



COVID-19 IMPACT AND BASIC NEEDS SURVEY **FINAL REPORT**

Summary

A quality improvement team from Hennepin Healthcare Research Institute and Hennepin Healthcare collaborated to design and collect phone surveys from May 11-June 12, 2020. Participants included 397 adult primary care patients (44% response rate) with targeted inclusion of people of diverse race/ethnicity, language, health complexity, and history of homelessness or jail stay. Surveyors asked patients to reflect on their experiences since March 16 when our clinics began restricting in-person visits due to rising risk of Covid-19/the coronavirus.

397

TOTAL PARTICIPANTS



35%

of respondents worried about affording food.

Spanish speaking (58%) and Black patients (42%) were disproportionately food insecure.



14%

reported being homeless at the time of the survey.

32% were worried about being able to pay their rent/mortgage or other housing costs. Non-English speakers were the most likely to report worry about paying housing costs, with 53% of Spanish speakers and 62% of Somali speakers reporting concerns.



29%

of patients reported very good or excellent physical health and 33% reported very good or excellent mental health.

20% of respondents reported improved mental health since March 16.



397

TOTAL PARTICIPANTS



41%

of respondents experienced care delays since start of new COVID-19 related clinic restrictions.

75% of delays were clinic-initiated, and 34% of patients said they were afraid to go into the clinic for a variety of reasons.



89%

of respondents reported access to internet connected smartphones and email (81%).

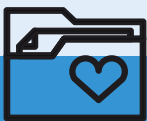
Patients varied in their access to an internet-connected computer (57%), and some expressed challenges paying their phone bill (26%).



72%

of respondents were willing to use video visits with their provider.

Qualitative feedback from patients indicated that many would need support to learn how to use necessary technologies.



62%

of respondents expressed openness to using MyChart for an E-Visit.

Those who speak Spanish or Somali were less willing to use MyChart (41%).

Introduction

In mid-March, Hennepin Healthcare, along with the rest of the state of Minnesota, changed the way it operates to protect patients and staff from COVID-19. During this time a collaboration for quality improvement between Hennepin Healthcare and the Hennepin Healthcare Research Institute emerged to design and collect a phone-based survey. The goal was to inform Hennepin Healthcare's response to the COVID-19 pandemic by assessing the needs of Hennepin Healthcare primary care patients, especially those at highest risk of poor outcomes. We asked respondents to focus on the time since Minnesotans started staying at home (around March 16).

Methods

Between May 11 and June 12, 2020 we conducted a phone survey with 397 patients. The goal was to generate representative knowledge about the needs of Hennepin Healthcare patients, especially those with risk for poor health outcomes, in order to inform our system, services, and policies responding to COVID-19/the coronavirus. Survey respondents resembled the proportion of primary care patients who attend each clinic and met the following inclusion criteria:

- Adults over 18 years of age, one per household
- 2 or more Hennepin Healthcare primary care visits in the last 2 years
- English, Spanish, or Somali as their preferred language.

In order to ensure the diversity of our sample and include groups at highest risk for poor outcomes related to COVID-19, we oversampled Spanish and Somali-speakers, those with a history of homelessness or a jail stay, and those with high levels of medical complexity. Respondents received a \$10 gift card.

In total, 910 patients were called, and 397 agreed to participate (44%), 138 declined to participate (15%) and 375 could not be reached (41%). Patients were called a maximum of three times. If a patient did not answer the phone and either agree or decline to participate after three calls, they were considered non-respondent.

We added fictional vignettes based on real patients to further illustrate the findings from our survey data.



Limitations

In conducting this survey, the team weighed several tradeoffs and limitations which are important to note:

- **Respondent reporting bias:** Surveys frequently suffer from self-report bias, where respondents change their responses to be seen more favorably. Despite assurances of confidentiality and lack of connection to their medical record, respondents still likely answered favorably to a survey from their health system.
- **Phone survey:** Patients were called using the phone numbers listed in their electronic health record. This means that we could only reach patients who had consistent access to the same phone. Our survey likely underrepresents those who do not have stable phone access and access to other technologies.
- **Race/ethnicity and language subgroups:** Common classifications of race/ethnicity often simplify the complex cultural heritage of our communities. The survey team carefully considered how to present the results of this survey. We present five groups: English-speaking patients that identify as white, Black, or other races, and Spanish-speaking and Somali-speaking patients, regardless of their identified race. Due to concerns over anonymity, we do not report any percentages that represent fewer than 10 respondents. You'll see these areas shaded out with grey bars in graphs below.

