NATIONAL ASSOCIATION OF Community Health Centers®

Emerging Health Center Research

NACHC Policy & Issues Forum

March 10, 2023

Agenda

Susan Petrie, MBA

- COO/CFO, Capital Link

Louise McCarthy, MPP

- President & CEO, Community Clinic Association of LA County

Jen Saber, MBA, DrBA

- Director of Data & Information Systems, Capital Link

Michael Curry, Esq.

- President & CEO, Massachusetts League of Community Health Centers

Factors Influencing Health Equity Among Community Health Center Patients

A Data-Driven Analysis

March 10, 2023

Susan Petrie

Chief Financial & Operating Officer

Jen Saber

Senior Director of Data & Information Systems

About Capital Link

Our Vision: Stronger health centers, actively building healthy communities.

Our Mission: Capital Link works to strengthen community health centers—financially and operationally—in a rapidly changing marketplace.

WE HELP HEALTH CENTERS:

- Plan for sustainability and growth
- Access capital
- Improve and optimize health center operations and financial management
- Articulate value

Nearly **30 years** of experience

Worked with **50+** PCAs/HCCNs and regional consortia

ASSISTED **2/3rds** OF HEALTH CENTERS NATIONALLY

LEVERAGED **$1.4 billion**

FOR **244+** HEALTH CENTER PROJECTS

TOTALING OVER **$2 billion**

WHAT IS HEALTH EQUITY?

"Health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment." [1]

[1] *https://www.cdc.gov/chronicdisease/healthequity/index.htm*

Cedars-Sinai-Supported Study

QUESTION:

Are health centers that serve a higher proportion of minority patients and/or those with higher social deprivation weaker financially or do they exhibit other characteristics that may consistently limit their ability to achieve equitable health access and outcomes for patients of all backgrounds?

If so, what can we do to close the gap?

Detailed Data Analysis of 100 Factors

Who: 58 FQHC members of CCALAC (Community Clinic Association of L.A. County)

When: 2017 – 2020

Factors: Racial/Ethnic Patient Composition, Social Deprivation Index (SDI), Insurance Mix, Service Offerings, Growth Rates, # of Visits

Data Sources: UDS data, Financial audits, SDI

Reviewed Impact on:

- Financial sustainability
- Access to healthcare
- Quality outcomes
- Ability to respond to COVID-19 health emergency

Health Equity Measures for Study

Clinical Outcomes:

8 uniform data system (UDS) quality measures, tracked by CHCs for HRSA

Access to Healthcare:

Number of annual visits per patient, patient and visit growth rates, and depth of services offered

LA County Findings

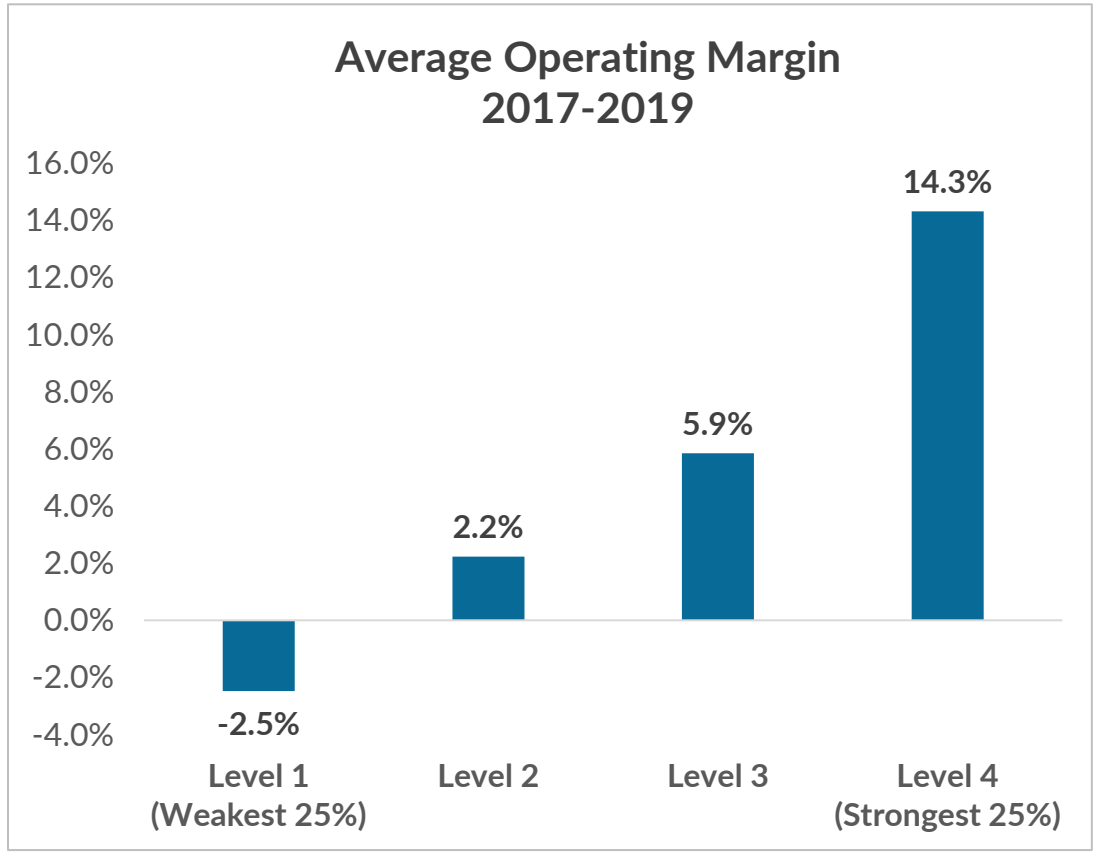
CHCs with specific patient population characteristics consistently scored strongest on financial measures including available cash, operating margin, and revenue growth.

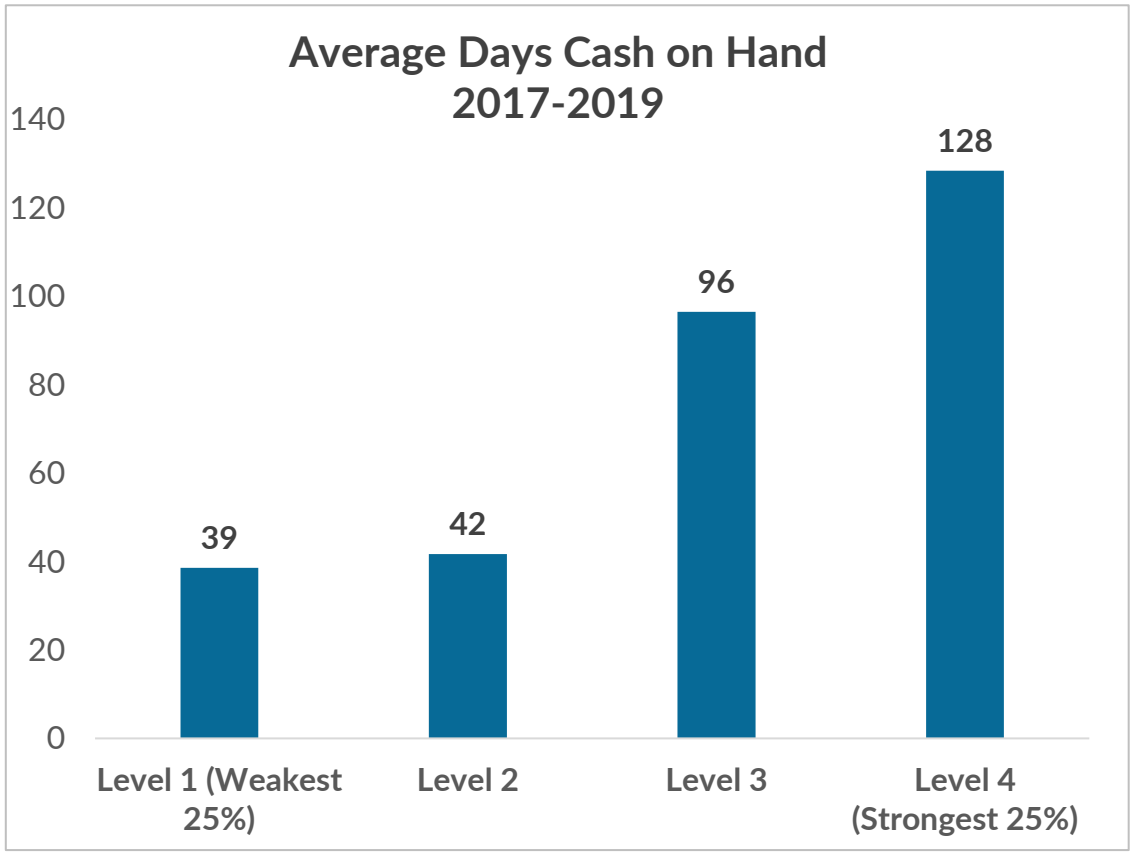
Those CHCs also earned statistically higher clinical outcome scores than their peers in several areas.

Access to care did not generally differ based on patient mix, but health centers that were financially stronger to begin with offered better access during the COVID-19 health emergency.

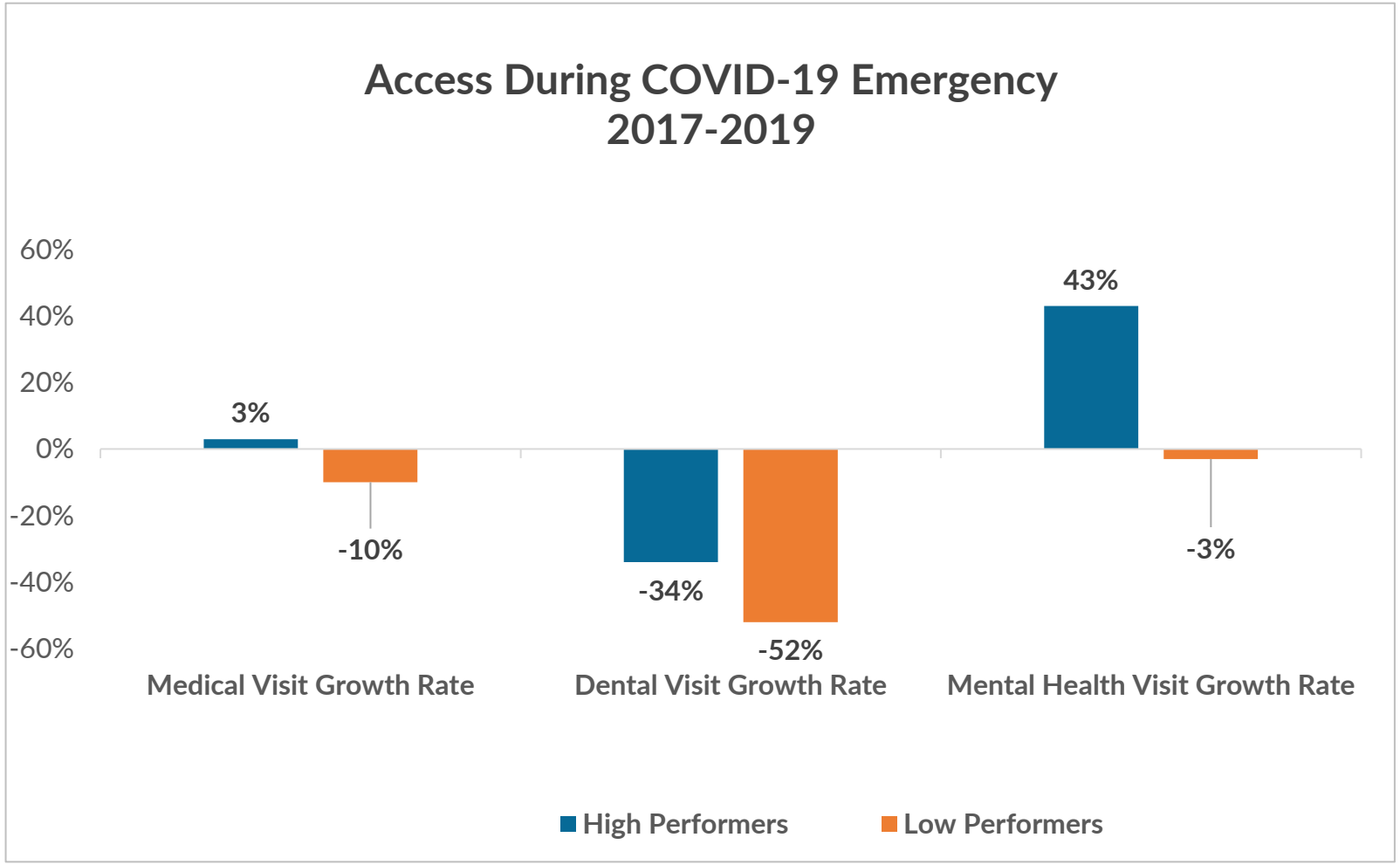
Success often stemmed from operational nimbleness and the ability to pivot to telehealth more quickly than financially weaker peers.

