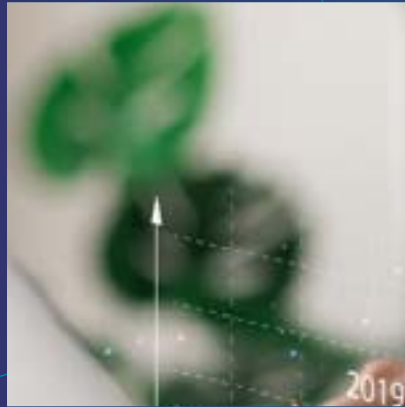




HEALTH CENTER ASSESSMENT

A Data-Driven Approach to Understanding Factors Contributing to Health Inequities at Indiana FQHCs



Prepared by Capital Link, with statistical assistance from *HealthLandscape*
Funded by Indiana Primary Health Care Association



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EXECUTIVE SUMMARY

Capital Link has prepared a 2019-2022 data-driven analysis for the Indiana Primary Health Care Association, looking at key factors influencing health inequities¹. Since their inception, community health centers have made great strides in reducing the health inequities that affect the nation's underserved and marginalized communities. Report findings affirm that specific patient and health center characteristics have an impact on access to care and health outcomes among various sub-populations of patients. Despite best intentions, these characteristics often perpetuate systemic racism and health disparities.

Capital Link, with the assistance of *HealthLandscape*, reviewed more than 100 metrics from the 39 FQHC members of the Indiana Primary Health Care Association collected between the years of 2019 and 2022. The analysis considered population demographic factors such as Social Deprivation Index (SDI)² level, poverty, and homelessness, racial and ethnic population composition, patient and payer insurance mix, service offerings, growth rates, and other factors related to a health center's long-term financial sustainability, accessibility, and health outcomes. Results were reviewed from four criteria: strongest financial performers in the region, health center performance based on COVID-19 grants, access to care, and clinical outcomes based on patient population. The results confirmed important differences among FQHCs in Indiana based on the characteristics of the health centers and their patient populations.

This study aims to utilize findings in order to make informed recommendations on how to improve patient equity and inclusion efforts across health centers both in Indiana and nationally.

Characteristics of the Strongest Financial Performers in the Region

IPHCA Health Center's financial strength was assessed based on four key financial measures between 2019 and 2022: operating margin, total net assets, total operating revenue, and days of cash on hand. The centers were ordered from financially weakest to strongest and sorted into four quartiles. Each quartile consisted of 25% of all Indiana health centers.

When comparing average scores for the strongest and weakest financial quartiles³, several factors had a statistically significant⁴ association with stronger financial performance (i.e., the difference had a high probability of being related to something other than chance). The top financial-performing health centers demonstrated:

- A lower percentage of patients with income at or below 200% of the federal poverty level.
- A patient demographic mix with a relatively smaller percentage of Asian, Black/African American, and Non-White patients and a larger share of White patients.
- A more favorable payer mix, consisting of fewer uninsured or Medicaid patients, but more Medicare and private insurance patients.
- Higher patient and visit growth rates as well as better health outcomes.

Analysis of Health Center Performance Based Upon COVID-19 Grants

The health centers' performance (i.e., financial strength, patient/payer mix, access to care, and health outcomes) were analyzed based on the COVID-19 grants they received. The centers were sorted into four equal quartiles (with

¹FQHCs are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas.

²Social Deprivation Index (SDI) is a composite measure of area level deprivation based on seven demographic characteristics collected in the [American Community Survey](#) and used to quantify the socio-economic variation in health outcomes.

³A quartile is a statistical term that describes a division of observations into four defined intervals based on the values of the data and how they compare to the entire set of observations. Quartiles are organized into lower quartiles, median quartiles, and upper quartiles. ([Source](#))

⁴Statistical significance is a determination that a relationship between two or more variables is caused by something other than chance. ([Source](#)) The words "statistical" "significant" and "statistically significant" are used interchangeably to describe such a relationship, consistent with industry practice. ¹⁰p-values of .05, .01, .001, and .000 are considered statistically significant and included in this report.

each quartile consisting of 25% of all Indiana health centers) from highest to lowest by COVID-19 grant revenue. When comparing the top and bottom quartiles of health centers, several key factors had statistically significant differences. The health centers with the highest levels of COVID-19 funding had:

- Higher poverty rates
- Statistically higher numbers of Non-White and Hispanic patients and a lower share of White patients.
- More than half of patients covered by Medicaid as the major payor source, while Medicare patients/collections were statistically lower.
- Statistically higher medical visit growth rates accompanied by lower mental health visit growth, suggesting more limited access to integrated health care.

Financial Strength, Access to Care, and Clinical Outcomes Based Upon Patient Population

Health center data were also sorted by patient populations (including those with a high percentage of Asian, Black/African American, Hispanic/Latino, and White patients) as well as by those with a large portion of Medicaid patients and high SDI scores. A comparison of average health centers in the top and bottom quartiles within each patient population revealed several different characteristics.

Notable Findings

Asian Patients:

- Top quartile health centers had higher poverty rates, lower SDI scores, more uninsured patients, and fewer Medicare patients than the bottom quartile.
- They also showed a higher operating margin, greater grant revenue as a percentage of total revenue, higher average Full-Time Equivalents (FTEs), more virtual visits, and fewer visits per patient.
- The top quartile performed better on seven out of eight UDS quality measures, with statistically significant better performance in two measures.⁵

Black/African American Patients:

- Top quartile health centers had more homeless patients, higher SDI scores, higher poverty rates, more Medicaid patients, and fewer Medicare patients than the bottom quartile.
- Financially, they had a higher operating margin and days cash on hand but a lower growth rate in grant and contract revenue.
- The top quartile showed slower growth in patients and visits, and performed worse on seven out of eight UDS quality measures, with two statistically significant differences.

Hispanic/Latino Patients:

- Top quartile health centers had higher poverty rates, SDI scores, more uninsured and Medicaid patients, and fewer Medicare patients than the bottom quartile.
- They had a higher operating margin, more days of cash on hand, and total operating revenue, yet a lower grant and contract revenue growth rate.
- The top quartile showed slower growth in the number of patients and visits, fewer mental health visits per patient, and performed better on most quality care measures, despite high poverty and uninsured rates.

⁵ Health Center Program awardees and look-alikes report on a core set of operational and performance measures each calendar year as defined in the Uniform Data System (UDS). The UDS is a standardized data set and annual program requirement that is defined in Section 330 of the Public Health Service Act.

- Some of these differences may be attributable to cultural differences related to mental health.⁶ There is a perception among some in the Hispanic/Latino community that talking about mental health is embarrassing or shameful, which may discourage individuals from accessing help.⁷

White⁸ Patients:

- Top quartile health centers had lower rates of poverty, homelessness, and SDI scores, more Medicare patients, and fewer uninsured patients than the bottom quartile.
- They experienced higher growth in grants and contract revenue but lower in key financial factors like operating margin and days cash on hand.
- The top quartile showed higher patient and visit growth rates, suggesting better access to integrated care, with mixed quality scores.

Medicaid Patients:

- Top quartile health centers had higher SDI scores, poverty rates, and more patients experiencing homelessness than the bottom quartile.
- They had a higher portion of Asian, Other Patients of Color⁹, and Black/African American patients, performed strongly on financial factors, but showed weaker patient and visit growth and worse performance on most clinical quality measures.

High SDI Scores:

- Top quartile health centers had higher poverty rates, more Black/African American and Hispanic/Latino patients, and fewer White patients than the bottom quartile.
- They showed lower performance in crucial financial factors, slower growth in patient and visit rates, but a higher dental visit growth rate and better performance on several quality measures.

The comparison of quality outcomes for specific patient population percentages showed that the 25% of health centers with the largest portion of Hispanic patients had the best scores on three of the eight quality measures tested, while the top 25% of health centers with the largest portion of Black patients did not perform better than any of the comparison groups on the eight quality measures analyzed.

Health Care Access and Outcomes by Race, Ethnicity, and Insurance (Indiana Median)

For the third set of analyses, healthcare access was examined based on race, ethnicity, and insurance status for the median Indiana health center from 2019 to 2022. All populations grew over the four-year period except for the Black/African American patient population, which dropped by 3%. Patient growth did not vary significantly based on ethnicity. However, the patient and payer mix changed considerably. The percentage of uninsured patients dropped year after year from 2020-2021, similar to the national pattern. The decrease in the national uninsured patient rate is attributable to temporary policies encouraging continuous enrollment in [public](#) health insurance throughout the COVID-19 emergency. Likely due in part to this policy, the percentage of public health insurance patients served by health centers increased in 2021.

⁶ Latinx/Hispanic Communities and Mental Health. [\(Source\)](#)

⁷ Cultural Barriers to Mental Health Treatment Among Hispanics/Latinos(A) S – Vecinos. [\(Source\)](#)

⁸ The White category includes both Hispanic White and non-Hispanic White patients, which may skew results in some areas.

⁹ Other patients of color includes Native Hawaiian, Other Pacific Islander, American Indian/Alaskan Native, and more than one race.

Health outcomes and disparities based on race and ethnicity were also analyzed for the three available measurements in UDS: deliveries and birthweight, controller high blood pressure, and diabetes-hemoglobin A1C poor control.

- For the median Indiana health center, the proportion of low and very low birth-weight babies delivered to Black/African American patients was consistently above that of the White patient population from 2020-2022.
- Outcomes for Black/African American patients were worse than for other races for controlled blood pressure.
- Compared to all patient race populations, Asian patients reported better diabetes/hemoglobin A1C poor control throughout the review period.
- Results for centers with the highest Hispanic/Latino compared to non-Hispanic/Latino patient populations were mixed, with each scoring comparatively higher on different measures.

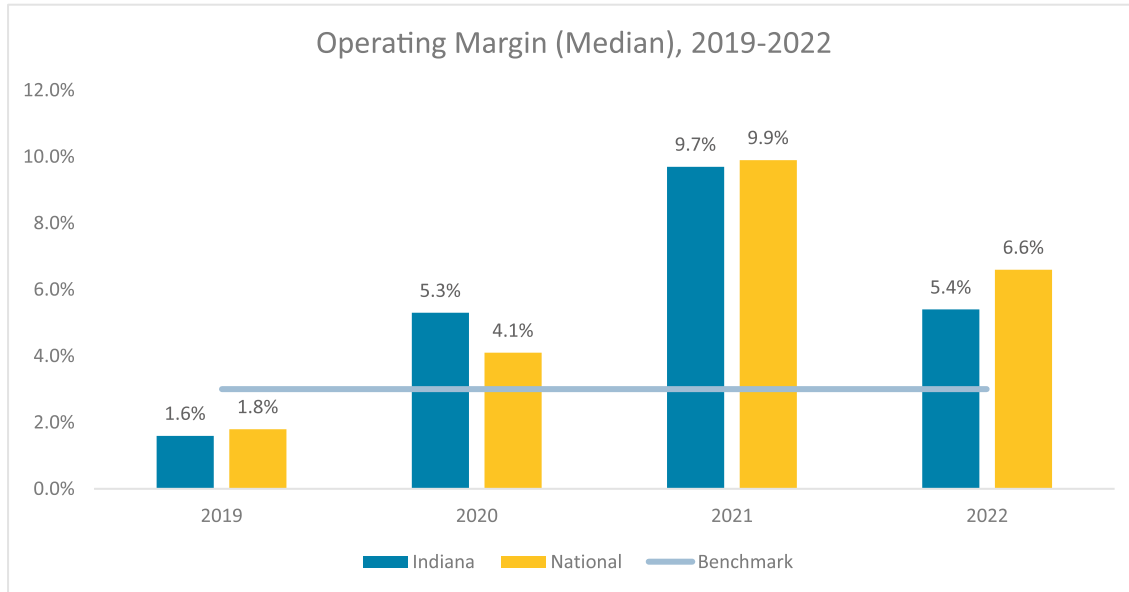
Conclusion and Recommendations

This analysis documented statistically weaker health outcomes among health centers with higher percentages of Black and Medicaid patients and stronger health outcomes among health centers with higher percentages of Asian patients, as well as stronger financial performance. Since more financially robust health centers scored higher on metrics measuring access to care and quality performance, it can be inferred that improving financial operations is one important step toward reducing observed health disparities. Capital Link looks forward to further collaboration opportunities with the Indiana Primary Health Care Association to support efforts to build the financial capacity of its members.

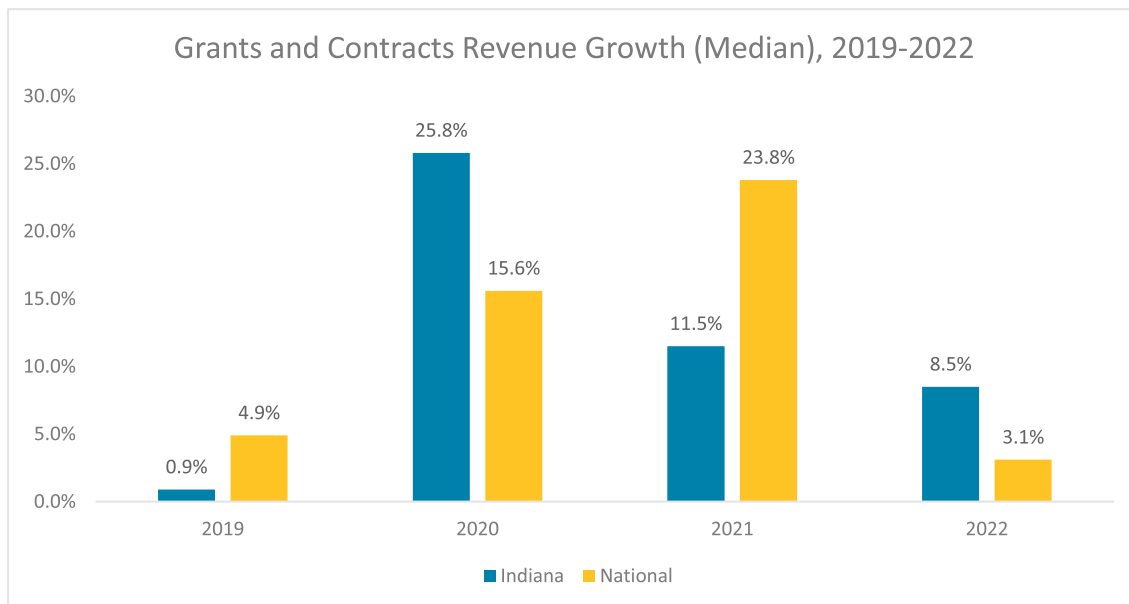
Additional research can help determine if existing health disparities are due to insurance coverage, cultural concerns, lack of access to telehealth resources, transportation, translation services, health literacy, food insecurity, and/or other factors. Increased access to more extensive primary care services (particularly oral and mental health) is needed to promote true health equity among the most vulnerable populations, including people of color and other underserved groups. Increasing health insurance coverage, expanding services in lower-income neighborhoods, and enhancing resource coordination will also help those populations that health disparities harm most. Grant and support from foundations, programs from primary care associations to access community needs, and health center capacity to respond, will all be instrumental moving forward to eliminate some of the identified health equity gaps.

