Leveraging Faith Community Investments to Accelerate COVID-19 Testing and Vaccination within Community Hot Spots

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ABSTRACT:

This paper demonstrates the use of a Memorandum of Understanding (MOU) to accelerate our ability to implement and maintain mobilization of community partner networks. To provide equity-centric Severe Acute Respiratory Syndrome-Coronavirus-2 (SARS-CoV-2 virus, COVID-19) testing and vaccination to historically medically underserved areas in a densely populated metropolitan district, Cobb & Douglas Public Health (Georgia) partnered with Wellstar Health System (Wellstar) through an MOU. Wellstar activated its Congregational Health Network to target COVID-19 testing and vaccination sites, identified by review of local COVID-19 transmission data. The MOU enabled rapid deployment of public health and health care resources, which grew into a consortium that held 141 local events that provided over 3,000 tests and 10,000 vaccinations. Health care organizations can use an MOU structure to establish partnerships and increase equity-centric COVID-19 testing and vaccination accessibility for disparate communities.

KEYWORDS: COVID-19; COVID-19 Screening; Emergency Response; Health Equity; Organization and Administration; Pandemics; Public Health; Public-private Partnerships; SARS-CoV-2

Introduction

The COVID-19 pandemic continues to plague communities across the US, particularly affecting those with low vaccination rates like the Southeast. [1] As the spread of new variants and strains of COVID-19 continues, both testing and vaccination efforts are required to combat this deadly pandemic. Others have identified numerous strategies to tackle testing and vaccination racial disparities[2–4], but few have discussed in detail how partnerships between Public Health Departments and Integrated Health Systems can work together through innovative programs to meet community needs for COVID-19 testing and vaccination.

In particular, very little literature exists on how health systems and public health departments can leverage Community Health Networks[5] to fill this need for communities across the country. The following is an example of how the use of a memorandum of understanding (MOU) between a healthcare system's congregational health network and a local public health department facilitated a successful partnership impacting historically medically underserved communities. The MOU enabled rapid and nimble deployment of public health and health care resources, which resulted in 50 COVID-19 testing and 91 vaccination events that provided over 3,000 tests and 10,000 vaccinations across 24 cities in the state of Georgia. Further, these efforts successfully reached Black and Latino community members in areas where testing and vaccination rates were considerably lower for this group than among White communities.

In this paper, we describe how we created the partnership, the challenges we faced and how we used this model to scale into other communities with disproportionately low vaccination and testing rates due to barriers related to health care access and mistrust. We provide a model for

effective partnership that other health systems and public health agencies can follow, with emphasis on the implications for achieving health equity.

Faith Community Nursing in a Health System Context

An essential element of the approach to partnerships for this effort was the use of Faith Community Nursing (FCN) to address health needs among historically medically underserved communities, including Black and Latino people. FCN is recognized by the American Nurses Association as a nursing practice specialty. Focusing on the intentional care of the spirit, the faith community nurse considers the spiritual, physical, psychological, and social aspects of an individual to create a sense of harmony with self, others, the environment, and a higher power[6–8]. FCN enhances the ability of faith institutions and organizations to respond to identified health needs which, in turn, impacts the wellness of that community. FCN also increases awareness of and access to community health resources, health care expertise and services[6–8]. Best practices in FCN programs typically include: empowering faith partners to identify their assets and challenges to inform prioritization of any strategic approaches to support target populations; recognizing the faith partners' expertise and understanding of their community; respecting faith partners as community leaders and collaborators that can improve the physical and spiritual health outcomes; understanding that ideological differences do not need to also serve as barriers to identifying commonalities in the need for health partnerships; and, the importance of maintaining health partnerships that can be called on when emergencies arise[6]. In addition, the Memphis Model is recognized as an evidenced-informed model in FCN that specifically leverages partnerships with healthcare systems[9,10]. Faith communities, with their consistent

visibility and capacity to serve, are an ideal partner to reach people in historically medically underserved communities[11].

