

Rapid Community Engagement in Response to SARS-CoV-2 Funding Opportunities: New York City, 2020–2021

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In response to fast-turnaround funding opportunities, collaborations have been forming across the country to address severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) disparities. Here we describe the process, notes from the field, and evaluation results from a new collaboration involving multiple partners, formed in October 2020 in New York City as part of the Rapid Acceleration of Diagnostics initiative. We used the validated Research Engagement Survey Tool to evaluate the partnership. Results can inform future research and improve engagement efforts aimed at reducing SARS-CoV-2 disparities. (*Am J Public Health*. 2022;112(S9):S904–S908. <https://doi.org/10.2105/AJPH.2022.307072>)

Despite important discussions around health equity, partnership, and trustworthiness, strategies to rapidly engage communities in the context of public health emergencies in the United States are limited.

INTERVENTION AND IMPLEMENTATION

The National Institutes of Health launched the Rapid Acceleration of Diagnostics (RADx) initiative to speed innovation in the development, commercialization, and implementation of technologies for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) testing. The initiative focused on four programs, one of which included improving access to rapid, accurate diagnostics for SARS-CoV-2 in underserved populations (RADx-UP) with an emphasis on community engagement.

Our study focused on New York City Housing Authority (NYCHA), the largest public housing authority in the United States, accounting for 15% of the nation's public housing units and comprising 400 000 residents, most of whom are Black or Latinx.¹

To implement our approach, we relied on well-delineated methods for partnership engagement with community and academic partners.² We also borrowed from models of community organizations that have a focus on justice, fairness, and empowerment, including those born from racial equity demonstrations unfolding concurrently in the United States, such as Black Lives Matter.^{1,3} To create a sustainable community engagement structure, we chose to convene the Community Steering Committee (CSC), with the goal of sharing resources and information, and providing evidence-based COVID-19 testing

options while giving residents a voice in shaping these initiatives. A summary of the CSC's principles and structure is outlined in [Box 1](#).

PLACE, TIME, AND PERSONS

In October 2020, we launched the CSC, which comprises more than 30 diverse organizations and residents in New York City (NYC). We relied on our existing, long-standing relationships with NYCHA and the NYC Department of Health and Mental Hygiene to identify community-based organizations (CBOs) providing services to residents in three neighborhoods, selected based on high concentrations of SARS-CoV-2 infection: Central Harlem, Lower East Side, and East New York. Once identified, we approached these organizations through common trusted collaborators. To determine the structure

BOX 1— Examples of Successful Practices to Create a Sustainable Community Engagement Structure

Principle	Description
Create a space of meaningful listening and co-learning	Limit the number of representatives from the academic research partner. Set agendas and make project decisions in partnership with CBOs, such as naming the CSC (i.e., NYCHA Resident COVID-19 Response initiative). Allot time for partners to provide updates about their work related to SARS-CoV-2 and share information, ideas, and communities' perspectives on the pandemic.
Establish trustworthiness and respect	Co-chairs of CSC are from the community, not an academic medical center. Communicate late-breaking information about the pandemic to community partners early and often. Address misinformation and disinformation by serving as scientific experts at virtual town halls, Facebook Live sessions, and other events organized by our partners.
Acknowledge inequities and justified mistrust	Engage in deep discussions during meetings, including history of medical mistrust and abuse in research and implications of our research protocols in the community.
Engage in bidirectional communication and transparency	Establish biweekly meetings with CBO partners, frequent e-mail communication, and community-partner mediations as needed. Report research updates, challenges and barriers to the study, grant funding announcements, new developments about SARS-CoV-2, and planned projects (e.g., RADx-UP phase 2).
Ensure transparency of information and data	Partner with the NYC Department of Health and Mental Hygiene for weekly data on COVID-19 testing and infection rates in NYCHA. Identify uptake of testing and infection rates in the NYC public housing population. Summarize and report data in plain language to the CSC and members of the CSC. Assist with forming recommendations to the municipal agency partners on where city mobile testing vans and pop-up clinics should be placed.

