**The Role of SHIELD Test Centers in Reducing COVID-19 ICU Admissions in Disadvantaged Communities**

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**Abstract**

**Background**

The COVID-19 pandemic, particularly with variants Alpha, Delta, and Omicron, presented major challenges in managing severe cases. Disadvantaged communities were disproportionately affected, especially during the Delta and Omicron waves. SHIELD Illinois, a statewide saliva-based testing program, aimed to increase testing access, but its impact on COVID-19 outcomes in these communities remains unclear. This study investigates the impact of SHIELD test centers on the rate of COVID-19 admissions to intensive care units (ICUs) in the communities they serve, with a particular focus on the socioeconomic factors of these communities in the greater Chicago area.

**Method**

We conducted a secondary analysis using data from the Electronic Health Record (EHR) system of a large quaternary care medical center in a western Chicago suburb and the SHIELD Illinois Testing Program. The study covers the Alpha (March–June 2021), Delta (August–November 2021), and Omicron (December 2021–March 2022) waves. A linear mixed-effects regression model, along with robustness checks, was used to assess the relationship between SHIELD test center availability and ICU admissions, adjusting for SHIELD center density and area deprivation index scores.

**Result**

Increasing SHIELD centers during Omicron was associated with a reduction in ICU admissions. A lag analysis further confirmed that enhanced SHIELD center effectiveness led to lower ICU admission rates, with an even more pronounced reduction in disadvantaged communities.

**Conclusion**

These findings highlighted the importance of strategically deploying SHIELD test centers to reduce severe outcomes and ensure equitable healthcare responses in future pandemics.

**Keywords**

SHILED Illinois; COVID-19 ICU admission; Socioeconomic disparities; Linear mixed-effect model; Pandemic response strategies

**Background**

The World Health Organization declared COVID-19 a pandemic on March 11, 2020, resulting in over 7 million deaths globally (1–3). COVID-19 symptoms range from mild to critical, with ICU admission rates varying widely, from 5% to 32% globally (4–6). Among ICU patients, 99% require respiratory support, and 26% do not survive (7,8). These statistics highlight the importance of understanding ICU admission drivers and examining the role of interventions, such as testing programs, in mitigating severe outcomes. Such efforts must account for the dynamic nature of the pandemic, as variants like Alpha, Delta, and Omicron have demonstrated varied impacts on ICU outcomes. The Alpha variant increased ICU rates by 2.72%, while Delta caused surges in ICU admissions and deaths, especially among the unvaccinated, who were five times more likely to be hospitalized and seven times more likely to die in areas like Chicago (9) (10). Omicron, though more transmissible, led to milder disease, shorter hospital stays, and fewer ICU admissions, particularly among vaccinated individuals (11–19).

The COVID-19 pandemic disproportionately impacted disadvantaged communities, with higher COVID-19 prevalence and deaths driven by systemic inequities such as poverty, limited healthcare access, segregation, and occupational risks (20–26). Studies show a strong link between COVID-19 outcomes and the area deprivation index (ADI), a measure of social disadvantage (27–30). The National Institutes of Health emphasizes the importance of testing in vulnerable populations and high-ADI communities to enable early detection and curb the virus's spread in these disproportionately affected areas (31). Targeted testing programs are essential for reducing adverse health outcomes in such populations.

One example is the University of Illinois System’s SHIELD Illinois testing program, which provides innovative saliva-based COVID-19 tests to K-12 schools, colleges, universities, businesses, and community centers across Illinois (32). Initially, SHIELD focused on preserving lives by allowing businesses to stay open. As it expanded into schools, the program shifted towards ensuring students could remain in the classroom by maximizing access to testing and the number of students tested. A standout feature of the SHIELD program is its ability to provide schools with adequate test kits (33). While the program has successfully increased testing rates across Illinois, its effectiveness in improving COVID-19 outcomes in disadvantaged communities remains unclear. The program has amassed extensive data on testing, encompassing the number and types of tests conducted, test results, and demographic information of those tested. This presents a unique opportunity to gain a comprehensive understanding of SHIELD Illinois's impact on the health of disadvantaged communities in Chicago, especially when combined with data from the Chicago Department of Public Health and Electronic Health Record (EHR).

