

# Data Note

November 23, 2020

## ***Key Updates from the Health Center COVID-19 Survey (Week #32): The Status of Community Health Centers as the Nation Enters the Worst Phase of the COVID-19 Pandemic***

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### **Introduction**

As the nation entered the worst phase of the COVID-19 pandemic to date, data from the Health Resources and Services Administration's (HRSA's) weekly [Health Center COVID-19 Survey](#) indicate that the number of patients tested for the COVID-19 virus this week (244,945) neared the peak level (251,246) reported in mid-August. Similarly, the number of health center patients (31,519) and staff members (1,164) who tested positive for the virus also trended upward, raising additional concern. Additionally, with weekly health center visits consistently lower than before the pandemic and with no additional federal COVID-19 financial relief committed, the pandemic has taken an enormous financial toll on health centers. Cumulative patient revenue losses over seven months are estimated at \$3.714 billion, which amounts to nearly 12 percent of total health center revenue reported nationally in 2019. Other key findings include:

- The share of health centers with the capacity to provide COVID-19 diagnostic testing grew from 80 percent in early April to nearly all (96 percent) seven months later.
- Community health centers have tested a total of more than five million patients for COVID-19 virus over seven months. In the aggregate, a total of 561,777 health center patients and 18,518 staff members have tested positive for the COVID-19 virus. With [9.7 million cases of coronavirus in the U.S.](#) reported as of November 6th, the number of health center patients who have tested positive accounted for 5.8 percent of cases nationally, or one in 17 of all U.S. cases.
- Average turn-around times for test results have improved from their lowest point in mid-July, when turn-around times of four or more days were reported by two thirds of responding health centers, to 16 percent as of the most current reporting period.
- In line with research that has found that minorities are disproportionately at risk for infection with the COVID-19 virus, patients reported as racial and ethnic minorities, particularly Hispanic/Latino patients, accounted disproportionately for patients who tested positive, both this week and consistently over the seven months of survey data.
- Measures of operational capacity including temporary site closures, staff unable to work, and declines in weekly visits have improved over the seven months but remain significant.

This month, the nation entered the [worst phase of the pandemic to date](#), with more than 100,000 coronavirus cases reported each day for the past two weeks, 49 states reporting increased cases, more than [80,000 people hospitalized with COVID-19, and COVID-19 deaths now exceeding a quarter of a million](#). Twenty-two percent of hospitals in the country are [anticipating staffing shortages this week](#); staffing shortages are expected by more than 35 percent of hospitals in eight states including North Dakota, where the situation is so dire that the governor has ordered that asymptomatic health workers infected with the COVID-19 virus can return to work. There were glimmers of hope in the news with two candidate COVID-19 vaccines, from [Pfizer](#) and [Moderna](#), demonstrating

effectiveness levels of about 95 percent, and [Pfizer applied for emergency-use FDA authorization on November 20th](#). However, the COVID-19 vaccine is not expected to be available for the [general population before April 2021](#).

Community health centers are an essential source of care for populations who are at high risk of COVID-19 infection and poor health outcomes. [In 2019, 1,385 federally-funded community health centers](#) served nearly 30 million patients in the U.S., or [one in eleven residents nationally](#). Nearly all (91 percent) [health center patients in 2019](#) were low-income and about two in three (63 percent) were racial/ethnic minorities. The sociodemographic make-up and higher rate of chronic conditions among the [health center patient population](#) put them at greatest risk of poor outcomes from COVID-19.

Community health centers are required by statute to serve all patients regardless of their income or health insurance status and to charge patients on a sliding fee scale based on their ability to pay. Community health centers served [one in three people living in poverty](#) and [one in five uninsured](#) individuals before the pandemic. Their importance for low-income and uninsured patients has grown as [millions of Americans remain unemployed](#) and [have lost their employer-sponsored health insurance](#), and has been heightened with [unemployment benefits and a nationwide eviction moratorium](#) slated to end at the end of December in the [absence of additional federal COVID-19 relief legislation](#). In addition to offering local access to both COVID-19 testing and ongoing, comprehensive primary medical care, community health centers offer services that address the [pandemic-related rise in mental health and substance use disorder problems](#). These services provided by health centers will be essential as the [pandemic is expected to worsen through the fall and winter seasons](#) with COVID-19 cases surging contemporaneously to the regular flu season.

## HRSA's Weekly Health Center COVID-19 Survey

The Health Resources and Services Administration (HRSA) has been administering a [weekly Health Center COVID-19 Survey](#) to all health centers nationally since early April 2020 and this report is based on 32 weeks of survey data. The survey captures data on health centers' COVID-19 virus testing capacity, the number and race/ethnicity of all patients tested and those who tested positive for both the COVID-19 virus and antibodies, the effects of the pandemic on health centers' operational capacity, measured in site closures, weekly visit declines, and staff unable to work, and the adequacy of personal protective equipment (PPE) supplies. HRSA reports summary data for health centers nationally, by state, and for [look-alike health centers](#), which meet all health center program requirements but do not receive federal health center grants (this data note excludes data on look-alike health centers). Because the data are cross-sectional, with different health centers reporting each week, and the response rates vary by week, [HRSA cautions against comparing data over the weeks](#); notably, however, overall response rates have ranged from 62 percent to 83 percent and have met or exceeded 70 percent in 24 out of the 32 weeks of data. The Geiger Gibson/RCHN Community Health Foundation Research Collaborative has produced a series of [weekly updates based on HRSA's survey data](#). This data note reports on the current COVID-19 experience of the nation's community health centers as of the week of November 6th. We also report updated trend data, last reported for the six month period beginning April 3rd 2020, to a seven-month period for the week ending November 6th. Finally, we present updated estimates on the cumulative national and state losses to date in patient revenue.

