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**Author:** Golden Sherita H. MD, MHS; Galiatsatos Panagis MD, MHS; Wilson Cheri MA, MHS; Page Kathleen R. MD; Jones Vanya PhD, MPH; Tolson Tina RN, MSN; Lugo April; McCann Nicki JD; Wilson Alicia JD; Hill-Briggs Felicia PhD

**Title:** Approaching the COVID-19 Pandemic Response With a Health Equity Lens: A Framework for Academic Health Systems

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Approaching the COVID-19 Pandemic Response With a Health Equity Lens: A Framework for Academic Health Systems

Sherita H. Golden, MD, MHS, Panagis Galiatsatos, MD, MHS, Cheri Wilson, MA, MHS, Kathleen R. Page, MD, Vanya Jones, PhD, MPH, Tina Tolson, RN, MSN, April Lugo, Nicki McCann, JD, Alicia Wilson, JD, and Felicia Hill-Briggs, PhD

S.H. Golden is professor of medicine, Department of Medicine, Division of Endocrinology, Diabetes, and Metabolism, Johns Hopkins University School of Medicine; professor of epidemiology, Johns Hopkins University Bloomberg School of Public Health; and vice president and chief diversity officer, Office of Diversity, Inclusion, and Health Equity, Johns Hopkins Medicine, Baltimore, Maryland.

P. Galiatsatos is assistant professor of medicine, Department of Medicine, Division of Pulmonary and Critical Care Medicine, Johns Hopkins University School of Medicine; and health equity co-lead, Office of Diversity, Inclusion, and Health Equity, Johns Hopkins Medicine, Baltimore, Maryland.

C. Wilson is diversity and inclusion education and training program manager, Office of Diversity, Inclusion, and Health Equity, Johns Hopkins Medicine, Baltimore, Maryland.

K. Page is associate professor of medicine, Division of Infectious Disease Center for Clinical Global Health Education, Johns Hopkins University School of Medicine, Baltimore, Maryland.

V. Jones is associate professor, Department of Health, Behavior, and Society, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland.
T. Tolson is senior director, Office of Language Services, Johns Hopkins Medicine, Baltimore, Maryland.

A. Lugo is diversity, inclusion, and health equity program coordinator, Office of Diversity, Inclusion, and Health Equity, Baltimore, Maryland.

N. McCann is vice president for payor/provider transformation, Presidents Office Administration, Johns Hopkins Health System, Baltimore, Maryland.

A. Wilson is vice president for economic development, Presidents Office Administration for Johns Hopkins University and Johns Hopkins Health System, Baltimore, Maryland.

F. Hill-Briggs is professor, Department of Medicine, Division of General Internal Medicine, Johns Hopkins University School of Medicine; Department of Health, Behavior and Society, Johns Hopkins University Bloomberg School of Public Health; Department of Acute and Chronic Care, Johns Hopkins University School of Nursing; and health equity senior lead, Office of Diversity, Inclusion, and Health Equity, Johns Hopkins Medicine, Baltimore, Maryland.

Correspondence should be addressed to Sherita H. Golden, 1620 McElderry Street, Reed Hall, Room 420, Baltimore, MD 21205; telephone: (443) 287-4827; email: sahill@jhmi.edu.

