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This study focused on the use of 14 evidence-based preventive services for the low-income population over age 50: colorectal, breast and cervical cancer screening, cholesterol screening, counseling around diet, exercise, tobacco, alcohol and illicit drugs, and immunizations for influenza, tetanus and pneumonia. Population characteristics and rates of delivery of these preventive services are compared for low-income users of community health clinics vs private doctors' offices/HMOs. Three nationally representative data-files from the National Health Interview Survey-the Person-Level File, Sample Adult File, and Sample Adult Prevention File-were linked to obtain the necessary data on preventive services use in the 12,024 persons over age 50. Among the population of persons over age 50 living below 200% of the poverty threshold, those using community clinics were more likely to be younger, a racial or ethnic minority, less formally educated, in poorer health, uninsured, and more likely to face time, transportation or cost barriers to obtaining health care ($p < .01$ for all comparisons), than their counterparts using private doctors' offices/HMOs. Community health clinics performed as well as private doctors/HMOs in the delivery of cancer screening, cholesterol screening and immunizations to lower income persons over 50 years. Rates of counseling about diet and exercise were higher among users of private doctor's offices than among users of community health clinics users (40% vs. 31% respectively, $p = .02$). Despite the severe resource constraints under which they operate, and the greater vulnerability of the population they serve, community clinics deliver preventive services at rates comparable to private doctors' offices and HMOs. [PUBLICATION ABSTRACT]

KEY WORDS: primary health care; preventive services; low-income; community health clinics.

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INTRODUCTION

Low-income persons, defined in this study as persons with incomes less than 200% of the poverty threshold, suffer disproportionately from preventable morbidity and mortality. Improving the rates of adherence to effective preventive interventions by low-income groups is a goal of HP2010.¹ Physicians' practices/HMOs and community health clinics constitute the bulk of primary care safety net providers² for low-income persons over age 50, the age group for whom most preventive interventions are recommended.³

Within this "low-income" population using the primary care safety net, patient characteristics differ by site. Community clinics tend to have a larger proportion of clients who are uninsured and in poorer health than do physicians' private practices.⁴ From the health care delivery perspective, differences also exist by site infrastructure: Community clinics tend to have less financial security, relying on a tenuous patchwork of funding,⁴ and in some cases carrying out their mission while on the verge of financial insolvency.⁵ As core safety net providers,⁴ community clinics are often viewed as operating less efficiently than private practices or HMOs and are less able, due to resource constraints, to document their health care delivery outcomes.^{4,6} Some have further argued that government run safety net community clinics are at a financial disadvantage not just because they serve larger proportions of patients unable to pay for their care, but also because they are subject to hiring, procurement and other rules with which they must comply.^{4,7-8} Given these challenges faced by community clinics, it seems logical to ask whether they do as good of a job as private practices and HMOs in delivering preventive services to the low-income population over age 50.

Outside of studies focused on breast and cervical cancer screening⁹⁻¹³ little has been published using national data comparing this age group's use of other preventive services in these two settings. This study focuses on the use of 14 preventive services recommended for the general adult population over age 50 by evidence-based guidelines:^{3,14-15} namely, colorectal, breast and cervical cancer screening, cholesterol screening, counseling around diet, exercise, tobacco, alcohol and illicit drugs, and immunizations for influenza, tetanus and pneumonia. The purpose of this study was twofold, 1) To describe the low-income U.S. population over age 50 using the two most common types of primary care safety net sites, private physician's offices/HMOs and community clinics; and, 2) To compare the utilization of preventive services in these two settings.

METHODS

Data Source and Sample

The 1998 National Health Interview Survey (NHIS)¹⁶ was the source of data for this study. The NHIS is conducted by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC). The NHIS administers face-to-face interviews to a nationally representative sample of households to obtain information on the health and other characteristics of each member of the household. The 1998 NHIS was designed to over-sample black and Hispanic persons for more reliable estimates of these groups. The weights have been adjusted to the national civilian, non-institutional population estimates by age, sex and race/ethnicity based on projections from the US census. NHIS uses a complex sampling design requiring special software (SUDAAN¹⁷) to estimate sampling errors for population-based estimates.