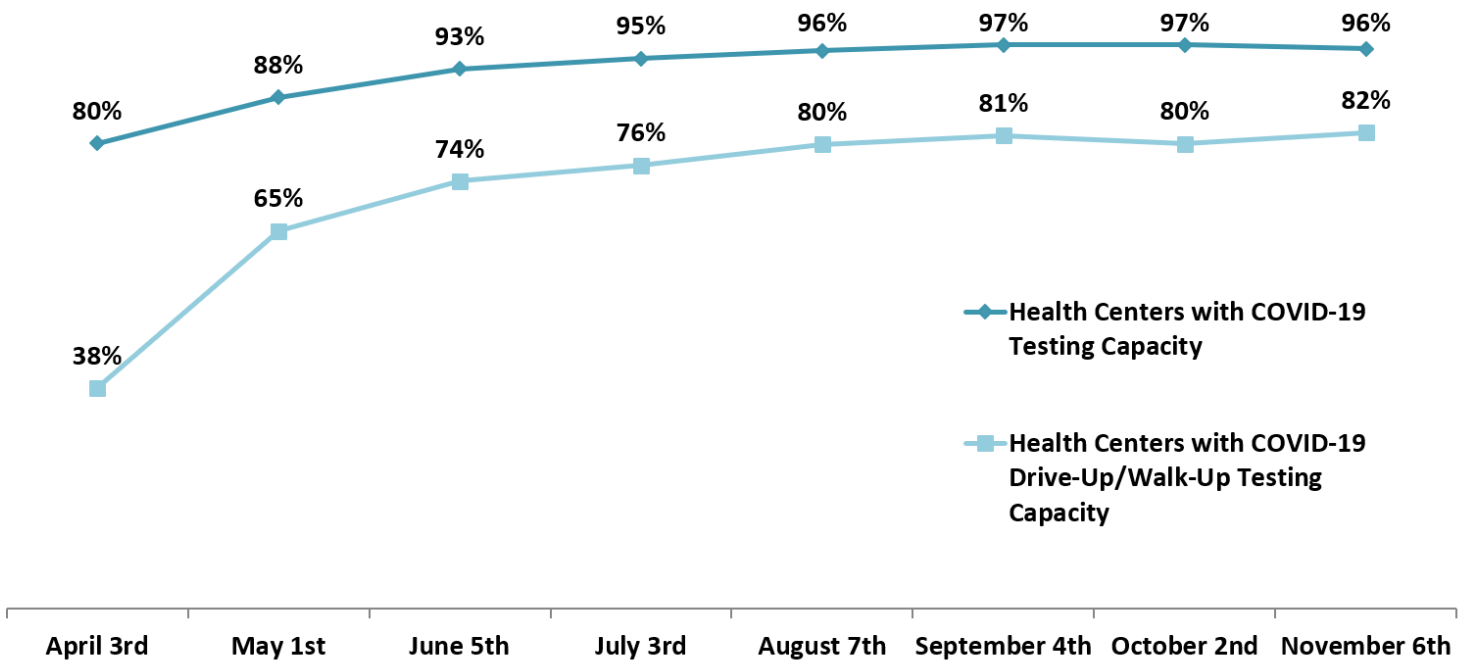
## Testing Capacity and Average Turn-Around Times for COVID-19 Viral Test Results

Seven months after HRSA began reporting this data, nearly all (96 percent) responding health centers report capacity for diagnostic testing for the novel coronavirus, up from 80 percent as of the first reporting period but slightly lower than the 97 percent reported in September and October (**Figure 1**). Among health centers with testing capacity, the share with drive-up/walk-up testing capacity has more than doubled, from 38 percent to 82 percent. The increase in testing capacity reflects funding provided to community health centers to respond to the COVID-19 pandemic, including [an initial \\$100 million](#) through the Coronavirus Preparedness and Response Supplemental App

Appropriations Act in early March, and [\\$1.32 billion in the Coronavirus Aid, Relief, and Economic Security \(CARES\) Act](#), and [\\$583 million in additional grants](#) to expand health center testing capacity, funded through the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA or “COVID-19 3.5” relief package).

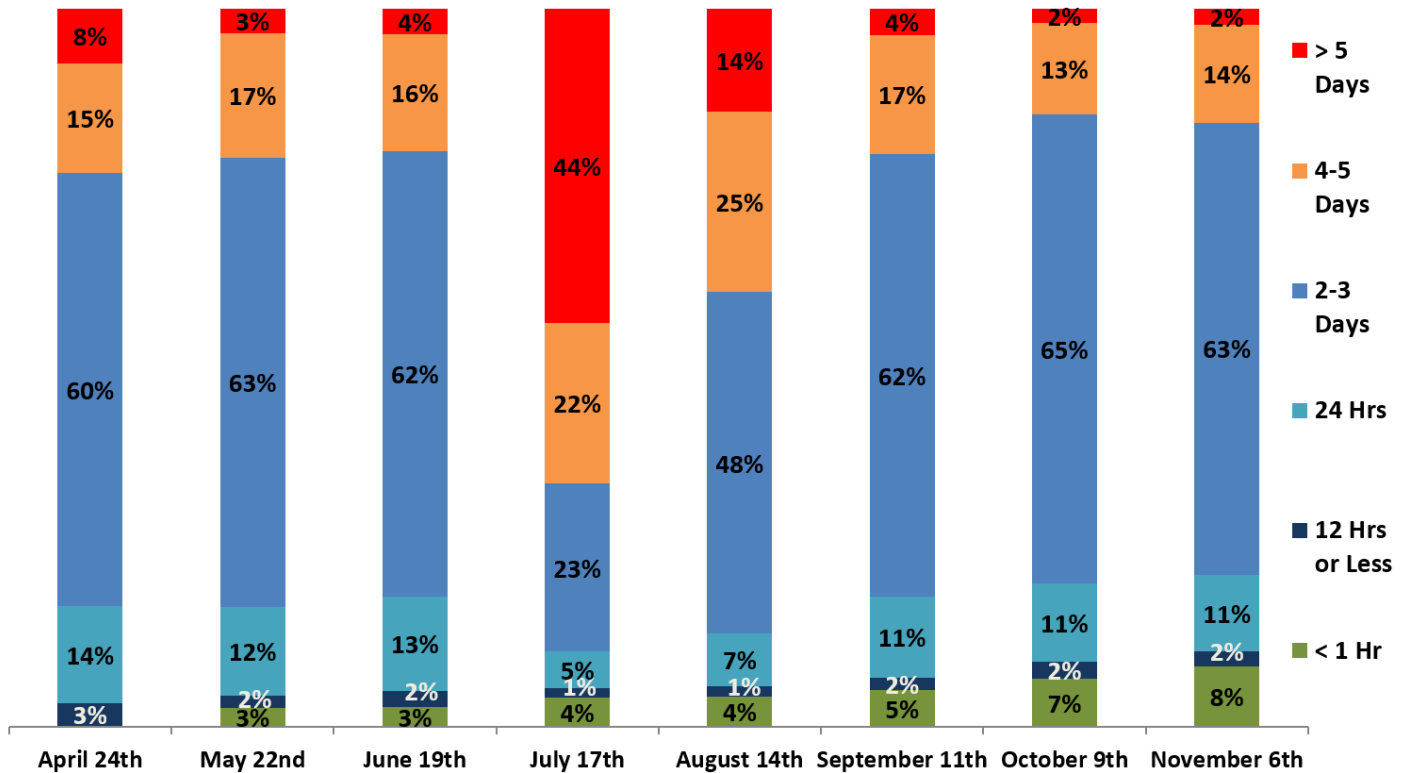
**Figure 2** illustrates how average turn-around times for COVID-19 viral test results have changed over the seven months. In the first few months of testing, about four in five test results came back within an average of three days or less. However, with the spike in cases over the summer, associated increases in testing demands, and broader delays in lab capacity, average turn-around times worsened dramatically and reached a peak in mid-July, when two in three (66 percent) results were returned in four or more days, including 44 percent in more than five days. As of November 6th, average turn-around times of four or more days were experienced by 16 percent of all reporting health centers, up from 14 percent as of [October 2nd](#); while this is a vast improvement from earlier months, it still means that one in six test results is [clinically useless](#) in the effort to conduct contact tracing and to stop further transmission. There is concern that the surge in coronavirus cases will worsen turn-around times, as [Quest Diagnostics recently has reported a slight increase in turn-around times](#) for test results due to a 50 percent increase in testing demand and constrained testing supplies.

