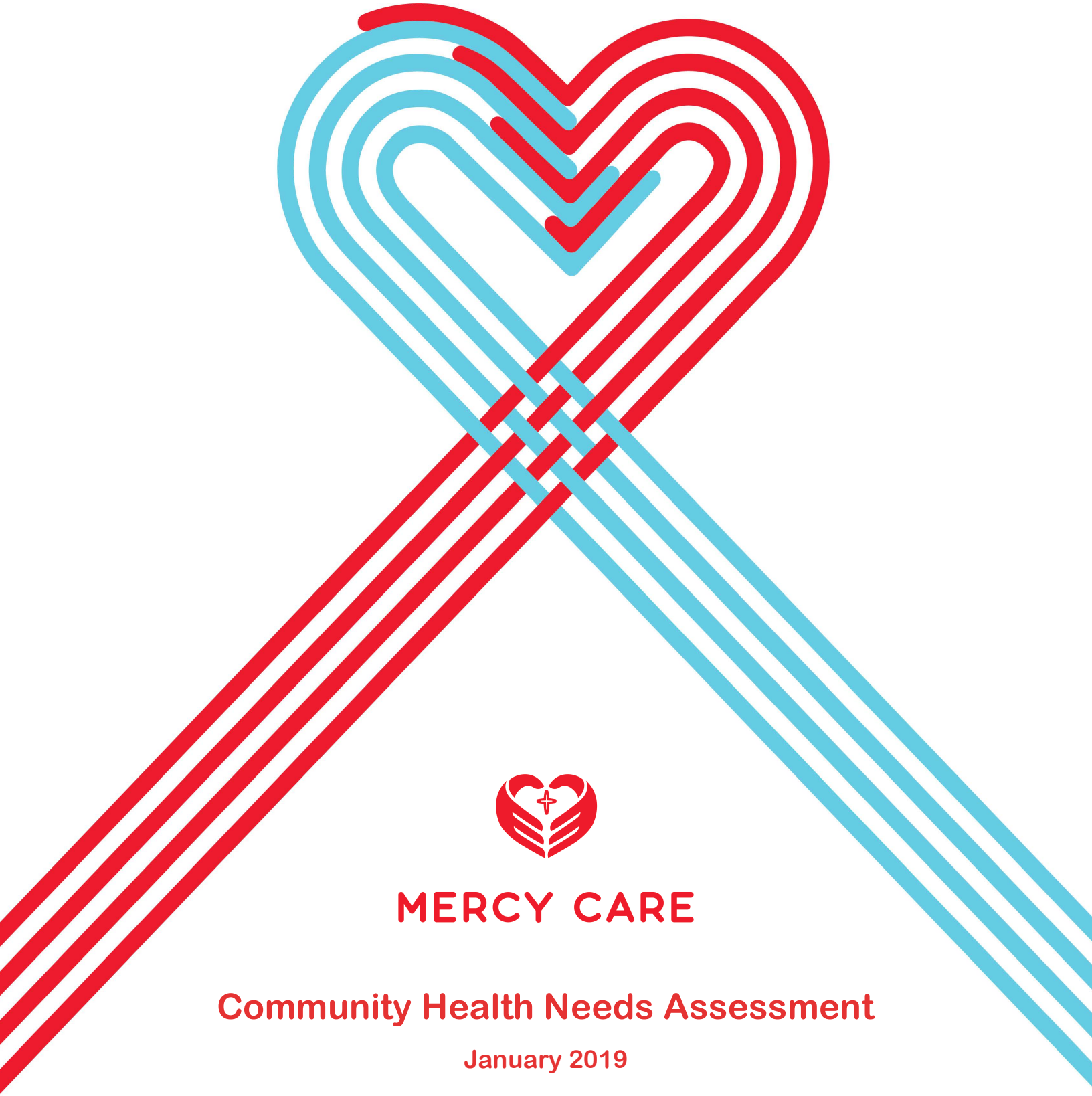

MERCY CARE

Community Health Needs Assessment

January 2019

EXECUTIVE SUMMARY

The Social Determinants of Health are the conditions in which individuals live that impact their health status. Social Determinants of Health include housing, income, employment, education, personal and community safety, and access to health foods. It is estimated that social determinants have an even larger impact on health than actual medical care. Historically, however, the Social Determinants of Health have not received much attention or funding. The first step in understanding how social factors impact health is to collect robust data on the situation in which people live and relate it to their health status. This Community Health Needs Assessment attempts to do that, using data from Mercy Care's new Social Determinants of Health screening tool in the Electronic Health Record.

Data were collected from clients and stratified by housing status. Of the clients that responded, 70% reported having at least a high school education, yet only half said that they learn best by reading. Many of Mercy Care's clients experience financial resource strain: 82% said that it is hard for them to pay for basics like housing, food, heating, medical care, and transportation. Almost half of all respondents said that a lack of transportation has kept them from getting where they need to go—including work and medical appointments. Survey respondents also reported difficulty in obtaining healthy food. Food insecurity is an issue that affects 2 out of 3 Mercy Care clients, and can cause or worsen chronic conditions like obesity, hypertension, and diabetes.

Isolation and loneliness also contribute to poor mental health and can exacerbate chronic conditions. Of clients that responded, 31% reported feeling lonely or isolated from those around them. When broken down by housing status, twice as many persons experiencing homelessness reported feeling isolated as compared to those in stable housing (37% vs. 17%). Persons who are currently experiencing homelessness also report exposure to violence at a rate six times that of persons in housing (12% vs. 2%). Isolation and exposure to violence play a part in contributing to a person's overall stress level, which in turn impacts the physiology of the body. High levels of stress were reported in nearly half of clients without a steady place to live, twice the rate of clients in a stable home.

Feedback from clients, staff, and local community organizations affirms that Mercy Care is providing valuable and necessary health services to people in Atlanta who are in need, especially those experiencing homelessness. Mercy Care seeks to serve the whole person, and provides services in an integrated care model. This is further advanced by screening for and assessing clients' Social Determinants of Health, but this is only the first step toward addressing these key drivers of health status. Mercy Care will continue to seek to mitigate the impact of negative Social Determinants of Health, with a special focus on persons who experience homelessness.

BACKGROUND

Mercy Care is one of metro Atlanta's oldest and largest health care and outreach organizations. It is the only federally qualified health center (FQHC) based in downtown Atlanta, designated specifically to provide health care for the homeless. Over the course of its 35-year history, the organization has developed a solid reputation among its target population and among other community-based organizations as a trusted provider of compassionate, quality, affordable care. In 2017, Mercy Care served 13,459 clients through 57,732 encounters across 13 clinic sites. Of those served, approximately 70% were homeless, 60% were African-American, 27% were Hispanic, 25% were best served in a language other than English, and 79% were uninsured.

With an experienced team of medical, dental, behavioral health, and vision providers, and supportive services staff, Mercy Care provides a comprehensive continuum of care focused on providing a patient-centered medical home for its target population. Programs include primary and preventive health care, integrated behavioral health care, oral health care, vision care, health education presented in both English and Spanish, a broad range of HIV prevention, primary care and supportive services, breast cancer screening and supportive services, mental health case management, recuperative care for medically fragile homeless individuals, and Street Medicine and outreach.

Mercy Care has a long history of treating the whole person, integrating traditional medical care with non-medical needs like housing, food, clothing, and transportation assistance. Every day, Mercy Care sees how social needs "create access, adherence, or performance barriers, often impeding efforts to provide evidence-based clinical care that improves overall health".[1]A culture of innovation and continuous quality improvement provides a foundation for ensuring compassionate, high-quality, and person-centered care.

The term "Social Determinants of Health" (SDH)[2] refers to the conditions in which people are born, grow, live, work, and age[3] which have a substantial impact on their health status. In fact, across the United States, it is estimated that clinical medical care is responsible for preventing only 10-15% of preventable mortality in the US, but represents a disproportionate share of health spending. The Unites States spends 3.5 trillion dollars per year, or $10,739 per person, on health spending, ranking #1 in the world[4]. This represents 17.9% of the nation's Gross Domestic Product, compared to the average of 11.5% in comparable high-income countries. Unlike other nations, this healthcare spending does not include health insurance coverage for every American, and cannot be explained by higher utilization rates as Americans have fewer hospital and physician visits[5].

Despite spending a disproportionate amount on healthcare, the US does not rank highest in the world for health outcomes, often falling well below the average for leading health indicators. Life expectancy in the US is nearly three years shorter than other high-income countries, and the US has higher than average rates of obesity, heart disease, and infant mortality[6].

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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However, compared to similar high-income nations, the United States spends the least on social services, like retirement and disability benefits, employment programs, and supportive housing[7]. Social and behavioral factors have a much larger impact on a person's health than medical care. The effect of these "upstream" SDH factors compounds over time, and it is challenging, ineffective, and costly to try to remedy these intersecting problems in the clinic ("downstream"). This is especially true for chronic diseases such as diabetes and hypertension.