Recent studies have assessed the effectiveness of SHIELD Illinois in managing COVID-19, but its specific impact on ICU admissions, particularly in socioeconomically disadvantaged areas, remains underexplored. This study aims to address this gap by investigating the relationship between SHIELD test center availability and COVID-19 ICU admission rates, with a focus on the moderating role of socioeconomic factors. Additionally, we evaluate the effect of SHIELD test centers in reducing ICU admissions across different COVID-19 waves, particularly in disadvantaged communities. This study highlights the benefits of expanding test center access to reduce severe COVID-19 cases and underscores the importance of ensuring equitable resource distribution in future pandemics.

**Methods**

**Study Design and Population**

This cohort study was a secondary analysis using deidentified data from the EHR data of ICU patients at Loyola University Medical Center, and the SHIELD Illinois Testing Program. The Loyola University Chicago Institutional Review Board (IRB) approved the study.

Loyola University Medical Center (LUMC) is a regional academic health system and a nationally ranked quaternary care facility with 547 licensed beds, located in Chicago’s western suburbs (34,35). LUMC’s extensive catchment area and the high number of ICU admissions make it an ideal representative for examining the effectiveness of SHIELD testing and its correlation with COVID-19 ICU outcomes.

We used datasets from the ICU at LUMC and the SHIELD testing data covering January 2020 to December 2023. To ensure a relevant and accurate analysis of COVID-19 ICU outcomes, a filtration process was applied to the original ICU dataset. This filtration was necessary to focus on the zip codes most affected by ICU admissions, thereby improving the reliability of the analysis. The dataset includes 29,779 patient visits from 585 zip codes across Illinois, providing a robust sample for analysis. The initial dataset was refined by selecting the top 25% of zip codes with the highest frequency of patients served by LUMC. Figure 1 illustrates the data filtration process used to refine the ICU dataset, focusing on COVID-19 ICU admission rates. This reduction to 147 zip codes, depicted in Figure 2, allowed for a more targeted examination of the areas that experienced the greatest impact from ICU admissions during the pandemic. Selecting the top 25% helps to reduce noise in the dataset by excluding zip codes with lower patient volumes at LUMC, where the data might be less representative of broader trends. This strategic selection allowed us to focus on the areas that were most significantly affected by ICU admissions at LUMC, thereby enhancing the robustness and reliability of our analysis of COVID-19 ICU admission rates. The next step involved refining the dataset to focus exclusively on patients treated for COVID-19, achieved by filtering out non-COVID-19 cases using the appropriate ICD-10 codes for COVID-19 diagnoses (see Appendix 1), standardized codes used to identify and classify COVID-19 cases. The final dataset included only COVID-19 patients from the 147 selected zip codes, spanning the same 2020-2023 timeframe. This refined dataset was then used for further analysis in the study.

A flowchart of a patient

Description automatically generated

**Figure 1**: Data Exclusion Diagram

A map with different colored areas

Description automatically generated

**Figure 2:** Distribution of 147 zip codes with COVID-19 patients frequently served by LUMC

**Independent variables**

Area deprivation index (ADI) is an index that uses publicly available data to assess factors such as income, education, employment, and housing quality. ADI ranks neighborhoods by comparing their socioeconomic conditions to state and national averages, with higher rankings indicating greater disadvantage (36). This tool helps identify neighborhoods facing significant socioeconomic challenges, making them potential priorities for future investment and support initiatives (37,38). We consider low disadvantaged zip codes to be scores 1 through 4 and high disadvantaged zip codes to be scores 5 through 9 based on socioeconomic factors (37).

**Number of SHIELD test centers**

The effective number of SHIELD test centers defined as the proportion of a test center’s service to a given area. To calculate the effective number of SHIELD test centers each month, we determined the proportion of samples from each center and aggregated these proportions to find the effective number of SHIELD test centers per zip code (see Appendix 2). Furthermore, we use the COVID-19 ICU admission rate as the dependent variable in this study, calculated as the number of ICU admissions per zip code per month, normalized by the population of each zip code, and multiplied by 1,000 for scaling. This measure allows us to standardize the ICU admission data across zip codes of varying population sizes (see Appendix 3). Table 1 provides a brief description of each variable included in the dataset.