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Abstract

Racially and ethnically diverse and socioeconomically disadvantaged communities have historically been disproportionately affected by disasters and public health emergencies in the United States. The U.S. Department of Health and Human Services’ Office of Minority Health established the National Consensus Panel on Emergency Preparedness and Cultural Diversity to provide guidance to agencies and organizations on developing effective strategies to advance emergency preparedness and eliminate disparities among racially and ethnically diverse communities during these crises. Adopting the National Consensus Panel recommendations, the Johns Hopkins Medicine Office of Diversity, Inclusion, and Health Equity (ODIHE), Language Services, and academic–community partnerships utilized existing health equity resources and expertise to develop an operational framework to support the organization’s COVID-19 response and to provide a framework of health equity initiatives for other academic medical centers. This operational framework addressed policies to support health equity patient care and clinical operations, accessible COVID-19 communication, and staff and community support and engagement, which also supported the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care. Johns Hopkins Medicine identified expanded recommendations for addressing institutional policy-making and capacity-building, including unconscious bias training for resource allocation teams and staff training accurate race, ethnicity, and language data collection, that should be considered in future updates to the National Consensus Panel’s recommendations.
Racially and ethnically diverse communities and socioeconomically disadvantaged communities have historically been disproportionately affected by disasters and public health emergencies in the United States.\(^1\) In the aftermath of Hurricane Katrina on the Gulf Coast in 2005, those who were poor, African American, Latinx, and/or disabled were overrepresented among those displaced and affected.\(^2\) Following Hurricane Katrina, the United States Department of Health and Human Services’ Office of Minority Health established the National Consensus Panel on Emergency Preparedness and Cultural Diversity.\(^3\) The primary goal of this panel was to provide guidance to agencies and organizations on development of effective strategies to advance emergency preparedness and eliminate disparities among racially and ethnically diverse communities during future disasters and public health emergencies. During the 2009–2010 H1N1 influenza pandemic, the panel applied its all-hazards framework to examining the drivers of racial and ethnic disparities in that public health emergency.\(^4\) Their findings unfortunately showed that hospitalizations and deaths were higher for African Americans, Hispanics, and Native Americans due to linguistic and cultural barriers to understanding and implementing social distancing—barriers further facilitated by many from these populations being employed in jobs without paid sick leave policies, living in domestic and urban crowding conditions, and relying on public transportation.\(^4\) While there was an effective vaccine and antiviral treatment, both were effective interventions that had lower rates of uptake in these affected communities. Just as in the H1N1 influenza pandemic, racially and ethnically diverse and poor populations are bearing the brunt of infections, hospitalizations, and deaths in the COVID-19 pandemic.\(^5,6\) As the pandemic evolved in cities and states across the United States in April 2020 30%–80% of COVID-19 deaths have occurred in African Americans and one quarter to one third of deaths have occurred in Latinx/Hispanic individuals.\(^6–8\) What is most compelling about these data at the
state and city levels is that the proportion of African American and Latinx patients hospitalized and dying is significantly higher than the proportion of African Americans and Latinx individuals living in the affected municipalities. Unlike the H1N1 influenza pandemic, a vaccine has only recently been made available and is not yet universally available, nor is there definitive treatment for COVID-19, making social distancing and public health interventions imperative to prevent its spread to these vulnerable populations. Even when vaccines are widely available, racial and ethnic minority groups may avoid vaccination because of the past history of performing unconsented medical experiments in these communities.9–14

In developing an institutional response at Johns Hopkins Medicine (JMH) to the COVID-19 pandemic, we believe that the National Consensus Panel recommendations remain relevant and provide a framework for academic medical centers to respond to the COVID-19 pandemic with a health equity lens to support staff, patients, and trainees. In addition, we observed needs not previously addressed by the National Consensus Panel that serve as opportunities for expanded recommendations addressing institutional policy-making and capacity-building. In this article we describe how we utilized existing Johns Hopkins Medicine health equity resources and expertise from the Office of Diversity, Inclusion, and Health Equity (ODIHE), Language Services, and academic-community partnerships to support our organization’s COVID-19 response and to provide a framework of health equity initiatives for other academic medical centers. Our operational framework also supports the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care with a principal standard to “provide effective, equitable, understandable, and respectful, quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.”15
Health Equity-Focused Institutional Policy Development and Operations

In order to address biases in policies, practices, and workflows, it is critical to ensure that health equity principles are incorporated into a health system’s clinical operations infrastructure developed to support a pandemic. Although not among the National Consensus Panel recommendations, embedding health equity in policies and conducting trainings to build institutional culture and capacity for health equity were critical interventions at JHM in the setting of this pandemic. In Table 1 and below we summarize how we operationalized these recommendations.

