

Months into the COVID-19 Pandemic, Community Health Centers Report Signs of Improvement, But Face Financial Uncertainty

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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 Milken Institute School of Public Health 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 is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing 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 <https://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy> or at www.rchnfoundation.org.

Executive Summary

This policy brief reports on the COVID-19 experience of the nation's community health centers over a six-month period, utilizing data from the Health Resources and Services Administration's (HRSA's) weekly Health Center COVID-19 Survey from April 3rd, 2020 to October 2nd, 2020. The data demonstrate that community health centers were immediately responsive to the public health crisis, initiating diagnostic testing for the COVID-19 virus, and adapting care such as telehealth to address patient needs. However, with visits down overall and limited financial relief, the pandemic has taken an enormous financial toll on health centers. Cumulative patient revenue losses over six months are estimated at \$3.364 billion, which amounts to nearly 11 percent of total health center revenue reported nationally in 2019. Other key findings include:

- The share of health centers with the capacity to provide COVID-19 diagnostic testing grew from 80 percent in early April to nearly all (97 percent) six months later.
- Community health centers have tested a total of more than four million patients for COVID-19 virus over six months. In the aggregate, a total of 456,682 health center patients and 14,562 staff members have tested positive for the COVID-19 virus. With 7.3 million cases of coronavirus in the U.S. reported as of October 2nd, the number of health center patients who have tested positive accounted for 6.2 percent of cases nationally, or one in 16 of all U.S. cases.
- Average turn-around times for test results have improved from their lowest point in mid-July, when turn-around times of four or more days were reported by two thirds of responding health

centers, to 14 percent as of the most current reporting period.

- In line with research that has found that minorities are disproportionately at risk for infection with the COVID-19 virus, patients reported as racial and ethnic minorities, particularly Hispanic/Latino patients, accounted disproportionately for patients who tested positive.
- Measures of operational capacity including temporary site closures, staff unable to work, and declines in weekly visits have improved over the six months, but remain substantial and vary greatly by state.

Introduction

Community health centers are an essential source of care for low-income and racial and/or ethnic minority patients, who are at high risk of COVID-19 infection and poor health outcomes. In 2019, 1,385 federally-funded community health centers served nearly 30 million patients in the U.S.,¹ or one in eleven residents nationally.² That year, 91 percent of patients served by health centers were low-income and 63 percent were racial/ethnic minorities;³ health center patients generally are at elevated risk of poor health, with both demographic characteristics and chronic conditions that put them at greatest risk of poor outcomes from COVID-19.⁴

Community health centers are required by statute to serve all patients regardless of their income or health insurance status and to charge patients on a sliding fee scale based on their ability to pay. Before the pandemic, community health centers served one in three people living in poverty,⁵ one in five uninsured individuals,⁶ and one in five Medicaid and Children's Health Insurance Program (CHIP) enrollees.⁷ Their

¹ Health Resources and Services Administration (HRSA). (2020). 2019 Health Center Data: National Data. <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2019>

² HRSA. (2020). HRSA Health Center Program. <https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf>

³ HRSA. (2020). National Health Center Data. <https://data.hrsa.gov/tools/data-reporting/program-data/national>

⁴ Sharac, J., Shin, P. & Rosenbaum, S. (2020). Community Health Centers on the Eve of the COVID-19 Pandemic: An Overview of Findings from the 2019 Uniform Data System. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 63. <https://www.rchnfoundation.org/?p=9180>

⁵ HRSA. (2020). HRSA Health Center Program. <https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf>

⁶ National Association of Community Health Centers. (2020). Community Health Center Chartbook 2020. <https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf>

⁷ Sharac, J., Shin, P. & Rosenbaum, S. (2020). Community Health Centers on the Eve of the COVID-19 Pandemic: An Overview of Findings from the 2019 Uniform Data System. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 63. <https://www.rchnfoundation.org/?p=9180>

importance for low-income, uninsured, and Medicaid/CHIP patients has only grown at a time when one in three U.S. adults has reported difficulty covering usual household expenses,⁸ an estimated 14.6 million workers and their dependents have lost employer-sponsored insurance coverage following job losses,⁹ and as new Medicaid and CHIP enrollments increased by over four million from February to June 2020.¹⁰ In addition to offering local access to both COVID-19 testing and ongoing, comprehensive primary medical care, community health centers offer services that address the pandemic-related rise in mental health and substance use disorder problems.¹¹ Distancing requirements and federal recommendations to avoid “non-essential” care in the early months of the pandemic led to drastic reductions in vaccinations, screenings, and dental services utilization among Medicaid and CHIP child enrollees;¹² health centers will likely face a surge in patient demand as social distancing requirements ease, and those who may have avoided health care due to cost or coronavirus concerns return.¹³

HRSA’s Weekly Health Center COVID-19 Survey

The Health Resources and Services Administration (HRSA) has been administering a weekly Health Center

COVID-19 Survey to all health centers nationally since early April 2020.¹⁴ The survey captures data on health centers’ COVID-19 virus testing capacity, the number and race/ethnicity of all patients tested and those who tested positive for both the COVID-19 virus and antibodies, the effects of the pandemic on health centers’ operational capacity, measured in site closures, weekly visit declines, and staff unable to work, and the adequacy of personal protective equipment (PPE) supplies. HRSA reports summary data for health centers nationally, by state, and for look-alike health centers, which meet all health center program requirements but do not receive federal health center grants.¹⁵ Because the data are cross-sectional, with different health centers reporting each week, and the response rates vary by week, HRSA cautions against comparing data over the weeks;¹⁶ notably, however, overall response rates have ranged from 62 percent to 83 percent and have met or exceeded 70 percent in 22 out of the 27 weeks of data. The Geiger Gibson/RCHN Community Health Foundation Research Collaborative has produced a series of weekly updates based on HRSA’s survey data.¹⁷ This policy brief presents trend data for a full six months (27 weeks) of HRSA’s survey data, from the first week of the survey, as of April 3rd, 2020, to the most recent week, as of October 2nd. We also present

⁸ Center on Budget and Policy Priorities. (October 2020). Tracking the COVID-19 Recession’s Effects on Food, Housing, and Employment Hardships. <https://www.cbpp.org/sites/default/files/atoms/files/8-13-20pov.pdf>

⁹ Fronstin, P. & Woodbury, S.A. (October 2020). How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic? The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/how-many-lost-jobs-employer-coverage-pandemic>

¹⁰ CMS.gov. (September 30, 2020). CMS Releases Medicaid and CHIP Enrollment Trends Snapshot Showing COVID-19 Impact on Enrollment. <https://www.cms.gov/newsroom/press-releases/cms-releases-medicaid-and-chip-enrollment-trends-snapshot-showing-covid-19-impact-enrollment>

¹¹ Czeisler, M. É., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., ... & Czeisler, C. A. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic—United States, June 24–30, 2020. *Morbidity and Mortality Weekly Report*, 69(32), 1049. ; Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel, L., & Chidambaram, P. (2020). The implications of COVID-19 for mental health and substance use. <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>

¹² Center for Medicaid & CHIP Services (CMCS). (September 2020). Centers for Medicare & Medicaid Services. <https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-18-under-covid-19-snapshot-data.pdf>

¹³ Gonzalez, D., Zuckerman, S., Kenney, G. M., & Karpman, M. (2020). Almost Half of Adults in Families Losing Work during the Pandemic Avoided Health Care Because of Costs or COVID-19 Concerns. Washington, DC: Urban Institute. https://www.urban.org/sites/default/files/publication/102548/almost-half-of-adults-in-families-losing-work-avoided-health-care-because-of-cost-or-covid-19-concerns_2.pdf

¹⁴ HRSA. (2020). Health Center COVID-19 Survey. <https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data>

¹⁵ The most recent survey data for look-alike health centers is available here: <https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data/look-alikes>. This brief presents data only on federally-funded health centers and does not include data on look-alike health centers.

¹⁶ “Data represents information provided by health centers from a single, specified reporting date. Summary information across report dates is not comparable due to differences in which health centers responded for a given report date.” <https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data>

¹⁷ The weekly updates can be accessed here: https://www.rchnfoundation.org/?page_id=8918

updated estimates on the cumulative losses to date in patient revenue, both nationally and at the state level.

