

Realizing Resilience Part 3



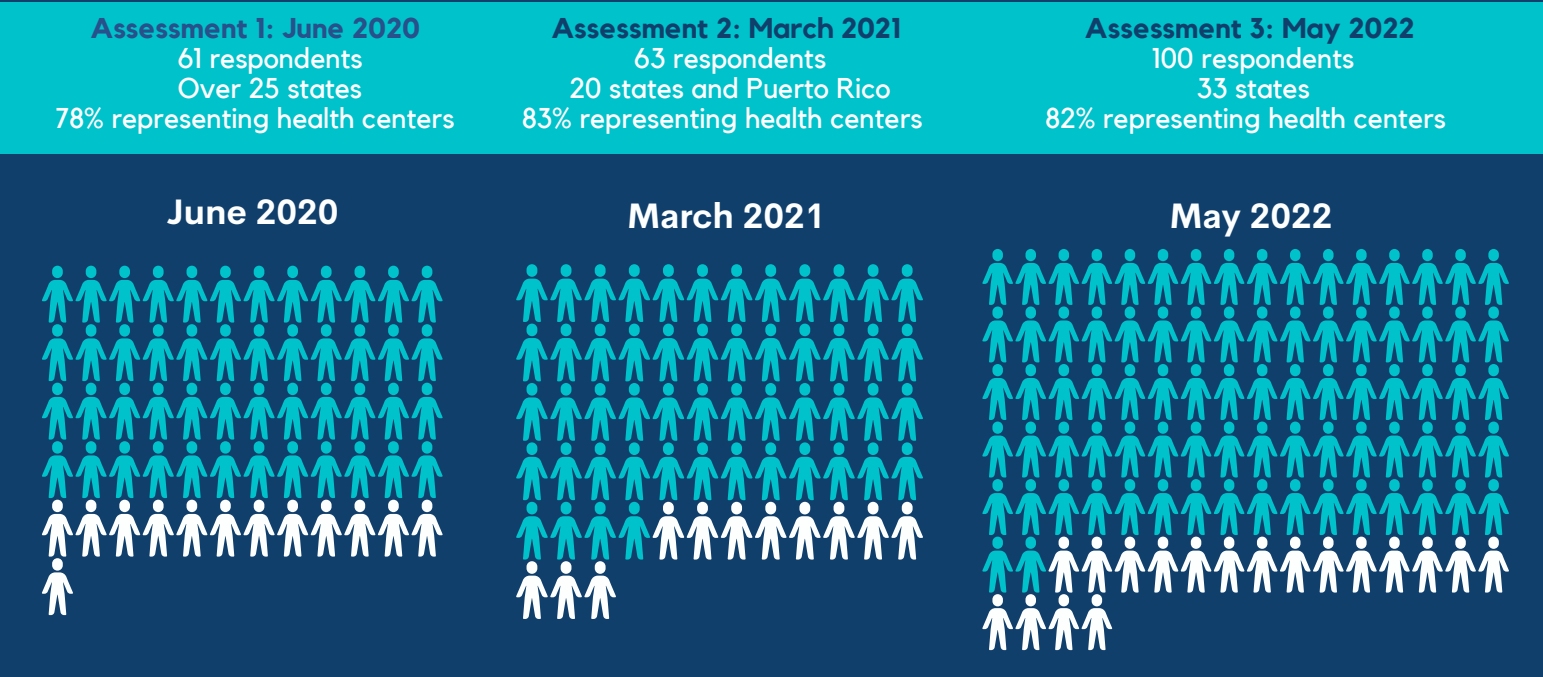
Two Years Later, Updates on Health Center and Social Sector Response to Address Social Drivers of Health Needs during COVID-19

Background

Nearly 27 months. Over 821 days. Close to 20,000 hours.