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



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

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



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

### COVID-19 Diagnostic and Antibody Tests

Over 31 weeks of reported data<sup>1</sup>, community health centers tested a total of 5,035,426 patients for the COVID-19 virus and a total of 561,777 patients and 18,518 health center staff members had confirmed cases. As of **November 6th**, there were a reported **9,757,612 cases of coronavirus in the U.S.**, meaning that the 561,777 health center patients with confirmed infection accounted for one in 17 (5.8 percent) of cases nationally.

**Figure 3** shows the number of patients tested for COVID-19 virus (PCR, antigen), the number of patients and health center staff members who tested positive, and the percentage of health center patients who tested positive for COVID-19 at approximately monthly intervals since April 2020. At its highest point, the week of August 14th, community health centers nationally conducted over a quarter of a million COVID-19 virus tests (251,246). The number of tests conducted per week then decreased to a new low of 121,184 the week of September 11th but is now approaching the earlier peak, with 244,945 tests conducted as of November 6th. Patients who tested positive decreased from a peak of 36,155 in early May to 9,750 as of September 11th and this figure is also approaching its peak level, with 31,519 positive cases as of November 6th. The number of staff members who tested positive dropped from a high of 1,381 in April to lows over the seven months of data of 318 and 339 in June and September, but is now increasing to near-peak levels, with 1,164 staff members with confirmed infection as of November 6th.

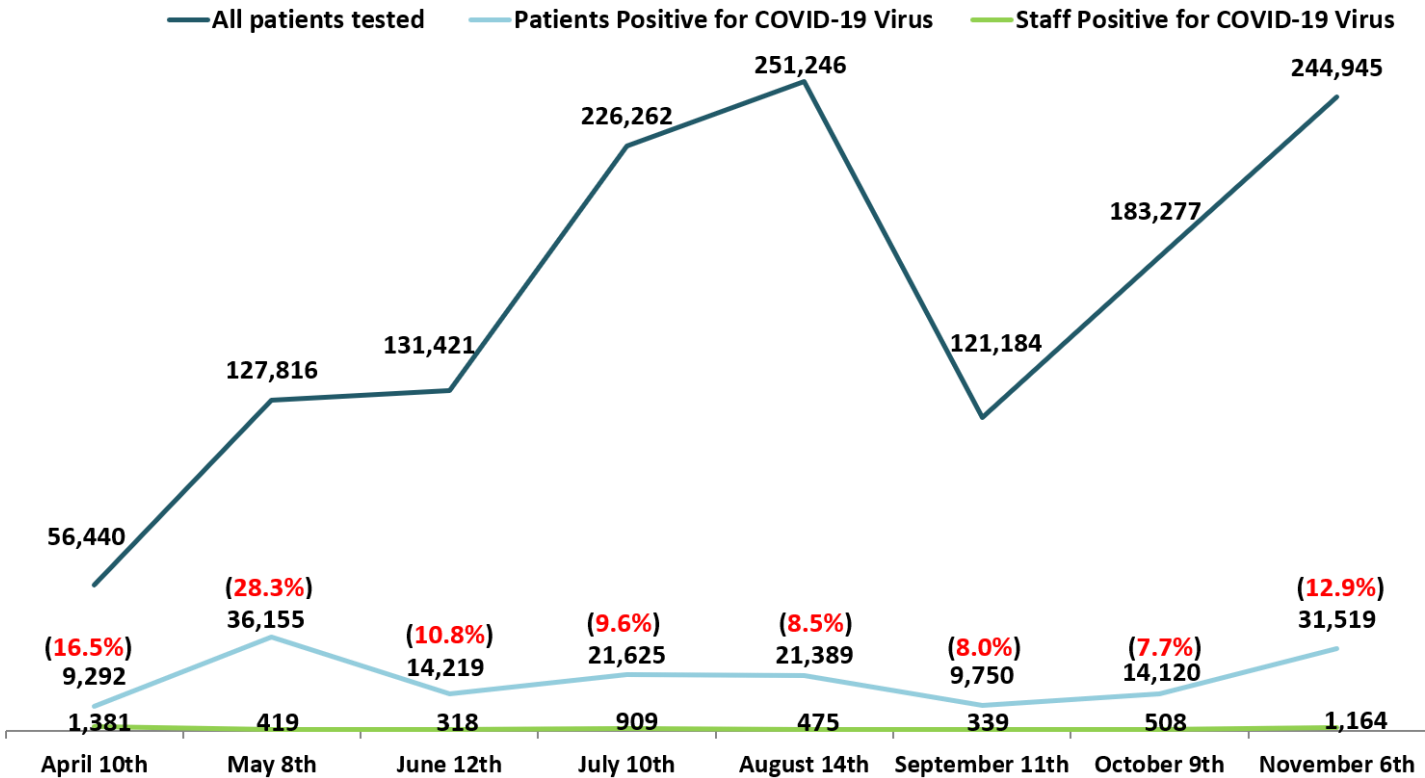
Based on the reported numbers of patients tested for COVID-19 virus and those who tested positive each week, the

<sup>1</sup> HRSA began reporting patient testing numbers for the second week of the survey (April 10, 2020).

percentage testing positive over seven months was at its peak in early May, at 28.3 percent, and at its lowest point was [6.2 percent as of August 21st](#). However, given the widespread delays in test results over the summer months, the latter percentage may not reflect the true positive rate due to the lag in results reporting. [HRSA notes that](#) “the reported number of patients tested do not represent the same patients included in the reported number of patients tested positive due to a lag between the date the specimen is collected and the availability of test results.” Despite that caveat, the November 6th percentage of 12.9 is twice the lowest 6.2 percent positive rate, and reflects the surge in COVID-19 infections that began this month. Over the seven months, the percentage of positive testing results reported by community health centers has fairly consistently exceeded the national positive case rate across public health, clinical and commercial labs reported to the Centers for Disease Control and Prevention (CDC). Results for the most recent week are consistent with this experience; the 12.9 percent positive case rate at health centers as of November 6th was above the 10.5 percent reported nationally to the CDC for [the week ending November 7th](#).