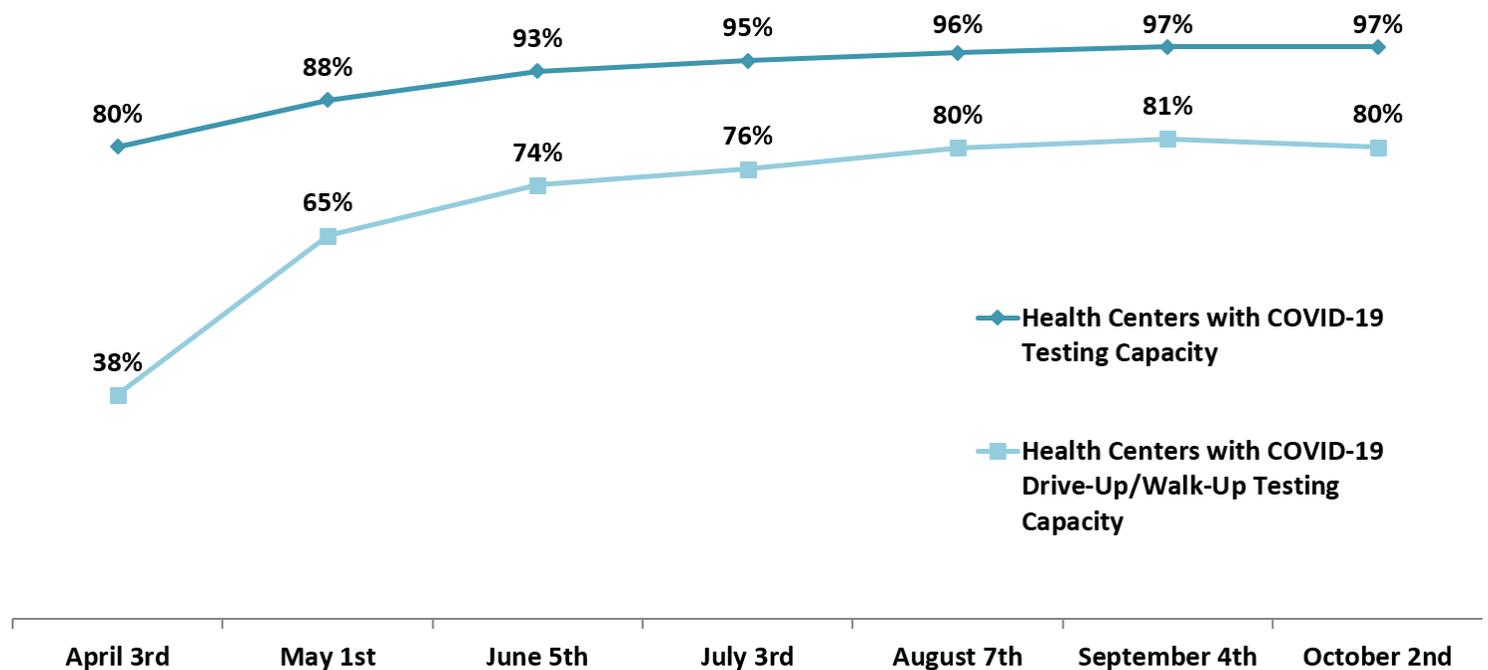
Testing Capacity and Average Turn-Around Times for COVID-19 Viral Test Results

Six months after HRSA began reporting this data, nearly all (97 percent) responding health centers report capacity for diagnostic testing for the novel coronavirus, up from 80 percent as of the first reporting period (**Figure 1**). Among health centers with testing capacity, the share with drive-up/walk-up testing capacity more than doubled, from 38 percent to 80 percent. The increase in testing capacity reflects

funding provided to community health centers to respond to the COVID-19 pandemic, including an initial \$100 million through the Coronavirus Preparedness and Response Supplemental Appropriations Act in early March¹⁸ and \$1.32 billion in the Coronavirus Aid, Relief, and Economic Security (CARES) Act.¹⁹ On May 7th, HRSA announced \$600 million in additional grants to expand health center testing capacity, funded through the Paycheck Protection Program and Health Care Enhancement Act (PPPHEA or “COVID-19 3.5” relief package), and signed into law on April 24th.²⁰

Figure 2 illustrates how average turn-around times

Figure 1. Community Health Center COVID-19 Virus Testing Capacity, April-October 2020



Note: Percentage with drive-up/walk-up testing capacity based on health centers that responded "yes" to having COVID-19 testing capacity. Percentages are reported for the first week of each month. Source: Bureau of Primary Health Care. Health Center COVID-19 Survey.

¹⁸ HHS.gov. (March 24, 2020). HHS Awards \$100 Million to Health Centers for COVID -19 Response. <https://www.hhs.gov/about/news/2020/03/24/hhs-awards-100-million-to-health-centers-for-covid-19-response.html>

¹⁹ NACHC. (2020). Summary of Key CHC Provisions in the Coronavirus Aid, Relief, and Economic Security (CARES) Act. <https://wsd-nachc-sparkinfluence.s3.amazonaws.com/uploads/2020/03/CARES-Act-Summary-for-Health-Centers.pdf>

²⁰ HHS.gov. (May 7, 2020). HHS Awards More than Half Billion Dollars Across the Nation to Expand COVID-19 Testing. <https://www.hhs.gov/about/news/2020/05/07/hhs-awards-more-than-half-billion-across-the-nation-to-expand-covid19-testing.html>

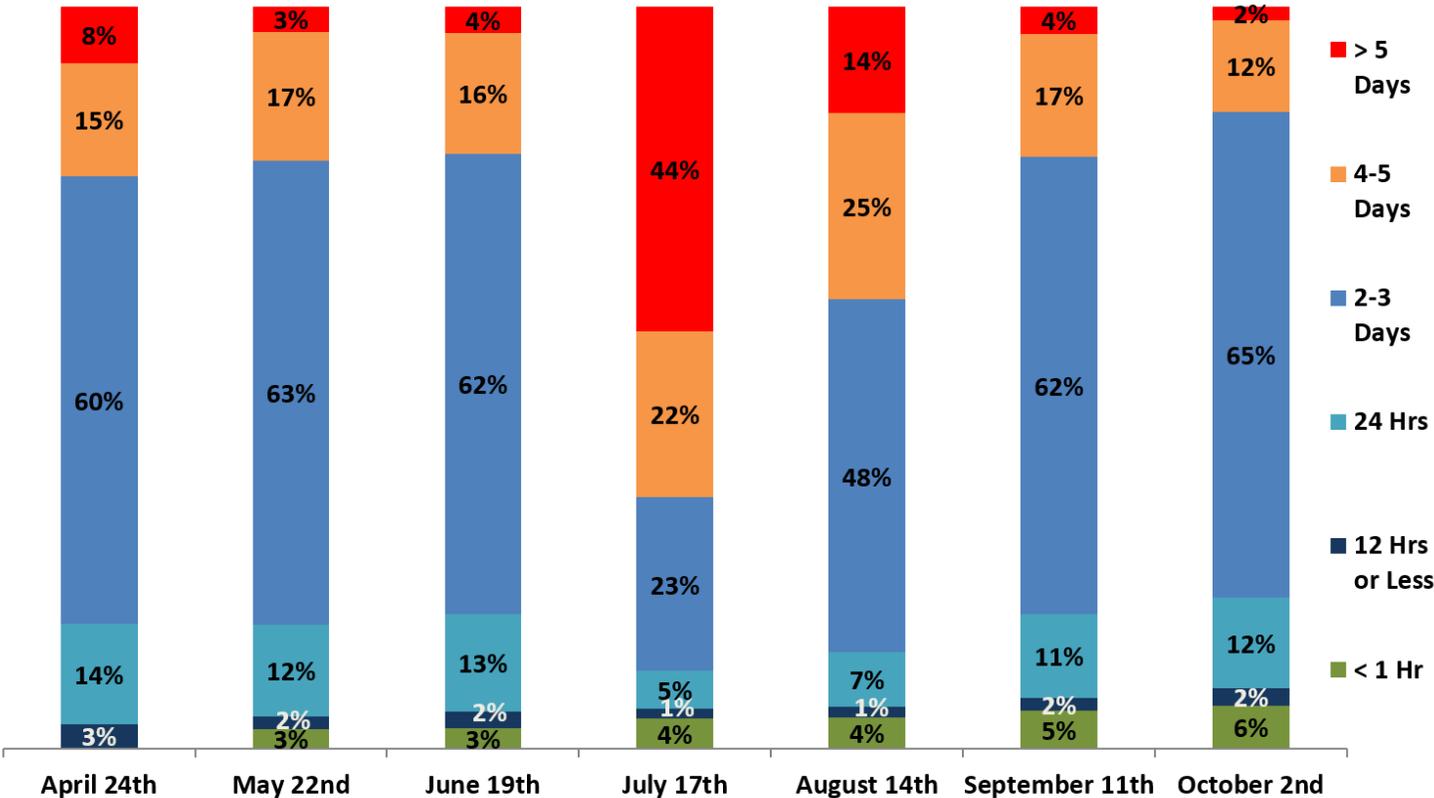
for COVID-19 viral test results have changed over the six months. In the first few months of testing, about four in five tests came back within an average of three days or less. However, with the spike in cases over the summer, associated increases in testing demands, and broader delays in lab capacity, average turn-around times worsened dramatically, reaching a peak in mid-July, when two in three (66 percent) results were returned in four or more days, including 44 percent returned in more than five days. As of the most current reporting period of October 2nd, average turn-around times of four or more days were experienced by just 14 percent of all reporting health centers;

