HCAP grantee, other non-profit safety net provider
PO Box 2742
Hendersonville, NC 28793
Phone: 828-698-4600

Volunteer Medical Resource Center
Free clinic
PO Box 1086
Hendersonville, NC 28793
Phone: 828-243-0138

Western Highlands MH/DD/SAS
356 Biltmore Avenue
Asheville, NC 28801
Phone: 828-258-3500
Emergency Phone: 800-951-3792
Fax: 828-252-9584

Hertford County

Helping Hands Clinic
Free clinic
828 Academy Street
Ahoskie, NC 27910
Phone: 252-358-7833

Hertford County Department of Social Services
PO Box 218
Winton, NC 27986
Phone: 252-358-7830

Hertford Gates District Health Department
PO Box 246
Winton, NC 27986
Phone: 252-358-7833
Fax: 252-358-7869

Roanoke-Chowan Human Services Center
MH/DD/SA Services
144 Community College Road
Ahoskie, NC 27910-9320
Phone: 252-332-4137
Emergency Phone: 252-332-4442
Fax: 252-332-8457

Roanoke Chowan Medical Center PA
Rural health clinic
305 Beachwood Boulevard
Murfreesboro, NC 27855
Phone: 252-398-3323

Roanoke-Chowan Hospital
PO Box 1385
Ahoskie, NC 27910
Phone: 252-209-3000
Fax: 252-209-3049

Hoke County

Hoke County Department of Social Services
PO Box 340
Raeford, NC 28376
Phone: 910-875-8725
Fax: 910-875-1068

Hoke County Health Department
Primary care services available
429 East Central Avenue
Raeford, NC 28376
Phone: 910-875-3717
Fax: 910-875-6351

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Emergency Phone: 800-256-2452
Fax: 910-673-6202

Hyde County

Engelhard Medical Center
State-funded rural health center
34575 US 264
PO Box 277
Engelhard, NC 27824
Phone: 252-925-7000
Fax: 252-925-7700

Hyde County Department of Social Services
PO Box 220
Swan Quarter, NC 27885
Phone: 252-926-4199
Fax: 252-926-3711

Hyde County Health Department
US 264 E Business
PO Box 100
Swan Quarter, NC 27885
Phone: 252-926-4200
Fax: 252-926-3702

Ocracoke Health Center, Inc.
State-funded rural health center
Highway 12, Back Road
PO Box 543
Ocracoke, NC 27960
Phone: 252-928-1511

Tideland Mental Health Center
MH/DD/SA services
1308 Highland Drive
Washington, NC 27889-3494
Phone: 252-946-8061
Emergency Phone: 800-682-0767
Fax: 252-946-1537

Iredell County

Crossroas Behavioral Healthcare
MH/DD/SA services
200 Business Park Drive
Elkin, NC 28621
Phone: 336-835-1000
Emergency Phone: 888-235-HOPE
Fax: 336-835-1002

Davis Regional Medical Center
Hospital
PO Box 1823
Statesville, NC 28687
Phone: 704-873-0281
Fax: 704-873-9894

Harmony Medical Care PA
Rural health clinic
110 West Memorial Highway
PO Box 316
Harmony, NC 28634
Phone: 704-546-7587

Iredell County Department of Social Services
PO Box 1146
Statesville, NC 28677
Phone: 704-873-5631
Fax: 704-878-5419

Iredell Memorial Hospital, Inc.
PO Box 1828
Statesville, NC 28677
Phone: 704-878-4500
Fax: 704-872-7924

Iredell County Health Department
318 Turnersburg Highway
Statesville, NC 28625
Phone: 704-878-5300
Fax: 704-878-5357

Lake Norman Regional Medical Center
Hospital
PO Box 3250
Mooresville, NC 28117
Phone: 704-660-4010
Fax: 704-660-4049

Mooresville South Iredell Health Assistance Clinic
Free clinic
150 S Church Street
Mooresville, NC 28115
Phone: 704-662-6904

Open Door Clinic
Free clinic
1421 Wilmington Avenue
Statesville, NC 28677
Phone: 704-838-1108

Jackson County

Good Samaritan Clinic of Jackson County
Free clinic
538 Scotts Creek Drive
Sylva, NC 28144
Phone: 828-586-3146

Harris Regional Hospital, Inc.
68 Hospital Road
Sylva, NC 28779-2795
Phone: 828-586-7000
Fax: 828-586-7467

Jackson County Department of Social Services
Community Service Center
538 Scotts Creek Road, Suite 200
Sylva, NC 28779
Phone: 828-586-5546
Fax: 828-586-6270

Jackson County Health Department
538 Scotts Creek Road, Suite 100
Sylva, NC 28779
Phone: 828-586-8994
Fax: 828-631-3617

Smoky Mountain Center for MH/DD/SAS
PO Box 127
Sylva, NC 28779
Phone: 828-586-5501
Emergency Phone: 800-849-6127
Fax: 828-586-3965

Johnston County

Benson Area Medical Center, Inc.
State-funded rural health center
3333 NC Highway 242, N
PO Box 399
Benson, NC 27504
Phone: 919-894-2011
Fax: 919-894-7645

Johnston County Area MH/DD/SA Authority
Highway 301, North
PO Box 411
Smithfield, NC 27577-0411
Phone: 919-989-5500
Fax: 919-989-5532

Johnston County Department of Social Services
PO Box 911
Smithfield, NC 27577
Phone: 919-989-5300
Fax: 919-989-5324

Johnston County Health Department
Primary care services available
517 N Bright Leaf Boulevard
Smithfield, NC 27577
Phone: 919-989-5200
Fax: 919-989-5208

Johnston Family Care Center
Rural health clinic
70 Crape Myrtle Drive, Suite 104
Benson, NC 27504
Phone: 919-938-0260

Johnston Family Care Center
Rural health clinic
400 Englewood Drive
Kenly, NC 27542
Phone: 919-284-4149

Johnston Memorial Hospital
PO Box 1376
Smithfield, NC 27577
Phone: 919-934-8171
Fax: 919-989-7297

Princeton Family Care PA
Rural health clinic
213 Barden Street
Princeton, NC 27569
Phone: 919-936-5171

Jones County

Jones County Department of Social Services
PO Box 250
Trenton, NC 28585
Phone: 252-448-2581
Fax: 252-448-5651

Jones County Health Department
Primary care services available
401 Highway 58, South
Trenton, NC 28585
Phone: 252-448-9111
Fax: 919-448-1443

Neuse Center for MH/DD/SAS
PO Box 1636
New Bern, NC 28563-1636
Phone: 252-636-1510
Fax: 252-633-1237

Lee County

Central Carolina Hospital
1135 Carthage Street
Sanford, NC 27330
Phone: 919-774-2100
Fax: 919-774-2295

Helping Hand Clinic
Free clinic
507 N Steele Street
Sanford, NC 27330
Phone: 919-776-6677

Lee County Department of Social Services
PO Box 1066
Sanford, NC 27330
Phone: 919-718-4690
Fax: 919-718-4634

Lee County Health Department
106 Hillcrest Drive
PO Box 1528
Sanford, NC 27331-1528
Phone: 919-718-4640, Ext 5388
Fax: 919-718-4632

Lee-Harnett Area MH/DD/SA Authority
130 Carbonton Road
Sanford, NC 27330-4009
Phone: 919-774-6521
Emergency Phone: 910-774-4520
Fax: 919-776-6179

Lenoir County

Eastpointe
MH/DD/SA services
117 Beasley Street
PO Box 599
Kenansville, NC 28349-0599
Phone: 910-296-1851
Emergency Phone: 800-513-4002
Fax: 910-296-1731

Junius H. Rose, Jr. Dental Center
Federally qualified health center
324 N Queen Street
PO Box 2278
Kinston, NC 28502-2278
Phone: 252-522-9800

Kinston Community Health Center, Inc.
Federally qualified health center
324 N Queen Street
PO Box 2278
Kinston, NC 28502
Phone: 252-522-9800

Lagrange Medical Center
Rural health clinic
101 S Carey Street
LaGrange, NC 28551
Phone: 252-566-4021

Lenoir County Department of Social Services
PO Box 6
Kinston, NC 28502
Phone: 252-559-6400
Fax: 252-559-6380

Lenoir Memorial Hospital, Inc.
PO Drawer 1678
Kinston, NC 28503-1678
Phone: 252-522-7797
Fax: 252-522-7007

Lenoir County Health Department
201 N Mclewean Street
PO Box 3385
Kinston, NC 28502
Phone: 252-526-4212
Fax: 252-526-4299

Lincoln County

Helping Hands Health Clinic
Free clinic
PO Box 2031
Lincolnton, NC 28093
Phone: 704-735-7145

Lincoln County Department of Social Services
PO Box 130
Lincolnton, NC 28093
Phone: 704-732-0738
Fax: 704-736-8692

Lincoln Medical Center
Hospital
PO Box 677
Lincolnton, NC 28093-0677
Phone: 704-735-3071
Fax: 704-735-0584

Lincoln County Health Department
151 Sigmon Road
Lincolnton, NC 28092-8643
Phone: 704-736-8634
Phone: 704-736-8658
Fax: 704-732-9034

Pathways MH/DD/SA
901 S New Hope Road
Gastonia, NC 28054
Phone: 704-867-2361
Emergency Phone: 704-867-4357
Fax: 704-854-4809

Macon County

Angel Medical Center, Inc.
Hospital
PO Box 1209
Franklin, NC 28744
Phone: 828-524-8411
Fax: 828-369-4162

Angel Urgent Care Center
Rural health clinic
195 Franklin Plaza Drive
Franklin, NC 28734
Phone: 828-369-4427

Highlands-Cashiers Hospital, Inc.
PO Drawer 190
Highlands, NC 28741
Phone: 828-526-1200
Fax: 828-526-1230

Macon County Department of Social Services
5 West Main Street
Franklin, NC 28734
Phone: 828-349-2124
Fax: 828-349-2401

Macon County Health Department
1830 Lakeside Drive
Franklin, NC 28734
Phone: 828-349-2420
Fax: 828-349-2501

Smoky Mountain Center for MH/DD/SAS
PO Box 127
Sylva, NC 28779
Phone: 828-586-5501
Emergency Phone: 800-849-6127
Fax: 828-586-3965

Madison County

Hot Springs Health Program
Rural health clinic
66 NW Highway 25-70
Hot Springs, NC 28743
Phone: 828-622-3245

Hot Springs Medical and Dental Center
State-funded rural health center
66 NW Highway 25-70
PO Box 68
Hot Springs, NC 28743
Phone: 828-622-3245

Laurel Medical Center
State-funded rural health center
80 Gunter Town Road
Marshall, NC 28753
Phone: 828-656-2611

Madison County Department of Social Services
PO Box 219
Marshall, NC 28753
Phone: 828-649-2711
Fax: 828-649-2097

Madison County Health Department
140 Health Care Lane
Marshall, NC 28753
Phone: 828-649-3531
Fax: 828-649-9078

Mars Hill Medical Center
State-funded rural health center
119 Mountain View Road
PO Box 910
Mars Hill, NC 28754
Phone: 828-689-3507

Marshburn Medical Center
State-funded rural health center
590 Medical Park Drive
Marshall, NC 28753
Phone: 828-649-3500

Western Highlands MH/DD/SAS
356 Biltmore Avenue
Asheville, NC 28801
Phone: 828-258-3500
Emergency Phone: 800-951-3792
Fax: 828-252-9584

Martin County

Martin County Department of Social Services
PO Box 809
Williamston, NC 27892
Phone: 252-809-6400
Fax: 252-792-5186

Martin General Hospital
PO Box 1128
Williamston, NC 27892
Phone: 252-809-6179
Fax: 252-809-6263

Martin Tyrell Washington District Health Department
210 West Liberty Street
Williamston, NC 27892
Phone: 252-792-7811
Fax: 252-792-8779

Tideland Mental Health Center
MH/DD/SA services
1308 Highland Drive
Washington, NC 27889-3494
Phone: 252-946-8061
Emergency Phone: 800-682-0767
Fax: 252-946-1537

McDowell County

Foothills Area MH/DD/SA Program
306 S King Street
Morganton, NC 28655
Phone: 828-438-6230
Fax: 828-438-6238
Emergency Phone: 800-942-1797

Health Plus of the McDowell Hospital
Rural health clinic
430 Rankin Drive
Marion, NC 28752
Phone: 828-652-1400

McDowell County Department of Social Services
PO Box 338
Marion, NC 28752
Phone: 828-652-3355
Fax: 828-652-9167

McDowell County Health Department
Rutherford Polk McDowell District
140 Spaulding Road
Marion, NC 28752
Phone: 828-652-6811
Fax 828-652-9376

The McDowell Hospital
PO Box 730
Marion, NC 28752
Phone: 828-659-5000
Fax: 828-652-1626

Mecklenburg County

Carolinas Medical Center Mercy/Pineville
Hospital
2001 Vail Avenue
Charlotte, NC 28207
Phone: 704-379-5000
Fax: 704-379-5695

Carolinas Medical Center/Center for Mental Health
Hospital
PO Box 32861
Charlotte, NC 28232
Phone: 704-355-2000
Fax: 704-355-5073

Carolinas Medical Center - University
Hospital
8800 N Tryon Street
PO Box 560727
Charlotte, NC 28256
Phone: 704-548-6000
Fax: 704-548-6236

Carolinas Specialty Hospital
Seventh Floor, South
Charlotte, NC 28207
Phone: 704-379-5117

Charlotte AHEC-Carolinas HealthCare System
PO Box 32861
Charlotte, NC 28232-2861
Phone: 704-697-6523
Fax: 704-697-6564

Charlotte Community Health Clinic
Free clinic
3040 Eastway Drive
Charlotte, NC 28205
Phone: 704-316-6561

Charlotte Institute of Rehabilitation
Hospital
1100 Blythe Boulevard
Charlotte, NC 28203
Phone: 704-355-4300
Fax: 704-355-4231

Carolinas Medical Center Biddle Point
Hospital outpatient clinic
1801 Rozelles Ferry Road
Charlotte, NC 28208
Phone: 704-446-9987

Carolinas Medical Center Eastland Family Practice
Hospital outpatient clinic
5516 Central Avenue
Charlotte, NC 28212
Phone: 704-446-1000

Carolinas Medical Center Myers Park Pediatrics
Hospital outpatient clinic
1350 S Kings Drive
Charlotte, NC 28207
Phone: 704-446-1422

Carolinas Medical Center NorthPark
Hospital outpatient clinic
251 Eastway Drive
Charlotte, NC 28213
Phone: 704-446-9991

Community Health Services
Free clinic
1401 E 7th Street
Charlotte, NC 28204
Phone: 704-375-0172

CW Williams Health Center
Federally qualified health center
3333 Wilkinson Boulevard
Charlotte, NC 28208
Phone: 704-393-7720

Free Clinic of Our Towns
Free clinic
PO Box 1842
Davidson, NC 28036
Phone: 704-896-0471

Lake Norman Free Clinic
Free clinic
119 Old Statesville Road
Huntersville, NC 28078
Phone: 704-947-1350

Mecklenburg County Area Mental Health Authority
429 Billingsley Road
Charlotte, NC 28211-1098
Phone: 704-336-2023
Emergency Phone: 704-358-2800
Fax: 704-336-4383

Mecklenburg County Department of Social Services
PO Box 220999
Charlotte, NC 28222
Phone: 704-336-3150
Fax: 704-336-3361

Mecklenburg County Health Department
249 Billingsley Road
Charlotte, NC 28211
Phone: 704-432-3199
Fax: 704-432-0217

Mecklenburg Project Access
1112 Harding Place, Suite 200
Charlotte, NC 28204
Phone: 704-376-3688

Metrolina Midtown Medical Office
Federally qualified health center
1918 Randolph Road, Suite 670
Charlotte, NC 28207
Phone: 704-335-0304

Nursing Center for Health Promotion
Free clinic
UNC-Charlotte
9201 University City Boulevard
Charlotte, NC 28223
Phone: 704-687-3180

Presbyterian Hospital
PO Box 33549
Charlotte, NC 28233-3549
Phone: 704-384-4000
Fax: 704-384-4296

Presbyterian Hospital Matthews
PO Box 3310
Matthews, NC 28106
Phone: 704-384-6370
Fax: 704-384-6515

Presbyterian Orthopaedic Hospital
1901 Randolph Road
Charlotte, NC 28207-1101
Phone: 704-375-6792
Fax: 704-370-1444

Presbyterian Specialty Hospital
PO Box 33549
Charlotte, NC 28233-3549
Phone: 704-384-6050
Fax: 704-377-2791

Teen Health Connection
School-linked health center
251 Eastway Drive
Charlotte, NC 28213
Phone: 704-921-6053
Fax: 704-921-6054
Sponsor: Carolinas Health Care

Mitchell County

Bakersville Community Medical Clinic, Inc.
State-funded rural health center
86 N Mitchell Avenue
PO Box 27
Bakersville, NC 28705
Phone: 828-688-4970
Fax: 828-688-4257

Buladean K-8
School-based and family health center
4256 NC 197
Green Mountain, NC 28740
Phone: 828-688-5998
Fax: 828-688-4257
Sponsor: Bakersville Community Medical Clinic

Kalmia Community Health Center, Inc.
Rural health clinic
102 Ridge Road
Spruce Pine, NC 28777
Phone: 704-765-8566

Mitchell County Department of Social Services
PO Box 365
Bakersville, NC 28705
Phone: 828-688-2174
Fax: 828-688-4940

Spruce Pine Community Hospital
PO Drawer 9
Spruce Pine, NC 28777
Phone: 828-765-4201
Fax: 828-765-0824

Spruce Pine Family Medical Center
Rural health clinic, hospital outpatient clinic
496 Altapass Road
Spruce Pine, NC 28777
Phone: 828-765-0330

Tipson Hill K-8
School-based and family health center
4256 NC 197
Green Mountain, NC 28740
Phone: 828-688-5998
Fax: 828-688-4257
Sponsor: Bakersville Community Medical Clinic

Toe River District Health Department
130 Forest Service Drive, Suite A
Bakersville, NC 28705
Phone: 828-688-2371
Fax: 828-688-3866

Toe River Project Access
PO Box 247
Spruce Pine, NC 28777
Phone: 828-766-1750

Western Highlands MH/DD/SAS
356 Biltmore Avenue
Asheville, NC 28801
Phone: 828-258-3500
Emergency Phone: 800-951-3792
Fax: 828-252-9584

Montgomery County

East Montgomery Middle School
School-based health centers
First Health of the Carolinas
181 A Westgate Drive
West End, NC 27376
Phone: 910-572-1979
Sponsor: First Health of the Carolinas

FirstHealth Family Care Center - Mount Gilead
Rural health clinic
206 W Allenton Street
PO Box 1348
Mount Gilead, NC 27306
Phone: 910-439-6695
Fax: 910-439-1130

FirstHealth Family Care Center - Seven Lakes
Rural health clinic
1035 C Seven Lakes
PO Box 789
West End, NC 27376
Phone: 910-673-0045

FirstHealth Family Care Center - Star
Rural health clinic
128 Okeeweemee Road
Star, NC 27356
Phone: 910-428-1111
Fax: 910-428-2506

FirstHealth Family Care Center - Troy
Rural health clinic
522 Allen Street, Suite 101
Troy, NC 27371
Phone: 910-571-5510
Fax: 910-571-5535

FirstHealth Family Care Center - Troy Immediate Care
Rural health clinic
522 Allen Street, Suite 202
Troy, NC 27371
Phone: 910-571-5510
Fax: 910-571-5535

FirstHealth Montgomery Memorial Hospital
PO Box 486
Troy, NC 27371
Phone: 910-572-1301
Fax: 910-572-4140

Montgomery County Department of Social Services
Drawer N
Troy, NC 27371
Phone: 910-576-6531
Fax: 910-576-5016

Montgomery County Health Department
Primary care services available
217 South Main Street
Troy, NC 27371
Phone: 910-572-1393
Fax: 910-572-8177

Mount Gilead Medical Services
Rural health clinic
202 North Main Street
PO Box 1256
Mount Gilead, NC 27306
Phone: 910-439-1573
Fax: 910-439-1773

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Emergency Phone: 800-256-2452
Fax: 910-673-6202

Troy Medical Services
Rural health clinic
835 Albemarle Road
Troy, NC 27371
Phone: 910-572-2309