Antibody tests, also known as serological tests, indicate if a person was previously infected with the COVID-19 virus. HRSA began reporting the number of health center patients tested for COVID-19 antibodies in June 2020. Over 23 weeks of reported data, a total of 294,119 health center patients were tested for antibodies and 49,212 tested positive. [Over the seven months of all testing data](#), community health centers have tested a total of 5,329,545 patients with a COVID-19 test of any type, and a total of 610,989 patients have tested positive for either COVID-19 virus or antibodies.

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



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

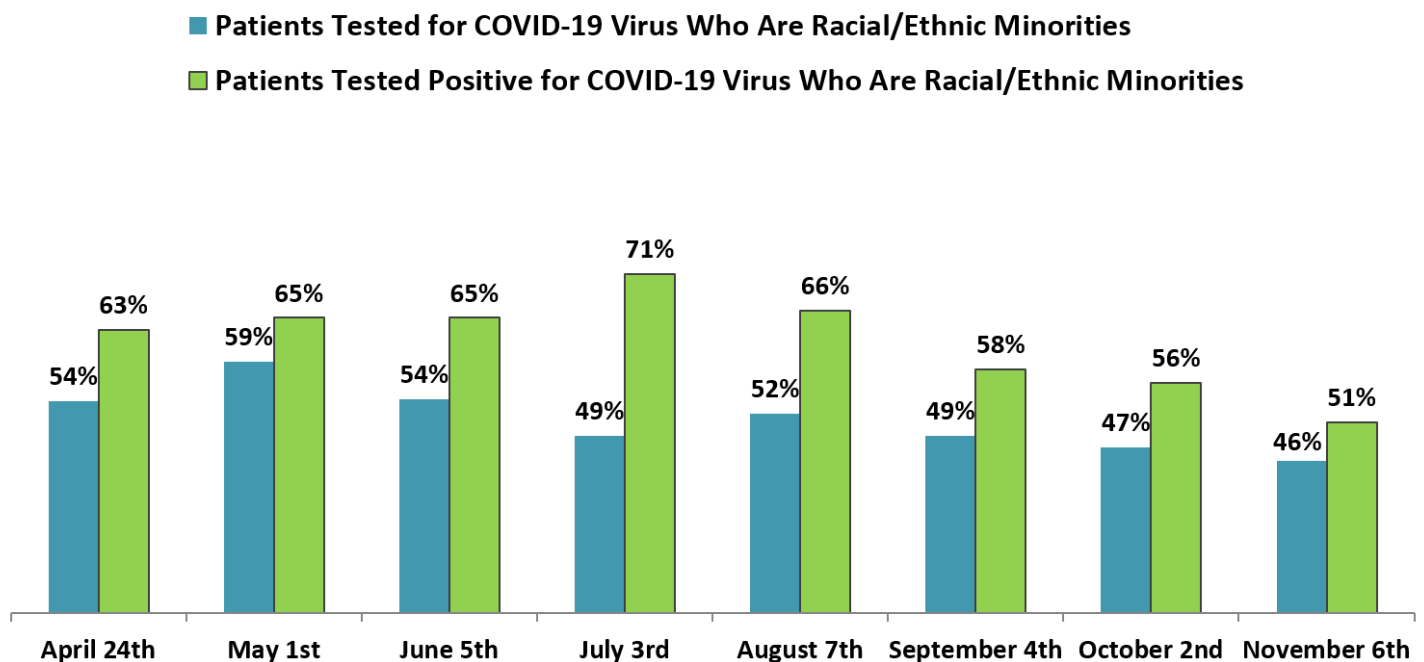
## Race and Ethnicity of Health Center Patients Testing Positive for COVID-19 Virus

Community health centers, which by mission and federal mandate are located in underserved communities, are a vital resource in many minority communities. The Department of Health and Human Services (HHS) counts community health center testing capacity among their initiatives to make testing more accessible and to [reduce COVID-19 racial/ethnic disparities](#). As the pandemic continues, a wide body of research has found that members of racial and/or ethnic minority groups are disproportionately more likely to be infected with the novel coronavirus and to have serious illness, to be hospitalized, and to die from COVID-19 (see [p. 8 of our six-month report](#)).

