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Federally Qualified Health Centers (FQHCs) and the Black-White Health Gap

Alarming Trends Between 2014 and 2021; Investment and Research Opportunities

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INTRODUCTION

The COVID-19 pandemic has drawn critical attention to the distressing racial health disparities in the United States. It has uncovered the Black-White health gap, exposing significant differences in life expectancy, maternal and infant mortality rates, and the prevalence of chronic diseases like diabetes, heart disease, and hypertension. In a recent paper, Broadstreet Impact Services delved into the underlying causes fueling this health gap and put forward practical recommendations for investors seeking to narrow these concerning disparities. One key factor that emerged from this investigation was the accessibility and affordability of healthcare. Alarmingly, the research highlighted that Black Americans are less likely to have jobs that provide employer-subsidized health insurance, leading to a higher likelihood of forgoing preventive care or treatment due to financial barriers.

Addressing these inequities head-on, Broadstreet is committed to making investments that contribute to equitable access to healthcare for all. To achieve this goal, Broadstreet has provided financing for the development or renovation of health centers to improve the quality and accessibility of healthcare services across the country. While we rely on the expertise of LISC local offices to identify viable health centers that address the healthcare needs of residents in low-income communities, it is crucial to deepen our understanding of how these health centers compare to others across the country. This analysis enables us — along with other investors committed to equitable healthcare access — to effectively allocate financial resources and address the challenges that health centers face in delivering quality care. This is why we have chosen to publish our initial findings.

This brief examines the health outcomes of patients utilizing Federally Qualified Health Centers (FQHCs) and further investigates the Black-White gap in relation to specific adverse health outcomes, namely low birth weight births, uncontrolled high blood pressure, and poor control of diabetes. FQHCs, as defined by the Health Resources and Services Administration (HRSA), are community-based and patient-directed organizations that offer affordable, accessible, and high-quality primary health care services to diverse populations, including individuals experiencing homelessness, agricultural workers, residents of public housing, and veterans. These health centers integrate various services such as pharmacy, mental health, substance use disorder, and oral health, thereby overcoming barriers to healthcare access imposed by economic, geographic, or cultural factors.

DATA

The HRSA requires FQHCs to report a core set of individual patient variables such as demographic and health outcome data, services provided, and patient utilization. These data are part of the Uniform Data System (UDS), a standardized reporting system implemented by HRSA to assess the effectiveness of FQHCs in meeting the healthcare needs of diverse communities. In our analysis, we also include FQHC "look-alike" clinics that meet the service criteria but do not receive HRSA funding. Although not obligated to report to HRSA, data from these look-alike clinics enhances the scope of our analysis by including a more representative sample of health centers operating in underserved communities. The self-reported data from "look-alike" clinics, which see similar patients experiencing similar health outcomes to those served by FQHCs, is crucial for HRSA to expand healthcare access, evaluate care quality, reduce costs, and address health disparities affecting the communities served by these health centers.

To examine health outcome trends across different racial groups and time periods, we utilize publicly available data from HRSA. Data include the number of patients with chronic conditions (e.g., high blood pressure and diabetes), and acute healthcare outcomes such as low birthweight babies. To further evaluate the performance of health centers based on race, we categorize FQHCs into three groups:

- Majority White serving health centers: These centers have over 50 percent of patients identifying as white.
- Majority Black serving health centers: These centers have over 50 percent of patients identifying as Black.
- Majority Non-White serving health centers: These centers have over 50 percent of patients identifying as non-White, but less than 50 percent identify as Black.

For our analysis in this brief, we utilize publicly available data reported by the HRSA for the years 2014, 2019, and 2021. Examining the data from 2014 and 2019 allows us to explore health outcome trends and disparities before the pandemic. Additionally, the 2021 data enables us to investigate health outcomes for the most recent year available and assess the impact of the pandemic on health outcomes and disparities.

RESULTS

The following reported statistics are based on aggregate values and do not account for differences in patient health outcomes across individual health clinics who share an HRSA ID as a single health center.