Items on Preventive Interventions including screening, counseling and immunizations come from the 1998 NHIS Adult Prevention Module. This was linked with data resulting from the Adult Core of the NHIS that included items on health care access and utilization. In total, three NHIS data files, the Person-Level File, Sample Adult File, and Sample Adult Prevention File, were linked to obtain the necessary data on the 12,024 persons over age 50 that constitute the sample for the present analyses. The total household response rate was approximately 90.0%; the response rate for the Sample Adult component was 83.8%.¹⁶

Setting

NHIS respondents obtaining their routine and primary care in physicians' practices/ HMOs and community health clinics were the focus of these analyses because these sites were the routine care providers for the vast majority of this population. "Community health clinics" include federally qualified community health centers (FQHC), FQHC "look-alikes" which do not receive federal Section 300 funds, rural health clinics, independent community clinics, private not-for-profit clinics, and local health department primary care clinics.⁴

Main Independent Variable: Type of Primary Care Site

The "type of primary care site" variable was constructed from four items in the Adult Core of the 1998 NHIS section on Health Care Access and Utilization. These items were: 1) "Is there a place that you USUALLY go to when you are sick or need advice about your health?" 2) What kind of place is it—a clinic, doctor's office, emergency room or some other place? Response categories were: "Clinic or health center," "Doctor's Office or HMO," "Hospital Emergency Room," "Hospital Outpatient Department," "Some other place," or Refused/Don't Know. Those who responded that they had more than one place in question #1 were asked: 3) "What kind of place do you go to most often—a clinic, doctor's office, emergency room or some other place?" All respondents were then asked, 4) "Is that the same place you USUALLY go when you need routine or preventive care, such as a physical examination or check-up?" For the overwhelming majority (96%), the routine care place was the same as the sick care place. Those respondents who reported a different routine and sick care place were asked, 5.) "What kind of place do you go to when you need routine preventive care, such as a physical examination or check-up?" For the four percent of respondents who went to different places for routine care and sick care, their "primary care site" for these analyses was designated by their routine care site. Thirteen people were missing data for the variables used to create the "type of primary care site" variable.

While important as providers of safety net care, the sample sizes of respondents using hospital out-patient department/Other and Emergency Room/No Site categories were too small to make reliable estimates in bivariate and stratified analyses; thus, these two safety-net sites were excluded from the analyses. Since the structure and process of care in hospital outpatient departments and emergency rooms can vary greatly, we felt that it would be inappropriate to combine these groups into one category.

Dependent Variables-Preventive Services Utilization

Colorectal cancer screening was assessed via two indicators, fecal occult blood tests and proctoscopy/sigmoidoscopy/colonoscopy, the latter three referred to collectively in this paper as "endoscopy."¹⁸ All screening tests were defined for the participant prior to questions on utilization. Based on screening guidelines,^{3,14} FOBT is recommended annually for persons 50 years and over. An endoscopy was considered "recent" if it had been obtained in the prior five years. For mammography and clinical breast exams, a recent test was one delivered in the previous two years. Pap smears were considered "recent" if received at least once in the previous three years.

Respondents were also asked about receipt of immunizations: a tetanus shot in the previous ten years; and, for persons over age 65, a flu shot in the past year, and ever-receipt of a pneumonia vaccine. Lifestyle counseling by the primary care provider was also queried among those who had a general physical exam or routine checkup in the past three years. Counseling interventions measured included: whether the provider had asked about diet, exercise, tobacco use, alcohol use and illicit drug use during the past three years. Respondents were also asked when a doctor or other health professional checked their most recent total blood cholesterol. Evidence-based guidelines available to clinicians prior to the 1998 NHIS included the USPSTF³ and the NCEP.¹⁵ For these analyses, receipt of a non-fasting cholesterol in the past five years is therefore considered recent.