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

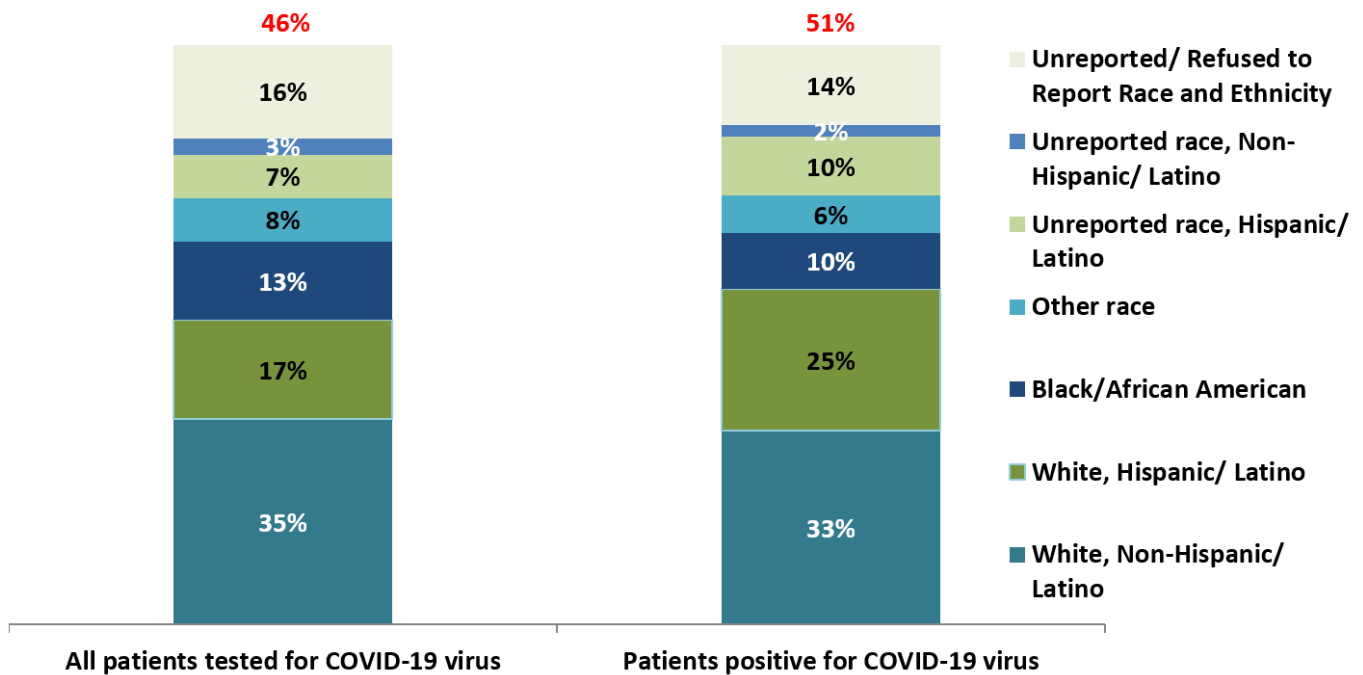
**Figure 5** provides more detail on the race and ethnicity of tested patients and patients who tested positive for COVID-19 infection from the reporting period as of November 6th. While White, Hispanic/Latino patients accounted for 17 percent of health center patients tested for COVID-19 infection in this reporting period, they represented 25 percent of all positive cases. Similarly, Hispanic/Latino patients with no reported race accounted for seven percent of those tested for infection, but ten percent of positive cases for infection. [HRSA reports](#) that over all weeks of reported race and ethnicity patient testing data from April to November 6th, Hispanic patients accounted for 30 percent of patients tested with a COVID-19 test of any type but 44 percent of patients who tested positive for either COVID-19 virus or antibodies.

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



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

**Figure 5. Health Center Patients Tested for COVID-19 Virus and Patients Who Tested Positive, by Race/Ethnicity, as of November 6th**



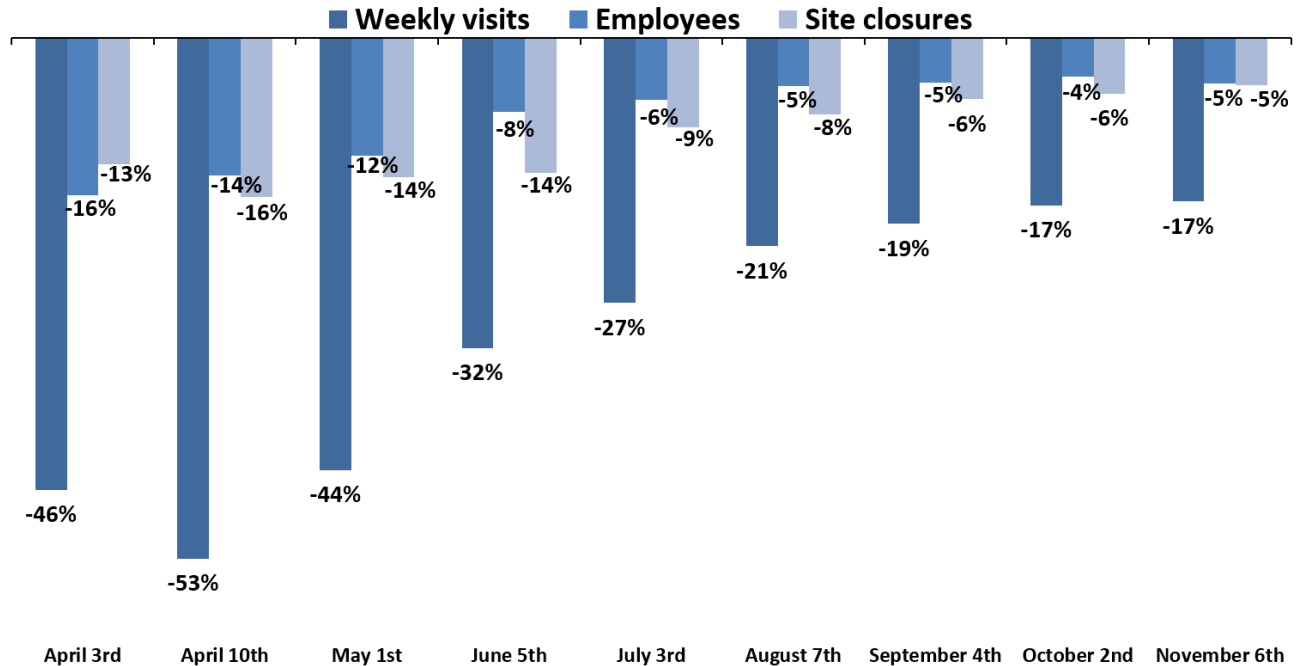
Note: The figures in red indicate patients who are racial/ethnic minorities as a percentage of those tested and of those who tested positive and aggregate Hispanic/ Latino White, Black/African American, Other race, and Hispanic /Latino patients with unreported race. “Other race” includes Asian, American Indian/ Alaska Native, and Native Hawaiian/Other Pacific Islander patients, and patients with more than one race. Black/African American and Other race include both Hispanic/Latino and Non-Hispanic/Latino patients. Source: Bureau of Primary Health Care. Health Center COVID-19 Survey. HRSA. Data as of November 6th.

### Losses of Operational Capacity: Sites, Staffing, and Visits

While adding testing and adapting their services, health centers have been operating at reduced capacity since the pandemic began. As **Figure 6** illustrates, health center activity has been recovering; the decline in weekly visits compared to average weekly visits before the pandemic has greatly improved, from a reduction in visits of 53 percent as of April 10th to 17 percent as of November 6th. Similarly, the share of temporarily closed sites improved over that same time period, from 16 percent to five percent, while the share of health center staff members unable to work due to COVID-19, for reasons that included site closures, family/home obligations, lack of personal protective equipment, and exposure to coronavirus fell from 16 percent in the first week of the survey to four percent in October, but increased slightly to five percent as of November 6th.