SECTION ONE -Analysis of Indiana Health Centers Performance Based on Financial and COVID-19 Grants, 2019-2022

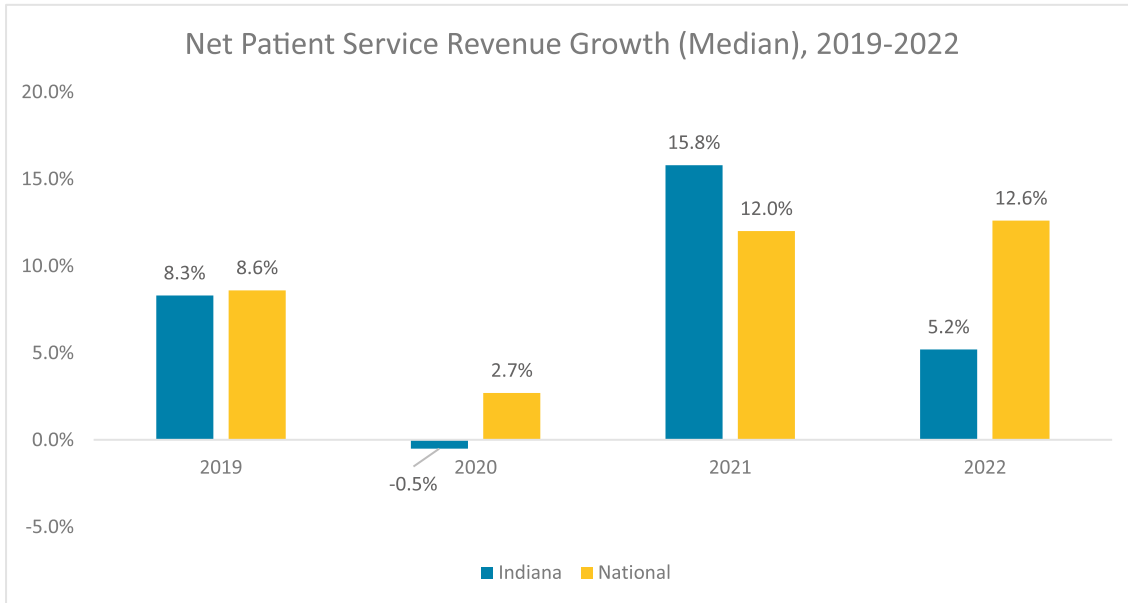
A review of financial audits for Indiana health centers indicates that the median health center improved its operating margin from 1.6% in 2019 to 5.3% in 2020, a period when the COVID-19 health emergency first affected health center operations. With an influx of COVID-19 grants, the median operating margin for the group nearly doubled to 9.7% in 2021. Due to the end of COVID-19 grants in 2022, the median operating margin decreased to 5.4%. Both the Indiana and National 2022 medians exceeded the 3% industry-recommended minimum by a sizable amount.



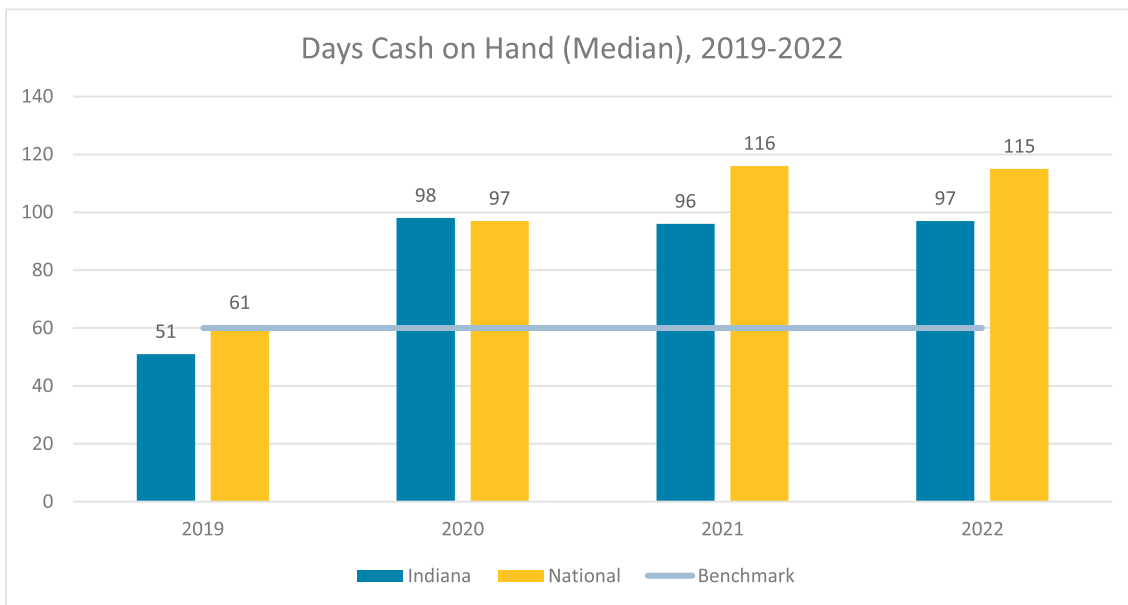
While achieving such high operating margins during the challenging environment of a public health emergency may seem counter-intuitive, the pandemic response funding was critical to the strong 2020-2021 results. For example, the median Indiana center experienced an 11.5% jump in 2021 in grants and contracts revenue from both federal and private sources after a 25.8% increase in 2020. These growth rates were quadruple the prior year annual increase amount of 1%. National median growth in grant and contract funding was 23.8% in 2021 and 15.6% in 2020. However, the COVID-19-specific grants may have masked the true operational challenges faced by health centers during the pandemic. In this light, the decline in FY22 operating results was to be expected.



Indiana's median growth in net patient service revenue (NPSR) of 15.8% in 2021 was encouraging after revenues declined -0.5% the prior year. In 2022, however, median NPSR growth declined sharply to 5.2%. The robust median NPSR growth rates for the national data set in 2021 and 2022 were 12.0 and 12.6%, respectively. This is particularly notable given the 2.7% growth in 2020.



Indiana health centers also had a strong cash position over the 2020-2022 period, albeit lower than national peers. Strong operating performance and substantial pandemic funding assistance provided health centers with high liquidity, with the median health center exhibiting 97 days cash on hand.



Review of Factors Influencing Financial Performance by Quartile, 2019-2022

A detailed analysis of over 100 financial and operating statistics, Uniform Data Systems (UDS)¹⁰ measures, and other data was conducted to understand better the factors contributing to Indiana health centers' financial strength and

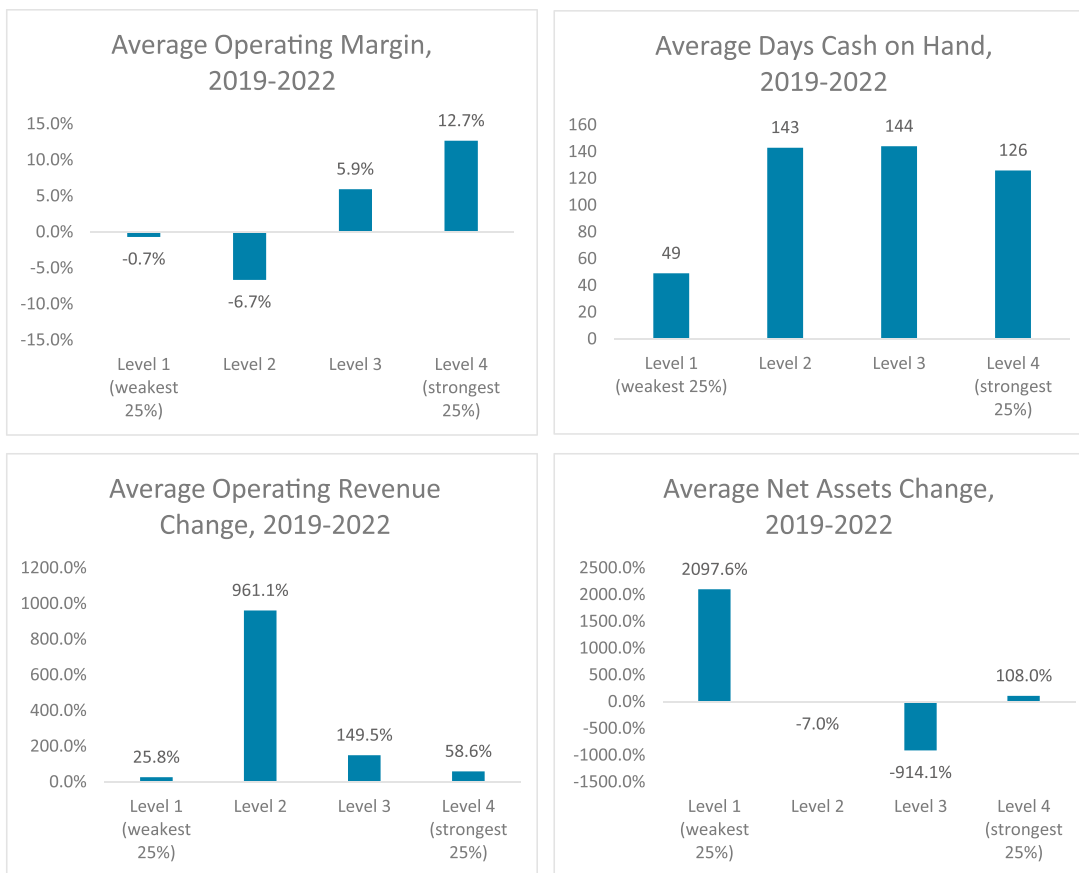
¹⁰ Each calendar year, HRSA Health Center Program awardees and look-alikes are required to report a core set of information, including data on patient characteristics, services provided, clinical processes and health outcomes, patients' use of services, staffing, costs, and revenues as part of a standardized reporting system known as the UDS. [\(Source\)](#)

sustainability. Factors reviewed and tested for statistical significance include the demographic characteristics and SDI¹¹ of the patient population, insurance mix by payer and patient, revenue sources, and service mix. Quality and health outcomes based on information available in UDS were also analyzed in relation to health centers' financial success.

To determine the financial strength and sustainability of the 39 Indiana health centers, for which 34 financial audits were available at the time of the study, Capital Link calculated four fundamental financial ratios for measuring financial success and sustainability based on 2019-2022 financial audits. These ratios were operating margin, days of cash on hand, operating revenue growth, and net asset change. Health centers were then sorted into quartiles based on performance results. The centers that met the minimum requirement for all four metrics were considered the strongest, while the weakest centers only achieved one or none of the minimum metric goals. We sorted the individual health center quartile results into four levels, with approximately 25% of the total in each group. See Appendix A for more details.

Financial performance by quartile for 2019-2022 varied significantly, as illustrated in the charts below, with the four components of the overall financial scores. Average operating margins by quartile ranged from -0.7% to 12.7%, and the amount of cash available for the top quartile of health centers was almost triple that of the lowest (126 days vs. 49 days). The top 25% of financial performers reported an average of 58.6% in operating revenue growth and a 108% increase in net assets from 2019 to 2022. The bottom financial quartile, however, grew revenues by 25.8% and increased net assets by over 2000% over the same period.

Financial Performance by Quartile: Top 25% vs. Bottom 25%



¹¹ SDI is used as a proxy for Social Drivers of Health (SDOH) in this document. A higher SDI score indicates more social deprivation and need. SDI is a composite measure of area level deprivation based on seven demographic characteristics collected in the American Community Survey (<https://www.census.gov/programs-surveys/acs/>) and used to quantify the socio-economic variation in health outcomes. [\(Source\)](#)

Analysis of Financial Factors Affecting Health Center Performance 2019-2022

Items of interest are noted below and included in [Table A's](#) Data Summary of Financial Performance.



Demographics/Social Drivers of Health

The top quarter of financial performers had a significantly lower percentage of patients with income at or below 200% of the federal poverty level. Also, high financial performers had a much smaller share of patients (3.8%) who were best served in a language other than English, and a lower homeless patient percentage compared to the lowest performers (16.7%). There was no significant difference in SDI scores between the quartiles.



Patient/Payer Mix

Health centers with the largest share of Asian, Black/African American, or Hispanic/Latino/a patients showed statistically weaker financial results, while those with the highest percentage of White patients performed significantly better. It is important to acknowledge that the systemic racism often found in communities with high Hispanic/Latino populations may be contributing to the disparate performances¹².

A health center's insurance mix affected financial performance as well. High performers had a statistically larger percentage of Medicare and privately insured patients and a significantly lower share (3 points) of uninsured patients. High financial performers collected a statistically smaller portion of revenues from Medicaid and more from Medicare and privately insured patients than the weaker financial performers.



Other Financial/Operational Factors

In addition to the four measures previously mentioned, the top financial quartile had several other statistically significant characteristics, including higher annual revenues, days of cash on hand, grants, and contracts revenue per patient, and NPSR growth rates (driven by stronger patient and visit growth rates). Their personnel expense ratio percentage was also significantly lower than for the bottom financial quartile, boosting performance.



Access to Care

A significant relationship was found between stronger financial performance and higher annual visits, consistent with the current fee-for-service reimbursement model. Medical visits comprised a significantly larger percentage of total visits for the highest financial performers, while mental health visits were a significantly smaller portion. It is important to further examine the impact of service mix on profitability and how that may impact clinical integration¹³ efforts to provide appropriate financial and other support for Indiana health centers.

Several assessment areas showed statistically stronger performance for the top quartile, including the growth rate in total patients, visits as well as the growth rate of medical and mental health visits. The number of total visits per patient was lower for the top financial quartile, due to fewer mental health and dental visits per patient compared to financially weaker health centers. This suggests that patients who are served at health centers that are stronger financially may have better access to care.

¹² Toward a More Perfect Union: Understanding Systemic Racism and Resulting Inequity in Latino Communities. ([Source](#))

¹³ What is clinical integration? ([Source](#))



Quality Performance/Health Outcomes

Eight quality characteristics and health outcomes measured in UDS were analyzed to determine if there was a statistically significant relationship with financial performance. High financial performers had considerably stronger health outcomes. They outperformed the bottom financial quartile by a statistically significant amount on four of the eight quality measures. For the remaining four quality measures, the high-performing financial quartile tied on one and scored worse on the three measures. These findings indicate a relationship between strong financial performance and quality outcomes.

Analysis of COVID-19 Grants Affecting Health Center Performance 2019-2022

Items of interest are noted below and included in [Table B's](#) Data Summary of COVID-19 Grants.



Demographics/Social Drivers of Health

The top quartile of health centers receiving more COVID-19 grants had a significantly higher percentage of patients with income at or below 200% of the federal poverty level. Also, centers receiving more COVID-19 grants were more likely to be centers with a larger share of patients who were best served in a language other than English and a lower homeless patient percentage. There was no significant difference in SDI scores between the quartiles.



Patient/Payer Mix

Health centers with the largest share of Non-White or Hispanic/Latino/a patients received significantly larger COVID-19 grants, while those with the highest percentage of White patients received less funding. A health center's insurance mix affected COVID-19 grants as well. Those in the top quartile of COVID-19 grants had a significantly larger percentage of Medicaid and privately insured patients and a significantly lower share (13 points) of Medicare and uninsured patients. Larger grants were given to the centers that collected a statistically smaller portion of revenues from Medicare and more from Medicaid or had a larger percentage of uninsured patients.



Financial Results

Health centers in the top quartile that received COVID-19 funding had better characteristics in some areas, including higher operating margins and total operating revenues. This was found to be statistically significant. Their personnel expense ratio percentage was lower than the bottom quartile, boosting performance. However, the health centers in the bottom quartile received few COVID-19 grants but had higher NPSR per patient, days of cash on hand, grants, and contracts revenue growth rates, and NPSR growth rates.



Access to Care

A significant relationship was found between larger COVID-19 grants and higher annual visits, consistent with the current fee-for-service reimbursement model. Medical visits comprised a significantly smaller percentage of total visits for the health centers with higher grants, although dental health visits were a significantly larger portion.

Several areas showed statistically stronger performance for the top quartile of grant recipients. This included the growth rate in overall patients, total visits, and medical visits.

On average, health centers receiving a high percentage of COVID-19 grants had more FTEs and more patients **and statistically significantly better visit growth rates** than health centers that received a lower percentage of COVID-19 funding.



Quality Performance/Health Outcomes

Eight quality characteristics and health outcomes measured in UDS were analyzed to determine if there was a statistically significant relationship between those measures and higher COVID-19 grants. Centers that reported weaker health outcomes received higher levels of grant funding. They performed poorly on seven out of eight quality measures.

SECTION TWO - Review of Health Center Characteristics and Performance Levels Based on Patient Population

Indiana health centers were also analyzed based on their specific patient populations to understand better if and how the demographic and socioeconomic composition of a health center's patients impacted financial sustainability, access to healthcare, and health outcomes.