while this is a vast improvement, it still means that one in seven test results is clinically useless in the effort to conduct contact tracing and to stop further transmission.

COVID-19 Diagnostic and Antibody Tests

Over 26 weeks of reported data,²¹ community health centers tested a total of 4,033,327 patients for the COVID-19 virus and a total 456,682 patients and 14,562 health center staff members had confirmed cases. As of October 2nd, there were a reported 7,332,297 cases of coronavirus in the U.S.,²² meaning that the 456,682 health center patients with confirmed

Figure 2. Community Health Center Average Turn-around Time to Obtain COVID-19 Virus Test Results for the Prior Week, April-October 2020



Note: HRSA did not report any health centers with an average turn-around time of less than one hour as of April 24th. Percentages are reported for every fourth week, except for October 2nd.
 Source: Bureau of Primary Health Care. Health Center COVID-19 Survey.

²¹ HRSA began reporting patient testing numbers for the second week of the survey (April 10, 2020).
²² Johns Hopkins University Coronavirus Resource Center. (2020). Cumulative Cases. <https://coronavirus.jhu.edu/data/cumulative-cases>; https://www.statspost.com/world/country-covid-19-data/United_States

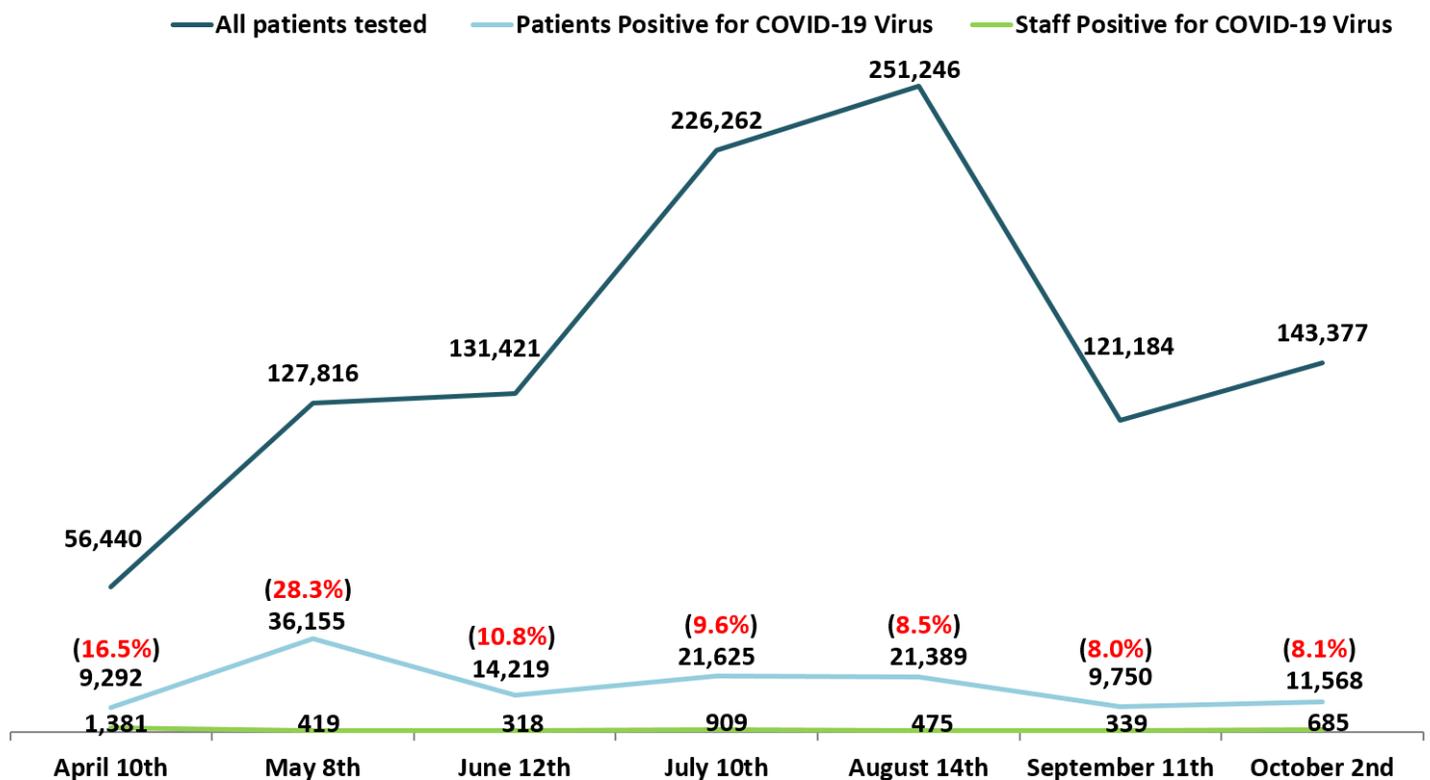
infection accounted for one in 16 (6.2 percent) of cases nationally.

Figure 3 shows the number of patients tested for COVID-19 virus (PCR, antigen), the number of patients and health center staff members who tested positive, and the percentage of health center patients who tested positive for COVID-19 at approximately monthly intervals since April 2020. At its highest point, the week of August 14th, community health centers nationally conducted over a quarter of a million COVID-19 virus tests (251,246). The number of tests conducted per week then decreased by nearly 108,000, to 143,377 as of the most recent reporting period. Patients who tested positive decreased from a peak of 36,155 in early May to 11,568 as of the current reporting period, and the number of staff members who tested positive

dropped by about half, from a high of 1,381 in April to 685 as of October 2nd.

Based on the reported numbers of patients tested for COVID-19 virus and those who tested positive each week, the percentage testing positive over six months was at its peak in early May, at 28.3 percent, and as of October 2nd stood at 8.1 percent. However, given the widespread delays in test results over the summer months, these percentages may not reflect the true positive rates over time due to the lag in results reporting. HRSA notes that "the reported number of patients tested do not represent the same patients included in the reported number of patients tested positive due to a lag between the date the specimen is collected and the availability of test results."²³ Over the six months, the percentage of positive testing results

Figure 3. Community Health Center Patients Tested for COVID-19 Infection and Patients and Staff Who Tested Positive, April-October 2020



Note: The figures in red indicate the percentage of health center patients who tested positive for COVID-19 that week. Numbers are reported for the second week of each month, except for October. HRSA began reporting patient testing numbers for the second week of the survey (April 10, 2020). The percentage testing positive for the weeks of July 10th and August 14th should be interpreted cautiously given widespread delays in test results those months. Source: Bureau of Primary Health Care. Health Center COVID-19 Survey.