Top Financial Performers vs. Weakest





Top Financial Performers vs. Weakest



Note: Difference was notable but not statistically significant

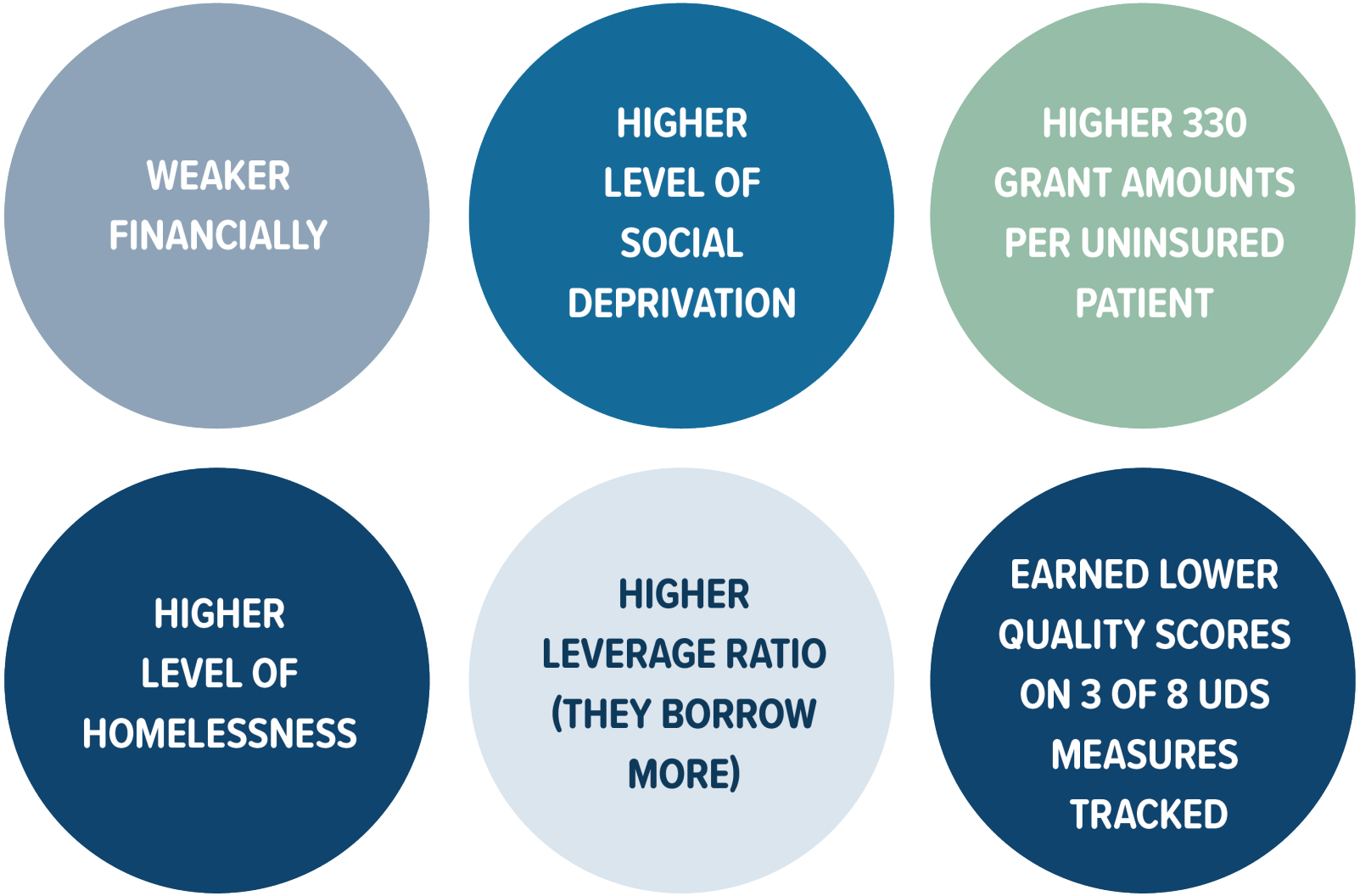
Characteristics of LA County CHCs with the Strongest Financial Performance

LA County Findings

Centers with the highest proportion of minority patients—particularly Black and Hispanic patients—**were, on average, financially weaker than their peers.**

Improving long-term financial and operational success for all centers is essential since the analysis also confirmed a connection between stronger financial performance and better clinical outcomes.

Characteristics of LA County CHCs with Highest Percentage of Black Patients



Characteristics of LA County CHCs with Highest Percentage of Hispanic Patients

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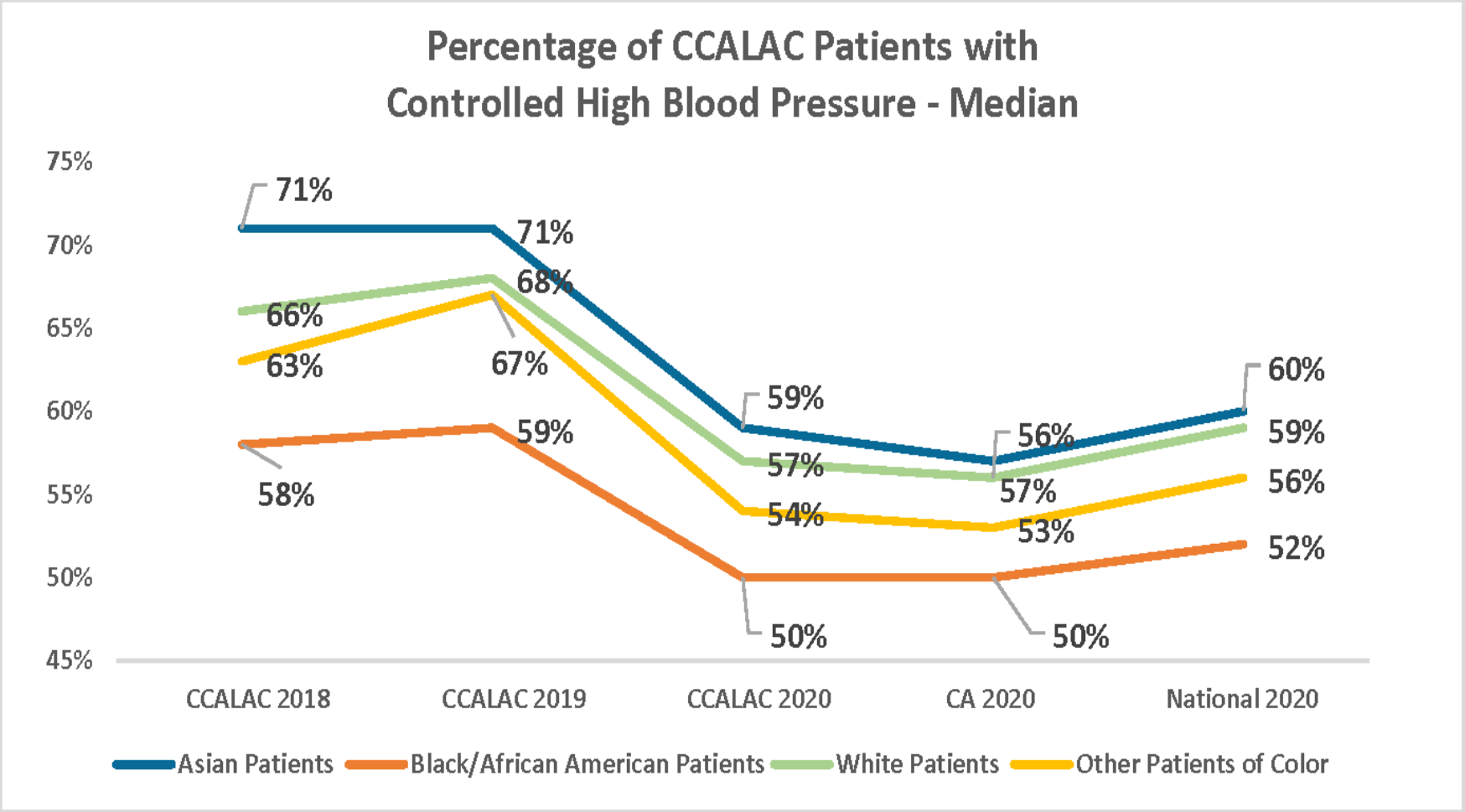
- WEAKER FINANCIALLY
- HIGHER POVERTY RATE AND SOCIAL DEPRIVATION
- FEWER 330 GRANT DOLLARS PER UNINSURED PATIENT
- MENTAL HEALTH VISITS SMALLER SHARE OF TOTAL VISITS
- PATIENT MIX HAD MORE UNINSURED AND FEWER MEDICARE & PRIVATELY INSURED PATIENTS
- SCORED LOWER ON 3 OF THE 8 UDS MEASURES TRACKED & HIGHER ON 1

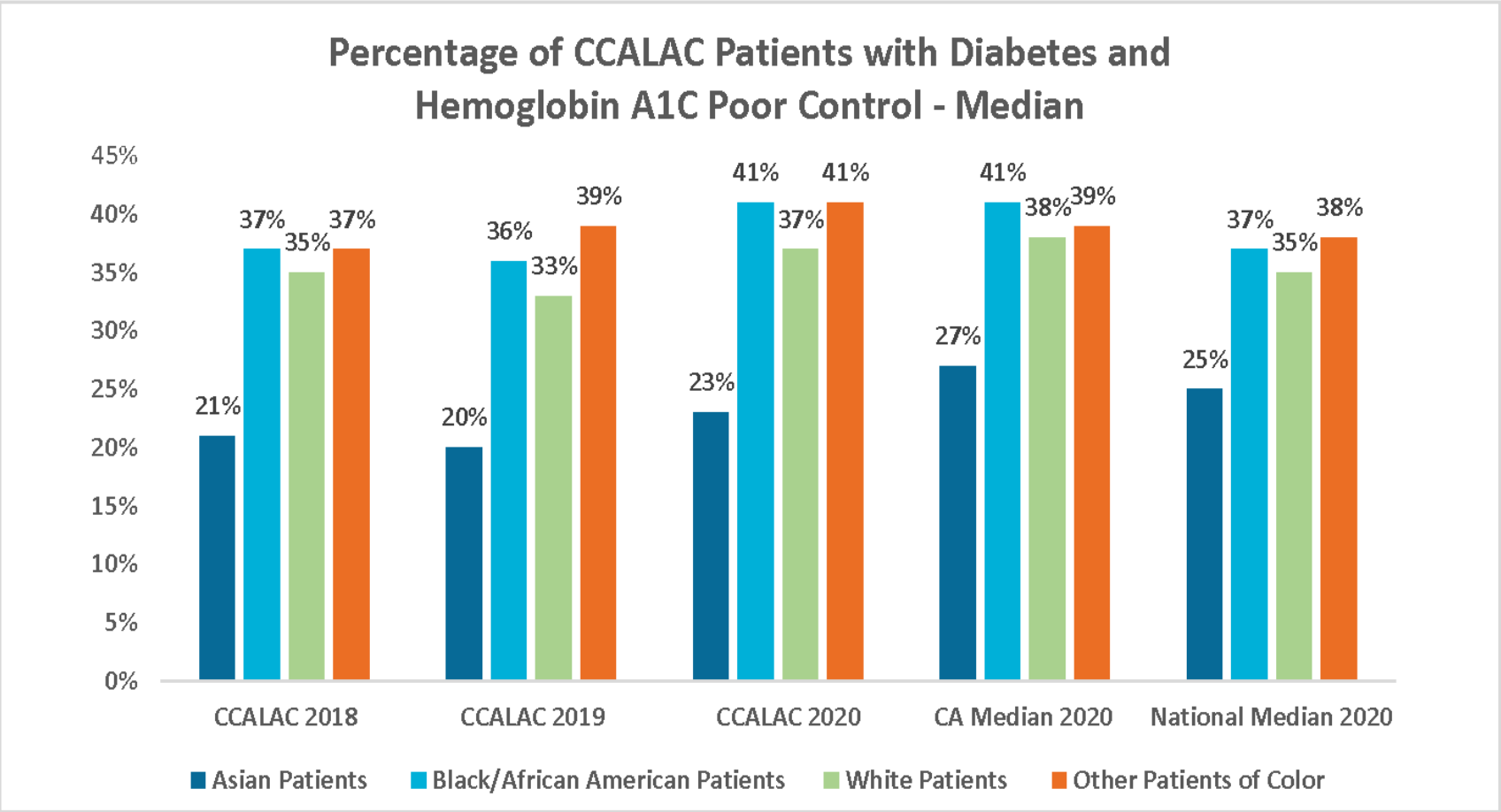
LA County Clinical Outcomes Varied by Race and Ethnicity

CCALAC Patients with Controlled High Blood Pressure – By Race



Other Patients of Color includes patients labeled as Native Hawaiian, Other Pacific Islander, American Indian/Alaskan Native, and More than one race in the UDS.