Mercy Care has a special focus on serving individuals who are experiencing homelessness. Homelessness is a particularly complicated intersection of social determinants and health status. While homelessness is a key driver of poor health, homelessness itself results from "accumulated adverse social and economic conditions[8]. Homelessness often complicates treatment or management of diseases,[9] resulting in poorer health overall. According to the National Health Care for the Homeless Council, compared to the general housed population, people without homes are more severely impacted by SDH, leading to increased mortality, chronic health conditions, mental illness, substance use, and risky health behaviors. They are more likely to face extreme poverty resulting in an inability to obtain and maintain housing, pay for health services, and afford basic daily necessities like food and clothing.[10]

At Mercy Care, staff members see firsthand how social needs impact health and are inherently aware of the challenges faced by clients, but historically, it has been impossible to quantify the needs of the population. Mercy Care's history of treating the full person was enhanced in

summer 2018 through the implementation of a new screening tool which enables all providers to see the many facets of the patient's experience. The results of the SDH screen are easily visible by all members of the care team in the patient's electronic health record (EHR), and form the basis of this Community Health Needs Assessment.

METHODOLOGY

This Community Health Needs Assessment is comprised of primary data collected from three groups of people: Mercy Care current or prospective clients, Mercy Care staff members, and Mercy Care's community partners who serve a similar population. Client data was collected via a screening tool for Social Determinants of Health (either in-person or online), and a series of focus groups held at local shelters. Responses from staff and community partners were collected via an electronic survey. Further detail about the methods for each audience is described below.

PARTICIPANT GROUPS

CLIENTS

Information was collected directly from clients in two ways: a Social Determinants of Health (SDH) screening survey (administered either electronically or in the clinic), and in-person focus groups.

Clinic Screening. Clients were screened using a validated survey tool integrated into the Electronic Health Record. This survey was based on the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), developed by the National Association of Community Health Centers[11]. PRAPARE assesses the following domains:

- Education
- Material security
- Social integration
- Stress
- Transportation
- Exposure to violence
- Housing quality

After several months of planning, the Social Determinants of Health Screening was rolled out for use by Mercy Care staff on July 6, 2018 via an all-users email. Staff handed out a paper version of the form or helped clients complete the form during the rooming process of a visit. In the following weeks, members of the Quality Team visited clinics to demonstrate the new screening tool and answer any questions. The Quality Team encouraged staff to complete as many screenings as possible in the summer months. Student volunteers were also trained to collect this information and positioned in the Mercy Care Decatur Street clinic waiting room. The surveys were available as a paper copy so that clients could fill them out independently, or staff could ask the questions during a visit and enter this information directly into the Electronic Health Record (EHR). Mercy Care staff collected 722 patient surveys and student volunteers collected an additional 474 results.

Electronic Survey. To collect data, an electronic message was sent in late July 2018 to the 2,006 patients who were active on MyChart since January 1, 2017. This mass communication prompted clients to complete the SDH screening tool via the online patient portal (MyChart), which was then appended to their electronic health record. This could be completed on a desktop or mobile device, and yielded 120 survey completions.

From the first result collected on July 10 until the end of August, a total of 1,316 screening surveys were completed, via MyChart, staff, and student volunteers.

Focus Groups. Qualitative data were collected via three focus groups in order to explore some of the predominant needs identified in the SDH screen. These focus groups were conducted at Mercy Care clinics or partner homeless shelters, with a total of 39 participants. This included 15 participants at the Atlanta Day Shelter for Women and Children, 9 participants at City of Refuge, and 15 participants at Atlanta Mission: Shepherd's Inn.

STAFF

Electronic Survey. Staff were surveyed about their perceptions of the needs experienced by their clients, with sections relating to the social determinants of health, access to medical care, barriers to being healthy, and an opportunity to assess Mercy Care's service provision. An electronic version of a survey was sent via email to all Mercy Care staff on August 20th, and 2 follow-up emails encouraged staff to participate. There were 91 staff members who completed the survey. Of the 91 responses, 80% reported a job function primarily in the clinic, with only 20% reporting spending 35% or less of their average day working with clients (primarily administrative roles).

COMMUNITY PARTNERING ORGANIZATIONS

Electronic Survey. A survey version similar to the staff survey was distributed via email to 50 community organizations ("community partners") with a shared focus and experience in serving low-income and homeless individuals. The email was forwarded by Partners for Home to the entire Atlanta Continuum of Care's mailing list for a wide distribution. The survey opened on July 25th and was closed on August 10th. There were 55 respondents across 39 different organizations. Respondents included representation from the following organizations:

Action Ministries, Inc.
Atlanta Mission
Atlanta Regional Commission
Buckhead Christian Ministry
CaringWorks, Inc.
Central Atlanta Progress
Central Night Shelter
Central Outreach and Advocacy Center
Christian City Children's Village
Church of the Common Ground
Community Advanced Practice Nurses, Inc.
Community Friendship, Inc.
Covenant Community
Covenant House Georgia
Crossroads Community Ministries
DBHDD (Georgia Department of Behavioral Health and Developmental Disabilities
Essence of Hope, Inc.
First Presbyterian Church of Atlanta
First Step Staffing

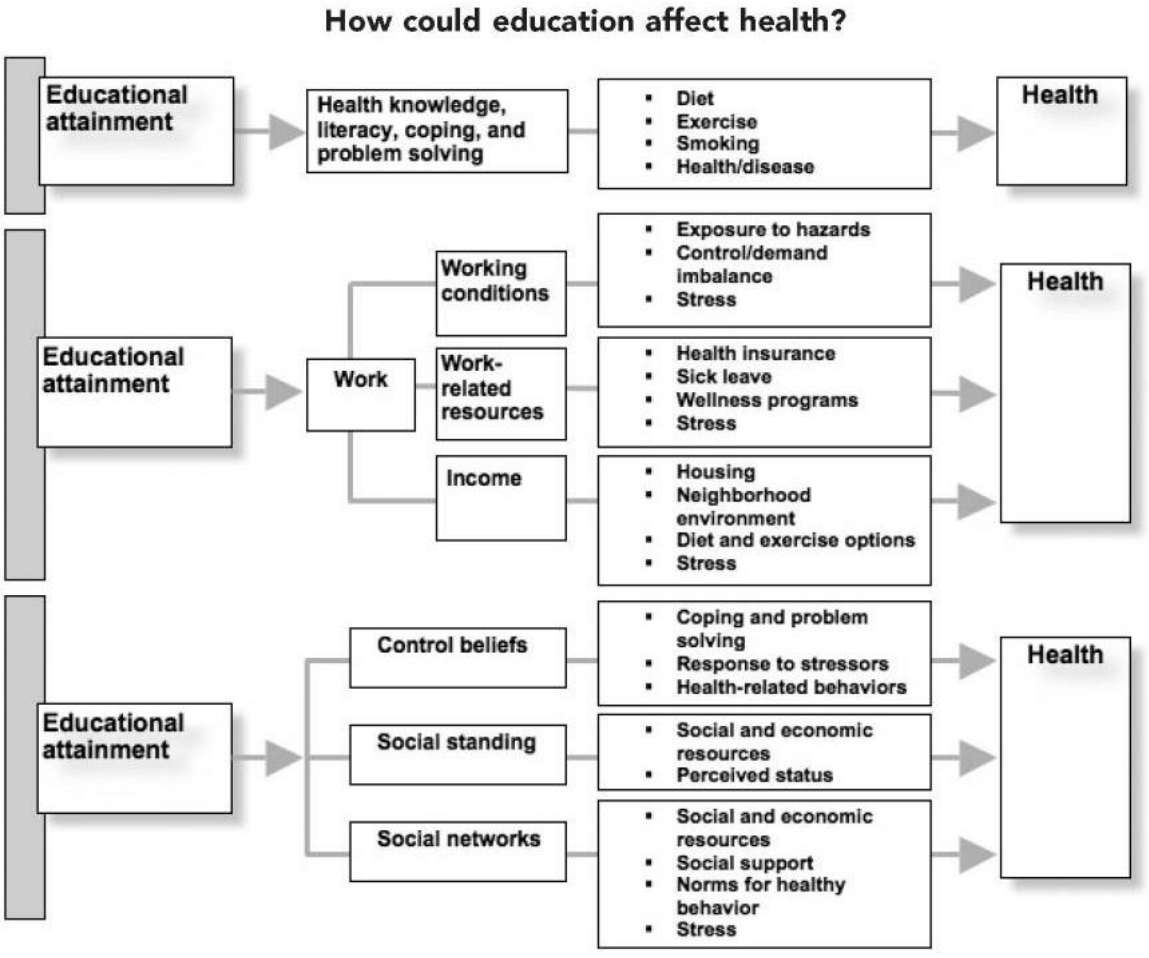
Fulton County Board of Health
Gateway Center
Georgia Rehabilitation Outreach, Inc.
Grady Health System
Hope Atlanta
Hosea Feed the Hungry
Intown Collaborative Ministries
Latin American Association
Metro Atlanta Task Force for the Homeless
Oakhurst Recovery Program
Partners for HOME
Partnership Against Domestic Violence
Regional Commission on Homelessness
Step Up
The Norman Spruill House Foundation
Wheat Street Baptist Church
WILIN2b
Young Adult Guidance Center, Inc.

