Title: Role of Community Health Outreach Program "Living for Health" (R) in Improving Access to Federally Qualified Health Centers in Miami-Dade County, Florida: A Cross-sectional Study

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Version: 2
Date: 16 February 2015

Author's response to reviews: see over
Dear Editor,

Thank you very much for considering our paper “Role of Community Health Outreach Program “Living for Health”® in Improving Access to Federally Qualified Health Centers in Miami-Dade County, Florida: A Cross-sectional Study” for publication in your esteemed journal as a research Article. We have edited the paper based on the valued comments of Mr. Rahbel Rahman and Mr. Hector Balcazar. Below are a few points of clarification for questions raised by the reviewers:

In the background section,
We have added statistics to show how cardiovascular disease is a very significant public health problem in the United States affecting 17.6 Millions and responsible for about one third of all deaths. It also emphasizes the rationale behind focusing on cardiovascular risk factors detection and management in L4H. To address this pressing issue, not only a physician access is important but also an approachable healthcare access.

With regards to the distinction between Community Health Clinics (CHCs) and Federally Qualified Health Centers (FQHCs), we have indicated that FQHCs are in fact a type of CHCs that provide healthcare to patients regardless of their ability to pay and dedicate a substantial portion of patient share to be of uninsured, under-insured and Medicaid beneficiaries.

In the methods section,
The L4H program educators are the ones who make referral decisions based on pre-determined standardized criteria that include abnormalities in blood pressure, blood glucose and cholesterol. Educators receive training on recognizing abnormal health parameters and to deciding on whether a participant needs referral. “Events” written in line 114 had been clarified further as cardiovascular screening events. As we further clarified at the end of background section, the importance of using match rate is to provide an objective quantitative measure for FQHC access and utilization.

We have clarified how data collection was performed in the methods section. The participants’ identifying information was maintained strictly at FHRI office and only shared with concerned FQHCs if referral is indicated after the participant signs consent for sharing information.

We used the 16th version of SPSS for our data analysis. Chi-square was used to determine the significance of relationship between matching and other categorical variables (tables 1 and 2). Significant variables on univariate testing were fitted into a logistic regression model to determine which retained their significance (table 3). Variables which attained a P-value <.05 were considered significant.

In results section,
As suggested, we added a figure to explain how we reached to 201 matched participants (matching rate of 11%) starting from the total L4H population screened (n=9453). It provides a visual aid to explain the first paragraph of our results section.

Conclusion section was summarized to better deliver the key points of the article.
Should there be any comments or revisions, please do not hesitate to contact me.

Yours’ sincerely,

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