Note. CBO = community-based organization; CSC = Community Steering Committee; NYCHA = New York City Housing Authority; RADx-UP = Rapid Acceleration of Diagnostics-Underserved Populations; SARS-CoV-2 = severe acute respiratory syndrome coronavirus 2.

and function of the CSC, we held several one-on-one and small-group meetings between study investigators, potential CBO partners, NYCHA leadership, and residents living in NYC public housing. All members of the CSC were aged 18 years or older and received compensation to acknowledge their time and contribution to the project.

PURPOSE

Our motivation for this initiative was to expand and strengthen existing community partnerships, with the aim of addressing SARS-CoV-2 testing disparities.

EVALUATION AND ADVERSE EFFECTS

In April 2021 (six months into the partnership), we applied the validated Research Engagement Survey Tool (REST).⁴ The REST is a process measure

designed to understand how engagement occurred and is meant to be completed by partners and other stakeholders involved in the engagement activities. The tool consists of 32 items and assesses eight engagement principles, with two scales asking partners to rate the items on both quality and quantity. An anonymous link to the REST was circulated to all CSC voting members (n = 20) and yielded a 70% response rate.

Results indicated very high levels of satisfaction with the engagement process across all engagement principles (Table 1). For the quality scale items, the mean score was 4.3, indicating an overall score between “very good” and “excellent.” The quantity scale items also yielded a mean score of 4.3, indicating an overall score between “often” and “always.” Using these results, we coordinated a discussion led by author M. G., who is not directly involved in the engagement activities, involving members

of the CSC to ensure that partners felt their needs and the needs of their community were being met in the partnership.

Our sample consists only of a small number of partners and, thus, their observations may not be representative of other academic partnerships. In addition, we conducted our evaluation at six months and cannot address the sustainability of participation and maintaining trust among partners over the course of the study.

SUSTAINABILITY

The CSC has convened for nearly two years (all virtually) with a relatively high rate of participation, and members were prepared to continue to meet after funding concluded. Over the duration, we learned our community partners have a strong interest in addressing social determinants of health including food insecurity, access to care, and

TABLE 1— Community Steering Committee Research Engagement Survey Tool Results: New York City, April 2021

Engagement Principles and Scale	No.	Likert Response, ^a %					Mean Score (95% CI)
		1	2	3	4	5	
Focus on community perspectives and determinants of health							
Quality	14	1.8	5.4	16.1	25.0	51.8	4.2 (3.7, 4.7)
Quantity	12	0.0	0.0	6.3	50.0	43.8	4.4 (4.1, 4.6)
Partner input							
Quality	14	0.0	1.8	17.9	21.4	58.9	4.4 (3.9, 4.8)
Quantity	12	0.0	0.0	17.0	38.3	44.7	4.3 (3.9, 4.7)
Partnership sustainability to meet goals and objectives							
Quality	14	1.4	7.1	12.9	27.1	48.6	4.2 (3.7, 4.8)
Quantity	12	1.7	1.7	23.3	25.0	45.0	4.2 (3.7, 4.7)
Colearning, capacity building, and cobenefit for all partners							
Quality	13	1.9	1.9	13.5	28.8	53.8	4.3 (3.8, 4.8)
Quantity	11	0.0	4.5	9.1	29.5	56.8	4.4 (3.9, 4.9)
Building on strengths and resources within the community or patient population							
Quality	13	0.0	5.1	15.4	20.5	59.0	4.3 (3.8, 4.8)
Quantity	11	0.0	0.0	21.2	12.1	66.7	4.5 (3.9, 5.0)
Facilitating collaborative, equitable partnerships							
Quality	12	0.0	4.3	0.0	38.3	55.3	4.5 (4.2, 4.8)
Quantity	10	0.0	0.0	7.7	38.5	51.3	4.6 (4.1, 4.9)
Involving all partners in the dissemination process							
Quality	12	0.0	0.0	2.8	47.2	44.4	4.5 (4.2, 4.8)
Quantity	10	0.0	0.0	10.0	40.0	46.7	4.4 (4.0, 4.9)
Building and maintaining trust in the partnership							
Quality	12	0.0	0.0	1.7	33.3	65.0	4.6 (4.3, 4.9)
Quantity	10	0.0	0.0	8.0	42.0	50.0	4.4 (4.0, 4.8)
Overall							
Quality	13	0.7	3.4	10.3	29.6	54.8	4.3 (3.9, 4.8)
Quantity	11	0.3	0.9	13.1	34.8	49.9	4.3 (4.0, 4.7)

