



## One Year Later, Updates on Health Center and Social Sector Response to Social Determinants of Health Needs during COVID-19

### Background

In June 2020, six months after the novel coronavirus (COVID-19) reached the United States and required an almost overnight shift to complete quarantine, the National Association of Community Health Centers (**NACHC**) and Association of Asian Pacific Community Health Organizations (**AAPCHO**) jointly conducted a **national survey** capturing key takeaways when detecting, prioritizing, and informing community needs magnified by the COVID-19 pandemic. In addition, the survey identified methods to strengthen cross-sector alignment strategies between health center, public health, and social service partners.

Today, one year later, our country has settled into a “new normal” in which businesses, schools, community-based organizations, and health delivery systems have all pivoted to provide programming and resources in both virtual and in-person capacities. Furthermore, we have more data on COVID-19 screening, treatments, morbidity, and mortality – all of which have identified significant disparities in our most vulnerable communities. In December 2020, the Centers for Disease Control and Prevention stated that “some racial and ethnic minority groups are disproportionately affected by COVID-19” and that “long-standing inequities in social determinants of health that affect these groups, such as poverty and healthcare access, are interrelated and influence a wide range of health and quality-of-life risks and outcomes.”

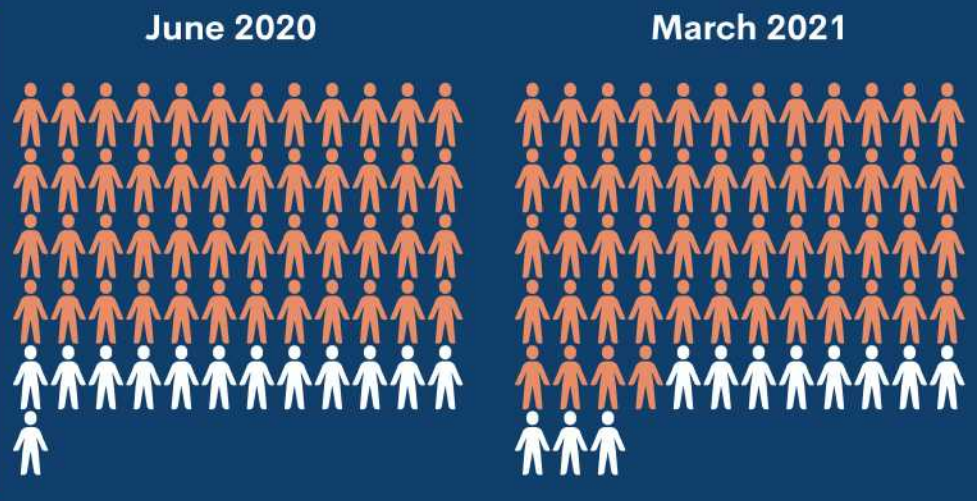
To check-in on activities, lessons learned, and best practices of NACHC and AAPCHO partners from the start of COVID-19 to now, NACHC and AAPCHO redistributed a similar survey to PRAPARE users (e.g., health centers, primary care associations, social services organizations) in March 2021. This second publication, part of a series of surveys and complementary documents being developed by NACHC and AAPCHO, identifies how health centers, social service agencies, and others are aligning and supporting ongoing social determinants of health (SDOH) efforts, informing methods and policies to address health equity, and plans for future work in their communities.

