

COVID-19: Addressing Patients' Social Needs Can Help Reduce Health Inequity During COVID-19

The COVID-19 pandemic is disproportionately affecting our Black, Indigenous and people of color (BIPOC) communities. Black and Latino Americans are three times more likely than white people to contract COVID-19. The Centers for Disease Control and Prevention reports the COVID-19 hospitalization rate for American Indian/Alaskan Native people is five times higher than white Americans. Black and Latino persons also face similar grim hospitalization rates, 4.7 and 4.6 times higher, respectively, compared to white persons.



Black people are dying at a rate nearly two times higher (24%) than their share of the population (13%), and, in 42 states, Latino people make up a greater share of confirmed cases than their share of the population, according to the COVID Data Tracking Project at The Atlantic.

Reasons for the health inequities are multipronged:

- Systemic inequities, such as racism or community disinvestment, lead to inadequate investment in education, safe and affordable housing, and food access, creating an environment that exacerbates the spread of the virus.
- BIPOC communities and individuals with lower socio-economic status may have higher rates of certain chronic conditions, such as diabetes, asthma and hypertension, that exacerbate symptoms of COVID-19.
- Individuals who are unable to socially distance because of work or living situations are more likely to be exposed to the virus.

The COVID-19 pandemic has further highlighted how societal factors influence health; and the data make it abundantly clear – understanding and addressing those societal factors is necessary to improve health and save the lives of America's BIPOC communities. Awareness of patients' social needs enables hospitals and health systems to take the first step to address health inequities while providing person-centric care.

The following considerations can help hospitals address the social needs of their patients and work with others in their community to improve health equity during the COVID-19 pandemic.

Screening and Documenting Social Needs

The nature of how COVID-19 spreads makes it important to understand patients' social circumstances. For example, living and working situations impact patients' exposure, contraction and the spread of the virus. Providers are encouraged to continue screening for social needs and documenting responses in electronic health records.

Action Steps:

- As part of the social needs screening, ask patients about their living and working situations to assess the level of potential exposure to the virus.

- Use patient data to identify COVID-19 hot spots in the community.
- Include social workers on the care team to support the patient's and family's social needs.

Hospitals in Action

As care shifted to telemedicine during COVID-19, [Allina Health](#) digitized its approach for screening and addressing patients' social needs. The Minnesota-based system worked with NowPow to integrate its social needs screening tool into the patient portal, allowing providers to virtually collect patient information and make connections with community-based services. The new platform links patient responses back to the electronic medical record where care navigators can track referral outcomes.

The [University of Arkansas for Medical Sciences'](#) self-quarantine capacity screening tool determines whether patients who tested positive for COVID-19 are able to self-quarantine. Individuals who cannot self-quarantine due to homelessness are connected with stable, safe housing options.

Unconscious Bias

There is concern that BIPOC are being tested for the coronavirus at a lower rate, yet may be infected at a [higher rate than non-BIPOC](#). The AHA, the American Medical Association and the American Nurses Association [urged](#) the Department of Health & Human Services to increase the availability of testing to ensure access to equitable treatment and disseminate timely, relevant, culturally appropriate and culturally sensitive public health information. The groups also [pressed](#) Senate leaders to include in the next COVID-19 relief bill provisions to further improve data collection and testing, and to address the urgent needs of minority and marginalized communities, including workforce needs and the fundamental root causes of health disparities.



As testing and treatment decisions are made, care providers should be aware of any unconscious biases and continue to collect and record demographic data. In addition, the complex nature of the coronavirus makes it important to be aware of patients' linguistic and cultural needs to ensure that they and their families understand COVID-19's treatment and how to prevent its spread.

Action Steps:

- Engage and educate BIPOC communities regarding COVID-19 transmission and testing.
- Record patient race, ethnicity and language data to detect disparities in disease burden and outcomes.
- Offer access to translators and materials that reflect a community's predominant cultures.

Hospitals in Action

[Atrium Health and Novant Health's](#) mobile testing program is aimed toward expanding COVID-19 testing in BIPOC communities in Charlotte, N.C., where black residents comprised 50% of the confirmed COVID-19-positive individuals in the county.

Massachusetts General Hospital's registry of multilingual, front-line staff helps assign Spanish-speaking doctors to each medical team whenever possible to avoid having to use remote interpretation services.

Cambridge Health Alliance is identifying patients who would benefit from in-person interpretation, such as those who are hearing-impaired and do not use American Sign Language. It also has allocated personal protective equipment (PPE) for on-site interpreters. The hospital's discharge instructions also are in Arabic, Nepali and other languages, expanding beyond the Spanish, Portuguese and Haitian Creole translations it traditionally offers.

Housing

Housing security is a significant factor for COVID-19 prevention and treatment. Housing insecurity manifests itself through patients' inability to pay rent, mortgage or utilities due to job loss. Sometimes this puts individuals and families at risk of eviction or homelessness.

Job losses associated with the sharp reduction in economic activity have endangered individuals' ability to pay their rent or mortgage. For those individuals living in high-density homes or homeless shelters, social distancing or self-quarantine is nearly impossible, increasing the likelihood they contract COVID-19 and spread it to other household members.