The health centers were first sorted from the highest to lowest percentages of a specific patient population according to 2019-2022 UDS data, then distributed into four equal quartiles based on their patient compositions. Differences between the top quartile (the highest 25% of a particular patient population) and the bottom quartile (the lowest 25%) were analyzed and tested for statistical significance.

Patient Populations Tested

1. Asian patient population percentage by quartile.
2. Black/African American patient population percentage by quartile.
3. Hispanic/Latino patient population percentage by quartile.
4. White patient population percentage by quartile.
5. Medicaid patient population percentage by quartile.
6. Patient SDI level by quartile.

Findings from each analysis and statistical testing are summarized below and listed in detail in Tables 1-6.

Patient Population One - Asian Patient Population Percentage, 2019-2022

Data Summary in Table 1



Demographics/Social Drivers of Health

The 25% of health centers with the largest portion of Asian patients (the "top quartile") had a larger number of patients who preferred to be served in a language other than English and a slightly higher poverty rate than the 25% of health centers with the smallest portion of Asian patients (the "bottom" quartile). Although not statistically different, the top quartile had a lower SDI score than the bottom quartile, indicating lower levels of social need among patients.



Patient/Payer Mix

Health centers in the top quartile had statistically higher levels of uninsured patients, yet fewer Medicare patients, and lower rates of Medicare collections than those in the bottom quartile. Although not statistically different, uninsured collections as a portion of total collections were higher for health centers with high percentages of Asian patients.



Financial Results

Operating margin is a good indicator of how well an organization is being managed as it provides insight into business operations and profitability. Health centers often have modest operating margins, but maintaining positive margins is essential for long-term sustainability. Operating margins were negative and lower for centers in the bottom quartile as compared to the top quartile (-1.33% vs. 5.30%), although this difference was not statistically significant.

Another important indicator is average days in accounts. Tracking average days in accounts payable is essential for any health center wanting to remain financially healthy in a competitive market. The top Asian quartile centers had statistically fewer days in accounts payable than the bottom quartile, indicating that health centers in the top quartile take less time to pay their outstanding balances.

Albeit not statistically significant, the top quartile had a higher average operating revenue than the bottom quartile. The top quartile also had higher grant revenue yet lower net patient service revenue as a percentage of total operating revenue.



Access to Care

The top quartile had different access to care results than the bottom quartile. Average FTEs for the top quartile was statistically higher than that of the bottom quartile (161.7 vs. 54.5). Additionally, the top quartile conducted more visits virtually (12.46% vs. 8.24%) but had statistically fewer visits per patient (3.74 vs. 4.36) than the bottom quartile. Furthermore, statistically, the top quartile had much weaker dental visit growth, data that further supports the findings of this [report on oral health disparities](#) among the Asian patient population.

When compared to the bottom quartile, the quartile of health centers with the highest percentage of Asian patients also had significant:

- Lower average patient growth rate (4.0% vs 7.05%)
- Lower average visit growth rate (8.92% vs 11.79%)
- Lower average medical visit growth rate (4.21% vs 12.01%)



Quality Performance/Health Outcomes

The top quartile performed well on seven out of eight UDS quality measures and statistically better than the bottom quartile in two of them. The top quartile scored statistically better (by 7 points) for poor diabetes control but scored statistically lower (by 16 points) for the health outcome and disparity measure of controlled high blood pressure. Although not statistically significant, the top quartile scored 16 points better for the percentage of patients aged 3 to 17 with documented BMI, Nutrition, and Physical Activity data.

Patient Population Two - Black/African American Patient Percentage, 2019-2022

[Data Summary in Table 2](#)



Demographics/Social Drivers of Health

The 25% of health centers with the largest portion of Black/African American patients (the "top quartile") had a significantly higher average SDI score (73.9) than the 25% of health centers with the smallest portion of Black/African American patients (the "bottom quartile") (56.8). The portion of homeless patients served by the top quartile was three percentage points higher (significantly greater) than that of the bottom quartile. In addition, the top quartile had a statistically higher poverty rate, which was eight percentage points above that of the bottom quartile. It also had a significantly lower number of patients who preferred to be served in a language other than English, which was three percentage points lower than that of the bottom quartile.



Patient/Payer Mix

Statistically significant differences in insurance coverage were also noted between centers with the highest and lowest portions of Black/African American patients. The top quartile had more Medicaid patients, a higher portion of Medicaid collections, significantly fewer Medicare patients, and a lower portion of Medicare collections than the bottom quartile.



Financial Results

The top quartile had significantly higher operating margins and days cash on hand than health centers in the bottom quartile. The average top quartile operating margin was 13.1 percentage points higher than that of the bottom quartile (4.84% vs. -8.22%), and the top quartile had 27 more days cash on hand (103 days vs. 76 days). The high operating margin and available days of cash suggest that health centers within the top quartile are particularly well-positioned to support long-term community health needs. This group of health centers also had statistically higher days in net patient receivables (18 more days) and a statistically lower grant and contract revenue growth rate.

Personnel related expenses encompass employment costs such as salaries, benefits, and contracted and professional services. These expenses are a vital component of the operating budget for health centers. Health centers with personnel costs at 70% or less of their annual operating revenues are more likely to have positive operating margins.

Conversely, health centers spending 75% or more of their operating revenues on personnel-related costs often have less budgetary room to support overall needs and are at higher risk of reporting operating deficits. Although both the top and bottom quartiles had personnel expenses of more than 70%, health centers in the top quartile had significantly lower per-patient and per-visit operating expenses compared to health centers in the bottom quartile.

The health centers with the highest percentage of Black/African American patients had an average operating revenue of \$23 million, a figure that is statistically higher (by \$15 million) than the average operating revenue of the health centers in the bottom quartile.



Access to Care

Health centers in the top quartile had statistically lower patient and medical visit growth rates yet a significantly higher (although not statistically different) dental growth rate as compared to the bottom quartile (687.94% vs -7.27%). However, the top quartile's mental health visit growth rate was significantly lower, by 42 percentage points, than the bottom quartile.

On average, the quartile of health centers with the highest percentage of Black/African American patients also had significantly:

- Lower medical visits as a percentage of total visits.
- Higher dental visits as a percentage of total visits.
- Similar mental health visits as a percentage of total visits.
- A higher percentage of visits handled virtually.



Quality Performance/Health Outcomes

The top quartile **performed worse on seven out of eight UDS quality measures** and **statistically worse** on two quality measures as compared to the bottom quartile.

These very weak quality outcomes highlight the longstanding health inequities and challenges faced by many in the Black/African American community in Indiana, as well as across the nation, due in large part to historic racism in healthcare and beyond. Black/African Americans may continue to be [negatively impacted by discrimination](#), which is a chronic stressor that appears to contribute to adverse health outcomes.

Patient Population Three - Hispanic/Latino Patient Percentage, 2019-2022

[Data Summary in Table 3](#)



Demographics/Social Drivers of Health

The 25% of health centers with the largest portion of Hispanic/Latino patients (the “top quartile”) had a significantly larger share of patients with income at or below 200% of the federal poverty level, a higher SDI score, more homeless patients, and a larger proportion of patients who preferred to be served in a language other than English than the 25% of health centers with the smallest portion of Hispanic/Latino patients (the “bottom quartile”). This reflects a higher level of socioeconomic need among top-quartile health centers.



Patient/Payer Mix

The top quartile had roughly three times of uninsured patients (24.02% vs. 7.08%) than the bottom quartile. This difference was found to be statistically significant. The top quartile also had a statistically higher portion (approximately 9 percentage points) of Medicaid patients than the centers in the bottom quartile.

The average share of Medicare patients, as well as average collection rates for Medicare and uninsured patients, was statistically lower for the top quartile health centers than the bottom quartile.



Financial Results

Health centers with the highest percentage of Hispanic/Latino patients had significantly stronger operating margins at 5.4%. This is approximately ten percentage points higher than the bottom quartile health centers (4.71%). Days of cash on hand, a measure of liquidity and financial sustainability, was also statistically higher for the top quartile.

The top Hispanic/Latino quartile had a significantly lower grant and contract revenue growth rate compared to the bottom quartile. In addition, the largest portion of health center costs, the top quartile's personnel expenses, were comparatively low. This can be represented by a ratio of personnel costs to operating revenue of 75.57% and was statistically lower (by five percentage points) in the top quartile than that of the bottom Hispanic/Latino quartile.



Access to Care

Health centers with a high percentage of Hispanic/Latino patients had a statistically lower (22 percentage points) rate of mental health visits as a percentage of total visits. Mental health visits per patient and overall mental health visit growth rate were also statistically lower for the top quartile compared to the bottom quartile.

It is important to recognize, however, that some of the perceived inequities may be more related to culture than access. For example, there is a [perception](#) among some in the Hispanic/Latino community that talking about mental health is embarrassing or shameful. This can cause Hispanic/Latino individuals to [avoid accessing treatment](#) and may limit their ability to recognize the signs and symptoms of mental health conditions and be aware of resources available for getting help. Finding opportunities for the Hispanic/Latino community to enhance their knowledge of mental health conditions, increase their comfort sharing mental health concerns and asking for help, and access high-quality mental health services within their communities could help decrease the disparities in mental health care among Hispanic/Latino patient populations.

The top quartile experienced significantly slower overall patient and visit growth over the period analyzed than the bottom quartile. Visit growth by service category was also comparatively weak for the top quartile. Medical visit growth (2.73%) was ten percentage points lower than that of the bottom quartile (12.89%), dental visit growth (-1.62%) was 22 percentage points lower than the bottom quartile (20.42%), and mental health visit growth (32.35%, while strong, was 56 percentage points lower than the bottom quartile (88.24%).

Although not statistically significant, health centers in the top quartile had a noticeably lower portion of virtual visits as a percentage of all visits, it is difficult to know if the discrepancy was related to language, cultural differences, capabilities, access to technology that facilitates virtual care, and/or other factors. These discrepancies should be further investigated to improve access to quality care for all patient populations.



Quality Performance/Health Outcomes

The health of a particular patient population is influenced by both social and economic circumstances. Despite high SDI scores, uninsured rates, and poverty rates, the top quartile scored better on most quality care measures than did the bottom quartile. The largest discrepancy was in the measure of 'patients aged 3-17 with BMI, nutrition & physical activity documented'. For this metric, the top quartile performed 24 percentage points better than the bottom quartile.

Although not statistically significant, centers with a large Hispanic/Latino population showed worse performance in the following measures:

- 'Children Receiving Appropriate Vaccinations by Age 2' (3 percentage points lower).
- 'Patients Aged 6-9 at Moderate to High Risk of Caries Receiving Sealant on First Permanent Molar' (2 percentage points lower).
- 'Patients with Controlled High Blood Pressure' (0.46 percentage points lower).

Compared to the Non-Hispanic patient population, the outcome for diabetes control was significantly poorer among the Hispanic patient group.

Patient Population Four - White Patient Percentage, 2019-2022

[Data Summary in Table 4](#)



Demographics/Social Drivers of Health

The 25% of health centers with the largest portion of White patients (the "top quartile") had a significantly lower average SDI score of 61.1, which is 15.7 points less than the 25% of health centers with the smallest portion of White patients (the "bottom quartile") (76.8). The top quartile also had a statistically lower percentage of homeless patients (by four percentage points) and a statistically lower poverty rate (by eight percentage points) than the bottom quartile. Additionally, the top quartile had statistically fewer patients who preferred to be served in a language other than English as compared to the bottom quartile.



Patient/Payer Mix

At 42.34%, the top quartile had a significantly smaller portion of Medicaid patients than the bottom quartile (56.47%) and a statistically larger portion of Medicare patients (18.87% vs. 9.29%). The top quartile's collections were statistically higher for Medicare yet statistically lower for Medicaid as compared to the bottom quartile.



Financial Results

The top quartile had a statistically lower operating margin than the bottom quartile. In addition to the less favorable payer mix mentioned above, the top quartile's weaker financial performance was impacted by its lower grants and contract revenue per patient ratio. Compared to the bottom quartile, health centers in the top quartile had an average of 12 fewer days of cash on hand (statistically lower).

Centers in the top quartile had a significantly larger personnel expense ratio of 80.74%, a value 6.2 percentage points higher than the bottom quartile (74.53%). In addition, despite the top quartile's low average grant and contract revenue per patient, this group had significantly higher overall grant and contact revenue growth at 487.91%, versus. 1.18% for the bottom quartile. However, the top quartile also exhibited statistically lower total operating revenue of \$6 million during the review period compared to. \$18 million for the bottom quartile).



Access to Care

Access to medical care refers to the degree to which patients can promptly obtain appropriate treatment from a health center promptly. The degree of acculturation, language barrier, insurance, and immigration status all impact access to care both directly and indirectly. Health centers within the top quartile had statistically lower poverty and uninsured rates than the bottom quartile. The top quartile provided better access to care overall, with a statistically higher (by 19 percentage points) patient growth rate as well as a statistically higher (by 20 percentage points) visit growth rate during the review period.

On average, the quartile with the largest percentage of White patients had a statistically higher:

- Medical visit growth rate.
- Mental health visit growth rate.
- Medical visits as a percentage of total visits.

Health centers in the top quartile reported low growth in dental visits, with fewer dental visits as a percentage of total visits compared to the health centers in the bottom quartile. This difference was found to be statistically significant.



Quality Performance/Health Outcomes

The top quartile performed better on four out of eight UDS quality measures and statistically better on two quality measures as compared to the bottom quartile. The two metrics on which the top quartile performed statistically well are:

- 'Percentage of Patients with Controlled High Blood Pressure' (10 percentage points higher).
- 'Percentage of Patients Being screened for Colorectal Cancer' (2 percentage points higher).

There was a statistically significant association between a health center's percentage of White patients and its proportion of patients struggling with poor diabetes control. A higher percentage of White patients was associated with a weaker outcome on this measure (i.e., more patients struggling). In addition, the top quartile also performed worse on the measure of patients aged 3-17 with BMI, nutrition and physical activity documented, reporting a metric of 50.31%, which is statistically lower than the bottom quartile by 14 percentage points.

Patient Population Five - Medicaid Patient Percentage, 2019-2022

[Data Summary in Table 5](#)



Demographics/Social Drivers of Health

A statistically significant relationship was found between a health center's percentage of Medicaid patients and its patient population's poverty rate, SDI score, and percentage of homeless patients. The 25% of health centers with the largest portion of Medicaid patients (the "top quartile") had a greater share of patients below the federal poverty level (by 11 percentage points), a higher SDI score (by 16.2), and more homeless patients (by two percentage points) than the 25% of health centers with the smallest portion of Medicaid patients (the "bottom quartile").

A statistically significant relationship was also found between a health center's percentage of Medicaid patients and portion of patients of different races and ethnicities. Compared to the bottom quartile, the top quartile reported on average:

- A higher percentage of Asian patients (2.30% vs. 0.59%).
- A higher percentage of Black/African American patients (39.89% vs. 5.73%).
- A lower percentage of White patients (49.62% vs. 84.69%).
- A higher percentage of Other Patients of Color (2.35% vs. 1.20%).
- A higher percentage of Non-White Patients (44.54% vs. 7.52%).
- A higher percentage of Non-Hispanic/Latino patients (44.59% vs. 8.05%).



Patient/Payer Mix

The top quartile had a significantly different payer mix than the bottom quartile, with lower percentages of patients and collections in the uninsured, Medicare, and private insurance categories. This is no surprise,

given this section of the top quartile is defined by those health centers with the largest portion of patients with Medicaid (the fourth major payor group).



Financial Results

The top quartile had significantly higher average operating margin and days cash on hand than the bottom quartile. At 4.77%, the top quartile's average operating margin was 14.4 percentage points higher than bottom quartile (-9.61%). In addition, albeit not statistically significant, the top quartile had significantly better liquidity, as demonstrated by an average of 138 days of cash on hand, compared to an average of 91 days within the bottom quartile. The high days of cash on hand suggest that centers with a large proportion of Medicaid patients are particularly well-positioned to support long-term community health needs.