**Survey 1: June 2020**

- 61 respondents
- Over 25 states
- 78% representing health centers

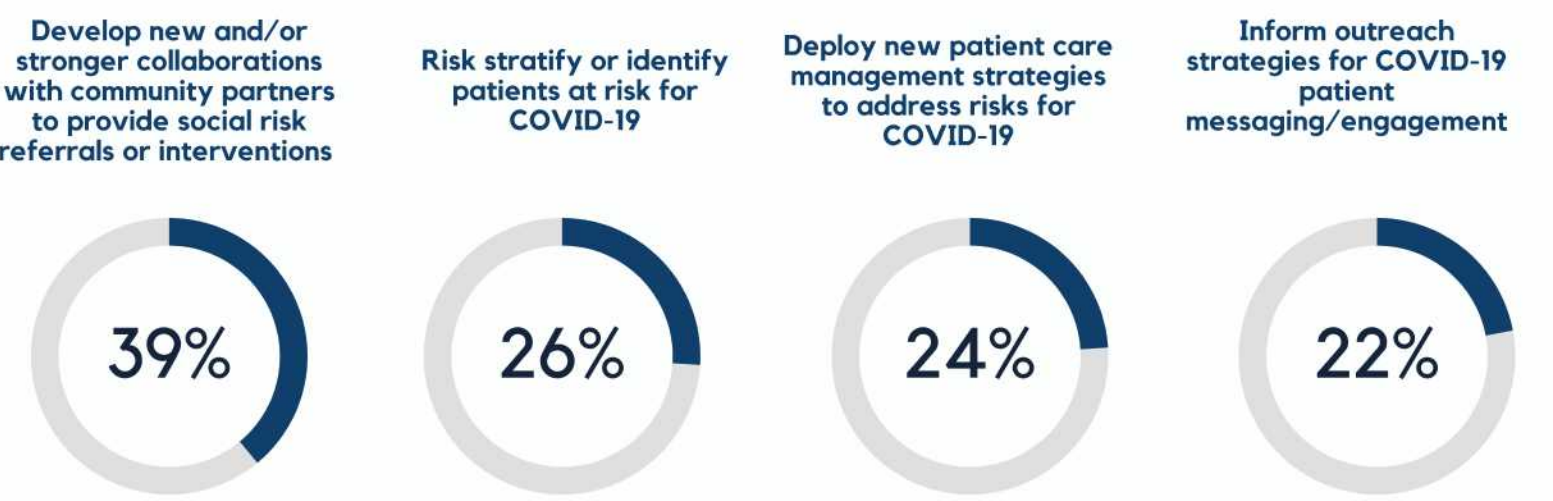
**Survey 2: March 2021**

- 63 respondents
- 20 states and Puerto Rico
- 83% representing health centers

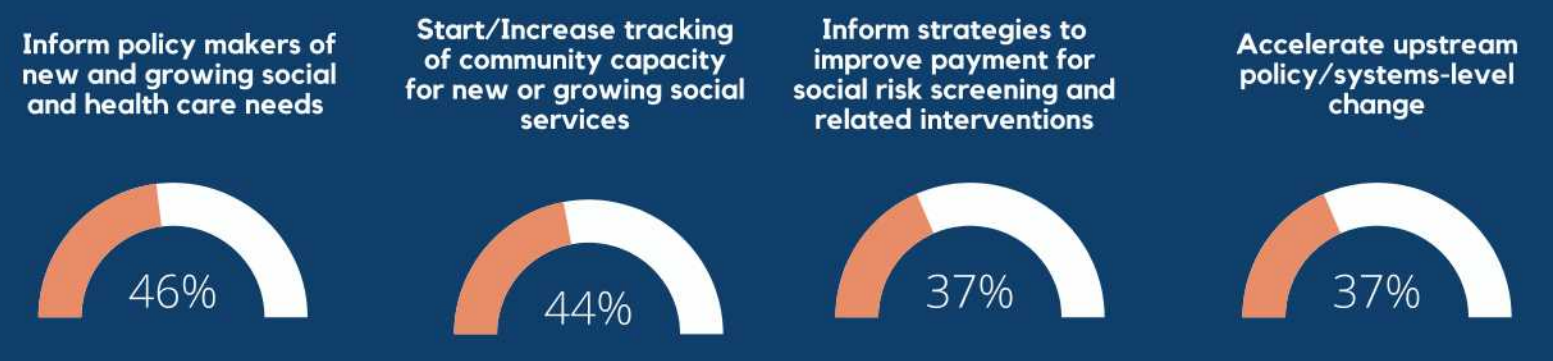


### SDOH Screening and Use

Over 80% of participants who responded to the June 2020 or March 2021 survey stated that they use SDOH instruments like PRAPARE, the most widely used social risk screening tool among health centers, to streamline activities designed to assess patients’ well-being and identify their most pressing needs at nearly the same rate as the start of the pandemic. **Specifically, Participants noted *currently* using the PRAPARE tool to:**



