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RCHN Community Health Foundation Research Collaborative

Policy Research Brief No. 28

Role of Community Health Centers in Providing Services to Low-income Women

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at www.gwumc.edu/sphhs/departments/healthpolicy/ggprogram or at rchnfoundation.org.

Executive Summary

Because of their location and ability to serve populations with complex health and social needs, CHCs reduce disparities in access to care and generate significant cost-savings. This brief examines the role CHCs play in mitigating disparities for one population subgroup, low-income women of childbearing age (defined as age 15-44), and the challenges that they will need to overcome to build upon their success in delivering care to vulnerable populations. Key findings include:

- CHCs serve approximately one in five (21.5%) low-income women of childbearing age nationally.
- The number of women of child-bearing age receiving health center services at CHCs increased by 94 percent over the past decade.
- CHCs serve a low-income population—approximately 93 percent of patients have incomes below 200 percent of the Federal Poverty Level.
- CHCs generate cost savings by providing a comprehensive array of services that support women across the lifespan, as well as preventive and enabling services shown to improve pregnancy outcomes

While the Affordable Care Act bolsters access to care for low-income women of childbearing age and builds on the success of CHCs in providing high-quality, prevention-based health care to medically underserved and low-income populations, CHCs face a number of workforce and funding obstacles in ensuring that this patient subgroup gets the care they need.

Background

In 2010, over 1,100 community health centers (CHCs) across more than 8,100 sites furnished health care to nearly 20 million individuals with low-income (at or less than 200% of the federal poverty level).¹ These CHCs are located in federally-designated medically underserved communities and serve populations at high risk for poor health, including homeless, migrant, and public housing residents.² They are required to be governed by patient-majority boards and to provide clinical and non-clinical services that are tailored to meet the unique needs of their communities. Health centers are also required to provide comprehensive primary care on a sliding fee scale as they serve a population that is disproportionately poor and uninsured compared to the general US population.³ Because of their location and ability to serve populations with complex health and social needs, CHCs reduce disparities across population subgroups⁴ and generate significant cost-savings.⁵

Community health centers serve as an important source of care to low-income women of childbearing age (defined in this case as age 15-44). Approximately 93 percent of CHCs patients are low-income (72 percent CHC are poor and 21 percent are between 100% and 200% of Federal Poverty Level).⁶ Nationally, about a third of women of childbearing age are low-income (15 percent are poor, and 18 percent are between 100% and 200% of the FPL).⁷ Low-income is significantly correlated to higher rates of risk factors such as inadequate physical activity, smoking, and obesity.⁸ These risk factors are associated with higher rates of chronic diseases; accordingly, rates of

¹Bureau of Primary Health Care. (2011). *Uniform Data System (UDS) Report 2010*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services. http://bphc.hrsa.gov/uds/doc/2010/National_Universal.pdf

²Centers for Medicare & Medicaid Services.(2011). Federally Qualified Health Center fact sheet.<http://www.cms.gov/MLNProducts/downloads/fqhcfactsheet.pdf>

³Hing, E., Hooker, R.S., & Ashman, J.J. (2011). Primary health care in community health centers and comparison with office-based practice. *Journal of Community Health, 36*(3):406-13.

⁴U.S. Department of Health and Human Services. (2011) HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care. <http://minorityhealth.hhs.gov/npa/templates/content.aspx?vl=1&lvlid=33&ID=285>.