Uwharrie Family Health Care PA
Rural health clinic
104 Professional Drive
PO Box 429
Biscoe, NC 27209
Phone: 910-428-9607

West Montgomery Middle School
School-based health centers
First Health of the Carolinas
181 A Westgate Drive
West End, NC 27376
Phone: 910-572-1979
Sponsor: First Health of the Carolinas

Moore County

FirstHealth Moore Regional Hospital and Pinehurst Treatment
PO Box 3000
Pinehurst, NC 28374
Phone: 910-215-1000
Fax: 910-215-1444

Moore County Department of Social Services
PO Box 938
Carthage, NC 28327
Phone: 910-947-2436

Moore County Health Department
705 Pinehurst Avenue
PO Box 279
Carthage, NC 28327
Phone: 910-947-3300
Fax: 910-947-1663

Moore Family Care Center
Rural health clinic
304 Saunders Street
PO Box 568
Carthage, NC 28327
Phone: 910-947-3000

Moore Free Care Clinic
Other non-profit safety net provider
PO Box 1656
Carthage, NC 28327
Phone: 910-947-6550
Fax: 910-947-6551

MooreHealth, Inc.
FirstHealth of the Carolinas
HCAP grantee, other non-profit safety net provider
30 Page Drive
PO Box 3000
Pinehurst, NC 28374
Phone: 910-215-1563
Fax: 910-215-5054

Moore Regional Hospital, FirstHealth of the Carolinas
Hospital outpatient clinic
155 Memorial Drive
Pinehurst, NC 28374
Phone: 910-215-1000

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Emergency Phone: 800-256-2452
Fax: 910-673-6202

Nash County

Area L AHEC
PO Drawer 7368
Rocky Mount, NC 27804-0368
Phone: 252-972-6958
Fax: 252-972-0419

Edgecombe-Nash MH/DD/SAS
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 252-937-8141
Emergency Phone: 888-893-8640
Fax: 252-443-9574

Harvest Family Health Center
Federally qualified health center
9088 Old Bailey Highway
Spring Hope, NC 27882
Phone: 252-237-9383

LifeCare Hospitals of North Carolina
1031 Noell Lane
Rocky Mount, NC 27804
Phone: 252-451-2300
Fax: 252-451-2301

Nash County Department of Social Services
PO Drawer 819
Nashville, NC 27856
Phone: 252-459-9818
Fax: 252-459-9833

Nash General Hospital
2460 Curtis Ellis Drive
Rocky Mount, NC 27804
Phone: 252-443-8070
Fax: 252-443-8877

Nash County Health Department
214 South Barnes Street
PO Box 849
Nashville, NC 27856
Phone: 252-459-9819
Fax: 252-459-9834

Sharpsburg Family Medicine
Rural health clinic
9201 County Line Road
PO Box 27878
Sharpsburg, NC 27878
Phone: 252-446-5755

Whitakers Medical Center
Rural health clinic
106 SE Railroad Street
PO Box 760
Whitakers, NC 27891
Phone: 252-437-2171

New Hanover County

Coastal AHEC
2131 South 17th Street
Wilmington, NC 28402
Phone: 910-343-0161
Fax: 910-762-9203

Lakeside High School
School-based health center
4005 Oleander Drive
Wilmington, NC 28403
Phone: 910-790-9949
Fax: 910-790-9996
Sponsor: Wilmington Health Access for Teens, Inc.

New Hanover Community Health Center, Inc.
Federally qualified health center
925 North Fourth Street
Wilmington, NC 28401
Phone: 910-343-0270

New Hanover County Department of Social Services
PO Drawer1559
Wilmington, NC 28402
Phone: 910-341-4700
Fax: 910-341-4022

New Hanover County Health Department
2029 South 17th Street
Wilmington, NC 28401
Phone: 910-343-6591
Fax: 910-341-4146

New Hanover High School
School-based health center
4005 Oleander Drive
Wilmington, NC 28403
Phone: 910-790-9949
Fax: 910-790-9996
Sponsor: Wilmington Health Access for Teens, Inc.

New Hanover Regional Medical Center
Hospital
2228 S 17th Street
Fiscal Services
Wilmington, NC 28401
Phone: 910-343-7040
Fax: 910-343-7220

Southeastern Center for MH/DD/SAS
PO Box 1230
Wilmington, NC 28402-1230
Phone: 910-251-6440
Emergency Phone: 910-251-6551
Fax: 910-796-3133

Tileston Outreach Health Center
Free clinic
412 Anne Street
Wilmington, NC 28401
Phone: 910-343-8736

Wilmington Health Access for Teens
School-linked health center
4005 Oleander Drive
Wilmington, NC 28403
Phone: 910-790-9949
Fax: 910-790-9996
Sponsor: Wilmington Health Access for Teens, Inc.

Northampton County

Northampton County Department of Social Services
PO Box 157
Jackson, NC 27845
Phone: 252-534-5811
Fax: 252-534-0061

Northampton County Health Department
9495 NC Highway 305
PO Box 635
Jackson, NC 27845
Phone: 252-534-5841
Direct: 252-574-0208

Rich Square Medical Center, Inc.
State-funded rural health center
265 S Main Street
PO Box 710
Rich Square, NC 27869
Phone: 252-539-2082

Roanoke Amaranth Community Health Group, Inc.
Federally qualified health center
1213 N Church Street
Jackson, NC 27845
Phone: 252-534-1661

Roanoke-Chowan Human Services Center
MH/DD/SA Services
144 Community College Road
Ahoskie, NC 27910-9320
Phone: 252-332-4137
Emergency Phone: 252-332-4442
Fax: 252-332-8457

Wildwood Medical Clinic
Rural health clinic
2053 River Road
PO Box 392
Henrico, NC 27842
Phone: 252-537-9176

Onslow County

Caring Community Clinic
Free clinic
615 College Street
Jacksonville, NC 28540
Phone: 910-938-1688

Onslow County Behavioral Healthcare
MH/DD/SA services
165 Center Street
Jacksonville, NC 28546
Phone: 910-219-8000
Emergency Phone: 910-353-5118
Fax: 910-219-8072

Onslow County Department of Social Services
PO Box 1379
Jacksonville, NC 28541
Phone: 910-455-4145
Fax: 910-455-2901

Onslow Memorial Hospital
PO Box 1358
Jacksonville, NC 28541-1358
Phone: 910-577-2345
Fax: 910-577-4741

Onslow County Health Department
612 College Street
Jacksonville, NC 28540
Phone: 910-347-7042
Fax: 910-347-7941

Penslow Medical Center
Rural health clinic
206 North Dyson Street
Holly Ridge, NC 28445
Phone: 910-329-7591

Swansboro Medical Center PA
Rural health clinic
718 W Corbett Avenue
Swansboro, NC 28584
Phone: 910-326-5588

Orange County

Orange-Person-Chatham MH/DD/SA Authority
100 Europa Drive, Suite 490
Chapel Hill, NC 27517
Phone: 919-913-4000
Emergency Phone: 800-233-6834
Fax: 919-913-4001

Orange County Department of Social Services
300 West Tryon Street
Hillsborough, NC 27278
Phone: 919-732-8181
Fax: 919-644-3005

Orange County Health Department
300 West Tryon Street
Hillsborough, NC 27278
Phone: 919-245-2411, Ext 2412
Fax: 919-644-3007

Piedmont Womens Health Center
Federally qualified health center
930 Airport Road
Chapel Hill, NC 27514
Phone: 919-933-3301

Student Health Action Coalition, UNC School of Medicine
Free clinic
065 McNider
CB#7000
Chapel Hill, NC 27599
Phone: 919-843-6841

University of North Carolina Hospitals
Hospital outpatient clinic
101 Manning Drive
Chapel Hill, NC 27514
Phone: 919-966-4131
Fax: 919-966-3709

Pamlico County

HOPE Clinic
Free clinic
203 N Street
PO Box 728
Bayboro, NC 28515
Phone: 252-745-5760

Neuse Center for MH/DD/SAS
PO Box 1636
New Bern, NC 28563-1636
Phone: 252-636-1510
Fax: 252-633-1237

Pamlico County Department of Social Services
PO Box 395
Bayboro, NC 28515
Phone: 252-745-4086
Fax: 252-745-7384

Pamlico County Health Department
203 North Street
PO Box 306
Bayboro, NC 28515
Phone: 252-670-5017
Fax: 252-745-7684

Pasquotank County

Albemarle Hospital
PO Box 1587
Elizabeth City, NC 27906-1587
Phone: 252-384-4600
Fax: 252-331-4677

Albemarle Mental Health Center & Development Disabilities and Substance Abuse Services
305 E Main Street
Elizabeth City, NC 27906
Phone: 252-335-0803
Emergency Phone: 888-627-4747
Fax: 252-335-9143

Albemarle Regional Health Services
Multi-county health department, primary care services available
711 Roanoke Avenue
PO Box 189
Elizabeth City, NC 27907
Phone: 252-338-4404
Fax: 252-338-4449

Coastal Rehabilitation, Inc.
Rural health clinic
101 Medical Drive
Elizabeth City, NC 27909
Phone: 252-338-2114
Fax: 252-328-2115

Community Care Clinic
Free clinic
PO Box 1412
Elizabeth City, NC 27909
Phone: 252-337-6773

Pasquotank County Department of Social Services
PO Box 159
Elizabeth City, NC 27907
Phone: 252-338-2126
Fax: 252-338-7512

Pender County

Black River Family Practice
State-funded rural health center
301 S Campbell Street
PO Box 1488
Burgaw, NC 28425
Phone: 910-259-5721

Black River Health Services
State-funded rural health center
126 W Main Street
Atkinson, NC 28421
Phone: 910-259-6973

Homestead Health Center
Federally qualified health center
5345 Eleanor Roosevelt Lane
Willard, NC 28478
Phone: 910-285-0400
Fax: 910-285-0772

Maple Hill Medical Center
State-funded rural health center
4811 NC Highway 53
Maple Hill, NC 28454
Phone: 910-259-6444

Pender County Department of Social Services
PO Drawer 1207
Burgaw, NC 28425
Phone: 910-259-1240
Fax: 910-259-1418

Pender Memorial Hospital, Inc.
507 E Fremont Street
Burgaw, NC 28425
Phone: 910-259-5451
Fax: 910-259-6182

Pender County Health Department
Primary care services available
803 S Walker Street
PO Box 1209
Burgaw, NC 28425
Phone: 910-259-1230
Fax: 910-259-1258

Southeastern Center for MH/DD/SAS
PO Box 1230
Wilmington, NC 28402-1230
Phone: 910-251-6440
Emergency Phone: 910-251-6551
Fax: 910-796-3133

Perquimans County

Albemarle Mental Health Center & Development Disabilities and Substance Abuse Services
305 E Main Street
Elizabeth City, NC 27906
Phone: 252-335-0803
Emergency Phone: 888-627-4747
Fax: 252-335-9143

Albemarle Regional Health Services
Multi-county health department
103 Charles Street
Hertford, NC 27944
Phone: 252-426-2100
Fax: 252-426-2126

Perquimans County Department of Social Services
PO Box 107
Hertford, NC 27944
Phone: 252-426-7373
Fax: 252-426-1788

Person County

Orange-Person-Chatham MH/DD/SA Authority
100 Europa Drive, Suite 490
Chapel Hill, NC 27517
Phone: 919-913-4000
Fax: 919-913-4001
Emergency Phone: 800-233-6834

Person County Department of Social Services
PO Box 770
Roxboro, NC 27573
Phone: 336-599-8361
Fax: 336-597-9339

Person County Health Department
325 South Morgan
Roxboro, NC 27573
Phone: 336-597-2204, Ext 241
Fax: 336-597-4804

Person Family Medical Center, Inc.
Federally qualified health center
702 North Main Street
PO Box 350
Roxboro, NC 27573
Phone: 336-599-9271

Person Memorial Hospital
615 Ridge Road
Roxboro, NC 27573
Phone: 336-599-2121
Fax: 336-503-5765

Pitt County

Eastern AHEC
PO Drawer 7224
Greenville, NC 27835-7224
Phone: 252-744-8214
Fax: 252-744-8596

Greenville Community Shelter Clinic
Free clinic
1600 Chestnut Street
PO Box 8322
Greenville, NC 27834
Phone: 252-758-9244

Health Assist
HCAP grantee, Project Access program, free clinic
PO Box 6028
Greenville, NC 27835-6028
Phone: 252-816-7016

JR Harvey Health Resource Center
Federally qualified health center
202 Queen Street
Grifton, NC 28530
Phone: 252-524-3475

Pactolus Community Resource Center
Federally qualified health center
5866 Hwy 264, E
Greenville, NC 27834
Phone: 252-752-2319

Pitt County Department of Social Services
1717 W Fifth Street
Greenville, NC 27834
Phone: 252-413-1101
Fax: 252-413-1252

Pitt County Health Department
201 Government Circle
Greenville, NC 27834
Phone: 252-902-2300
Fax: 252-413-1446

Pitt County Indigent Care Clinic
Free clinic
1413 SE Greenville Boulevard
Greenville, NC 27858
Phone: 252-758-2678

Pitt County Memorial Hospital
Hospital outpatient clinic
2100 Stantonsburg Road
PO Box 6028
Greenville, NC 27835
Phone: 252-816-4100
Fax: 252-816-5147

Pitt County MH/DD/SA Center
203 Government Circle
Greenville, NC 27834-7706
Phone: 252-413-1600
Fax: 252-413-1606

Polk County

Foothills Medical Associates
Rural health clinic
301 W Mills Street
PO Box 8
Columbus, NC 28722
Phone: 828-894-5627

Polk County Department of Social Services
500 Carolina Avenue
Tryon, NC 28782
Phone: 828-859-5825
Fax: 828-859-9703

Rutherford Polk McDowell District Health Department
221 Callahan Koon Road
Spindale, NC 28160
Phone: 828-894-8271
Fax 828-894-8678

Saluda Medical Center, Inc.
State-funded rural health center
86 Greenville Street
PO Box 577
Saluda, NC 28773
Phone: 828-749-4411

St. Luke's Hospital
101 Hospital Drive
Columbus, NC 28722
Phone: 828-894-3311
Fax: 828-894-2155

Western Highlands MH/DD/SAS
356 Biltmore Avenue
Asheville, NC 28801
Phone: 828-258-3500
Emergency Phone: 800-951-3792
Fax: 828-252-9584

Randolph County

Merce Clinic
State-funded rural health center
1831 N Fayetteville Street
PO Box 4248
Asheboro, NC 27204
Phone: 336-672-1300

Randolph County Department of Social Services
PO Box 3239
Asheboro, NC 27204
Phone: 336-683-8000
Fax: 336-683-8131

Randolph County Health Department
2222 B South Fayetteville Street
Asheboro, NC 27203
Phone: 336-318-6217
Fax: 336-318-6234

Randolph Hospital, Inc.
PO Box 1048
Asheboro, NC 27204-1048
Phone: 336-625-5151
Fax: 336-626-7664

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Emergency Phone: 800-256-2452
Fax: 910-673-6202

Seagrove Medical Clinic
Rural health clinic
614 N Broad Street
Seagrove, NC 27341
Phone: 336-873-7248

Richmond County

FirstHealth Richmond Memorial Hospital
925 Long Drive
Rockingham, NC 28379
Phone: 910-417-3000
Fax: 910-417-3709

FirstHealth Family Care Center - Ellerbe
Rural health clinic
12 E Ballard Street
Ellerbe, NC 28338
Phone: 910-652-2663
Fax: 910-652-3150

Hermitage Retirement Center
Federally qualified health center
139 Mallard Lane
Rockingham, NC 28379-5203
Phone: 910-895-0750

Richmond County Department of Social Services
PO Box 518
Rockingham, NC 28379
Phone: 910-997-8400
Fax: 910-997-8447

Richmond County Health Department
127 Caroline Street
Rockingham, NC 28379
Phone: 910-997-8365
Fax: 910-417-4924

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Emergency Phone: 800-256-2452
Fax: 910-673-6202

Sandhills Regional Medical Center
Hospital
PO Box 1109
Hamlet, NC 28345
Phone: 910-205-8000
Fax: 910-205-8107

Robeson County

Arthur L. Bradford, MD, PA
Rural health clinic
123 E Broad Street
St. Pauls, NC 28384
Phone: 910-865-5177

Child Health Plus Bus
School-linked health center
Robeson Co. Health Department
Phone: 910-671-3281
Sponsor: Robeson County Health Department

CI Smith Family Dental Practice
Federally qualified health center
800 S Martin Luther King, Jr. Drive
Lumberton, NC 28358
Phone: 910-738-4770

AJ Robinson Medical Clinic
Rural health clinic
800 S Martin Luther King, Jr. Drive
Lumberton, NC 28359
Phone: 910-738-3957

Express Medical Center
Rural health clinic
229 S Main Street
Red Springs, NC 28377
Phone: 910-843-9991

Fairmont Medical Clinic
Rural health clinic
101 N Walnut Street
Fairmont, NC 28340
Phone: 910-628-0655

Greenbrier
Federally qualified health center
703 S Walnut Street
Fairmont, NC 28340-1848
Phone: 910-628-9021

Hope Retirement Village
Federally qualified health center
104 Hope Lane
Red Springs, NC 28377
Phone: 910-843-5461

Johnson Medical Clinic
Rural health clinic
220 S Main Street
Red Springs, NC 28377
Phone: 910-843-4576

Julian T Pierce Health Center
Federally qualified health center
East Wardell Drive
PO Box 1629
Pembroke, NC 28372
Phone: 910-521-2816

Leisure Living
Federally qualified health center
Gerome Street
Lumberton, NC 28358-6025
Phone: 910-739-7592

Lumberton Family Medical Center
Rural health clinic
585 Farringdom Street
Lumberton, NC 28358
Phone: 910-671-0052

Lumberton Health Center
Federally qualified health center
901 North Chestnut Street
Lumberton, NC 28358
Phone: 910-739-1666

Maxton Family Practice Center
Rural health clinic
1001 W Martin Luther King, Jr. Drive
PO Box 907
Maxton, NC 28364
Phone: 910-521-4462

Maxton Medical Center
Federally qualified health center
610 E Martin Luther King, Jr. Drive
Maxton, NC 28364
Phone: 910-844-5253
Fax: 910-844-3716

Parkton Family Medical Center
Rural health clinic
101 W Third Street
Parkton, NC 28371
Phone: 910-858-3913

Pembroke Family Practice Center
Rural health clinic
410-D S Jones Street
PO Box 2349
Pembroke, NC 28372
Phone: 910-521-4462

Pembroke Medical Center PA
Rural health clinic
102 S Main Street
PO Box 3609
Pembroke, NC 28372
Phone: 910-521-0510

Riverquest Medical Care
Rural health clinic
258 Lowe Road
Lumberton, NC 28360
Phone: 910-735-1234

Robeson County Department of Social Services
435 Caton Road
Lumberton, NC 28358
Phone: 910-671-3500
Fax: 910-671-3092

Robeson County Health Department
Primary care services available
460 Country Club Road
Lumberton, NC 28360
Phone: 910-671-3200
Fax: 910-671-3484

Rosemont Rest Home
Federally qualified health center
602 Glendale Avenue
Lumberton, NC 28358-6724
Phone: 910-738-9287

Rowland Medical Clinic
Rural health clinic
102 N Bond Street
Rowland, NC 28383
Phone: 910-422-3350

Sampson's Rest Home
Federally qualified health center
901 Goins Road
Pembroke, NC 28372
Phone: 910-521-8544

Scotland Memorial Hospital, Inc. Family Practice Center
Rural health clinic
2362 NC Highway 130, West
Rowland, NC 28383
Phone: 910-422-8811

Shoeheel Medical Arts
Rural health clinic
102 Pine Street
Maxton, NC 28364
Phone: 910-844-5681

South Robeson Medical Center
Federally qualified health center
1212 South Walnut Street
Fairmont, NC 28340
Phone: 910-628-6711

Southeastern Regional Medical Center
Hospital
PO Box 1408
Lumberton, NC 28359
Phone: 910-671-5000
Fax: 910-671-5200

Southeastern Regional MH/DD/SA Services
2003 Godwin Avenue
Lumberton, NC 28358-2901
Phone: 910-738-5261
Emergency Phone: 800-672-8255
Fax: 910-738-8230