FQHC AND PATIENT CHARACTERISTICS

The dataset includes information from 1,481 FQHCs operating across more than 14,000 locations throughout the United States. Among these health centers, 922 are majority White serving, 180 are majority Black serving, and 379 serve a majority non-White patient population. In 2021, FQHCs served nearly 1 out of 10 Americans, amounting to over 31 million patients. Out of these patients, 5.6 million (18 percent) identified as Black, 18 million (58 percent) identified as White, and the remaining 7.6 million (24 percent) identified as another race or chose not to report their race.

Among patients with available income data (70 percent), nearly 90 percent were living below 200 percent of the poverty line. Majority Black and Majority Non-White health centers have a slightly higher proportion of patients living below 200 percent of the poverty line compared to majority White-serving centers (93 percent versus 88 percent). Medicaid coverage is prevalent, with over 48 percent of patients paying with Medicaid, while 20 percent of all patients were uninsured. Overall, over 68 percent of FQHC patients are on Medicaid or are uninsured, highlighting the important role of FQHCs in providing health care to the poorest and most vulnerable population.

In majority White serving centers, approximately 74 percent of patients are White. Even though majority White serving centers have a smaller proportion of Black patients (10 percent), they still provide care for 34 percent of all Black patients who receive care from FQHCs. In majority Black serving centers, about 67 percent of patients are Black, and 20 percent are White. In majority non-White serving centers, approximately 21 percent of patients are Black, and 31 percent are White.

Table 1. Summary statistics, Health Centers and Lookalikes 2021

	Full sample	Majority White	Majority Black	Majority Non-White
Percent of Patients Uninsured	20.0%	19.8%	23.5%	19.3%
Percent Living <200% of Poverty Line	89.6%	87.9%	92.7%	92.5%
Percent on Medicaid	48.1%	45.8%	45.9%	54.2%
Total Black Patients	5,597,204	1,908,661	1,937,706	1,750,837
Total White Patients	17,901,368	14,694,481	567,910	2,638,977
Percent of Patients Identify as Black	18.0%	9.7%	66.9%	20.6%
Percent of Patients Identify as White	57.5%	74.3%	19.6%	31.1%
Number of Health Centers	1,481	922	180	379

LOW BIRTHWEIGHT BIRTHS

Low birthweight births refer to babies born weighing less than 5 pounds and 8 ounces. The primary cause of low birthweight is premature birth. Other factors contributing to low birthweight include inadequate fetal growth (intrauterine growth restriction) due to maternal health issues, placental problems, and behavioral and environmental factors. Infants with a low birthweight are at risk for complications such as respiratory problems, infections, and other medical issues throughout their life course.

In 2019, 8 percent of infants born in health centers had a low birthweight, marking a 10 percent increase from 2014. Among these births, 12 percent of Black infants had a low birthweight compared to 7.7 percent of White infants. Between 2014 and 2019, the prevalence of low birthweight increased by 12 percent for Black infants and 6 percent for White infants, resulting in a widening of the Black-White low birthweight gap. Unfortunately, publicly available birth weight data for 2021 was incomplete at the time of writing this brief, preventing the reporting of post-pandemic changes in birth weight.

Similar patterns were observed when examining race at the health center level, with some interesting variations. In 2019, majority Black serving health centers had the highest percentage of infants born with low birth weight at 11 percent, compared to 7.6 percent for majority White serving health centers and 8.2 percent for majority Non-White serving health centers. Across all health center types, there was an increase in the percentage of infants born with low birth weight between 2014 and 2019. The most substantial increase of 15 percent occurred in majority Black serving health centers.

Interestingly, while there was an overall increase in low birth weight births among Black infants between 2014 and 2019, regardless of health center type, majority Black serving health centers experienced a decrease in the

percentage of low birth weight births among White infants. In 2014, majority Black and majority non-White serving health centers had the smallest Black-White low birth weight gap, with Black women being 1.4 times more likely to have a low birth weight baby than White women, compared to 1.6 times more likely in majority White serving health centers. However, due to the larger increase in low birth weight births among Black women and the decrease in low birth weight births among White women, majority Black serving health centers had the largest gap in 2019, with Black women being 1.7 times more likely to have a low birth weight baby. This is compared Black women being 1.3 and 1.6 times more likely to have a low birth weight baby than White women in majority non-White and majority White serving health centers, respectively.