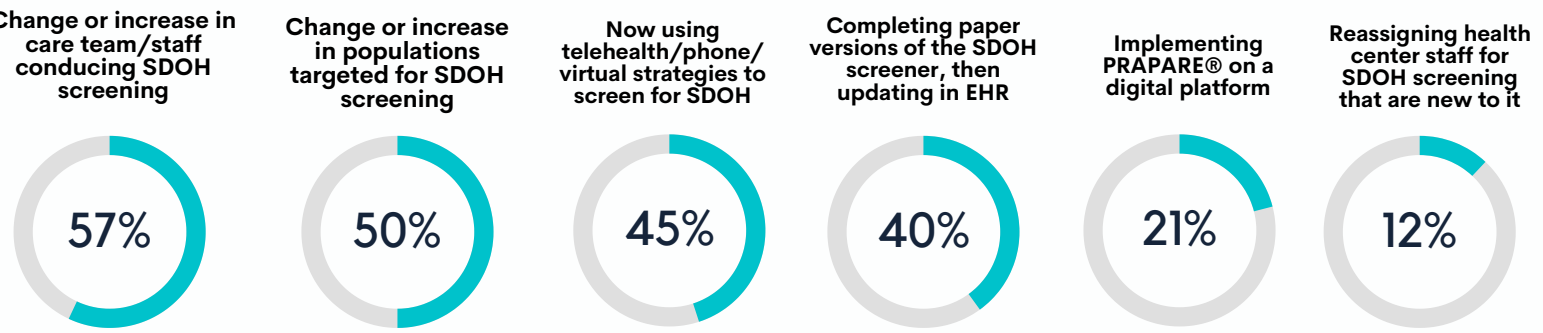
This is how long US health centers and social service organizations have been responding to the vital needs of the nation's most vulnerable communities as a result of the novel coronavirus (COVID-19). Throughout this time, the National Association of Community Health Centers (**NACHC**) has conducted three national needs assessments identifying the changing role of health centers and the social sector when addressing social drivers of health (SDOH) in an effort to understand their journey in navigating SDOH needs during COVID-19 and policy implications/considerations related to health equity.

This third brief from the Realizing Resilience series summarizes responses from health centers and their partners (Participants) from March to May 2022, focusing on the assessment and response to SDOH needs of special and vulnerable populations, the use of funding from the American Rescue Plan Act to address SDOH needs, and initial thoughts on health center capacity to address SDOH needs once the public health emergency declaration expires.