The top quartile was significantly more dependent on net patient service revenue (NPSR) than the bottom quartile. For the top quartile, NPSR represented 59.51% of revenues, while grant and contract funding was nearly half that level at 30.53%. Comparatively, the bottom quartile's revenues consisted of 57.89% NPSR and 25.72% grants and contracts. Although the top quartile had significantly higher grant and contract revenue per patient than the bottom quartile, the grants, and contracts revenue growth rate over the reporting period for the top quartile (15.23%) was significantly lower than that of the bottom quartile (595.9%).

Health centers in the top quartile had statistically significant higher operating revenue and lower personnel-related expenses than the bottom quartile, which also contributed to their higher operating margins.



Access to Care

The centers in the top quartile had, on average, more FTEs, and a higher number of patient visits than the centers in the bottom quartile, yet a significantly lower patient growth rate. In addition, the top quartile had a higher, although not statistically significant, portion of total visits conducted virtually, which is perhaps reflective of better access to technology and the Internet among this patient population. Overall visits per patient were also higher for the top quartile.

Despite relatively low overall patient growth, the dental visit growth rate for the top quartile was 604.36%, a rate notably higher than the bottom quartile at -12.76%. The explosive growth in dental visits among the top quartile may help minimize or fully eliminate oral health access disparities in the future.



Quality Performance/Health Outcomes

The top quartile **performed better on two out of eight UDS quality measures**. A statistically significant relationship existed for only three measures, on which the top quartile performed worse than the bottom quartile on two measures and better on one. The metrics with statistically significant relationships were:

- Percentage of Patients with Diabetes Poor Control (1 percentage point higher).
- Percentage of Low and Very Low Birth Weight Babies Delivered During the Year – Hispanic/Latino Patients' (3 percentage points higher).
- Percentage of Patients with Controlled High Blood Pressure' (10 percentage points lower).

Patient Population Six - Percentage Based Upon Patients' SDI, 2019-2022

Data Summary in Table 6



Demographics/Social Drivers of Health

The 25% of health centers with the highest SDI scores (the “top quartile”) had a significantly higher percentage of patients that were below 200% of the federal poverty level as well as a higher share of patients who preferred to be served in a language other than English than the 25% of health centers with the lowest SDI scores (the “bottom quartile”).

Compared to the bottom quartile, the top quartile, had a statistically larger share of Black/African American patients (42.62% vs 11.23%), Non-White patients (47.28% vs 17.64%), Non-Hispanic or Latino patients (46.85% vs 17.88%), and Hispanic/Latino patients (16.1% vs 12.62%). Relatedly, the top quartile had a statistically smaller percentage of White patients (44.00% vs 76.50%) compared to the bottom quartile.



Patient/Payer Mix

The patient and payer mix of the top quartile was, for the most part, statistically different than that of the bottom quartile. The top quartile had a lower rate of patients and collections in the Private Insurance, uninsured, and Medicare categories than the bottom quartile. In contrast, the top quartile was far more dependent upon Medicaid patients and collections, at rates of 57.59% and 75.33% respectively, compared to 46.04% and 55.35% for the bottom quartile.



Financial Results

Albeit not statistically different, the top quartile had a lower average operating margin than the bottom quartile (-0.96% vs. 3.7%) and fewer days of cash on hand (106 vs. 111). In addition, the top quartile had very high days in net patients' receivable and days in accounts payable, which were 27 and 170 days higher respectively than the bottom quartile. This difference was statistically significant. The top quartile's low grant and contract revenue per patient drove much of the centers' financial weakness. Furthermore, health centers in the top quartile had statistically very low growth rates for grant and contract revenue, at a level 429.5 percentage points lower than the bottom quartile, making them more dependent upon net patient service revenue. Although not statistically significant, the top quartile's higher personnel expense ratio also contributed to weaker financial and operating results.



Access to Care

The top quartile had a significantly lower patient growth rate compared to bottom quartile (5.35% vs. 128.03%). Also, although not statistically different, the visit growth rate for the top cohort was significantly low. Among the different types of services, the top cohort had lower rates of medical and mental health visit growth, but a statistically very high rate of dental visit growth, at a rate 824 percentage points greater than that of the bottom quartile.

The service mix for the top quartile differed from the bottom quartile (although the variances were not statistically significant) for medical and mental health visits. Medical visits comprised a relatively large percentage of overall visits within the top quartile (72.09%), while both dental visits (4.63%) and mental

health visits (13.79%) represented a noticeably smaller portion of total visits. This suggest slightly less access to integrated care.



Quality Performance/Health Outcomes

The top quartile performed statistically better on the quality measures of 'Patients aged 3-17 with BMI, Nutrition & Physical Activity Documented' and 'High Blood Pressure Control' than the bottom quartile. In addition, although not statistically different, the top quartile performed 22 percentage points better on the quality measure 'Patients aged 6-9 at Moderate to High Risk of Caries Receiving Sealant on First Permanent Molar' as well as 3 percentage points better on 'Diabetes Control' than the bottom quartile.

Comparison of Quality Performance for Specific Patient Population Percentages: Patient Populations #1-6

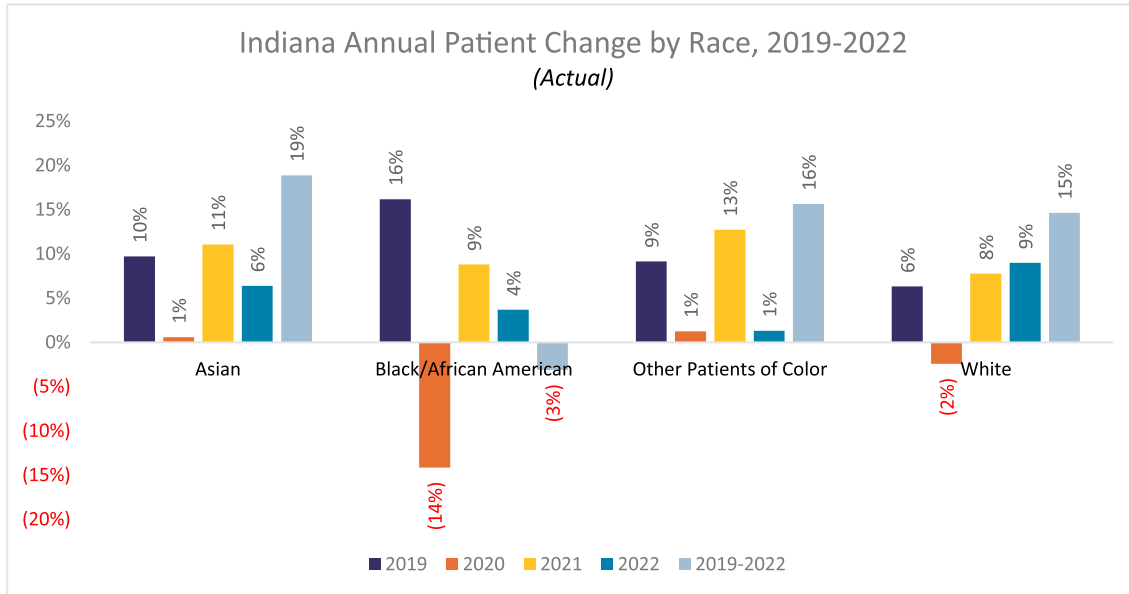
The table below compares the quality outcomes of the different types of patient population quartiles. The top performer in each patient category by quality measure is highlighted in yellow. For example, the top quartile within the Hispanic patient population group, on average, measured and documented information on BMI and related activity for 72% of patients aged 3-17. However, the top quartile within the White patient population group only achieved that outcome 50% of the time. The top quartile within the Hispanic patient population group had the best scores on three of the eight quality measures tested, while the top quartile within the Black patient population group did not perform best in any of the eight quality measures.

Quality Performance (Top Performer in Each Category Highlighted in Yellow)	Table 1 Top 25% of Asian Patient Percentage	Table 2 Top 25% of Black Patient Percentage	Table 3 Top 25% of Hispanic Patient Percentage	Table 4 Top 25% of White Patient Percentage	Table 5 Top 25% of Medicaid Patient Percentage	Table 6 Top 25% of High SDI Patient Percentage
Percentage of Children Receiving Appropriate Vaccinations by Age 2	36%	25%	34%	34%	29%	32%
Percentage of Patients 12 and over Screened for Depression/Follow-up Plan Documented	63%	59%	65%	54%	53%	54%
Percentage of Patients over 18 with BMI & Follow Up Documented (If BMI outside normal)	57%	57%	63%	62%	62%	55%
Percentage of Patients 3-17 with BMI, Nutrition & Physical Activity Documented	65%	61%	72%	50%	66%	69%
Percentage of patients aged 6-9 at Moderate to High Risk of Caries Receiving Sealant on First Permanent Molar	43%	37%	37%	36%	45%	48%
Percentage of patients being screened for colorectal cancer	41%	38%	43%	44%	39%	46%
Percentage of Patients with Controlled High Blood Pressure	61%	57%	63%	69%	58%	61%
Percentage struggling with poor diabetes control (lower is better)	30%	35%	31%	35%	34%	34%
Quality Performance: # of Times this Category had Best Performance (Including Ties)	2		3	1		2

Section 3 - Health Care Access, Outcomes, and Disparities by Race, Ethnicity, and Insurance

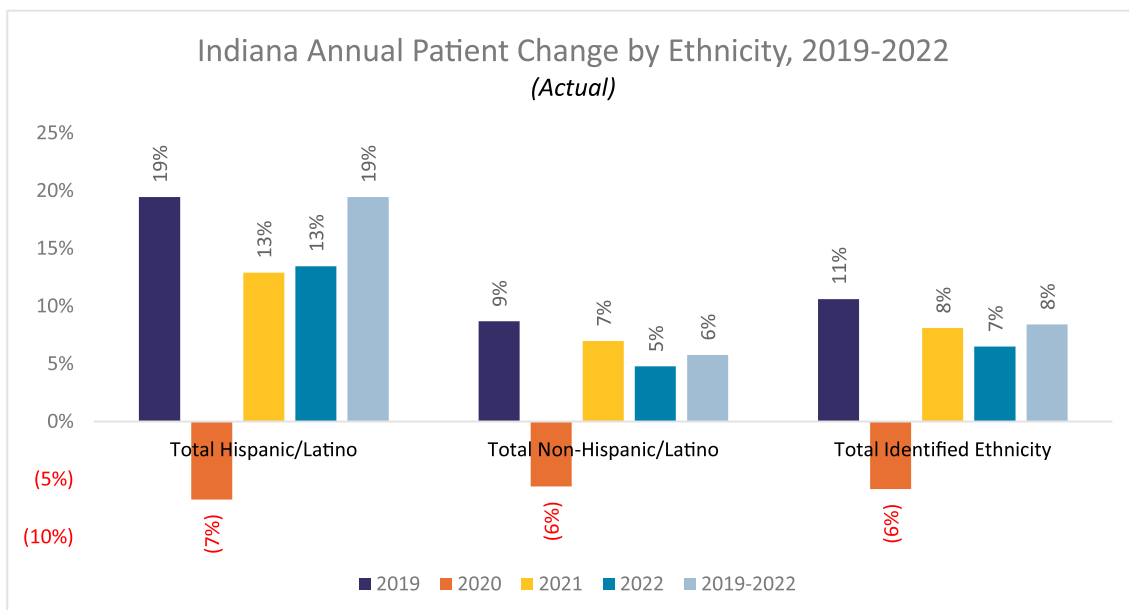
Indiana Health Centers Health Care Access by Race, 2019-2022

At the height of the pandemic in 2020, Indiana reported a drop in all patient groups. Asian and Other Patients of Color dropped by 1%, White patients declined by 2%, and the Black/African American patient population fell by 14%. In 2021, all patient populations recovered to positive growth rates, which all exceeded the 2019 levels, with the exception of the Black/ African Americans. The number of Black/African American patients dropped by 3% over the entire period tracked, a notable trend.



Indiana Health Centers Health Care Access by Ethnicity, 2019-2022

From 2019 to 2022, patient growth at Indiana health centers varied slightly based on ethnicity. Hispanic/Latino patients grew by 19% during the entire period, while non-Hispanic/Latino patients rose by 6%, which is less than half that rate. During the 2020 pandemic, Hispanic/Latino and non-Hispanic/Latino patients declined by 7% and 6%, respectively. Following the 2020 global health crisis, Hispanic/Latino and non-Hispanic/Latino patient groups improved during 2021 and 2022 but did not return to pre-pandemic levels. As health centers continue to recover, it is important to continue data monitoring in order to determine whether improvements return to pre-pandemic rates.

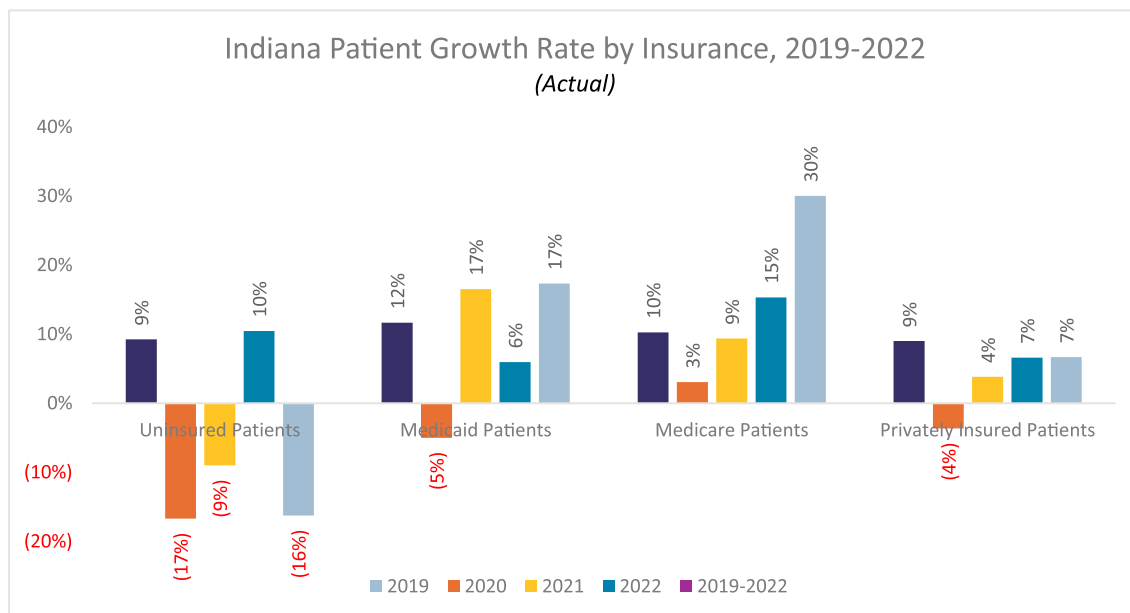


Indiana Health Centers Health Care Access by Payer, 2019-2022

In 2019, Indiana health centers reported strong patient growth rates in all payer categories, followed by a sharp decline during 2020. The sharp decline is likely due in-part to the global COVID-19 pandemic, which disproportionately impacted the uninsured and Medicaid populations with respect to access to care, with those patient groups respectively dropping by 17% and 5% during 2020. Although the Medicaid patient population jumped to 17% in 2021 and grew 17% over the total four-year period, the uninsured population maintained a decline during 2021, reporting a 16% drop between 2019 and 2022.

It is difficult to determine if the decline in uninsured patients was primarily due to transferring to paid sources such as Medicaid (a positive result) or if the decline is indicative of challenges related to accessing care (an area of concern). More analysis in this area is required to better understand to determine the types of assistance most beneficial for this group.

Over the review period, the number of Medicare patients rose by 30%, and the privately insured population grew 7%.