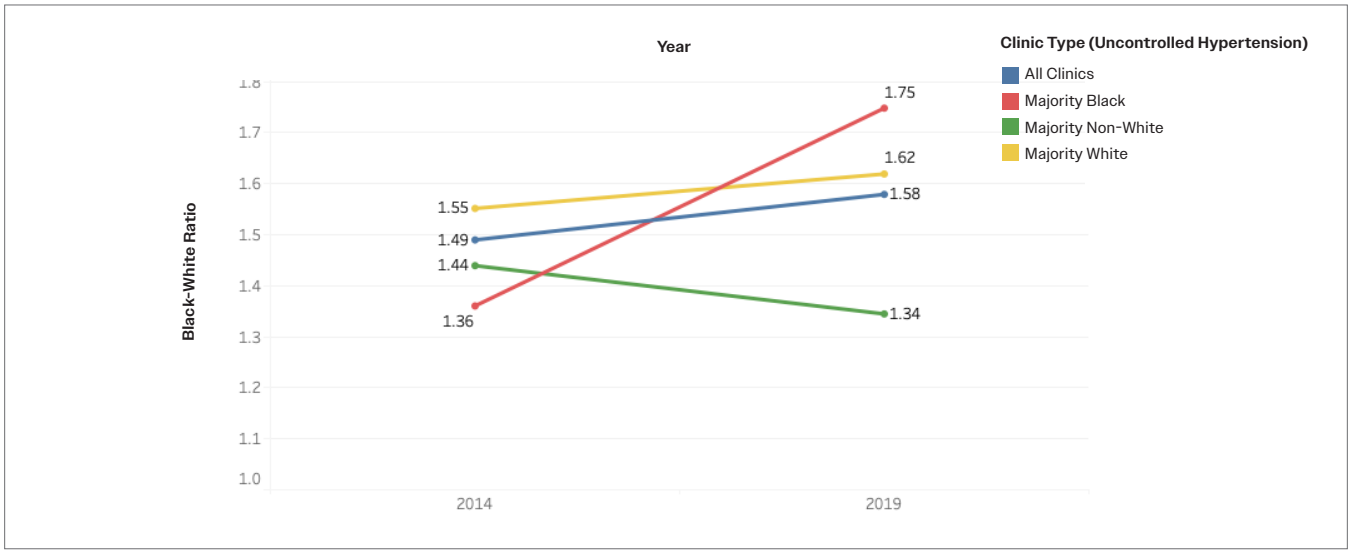
In summary, there was a general deterioration in birthweight outcomes between 2014 and 2019, especially for Black mothers and especially at health centers primarily serving Black patients. These trends contributed to the widening of the health gap between Black and White populations.

UNCONTROLLED HIGH BLOOD PRESSURE

High blood pressure is a risk factor for heart disease and stroke by affecting the body's arteries. In 2021, 18 percent of health center patients were diagnosed with high blood pressure. This was an increase of 36 percent from 2014 when 13.5 percent of health center patients were diagnosed with high blood pressure. Black patients were 1.8 times more likely to be diagnosed with high blood pressure than White patients in 2014, a rate that did not increase meaningfully in 2019 or 2021.

While the Black-White health gap in relation to high blood pressure diagnoses did not increase between 2014 and 2021, Majority Black serving health centers experienced the largest increase in high blood pressure. The prevalence of high blood pressure increased by 48 percent in Majority Black serving health centers compared to 37 percent in Majority White serving health centers and 32 percent in majority non-White serving health centers.

Black-White Ratio of Low-Birthweight Births (2014-2019)



Source: HRSA Uniform Data System (UDS)
The trend of Black-White Ratio of Poor Diabetes Control by year. Color shows details about Clinic Type. The marks are labeled as the Black-White Ratio of reported Poor Diabetes Control for 2014 and 2019.