St Pauls Medical Clinic
Rural health clinic
128 East Broad Street
St. Pauls, NC 28384
Phone: 910-865-5955

Rockingham County

Annie Penn Hospital
618 South Main Street
Reidsville, NC 27320
Phone: 336-951-4000
Fax: 336-951-4561

Free Clinic of Reidsville and Vicinity, Inc.
Free clinic
315 South Main Street
PO Box 2668
Reidsville, NC 27323-2668
Phone: 336-349-3220

Morehead Memorial Hospital
117 East Kings Highway
Eden, NC 27288
Phone: 336-623-9711
Fax: 336-623-7660

Rockingham County Area MH/DD/SA Program
405 NC 65
PO Box 355
Wentworth, NC 27375-0355
Phone: 336-342-8316
Emergency Phone: 336-634-3300
Fax: 336-342-8352

Rockingham County Department of Social Services
PO Box 361
Wentworth, NC 27375
Phone: 336-342-1394
Fax: 336-634-1847

Rockingham County Health Department
Primary care services available
371 NC 65
PO Box 204
Wentworth, NC 27375-8881
Phone: 336-342-8143
Fax: 336-342-8356

Rockingham County Prescription Assistance Program
Free clinic (pharmacy only)
105 Lawsonville Avenue
Reidsville, NC 27323
Phone: 336-349-2343

Rockingham County Student Health Center
School-based health center
117 E Kings Highway
Eden, NC 27288
Phone: 336-623-9711, Ext 2341
Fax: 336-623-2434
Sponsor: Morehead Memorial Hospital

Rowan County

Community Care Clinic of Rowan County
Free clinic
315-G Mocksville Avenue
Salisbury, NC 28144
Phone: 704-636-4523

Good Shepard's Clinic
Free clinic
120 North Jackson Street
Salisbury, NC 28144
Phone: 704-636-7200

Piedmont Behavioral Healthcare
MH/DD/SA services
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010

Rowan County Department of Social Services
1236 West Innes Street
Salisbury, NC 28144
Phone: 704-633-4921
Fax: 704-638-3041

Rowan County Health Department
Primary care services available
1811 East Innes Street
Salisbury, NC 28146
Phone: 704-638-2900
Fax: 704-638-312

Rowan Regional Medical Center
Hospital
612 Mocksville Avene
Salisbury, NC 28144
Phone: 704-210-5000
Fax: 704-210-5562

Rutherford County

James Medical Clinic
Rural health clinic
Highway 221 A
PO Box 519
Caroleen, NC 28019
Phone: 828-657-5371

Rutherford County Department of Social Services
PO Box 237
Spindale, NC 28160
Phone: 828-287-6199
Fax: 828-287-6350

Rutherford East Medical Service
Rural health clinic
605 NC Highway 120
Mooresboro, NC 28114
PO Box 700
Ellenboro, NC 28040
Phone: 828-453-0703

Rutherford Hospital, Inc.
288 South Ridgecrest Avenue
Rutherfordton, NC 28139
Phone: 828-286-5000
Fax: 828-286-5207

Rutherford Polk McDowell District Health Department
221 Callahan-Koone Road
Spindale, NC 28160
Phone: 828-287-6620
Fax 828-287-6314

Senior Care Pharmacy
Free clinic (pharmacy only)
193 Callahan-Koon Road
Spindale, NC 28160
Phone: 828-286-4222

Western Highlands MH/DD/SAS
356 Biltmore Avenue
Asheville, NC 28801
Phone: 828-258-3500
Emergency Phone: 800-951-3792
Fax: 828-252-9584

Sampson County

Carolina Pines Community Health Center
Federally qualified health center
500 South Fayetteville Street
Salemburg, NC 28382
Phone: 910-525-5515

Eastpointe
MH/DD/SA services
117 Beasley Street
PO Box 599
Kenansville, NC 28349-0599
Phone: 910-296-1851
Emergency Phone: 800-513-4002
Fax: 910-296-1731

Four County Medical Center
State-funded rural health center
194 Tomahawk Highway
PO Box 89
Harrells, NC 28444
Phone: 919-532-4106

Garland Medical Center
Rural health clinic
105 S Lisbon Avenue
PO Box 398
Garland, NC 28441
Phone: 910-529-1827

Goshen Medical Center, Inc.
Federally qualified health center
444 Southwest Center Street
PO Box 187
Faison, NC 28341
Phone: 910-267-1942

Newton Grove Medical Center (Dental)
State-funded rural health center
301 N Main Street
PO Box 182
Newton Grove, NC 28366
Phone: 910-594-1063

Roseboro Medical Clinic, Sampson Regional Medical Center
Rural health clinic, hospital outpatient clinic
304 W Fayetteville Street
Roseboro, NC 28382
Phone: 910-525-5055

Sampson County Department of Social Services
PO Box 1105
Clinton, NC 28328
Phone: 910-592-7131
Fax: 910-592-4297

Sampson County Health Department
360 County Complex Road
Clinton, NC 28328
Phone: 910-592-1131
Fax: 910-592-1901

Sampson Regional Medical Center
Hospital
PO Box 260
Clinton, NC 28329-0260
Phone: 910-592-8511
Fax: 910-590-2321

Tri-County Community Health
Federally qualified health center
3331 Easy Street
PO Box 227
Newton Grove, NC 28366
Phone: 910-567-6194

Scotland County

Laurel Hill Medical Clinic
Rural health clinic
18901 Ida Mill Road
PO Box 797
Laurel Hill, NC 28351
Phone: 910-462-2707

Scotland County Department of Social Services
PO Box 1647
Laurinburg, NC 28353
Phone: 910-277-2500
Fax: 910-277-2402

Scotland Memorial Hospital and Edwin Morgan Center
500 Lauchwood Drive
Laurinburg, NC 28352
Phone: 910-291-7000
Fax: 910-291-7499

Scotland Memorial Hospital Wagram Family Practice Center
Rural health clinic
24420 Marlboro Street
Wagram, NC 28396
Phone: 910-369-3136

Scotland County Health Department
1405 West Boulevard
PO Box 69
Laurinburg, NC 28352
Phone: 910-277-2440
Fax: 910-277-2450

Scotland Urgent Care Center
Rural health clinic
205F Lauchwood Drive
Laurinburg, NC 28352
Phone: 910-277-8300

Southeastern Regional MH/DD/SA Services
2003 Godwin Avenue
Lumberton, NC 28358-2901
Phone: 910-738-5261
Emergency Phone: 800-672-8255
Fax: 910-738-8230

Stanly County

Community Care Clinic
Free clinic
220 Yadkin Street
Albemarle, NC 28001
Phone: 704-982-6640
Fax: 704-982-1320

Locust Medical Services
Rural health clinic
501 N Central Avenue
Locust, NC 28097
Phone: 704-888-0580

Oakboro Medical Services
Rural health clinic
223 W Third Street
Oakboro, NC 28129
Phone: 704-485-3319

Piedmont Behavioral Healthcare
MH/DD/SA services
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010

Stanly County Department of Social Services
1000 N First Street, Suite 2
Albemarle, NC 28001
Phone: 704-982-6100
Fax: 704-983-5818

Stanly Memorial Hospital
PO Box 1489
Albermarle, NC 28002
Phone: 704-984-4347
Fax: 704-983-3562

Stanly County Health Department
Primary care services available
1000 N First Street, Suite 3
Albemarle, NC 28001
Phone: 704-986-3000
Fax: 704-982-8354

West Stanly Medical Center
Rural health clinic
210 W Main Street
PO Box 189
Locust, NC 28097
Phone: 704-888-6156

Stokes County

CenterPoint Human Services
MH/DD/SA services
4045 University Parkway
Winston-Salem, NC 27106
Phone: 336-714-9100
Emergency Phone: 888-581-9988
Fax: 336-714-9111

King Medical Center
Rural health clinic
617 East King Street
King, NC 27021
Phone: 336-983-3113

Stokes County Department of Social Services
PO Box 30
Danbury, NC 27016
Phone: 336-593-2861
Fax: 336-593-9362

Stokes County Health Department
Primary care services available
Highways 8 & 89
PO Box 187
Danbury, NC 27016
Phone: 336-593-2400
Fax: 336-593-3511

Stokes Dental Center
Federally qualified health center
Chimney Rock Road
Hendersonville, NC 28739
Phone: 828-696-0512

Stokes-Reynolds Memorial Hospital, Inc.
PO Box 10
Danbury, NC 27016
Phone: 336-593-2831
Fax: 336-593-5350

Westfield Medical Center
Rural health clinic
6740 Westfield Road
PO Box 62
Westfield, NC 27053
Phone: 336-351-3102

Surry County

Crossroads Behavioral Healthcare
MH/DD/SA services
200 Business Park Drive
Elkin, NC 28621
Phone: 336-835-1000
Emergency Phone: 888-235-4673
Fax: 336-835-1002

Dobson Medical Center
Rural health clinic
220 West Kapp Street
Dobson, NC 27017
Phone: 336-386-8270

Health Plus by Nurse Practitioners
Rural health clinic
835 Highway 52, North
Mount Airy, NC 27030
Phone: 336-789-6503
Fax: 336-789-6687

Hugh Chatham Memorial Hospital, Inc.
PO Box 560
Elkin, NC 28621-0560
Phone: 336-527-7000
Fax: 336-835-9262

Northern Hospital of Surry County
PO Box 1101
Mount Airy, NC 27030
Phone: 336-719-7100
Fax: 336-789-3470

Surry County Department of Social Services
118 Hamby Road
Dobson, NC 27017
Phone: 336-401-8700

Surry County Health Department
Primary care services available
118 Hambry Road
Dobson, NC 27017
Phone: 336-401-8411
Fax: 336-401-8599

Surry Medical Ministries Clinic
Free clinic
813 Rockford Street
PO Box 349
Mount Airy, NC 27030
Phone: 336-789-5058

Swain County

Smoky Mountain Center for MH/DD/SAS
PO Box 127
Sylva, NC 28779
Phone: 828-586-5501
Emergency Phone: 800-849-6127
Fax: 828-586-3965

Swain County Department of Social Services
PO Box 610
Bryson City, NC 28713
Phone: 828-488-6921
Fax: 828-488-8271

Swain County Health Department
100 Teptal Terrace
Bryson City, NC 28713
Phone: 828-488-3198
Fax: 828-488-8672

Swain County Hospital
45 Plateau Street
Bryson City, NC 28713
Phone: 828-488-2155
Fax: 828-488-4039

Swain Medical Center
Rural health clinic
45 Plateau Street
Bryson City, NC 28713
Phone: 828-488-4205

Transylvania County

Transylvania Community Hospital and Bridgeway
PO Box 1116
Brevard, NC 28712
Phone: 828-883-5302
Fax: 828-883-5370

Transylvania County Department of Social Services
207 S Broad Street
Brevard, NC 28712
Phone: 828-884-3174
Fax: 828-884-3263

Transylvania County Health Department
Community Services Building
203 East Morgan Street
Brevard, NC 28712
Phone: 828-884-3135
Fax: 828-884-3140

Transylvania County Volunteers in Medicine
Free clinic
248 S Caldwell Street
PO Box 1303
Brevard, NC 28712
Phone: 828-883-4454

Western Highlands MH/DD/SAS
356 Biltmore Avenue
Asheville, NC 28801
Phone: 828-258-3500
Emergency Phone: 800-951-3792
Fax: 828-252-9584

Tyrrell County

Martin Tyrell Washington District Health Department
408 Broad Street
PO Box 238
Columbia, NC 27925
Phone: 252-796-2681
Fax: 252-796-0818

The Columbia Medical Center
State-funded rural health center
208 North Broad Street
PO Box 189
Columbia, NC 27925
Phone: 252-796-0689

Tideland Mental Health Center
1308 Highland Drive
Washington, NC 27889-3494
Phone: 252-946-8061
Emergency Phone: 800-682-0767
Fax: 252-946-1537

Tyrrell County Department of Social Services
PO Box 449
Columbia, NC 27925
Phone: 252-796-3421
Fax: 252-796-1732

Union County

Family Medical Center
Rural health clinic
303 Old Highway 74
Marshville, NC 28103
Phone: 704-624-3790

First Care Medical Clinic
Rural health clinic
404 S Sutherland Avenue
Monroe, NC 28110
Phone: 704-291-9267
Fax: 704-291-2147

HealthQuest of Union County
Free clinic
412 East Franklin Street
Monroe, NC 28112-5600
Phone: 704-226-2050
Fax: 704-226-0712

Monroe Urgent Care
Rural health clinic
613 E Roosevelt Boulevard
Monroe, NC 28112
Phone: 704-283-8193
Fax: 704-283-7252

Piedmont Behavioral Healthcare
MH/DD/SA services
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010

Union County Department of Social Services
PO Box 489
Monroe, NC 28111
Phone: 704-296-4300
Fax: 704-296-6151

Union County Health Department
Primary care services available
1224 West Roosevelt Boulevard
Monroe, NC 28110
Phone: 704-296-4800
Fax: 704-296-4807

Union Regional Medical Center
Hospital
PO Box 5003
Monroe, NC 28111
Phone: 704-283-3100
Fax: 704-296-4175

Vance County

Convenient Care Center
Rural health clinic
566 Ruin Creek Road
Henderson, NC 27536
Phone: 704-283-3100

Four County Health Network
Project Access program
511 Ruin Creek Road, Suite B-1
Henderson, NC 27536
Phone: 252-430-0360
Fax: 252-430-8980

Granville Vance District Health Department
115 Charles Rollins Road
Henderson, NC 27536
Phone: 252-492-7915
Fax: 252-492-4219

Maria Parham Hospital Medical Center
PO Box 59
Henderson, NC 27536
Phone: 252-436-1100
Fax: 252-438-3690

Vance County Department of Social Services
2035 Ruin Creek Road
Henderson, NC 27536
Phone: 252-492-5001
Fax: 252-438-5997

Vance Family Medicine
Rural health clinic
568 Ruin Creek Road
Suite 128
Henderson, NC 27536
Phone: 252-438-7102

Vance Granville Franklin Warren Area Authority
MH/DD/SA services
134 S Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Emergency Phone: 877-619-3761
Fax: 252-430-0909

Vance-Warren Comprehensive Health Center
Federally qualified health center
1 Opportunity Drive
Soul City, NC 27553
Phone: 252-456-2181

Wake County

Apex Family Medicine
Federally qualified health center
212 South Salem Street
Apex, NC 27502
Phone: 919-362-5201

Carolina Women's Medical Clinic
Hospital
3301 Executive Drive
Raleigh, NC 27611-8280
Phone: 919-954-3000
Fax: 919-954-3900

Community Mental Health Clinic
Free clinic
228 West Edenton Street
Raleigh, NC 27603
Phone: 919-779-3979

Horizon Health Center
Federally qualified health center
102 N Tarboro Road
Raleigh, NC 27610
Phone: 919-743-3315

New Bern Avenue Medical & Dental Center
Federally qualified health center
2620 New Bern Avenue
Raleigh, NC 27610
Phone: 919-319-4770

Open Door Clinic, Urban Ministries of Raleigh
Free clinic
840 Semart Drive
PO Box 26476
Raleigh, NC 27611
Phone: 919-832-0820

Project Access Program of Wake County
2500 Blue Ridge Road, Suite 312
Raleigh, NC 27607
Phone: 919-783-0404

Rex Hospital
4420 Lake Boone Trail
Raleigh, NC 27607
Phone: 919-784-3111
Fax: 919-784-3336

Rock Quarry Road Family Medicine
Federally qualified health center
1001 Rock Quarry Road
Raleigh, NC 27610
Phone: 919-833-3111

Southern Wake Family Medicine
Federally qualified health center
130 N Judd Parkway, NE
Fuquay-Varina, NC 27526-2367
Phone: 919-557-1110

Wake AHEC
3024 New Bern Avenue, Suite 302
Raleigh, NC 27610
Phone: 919-350-8228
Fax: 919-350-7850

Wake County Department of Social Services
PO Box 46833
Raleigh, NC 27620
Phone: 919-212-7000
Fax: 919-212-7309

Wake County Health Department
Primary care services available
10 Sunnybrook Road
PO Box 14049
Raleigh, NC 27620-4049
Phone: 919-250-4516
Fax: 919-250-3984

Wake County Human Services
MH/DD/SA services
PO Box 46833
Raleigh, NC 27620-6833
Phone: 919-212-7199
Emergency Phone: 919-250-3133
Fax: 919-212-7285

Wake Teen Medical Services, Inc.
School-linked health center
505 Oberlin Road, #204
Raleigh, NC 27605
Phone: 919-828-0035
Fax: 919-828-0355

WakeMed
Hospital
PO Box 14465
Raleigh, NC 27620-4465
Phone: 919-350-8000
Fax: 919-350-8868

Western Wake Medical Center
Hospital
1900 Kildaire Farm Road
Cary, NC 27511
Phone: 919-350-2550

Warren County

Four County Health Network
Project Access program
511 Ruin Creek Road, Suite B-1
Henderson, NC 27536
Phone: 252-430-0360
Fax: 252-430-8980

Norlina Medical Clinic
Rural health clinic
110 Division Street
Norlina, NC 27563
Phone: 252-456-3720
Phone: 252-456-2692 (pharmacy)

Norlina Medical Clinic, Maria Parham Medical Center
Hospital outpatient clinic
1010 Division Street
PO Box 1057
Norlina, NC 27563
Phone: 252-438-4143

Warren County Department of Social Services
307 N Main Street
Warrenton, NC 27589
Phone: 252-257-5000
Fax: 252-257-4656

Warren County Health Department
544 West Ridgeway Street
Warrenton, NC 27589
Phone: 252-257-6000
Fax: 252-257-2897

Vance Granville Franklin Warren Area Authority
MH/DD/SA services
134 S Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Emergency Phone: 877-619-3761
Fax: 252-430-0909

Washington County

Martin Tyrell Washington District Health Department
198 NC Highway 45, North
Plymouth, NC 27962
Phone: 252-793-3023
Fax: 252-791-3158

Tideland Mental Health Center
MH/DD/SA services
1308 Highland Drive
Washington, NC 27889-3494
Phone: 252-946-8061
Emergency Phone: 800-682-0767
Fax: 252-946-1537

Washington County Department of Social Services
PO Box 10
Plymouth, NC 27962
Phone: 252-793-4041
Fax: 252-793-3195

Washington County Hospital, Inc.
PO Box 707
Plymouth, NC 27962
Phone: 252-793-4135
Fax: 252-793-1530

Watauga County

Appalachian HealthCare Project
Hospital outpatient clinic, Project Access program
155 Furman Road, Suite 7
Boone, NC 28607
Phone: 828-263-9493

Blowing Rock Hospital
PO Box 148
Blowing Rock, NC 28605
Phone: 828-295-3136
Fax: 828-295-4587

Foscoe Family Health Center
Rural health clinic
Route 3
PO Box 431
Boone, NC 28607
Phone: 828-268-9967
Fax: 828-268-9970

New River Behavioral HealthCare
MH/DD/SA services
895 State Farm Road, Suite 508
Boone, NC 28607-4996
Phone: 828-264-9007
Fax: 828-264-9468

Watauga County Department of Social Services
132 Poplar Grove Connector, Suite C
Boone, NC 28607
Phone: 828-265-8100
Fax: 828-265-7638

Watauga County Health Department
Part of the Appalachian District Health Department, primary care services available
126 Poplar Grove Connector
Boone, NC 28607
Phone: 828-264-4995
Fax: 828-264-4997

Watauga County Hunger Coalition
Free clinic (pharmacy and food only)
417 Meadowview Drive
Boone, NC 28607
Phone: 828-262-1628

Watauga Medical Center, Inc.
Hospital
PO Box 2600
Boone, NC 28607
Phone: 828-262-4100
Fax: 828-262-4103

Wayne County

Brogden Middle School
School-based health center
801 N Lionel Street
Goldsboro, NC 27530
Phone: 919-739-4905
Fax: 919-739-4906
Sponsor: Wayne Initiative for School Health

Community Health Services
Federally qualified health center
325 NC Highway 55, West
Mount Olive, NC 28365
Phone: 919-658-5900

Dillard Middle School
School-based health center
801 N Lionel Street
Goldsboro, NC 27530
Phone: 919-739-4905
Fax: 919-739-4906
Sponsor: Wayne Initiative for School Health