²³ <https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data>

reported by community health centers has fairly consistently been above the national positive case rate across public health, clinical and commercial labs reported to the Centers for Disease Control and Prevention (CDC). Results for the most recent week are consistent with this experience; the 8.1 percent positive case rate at health centers as of October 2nd was much higher than the 4.9 percent reported nationally to the CDC as of the week ending October 3rd.²⁴

Antibody tests, also known as serological tests, indicate if a person was previously infected with the COVID-19 virus. HRSA began reporting the number of health center patients tested for COVID-19 antibodies in June 2020. Over 18 weeks of reported data, a total of 251,628 health center patients were tested for antibodies and 41,008 tested positive. Over the half-year of all testing data, community health centers have tested a total of 4,284,955 patients with a COVID-19 test of any type and a total of 497,7690 patients have tested positive for either COVID-19 virus or antibodies.

Race and Ethnicity of Health Center Patients Testing Positive for COVID-19 Virus

Community health centers, which by mission and federal mandate are located in underserved communities, are a vital resource in many minority communities. The Department of Health and Human Services (HHS) counts community health center testing capacity among their initiatives to make testing more accessible and to reduce COVID-19 racial/ethnic disparities.²⁵ As the pandemic continues,

a wide body of research has found that members of racial and/or ethnic minority groups are disproportionately more likely to be infected with the novel coronavirus and to have serious illness, to be hospitalized, and to die from COVID-19.²⁶

Findings from HRSA's survey are consistent with evidence of racial/ethnic disparities in COVID-19 infection. **Figure 4** shows that for each week of reported data, the share of patients who tested positive for COVID-19 virus who are racial/ethnic minorities exceeded the share of tested patients who are racial/ethnic minorities.

Figure 5 provides more detail on the race and ethnicity of tested patients and patients who tested positive for COVID-19 infection from the most recent week of reporting. While White, Hispanic/Latino patients accounted for 19 percent of health center patients tested for COVID-19 infection in this reporting period, they represented 27 percent of all positive cases. Similarly, Hispanic/Latino patients with no reported race accounted for six percent of those tested for infection, but nine percent of positive cases for infection. HRSA reports that over all the weeks of reported race and ethnicity patient testing data from April to October, Hispanic patients accounted for 30 percent of patients tested with a COVID-19 test of any type but 45 percent of patients who tested positive for either COVID-19 virus or antibodies.²⁷

Losses of Operational Capacity: Sites, Staffing, and Visits

While adding testing and adapting their services, health centers have been operating at reduced

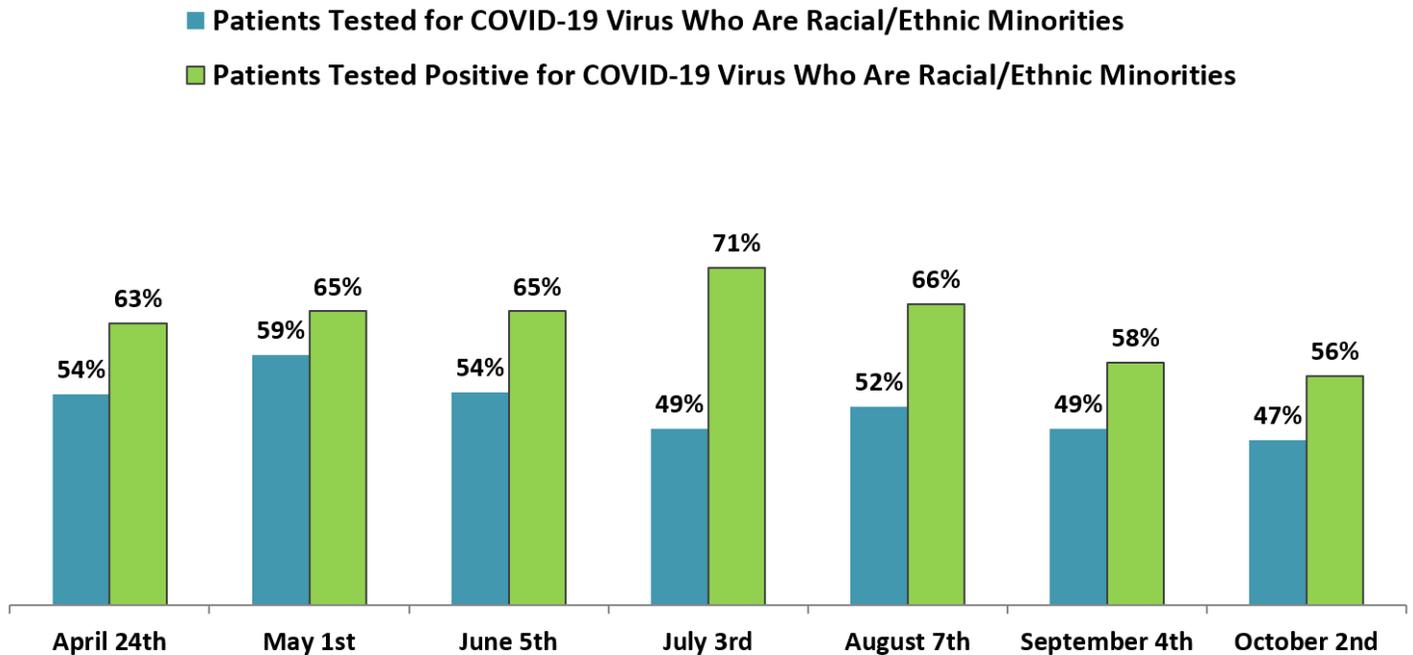
²⁴ CDC. (October 9, 2020). COVIDVIEW: Key Updates for Week 40, ending October 3, 2020. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>

²⁵ HHS. (2020). HHS Initiatives to Address the Disparate Impact of COVID-19 on African Americans and Other Racial and Ethnic Minorities. <https://www.hhs.gov/sites/default/files/hhs-fact-sheet-addressing-disparities-in-covid-19-impact-on-minorities.pdf>

²⁶ CDC.gov. (2020). COVID-19 Hospitalization and Death by Race/Ethnicity. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>; Kim et al. (2020). Hospitalization rates and characteristics of children aged < 18 years hospitalized with laboratory-confirmed COVID-19—COVID-NET, 14 States, March 1–July 25, 2020. *Morbidity and Mortality Weekly Report*, 69(32), 1081.; Moore et al. (2020). Disparities in Incidence of COVID-19 Among Underrepresented Racial/Ethnic Groups in Counties Identified as Hotspots During June 5–18, 2020—22 States, February–June 2020. *Morbidity and Mortality Weekly Report*, 69(33), 1122.; Stokes et al. (2020). Coronavirus disease 2019 case surveillance—United States, January 22–May 30, 2020. *Morbidity and Mortality Weekly Report*, 69(24), 759.; Wortham et al. (2020). Characteristics of persons who died with COVID-19—United States, February 12–May 18, 2020. *MMWR. Morbidity and Mortality Weekly Report*, 69.