CCALAC Patients with Diabetes and Hemoglobin A1C Poor Control – By Race



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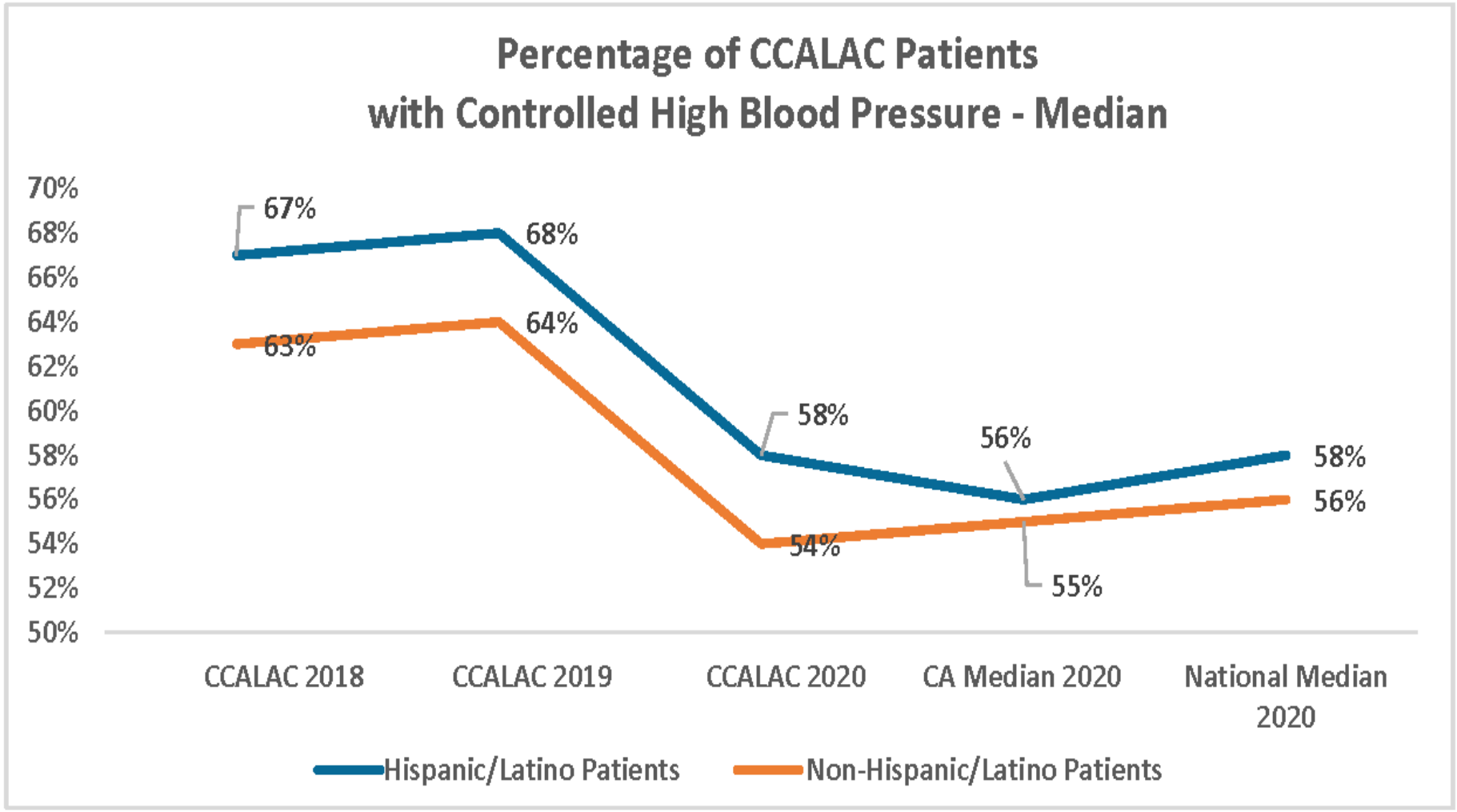
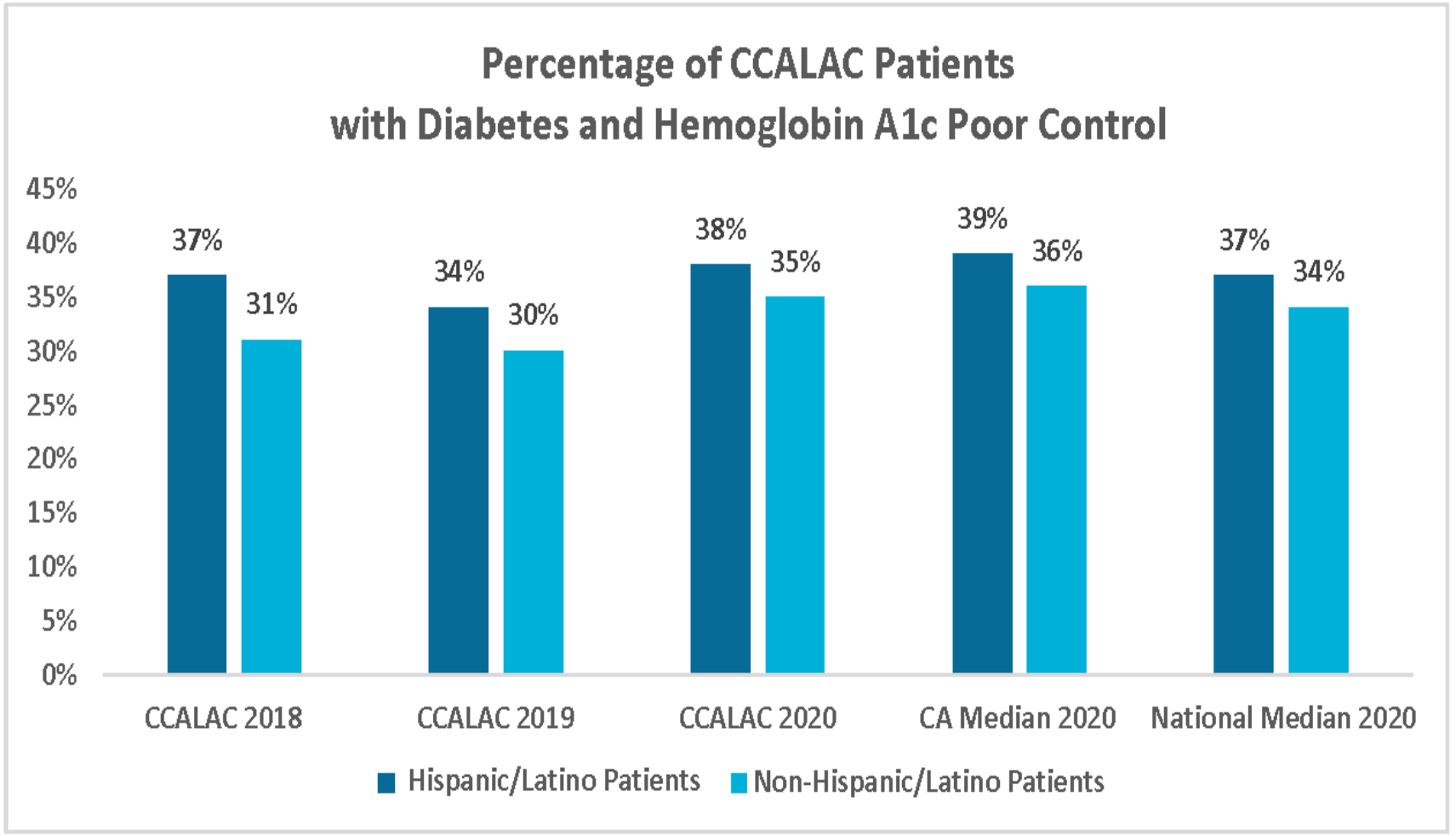
CCALAC Patients with Controlled High Blood Pressure – By Ethnicity



CCALAC Patients with Diabetes and Hemoglobin A1C Poor Control – By Ethnicity



Note that a higher number on this metric represents a weaker performance.

LA County Access to Care Varied by Race/Ethnicity/Insurance During COVID-19

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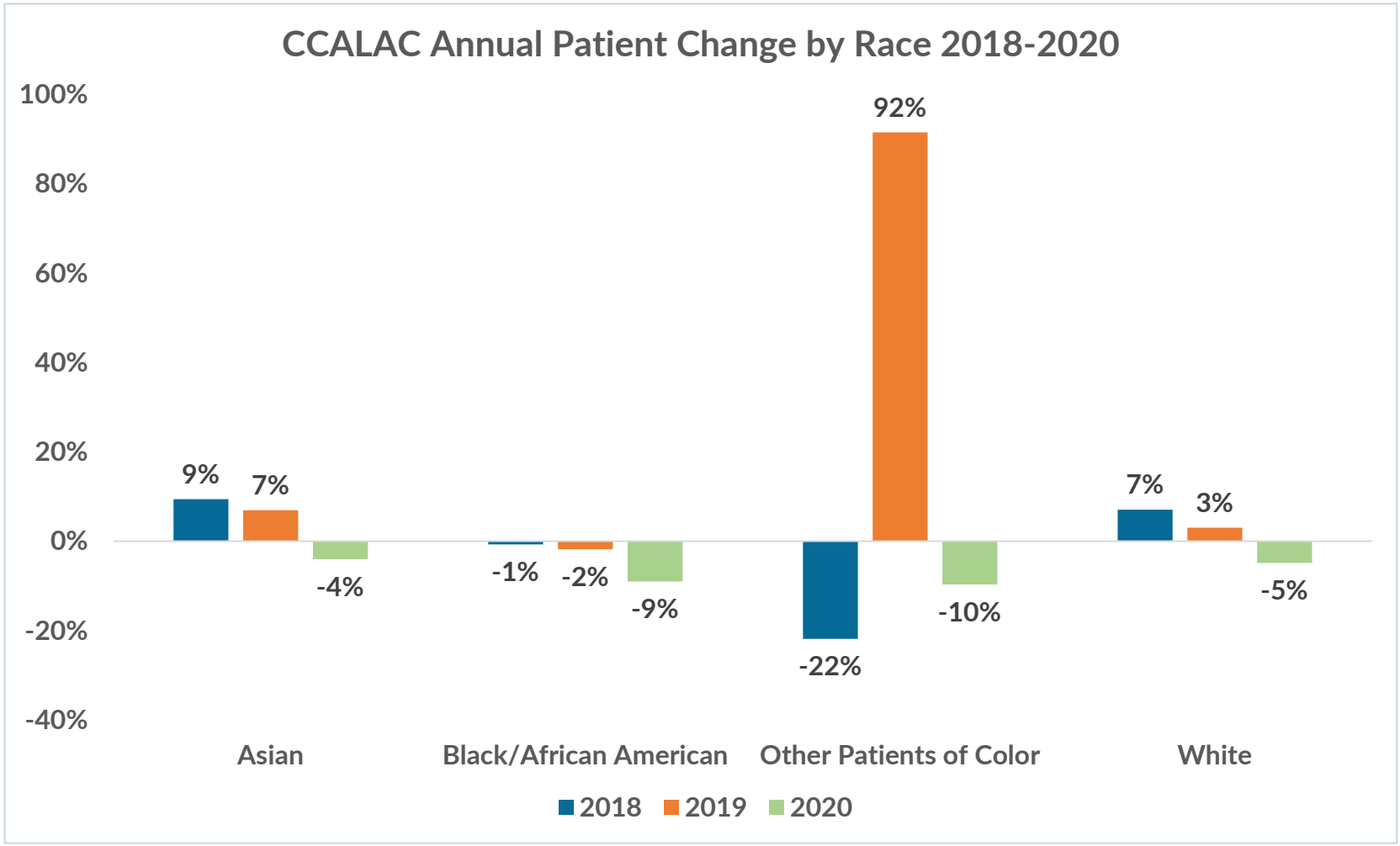
Healthcare Access by Race