Controlling Variables

Demographic (age, gender, race/ethnicity, region) socioeconomic (education), health insurance and health status were assessed as controlling variables in stratified analyses and in logistic regressions. Additional independent variables of interest assessed respondents' reasons for delaying care in the past year. We felt that it was important to assess respondent-specific (as opposed to site-specific) perceived barriers to obtaining preventive care. Respondents were asked whether they had delayed getting medical care in the past 12 months for any of the following reasons: Time limitations (Not being able to get through by phone, not being able to get an appointment soon enough, having to wait longer than they were able to see the doctor, hours open for clinic/doctor office visits), and lacking transportation. In exploratory analyses, reasons for delay correlated highly with income and socioeconomic status. Hence it seems that these reasons for delaying care were better indicators of the respondent-specific barriers, i.e. (income, child care, job demands) than being indicators of the accessibility of their primary care sites. If they said yes to any of these items, they were categorized as delaying care for a reason related to "time or transportation barriers." Respondents were also asked if they didn't get certain types of care in the past 12 months because they could not afford it, including prescription medicines, mental health care or counseling, and dental check-ups or dental care. If they said, "yes" to any of these three items, respondents were categorized as not getting care in the past 12 months due to cost barriers.

Analyses

All statistics were weighted by the NHIS sample weights to the U.S. population. The Survey Data Analysis statistical computer package (SUDAAN)¹⁷ was used to take into account the complex sampling design of NHIS in order to calculate the standard errors. Cross-tabulations used the chi-square statistic to assess significance. Logistic regressions were used to determine the adjusted proportions of persons receiving each of the preventive services of interest according to the main independent variable, type of site, adjusting for age, gender, race/ethnicity, education, region, health and status. Statistical significance was assessed for all comparisons made in Tables 1 and 2 between the two types of primary care sites (community clinics vs. private doctors' offices/HMOs).

RESULTS

Among the population over age 50 living below 200% of the poverty threshold, those using community clinics were more likely to be younger, a racial or ethnic minority, less formally educated, in poorer health, uninsured and to face time, transportation or cost barriers to obtaining health care than their counterparts using private doctors' offices/HMOs (Table 1). Of the 3377 persons over age 50 living at less than 200% of the poverty threshold who responded to the 1998 Adult Prevention Supplement, 18.2% (611) used community clinics as their site of primary care (includes routine care), 68.3% (2298) used private doctor's offices or HMOs, 8.3% (280) had no routine care place or used the emergency room, and 5.2% (175) used a hospital out-patient department or "other place" (Figure 1).

While serving a population with poorer health status and less insurance, community health clinics performed as well as private doctors/HMOs in the delivery of colorectal, breast and cervical cancer screening and cholesterol screening, and immunizations to lower income persons over 50 years (Table 2). Rates of counseling around diet and exercise were higher among users of private doctor's offices/HMOs than among users of community clinics. For users of both types of primary care settings, rates of colorectal cancer screening and immunizations were considerably lower than recommended.¹

CONCLUSIONS

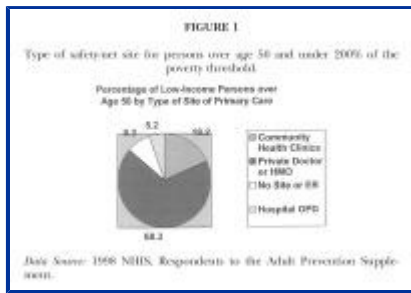
Despite severe resource constraints, and the greater vulnerability of the population they serve, community clinics deliver preventive services at rates comparable to private doctors' offices and HMOs for low-income persons over age 50. A large subgroup of this low-income population, i.e., persons age 50-64, for whom many preventive interventions are recommended, do not yet qualify for Medicare. Thus, this population is especially dependent on the primary care safety net, and it is reassuring that their rates of receipt of preventive services are similar whether they are seen in community clinics or physicians' private practices/HMOs.