**Table 1:** Variable description

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Variable | Type | Class | Description | Mean | SD |
| COVID-19 ICU admission rate | Dependent | Continuous | The rate of ICU admission for COVID-19 per zip code, adjusted for population size. It is calculated by dividing the total COVID-19 ICU admissions by the zip code’s population and multiplying by 1000 to standardize the rate per 100,000 people. | 0.044 | 0.091 |
| Zip code | Independent | Categorical | 147 unique zip codes across Illinois, where LUMC frequently treated COVID-19 patients |  |  |
| Total COVID-19 ICU admission per zip code per month | Independent | Continuous | Total number of COVID-19 ICU admissions recorded each month for each zip code | 1.152 | 1.961 |
| Zip code population | Independent | Continuous | The population of each zip code | 35,432.58 | 20,722.64 |
| Effective number of SHIELD test centers | Independent | Continuous | the proportion of a zip code served by a test center | 1.59 | 2.676 |
| State ADI | Independent | Categorical | The ADI score for each zip code | - | - |
| *NOTE:* Several control variables were considered to account for factors that may also influence COVID-19 ICU admission rates. These include population density, gender distribution, age distribution, racial and ethnic composition, pre-existing health conditions (such as diabetes and heart disease), insurance status, and marital status across different zip codes. | | | | | |

**Statistical Analyses**

Three linear mixed-effects regression (LMER) models were employed to investigate the association between the effective number of SHIELD test centers and the COVID-19 ICU admission rate. We focused on data from March 2021 to June 2021 for the Alpha wave, August 2021 to November 2021 for the Delta wave (40), and December 2021 to March 2022 for the Omicron wave (2). The Beta and Gamma COVID-19 waves are not considered because of the small number of patients involved (41). The models include fixed effects such as the effective number of SHIELD centers per zip code per month and the ADI category. We incorporate a zip code-level random intercept for the monthly COVID-19 ICU admission rate clustering. The details of the models are as follows:

* Model 1 evaluates the direct effect of the effective number of SHIELD centers on ICU admission rates without considering any additional covariates or interaction terms.
* Model 2 introduces the ADI variable to examine how socioeconomic deprivation influences ICU outcomes, allowing for a deeper understanding of disparities across zip codes.
* Model 3 builds on the previous models by incorporating an interaction term between the effective number of SHIELD centers and ADI.This interaction term helps identify whether the presence of SHIELD centers has a differential impact in highly disadvantaged areas compared to low disadvantaged ones.

Additionally, we conducted robust checks using lag analysis to assess the impact of SHIELD testing on the COVID-19 ICU admission rate across different waves. We examined the effects with two-month lags to determine whether the timing of testing influenced subsequent COVID-19 ICU admissions (42). All models utilized Poisson regression. Exponentiated Betas coefficients estimated the increase or decrease in incidence rate ratio (IRR) for ICU admission. All analyses were conducted using R statistical software version 2024.04.1, and the data analysis period spanned from March 1, 2024, to August 9, 2024. Two-sided p-values <0.1 were considered statistically significant. Additionally, assistance from ChatGPT, a large language model developed by OpenAI, is used for language editing and clarity improvements. The authors have reviewed and approved all final content to ensure accuracy and integrity.

**Results**

The preliminary analysis provides insight into how the COVID-19 ICU admissions rate and the effective number of test centers have evolved during the different COVID-19 waves. We examined the overall trends in the COVID-19 ICU admission rate and the availability of SHIELD test centers across all zip codes over the study period. Figure 3 illustrates the relationship between the effective number of SHIELD test centers and COVID-19 ICU admission rates, both averaged over time per month, across various zip codes categorized by their ADI levels. The data shows that during the peaks of the pandemic, particularly during the Delta and Omicron waves, the number of SHIELD test centers was greater in low-disadvantaged areas while ICU rates were lower compared to highly-disadvantaged areas. . Despite the rise in test centers, COVID-19 ICU admission rates remained notably higher in high disadvantaged zip codes, especially during these waves. This suggests that, even with increased access to testing, socioeconomically disadvantaged areas faced a disproportionately heavier burden of severe COVID-19 cases, underscoring the persistent health disparities in these communities during the pandemic.