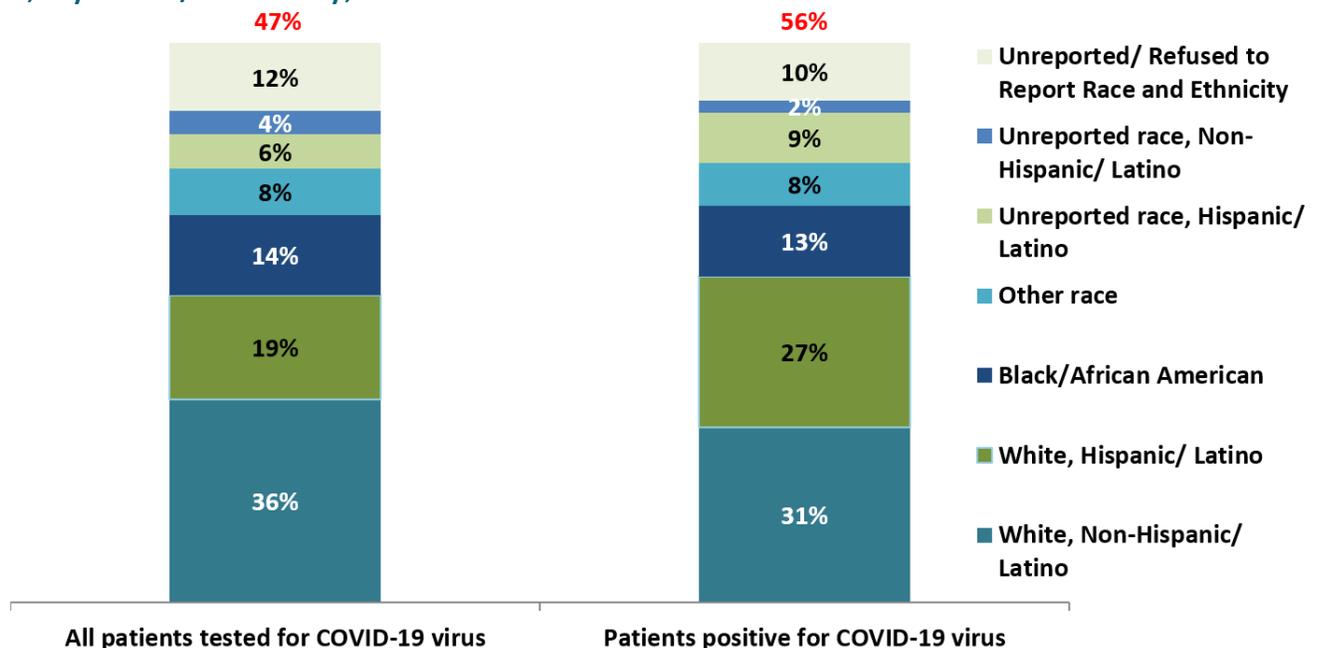
²⁷ HRSA. (2020). Health Center COVID-19 Testing: Explore COVID-19 Testing by Race/Ethnicity. <https://data.hrsa.gov/topics/health-centers/covid-testing>

Figure 4. Share of Community Health Center Patients Tested for COVID-19 Virus and Patients Who Tested Positive Who are Racial/Ethnic Minorities, April-October 2020



Note: Percentages indicate patients who are racial/ethnic minorities as a percentage of those tested and of those who tested positive and aggregate Hispanic/Latino White, Black/African American, Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander patients, patients with more than one race, and Hispanic/Latino patients with unreported race. Percentages are reported for the first week of the month, except for April, because HRSA began reporting racial and/or ethnic minority percentages for patients tested for COVID-19 virus on April 24th, 2020. Source: Bureau of Primary Health Care. Health Center COVID-19 Survey.

Figure 5. Health Center Patients Tested for COVID-19 Virus and Patients Who Tested Positive, by Race/Ethnicity, as of October 2nd



Note: The figures in red indicate patients who are racial/ethnic minorities as a percentage of those tested and of those who tested positive and aggregate Hispanic/Latino White, Black/African American, Other race, and Hispanic/Latino patients with unreported race. "Other race" includes Asian, American Indian/Alaska Native, and Native Hawaiian/Other Pacific Islander patients, and patients with more than one race. Black/African American and Other race include both Hispanic/Latino and Non-Hispanic/Latino patients. Source: Bureau of Primary Health Care. Health Center COVID-19 Survey. Data as of October 2nd, 2020.

capacity since the pandemic began. As **Figure 6** illustrates, health center activity has been recovering; the decline in weekly visits compared to average weekly visits before the pandemic has greatly improved, from a peak decline of 53 percent as of April 10th to 17 percent currently. Similarly, the share of temporarily closed sites improved over that same time period, from 16 percent to six percent, while the share of health center staff members unable to work due to COVID-19, for reasons that included site closures, family/home obligations, lack of personal protective equipment, and exposure to coronavirus, fell from 16 percent in the first week of the survey to four percent in the most recent week.

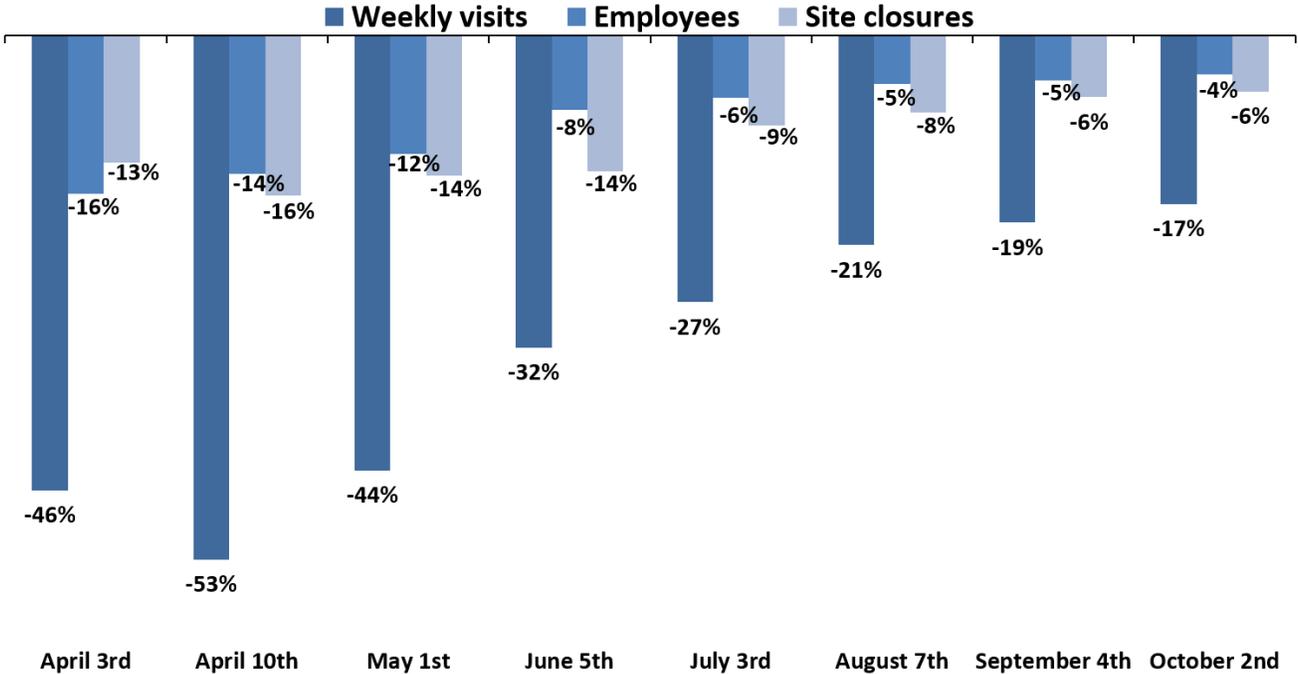
Still, these losses continue to reflect the toll that COVID-19 is having on health center capacity, staffing, and operations. A four percent reduction in health center employees translates to about 10,000 fewer working full-time equivalent (FTE) staff members who are essential to serve patients and to keep health

centers running.²⁸ Similarly, the 17 percent reduction in weekly visits amounts to approximately 400,000 fewer weekly health center visits nationally,²⁹ for services which may include routine check-ups, vaccinations, and other preventive care services. Furthermore, while losses in operational capacity may have improved nationally over time, they vary greatly by state.³⁰ As shown in **Figure 7**, as of October 2nd, nearly seven months into the public health emergency, ten states were reporting declines in weekly visits of at least 25 percent (with the greatest decline of 36 percent reported by New Jersey health centers),³¹ and in an additional seven states, visits were down by at least 20 percent.