Note: The murder of George Floyd on May 25th and subsequent social unrest in the Twin Cities occurred part way through data collection. Many of the patients targeted for this survey live in the neighborhoods most affected by this unrest. We paused data collection from May 28-June 1 in order to give patients and staff time to grieve and reflect. Unless otherwise noted, findings combine data collected before and after the unrest.



Demographics

	Respondents (N = 397)		Primary Care Patients (N = 56,502)	
Age (median)	47.3		44.8	
History of Homelessness^a	75	18.9%	2,853	5%
History of Jail stay^b	43	10.9%	1,770	3.1%
No SSN	85	21.4%	10,662	19.3%
SEX				
Male	162	40.9%	24,808	43.9%
Female	243	59.1%	31,692	56.1%
RACE/LANGUAGE				
English speaking				
Black/African American	130	32.7%	15,862	28.1%
White	106	26.7%	19,893	35.2%
Other	53	13.4%	7,451	13.2%
Spanish speaking	86	21.7%	10,452	18.5%
Somali speaking	22	5.5%	1,534	2.7%
MEDICAL RISK (HCC)				
Average risk	.72		.60	
Low/Unknown risk	94	23.7%	35,355	62.6%
Rising risk	156	39.4%	12,207	21.6%
High/Extreme risk	146	36.9%	8,940	15.8%
CLINIC LOCATION				
Downtown Clinics	127	32.1%	18,094	32%
Medicine Clinic	121	30.6%	17,412	30.8%
Coordinated Care Center^c	6	1.5%	682	1.2%
Community Clinics	269	67.9%	38,408	68%
North Loop	17	4.3%	3,082	5.5%
Brooklyn Park	33	8.3%	5,790	10.2%
St. Anthony Village	8	2.0%	2,226	3.9%
Golden Valley	26	6.6%	3,753	6.6%
Whittier	132	33.3%	13,721	24.3%
East Lake	26	6.6%	3,255	5.8%
Richfield	27	6.8%	6,581	11.6%

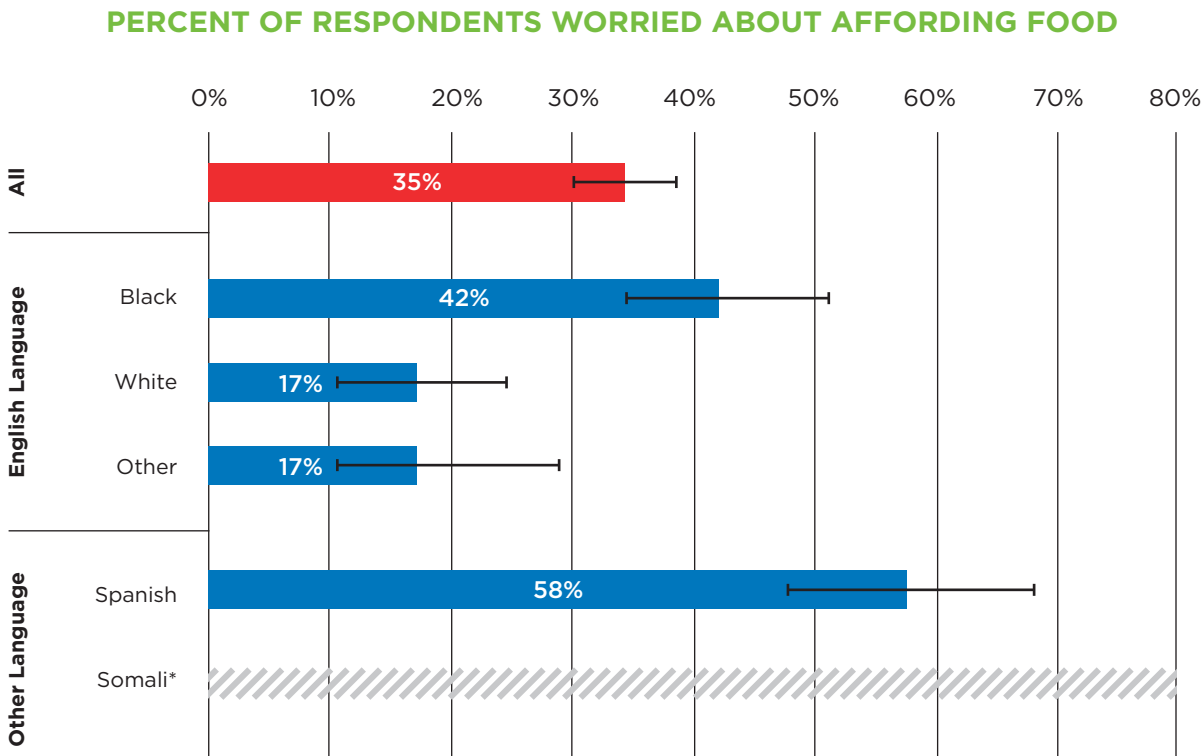
a. Homeless address indicator in electronic health record in previous two years; this likely under-estimates true homelessness.

