

Massachusetts Community Health in Covid-19 by Health System

Neeraj Rao*

Department of Disease Control and Environmental Health, University of Brawijaya, Indonesia

Corresponding author: Neeraj Rao

✉ NeerajRao56@gmail.com

Department of Disease Control and Environmental Health, University of Brawijaya, Indonesia

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Abstract

For low-income and uninsured people, Community Health Centers are an essential source of medical treatment [1]. In order to include the people they serve in COVID-19 testing during the pandemic, CHCs have taken advantage of their infrastructure and position as a reliable provider of care [2]. Methods we created a study of community-engaged COVID-19 testing expansion to quickly disseminate efficient implementation strategies, accelerate COVID-19 testing, and address key barriers to testing participation in communities at increased risk for COVID-19 [3]. To directly address the effects that COVID-19 has had on historically marginalised populations in Massachusetts [4]. In order to promote community outreach, communication and science translation procedures must be developed [5]. We compare the overall and among individuals classified as members of high-risk groups served by intervention CHCs in Massachusetts to six matched control CHCs using a controlled interrupted time series design [6]. We next utilise a stepped wedge design to pilot test different CHC outreach tactics [7]. Conclusions Here, we provide a community-based approach to accelerating COVID-19 testing in historically underserved groups, which gives CHCs continuous support for satisfying testing requirements in their local communities [8]. The project adheres to the fundamentals of community-engaged research, such as sharing leadership, providing sufficient resources for community partners, and being adaptable enough to address changing requirements over time [9].

Keywords: Community health centers; COVID-19 testing; Community-engaged research; Health equity; Implementation science

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Introduction

During the COVID-19 pandemic, predictable patterns of incidence, morbidity, and mortality have evolved globally [10]. Black and Latino people in the United States had greater COVID-19 infection rates than white people, with minorities suffering poverty especially at risk for the disease's occurrence and severity [11]. The unequal distribution of COVID-19 disease burden has brought to light the urgent need for better testing, surveillance, and monitoring, data transparency, and public health interventions that are tailored to the needs of individuals' homes and workplaces, with a focus on historically marginalised communities [12]. For people with low incomes and those

without insurance or with inadequate insurance, community health centres are an essential source of medical treatment [13]. All service seekers must be accommodated by federally qualified CHCs, regardless of financial means [14]. CHCs were created with the goal of reducing health inequities that impact those without insurance, those living in poverty, and members of racial and ethnic minorities [15]. The 28 million patients served by the country's CHCs include one in three people living in poverty, one in seven members of racial and ethnic minorities, and one in five who are either uninsured or on Medicaid. Additionally, 82% of CHC patients lack insurance or are covered by the government, and more than 90% of them live within 200% of the federal poverty level. CHCs are perfectly situated to tackle some of the

most difficult issues affecting health equity, such as COVID-19. CHCs have engaged the community during the epidemic by utilising their resources, services, and position as reliable information sources.

Discussion

They provide. CHCs are a strong force in advancing health equality, social justice, community pride, and resilience because of their role in the community. By October 2020, 97% of CHCs in the US have adopted COVID-19 testing services to suit the requirements of their communities. In cooperation with Massachusetts CHCs who provide services to communities that have been severely affected by the pandemic, we developed a research that aims to increase COVID-19 testing. In order to accomplish this, we are building on solid existing partnerships, creating an ethical framework to promote health equity, creating science translation and communication mechanisms for community outreach and utilising practise facilitation and technical assistance to speed up COVID-19 testing and widely disseminate successful strategies. In this article, we describe our procedure for Project called Rapid Acceleration of Diagnostics in Underserved Populations, financed by the National Institutes of Health. We know that the phrase "underserved" isn't always the best choice for inclusive communication, but we nonetheless use it occasionally to refer to this funding source. Using a community-engaged strategy, this study seeks to adopt more COVID19 testing among CHCs in Massachusetts. Our goal is to hasten COVID-19 testing among CHC patients and community members who are historically disenfranchised or underserved in terms of medical care, such as those who reside in communal housing, are homeless, or earn low wages as essential labourers. A Testing Capacity and Innovation Team, which offers knowledge of infectious diseases, and a Community Communications Team, which employs educational and communication design techniques to create culturally and linguistically appropriate materials to support pandemic response outreach activities, as well as technical advice, support the CHC-community partnerships. The Massachusetts League of Community Health Centers MA League encourages implementation strategies that are both community-engaged and equity-focused. The League is the Massachusetts health centres' Primary Care Association. They support and help with advocacy, technical support, workforce development, and communication for health centres and the communities they serve. In order to help CHCs, this collaborative design combines the implementation and quality improvement programme experience of MA League with the concepts of community-engaged research and the tools of implementation science. Our key premise is that increasing the amount of COVID-19 testing in marginalised populations will be achieved by enhancing CHC-community relationships through equity-focused implementation initiatives, participation of local advisory committees, and community outreach communications. RADxMA has three distinct objectives through six CHC-community collaborations in Massachusetts, this research attempts to hasten COVID-19 testing in areas that have been severely hit by the epidemic. This includes one set of CHCs authorised by an academic medical institution that itself serves four towns, as well as five federally certified health centres.