A local study of older black patients (> or =70 years old) using neighborhood health centers in Cleveland, Ohio¹³ found that FQHCs achieved high rates of performance for influenza and pneumococcus vaccination (59% and 64% respectively). As in our national analyses, their rates of fecal occult blood testing for colorectal cancer screening were extremely low.

A recent analysis of CHC users found that: Individuals of lower (vs. higher) socioeconomic status were more likely to use the CHC for their preventive care services. Individuals with some type of insurance other than Medicaid or Medicare were less likely to obtain cancer screening services at a CHC than uninsured individuals.¹⁹ In our study of the NHIS data, persons were categorized by the type of site that they said they used for their primary care, including their routine care. Thus it is unlikely that the comparable use of preventive services in community clinics and doctors' offices is simply a result of persons going to community clinics for just their routine care needs.

Limitations of this study include our inability to include hospital outpatient departments since the sample size of respondents in the adult prevention supplement was too small for this type of site. Secondly, self-report of receipt of screening services usually overestimates rates, but there is no reason to think that this bias would not be consistent across types of sites of primary care. Thirdly, there is wide variation in type of community health clinics across the country. While we cannot break down NHIS respondents using community clinics into those at federally qualified (FQHC) vs. non-federally qualified clinics, this sample should still be an accurate reflection of community clinic care for this population as it is practiced today in the U.S. More specific data collection within national health care survey efforts, on the types of clinics people use, would help to identify the types of community clinics people use. This would likely require a provider level component such as that used by the National Ambulatory Medical Care Survey that specifies characteristics of the clinics' organization, administration and funding.

Research on federally qualified community health centers has documented that they are effective in improving access to primary care, reducing inappropriate hospitalizations, and delivering care of a quality similar to other provider types.²⁰⁻²³ While much research and policy attention has been paid to federally qualified community health centers (Section 330 of the Public Health Service Act), the majority of lower income persons obtain their primary care in clinics which are not federally qualified community health centers. For example, in 1998 only an estimated 8% of uninsured Americans, 20-25% of poor and near poor uninsured Americans, and 9% of Medicaid beneficiaries, received their primary care at federally qualified health centers.²⁴ Since the majority of community clinics are not federally qualified, it is important to assess all types of community clinics in research because the majority of lower income persons who get their primary care from community clinics get them from sites other than Section 330 designated sites.



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FIGURE 1

Type of safety-net site for persons over age 50 and under 200% of the poverty threshold.

Assessment of nationally representative data on preventive services utilization stratified by the type of site of care is useful in order to gain insight into how to target primary care-based screening interventions. Even though they serve a more vulnerable subgroup of low-income persons, community health clinics performed as well as private doctors/HMOs in the delivery of colorectal cancer and cholesterol screening, counseling around exercise and drugs, and immunizations. In both primary care settings, rates of colorectal cancer screening and immunization were considerably lower than recommended. The populations obtaining care in the different types of safety net sites, while all "poor" still had additional socioeconomic and demographic differences according to the type of setting. Thus, intervention efforts to improve rates of preventive services use in one setting may not apply to patients in the other types of settings.

In sum, community health clinics perform as well as private doctors' offices and HMOs in delivering evidence-based preventive services to low-income persons over age 50. In the absence of universal health care coverage, ensuring the viability of these safety-net sites is critical to the receipt of preventive services by a large segment of the U.S. population.