Financial Uncertainty and Revenue Losses

The loss in patient visits has translated into ongoing and substantial revenue losses, estimated at \$3.364 billion nationwide over the six months, an amount that represents 10.7 percent of total revenue reported nationally in 2019 (**Figure 8**). Cumulative patient

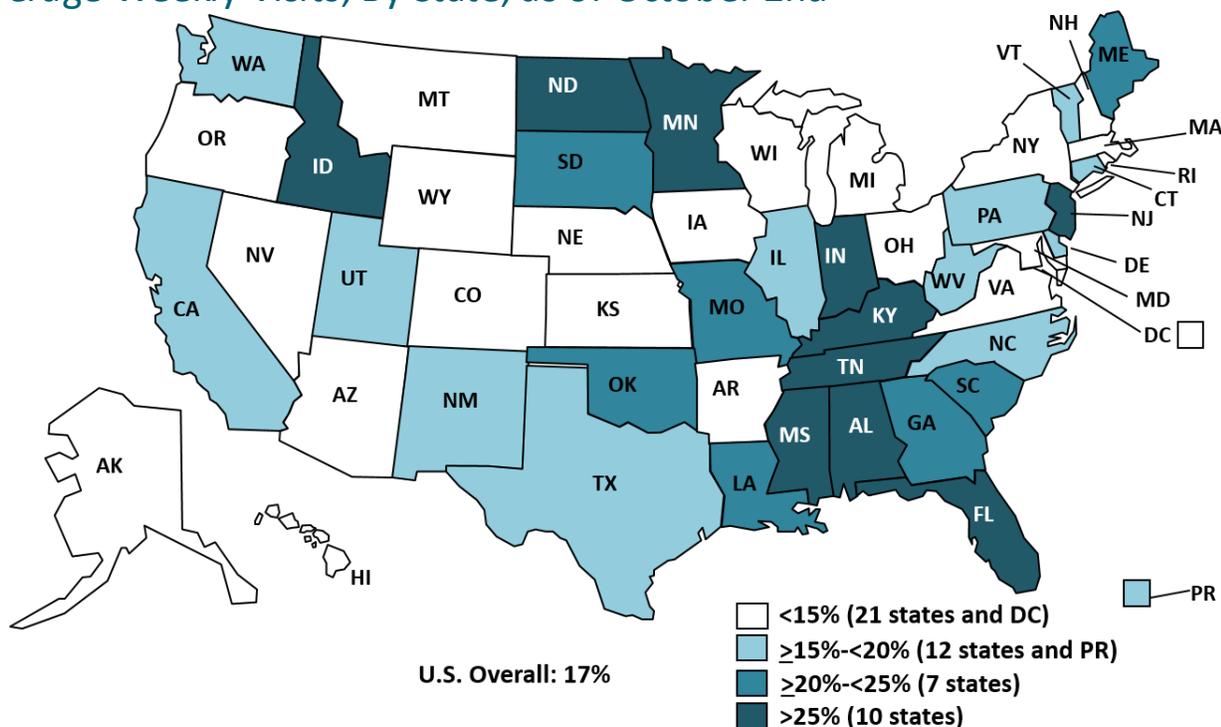
Figure 6. COVID-19 Impact on Community Health Centers, April-October 2020



Notes: Percentages are reported for the first week of the month, except for April 10th, which shows peaks losses in terms of site closures and weekly visit declines. Weekly visit losses compared to average pre-COVID-19 weekly visits, and include “all visits regardless of service type (e.g., medical, dental, behavioral health, etc.), including virtual visits” (<https://bphc.hrsa.gov/emergency-response/covid-19-survey-tools-questions>). Site closure percentages are based on 12,785 sites reported in 2019; percentages published in earlier reports (before August) may differ slightly because they were based on an approximated number of 12,000 sites. Sources: 2019 UDS; Bureau of Primary Health Care. Health Center COVID-19 Survey.

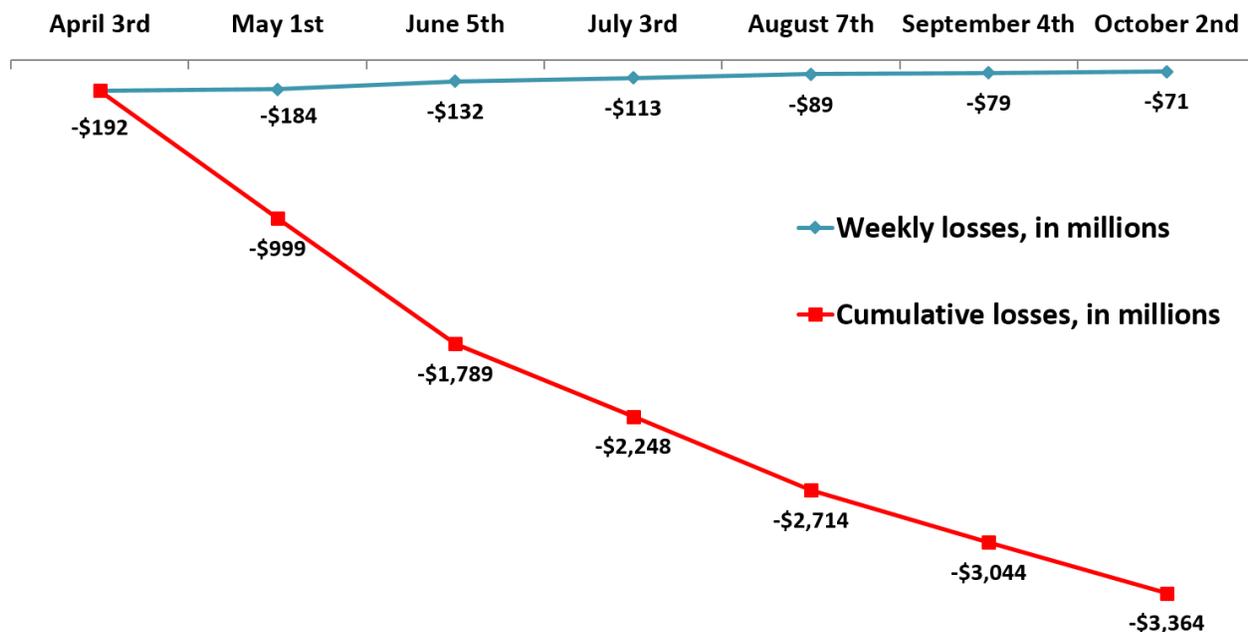
²⁸ Based on 252,867.67 FTE staff members reported in the 2019 UDS. HRSA. (2020). National Data. Table 5: Staffing and Utilization. <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2019>
²⁹ Based on 122.8 million visits reported in 2019, divided by 52. HRSA. (2020). National Data. Table 5: Staffing and Utilization. <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2019>

Figure 7. Decline in Community Health Center Weekly Visits Compared to Pre-COVID-19 Average Weekly Visits, By State, as of October 2nd



Notes: U.S. percentage includes health centers in Puerto Rico (PR) and four other health centers in the U.S. territories. One state (NV) reported an increase of 3% rather than a decline. States were categorized based on rounded percentages.
 Source: Bureau of Primary Health Care. Health Center COVID-19 Survey. Data as of October 2nd, 2020.

Figure 8. National Community Health Center Estimated Weekly and Cumulative Patient Revenue Losses over Six Months, April-October 2020



Estimated cumulative losses of \$3.364 billion over 6 months accounted for 10.7% of total revenue reported in 2019.

Note: Weekly patient revenue losses estimated based on the decline in weekly visits compared to pre-COVID-19 average weekly visits reported each week from the Health Center COVID-19 Survey and weekly patient revenue (total patient revenue reported for 2019 in the 2019 Uniform Data System, divided by 52). "National" includes federally-funded community health centers in the 50 states, DC, and U.S. territories/COFA states.
 Sources: Bureau of Primary Health Care (BPHC). (2020). Health Center COVID-19 Survey; HRSA. (2020). 2019 Uniform Data System data.

revenue losses over this time period varied by state, ranging from three million in Wyoming to \$686 million in California. (Table 1).