**Omicron Wave**

**Delta Wave**

**Alpha Wave**

**Figure 3:** Trends in COVID-19 ICU admission rates and effective number of SHIELD test centers across zip codes over time

**Linear Mixed-Effect Regression Model**

Table 2 summarizes regression models examining the relationship between the effective number of SHIELD test centers and COVID-19 ICU admission rates during the Alpha, Delta, and Omicron waves. While none of the models indicate a significant impact of SHIELD test centers in disadvantaged areas during the Alpha wave, Model 2 during the Delta wave shows a positive and statistically significant effect () for areas with a higher ADI, which indicate 2% () increase in incidence rate ratio (IRR) for high ADIs compared to low ones. This suggests that these zip codes experienced higher COVID-19 ICU admission rates, reflecting a socioeconomic disparity in the burden of severe COVID-19 cases. For the Omicron wave, Model 2 shows a positive and statistically significant impact of ADI ( ,). Just like Delta wave, this indicates 2% () increase in IRR, further supporting the conclusion that highly disadvantaged zip codes experienced higher COVID-19 ICU admission rates compared to less disadvantaged areas.

**Table 2**: Impact of SHIELD test centers and ADI on COVID-19 ICU admission rates

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Dependent Variable: COVID-19 ICU Admission Rate | | | | | | | | |
| Independent Variable | Model 1  (Alpha) | Model 1  (Delta) | Model 1  (Omicron) | Model 2  (Alpha) | Model 2  (Delta) | Model 2  (Omicron) | Model 3  (Alpha) | Model 3  (Delta) | Model 3  (Omicron) |
| Effective Number of SHIELD Centers | -0.00542 (0.00542) | 0.00004 (0.00088) | -0.00249 (0.00165) |  |  |  | -0.00853  (0.00957) | 0.00086  (0.00104) | 0.00030  (0.00217) |
| ADI (High Disadvantaged) |  |  |  | 0.00873 (0.00839) | 0.01609**\*** (0.00935) | 0.02076**\*** (0.01259) | 0.00833  (0.00883) | 0.02103\*\*  (0.01012) | 0.03842\*\*  (0.01652) |
| Effective Number of SHIELD Centers for high ADI |  |  |  |  |  |  | 0.00408 (0.01162) | -0.00247 (0.00199) | -0.00594\* (0.00331) |
| Number of observations | 573 | 588 | 588 | 573 | 588 | 588 | 573 | 588 | 588 |
| Mean of the dependent variable in the control group | 0.03 | 0.04 | 0.04 | 0.03 | 0.04 | 0.04 | 0.03 | 0.04 | 0.04 |
| Conditional R squared | 0.59 | 0.60 | 0.76 | 0.59 | 0.60 | 0.76 | 0.60 | 0.59 | 0.76 |
| Intraclass Correlation Coefficient (ICC) | 0.60 | 0.60 | 0.76 | 0.60 | 0.60 | 0.76 | 0.60 | 0.59 | 0.76 |
| *NOTE*: The LMER model included fixed effects such as the effective number of SHIELD centers per zip code per month and the ADI category. The model included a random effect for zip code. The unit of observation is the number of zip codes that have patients in LUMC ICU. Regression coefficients are shown with robust standard errors in parentheses. \*\*\*p<0.01, \*\*p<0.05, \*p<0.1 | | | | | | | | | |

**Lag Analysis**

Table 3 displays a regression analysis investigating the influence of SHIELD test centers and ADI on COVID-19 ICU admission rates with a two-month delay. While none of the models indicate a significant impact of SHIELD test centers in disadvantaged areas during the Alpha wave, in the Delta wave, Model 1 presents a negative and statistically significant estimate (, *p* < 0.1), which indicate 0.2% () decrease in incidence rate ratio (IRR) for high ADIs compared to low ones. indicating a considerable reduction in the COVID-19 ICU admission rate two months after an increase in the effective number of SHIELD test centers.