RESULTS AND ANALYSIS

Results were collected and analyzed for a "point in time" view as of September 2018.

LEARNING AND EDUCATION:

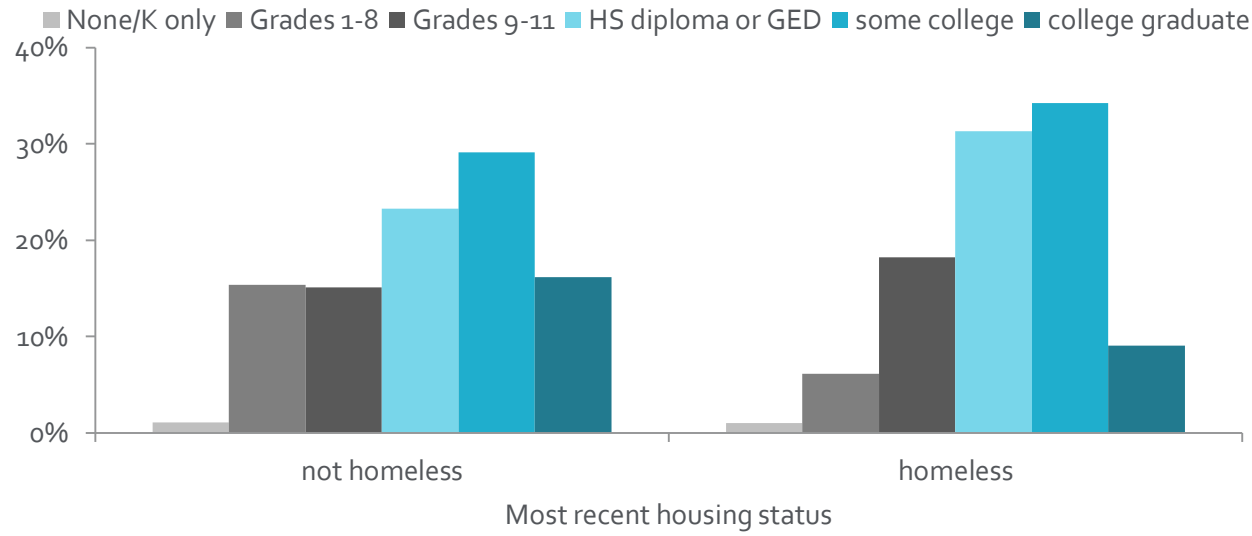
Educational attainment has a large impact on the health and lifespan of individuals. This is often the foundation of a person's career path, choice of neighborhood, and socioeconomic standing. Like many of the social determinants of health, low educational attainment is often both a cause **and** an effect of other social factors.[12]



Findings

Of the clients that responded, 44% reported having at least some college education. Around 27% of clients have not finished high school. Notably, when respondents were stratified by their current housing status, 75% of clients who are currently experiencing homelessness have at least a high school diploma, compared to 69% of clients who are stably housed. However, clients experiencing homelessness are half as likely to have graduated from a four-year college (9% of clients experiencing homelessness vs. 18% of clients in stable housing).

70% of all clients have **at least a high school education**



On the next question, "How do you learn best?", 1,288 clients responded by selecting at least one option. Of these, more than half (52%) indicated that they learn best by reading. The second highest response was hands-on (46%), followed by listening (43%). Only 18% of clients said that they preferred to learn via pictures.

FINANCIAL RESOURCE STRAIN

It is expected that persons who experience homelessness also experience financial limitations. This lack of resources manifests in many different ways, perniciously affecting many aspects of life. It is impractical to discuss the myriad ways that limited financial resources both result from and further intensify poor health.

In 2017, 12.3% of all Americans were living below the poverty level. This number is slightly higher in the south: 13.6% are estimated to be living in poverty. This figure varies dramatically when broken down by race and ethnicity: 8.7% of non-Hispanic whites are in poverty, 21.2% of blacks, 10.0% of Asians, and 18.3% of Hispanics live in poverty[13].

% living in poverty	United States	Fulton/DeKalb	Mercy Care
Overall population	12.3%	17.8	82.5
White (non-Hispanic)	8.7%	9.7	72.3
Black	21.2%	23.9	85.6
Hispanic	18.3%	29.7	65.1
Asian	10.0%	16.1	75.3

Race and socioeconomic status are strongly associated, and this is particularly true in Atlanta. In Fulton and DeKalb Counties, 9.7% of non-Hispanic whites live in poverty, while 23.9% of black and 29.7% of Hispanic/Latinos live below the poverty line[14]. Out of all clients served by Mercy Care in FY 2018, 82.5% were living below the poverty line.

Findings

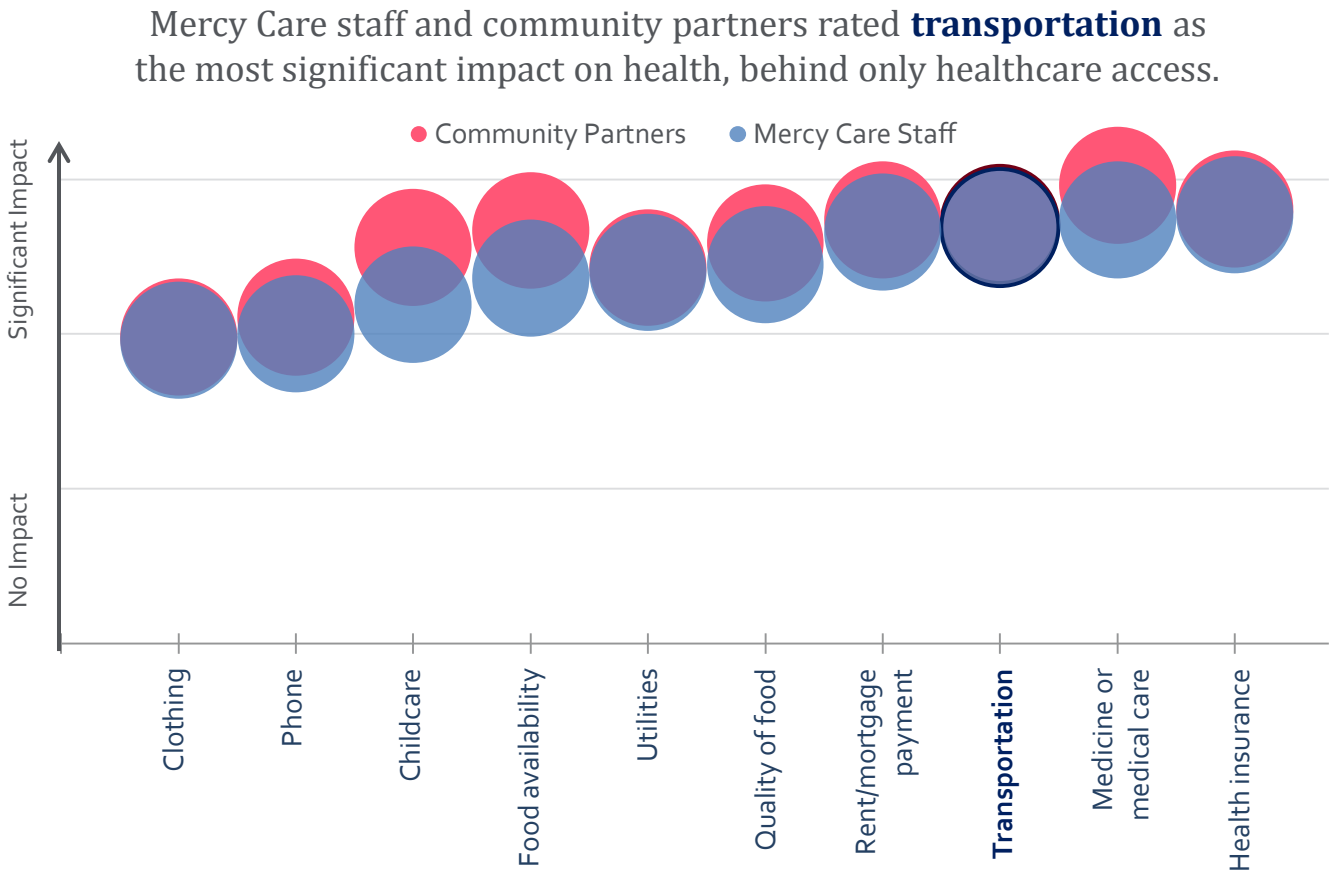
On the SDH Screening, overall, 82% of all clients said it is "somewhat hard" or "very hard" for them to pay for the very basics like food, housing, heating, medical care, and transportation (85% of clients experiencing homelessness, 75% of stably housed clients). Across the focus groups, participants noted several shared needs. The most frequently mentioned needs were: transportation, medical specialty care, and healthy food.