Indiana Health Centers Health Care Outcomes and Disparities by Race and Ethnicity, 2019-2022

Three health outcomes are tracked by ethnicity and race in UDS as follows:

1. Percentage of low and very low birth weight babies as a percent of all deliveries during the year (the goal is to keep this figure as low as possible).
2. Patients with controlled high blood pressure (the goal is to maximize this figure).
3. Patients with diabetes and hemoglobin A1c poor control (the goal is to keep this figure as low as possible).

Health Outcome One - Percentage of Low and Very Low Birth Weight Babies

For the median Indiana center, the proportion of low and very low birth-weight babies in the Black/African American patient population was consistently higher than the White patient population. This proportion was consistently two to four points higher each of the last four years.

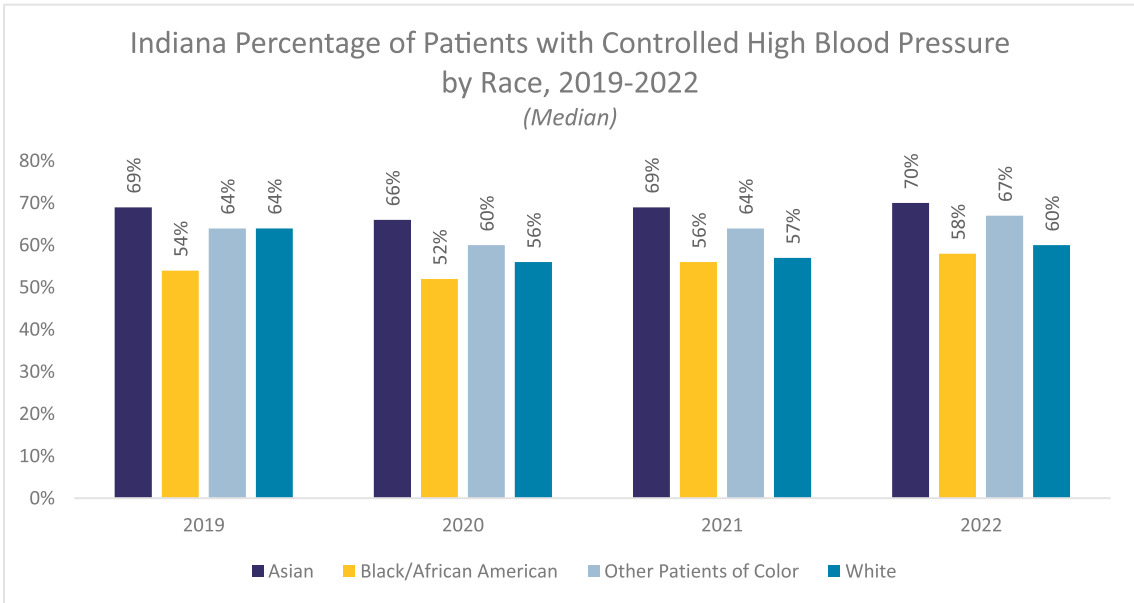
Key Health Outcomes Metrics – by Race	2019	2020	2021	2022
Percentage of Low and Very Low Birth Weight Babies Delivered During the Year – Black/African American Patients	2%	10%	9%	10%
Percentage of Low and Very Low Birth Weight Babies Delivered During the Year – White Patients	6%	8%	6%	7%

There was a significant difference in the percentage of patients with low and very low birth weight babies over the period tracked based on ethnicity. Non-Hispanic/Latino patients consistently reported a higher percentage of low-birth-weight babies from 2019-2022, with a four-percentage point gap in 2022. Hispanic/Latino patients dropped to 2% low and very low birth weight babies in 2021 but rose four points in 2022 to 6%.

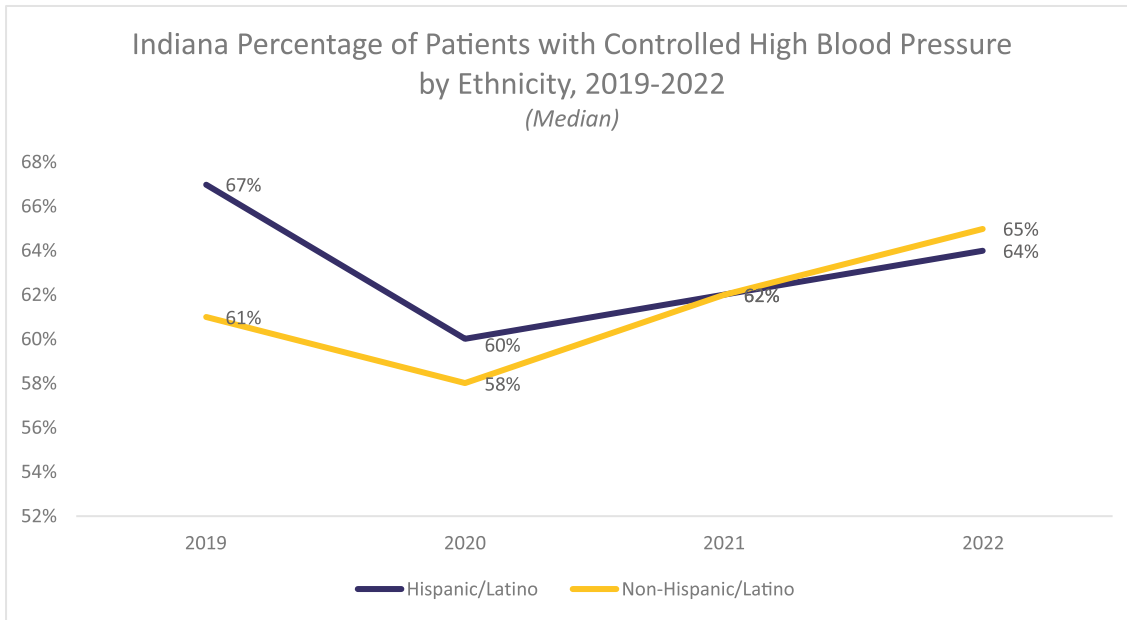
Key Health Outcomes Metrics – by Ethnicity	2019	2020	2021	2022
Percentage of Low and Very Low Birth Weight Babies Delivered During the Year – Hispanic/Latino Patients	4%	4%	2%	6%
Percentage of Low and Very Low Birth Weight Babies Delivered During the Year – Non-Hispanic/Latino Patients	8%	10%	7%	10%

Health Outcome Two - Patients with Controlled High Blood Pressure

Asian patients at the median Indiana health center achieved higher controlled blood pressure throughout the review period. Other Patients of Color saw a four-point decline in 2020 but rebounded in 2021 and 2022. Similar to White patients, Black/African American patients who controlled high blood pressure declined in 2020 and 2021, with a slight 2-point increase to 58% in 2022, the highest of the four-year review period. White patients increased in 2022 to 60% compared to 57% in 2021.

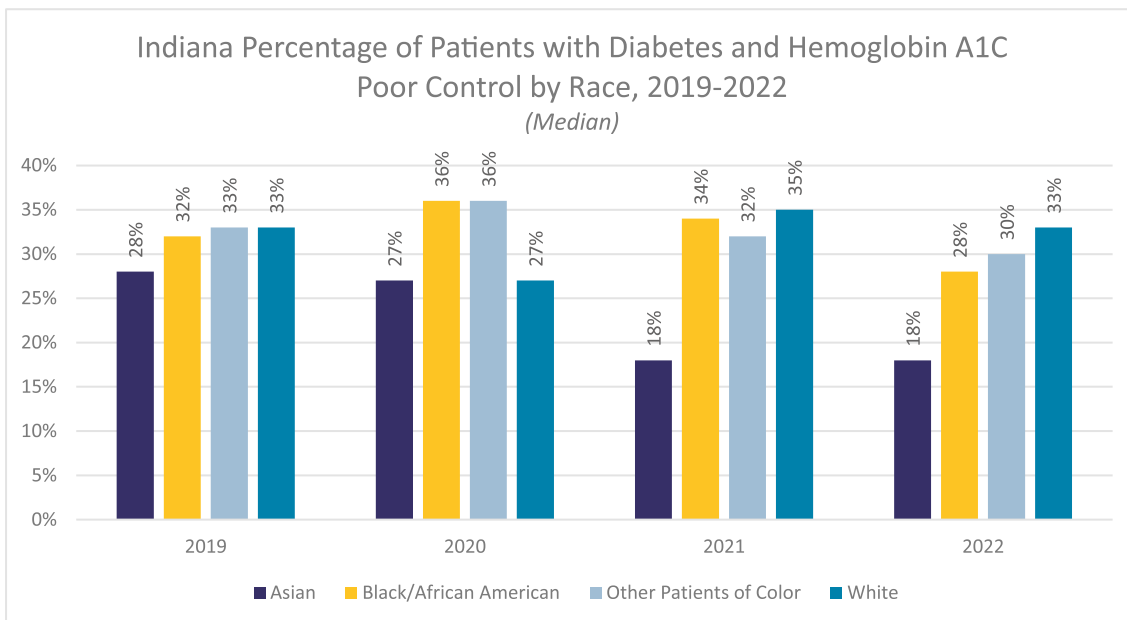


Indiana's Hispanic/Latino median patient population outperformed the Non-Hispanic/Latino group on the controlled high blood pressure outcome measure. Hispanic/Latino patients reporting two to six percentage points above Non-Hispanic/Latino patients from 2019-2020. In 2021, both groups reported 62%. Then, in 2022, the Non-Hispanic/Latino patient population exceeded the Hispanic/Latino group by one percentage point. A review of the 2023 numbers is warranted to see if this trend continues.

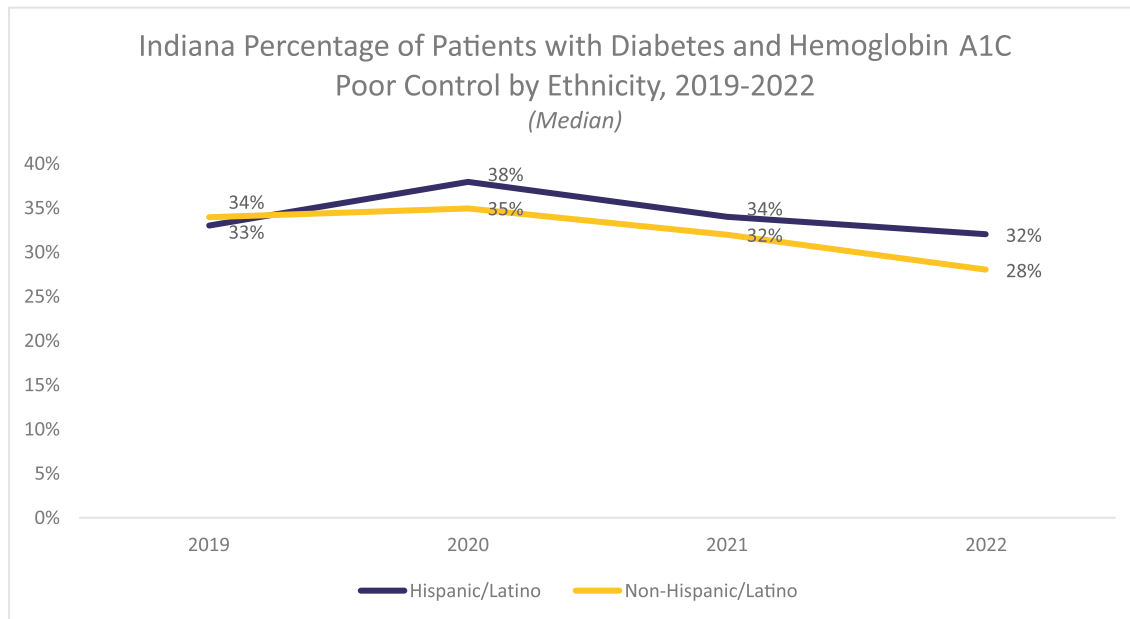


Health Outcome Three - Patients with Diabetes and Hemoglobin A1c Poor Control

In 2020, at the median Indiana health center, the Black/African American and Other Patients of Color patient populations reported weak outcomes for 'Poor Control Diabetes'. These populations saw a three to four percentage point increase in this health outcome during that 2020. The 2021 figures improved for all racial categories except for White patients, which went up by seven points. In 2022, all patient populations saw a return to pre-pandemic numbers, with even better improvements for the Black/African American and Other Patients of Color populations at 28% and 30%, respectively.



The proportion of Indiana's Hispanic/Latino patients suffering from poor diabetes control was one to four percentage points higher than Non-Hispanic/Latino patients during 2020-2022. The measure jumped for all Indiana health center patients in 2020—consistent with weaker access during the COVID-19 pandemic—but started to recover in 2021, with the lowest numbers in 2022.



CONCLUSION

Over the past several years, despite the COVID-19 health emergency, Indiana health centers posted robust financial results as well as strong patient and visit growth. However, while some centers consistently managed finance and operations well, significant one-time government and private grants and assistance were largely responsible for the region's successful performance. Health centers must carefully monitor performance and adapt operations accordingly in the changing socioeconomic climate to ensure ongoing financial sustainability, particularly given the statistically significant relationship observed between strong health center financial performance and quality health outcomes.

While most health centers fared relatively well, and strong financial performers and health centers that received large COVID grants reported excellent results in providing access to care for their patients, health centers with high SDI score populations did not perform well regarding healthcare access. Patients of color, particularly Black/African Americans, struggled considerably during the review period. Health centers with the highest proportion of Black/African American patients scored worse than peers on seven out of eight of the UDS quality measures analyzed, while health centers with the highest proportion of Asian patients performed well on seven out of eight UDS quality measures.

The weak financial position of health centers with high SDI scores may have placed additional pressure on their ability to provide better levels of access, even though they were able to provide high quality healthcare to their patients. In contrast, health centers with a high proportion of Black/African American patients scored fairly well on several financial measures, making their weak average quality performance particularly perplexing. The health outcome disparities are likely attributable, at least in part, to deep socially driven health challenges, cultural differences, as well as potential discrepancies in funding and support for racially and ethnically diverse patient populations, including patients of color.

Although health centers are well-suited to address and combat barriers to access to care and health inequities in at-risk populations, addressing systemic challenges is difficult and time-consuming. Cultural differences and norms, such as Hispanic/Latino perception of mental health care, are an additional difficulty. The social drivers of health (SDOH), including higher homelessness, poverty rates, and uninsured rates among Black/African American populations in Indiana, are a further barrier to improving outcomes on certain chronic health conditions that require ongoing management, such as diabetes and high blood pressure monitoring.

Insurance coverage also plays an important role in helping patients get better access to healthcare and protect them from major financial costs. There have been long-standing racial and ethnic disparities in health coverage that also contribute to health disparity. This study highlights the existence of coverage disparities among Black and Hispanic patients. Although the overall uninsured rate continued to decline after the pandemic, Hispanic and Black patients are more likely than their White patient counterparts to be uninsured, consistent with the recently conducted research showing [health coverage](#) by race and ethnicity.

Some health centers have implemented changes to improve health outcomes while acknowledging significant, long-lasting change requires time and commitment from multiple stakeholders. Health centers can execute community outreach efforts and chronic disease management initiatives for affected populations by raising awareness and expanding health literacy programs for affected and underserved population groups. Some other recommendations include an, "...increase In proportion of underrepresented minority groups In the [workforce](#), Integrate cross-cultural education In healthcare training, and advance research efforts to identify sources of disparities..."¹⁴⁷. Increasing health insurance coverage, developing better healthcare access in lower-income neighborhoods, and enhancing resource coordination can also help populations most harmed by health disparities. Another strategy to improve results in the short term includes strengthening financial and operational performance through training and development.

Co-locating health centers with supportive housing is another, "...effective way of providing services to high-need individuals, often reducing the burden of transportation, childcare, or other competing priorities to access health care."⁸ Maximizing health care coverage for vulnerable populations is also critical, which includes leveraging recent policy changes in programs that have strengthened the Medicaid and Affordable Care Act.⁹

Addressing these factors is an important step to strengthening health center financial sustainability, combating SDOH challenges, and bridging the insurance gap. We hope that these actions will lay the groundwork for long-term substantive improvements to health center financial sustainability, access to care, and health outcomes.

