

Himmelfarb Health Sciences Library, The George Washington University Health Sciences Research Commons

Geiger Gibson/RCHN Community Health
Foundation Research Collaborative

Health Policy and Management

12-2013

A Profile of Community Health Center Patients: Implications for Policy

Peter Shin

George Washington University

Carmen Alvarez

Jessica Sharac

George Washington University

Sara J. Rosenbaum

George Washington University

Amanda Van Vleet

See next page for additional authors

Follow this and additional works at: http://hsrc.himmelfarb.gwu.edu/sphhs_policy_ggrchn

 Part of the [Community Health and Preventive Medicine Commons](#), [Health Policy Commons](#),
and the [Health Services Research Commons](#)

Recommended Citation

Shin, P., Alvarez, C., Sharac, J., Rosenbaum, S.J., van Vleet, A. et al. A Profile of Community Health Center Patients: Implications for Policy. The Henry J. Kaiser Family Foundation, Dec. 2013.

This Report is brought to you for free and open access by the Health Policy and Management at Health Sciences Research Commons. It has been accepted for inclusion in Geiger Gibson/RCHN Community Health Foundation Research Collaborative by an authorized administrator of Health Sciences Research Commons. For more information, please contact hsrc@gwu.edu.

Authors

Peter Shin, Carmen Alvarez, Jessica Sharac, Sara J. Rosenbaum, Amanda Van Vleet, Julia Paradise, and Rachel Garfield

December 2013 | Issue Brief

A Profile of Community Health Center Patients: Implications for Policy

Peter Shin, Carmen Alvarez, Jessica Sharac, Sara Rosenbaum, Amanda Van Vleet, Julia Paradise and Rachel Garfield

Community health centers are a key source of comprehensive primary care in medically underserved communities across the country, and their role is expected to grow as health coverage expands under the Affordable Care Act (ACA). To sharpen understanding of the health center patient population, this brief compares it to the overall low-income population, using data from the Health Center Patient Survey and the National Health Interview Survey, respectively. The pre-ACA profile of health center patients that emerges sets the stage for measuring change following implementation of the reform law and can inform health center policy, planning, and assessment moving forward.

KEY FINDINGS

- **Compared to the overall low-income population, health center patients are more disadvantaged.** Health center patients are poorer, more racially and ethnically diverse, and more likely to be unemployed and uninsured than the broader low-income population.
- **Health center patients are twice as likely as low-income people overall to report being in only fair or poor health – 32% compared to 16%.** The disparity in self-reported health status is apparent not only in the aggregate, but also within different insurance categories. For example, among both Medicaid beneficiaries and the uninsured, 1 in 3 health center patients reports being in fair or poor health, compared to about 1 in 7 low-income individuals generally. These findings point to health centers as a locus of care for a largely low-income population with substantial health burdens.
- **Rates of chronic conditions are higher among the health center patient population.** Adult health center patients report having diabetes and asthma at rates 50% higher than the rates among all low-income adults. Their self-reported rate of hypertension is also higher.
- **On key measures of preventive care and care management, health center patients fare as well as or better than the low-income population in general.** Children who were health center patients were more likely than all low-income children to have received a check-up and a dental visit in the past year. Cancer screening rates were roughly similar between adult health center patients and all low-income adults, and adult health center patients with chronic diseases were at least as likely to receive chronic care services. However, mixed findings on cancer care and low rates of chronic care receipt point to health center difficulties in securing access to specialist care for their patients.

CONCLUSION

Expanded coverage under the ACA promises health centers new revenues to expand and improve care, and newly insured patients stand to gain greater access to specialists as they join health plans with broader provider networks. In states that do not expand Medicaid, health centers and some 1 million uninsured health center patients will miss out on these improvements. Even as coverage expands, health centers will continue to serve many uninsured people and provide services not covered by insurance. Ongoing grant funding is needed to meet these costs. With expected changes in the health center population as many uninsured adults gain coverage, health centers may begin to strengthen their capacity to manage serious and chronic conditions and to enhance their adult preventive services to keep adults healthy and active.

INTRODUCTION

Community health centers play a central role in ensuring access to care in medically underserved communities across the country. Typically, they are located in low-income areas that are lacking in other health care resources. In 2011, over 1,100 federally funded health centers operating in about 8,500 urban and rural locations across the United States served more than 20 million patients. Health centers provide comprehensive primary medical care, often including behavioral health services and dental care, and provide support services such as translation, transportation, and case management that help patients to gain access to care.* The nation's reliance on health centers is likely to grow as health insurance coverage expands under the Affordable Care Act (ACA). Recognizing the need to expand the role of health centers, the ACA established a dedicated five-year \$11 billion health center trust fund to broaden access to care in medically underserved, low-income communities.

Knowledge about the characteristics of health center patients and how they use care is important for several reasons. First, the increased emphasis on “patient-centeredness” as part of comprehensive health system reform begins with an understanding of the patients being served. This understanding is also needed to inform policy related to the establishment, operation, payment, and funding of community health centers.

Second, it is likely that, as health centers grow in number and strength in response to the ACA's insurance expansions and direct investments, the profile of health center patients may change. Health centers already play a key role in the provider networks of Medicaid and CHIP health plans, and, in many communities, they are expected to play a key role in the provider networks offered by Qualified Health Plans, especially plans offered by firms that do business in both the Medicaid market and the new Marketplaces (either through a single plan positioned to satisfy the requirements of both markets, or through affiliated plans that share common networks). Establishing a profile of health center patients before the ACA is implemented sets the stage for measuring change over time, understanding the impact of the ACA, particularly the impact of state decisions regarding the Medicaid expansion, and assessing the environment in which health centers operate and the resources available to them to carry out their mission.

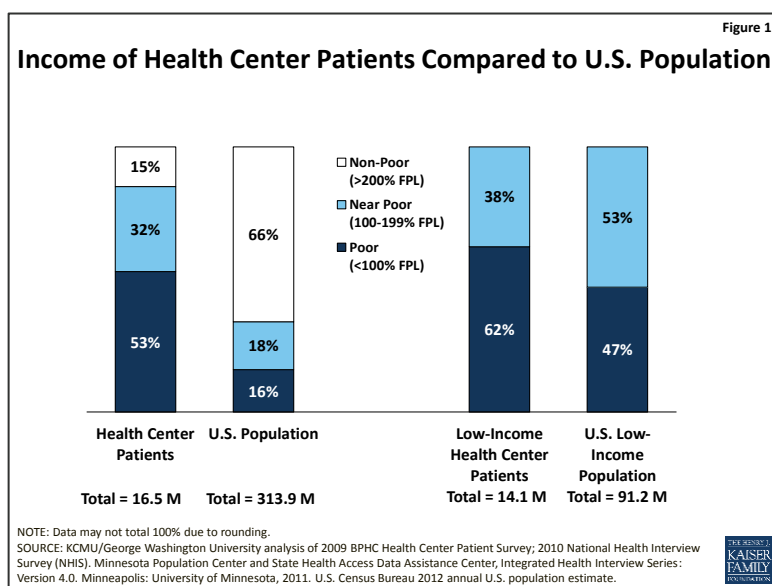
The Health Resources and Services Administration (HRSA), through its Bureau of Primary Health Care, periodically collects information on a nationally representative sample of health center patients through its Health Center Patient Survey. To learn more about the health center population, this brief compares data from the most recent Health Center Patient Survey, conducted in 2009, to data on the low-income population, drawn from the 2010 National Health Interview Survey (NHIS), on which the Health Center Patient Survey is also modeled. The 2010 NHIS was used because it included more variables of interest for this study than the 2009 NHIS. The low-income* subpopulation, rather than the total population, was used as the comparison group because it much more closely mirrors the health center patient population. Details on the data and methodology associated with each of the two surveys are available in the Methods Appendix at the end of this report.