TRANSPORTATION

Transportation is an issue that comes up often in clinic conversations. Clients report difficulty in getting where they need to go, and almost half of survey respondents said that a lack of transportation has kept them from work, medical appointments, meetings or getting things needed for daily living in the past twelve months (56% of those experiencing homelessness, and 23% of clients who are not homeless)[15].

This topic came up repeatedly in focus groups and in the surveys sent out to Mercy Care staff and community partners. Focus group participants at local shelters rely mainly on walking to get where they need to go. For some, even a Marta public transit pass is a luxury. Because of this, a "one-stop shop" experience is desirable when it comes to receiving healthcare, especially if the clinic is co-located with another service provider like a shelter or workforce development agency. Clients like to be able to see their medical, dental, vision, and behavioral health provider in one location on the same day. For services like dental work that require follow-up appointments, there seemed to be a lot of missed appointments or lengthened treatment times due to inconsistency rooted in a lack of transportation. Clients also expressed appreciation for mobile clinic services, the street medicine team, and other services that travel to them where they are, eliminating the transportation barrier. Many focus group participants disliked ride-sharing services like Uber or Lyft, mainly due to the cost of a ride. Clients also expressed fear and mistrust of the ride-sharing service and/or drivers.

Staff and partners were asked to determine the impact of transportation on the health of clients. Over 95% of partners and 92% of staff members agree that transportation has a moderate or significant impact on health.



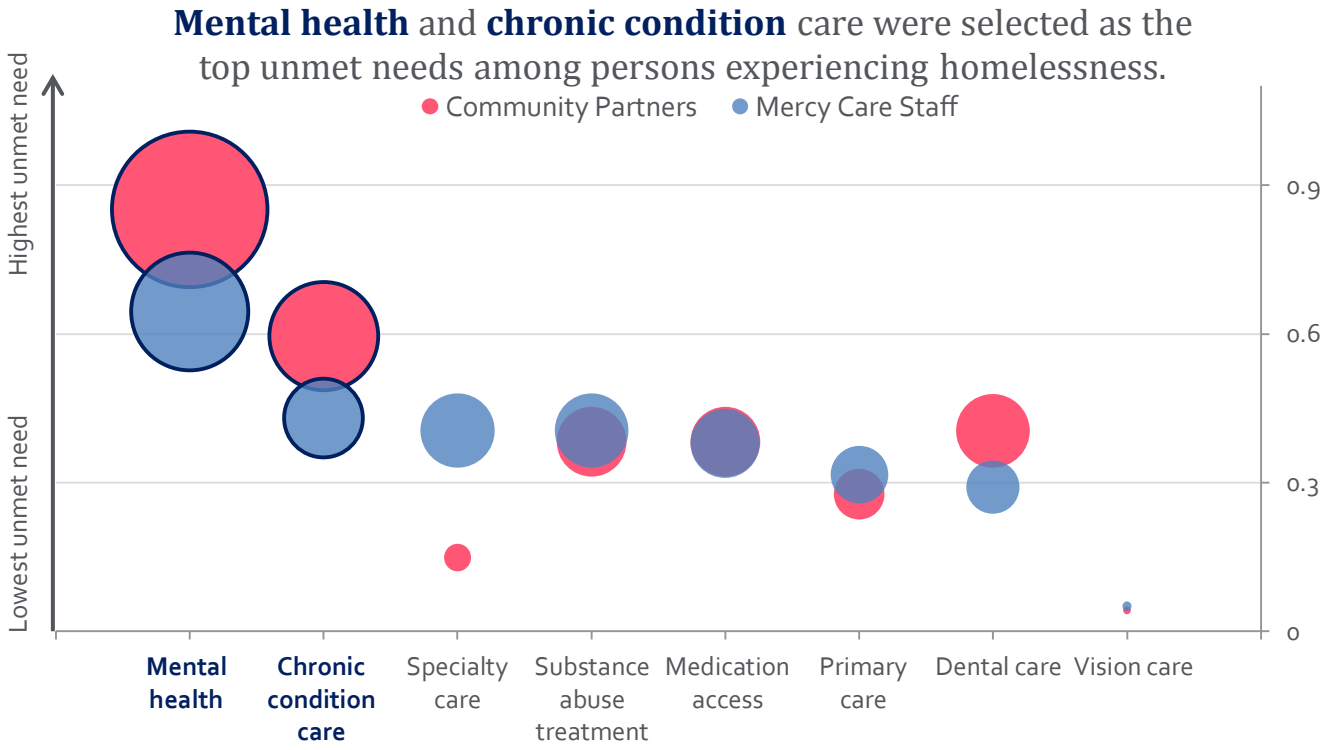
MEDICINE/MEDICAL CARE

Despite efforts to make health insurance attainable and affordable for all Americans, many Georgians remain unable to pay for health insurance or basic medical care. Georgia has chosen not to accept billions of dollars of funding from the federal government to expand Medicaid under the Affordable Care Act, which would cover an additional 240,000 Georgians[16]. Georgia is one of 19 states that has not expanded Medicaid. Georgia has one of the most restrictive Medicaid requirements in the nation, with only six states having lower income limits for Medicaid eligibility for low-income parents[17]. Regardless of income levels, non-disabled adults without dependent children are ineligible for Medicaid in the state.

Mercy Care does not turn anyone away based on their ability to pay. Most insurance plans are accepted and individuals without insurance are welcome as well. Client fees are adjusted based on ability to pay, using a sliding fee scale based on household income and family size.

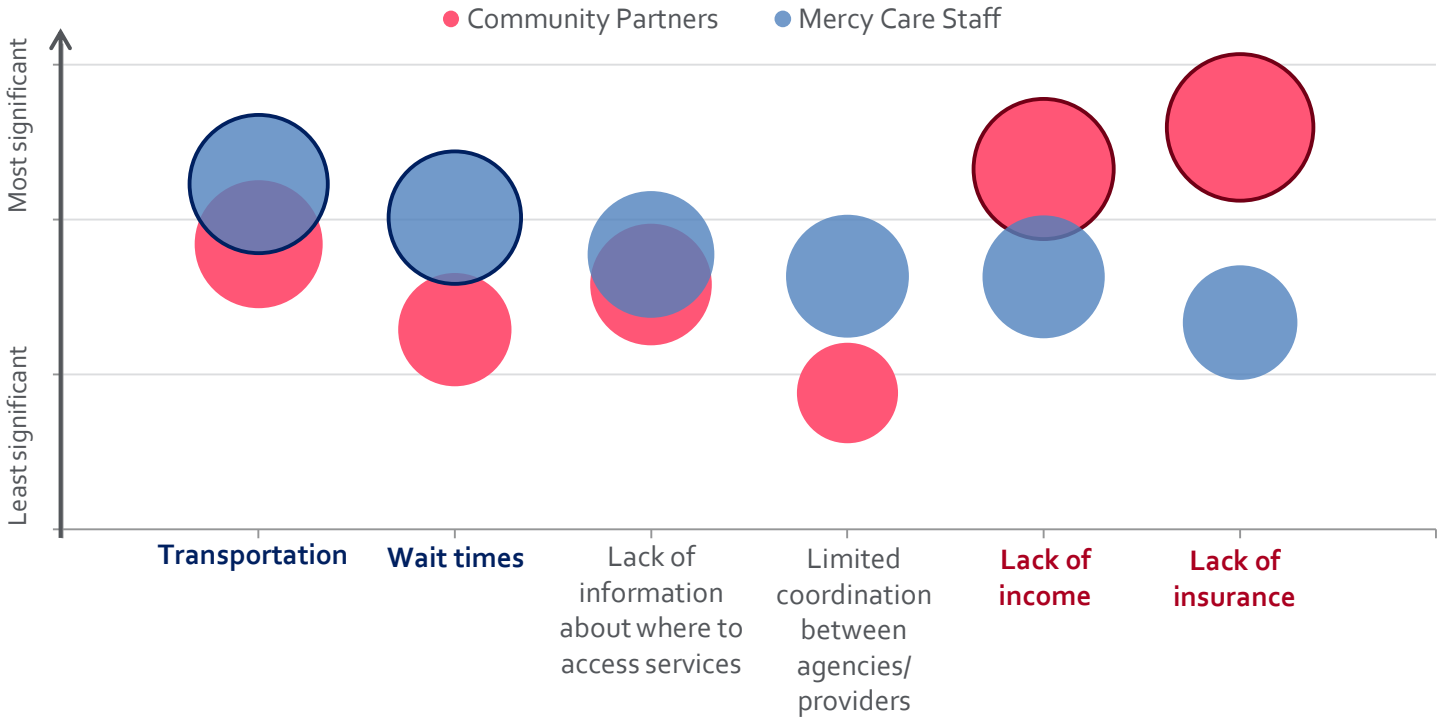
In focus group discussions, participants were aware of and used Mercy Care for health services. Most people expressed appreciation for the integrated care model and at being able to be seen by several providers in one day. They said that people in need of services were mostly aware that they could go to Mercy Care and receive affordable medical care and medications. However, there was some misinformation about the services provided, mainly due to information being passed by word-of-mouth. The majority of focus group participants heard about Mercy Care from a friend, had been referred to Mercy Care by a case manager or advocate, or had heard about Mercy Care during intake at a shelter. Several mentioned seeing Mercy Care vans or posters/flyers, but did not seek out services until after urging by a friend. A few people walked in to one of the clinics and asked questions.