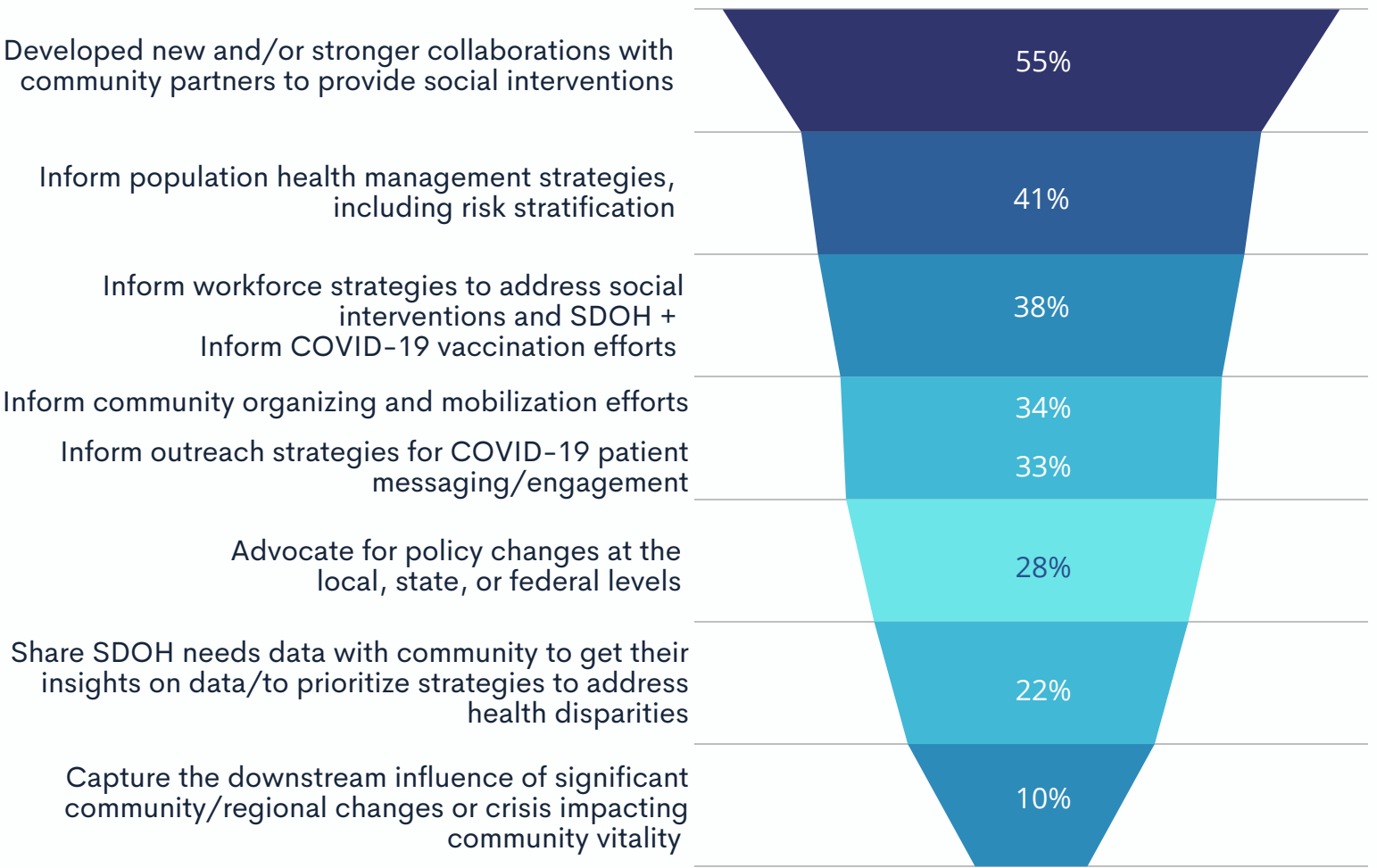


SDOH Screening Activities, Approaches, and Use

Over the last year, 86% of participants reported screening patients for SDOH needs, a 6% increase from this time last year. Those who are not currently implementing standardized SDOH screeners stated that competing priorities and limited staff time and capacity continued to be their biggest barriers. The PRAPARE® tool remains the most frequently used SDOH screener by participants (65%) with 40% reporting they use the tool in its entirety. **Nearly half of participants (47%) noted that their organizations have increased the number of clients/patients/users being screened for SDOH via several approaches:**

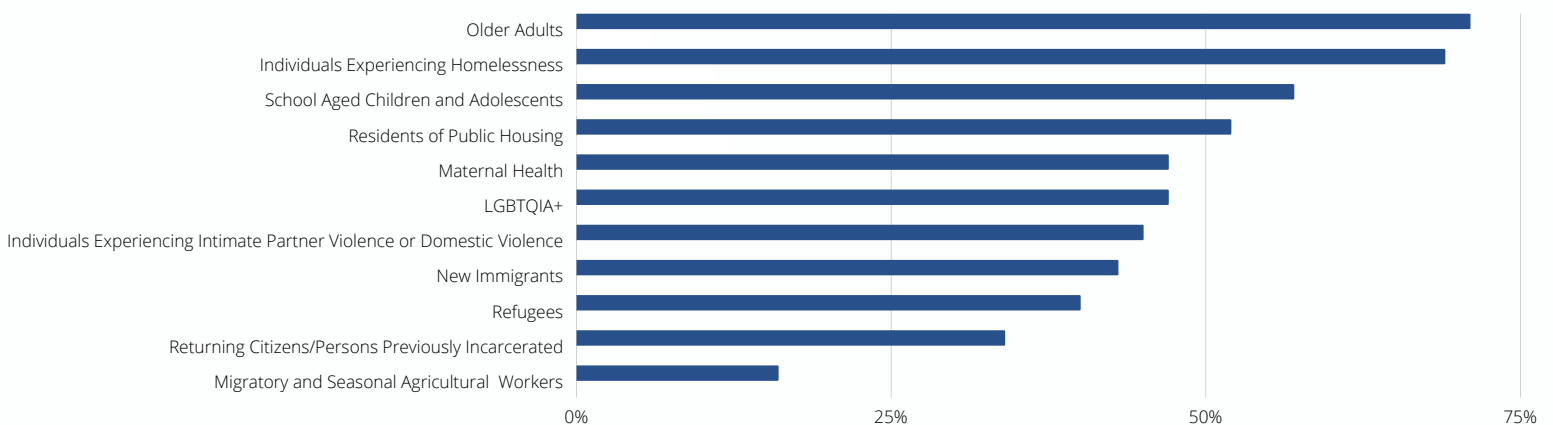


Participants reported currently using SDOH data to:



Vulnerable Populations' SDOH Needs

The importance of responding to vulnerable populations' SDOH needs has been magnified by the COVID-19 pandemic. Participants reported tailoring programs and services to focus on the needs of priority communities that they serve. The bar graph below indicates those priority communities served by health centers, with older adults, individuals experiencing homelessness, and school-aged children/adolescents being the top three populations served.