Development of scarce resource allocation guidance document

Recent publications have raised concerns about scarce resources during the pandemic such as ventilators, intensive care unit beds, and medications not being allocated to disadvantaged and marginalized populations. To address these concerns, a team including the JHM chief diversity officer (S.H.G.) and other authors of this article (C.W.) developed a framework and guidance document that had minimal bias against underserved and disabled patients who might be infected with COVID-19, specifically including a nondiscrimination clause related to social characteristics and removing age as a primary consideration. We also specifically addressed concerns raised by the disability community and included guidance to avoid assigning value based on perceptions of functional level or needed support unrelated to response to treatment: avoiding reallocation of ventilators for individuals with disabilities who are chronically ventilator-dependent as well as allowing a family member, personal care assistant, communicator, or other disability service provider to assist with communication in the hospital.
Health equity capacity-building through targeted training

To more directly address unconscious bias that can influence health care decision-making, the ODIHE conducted five 1-hour workshops via webinar on unconscious bias mitigation strategies for the Triage and Secondary Review Team members across Johns Hopkins Health System (JHHS). In addition, members of the ODIHE health equity operations team are members of the Secondary Review Teams as another bias mitigation approach.

For health care institutions to be accountable for health equity, the National CLAS Standards call for collecting and maintaining accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.15 This makes it imperative to collect accurate, high quality data on race, ethnicity, and preferred language (REaL) for health care when patients interface with our systems. If these data are inaccurate, it would be impossible to accurately identify which populations are most at risk for adverse clinical outcomes. In the context of the current pandemic, a large amount of missing data on race/ethnicity would result in an underestimation of infections, hospitalizations, deaths, and resource needs for vulnerable populations.

To ensure that the demographic data for patients in our health system are accurate, we trained our JHM COVID Call Center, clinical, and registration staff in how to properly collect self-identified demographic data (see Supplemental Digital Appendix 1, at http://links.lww.com/ACADMED/B72). We conducted 17 virtual workshops via Zoom that included up to 250 total staff members to demonstrate the importance of their role in collecting patient sociodemographic data to delivery culturally and linguistically appropriate care and reduce health disparities. The objectives were to discuss the business case for cultural competency; define REaL data; discuss how collection of patient sociodemographic data can
help eliminate health disparities; discuss the best practices to collect patient sociodemographic data; and practice addressing patient questions and concerns. These training sessions will occur quarterly moving forward to refresh current staff and train new staff. Finally, we have also worked on ways for the patients to update their REaL information on their own through MyChart in the electronic health record.

**Ensuring Delivery of Culturally and Linguistically Appropriate Services**

Our work in this area supports the National Consensus Panel recommendation to ensure delivery of culturally and linguistically appropriate services. Our approach supports the National CLAS Standards for communication and language assistance, including offering language assistance to those with limited English proficiency (LEP), utilizing qualified interpreters, and providing easy-to-understand print and multimedia materials in common languages of the communities we serve—Spanish, Russian, Arabic, Mandarin Chinese, and Korean.\(^\text{15}\)

**Acute care patient education and consent communication support**

To be consistent with the National CLAS Standards, we incorporated health equity and literacy-adapted talking points and scripts for providers to use with patients and families to explain triage decisions as well as literacy-adapted patient handouts on resource allocation scenarios in collaboration with the JHM Patient Education Department. The patient handouts were subsequently translated into the 5 most common languages of patients seen across our health system in partnership with JHM Language Services.