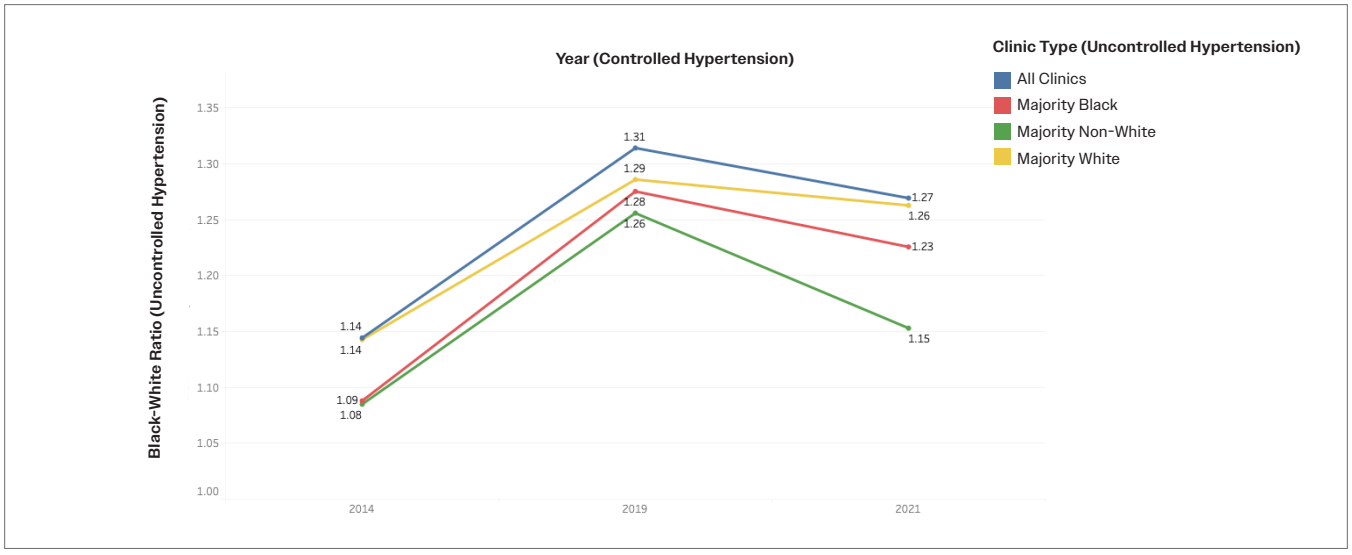
Among people with high blood pressure, blood pressure control means having a systolic blood pressure less than 140 mmHg and a diastolic blood pressure less than 90 mmHg. In 2014, 53 percent of high blood pressure patients did not have their blood pressure under control. Rates of uncontrolled blood pressure decreased by an impressive 31 percent between 2014 and 2019, and then increased by 10 percent between 2019 and 2021. Notably, the trend of a large decline followed by a moderate increase in uncontrolled blood pressure was experienced by patients of all races and across each type of health center.

Despite being almost twice as likely to be diagnosed with high blood pressure compared to White patients, Black patients with high blood pressure were only 15 percent more likely in 2014 to not have their blood pressure under control compared to White patients with high blood pressure. This percentage jumped to 31 percent in 2019 and declined to 27 percent in 2021, reflecting a widening Black-White health gap that counterintuitively did not increase during the first years of the COVID-19 pandemic.

The Black-White gap in blood pressure control for all health center types mimic trends in disparities for the full sample of health centers, with the gap increasing between 2014 and 2019 and then declining between 2019 and 2021. Disparities did not differ substantially between health center types, yet Majority Black serving health centers' patients were 20 percent more likely to have uncontrolled blood pressure in 2021 than White serving health centers – another reflection of the Black-White health gap.

In summary: although the total number of people with high blood pressure (controlled or uncontrolled) increased between 2014 and 2021, a greater percentage of people diagnosed with high blood pressure in 2021 had their blood pressure under control. Black patients were significantly more likely to have high blood pressure than White patients, and yet only somewhat more likely to have uncontrolled blood pressure. The Black-White gap in uncontrolled blood pressure worsened between 2014 and 2021 yet improved slightly during the first years of the COVID-19 pandemic.