Best Practices

As a part of these efforts, participants also shared both best practices and challenges to assessing and addressing vulnerable populations' SDOH needs:

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"We find that administering the SDOH questionnaire while the patient is in the clinic works best for us. We have corrected our work flow to reflect a warm hand-off to a case manager or CHW to be able to complete the questionnaire with the patient before they leave the building."
- FQHC Participant

"...working with EHR (staff) to develop risk stratification utilizing SDOH data from screenings and connecting with local organizations providing our most requested assistance services, reviewing workforce capabilities to expand our screening efforts."
- FQHC Participant

"By using an integrated health model and partnering with other services we are able to make referrals in house very quickly and work with our referral sources to get folks needs addressed."
- FQHC Participant

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Challenges

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"The inability to receive payment for our services via funding, it is hard to expand a team that is working without high ROI even though their work is invaluable."
- FQHC Participant

"...staff time and trying to learn/unlearn scope of practice. How do we make sure we're providing warm hand-offs/referrals and not just passing people around."
- FQHC Participant

"Community Based organizations have limit on resources. There is a lot of need with housing insecurity, and agencies have waiting lists or no affordable housing."
- FQHC Participant

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Addressing Racial and Structural Inequalities

The centuries-long presence of systemic racism in healthcare access and outcomes has long been documented and remains the cause of significant disparities among vulnerable populations as surges in COVID-19 continue. Participants reported a number of ways in which they are using SDOH screening data to address these ongoing inequities, including:

- Demonstrating the importance of intentional and pro-active collaboration between Healthcare and Social Services
- Showing the impact of addressing social needs in a wholistic approach
- Ensuring all patient education resources are available in the primary languages of the patients and not just English
- Providing outreach to areas where there is a high prevalence of structurally marginalized people
- Developing expanded trainings for providers, staff, and partners
- Informing advocacy efforts

Nearly **40%** of participants reported using SDOH data to address structural racism and discrimination at the systems/policy levels in their community or state - *an increase of 10% since last year.*

Challenges to this critical work remain, with participants sharing that they are lacking access to a system to collect, send, and report SDOH data within their networks, staffing shortages, engagement in and access to tailored trainings and evidence-based interventions, funding, consistency in SDOH screening, and the feeling that there is so much to do - *where does one even start?*



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American Rescue Plan Act Funding and Sustaining SDOH Needs

In April 2021, the American Rescue Plan Act (ARPA) provided one-time two-year funding to organizations funded under the nation's Health Center Program to support COVID-19 prevention and response efforts. **One quarter of participants stated that they utilized ARPA funding to specifically assess and/or address SDOH needs at their health center** with some (14%) sharing that they have been invited to inform or collaborate with local agencies on identifying community-level SDOH priorities like:



Given the increasing likelihood that the ARPA public health emergency declaration will expire in early 2023, participants shared many of the concerns they have in terms of assessing and addressing SDOH needs in patients:

Ability to cover rent,
housing, food, and
medical needs

Employment, Job
Security, Health
Insurance Access,
Economic Insecurity

Medicaid
eligibility/loss of
insurance coverage
overall, resulting in
exacerbated SDOH
needs

Increased social
isolation and unmet
needs to address
SDOH

Not having the resources to sustain the current level of health care and social services

Decreased
telehealth
availability for
patients without
transportation

Exacerbation of
already strained
SDOH needs

Next Steps

While the world continues to mitigate and understand the COVID-19 virus, SDOH screening and data use remains pivotal in identifying the trends and outcomes necessary to provide patients with equitable and quality care.

Whether your organization has implemented SDOH screening for some time, ***"Having SDOH data, we've discovered new ways to triage care, organize intake, and learn about needs we previously weren't aware of...the screener doubles as a conversation starter. Overall, I'm excited to see how we continue our SDOH initiatives given what we've seen thus far."*** Or is new to/planning to standardize these activities, **"While we have not formally started assessing SDOH, as part of our normal processes these are topics of discussions with all patients at every visit. We have been connecting patients to services and necessities for many years."** One thing is clear,

Screening...all patients has been helpful in finding which patients are having issues, with getting food, being able to afford their medications, utilities, and housing. This screening has given our staff more opportunities to better serve all aspects of our patients needs.

- FQHC Participant