Unsafe homes expose individuals to dangerous environmental threats, including poor air quality, mold, lead or pests, which may be particularly problematic for people with existing respiratory conditions. This is the same population that is particularly susceptible for contracting COVID-19.

Action Steps:

- Learn about the patient's living situation to identify any risk factors.
- Ensure that infected individuals have a safe space to self-quarantine.
- Connect with community partners to explore housing options for homeless and housing insecure patients.

Hospitals in Action

The city of Chicago helped broker a deal between local hospitals and five hotels to repurpose empty rooms for patients. The hotels will house people who are waiting for test results but cannot return home; quarantine high-risk healthy individuals who cannot stay at home because of an ill family member; and isolate people who have been diagnosed with COVID-19 but cannot return home because of their living situation.

Alameda Health System is launching two housing initiatives with Abode, a supportive housing and homeless services provider, and other Oakland, Calif., community stakeholders. Operation Comfort provides isolation housing for symptomatic or COVID-19-infected people experiencing homelessness, and Operation Safer Ground offers safe housing for people experiencing homelessness.

Providence St. Joseph Health's foundation is donating \$500,000 to support its community health partners throughout the COVID-19 outbreak. The donation is aimed at reducing social risk factors that could lead to disparate outcomes, such as housing and food insecurity.



Food

Many people are struggling to keep food in their homes and on their tables due to lost jobs or lost school meals. Where feasible, providers are encouraged to connect food-insecure patients and families with existing programs or community resources.

Action Steps:

- Refer food-insecure patients and families to food banks.
- Assist with the application for food stamps.
- Partner with food delivery services.

Hospitals in Action

Boston Medical Center's on-site food pantry serves as a food access point for its community. Social workers pick up food from the pantry and make home deliveries to families in need. They have lifted frequency restrictions on the pantry throughout the pandemic, allowing families to come more often than the normally allotted visits every two weeks.

Henry Ford Health System partnered with the United Way of Southeastern Michigan and the BET COVID-19 Relief Fund to launch *At Your Door: Food & More*, a rapid-response community outreach program to address African American health disparities exacerbated by COVID-19. At Your Door promotes health and well-being by providing contact-free deliveries of food boxes, PPE, diapers, culturally informed education, and equipment for virtual support, allowing vulnerable populations to reduce risk of exposure.

Ascension Seton and Dell Medical School received a \$250,000 grant from the Bank of America Charitable Foundation to help address community nutritional needs in Austin, Texas, during the pandemic. By partnering with Good Apple, a doctor-prescribed grocery delivery service, they are providing Central Texas seniors and residents with compromised immune systems access to fresh, healthful food.

Rush University Medical Center and West Side United are anchoring *Live Healthy Chicago*, a community collaborative to assist older adults and other high-risk populations in the city's south and west sides who are experiencing disparities in COVID-19's impact. With support from the Oprah Winfrey Charitable Foundation, Live Healthy Chicago's COVID-19 work will distribute wellness kits and PPE to at-risk older adults, deploy community health workers, provide meal delivery, and implement contact tracing.



Conclusion

While medically treating COVID-19 is urgent and essential, the need to address our most vulnerable individuals' social needs will not wane over the course of the pandemic. Identifying and addressing the social needs of patients and families is an important step to mitigate the inequities of COVID-19.

The AHA wants to hear how your hospital is addressing health equity and your patients' social needs. Share your story with us.

AHA Resources

[Acknowledging and Addressing Racism and Xenophobia](#) provides action steps hospitals can take to address these pressing issues.

[Caring for our Health Care Heroes During COVID-19](#) offers considerations for how hospitals can support the social needs of their workforce during the pandemic.

[5 Actions to Promote Health Equity During the COVID-19 Pandemic](#) describes steps hospitals are taking to address disparities illuminated by the health crisis.

[5 Actions to Promote Housing Access During and Beyond the COVID-19 Pandemic](#) identifies steps hospitals can take to address housing instability.

[Partnering to Address COVID-19 in Under an Hour](#) is a three-step guide that offers strategic considerations for how to partner with stakeholders to address the virus.

[Screening for Social Needs: Guiding Care Teams to Engage Patients](#) helps hospitals facilitate sensitive conversations with patients about their nonmedical needs that may be a barrier to good health.

Resources

[Jvion's COVID Community Vulnerability Map](#) allows users to search at the census block level to identify populations most vulnerable for severe outcomes if infected with COVID-19, and the socio-economic factors driving that risk.

[Medicare COVID-19 Data Snapshot](#) produced by the Centers for Medicare & Medicaid Services examines cases and hospitalizations data for Medicare beneficiaries diagnosed with COVID-19.

[Rensselaer Polytechnic Institute's COVIDMinder](#) shows how the social determinants of health are affecting COVID-19 risk and outcomes communities nationwide. The tool reviews community health risks, mediation measures and COVID-19 outcomes across states and displays them in a data map.

[State of Black America](#), the National Urban League's annual report, examines racial equality in the U.S. across economics, employment, education, health, housing, criminal justice and civic participation.

[The Atlantic's COVID Tracking Project's Racial Data Tracker](#) collects, publishes and analyzes racial data on the pandemic.

[The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S.](#) in the U.S. from APM Research Lab monitors where the burden of this virus falls inequitably upon certain communities to guide policy and community responses to these disproportionate COVID-19 deaths.