Wellstar Health System's Congregational Health Network

In 2000, Wellstar Health System ("Wellstar") started its journey to partner with faith communities to improve population health. Based on the FCN model, Wellstar's Congregational Health Network (CHN) builds a bridge with all communities of faith to strengthen the health system's relationships with the communities it serves. This unique opportunity gives support to faith organizations as they seek to increase health and wellness activities in their congregations. The CHN is coordinated by a Registered Nurse who has had specialized training as a Faith Community Nurse.

Once a specific faith organization shows interest, our Congregational Health Nurse arranges a meeting to explain the benefits of joining the CHN and grow understanding of the unique needs of each community. A covenant agreement between the church and Wellstar is signed by the senior minister, the volunteer health minister/nurse, and the Congregational Health Nurse to establish the faith institutions' membership in the CHN, which is free of charge or cost to the faith institution. This agreement defines the expectations of both the health system and the church as they seek to improve the health of their communities. Each health and wellness leader is added to an email list for regular updates and distribution of health and wellness resources and materials. Wellstar's Congregational Heath Nurse provides support for health events and securing health system experts as keynote speakers for events concerning specific priority health topics. The CHN is also a supportive network that shares best practices, policies, and ideas.

Before the current COVID-19 pandemic, the Wellstar CHN routinely performed health promotion and screening tests to detect blood pressure and lipid levels. The disproportionate burden of disease was evidenced by higher rates of cardiovascular disease among Black and Latino residents in communities served by Wellstar.[12] However, upon to the emergence of COVID-19, Wellstar leaders held thoughtful and intentional conversations with congregational partners, already in relationship with Wellstar through signed CHN covenant agreements prior to the pandemic, to identify new needs related to COVID-19 testing and vaccinations.

Uses of a Memorandum of Understanding to Advance a Health-enhancing Partnership

A memorandum of understanding (MOU) is a recognized tool for cross-sector collaboration in emergency response settings.[13] An MOU strengthens the availability and distribution of resources in times of rapid need. The MOU details each partner's responsibilities and includes measures of accountability. We use MOUs instead of contracts when formalizing relationships with partners that do not involve an exchange of funds, but rather establish roles and responsibilities for pooling resources to meet public health needs in a community (Figure 1).

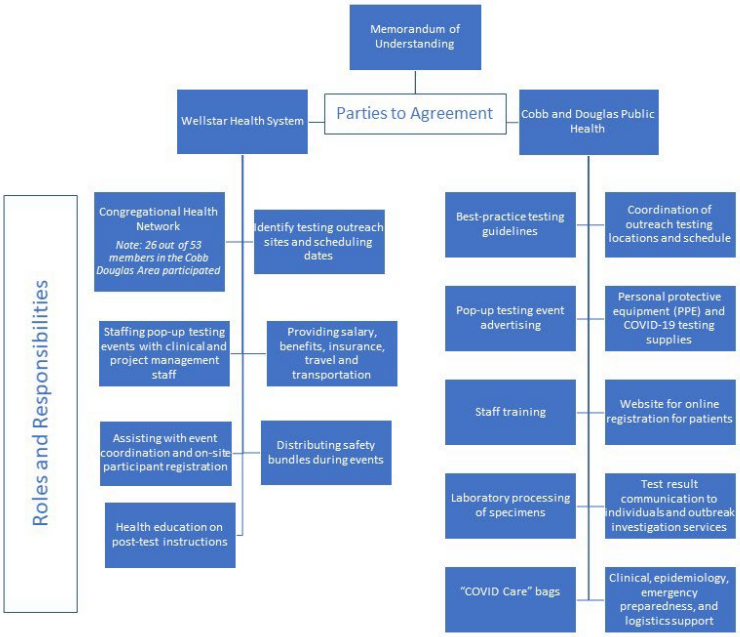

Figure 1. Wellstar Health System and Cobb and Douglas Public Health Memorandum of Understanding for COVID-19 Testing

We established MOUs with Cobb and Douglas Public Health (CDPH), a Georgia health district responsible for carrying out a wide range of public health services for residents of the two counties, to manage health care referrals and health promotion activities. The jurisdiction of this local public health department overlapped significantly with communities served by Wellstar Health System. As data from the Georgia Department of Public Health (DPH) COVID-19 Status Report website[14] demonstrated underrepresentation of Black and Latino residents in testing surveillance, CDPH leaders connected with Wellstar senior leaders to identify opportunities for leveraging staff and partnerships to close this gap.