* In this paper, “low-income” is defined as income below 200% of the federal poverty level (FPL), which was \$22,980 for an individual and \$47,100 for a family of four in 2013.

DEMOGRAPHIC CHARACTERISTICS

Community health center patients are different demographically from the total U.S. population and even from the low-income U.S. population. In part, the differences reflect health centers' specific statutory mission to serve medically underserved communities and populations. Some of the differences reported in this analysis may also stem from the fact that the comparison presented here is between people who use health center services and a general low-income population that comprises both people who use and people who do not use health care (including care offered by health centers) in the survey period. Compared to the overall low-income population, health centers users are poorer, more racially and ethnically diverse, more likely to be working-age adults, and more likely to be unemployed and uninsured. Many of these factors relate to one another. For example, people of color experience disproportionately high rates of unemployment and low income,¹ and low-income working-age adults are more likely than others to be uninsured.²

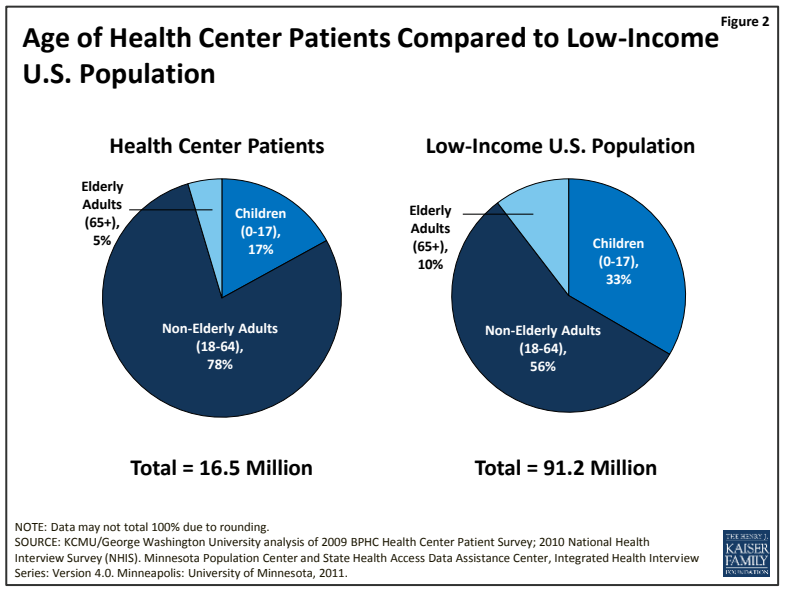
INCOME. Community health center patients are much more likely to be low-income than the U.S. population overall. More than half (53%) of individuals who obtain at least some of their care from health centers have income below the federal poverty level (FPL) (\$11,490 for an individual and \$23,550 for a family of four in 2013), and almost another third (32%) have income between 100% and 199% FPL. The remaining 15%, who have income equal to at least 200% FPL, tend to have very limited income as well.* A recent analysis found that only 3% of CHC patients had incomes above 400%.³ In short, the health center patient population is overwhelming (85%) a low-income one. The income distribution of the general population is much different. One-third (34%) are low-income, divided about evenly between those below poverty and those between 100% and 199% FPL (Figure 1, left panel). Fully two-thirds have income at or above 200% FPL and income levels in this group are not bunched near 200% FPL but are widely distributed.



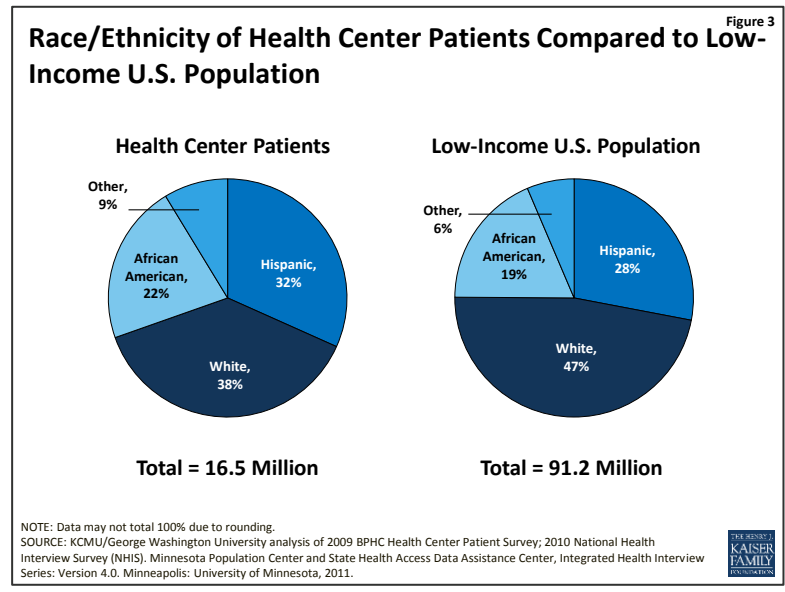
Even within the population below 200% FPL, poverty is deeper among health center patients. More than six in ten low-income health center patients have income below 100% FPL while, by contrast, less than half (47%) of the general low-income population is in this lowest income band (Figure 1, right panel). Because low income is so strongly associated with certain other patient characteristics, for the remainder of this analysis, we compare the health center patient population to the U.S. low-income population.

* The difference between the 16.5 million health center patients shown in Figures and the 20 million health center patients cited earlier is attributable to the different data sources used (2009 Health Center Patient Survey and 2011 Uniform Data System Report (HRSA, 2012), respectively), and to the weighting methodology and additional adjustments to the data in the Health Center Patient Survey.

AGE. Nonelderly adults (age 18-64) make up a much larger share of the health center patient population than of the low-income population overall. More than three-quarters of health center patients are working-age adults, compared to 56% of low-income people generally (Figure 2). Correspondingly, both children and people ages 65 and older make up smaller shares of the health center population. Children represent 17% of health center patients, compared to 33% of low-income people overall; people ages 65 and older represent 5% of health center patients, compared to 10% of all low-income people. The higher representation of working-age adults among health center patients suggests that low income non-elderly adults are especially reliant on health centers, compared to either low-income children or older adults. This finding likely reflects the significantly elevated uninsured rate among low-income working-age adults compared to other low-income age groups, a fact that requires them to depend more heavily on safety-net providers for care.⁴ It also may reflect the relatively high and unmet need for health care among a segment of the low-income adult population, which, when a health center is present in the community, leads them to seek care.



RACE/ETHNICITY. Health center patients are more racially and ethnically diverse than the low-income population overall. They are more likely to be Hispanic, African-American, or a member of another racial or ethnic minority group. Patients are less likely to be White than the general low-income population (Figure 3). Thus, health centers play an important role in serving communities of color and helping narrow racial and ethnic disparities in health care. The relatively high representation of people of color among health center patients is likely a reflection of the strong correlations between race/ethnicity and low income, poorer health status, higher uninsured rates, and residence in medically underserved areas.