Black-White Ratio of Uncontrolled Hypertension (2014-2021)



Source: HRSA Uniform Data System (UDS)
The trend of Black-White Ratio of Uncontrolled Hypertension by year. Color shows details about Clinic Type. The marks are labeled as the Black-White Ratio of reported Uncontrolled Hypertension for 2014, 2019, and 2021.

DIABETES AND HEMOGLOBIN A1C POOR CONTROL

In 2021, 8.8 percent of health center patients had a diabetes diagnosis. This was an increase of 23 percent from 2014 when 7.1 percent of health center patients had a diabetes diagnosis. There was no noticeable difference in prevalence rates of diabetes between 2019 and 2021. Ten percent of Black patients and 5 percent of White patients were diagnosed with diabetes in 2021.

The largest increase in diabetes between 2014 and 2021 occurred among patients from Majority Black serving health centers. The prevalence of diabetes increased by 31 percent in Majority Black serving health centers compared to only 23 percent in Majority White and majority non-White serving health centers. Between 2014 and 2021, the percent of Black patients with diabetes increased by 20 percent in majority White and majority non-White serving health centers but increased by 33 percent in majority Black serving health centers. The prevalence of diabetes among White patients decreased by 3 percent in majority non-White health centers but increased by 17 percent and 30 percent in majority White serving health centers and majority Black serving health centers, respectively.

Among diabetic patients, a Hemoglobin A1c (HbA1c) level greater than 9 percent indicates poor control of diabetes. Poor control of diabetes is a risk factor for complications including renal failure, blindness, and neurologic damage. In 2014, the share of diabetic patients with HbA1c levels greater than 9 percent was about the same for Black and White patients, 24 percent of Black patients and 23 percent for White patients; Black diabetic patients were 1.04 times more likely to have HbA1c levels greater than 9 percent. Levels started to diverge after 2014: in 2021, 32 percent of

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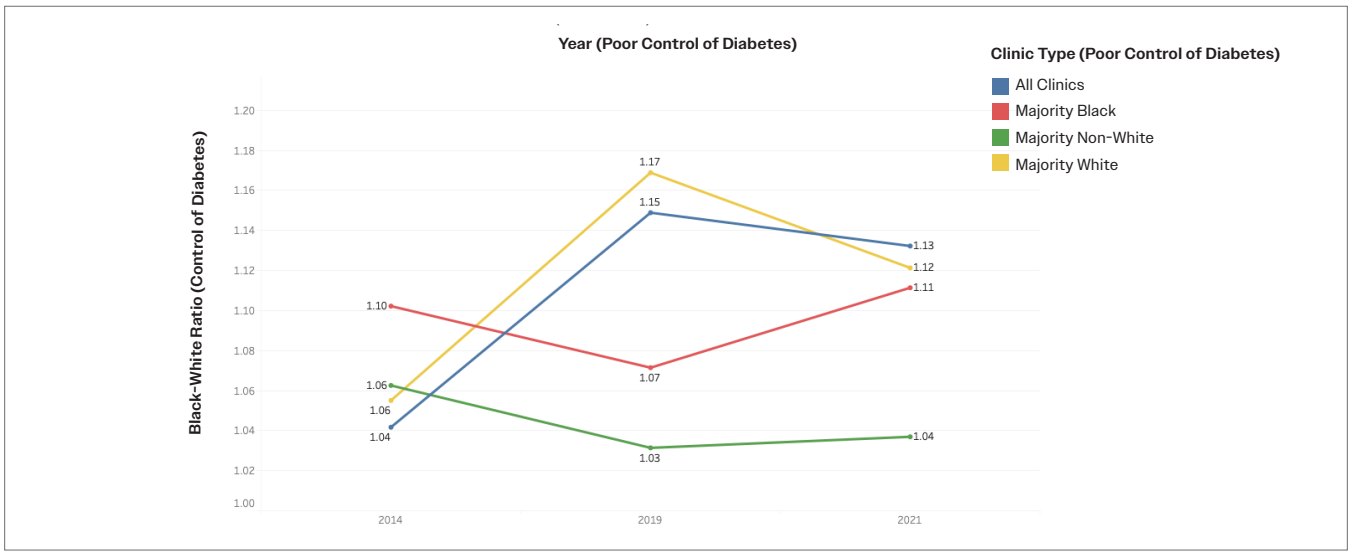
all diabetic patients had HbA1c levels greater than 9 percent. Black patients were 1.13 times more likely to have HbA1c levels greater than 9 percent with 33 percent of Black patients having poor control of their diabetes compared to 29 percent of White patients. The Black-White gap in poorly controlled HbA1c levels for majority White serving health centers mimics the gap and trend for the full sample of health centers. Black diabetic patients were 1.06 and 1.12 times more likely to have HbA1c levels greater than 9 percent than White diabetic patients in 2014 and 2021, respectively. In majority Black and majority non-White serving health centers the Black-White gap in poorly controlled HbA1c levels did not change substantially between 2014 and 2021. Black diabetic patients were 1.11 and 1.04 times more likely to have HbA1c levels greater than 9 percent at majority Black and majority non-White serving health centers, respectively.