Both partners agreed to accelerate signing of a new MOU (Table 1, Supplemental Material 1) by ensuring active communication between the most senior decision makers at both institutions. The

MOU detailed that CDPH would provide best-practice Centers for Disease Control and Prevention (CDC) and Georgia DPH testing guidelines; [15] coordinate outreach testing locations and schedule; advertise pop-up testing events; distribute personal protective equipment (PPE) and COVID-19 testing supplies; train staff; host a website for online registration for patients; process laboratory specimens; communicate test results and investigate outbreaks; and, distribute "COVID Care" bags (also described as "safety bundles") to each person tested. Each safety bundle included post-test instructions that Community Health clinical staff explained to individuals. CDPH also agreed to provide additional expertise, in the form of clinical, epidemiology, emergency preparedness, and logistics support. CDPH planned to utilize the Georgia DPH result notification system to alert participants of their COVID-19 status, with follow-up provided by health department staff.

Wellstar's leaders identified Community Health, a collaborating department within the Wellstar Center for Health Equity (WCHE), as the lead internal agent to perform duties in alignment with the MOU. Consistent with its mission to implement and monitor interventions to improve health among residents in Wellstar's communities, Community Health committed to identifying testing outreach sites and scheduling dates; staffing pop-up testing events with clinical and project management staff; providing salary, benefits, insurance, travel and transportation needed to staff and contractors; assisting with event coordination and on-site participant registration; and, distributing safety bundles during events (Figure 1).

Wellstar and Cobb and Douglas Public Health leaders drafted, reviewed, approved, and signed the MOU within one month. Upon signing, each partner organization identified key initiative leaders. These leaders collaborated to arrange regular check-ins, communicate needs and

priorities, and coordinate staff training. These leaders also organized supply pick-ups and other logistics. Wellstar held the first testing event in partnership with a member CHN congregation 15 days after MOU signing.

Application of a Memorandum of Understanding for Rapid Deployment of COVID-19 Testing and Vaccination

The development of this MOU allowed for tactics that supported targeted distribution of COVID-19 testing, first, and later, vaccination, that enhanced access for Black and Latino community members at a time when these communities were experiencing disproportionately high infection and mortality rates. Both parties in the MOU acknowledged the importance of reaching these historically medically underserved communities in the response strategy and worked together effectively to reduce racial disparities in COVID-19 testing and vaccination rates.

Identifying COVID-19 Hot Spots

The amount of community members infected by COVID-19 changes over time. Therefore, the CDC, in collaboration with other federal agencies, began a process to identify county hotspots using the incidence of coronavirus cases.[16] Using CDC information and local epidemiological data, CDPH and WCHE met weekly during three surges of the pandemic to identify infection hotspots at the community level where testing was limited or not easily accessible, especially for Black and Latino residents. During these meetings, the partnership team identified CHN community contacts serving in the geographical hotspots and assessed the feasibility of setting up COVID-19 outreach events.

Developing and Implementing a Process for Hosting Testing and Vaccination Events

The CHN had previously leveraged faith congregation locations, such as churches, for health promotion events. However, due to COVID-19-related limitations on in-person gatherings, most faith congregations stopped in-person services. Some of these congregations and partner social service organizations began addressing the food access needs of their communities by arranging drive-through food distribution. These sites then served as important locations for gathering communities and delivering services. Food distribution parking lot arrangements, notification pathways like email eased each faith community's ability to support many individuals in vehicles receiving a drive-through service. Emails and telephone calls to the CHN quickly identified mostly Black and Latino faith communities best-suited to host pop-up COVID-19 testing and vaccination on the same days as their food distribution.

Site visits to each faith congregation location allowed us to identify the best setup location to support delivery of testing and vaccinations in a way that would not impede the flow of traffic. Food distribution and COVID-19 testing and vaccination would occur in separate lines as to not induce someone to receive health care services in exchange for food. Faith community leaders offered help via their "parking ministry" volunteers for directing traffic and preventing traffic backlogs on surrounding roads. They also offered volunteer support for assisting with on-site testing and vaccination, registration, and language translation.