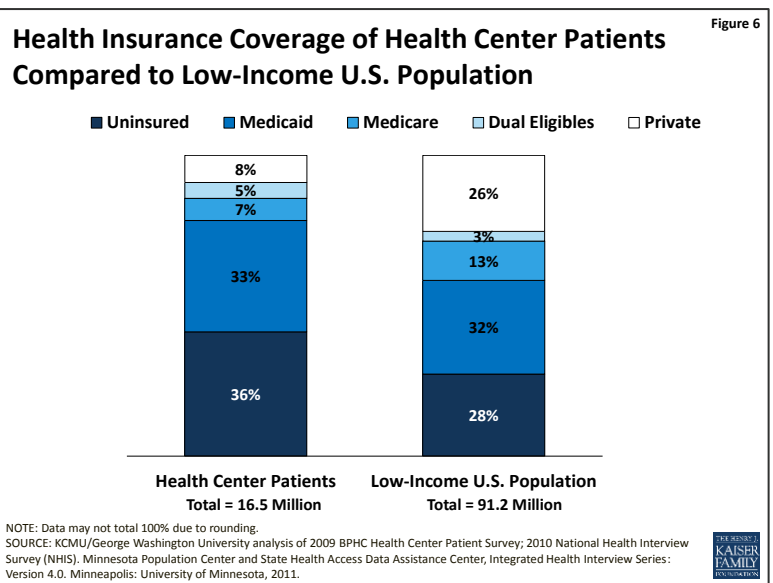
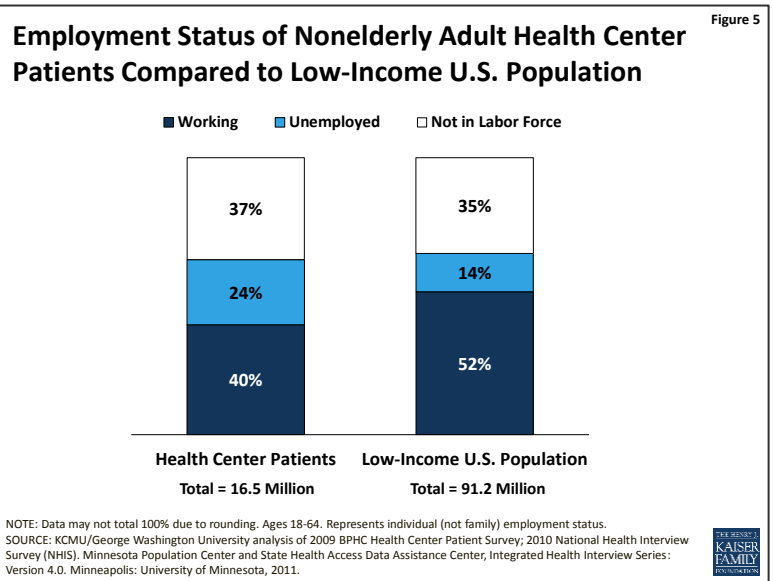
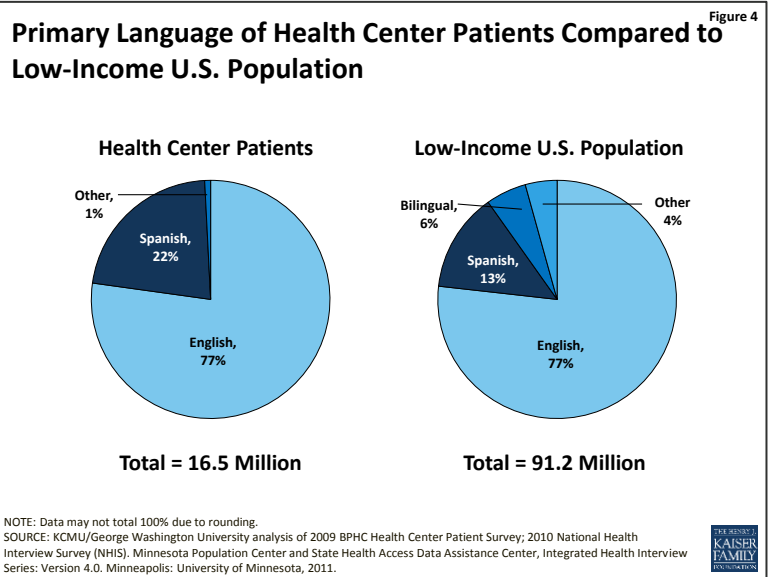


LANGUAGE PREFERENCE/PRIMARY LANGUAGE.

Roughly three-quarters of both health center patients and the low-income population overall report English as their preferred or primary language. Over a fifth (22%) of health center patients say they prefer to speak Spanish over English or another language. Among the general low-income population, 13% say they speak only or mostly Spanish, while another 6% say they speak both English and Spanish. However, the two surveys ask about primary language differently, so the measures are not directly comparable between the two populations (Figure 4).⁵

EMPLOYMENT STATUS. Health center patients are more likely to be unemployed than low-income people overall. In 2009-2010, 24% of working-age adult health center patients were unemployed, compared to 14% of all low-income working-age adults (Figure 5). Given the adverse impact of joblessness on insurance coverage, the resulting difficulty that unemployed people face affording necessary health care, and the fact that health centers have traditionally served as a source of care for people who have trouble affording services, the higher unemployed rate among health center patients is not surprising.

UNINSURED RATE. Health center patients have higher uninsured rates than the general low-income population, in part because they are more likely to fall into the age range (nonelderly adults) in which the risk of being uninsured is highest. While 28% of all low-income people are uninsured, 36% of all health center patients are uninsured (Figure 6). Despite the fact that health center patients are more likely to be uninsured, the proportion of people with Medicaid coverage is almost the same – roughly one-third – among health center patients and the low-income



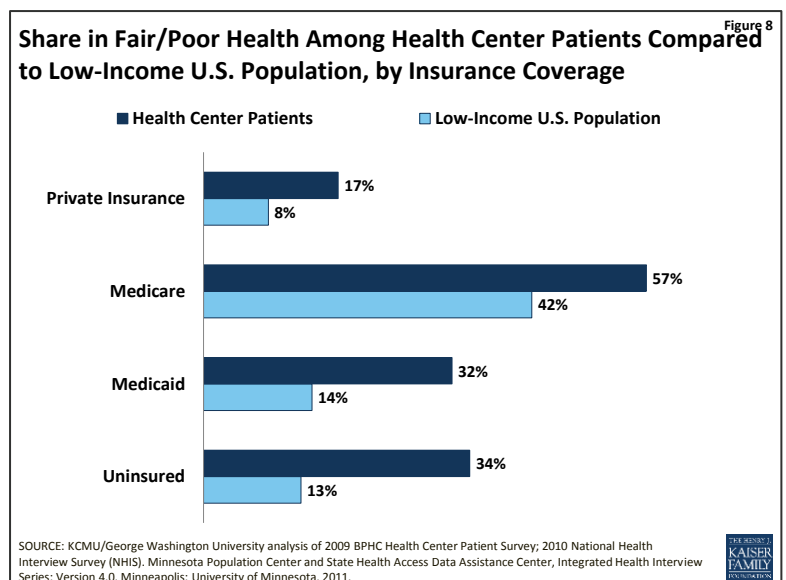
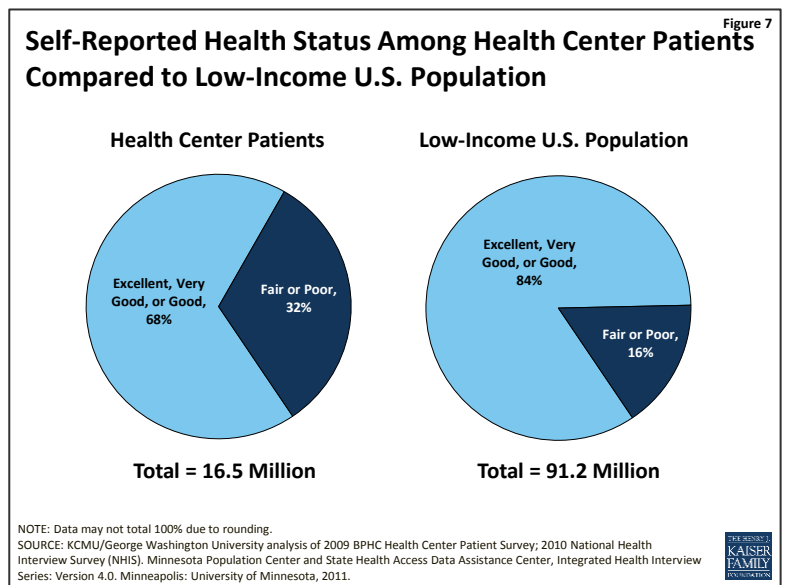
population generally. Not unexpectedly, given the under-representation of patients ages 65 and older among health center users (relative to the overall low-income population), the share of individuals with Medicare is relatively low among health center patients, compared to the overall low-income population (7% versus 13%). Also, even though working-age adults make up a substantially larger share of health center patients than of the broader low-income population, the rate of private coverage – largely, employer-sponsored insurance – is much lower among health center patients than among low-income people generally – 8% compared to 26%. Factors that may help to explain health center users’ lower rate of private coverage include the deeper poverty of health center users, their worse health status (discussed below), and their higher rate of unemployment.

