# Addressing Patients' Social Needs During COVID-19

Produced by the **MacColl Center for Health Care Innovation** for the **Washington Association for Community Health**

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# Outline

# Background

## Purpose

- Identify best practices and gather resources for addressing social needs within health centers during the COVID-19 pandemic.
- Apply learnings to Washington Association for Community Health's social needs collaborative and share results with participating health centers.

## Methods

- Scan of peer reviewed and gray literature published since March 2020.
  - Started with the Social Interventions Research and Evaluation Network (SIREN) Evidence and Resource Library to find curated results related to social needs in the healthcare setting.
  - Other research databases used: PubMed Central, CDC Library, Health City Boston Medical Center Health System.
- Interviews with organizations (National Associations, PCAs, FQHCs) identified through professional connections who are testing best practices for addressing social needs within health centers during a pandemic.
- Summary of best practices from the literature and interviews by topic.

# Best practices for addressing social needs within health centers during COVID-19

| | Best Practices | Examples from Interviews/Literature |
|---|---|---|
| **Screen for Social Needs** | • Use a social needs screener, adapt it as needed (to address most critical or relevant emerging needs first).<br>• Train staff on empathic inquiry to help increase their comfort with asking about social needs. | ➢ MAs use a universal pre-screen question during rooming: "We know there are things that effect health beyond health care, is that something you could use help with?"<br>➢ Adapt screening tool to focus on the most important or immediate needs. If short on time, prioritize questions and skip the full tool.<br>➢ Integrate social needs screening into the electronic health record. |
| **Do Proactive Outreach** | • Conduct proactive outreach and wellness checks to all patients or to the most vulnerable (as resources allow). | ➢ Community Health Workers reach out by phone to support patients with COVID-19 to address their needs for self-quarantine.<br>➢ Stratify patients for outreach to create care pathways to inform public health emergency preparation. |
| **Plan to Problem Solve** | • Designate a champion to lead the work of addressing social needs. This person should anticipate challenges and respond with persistence and flexibility. | ➢ Bring community-based organizations and health center staff together to problem solve and develop shared workflows for connecting patients to resources.<br>➢ Be collaborative; anticipate resistance and work to address people's concerns.<br>➢ Take the steps you can now, and plan to figure out additional steps down the road. Think of the work as iterative. |

Staff had a fear of cold calling patients, but we actually heard a lot of gratitude for reaching out. "Thanks for checking in. I didn't expect to hear from the health center." –Oregon Primary Care Association

You need a champion, someone willing to break down barriers and try again if they get a "no." You have to be in a learning mode. You aren't going to find the right answer at first. –Cambridge Health Alliance



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# Best practices for addressing social needs within health centers during COVID-19

| | Best Practices | Examples from Interviews/Literature |
|---|---|---|
| **Leverage the Full Care Team** | • Leverage staff skills and knowledge. Get the full care team involved in social needs work and revise workflows to support this. | ➢ Community health workers stepping into leadership roles as the need for non-clinical work increases.<br>➢ Staff who may have otherwise been furloughed are redeployed to help with social needs screening. |

Even schedulers should be aware of social determinants of health challenges and be empowered to refer if they notice any distress. –Pueblo Community Health Center

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| **Strengthen Partnerships** | • Strengthen existing partnerships, especially with community organizations and local public health departments. | ➢ Connect with other Community Health Centers to share successes and challenges through peer groups.<br>➢ Leverage partnerships with food distribution centers, schools, and lawmakers to distribute food to kids during COVID-related school closures. |

Partnerships were almost non-existent before, and people were duplicating work. Since COVID we've strengthened those partnerships. –Colorado Community Health Network

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| **Bring Resources into the Clinic** | • If a need cannot be met in the community, bring services in house. If there is a community organization that meets the need, partner with them. | ➢ New resources clinics are offering in house include hygiene supplies, food distribution, utility assistance, housing coordinator, and legal services.<br>➢ In house resources allow clinics to meet multiple needs at the same time. For example, if transportation is an issue, offer a clinic visit on food distribution day so both needs can be met (Snow 2020). |



