Addressing Community Needs and Preparing for the Secondary Impacts of Covid-19

Alexandra Quinn, MA, Margaret Laws, MPP

Flattening the curve of Covid-19 infections and deaths requires a multidisciplinary approach where health care, government, and community all play a role. But the impact of this pandemic extends far beyond the illness itself — and right now, a separate curve tied to the need for essential resources is surging as the secondary impacts of Covid-19 ignite. In the same way that there has been a global call to action to “flatten the curve” of coronavirus infections through interventions like social distancing, there must also be a new call to action to ensure that our most vulnerable have food, housing, health, mental health, and other essential resources. The CEOs of Health Leads and Hopelab provide learnings from the field, and a framework for understanding the dimensions of the growing gap between essential resource needs and the capacity to meet those needs, which includes the ability to effectively coordinate resources and facilitate cross-sector collaboration as we rebuild systems with sustainable solutions.

As the impacts of the coronavirus pandemic, including those associated with shelter-in-place, began to spread across the United States, we followed the suggestion of the director of homeless services for one of our county partners who remarked, “I just wish everyone would stop talking and listen to what communities need.” We listened. We conducted more than 60 conversations as well as a survey of 115 individuals to better understand what our partners in health care, community, and government needed in this unprecedented moment.

We need to pay special attention to the second-order effects of the pandemic, those caused not directly by the virus, but indirectly by our response to the clinical threat. Those who already were suffering from the broad systemic inequities embedded in our health care and social service systems are now being further harmed by the biggest economic crisis we’ve seen in our lifetimes.
The Covid-19 crisis will continue to challenge vulnerable populations and communities in dramatically disproportionate ways long after the infection numbers peak.

Beyond the immediate, acute need for personal protective equipment, effective testing, and proven therapeutics, health care and community leaders are focusing on the need to address the inadequacy of their under-resourced essential resource programs. At the same time, many theoretically available community resources have become almost impossible for individuals to access because of shelter-in-place orders, unprecedented layoffs, and widespread economic disruption. From our survey and conversations, five major resource needs emerged:

**Food**: Food distribution is more challenging due to shelter-in-place orders, joblessness, and dwindling staff and volunteers for programs.

**Mental health, substance, and abuse support**: Resources are needed to address mental health challenges amplified by the pandemic, including stress, abuse, and neglect.

**Childcare**: Childcare needs are more challenging to meet, especially for essential workers who are keeping so many other families fed, safe, and healthy.

**Curated, accurate, and regularly updated resource mapping**: Community organizations and particularly those serving vulnerable populations need a way to understand what resources are available in a community and how to connect with those resources, especially as many programs adjust to shelter-in-place orders and numerous federal, state, and local efforts create new support programs.

**A deployable community-focused workforce**: Local community organizations and health care providers need a more flexible workforce (for example, community health workers and *promotores de salud*) that can be trained and deployed during and after shelter-in-place to support both direct health care services and essential resource interventions, including the ability to effectively collaborate across the myriad sectors of the health and social services systems.

In addition, health care and community partners expressed a strong desire to learn from each other and quickly identify and utilize best practices (Figure 1).
The survey results yielded several key takeaways:

The majority of survey respondents wanted to learn how their peers were adjusting their social need interventions as the coronavirus was spreading and sheltering-in-place orders were being adopted across communities.

There was also strong interest in learning how best to support vulnerable communities.

We received additional insights from our partners as free-text responses in the “other” category. Pattern recognition found that these responses fell into the following areas:
Technology: adjusting to new technologies (such as telehealth) to continue screening and to reach high-risk patients

Additional resources: information on where to find resources for specific populations such as undocumented families, Spanish speakers, children impacted by suspension of free school lunch, health care workers needing childcare resources

Support for clinical workers: personal protective equipment, mental health counseling, how best to leverage community health workers during this time

Policy and payment: understanding policy and funding changes in response to the pandemic

While these themes and challenges are not new, they are more widely exposed through the lens of Covid-19. Both the pandemic and the secondary impacts are highlighting the already existing racial disparities in the United States, as well as implicit biases in the health care system.1-3