Outcomes during COVID-19 testing

This MOU provided an opportunity for scaling effective partnerships to reach more people. Our successful partnership with CDPH influenced expansion to partner with District 4 Public Health, the governing public health authority for rural middle Georgia, to support COVID-19 testing and vaccination. Wellstar Community Health Nurses, activated by a similar MOU, provided clinical

and project management staff support to COVID-19 testing and vaccination events organized by District staff.

According to data tracked by Wellstar during events, these collaborations resulted in over 50 testing and 91 vaccination events, resulting in 3,635 testing specimens collected and 10,434 vaccines provided (Figure 2). A sample of data retrieved from Georgia DPH determined that 58.7% of participants at testing events identified as female. Testing events hosted with faith communities engaged a greater proportion of Black community members (47.5%) than White (36.2%). More than half of the people served at eight (of eleven) faith community partner locations identified as a non-White racial identity (range: 59.3% - 80.0%). Approximately a third of patients who attended testing events at a Latino-serving partner organization identified as Latino. Approximately, 4.7% of test specimens returned a positive result. The reach of these events in Black and Latino communities is a critical achievement of this partnership in meeting community needs to reduce health disparities.

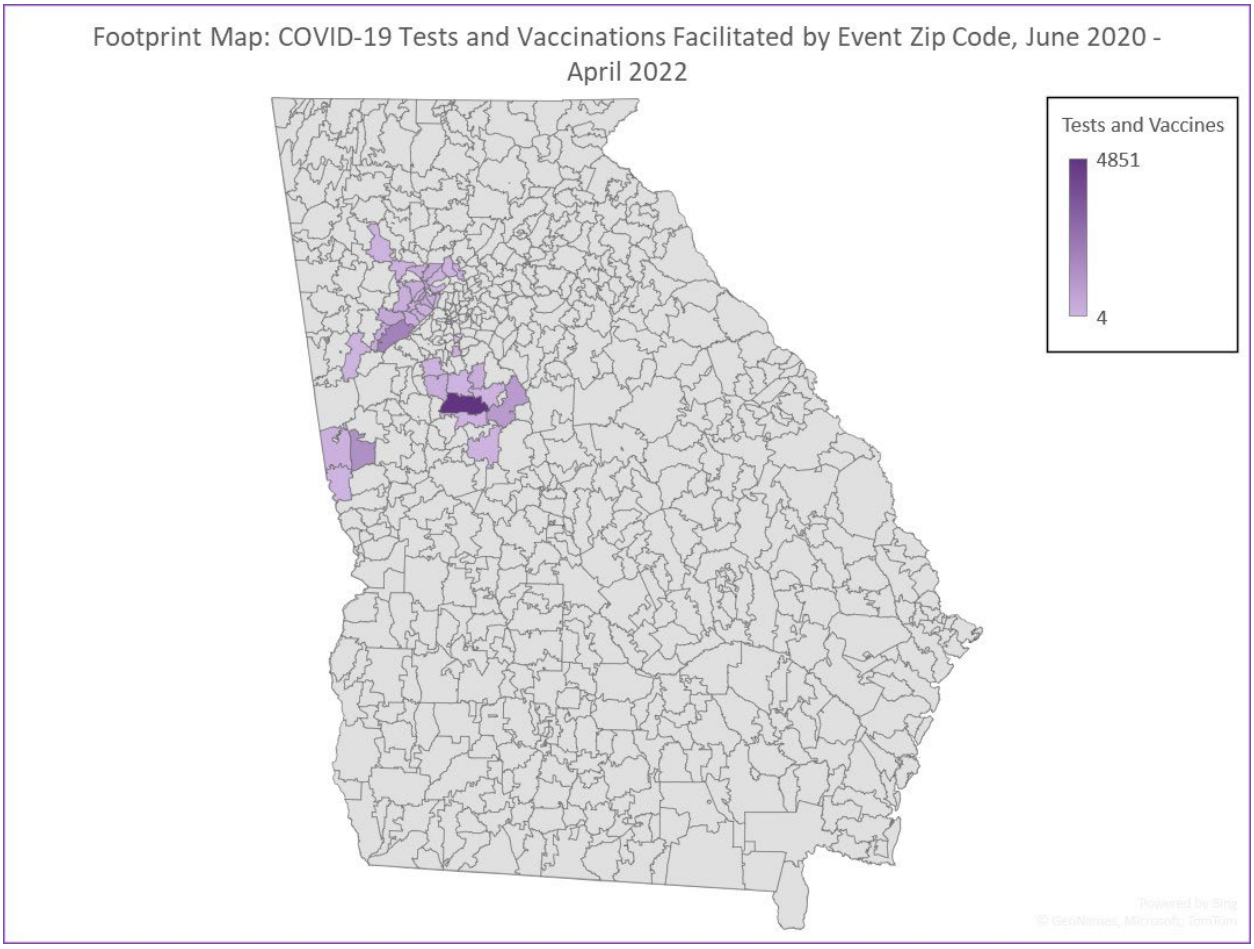

Figure 2. Wellstar Community Health COVID-19 Outreach Distribution Map and Results of Partnership

MOU Opportunities and Limitations

After orienting with CDPH, the Community Health team met to discuss how our team, comprised of three RNs and three non-clinical team members, would implement pop-up COVID-19 testing and vaccination locations in the community. Our first stage of implementation involved developing departmental policies, procedures, and competencies. For example, with limited RN resources, we knew we would only be able to have one drive-through testing lane

staffed with a RN collecting specimens and an uncontaminated person to provide education, information on results retrieval, holding and packaging specimens for transport to lab. However, the partnership established through the MOU enabled us to identify other sources to mitigate the impact of staffing shortages on vaccine and testing delivery.

Further, not all partnership responsibilities or requirements could be fulfilled or anticipated through the MOU. We incurred costs for purchasing right-fitted staff PPE and outdoor testing resources like signs, tents, fans, and traffic control supplies. The MOU did not contain a component describing how registration and test result data would be shared with us. Instead, we submitted a state data request to obtain this information.