In brief, the prevalence of diabetes – both controlled and uncontrolled – increased between 2014 and 2021, yet counterintuitively did not worsen over the first years of the COVID-19 pandemic. While Black patients were significantly more likely to be diagnosed with diabetes than White patients, the Black-White health gap in poorly controlled diabetes was only noticeable after investigating outcomes by health center type. While the gap in poorly controlled diabetes widened in majority White serving health centers between 2014 and 2021, the gap was mainly unchanged in majority Black and majority non-White serving health centers.

Black-White Ratio of Poor Diabetes Control (2014-2021)



Source: HRSA Uniform Data System (UDS)
The trend of Black-White Ratio of Poor Diabetes Control by year. Color shows details about Clinic Type. The marks are labeled as the Black-White Ratio of reported Diabetes Control for 2014, 2019, and 2021.

DISCUSSION AND IMPLICATIONS FOR INVESTORS

Across the three health outcomes examined, we have observed that low birth weight and poorly controlled diabetes have worsened from 2014 to 2021, while poorly controlled high blood pressure has shown improvement.[1] Racial health gaps exist for each of these outcomes and have been exacerbated over time. Black patients were 1.6 times more likely to have babies with low birth weight and approximately 2.1 times more likely to have uncontrolled high blood pressure or diabetes compared to White patients.[2] These disparities are particularly pronounced among patients served at majority Black serving health centers, which have the worst patient outcomes.

The racial health disparities experienced by patients of Federally Qualified Health Centers (FQHCs) show some notable differences compared to national trends. According to the US Department of Health and Human Services' Office of Minority Health, African Americans were 1.4 times as likely to have uncontrolled high blood pressure than Whites—a smaller disparity than what was identified in this study.[3] On the other hand, the Black-White health gap concerning uncontrolled diabetes and low birth weight prevalence is larger at the national level than what this paper reveals: Blacks were 3.8 times more likely to be admitted to a hospital for uncontrolled diabetes than Whites, and they were 2 times as likely to have low birth weight babies.[4] Since FQHCs primarily serve low-income patients, income is an established social determinant of health, and Black people are more likely to be low income than Whites, it stands to reason that Black-White health disparities would generally be greater at the national level than within the subset of patients served by FQHCs. Furthermore, our finding that Black and White patients served by FQHCs have similar income levels and divergent health outcomes contributes to the large body of evidence indicating that race effects health independent of economic status.

In light of these concerning trends, how can investors effectively address racial health inequities? One clear finding is that investing in

health centers primarily serving Black patients is crucial for narrowing the Black-White health gap. Enhancing their capacity to treat and control hypertension and diabetes effectively has been shown to increase life expectancy by an average of two to five years.[5]

Furthermore, investors have an opportunity to reduce health disparities by financing programs focused on maternal and child health, particularly in majority Black-serving health centers. Investing in the establishment or expansion of evidence-based programs that target the reduction of low birth weights, such as prenatal care services, nutritional support initiatives, and mental health services, holds promise for narrowing the Black-White health gap.[6] While these investment strategies may seem apparent, the widening disparities in racial birthweight outcomes emphasize the real need for greater investment in evidence-based programs.