⁵Richard, P., Ku, L., Dor, A., Tan, E., Shin, P., & Rosenbaum, S. (2012) Cost savings associated with the use of community health centers. *Journal of Ambulatory Care Management 35*(1):50-59; Ku, L., Richard, P., Dor, A., Tan, E., Shin, P. & Rosenbaum, S. (2010). Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform. Geiger Gibson/RCHN Community Health Foundation Research Collaborative Policy Research Brief No. 19; National Association of Community Health Centers, Capital Link, and the Robert Graham Center (2007) *Access Granted: The Primary Care Payoff*. http://www.nachc.com/client/documents/issues-advocacy/policy-library/research-data/research-reports/Access_Granted_FULL_REPORT.pdf

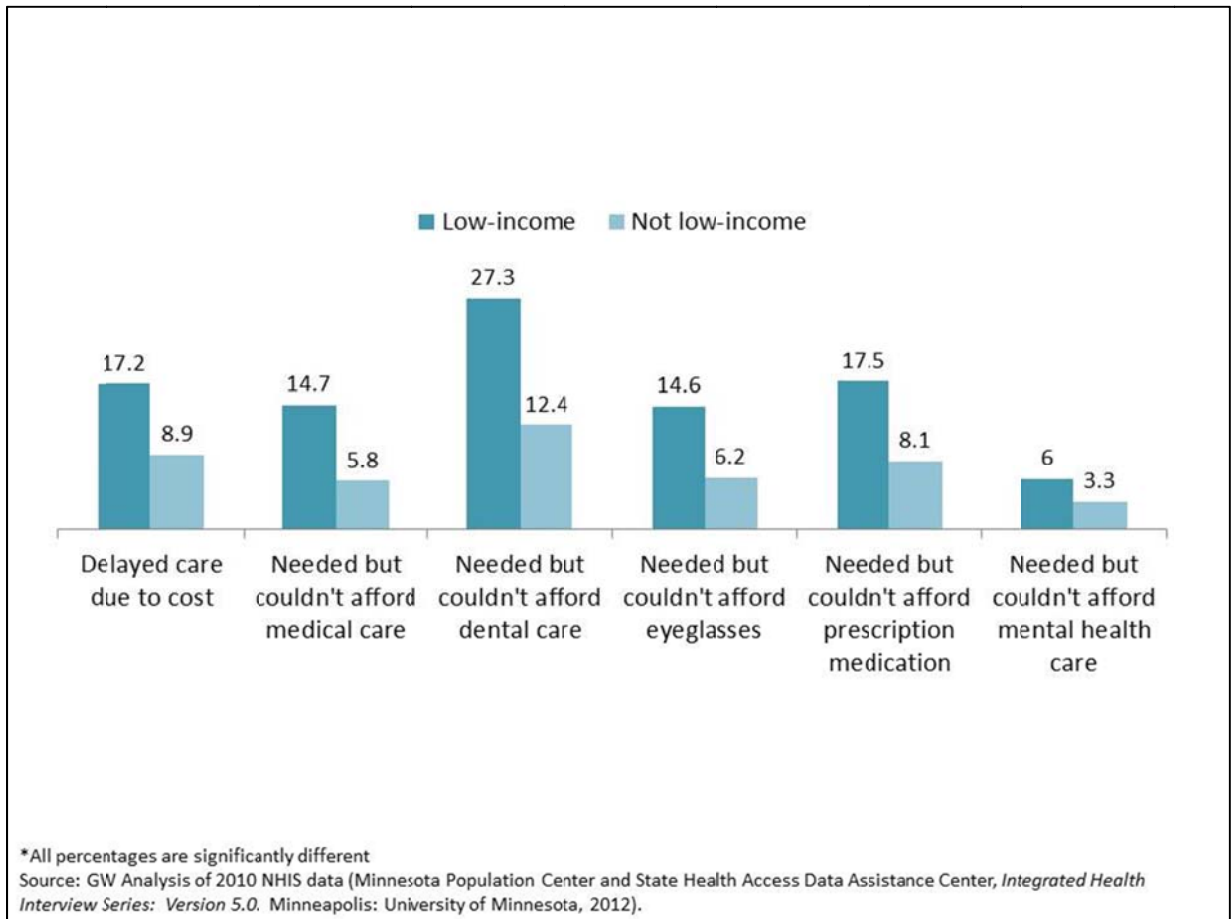
⁶The annual federal poverty guideline for a family of three in the 48 contiguous states and D.C. was \$18,310 in 2011.