Other health systems looking to use MOUs as vehicles for partnerships should ensure capacity and resources are available from each party to the agreement to support the service areas within their scope; provide a contingency budget for out-of-scope costs that are not accounted for in the MOU, and engage in regular communication between entities in the MOU to ensure activities are staffed and resource needs are met. Further, the strength of the relationship and trust built ahead of the establishment of this MOU to provide these services allowed for this collaboration to adapt to changing pandemic conditions. Consistent and intentional engagement of community partners is critical for ensuring strong partnerships during times of rapid change or crisis such as the COVID-19 pandemic.

Next Steps for Strengthening Partnerships and Implications for Practice

WCHE activates system-wide strategies, initiatives, and programs to address health disparities. Driven by a cross-functional team, WCHE leverages Wellstar's diverse leadership and expertise to show up for our community when and where they need us most. Through internal and external

strategic partnerships, governed by MOUs, WCHE is positioned to implement multi-disciplinary approaches to address factors that drive deeply entrenched health inequities focusing on systemic racism and the social determinants of heath.

Meaningful engagement of WCHE leaders with key partners enables our ability to advance public health work and mitigate community disease spread. WCHE strategically leveraged local government and faith community partners early during the pandemic. We aim to continue enhancing these partnerships and community engagement tactics, to include continuous feedback loops with community participants.

Our organizations supported and amplified our work in historically medically underserved communities. According to Wellstar's community health needs assessment[12], these were the same communities suffering from a disproportionate amount of food insecurity. The partnership established through the MOU enabled Wellstar to meet the needs of communities more fully, by coordinating pop-up testing with food distribution. This wrap-around service model of distributing food, providing testing, and connecting residents to important resources allows for a platform to address social determinants of health. Today, WCHE partners with eight food organizations to ensure fresh food access throughout Wellstar's service area.

The MOU provided initial infrastructure around testing, which allowed us to nimbly pivot to address vaccination hesitancy and targeted equity-centric vaccination in these same historically medically underserved communities. Other health care organizations can use the MOU structure (see Table 1) as a template to establish partnerships that support enhanced service delivery during the pandemic and beyond.