b. Overnight stay in Hennepin County Detention Center or Adult Corrections Facility in previous year

c. Includes Hennepin Health Access Clinic

Basic Needs

Food security: Black and Spanish speaking patients were the most likely to report food insecurity.



After the murder of George Floyd, non-English speaking patients reported barriers in accessing a grocery store, with **31% of Spanish and Somali speaking patients reporting that they could not safely access a grocery store during this time period.**



*Fewer than 10 Somali participants responded to this item, therefore data is suppressed. See Limitations.

Basic Needs continued

Employment: Somali respondents were the most likely to report being unemployed and Spanish speaking patients were the most likely to only having part-time work. Of those employed, white respondents were the most likely and Spanish speaking patients were the least likely to report working from home.



21% of respondents reported full time work, 18% part time work, and **25% were unemployed.**



34% of respondents reported a change in employment since March 16. 15% of respondents became unemployed, 11% moved into a part-time position, and 3% gained full time employment.



Overall, 15% of respondents reported receiving disability or SSI and 23% of Black respondents received disability/SSI support.

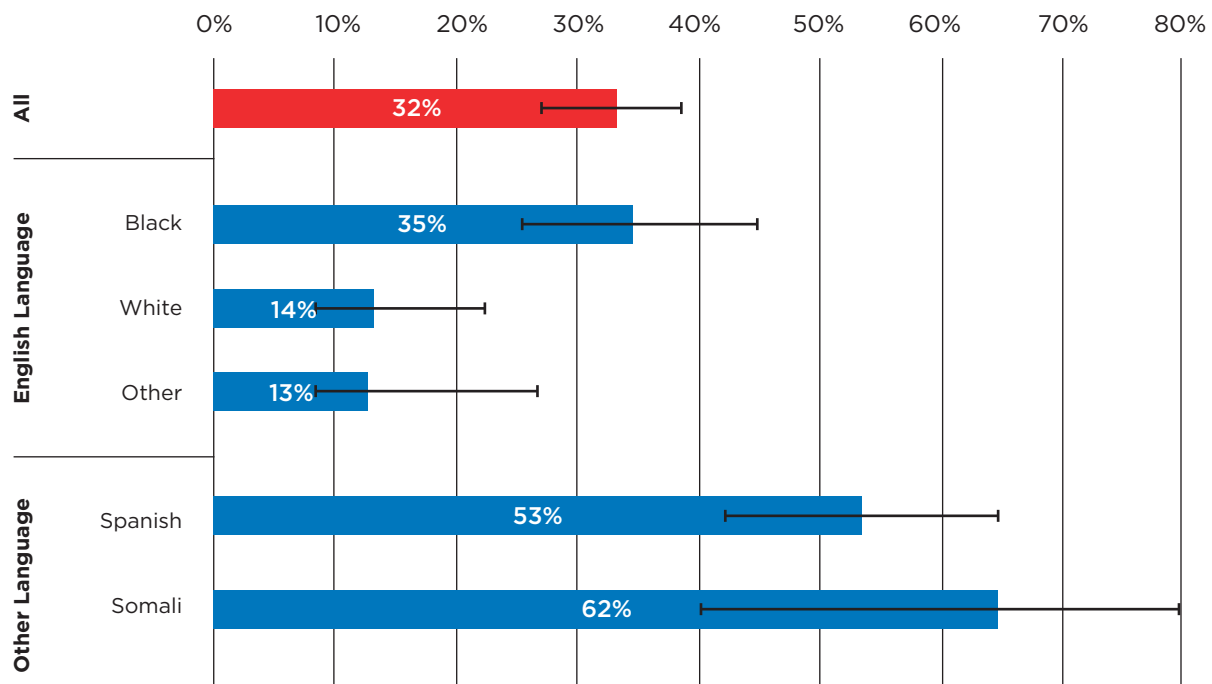
Diego and Emilia are undocumented and work in restaurants to support their family. **Diego tested positive for COVID-19 and went back to work after two weeks of quarantine because he felt he had no choice.** Diego's wife Emilia told a Hennepin Healthcare social worker, "I am too scared to go back to work." She is a server at the restaurant and **their family, including 2 children, depend on her wages and tips because they do not qualify for government assistance programs due to their legal status.**



