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ORIGINAL PAPER

Community Calls: Lessons and Insights Gained from a Medical–Religious Community Engagement During the COVID-19 Pandemic

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Abstract

During the pandemic caused by the severe acute respiratory syndrome coronavirus-2, public health instructions were issued with the hope of curbing the virus' spread. In an effort to assure accordance with these instructions, equitable strategies for at-risk and vulnerable populations and communities are warranted. One such strategy was our community conference calls, implemented to disseminate information on the pandemic and allow community leaders to discuss struggles and successes. Over the first 6 weeks, we held 12 calls, averaging 125 (standard deviation 41) participants. Participants were primarily from congregations and faith-based organizations that had an established relationship with the hospital, but also included school leaders, elected officials, and representatives of housing associations. Issues discussed included reasons for quarantining, mental health, social isolation, health disparities, and ethical concerns regarding hospital resources. Concerns identified by the community leaders as barriers to effective quarantining and adherence to precautions included food access, housing density, and access to screening and testing. Through the calls, ways to solve such challenges were addressed, with novel strategies and resources reaching the community. This medical–religious resource has proven feasible and valuable during the pandemic and warrants discussions on reproducing it for other communities during this and future infectious disease outbreaks.

Keywords COVID19 · Community engagement · Medical–religious partnerships

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Introduction

The aging of the population and the accompanying chronic disease epidemic have brought heightened awareness of the importance of health literacy (Geboers et al. 2015; Chesser et al. 2016). While medical professionals continue to play essential roles with respect to managing chronic diseases, particularly acute exacerbations, the responsibility for the day-to-day management of most of these diseases—monitoring the conditions, using medications correctly, implementing and then sustaining recommended lifestyle modifications—rests largely with the affected individuals themselves. Thus, health care organizations must find ways to reach out to those who have chronic diseases and others who are at risk of chronic diseases and to provide them with the information and support they need to manage their conditions and to use medical services in a timely and appropriate way.

One of the approaches to this health literacy challenge adopted by Johns Hopkins Bayview Medical Center was to create in 2011 the Healthy Community Partnership. Relying on its Department of Spiritual Care and Chaplaincy for guidance, the hospital began offering health education programs for leaders from local religious congregations who would, in turn, share what they learned with members of their congregation and community. The instruction for most of these programs has been provided by interns and residents in the hospital's internal medicine residency program who quickly recognized the value of these programs and enthusiastically welcomed the opportunity to play an active role in improving health literacy in their community. One of the most significant and far-reaching developments emerging from these programs occurred in 2013 with the creation of Medicine for the Greater Good (MGG), a medical education initiative aimed at teaching physicians-in-training about the impact of socioeconomic variables (individual- and contextual-level) on health outcomes. By 2020, the hospital, through the collaborative efforts of the Healthy Community Partnership, Medicine for the Greater Good, and the Department of Spiritual Care and Chaplaincy, had established trusted relationships with more than 500 individuals from local congregations.

Although the primary focus of these programs has been on chronic conditions, in early 2020, the leaders of these programs recognized that the focus would need to shift, and shift quickly, to an infectious disease. It had become clear that the disease (COVID-19) caused by the severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) had the potential to spread widely throughout the USA, taking thousands of lives. The only way to slow the spread would be to intervene at the community level, educating community members about the importance of taking appropriate precautions regarding hygiene and viral transmission (Adhikari et al. 2020), and providing a platform to hear of their struggles and successes during the pandemic and resulting public health policies.

In early March, the leaders met to discuss strategies for reaching out to the community. It was decided that the best strategy, and one that could be implemented quickly, would be to mobilize their network of faith community leaders by inviting them to participate in twice-weekly conference calls. These calls would

feature the latest information on COVID-19 and various medical and community resources, and also give participants the opportunity to voice concerns and ask questions. In this narrative, we review the outcomes of these calls, describing their feasibility and process implementation.

Methods

Community Calls

Beginning on Monday, March 16th, building on the relationships created and fostered by the Healthy Community Partnership, Medicine for the Greater Good, and the Department of Spiritual Care and Chaplaincy, we initiated a community conference call series. It was decided to hold the calls twice a week (Mondays and Fridays) for 60 min. The breakdown of the call's timeline generally included a 5-min introduction, 15 min of COVID-19 updates (by a pulmonary and critical care physician), 15–20 min on a specific COVID-19 health issues, 10 min of questions from callers, and a closing meditation for the final 5 min. On Friday calls, we invited community leaders to share their thoughts on their community needs and successes (5–10 min). During the calls, participants are asked to send their questions to a distinct e-mail account utilized for COVID-19-related purposes for the community. The questions are monitored regularly and are addressed during the question and answer portion of the calls or a response is transmitted back to them via e-mail or a follow-up phone call. Finally, all of the telephone calls are recorded and accessible to community members at any time by dialing a toll-free number.

