

Federally Qualified Health Centers: Providing Healthcare to North Carolina's Communities in Medical Need

Sonya J. Bruton, MPA

"I wouldn't trade Lincoln doctors for nothing. Whatever illnesses I have, they deal with it right away. If I have to see a specialist, they try and send me to one. They don't take chances. They always deal with my heart to make sure that it's in good condition; because, everything starts from the heart."

Sixty-four years ago, Thelma Woods was born at Lincoln Hospital—now Lincoln Community Health Center—in Durham, North Carolina. She grew up receiving care at the Center, and when she returned from New York after 30 years, it once again became her medical home. Ms. Woods discovered during a pre-employment physical that she had a blood pressure reading of 200/200. She sought care at Lincoln the next morning and learned that she had hypertension, high cholesterol, and diabetes. For three years, the medical staff helped Ms. Woods manage those conditions, and on January 18, 1993, they navigated her through a successful open-heart surgery. Today she serves as a member of the Board of Directors, and Lincoln provides medical care to Ms. Woods, her children, and grandchildren. "I think Lincoln has some of the best doctors around," she said. "I know without them caring for my health, I wouldn't be here today."

Lincoln Community Health Center is one of 23 federally qualified health centers operating in North Carolina. Federally qualified health centers (FQHCs) were created 40 years ago to respond to the reality that the poor have fewer options in the healthcare marketplace and are often shut out entirely from private medical practices. The statute authorizing the award of federal grants to health centers can be found under section 330 of the Public Health Service Act and includes a family of broad and specific health

options: (1) Community Health Centers (CHCs), (2) Migrant Health Centers, (3) Public Housing Primary Care, and (4) Healthy Schools, Healthy Communities.

FQHC Defined

FQHC-designated community health centers are community-located and -operated clinics that receive federal support to care for residents living in the targeted area surrounding the center. The geographic scope may extend to zip codes or counties in an attempt to provide access to care for those in need. In order to receive federal assistance, the specified community must have a medical need. The need could be for more physicians, for more places willing to accept Medicaid/Medicare, or for a place that will care for community members who have no healthcare coverage. The care offered to these residents must include primary care services, health education, preventive care, chronic disease management, oral health, and behavioral health services. They also have to make sure that language, cultural, or economic factors neither impact a patient's ability to schedule or complete a visit nor stop them from receiving all of the follow-up

services that may be needed to recover from an illness. This may mean making sure that medication or specialty services are secured. Federally-funded community health centers offer the following menu of primary care and enabling services to all patients either at the office or through a pre-arranged referral:

- Preventive dental services;
- Immunizations;
- Primary medical care;
- Immunizations;

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- Diagnostic laboratory services;
- Preventive services including prenatal, perinatal, and well-child services (such as 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; and
- Services to help the health center's patients gain financial support for health and social services.

When referrals are made, health centers must coordinate and oversee the care provided to their patients, and access to care must be available through an after-hours call system or clinic hours that extend beyond the normal 9:00 am-5:00 pm work schedule.

Nationally, the community health center program was created in 1965 as part of President Lyndon Johnson's "Great Society" and "War on Poverty" initiatives. The movement came to North Carolina in March of 1970 with the creation of the Orange-Chatham Comprehensive Health Center in Chapel Hill, North Carolina. This center was followed by Lincoln Community Health Center in June of that same year.

Today there are 23 federal grantees, receiving section 330 funds, operating 76 delivery sites in North Carolina. These primary care facilities serve 56 counties and nearly 300,000 patients. In addition, there are three community-based primary care providers that are in compliance with Section 330 program requirements, but do not receive federal grant support. Instead, these centers, known as federally qualified health center look-alikes, receive:

- Drug pricing discounts;
- Special Medicaid reimbursement rates;
- Onsite Medicaid eligibility workers;
- Waived Medicare deductibles;
- Ability to waive co-payments of patients <200% of FPG;
- Medical providers through the National Health Service Corps; and
- No-cost vaccines for children.

Nevertheless, the proportion of residents without a usual source of care is much higher than the national average in North Carolina. At least one-in-five residents has no regular provider of care.¹ As a result, the push to develop more FQHCs throughout North Carolina continues. Research indicates that more health centers would significantly diminish the Hispanic/white and black/white primary care visit disparity.² One study recently found that a 10% increase in the number of health centers per 10,000 population would lead to a 6% increase in the probability of visiting a physician.³ In general,

expanding health center capacity reduces unmet need and increases the percent of the uninsured with a regular source of care.

Governance Structure

One of the foundations of the FQHC program is the mandate that governance of the health center organization involve a Board of Directors made up predominately of the people who use the health center's services (consumers/users). A consumer member should have used the health center services within the last two years and consider the health center his or her medical home. Health center expectations indicate that a user should be an individual who considers the health center his or her medical home for the purposes of receiving primary and preventive care.⁴ For example, if upon becoming ill with the flu, an individual makes an appointment at the health center for diagnosis and treatment, the person would be considered a user of the health center's services. Conversely, if an individual uses the health center annually for a blood pressure check, but uses the services of a private physician in the community when he or she becomes sick, the individual would not be considered a health center user for the purposes of satisfying the requirement, because he or she is not using the health center as the principal source of primary healthcare. The section 330 implementing regulations state, "a majority of board members shall be individuals who are or will be served by the center and who, as a group, represent the individuals who are or will be served by the center and who, as a group, represent the individuals being or to be served in terms of demographic factors, such as race, ethnicity, sex."

From the inception of the health center program, Congress indicated that health centers should be governed predominately by the people who would care most about, and have the greatest interest in and commitment to, the scope of services offered by the health center, the health center's location and accessibility, the hours that services would be available, the programmatic priorities that the health center would pursue, etc.—the patients themselves.

Financial Stability

This year, the federal Community Health Center program celebrates its 40th anniversary. Also celebrating 40 years of service is the Medicaid program. In 1977, Dr. Karen Davis, President of the Commonwealth Fund, said, "the two programs were specifically designed to work in tandem with one another to make access to quality healthcare available to millions of Americans who previously had, at best, extremely limited access to needed care and who, as a result, experienced the worst health status among all Americans."

At 40, the FQHC program is thriving and growing under President George W. Bush's campaign to double the number of communities and people served by the end of 2006; while the Medicaid program is facing escalating costs that threaten its ability to offer coverage through the existing formula.

The weakened position of Medicaid, combined with an

increasing number of uninsured, increasing healthcare costs, and downsizing of worker health benefits threaten the financial position of Community Health Centers. Approximately 25% of North Carolina health center patients are Medicaid beneficiaries, resulting in nearly 43% of North Carolina FQHC total revenues. FQHCs are left to wonder how they will continue to deliver high quality primary care to their vulnerable patients in the face

of a disproportionate funding-to-need ratio environment. During this fiscal year (2005), federal grant dollars to North Carolina health centers decreased by nearly 1% across the board. Reductions to North Carolina Medicaid funding could result in increased cost sharing, forcing health centers to subsidize Medicaid using the already dwindling federal grant dollars intended for the uninsured. **NCMJ**

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