Also, model 2 shows a positive and statistically significant estimate (, *p* < 0.1) for the high disadvantaged zip codes, suggesting that these areas experienced significantly higher COVID-19 ICU admission rates two months after testing. In the Omicron wave, Model 2 shows a positive and statistically significant estimate (, *p* < 0.1) for the high disadvantaged zip codes. This suggests that these experienced significantly higher COVID-19 ICU admission rates two months after testing. Also, Model 3 presents a negative estimate (, *p* < 0.1) for the interaction between the effective number of SHIELD test centers and high disadvantaged zip codes. As a result, during the Omicron wave, adding one SHIELD test center is estimated to lower the COVID-19 ICU admission rate in highly disadvantaged zip codes from 0.063 to 0.056 per 1,000 population. For all models in the analysis, multicollinearity is assessed using the Variance Inflation Factor (VIF), with all VIF values remaining below 4. This indicates that multicollinearity is not a concern in the models, ensuring reliable coefficient estimates.

**Table 3**: Impact of SHIELD test centers and ADI on COVID-19 ICU admission rates (two-month lag)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Dependent Variable: COVID-19 ICU Admission Rate | | | | | | | | |
| Independent Variable | Model 1  (Alpha) | Model 1  (Delta) | Model 1  (Omicron) | Model 2  (Alpha) | Model 2  (Delta) | Model 2  (Omicron) | Model 3  (Alpha) | Model 3  (Delta) | Model 3  (Omicron) |
| Effective Number of SHIELD Centers | -0.00154 (0.00314) | -0.00199**\*** (0.00114) | -0.00236 (0.00158) |  |  |  | 0.00049  (0.00366) | -0.00034  (0.00154) | 0.00038  (0.00199) |
| ADI (High Disadvantaged) |  |  |  | 0.00885 (0.00840) | 0.01609**\*** (0.00935) | 0.02076**\*** (0.01259) | 0.01204  (0.00885) | 0.02384\*\*  (0.01178) | 0.04066\*\*  (0.01604) |
| Effective Number of SHIELD Centers\*ADI (High Disadvantaged) |  |  |  |  |  |  | -0.00806 (0.00713) | -0.00313 (0.00230) | -0.00678\*\* (0.00323) |
| Number of observations | 570 | 588 | 588 | 570 | 588 | 588 | 570 | 588 | 588 |
| Mean of the dependent variable in the control group | 0.03 | 0.04 | 0.04 | 0.03 | 0.04 | 0.04 | 0.03 | 0.04 | 0.04 |
| Conditional R squared | 0.59 | 0.59 | 0.76 | 0.59 | 0.60 | 0.76 | 0.59 | 0.59 | 0.77 |
| Intraclass Correlation Coefficient (ICC) | 0.59 | 0.59 | 0.76 | 0.59 | 0.60 | 0.76 | 0.60 | 0.59 | 0.76 |
| *NOTE*: The LMER model included fixed effects such as the effective number of SHIELD centers per zip code per month and the ADI category. The model included a random effect for zip code. The unit of observation is the number of zip codes that have patients in LUMC ICU. Regression coefficients are shown with robust standard errors in parentheses. \*\*\*p<0.01, \*\*p<0.05, \*p<0.1 | | | | | | | | | |

Finally, the root mean square error (RMSE) between the average number of SHIELD test centers and the average effective number across all zip codes over time was 0.94, indicating a close alignment between these two metrics (see Appendix 4). While some variation exists, this small RMSE suggests that, in general, the centers were effective in serving their communities.

**Discussion**

Our study evaluated how SHIELD testing influences the severity of outcomes, particularly ICU admissions, with a focus on disadvantaged communities. This study demonstrates that the impact of the SHIELD testing program was not solely dependent on the number of testing centers but on their strategic deployment in reducing COVID-19 ICU admissions, particularly in socioeconomically disadvantaged areas. Our findings suggest that higher disadvantaged areas consistently experienced higher ICU admission rates despite an increase in test centers, emphasizing the importance of targeted resource allocation.