⁷U.S. Census Bureau. (2011). *Current Population Survey, Annual Social and Economic Supplement, 2011*. http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

⁸U.S. Department of Health and Human Services, Health Resources and Services Administration. (2011). *Women's Health USA 2011*. Rockville, Maryland: U.S. Department of Health and Human Services.

asthma, heart disease, obesity, and depression or anxiety are higher among low-income women as compared to higher-income women.⁹ Despite being at greater risk for poor health, low-income women are twice as likely as higher-income women to report difficulties in affording needed health care, indicating the importance of CHC to low-income women (Figure 1).

Figure 1. Financial difficulties in accessing health care services for women age 15-44, by income, 2010

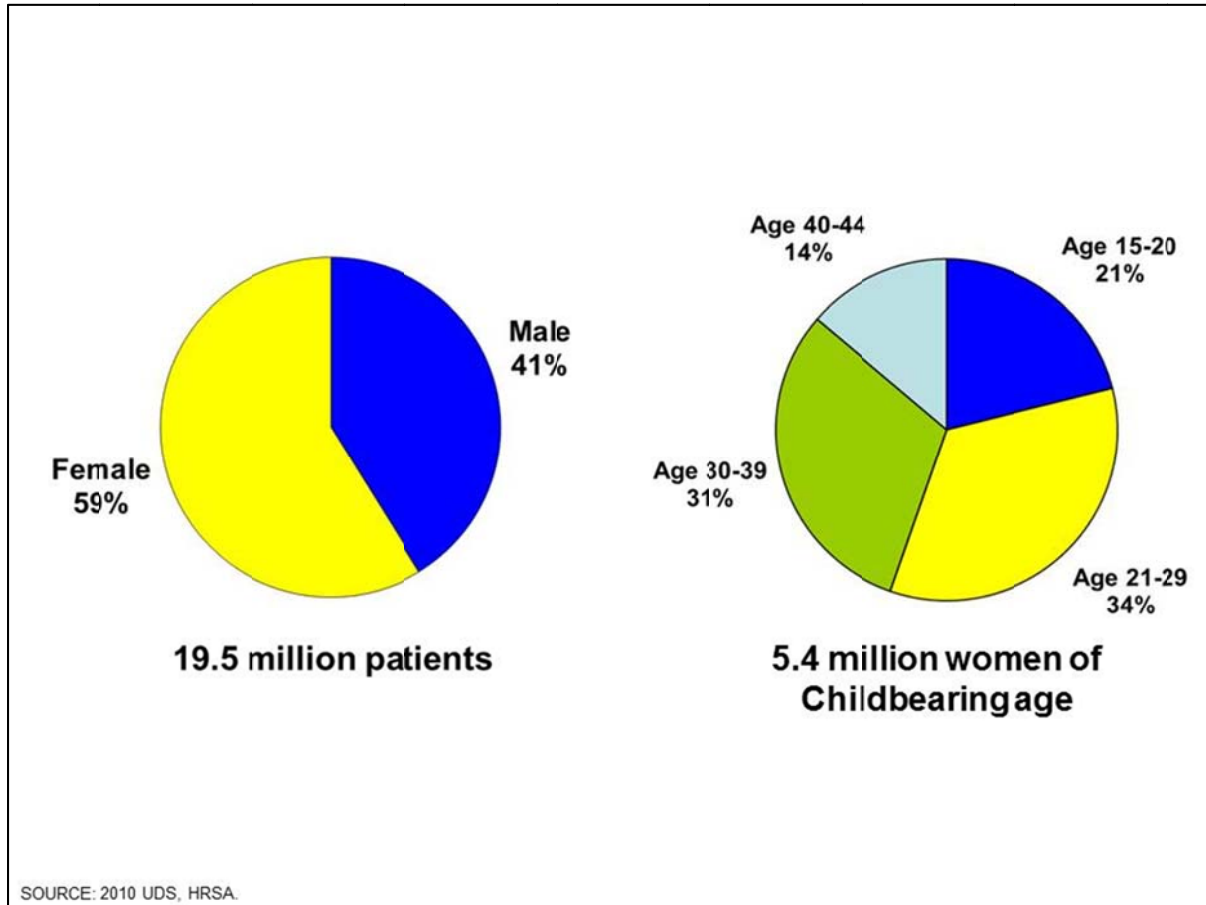


As shown in Figure 2, the CHC patient population currently is comprised of more females (59%) than males (41%), with one in four health center patients (5.4 million) being a woman of childbearing age. While these proportions have stayed relatively constant, the number of women age 15-44 seeking care at CHCs has increased

⁹ Kaiser Family Foundation. (2011). Women's Health Care Chartbook: Key Findings from Kaiser Women's Health Survey. <http://kff.org/womenshealth/8164.cfm>

dramatically. Between 2000 and 2010 alone, the number of women of child-bearing age receiving health center services increased by 94 percent.¹⁰