HEALTH STATUS

Health center patients are in poorer health than the low-income population overall. They report poorer health status, more chronic health conditions, and higher rates of smoking and obesity. These patterns reflect underlying differences in health status between health center patients and the general low-income population, but also the fact that people who seek health care – here, health center users – are, by definition, likely to need services, whereas the overall low-income population includes both health care users and non-users (whose health care needs presumably are more limited). The data show that health center patients are a population with substantial needs for health care.

SELF-REPORTED HEALTH STATUS. Health center patients are twice as likely as low-income people overall to report being in fair or poor health, as opposed to good, very good, or excellent health (32% vs. 16%) (Figure 7). It is important to note again that all individuals participating in the Health Center Patient Survey are seeking care and, thus, might be more likely to be in fair or poor health than the broader low-income population captured in the NHIS, a household survey that includes both users and non-users.

Self-reported health status, by insurance coverage. Health center patients are more likely to report being in fair or poor health than the general low-income population, not only in the aggregate but also within different health insurance categories. Among the privately insured, the share reporting fair/poor health is



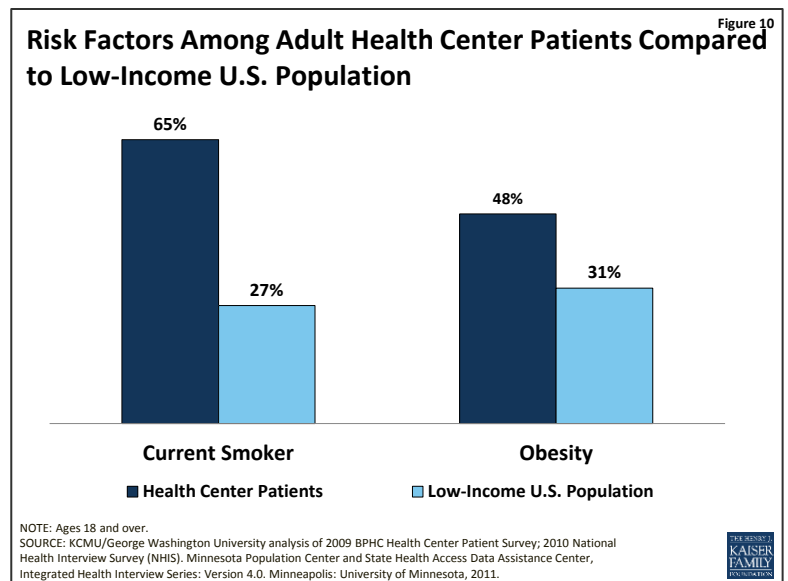
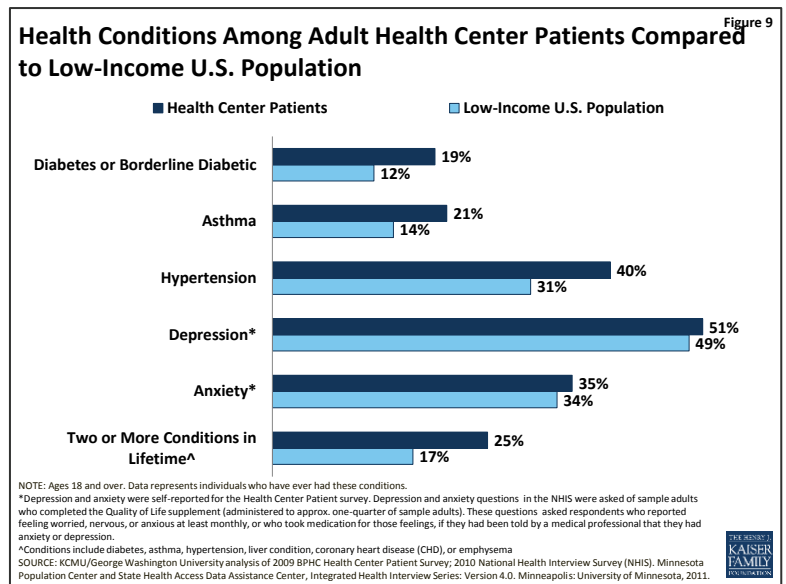
twice as high for health center patients as for low-income people overall (17% vs. 8%) (Figure 8). Within the Medicare, Medicaid, and uninsured populations, which have much higher rates of fair/poor health than the privately insured, the rates for health center patients far exceed those for low-income people overall in the same insurance group. Among Medicaid beneficiaries, 42% of all low-income people but 57% of health center patients report fair/poor health. Among both Medicaid beneficiaries and the uninsured, 1 in 3 health center patients reports being in fair/poor health, compared to about 1 in 7 low-income individuals generally. These findings point to health centers as a locus of care for a low-income subpopulation with substantial health burdens.

CHRONIC CONDITIONS. Adult health center patients are more likely than low-income adults overall to report that they have had one or more of a number of major chronic conditions during their lifetime. In particular, adult health center patients report rates of diabetes and asthma 50% higher than in the total low-income adult population (Figure 9). They also report higher rates of hypertension.

In addition, a quarter of all adult health center patients report having had two or more chronic conditions, compared to 17% of all low-income adults. Half of both adult health center patients and low-income adults overall report depression, and about a third of both populations report anxiety. These high rates of mental health conditions may in part stem from the way the survey questions related to these conditions were framed. The Health Center Patient Survey asked patients to self-report whether they had ever had depression or anxiety in their lifetime. The NHIS asked only a subsample of adults who reported symptoms of anxiety/depression whether they had been told by a medical professional that they had either of these conditions.

The high rates of chronic illness among adult health center patients may be one reason these individuals presented for care. The high rates also demonstrate that care of people with chronic diseases and conditions is central to the work of health centers.

HEALTH RISK FACTORS. Smoking and obesity rates are not only high among adult health center patients, but also much higher than for the low-income population overall. Nearly two-thirds (65%) of health center



patients are current smokers, compared to about a quarter (27%) of all low-income adults (Figure 10). Almost half are obese, compared to 31% of low-income adults overall. Smoking and obesity are closely linked with serious health problems such as cardiovascular disease and diabetes. The very high prevalence of these risk factors in the health center population may help to explain the patterns in chronic disease prevalence discussed above.