Basic Needs

Housing: 73% of respondents report stable housing, 13% supported living, and 14% homelessness. Though living situation did not differ substantially between race/language groups, **respondents' worry about being able to pay their housing costs did vary substantially.**

PERCENT OF RESPONDENTS WORRIED ABOUT PAYING RENT, MORTGAGE OR OTHER HOUSING COSTS



Basic Needs housing continued



60% of respondents lived in households of 3 or more people. Somali (73%) and Spanish (90%) speaking patients were more likely to live in a large household than English speaking patients



38% of respondents had at least one child (under 18) in their home. 11% of respondents live with 3 or more children.



73% of respondents reported that they would be able to isolate at home if necessary.

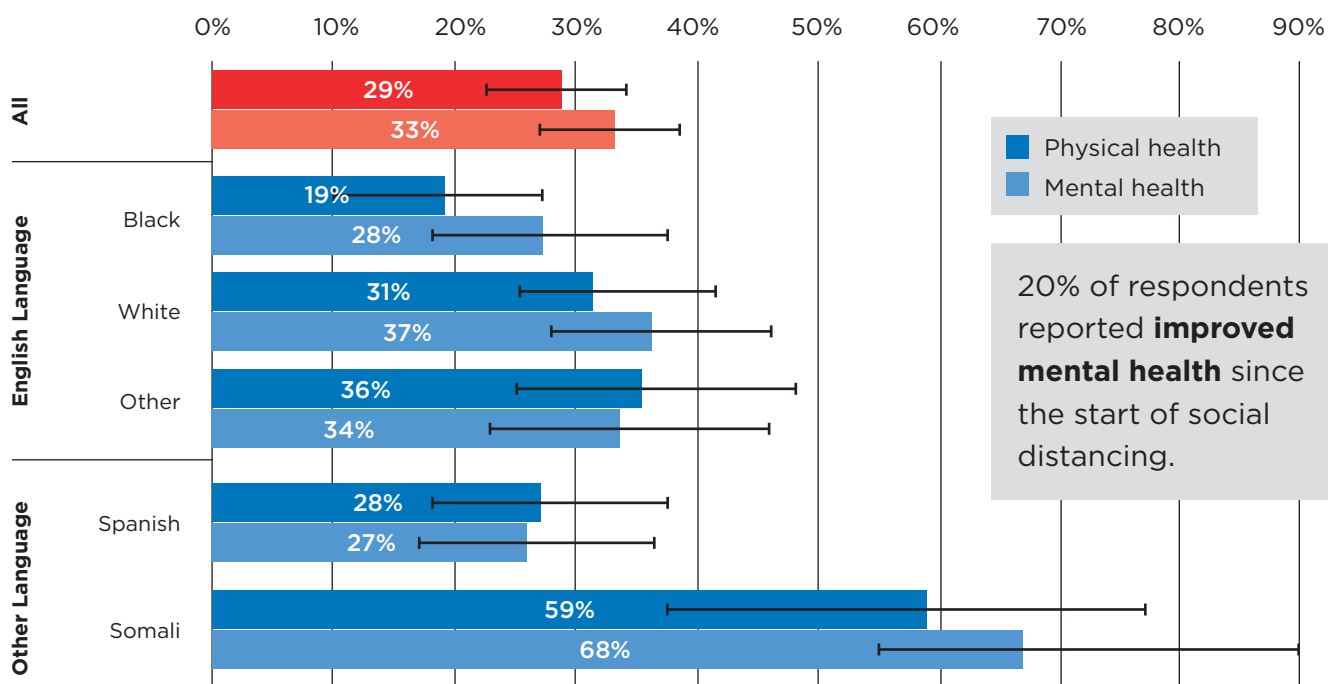


Monica, a 60-year old Black woman, rents a home in North Minneapolis where she raises her three grandchildren. Monica was furloughed from her job in May. **Even though she applied for unemployment benefits, it was not enough for her to pay her \$1,100 monthly rent plus other expenses.