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References

1. Ndugga N, Pham O, Hill L, Artiga S. Latest Data on COVID-19 Vaccinations Race/Ethnicity. *Kaiser Family Foundation*. Published online 2021.
2. Marquez C, Kerkhoff AD, Naso J, et al. A multi-component, community-based strategy to facilitate COVID-19 vaccine uptake among Latinx populations: From theory to practice. *PLoS One*. 2021;16(9):e0257111. doi:10.1371/journal.pone.0257111
3. Dada D, Djiometio JN, McFadden SM, et al. Strategies That Promote Equity in COVID-19 Vaccine Uptake for Black Communities: a Review. *Journal of Urban Health*. 2022;99(1):15-27. doi:10.1007/s11524-021-00594-3
4. Jimenez ME, Rivera-Núñez Z, Crabtree BF, et al. Black and Latinx Community Perspectives on COVID-19 Mitigation Behaviors, Testing, and Vaccines. *JAMA Netw Open*. 2021;4(7). doi:10.1001/jamanetworkopen.2021.17074
5. Manning MA, Bollig-Fischer A, Bobovski LB, Lichtenberg P, Chapman R, Albrecht TL. Modeling the sustainability of community health networks: novel approaches for analyzing collaborative organization partnerships across time. *Transl Behav Med*. 2014;4(1):46-59. doi:10.1007/s13142-013-0220-5
6. Campbell MK, Hudson MA, Resnicow K, Blakeney N, Paxton A, Baskin M. Church-Based Health Promotion Interventions: Evidence and Lessons Learned. *Annu Rev Public Health*. 2007;28(1):213-234. doi:10.1146/annurev.publhealth.28.021406.144016
7. Levin J. Partnerships between the faith-based and medical sectors: Implications for preventive medicine and public health. *Prev Med Rep*. 2016;4:344-350. doi:10.1016/j.pmedr.2016.07.009
8. Westburg Institute for Faith Community Nursing. What is Faith Community Nursing? Accessed March 27, 2023. https://www.westberginstitute.org/faith-community-nursing/

9. Cutts T, Gunderson G, Carter D, et al. From the Memphis Model to the North Carolina Way: Lessons Learned from Emerging Health System and Faith Community Partnerships. *N C Med J*. 2017;78(4):267-272. doi:10.18043/ncm.78.4.267

10. Cutts T. *The Memphis Model: ARHAP Theory Comes to Ground in the Congregational Health Network*. Accessed March 27, 2023. https://faithhealth.org/wp-content/uploads/2017/01/Cutts_Memphis-model_CHN-final-for-pub-LAYOUT.pdf

11. Idler E, Levin J, VanderWeele TJ, Khan A. Partnerships Between Public Health Agencies and Faith Communities. *Am J Public Health*. 2019;109(3):346-347. doi:10.2105/AJPH.2018.304941

12. Wellstar Health System. *Community Health Needs Assessment*.; 2019. Accessed March 27, 2023. https://www.wellstar.org/community/community-health-needs-assessment

13. Centers for Disease Control and Prevention. Model Memoranda of Understanding. Published April 13, 2012. Accessed March 27, 2023. https://www.cdc.gov/phlp/publications/topic/mmou.html

14. Georgia Department of Public Health. COVID-19 Status Report. Accessed March 27, 2023. https://dph.georgia.gov/covid-19-status-report

15. Centers for Disease Control and Prevention. Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing. Published July 15, 2022. Accessed March 27, 2023. https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html

16. Oster AM, Kang GJ, Cha AE, et al. Trends in Number and Distribution of COVID-19 Hotspot Counties — United States, March 8–July 15, 2020. *MMWR Morb Mortal Wkly Rep*. 2020;69(33):1127-1132. doi:10.15585/mmwr.mm6933e2

Tables

Table 1. Core Components of a Public Health & Health System Memorandum of Understanding for COVID-19 Testing and Vaccination

Core Memorandum of Understanding Component	Component Description
Statement of Need	The "Statement of Need" component of the agreement describes each partner's mission, commitment to the emergency response, and willingness to leverage resources to reach the most vulnerable.
Statement of Action	The "Statement of Action" component of the agreement lists the responsibilities of each partner throughout the time-bound relationship.
Statement of Legal Stipulations	The "Statement of Legal Stipulations" section of the agreement shares the effective and termination dates, states that each partner will absorb their own related expenses, and that the agreement may be terminated by a thirty-day notice to the other party.
Signature Block	The "Signature Block" component of the agreement contains space for each party's senior leader to sign and date.