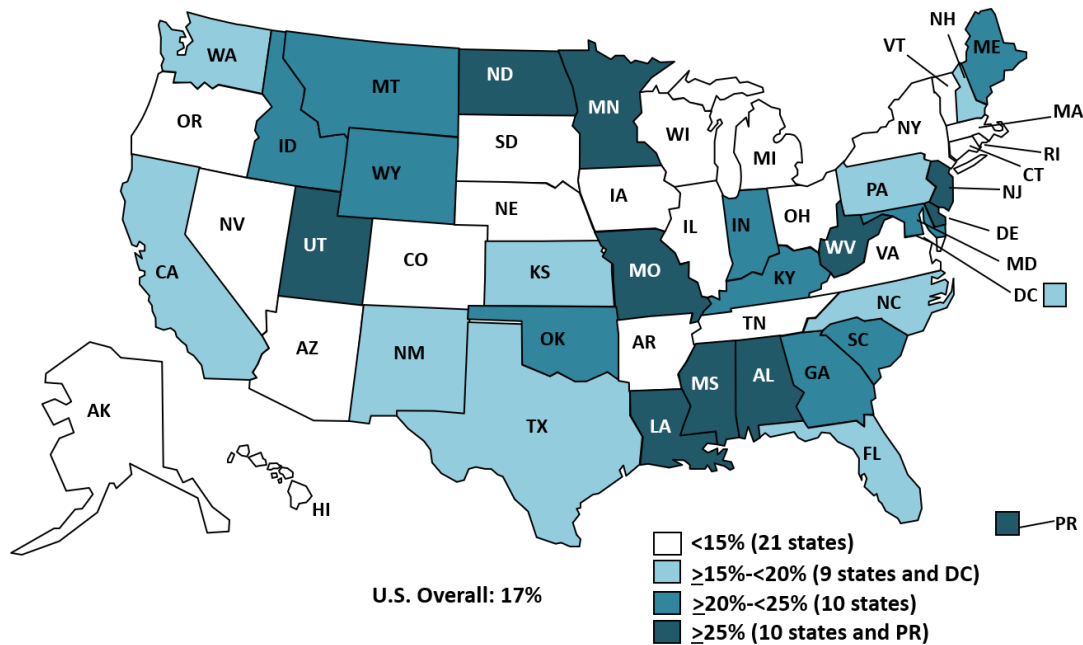
Despite these positive trends, these losses continue to reflect the toll that COVID-19 is having on health center capacity, staffing, and operations. A five percent reduction in health center employees translates to about 12,000 fewer working **full-time equivalent (FTE) staff members** who are essential to serve patients and to keep health centers running. Similarly, the 17 percent reduction in weekly visits amounts to nearly 400,000 fewer weekly **health center visits nationally**, for services which may include routine check-ups, vaccinations, and other preventive care services. Furthermore, while losses in operational capacity may have diminished nationally over time, they vary greatly by state (HRSA has created **maps that show state variation** in the percentages of site closures and staff unable to work). Nearly eight months into the pandemic, as of November 6th, health centers in ten states and Puerto Rico were reporting weekly visit declines of at least 25 percent, with the greatest declines of 37 percent reported in **Alabama** and **Mississippi**. In an additional ten states, visits were down by at least 20 percent (**Figure 7**).

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



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

### Figure 7. Decline in Community Health Center Weekly Visits Compared to Pre-COVID-19 Average Weekly Visits, By State, as of November 6th



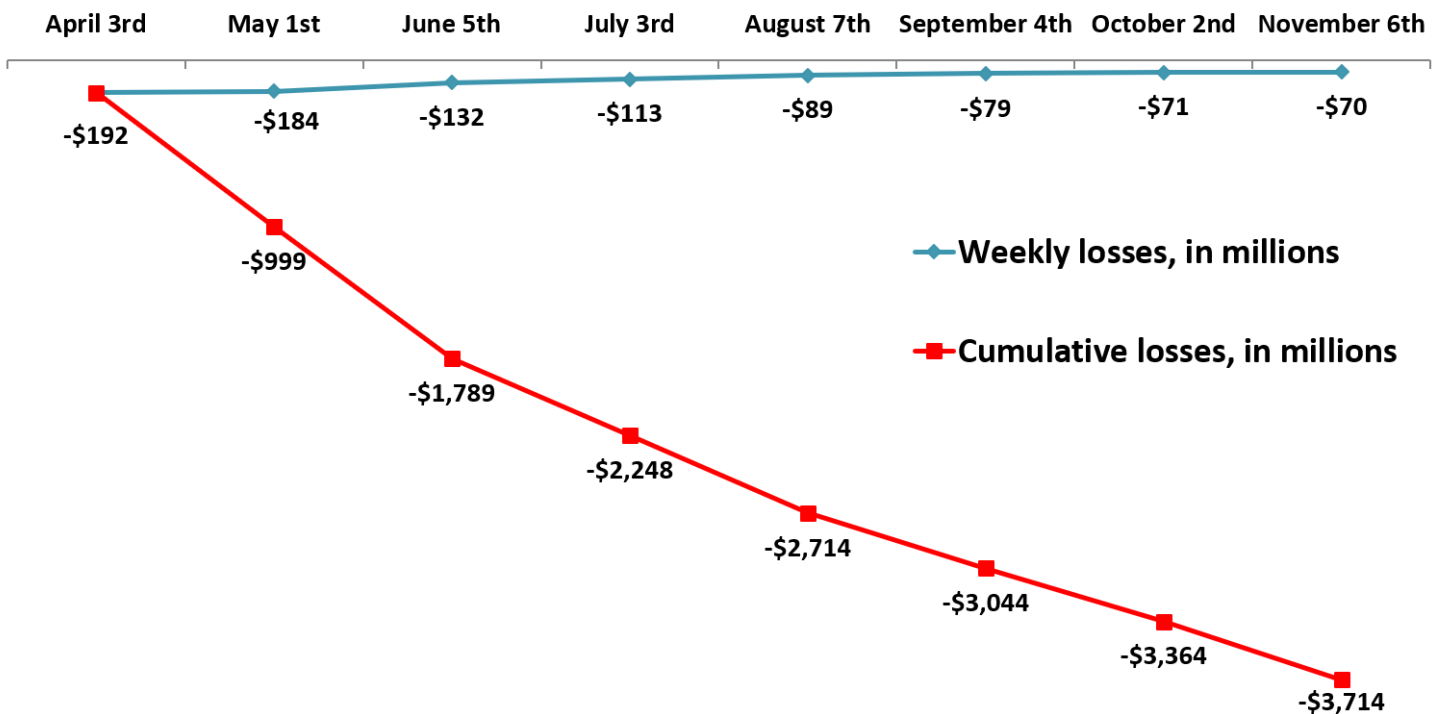
Notes: U.S. percentage includes health centers in Puerto Rico (PR) and two other health centers in the U.S. territories. States were categorized based on rounded percentages. Source: Bureau of Primary Health Care. Health Center COVID-19 Survey. Data as of November 6th, 2020.