Investing in health centers primarily serving Black patients not only benefits Black patients disproportionately but also provides vital funding to health centers that generally exhibit poor patient outcomes, regardless of race.[7] It is worth noting that investing in White-majority serving clinics, without addressing racial disparities, may inadvertently widen health inequities even if health outcomes improve for their patients of color.

ADDITIONAL RESEARCH QUESTIONS

The following research questions should be further explored to inform the efforts of investors and others in advancing health equity:

1. Why have health outcomes shown a downward trend since 2014? The aging population in the US is a primary contributing factor, as the percentage of people over 55 grew 20 times faster (27%) than the collective population under 55 (1.3%) between 2010 and 2020. This helps explain the rise in hypertension and diabetes since the risk of both conditions increases significantly with age. However, further research is needed to understand the causes behind the increase in low birth weights.

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2. Why did health outcomes generally worsen more rapidly between 2014 and 2019 compared to the period between 2019 and 2021? This counterintuitive finding requires examination, considering the disparate racial health outcomes observed during the COVID-19 pandemic.

3. Why are Black-White disparities in uncontrolled diabetes greater among FQHC patients than patients at all hospitals and clinics reporting to the National Center for Health Statistics? Why are Black-White disparities in low birth weights and uncontrolled hypertension among FQHC patients smaller than national-level statistics suggest?

4. Why did the prevalence of controlled hypertension improve despite an overall increase in high blood pressure diagnoses? How can investors and health centers build upon the gains made between 2014 and 2019?

5. What is the prevalence of maternal, child, and adolescent facilities/services (e.g., prenatal clinics, OB/GYNs, doulas) in communities with the highest and lowest rates of low birth weight? What are the rates of prenatal care utilization? Is the accessibility of prenatal care a significant contributing factor to the gap in these outcomes?

6. How accessible are the clinics included in this study to the communities they serve? Overflowing clinics and overburdened staff hinder improvements in patient outcomes. What percentage of these clinics are located in medically underserved areas, and does this vary by race? For each type of health center (majority Black-serving, majority White-serving, and majority non-White-serving), what percentage of them operate above their targeted patient capacity?

Addressing these research questions can provide meaningful insights into how investors can allocate resources to eliminate barriers to long and healthy lives, irrespective of individuals' skin color. With health outcomes worsening and racial health disparities widening, this is an urgent ethical imperative.

1. While a larger share of people with high blood pressure have it under control in 2021 than 2014, the prevalence of high blood pressure dramatically increased between 2014 and 2021. This means that more people in absolute terms have uncontrolled blood pressure in 2021 than 2014.

2. Black patients are 1.8 times more likely to have high blood pressure and 1.3 times more likely to have uncontrolled high blood pressure if they are diagnosed with high blood pressure. Multiplying 1.8 by 1.3 indicates that Black patients are 2.1 times more likely to have uncontrolled blood pressure than White patients. Similarly, Black patients are twice more likely to be diagnosed with diabetes and 1.13 times more likely to have uncontrolled diabetes if they are diagnosed with diabetes. Therefore, they are 2.1 times (1.8*1.13) more likely to have uncontrolled diabetes.

3. Heart Disease and African Americans | Office of Minority Health (hhs.gov)

4. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18; https://www.marchofdimes.org/peristats/

5. https://www.cdc.gov/diabetes/resources-publications/research-summaries/reaching-treatment-goals.html; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1993937/

6. https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/evidence-based-resources

7. Rather than a reflection of an intrinsic deficiency of the health clinics (or the staff) serving predominantly Black patients, it is most likely that this disparity in health outcomes is the result of other confounding factors beyond the scope of our data which is discussed further in Narrowing the Black-White Health Gap: Opportunities for Private Investment, for example limited or difficult access to healthcare facilities for Black patients or the quality of health insurance coverage and the resultant affordability of care. Likewise, controlling for many of the social determinants of health (e.g. education, employment status, and income level) at the FQHC level would assist investors in determining which interventions would be most effective in narrowing health equity gaps.

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(Data as of 9/30/2023).

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