**Language and translation services**

JHM Language Services provides our patients and families access to qualified medical interpreters for over 250 languages through a variety of modalities, including in-person, over the phone, and video remote interpretation services. In response to the pandemic, information on
COVID-19, testing, and social distancing was translated into Spanish and Arabic infographics and the updated visitor policy was translated into Spanish, Arabic, and Chinese. Given that the majority of our in-person ambulatory visits have been converted to telemedicine visits, documents with Zoom and Polycom connectivity instructions were translated into the 5 most common languages of outpatients across our enterprise. JHM Language Services also supports patients who are blind or have low vision and those who are deaf or hard of hearing. Additional patient education materials are provided in the top 10 languages through our patient education vendor, Krames.

As the pandemic evolved, our clinicians identified limited English proficiency (LEP) Latinx immigrants in our community as a particularly vulnerable population at high risk of COVID-19 infection and late presentation to care. Communication with these patients in the hospital was particularly complicated by the use of personal protective equipment, as well as fears of deportation, stigmatization, and income loss during recovery. In a collaborative effort between the ODIHE, JHM Language Services, and Centro Sol (our center to promote equity in health and opportunity for Latinx persons), we launched “Juntos,” a consultation team to improve communication with LEP Latinx immigrant patients with COVID-19. This program deploys qualified bilingual and culturally competent clinicians and social workers who work together (Juntos) with the primary team to optimize clinical care communication, engage family members as appropriate, and address relevant issues that may affect recovery and safe discharge. In addition, JHM Language Services has been instrumental in identifying qualified bilingual providers and staff in the system to support this role as well as other community-based public health interventions. For example, at the request of the health department, bilingual bicultural JHM Latinx outreach workers and staff were identified and trained to conduct contact tracing for
Spanish-speaking LEP patients with COVID19.

Staff and Community Support and Engagement

In responding to a pandemic, the National Consensus Panel indicated the importance of developing clear, concise, and culturally and linguistically appropriate messages; coordinating information and resources; identifying diverse communities and their needs, attitudes, and beliefs; and building partnerships with communities that foster trust (Table 1). During the COVID-19 pandemic, our organization focused not only on supporting its external community but also, its internal community—our staff.

Staff communication and support

We have worked collaboratively with Johns Hopkins Medicine Human Resources and Marketing and Communications departments to ensure that crucial information is communicated in multiple formats for all staff and have developed literacy-adapted COVID-19 infographics (see Supplemental Digital Appendix 2, at http://links.lww.com/ACADMED/B72) and videos showing which types of personal protective equipment to wear for various clinical and nonclinical activities. Because many of our frontline staff in environmental services, food services, patient transportation, security, and general services are away from computers most of the day, posters with key messaging were hung in common areas for visibility. To coordinate dissemination of COVID-19 pandemic information and resources as recommendations were evolving daily and at a rapid pace, we created a central JHM internal resource website for faculty, staff, trainees, and students and a public facing website for patients.

Food insecurity quickly arose as a concern for our staff and manifested in 2 forms—lower wage employees who were unable to access public assistance food support programs because they did not meet age criteria (≤18 years or ≤60 years) and frontline clinical staff who were unable to
shop for groceries or prepare meals due to long hours and exhaustion. We responded to this need by establishing an emergency employee food pantry in collaboration with the Maryland Food Bank for our 2 Baltimore-based hospitals.21,22 Each week from April through July 2020, we purchased 6,000 pounds of food (cost $6,900) that enabled us to provide 2 meals for 300 families of 4. Our Nutrition Department reviewed the food options to ensure that the foods selected for distribution had the greatest nutritional value. In addition, the other 4 hospitals in our health system also set up food pantries and meal delivery services for their employees. We are making plans to sustain this effort throughout and beyond the pandemic.