Clients noted that the cost of healthcare is often a barrier to accessing services. When asked what a "nominal fee" for medical services might mean for them, most people said between $5 and $10 would be reasonable. As one person said, "You can get $5 if you really need to see the doctor—a quarter here, dime there, [you could] scrape together enough". Another person disagreed, saying, "There's been times I've been sick and needy and I haven't been able to get $5 together". Several other people said that even $5 would be a barrier to receiving care. Clients described difficulty in obtaining specialty care outside of Mercy Care due to the associated cost. Community partners and Staff recognized that medical care can be a challenge to access and afford, particularly for persons experiencing homelessness. In particular, when asked, "What are the top three unmet health/wellness needs of our target population?", mental health treatment was the most frequently cited need, selected by 85% of community partners and 65% of staff. Chronic condition care was perceived to be the second-highest unmet health need, selected by 60% of community partners and 40% of Mercy Care staff.



Behavioral Health services are a challenge to access in Atlanta, due to the cost and the shortage of providers. This was ranked as the #1 unmet health need by both staff and partners. There is also a high need for dental services among persons experiencing homelessness in Atlanta. There are very few affordable options available for individuals without dental insurance, and reconstructive services can be especially expensive.

Mercy Care staff said that **transportation** and **long wait times** prevented people from accessing health services. Community partners, however, said that **lack of insurance** and **lack of income** were the two biggest barriers to healthcare for people experiencing homelessness.



Community partners were queried as to what barriers exist to accessing services medical services, and staff were asked to assess barriers to receiving medical services at Mercy Care in particular. Mercy Care staff members answered transportation, wait times, and limited information about where to access services as the three primary barriers. Community Partners, on the other hand, perceived the biggest barriers to be lack of insurance, lack of income, and transportation. Although Mercy Care waives the out-of-pocket expenses for clients who are experiencing homelessness, this is not the case for all medical providers, and can be a problem for specialty care in particular (as mentioned in focus group discussions).

Other items mentioned by staff and community partners included the mistrust or fear of service providers as a hindrance to receiving care. Mental health pathologies can also limit someone from receiving necessary treatment, as well as a lack of documentation (ID or paperwork required for services).

PHONE/TECHNOLOGY

On a positive note, focus group participants unanimously said they have easy access to Wi-Fi and either a computer or smart phone – a necessary tool in staying connected with their health providers. Many clients were aware of and active in MyChart, Mercy Care's patient portal. Clients who had used MyChart appreciated the convenience and accessibility of being able to message their provider and request an appointment or a refill without calling the clinic or finding transportation to show up in person.

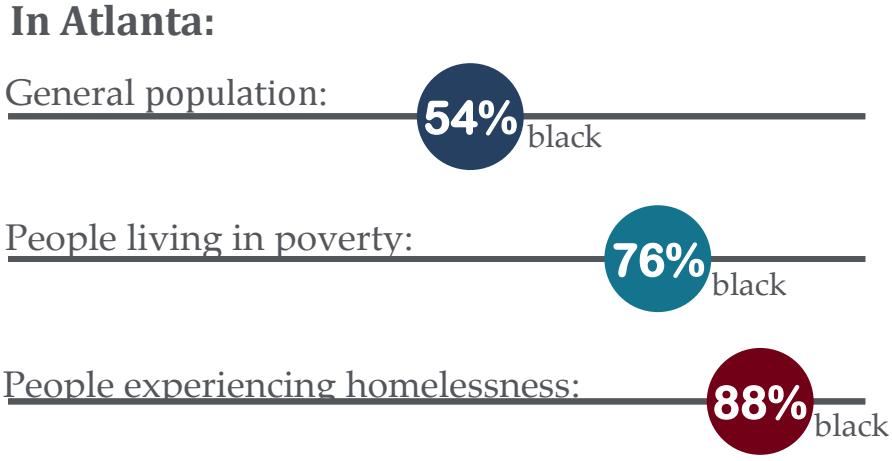
HOUSING

Persons experiencing homelessness have been found to have a lifespan around 20 years shorter than those who are stably housed[18]. Researchers in Boston found that the mortality rate for unsheltered adults was three times higher than adults living in homeless shelters, and ten times higher than the mortality rate of the general population. That is: adults who are homeless die at a rate that is ten times higher than the general (housed) population. This could not be attributed only to environmental factors, like cold or violence; the most common causes of death were cancer and heart disease, followed by alcohol use disorder and chronic liver disease. In this study, the average age at death was 53 years for individuals experiencing homelessness, compared to 78 years in the general population[19].

Findings

Of the clients seen at Mercy Care, men are more likely than women to be experiencing homelessness. In 2017, 70% of the clients served at Mercy Care were experiencing homelessness, and 55% of these were male. Men are more likely to be living in a shelter (60% male/40% female), in transitional housing (61% male/39% female), and on the street (66% male/34% female). Out of the clients served who in stable housing, men represented only 39% of the total.

There are documented racial inequities when it comes to persons experiencing homelessness. In Atlanta, approximately 54% of the general population is black. However, black people make up 76% of people living in deep poverty and 88% of people experiencing homelessness[20]. At Mercy



Care, 81% of clients served in downtown Atlanta locations[21] are black, 82% of clients in poverty are black, and 83% of clients experiencing homelessness are black.