Other studies have leveraged SHIELD data to assess its role in managing COVID-19, focusing on optimizing resource allocation, reducing transmission rates, and improving testing outcomes in educational settings (43–45).

To provide a more accurate understanding of the program’s impact, this study highlights the importance of the effective number of SHIELD test centers, which is defined as the proportion of a test center’s service to a given area. While test centers are located in facilities such as schools within specific zip codes, many students attend schools outside their residential areas. Since students represent their home communities, considering the effective number of centers better reflects the broader reach of testing across adjacent regions.

Our analysis indicates that as the overall number of SHIELD test centers increased during major pandemic waves, the proportion of centers effectively serving their respective zip codes was associated with reduced COVID-19 ICU admission rates. The LMER models’ results demonstrate the evolving relationships between SHIELD test centers and ICU admission throughout the pandemic. During the Alpha wave, the presence of test centers showed limited association with ICU admissions, likely to reflect early-stage testing efforts that were not yet fully optimized or widespread. By the Delta and Omicron waves, the data indicate stronger associations between the effective use of test centers and reduced ICU admissions, particularly in disadvantaged areas (higher ADI scores). The positive association observed during the Delta and Omicron waves indicates that socioeconomically disadvantaged zip codes experienced disproportionately higher ICU admission rates, highlighting ongoing disparities in the pandemic’s burden. Notably, the reduction in ICU admissions during the Omicron wave, correlated with an increase in the effective number of SHIELD test centers, suggests that improved access and utilization of these centers may have contributed to mitigating severe outcomes. This finding underscores the importance of not just the availability of test centers but also their active utilization and accessibility in reducing COVID-19’s most severe effects, particularly in vulnerable populations.

The lag analysis further illustrates the evolving relationship between SHIELD test centers and COVID-19 ICU admissions, especially when considering a two-month delay. During the Alpha wave, the presence of SHIELD test centers showed limited association with ICU admissions in disadvantaged areas, likely reflecting early-stage testing infrastructure that was not yet fully optimized. By the Delta wave, however, an increase in the effective number of SHIELD test centers was associated with a significant reduction in ICU admissions two months later. This delayed association suggests that expanded testing efforts may have played a role in alleviating severe outcomes over time. Specifically, a higher number of effective SHIELD test centers corresponded with a reduced burden on healthcare systems during the Delta wave, emphasizing the importance of sustained and targeted testing initiatives.

Despite these improvements, disadvantaged zip codes continued to face disproportionately higher ICU admission rates, as reflected in the positive association found during both the Delta and Omicron waves. This highlights the persistent challenges faced by these communities, where broader socioeconomic barriers may have limited the immediate benefits of increased testing. Nonetheless, the reduction in ICU admissions associated with an increase in the effective number of SHIELD test centers during the Omicron wave, particularly in high-ADI areas, suggests that targeted testing interventions can make a substantial difference over time. These findings demonstrate that by strategically increasing testing in disadvantaged communities, significant reductions in severe outcomes can be achieved, even with a delayed effect.

The main limitation of this study is that it relies on ICU data from a single hospital, which may affect the generalizability of the findings. However, the hospital serves a racially, economically, and linguistically diverse population, reflecting the demographics of its surrounding area, Cook County (Appendix 5). This includes a significant proportion of individuals from underrepresented groups and economically disadvantaged backgrounds, providing valuable insights into the impact of SHIELD test centers on diverse communities. Despite this, future studies should incorporate data from multiple hospitals to capture a broader and more representative perspective.

The SHIELD Illinois program was conducted solely within Illinois, primarily near urban areas, without consideration of data from other states or more rural regions. This restricts the ability to evaluate SHIELD's effectiveness in different geographic contexts. Future research should assess similar programs across multiple states to provide more generalizable findings. Furthermore, key factors such as comorbidities, vaccination status, and early treatment interventions were not accounted for in this study, which may influence ICU outcomes. Including these variables in future research would offer a more comprehensive understanding. Lastly, the voluntary nature of SHIELD participation may have introduced selection bias, as wealthier districts were more likely to adopt the program early. Addressing these limitations will provide a clearer assessment of SHIELD's overall impact and help guide equitable resource allocation in future pandemic responses.