Over 1.3 million people live in the neighbourhoods around the RADx-MA CHCs, which provide medical treatment for patients. Our Implementation Science Center for Cancer Control Equity (ISCCCE), a partnership between the MA League and the National Cancer Institute, is funding the project. To facilitate community-engaged implementation science research, ISCCCE maintains an implementation laboratory of collaborations with Massachusetts CHCs. Additionally, ISCCCE collaborates with Azara Healthcare, the maker of the Data Reporting and Visualization System, a population management tool utilised by CHCs throughout Massachusetts. nationally. Rapid data gathering and reporting are made possible by DRVS, including the collection of COVID-related data from the various electronic health records used by Massachusetts CHCs. The Mass General Brigham Institutional Review Board gave its approval to the project. Our goal is to hasten COVID-19 testing among CHC patients and community members who are historically disenfranchised or underserved in terms of medical care, such as those who reside in communal housing, are homeless, or earn low wages as essential labourers. Using a Community Communications Team that employs educational and communication design strategies to develop culturally and linguistically appropriate materials to support pandemic response outreach activities, a Testing Capacity and Innovation Team that provides infectious disease expertise and technical guidance on COVID-19 testing, and a community-engaged, equity-focused implementation approach supported by the Community Health Centers League of Massachusetts. The Primary Care Association representing Massachusetts' health facilities is called the MA League. They support and help with advocacy, technical support, workforce development, and communication for health centres and the communities they serve. With this collaborative design, MA League's implementation and quality-improving abilities are combined. Communities that are more vulnerable to COVID-19 and were severely hit by the initial spike in Massachusetts in late summer 2020 are served by RADx-MA CHCs. Before the commencement of this research in June 2020, the six CHCs were doing 150 to 500 tests each week with positive rates of The CHCs identified groups, such as critical employees and those with weak English proficiency, who were more susceptible to COVID-19 and faced testing challenges in summer 2020. Individuals, immigrant populations, those who are jailed or were recently incarcerated, those who are homeless or are experiencing housing instability, elderly living in communal housing, those who have substance use problems, and those who live in multigenerational families.

Conclusion

For the primary outcome analysis, the six RADx-MA CHCs were paired with six controls CHCs. Matching clinics were deliberately chosen to have similar patient populations, racial or ethnic minorities' population percentage, and COVID-19 testing volume). We employed a multiple principal investigator approach, in which the project leadership tasks are split between two researchers and the lead of MA League. We created a research team structure in collaboration to assist the CHCs in their rapid testing efforts. The study team's organisational structure places CHCs and their neighbourhood. As the main focuses, partners include local government and community-based groups. Our section

for implementation research, the Implementation Laboratory, supports financial resources as well as the development of organisational capacity, knowledge transfer, and technical help. Through monthly meetings with each CHC team, the I Lab team, which includes members of the MA League and the investigator team, works to develop capacity and assist the deployment of testing services and community relationships. The MA League was given a key position in the creation of the I Lab so that they could make use of their expertise in CHC implementation as well as their position in pandemic-related lobbying and coordination as the state's leading CHC organisation. The I Lab runs an online learning community to help with knowledge transfer and technical support. Through the MA League to exchange resources, compare methods, and share results with RADx-MA partner CHCs. Additionally, technical support is given for the collecting of

research data and DRVS data. Each of the six RADx-MA CHCs will receive \$300,000 in year one and \$75,000 in year two to promote testing growth, community collaborations, and implementation and assessment of testing. Year one will get greater funds owing to financing mechanism requirements. A data sharing agreement is signed by the six matched control CHCs, who also receive a grant of \$3,000 to help with data sharing.

Acknowledgement

None

Conflict of Interest

None

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