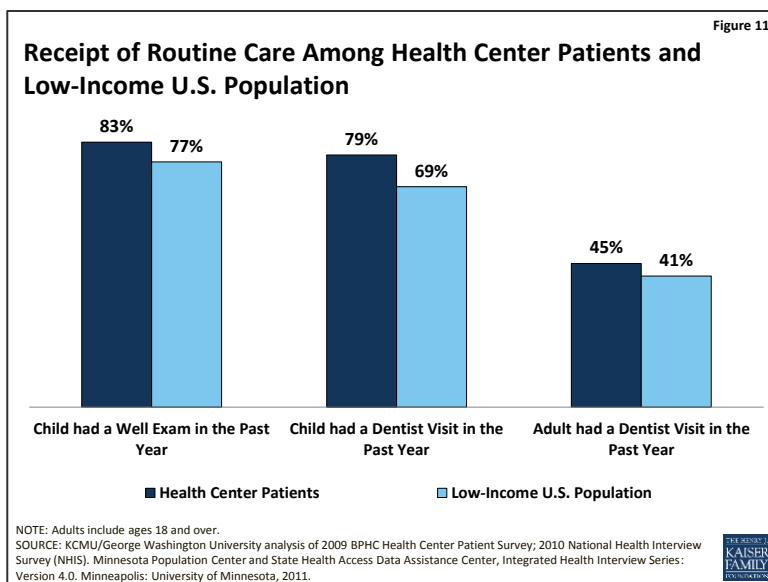
USE OF CARE

Health centers' mission is to provide comprehensive primary care to their patients. Preventive health services and care management for ongoing health conditions are core components of this care, and several of the metrics used to evaluate health center quality focus on such services. Other research has demonstrated that health centers perform comparably to, if not better than, private practice physicians and other primary care providers in these spheres of care.⁶ This analysis, which complements that research, finds that, on key measures of preventive care and care management, health center users fare better than the low-income population in general. As with the results on health status, comparisons of utilization between health center patients and the low-income population overall may partly reflect the fact that health center patients are, by definition, already receiving care. However, even accounting for this difference, the analysis indicates some areas for concern regarding health center patients' ability to access follow-up services, which may be outside the scope of services available at most health centers and thus require referrals. Because so many health center patients are uninsured, health centers face particular challenges in obtaining referrals.

PREVENTIVE CARE

Well-child visits. On the most basic measure of preventive care for children—whether a child had a check-up within the past year—the data show that children who were health center patients fared better than children in the broader low-income population (Figure 11). This difference could reflect several underlying causes: patients who visit health centers may be more engaged in their care and thus more likely to visit a doctor for well-visits; health centers may do a better job of bringing patients in for routine care; or patients not seeking care at a health center may encounter barriers to well-child visits.

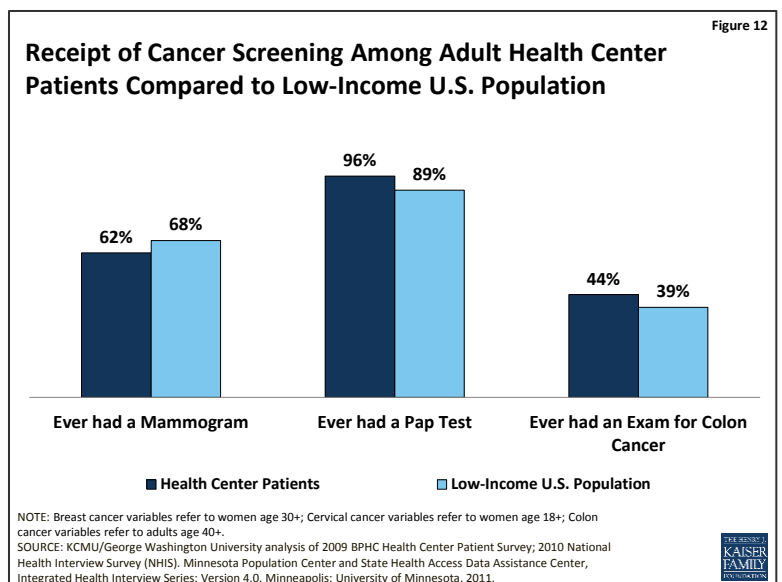
Dental visit. Health center patients are at least as likely as the general low-income population to report having had a dental visit in the past year (Figure 11). The share of adults with a dental visit is similar between the two populations. The fact that, in both groups, fewer than half received a visit warrants concern given the importance of good oral health to good overall health. The low visit rate likely reflects the high uninsured rate among low-income adults as well as very limited Medicaid coverage of adult dental benefits and low dentist participation in Medicaid. The low proportion of adult health center patients with a dental visit may also



reflect the fact that, while dental care has been a priority expansion service for health centers, as of 2011, only 78% of all health centers reported offering dental care.⁷ Dental visit rates are higher among children, likely because of Medicaid’s comprehensive benefit package for children, known as EPSDT, which includes oral health services. Notably, children who are health center patients are more likely than low-income children overall to report a dental visit in the past year (79% vs. 69%). It is possible that children who receive at least some care in health centers are more connected to the health care system generally (including dental care), compared to all low-income children, or that they have better access to dental care through health centers compared to children who do not use health centers. The extent to which health centers that offer dental care focus on pediatric oral health also may be a factor.

Considering that health center patients are more likely to be uninsured than low-income people overall, it is interesting that they appear at least as likely to secure a dental visit. This finding may reflect the fact that, as mentioned earlier, most health centers offer dental care. At the same time, given that it is not possible to know whether the care received was preventive in nature or treatment for a dental problem, this finding is difficult to interpret. It could indicate a stronger connection to the health care system among health center users compared to low-income people overall, the availability of dental services in most health centers, and/or higher rates of oral disease among health center patients.

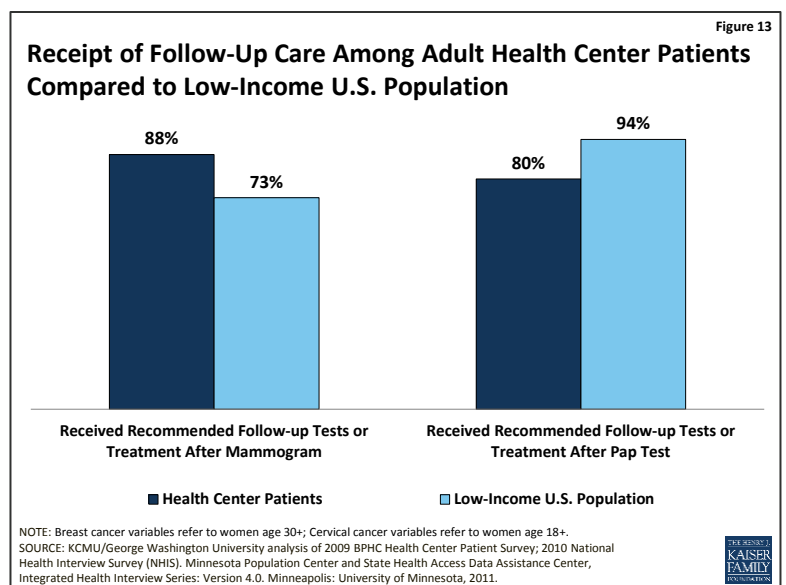
Cancer screening. Adult health center patients are at least as likely as low-income adults overall to report ever having received a Pap test (women only) or an exam for colon cancer, but appear slightly less likely to report ever having received a mammogram (women only) (Figure 12).