The meditation that was offered at the conclusion of the calls was organized and overseen by our Department of Spiritual Care and Chaplaincy. Meditations were meant to be inclusive of all faith traditions and non-sectarian in their focus. If the calls were conducted during a time of special religious observance, this was noted (e.g., Passover, Good Friday, and Ramadan) through a more religion-specific offering. The goals of the meditation were twofold: first, to offer a chance for community faith leaders to pause for their own spiritual nurturance; and second, to plant seeds for sustaining resilience through the use of spiritual tools that the faith leaders might employ themselves for their congregants. Community input on the meditation topic and discussion was also welcomed, and invited suggestions were sent to the aforementioned COVID-19 e-mail.

Outcome Variables

In an effort to discuss the feasibility and process outcomes, we have collected data on several variables. First, we identify how many callers dialed into each call. Second, we highlight the specific COVID-19 health issues requested and discussed. Finally, we review community outcomes that occurred due to these calls (e.g., requests to conduct additional calls for a congregation, ability to allocate community resources), many of which were collected through a survey sent electronically after

the calls. The surveys were meant to provide feedback on the calls, how the information obtained has been shared, and which topics they would like to have discussed on the calls.

Statistical Analyses

All continuous variables are presented as mean (standard deviation, SD). Categorical variables were summarized as counts and percentages. Since the cohort of participants was not randomly selected, all statistics are deemed descriptive. Statistical analyses were conducted with R software (V.0.99.903).

Results

Between March 16 and April 24, 2020, we held a total of 12 telephone calls. The mean number of participants on each individual call was 125 (SD = 41), with the range from 78 to 202. The mean weekly participation was 250 (SD = 68). The greatest participation of callers occurred during the second week of the Maryland's stay-at-home order (174 and 202, totaling 376 participants). Week five of the community calls drew the least community participants (85 and 102, totaling 187 participants).

Originally, the calls were promoted to community members who participated in training programs offered by the Healthy Community Partnership and the Department of Spiritual Care and Chaplaincy. Subsequently, the number of callers escalated as word spread throughout the community. Representatives from religious communities, senior centers, hospitals and other health care centers, community service organizations, and the local government joined the calls.

There have been several medical experts who have shared their expertise and insight into the pandemic, including specialists in infectious disease, geriatrics, physical therapy, chaplaincy, psychology, pediatrics, ethics, and health equity. The various topics that have been discussed during the calls include advance care planning, telemedicine, social isolation, mental health, meditation and other coping strategies, and inequalities among vulnerable populations. Representatives from government agencies and community organizations (e.g., Baltimore City Health Department, Maryland Legal Aid, Baltimore City Public School Systems, Beth El Soul Center) shared valuable resources and services they provide to community members such as food access, counseling, assistance with civil legal issues, and aging services.

After our 5th community call, a survey was sent out to 200 community members who participated. Of these 200 community members, 56 responses (28%) were received. From the responses, 40 community members were on at least three of the five calls. From the responses, information from the community calls were being shared by phone calls, texts and e-mails. Other participants have shared the information with caregiver support groups, book clubs, community associations, Sunday school classes, and colleagues. In regards to topics that participants wanted addressed, these included mental health, antibody tests, and pharmacological

responses, self-care during self-isolation, home care practices after being discharged from the hospital with a diagnosis of COVID-19, and the virus' effect on various races and ethnicities. Many of the participants on the calls expressed an interest in having the calls continued after the pandemic has dwindled to develop strategies and coping mechanisms on how to adapt to the new 'normal.'

Several immediate outcomes were identified from the community calls. Four additional community calls were requested for specific congregations (two synagogues, one mosque, one church) and one in-person discussion at a mosque where food was being distributed (in compliance with social distancing and facemask requirements). Five calls were requested for insight into mental health consequences during the pandemic. Distribution of food and facemasks was also achieved at three congregations (one mosque, one synagogue, and one church). The calls also served to identify and correct any potentially harmful misinformation circulating among the communities. Finally, the calls resulted in questions from religious leaders of how to best prepare their congregations for re-opening services in a manner that is in accordance with recommendations from state-level authorities and the Centers for Disease Control and Prevention (CDC).

Discussion

Through our community calls held twice weekly, provided in both a culturally sensitive manner and at an appropriate health literacy level with our established partners and network, we have been able to demonstrate the calls' feasibility as well as significant immediate outcomes. From discussing COVID-19 health-related recommendations in actionable manners that can be adapted to individual neighborhoods or housing units to allocating resources such as facemasks, these calls drew a significant audience of leaders who in turn impacted their communities. Such action executed with short preparation time using a low-tech and easily accessible communication platform was achieved in large measure because of established relationships and a high level of trust that had developed over almost a decade of regular programming and support.

