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Health centers let doctors help low-income patients at lower risk


Lee Francis, M.D.

Community health centers that serve low-income and uninsured patients have always been a landing spot for mission-driven physicians. Now they have also become a haven for some who are feeling squeezed by malpractice insurance costs and other administrative burdens of private practice.

So-called federally qualified health centers are not-for-profit organizations that meet certain criteria and in return are eligible for federal grants and enhanced Medicaid and Medicare reimbursements. They are located in medically underserved areas, are governed by community boards and provide comprehensive primary-care services, as well as support services such as translation and patient transportation. Nationally, about 40% of their patients were uninsured in 2006, the latest year data are available from HHS' Health Resources and Services Administration, which oversees them. In 2007, these health centers provided care to more than 16 million patients, up from 13 million in 2004, according to HRSA spokeswoman Tara Balsley.

John Frana, president of the Frana Group, a healthcare consulting firm in Rockford, Ill., says his firm specializes in helping hospitals and health systems create or affiliate with such health centers to maximize their federal grant and reimbursement opportunities for treating underserved patients. Reimbursements for Medicare patients at community health centers are provided on a cost basis and can be double what they would be if the same patient were treated in private practice.

"There could be private groups that, quite frankly, could look at their market, and it could be advantageous for them to see that a community health center gets created not only because they could contract for services with that organization," Frana says, "but to the extent that they get their low-income patients taken care of in a subsidized manner, it could

make the rest of their practice more profitable."

Profit, however, is not generally the top motive cited by physicians who choose to affiliate with community health centers.

Edward Zuroweste, M.D., a family physician, started a private practice with two other physicians in the 1980s in the rural Pennsylvania town of Chambersburg, which happened to have a population of migrant farm workers. Many of these migrant workers could not get to his practice during the day, so he opened an evening clinic to see them.

"Then I found out we could receive funding for that," Zuroweste says. By 1992, the evening clinic had developed into a full-fledged migrant and community health center, called Keystone Health Center, which grew rapidly and still exists today. He was its medical director and remained there until 2001, when he left to become chief medical officer of the Migrant Clinicians Network. He also is an assistant professor of medicine at the Johns Hopkins School of Medicine, where he leads a rural health elective in Honduras for third- and fourth-year medical students.

Zuroweste says that, philosophically, he liked working in the community health-center environment because he never had to turn anyone away because of an inability to pay or an inability to show up at certain times of the day. "I slept better at night," he explains. But it is also an appealing option for the physician who does not want to worry excessively about the administrative side of running a practice, he says.

"I made more money in private practice, but I was also the CEO, the CFO and the HR department," he says. "If you're a community health center you don't have to do that as a provider. If you take that away, our base salary isn't a lot lower than private practice anymore."

Another difference between the two worlds involves malpractice insurance. Physicians who work for community health centers are covered under the Federal Tort Claims Act, which basically protects them from medical malpractice liability as if they were federal employees. They don't have to purchase medical malpractice insurance because the federal government picks up the tab for any malpractice claims.

The escalating cost of malpractice insurance was one of the primary reasons Eileen Murphy, M.D., an obstetrician/gynecologist who had had a private practice in Chicago for 16 years, closed her practice in 2004. Under the terms of her malpractice insurance policy, she could not join another private practice for two years unless she wanted to foot the $270,000 bill for her "tail insurance"—the portion that indemnifies a physician for any malpractice activity that occurred during the years of insurance coverage. However, she was allowed to work for government health organizations. That's when she found a position

with Access Community Health Network, the nation's largest federally qualified health center organization with more than 50 centers in the Chicago area. For over a year she provided gynecological services to women with disabilities before she moved to another community health center, the Erie Family Health Center, in 2006, where she remains today.

"You don't have to worry about your malpractice premiums, and should you separate, there are no tail insurance issues," Murphy explains. "It's an attractive aspect because this portion of the business equation is maddeningly expensive, and to not see it or feel it is therapeutic."

That said, Murphy has benefited in other meaningful ways from the experience. "It's been really honorable and inspiring, and I think it's been a privilege to experience this system of care and to have a large peephole into a slice of our community that I had not experienced to this degree before," she says.

Lee Francis, M.D., the president and chief executive officer of the Erie Family Health Center, says he has always worked in the world of public health and has spent most of his career at Erie. "I think nowadays we're seeing some physicians come to community health centers not only for mission but also because the malpractice premiums are going up, and some physicians find they can relieve themselves of a lot of the headaches of private practice by working at a community health center," he says.

Others note that working for a community health center can be a good way for a doctor coming out of medical school to help pay off state or federal loans through available grants and loan forgiveness programs offered in return for serving in community health centers.

Until 15 months ago, Steve Lidvall, M.D., was at 269-bed SwedishAmerican Hospital in Rockford, Ill., where he spent 70% of his time as a family practitioner and 30% on administrative duties as the hospital's liaison with Crusader Clinic, a community health center in Rockford. After obtaining a master's degree in public health, he took a position as the chief medical officer at the clinic, where he has been able to "look at healthcare from a broader viewpoint," he says.

While Lidvall says there are many compelling reasons for physicians to align themselves with federally supported community health centers, ultimately those who will be most successful are doctors who simply want to provide care to economically disadvantaged members of the community. "You have to have that mission or desire to do this first," he says. "The only thing we can guarantee you when you come to work here is that we won't pay you as much as in the private sector."

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