FOLLOW-UP AND CHRONIC CARE

Follow-up cancer care. In addition to check-ups and screenings, referral for follow-up services and ongoing management of chronic illnesses are core components of comprehensive care. The findings on health center patients’ access to follow-up cancer tests are mixed, and caution is required in interpreting them.

Although female health center patients are slightly less likely than all low-income women to report ever having received a mammogram, those who did have a mammogram and were

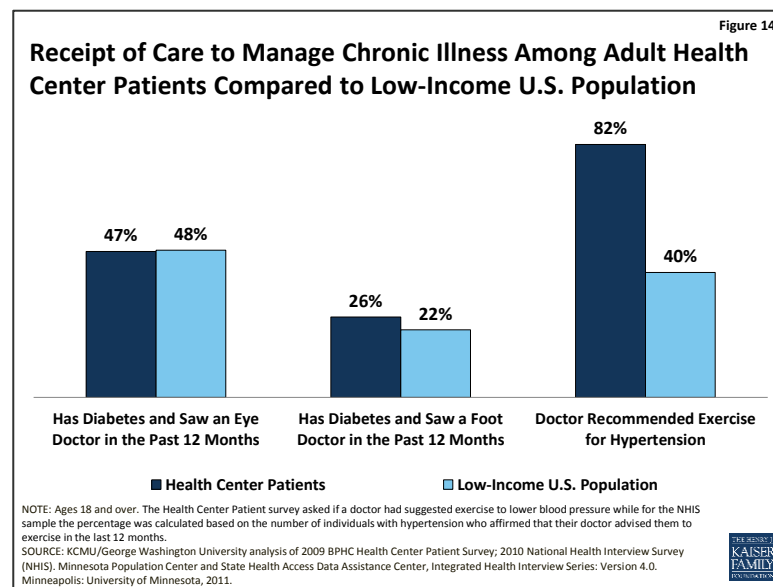
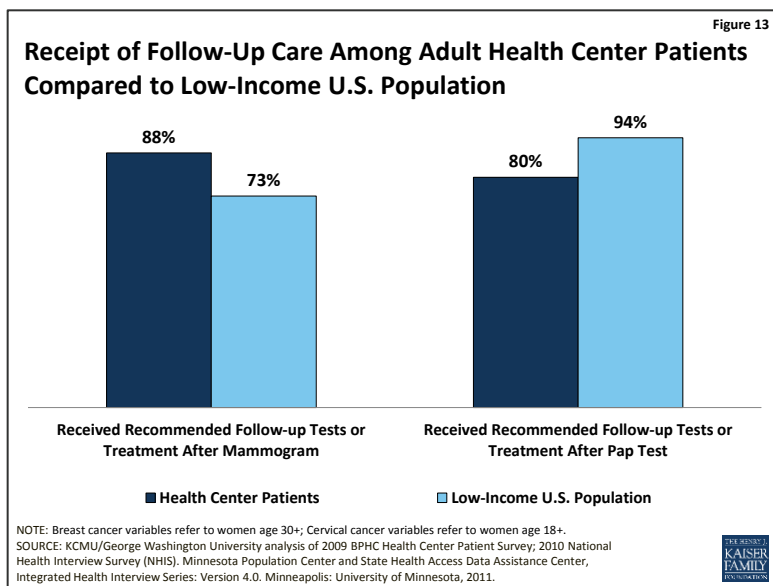


referred for follow-up care are more likely (88% versus 73%) to have reported receiving the recommended follow-up care (Figure 13). At the same time, although they are slightly more likely than low-income women overall to report ever having received a Pap test, health center patients who did receive a Pap test are markedly less likely to report that they received the recommended follow-up care. Because health centers' capacity to provide or arrange for specialist care, including cancer treatment, is very limited, measures of receipt of recommended follow-up cancer care by health center patients may reflect more about the broader issue of low-income people's access to specialty care than about health centers or health center patients in particular. At the same time, a separate study of family planning services at health centers (which include Pap tests) suggests that health centers may focus less sharply on this cancer screening service than on other family planning services.⁸ Differences in follow-up care between health center patients and all low-income people may also stem from insurance differences between the two groups that affect their access.

Chronic care. Among adults with diabetes, health center patients and all low-income adults report relatively similar rates of receipt of care to manage their diabetes. Roughly half of both populations reported seeing an eye doctor in the past 12 months, and about one-quarter reported seeing a foot doctor (Figure 14). As with cancer care, the follow-up eye and foot care described here is specialty care that health centers generally do not offer; thus, these measures, too, are indicators of access to specialty care among low-income people, rather than of health center performance or effectiveness..

Adult health center patients with hypertension are more than twice as likely as all low-income adults with hypertension to report that a doctor recommended exercise for them (82% vs. 40%).

Some of this difference may reflect methodological differences in how the rates for the two groups are determined. The rate for health center patients is based directly on the Health Center Patient Survey question that asks respondents if a doctor suggested exercise to lower their blood pressure. The rate for low-income adults was derived as the share of NHIS respondents with hypertension who affirmed that their doctor advised them to exercise in the last 12 months. As distinct from the other two measure of chronic care, which require access to specialists, a recommendation to exercise is squarely within health centers' preventive and primary care capacity. The higher rate of receipt of this intervention for hypertension among health center patients



compared to low-income adults overall suggests that health centers are playing an important role in fostering patient self-management of this prevalent chronic condition.

CONCLUSION

The findings presented in this analysis point to two important sets of implications stemming from the ACA. The first set has to do with the impact of health reform – primarily, the Medicaid expansion – on current health center patients and operations. The second set concerns potential changes in the profile of the patients who seek care from health centers and potential changes, as a result, in health centers' activities and role in the health care system.

Impact of coverage expansions on current health center patients and operations. The ACA is expected to significantly expand health coverage among current health center patients. A recent study estimates that approximately 4 million uninsured health center patients will gain coverage in 2014 through the Medicaid expansion and the new Marketplaces.⁹ In the 26 states (including DC) that are moving forward with the expansion, an estimated 2.8 million uninsured health center patients will gain coverage, of whom roughly 1.2 million will gain their coverage through Medicaid. In the 25 states that, as of October 2013, were not moving forward with the expansion, about 1.2 million uninsured health center patients will gain coverage through the Marketplaces. However, over 1 million uninsured health center patients who could have gained Medicaid coverage will remain uninsured.

State decisions on the Medicaid expansion have implications not only for health center patients but also for health center operations, because increased insurance coverage will generate new third-party revenues that health centers need to expand and improve care. The same study mentioned above estimates that health centers in the states expanding Medicaid will see \$900 million more in patient revenues than they would have had they elected not to expand Medicaid. By the same token, health centers in the states not moving forward will miss out on an estimated \$555 million in Medicaid revenues in 2014 – about half of the total \$1.2 billion in new patient revenues they could have generated if their states had opted in favor of the expansion.

An important positive implication of expanded coverage is that patients will join health plans that offer provider networks and formal referral arrangements, which should improve their access to specialist care not furnished directly by health centers. Several factors currently contribute to health centers' struggle to secure referrals.¹⁰ The first is their location in medically underserved communities, where the availability of specialists is limited. A second factor is the slow development of formal affiliation agreements between health centers and specialty care practices and institutions, which has now begun to receive greater national attention.¹¹ A third factor may be the fact that health centers must guarantee that *all* their patients, not only their insured patients, have access to specialty referrals; this requirement may reduce specialists' willingness to enter referral arrangements because they wish to avoid a high volume of uncompensated referral cases. Even as health center patients gain insurance and health plan membership under the ACA, travel time and distance to providers may continue to pose obstacles to access. In many communities, health centers are seeking to overcome travel and financial barriers by implementing telemedicine arrangements with specialists. However, whether insurers will cover telemedicine consultations remains to be seen.

