Community Health Centers Caring for Adults With Hypertension and Diabetes

John Z. Ayanian, MD, MPP

Federally qualified health centers (FQHCs) play a special role in caring for 30 million adults and children in low-income urban and rural communities in the US. These communities often have high rates of chronic health conditions, such as hypertension and diabetes. Without high-quality primary care that includes regular screening and monitoring, guidance on lifestyle modifications, and use of effective medications to control blood pressure, glucose, and cholesterol levels, hypertension and diabetes can often lead to myriad complications, including coronary artery disease, congestive heart failure, cerebrovascular disease, chronic kidney disease, peripheral arterial disease, dementia, retinopathy, and neuropathy.

In this issue of *JAMA Health Forum*, Cole and colleagues assessed the control of blood pressure and glucose levels, respectively, for adults with hypertension and diabetes in 946 FQHCs that were providing care for about 19 million patients annually from 2012 through 2018. Using a difference-in-differences analysis, they compared facility-level changes in uninsurance and control of these intermediate outcomes in 578 FQHCs in 26 states and Washington, DC, that expanded Medicaid to low-income adults in 2014 compared with 368 FQHCs in 19 states that did not expand Medicaid through 2016. Because the authors assessed changes over the first 5 years of Medicaid expansion through 2018, they excluded 110 FQHCs in 5 states that expanded Medicaid during 2015 (Indiana and Pennsylvania) or 2016 (Alaska, Louisiana, and Montana).

As depicted in the first figure of this study, FQHCs in Medicaid expansion and nonexpansion states had sizable reductions in their proportions of uninsured patients from 2012 to 2018. As expected, the adjusted reduction was substantially larger in Medicaid expansion states, by 7 percentage points. Most notably, the greater reduction in uninsurance at FQHCs in Medicaid expansion states was associated with significantly better control of hypertension and diabetes compared with FQHCs in nonexpansion states (Tables 2 and 3). These differences in intermediate outcomes steadily increased in magnitude from 2014 through 2018.

The relative differences between FQHCs in Medicaid expansion and nonexpansion states were mainly because of worsening control of hypertension and diabetes in nonexpansion states rather than absolute improvements in expansion states. Following improvements in control of hypertension and diabetes nationally from 1999 through 2010, recent studies have shown concerning declines in blood pressure and glucose control among all US adults with hypertension and diabetes over the past decade. Thus, by maintaining stable levels of blood pressure and glucose control, FQHCs in Medicaid expansion states withstood these underlying negative national trends.

In analyses stratified by race and ethnicity, Cole and colleagues found that the relative stability in hypertension and diabetes control was most pronounced for Black patients who were receiving care at FQHCs in Medicaid expansion states. However, Black patients continued to have worse control of each condition than White and Asian patients in expansion and nonexpansion states. These persistent racial disparities are particularly important, because Black adults in the US have markedly higher age-adjusted mortality rates than any other racial and ethnic group because of diabetes and major complications of hypertension, including cardiovascular, cerebrovascular, and kidney diseases. Disparities in hypertension and diabetes control have also likely contributed to the marked reductions in US life expectancy observed among Black and Hispanic adults in 2020 during the COVID-19 pandemic.

The study by Cole and colleagues demonstrates that health outcomes are more stable for patients served by community health centers in states with Medicaid expansion than in...
nonexpansion states, as shown in other recent research. This study also underscores that even with Medicaid expansion and access to community health centers, more effective clinical and social policy interventions are needed to address persistent racial disparities in health outcomes that are associated with hypertension and diabetes.