Community communication and support

We believe that academic–community partnerships can be leveraged to support innovative public health messaging. To facilitate more widespread adherence to social distancing in our most vulnerable communities, who are less likely to watch television or engage in social media where much information is circulated, we partnered with the Baltimore Chapter of the National Association for the Advancement of Colored People to support a sound truck promoting key COVID-19 prevention messages. The messages—stay at home, if you must go out observe social distancing, avoid congregating in groups, wash your hands, and wear a mask—were delivered by local celebrities, who were considered trusted messengers, with whom at risk, low-income neighborhood residents could identify. The truck circulates several hours daily in neighborhoods where it was noted that residents were still gathering in groups. Finally, our chief diversity officer participated in several educational tele-town halls and webinars focused on COVID-19 and health disparities23–26 and provided briefings to national minority-serving organizations and universities; to the Maryland State Black, Hispanic, and Asian-Pacific Islander Caucuses; and to the Maryland Assembly Joint Legislative Workgroup.
Johns Hopkins University/Johns Hopkins Medicine COVID-19 Anchor Strategy Work Group. At the start of the pandemic, our JHU/JHM vice president for business and economic development organized an anchor strategy work group, with the support of senior leadership, to coordinate and consolidate information sharing and gathering on substrategies that were being implemented across the health system and the university. The work group’s committees have focused on communication/information sharing, employee engagement, youth programs, external anchor institution coordination, and small business support. This is to highlight the need for a bidirectional partnership between academic institutions and the partnering community.27

Our health equity operational team has lent its expertise to educate community members about the impact of COVID-19 on vulnerable populations via twice-weekly calls through a previously established academic–community religious partnership.28

Baltimore public–private partnership. When the COVID-19 pandemic started, we recognized the unprecedented public health and safety challenges were ones that no single health system or state or local government was prepared to address alone. Under the leadership of the chief executive officers (CEOs) of CareFirst BlueCross BlueShield, Johns Hopkins Health System, and University of Maryland Medical System, a public–private partnership was established to ensure a comprehensive, robust, and coordinated response to COVID-19. The 3 CEOs approached state and local leaders out of concern that Baltimore would experience a disproportionate COVID-19 impact due to the city’s dense population, high rate of poverty, and prevalence of multiple chronic conditions amongst Baltimore’s residents. The public–private partnership is directed by an oversight board consisting of the city’s mayor, the 3 CEOs, and a state representative (see Figure 1). The daily operations of the partnership are co-led by Baltimore’s health commissioner and a private sector representative (see Figure 1). A steering
committee of private sector leads meets twice per week to escalate challenges and discuss issue resolution to concerns raised by the city. The partnership developed 7 “workstreams” as part of the coordinated response (see Figure 1 and Table 2). Workstream teams convene regularly, identified co-leaders have daily check-ins with the partnership co-leads, and work plans are developed and refreshed at least twice per week. The successful collaboration across the public and private sector, along with a communal desire to respond to COVID-19, resulted in additional partners from hospitals and non-profits joining the partnership. The partnership captured local and national attention as a positive example of extraordinary efforts taken to stabilize and secure a community during crisis.

Data Collection, Monitoring, and Evaluation

The National Consensus Panel has 2 broad recommendations focused on data collection, monitoring, and evaluation: ensure community representatives and organizations in evaluation of public health interventions by creating partnerships and ensure that diversity and health equity are part of funding and program priorities for the pandemic, requiring the formation of community partnerships with at risk communities. We are addressing these recommendations regionally through the Baltimore public–private partnership and collaborations with the state legislature. We have also advocated for collection of REaL data at the call center for the Baltimore public–private partnership, which will facilitate regional data collection, monitoring, and evaluation around questions of health equity. Monitoring and evaluating our response and programs will be an important focus of the next stages of our pandemic response.

