

# Community Health Centers: Medical Homes for Children?

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## ABSTRACT

**OBJECTIVE:** To explore medical home attributes of community health centers (CHCs) that provide care to low-income children nationwide compared to other providers for the poor.

**METHODS:** Cross-sectional study of children aged 0 to 17 years in the Medical Expenditure Panel Survey (MEPS; 2003 to 2009) who resided in families living at <200% of the federal poverty level (FPL) and had visits to a primary care setting. CHC visits were defined as a visit to a neighborhood/family health center, rural health clinic, or community health center. Independent measures included provider type, age, gender, race/ethnicity, insurance, FPL, number of parents at home, language, maternal education, health status, and special health care need. Dependent measures included 4 medical home attributes: accessibility, and family-centered, comprehensive, and compassionate care.

**RESULTS:** CHCs typically serve low-income children who are publicly insured or uninsured, come from racial/ethnic minority groups, and have poorer health status. Eighty percent to 90% of parents visiting both CHCs and other primary care providers

rated high levels of family-centered, comprehensive, and compassionate care. However, CHCs had a 10% to 18% lower rating of accessibility (after-hours care, telephone access) even after controlling for sociodemographic characteristics. Racial/ethnic disparities existed at both settings, but these patterns did not differ between CHCs and other settings.

**CONCLUSIONS:** On the basis of parental reports, CHCs received similar ratings to other primary care providers for family-centered, comprehensive, and compassionate care, but lower ratings for accessibility. Further studies should examine strategies for practice transformation in CHCs to improve patient satisfaction and accessibility to optimize child health outcomes.

**KEYWORDS:** children; community health centers; medical home; safety net

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## WHAT'S NEW

This national study examining medical home attributes of community health centers (CHCs) for children found that parent-reported quality of CHCs is similar to that of other primary care providers; however, both show room for improvement.

SAFETY NET PRIMARY care practices serve as the backbone of the US health care system for the medically underserved.<sup>1</sup> These practices include community health centers (CHCs), public hospital clinics, county or city operated clinics, and free clinics, all of which serve a disproportionate number of racially and ethnically diverse patients, uninsured individuals, and Medicaid enrollees. Free-standing community health centers represent critical strands in the safety net.<sup>2</sup> These include 1200 federally qualified health centers (FQHCs) and about 100 FQHC look-alikes, in addition to city/county operated clinics and community health centers sponsored by charitable organizations such as churches.<sup>3</sup> FQHCs are independently operated and governed by a community board of directors, receive modest federal subsidies, and receive enhanced

Medicaid and Medicare payments for the provision of comprehensive primary care.<sup>3,4</sup> The Patient Protection and Affordable Care Act dedicated funds to FQHCs with the goal of doubling community health center capacity to serve 40 million patients by 2015. With millions of uninsured people gaining access to insurance as health care reform is implemented,<sup>5</sup> CHCs continue to play an increasingly important role in the primary care safety net in the United States. Although the majority of patients attending CHCs are adults, a large number of low-income children are also served.<sup>3,6</sup> Therefore, as health reform is realized in the United States, the reported quality of care provided by CHCs could contribute to further improving care delivered to a sizable portion of our nation's most vulnerable children.

Safety net practices are challenged by caring for many patients with chronic diseases and complex social and mental health conditions. Their quality is affected by limited resources, difficulty in both recruiting and retaining providers, inadequate staffing, and often limited access to specialty referral services for mental, surgical, dental, and vision care, and even social work.<sup>7,8</sup> Further, although some studies have found that CHCs provide care for adult populations that is equal to or better in quality than that of

other primary care providers,<sup>9–12</sup> this may not be the case for children. It is not known whether CHCs deliver the same quality of care to children as other primary care settings.

Measuring the quality of care delivered by CHCs to children is challenging because only a limited number of quality metrics are available for children,<sup>13,14</sup> and national data on CHCs are lacking. Recently the quality of primary care has come to be measured using the criteria of the medical home, which categorize high-quality care in 7 dimensions: it should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.<sup>12</sup> Each dimension has metrics that can be assessed using national patient surveys.<sup>12,15</sup> Application of these metrics to CHCs could help assess how well they are providing care and identify areas for improvement.