[Sidebar]

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[Sidebar]

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[Reference]

REFERENCES

1. U.S. Department of Health and Human Services. Healthy People 2010 (Conference Edition, in Two Volumes). Washington, DC: January 2000.
2. Forrest CB, Whelan EM. Primary Care Safety-Net Delivery Sites in the United States. *JAMA*. 2000;284:2077-83.
3. U.S. Preventive Services Task Force, 1996. Baltimore, MD: Williams and Wilkins, 2nd ed.
4. Institute of Medicine. America's Health Care SAFETY NET: Intact but Endangered. National Academy Press, Washington DC. 2000.
5. McAlearney JS. The Financial Performance of Community Health Centers, 1996-1999. *Health Affairs* 2002;21:219-225.
6. Harrington M, Frazer H, Aizer A. Medicaid Managed Care and FQHCs: Experience of Plans, Networks, and Individual Health Centers. 1998. Washington, DC: Mathematica Policy Research Inc.
7. Bovbjerg R, Marsteller J. Health Care Market Competition in Six States: Implications for the Poor. 1998. Paper No. 17. Washington D.C. Urban Institute.
8. West D. Medicaid Managed Care: Linking Success to Safety-Net Provider Recruitment and Retention. *J Ambul Care Management* 1999;22:28-32.
9. Lane DS, Polednak AP, Burg MA. Breast Cancer Screening Practices among Users of County-Funded Health Centers vs. Women in the Entire Community. *Am J Pub Health* 1992;82:199-203.
10. Bloom JR, Stewart SL, Koo J, Hiatt RA. Cancer screening in public health clinics: the importance of clinic utilization. *Med Care* 2001;39:1345-51.
11. Regan J, Lefkowitz B, Gaston MH. Cancer screening among community health center women: eliminating the gaps. *J Ambulatory Care Manage* 1999;22:45-52.
12. Rimer BK, Conaway MR, Lyna PR, Rakowski W, Woods-Powell CT, Tessaro I, Yarnall KS, Barber LT. Cancer screening practices among women in a community health center population. *Am J Prev Med* 1996;12:351-7.
13. Wright PJ, Fortinsky RH, Covinsky KE, Anderson PA, Landefeld CS. Delivery of preventive services to older black patients using neighborhood health centers. *J Am Geriatr Soc* 2000;48:124-30.
14. Winawer SJ, Fletcher RH, Miller L, Godlee F, Stolar MH, Mulrow CD, et al. Colorectal cancer screening: clinical guidelines and rationale. *Gastroenterology* 1997;112:594-642.
15. National Cholesterol Education Program. Second Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel II). Bethesda: National Health, Lung and Blood Institute, [National Institutes of Health](#), 1993, Publication No. 93-3095.)
16. National Center for Health Statistics (2000). Data File Documentation, National Health Interview Survey, 1998 (machine readable data file and documentation, CD-ROM Series 10, No. 13A), National Center for Health Statistics, Hyattsville, Maryland.

17. Shah BV, Barnwell BG, Bieler GS. (1997) SUDAAN User's Manual; Release 7.5, Research Triangle Institute, Research Triangle Park, NC.
18. Breen N, Wagener DK, Brown ML, Davis WW, Ballard-Barbash R. Progress in cancer screening over a decade: results of cancer screening from the 1987, 1992, and 1998 National Health Interview Surveys. J Natl Cancer Inst 2001 Nov 21;93(22):1704-13.
19. Frick KD, Regan J. Whether and Where Community Health Center Users Obtain Screening Services. J Health Care Poor Underserved 2001;12:429-445.
20. Davis K, Shoen C. Health and the War on Poverty: A Ten-Year Appraisal. Washington DC: The Brookings Institution. 1977
21. Dievler A, Giovannini T. Community Health Centers: Promise and Performance. Medical Care Research and Review 1998;55:405-431.
22. Hawkins D, Rosenbaum S. The Challenges Facing Health Centers in a Changing Healthcare System. In: Who Will Take Care of the Poor and Uninsured? Altman S, Reinhardt U, Shields A. (eds.) Chicago IL: Health Administration Press. 1998
23. Okada L, Wan T. Impact of Community Health Centers and Medicaid on the Use of Health Services. Public Health Rep 1980;95:520-534.
24. Bureau of Primary Health Care. 1998. Uniform Data System. Bethesda, MD: Bureau of Primary Health Care/Health Resources and Services Administration, U.S. Department of Health and Human Services. As cited by IOM, America's Health Care Safety Net, 2000.

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