They also shared that they *plan* to use the PRAPARE tool to:



In addition to changes in how the PRAPARE tool is being used, Participants also stated that how they are screening for SDOH needs during the pandemic has changed with 52% of respondents sharing that they have increased the number of clients/patients/users being screened using the PRAPARE tool.



## Lessons Learned

Many successful examples of emerging partnerships and updated organizational operations have been developed since the start of COVID-19, while barriers to screening for SDOH needs, such as limited staffing and competing priorities persist.

### Successes

“[A] Case Management Navigation Team has been developed from Health Department COVID-19 response; Several PRAPARE questions are used to screen for SDOH needs of families with active COVID-19.” – Health Department Partner

“[We have developed] new and/or stronger collaborations with community partners to provide social interventions...for example, we have a wireless [phone] representative now onsite once a week to address (patients') phone. We have a contact at [Center for Urban Community Services] to share info on homeless patients. We've found some legal aid orgs especially for housing-related issues.” – FQHC Participant

“[Using PRAPARE to assess SDOH needs gives our organization] the opportunity to provide services to more community members and to work with other [community based organizations] to help...understanding the needs [of our clients] will help with our healthcare for the patient and get them closer to their wellness goals.” – FQHC Participant

### Barriers

“It has been hard to screen for needs when a lot of the resources shut down...and [we] did not have places to refer people to. Even when these resources started to open up, it left limited access to some who either could not get transportation to utilize these resources or could not utilize technology to do things virtually.” – FQHC Participant

“It [is] more important than ever to gather SDOH data and use it to address unmet patient needs, but unfortunately it was repeatedly de-prioritized because of more urgent activities...” – FQHC Participant

“We don't do a high volume of PRAPARE [screenings] due to staffing limitations but also because many times patients decline. They come for a specific SDOH need (usually health insurance or SNAP) and don't want to be assessed for other needs.” – FQHC Participant

## Addressing Racial and Structural Inequalities

Amidst the urgency of fighting the COVID-19 virus within the vulnerable communities oftentimes served by Participant organizations, the murder of George Floyd by Minneapolis police officers in May 2020 tore at the centuries-old scar created by structural racism in the United States. While tools like PRAPARE were not originally developed to address institutional inequalities, we know that SDOH needs and poorer health outcomes are disproportionately found in marginalized communities. **“Through the [PRAPARE] data we capture we are able to bring [racial and structural inequality] issues to groups we are involved in or to find groups that are working on issues we are identifying that are already working on them,”** shared one FQHC Participant.

Nearly **30%** of Participants reported using the PRAPARE tool to inform racial and structural inequalities.

“We are only just beginning [to use PRAPARE data for this reason]. The data that comes from this [tool] simply proves what we already know to be true about the inequities that our [Hispanic] population faces.” – FQHC Participant

“A designated staff member performs the PRAPARE screenings, and based on the patients' replies, she works with individual patients to address racial and social structural inequality issues in their lives, on an individual, case-by-case basis.” – FQHC Participant

## Next Steps

As our country continues to combat the COVID-19 virus and examine the long-lasting effects it has had on our country's economic, social justice, and health care systems, NACHC and AAPCHO will remain engaged with Participants to understand what is happening where the work is being done, where communities are in need, and where voices must be heard.

Please continue to follow our Realizing Resilience series by joining the [PRAPARE listserv](#).

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