Figure 2. Characteristics of community health center patients, 2010

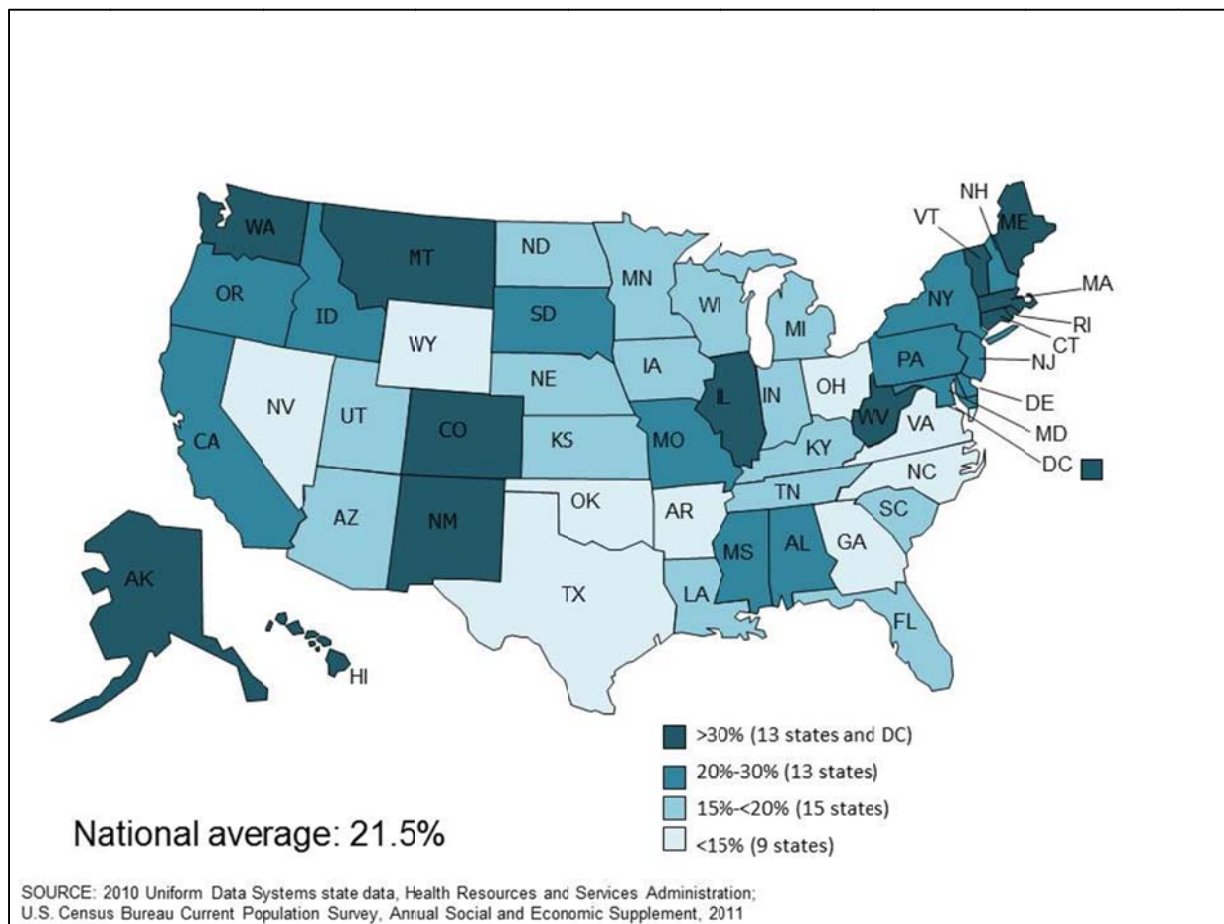


Nationally, CHCs provide a medical home for one in five low-income women of childbearing age. Figure 3 shows that in 13 states and the District of Columbia, CHCs serve at least 30 percent of all low-income women age 15-44. The national CHC estimate is based on 5.4 million female patients age 15-44 served by CHCs and proportion [93%] of patients with incomes at or below 200 percent of the Federal Poverty Level in 2010. Similarly, state CHC estimates account for the proportion of patients at or below 200% FPL, which vary from 68% to 98%, and the number of CHC female patients age 15-44. At the state level, West Virginia (63%), D.C. (61%), and

¹⁰Bureau of Primary Health Care.(2001). *Uniform Data System (UDS) Report 2000*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services. Bureau of Primary Health Care. (2011). *Uniform Data System (UDS) Report 2010*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services. http://bphc.hrsa.gov/uds/doc/2010/National_Universal.pdf

Rhode Island (55%) CHCs serve the largest proportion of low-income women of childbearing age.

Figure 3. Percent of low-income women age 15-44 who receive care from health centers, by State, 2010



According to the most recent data available on CHC services,¹¹ nearly all CHCs provide either on-site or referral services that are key to patients' health and mental well-being. Some CHCs provide services beyond traditional primary care, such as legal services to help patients address underlying health-related legal issues, for example, domestic violence and wrongful termination which results in loss of health care coverage.¹² Health centers may also host other federal programs, for example WIC and

¹¹Bureau of Primary Health Care. (2008) *Uniform Data System (UDS) Report 2007*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services.