Eastpointe
MH/DD/SA services
117 Beasley Street
PO Box 599
Kenansville, NC 28349-0599
Phone: 910-296-1851
Emergency Phone: 800-513-4002
Fax: 910-296-1731

Goldsboro High and Middle Schools
School-based health center
801 N Lionel Street
Goldsboro, NC 27530
Phone: 919-739-4905
Fax: 919-739-4906
Sponsor: Wayne Initiative for School Health

Mount Olive Family Medicine Center
State-funded rural health center
238 Smith Chapel Road
Mount Olive, NC 28365
Phone: 919-658-4954

Mount Olive Middle School
School-based health center
801 N Lionel Street
Goldsboro, NC 27530
Phone: 919-739-4905
Fax: 919-739-4906
Sponsor: Wayne Initiative for School Health

WATCH Mobile Unit
Free clinic
PO Box 8001 2700
Goldsboro, NC 27533
Phone: 919-731-6653

Wayne County Department of Social Services
301 N Herman Street, Box HH
Goldsboro, NC 27530
Phone: 919-580-4034
Fax: 919-731-1350

Wayne County Health Department
301 North Herman Street
PO Box CC
Goldsboro, NC 27530
Phone: 919-731-1302
Fax: 919-739-5023

Wayne Memorial Hospital, Inc.
PO Box 8001
Goldsboro, NC 27533-8001
Phone: 919-736-1110
Fax: 919-731-6966

Wilkes County

Boomer Medical Center, Inc.
State-funded rural health center
156 Boomer Community Center Road
PO Box 238
Boomer, NC 28606
Phone: 336-291-2273
Fax: 336-921-2405

Clingman Medical Center
Rural health clinic
3369 Clingman Road
Ronda, NC 28670
Phone: 336-984-3003
Fax: 336-984-2700

FastTrack of Wilkes Regional Medical Center
Rural health clinic
1370 West D Street
PO Box 609
North Wilkesboro, NC 28659
Phone: 336-651-8110

Mobile Expanded School Health
School-linked health center
306 College Street
Wilkesboro, NC 27020
Phone: 336-903-7668
Sponsor: Wilkes County Health Department

Mountain View Medical Center
Rural health clinic
5229 Rock Creek Road
PO Box 82
Hays, NC 28635
Phone: 336-696-2711
Fax: 336-696-2829

New River Behavioral HealthCare
MH/DD/SA services
895 State Farm Road, Suite 508
Boone, NC 28607-4996
Phone: 828-264-9007
Fax: 828-264-9468

West Wilkes Medical Center
State-funded rural health center
171 W Wilkes Medical Center Road
Ferguson, NC 28624
Phone: 336-973-7050
Fax: 336-973-8277

Wilkes County Department of Social Services
PO Box 119
Wilkesboro, NC 28697
Phone: 336-651-7400
Fax: 336-651-7568

Wilkes County Health Department
Primary care services available
306 College Street
Wilkesboro, NC 28697
Phone: 336-651-7450
Fax: 336-651-7389

Wilkes Regional Medical Center
Hospital
PO Box 609
North Wilkesboro, NC 28659
Phone: 336-651-8100
Fax: 336-651-8465

Wilson County

Carolina Family Health Centers, Inc.
Federally qualified health center
303 East Green Street
Wilson, NC 27893
Phone: 252-293-0013
Fax: 252-243-9888

Statonsburg Medical Center
Rural health clinic
312 S Main Street
Statonsburg, NC 27883
Phone: 252-238-2757

Wilson Community Health Center
Rural health clinic
303 East Green Street
Wilson, NC 27893
Phone: 252-243-9800

Wilson County Department of Social Services
PO Box 459
Wilson, NC 27894
Phone: 252-206-4000
Fax: 252-237-1544

Wilson County Health Department
1801 Glendale Drive
Wilson, NC 27893
Phone: 252-291-5470
Fax: 252-293-8300

Wilson Medical Center
Hospital
1705 South Tarboro Street
Wilson, NC 27893
Phone: 252-399-8040
Fax: 252-399-8778

Yadkin County

Crossroads Behavioral Healthcare
MH/DD/SA services
200 Business Park Drive
Elkin, NC 28621
Phone: 336-835-1000
Emergency Phone: 888-235-4673
Fax: 336-835-1002

East Bend Family Practice
Rural health clinic
Main Street Highway 17 Business
PO Box 126
East Bend, NC 27018
Phone: 336-699-4200

Yadkin Family Medical Associates
Rural health clinic
112 E Main Street
Yadkinville, NC 27018
Phone: 336-679-2661
Fax: 336-677-6497

Hoots Memorial Hospital, Inc.
624 West Main Street
Yadkinville, NC 27055
Phone: 336-679-2041
Fax: 336-679-6717

Yadkin County Department of Social Services
PO Box 548
Yadkinville, NC 27055
Phone: 336-679-4210
Fax: 336-679-2664

Yadkin County Health Department
Primary care services available
217 E Willow Street
Yadkinville, NC 27055
Phone: 336-679-4203
Fax: 336-679-6358

Yancey County

Cane River Middle School
School-based health center
Yancey County Health Department
10 Swiss Avenue
Burnsville, NC 28714
Phone: 828-682-4758
Fax: 828-682-3754
Sponsor: Yancey County Health Department

Celo Health Center
State-funded rural health center
200 Seven Mile Ridge Road
Burnsville, NC 28714
Phone: 828-675-4116

East Yancey Middle School
School-based health center
Yancey County Health Department
10 Swiss Avenue
Burnsville, NC 28714
Phone: 828-682-6152
Fax: 828-682-3513
Sponsor: Yancey County Health Department

Toe River Project Access
PO Box 247
Spruce Pine, NC 28777
Phone: 828-766-1750

Western Highlands MH/DD/SAS
356 Biltmore Avenue
Asheville, NC 28801
Phone: 828-258-3500
Emergency Phone: 800-951-3792
Fax: 828-252-9584

Yancey Community Medical Center
Hospital
320 Pensacola Road
Burnsville, NC 28714
Phone: 828-682-6136
Fax: 828-682-4171

Yancey County Department of Social Services
PO Box 67
Burnsville, NC 28714
Phone: 828-682-6148
Fax: 828-682-6712

Yancey County Health Department
10 Swiss Avenue
Burnsville, NC 28714
Phone: 828-682-6118
Fax: 828-682-6262

Appendix B | Uninsured Seen by Safety Net Providers, Clinical Indicators of Need, Primary Care Provider-to-Population

Data and Methodology

Columns A-F. Uninsured Data (2003). Estimates of the uninsured in each county are based on a model developed by the Sheps Center for Health Services Research. They are based on statewide Current Population Survey (CPS) data, not county level survey data. County level estimates were developed using: age, gender, race/ethnicity, employment status, industry, income, and education of the county population as predictors of uninsured status. The limitations are that these are only estimates. Source: Cecil G. Sheps Center for Health Services Research. The University of North Carolina at Chapel Hill. December 2004.

Column G. Total Uninsured Primary Care Clients. This number represents the sum of all of the uninsured or self-pay patients seen in various safety-net organizations in 2003. Specifically, Column G is the total of the clients reported by FQHC, state-funded rural health centers, free clinic (primary care only), hospital primary care clinics, AHEC residency teaching primary care clinics, other safety net organizations, and local health department uninsured patients.

Column H. Estimate of Unduplicated Primary Care Clients (2003). The number in Column G was reduced by approximately 11% to get an estimate of unduplicated individuals. NC Behavioral Risk Factor Surveillance Survey data indicate that approximately 11% of uninsured who report a usual source of care report two or more sources of care.

Column I. Percentage of Uninsured Who Have a Primary Care Home. This percentage was determined by dividing the estimate of the unduplicated primary care clients (Column H), by the total county estimates of the uninsured (Column E).

Column J. Percentage of Uninsured Who Did Not Have a Primary Care Home. This percentage was determined by subtracting Column I from 100%.

Column K. Number of Uninsured Who Did Not Receive Primary Care Services from Safety Net Organizations. This number was determined by taking the difference of the county level uninsured estimates (Column E) and the estimate of unduplicated primary care clients (Column H).

Column L. Uninsured Federally Qualified Health Center (FQHC) Users (2003). Data on uninsured users were provided by NC Association of Community Health Centers (June 2004). Health centers provided total numbers of uninsured users in Uniform Data System 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.

Column M. State Funded Rural Health Centers Uninsured Users (2003). Data on uninsured were provided by NC Office of Research, Demonstrations and Rural Health Development, NC Department of Health and Human Services (June 2004). Numbers of uninsured users only include Medical Assistance Program (MAP) eligible individuals (e.g., individuals who are uninsured with incomes below 200% FPG). State-funded rural health centers also see other uninsured individuals that do not apply for or qualify for MAP.

Columns N-0. Free Clinics Uninsured Users (2003). Data was provided by the NC Association of Free Clinics (August 2004). These estimates are based on unduplicated uninsured users. Free clinics do not report on the county of residence of the free clinic users, so users were assigned to the county where their free clinic was located.

Column P. Hospital Primary Care Clinics Self Funded or Uninsured Patients (2003). Data from hospital primary care clinics were reported by the NC Hospital Association and/or individual hospitals (October-December 2004). The information was typically provided as the number of visits of uninsured or self-pay patients. The number of visits was divided by 3.2 to estimate the number of uninsured patients. We used 3.2 visits per person to approximate number of patients because we had data from FQHC to show that the average North Carolina low-income patient visits the FQHC 3.2 times per year. The hospitals did not report on the county of residence of these patients, so they were assigned to the county where the hospital outpatient clinic was located.

Column Q. AHEC Outpatient Clinics Self-Funded Patients. Data on the uninsured seen in AHEC residency clinics was reported by the NC Area Health Education Center Program (July-October 2004.) The clinics reported the number of visits by uninsured or self-pay patients. The number of visits was divided by 3.2 to estimate the number of uninsured patients. The residency clinics did not report on the county of residence of these patients, so they were assigned to the county where the residency clinic was located. We have no data to know whether the patients seen in the AHEC outpatient clinics are from that particular county or from surrounding counties. By attributing all of the uninsured patients to the county where the AHEC clinic is located may create the appearance that more of the uninsured in those counties have a primary care home than is the reality, and that fewer in other counties have access to primary care.

Column R. Other Safety Net Organizations Uninsured Users (2003). Data provided by members of the Task Force and other safety net organizations, including representatives of Project Access, Guilford Child Health and Adult Health, Downtown Health Plaza, Appalachian Healthcare Project, Carolinas Healthcare System, People Caring for People, Mountain View Medical Center, and Yancey Primary Care Center (June-December 2004).

Column S. Division of Public Health Survey Data of Local Health Departments Providing Primary Care (2003). Data on local health departments that provide primary care services was provided by the NC Division of Public Health (April 2004). Data from the FY 2003 Local Health Department Survey, Staffing and Services. The NC Division of Public Health provided a list of health departments that identified themselves as providing primary care services in a survey of local health departments. The health departments specified whether they provided primary care to adults, children, or both; however, no definition of primary care was provided to the health directors in the survey. Therefore, it is unclear what services these health departments are actually provided or whether the health departments have the capacity to provide comprehensive preventive, well and acute care services.

Column T. Local Health Departments Participating as Carolina Access or CCNC Primary Care Providers (2003). These data were provided by the Division of Medical Assistance, NC Department of Health and Human Services (May 2004). These are health departments that are designated as primary care providers for Medicaid patients in the Carolina Access or Community Care of North Carolina program. To be designated as a primary care provider, the health department must have the capacity to provide comprehensive services, 24 hours a day, 7 days a week. (See definition of primary care providers in Chapter 4).

Column U. Health Department Primary Care Uninsured Patients. Data from the Health Services Information System (HSIS), Division of Public Health, NC Department of Health and Human Services (March 2003). Because there was uncertainty about which health departments offer comprehensive primary care, we only included data for those health departments that reported that they provided primary care services (Column S) *and* that were listed as primary care providers for Medicaid patients (Column T). 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.

Columns V-MM. Public Health Department Unduplicated Uninsured Users by Health Department Clinic (2003). Data on uninsured users provided by the Division of Public Health is from the Health Service Information System (HSIS), March 2004. User information was provided by service area (e.g., adult health, child health, and maternal health). 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 comprehensive primary care visits.

Columns NN-PP. Avoidable Hospitalizations. Data were obtained from the Safety Net Monitoring, Agency for Healthcare Research and Quality, US Department of Health and Human Services, using 1999 Healthcare Cost Utilization Project data. (Available at http://www.ahcpr.gov/data/safetynet/document.htm, accessed 2/21/2004.) These data do not distinguish between conditions that are very preventable (e.g., asthma admissions) from those that are not as preventable (e.g., congestive heart failure). Also, it is unclear whether high Ambulatory Care Sensitive rates are due to lack of primary care, physician practice patterns, or other factors.

Column QQ. Infant Mortality Rates. Data based on 5-year rates (1998-2002) from State Center for Health Statistics available online at: http://www.schs.state.nc.us/SCHS/deaths/ims/2002/fiveyear.html (Accessed May 2004).

Columns RR-TT. Primary Care Provider data (2003). Sheps Center for Health Services Research. The University of North Carolina at Chapel Hill. September 2003.

Limitations

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). The North Carolina Institute of Medicine (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 uninsured veterans who receive care at Veterans Affairs clinics.

Attributing all of the hospital outpatient clinic patients and AHEC residency clinic patients to the county where the clinic is also a limitation of this analysis. This process will lead to over- and under-estimates of the numbers of uninsured patients seen in any particular county. Hospitals, especially larger tertiary hospitals, serve as referral centers and provide inpatient services to patients from many counties. It is reasonable to suspect that some of their outpatient clients are also from surrounding counties. However, we were unable to attribute patients to any specific county, and therefore listed them in the county where the clinic was located. By attributing all of the uninsured patients to the county where the hospital is located may create the appearance that more of the uninsured in those counties have a primary care home than is true, and that fewer uninsured in other counties have access to primary care.

As noted previously, the NC 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 (for example, child health or adult health clinics). Some health departments have the capacity to offer comprehensive primary care, 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 methodology may lead to either an overestimate or an underestimate of the uninsured seen. Including all the uninsured who used the adult health, child health, or maternal health clinics may be an overestimate of the number of people who receive primary care, since not all of these visits would constitute primary care. However, because health departments are not required to report on primary care visits, the data may be an underestimate of the number of people who receive primary care.

Additional Notes

[1] The following health departments are part of district health departments, not single county health departments:

- Alleghany/Ashe/Watauga
- Avery/Mitchell/Yancey
- Camden/Chowan/Currituck/Gates/Pasquotank/Perquimmans
- Granville/Vance
- Martin/Tyrrell/Washington
- McDowell/Polk/Rutherford

[2] 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.

[3] Data provided directly from these health departments on the numbers of uninsured patients they saw in 2003 for primary care services. Therefore, we did not use the formula described in Column U listed above.

[4] These rates are based on less than 10 deaths and are considered unstable.

[5] In the following table, 100 counties are listed, and a row is designated as "other." Data in the "other" row accounts for persons from other states who receive services in North Carolina (FQHC data) or people who are receiving public health services from agencies other that local health departments (e.g., hospitals, CDSAs, or other health providers).

	Columns A, B		Columns C, D		Columns E, F		Column G	Column H	Column I	Column J	Column K
	Uninsured Aged 0-17 (2003)		Uninsured Aged 18-64 (2003)		Uninsured Aged 0-64 (2003)		Total Uninsured Primary Care Clients (2003)	Estimate of Unduplicated Primary Care Clients (2003)	Percentage of Uninsured who have Primary Care Home (2003)	Percentage of Uninsured who do not have Primary Care Home (2003)	Number of Uninsured who did not Receive Primary Care Services from Safety Net Organization (2003)
County	Number	Percent	Number	Percent	Number	Percent					
Alamance	4,106	12.1%	18,872	22.8%	22,978	19.7%	4,131	3,718	16.2%	83.8%	19,260
Alexander	915	11.0%	4,811	22.3%	5,727	19.1%	0	0	0.0%	100.0%	5,727
Alleghany [1]	282	13.7%	1,825	26.5%	2,107	23.5%	704	684	32.5%	67.5%	1,423
Anson	704	11.5%	3,988	26.0%	4,693	21.8%	1,197	1,077	23.0%	77.0%	3,615
Ashe [1]	629	13.0%	4,160	25.7%	4,789	22.8%	1,414	1,414	29.5%	70.5%	3,375
Avery	472	13.3%	3,069	26.0%	3,542	23.0%	105	105	3.0%	97.0%	3,437
Beaufort	1,289	12.5%	7,050	25.0%	8,339	21.6%	671	671	8.0%	92.0%	7,668
Bertie [1]	592	12.3%	3,334	28.3%	3,926	23.6%	4,463	4,017	102.3%	-2.3%	-91
Bladen	996	12.6%	5,526	27.6%	6,523	23.4%	1,483	1,392	21.3%	78.7%	5,131
Brunswick	2,056	12.3%	12,002	22.8%	14,057	20.2%	1,233	1,110	7.9%	92.1%	12,948
Buncombe [2]	5,405	11.6%	26,738	20.0%	32,143	17.8%	32,173	28,956	90.1%	9.9%	3,188
Burke	2,566	12.0%	11,861	21.7%	14,427	18.9%	1,300	1,300	9.0%	91.0%	13,127
Cabarrus	3,924	10.5%	17,989	20.6%	21,914	17.5%	3,726	3,353	15.3%	84.7%	18,560
Caldwell	1,985	10.9%	10,528	21.5%	12,513	18.6%	3,411	3,070	24.5%	75.5%	9,443
Camden [1]	197	10.8%	1,060	21.4%	1,258	18.5%	0	0	0.0%	100.0%	1,258
Carteret [2]	1,367	11.6%	7,535	19.2%	8,902	17.5%	1,000	1,000	11.2%	88.8%	7,902
Caswell	643	12.0%	3,626	24.1%	4,269	20.9%	3,965	3,569	83.6%	16.4%	700
Catawba	4,255	11.8%	19,462	21.5%	23,717	18.7%	3,265	2,939	12.4%	87.6%	20,779
Chatham	1,685	14.0%	7,849	23.3%	9,534	20.8%	2,791	2,512	26.3%	73.7%	7,022
Cherokee	612	12.3%	3,886	24.3%	4,498	21.4%	354	354	7.9%	92.1%	4,144
Chowan [1]	378	11.3%	2,008	23.4%	2,387	20.0%	108	108	4.5%	95.5%	2,279
Clay	203	12.5%	1,366	22.6%	1,569	20.4%	353	353	22.5%	77.5%	1,216
Cleveland	2,607	10.7%	13,566	22.9%	16,174	19.3%	5,426	2,255	13.9%	86.1%	13,919
Columbus	1,664	12.4%	9,166	27.6%	10,830	23.2%	1,757	1,581	14.6%	85.4%	9,249
Craven	2,600	11.5%	12,011	21.0%	14,611	18.3%	3,737	3,363	23.0%	77.0%	11,248
Cumberland [2]	10,150	11.8%	42,254	22.6%	52,404	19.2%	6,247	5,622	10.7%	89.3%	46,782
Currituck [1]	546	11.0%	3,205	24.7%	3,751	20.9%	0	0	0.0%	100.0%	3,751
Dare	773	11.2%	3,994	18.2%	4,767	16.5%	0	0	0.0%	100.0%	4,767
Davidson	4,099	11.3%	20,757	21.9%	24,855	19.0%	1,500	1,500	6.0%	94.0%	23,355
Davie	984	11.0%	4,929	21.4%	5,913	18.5%	656	590	10.0%	90.0%	5,323
Duplin	2,138	16.1%	9,662	31.8%	11,800	27.0%	5,754	5,179	43.9%	56.1%	6,621
Durham [2]	7,991	13.7%	32,163	21.5%	40,154	19.3%	48,940	44,046	109.7%	-9.7%	-3,892
Edgecombe	1,626	11.6%	8,815	27.2%	10,441	22.5%	240	240	2.3%	97.7%	10,201
Forsyth [2]	9,228	11.8%	39,051	20.0%	48,279	17.6%	10,000	9,000	18.6%	81.4%	39,279