Observations and Concluding Remarks

The COVID-19 pandemic brings need for concerted health equity-focused interventions to reduce the disproportionate impact on racial/ethnic and lower socioeconomic populations
evidenced in prior disasters and public health emergencies in the United States. The National Consensus Panel’s recommendations are a useful guide for academic medical centers’ health equity response during this pandemic. Although challenging, we found the recommendations feasible to operationalize and to implement. Several factors are needed, however, for feasibility. First is an organizational commitment to health equity strategy. For JHM, this was manifested in the formal ODIHE with a chief diversity officer and a health equity leadership committee. Second was the addition of health equity leadership as an essential member of the task forces and committees initiated for specific pandemic operations and strategies. Third was establishment of partnerships with service committees or organizational units to bring CLAS expertise in language services standards and ensuring implementation in all pandemic-related communications. Fourth was the formation or expansion of regional multi-stakeholder partnerships comprising community organizations, public health agencies, hospitals/health care systems, and payers to meet the multiple health and social needs of vulnerable populations at risk to experience health inequity. The key to allowing us to implement these interventions in a short timeframe was the community and neighborhood relationships and partnerships built prior to the pandemic. A lesson taken from this experience is to assure ongoing community collaborations are maintained, emphasized, and continue to grow both during and after a public health crisis. In addition to the essential factors for implementing the National Consensus Panel’s recommendations, the ODIHE observed additional opportunities that are not yet listed among the National Consensus Panel’s current recommendations. These include: the importance of health equity in policy-making for pandemic response to ensure “upstream” interventions that mitigates unintended health inequities resulting from operational decisions and training key institutional leadership and staff in unconscious bias and in REaL data collection. We suggest these
additional recommendations be considered in future updates to the National Consensus Panel’s recommendations. It is critical that we position our academic health systems to address and mitigate the long-standing health inequities so vividly displayed in the setting of the COVID-19 pandemic. Our patients and communities are counting on us to lead this important charge.
References


Figure Legend

Figure 1

Baltimore public–private partnership organizational structure.

Abbreviation: CEO, chief executive officer.
### Table 1

**JHM Response to National Consensus Panel on Emergency Preparedness and Cultural Diversity Recommendations**

<table>
<thead>
<tr>
<th>Health equity strategy</th>
<th>National consensus panel recommendation</th>
<th>JHM response (and relevant National CLAS Standard number)¹⁵</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional policy development to support health equity</td>
<td>Develop trainings, drills, and exercises that engage and reflect diverse communities</td>
<td>Allocation of scarce resource guidance document work group</td>
</tr>
<tr>
<td>focused clinical operations and patient care</td>
<td></td>
<td>- Chief diversity officer was team member to help craft a framework with minimal bias against disadvantaged and disabled populations (2, 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- ODIHE conducting unconscious bias training for triage and secondary review teams (4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- ODIHE membership on secondary review team (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>JHM Language Services</td>
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<tr>
<td></td>
<td>Ensure delivery of culturally and</td>
<td>- Provision of interpretation services for variety of</td>
</tr>
<tr>
<td></td>
<td>linguistically appropriate services</td>
<td>settings— in-person, over-the-phone, video remote</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(5, 7)</td>
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<tr>
<td></td>
<td></td>
<td>Collaboration with ODIHE and Centro Sol to develop provider support service for primary care teams of limited English proficiency patients using qualified bilingual and culturally competent clinical staff (5, 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Translation of COVID-19 patient education materials into our 5 most common languages (Spanish, Russian, Arabic, Mandarin Chinese, Korean) (8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ensuring COVID-19 information accessible to disability community (8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>JHM allocation of scarce resource framework work group</td>
</tr>
<tr>
<td>Category</td>
<td>Action</td>
<td>Responsible Party</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Public health and patient COVID-19 communication</td>
<td>Develop clear, concise, and culturally and linguistically appropriate messages</td>
<td>JHM Human Resources and Marketing and Communications <strong>•</strong> Ensuring crucial information is communicated in various formats and at different levels for all staff (currently developing literacy-adapted with infographics) (8) <strong>•</strong> COVID-19 information resource page on internal and public-facing website (8)</td>
</tr>
<tr>
<td></td>
<td>Coordinate information and resources</td>
<td>JHU/JHM Anchor Strategy Workgroup <strong>•</strong> Developed website for community resources, including in multiple languages (8) <strong>•</strong> ODIHE participation in community briefings (13)</td>
</tr>
<tr>
<td>Staff and community support and engagement</td>
<td>Identify diverse communities and their needs, attitudes and beliefs</td>
<td>JHM Human Resource Leadership Team, Office of Wellbeing, and Food Services <strong>•</strong> ODIHE collaborated to start emergency food pantry program for staff (12)</td>
</tr>
<tr>
<td></td>
<td>Build partnerships with communities to foster trust</td>
<td>Medicine for the Greater Good and Medical-Religious Partnership (13) <strong>•</strong> Biweekly community COVID-19 briefings JHU/JHM Anchor Strategy Workgroup (13) Centro Sol (13)</td>
</tr>
<tr>
<td>Data collection, monitoring, and evaluation</td>
<td>Ensure community representatives and organizations are part of evaluation of public health interventions by creating partnerships</td>
<td>JHM COVID-19 Call Center <strong>•</strong> ODIHE conducting training in proper collection of race, ethnicity, and language data (4) Baltimore Public-Private Partnership</td>
</tr>
</tbody>
</table>
Ensure that diversity and health equity are part of funding and program priorities for the pandemic.