## Financial Uncertainty and Revenue Losses

The loss in patient visits has translated into ongoing and substantial revenue losses, estimated at \$3.714 billion nationwide over the seven months, an amount that represents 11.8 percent of total revenue reported nationally in 2019 (**Figure 8**). Cumulative patient revenue losses over this time period varied by state, ranging from four million in Wyoming to \$751 million in California (**Table 1**).

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



Estimated cumulative losses of \$3.714 billion over 7 months accounted for 11.8% of total revenue reported in 2019.

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

In addition to the funding directly allocated to community health centers through the Coronavirus Preparedness and Response Supplemental Appropriations Act, the CARES Act, and the PPPHCEA, [community health centers also have received some financial support](#) through the Paycheck Protection Program, the HHS Provider Relief Fund, and HRSA Uninsured Claims Fund. However, it is unclear when – or how much – additional COVID-19 relief aid will be forthcoming, with the delays adding to the financial burden. Health centers are also facing financial uncertainty because the Community Health Center Fund (CHCF), which [accounted for over 70 percent of federal health center grant funding in FY2019](#), has been extended only to December 11th, 2020. The continued financial uncertainty about both any additional COVID-19 relief funding and the extension of the CHCF, coupled with the sheer magnitude of estimated patient revenue losses to date, could prevent health centers from fully restoring services and reopening sites, and could also force health centers to cut back and lay off staff members, resulting in further job losses and economic distress in the communities that health centers serve.

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

State	Cumulative losses (in millions)	State	Cumulative losses (in millions)
AK	-\$24	MT	-\$17
AL	-\$22	NC	-\$57
AR	-\$21	ND	-\$6
AZ	-\$61	NE	-\$11
CA	-\$751	NH	-\$9
CO	-\$62	NJ	-\$49
CT	-\$45	NM	-\$29
DC	-\$38	NV	-\$6
DE	-\$5	NY	-\$302
FL	-\$154	OH	-\$75
GA	-\$50	OK	-\$28
HI	-\$25	OR	-\$77
IA	-\$25	PA	-\$91
ID	-\$32	PR	-\$44
IL	-\$124	RI	-\$24
IN	-\$69	SC	-\$65
KS	-\$22	SD	-\$6
KY	-\$78	TN	-\$33
LA	-\$51	TX	-\$176
MA	-\$84	UT	-\$17
MD	-\$60	VA	-\$31
ME	-\$32	VT	-\$21
MI	-\$72	WA	-\$195
MN	-\$25	WI	-\$50
MO	-\$86	WV	-\$67
MS	-\$34	WY	-\$4

Note: Weekly patient revenue losses estimated based on the decline in weekly visits compared to pre-COVID-19 average weekly visits reported each week from the Health Center COVID-19 Survey and weekly patient revenue (total patient revenue reported for 2019 in the 2019 Uniform Data System, divided by 52). Data for DC and LA health centers were not reported the week of September 4th, and ND and OK health centers for the week of October 30th, so the visit declines for those weeks were imputed by taking the average of the weekly declines the week before and after. Cumulative losses reflect the sum of estimated losses based on 32 weeks of survey data.

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

## Virtual Visits

As a way to continue to provide care to their patients and to earn patient revenue, community health centers rapidly pivoted to telehealth. In 2019, [less than half \(43 percent\)](#) of community health centers reported using telemedicine to provide remote clinical care services and virtual visits accounted for [only 0.4 percent of the 122.8 million health center visits that year](#). At its peak, as of April 24th, 54 percent of visits on average were conducted virtually; this percentage had fallen by half, to [27 percent in October](#), and the same percentage was reported as of November 6th. Recent policy changes may have helped to increase [health centers' use of telehealth services](#) during the pandemic, but [telehealth utilization is not uniform across health centers](#), and many still face barriers to adopting or expanding telehealth.

## Supply of Personal Protective Equipment

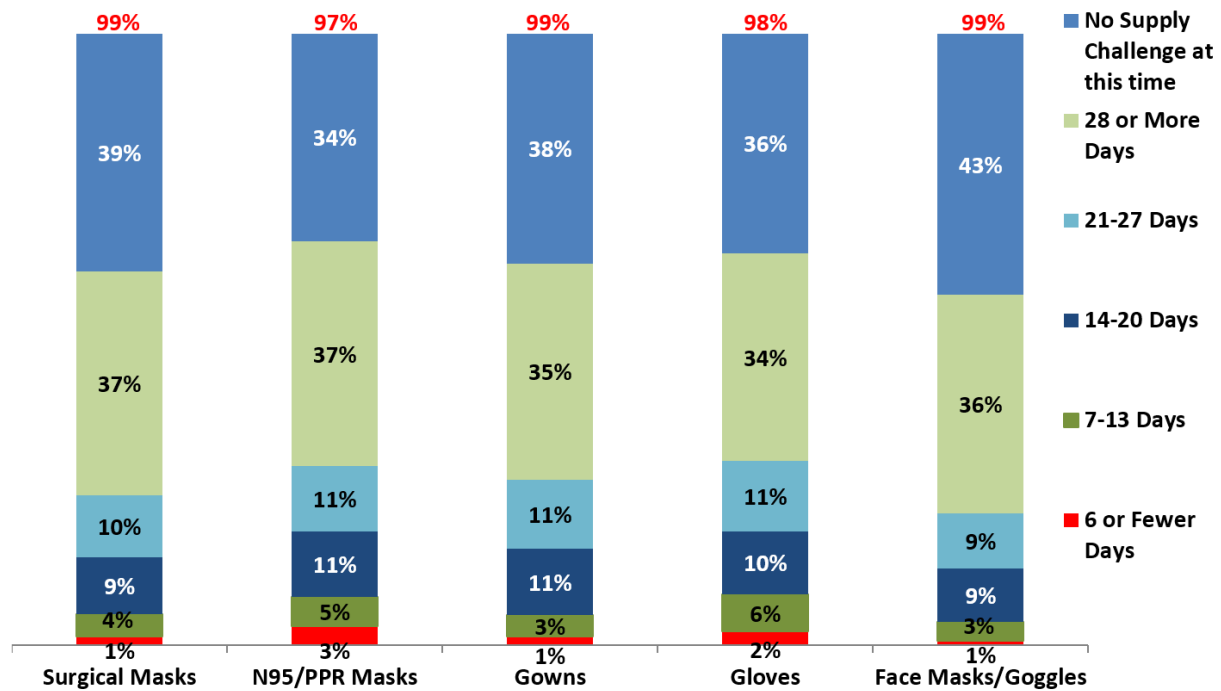
HRSA has queried health centers about their supply of personal protective equipment (PPE) over seven months. The [question on PPE supply](#) was amended in September so that data are not comparable over the seven months, but as of November 6th (**Figure 9**), nearly all health centers reported that they either do not need some types of PPE or have adequate supplies of all five types of PPE supplies for the next week or more. Earlier data based on the original PPE question show that the share of responding health centers reporting adequate supplies of PPE ranged by type from 67 percent to 89 percent in the first week to 94 to 97 percent by the end of August (see [Figure 11 in our six-month report](#)).