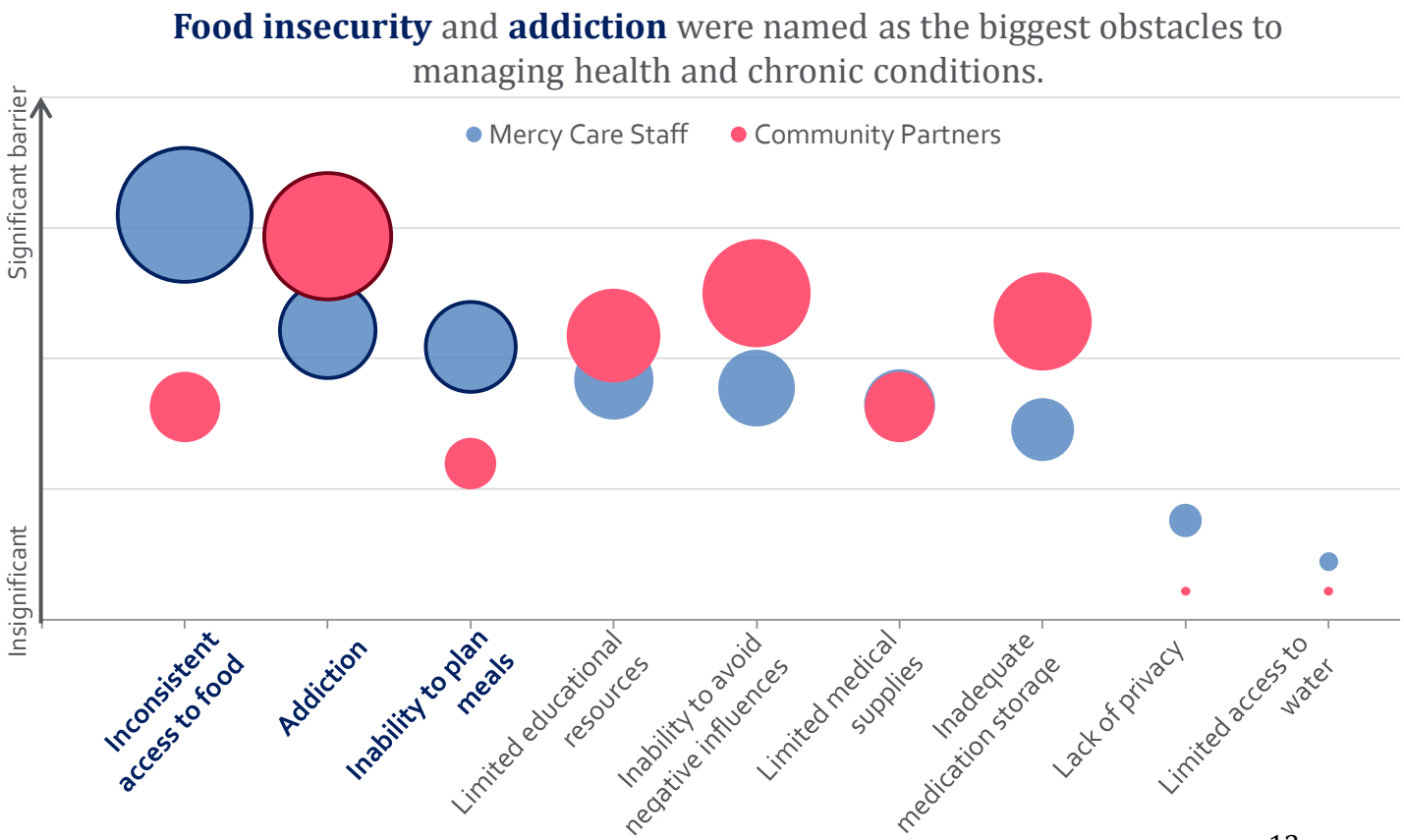
NUTRITION

A person's diet affects their health in many ways. The consumption of fruits and vegetables has been shown to reduce the risk of diseases like hypertension, heart disease, and stroke, and decreases the risk of cancer[22]. Fruit and vegetable consumption may prevent weight gain, and therefore reduce the risk of diabetes. There is a growing body of evidence that shows increased consumption of fruits and vegetables lowers the risk of developing diseases such as: eye diseases, dementia, osteoporosis, asthma, chronic obstructive pulmonary disease, and rheumatoid arthritis[23].

Findings

In calendar year 2017, Mercy Care served 1,454 clients with diabetes (over 10% of all clients) and 3,349 clients with hypertension (almost 25% of all clients). Among adult clients with at least one medical visit in 2017, almost 75% were overweight or obese.

Food insecurity is closely associated with housing status. For clients who are experiencing homelessness, 71% also responded that they struggle with food security. Out of the clients who are in stable housing, 47% reported food insecurity. Altogether, almost 2 out of 3 clients (64%) that are seen by Mercy Care providers are facing food insecurity.



In focus group discussions, participants talked about the impact poor nutrition has on their health. Participants talked about their desire to make healthy choices and their growing understanding of what comprises a healthy diet. Focus group participants were grateful to receive food from shelters, but many of the participants in the focus group faced frustration with the inflexibility and lack of choices in meals served in the shelters. One client said, "I have a doctor's letter for a CKD (chronic kidney disease) diet. [I'm supposed to] double up on vegetables and fruit, but it's impossible to eat that way" while living in a shelter. (The Chronic Kidney Disease diet preserves the kidney's remaining function for as long as possible before dialysis or kidney transplant is needed.) Even with the physician's note, the food is unavailable. Another participant agreed: "Before I got [to the shelter], I really changed my diet to be healthier. Since I've been here, I've been to the hospital twice." In the same group, a third participant explained, "I have diabetes and hypertension. I'm supposed to be on a special diet, but they don't want to cook separate meals for me. I'm pretty much supposed to be eating fruits and vegetables and fish," which can be hard to access or afford. Another person stated, "Living in the shelter, I don't have the right things to help me with [managing my chronic conditions]. They feed you what they're going to feed you; they have rules and regulations" that may not be best for residents' health.

ISOLATION AND LONELINESS

A strong social support system has many positive influences on health. People with a strong social support system display a heightened resiliency to stress. This ability to cope can help overcome some of the deleterious effects of stress responses on the body. Loneliness has been described as the "discrepancy between desired and perceived social relationships. … Research has consistently found that weak social relationships are associated with a variety of co-morbid conditions, in addition to premature mortality. Negative health outcomes linked to loneliness include high blood pressure, cardiovascular disease, disability, cognitive decline, and depression. Such morbidities may, in turn, create higher need for health care and be linked to higher health care utilization"[24]

Social disconnectedness often contributes to a person losing a stable place to live. Often, a divorce or familial estrangement can force someone out of a stable living situation to the streets or a homeless shelter. Individuals experiencing homelessness are frequently socially isolated, with "low levels of social support and social functioning, and … this lack of social resources contributes to their ill health".[25]

Findings

Among Mercy Care's clients, persons experiencing homelessness were more than twice as likely to report feeling lonely or isolated (37% vs. 17%). Overall, 31% of clients surveyed reported "often" or "always" feeling lonely or isolated from others.

Clients were also asked whether they had someone they could call if they needed help. Overall, 76% of clients reported that they had someone who they could call for help. Among persons

experiencing homelessness, this number dropped to 72%, while 87% of clients in stable housing said that they had someone to call for help.

EXPOSURE TO VIOLENCE

Aside from the physical harm caused by violence, exposure to violence has a lasting impact on a person's physiology, including abnormal brain development, and increased risk for smoking, alcoholism, depression, heart disease, and many other illnesses and unhealthy behaviors[26].

Intimate Partner Violence (IPV) is aggression that occurs within a close relationship, especially among couples who are currently or were formerly in a romantic relationship. This can include sexual violence, stalking, physical violence, or psychological aggression[27]. The consequences of IPV can be direct, as in physical injury, or indirect though chronic health problems that may arise from prolonged stress[28]. This could also lead to a higher level of depression, anxiety, phobias, and attempted suicide.

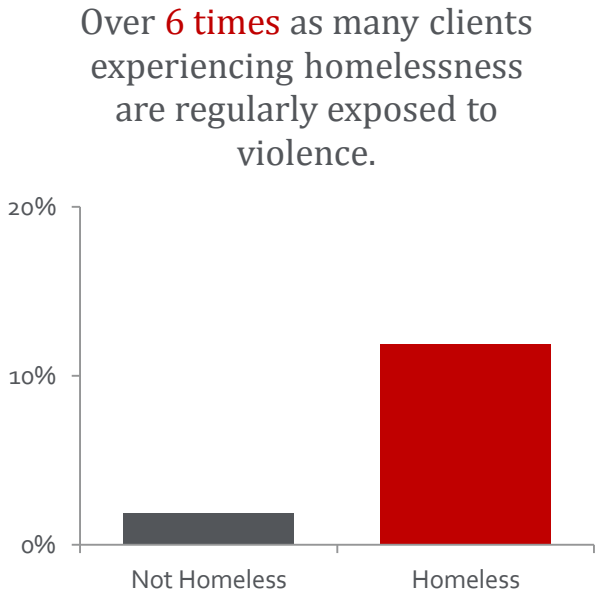
Children are particularly susceptible to the results of violence exposure, including negative effects on learning, behavior, and health[29]. Adverse Childhood Experiences (ACEs) are "stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse"[30]

Violence often affects social and economic conditions in neighborhoods. Violence or perceived danger can "lead to widespread feelings of fear, distrust, and isolation, which in turn can contribute to diminished levels of health-promoting social support and social cohesion".[31]

Findings

The SDH screening tool asked clients, "Because violence and abuse happens to a lot of people and affects their health, we are asking the following questions. 1.) How often does anyone, including family and friends, physically hurt you? 2.) How often does anyone, including family and friends, insult or talk down to you? 3.) How often does anyone, including family and friends, threaten you with harm? 4.) how often does anyone, including family and friends, scream or curse at you?"

Overall, 13% of clients reported often or frequent exposure to violence. Again, there was a strong correlation between housing status and exposure



to violence. Of clients experiencing homelessness, 12% also report a high exposure to violence. This figure is **six times greater** than that of clients who are in stable housing (2% reported exposure to violence).

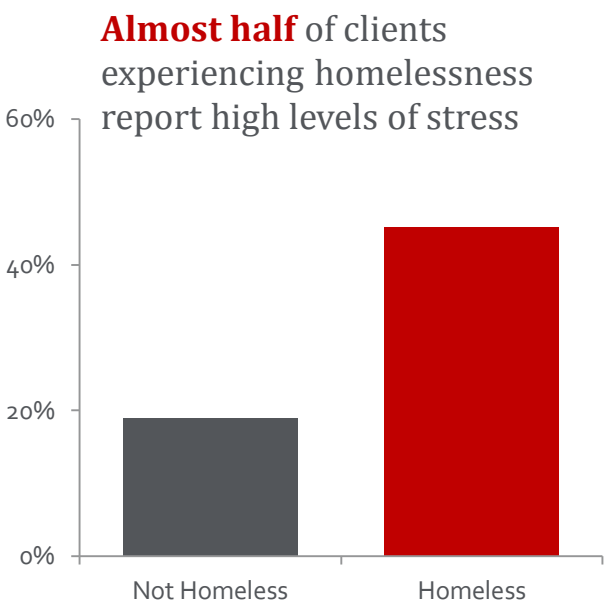
Focus group participants mentioned unsafe neighborhoods as a barrier to exercise. It is a challenge to find a convenient and safe place to exercise. Participants talked about poorly lit and unmaintained parks and sidewalks, which act as a deterrent to physical activity. This has a negative impact on achieving a healthy body weight and preventing or controlling many different chronic diseases.