In addition to the funding directly allocated to community health centers through the Coronavirus Preparedness and Response Supplemental Appropriations Act, the CARES Act, and the PPPHCEA, community health centers have also received some financial support through the Paycheck Protection Program, the HHS Provider Relief Fund, and HRSA

Uninsured Claims Fund.³² However, it is unclear when – or how much – additional COVID-19 relief aid will be forthcoming, with the delays adding to the financial burden. Health centers are also facing financial uncertainty because the Community Health Center Fund (CHCF), which accounted for over 70 percent of federal health center grant funding in FY2019,³³ has been extended only to December 11th, 2020. The continued financial uncertainty about both any additional COVID-19 relief funding and the extension of the CHCF, and the sheer magnitude of estimated

Table 1: Cumulative losses in health center patient revenue, by state, April to October 2020

State	Cumulative losses (in millions)	State	Cumulative losses (in millions)
AK	-\$22	MT	-\$16
AL	-\$19	NC	-\$52
AR	-\$20	ND	-\$5
AZ	-\$56	NE	-\$10
CA	-\$686	NH	-\$8
CO	-\$57	NJ	-\$42
CT	-\$42	NM	-\$25
DC	-\$34	NV	-\$5
DE	-\$4	NY	-\$283
FL	-\$141	OH	-\$69
GA	-\$44	OK	-\$24
HI	-\$23	OR	-\$69
IA	-\$24	PA	-\$83
ID	-\$29	PR	-\$38
IL	-\$113	RI	-\$22
IN	-\$62	SC	-\$59
KS	-\$20	SD	-\$5
KY	-\$70	TN	-\$30
LA	-\$45	TX	-\$160
MA	-\$79	UT	-\$15
MD	-\$54	VA	-\$29
ME	-\$29	VT	-\$20
MI	-\$67	WA	-\$180
MN	-\$22	WI	-\$48
MO	-\$76	WV	-\$59
MS	-\$29	WY	-\$3

Note: Weekly patient revenue losses estimated based on the decline in weekly visits compared to pre-COVID-19 average weekly visits reported each week from the Health Center COVID-19 Survey and weekly patient revenue (total patient revenue reported for 2019 in the 2019 Uniform Data System, divided by 52). Data for DC and LA health centers were not reported the week of September 4th, so the visit declines for that week were imputed by taking the average of the weekly declines the week before and after. Cumulative losses reflect the sum of estimated losses based on 27 weeks of survey data.

Sources: HRSA. (2020). Health Center COVID -19 Survey; HRSA. (2020). 2019 Uniform Data System data.

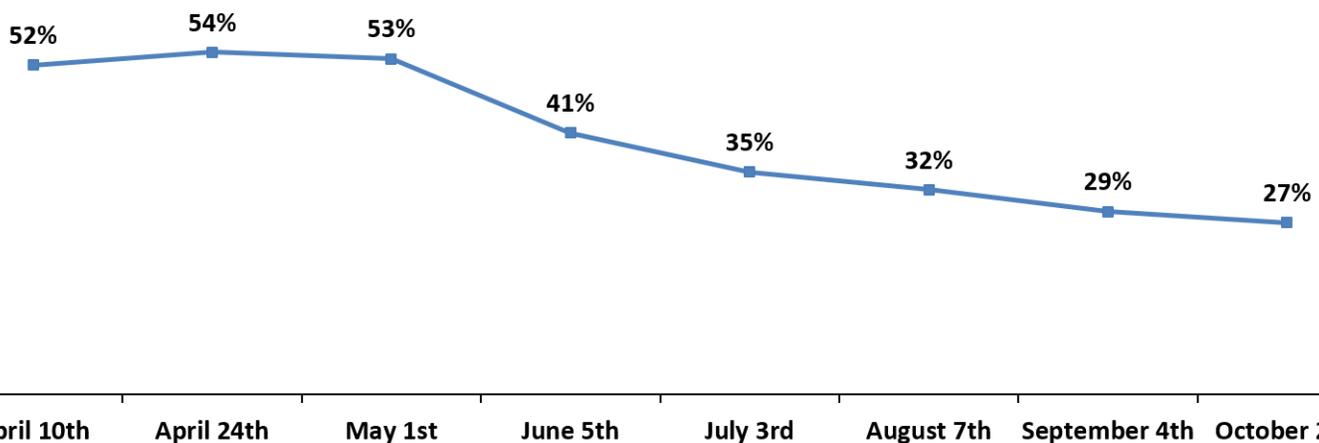
patient revenue losses to date, could prevent health centers from fully restoring services and reopening sites, and could also force health centers to cut back and lay off staff members, resulting in further job losses and economic distress in the communities that health centers serve.

Virtual Visits

As a way to continue to provide care to their patients and to earn patient revenue, community health centers rapidly pivoted to telehealth. In 2019, less

than half (43 percent) of community health centers reported using telemedicine to provide remote clinical care services³⁴ and virtual visits accounted for only 0.4 percent of the 122.8 million health center visits that year.³⁵ At its peak, as of April 24th, 54 percent of visits on average were conducted virtually; this percentage had fallen by half, to 27 percent, as of October 2nd, but virtual visits still accounted for over a quarter of visits that week (**Figure 9**). Recent policy changes may have helped to increase health centers' use of telehealth services during the pandemic, yet many still

Figure 9. Average Percentage of Community Health Center Visits Conducted Virtually, April-October 2020



Note: Virtual visits include all telehealth/telephonic visits of any service type (e.g., medical, dental, behavioral health, etc.). Percentages are reported for the first week of the month, except for April, because HRSA began reporting the average percentage of health center visits conducted virtually for the second week of the survey (April 10, 2020) and to show the peak percentage (April 24th) over six months.

Source: Bureau of Primary Health Care. Health Center COVID-19 Survey.

³⁰ HRSA has created maps that show state variation in the percentages of site closures and staff unable to work, available here: HRSA. (2020). COVID-19 Health Center Survey Maps. <https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data/survey-maps>

³¹ HRSA. New Jersey Health Center COVID-19 Survey Summary Report. Latest data from October 2, 2020. <https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data/nj>

³² Shin, P., Sharac, J., Morris, R., Jacobs, F., & Rosenbaum, S. (2020). As COVID-19 Surges, Community Health Centers Face Near-Term and Long-Term Funding Instability. Geiger Gibson/RCHN Community Health Foundation Research Collaborative Data Note. <https://www.rchnfoundation.org/?p=9075> Note that the estimated losses published in this brief differ from those reported in Figure 8 because they were based on 2018 patient revenue data while later estimates of losses were updated with 2019 patient revenue data once it was available.

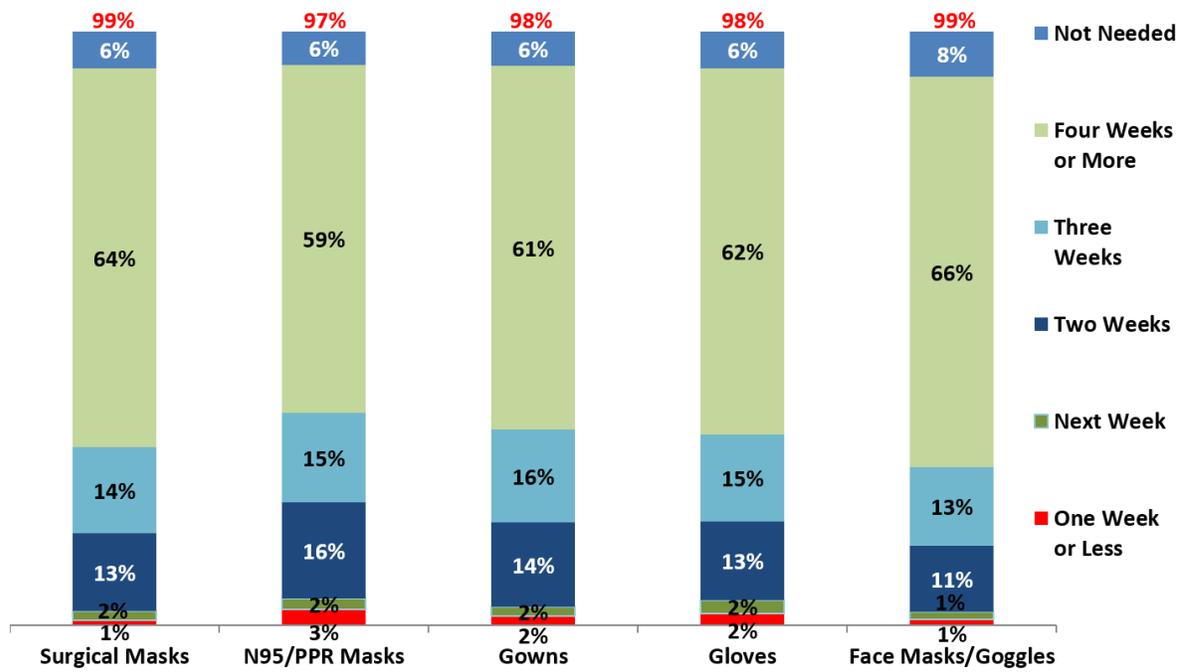
³³ NACHC. Federal Grant Funding. <https://www.nachc.org/focus-areas/policy-matters/health-center-funding/federal-grant-funding/>