** Though her landlord is working with her on making rent payments, she is concerned about making up the payments and **facing possible eviction if she cannot catch up.**

Health and Health Care

Self-reported physical and mental health: At the time of the survey 34% of respondents reported that their physical health was fair or poor, and 31% of respondents reported fair or poor mental health. This is similar to the percent of respondents reporting that their health was very good or excellent.

PERCENT OF RESPONDENTS REPORTING “VERY GOOD” OR “EXCELLENT” HEALTH



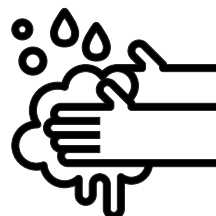
Supplies for maintaining health: Despite challenges accessing cleaning supplies, OTC medication, hand sanitizer, or face masks, most patients reported taking actions to protect themselves from COVID-19.



66% of patients reported difficulty accessing supplies.



93% of patients reported wearing a mask.

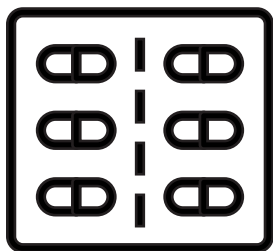
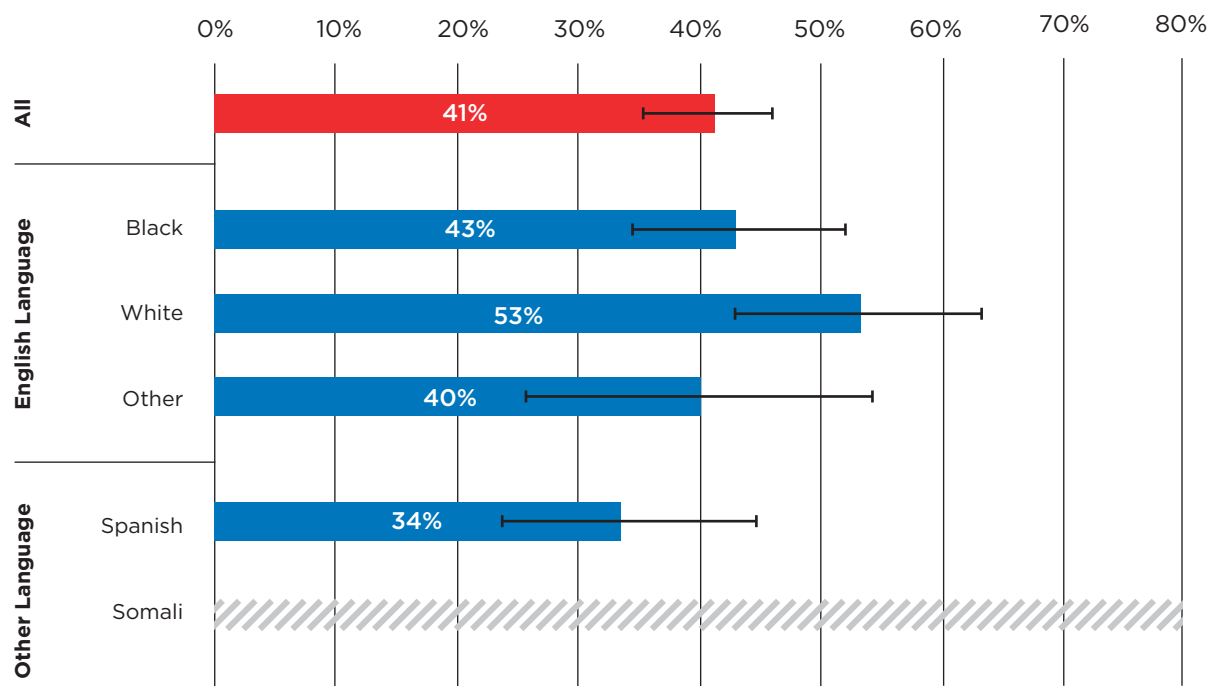