http://bphc.hrsa.gov/healthcenterdatastatistics/nationaldata/2007/2007_nat_uds_summary.pdf

¹² Shin P., Byrne, F.R., Jones, E. Teitelbaum, J., Repasch, L., & Rosenbaum, S. (2010). Medical-legal Partnerships: Addressing the Unmet Legal needs of Health Center Patients. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University, Policy Research

Head Start, to better promote healthier pregnancies and families. Table 1 lists some of the clinical and non-clinical services that are available on-site at CHCs that help to address women’s health care needs across the lifespan. However, due to data limitations, there is little detail on the exact scope of services or quality of the services offered.

Table 1: Percentage of all CHCs that provide select on-site services, 2007

Service	Percent of CHCs that offer service on-site
Immunizations	98%
Health education	97%
Gynecologic	97%
Pap test	96%
Family planning	95%
HIV testing and counseling	91%
Translation/interpretation	90%
Mental health treatment	77%
Testing for blood lead levels	77%
Postpartum care	71%
Prenatal	70%
Parenting education	68%
Home visiting	60%
Smoking cessation	58%
Substance abuse treatment	51%
Antepartum fetal assessment	50%
Labor and delivery	38%
Nursing home/assisted-living placement	37%
Pharmacy	35%
WIC	22%
Genetic counseling & testing	14%
Mammograms	12%
Respite care	6%
Head Start	5%

Source: BPHC, 2007 UDS.

The integration of family planning, reproductive health, and other essential women’s health services in the primary care setting is not only convenient for patients, but also helps improve outcomes, narrows disparities in birth outcomes, and ultimately, reduce cost.¹³ Adverse outcomes, such as preterm/low birthweight, can lead to lifelong

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http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_60CE05B1-5056-9D20-3D0F917148C7E929.pdf.

