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Addressing COVID-19 health disparities through a regional community health response

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ABSTRACT

To combat racial/ethnic and socioeconomic health disparities associated with COVID-19 in our surrounding communities, the Cleveland Clinic Community Health & Partnership team developed a comprehensive program focused on connecting and communicating with local officials, faith-based organizations, and individual community members. Since March of 2020, our team has donated resources (e.g., personal protective equipment) to local organizations, referred thousands of community members to community or clinical resources, and partnered with federally-qualified health centers to support community COVID-19 testing. Future work will include the use of these networks to deploy the COVID-19 vaccine.

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The statements and opinions expressed in COVID-19 Curbside Consults are based on experience and the available literature as of the date posted. While we try to regularly update this content, any offered recommendations cannot be substituted for the clinical judgment of clinicians caring for individual patients.

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INTRODUCTION

The COVID-19 pandemic has exacerbated existing racial/ethnic and socioeconomic health disparities.^{1,2} Contributors to these disparities include social determinants of health and pre-existing chronic conditions leading to severe COVID-19 outcomes.^{3,4} Social determinants include disadvantaged neighborhood and living conditions, underemployment (often in service industry/essential jobs) or unemployment, and lower rates of healthcare access and utilization.²

In collaboration with Zone 1 Northern Ohio regional hospital and health department partners, the Cleveland Clinic Community Health & Partnerships team developed a proactive strategy to address the COVID-19 related needs among disproportionately impacted populations using a health equity focus. Our community response was to connect, communicate, and mitigate.

CONNECTING WITH THE COMMUNITY DURING THE INITIAL STAGES OF THE PANDEMIC

During the initial stay-at-home order in Ohio from March to May 2020, we hosted weekly virtual meetings where Cleveland Clinic hospital presidents met with local officials, including mayors, school superintendents, fire and law enforcement personnel, public health officials, and local elected council members (200 officials) and regularly communicated via email with trusted community-based organizations, faith-

based organizations, and key community stakeholders providing direct service to vulnerable community members (126 organizations). The Team also called community members who had previously participated in community benefit programs (1,500 individuals).

We had bidirectional communication with these groups in order to share critical health information, hear concerns from constituents, and respond to their concerns. In order to mitigate the impact of COVID-19, we first conducted a needs assessment. We surveyed organizations about their existing assets, services they were able to deliver, and client needs. For individuals, we screened for health behaviors as well as for health, social, and economic needs. After the assessment, we responded by donating available resources including personal protective equipment (PPE) (eg, 335 thousand face masks and 62 thousand gloves) as well as 4 thousand pounds of hygiene products. Connection with community members through regular phone calls served as an intervention since community residents discussed social isolation as a critical need; the majority reached were older women and 48% identified as African-American or Black.

■ BUILDING TRUST, STRENGTHENING WORKING RELATIONSHIPS WITH COMMUNITY LEADERS

After the stay-at-home was lifted in May 2020, we continued to support COVID-19 outreach, education, and community testing. Health care systems have several important community responsibilities during a pandemic. They provide:

- Reliable and trusted health information for corporations, non-profit organizations, health centers, homeless shelters, and businesses;
- Guidance for testing workflows, patient care, telehealth, PPE use and infection control, and reopening guidelines for business and schools;
- Testing access via drive-through and walk-up centers;
- Large-scale ability to screen patients and community residents for physical and mental health behaviors and connect individuals to resources for unmet health/basic needs;
- Advocacy at the local, state, and federal level to address pandemic needs.

We hosted monthly forums with faith-based leaders—topics included how to safely open sacred spaces, resiliency and compassion fatigue, and support for bereavement and congregants' mental health. Our team partnered with schools to provide COVID-19 specific programming for elementary, middle, and high school youth. Cleveland Clinic guided a testing

and workforce strategy for more than 400 congregate care living settings and nursing facilities in the region and partnered with federally-qualified health centers (FQHCs) to support community testing. Support for FQHCs, or community health centers that provide primary care services in underserved communities, included respirator fit testing, PPE education, swab training, observation of testing sites, mobile team training, and provider support. Cleveland Clinic served as the reference lab for several FQHCs when there were testing delays from commercial laboratories.