- ODIHE advocating for regional data collection, monitoring, and evaluation around questions of COVID-19 health equity (11)

Abbreviations: JHM, Johns Hopkins Medicine; COVID-19, novel coronavirus disease 2019; ODIHE, Office of Diversity, Inclusion, and Health Equity; JHU, Johns Hopkins University.

*Relevant National CLAS Standard*:

**Governance, leadership, and workforce**

- Standard 2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
- Standard 4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

**Communication and language assistance**

- Standard 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- Standard 7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Standard 8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

**Engagement, continuous improvement, and accountability**

- Standard 9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.
- Standard 11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- Standard 12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- Standard 13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- Standard 15. Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.
### Table 2

**Baltimore Public–Private Partnership Workstreams**

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call center</td>
<td>Provide community members, including those without a doctor or insurance, access to clinical providers who can assess individuals, make testing recommendations, and schedule tests at various sites.</td>
</tr>
<tr>
<td>Communications</td>
<td>Expanded communications and public outreach strategies aimed at creating widespread, shared behaviors to slow the spread of COVID-19. Communications strategies include twice-weekly briefings from the Mayor that allows for routine updates, as well as targeted information from subject matter experts. Developed targeted amplification efforts through external networks such as faith leaders, and neighborhood and business associations.</td>
</tr>
<tr>
<td>Resource dashboard</td>
<td>Developed an integrated dashboard with key information on COVID-19 testing, results, scarce resources capacity, hospital bed availability and other critical data (<a href="https://coronavirus.baltimorecity.gov/">https://coronavirus.baltimorecity.gov/</a>).</td>
</tr>
<tr>
<td>Hotspots data project</td>
<td>Created actionable insights about the spread of COVID-19 in Baltimore by harnessing data from a range of data sources, helping to prioritize resources and messaging.</td>
</tr>
<tr>
<td>Special populations</td>
<td>Developed strategies to address disease suppression and mitigation strategies including an increase in capacity to isolate and support vulnerable populations that are waiting for testing results, who are positive for COVID-19, or who do not require hospitalization but need additional supports.</td>
</tr>
<tr>
<td>Care coordination</td>
<td>Developed strategies for performing needs assessments to facilitate transitions to the appropriate level of care with required resources, supplies and post-acute staff support.</td>
</tr>
</tbody>
</table>

Figure 1

OVERSIGHT BOARD
Guide strategic decision making and major resource allocation
Mayor • Private sector CEOs • State of Maryland representative

Coordination co-leads
Oversee and manage the workstreams

City lead is responsible for briefing and obtaining real time decisions from the mayor
Private lead is responsible for briefing and obtaining real time decisions from the private sector CEOs

City lead: Baltimore City Health Commissioner
Private lead: Local CEO

Care coordination • Public health and special populations • Testing and transportation • Hotspot data project • Resource dashboard • Communications • Call center