Health center patients are at higher risk for social and behavioral as well as health problems. To serve these patients effectively, the health care system, including health centers, must function at a higher level and on a broader set of fronts than the clinical health care front alone. A number of new demonstration programs and funding opportunities under the ACA are ushering in important system changes that have the potential to improve care for health center patients. In particular, increased funding for health centers provides support for expanded services in health centers, such as behavioral health care and dental care. Further, a new ACA demonstration program to test the patient-centered medical home (PCMH) model in health centers offers promise as path to addressing patient needs more comprehensively. More than 500 health centers are participating in this program. Going forward, a key challenge will be to ensure that public and private insurers incorporate into their payment systems the financial support needed to sustain the PCMH model, which requires not only excellent clinical practice, but also deeper patient engagement efforts, including the development of strong provider-patient relationships, investment in care management and health support services, ongoing communication, the devotion of time resources, health education and patient supports, and the use of health information technology.

Health centers in these states, and even in the states that expand Medicaid, will continue to serve a large share of uninsured people and will need ongoing grant funding to treat these patients. They will also need grant support to cover the costs they absorb for their insured patients who are unable to afford their cost-sharing amounts. In addition, they will have to bear the costs of non-covered services (e.g., adult dental care) and services for insured patients who hit their treatment limits (e.g., an annual maximum number of mental health visits). Further, despite the relative breadth of the essential health benefits, they are unlikely to include the array of health supports needed by low-income adult health center patients, such as health education and transportation, or social services, such as assistance with insurance enrollment and renewal. In Massachusetts, where health centers are in their sixth year of operating in a health reform environment, grant funding remains essential to program operations. Federal grant funding comprised approximately 18.3% of Massachusetts health center revenues in 2011, defraying the costs of serving both uninsured patients and uninsured clinical and health support services.¹²

ACA impact on the profile of patients that health centers will serve. The ACA will expand coverage not only among current health center patients, but also among the broader communities that health centers serve. As adults gain coverage, they can be expected to seek care, and in medically underserved communities (where uninsured adults disproportionately reside), the quest for care can be expected to further heighten the need for health center resources. An immediate after-effect of health reform in Massachusetts was a surge in the demand for primary care from health centers.¹³ Over the 2007-2011 time period, the number of patients served by health centers in Massachusetts grew by 6%, from 123,388 to 131,141. The growth was fueled by both insured and uninsured patients, as more insured people sought care and as more uninsured people turned to health centers as other sources of care for the uninsured shrank.

What will the new health center patients be like? Presumably, some will be similar to patients who currently use health centers – deeply poor and confronting serious health risks and health conditions. But many others can be expected to be younger, healthier, and less deeply impoverished men and women seeking comprehensive primary health care that, for the first time, they can afford. Many health centers now have located clinical sites on community college campuses and in other locations accessible to lower-income

younger workers and their families. Given the possible demographic shift in the health center population under the ACA, health centers' current re-positioning, to offer care for healthy individuals and families as well as patients with significant health needs, seems likely to continue and might imply a further reshaping of health centers. In addition to strengthening their capacity to manage serious and chronic health conditions, health centers may begin to focus on building strong adult preventive services, including wellness programs, women's preventive services, the full complement of adult immunization services, and other types of clinical services whose basic aim is to keep adults healthy and active. This increased focus on prevention might also, in many communities, lead to partnerships between health centers and employers to offer worksite and community wellness activities that may reduce downstream health care costs and expand the role of health centers in advancing community health.

Additional support for this paper was provided by the RCHN Community Health Foundation.

Table 1: Demographic Characteristics, Health Status, and Receipt of Preventive Care of Community Health Center Patients and the Low-Income U.S. Population, 2009/2010

	Health Center Patients	Low-Income U.S. Population
Weighted N	16.5 Million	91.2 Million
Demographic Characteristics		
Age		
Children (Age 0-17)	17.0%	33.4%
Non-Elderly Adults (Age 18-64)	78.4%	56.2%
Elderly Adults (Age 65+)	4.6%	10.4%
Race/Ethnicity		
White	37.9%	47.1%
Hispanic	31.7%	28.0%
African American	21.7%	18.5%
Other	8.7%	6.4%
Nativity		
U.S. Born	78.4%	81.0%
Foreign Born	21.6%	19.0%
Primary Language		
English	77.2%	76.7%
Spanish	22.0%	13.4%
Bilingual	N/A	5.5%
Other	0.8%	4.3%
Employment Status (Ages 18-64)		
Working	39.6%	51.6%
Unemployed	23.5%	13.8%
Not in the Labor Force	36.8%	34.6%
Health Insurance Coverage		
Uninsured	36.4%	27.7%
Medicaid	32.6%	31.6%
Medicare	6.5%	13.3%
Medicare-Medicaid Dual Eligible	4.6%	3.3%
Private Insurance	8.0%	25.7%
Health Status		
All Ages		
Self-Reported Health Status		
Excellent, Good, or Very Good	67.7%	84.1%
Fair or Poor	32.3%	15.9%
Share in Fair/Poor Health by Insurance Coverage		
Uninsured	34.4%	12.6%
Medicaid	32.1%	13.5%
Medicare	57.2%	42.4%
Private Insurance	17.4%	8.4%

Table 1 (continued): Demographic Characteristics, Health Status, and Receipt of Preventive Care of Community Health Center Patients and the Low-Income U.S. Population, 2009/2010

	Health Center Patients	Low-Income U.S. Population
Adults (Ages 18+)		
Health Conditions that Individuals have Ever Had		
Diabetes or Borderline Diabetic	19.2%	12.0%
Depression*	50.8%	49.2%
Anxiety*	35.4%	33.6%
Asthma	20.6%	14.3%
Hypertension	39.9%	30.5%
Two or More Conditions in Lifetime [^]	25.4%	16.6%
Risk Factors		
Current Smoker	64.9%	27.1%
Obesity	48.1%	31.1%
Use of Care		
Children		
Receipt of Routine/Well Care		
Child had Well Exam in the Past Year	83.0%	76.8%
Child had Dentist Visit in the Past Year	78.7%	69.4%
Adults		
Receipt of Routine/Well Care		
Adult had Dentist Visit in the Past Year	44.8%	41.4%
Receipt of Cancer Screening		
Ever Had a Mammogram (Women ages 30+)	62.3%	67.7%
Ever Had a Pap Test (Women ages 18+)	95.5%	89.4%
Ever Had an Exam for Colon Cancer (Ages 40+)	44.4%	38.8%
Receipt of Follow-Up Care (Among Those Who Needed It)		
Received Recommended Follow-Up Tests/Treatment for Mammogram (Women ages 30+)	88.4%	73.4%
Received Recommended Follow-Up Tests/Treatment for Pap Test (Women ages 18+)	79.9%	93.6%
Receipt of Care to Manage Chronic Illness		
Has Diabetes and Saw Eye Doctor in Past 12 Months	47.2%	47.6%
Has Diabetes and Saw Foot Doctor in Past 12 Months	26.0%	21.8%
Doctor Recommended Exercise for Hypertension	81.8%	40.4%

NOTES: Data represent all ages unless otherwise noted. Data for health center patients are for the year 2009, and data for the U.S. low-income population are for the year 2010.