¹³ Wilensky, S. & Proser, M. (2008). Community approaches to women’s health: Delivering preconception care in a community health center model. *Women’s Health Issues* 18(6)Suppl: S52-S60; Proser M.

health problems and contribute to the high cost of health care.¹⁴ The annual societal cost of preterm/low birthweight births in the United States, for example, was \$26.2 billion in 2005.¹⁵ Because CHCs effectively provide a comprehensive array of services that support women across the lifespan, as well as preventive and enabling services, they are associated with improving pregnancy outcomes and reducing disparities. In 2009, the percentage of low birthweight babies born to mothers who obtained prenatal care services at CHCs was 7.3 percent, which compared favorably to the national average of 8.2 percent.¹⁶ The disparity in rates of low birthweight between non-Hispanic white and African American infants was also less pronounced in CHCs (7.5% vs. 11.2%, respectively, a 4.3 percentage point difference) compared to the national rates (7.2% vs. 13.6%, respectively, a 6.4 percentage point difference) in 2009. In 2010, the percentage of low-birth weight births for non-Hispanic white and African-American infants in CHCs dropped slightly to 7.2 percent and 10.9 percent, respectively.¹⁷ The demonstrated success of CHCs in providing care to women at high risk for poor pregnancy outcomes bodes well for further mitigating disparities and generating cost savings as health centers expand to serve a larger number of patients. However, persistent outcome disparities, among CHC patients and nationally, underscore the need to better target and coordinate the provision of family planning and reproductive health services.¹⁸

(2005) Deserving the spotlight: health centers provide high-quality and cost-effective care. *Journal of Ambulatory Care Management* 28(4):321-330.

¹⁴ Weisman, C.S., Chuang, C.H., & Scholle, S.H. (2010). Still piecing it together: women's primary care. *Women's Health Issues* 20(4): 228-230.

¹⁵ Behrman, R.E. & Butler, A.S. (2007). Institute of Medicine, Committee on Understanding Premature Birth and Assuring Healthy Outcomes: Preterm Birth: Causes, Consequences, and Prevention. The National Academies Press.

¹⁶ Martin J.A., Hamilton, B.E., Ventura, S.J., Osterman, M.J.K., Kirmeyer, S., Mathews, T.J., & Wilson, E. (2011) Births: Final Data for 2009. *National Vital Statistics Reports*, 60(1); Haq, S. (2007) *A Report on New Jersey's Federally Qualified Health Centers (FQHCs) Performance in Prenatal Care*. New Jersey Primary Care Association. http://www.njpc.org/whatsnew/Prenatalcare_1.pdf; Shi, L., Stevens, G.D., Wulu, J.T., Politzer, R.M. & Xu, J. (2004). America's health centers: reducing racial and ethnic disparities in perinatal care and birth outcomes. *HSR: Health Services Research* 39(6): 1881-1902; Politzer, R. M., Yoon, J., Shi, L., Hughes, R. G., Regan, J. & Gaston, M. H. (2001) Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care. *Medical Care Research and Review*, 58 (2). pp. 234-248.

¹⁷ Bureau of Primary Health Care. (2011) *Uniform Data System (UDS) Report 2010*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services. http://bphc.hrsa.gov/uds/doc/2010/National_Universal.pdf

¹⁸ Gold, R.B., Zakheim M., Schulte, J.M, Wood, S., Beeson, T. & Rosenbaum, S. (2011). A natural fit: collaborations between community health centers and family planning clinics. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 26.

http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_13_AFEE26-5056-9D20-3D3479861216C7E4.pdf