94% of patients reported washing their hands more often than usual.

Health and Health Care

Delays in medical care: 41% of respondents reported experiencing delays in healthcare. 75% described delays due to clinic-initiated cancellations; 34% reported being afraid to go to the clinic. Of patients reporting delays, 91% said it was for their physical health, 20% for dental, and 13% experienced delays in accessing mental healthcare. Qualitatively, individuals with delays in care related to pain concerns expressed frustration to surveyors.

RESPONDENTS EXPERIENCING DELAYS IN HEALTHCARE

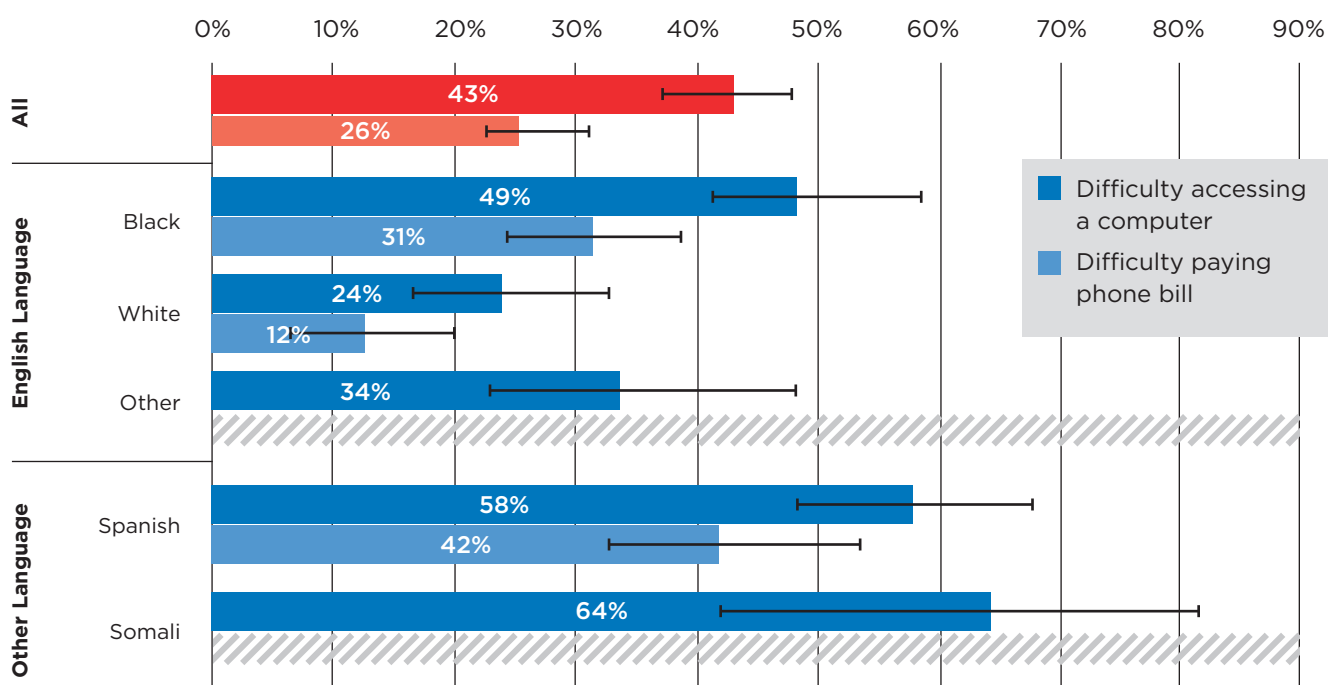


Joseph is a 45 year-old Black man who lives in Brooklyn Park with his family. Since starting to work from home during the pandemic, **he has noticed worsening of his back pain.** He had been scheduled for an injection with interventional radiology **which was postponed indefinitely when the pandemic arrived.** He also had difficulty filling his prescription medications for the pain. **After connecting with a community health worker, Joseph was able to activate mail-ordered medications.** He's hopeful that as things begin to open up he can have his injection.