* The Health Center Patient Survey asked respondents to self-report whether they had ever had anxiety or depression in their lifetime. The NHIS depression and anxiety questions were asked of sample adults who completed the Quality of Life supplement (administered to approximately one-quarter of sample adults). The questions asked respondents who reported feeling worried, nervous, or anxious at least monthly, or who took medication for those feelings, whether they agreed with the statement: "I have been told by a medical professional that I have anxiety/depression."

[^] Conditions include diabetes, asthma, hypertension, liver condition, coronary heart disease (CHD), and emphysema.

SOURCE: KCMU/George Washington University analysis of 2009 Health Center Patient Survey; 2010 National Health Interview Survey (NHIS). Minnesota Population Center and State Health Access Data Assistance Center, Integrated Health Interview Series: Version 4.0. Minneapolis: University of Minnesota, 2011.

APPENDIX: METHODS

DATA SOURCES: This analysis uses data from 2009 Health Center Patient Survey and 2010 National Health Interview Survey (NHIS). The Health Center Patient Survey is a nationally representative survey of patients served by HRSA-supported community health centers. The survey collects self-reported information on socio-demographic characteristics, access to health care services, health status, utilization of services, and satisfaction and perceived quality of care. In the 2009 survey, 4,562 individuals were surveyed at 347 health center sites.

To compare health center patients to the general population, we rely on the 2010 NHIS, a nationally representative survey of the health, health care access, and health services use of the civilian non-institutionalized population in the United States.¹⁴ We use the 2010 NHIS (rather than 2009, the year of the HRSA survey) because it includes more variables of interest for this analysis than the 2009 NHIS. In order to have a national comparison group similar to health center patients, we restrict the NHIS sample for most of the analysis to the low-income subpopulation (<200% of the federal poverty level). The sample size for the NHIS low-income subpopulation was 31,020.

ANALYSIS. For both the health center patient and NHIS samples, we examined socio-demographic characteristics including age, gender, race/ethnicity, income as a percentage of the federal poverty level, employment and insurance status, and language preference.

To evaluate adult health status, we compared self-perceived health status, report of smoking, and whether the respondent had ever been told that he or she had asthma, diabetes, hypertension, emphysema, liver or heart disease. We also assessed whether respondents had depression or anxiety. In the Health Center Patient Survey, we captured depression and anxiety based on self-reports of whether the respondent had ever had these illnesses in his/her lifetime. In the NHIS, we measured depression and anxiety using questions in the Quality of Life supplement, which is administered to approximately one-quarter of adults in the overall sample. These questions asked respondents who either (i) reported feeling worried, nervous, or anxious at least monthly, or (ii) took medication for those feelings, a follow-up question about whether they had been told by a medical professional that they had anxiety or depression. We use the follow-up question to estimate overall prevalence of depression or anxiety. Last, we measured obesity by calculating each respondent's body mass index (BMI) based on self-report of height and weight.

We assess receipt of preventive services based on whether respondents report receiving routine annual physical and dental exams as well as cancer screenings applicable to their age and gender. Last, we measure receipt of follow-up care for women and chronic condition management for respondents with diabetes and hypertension.

ENDNOTES

- ¹ Samantha Artiga, *Health Coverage by Race and Ethnicity: The Potential Impact of the Affordable Care Act* (Washington, DC: Kaiser Family Foundation, March 2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8423.pdf>.
- ² Vann Newkirk et al., *The Uninsured: A Primer* (Washington, DC: Kaiser Family Foundation, October 2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/10/7451-09-the-uninsured-a-primer-e28093-key-facts-about-health-insurance1.pdf>.
- ³ Peter Shin, Jessica Sharac, and Sara Rosenbaum, *Assessing the Potential Impact of the Affordable Care Act on Uninsured Community Health Center Patients: A Nationwide and State-by-State Analysis* (Washington, DC: George Washington University School of Public Health and Health Services, October 2013), <http://sphhs.gwu.edu/sites/default/files/GG%20uninsured%20impact%20brief.pdf>.
- ⁴ Newkirk et al. Op. cit.
- ⁵ The Health Center Patient Survey asks respondents what language they prefer to speak, with response categories of English, Spanish, or another language. The NHIS ask respondents what language they use most often and allows respondents to answer that they speak only Spanish, only English, a mixture of Spanish and English, or some other language.
- ⁶ Peter Shin et al., *Quality of Care in Community Health Centers and Factors Associated with Performance* (Washington, DC: Kaiser Family Foundation, June 2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8447.pdf>; Lei Yu Shi et al., "Clinical Quality Performance in U.S. Health Centers," *Health Services Research* 47, 6. (December 2012): 2225-2249, <http://bphc.hrsa.gov/publications/clinicalquality.pdf>; L. Elizabeth Goldman et al., "Federally Qualified Health Centers and Private Practice Performance on Ambulatory Care Measures," *American Journal of Preventive Medicine* 43, 2. (August 2012):142-149, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3595189/pdf/nihms446225.pdf>; Deborah Gurewich et al., "Comparative Performance of Community Health Centers and Other Usual Sources of Primary Care," *Journal of Ambulatory Care Management* 34, 4. (October/December 2011): 380-390, http://journals.lww.com/ambulatorycaremanagement/Abstract/2011/10000/Comparative_Performance_of_Community_Health.11.aspx.
- ⁷ Peter Shin et al., *Community Health Centers in an Era of Health Reform: An Overview and Key Challenges to Health Center Growth* (Washington, DC: Kaiser Family Foundation, March 2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8098-03.pdf>.
- ⁸ Susan Wood et al., *Health Centers and Family Planning: Results of a Nationwide Study* (Washington, DC: George Washington University School of Public Health and Health Services, March 2013), http://sphhs.gwu.edu/departments/healthpolicy/publications/Health_Centers_and_Family_Planning.pdf.
- ⁹ Peter Shin, Jessica Sharac, and Sara Rosenbaum, *Assessing the Potential Impact of the Affordable Care Act on Uninsured Community Health Center Patients: A Nationwide and State-by-State Analysis* (Washington, DC: George Washington University School of Public Health and Health Services, October 2013), <http://sphhs.gwu.edu/sites/default/files/GG%20uninsured%20impact%20brief.pdf>.
- ¹⁰ Nakela Cook et al., "Access to Specialty Care and Medical Services in Community Health Centers," *Health Affairs* 26, 5. (September 2007): 1459-1468, <http://content.healthaffairs.org/content/26/5/1459.full.pdf+html>; Michael Gusmano, Gerry Fairbrother, and Heidi Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured," *Health Affairs* 21, 6. (November 2002): 6188-194, <http://content.healthaffairs.org/content/21/6/188.full.pdf+html>.
- ¹¹ Michelle Doty et al., *Enhancing the Capacity of Community Health Centers to Achieve High Performance: Findings from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers* (New York, NY: The Commonwealth Fund, May 2010), <http://www.commonwealthfund.org/Publications/Fund-Reports/2010/May/Enhancing-the-Capacity-of-Community-Health-Centers-to-Achieve-High-Performance.aspx?page=all>.

¹² Kaiser Family Foundation State Health Facts, *Distribution of Revenue by Source for Federally-Funded Federally-Qualified Health Centers* (Washington, DC: Kaiser Family Foundation, 2011), <http://kff.org/other/state-indicator/fqhc-revenue-by-source/>.

¹³ Leighton Ku et al., *How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform* (Washington, DC: Kaiser Family Foundation, March 2009), <https://www.nachc.com/client/MA%20Health%20Reform%20Kaiser%20GW.pdf>.

¹⁴ For more information on NHIS, see: Centers for Disease Control and Prevention. About the National Health Interview Survey. Available at: http://www.cdc.gov/nchs/nhis/about_nhis.htm.