Wellstar Health System collaborated with local public health and faith community organizations to support:

- **50** COVID-19 testing and **91** COVID-19 vaccination events
- **3,635** specimens collected and COVID Care bags distributed
- **10,434** vaccinations provided

Supplemental Material 1. Example MOU Used in Partnership

Memorandum of Understanding
Between Wellstar Health System and
Cobb & Douglas Public Health for the
Community Outreach efforts for COVID-19 Specimen Collection

WHEREAS, Cobb & Douglas Public Health (CDPH), with our partners, promotes and protects the health and safety of Cobb and Douglas counties, and;

WHEREAS, The Wellstar Health System (WS) is an established world class healthcare provider for metro Atlanta and its surrounding communities, and;

WHEREAS, both agencies are key leaders in the fight against the COVID-19 outbreak in our communities, and;

WHEREAS, people of color, seniors and others in low income areas in Cobb and Douglas Counties are the most vulnerable to this virus, which can result in severe health complications and even death, and;

WHEREAS, WS and CDPH have the capacity and expertise to provide COVID-19 testing and education to these residents and facilities;

NOW THEREFORE, do CDPH and WS agree to work together cooperatively to provide a COVID-19 Outreach Testing Team ("the Team") to our community through the following terms and conditions:

Cobb & Douglas Public Health, in conjunction with WS, will:

1. Provide the Georgia State of Emergency Public Health Authority over this process to assure compliance to Centers for Disease Control and Prevention (CDC) guidance.
2. Assure best-practice guidelines are available to the Team from the CDC and the Georgia Department of Public Health.
3. Provide coordination of outreach testing locations and schedule and a CDPH Point of Contact for WS.
4. Provide individuals with needed expertise (e.g., clinical, epidemiology, emergency preparedness) to the Team.
5. Coordinate any additional expertise as needed (e.g., National Guard, Contractors).
6. Work jointly with WS to advertise community pop-up testing events to assure utilization and pre-registration of participants.
7. Provide needed Personal Protective Equipment (PPE) and COVID-19 testing supplies as available to the Team.
8. Provide WS staff training in the proper COVID-19 testing procedures, and reporting process of collected specimens to CDPH.
9. Provide internet registration site and process to register individuals in advance of testing event.

10. Assure compliance to HIPAA confidentiality laws in all interactions.
11. Process all testing specimens through usual CDPH laboratory partners, register results, communicate results to individuals and provide any outbreak investigation, as needed.
12. Provide "COVID Care" bags to be given to each person tested, including post-test instructions as available and appropriate.

In conjunction with Cobb & Douglas Public Health, WS will:

1. Jointly decide which outreach sites will be scheduled and dates selected.
2. Provide individuals with needed expertise (e.g., nurses and clerical staff) to the Team.
3. Assure best-practice testing, patient education, infection control, PPE use, and patient care.
4. Provide any and all salary, benefits, insurance, travel and transportation needed to WS staff or contractors to provide this service.
5. Assure that WS staff adhere to the proper CDPH COVID-19 testing procedures, specimen storage and delivery of specimens to CDPH.
6. Assist with coordination of outreach testing through staff scheduling and provide a WS Point of Contact to CDPH.
7. Work jointly with CDPH to advertise community pop-up testing events to assure utilization and pre-registration of participants.
8. Distribute any COVID Care bags to individuals being tested and return unused bags to CDPH. Contribute COVID Care bag items as available and appropriate.
9. Assure compliance to HIPAA confidentiality laws in all interactions.

This agreement will remain in effect beginning on May 15, 2020 and end on June 30, 2021 and is renewable thereafter by mutual written consent. Each party agrees to absorb their own related expenses unless an opportunity for external emergency funding or additional grant funding becomes available. Either party may terminate this agreement by a thirty day notice to the other party. By their signatures below, each of the parties affirms their agreement to the conditions listed in this Memorandum of Understanding.