	Columns A, B		Columns C, D		Columns E, F		Column G	Column H	Column I	Column J	Column K
	Uninsured Aged 0-17 (2003)		Uninsured Aged 18-64 (2003)		Uninsured Aged 0-64 (2003)		Total Uninsured Primary Care Clients (2003)	Estimate of Unduplicated Primary Care Clients (2003)	Percentage of Uninsured who have Primary Care Home (2003)	Percentage of Uninsured who do not have Primary Care Home (2003)	Number of Uninsured who did not Receive Primary Care Services from Safety Net Organization (2003)
County	Number	Percent	Number	Percent	Number	Percent					
Franklin	1,562	12.0%	8,049	25.1%	9,611	21.3%	776	698	7.3%	92.7%	8,913
Gaston	5,020	10.8%	24,168	20.4%	29,188	17.7%	8,833	7,950	27.2%	72.8%	21,238
Gates [1]	303	11.1%	1,492	22.8%	1,794	19.4%	172	172	9.6%	90.4%	1,622
Graham	212	12.5%	1,403	28.0%	1,615	24.1%	0	0	0.0%	100.0%	1,615
Granville	1,525	12.3%	7,550	22.7%	9,076	19.9%	282	282	3.1%	96.9%	8,794
Greene	689	13.9%	3,590	29.4%	4,279	24.9%	7,196	7,196	168.2%	-68.2%	-2,917
Guilford	12,475	11.6%	54,272	20.3%	66,747	17.8%	16,795	15,116	22.6%	77.4%	51,631
Halifax	1,660	11.8%	9,157	26.9%	10,818	22.5%	3,737	3,363	31.1%	68.9%	7,454
Harnett	3,207	12.0%	15,475	26.2%	18,682	21.8%	3,427	3,084	16.5%	83.5%	15,598
Haywood	1,271	11.3%	7,112	20.3%	8,383	18.1%	1,300	1,300	15.5%	84.5%	7,083
Henderson	2,406	12.4%	11,742	20.2%	14,148	18.2%	5,820	5,238	37.0%	63.0%	8,910
Hertford [1]	701	12.4%	3,723	25.9%	4,424	22.1%	287	258	5.8%	94.2%	4,165
Hoke	1,363	12.3%	5,903	27.1%	7,266	22.1%	344	344	4.7%	95.3%	6,922
Hyde	148	13.7%	982	26.3%	1,130	23.5%	503	503	44.5%	55.5%	627
Iredell	3,614	10.7%	17,131	21.0%	20,745	18.0%	2,700	2,700	13.0%	87.0%	18,045
Jackson	962	12.2%	5,187	23.4%	6,149	20.5%	356	356	5.8%	94.2%	5,793
Johnston	4,400	12.3%	20,963	24.9%	25,362	21.1%	8,684	7,816	30.8%	69.2%	17,547
Jones	301	12.4%	1,614	26.1%	1,915	22.2%	470	423	22.1%	77.9%	1,492
Lee	1,763	14.0%	7,595	25.0%	9,358	21.8%	1,665	1,665	17.8%	82.2%	7,693
Lenoir	1,679	11.7%	8,547	24.0%	10,226	20.5%	3,022	3,022	29.6%	70.4%	7,204
Lincoln	1,953	11.9%	9,656	22.9%	11,609	19.8%	350	350	3.0%	97.0%	11,259
Macon	759	12.3%	4,516	23.2%	5,275	20.5%	0	0	0.0%	100.0%	5,275
Madison	536	12.1%	2,962	23.6%	3,498	20.6%	1,430	1,430	40.9%	59.1%	2,068
Martin [1]	723	12.0%	3,903	26.1%	4,627	22.1%	130	130	2.8%	97.2%	4,497
McDowell	1,172	12.1%	6,502	24.0%	7,674	20.8%	0	0	0.0%	100.0%	7,674
Mecklenburg [2]	23,969	12.3%	95,748	20.4%	119,717	18.0%	33,439	30,095	25.1%	74.9%	89,622
Mitchell	399	12.3%	2,452	24.5%	2,851	21.5%	605	545	19.1%	80.9%	2,307
Montgomery	969	14.5%	4,809	28.7%	5,779	24.7%	81	81	1.4%	98.6%	5,698
Moore	1,978	11.9%	9,929	20.8%	11,907	18.5%	3,241	2,917	24.5%	75.5%	8,990
Nash	2,533	11.3%	12,862	23.4%	15,394	19.9%	3,377	3,039	19.7%	80.3%	12,355
New Hanover [2]	4,234	11.4%	21,223	19.4%	25,457	17.4%	4,301	3,871	15.2%	84.8%	21,586
Northampton	608	12.3%	3,674	27.8%	4,282	23.6%	1,733	1,560	36.4%	63.6%	2,722
Onslow [2]	5,424	12.3%	26,128	27.1%	31,552	22.4%	1,016	914	2.9%	97.1%	30,638
Orange	3,998	13.3%	16,420	21.3%	20,418	19.1%	23,786	21,407	104.8%	-4.8%	-990

	Columns A, B		Columns C, D		Columns E, F		Column G	Column H	Column I	Column J	Column K
	Uninsured Aged 0-17 (2003)		Uninsured Aged 18-64 (2003)		Uninsured Aged 0-64 (2003)		Total Uninsured Primary Care Clients (2003)	Estimate of Unduplicated Primary Care Clients (2003)	Percentage of Uninsured who have Primary Care Home (2003)	Percentage of Uninsured who do not have Primary Care Home (2003)	Number of Uninsured who did not Receive Primary Care Services from Safety Net Organization (2003)
County	Number	Percent	Number	Percent	Number	Percent					
Pamlico	318	12.6%	1,960	23.5%	2,278	21.0%	572	572	25.1%	74.9%	1,706
Pasquotank [1]	1,057	11.7%	5,128	23.2%	6,185	19.9%	644	644	10.4%	89.6%	5,541
Pender	1,234	12.6%	6,840	24.5%	8,075	21.4%	2,839	2,596	32.2%	67.8%	5,479
Perquimans [1]	302	12.1%	1,737	24.0%	2,040	21.0%	0	0	0.0%	100.0%	2,040
Person	955	11.0%	5,295	23.0%	6,249	19.7%	2,463	2,463	39.4%	60.6%	3,786
Pitt [2]	4,392	12.1%	20,947	24.5%	25,339	20.8%	22,050	19,845	78.3%	21.7%	5,494
Polk	447	12.1%	2,430	20.9%	2,877	18.8%	333	333	11.6%	88.4%	2,544
Randolph	4,093	12.2%	19,755	23.7%	23,848	20.4%	3,065	2,759	11.6%	88.4%	21,089
Richmond	1,399	11.7%	7,173	25.8%	8,572	21.5%	180	180	2.1%	97.9%	8,392
Robeson	4,493	12.5%	21,921	29.6%	26,414	24.1%	7,953	7,158	27.1%	72.9%	19,257
Rockingham	2,479	11.7%	13,654	23.8%	16,133	20.5%	2,457	2,211	13.7%	86.3%	13,921
Rowan [2]	3,698	11.2%	17,980	22.1%	21,678	19.0%	4,895	4,406	20.3%	79.7%	17,273
Rutherford	1,656	11.3%	9,354	24.1%	11,010	20.6%	251	226	2.1%	97.9%	10,784
Sampson	2,260	14.1%	11,213	29.8%	13,473	25.1%	4,463	4,017	29.8%	70.2%	9,457
Scotland	1,028	10.8%	5,292	25.0%	6,321	20.6%	1,385	1,336	21.1%	78.9%	4,985
Stanly	1,582	10.9%	8,123	22.6%	9,705	19.2%	895	806	8.3%	91.7%	8,900
Stokes	1,166	10.8%	6,342	22.2%	7,507	19.0%	1,566	1,566	20.9%	79.1%	5,941
Surry	2,148	12.7%	11,510	26.1%	13,658	22.4%	1,922	1,730	12.7%	87.3%	11,928
Swain	385	12.1%	2,012	24.7%	2,397	21.2%	0	0	0.0%	100.0%	2,397
Transylvania	657	11.3%	3,718	20.3%	4,375	18.1%	551	496	11.3%	88.7%	3,879
Tyrrell [1]	130	14.4%	757	28.2%	887	24.7%	874	874	98.6%	1.4%	13
Union	4,312	10.6%	19,214	22.0%	23,526	18.4%	381	343	1.5%	98.5%	23,183
Vance	1,397	11.9%	7,158	27.6%	8,555	22.7%	515	515	6.0%	94.0%	8,040
Wake	21,767	12.0%	81,845	18.5%	103,612	16.6%	20,076	18,068	17.4%	82.6%	85,544
Warren	593	13.1%	3,351	27.2%	3,944	23.4%	1,496	1,346	34.1%	65.9%	2,598
Washington [1]	394	12.1%	2,099	25.9%	2,492	21.9%	0	0	0.0%	100.0%	2,492
Watauga [1]	1,233	12.6%	6,687	24.2%	7,920	21.2%	2,435	2,247	28.4%	71.6%	5,673
Wayne	3,519	11.9%	16,358	23.7%	19,877	20.1%	5,107	4,596	23.1%	76.9%	15,281
Wilkes	1,798	11.9%	10,059	23.8%	11,857	20.7%	1,458	1,312	11.1%	88.9%	10,545
Wilson	2,380	12.5%	12,067	26.3%	14,448	22.2%	6,451	5,806	40.2%	59.8%	8,642
Yadkin	1,070	12.2%	5,548	24.4%	6,619	21.0%	1,359	1,359	20.5%	79.5%	5,260
Yancey	473	12.8%	2,914	25.8%	3,388	22.6%	1,923	1,731	51.1%	48.9%	1,657
Other [5]											
North Carolina	249,007	12.0%	1,165,031	22.3%	1,414,159	19.4%	392,521	354,442	25.1%	74.9%	1,059,717

	Column L	Column M	Column N	Column O	Column P	Column Q	Column R	Column S	Column T	Column U	
	Uninsured Users FQHC (2003)	State Funded RHS Uninsured Users (2003)	Free Clinics Uninsured Users (2003) [4]	Free Clinics Mental Health or Pharmacy only	Hospital Primary Care Clinics (Self-Pay) (2003)	AHEC Outpatient Uninsured (Self-Pay) Patients [3]	Other Safety Net Organization Uninsured Users	DPH Survey Primary Care (Adults, Child) (FY03)	Health Dept. Participating as Medicaid Access 1/ CCNC PCP (DMA data, May 04)	Health Dept. Primary Care Uninsured Clients (if listed as PCP for CA and DPH Survey)	
County											
Alamance	3,512		619					C			
Alexander											
Alleghany [1]					20			A,C*	CA-I	684	
Anson	690							A,C	CA-I	507	
Ashe [1]								A,C*	CA-I	1,414	
Avery							105				
Beaufort		671									
Bertie [1]	3,845				618			C*			
Bladen	91				1,392						
Brunswick	215		600					C	CA-II	418	
Buncombe [2]	251		6,065			3,057	8,800	A,C	CA-II	14,000	[3]
Burke			1,300								
Cabarrus	116		1,100			1,231		A,C	CA-II	1,279	
Caldwell		927	1,071					A,C	CA-II	1,413	
Camden [1]								C*			
Carteret [2]			1,000					A,C			
Caswell	2,942							A,C	CA-I	1,023	
Catawba			2,923					C	CA-II	342	
Chatham	1,665							A,C	CA-I	1,126	
Cherokee		354									
Chowan [1]	108							C*			
Clay		353									
Cleveland								A,C	CA-II	5,426	[3]
Columbus	65	651						A,C	CA-II	1,041	
Craven	271		2,810	750				C	CA-II	656	
Cumberland [2]	1,505		1,563			562		A,C	CA-I	2,617	
Currituck [1]								C*			
Dare											
Davidson			1,500								
Davie			252					C	CA-II	404	
Duplin	3,699	1,072						A,C	CA-I	983	
Durham [2]	23,868			800	25,072						
Edgecombe	240										
Forsyth [2]			2,000	2,600	8,000						

	Column L	Column M	Column N	Column O	Column P	Column Q	Column R	Column S	Column T	Column U	
	Uninsured Users FQHC (2003)	State Funded RHS Uninsured Users (2003)	Free Clinics Uninsured Users (2003) [4]	Free Clinics Mental Health or Pharmacy only	Hospital Primary Care Clinics (Self-Pay) (2003)	AHEC Outpatient Uninsured (Self-Pay) Patients [3]	Other Safety Net Organization Uninsured Users	DPH Survey Primary Care (Adults, Child) (FY03)	Health Dept. Participating as Medicaid Access 1/ CCNC PCP (DMA data, May 04)	Health Dept. Primary Care Uninsured Clients (if listed as PCP for CA and DPH Survey)	
County											
Franklin	320							A,C	CA-I	456	
Gaston	6,725							A,C	CA-II	2,108	
Gates [1]		172						A,C*			
Graham											
Granville	282										
Greene	7,196							C			
Guilford	16		2,005	1,000		1,634	7,548	A	CA-I	5,592	[3]
Halifax	914	1,682	478					A,C	CA-II	663	
Harnett	3,084							C	CA-I	343	
Haywood			1,300	403				C			
Henderson	4,260		918			238		C	CA-II	404	
Hertford [1]	190		97					A,C*			
Hoke								A,C	CA-II	344	
Hyde		503									
Iredell			2,700								
Jackson			356								
Johnston	7,145	541						A,C	CA-I	998	
Jones	76							A,C	CA-II	394	
Lee	1,665			100				A,C			
Lenoir	3,022										
Lincoln			350					A,C			
Macon											
Madison		1,430									
Martin [1]	130							A,C*			
McDowell											
Mecklenburg [2]	1,855		13,826	1,200		17,758					
Mitchell					168		438				
Montgomery								A,C	CA-II	81	
Moore			475		2,766						
Nash	1,402	1,975						C			
New Hanover [2]	1,613		1,147			1,541					
Northampton	773	960									
Onslow [2]	140		876					A,C			
Orange	3,755		635		19,396				CA-I		

	Column L	Column M	Column N	Column O	Column P	Column Q	Column R	Column S	Column T	Column U	
County	Uninsured Users FQHC (2003)	State Funded RHS Uninsured Users (2003)	Free Clinics Uninsured Users (2003) [4]	Free Clinics Mental Health or Pharmacy only	Hospital Primary Care Clinics (Self-Pay) (2003)	AHEC Outpatient Uninsured (Self-Pay) Patients [3]	Other Safety Net Organization Uninsured Users	DPH Survey Primary Care (Adults, Child) (FY03)	Health Dept. Participating as Medicaid Access 1/ CCNC PCP (DMA data, May 04)	Health Dept. Primary Care Uninsured Clients (if listed as PCP for CA and DPH Survey)	
Pamlico			572					A,C			
Pasquotank [1]				850				C*	CA-I	644	
Pender	183	2,596						A,C	CA-II	60	
Perquimans [1]								C*			
Person	2,463										
Pitt [2]	2,571		1,000		18,479				CA-II		
Polk		333									
Randolph	1,399	1,666									
Richmond	180										
Robeson	4,838				1,250			A,C	CA-II	1,865	
Rockingham	16		307	250				A,C	CA-I	2,134	
Rowan [2]			3,350					A,C	CA-I	1,545	
Rutherford	251			347							
Sampson	3,694	144			625			A			
Scotland	49				1,336			A			
Stanly	180		450					A,C	CA-I	265	
Stokes								A,C	CA-II	1,566	
Surry			1,400					C	CA-II	522	
Swain											
Transylvania	251		300								
Tyrrell [1]		874						A,C*			
Union	116			430				C	CA-II	265	
Vance	515										
Wake	7,510		2,970			6,821		C	CA-II	2,775	
Warren	1,269				227						
Washington [1]								A,C*			
Watauga [1]				750			188	A,C*	CA-I	2,247	
Wayne	2,423	684	2,000								
Wilkes		1,086					278	A,C	CA-II	94	
Wilson	4,476	1,975									
Yadkin								A,C	CA-II	1,359	
Yancey		603					1,320				
Other [5]	2,427										
North Carolina	**122,457**	**21,252**	**60,315**	**9,480**	**77,318**	**32,842**	**18,677**				

	Columns V, W		Columns X, Y		Columns Z, AA		Columns BB, CC		Columns DD, EE		Columns FF, GG		Columns HH, II	
	Total Public Health Unduplicated Clients		Adult Health Clients		Child Health Clients		Maternal Health Clients		General Billing		Dental Services		Epidemiology	
County	Unins.	Total	Unins.	Total	Unins.	Total	Unins.	Total	Unins.	Total	Unins.	Total	Unins.	Total
Alamance	5,827	9,510	5	5	315	1,052	313	1,090	69	113	59	1,038	2,515	2,928
Alexander	943	2,240	47	79	53	254	103	221	269	500			205	424
Alleghany [1]	914	1,360	499	575	131	360	54	102	82	116	6	67	114	129
Anson	822	2,466	252	415	106	753	149	429	42	165			144	465
Ashe [1]	1,725	3,537	978	1,353	340	1,183	96	198	167	220	49	616	119	155
Avery	306	437	22	31	1	33	31	76						
Beaufort	6,649	7,907	230	247	125	152	407	413					1,170	1,240
Bertie [1]	1,006	3,196	272	431	36	548	56	247	29	114	1	1	359	665
Bladen	1,574	3,963	153	214	64	660	200	485					486	1,009
Brunswick	3,012	5,060	203	302	418	1,186	247	629	1,167	1,629			373	627
Buncombe [2]	15,443	30,378	3,812	6,484	1,185	5,378	337	2,002	671	958	46	3,420	3,722	4,904
Burke	2,584	6,738	83	105	88	532	461	943	231	264	37	2,843	1,036	1,358
Cabarrus	4,837	9,671			636	2,137	643	1,179	66	142	180	2,265	88	192
Caldwell	3,023	8,788	728	1,733	546	2,292	139	802			35	1,357	425	745
Camden [1]	143	904	11	47	19	129	12	38	12	39			22	77
Carteret [2]	1,611	4,224	427	537	150	949	79	351			7	375	460	688
Caswell	1,648	1,954	445	474	468	621	110	148	88	97			460	513
Catawba	3,973	10,109	1,793	3,682	342	1,993	672	1,373	434	720	77	1,231	103	335
Chatham	3,114	4,524	499	929	211	643	416	677	172	274			127	183
Cherokee	686	1,583			117	453	73	232					8	10
Chowan [1]	237	2,645	25	154	37	492	19	107	16	117	-	1	52	427
Clay	240	2,418	181	264	18	208	11	118	2	27	1	1,639	-	2
Cleveland	7,640	18,128	629	1,086	1,480	4,872	146	984	654	1,257	51	1,290	915	2,054
Columbus	2,389	6,823	728	1,320	149	1,048	164	448			25	1,400	1,056	1,872
Craven	2,907	6,457	168	276	656	2,218	100	378	213	391	19	973	1,202	1,850
Cumberland [2]	10,504	17,462	852	1,617	969	2,545	796	1,471	6	26	15	433	3,174	4,120
Currituck [1]	518	2,568	55	203	69	412	36	99	44	110	4	54	54	200
Dare	3,267	5,865	884	1,234	331	735	150	388	67	107	79	356	742	994
Davidson	5,824	8,205	320	329	242	878	650	909	705	843	147	887	2,372	2,977
Davie	1,305	2,668	3	4	404	818	81	164	317	714			144	317
Duplin	1,904	4,247	154	273	479	1,533	350	610	55	85	13	649	465	608
Durham [2]	6,758	11,698	288	579	444	1,392	846	2,271			102	670	3,952	5,007
Edgecombe	3,614	10,844	1,087	2,592	404	1,953	161	577			38	743	688	1,973
Forsyth [2]	-	19,241			-	1,267	-	1,483	-	2,589			-	4,658