One U.S. Centers for Disease Control and Prevention study4 of Covid-19-related hospitalizations in March 2020 across 14 states found that “black populations might be disproportionately affected by Covid-19” as 33% of those who had been hospitalized were Black — even though that racial group made up just 18% of the population for that catchment area, and makes up only 13% of the population of the United States. More recent data has indicated the overall Covid-19 mortality rate for Black Americans is 2.4 times as high as the rate for white populations, and 2.2 times as high as the rate for Asians and Latinos. For indigenous people, the mortality rate is 5–8 times as high as the white mortality rate. Even while not every state is collecting demographic data that would paint the full picture, existing data demonstrate deep racial inequities.5

Such disparities are not surprising given the underinvestment in the health of communities of color,6 and that social distancing is a luxury not available to lower-income blue-collar or service sector workers who may be unable to work from home or receive paid time off.7

The Secondary-Impact Covid Curve: Growing Demand for Essential Resources

The “Covid-19 death curve” is one measure of the toll of the pandemic on our society, and certainly, the mortality associated with this novel coronavirus is a core concern.8 But the concept of an “essential resources curve” is now being used broadly to illustrate the impact of the societal challenges caused by the measures taken in response to the virus9,10 (Figure 2).
The “secondary-impact curve” illustrates growing demand for an already under-resourced essential resource landscape that will be further strained by the secondary economic and social consequences of the pandemic. Similar to the Covid-19 infection-rate curve, to flatten this “secondary curve,” multiple interventions will be required in a coordinated effort among health care, public health, human services, and the private sector. With unemployment rates drawing comparisons to those of the Great Depression, no one is immune to these secondary impacts.11,12
We continue to spend billions of dollars a year pursuing incremental progress in siloed sectors and are surprised when health outcomes of both individuals and communities fail to improve."

At baseline, the U.S. has large disparities across racial identities and other social determinants seen in health outcomes that are influenced by food insecurity, income, and access to adequate housing and education. Moreover, during the Great Recession, unemployment across race, gender, and education level varied greatly. For example, unemployment for white Americans peaked at 9.2% in October 2009, whereas the rate for Black Americans peaked at 16.8% in March 2010.13

The nation’s health care and human services organizations are complex; they lack effective coordination and interaction and were not built with health equity at the center. We continue to spend billions of dollars a year pursuing incremental progress in siloed sectors and are surprised when health outcomes of both individuals and communities fail to improve.

Many OECD countries that have consistently invested in both health and essential resources achieve better health outcomes while spending a far lower percentage of GDP on health care.14,15 During the pandemic, several countries, such as Germany and Denmark, have used interventions to guarantee direct assistance to freelancers, institute working allowances, and expand childcare benefits for low-income parents.16 Such investments put these countries in a much better position to flatten their secondary, essential resource needs curve.

**Respond and Rebuild: Working Toward Solutions**

Together, the medical and social consequences of Covid-19 are unprecedented in our lifetimes. The impact on essential resources will be experienced by a far larger subset of the population than the health crisis itself due to the sharp downturn of the economy and deep inequities that pre-date Covid-19. This situation presents us with the opportunity — and the obligation — to clearly name the problem and rewrite — for good — how health care, public health, human services, government, community members, and the private sector can work together to design multiple interventions to address inequities and to improve health care and the related social determinants of health.17,18

This is not the moment to “just fix” what is in front of us. While frontline health care and public health workers address the acute presentations of the virus, those of us focused on essential resource needs must work together to ensure there is local access to food, shelter, and mental health services. The ability to effectively coordinate these disparate resources and facilitate such cross-sector collaboration is essential.