Discussion

There is substantial evidence to support focused attention on disparities in health care for low-income women. The Affordable Care Act (ACA) contains a number of provisions that will help to enable CHCs to secure better health outcomes for low-income women.¹⁹ Firstly, the ACA provides \$11 billion in health center funding along with a Medicaid expansion that guarantees coverage for adults up to 133% of poverty and the establishment of health insurance Exchanges to provide subsidized private health insurance to individuals and small businesses; together, these changes are expected to double CHC capacity by 2019.²⁰ The health reform legislation also ensures access to primary care for women by mandating services that must be covered by Exchange plans, such as annual well-women preventive care visits, prenatal care, lead screening, genetic screening and counseling, contraception, Pap testing, tobacco counseling and cessation services, sexually transmitted infection and HIV screening, and depression screening.²¹ Although the expansion of primary care services is expected to help address the complex health and social needs of low-income women at risk for acute and chronic conditions, fewer women may benefit if the individual mandate provision of the ACA is struck down by the U.S. Supreme Court.²²

To fully leverage the investments made under the ACA, CHCs will need to overcome significant workforce obstacles, such as retention and recruitment barriers in isolated and rural areas.²³ In addition to \$11 billion in federal funding to CHCs, the ACA also provided a number of measures to help address provider shortages, including significant increases in funding for new residency positions, training programs, and payment incentives. However, recent budgets cuts threaten key workforce programs; the National Health Service Corps, which provides loan repayment and scholarships to primary care providers in exchange for service in health professional shortage areas, saw its funding reduced by \$117 million in FY 2011,²⁴ making it less likely that isolated and rural communities will have sufficient numbers of providers to serve the expanded patient population at CHCs by 2014. At the same time, CHCs are unlikely to overcome the loss, beginning in FY 2011, of \$600 million in federal base funding, which will leave over 5 million Americans, of whom approximately half are women, without access to

¹⁹Shin, P. & Sharac, J. (2012). Opportunities and Challenges for Community Health Centers in Meeting Women's Health Care Needs. *Women's Health Issues* 22(2):e119-e121.

²⁰ Hawkins, D. & Groves, D. (2011). The future role of community health centers in a changing health care landscape. *Journal of Ambulatory Care Management*, 34(1):90-99.

²¹ Institute of Medicine (2011). *Clinical Preventive Services for Women: Closing the Gaps*. Washington, DC: The National Academies Press.

²² Sonfield, A. (2011). Political tug-of-war over Medicaid could have major implications for reproductive health care. *Guttmacher Policy Review*, 14(3): 11-16.

²³ Bodenheimer, T. & Pham, H.H. (2010). Primary Care: Current Problems and Proposed Solutions. *Health Affairs* 29(5): 5799-80;

²⁴ Health Resources and Services Administration Operating Plan for FY 2011.

care. Ongoing threats to defund Title X programs similarly endanger a key component of the safety net infrastructure for nearly five million low-income young women and adolescents (and over 402,000 men).²⁵ Although Medicaid is an essential pathway to healthcare for poor and low-income women, further obstacles to care remain for Medicaid-enrolled women, as many private physicians do not accept Medicaid patients due to poor reimbursement levels.²⁶ Improving primary health care infrastructure and health workforce capacity in medically underserved areas is considered one of the cornerstones of improving women's reproductive health in the US.²⁷ Unless such obstacles to strengthening the infrastructure and expanding capacity are adequately addressed, low-income women will continue to face significant challenges to getting the care they need.

²⁵Fowler, C.I., Lloyd, S.W., Gable, J., Wang, J., & Krieger, K. (2011). *Family Planning Annual Report: 2010 National Summary*. Research Triangle Park, NC: RTI International. <http://www.hhs.gov/opa/pdfs/fpar-2010-national-summary.pdf>

²⁶ Kaiser Family Foundation. (2011). Women's Health Care Chartbook: Key Findings from Kaiser Women's Health Survey. <http://kff.org/womenshealth/8164.cfm>

²⁷ Chavkin, W. & Rosenbaum, S. (2008) Women's health and health care reform: the key role of comprehensive reproductive health care: a white paper. New York: Mailman School of Public Health, Columbia University. <http://www.mailmanschool.org/facultypubs/womenshealthcarereform.pdf>