The development of medical–religious partnerships has shown significant value in the past for non-communicable disease outcomes (Newlin et al. 2012; Liao et al. 2016). Therefore, having significant value during the SARS-CoV-2 pandemic is an extension of its already established significance. During the last coronavirus outbreak, specifically that of the Middle East Respiratory Syndrome (MERS) coronavirus, a cross-sectional study was carried out during Ramadan at the Holy Mosque in Makkah, Saudi Arabia, with the objective of understanding what travelers and residents understood about the current viral epidemic (Alotaibi et al. 2017). Other studies were also conducted with persons who underwent a holy pilgrimage to Saudi Arabia for religious purposes (Althobaity et al. 2017). These studies highlight how faith-based organizations can assure that accurate information about an infectious outbreak is distributed while simultaneously learning of knowledge gaps of congregants. Such information may help refine public health messaging and policies

intended to mitigate the spread of the infection, reaffirming the value of medical–religious partnerships during epidemics and, now, a pandemic.

The community calls have identified the need for a significant role moving forward: assisting religious leaders in understanding how to assure the public safety of congregants as quarantine measures begin to be scaled back. Depending on the local government, the easing of quarantine restrictions is likely to be performed in phases, in accordance with recommendations from local health officials as well. At the time of reporting on the feasibility of the early stages of the community calls with medical–religious partners, our designated COVID-19 e-mail has begun to see questions arise on how to best implement safe practices during the next phase of re-opening. It is clear that diverse congregations with diverse worship practices and services will need equitable and actionable insight into how to best transition into these quarantine measure phases. While currently not addressed at the time of this publication, this will be an educational priority for our medical–religious partnerships moving forward.

The medical–religious resource of community calls during the COVID-19 pandemic has proven feasible and valuable, with discussions on reproducing it for more communities during this quarantine and government-issued lockdowns. With established community partners, medical organizations should work to assure these relationships are strengthened during dire public health moments in order to communicate appropriate and effective messaging and resources. Medical–religious partnerships are effective in such moments, drawing from prior health care-related successes that can be transitioned into significant, and feasible, interventions, such as community calls. As the pandemic continues, further insight into outcomes from this intervention warrant monitoring and insight into its successes and challenges.

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Compliance with Ethical Standards

Conflict of interests The authors have no conflicts of interest and no financial disclosures to reveal and have no competing interests to declare.

Ethical Standards This initiative complied with ethical standards set forth by Johns Hopkins School of Medicine as well as in accordance with the Declaration of Helsinki.

References

Adhikari, S. P., Meng, S., Wu, Y. J., Mao, Y. P., Ye, R. X., Wang, Q. Z., et al. (2020). Epidemiology, causes, clinical manifestation and diagnosis, prevention and control of coronavirus disease (COVID-19) during the early outbreak period: A scoping review. *Infectious Diseases of Poverty, 9*(1), 29.

Alotaibi, M. S., Alsubaie, A. M., Almohaimede, K. A., Alotaibi, T. A., Alharbi, O. A., Aljadoa, A. F., et al. (2017). To what extent are Arab pilgrims to Makkah aware of the middle east respiratory syndrome coronavirus and the precautions against it? *Journal of Family and Community Medicine, 24*(2), 91–96.

Althobaity, H. M., Alharthi, R. A. S., Altowairqi, M. H., Alsufyani, Z. A., Aloufi, N. S., Altowairqi, A. E., et al. (2017). Knowledge and awareness of Middle East respiratory syndrome coronavirus among Saudi and Non-Saudi Arabian pilgrims. *International Journal of Health Sciences, 11*(5), 20–25.

Chesser, A. K., Keene Woods, N., Smothers, K., & Rogers, N. (2016). Health literacy and older adults: A systematic review. *Gerontology and Geriatric Medicine, 2,* 2333721416630492.

Geboers, B., Brainard, J. S., Loke, Y. K., Jansen, C. J., Salter, C., Reijneveld, S. A., et al. (2015). The association of health literacy with adherence in older adults, and its role in interventions: A systematic meta-review. *BMC Public Health, 15,* 903.

Liao, Y., Siegel, P. Z., White, S., Dulin, R., & Taylor, A. (2016). Improving actions to control high blood pressure in Hispanic communities—Racial and ethnic approaches to community health across the U.S. Project, 2009–2012. *Preventive Medicine, 83,* 11–15.

Newlin, K., Dyess, S. M., Allard, E., Chase, S., & Melkus, G. D. (2012). A methodological review of faith-based health promotion literature: Advancing the science to expand delivery of diabetes education to Black Americans. *Journal of Religion and Health, 51*(4), 1075–1097.

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