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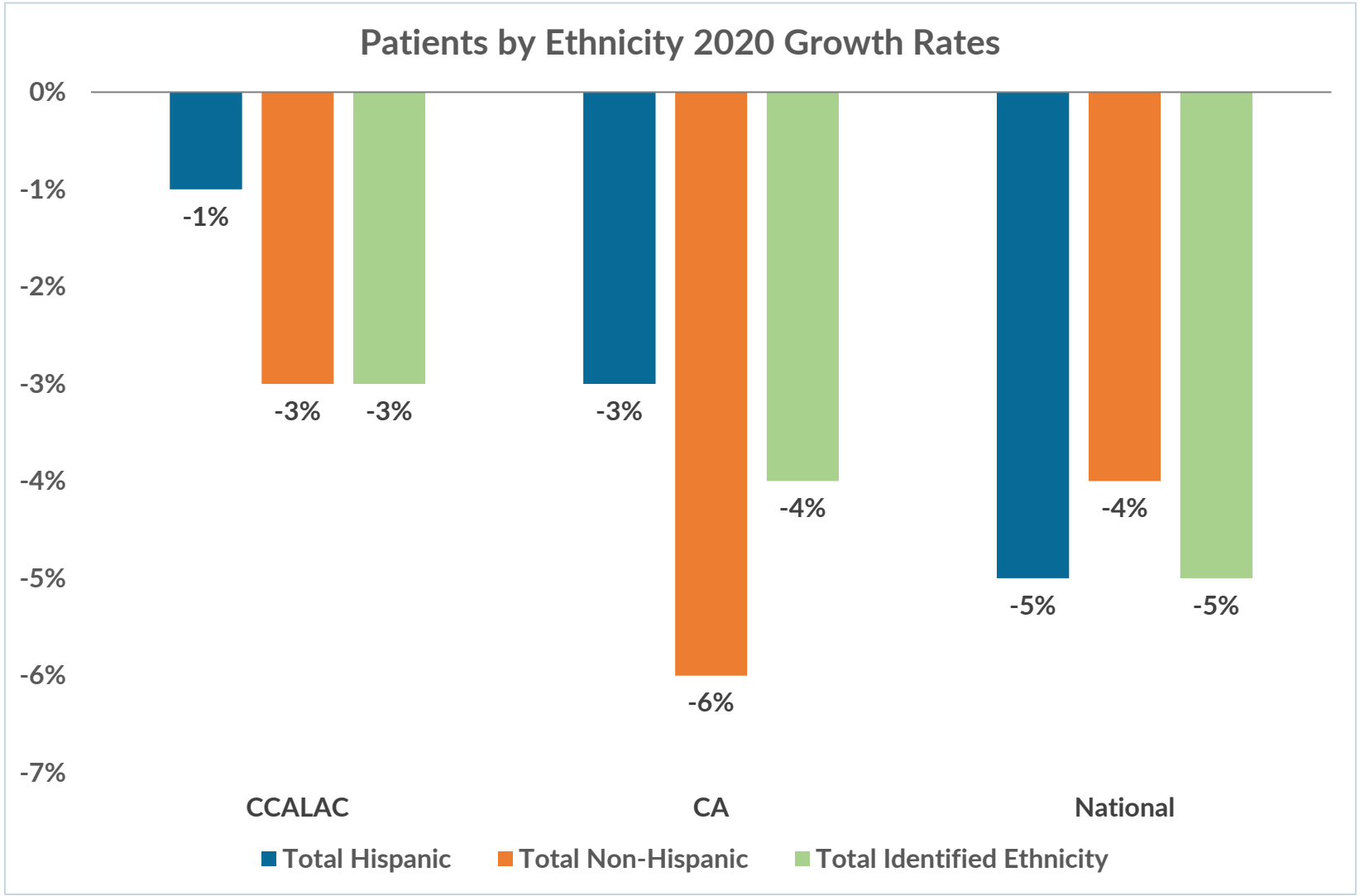
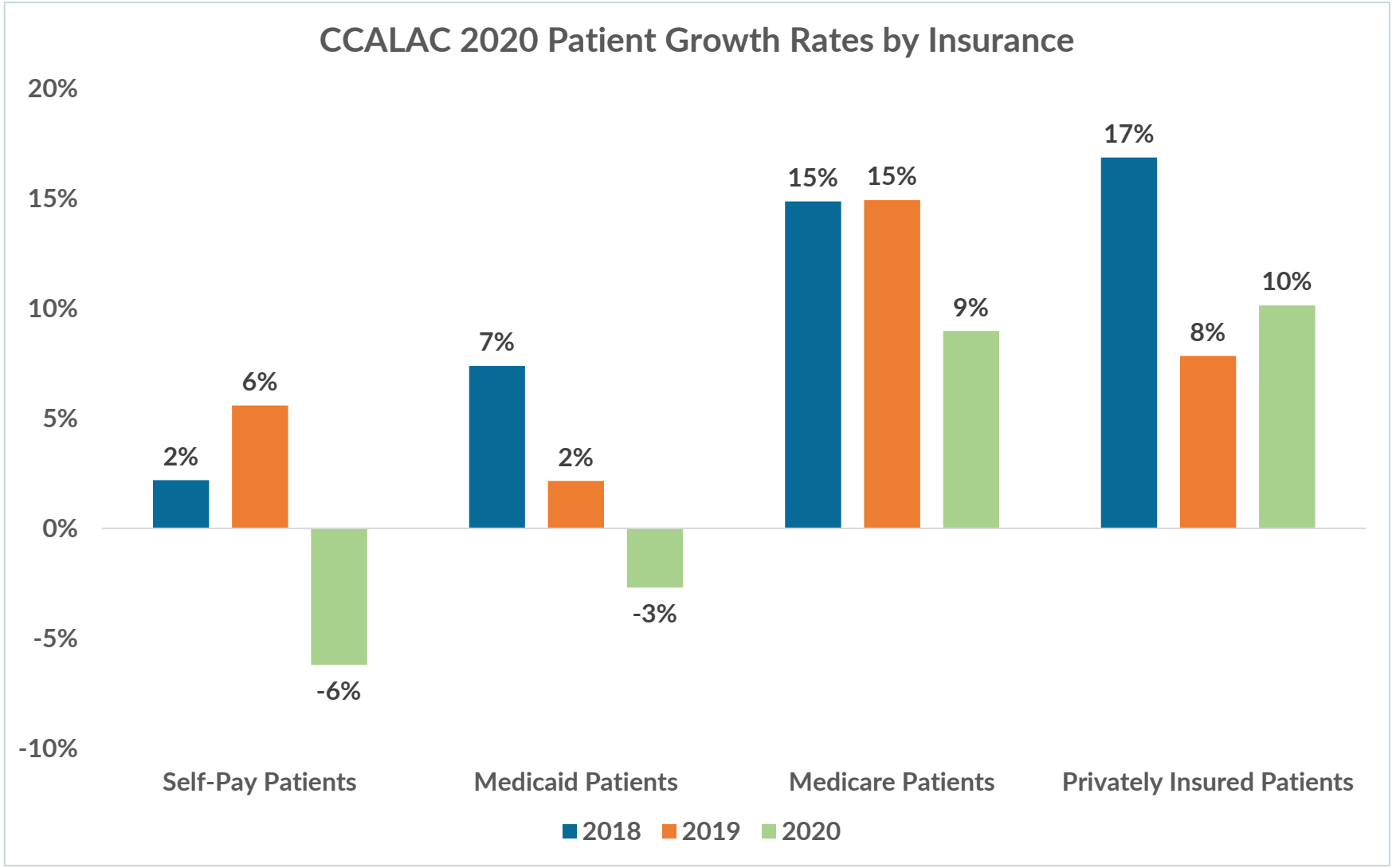
Healthcare Access by Ethnicity



Healthcare Access by Payer



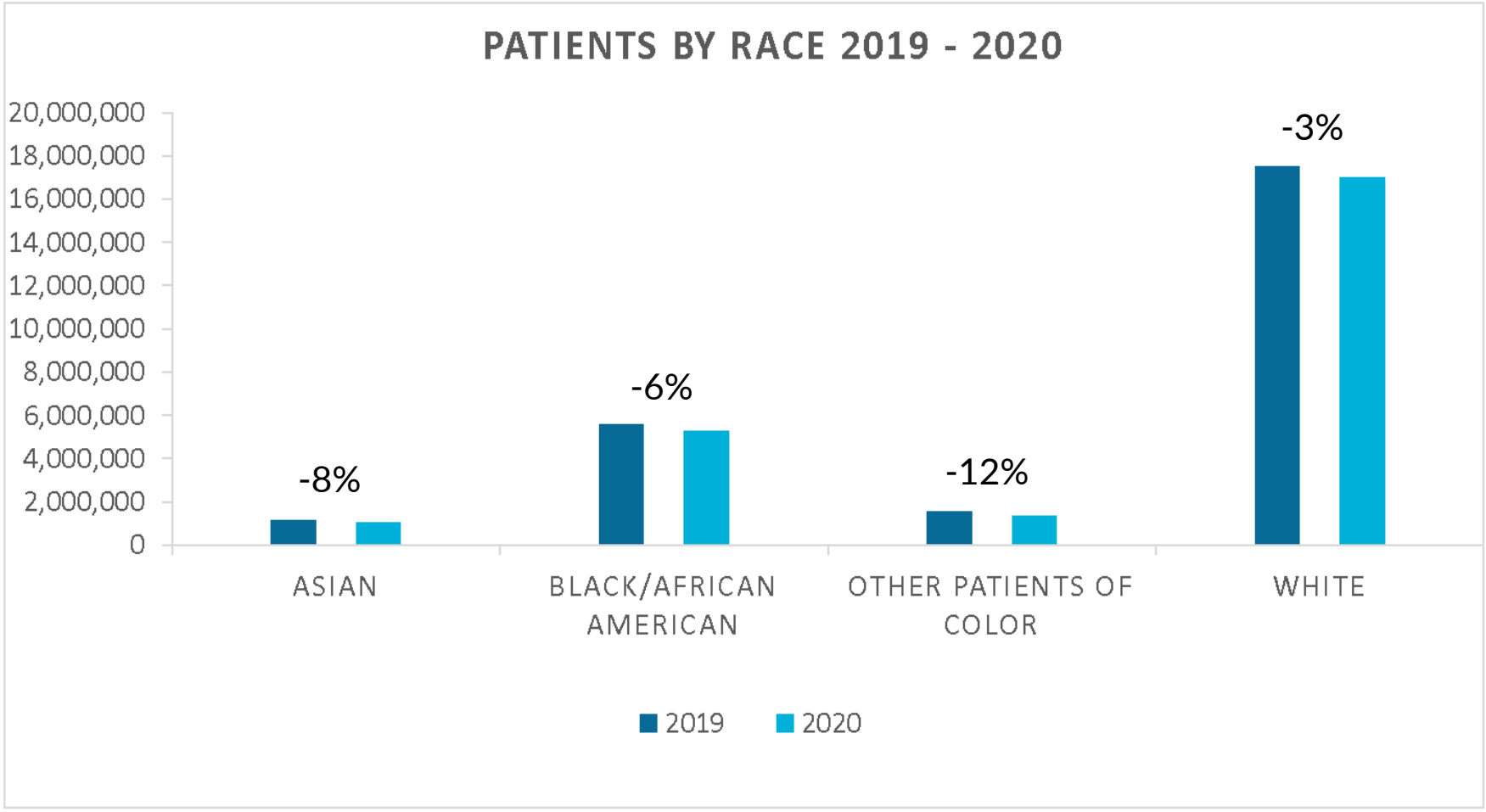
National Healthcare Access at CHCs by Race, Ethnicity, and Insurer

Barriers to care continue to disproportionally affect the most vulnerable patients nationally.

- During the COVID-19 pandemic the total number of patients served *nationally* at CHCs declined, but health care access for non-White patient populations at U.S. CHCs fell disproportionately.

- Similarly, COVID-19 appeared to have a disproportionately negative impact on Medicaid and uninsured populations *nationally* at CHCs with respect to access to care.