## Flu vaccines

In Week 30, HRSA began asking health centers about the number of flu vaccines that they had administered since August 2020 and for the following weeks, how many they had administered in the past week. As of the week of October 23rd, health centers had administered 1,201,345 flu vaccines since August 2020, and administered 441,776 the week ending October 30th and 363,899 the week ending November 6th, for a total of 2,007,020 flu vaccines. This number amounts to 42 percent of the [4.79 million health center patients who received seasonal flu vaccines](#) for the entire year of 2019, although it cannot be determined from the UDS data when flu vaccines were administered. However, this may suggest an increase in flu vaccines at health centers that aligns with recent reports [of increased flu vaccinations in New York as a precautionary measure against a potential "twindemic"](#) from the regular flu season and the COVID-19 pandemic.

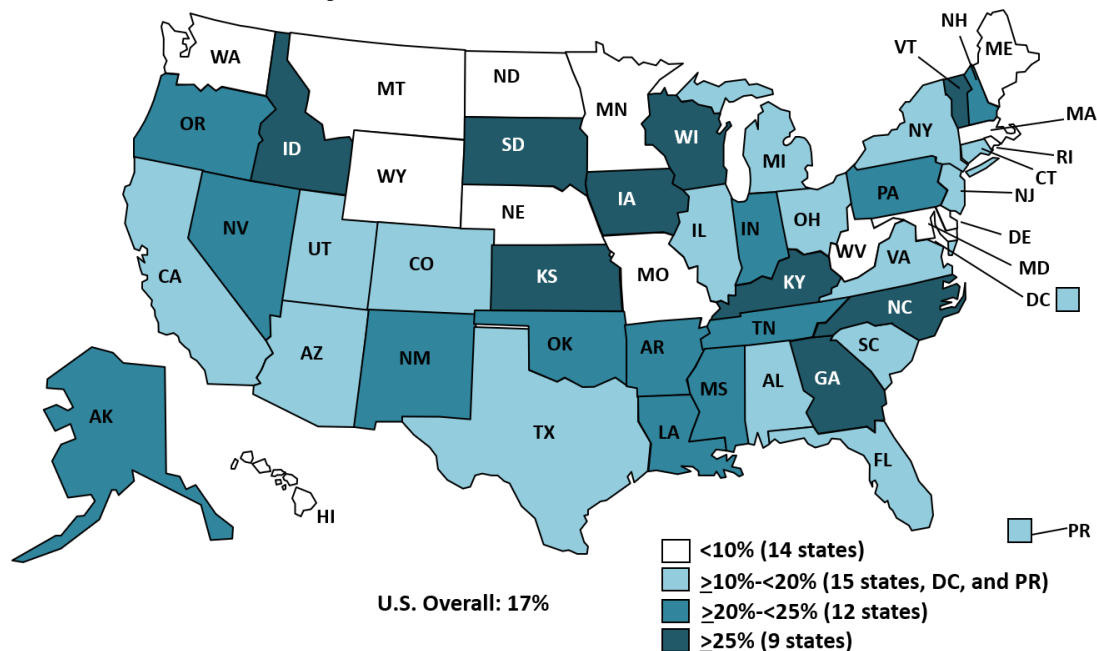
Perhaps to gauge potential future challenges for health center distribution of a COVID-19 vaccine, HRSA also began asking that week about the share of health centers that experienced challenges obtaining an adequate supply of flu vaccine. The share of health centers nationally reporting challenges fell from 27 percent as of October 23rd, to 21 percent as of October 30th, and then to 17 percent as of November 6th. However, there is considerable state variation, with at least 25 percent of health centers in nine states reporting challenges obtaining an adequate flu vaccine supply that week, and in an additional 12 states, at least 20 percent of health centers reporting such challenges (**Figure 10**). According to [CDC guidance on distribution plans for an eventual COVID-19 vaccine](#), community health centers are expected to be involved in planning efforts for vaccine distribution and COVID-19 vaccine administration. However, there is uncertainty about the extent to which health centers will be involved in administering the vaccine. In the first phases of vaccine distribution, the [vaccine is most likely to be administered by hospitals](#) and [it is expected that the first vaccines](#) will go to health care workers, essential workers, the elderly, and people with certain medical conditions. It appears that the federal government is planning for [retail pharmacies to administer the vaccine in community settings](#).

**Figure 9. Community Health Center Availability of Adequate PPE Supply, By Type and Duration, as of November 6th**



Note: The figures in red indicate the share of community health centers that either do not need PPE or have adequate PPE for one or more weeks. Source: Bureau of Primary Health Care. Health Center COVID-19 Survey. HRSA. Data as of November 6th, 2020.

**Figure 10. Share of Community Health Centers Experiencing Challenges in Obtaining an Adequate Supply of Flu Vaccine, By State, as of November 6th**



Notes: U.S. percentage includes health centers in Puerto Rico (PR) and two other health centers in the U.S. territories. States were categorized based on rounded percentages. Source: Bureau of Primary Health Care. Health Center COVID-19 Survey. Data as of November 6th, 2020.

## Conclusion

Seven months of reported data from HRSA's Health Center COVID-19 Survey indicate that community health centers have risen to meet the challenges of the COVID-19 pandemic, with nearly all offering COVID-19 testing and more than five million COVID-19 diagnostic tests conducted by health centers nationally over seven months. Operational capacity has also improved over this time period, but site closures and declines in weekly visits remain substantial, resulting in an estimated \$3.714 billion in cumulative patient revenue losses over seven months.

These steep revenue losses, as well as the known widespread racial/ethnic and income disparities in the risk of serious illness from COVID-19, the high proportion of low-income and racial/ethnic minority health center patients at greater risk for infection, and the recent surge in coronavirus cases, suggest a continued need for the expansion of health center testing resources and support for the full participation of health centers in vaccine distribution plans. Furthermore, the essential role of community health centers in serving Latino, Black, and other minority and low-income communities, those known to be the most affected by COVID-19 and other public health crises, underscores the need for long-term, stable federal investment to sustain and expand access to care.

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