¹⁴⁷ Addressing Health and Health-Care Disparities: The Role of a Diverse Workforce and the Social Determinants of Health. ([Source](#))

⁸ 5 building blocks to help achieve greater health equity. ([Source](#))

⁹ Disparities in Health and Health Care: 5 Key Questions and Answers: ([Source](#))

TABLES

Table A: Financial Performance Highest 25% vs. Lowest 25%, 2019-2022¹⁵

Factor	Low Finance Score %	High Finance Score %	Variance	Statistical Significance/ P-Value
DEMOGRAPHICS/SOCIAL DRIVERS OF HEALTH				
Percentage of Patients with Income at or Below 200% of Federal Poverty Level	89.25%	83.38	(6%)	0.1
Percentage of Patients Best Served in a Language Other than English	16.7%	3.8%	(13%)	0.05
Homeless Patient Percentage	2.69%	2.65%	(0%)	N/A
Asian Patient Percentage	4.67%	-0.58	(4%)	0.1
Black/African American Patient Percentage	24.98%	9.91%	(15%)	0.1
Non-White Patient Percentage	31.65%	13.06%	(19%)	0.1
White Patient Percentage	58.48%	83.20%	25%	0.05
PATIENT/PAYER MIX				
Percentage of Uninsured Patients (lower is better)	15.32%	12.45%	(3%)	N/A
Percentage of Uninsured Collection	11.16%	7.13%	(4%)	N/A
Percentage of Medicaid Patients	51.21%	49.15%	(2%)	0.1
Percentage of Medicaid Collections	64.24%	64.45%	0%	N/A
Percentage of Private Insurance Patients	22.51%	25.06%	3%	N/A
Percentage of Private Insurance Collections	14.06%	12.40%	(2%)	N/A
Percentage of Medicare Patients	10.96%	13.33%	2%	N/A
Percentage of Medicare Collections	10.40%	15.90%	6%	N/A
FINANCIAL RESULTS				
Annual Operating Revenues	\$23.3M	\$32.7M	\$9.4M	0.1
Days of Cash on Hand	49	126	77	0.001
Operating Margin	(0.71%)	12.64%	13.4	0.05
Days in Net Patient Receivables	51	40	(11)	0.1
Days in Accounts Payable	53	63	10	0.05
Personnel Expense as a Percentage of Revenues	77.17%	69.63%	(7.5%)	N/A
ACCESS TO CARE				
Medical Visits as a Percentage of Total Visits	67.37%	72.78%	5%	N/A
Mental Health as a Percentage of Total Visits	20.13%	15.01%	(5%)	N/A
Total Patients	15,320	16,847	1527	N/A
Patient Growth Rate	1.53%	143.76%	142%	0.1
Visit Growth Rate	5.14%	213.62%	208%	0.05
Medical Visit Growth Rate	3.59%	92.85%	89%	0.05
Mental Health Visit Growth Rate	27.69%	41.88%	14%	N/A
Percentage of Virtual Visits	10.77%	6.77%	(4%)	N/A
QUALITY PERFORMANCE/HEALTH OUTCOMES				
Percentage of Patients with Controlled High Blood Pressure	61.30%	63.65%	2%	N/A
Percentage of Patients 18 and over with BMI & Follow Up Documented (If BMI	52.08%	66.88%	15%	0.05
Percentage of Patients Screened for Colorectal Cancer	40.83%	44.79%	4%	0.05
Percentage of Patients with Diabetes and Hemoglobin A1c Poor Control –	36.36%	39.92%	4%	0.01
Percentage of Patients with Diabetes and Hemoglobin A1c Poor Control – Non-	30.58%	35.09%	5%	0.1
Percentage of Low and Very Low Birth Weight Babies Delivered During the Year –	7.22%	25.20%	18%	0.05
Percentage of Patients with Controlled High Blood Pressure – Black/African	53.84%	56.32%	2%	0.05
Percentage of Patients with Diabetes and Hemoglobin A1c Poor Control – Other	30.94%	28.77%	(2%)	0.05

¹⁵ Includes statistically significant differences as well as notable observations commented upon in the text.

Table B: COVID Grants Highest 25% vs. Lowest 25%, 2019-2022

Factor	Low COVID Grant Revenue %	High COVID Grant Revenue %	Variance	Statistical Significance/ P-Value
DEMOGRAPHICS/SOCIAL DRIVERS OF HEALTH				
Percentage of Patients with Income at or Below 200% of Federal Poverty Level	83.92%	89.61%	6%	0.1
Percentage of Patients Best Served in a Language Other than English	6.98%	12.61%	6%	N/A
Homeless Patient Percentage	3.35%	2.07%	(1%)	N/A
Non-White Patient Percentage	14.77%	28.87%	14%	0.1
Hispanic Patient Percentage	6.43%	17.81%	11%	0.05
Other Patient of Color Percentage	1.09%	3.36%	2%	0.000
White Patient Percentage	79.93%	63.67%	(16%)	0.1
PATIENT/PAYER MIX				
Percentage of Uninsured Patients (lower is better)	8.39%	15.39%	7%	0.05
Percentage of Uninsured Collection	8.78%	9.06%	0%	N/A
Percentage of Medicaid Patients	46.74%	56.44%	10%	0.1
Percentage of Medicaid Collections	61.44%	72.76%	11%	N/A
Percentage of Private Insurance Patients	25.43%	20.58%	(5%)	N/A
Percentage of Private Insurance Collections	9.87%	11.61%	2%	N/A
Percentage of Medicare Patients	19.43%	7.58%	(12%)	0.05
Percentage of Medicare Collections	19.86%	6.50%	(13%)	0.05
FINANCIAL RESULTS				
Annual Operating Revenues	\$17M	\$48.6M	\$31.6M	0.05
Days of Cash on Hand	156	97	(59)	0.05
Operating Margin	-5.61%	5.54%	11.2%	0.1
Grant and Contract Revenue Growth Rate	42.44%	15.49%	(27.0%)	0.1
Days in Accounts Payable	85	233	148	0.1
Net Patient Service Revenue per Patient % Change	855.38%	7.90%	(847.5%)	0.0
ACCESS TO CARE				
Total FTEs	32.45	283.77	251.32	0.000
Total Patients	3,624	38,286	34,622.0	0.000
Total Visits per Patient	3.50	3.49	0.0	0.01
Visit Growth Rate	36.11%	183.46%	147%	0.000
Medical Visit Growth Rate	25.28%	72.76%	47%	0.000
Dental Visit Growth Rate	24.68%	8.69%	(16%)	0.05
Mental Health Visit Growth Rate	72.23%	34.26%	(38%)	N/A
Mental Health Visits per Patient	3.70	4.29	0.6	0.1
QUALITY PERFORMANCE/HEALTH OUTCOMES				
Percentage of Patients 18 and over with BMI & Follow Up Documented (If BMI outside normal)	52.49%	63.74%	11%	0.1
Percentage of Patients 3-17 with BMI, Nutrition & Physical Activity Documented	42.00%	63.32%	21%	0.01
Percentage of Patients Screened for Colorectal Cancer	42.12%	31.92%	(10%)	0.1
Percentage of Patients with Controlled High Blood Pressure	68.94%	59.87%	(9%)	0.01
Percentage of Low and Very Low Birth Weight Babies Delivered During the Year – Hispanic/Latino Patients	1.54%	5.94%	4%	0.1
Percentage of Patients with Controlled High Blood Pressure – Hispanic/Latino Patients	65.34%	62.79%	(3%)	0.1
Percentage of Patients with Diabetes and Hemoglobin A1c Poor Control – Hispanic/Latino Patients	46.07%	39.37%	(7%)	0.1

Table 1: Asian Patient Population Percentage Highest 25% vs. Lowest 25%, 2019-2022¹⁶

Factor	Low Asian Patient %	High Asian Patient %	Variance	Statistical Significance/ P-Value
DEMOGRAPHICS/SOCIAL DRIVERS OF HEALTH				
Percentage of Patients Best Served in a Language Other than English	4.04%	22.42%	18%	0.001
Percentage of Patients with Income at or Below 200% of Federal Poverty Level	87.69%	88.23%	1%	0.1
Social Deprivation Index (SDI)	65.9	64.9	(-1.0)	N/A
PATIENT/PAYER MIX				
Percentage of Uninsured Patients	8.40%	21.33%	13%	0.05
Percentage of Uninsured Collections	7.27%	11.99%	5%	N/A
Percentage of Medicare Patients	17.63%	6.64%	(11%)	0.01
Percentage of Medicare Collections	18.86%	6.63%	(12%)	0.05
FINANCIAL RESULTS				
Operating Margin	(1.33%)	5.30%	6.6%	N/A
Days in Accounts Payable	84	41	(43)	0.1
Grant Revenue as a % of Total Operating Revenue	26.39%	34.27%	8%	N/A
Net Patient Services Revenue as a % of Total Operating Revenue	64.19%	56.53%	(8%)	N/A
Total Operating Revenues	\$ 17.1 M	\$26.3 M	\$9.2 M	N/A
ACCESS TO CARE				
Total FTEs	54.49	161.73	107.24	0.05
Percentage of all Visits that are handled Virtually	8.24%	12.46%	4%	N/A
Total Visits per Patient	4.36	3.74	(0.6)	0.1
Medical Visits per Patient	3.35	2.84	(0.5)	N/A
Patient Growth Rate	7.05%	4.00%	(3%)	0.1
Visit Growth Rate	11.79%	8.92%	(3%)	0.05
Medical Visit Growth Rate	12.01%	4.21%	(8%)	0.1
Dental Visit Growth Rate	1595.16%	-6.33%	(1601%)	0.01
QUALITY PERFORMANCE/HEALTH OUTCOMES				
Percentage of Patients 18 and over with BMI & Follow Up Documented (If BMI outside normal)	55.25%	57.38%	2%	0.05
Percentage of Patients 3-17 with BMI, Nutrition & Physical Activity Documented	49.26%	65.28%	16%	N/A
Percentage of Patients with Diabetes and Hemoglobin A1c Poor Control (lower is better)	37.91%	30.43%	(7%)	0.1
Percentage of Patients with Controlled High Blood Pressure – Asian Patients	79.50%	63.56%	(16%)	0.05

¹⁶ Includes statistically significant differences as well as notable observations commented upon in the text.

Table 2: Black Patient Population Percentage Highest 25% vs. Lowest 25%, 2019-2022¹⁷

Factor	Low Black Patient %	High Black Patient %	Variance	Statistical Significance/ P-Value
DEMOGRAPHICS/SOCIAL DRIVERS OF HEALTH				
Percentage of Homeless Patients	0.94%	3.98%	3%	0.1
Social Deprivation Index (SDI)	56.8	73.9	17.10	0.01
Percentage of Patients Served in a Language Other Than English	13.51%	10.45%	(3%)	0.05
Percentage of Patients with Income at or Below 200% of Federal Poverty level	82.85%	90.74%	8%	0.05
PATIENT/PAYER MIX				
Percentage of Medicare Patients	16.58%	9.23%	(7%)	0.05
Percentage of Medicare Collections	18.23%	7.49%	(11%)	0.1
Percentage of Medicaid Patients	40.70%	57.52%	17%	0.000
Percentage of Medicaid Collections	55.76%	77.28%	22%	0.01
Percentage of Uninsured Patients (lower is better)	10.72%	15.26%	5%	N/A
FINANCIAL RESULTS				
Operating Margin	-8.22%	4.84%	13.1%	0.01
Days Cash on Hand	76	103	27	0.05
Days in Net Patient Receivables	35	53	18	0.1
Grant and Contract Revenue Growth Rate	540.48%	5.43%	(535.1%)	0.05
Personnel Expense as a % of Operating Revenues (lower is better)	82.96%	74.09%	(8.9%)	0.01
Total Operating Revenues	\$8 M	\$23 M	\$15 M	0.05
Operating Expense per Patient Visit	\$215.00	\$690.00	\$475	0.05
Operating Revenue per Patient Visit	\$220.92	\$724.81	\$504	0.05
ACCESS TO CARE				
Patient Growth Rate	15.43%	2.70%	(13%)	0.1
Visit Growth Rate	16.49%	5.99%	(11%)	0.01
Dental Visit Growth Rate	-7.27%	687.94%	695%	N/A
Mental Health Visit Growth Rate	66.02%	24.46%	(42%)	0.1
Medical Visits as a % of Total Visits	76.69%	69.07%	(8%)	0.1
Dental Visits as a % of Total Visits	3.86%	5.95%	2%	N/A
Mental Health Visits as a % of Total Visits	15.42%	15.84%	0%	0.05
Percentage of All Visits That Are Handled Virtually	8.96%	11.69%	3%	N/A
QUALITY PERFORMANCE/HEALTH OUTCOMES				
Percentage of Patients with Controlled High Blood Pressure	68.50%	56.85%	(12%)	0.05
Percentage of Children Receiving Appropriate Vaccinations by Age 2	39.97%	24.87%	(15%)	N/A
Percentage of Patients 3-17 with BMI, Nutrition & Physical Activity Documented	58.66%	61.29%	3%	0.001
Percentage of Patients Being Screened for Colorectal Cancer	44.22%	37.52%	(7%)	N/A
Percentage of Patients with Diabetes and Hemoglobin A1c Poor Control (lower is better)	33.97%	35.06%	1%	0.1
Percentage of Patients 12 and over Screened for Depression and Follow-up Plan Documented (if positive)	61.45%	59.36%	(2%)	N/A
Percentage of Patients 18 and over with BMI & Follow Up Documented (If BMI outside normal)	61.85%	57.34%	(5%)	N/A
Percentage of Patients 6-9 at Moderate to High Risk of Caries Receiving Sealant on First Permanent Molar	42.44%	36.91%	(6%)	N/A

¹⁷ Includes statistically significant differences and notable observations commented upon in the text.

Table 3: Hispanic Patient Population Percentage Highest 25% vs. Lowest 25%, 2019-2022¹⁸

Factor	Low Hispanic Patient %	High Hispanic Patient %	Variance	Statistical Significance/
DEMOGRAPHICS/SOCIAL DRIVERS OF HEALTH				
Percentage of Patients Best Served in a Language Other Than English	3.86%	25.02%	21%	0.000
Percentage of Homeless Patients	1.87%	4.25%	2%	N/A
Percentage of Patients with Income at/or below 200% Federal Poverty Level	83.12%	91.14%	8%	0.05
Social Deprivation Index (SDI)	58.9	70.7	11.80	0.1
PATIENT/PAYER MIX				
Percentage of Uninsured Patients (lower is better)	7.08%	24.02%	17%	0.000
Percentage of Uninsured Collections	13.74%	9.17%	(5%)	0.1
Percentage of Medicaid Patients	43.48%	52.63%	9%	0.01
Percentage of Medicaid Collections	50.62%	74.76%	24%	0.000
Percentage of Medicare Patients	20.54%	6.77%	(14%)	0.000
Percentage of Medicare Collections	22.47%	6.44%	(16%)	0.001
FINANCIAL RESULTS				
Operating Margin	(4.71%)	5.40%	10.1%	0.1
Days of Cash on Hand	84	119	35	0.05
Operating Expense per Patient Visit	\$409.17	\$547.64	\$138	0.05
Operating Revenue per Patient Visit	\$418.59	\$575.86	\$157	0.05
Grant and Contract Revenue Growth Rate	510.58%	71.57%	(439.0%)	0.05
Personnel expense as a % of operating revenues (lower is better)	80.82%	75.57%	(5.3%)	0.1
Net Patient Services Revenue as a % of Total Operating Revenue	70.50%	54.38%	(16%)	0.1
Grant Revenue as a % of Total Operating Revenue	23.86%	32.54%	9%	N/A
Total Operating Revenues	\$16 M	\$24 M	\$8 M	0.1
ACCESS TO CARE				
Mental Health Visits as a % of Total Visits	30.33%	8.50%	(22%)	0.01
Medical Visits as a % of Total Visits	61.35%	76.86%	16%	0.1
Dental Visits as a % of Total Visits	3.47%	8.53%	5%	N/A
Mental Health Visits per Patient	4.84	3.62	(1.2)	0.1
Mental Health Visit Growth Rate	88.24%	32.35%	(56%)	0.01
Medical Visit Growth Rate	12.89%	2.73%	(10%)	0.1
Dental Visit Growth Rate	20.42%	-1.62%	(22%)	0.1
Patient Growth Rate	18.86%	2.76%	(16%)	0.1
Visit Growth Rate	23.96%	5.01%	(19%)	N/A
% of all Visits that are handled Virtually	15.69%	6.21%	(9%)	N/A
QUALITY PERFORMANCE/HEALTH OUTCOMES				
Percentage of Patients 3-17 with BMI, nutrition & physical activity documented	48.29%	72.00%	24%	0.05
Percentage of Patients 18 and over with BMI & Follow Up Documented (If BMI outside normal)	55.93%	63.44%	8%	N/A
Percentage of Patients Being Screened for Colorectal Cancer	40.50%	42.74%	2%	0.1
Percentage of Patients 12 and over Screened for Depression and Follow-up Plan Documented if Positive	53.83%	64.73%	11%	N/A
Percentage of Children Receiving Appropriate Vaccinations by Age 2	36.19%	33.5%	(3%)	N/A
Percentage of Patients 6-9 at Moderate to High Risk of Caries Receiving Sealant on First Permanent Molar	39.02%	36.95%	(2%)	N/A
Percentage of Patients with Controlled High Blood Pressure	63.12%	62.66%	0%	N/A
Percentage of Patients with Diabetes and Hemoglobin A1c Poor Control – Hispanic/Latino Patients (lower is better)	33.5%	32.94%	(1%)	0.01
Percentage of Patients with Diabetes and Hemoglobin A1c Poor Control – Non-Hispanic/Latino Patients (lower is better)	35.45%	29.5%	(6%)	0.050

¹⁸ Includes statistically significant differences as well as notable observations commented upon in the text.