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# Best practices for addressing social needs within health centers during COVID-19

| | Best Practices | Examples from Interviews/Literature |
|---|---|---|
| **Gather Information on Community Resources** | • Maintain detailed, up to date information on community resources, including eligibility criteria.<br>• Staff at the health center should be in contact with staff at community organizations offering resources. | ➢ Leverage Community Health Workers to connect with services and stay up-to-date on what resources are available and how people can access them in the ever-changing COVID-19 landscape.<br>➢ Case manager attends community resource meetings to learn about community resources.<br>➢ Health centers leverage staff knowledge of the community needs and resources.<br>➢ Provide resource information in multiple formats (i.e. fliers, phone numbers, website) and languages as needed. |
| **Engage Patients** | • Design interventions that work for patients. Ask for patient feedback and be responsive to it. | ➢ Engage patient partners to help with designing social needs interventions.<br>➢ Practice cultural humility by adapting to local contexts and communities (Bailey 2020). |
| **Pay Attention to New and Emerging Needs** | • Many patients are reaching out to services for the first time and need support with systems navigation. Others have new social needs. | ➢ Some emerging needs include food, utilities, pet food, hygiene supplies, mental health resources (including resources related to social isolation and loneliness), health insurance, parenting resources, financial assistance and job opportunities.<br>➢ Resource navigators can help reduce the stigma often associated with community resource use. |

We have an opportunity to expand the conversation: people don't normally expect to be asked about their housing, well-being when they go to the doctor. We have an opportunity to say, "We care about your housing and it's connected to your health." -Partnership Health Center



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# Best practices for addressing social needs within health centers during COVID-19

| | Best Practices | Examples from Interviews/Literature |
|---|---|---|
| **Focus on Health Equity** | • Harness the energy from the dual pandemics of COVID-19 and racism to focus on social needs with an equity lens. | ➢ Leaders hold space to discuss equity and rethink old approaches.<br>➢ Harness data: look at all metrics by race/ethnicity. |
| **Collect and Use Data** | • Collect, organize, standardize, and act on data related to social needs. Use data to identify patients, target outreach, and track intervention success. | ➢ Document what you are hearing from patients and track trends.<br>➢ Standardize data as much as possible to facilitate accurate measurement and data sharing.<br>➢ Collect data on the social determinants of health and intervene. |
| **Leverage Telehealth** | • Include social health in telehealth interventions.<br>• Address patient technology access issues. | ➢ Provide mental health services, social needs screening, and resource referrals virtually.<br>➢ Address technology access issues creatively. Have a patient come into the clinic and talk with a provider using a clinic computer. Connect patients to community spaces with Wi-Fi.<br>➢ Advocate for telehealth payment and sustainability. |
| **Plan for Sustainability** | • Think about sustainability into the future. Implement changes that will endure post-COVID. | ➢ Invest in technology to provide virtual services. This will likely be beneficial in the long-run, post-pandemic.<br>➢ Develop enduring workflows to address social needs in a virtual setting.<br>➢ Think about long-term impacts of COVID-19 to anticipate future needs. |

This situation has helped us think through our priorities and act on them. We've elevated things we've wanted to do forever and really gotten them done. –OHSU Family Medicine at Richmond



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# Resources

- PRAPARE implementation toolkit
- PRAPARE factsheet: the impact of COVID-19 on the social determinants of health
- Oregon Primary Care Association Empathic Inquiry Resources
- NEJM Catalyst Innovations in Care Delivery published recommendations for successful social needs screening
- Kaiser Permanente COVID-19 Social Health Playbook
- NACHC COVID-19: Information and Resources for Community Health Centers
- Health and Human Services COVID-19 Workforce Virtual Toolkit (including Health Equity Resources)
- Social Interventions Research and Evaluation Network (SIREN) Evidence and Resource Library
- SIREN Food Insecurity Interventions in Health Care Settings: A Review of the Evidence



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# Interview Participants

- Michelle Proser, National Association of Community Health Centers (NACHC)
- Jessica Sanchez, Colorado Community Health Network (CCHN)
- Carlie Hood-Ronick & Stephanie Castano, Oregon Primary Care Association (OPCA)
- Laurie Francis, Partnership Health Center (PHC)
- Cindy Jimenez, Pueblo Community Health Center (PCHC)
- Erin Kirk & Lia Sebring, OHSU Family Medicine at Richmond
- Andy Beck, Cincinnati Children's Hospital Medical Center (CCHMC)
- Sophia Alires-Morgan & Shaunette Meyer, STRIDE Community Health Center
- Amy Smith, Cambridge Health Alliance (CHA)

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