In an April McKinsey article,19 the authors describe four recommendations that can be applied to all essential resource interventions:

- Strengthen community harm prevention
- Leverage data and technology
• Integrate behavioral, physical health, and human services with a health equity lens

• Address unemployment and income disparities

With some tweaking, there’s not much to argue with in these recommendations; they feel familiar and are resonant to many working in health care today. We know these things, but too often we don’t do them. We underinvest in prevention; we leave things in silos to preserve payment streams; we underinvest in technology, especially in the government and nonprofit sectors; and we don’t address unemployment as a health risk factor, even as we can point to the health- and life-diminishing effects of joblessness.20

“This situation presents us with the opportunity — and the obligation — to clearly name the problem and rewrite — for good — how health care, public health, human services, government, community members, and the private sector can work together to design multiple interventions to address inequities and to improve health care and the related social determinants of health.”

Here are a few tangible examples of these recommendations brought to life and focused on some of the people most impacted by Covid-19. Each of these efforts has the potential to help stem the secondary impact of Covid-19 driven by demand for essential resource needs:

In New York City, a Covid-19 Rapid Response Coalition (CRRC), made up of cross-sector health care and non–health care companies, is focusing on at-risk populations during the pandemic, and seeing some early successes.21

Telehealth and digital health companies across the country have expanded access and offered free content22 Crisis Text Line has dramatically expanded capacity and added “For the Frontlines” for health care professionals and essential workers, and Hopelab launched a free version of the app Nod to address loneliness and social connection challenges for students.

211 San Diego built a multidisciplinary partner network — Community Information Exchange — to coordinate care using a shared language, essential resource database, and integrated technology platform. The exchange has allowed organizations across the county to use real-time data to respond to the quickly changing needs of community members and the rapidly changing resource landscape that includes health care, food, housing, and mental health services.

Roots Community Health Center continues to provide clinical services, while making adjustments where needed to provide virtual meetings or telephonic appointments for young mothers. They are also prioritizing acutely and chronically ill unsheltered individuals in Oakland, California. Food distribution has adjusted to offer a variety of ways that individuals and families can connect, from drive-through pickups as well as walk-up appointments. Being deeply centered on health equity
allows clinics like Roots to leverage existing practices in place-based, community-responsive approaches even, or perhaps, especially in times of crisis and change.

These interventions are a good start. As hard as it is to invest in prevention and population health when acute needs are staring us in the face, we have to prioritize these investments and ensure we are keeping health equity at the forefront of both the response and the rebuild. These efforts must extend beyond a “stimulus package” to a rebuilding of systems — and we must ensure we are not replicating or reinforcing the deep inequities in how those health, justice, and education systems operate. We already know this pandemic has and will continue to put unprecedented pressure on our health care system and community social services infrastructure. How we handle the aftermath will define our future.

Alexandra Quinn, MA
Chief Executive Officer, Health Leads

Margaret Laws, MPP
Chief Executive Officer, Hopelab Chair of Board, Health Leads

Acknowledgments

The authors would like to thank Sheena Nahm McKinlay, PhD, MPH, and Bridget Darby, MS, both from Health Leads, for creating the curve graphic and analytics.

Disclosures: Alexandra Quinn is CEO of Health Leads. Margaret Laws is CEO of Hopelab and Chair of Board for Health Leads.

References

1. Agrawal S, Enekwechi A. It’s Time to Address the Role of Implicit Bias within Health Care Delivery. Health Aff (Millwood).

2. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics.

3. National Research Council. Ver Ploeg M, Perrin E, eds. Eliminating Health Disparities: Measurement and Data Needs. Washington: The National Academies Press, 2004. https://www.nap.edu/catalog/10979/eliminating-health-disparities-measurement-and-data-needs.

4. Garg S, Kim L, Whitaker M, et al. Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 — COVID-NET, 14 States, March 1–30, 2020. Morbidity and Mortality Weekly Report. U.S. Centers for Disease Control and Prevention. April 17, 2020. Accessed April 23, 2020. Washington: U.S. Department of Health and Human Services. https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm.