Health and Health Care

Access to Technology: Patient access to the internet and comfort with technology is essential for telemedicine delivery. Most respondents reported access to smartphones (89%) and regularly checking their email (69%), although 26% of respondents experienced challenges paying their phone bill in the past year. Fewer respondents had computer access (57%), and 16% of respondents reported a change in their computer access due to COVID-19 either because of loss of the library or a work provided computer.

PERCENT OF RESPONDENTS REPORTING DIFFICULTY ACCESSING A COMPUTER AND PAYING PHONE BILLS

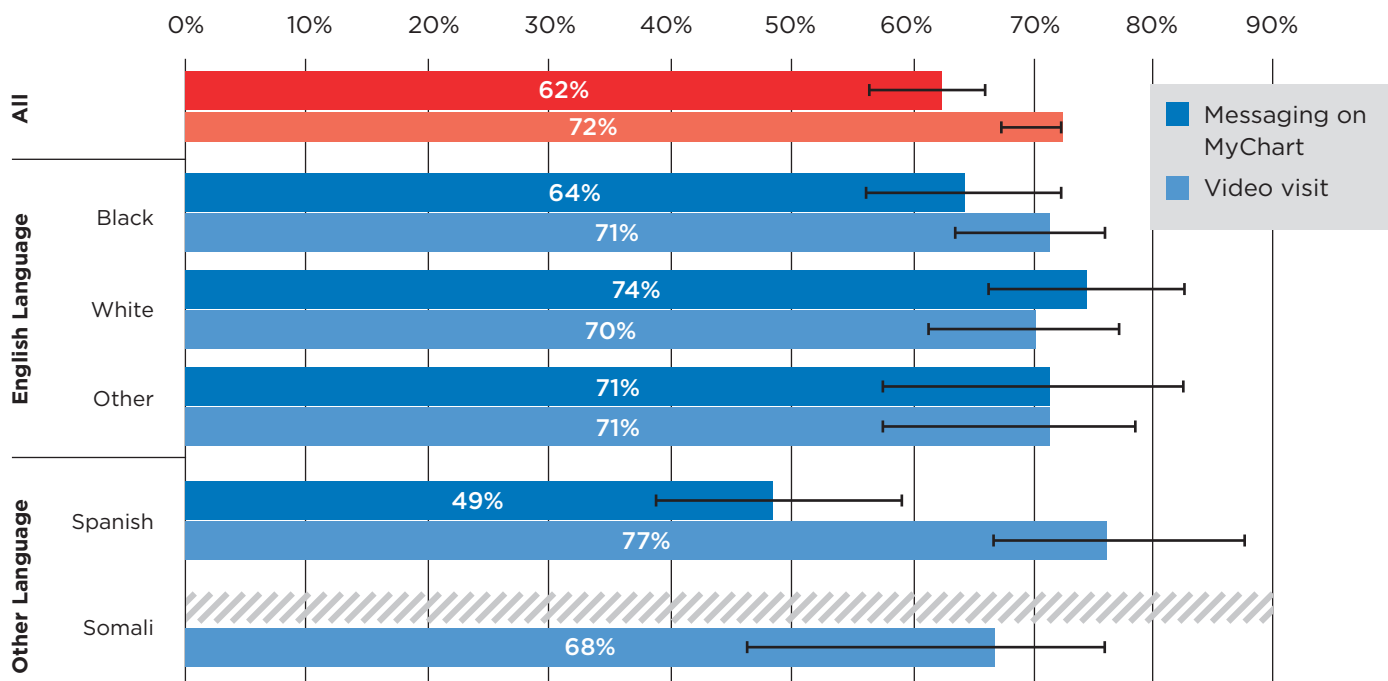


Andres, a Latino adolescent, was being followed at Whittier Clinic for problems with concentration and anxiety. The clinic recommended immediate evaluation through a neuropsychiatric assessment to evaluate for learning differences and attention challenges. **When the specialist finally had an opening several months later and called Andres' family's shared phone to schedule the appointment, the phone was disconnected.** The PCP called Andres' mom a month later for his regular follow up and asked her why she never scheduled the appointment. **His mom shared that her phone plan was canceled as they could not pay for it, and they were eventually able to pay their phone bill after receiving donations at their church.**