We took advantage of the fact that a recent national survey (Medical Expenditure Survey, MEPS) identified the type of primary care practice (including CHCs) and asked parents questions related to the quality of the medical home. Our broad goal was to assess whether CHCs match the quality of care delivered in pediatric settings that serve only children and may face fewer challenges. We assessed the degree to which a nationally representative sample of low-income children who visited CHCs received care that met medical home criteria compared with low-income children receiving care at non-CHCs that serve the poor. We hypothesized that despite the challenges discussed previously, CHCs are just as likely to exhibit attributes of the medical home for children compared with non-CHC providers. Our rationale was that if CHCs are able to perform on par with other primary care providers to meet the needs of an adult population, then they should be able to provide comparable care for children as well.

## METHODS

### STUDY DESIGN

We conducted a cross-sectional analysis of MEPS<sup>16</sup> to compare medical home attributes of CHCs versus other primary care settings.

### DATA SOURCE

MEPS collects data on health service use, costs, and payment, as well as the scope and breadth of health insurance available to the US noninstitutionalized population. The MEPS database is nationally representative, has patient-level health care data, and identifies types of primary care providers, including CHCs. In the household component of MEPS, 1 designated respondent provides information on everyone who lives in the household. We analyzed 6 years of pooled data from the most recently available MEPS data set (2003 to 2009) to obtain a sufficient sample size to assess medical home attributes.<sup>16</sup>

### POPULATION

We examined data from children 0 to 17 years of age who reside in families with incomes under 200% of the

federal poverty level (FPL), which is the general income cutoff for Medicaid and the State Children's Health Insurance Program.<sup>17</sup> We chose to focus our sample on low-income children to examine a homogenous population across providers where reports of quality would be more applicable across settings. To be included in our sample, a child had to have at least 1 visit to a primary care setting during the year surveyed, have a usual source of care that was not an emergency department, and have a completed Children With Special Health Care Needs (CSHCN) screener (99% of parents of children completed this screener).<sup>18</sup>

### MAIN EXPLANATORY VARIABLE

Each child in the pooled MEPS data set was categorized as having 1 or more visits to either a CHC or another primary care setting. We included only visits to an office or group practice, HMO, clinic, outpatient clinic, or CHC, where the patient saw a nurse, physician's assistant, nurse practitioner, midwife, or physician. We excluded psychotherapy and surgery visits. CHC visits were described by the respondent as at least 1 visit to a neighborhood/family health center, rural health clinic, or community health center. We created a composite CHC variable on the basis of these responses. Parents of patients who reported visits only to CHCs were included in the composite CHC variable. Parents who reported no visits to a CHC were classified in the non-CHC group. The MEPS data set does not distinguish between FQHCs and other CHCs.

### INDEPENDENT VARIABLES

A priori, we included patient characteristics that have in prior studies been associated with access to and quality of primary care,<sup>19</sup> based on the work of Romaine and Bell.<sup>20</sup> We used the Andersen-Newman model of health care utilization to guide our methods to control confounding factors.<sup>20,21</sup> This adaptation is based on a previously published approach used by the National Survey of Children with Special Health Care Needs and the National Survey of Children's Health.<sup>12,22</sup> Our variables included age (0 to 5, 6 to 11, and 12 to 17 years), gender, race/ethnicity (white, black, Hispanic, other), insurance status throughout the year (any private, public only, uninsured all year) and FPL (<100%, and 100% to 199%). We included the number of parents a child lives with (0, 1, or 2) and the language of the interview. We categorized health status as poor/fair or good/very good/excellent and also noted whether the child had a special health care need, as determined by the CSHCN screener.<sup>18</sup>

### DEPENDENT MEASURES (MEDICAL HOME ATTRIBUTES)

We analyzed questions from MEPS that closely approximated medical home attributes of the primary care setting<sup>20</sup> and compared these variables for children attending a CHC versus non-CHC. MEPS includes questions from the Access to Care and Child Health and Preventive Care Supplement surveys, which collect information

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