STRESS

Stress negatively affects the body in many different ways, and studies have shown that stress affects both children and adults in profound ways, compounding throughout the lifespan of an individual. Chronic exposure to stress (even perceived stress[32]) has been associated with a variety of adverse health outcomes, including[33]:

- High rates of preterm birth, which is a risk factor for infant mortality, and cognitive, behavioral, and physical problems in childhood.
- Higher rates of chronic diseases later in life, like cardiovascular disease, hypertension, and diabetes.
- Poorer mental and physical health in childhood and adolescence, including increased risk of overweight and obesity.
- Higher likelihood of dependence on tobacco and/or alcohol,
- Diminished behavioral health, including a tendency to make poor choices like unhealthy food choices, binge eating, and less frequent exercise.

The higher prevalence of disease ultimately results in an early death.



Chronic stress is also tied to social constructs like racism or exposure to violence (for example, stress that results from threats of violence that an individual perceives to be out of his or her control), which may lead to more rapid onset and progression of chronic disease and may cause accelerated aging[34] or "biological weathering". Biological weathering (also referred to as "allostatic load") is the idea that the bodies of people of color age prematurely because of the lived experience of race and the impact of racism, bias, and discrimination. These factors conspire to create toxic stress that leads to various health problems.[35] Chronic stress has been implicated as an important piece of the

puzzle for many health inequities, including the higher rate of maternal and infant mortality, which is more than double the rate for black mothers and babies as compared to whites[36].

Findings

The question posed to clients was: "Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?" Of clients experiencing homelessness, nearly half reported feeling stressed "quite a bit" or "very much", compared to less than a quarter of clients in stable housing.

FEEDBACK ON MERCY CARE

Staff and community partners were asked to describe Mercy Care's strengths and weaknesses and provide feedback on ways to improve. Among respondents, operational strengths such as the integrated care model, service accessibility, and the behavioral health program were commonly listed as strong points. 'Compassionate care' was rated highly by staff and partners alike, demonstrating the adherence Mercy Care maintains to its core values of excellence and compassion. Respondents also identified common barriers clients face when accessing care overall, and at Mercy Care in particular. Addressing these concerns, they wrote suggestions for how Mercy Care could handle and improve these situations. The feedback given by each participant group is summarized further below.

CLIENT RESPONSES (FOCUS GROUPS)

Open ended feedback from clients was obtained through focus groups to allow a deeper conversation on the client perspective. Participant feedback about Mercy Care's operations was overwhelmingly positive; however, they noted a few areas for improvement. While many use Mercy Care for affordable medications, they expressed difficulty in traveling to Mercy Care Decatur to pick up their prescriptions. All thought that medication delivery to local shelters or pickup points would help greatly. Additionally, Mercy Care services information should be better advertised, ensuring that people have full and accurate knowledge of the services offered at different locations. Almost all participants had initially learned about Mercy Care via word of mouth, and therefore, many were misinformed about what services were offered; especially in dental, vision, behavioral health and health education.

Clients who had received dental care were pleased with the service, but noted the long wait time due to a shortage of low- or no-cost dental providers across metro Atlanta. Focus group participants requested the addition of more dental providers to increase availability and access. Behavioral Health was also mentioned as an opportunity to expand so that more people could benefit from the services offered.

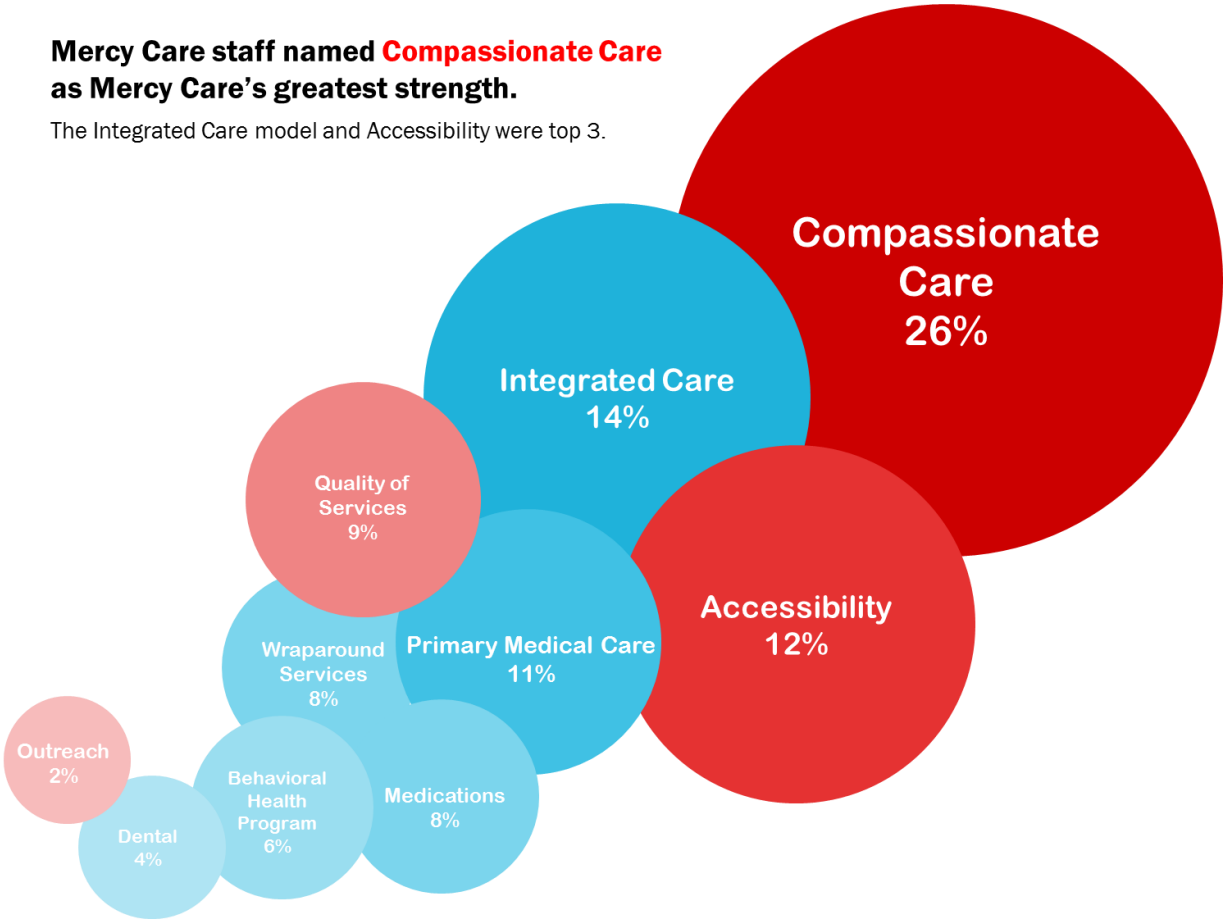
Most participants concurred that morning and early afternoon time slots, including Saturdays, are preferable for health appointments. Almost no one favored evening appointments, although

they offered that people who work during the daytime may prefer the later time slots.[37] With an afternoon appointment, it can be difficult to get back to the shelter in time for intake to get a bed that night.