	Columns V, W		Columns X, Y		Columns Z, AA		Columns BB, CC		Columns DD, EE		Columns FF, GG		Columns HH, II	
	Total Public Health Unduplicated Clients		Adult Health Clients		Child Health Clients		Maternal Health Clients		General Billing		Dental Services		Epidemiology	
County	Unins.	Total	Unins.	Total	Unins.	Total	Unins.	Total	Unins.	Total	Unins.	Total	Unins.	Total
Franklin	906	5,735	191	552	189	2,008	76	328	33	120	29	1,899	219	719
Gaston	8,360	18,280	890	1,820	697	2,784	521	1,687			250	3,063	766	1,540
Gates [1]	324	1,777	248	835	20	341	7	87					13	139
Graham	1,217	2,254	924	1,273	121	519	30	78			25	229		
Granville	260	3,122	5	29	-	923	29	398	3	98			23	447
Greene	2,045	3,474	230	260	536	769	216	280	179	204			380	1,291
Guilford	140	17,082	15	929	5	2,410	51	3,344	30	2,070	1	1,670	-	257
Halifax	1,084	5,014	342	1,082	220	2,003	101	593	60	195			193	674
Harnett	1,410	7,687	89	418	343	2,432	84	692			-	1	489	1,764
Haywood	2,181	4,924	358	414	213	812	50	435	130	469	49	1,232	341	439
Henderson	1,616	7,269	87	207	404	2,031	172	663	112	380			262	912
Hertford [1]	1,608	2,968	690	1,158	140	598	118	315					535	738
Hoke	759	3,482	26	68	166	1,488	152	374	320	1,083			82	400
Hyde	456	1,240	145	325	18	144	2	27					-	7
Iredell	5,489	12,085	140	195	190	979	176	551	261	564	39	1,094	1,350	2,060
Jackson	3,539	4,397	884	939	167	325	172	210	515	579	200	607	406	426
Johnston	3,863	8,651	44	58	509	2,107	445	714	539	1,449			383	562
Jones	722	1,298	149	187	206	517	39	86					242	334
Lee	1,171	3,922	23	45	34	290	65	270			10	752	536	1,259
Lenoir	2,228	5,696	104	813	90	713	18	279	197	625			480	1,526
Lincoln	1,522	2,206	457	715	255	455	232	391	31	46				
Macon	268	2,031	-	4	78	480	18	251	-	18	22	621	9	88
Madison	494	839			74	209	82	163	2	4			25	46
Martin [1]	968	2,985	175	604	50	526	60	272	-	3			309	779
McDowell	1,868	3,490	41	79	69	579	104	481	403	686			823	1,153
Mecklenburg [2]	15,249	25,536	2,043	3,225	464	1,314	381	1,947	684	1,695	67	2,028	6,116	7,315
Mitchell	522	972	175	209	38	227	48	122	21	35			30	56
Montgomery	119	2,932	26	358	27	798	28	365					10	689
Moore	1,642	4,280	422	774	112	946	266	633					339	717
Nash	5,311	10,200	859	1,154	640	2,008	552	828	780	1,064			1,755	2,985
New Hanover [2]	6,781	13,704	11	15	466	1,243	524	1,742	90	137			1,862	2,657
Northampton	717	3,075	175	662	110	839	7	252	144	438			199	703
Onslow [2]	4,382	6,971	584	704	425	1,313	484	1,199	380	636			1,528	1,907
Orange	4,780	8,723	181	301	219	716	147	349			100	577	1,007	1,741

	Columns V, W		Columns X, Y		Columns Z, AA		Columns BB, CC		Columns DD, EE		Columns FF, GG		Columns HH, II	
	Total Public Health Unduplicated Clients		Adult Health Clients		Child Health Clients		Maternal Health Clients		General Billing		Dental Services		Epidemiology	
County	Unins.	Total	Unins.	Total	Unins.	Total	Unins.	Total	Unins.	Total	Unins.	Total	Unins.	Total
Pamlico	450	1,943	231	782	81	529	23	121	8	30			89	277
Pasquotank [1]	2,961	7,844	432	1,153	644	2,139	174	346	168	360	88	405	690	1,310
Pender	98	3,436	30	649	18	920	12	291	4	137	5	685	8	251
Perquimans [1]	1,304	1,887	91	116	182	390	56	88	52	81			223	302
Person	1,314	2,903	758	1,043	71	590	88	267	160	338			170	392
Pitt [2]	4,060	13,178	179	414	160	1,648	550	1,667	604	1,198	4	468	946	2,748
Polk	419	1,062	7	11	2	180	5	43	76	174			264	406
Randolph	1,272	5,583			25	1,497	315	1,223			15	381	13	17
Richmond	2,085	4,682			121	926	281	732	48	95	34	887	1,034	1,324
Robeson	3,535	12,113	756	1,451	770	4,035	339	1,585			8	714	1,395	2,927
Rockingham	4,185	9,071	1,133	1,932	707	2,280	294	848	85	238	12	353	838	1,376
Rowan [2]	3,111	5,891	777	1,049	433	1,076	335	712	-	1	13	1,080	1,079	1,283
Rutherford	2,087	5,332	39	97	74	1,237	138	769	469	976	-	2	889	1,231
Sampson	720	5,360	157	640	55	644	74	708	23	261			321	1,470
Scotland	1,416	5,491	669	2,183	5	425	47	539	52	92			330	1,164
Stanly	1,582	4,341	119	175	73	489	73	492			22	907	786	1,031
Stokes	2,284	5,088	964	1,390	428	1,656	174	336	82	137			97	169
Surry	3,527	9,670	484	811	522	2,344	236	625	237	365	24	457	377	505
Swain	2,226	2,241	281	282	185	191	105	105	468	476			38	38
Transylvania	1,033	2,949	113	277	14	284	23	233	89	230	1	165	423	837
Tyrrell [1]	193	1,140	70	285	16	375	24	104	-	1			30	117
Union	4,690	9,299	54	118	265	1,640	250	940	569	1,150	87	716	436	642
Vance	239	2,618	4	29	-	789	13	410	13	258			22	470
Wake	8,404	23,667	9	135	2,775	11,056	2,330	4,977	25	436	89	1,983	50	765
Warren	1,477	2,561	262	373	326	883	69	176					354	476
Washington [1]	317	2,840	69	377	32	551	24	179			9	1,021	119	366
Watauga [1]	3,170	4,911	1,723	2,224	391	849	133	411	185	254			166	214
Wayne	6,130	12,880	56	81	260	1,297	539	1,471	479	782	73	782	1,474	2,133
Wilkes	306	6,775	58	833	33	1,553	3	897	16	306	97	2,238	4	180
Wilson	1,124	10,799	14	74	8	1,359	76	1,154	1	6			457	3,189
Yadkin	2,236	2,558	552	585	624	848	183	202	570	587			262	284
Yancey	784	1,219			116	323	67	190					1	2
Other [5]	2,427	4,150			1	56	508	2,848						
North Carolina	260,603	641,601	36,657	67,554	27,745	122,584	21,126	67,737	14,975	33,184	2,364	49,325	60,849	107,932

	Columns JJ, KK		Columns LL, MM		Column NN	Column OO	Column PP	Column QQ		Column RR	Column SS	Column TT
	Family Planning		Immunization Clients		Avoid Hospital (ACS Admissions), Ages 0-17 (OBS/ EXPECT RATIO)	Avoid Hospital (ACS Admissions), Ages 18-39 (OBS/ EXPECT RATIO)	Avoid Hospital (ACS Admissions), Ages 40-64 (OBS/ EXPECT RATIO)	Mortality Rate per 1,000 Pop (1998-2002)		2003 Total Primary Care Physicians	FTE Primary Care Physicians	Primary Care Physicians FTE/10,000
County	Unins.	Total	Unins.	Total								
Alamance	1,899	3,050	1,658	2,327	1.058	0.975	0.847	11.3		75	52.8	3.809
Alexander	280	428	164	695	1.683	1.024	0.993	5.6		10	8.7	2.451
Alleghany [1]	179	213	86	156	n/a	n/a	n/a	7.4	[4]	11	7.6	6.923
Anson	377	655	19	233	2.046	1.147	0.991	16.7		11	11.6	4.519
Ashe [1]	318	461	36	162	n/a	n/a	n/a	12.5		18	12.8	5.071
Avery	260	312			n/a	n/a	n/a	4.7	[4]	15	12.3	6.855
Beaufort	1,642	1,678	4,045	5,181	0.807	0.881	1.014	13.7		30	20.7	4.526
Bertie [1]	208	504	252	1,192	n/a	n/a	n/a	12.5		11	7.5	3.830
Bladen	468	768	517	1,549	1.148	0.643	0.791	9.9		20	14.2	4.259
Brunswick	773	927	781	1,336	0.820	0.962	1.129	6.0		37	36.5	4.517
Buncombe [2]	1,769	2,973	7,030	11,581	1.138	1.176	0.897	8.8		296	171.4	7.955
Burke	654	1,022	605	893	1.736	0.918	1.068	7.9		71	50.5	5.493
Cabarrus	1,085	1,866	2,960	4,373	1.228	1.208	1.453	7.6		137	86.3	6.019
Caldwell	502	1,436	1,216	2,619	1.358	1.254	1.372	7.9		46	33.5	4.248
Camden [1]	45	149	44	498	n/a	n/a	n/a	11.8	[4]	2	1.9	2.650
Carteret [2]	147	175	651	1,689	1.029	1.344	1.262	8.6		44	33.5	5.518
Caswell	503	548	107	160	n/a	n/a	n/a	16.9		10	4.9	2.005
Catawba	2,093	3,057	1,012	3,021	0.926	1.046	1.140	7.8		132	94.8	6.327
Chatham	459	806	2,033	2,355	0.606	1.111	1.020	6.6		28	21.8	4.115
Cherokee	504	598	31	493	n/a	n/a	n/a	7.6		23	16.1	6.324
Chowan [1]	73	443	70	1,331	n/a	n/a	n/a	9.1	[4]	13	10.1	6.866
Clay	35	228	-	167	n/a	n/a	n/a	10.9	[4]	5	0.8	0.837
Cleveland	577	2,177	4,524	9,317	0.955	1.089	1.013	9.7		75	57.2	5.773
Columbus	746	1,546	142	1,020	2.327	0.708	1.054	10.9		27	19.2	3.431
Craven	894	1,213	18	604	0.820	0.852	0.998	7.8		73	50.5	5.414
Cumberland [2]	1,310	2,265	4,403	7,268	1.021	0.847	0.923	11.2		206	167.0	5.411
Currituck [1]	115	374	227	1,486	n/a	n/a	n/a	10.5		5	4.6	2.332
Dare	968	1,122	898	2,219	0.718	1.010	1.529	8.9		27	17.7	5.441
Davidson	2,079	2,216	498	780	1.106	1.145	1.056	8.5		72	51.8	3.382
Davie	333	518	407	896	1.287	1.018	1.200	12.3		13	9.8	2.598
Duplin	753	980	157	529	0.777	0.790	0.950	9.4		25	20.8	4.005
Durham [2]	1,738	3,395	11	14	0.587	0.724	0.630	8.7		513	182.5	7.772
Edgecombe	300	1,368	1,548	3,837	1.010	0.842	1.030	11.6		22	12.8	2.337
Forsyth [2]	-	3,106	-	9,503	0.664	0.863	0.880	9.9		404	210.4	6.601

	Columns JJ, KK		Columns LL, MM		Column NN	Column OO	Column PP	Column QQ		Column RR	Column SS	Column TT
	Family Planning		Immunization Clients		Avoid Hospital (ACS Admissions), Ages 0-17 (OBS/ EXPECT RATIO)	Avoid Hospital (ACS Admissions), Ages 18-39 (OBS/ EXPECT RATIO)	Avoid Hospital (ACS Admissions), Ages 40-64 (OBS/ EXPECT RATIO)	Mortality Rate per 1,000 Pop (1998-2002)		2003 Total Primary Care Physicians	FTE Primary Care Physicians	Primary Care Physicians FTE/10,000
County	Unins.	Total	Unins.	Total								
Franklin	337	899	122	807	0.739	0.719	0.957	7.6		16	9.3	1.821
Gaston	1,492	3,415	5,004	7,979	1.153	1.018	1.009	9.5		146	105.7	5.447
Gates [1]	35	311	33	348	n/a	n/a	n/a	9.2	[4]	3	1.3	1.235
Graham	134	236	115	333	n/a	n/a	n/a	4.0	[4]	3	3.1	3.789
Granville	233	874	26	941	0.444	0.768	0.828	6.1		30	22.9	4.433
Greene	765	844	340	538	n/a	n/a	n/a	11.8		5	3.8	1.887
Guilford	74	7,808	6	868	0.760	0.759	0.670	8.7		400	235.0	5.332
Halifax	410	1,281	33	196	0.840	0.629	0.827	9.0		40	25.1	4.373
Harnett	325	1,450	376	2,399	1.174	0.929	1.095	7.7		47	28.6	2.889
Haywood	771	1,293	686	922	1.012	0.867	1.044	5.8		43	35.3	6.321
Henderson	514	1,350	583	3,336	1.309	1.202	0.990	6.8		107	64.9	6.806
Hertford [1]	291	384	152	296	n/a	n/a	n/a	17.5		17	18.9	8.480
Hoke	235	652	1	151	0.538	0.618	0.584	8.4		11	8.0	2.130
Hyde	98	259	252	648	n/a	n/a	n/a	10.4	[4]	2	2.1	3.559
Iredell	617	1,332	3,333	7,140	1.955	1.290	1.315	8.9		98	76.3	5.701
Jackson	590	662	986	1,106	1.565	0.954	1.363	7.3		38	31.3	9.013
Johnston	1,044	1,812	1,767	4,060	0.984	0.937	0.990	7.3		59	48.7	3.562
Jones	140	197	120	267	n/a	n/a	n/a	3.9	[4]	15	8.2	7.836
Lee	474	1,100	226	783	0.932	1.079	1.108	7.2		42	31.5	6.160
Lenoir	378	1,289	1,257	2,153	1.675	1.219	1.179	11.9		49	31.9	5.336
Lincoln	632	690	12	29	1.033	1.104	1.134	9.8		38	34.0	4.986
Macon	160	736	3	153	1.502	1.030	0.971	8.6		32	19.8	6.236
Madison	350	449	11	47	n/a	n/a	n/a	5.4	[4]	13	8.1	3.987
Martin [1]	254	784	339	691	0.766	0.984	1.091	10.1		13	13.6	5.324
McDowell	591	842	226	600	1.248	0.729	0.845	7.6		21	16.0	3.617
Mecklenburg [2]	3,469	5,210	3,613	5,883	1.003	0.864	0.812	7.6		724	432.4	5.726
Mitchell	309	365	6	141	n/a	n/a	n/a	9.6	[4]	15	10.6	6.582
Montgomery	68	710	19	1,052	0.741	0.693	0.709	7.3		9	10.0	3.597
Moore	663	1,345	407	889	0.913	0.978	1.006	9.3		69	37.8	4.759
Nash	1,694	2,335	718	2,437	0.883	0.828	0.940	11.4		73	49.7	5.490
New Hanover [2]	1,352	2,307	3,045	6,579	0.846	0.933	0.847	5.8		210	117.2	6.841
Northampton	172	588	78	566	n/a	n/a	n/a	16.6		7	5.5	2.454
Onslow [2]	1,572	1,858	138	525	0.741	0.788	1.365	7.7		59	43.7	2.898
Orange	665	1,065	2,972	4,895	0.756	0.737	0.731	7.3		424	135.1	10.776

	Columns JJ, KK		Columns LL, MM		Column NN	Column OO	Column PP	Column QQ		Column RR	Column SS	Column TT
	Family Planning		Immunization Clients		Avoid Hospital (ACS Admissions), Ages 0-17 (OBS/ EXPECT RATIO)	Avoid Hospital (ACS Admissions), Ages 18-39 (OBS/ EXPECT RATIO)	Avoid Hospital (ACS Admissions), Ages 40-64 (OBS/ EXPECT RATIO)	Mortality Rate per 1,000 Pop (1998-2002)		2003 Total Primary Care Physicians	FTE Primary Care Physicians	Primary Care Physicians FTE/10,000
County	Unins.	Total	Unins.	Total								
Pamlico	59	301	60	280	n/a	n/a	n/a	3.8	[4]	8	4.7	3.595
Pasquotank [1]	621	1,261	769	2,427	0.872	0.930	1.130	11.0		38	22.9	6.426
Pender	46	1,045	3	279	0.502	0.674	0.674	8.0		11	8.7	1.953
Perquimans [1]	248	331	671	893	n/a	n/a	n/a	13.7	[4]	2	2.8	2.355
Person	339	808	57	330	1.261	0.741	0.825	10.0		17	13.0	3.482
Pitt [2]	1,539	3,322	1,052	3,966	0.813	0.670	0.768	11.1		235	107.4	7.694
Polk	32	143	81	282	n/a	n/a	n/a	9.0	[4]	12	9.8	5.028
Randolph	1,076	2,250	99	908	1.397	1.088	1.191	9.2		70	57.0	4.146
Richmond	554	735	320	614	3.998	2.105	1.974	8.4		34	31.9	6.808
Robeson	736	1,874	216	1,510	1.041	1.146	1.090	12.5		75	59.2	4.622
Rockingham	657	1,552	1,202	2,374	1.113	0.778	1.126	8.0		51	41.9	4.506
Rowan [2]	977	1,349	242	742	2.080	1.196	1.024	7.3		72	61.2	4.492
Rutherford	625	1,118	389	1,554	0.628	0.672	0.902	10.3		44	30.5	4.720
Sampson	185	1,258	144	1,843	1.364	1.117	1.076	8.6		25	27.6	4.306
Scotland	433	1,280	48	581	0.960	1.034	1.071	12.8		31	23.5	6.476
Stanly	519	712	342	1,187	1.103	1.165	1.111	8.6		45	23.5	3.905
Stokes	697	939	633	1,869	0.516	1.086	1.595	6.2		13	11.9	2.544
Surry	606	1,216	1,883	5,467	1.118	0.746	1.299	6.8		62	52.4	7.132
Swain	210	210	1,359	1,362	n/a	n/a	n/a	2.3	[4]	18	13.5	9.997
Transylvania	393	628	278	1,085	0.617	0.965	0.649	8.6		25	14.2	4.709
Tyrrell [1]	100	411	19	175	n/a	n/a	n/a	13.5	[4]	1	1.2	2.844
Union	672	1,639	3,182	5,256	1.662	0.866	0.938	6.9		67	49.7	3.549
Vance	219	791	-	240	0.482	0.829	0.726	13.0		31	16.3	3.664
Wake	4,778	8,979	183	660	0.971	1.017	0.898	6.8		651	371.3	5.284
Warren	445	665	366	643	n/a	n/a	n/a	12.8		7	4.0	1.936
Washington [1]	55	480	92	489	n/a	n/a	n/a	14.2		5	4.1	2.994
Watauga [1]	867	1,066	352	903	1.357	0.892	0.973	8.2		39	24.0	5.495
Wayne	1,973	2,932	2,644	6,431	0.644	1.084	1.083	10.6		79	57.0	4.949
Wilkes	72	823	50	1,438	0.947	1.188	1.410	6.9		35	24.1	3.572
Wilson	235	1,637	540	5,103	0.481	0.696	0.735	11.3		46	28.4	3.730
Yadkin	569	606	214	268	0.976	1.164	1.533	6.2		16	16.6	4.359
Yancey	321	404	408	513	n/a	n/a	n/a	3.2	[4]	15	9.1	4.926
Other [5]	407	1,246										
North Carolina	66,259	133,320	81,053	190,914								

Appendix C | Technical Assistance and Financial Resources for Communities Interested in Developing Safety Net Services*

This document provides information for communities interested in developing safety net services, but would like more information about technical assistance, prescription drug assistance, or foundation funding. Organizations providing these types of assistance are outlined in three sections below. This is not an exhaustive list of potential resources, but may be helpful during the initial investigation of new safety net program development.

Technical Assistance Resources

American Project Access Network (APAN)
5809 East Washington Street
Indianapolis, IN 46219
Phone: 317-358-1066
Fax: 317-358-1908
E-mail: info@apanonline.org
Website: http://www.apanonline.org

American Project Access Network is a national non-profit 501(c)(3) service organization that is dedicated to assisting communities across the nation with establishing and sustaining coordinated systems of charity care based on the Asheville/Buncombe County, NC and other Project Access models. This proven approach is capable of providing access to the full continuum of care for the low-income, uninsured. It accomplishes its mission through a full-time, in-house consulting staff that works in partnership with national experts in access to care and a team of leaders from communities who have successfully established Project Access-type systems.