³⁴ Health Resources and Services Administration (HRSA). (2020). 2019 Health Center Data: National Data. Table ODE: Other Data Elements. <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=ODE&year=2019>

³⁵ Sharac, J., Shin, P. & Rosenbaum, S. (2020). Community Health Centers on the Eve of the COVID-19 Pandemic: An Overview of Findings from the 2019 Uniform Data System. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 63. <https://www.rchnfoundation.org/?p=9180>

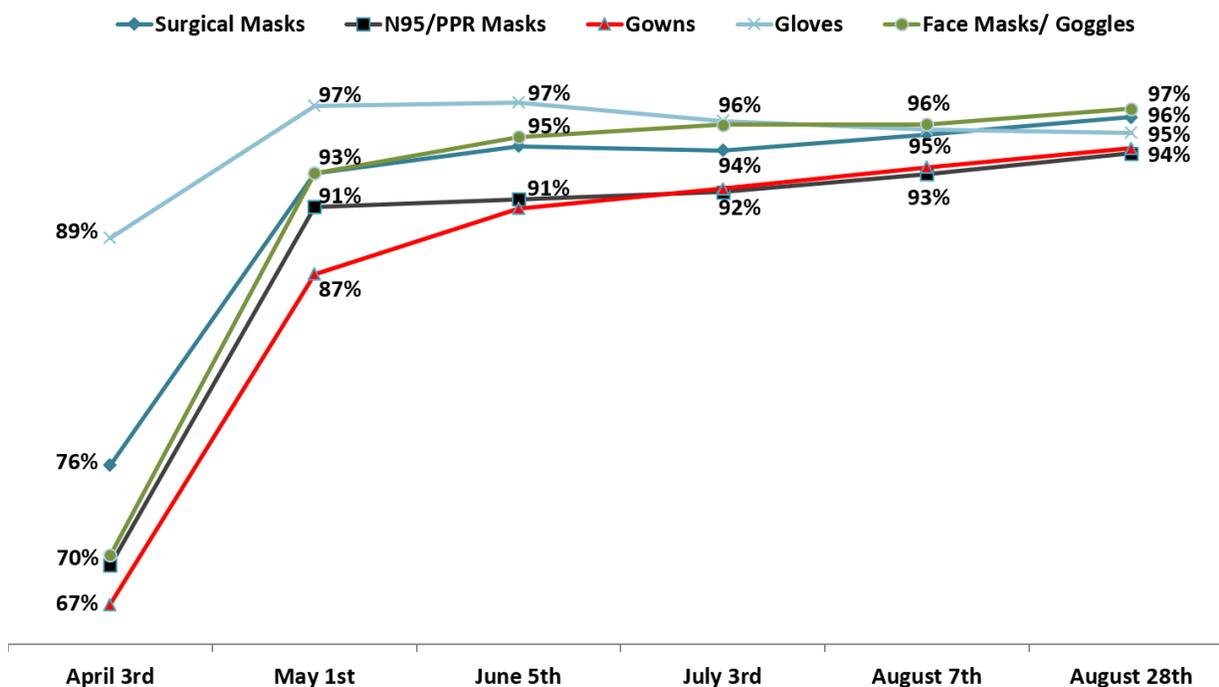
³⁶ Morris, R., Hernandez, J., Rosenbaum, S., Jacobs, F., Shin, P., & Sharac, J. (2020). What Can We Learn from Telehealth Experience of Community Health Centers During the COVID-19 Pandemic? Geiger Gibson/RCHN Community Health Foundation Research Collaborative Data Note. <https://www.rchnfoundation.org/?p=8744>

Figure 10. Community Health Center Availability of Adequate PPE Supply, By Type and Duration, as of October 2nd



Note: The figures in red indicate the share of community health centers that either do not need PPE or have adequate PPE for the next week or more. Source: Bureau of Primary Health Care. Health Center COVID-19 Survey. Data as of October 2nd, 2020.

Figure 11. Community Health Centers with an Adequate Supply of Personal Protective Equipment (PPE) for the Next Week, April-August 2020



Percentages are reported for the first week of the month, except for August, because HRSA revised the question on PPE for the September 4th survey so August 28th was the last week that provided comparable data. Source: Bureau of Primary Health Care. Health Center COVID-19 Survey.

³⁷ HRSA. (September 4, 2020). COVID-19 Data Collection Survey Tool Questions. <https://bphc.hrsa.gov/emergency-response/covid-19-survey-tools-questions>

³⁸ <https://web.archive.org/web/20200412205141/https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data>

face barriers to adopting or expanding telehealth.³⁶

Supply of Personal Protective Equipment

HRSA has queried health centers about their supply of personal protective equipment (PPE) over six months. The question on PPE supply was amended in September³⁷ so that data are not comparable over the six months, but for the most recent reporting period (**Figure 10**), nearly all health centers reported that they either do not need some types of PPE or have adequate supplies of all five types of PPE supplies for the next week or more. The question did not assess the extent to which health centers are prepared to secure an adequate supply of PPE should COVID-19 infections surge during this flu season. Earlier data based on the original PPE question, illustrated in **Figure 11**, show that the share of responding health centers reporting adequate supplies of PPE ranged by type from 67 percent to 89 percent in the first week³⁸ and that in April and May, a substantial percentage of health centers were unable to access a sufficient supply of gowns, a core PPE item. Additionally, the weekly survey shows that adequacy of the PPE supply can vary significantly from state to state.³⁹

Conclusion

Six months of reported data from HRSA's Health Center COVID-19 Survey indicate that community health centers have risen to meet the challenges of the COVID-19 pandemic, with nearly all offering COVID-19 testing and over four million COVID-19 diagnostic tests conducted by health centers nationally over six months. Operational capacity has also improved over this time period, but site closures and declines in weekly visits remain substantial, resulting in an estimated total of \$3.364 billion in cumulative losses of patient revenue over six months.

These steep revenue losses, as well as the known widespread racial/ethnic and income disparities in the risk of serious illness from COVID-19, and the high proportion of low-income health center patients at greater risk for infection, suggest a continued need for the expansion of health center testing resources.

Furthermore, the essential role of community health centers in serving Latino, Black, and other minority and low-income communities, those known to be the most affected by COVID-19 and other public health crises, underscores the need for long-term, stable federal investment to sustain and expand access to care.

Finally, while the data indicate a trend of improvement over time, it remains to be seen if community health centers can continue to provide COVID-19 diagnostic testing and to remain open and operational to provide other health care services, at a time of historic job losses and increased uninsured rates. In the face of deep financial losses, continued financial uncertainty, and as the nation faces the threat of both flu season and increased coronavirus cases in the fall and winter, the future of our nation's health centers should be a cause for both deep concern and renewed support.

³⁹ E.g., Sharac, J., Hernandez, J., Velasquez, M., Shin, P., & Jacobs, F. (2020). Key Updates from the Health Center COVID-19 Survey (Week #18): Average Turn-around Times for COVID-19 Viral Test Results Reported by Community Health Centers Improved this Week, but More than Half Still Experienced Long Waits. Geiger Gibson/RCHN Community Health Foundation Research Collaborative Data Note <https://www.rchnfoundation.org/wp-content/uploads/2020/08/Week-18-HRSA-COVID-19-Update-FINAL-8.11.20.pdf>