National Patients by Race 2019-2020



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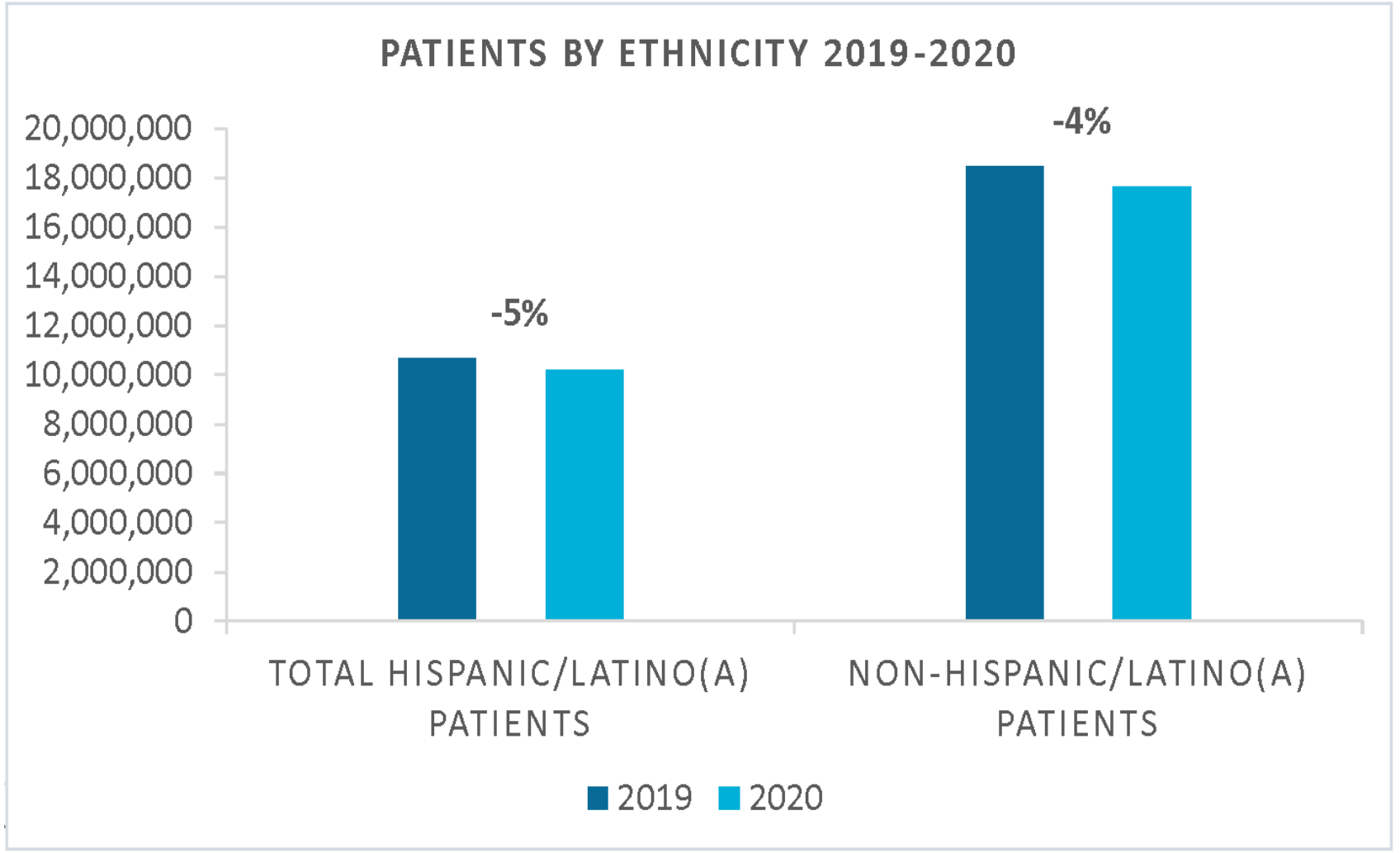
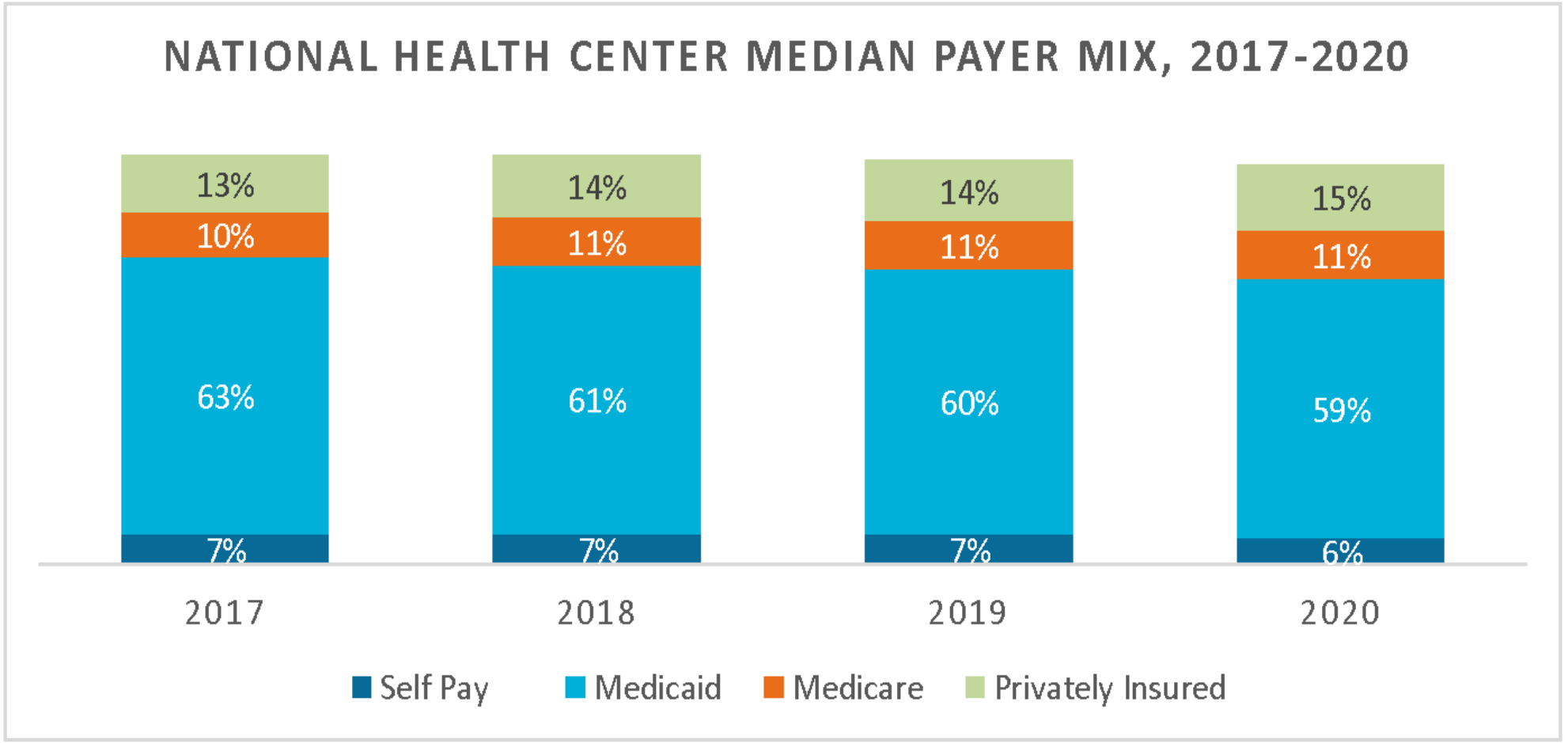
National Patients by Ethnicity 2019-2020



National Patients by Insurer, 2017-2020



National FQHCs 2021 Health Equity Top-Level Overview-First Peek

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National FQHCs Median Patient Profile

Key Patients Metrics	2018 *n = 1446*	2019 *n = 1457*	2020 *n = 1462*	2021 *n = 1481*	Rural Median 2021 *n = 609*	Urban Median 2021 *n = 872*
Percentage of Patients with Income at or below 200% of Poverty	94%	93%	93%	92%	86%	94%
Percentage of Patients Best Served in a Language Other than English	10%	11%	11%	11%	3%	20%
Percentage of Asian Patients	1%	1%	1%	1%	1%	2%
Percentage of Black/African American Patients	10%	9%	9%	9%	2%	19%
Percentage of White Patients	66%	66%	66%	66%	86%	52%
Percentage of Other Patients of Color	3%	3%	3%	3%	2%	3%
Percentage of Hispanic or Latino/a Patients	17%	18%	17%	18%	6%	30%

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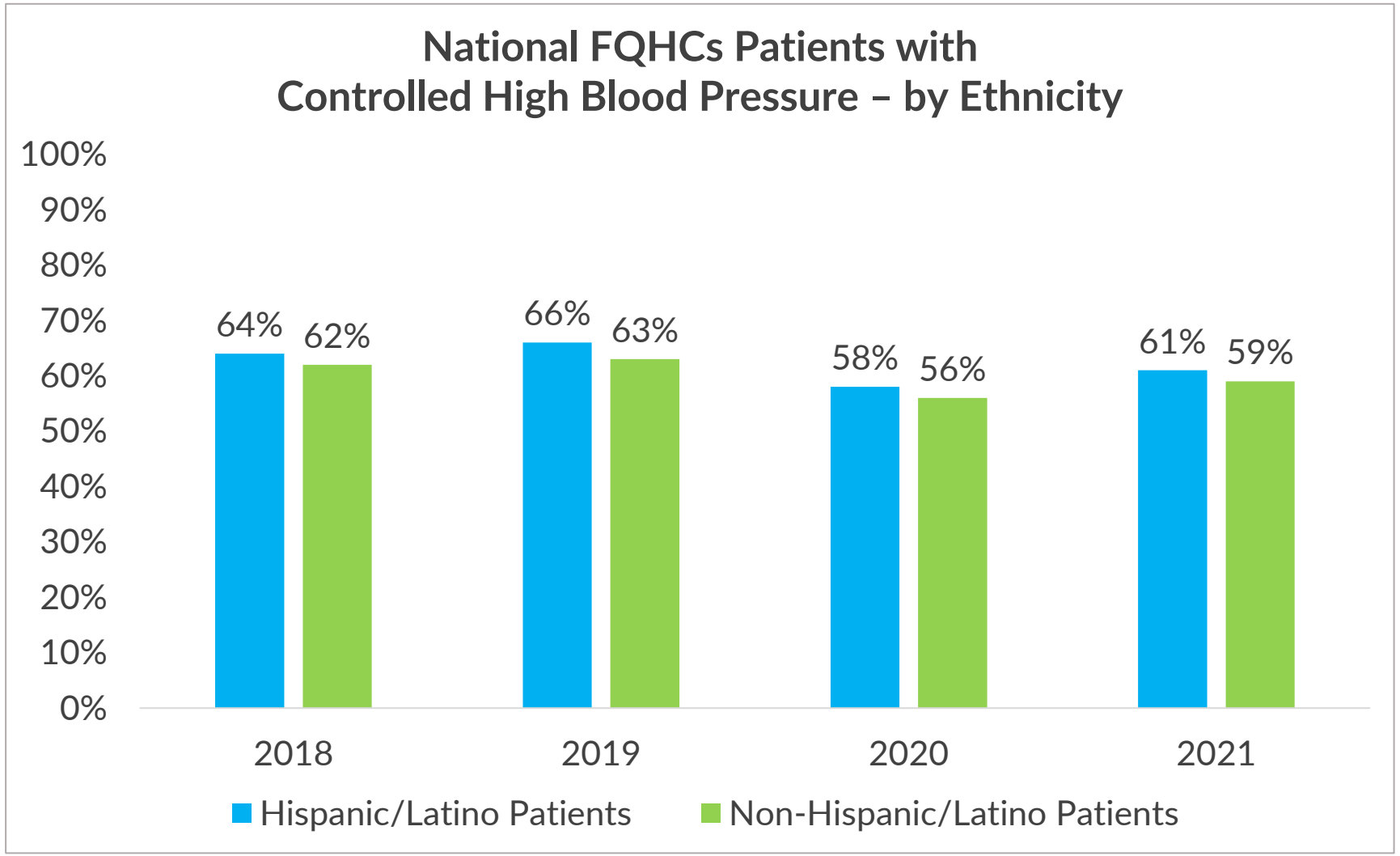
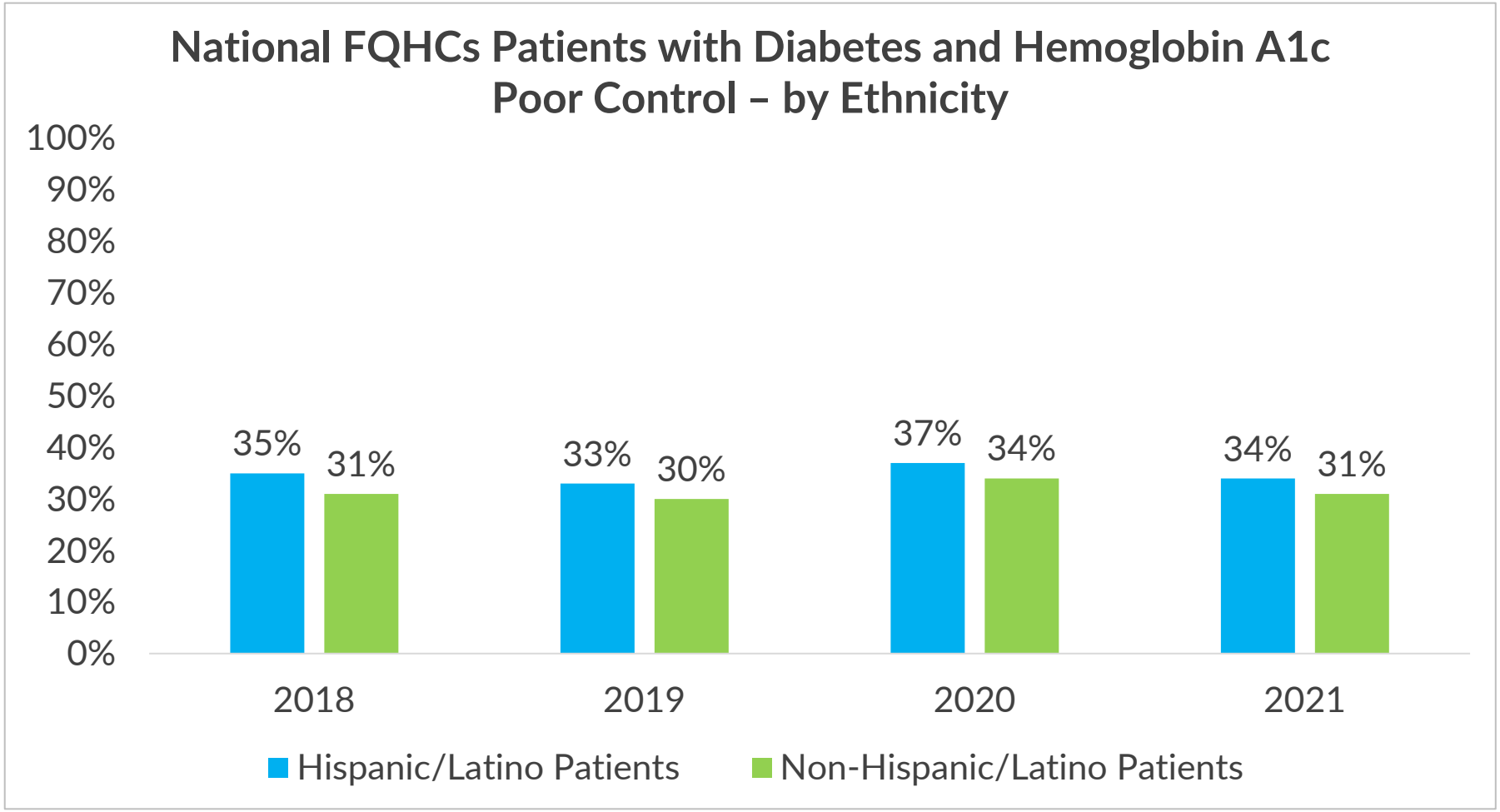
National FQHCs Patients with Controlled High Blood Pressure– by Ethnicity