Note. CI = confidence interval.

^aFor Likert responses, the scores indicate the following: quality: (1) poor, (2) fair, (3) good, (4) very good, (5) excellent; quantity: (1) never, (2) rarely, (3) sometimes, (4) often, (5) always.

transportation. SARS-CoV-2–related programs, including for those who experience long-term symptoms of COVID-19, may benefit from engagement with community partners. We hope to continue programs that address social determinants of health in subsequent phases of our study. The REST results and subsequent discussion, which was aimed specifically at sustainability and emphasizing community needs and perspectives, have informed conversations with the

CSC about how to continue and expand the project beyond its current scope. The CSC agreed that there is an important opportunity to leverage existing resources and identify gaps. For example, the project may benefit from including local government officials to pool resources and funding that are aligned with the goals of the CSC.

We connected CBO partners with funding opportunities including the National Institutes of Health Community

Engagement Alliance Against COVID-19.⁵ The collaboration has also led to partners applying for other federal and nonfederal funding opportunities, for which investigators provided letters of support and other technical assistance with grant applications, which, in turn, sustain their own engagement work. Flexibility of funding has been key for partners in addressing vaccine uptake, as many have successfully shifted and expanded their

work to include education and outreach about the vaccine. We quickly co-organized a town hall meeting around vaccine safety and access that was available to our partners and community health workers and moderated by public health officials and a vaccine trial scientist. We received more than 600 registrants, illustrating the timeliness of the topic and the need for information. We continue to provide guidance on messaging and disseminate information for communities to use in communicating with residents. CSC members reported feeling satisfied and understood the need to maintain momentum and engagement, including in low- or no-funding contexts.

PUBLIC HEALTH SIGNIFICANCE

Although the RADx-UP initiative was not intended to introduce new partnerships, we illustrate how bringing together multiple longstanding and new partners in a rapid timeframe can lead to meaningful collaboration. Though the science of engagement is still evolving,⁶ researchers agree on a few key best practices for establishing trustworthiness, involvement of local leaders and other partners, and consistent and ongoing communication.⁷ Most best practices focus on in-person engagement activities, and very few are implemented during a public health crisis. Though community-academic partnerships have convened during or immediately following other public health crises,⁸ the COVID-19 pandemic is different. The current pandemic covers multiple communities simultaneously with limited protocols in place. As such, this pandemic has tested engagement strategies and required “out-of-the-box” thinking. Though others have described

engagement with online platforms, those studies have focused on prioritizing health conditions.⁹

By critically reflecting on partnership engagement and insights on how to implement engagement, specifically in the context of fast-moving funding opportunities to address COVID-19 health inequities among low-income populations, we have contributed to advancing the important work of engaging community partners and focusing on inequities within underserved populations. *AJPH*

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CONTRIBUTORS

N. J. Williams contributed to conceptualization, methodology, investigation, writing the original draft, reviewing and editing the article, supervision, project administration, and funding acquisition. E. Gill contributed to formal analysis, investigation, writing the original draft, reviewing and editing the article, and project administration. M. Punter and J. Reiss contributed to supervision, reviewing and editing the article, and project administration. M. Goodman contributed to conceptualization,

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HUMAN PARTICIPANT PROTECTION

The survey referenced in our article was anonymous and distributed for quality improvement purposes and is exempt from institutional review board approval.

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