Local Technical Assistance and Training Branch, NC Division of Public Health
NC Department of Health and Human Services
1915 Mail Service Center
Raleigh, NC 27699-1915
Phone: 919-715-3354
Fax: 919-715-3104
Website: http://www.ncpublichealth.com/

The Local Technical Assistance and Training Branch of the NC Division of Public Health provides technical assistance and training to health departments throughout North Carolina. It also offers consultation for the Healthy Carolinians process, which develops community-based partnerships to identify and address the health concerns of local communities. Three types of consultations are available from the Branch, including policy and leadership consultations for the local health director and/or management team, nursing consultation for the clinical aspects of service delivery, and administration consultation for fiscal, billing and other administrative needs.

North Carolina Area Health Education Centers Program (AHEC)
101 Medical Drive, CB# 7165
Chapel Hill, NC 27599-7165
Phone: 919-966-2461
Fax: 919-966-5830
Email: ncahec@med.unc.edu
Website: http://www.med.unc.edu/ahec/

* *Information excerpted from the websites of specified organizations.*

The mission of the North Carolina AHEC Program is to meet the state's needs by providing educational programs in partnerships with academic institutions, healthcare agencies, and other organizations committed to improving the health of the people of North Carolina. AHEC operates a broad array of educational programs for health science students, primary care residents, and health professionals. The nine AHEC Centers each have a large multidisciplinary faculty and staff whose role is to prepare a health professions workforce to meet the health needs of the regions they serve. AHECs also provide technical assistance to health agencies in their regions, drawing on their own faculty and staff and the faculty from the academic health centers in the state. Services include workforce needs assessments, staff development and management training, and clinical training to meet specific organizational needs.

North Carolina Association of Free Clinics (NCAFC)
3447 Robinhood Road, Suite 312
Winston-Salem, NC 27106
Phone: 336-251-1111
Fax: 336-251-1110
Website: http://www.ncfreeclinics.org/

The North Carolina Association of Free Clinics, founded in 1998, is a private, nonprofit, 501(c)(3) tax-exempt organization that conducts advocacy, research, public relations, resource development, training, and technical assistance on behalf of its member Free Clinics and the people they serve. One of its goals includes providing technical assistance to member clinics and those interested in starting new clinics. North Carolina's Free Clinics provide medical and dental care, as well as prescription medications, for low-income, uninsured, and medically underinsured people in 48 counties and cities across North Carolina.

North Carolina Community Health Center Association (NCCHCA)
2500 Gateway Center, Suite 100
Morrisville, NC 27560
Phone: 919-69-5701
Fax: 919-469-1263
Website: http://www.ncphca.org/

NCCHCA represents Federally Qualified Health Centers (FQHCs) and serves all consolidated health center grantees. FQHCs are federally supported, not-for-profit healthcare organizations that provide primary care, interpretation/translation, transportation, outreach, and other enabling services. The community health centers it represents are built to serve the entire community and are used by those with and without insurance. The NCCHCA's community development initiatives focus on expanding the number of new and existing primary care access points within North Carolina, while concurrently strengthening present facilities.

North Carolina Institute for Public Health (NCIPH)
School of Public Health
University of North Carolina at Chapel Hill
CB# 8165
Chapel Hill, NC 27599-8165
Phone: 919-966-4032
Fax: 919-966-0478
Website: http://www.sph.unc.edu/nciph/

NCIPH is dedicated to the proposition that public health scholarship and practice go hand in hand. Its programs and services bridge the worlds of isolated academic disciplines, scholarship and practice, and human service organizations. NCIPH is a key public health information resource for legislators, the media, decision-makers in private and nonprofit organizations, and the general public, imparting timely and practical knowledge about ongoing and emerging public health issues. Its intention is to raise public awareness and stimulate discourse about public health issues, policy, and practice. NCIPH provides a complete range of public health professional development instructional services. It also offers consulting services that rely on evidence-based scholarship and the identification and dissemination of best practices. Consulting Services is dedicated to building the capacity of our clients by addressing their immediate needs and introducing

solutions that enable them to resolve future problems themselves. Finally, the Institute provides comprehensive, customer-focused, high quality program planning and evaluation services. The evaluation team has worked with a variety of clients, from local and state health departments to international clients.

North Carolina Rural Health Center
North Carolina Hospital Association
PO Box 4449
Cary, NC 27519-4449
Phone: 919-677-4222
Fax: 919-677-4200
Website: http://www.ncha.org/

The North Carolina Rural Health Center was created in 1996 through a grant funded by the Healthcare Division of Kate B. Reynolds Charitable Trust. The purpose of the grant is to encourage innovative, collaborative, community-wide healthcare networks in North Carolina; to assure continued, appropriate healthcare services in rural communities; and to gather and disseminate information. The Rural Health Center acts as a statewide resource for rural health organizations and communities; advises rural health organizations and communities regarding community health improvement, collaboration, and strategic planning; and promotes leadership and cooperation among rural health organizations and communities in their common mission to achieve a healthy community. Technical assistance for grant requests, strategic planning retreats, and collaborative models are some of the services provided.

Office of Research Demonstrations and Rural Health Development (ORDRHD)
311 Ashe Avenue
Raleigh, NC 27606
Mailing address: 2009 Mail Service Center, Raleigh NC 27699-2009
Phone: 919-733-2040
Fax: 919-733-8300

The NC Office of Research, Demonstrations, and Rural Health Development, founded in 1973 as the Office of Rural Health Services, provides technical assistance to small hospitals and community health centers in rural and medically underserved communities. The office also recruits healthcare providers to work in rural and medically underserved communities and provides grants for rural health centers. The Office is the lead agency for demonstrations in the delivery and financing of healthcare for the Department.

The Grantsmanship Center
PO Box 17220
Los Angeles, CA 90017
Phone: 213-482-9860
Fax: 213-482-9863
E-mail: info@tgci.com
Website: http://www.tgci.com/

The Grantsmanship Center Inc. (TGCI) offers workshops on grantsmanship, enterprise development, fundraising, and publications to non-profit organizations and governmental agencies. Its website has links to several funding sources.

The Foundation Center
76 Fifth Avenue
New York, NY 10003
Phone: 212-620-4230
Fax: 212-691-1828
Website: http://fdncenter.org/

The Foundation Center's mission is to strengthen the nonprofit sector by advancing knowledge about US philanthropy. To achieve this mission, The Foundation Center collects, organizes, and communicates information on US philanthropy;

conducts and facilitates research on trends in the field; provides education and training on the grantseeking process; and ensures public access to information and services through website, print, and electronic publications, five library/learning centers, and a national network of Cooperating Collections.

Prescription Drug Assistance Programs

Medpin
180 Grand Avenue
Suite 750
Oakland, CA 94612
Phone: 510-302-3300
Fax: 510-444-8253
E-mail: info@medpin.org
Website: http://www.medpin.org

Medpin works in several different ways to help get medicines and other healthcare to people in need. Medpin's small staff is assisted by a number of people in key positions and with special expertise regarding safety net providers, pharmaceuticals, pharmacists and pharmacies, and academic research. Medpin helps safety net providers become more informed about pharmaceutical management strategies through its bi-monthly newsletter, The Medicine Cabinet; conference call trainings that allow clinicians to interact with colleagues and healthcare experts without leaving their offices; and statewide and regional conferences offering in-person information and leadership development for pharmacists, clinicians, administrators, and policy makers. Medpin also works with pharmacists interested in working on a full-time or consulting basis to safety net clinics, clinics assessing their pharmacy-related resources and needs, and safety net clinics contracting with retail pharmacies to dispense 340B drugs. Medpin provides technical assistance to community clinics and county health systems on medication-access issues, including strategies to lower total drug spending and improve compliance with medication management requirements.

National Legislative Association on Prescription Drug Prices (NLaRx)
214 Water Street
PO Box 492
Hallowell, ME 04347
Phone: 207-622-5597
Fax: 207-621-0960
E-mail: nlarx@gwi.net
Website: http://www.nlarx.org/

The National Legislative Association on Prescription Drug Prices works to achieve the following goals: a) serve as a clearinghouse for research and information relative to the pricing of prescription drugs; b) provide a forum for the discussion, development and coordination of public policy strategies to reduce prescription drug prices; c) encourage and support the enactment of legislation to reduce prescription drug prices; d) initiate and coordinate communication with members of the United States Congress and with federal agencies to promote federal laws and policies to reduce prescription drug prices; e) provide a forum for the discussion and development of any other public policies and strategies that may provide greater access to pharmacy benefits at a fair price; and f) urge development of federal and state assistance insurance assistance programs offering prescription drug coverage.

Pharmacy Services Support Center
American Pharmacists Association
2215 Constitution Avenue, NW
Washington, DC 20037-2985
Phone: 202-429-7518 or 1-800-628-6297
Fax: 202-223-7193
E-mail: pssc@aphanet.org
Website: http://pssc.aphanet.org/

The HRSA Pharmacy Services Support Center (PSSC) is a unique collaboration between the federal government and the American Pharmacists Association (APhA) to bring comprehensive pharmacy services to patients who receive care at HRSA grantee and 340B-eligible healthcare delivery sites. The PSSC provides information and assistance to help eligible sites optimize the value of the 340B Program by increasing their patients' access to affordable drugs and the value of comprehensive pharmacy services.

Public Hospital Pharmacy Coalition (PHPC)
Powers, Pyles, Sutter, & Verville, PC
1875 Eye Street, NW
12th Floor
Washington, DC 20006
Phone: 202-466-6550
Fax: 202-785-1756
Website: http://www.phpcrx.org

PHPC is an organization of over 230 safety net hospitals and health systems throughout the US. The Coalition was formed to increase the affordability and accessibility of pharmaceutical care for the nation's poor and underserved populations. PHPC monitors, educates and serves as an advocate on federal legislative and regulatory issues related to drug pricing and other pharmacy matters affecting safety net providers. PHPC members participate in the Public Health Service's 340B drug discount program. The Coalition is dedicated to protecting the 340B program and creating new opportunities for members to save on pharmaceuticals.

Volunteers in healthcare (VIH)
111 Brewster Street
Pawtucket, RI 02860
Phone: 877-844-8442
Fax: 401-729-2955
Website: http://www.volunteersinhealthcare.org/home.htm

VIH is a national resource center funded by the Robert Wood Johnson Foundation for organizations and clinicians caring for the uninsured. It seeks provide technical assistance and small grants to organizations that use clinical volunteers; link organizations with each other, creating a communication and resource network and helping to share lessons learned; shine a light on the achievements, dilemmas, and scope of these organizations' efforts to care for the uninsured, and inform public policy. As a national resource center, VIH: provides technical assistance to organizations or individuals looking to start, expand, enhance or improve services; identifies and shares models for approaching common issues and challenges, such as improving access to pharmaceuticals; creates products, such as How to Start a Dental Program, tailored to the needs of organizations using clinical volunteers; responds to information requests unlikely to be found at any other single source; maintains a web site comprising a range of information, such as topical "field reports," current news and legislation, grant announcements and RxAssist, a searchable database on pharmaceutical company's patient assistance programs; awards small grants and helps fund networking opportunities such as meetings, site visits, and training sessions; and engages national partners and pursues innovative approaches on issues of importance to the uninsured.

Resources from the Volunteers in healthcare organization include:

- RxAssist (http://www.rxassist.org), a search engine for finding patient assistance programs that provide discount pharmaceuticals to low-income patients;
- Rx Outreach (http://www.rxoutreach.com/en/vih/), a program that allows individuals and families with incomes of up to 250 percent of the federal poverty level to qualify for more than 50 generic medications at reduced costs. People may take advantage of the program even if they receive medicines through another discount program.

Foundations/Grantmakers with Statewide Focus

Kate B. Reynolds Charitable Trust Health Division
128 Reynolda Village
Winston-Salem, NC 27106-5123
Phone: 336-723-1456
Website: http://www.kbr.org/

The healthcare Division of the Kate B. Reynolds Charitable Trust provides grants to serve the health and medical needs of the people of North Carolina who may be in need of medical care or assistance for financial reasons. The Division's objectives are to: increase the availability of health services to underserved groups; promote good health and prevent illness; support well-conceived studies that clearly define health problems in North Carolina and will assist the division in meeting its goal; and support other types of health programs that have merit and are related to the division's goal.

BlueCross BlueShield of North Carolina Foundation
5901 Durham-Chapel Hill Boulevard
Durham, NC 27707
Phone: 919-765-3569
E-mail: foundation@bcbsnc.com
http://www.bcbsnc.com/foundation/

The mission of the BlueCross BlueShield of North Carolina Foundation is to provide financial support to improve the health and well-being of North Carolinians. The foundation will support programs and services in response to grant requests as well as programs supporting needs identified by the foundation. The foundation funds programs and projects that focus on making healthcare accessible to as many people as possible. It also supports programs and projects that promote good health and well-being. One of the signature programs of the BlueCross and BlueShield of North Carolina Foundation is the Healthy Community Institute for Non-Profit Excellence, which provides training to strengthen the organizational capacity of non-profit organizations in North Carolina. It is a special two-day intensive course that engages three- to four-person teams from non-profit organizations in a comprehensive board and staff training curriculum. Over 350 organizations across the state have attended the Institutes.

The Belk Foundation
2801 W Tyvola Road
Charlotte, NC 28217-4500
Phone: 704-426-8404
Website: http://www.belk.com/main/belk_foundation.jsp

The mission of The Belk Foundation is to support local and regional educational, religious, cultural, social, and medical causes "for the up-building of mankind," including assisting secondary schools, colleges and universities and their programs; assisting religious institutions and organizations and their programs; supporting area arts and other cultural organizations and their programs; supporting community-based human services organizations and their programs; and aiding hospitals and healthcare organizations and their programs. The Belk Foundation's gifts are concentrated primarily in North Carolina, where Belk, Inc. is based. The Belk Foundation prefers not to accept grant requests for amounts less than $5,000 and grants from The Belk Foundation are not awarded to: individuals, including students; public, government or quasi-governmental programs, agencies or organizations (excluding certain public secondary schools, colleges and universities); or international programs and/or organizations.

Cannon Foundation
PO Box 548
Concord, NC 28026-0548
Phone: 704-786-8216
Website: http://www.thecannonfoundationinc.org/index.asp

The Cannon Foundation, Inc. began in 1943 and focused giving on communities where Cannon Mills plants were located. Virtually all giving is in North Carolina, and over the past few years has expanded from just the local area to reach

from Manteo to Murphy. However, the highest priority continues to be Cabarrus County and related communities, followed by the Piedmont region, and then rural areas of North Carolina. Normally, grant requests from organizations located in the state's major metropolitan areas do not receive a high priority unless the organization serves rural areas. Historically, one of the principal grant fields has been healthcare, primarily in the local area. The Foundation makes grants for capital purposes, (new construction, renovation and expansion) and projects and programs, but generally not for organizational operating expenses.

The Duke Endowment healthcare Division
100 North Tryon Street, Suite 3500
Charlotte, NC 28202-4012
Phone: 704-376-0291
Fax: 704-376-9336
Website: http://www.dukeendowment.org/

In the field of healthcare, the Duke Endowment usually limits assistance to not-for-profit hospitals located in the states of North Carolina and South Carolina. On occasion, requests are also considered from other NC and SC health organizations and agencies, including academic health centers, hospital associations, and area health education centers. The objectives and priorities of the healthcare Division are to: find efficient, compassionate, and cost-effective ways to address chronic disease and long-term illness; emphasize the prevention of illness and seek opportunities for early intervention and increased access to care; strengthen and improve not-for-profit hospitals and related health organizations.

Fletcher Foundation
220 Fayetteville Street Mall, Suite 400
Raleigh, NC 27601
Mailing address: PO Box 12800, Raleigh, NC 27605
Phone: 919-890-6086
Fax: 919-890-6279
E-mail: djohnson@ajf.org
Website: http://www.ajf.org

The Fletcher Foundation was developed to support nonprofit organizations in their endeavors to enrich the lives and well-being of people in North Carolina. The Foundation has changed its focus to human services, using grants and partnerships with others to give voice to North Carolinians who have no voice, and to affect policy change at the state level. One of the Fletcher Foundation's other five goals is the expansion of healthcare and medical research for underserved communities.

Foundation for the Carolinas
217 S Tryon Street
Charlotte, NC 28202
Phone: 704-973-4500 or 800-973-7244
Fax: 704-973-4946
Website: http://www.fftc.org/

The purpose of Foundation for the Carolinas is to advance philanthropy by serving donors, increasing charitable giving and improving our communities. The foundations it represents were established by local leaders to benefit a broad range of charitable purposes. The Foundation assists donors in making charitable gifts to the community, provides services for nonprofit organizations to create new or manage existing endowments, and makes grants for new projects. These foundations give priority to "seed grants" to initiate promising new projects by existing agencies or by new organizations. To receive consideration, any project or program must have potential continuity through other funding sources in future years.

Gladys Brooks Foundation
1055 Franklin Avenue
Garden City, New York 11530
Website: http://www.gladysbrooksfoundation.org/

The Gladys Brooks Foundation was created to provide for the intellectual, moral, and physical welfare of the people of the United States by establishing and supporting non-profit libraries, educational institutions, hospitals, and clinics. Generally speaking, grant applications will only be considered where: a) outside funding (including governmental) is not available; b) the project will be largely funded by the grant and will not be part of a larger project, and c) the funds will be used for capital projects including equipment or endowments. North Carolina is one of only 17 states and the District of Columbia that are regularly funded by the Foundation. Grant applications will be considered only for major expenditures generally between $50,000 and $100,000.

In the year 2004, grant applications considered included, but was not limited to: hospitals and clinics. Grant applications from hospitals and clinics will be considered generally where the proposal demonstrates one or more of the following: a) a new health need; b) an improvement in the quality of healthcare or c) reduced health costs with better patient outcomes. Proposals for a continuing project must include a commitment from the applicant or third party that the project will continue to receive all the necessary financial support after the grant from the Foundation is exhausted.

North Carolina Community Foundation (NCCF)
200 South Salisbury Street
Raleigh, NC 27602-2828
Phone: 919-828-4387
Fax: 919-828-5495
E-mail: general@nccommf.org
Website: http://www.nccommf.org

NCCF is one of the leading charitable resources for donors throughout North Carolina. Known for its unique network of affiliates that marshal resources, NCCF encourages community dialogue and builds permanent assets that enrich the quality of life for our citizens. NCCF is recognized as a resource for other statewide organizations, building endowments, and serving the needs of donors throughout North Carolina.

North Carolina Health and Wellness Trust Fund
501 N Blount Street
Raleigh, NC 27604
Mailing address: 7090 Mail Service Center, Raleigh, NC 27699-7090
Phone: 919-733-4011
Fax: 919-733-1240
E-mail: hwtfc@ncmail.net
Website: http://www.hwtfc.org/

The NC Health and Wellness Trust Fund (HWTF) was created by the NC General Assembly as one of three entities to invest North Carolina's portion of the Tobacco Master Settlement Agreement. HWTF offers grants in three major areas: teen tobacco prevention and cessation, obesity prevention, and medication assistance to seniors and low-income individuals. The latter program 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 non-profit or government programs access public and private medication assistance programs for the target population.

North Carolina Medical Society Foundation
PO Box 27167
Raleigh, NC, 27611
Phone: 919-833-3836 or 800-722-1350 (NC only)
Fax: 919-833-2023
Website: http://www.ncmedsoc.org/pages/ncms_foundation/ncms_foundation.html

The North Carolina Medical Society Foundation is the philanthropic arm of the North Carolina Medical Society. Its mission is to improve access to quality healthcare for all North Carolinians. The Foundation approaches this problem with a multi-pronged strategy: ensure that primary care practitioners are located in North Carolina's rural and underserved communities; work with local communities to improve the healthcare infrastructure of needy communities; and work to lower the cost of healthcare while improving quality. In 1989, the Medical Society Foundation created the Community Practitioner Program, which assists local communities, state agencies, and other healthcare 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. By offering partial relief for their often tremendous educational debts, practice management assistance and other incentives, the program's support encourages healthcare professionals to serve in the areas of North Carolina that need them most.

Warner Foundation
501 Washington Street, Suite D
Durham, NC 27701
Phone: 919-530-8842
Fax: 919-530-8852
E-mail: info@thewarnerfoundation.org
Website: http://www.thewarnerfoundation.org

The Warner Foundation supports projects that are working in North Carolina to improve economic opportunities for disadvantaged individuals and communities and to improve race relations. Strong preference will be given to applicants and projects that focus on self-sufficiency, create partnerships between people of different ethnicity and economic classes, provide access to new opportunities for economic independence, encourage mutual problem-solving, demonstrate a long-term commitment to a particular community, and provide measurable indicators of success.