National FQHCs Patients with Diabetes and Hemoglobin A1c Poor Control – by Ethnicity



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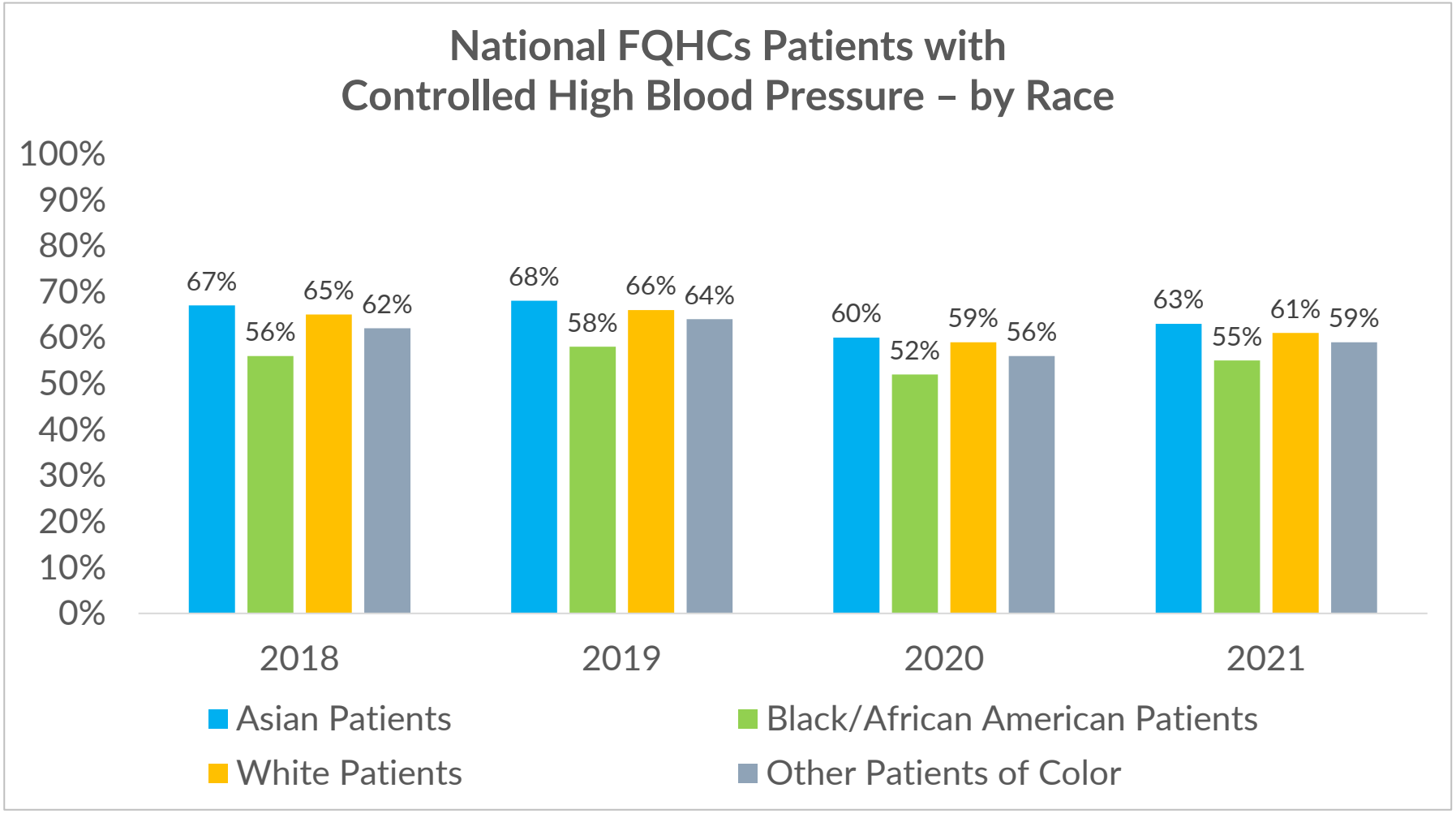
National FQHCs Patients with Controlled High Blood Pressure – by Race



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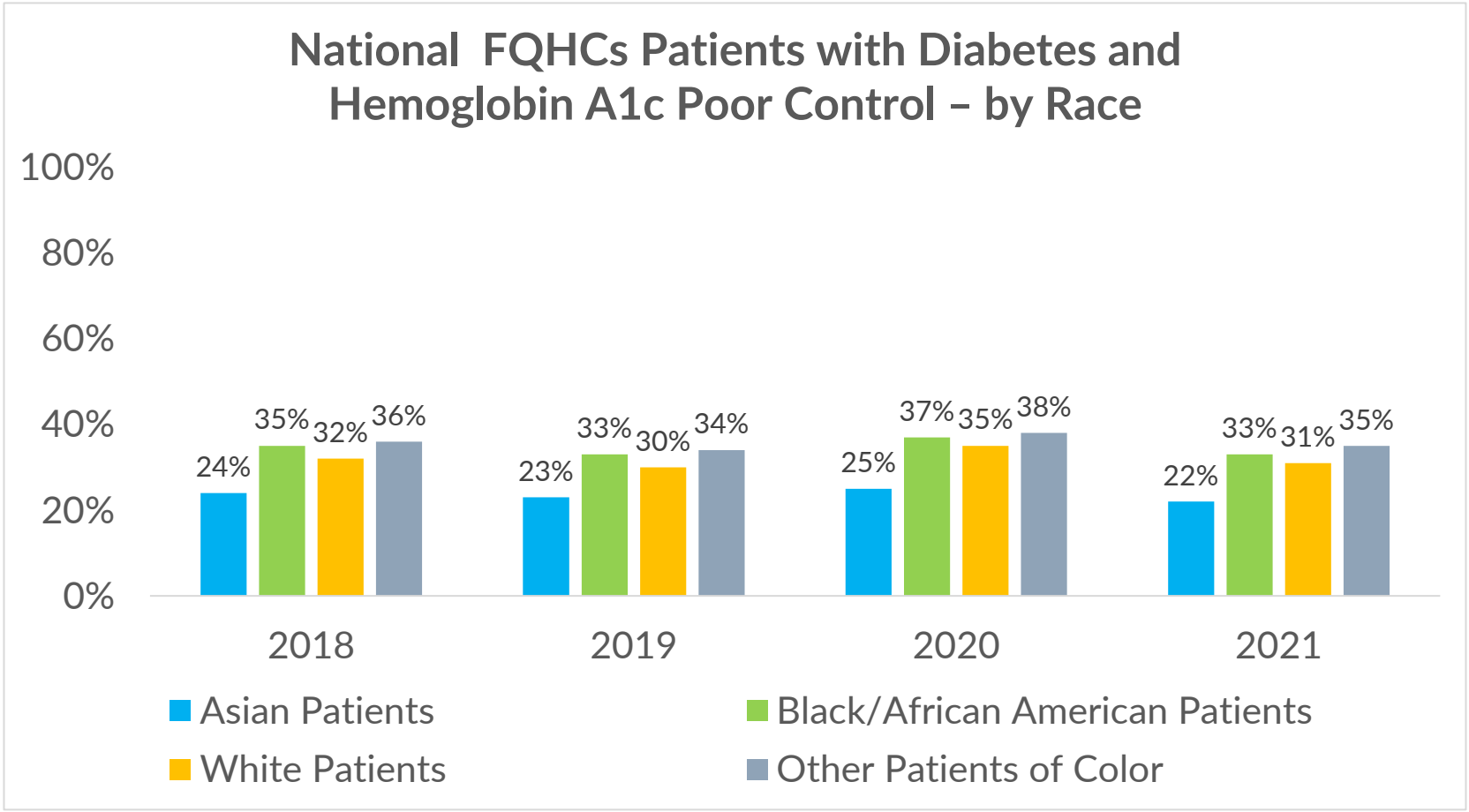

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Conclusions and Recommendations

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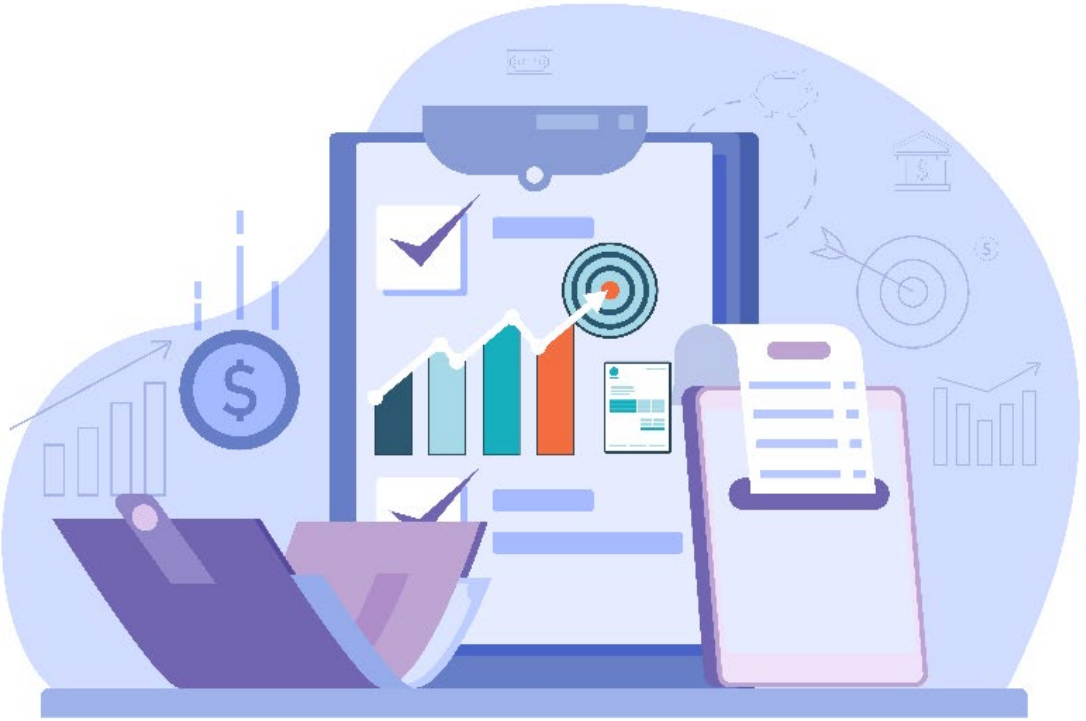
Efforts to improve health center financial and operational strength offer an important opportunity to reduce health disparities. Stronger financial and operating performance is associated with higher quality outcomes and ongoing access to care, even during challenging times.