Table 4: White Patient Population Percentage Highest 25% vs. Lowest 25%, 2019-2022¹⁹

Factor	Low White Patient %	High White Patient %	Variance	Statistical Significance/ P-Value
DEMOGRAPHICS/SOCIAL DRIVERS OF HEALTH				
Social Deprivation Index (SDI)	76.8	61.1	(15.70)	0.000
Percentage of Homeless Patients	4.54%	0.98%	(4%)	0.1
Percentage of Patients with Income at or Below 200% of Federal Poverty Level	91.13%	82.83%	(8%)	0.05
Percentage of Patients Served in a Language Other Than English	14.17%	5.91%	(8%)	0.01
PATIENT/PAYER MIX				
Percentage of Medicare patients	9.29%	18.87%	10%	0.001
Percentage of Medicare collections	7.81%	19.37%	12%	0.05
Percentage of Medicaid patients	56.47%	42.34%	(14%)	0.01
Percentage of Medicaid collections	76.69%	57.55%	(19%)	0.01
Percentage of Uninsured Patients (lower is better)	16.27%	8.58%	(8%)	0.05
Percentage of Uninsured Collections	4.00%	8.58%	5%	N/A
FINANCIAL RESULTS				
Operating Margin	4.50%	-5.87%	(10.4%)	0.05
Days Cash on Hand	112	100	(12)	0.1
Net Patient Service Revenue per Patient % Change	57.06%	454.79%	397.7%	0.05
Grant/Contract Revenue per Patient	\$689.31	\$188.70	(\$501)	N/A
Personnel Expense as a % of Operating Revenues (lower is better)	74.53%	80.74%	6.2%	0.1
Days in Accounts Payable	244	87	(157)	0.1
Grant and Contract Revenue Growth Rate	1.18%	487.91%	486.7%	0.1
Total Operating Revenues	\$18 M	\$6 M	(\$12 M)	0.01
ACCESS TO CARE				
Patient Growth Rate	2.45%	21.21%	19%	0.1
Visit Growth Rate	5.16%	25.21%	20%	0.1
Medical Visit Growth Rate	6.56%	15.92%	9%	0.1
Dental Visit Growth Rate	801.86%	22.20%	(780%)	0.1
Mental Health Visit Growth Rate	31.64%	84.03%	52%	0.05
Medical Visits as a % of Total Visits	68.69%	77.92%	9%	0.01
Dental Visits as a % of Total Visits	8.16%	4.38%	(4%)	N/A
Mental Health Visits as a % of Total Visits	15.00%	14.29%	(1%)	0.01
QUALITY PERFORMANCE/HEALTH OUTCOMES				
Percentage of Patients with Controlled High Blood Pressure	58.10%	68.53%	10%	0.05
Percentage of Children Receiving Appropriate Vaccinations by Age 2	26.36%	34.01%	8%	N/A
Percentage of Patients 3-17 with BMI, Nutrition & Physical activity documented	64.33%	50.31%	(14%)	0.05
Percentage of Patients Being screened for Colorectal Cancer	42.14%	44.07%	2%	0.05
Percentage of Patients with Diabetes and Hemoglobin A1c Poor Control (lower is better)	32.59%	35.05%	2%	0.01
Percentage of Patients 6-9 at Moderate to High Risk of Caries Receiving Sealant on First Permanent Molar	48.91%	36.03%	(13%)	N/A

¹⁹ Includes statistically significant differences as well as notable observations commented upon in the text.

Table 5: Medicaid Patient Population Percentage Highest 25% vs. Lowest 25%, 2019-2022²⁰

Factor	Low Medicaid Patient %	High Medicaid Patient %	Variance	Statistical Significance/
DEMOGRAPHICS/SOCIAL DRIVERS OF HEALTH				
Percentage of Patients with Income at or Below 200% of Federal Poverty Level	81.79%	93.2%	11%	0.01
Social Deprivation Index (SDI)	57.6	73.8	16.2	0.01
Percentage of Homeless Patients	1.26%	2.84%	2%	0.001
Percentage of Asian Patients	0.59%	2.30%	2%	0.05
Percentage of Black/African American Patients	5.73%	39.89%	34%	0.000
Percentage of White Patients	84.69%	49.62%	(35%)	0.01
Percentage of Other Patients of Color	1.20%	2.35%	1%	0.01
Percentage of Non-White Patients	7.52%	44.54%	37%	0.001
Percentage of Non-Hispanic or Latino/a Patients	8.05%	44.59%	37%	0.000
PATIENT/PAYER MIX				
Percentage of Uninsured Patients (lower is better)	15.02%	10.34%	(5%)	N/A
Percentage of Uninsured Collections	10.47%	3.72%	(7%)	N/A
Percentage of Medicare Patients	18.12%	10.42%	(8%)	0.01
Percentage of Medicare Collections	19.56%	8.85%	(11%)	0.05
Percentage of Private Insurance Patients	31.80%	15.70%	(16%)	0.000
Percentage of Private Insurance Collections	15.47%	10.45%	(5%)	0.05
FINANCIAL RESULTS				
Operating Margin	(9.61%)	4.77%	14.4%	0.01
Days Cash on Hand	91	138	47	N/A
Section 330 Grant per Uninsured Patient	\$851	\$1706	\$855	0.1
Net patient Service Revenue as a Percentage of Total Revenues	57.89%	59.51%	2%	N/A
Grant/contract revenues as a Percentage of Total Revenues	25.72%	30.53%	5%	N/A
Grant/Contract Revenue per Patient	\$245	\$1669	\$1424	N/A
Grant and Contract Revenue Growth Rate	595.9%	15.23%	(580.7%)	0.05
Total Operating Revenues	\$7.1 M	\$23.3 M	\$16.2 M	0.01
Personnel-Related Expense as a % of Operating Revenues (lower is better)	82.08%	75.64%	(6.4%)	0.05
ACCESS TO CARE				
Patient Growth Rate	18.32%	2.51%	(16%)	0.1
Visit Growth Rate	16.80%	7.45%	(9%)	N/A
Total FTEs	62.61	180.3	117.69	0.1
Total Visits	27,674	84,014	56,340	0.1
% of all Visits That are Handled Virtually	7.98%	9.6%	2%	N/A
Total Visits per Patient	3.71	3.84	0.1	N/A
Medical Visits as a % of Total Visits	77.76%	67.28%	(10%)	N/A
Dental Visits as a % of Total Visits	2.9%	8.58%	6%	N/A
Dental Visit Growth Rate	(12.76%)	604.36%	617%	N/A
QUALITY PERFORMANCE/HEALTH OUTCOMES				
Percentage of Patients 12 and Over Screened for Depression and Follow-up Plan Documented if Positive	60.53%	53.23%	(7%)	N/A
Percentage of patients 3-17 with BMI, Nutrition & Physical Activity Documented	49.76%	66.41%	17%	N/A
Percentage of Patients with Diabetes and Hemoglobin A1c Poor Control (lower is better)	33.66%	34.23%	1%	0.05
Percentage of Low and Very Low Birth Weight Babies Delivered During the Year – Hispanic/Latino Patients	2.37%	5.35%	3%	0.05
Percentage of Patients with Controlled High Blood Pressure	68.68%	58.26%	(10%)	0.050

²⁰ Includes statistically significant differences as well as notable observations commented upon in the text.

Table 6: Percentage Based Upon Patients' SDI, 2019-2022²¹

Factor	Low SDI Patient %	High SDI Patient %	Variance	Statistical Significance/
DEMOGRAPHICS/SOCIAL DRIVERS OF HEALTH/PATIENT MIX				
Percentage of Patients with Income at or Below 200% of Federal Poverty Level	85.58%	90.52%	5%	N/A
Percentage of Patients Served in a Language Other Than English	9.72%	13.48%	4%	N/A
Percentage of Black/African American Patients	11.23%	42.62%	31%	0.000
Percentage of White Patients	76.5%	44.04%	(32%)	0.000
Percentage of Non-White Patients	17.64%	47.28%	30%	0.000
Percentage of Non-Hispanic or Latino/a Patients	17.88%	46.85%	29%	0.000
Percentage of Hispanic or Latino/a Patients	12.62%	16.1%	3%	N/A
PATIENT/PAYER MIX				
Percentage of Private Insurance Patients	25.99%	18.31%	(8%)	0.05
Percentage of Private Insurance Collections	16.76%	11.14%	(6%)	0.01
Percentage of Uninsured Patients (lower is better)	14.78%	13.31%	(1%)	N/A
Percentage of Uninsured Collections		4.48%	(3%)	0.05
Percentage of Medicare Patients	13.18%	10.8%	(2%)	N/A
Percentage of Medicare Collections	20.13%	8.91%	(11%)	0.05
Percentage of Medicaid Patients	46.04%	57.59%	12%	0.05
Percentage of Medicaid Collections	55.35%	75.33%	20%	0.01
FINANCIAL RESULTS				
Operating Margin	3.7%	-0.96%	(4.7%)	N/A
Days Cash on Hand	111	106	(5)	N/A
Days in Net Patient Receivables	31	58	27	0.05
Days in Accounts Payable	64	234	170	0.1
Grant and Contract Revenue Growth Rate	432.28%	2.75%	(429.5%)	0.1
Grant/Contract Revenue per Patient	\$3157	\$547	(\$2611)	N/A
Personnel-Related Expense as a % of Operating Revenues	73.40%	77.63%	4.2%	N/A
Net Patient Services Revenue as a % of Total Operating Revenue	56.2%	57.29%	1%	N/A
ACCESS TO CARE				
Patient Growth Rate	128.03%	5.35%	(123%)	0.1
Visit Growth Rate	188.15%	14.55%	(174%)	N/A
Medical Visit Growth Rate	75.56%	14.2%	(61%)	N/A
Dental Visit Growth Rate	3.42%	827.31%	824%	0.1
Mental Health Visit Growth Rate	73.33%	32.6%	(41%)	N/A
Medical Visits as a % of Total Visits	66.33%	72.09%	6%	N/A
Dental Visits as a % of Total Visits	6%	4.63%	(1%)	0.1
Mental Health Visits as a % of Total Visits	22.99%	13.79%	(9%)	N/A
QUALITY PERFORMANCE/HEALTH OUTCOMES				
Percentage of Patients 3-17 with BMI, Nutrition & Physical Activity Documented	51.23%	69.12%	18%	0.1
Percentage of Patients with Controlled High Blood Pressure	58.44%	60.74%	2%	0.05
Percentage of Patients 6-9 at Moderate to High Risk of Caries Receiving Sealant on First Permanent Molar	26.56%	48.24%	22%	N/A
Percentage of Patients with Diabetes and Hemoglobin A1c Poor Control (lower is better)	36.77%	34.20%	(3%)	N/A

²¹ Includes statistically significant differences as well as notable observations commented upon in the text.

Appendix I: Financial Success Methodology

FY2019 through FY2022 financial audits were utilized to determine the financial strength and sustainability of the thirty-four Indiana health centers that had submitted audits for 2022 (i.e., post-COVID-19 pandemic) at the time of the study. Four critical financial ratios that measure financial success and sustainability were calculated, and health centers were sorted into four levels, with approximately 25% of the total in each group.

The highest performing health centers (Level 4) were defined as those that achieved a four-year average operating margin of 3% or higher (criteria #1 below) and met all three of the other criteria listed. In sum, they met four out of four targets listed. Nine health centers were at this level.

The next highest performers (Level 3) were defined as those that achieved a three-year average operating margin of 3% (criteria #1 below) and two of the other three criteria listed. In total, they met three of the four targets listed. Eight health centers were at this level.

Level 2 performers were defined as those that achieved a three-year average operating margin of 3% (criteria #1 below) and one of the other three criteria listed. In total, they met two of the four targets listed. Eight health centers were classified at this level.

Level 1 performers, the weakest ones, were those that achieved either zero or one of the four criteria listed. Eleven health centers were found to be at this level.

FY2019-FY2022 (4 Years) Criteria to Meet this Level

1. Operating Margin (four-year average) (3%)
2. Days of Cash on Hand (four-year average) (60 days)
3. Total Net Assets % change (four-year change) (45%)
4. Total Operating Revenue % change (four-year change) (45%)

The Indiana FQHCs included in the 2019-2022 analysis was the set of 27 FQHCs and 12 Look Alikes that submitted UDS information and financial audits in those years. The associations and any variances were also tested for statistical significance.

Appendix II: Factors Tested for Statistical Significance Financial Sustainability, Access, and Outcomes

In the table below, Capital Link provided *HealthLandscape* (HL) with the average measure for Level 1, 2, 3, and 4 health centers for each factor. HL tested the statistical significance of that factor's influence on the financial performance of each group of centers, providing p-values for any item that was statistically significant to .05 or lower. HL prepared average Social Deprivation Index (SDI) figures by quartile based on the patient service area for each center and provided Capital Link with the same summary of statistically significant items (those with a p-value of .05 or below). The following is a sample listing of some of the 100+ measures analyzed and the data sources.