County And Regional Financial Resources

The Blumenthal Foundation
Charlotte Region, Mecklenburg County, NC
PO Box 34689
Charlotte, NC 28234-4689
Phone: 704-688-2305
Fax: 704-688-2401
E-mail: foundation@gunk.com
Website: http://www.blumenthalfoundation.org/index.htm

The Blumenthal Foundation was established in Charlotte, North Carolina in 1953. The Foundation provides grants for seed money, annual operating budgets, capital campaigns, conferences and seminars, special projects, and endowments. The Foundation considers grant requests primarily in the Charlotte region and within the State of North Carolina. One of its grant making areas is health.

Cabarrus County Community Foundation
Cabarrus County, NC
PO Box 683
Concord, NC 28026
Phone: 704-782-8282

The Cabarrus County Community Foundation is a permanent endowment established in 1989 by local leaders to benefit a broad range of charitable purposes. The Foundation assists donors in making charitable gifts to the community, provides services for nonprofit organizations to create new or manage existing endowments, and makes grants for new projects. If the applicant has been in existence, the proposal must fall clearly outside the realm of regular budgetary expenditures or needs. To receive consideration, any project or program must have potential continuity through other funding sources in future years.

Cleveland County Community Foundation
Cleveland County, NC
PO Box 579
Kings Mountain, NC 28086
Phone: 704-739-6613
Email: ldhsr@bellsouth.net

The Cleveland County Community Foundation is a permanent endowment established in 1985 by local leaders to benefit a broad range of charitable purposes. The Foundation assists donors in making charitable gifts to the community, provides services for nonprofit organizations to create new or manage existing endowments, and makes grants for new projects. If the applicant has been in existence, the proposal must fall clearly outside the realm of regular budgetary expenditures or needs. To receive consideration, any project or program must have potential continuity through other funding sources in future years.

The Community Foundation of Davie County
Davie County, NC
194 Wilkesboro Street
PO Box 546
Mocksville, NC 27028
Phone: 336-753-6903
Fax: 336-753-6904
E-mail: info@daviefoundation.org
Website: http://www.daviefoundation.org/

The Community Foundation of Davie County, Inc. (CFDC) is a community trust, established in December of 1988 for the purpose of promoting the well-being of the people of the County of Davie and is operated exclusively for civic, educational, cultural, religious, and charitable purposes. Funds entrusted to the Foundation will be invested in the current and future well-being of Davie County citizens.

Community Foundation of Gaston County
Gaston County, NC
PO Box 123
Gastonia, NC 28053
Phone: 704-864-0927
E-mail: lslade@cfgaston.org
Website: http://www.cfgaston.org/

The mission of the Community Foundation of Gaston County is to provide effective operation of a permanent foundation to accept and manage gifts for charitable, benevolent, cultural, religious, civic, moral, and educational purposes benefiting Gaston County.

Community Foundation of Greater Greensboro, Inc.
Greater Greensboro Area, NC
100 South Elm Street, Suite 307
Greensboro, NC 27401-2638
Phone: 336-379-9100
Fax: 336-378-0725
E-mail: grants@cfgg.org
Website: http://www.cfgg.org

The Community Foundation of Greater Greensboro is a charitable organization dedicated to strengthening the community for present and future generations. The mission of the Community Foundation is to promote philanthropy, to build and maintain a permanent collection of endowment funds, and to serve as a trustworthy partner and leader in shaping effective responses to community issues and address emerging community issues.

Community Foundation of Henderson County, Inc.
Henderson County, NC
PO Box 1108
Hendersonville, NC 28793
Phone: 828-697-6224
Fax: 828-696-4026
E-mail: Info@cfhendersoncounty.org
Website: http://www.cfhendersoncounty.org/

The Community Foundation of Henderson County, Inc. receives gifts, endowments, and bequests from individuals, families, businesses and organizations. The income from these funds is used to make grants to qualified agencies and institutions primarily serving the people of Henderson County, North Carolina.

The Community Foundation of Southeastern North Carolina
Bladen, Brunswick, Columbus, New Hanover, and Pender Counties of North Carolina
PO Box 119
Wilmington, NC 28402-0119
Phone: 910-251-3911
Fax: 910-798-5292
E-mail: Info@communityfoundationsenc.org
Website: http://www.communityfoundationsenc.org

The Community Foundation of Southeastern North Carolina, formerly Cape Fear Community Foundation, is a resource to individuals and organizations in southeastern North Carolina with philanthropic desires. The mission of the Foundation is to encourage and facilitate charitable giving. The service area includes New Hanover, Pender, Brunswick, Columbus, and Bladen counties. The Foundation is governed by a Board of Directors of concerned local citizens who oversee investments, administration, and grant making.

The Community Foundation of the Dan River Region
Martinsville-Henry/County to South Boston/Halifax County, including the neighboring North Carolina counties
PO Box 1039
530 Main Street
Danville, VA 24543
Phone: 434-793-0884
Fax: 434-793-6489
E-mail: communityfoundation@gamewood.net
Website: http://www.cfdrr.org

The Community Foundation of the Dan River Region is a public charity established in September 1996 by a steering committee of civic leaders to meet a variety of social, educational, cultural, and other charitable needs in the Martinsville-Henry/County to South Boston/Halifax County, including the neighboring North Carolina counties.

The Community Foundation of Western North Carolina, Inc.
Western North Carolina
PO Box 1888
One West Pack Square, Suite 1600
Asheville, NC 28802
Phone: 828-254-4960
Fax: 828-251-2258
Website: http://www.cfwnc.org

The Community Foundation of Western North Carolina is a nonprofit organization that has served the mountain region since 1978 by professionally managing charitable funds created by individuals and families, and by using those funds to make grants that address the changing needs of an 18-county region.

Cumberland Community Foundation, Inc.
Cumberland County and Southeastern North Carolina
308 Green Street
PO Box 2345
Fayetteville, NC 28302
Phone: 910-483-4449
Fax: 910-483-2905
Website: http://www.cumberlandcf.org/

Cumberland Community Foundation exists to foster creative change, to encourage and test new ideas, and to work for the common good of all citizens of Cumberland County and the surrounding area. The Cumberland Community Foundation seeks to promote local philanthropy and its rewards, build and maintain a permanent endowment for the benefit of the community, provide a flexible vehicle for prospective donors with varied charitable interests and abilities to give, and develop solutions to changing community needs through effective grant making.

Chowan Hospital Foundation
Chowan County, NC
211 Virginia Rd
Edenton, NC 27932-9668
Phone: 252-482-6440

The mission of the Chowan Hospital Foundation is to improve healthcare for residents served by the Chowan County medical community. The Foundation, the fundraising division of Chowan Hospital, helps to raise funds for purchasing needed equipment, to sponsor community wellness programs, to assist with physician recruitment, and to administer health-related grants.

The Greater Greenville Foundation
Pitt County, NC
PO Box 20154
Greenville, NC 27858
Phone: 252-756-8549
Fax: 252-756-8549
Website: http://www.greenvillefoundation.com/

The vision of the Greater Greenville Foundation is to establish an office that serves as a nonprofit resource library to help nonprofits in their grant writing and other research, as well as provide meeting space for local nonprofits. The Foundation seeks to encourage programs to help in the capacity building needed for area nonprofits. The Foundation also seeks to encourage nonprofits to secure their own future by establishing an endowment fund with the Foundation.

Iredell County Community Foundation
Iredell County, NC
PO Box 312
Statesville, NC 28687
Phone: 704-872-7671
Fax: 704-872-7675

The Iredell County Community Foundation is a permanent endowment established in 1989 by local leaders to benefit a broad range of charitable purposes. The Foundation assists donors in making charitable gifts to the community, provides services for nonprofit organizations to create new or manage existing endowments, and makes grants for new projects. If the applicant has been in existence, the proposal must fall clearly outside the realm of regular budgetary expenditures or needs. To receive consideration, any project or program must have potential continuity through other funding sources in future years.

John Rex Endowment
Wake County and surrounding areas of North Carolina
118 South Person Street, Raleigh, NC 27601
Mailing address: PO Box 25425, Raleigh, NC 27611
Phone: 919-835-3565
Fax: 919-835-3566
E-mail: info@rexendowment.org (email)
Website: http://www.rexendowment.org/

The John Rex Endowment invests in the development and support of activities, programs, and organizations that improve the health of underserved people in Wake and surrounding counties. In the first few years, the Endowment will support visible and measurable improvements in the health of children by improving access to health services, by promoting healthy behaviors, and by providing children with opportunities for growth and development. As needs are identified, the Endowment will consider other underserved populations such as women and the elderly. The Endowment believes that increasing access to care is fundamental to improving children's health and a sound first step for the Endowment to take on behalf of low-income children in Wake County.

Kate B. Reynolds Charitable Trust Poor and Needy Division
Winston-Salem, Forsyth County, NC
128 Reynolda Village
Winston-Salem, NC 27106-5123
Phone: 336-723-1456
Website: http://www.kbr.org/

The Poor and Needy Division provides grants to improve the welfare of the people of Winston-Salem and Forsyth County with emphasis on those who require assistance with basic necessities for financial reasons. The objectives of the division are three-fold: support organizations that provide for the basic needs of the people of Forsyth County (i.e., food, clothing, shelter, and healthcare) either on a direct basis or through programs designed to meet such needs; fund efforts that seek to reduce reliance upon support services or that promote maximum levels of functioning for those with chronic problems; support other programs that have merit and are related to the division's goal.

Lexington Area Community Foundation
Davidson County, NC
PO Box 867
Lexington, NC 27293-0867
Phone: 336-248-6500

The Lexington Area Community Foundation is a permanent endowment established in 1996 by local leaders to benefit a broad range of charitable purposes. The Foundation assists donors in making charitable gifts to the community, provides services for nonprofit organizations to create new or manage existing endowments, and makes grants for new projects. If the applicant has been in existence, the proposal must fall clearly outside the realm of regular budgetary expenditures or needs. To receive consideration, any project or program must have potential continuity through other funding sources in future years.

Lincoln County Community Foundation
Lincoln County, NC
Jonas Law Firm
PO Box 38
Lincolnton, NC 28093
Phone: 704-735-1423

The Lincoln County Community Foundation became fully active in 2002. The Foundation assists donors in making charitable gifts to the community, provides services for nonprofit organizations to create new or manage existing endowments, and makes grants for new projects. If the applicant has been in existence, the proposal must fall clearly

outside the realm of regular budgetary expenditures or needs. To receive consideration, any project or program must have potential continuity through other funding sources in future years.

The Mebane Charitable Foundation
Davie and Yadkin Counties of North Carolina
Mebane Charitable Foundation, Inc.
PO Box 339
Mocksville, NC 27028
Phone: 336-936-0041
Fax: 336-936-0038
E-mail: mgreen@mebanefoundation.com
Website: http://www.mebanefoundation.com

The Mebane Charitable Foundation promotes and supports the highest quality early childhood education initiatives for children, beginning at birth in North Carolina. It also supports nonprofit initiatives in Davie and Yadkin Counties that will improve the lifestyle of citizens in those counties.

Moses Cone-Wesley Long Community Health Foundation
Guilford and Forsyth Counties of North Carolina
721 Green Valley Road, Suite 102
PO Box 4426
Greensboro, NC 27404-4426
Phone: 336-832-9555
Fax: 336-832-9559
Website: http://www.mcwlhealthfoundation.org/index.php

The Moses Cone-Wesley Long Community Health Foundation seeks to invest in the development and support of activities, programs, and organizations that measurably improve the health of people in the geographic area traditionally served by the Moses Cone Health System. Its funding priorities are: 1) access to health services, with particular emphasis on the elimination of barriers to health services by persons in need and 2) wellness, with particular attention to physical activity; nutrition/obesity; substance abuse, including tobacco use prevention/cessation; responsible sexual behavior, especially the prevention of HIV/AIDS, STDs, and adolescent pregnancy; mental health; and injury prevention. In addition to these priorities, the Foundation has a strong and special interest in funding organizational development and technical assistance projects that help communities build the capacity to improve the health of those in the community.

Outer Banks Community Foundation, Inc.
Dare County and all of the Outer Banks communities from Corolla to Ocracoke Island
PO Box 1100
Kill Devil Hills, NC 27948
Phone: 252-261-8839
Fax: 252-261-0371
E-mail: info@obcf.org
Website: http://www.obcf.org

The Outer Banks Community Foundation was organized in 1982 as a public charity to help meet local needs in Dare County and all of the Outer Banks communities from Corolla to Ocracoke Island. The Foundation accomplishes its mission by increasing charitable giving in the area, managing charitable funds for individuals and agencies, and by targeting grants toward the community's most pressing needs and promising opportunities.

Polk County Community Foundation, Inc.
Polk County, NC
255 South Trade Street
Tyron, NC 28782
Phone: 828-859-5314
Fax: 828-859-6122
E-mail: foundation@polkccf.org
Website: http://www.polkccf.org

The mission of the Polk County Community Foundation is to support charitable and beneficial activities in the community, to provide and administer a variety of planned giving programs, to serve as responsible stewards of all funds entrusted to it, and to provide initiatives in recognizing areas of community needs and supporting solutions.

Foundation for Richmond County
Richmond County, NC
926 Biggs Boulevard
Rockingham, NC 28379
Phone: 910-417-3379

The Foundation for Richmond County is a permanent endowment established in 1993 by local leaders to benefit a broad range of charitable purposes. The Foundation assists donors in making charitable gifts to the community, provides services for nonprofit organizations to create new or manage existing endowments, and makes grants for new projects. If the applicant has been in existence, the proposal must fall clearly outside the realm of regular budgetary expenditures or needs. To receive consideration, any project or program must have potential continuity through other funding sources in future years.

Salisbury Community Foundation, Inc.
Town of Salisbury and the Rowan County Area of North Carolina
520 S Fulton Street
Salisbury, NC 28144
Phone: 704-633-8896
Website: http://www.fftc.org/affiliates/community/nc/salisbury/

The mission of the Salisbury Community Foundation is to help fill the many charitable needs of the community in areas ranging from health and human service to education and religion. The Foundation for the Carolinas serves as its administrator, while the Salisbury Community Foundation, Inc. board continues to govern the organization and oversee the grant distribution and investment process. Preference will be given to non-recurring capital needs and one-time projects.

Sisters of Mercy of North Carolina Foundation, Inc.
Metrolina and Western North Carolina regions and other areas of North Carolina
2115 Rexford Road, Suite 401
Charlotte, NC 28211
Phone: 704-366-0087
Fax: 704-366-8850
E-mail: contact@somncfdn.org
Website: http://www.somncfdn.org/foundation.html

The Sisters of Mercy of North Carolina Foundation supports the work of selected tax-exempt healthcare, educational, and social service organizations. The Foundation seeks to assist projects which are designed to improve the quality of life for women, children, the elderly and those who are poor. Special attention is focused on promoting systemic change. The Foundation values working with organizations whose efforts are collaborative, ecumenical, and multicultural. Its grant-making focus is on organizations that serve the unserved or underserved. Grants are made primarily to organizations serving the Metrolina and Western North Carolina regions. Grant requests are also considered from organizations

serving other areas of North and South Carolina. Consideration of grant requests from organizations located outside North and South Carolina will be limited to ministries sponsored by the Sisters of Mercy of the Americas.

Stanly County Community Foundation
Stanley County, NC
505 Muirfield Drive
Albemarle, NC 28001
Phone: 704-982-2649

The Stanly County Community Foundation is a permanent endowment established in 1999 by local leaders to benefit a broad range of charitable purposes. The Foundation assists donors in making charitable gifts to the community, provides services for nonprofit organizations to create new or manage existing endowments, and makes grants for new projects. If the applicant has been in existence, the proposal must fall clearly outside the realm of regular budgetary expenditures or needs. To receive consideration, any project or program must have potential continuity through other funding sources in future years.

Triangle Community Foundation
Wake, Durham, Orange and Chatham Counties of North Carolina
PO Box 12834
Research Triangle Park, NC 27709
Phone: 919-474-8370
Fax: 919-941-9208
E-mail: info@trianglecf.org
Website: http://www.trianglecf.org

The mission of Triangle Community Foundation is to expand private philanthropy in Wake, Durham, Orange, and Chatham counties. This region includes Raleigh, Durham, Chapel Hill, and Carrboro. The Foundation perceives philanthropy to entail the gifting of assets for charitable purposes, and the use of those assets to create meaningful impact. The Foundation encourages individuals, families, and corporations to become effective and strategic philanthropists. In accomplishing its mission, the Foundation seeks to increase donors' satisfaction with their philanthropy, and, more importantly, increase the influence of their giving and its benefit to the public good.

Union County Community Foundation
Union County, NC
2652 Rolling Hills Drive
Monroe, NC 28110
Phone: 704-283-4414

The Union County Community Foundation is a permanent endowment established in 1989 by local leaders to benefit a broad range of charitable purposes. The Foundation assists donors in making charitable gifts to the community, provides services for nonprofit organizations to create new or manage existing endowments, and makes grants for new projects. If the applicant has been in existence, the proposal must fall clearly outside the realm of regular budgetary expenditures or needs. To receive consideration, any project or program must have potential continuity through other funding sources in future years.

The Winston-Salem Foundation
Greater Forsyth County Area, NC
860 West Fifth Street
Winston-Salem, NC 27101-2506
Phone: 336-725-2382 or 866-227-1209
Fax: 336-727-0581
E-mail: info@wsfoundation.org
Website: http://www.wsfoundation.org

The Winston-Salem Foundation connects people who care with causes that matter. Governed by a volunteer board, the Foundation is a pool of hundreds of charitable funds entrusted to it for long-term philanthropic good. These funds are invested and income is used to award grants, including scholarships, to benefit the community as the donors intended.

Appendix D | Acronyms

ADAP	AIDS Drug Assistance Program
AHEC	Area Health Education Center
AWP	Average Wholesale Price
BCBSNC	Blue Cross Blue Shield of North Carolina
BIPA	Benefits Improvement and Protection Act of 2000
BPHC	Bureau of Primary Health Care
BRFSS	Behavioral Risk Factor Surveillance System
CACFP	Child and Adult Congregate Feeding Programs
CAH	Critical Access Hospital
CARE	Comprehensive AIDS Resource Emergency Act
CCMAP	Cumberland County Medical Assistance Program
CCMP	Crisis Control Ministry Pharmacy
CCN	Coordinated Care Network
CCNC	Community Care of North Carolina
CDC	Centers for Disease Control and Prevention
CDSA	Children's Developmental Services Agencies
CHC	Community Health Center
COBRA	Federal Consolidated Omnibus Budget Reconciliation Act
CPS	Current Population Survey
NC DHHS	North Carolina Department of Health and Human Services
DMA	Division of Medical Assistance
DME	Durable Medical Equipment
DSH	Disproportionate Share Hospital
DSS	Department of Social Services
EMTALA	Emergency Medical Treatment and Active Labor Act
FPG	Federal Poverty Guidelines
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
GME	Graduate Medical Education
GPCF	Georgia Partnership for Caring Foundation
HCAP	Healthy Communities Access Program
HIPAA	Health Insurance Portability and Accountability Act
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMO	Health Maintenance Organization

HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
HSIS	Health Services Information System
HWTFC	Health and Wellness Trust Fund Commission
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MAP	Medical Access Plan
MARP	Medical Access and Review Program
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MNIL	Medically Needy Income Limit
LHD	Local Health Department
LME	Local Management Entity
MCH	Maternal and Child Health
MH/DD/SAS	Mental Health, Developmental Disabilities and Substance Abuse Services
NCCHCA	North Carolina Health Center Association
NC IOM	North Carolina Institute of Medicine
ORDRHD	Office of Research, Demonstrations and Rural Health Development
PCP	Primary Care Provider
PAP	Patient Assistance Program
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PRAMS	Prenatal Risk Assessment Monitoring System
RHC	Rural Health Center
ROI	Return on Investment
SBHC	School-Based Health Center
SCHIP	State Children's Health Insurance Program
SFSP	Summer Food Supplement Program
SFY	State Fiscal Year
SLHC	School-Linked Health Center
STD	Sexually Transmitted Disease
TB	Tuberculosis
UDS	Uniform Data System
UNC-CH	University of North Carolina at Chapel Hill
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
YRBS	Youth Risk Behavior Survey