Regular data information exchange and best practices sharing, including consideration of the cultural and qualitative factors impacting performance, provides context and support for ongoing improvements in health equity.

Conclusions and Recommendations

In the longer-term, access to deeper levels of primary care services (particularly oral and mental health) is needed to achieve health equity among vulnerable populations. Supporting policy changes and attracting foundation support for these efforts is essential.

Next Steps

Next Steps

- *Conduct an updated, data-driven study of LA County health centers, based on 2021 data, supported by the Cedars-Sinai Foundation, including a deeper focus on qualitative factors influencing health equity.*
- *Implement financial and operational excellence training programs for health centers with large vulnerable populations and/or weak results.*
- *Ongoing best practices sharing.*

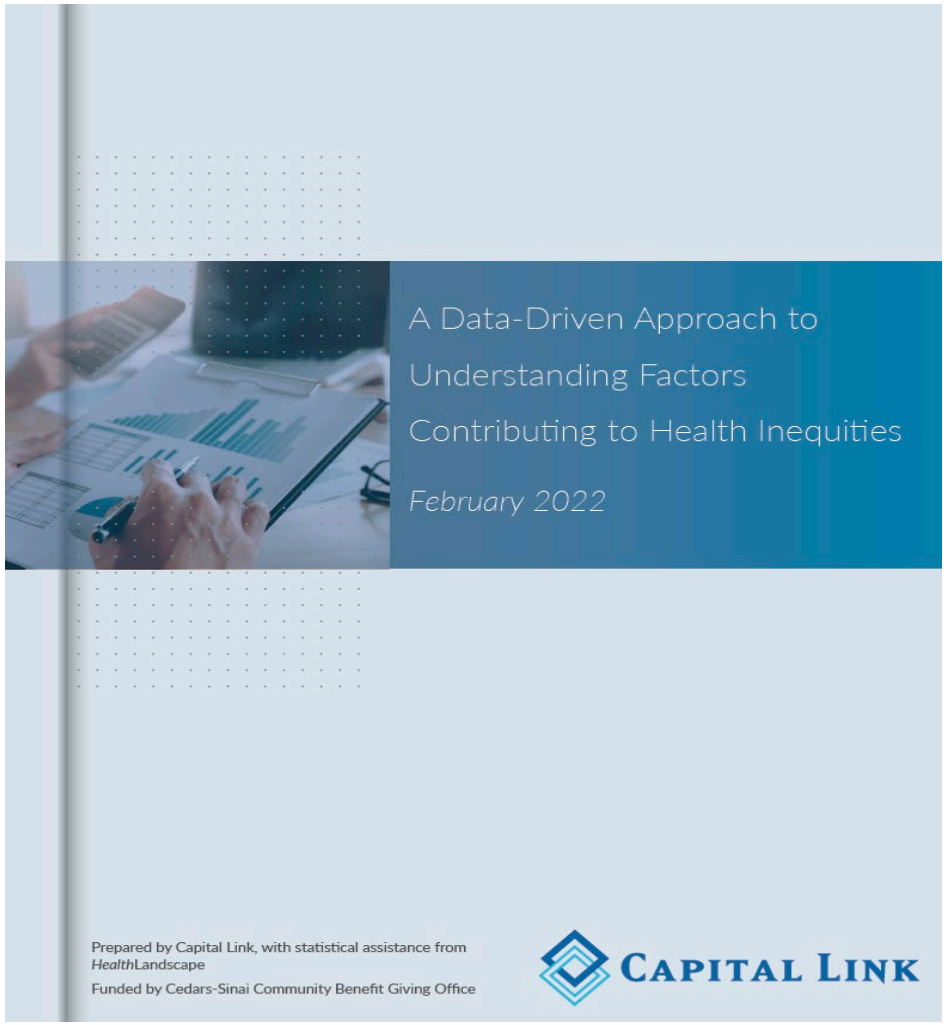
Access the Study

Health Center Financial Strength and Health Inequities: A Study of Los Angeles-Based FQHCs

This publication is a **summary** *of a data-driven analysis, conducted by Capital Link with the assistance of HealthLandscape and funded by Cedars-Sinai, of more than 100 factors for the 58 FQHC members of the Community Clinic Association of Los Angeles County (CCALAC) for the period of 2017-2020. (Released 2022)*

A Data Driven Approach to Understanding Factors Contributing to Health Inequity

To better understand whether, and to what extent, specific patient and health center characteristics influence health equity (including access to care and health outcomes) Capital Link, with the assistance of HealthLandscape and funded by Cedars-Sinai, conducted a data-driven analysis of more than 100 factors for the 58 federally qualified health center (FQHC) members of the Community Clinic Association of Los Angeles County (CCALAC) for the period of 2017-2020. Detailed findings and recommendations from the study are included in this report. (Released 2022)



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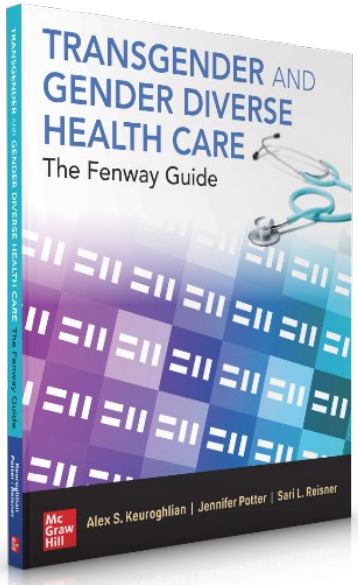
QUESTIONS

Health Equity Research, Evaluation and Policy Institute

NACHC Policy and Issues Forum



March 10, 2023

Michael Curry, Esq. President & CEO

Massachusetts League of Community Health Centers

If you know the beginning well…

- The nation's first community health center was founded in 1965 at Columbia Point in Dorchester, MA.
- Senator Kennedy was inspired to champion health centers nationally, leading to more than 13,000 communities served today.
- Health centers continue to offer primary & preventive care, behavioral health, vision and dental care to all, regardless of ability to pay.
- The Mass League, along with other Primary Care Associations (PCAs) were founded in the early 70's to provide training & technical assistance to community health centers in their states. The League turned 50 in 2022!

Massachusetts League
of Community Health Centers

The Mass League Today - By the Numbers

52

Member health centers in Massachusetts

Over 1 million

Patients or put another way … **1/7** residents of Massachusetts

83%

Of patients earn less than 200% of the federal poverty level, $55,500 for a family of four

69%

Are publicly insured or uninsured

69%

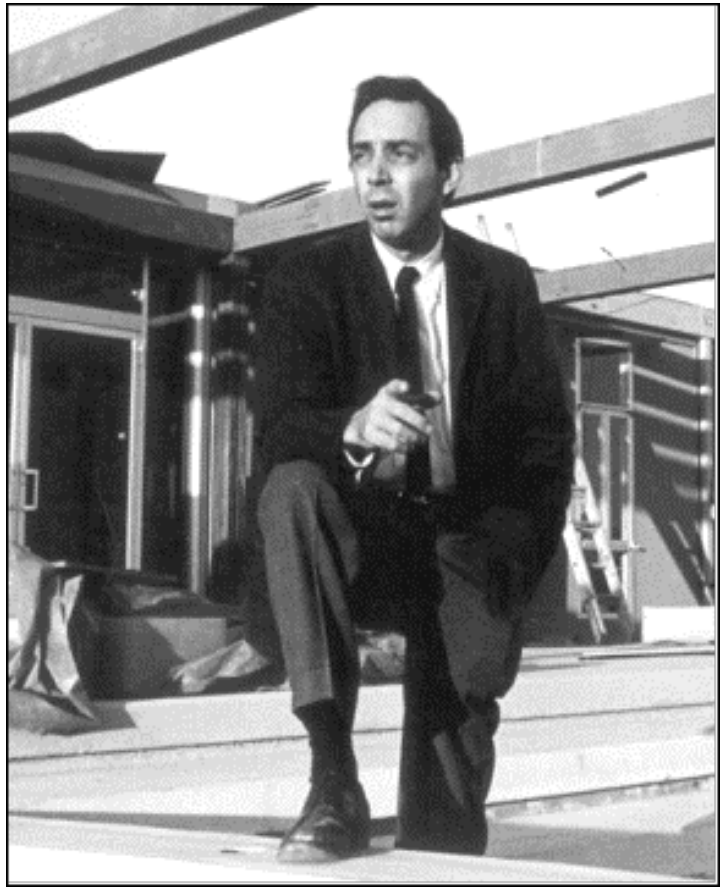
Identify as a racial or ethnic minority

Massachusetts League
of Community Health Centers

Reconnecting with Our Roots

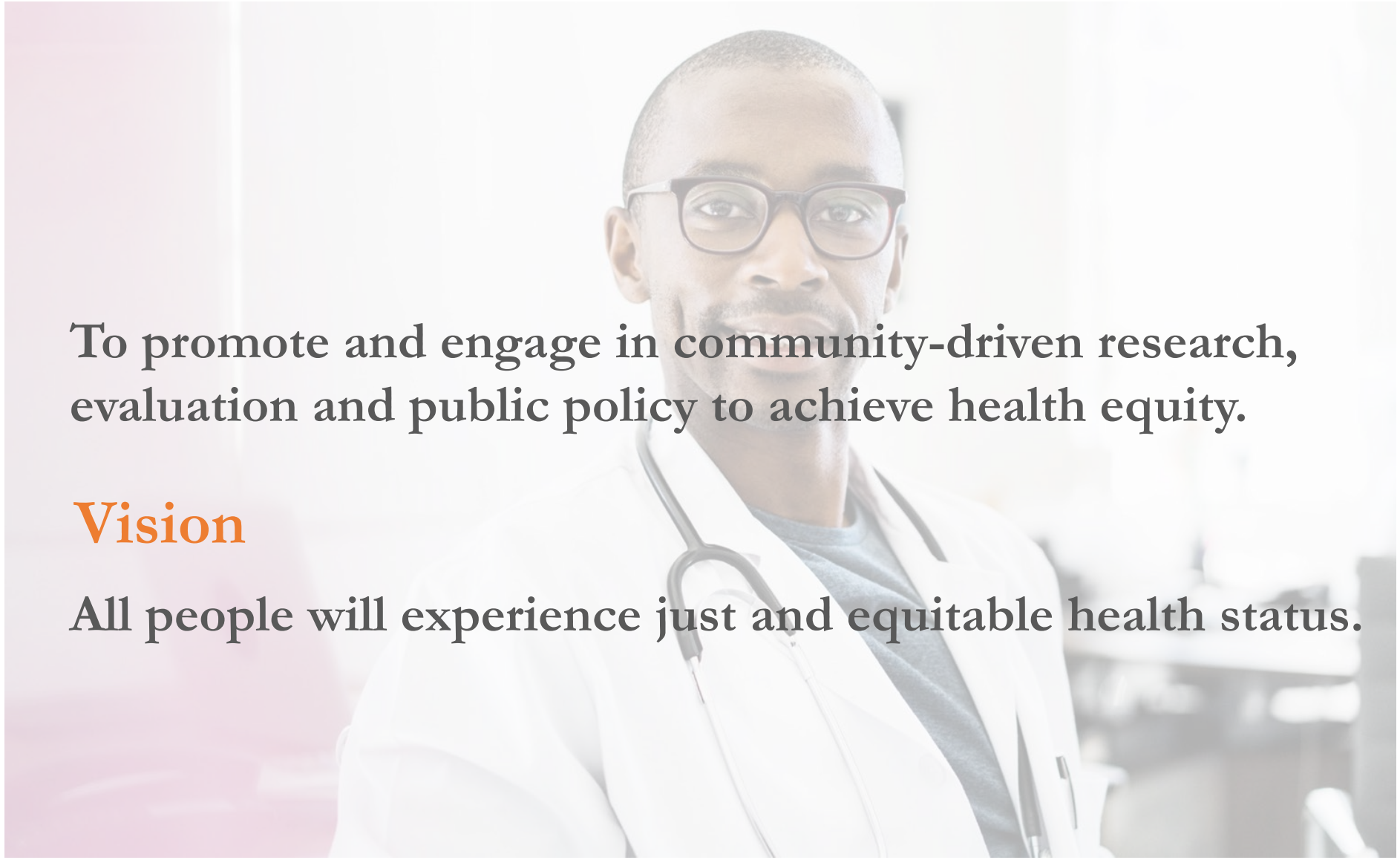
Dr. Jack Geiger* wrote in 1969:

"Right now we health professionals are standing in the middle of an endlessly revolving door … doing some good on a short-term basis…. [But] we cannot go on providing health services without regard to the system in which the roots of poverty, sickness, and many other social ills are embedded. We have to be willing to identify the real problems and confront them … we have to create new social institutions appropriate to the problem; and, finally, we need a sense of passionate commitment to bring about the changes that are so urgently needed."