#	FACTOR	SOURCE
1	Net Patient Service Revenue per Patient % Change	Audited Financial Statements FY2019-FY2022
2	Total Expenses % Change	Audited Financial Statements FY2019-FY2022
3	Days in Accounts Payable	Audited Financial Statements FY2019-FY2022
4	Grant and Contract Revenue Growth Rate	Audited Financial Statements FY2019-FY2022
5	Operating Margin	Audited Financial Statements FY2019-FY2022
6	Days Cash on Hand	Audited Financial Statements FY2019-FY2022
7	Days in Net Patient Receivables	Audited Financial Statements FY2019-FY2022
8	Personnel-Related Expense as a % of Operating Revenues	Audited Financial Statements FY2019-FY2022
9	Administrative, Facilities, and Patient Support FTEs as % of Total FTEs (lower is better)	Audited Financial Statements FY2019-FY2022 HRSA UDS 2019-2022
10	Operating Expense per Patient Visit	Audited Financial Statements FY2019-FY2022 HRSA UDS 2019-2022
11	Operating Revenue per Patient Visit	Audited Financial Statements FY2019-FY2022 HRSA UDS 2019-2022
12	Patient Growth Rate	HRSA UDS 2019-2022
13	Visit Growth Rate	HRSA UDS 2019-2022
14	% of Children Receiving Appropriate Vaccinations by Age 2	HRSA UDS 2019-2022
15	% of Patients 12 and over Screened for Depression and Follow-up Plan Documented (if positive)	HRSA UDS 2019-2022
16	% of Patients 18 and over with BMI & Follow Up Documented (If BMI outside normal)	HRSA UDS 2019-2022
17	% of Patients 3-17 with BMI, Nutrition & Physical Activity Documented	HRSA UDS 2019-2022
18	% of Patients 6-9 at Moderate to High Risk of Caries Receiving Sealant on First Permanent Molar	HRSA UDS 2019-2022
19	% of Patients Screened for Colorectal Cancer	HRSA UDS 2019-2022
20	% of Patients with Controlled High Blood Pressure	HRSA UDS 2019-2022
21	% of Patients with Diabetes and Hemoglobin A1c Poor Control (lower is better)	HRSA UDS 2019-2022
22	Medicaid Collections as % of Total Collections	HRSA UDS 2019-2022
23	Medicare Collections as % of Total Collections	HRSA UDS 2019-2022
24	Private Insurance Collections as % of Total Collections	HRSA UDS 2019-2022
25	Self-Pay Collections as % of Total Collections	HRSA UDS 2019-2022
26	330 Grant per Uninsured Patient	HRSA UDS 2019-2022

27	Medical Visit Growth Rate	HRSA UDS 2019-2022
28	Dental Visit Growth Rate	HRSA UDS 2019-2022
29	Mental Health Visit Growth Rate	HRSA UDS 2019-2022
30	% of Low and Very Low Birth Weight Babies Delivered During the Year – Hispanic/Latino Patients	HRSA UDS 2019-2022
31	% of Patients with Controlled High Blood Pressure – Hispanic/Latino Patients	HRSA UDS 2019-2022
32	% of Patients with Controlled High Blood Pressure – Non-Hispanic/Latino Patients	HRSA UDS 2019-2022
33	% of Patients with Diabetes and Hemoglobin A1c Poor Control – Hispanic/Latino Patients	HRSA UDS 2019-2022
34	% of Patients with Diabetes and Hemoglobin A1c Poor Control – Non-Hispanic/Latino Patients	HRSA UDS 2019-2022
35	% of Low and Very Low Birth Weight Babies Delivered During the Year – Asian Patient	HRSA UDS 2019-2022
36	% of Low and Very Low Birth Weight Babies Delivered During the Year – Black/African American Patients	HRSA UDS 2019-2022
37	% of Low and Very Low Birth Weight Babies Delivered During the Year – Other Patients of Color	HRSA UDS 2019-2022
38	% of Patients with Controlled High Blood Pressure – Asian Patients	HRSA UDS 2019-2022
39	% of Patients with Controlled High Blood Pressure – Black/African American Patients	HRSA UDS 2019-2022
40	% of Patients with Controlled High Blood Pressure – White Patients	HRSA UDS 2019-2022
41	% of Patients with Controlled High Blood Pressure – Other Patients of Color	HRSA UDS 2019-2022
42	% of Patients with Diabetes and Hemoglobin A1c Poor Control – Asian Patients	HRSA UDS 2019-2022
43	% of Patients with Diabetes and Hemoglobin A1c Poor Control – Black/African American Patients	HRSA UDS 2019-2022
44	% of Patients with Diabetes and Hemoglobin A1c Poor Control – White Patients	HRSA UDS 2019-2022
45	% of Patients with Diabetes and Hemoglobin A1c Poor Control – Other Patients of Color	HRSA UDS 2019-2022
46	Virtual Visits	HRSA UDS 2019-2022
47	Total Visits	HRSA UDS 2019-2022
48	% of all Visits that are handled Virtually	HRSA UDS 2019-2022
49	Grant/Contract revenue per patient	Audited Financial Statements FY2019-FY2022 HRSA UDS 2019-2022
50	Percentage of Patients with Income at or Below 200% of Federal Poverty Level	HRSA UDS 2019-2022
51	% of Asian Patients	HRSA UDS 2019-2022
52	% of Black/African American Patients	HRSA UDS 2019-2022
53	% of White Patients	HRSA UDS 2019-2022
54	% of Other Patients of Color	HRSA UDS 2019-2022
55	% of Non-White Patients	HRSA UDS 2019-2022
56	% of Hispanic or Latino/a Patients	HRSA UDS 2019-2022

57	% of Non-Hispanic or Latino/a Patients	HRSA UDS 2019-2022
58	% of Homeless Patients	HRSA UDS 2019-2022
59	% of Patients best served in a Language other than English	HRSA UDS 2019-2022
60	% of Uninsured Patients (lower is better)	HRSA UDS 2019-2022
61	% of Medicaid Patients	HRSA UDS 2019-2022
62	% of Medicare Patients	HRSA UDS 2019-2022
63	% of Private Insurance Patients	HRSA UDS 2019-2022
64	Grant Revenue as a % of Total Operating Revenue	HRSA UDS 2019-2022
65	Net Patient Services Revenue as a % of Total Operating Revenue	HRSA UDS 2019-2022
66	Medical Visits as a % of Total Visits	HRSA UDS 2019-2022
67	Dental Visits as a % of Total Visits	HRSA UDS 2019-2022
68	Mental Health Visits as a % of Total Visits	HRSA UDS 2019-2022
69	Total Operating Revenues	HRSA UDS 2019-2022
70	Total FTEs	HRSA UDS 2019-2022
71	Total Patients	HRSA UDS 2019-2022
72	Total Visits per Patient	HRSA UDS 2019-2022
73	Mental Health Visits per Patient	HRSA UDS 2019-2022
74	Dental Visits per Patient	HRSA UDS 2019-2022
75	Mental Health Visits per Patient	HRSA UDS 2019-2022
76	Social Deprivation Index (SDI)	<i>HealthLandscape</i> (based on zip code)

Appendix III: Patient Populations and Factors Analyzed

Section 1

Included an analysis of the High vs. Low financially performing health centers, including all patient populations (top 25% vs. bottom 25% of financial strength).

Factors Reviewed for Significant Difference

- Patient Demographics, Including Race and Ethnicity
- Social Drivers of Health
- Patient and Payer Mix
- Revenue Sources and Composition
- Access to Care/Service Mix
- Health Outcomes – All Patients
- Health Outcomes – By Race and Ethnicity

Section 2

Included an analysis of the 25% of health centers with the largest amount of a specific patient population vs. the 25% of health centers with the lowest amount of a specific patient population on six characteristics.

Patient Populations Reviewed

- Asian Patients
- Black/African American Patients
- Hispanic/Latino Patients
- White Patients
- Patients with Medicaid Insurance
- Patients from areas of High SDI

Factors Reviewed for Significant Significance Differences

- Patient Demographics Excluding Race and Ethnicity
- Social Drivers of Health
- Patient and Payer Mix
- Financial Performance
- Revenue Sources and Composition
- Access to Care/Service Mix
- Health Outcomes – All Patients
- Health Outcomes – By Race and Ethnicity

In all cases, the average score of the health centers in the highest quartile was compared to the average score of the health centers in the lowest quartile to determine statistically significant differences.

Appendix IV: Statistical Methodologies Utilized

HealthLandscape performed an analysis of the geospatial distribution and geospatial relationships between community needs, community demographics, health center characteristics, and health center financial measures and outcomes. To study community needs, *HealthLandscape* created a service area measure of social deprivation using the social deprivation index (SDI).

The SDI is a composite measure of area-level deprivation based on seven demographic characteristics collected in the American Community Survey (2019-2022). These characteristics consist of the percentage:

- Of the population living in poverty
- Of the population with less than 12 years of education
- Of the population consisting of single-parent households
- Of the population living in rented housing units
- Of the population living in overcrowded housing units
- Of households without a car
- Of non-employed adults under 65 years of age

An SDI score was given for each health center based on their patient origin (patient-reported ZIP Code) for its core service area, which is made up of the zip codes from which 75% of the health center's patients reside.

HealthLandscape utilized a variety of approaches to explore various relationships, including outlier mapping and spatial autocorrelation (Global Moran's I) tests, which measure whether the observed value of a variable at one locality is independent of the variable values of neighboring localities.²² Given the small sample and lack of clear geographic patterns, two different approaches (ANOVA, Chi-Square) were ultimately used to perform statistical tests of significance. Analysis of Variance (ANOVA) is a difference of means test that explores the null hypothesis that a set (2 or more) of populations' means are equal. *HealthLandscape* stratified measures by quartile and used ANOVAs to test if the means of explanatory variables were equal across the quartiles.

More specifically, ANOVAs compare the variation within each of the quartiles to the variation between quartile means—if the variation between the quartile means is much greater than the variation within each of the quartiles, then it is more likely that the null hypothesis of equal means is rejected and that there is a statistically significant difference between the quartiles. Any p-values less than .05 were considered significant.

HealthLandscape also used two-way crosstabs and conducted Chi-square tests to explore statistical significance. Two-way crosstabs (also known as contingency tables) provide information about the relationship between two categorical variables. Chi-square tests are non-parametric tests used to test differences in observed values compared to expected values when looking at categorical variables. Multiple outcome variables were converted to categorical based on quartiles (lowest quartile as Low, highest quartile as High, and interquartile range as Medium) and compared to explanatory variables.

²² Spatial Autocorrelation and Moran's I in GIS. ([Source](#))

Appendix V: Major Federal Program Funding to Health Centers for COVID Relief During 2020 and 2021

- Through COVID-19 Supplemental Appropriations (passed into law on March 4, 2020), HRSA made “H8C” grants totaling \$100 million to Section 330--funded health centers nationally. The grants were made via a formula to cover the costs of responding to COVID-19 and for maintaining or increasing grantee capacity. Awards were made on or around March 27, 2020, to cover costs incurred within one year of the award unless otherwise extended.
- Through the CARES Act (passed into law on March 27, 2020) HRSA made “H8D” grants totaling \$1.32 billion to Section 330–funded health centers nationally. The grants were made via a formula to cover the costs of responding to COVID-19 and for maintaining or increasing grantee capacity. Awards were made on or around April 7 and 8, 2020, to cover costs incurred within one year of the award unless otherwise extended.
- Through the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA) passed into law on April 24, 2020, HRSA made “H8E” grants totaling \$600 million to Section 330–funded health centers and Look-Alikes nationally. The grants were made via a formula to cover costs to purchase, administer, and expand capacity for testing to monitor and suppress COVID-19. Awards were made on or around May 7, 2020, to cover costs incurred within one year of the award unless otherwise extended.
- The Provider Relief Fund, administered by Health and Human Services, was originally funded in the CARES Act (\$100 billion). It was expanded in PPPHCEA (\$75 billion), and further expanded by the Consolidated Appropriations Act, 2021 (\$3 billion). Beginning in April 2020, it reimburses eligible healthcare providers for healthcare-related expenses or lost revenues that are attributable to coronavirus through July 31, 2021. Through December 2020, health centers had received several rounds of “General Distributions” totaling approximately \$401 million, equal to 2% of 2018 net patient revenue.
- A portion of the PRF was distributed to certain providers in rural areas, including FQHCs, beginning in May 2020. Funds were distributed to eligible sites, totaling approximately \$103,253 per site. Capital Link estimates that rural FQHCs received approximately \$322 million in total.
- Funded through the CARES Act (\$200 million nationally), the FCC made awards to FQHCs and others between April and July 2020 for devices and services related to telehealth. Capital Link estimates that FQHCs received approximately \$74 million in total.
- Administered by the Small Business Administration, Paycheck Protection Program Loans were made available to businesses with fewer than 500 employees beginning in April 2020 through the CARES Act (many large FQHCs were not eligible). The program was extended and expanded through the PPPHCEA. The loans, which are forgivable if borrowers meet certain criteria, were meant to incentivize small businesses (including nonprofits) to retain staff on their payrolls. According to a study by Capital Link, FQHCs received approximately \$2.3 billion from this source. During the 2020 period, it is unlikely that any of these loans were forgiven. As a result, while they would not be included in grant funding during this year, these funds would have augmented the cash balances of centers.
- Through the Americas Rescue Plan Act (ARPA), which was passed into law on March 21, 2021, HRSA made “H8F” grants totaling \$6 billion to Section 330–funded health centers nationally. The grants were made via a formula to support and expand COVID-19 vaccination, testing, and treatment for vulnerable populations; deliver needed preventive and primary healthcare services to those at higher risk for COVID-19; and expand health centers' operational capacity during the pandemic and beyond, including modifying and improving physical infrastructure and adding mobile units.
- Through the Americas Rescue Plan Act (ARPA) passed into law on March 21, 2011, HRSA made “H8F” grants totaling \$144 million to health center program Look Alikes nationally. The grants were made via a formula to respond to and mitigate the spread of COVID-19 and enhance healthcare services and infrastructure in communities across the country.

Appendix VI: Limitations - COVID-19 Testing by Race and Ethnicity

Capital Link investigated the possibility of reviewing COVID-19 testing accessibility and positive cases by race and ethnicity to further understand disparities in those areas. Data was derived from the HRSA Health Center COVID-19 Survey (<https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data>) but was insufficient to evaluate any statistically significant variances between different patient populations by health center, race, and ethnicity for purposes of this study.

ADDITIONAL RESOURCES

5 Building Blocks to Help Achieve Greater Health Equity

<https://www.brookings.edu/articles/5-building-blocks-to-help-achieve-greater-health-equity/>

Addressing Health and Health-Care Disparities: The Role of a Diverse Workforce and the Social Determinants of Health

<https://pubmed.ncbi.nlm.nih.gov/24385666/>

Cultural Barriers to Mental Health Treatment Among Hispanics/Latino(a)s

<https://vecinos.org/cultural-barriers-to-mental-health-treatment-among-hispanics/>

Discrimination, High Blood Pressure, and Health Disparities in African Americans

<https://www.health.harvard.edu/blog/discrimination-high-blood-pressure-and-health-disparities-in-african-americans-2020092120943>

Disparities in Health and Health Care: 5 Key Questions and Answers

<https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/>

Health Coverage by Race and Ethnicity, 2010-2022

<https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/>

How Poor Communication Exacerbates Health Inequities – and What To Do About It

<https://www.brookings.edu/research/how-poor-communication-exacerbates-health-inequities-and-what-to-do-about-it/>

Latinx/Hispanic Communities and Mental Health

<https://www.mhanational.org/issues/latinxhispanic-communities-and-mental-health>

Oral Health Disparities and Inequities in Asian Americans and Pacific Islanders

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5497891/>

Uninsured Rates Decreased in Over Half of U.S. States in 2022

<https://www.census.gov/library/stories/2023/09/health-insurance-coverage.html>

ACKNOWLEDGEMENTS

The authors thank the **Indiana Primary Health Care Association** for their generous support of this study.

ABOUT CAPITAL LINK, AUTHOR

Capital Link is a national, non-profit organization that has worked with hundreds of community health centers and primary care associations for nearly 30 years to plan for sustainability and growth, access capital, improve and optimize operations and financial management, and articulate value. Established through the health center movement, Capital Link is dedicated to strengthening health centers—financially and operationally—in a rapidly changing marketplace. For more information, visit us at www.caplink.org.

ABOUT HEALTHLANDSCAPE, STATISTICAL AND GEOSPATIAL ANALYSIS

The *HealthLandscape* team has extensive experience in research design and methodology, applying geospatial and statistical techniques to help answer questions about disparities in health outcomes. For more information, visit www.healthlandscape.org.

ABOUT INDIANA PRIMARY HEALTH CARE ASSOCIATION, FUNDER

Since 1982, The Indiana Primary Health Care Association, Inc. (IPHCA), has advocated for quality health care for all persons residing in Indiana. IPHCA supports the development of community-oriented primary care initiatives, including Community Health Centers (CHCs). To learn more, visit www.indianapca.org.

This resource is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$236,753.00 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.