Health and Health Care

Openness to Telemedicine: In order for telemedicine to be widely adopted by patients, they must be comfortable with technology. Most respondents were willing to have a phone visit with their provider (87%). People who spoke Spanish or Somali expressed hesitancy to use MyChart to do an e-visit, which is currently an English only application.

PERCENT OF PATIENTS WILLING TO USE TECHNOLOGY TO ACCESS HEALTHCARE



Many will need support to use Web- or app-based telemedicine effectively. For example, **only 34% of respondents were willing to receive their gift card via email** and patients expressed uncertainty about how e-gift cards work.

Samuel is a primary care patient in his mid 50's, who uses motorized wheelchair due to long-standing mobility issues related to his multiple medical issues.

Over the last few years his mobility challenges have caused him to miss appointments. Since the transition to telemedicine during COVID-19, he has been able to attend most of his appointments, and **has expressed appreciation for being able to stay connected with his health care without the burden of trying to navigate transportation to come in for all of his appointments.**



Health and Health Care Openness to Telemedicine continued



Among patients who expressed hesitancy to use to use telemedicine (47%):

Video visit (n = 111):

Prefer in-person (35%)
Don't know how to use it (29%)
Don't have the right device (27%)

MyChart/E-visit (n = 152):

Don't know how to use it (55%)
Prefer in-person (26%)
Other reasons (15%)

Conclusion

Real-time phone survey data about the state of primary care patients at Hennepin Healthcare deepens pre-existing concerns about stark disparities across race/ethnicity and language groups and highlight the differential impact of COVID-19 on these groups. The findings of this survey show the interconnectedness of complex social factors and health. This is most striking in the numbers of Black and Spanish-speaking patients experiencing food and housing insecurity.

Self-rated physical and mental health was relatively good among our sample of people with phone access who use Hennepin Healthcare primary care clinics. Most people reported following recommended behaviors to reduce the spread of COVID-19 such as regular hand washing and wearing a mask, though nearly two-thirds had difficulty finding needed supplies. Health care delays, mostly due to clinic-initiated cancellations, affected 41% of all respondents. Patients expressed willingness to participate in telemedicine, but many only have internet access on their phones (no computer) and they reported uncertainty about how to use technology. Further inquiry is needed to understand the conditions under which patients would be comfortable engaging in telemedicine. Almost 90% had access to smartphones, but those groups most affected by the pandemic (Latinos and Black) were also the most likely to report challenges paying their phone bill.

Survey results reveal a number of domains where concrete and actionable steps could be taken by Hennepin Healthcare and others in the community to better meet the needs of patients. It is important and urgent that health systems partner in this work to address inequities that have been exacerbated by the COVID-19 pandemic. Basic needs, also known as social determinants or drivers of health, are known to be the most influential factors impacting health and, by addressing them, communities can more equitably improve health outcomes.

First, as many patients experience housing, food, and employment insecurity, these data serve as a call to action to understand and adapt to patients' changing needs. Partnerships with government and community housing providers and advocacy groups will be critical to finding creative solutions to meet these needs.

Second, as health systems begin to rely more heavily on MyChart to communicate with patients during COVID-19 and after, it is essential to ensure MyChart, as well as text and email communication channels, are available in other languages to support non-English speaking populations. Since the time of the survey, Healthcare has already started making system and process improvements in this area.

Conclusion continued

Third, resources should be allocated to provide technical assistance to those unsure how to use telemedicine. In order to ensure critical access to healthcare for all patients, resources could include payment to retain telephone access, and easy access to a patient focused technical support staff.

Last, as health system's continue to respond to the COVID-19 pandemic, an equity lens must be taken to ensure the development of sustainable systems that support everyone in the community to obtain and maintain health.

Acknowledgments

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