Massachusetts League of Community Health Centers

Mission of the Health Equity Research, Evaluation & Policy Institute



To promote and engage in community-driven research, evaluation and public policy to achieve health equity.

Vision

All people will experience just and equitable health status.

Massachusetts League of Community Health Centers

Building on Experience with Researchers: Recent Examples

ISCCCE (Implementation Science Center for Cancer Control Equity)

Funder: NIH National Cancer Institute

Lead: Harvard Chan School of Public Health

Goal: Test cancer control interventions in low-resource settings. Eight health centers participating

Shaping the Narrative

Funder: Commonwealth Fund

Lead: Brigham and Women's Hospital partnering with the Mass League and the Community Health Center Association of Mississippi

Goal: Collect narratives from 150 Black/African American patients regarding experiences of structural racism to shape policy.

All of Us

Funder: National Institutes of Health

Lead: National study, local lead, Massachusetts General Hospital/Brigham and Women's Hospital.

Goal: Enroll 1,000,000 diverse volunteers across the U.S. to share their health information and biometrics to advance medical research. Three health centers participate.

Building on Lesson Learned, Locally and Nationally

If not us, then who? If not now, then when?

FENWAY HEALTH

WHITMAN-WALKER

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

Weitzman Institute

inspiring primary care innovation

Massachusetts League of Community Health Centers

Emancipatory Research

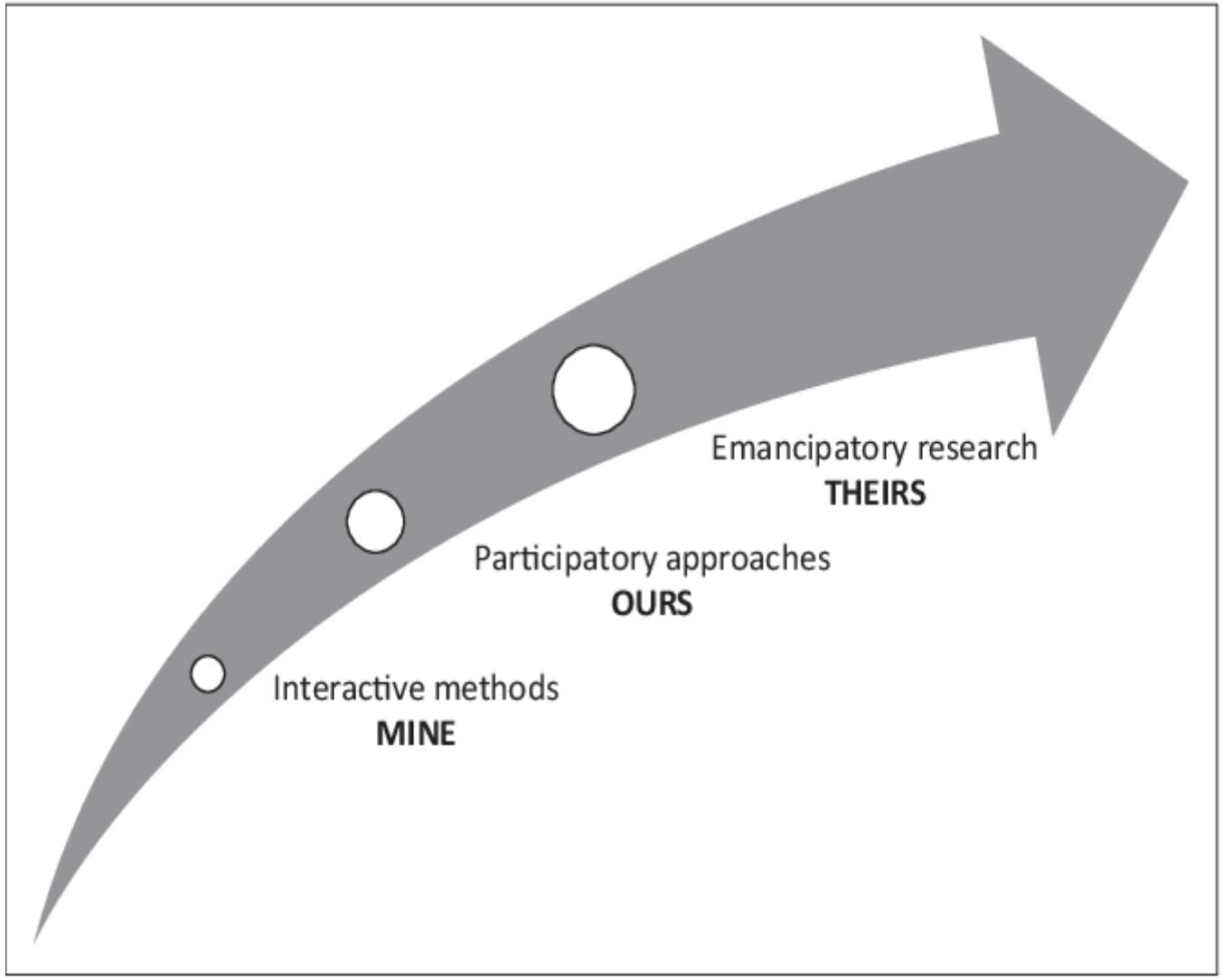


FIGURE 1: A proposed continuum of research methods.

Beyond participation, emancipatory research shifts ownership and empowers those most affected.

Published in HTS Teologiese Studies/Theological Studies 2018

Research as freedom: Using a continuum of interactive, participatory and emancipatory methods for addressing youth marginality

S. Swartz, A. Nyamnjoh

Massachusetts League of Community Health Centers

Three Critical and Related Key Activities of the Institute

Center communities in creating new knowledge toward equity.

Overcome a legacy of mistrust with participatory and “emancipatory” approaches to research.

Provide career development opportunities for the CHC workforce

… and create a diverse pipeline from high school through graduate students.

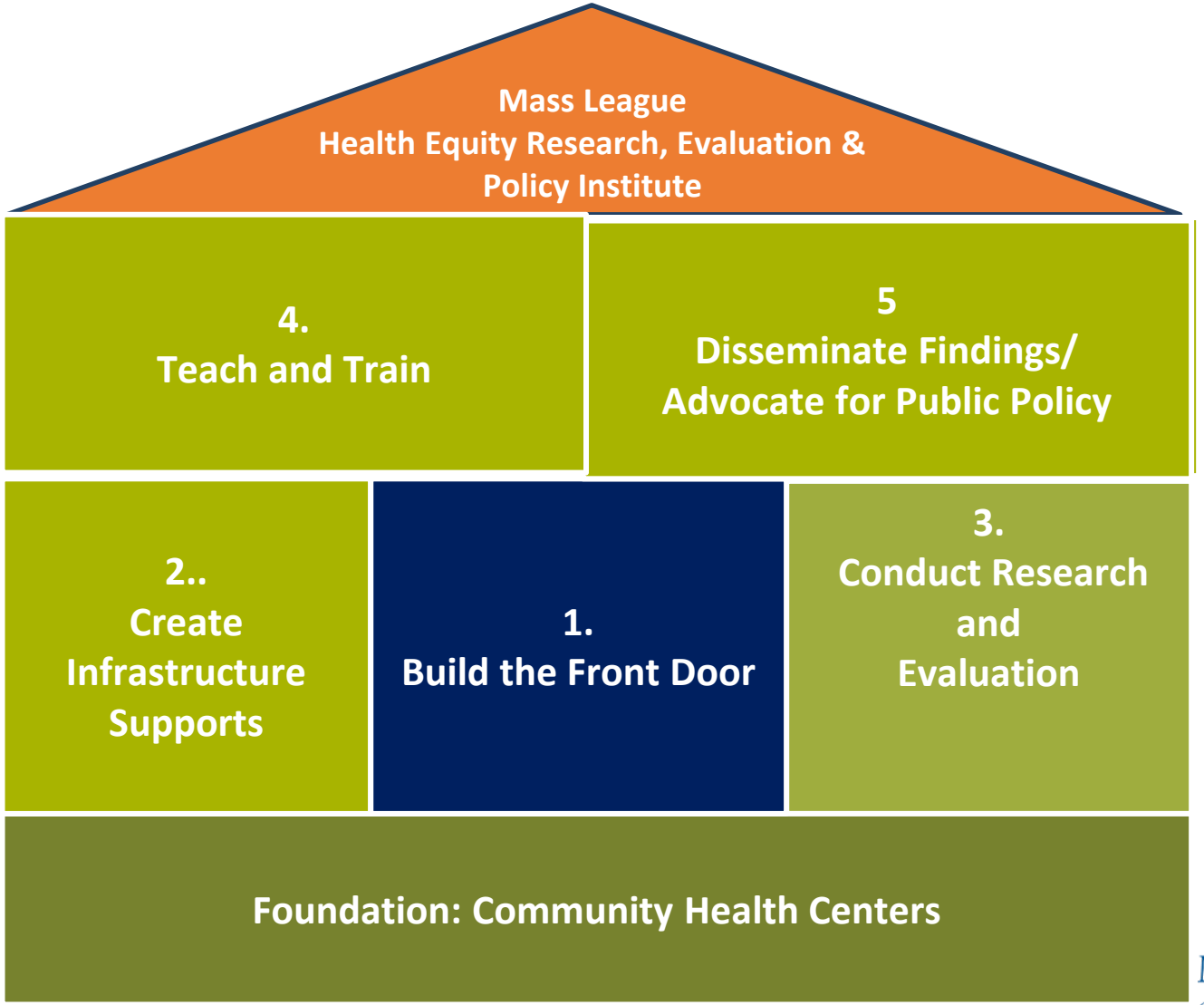
Inform Clinical Practice and Public Policy to Achieve Equity.

Quickly translate findings into change in the exam room and advocate to incorporate into public policy

Massachusetts League of Community Health Centers

The Health Equity Research, Evaluation & Policy Institute

Institute guided by Community/ Academic Advisory Board



Massachusetts League of Community Health Centers

Stage and Scale the Institute Over Time

The Front Door	• Develop research questions • Create criteria and a process to vet external researchers • Build the Community Advisory Board
Evaluation	• Build capacity to evaluate League and health center programs • Eventually generate revenue by evaluating external programs
Research	• Identify research opportunities and partners. • Apply for and obtain research grants
Career Development	• Educational programs for CHC staff • Fellowships • Pipeline programs high school through graduate school
Research Infrastructure	Build or Buy: • Institutional Review Board • Data warehouse • Biostatistics • Grant writing and management
Dissemination/ Advocacy	• Publish research results in peer-reviewed journals • Issue reports using data base • Sponsor symposia for policy makers • Present at conferences

usetts League
of Community Health Centers

Why Now? Why the Mass League?

- **We are at a unique moment in history.** Racial and social justice are at the forefront of public discourse. We must "Carpe Diem" or seize this opportunity!

- **The Mass League is uniquely positioned to leverage existing relationships with academic institutions** to elevate the voice of community, and create authentic partnerships.

- **Research requires robust data and the Mass League has it**, which includes demographics, clinical and social determinants of health data, updated daily, on three-quarters of a million patients. The system can share with other health centers around the country and is a rich and underutilized resource to be harnessed for equity.
  - Data Reporting and Visualization System (DRVS)

- **The League would be first primary care association to launch such an Institute, and will serve as a resource for the nation**, building on the success of other subsidiaries like Capital Link, Capital Fund and Commonwealth Purchasing Group.

Massachusetts League
of Community Health Centers

$6.5M Secured: Goal to Raise Additional Funds

Start up revenue secured for next five years

Mass General Brigham: $1,500,000 to evaluate funded programs

Commonwealth of Massachusetts: $5,000,000

Potential Additional Revenue

- Obtain research grants - NIH, AHRQ, PCOR, CDC and other research grants
- Foundations and corporations
- Ongoing public support (city, state, federal)
- Conduct evaluations for other non-profits/government
- Contracts with government, ACO's and other payers to analyze data/produce reports

Massachusetts League of Community Health Centers

Next Steps

- Conducting a national search for the inaugural Executive Director
- Hosting a Funder Briefing to pursue additional flexible dollars to build the infrastructure and create sustainability.
- Pursuing avenues to include all health center data, including those health centers not on DRVS.
- Build formal partnerships with academic research entities and others.
- Official Launch in 2023

Massachusetts League
of Community Health Centers

The Taint of Race in Health

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

Dr. Martin Luther King, Jr. at a Convention of the **Medical** Committee for Human Rights held in Chicago, March 1966

Words Matter

"We are concerned about the constant use of federal funds to support this most notorious expression of segregation. Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death."

"I see no alternative to direct action and creative nonviolence to raise the conscience of the nation."

Thank You and Questions

Michael Curry, Esq.

President and CEO

Massachusetts League of Community Health Centers

Massachusetts League
of Community Health Centers