STAFF RESPONSES

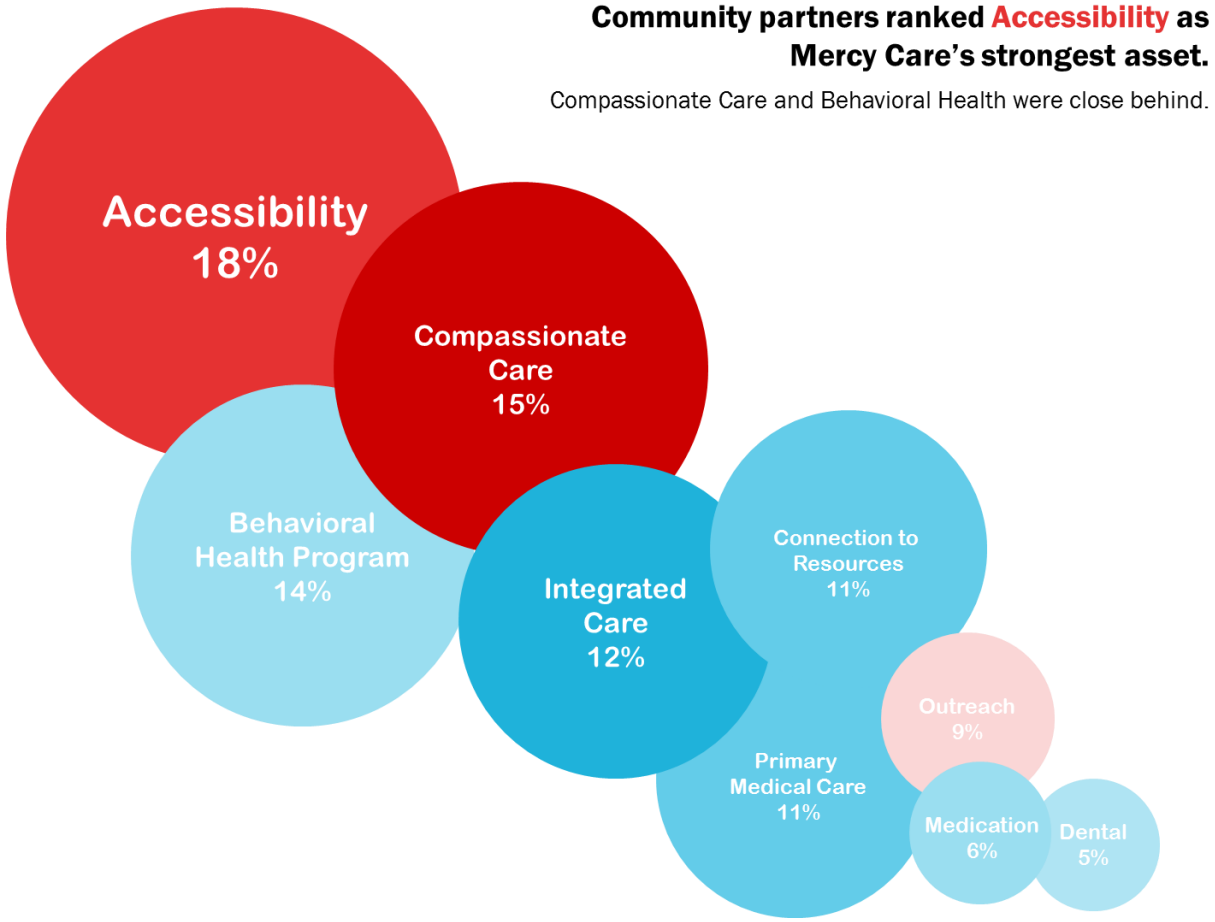
Overall, there was positive feedback about Mercy Care services and operations from community partners, staff, and clients alike. A consistent marker of success was in Mercy Care's mission to provide compassionate and accessible care. Staff felt the integrated care model – giving patients combined access to primary care and behavioral health care– is a big part of what makes accessing health services at Mercy Care unique.

Staff reflected on the issues that present barriers for clients accessing care. Primary barriers listed were a fear and mistrust of providers (29%) and mental health conditions (19%). Systemic issues in lack of documentation/identification (14%), housing (14%), transportation (10%), and misinformation (10%) contributed as barriers. Finally, several staff members pointed to gaps in the system between providers and social servants in helping clients navigate these complex systems.



COMMUNITY PARTNER RESPONSES

From the community partner perspective, Mercy Care excels when it comes to accessibility to clients – both in location and information. Compassionate care was ranked as the second strongest asset of Mercy Care, and Behavioral Health programming was a close third place. These three aspects of health services are central to Mercy Care's mission to take compassionate, excellent care where it is needed most.



RECOMMENDATIONS

Social determinants are often complicated and intertwined. Systemic inequalities often magnify and manifest themselves in an individual's physical health. Although it is impossible to address all of these needs in a clinic visit, quantifying and recognizing the influence on a person's life is a valuable first step.

Educational Attainment and Preferred Method of Learning

Consider educational level and preferred method of learning when designing and distributing literature, especially regarding chronic disease management and resource referrals. Visits with a healthcare provider are often limited by time, so it can be a challenge to incorporate hands-on learning. This can be overcome by referring to a health educator, a community health worker, or a nurse who can spend more time with the patient and answer any questions that remain. Part of delivering person-centered care is to consider the client's preferred method of delivery for health information, which creates patients who are empowered to understand and control their health and can be better prepared for visits and for self-care, and clinicians who know how best to explain pertinent information to patients.

Transportation

Several focus group participants requested a shuttle for transport to and from doctor's visits, or help obtaining a transit pass for this purpose. Staff and partners also agreed that transportation can be a limiting factor for individuals to get the care that they need. Continue to co-locate clinics with other service providers to reduce the burden of transportation as much as possible.

Medical Care and Medications

Several clients in the focus groups communicated that they were unaware of certain services offered at Mercy Care, or they had been under a false assumption about where to go or what was needed to get into care. Staff members and partners also recognize that the healthcare system can be difficult to navigate, and many people in need are not connected with the services they need. This can be mitigated by ensuring community partners are informed of the services offered and encouraged to refer clients to Mercy Care. Many clients entered into care only after the urging of a friend or trusted advisor, even if they were aware of some services offered. This may mean that advertisements such as billboards or posters on public transit are helpful, but may not be enough to get a new client to come to Mercy Care on his/her own.

Clients, staff, and partners appreciate Mercy Care's commitment to quality affordable, accessible health care. Clients were especially grateful for the medications provided, but expressed challenges in traveling to the clinic to pick up supplies. Mercy Care should continue to work out a delivery system for people to be able to consistently and easily pick up their refills.

Community partners and staff were especially grateful for the behavioral health services provided. They reported a great need for these services and recommended continuing to expand this program to serve as many clients as possible. The integrated system is a highly regarded asset by both partners and staff, and should continue to be strengthened. Ensure that

all clients are screened for Behavioral Health diagnoses and connected to services, and continue to seek sources of funding and expand the existing Behavioral Health team.

Dental Care

Clients were grateful for the services provided, but spoke of the long wait times and lack of options for dental procedures. Continue to expand the dental program and add more providers. Clients were also seeking options for referrals for dentures, and this linkage should be strengthened and supported.

Housing

A defining characteristic of many clients in the population Mercy Care serves is that they are currently experiencing homelessness. This is a complicated issue and not easily resolved, but having a stable place to call home is critical for the health and longevity of clients. Mercy Care should continue to partner with housing agencies and advocate for safe and affordable housing for all Atlantans. Several partners and staff are excited by the prospect of Mercy Care partnering to create units of permanent supportive housing for clients in need, as the demand for housing stock in the city far outpaces the supply. Continue to partner with organizations like Partners for Home and Mercy Housing to support or sponsor Permanent Supportive Housing programs with wraparound services (and to have referral sources to which to link clients).

Food Availability and Nutrition

Food accessibility and affordability of healthy foods was a concern emphasized by clients and staff (and partners, to a lesser extent). Mercy Care can act as an advocate for clients in explaining the importance of healthy eating, even when living on the streets or in a shelter. Referral networks to food providers should be explored and reinforced. Clients should be regularly screened for food insecurity and referred to local resources immediately. Additionally, the Health Education program can be used to teach clients practical skills for how to eat healthy in a way that makes sense in their current situation.

Isolation and Loneliness

Isolation and loneliness was a need in many clients. Mercy Care's pastoral care program provides a good venue for clients to connect to a chaplain who will listen to and pray with them. Additionally, the Behavioral Health program can provide strategies for people to connect with their community in a healthy way, especially though the use of Peer Support programming. Consider creating ways for clients to connect with a community and build social capital through events and ongoing groups. The return on investment in these programs may be harder to measure, but their impacts can be far-reaching and long-term.

Exposure to Violence

Mercy Care should continue to screen clients for exposure to violence and build out referral networks, especially for clients who are facing Intimate Partner Violence. Mercy Care staff is trained to provide Trauma-Informed Care; this critical understanding should continue to be incorporated. Training on Adverse Childhood Experiences should continue to be encouraged.

Stress

Stress comes from many different sources, and it is impossible to fix all sources of stress. However, coping strategies and stress management skills are valuable and can be taught to clients through robust wrap-around programming.

CONCLUSION

Overall, clients, community partners, and staff alike agree that Mercy Care is providing high-quality, compassionate care that meets the needs of those experiencing homelessness in metro Atlanta. Mercy Care has a long history of person-centered care, and this is further advanced by having clients describe their needs through the lens of the Social Determinants of Health. Screening for these needs and quantifying disparities is a critical first step. Much more can be done to address these core drivers of health. Mercy Care should continue to advocate for clients, build out referral networks for needs not addressed internally, and make sure that all staff is trained on the impact of social determinants on health status.

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