The Cleveland Clinic population health team instituted a community monitoring program reaching 20,000 patients with suspected or confirmed COVID-19 and/or those with chronic conditions.⁵ Social work teams, medical residents, and medical students helped address significant social, economic, and behavioral health needs among patients, including 18 thousand referrals for emotional support and assistance from local food banks. We were able to provide significant food, personal hygiene, bedding, face masks, and PPE donations to community organizations through partnerships with supply chain vendors.

National demonstrations for racial justice and civil unrest after George Floyd's death created additional opportunities for health care systems to lean into social determinants of health and health equity. Cleveland Clinic hospitals, along with many other health care delivery and advocacy organizations, supported declarations of racism as a public health crisis. This was followed by institutional and community listening sessions, marketing and communication strategies to reach African-American, LatinX, and limited English proficiency populations in culturally appropriate ways, and state and local action plans to advance equity.⁶

Furthermore, we reached out to more than 760 prior participants of the Cleveland Clinic's Minority Men's Health Fair to assess perceived COVID-19 threats and understanding of COVID-19 guidelines as well as address prevention strategies, coping mechanisms, financial impact, and any basic or health needs. Several follow-ups were conducted to provide resources for unmet needs and ensure gap closure. We also partnered with the Ohio Minority Strike Force and Ohio National Guard to offer COVID-19 testing for symptomatic and asymptomatic individuals in neighborhoods with dense African-American populations. Five testing events were conducted over a 6-week period from August to October 2020. Among

376 individuals screened, 74% of participants identified as African-American or Black and most were over 60 years old. Community testing events continued with the second surge in November 2020.

All of these efforts have strengthened working relationships with local health department and government officials, long-term care facilities, federally qualified health centers, faith-based organizations, and homeless shelters. The work has advanced our community health strategy goals focused on health equity, built trust as an effective partner, and helped flatten the curve through monitoring, education, and sharing of resources. Future work will include the use of these networks for continued outreach and testing, education and deployment of the COVID-19 vaccine, and mitigation of COVID-19 consequences on physical and emotional health and health care access/utilization. Together, we can ensure all patients, families, and communities have the opportunity to thrive and flourish.

■ DISCLOSURES

The authors report no relevant financial relationships which, in the context of their contributions, could be perceived as a potential conflict of interest.

■ REFERENCES

1. **Bambra C, Riordan R, Ford J, Matthews F.** The COVID-19 pandemic and health inequalities. *J Epidemiol Community Health* 2020; 74(11):964–968. doi: 10.1136/jech-2020-214401
2. **Webb Hooper M, Nápoles AM, Pérez-Stable EJ.** COVID-19 and Racial/Ethnic Disparities. *JAMA* 2020; 323(24):2466–2467. doi: 10.1001/jama.2020.8598
3. **Price-Haywood EG, Burton J, Fort D, Seoane L.** Hospitalization and Mortality among Black Patients and White Patients with Covid-19. *N Engl J Med* 2020; 382(26):2534–2543. doi: 10.1056/NEJMsa2011686
4. **U.S. Department of Health and Human Services.** Social Determinants of Health. Accessed January 5, 2021. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.
5. **Medina M, Babiuch C, Card M, et al.** Home monitoring for COVID-19. *Cleveland Clinic Journal of Medicine* June 2020. doi: 10.3949/ccjm.87a.ccc028 SHOULD BE: Medina M, Babiuch C, Card M, et al. Home monitoring for COVID-19. *Cleve Clin J Med*. Published on June 4, 2020. doi 10.3949/ccjm.87a.ccc028
6. **Ohio Department of Health.** Ohio's Executive Response: A Plan of Action to Advance Equity. Accessed January 5, 2021. <https://coronavirus.ohio.gov/static/MHSF/Executive-Response.pdf>.

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