5. APM Research Lab Staff. The Color of Coronavirus: Covid-10 Deaths by Race and Ethnicity in the U.S. APM Research Lab. American Public Media. May 27, 2020. Accessed May 28, 2020. https://www.apmresearchlab.org/covid/deaths-by-race.
6. Artiga S, Garfield R, Orgera K. Communities of Color at Higher Risk for Health and Economic Challenges Due to COVID-19. April 7, 2020. Accessed April 23, 2020. Kaiser Family Foundation. https://www.kff.org/disparities-policy/issue-brief/communitysof-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/.

7. Canipe C. The Social Distancing of America. Reuters Graphics. Reuters. April 2, 2020. Accessed April 23, 2020. https://graphics.reuters.com/HEALTH-CORONAVIRUS/USA/qmymkkmwpra/index.html.

8. Coronavirus Resource Center. Mortality Analyses. Johns Hopkins University. May 16, 2020. Accessed May 16, 2020. https://coronavirus.jhu.edu/data/mortality.

9. Lynch KS. Flattening the Second Curve Begins Now. Thrive Global. April 29, 2020. Accessed April 30, 2020. https://thriveglobal.com/stories/flattening-the-second-curve-begins-now/.

10. Norris T. Framework for Excellence Informing COVID-19 Response to Flatten the 2nd Curve and Lay a Foundation for Long-Term Recovery. April 6, 2020. Accessed April 23, 2020. Well Being Trust. https://wellbeingtrust.org/news/flattening-the-2nd-curve/.

11. Rampell C. Unemployment Is So Bad That These Economists Are Proposing a New Way to Measure It. May 16, 2020. Accessed May 17, 2020. The Washington Post. https://www.washingtonpost.com/opinions/2020/05/16/unemployment-is-so-bad-that-these-economists-are-proposing-new-way-measure-it/.

12. Wenger JB, Edwards KA. Is the Unemployment Rate Now Higher Than It Was in the Great Depression? May 7, 2020. Accessed May 8, 2020. The RAND Blog. RAND Corporation. https://www.rand.org/blog/2020/05/is-the-unemployment-rate-now-higher-than-it-was-in.html.

13. Cunningham E. Great Recession, Great Recovery? Trends from the Current Population Survey. Washington: U.S. Bureau of Labor Statistics, April 2018. Accessed April 23, 2020. https://www.bls.gov/opub/mlr/2018/article/great-recession-great-recovery.htm.

14. OECD. Public Funding of Health Care. February 2020. Accessed April 23, 2020. Organisation for Economic Co-operation and Development. https://www.oecd.org/health/Public-funding-of-health-care-Brief-2020.pdf.

15. OECD. How’s Life? 2020: Measuring Well-Being. Paris: Organisation for Economic Co-operation and Development Publishing, 2020. Accessed April 23, 2020. https://www.oecd-ilibrary.org/economics/how-s-life/volume/-9870c393-en.

16. Policy Responses to Covid-19. Policy Tracker. International Monetary Fund. Accessed May 16, 2020. https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19.

17. Myers G, Price G, Pykosz M. A Report from the Covid Front Lines of Value-Based Primary Care. .

18. Eisenson H, Mohta NS. Health Care Organizations Can and Must Incorporate Social Determinants. 2020;1(3) NEJM Catalyst https://catalyst.nejm.org/doi/10.1056/CAT.20.0130.
19. Coe EH, Enomoto K. Returning to Resilience: The Impact of COVID-19 on Mental Health and Substance Use. McKinsey & Company. April 2, 2020. Accessed April 23, 2020. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/returning-to-resilience-the-impact-of-covid-19-on-behavioral-health.

20. Voßemer J, Gebel M, Täht K. The effects of unemployment and insecure jobs on well-being and health: the moderating role of labor market policies. Soc Indic Res. 2018;138(6):1229-57

21. New York City COVID-19 Rapid Response Coalition. Playbook: City-Level COVID-19 Rapid Response to Serve At-Risk Populations. United States of Care. April 3, 2020. Accessed April 23, 2020. https://unitedstatesofcare.org/covid-19/playbook-and-case-study-of-nyc-covid-19-coalition/.

22. Webster P. Virtual health care in the era of COVID-19. Lancet. 2020;395(6):1180-1