**Conclusion**

This study demonstrates that the impact of the SHIELD testing program was not solely dependent on the number of testing centers but on their effectiveness in reducing COVID-19 ICU admissions, particularly in socioeconomically disadvantaged areas. Our findings suggest that higher disadvantaged areas consistently experienced higher ICU admission rates despite an increase in test centers, emphasizing the importance of targeted resource allocation. The strategic placement and utilization of SHIELD centers in these communities were crucial for mitigating severe health outcomes. Future public health strategies should prioritize not only the expansion of testing facilities but also their optimal placement and operation in vulnerable areas to maximize their effectiveness in reducing severe outcomes during pandemics. Further research will focus on refining the placement of testing centers to improve both coverage and equity in disadvantaged regions.

**Abbreviations**

***ICU:*** Intensive Care Unit

***ADI:*** Area Deprivation Index

***EHR:*** Electronic Health Record

***IRB:*** Institutional Review Board

***LUMC:*** Loyola University Medical Center

***LMER:*** Linear Mixed-Effects Regression

***IRR:*** Incidence Rate Ratio

***VIF:*** Variance Inflation Factor

**References**

1. Cucinotta D, Vanelli M. WHO Declares COVID-19 a Pandemic. Acta Bio Medica: Atenei Parmensis [Internet]. 2020 [cited 2024 Oct 3];91(1):157. Available from: /pmc/articles/PMC7569573/

2. CDC Museum COVID-19 Timeline | David J. Sencer CDC Museum | CDC [Internet]. [cited 2024 Oct 3]. Available from: https://www.cdc.gov/museum/timeline/covid19.html

3. COVID - Coronavirus Statistics - Worldometer [Internet]. [cited 2024 Oct 3]. Available from: https://www.worldometers.info/coronavirus/

4. Abdulfattah O, Kohli A, White P, Michael C, Alnafoosi Z. Impact of the COVID-19 Pandemic on Hospital Admission Rate, Length of Stay, and Mortality Rate for Patients with Chronic Obstructive Pulmonary Disease Exacerbation: A Retrospective Study. Journal of Community Hospital Internal Medicine Perspectives. 2024;14(2):1.

5. Halacli B, Kaya A, İSKİT AT. Critically ill COVID-19 patient. Turkish Journal of Medical Sciences. 2020;50(9):585–91.

6. Coronavirus (COVID-19) Hospitalizations - Our World in Data [Internet]. [cited 2024 Nov 16]. Available from: https://ourworldindata.org/covid-hospitalizations

7. Kim L, Garg S, O’Halloran A, Whitaker M, Pham H, Anderson EJ, et al. Risk factors for intensive care unit admission and in-hospital mortality among hospitalized adults identified through the US coronavirus disease 2019 (COVID-19)-associated hospitalization surveillance network (COVID-NET). Clinical Infectious Diseases. 2021;72(9): e206–14.

8. Grasselli G, Zangrillo A, Zanella A, Antonelli M, Cabrini L, Castelli A, et al. Baseline Characteristics and Outcomes of 1591 Patients Infected With SARS-CoV-2 Admitted to ICUs of the Lombardy Region, Italy. 2020.

9. Twohig KA, Nyberg T, Zaidi A, Thelwall S, Sinnathamby MA, Aliabadi S, et al. Hospital admission and emergency care attendance risk for SARS-CoV-2 delta (B. 1.617. 2) compared with alpha (B. 1.1. 7) Variants of concern: a cohort study. The Lancet Infectious Diseases. 2022;22(1):35–42.

10. City of Chicago [Internet]. [cited 2024 Nov 16]. Available from: https://www.chicago.gov/content/dam/city/sites/covid/breakthrough\_variant/10-06-2021/Breakthrough-Slides-10072021.pdf

11. Tabatabai M, Juarez PD, Matthews-Juarez P, Wilus DM, Ramesh A, Alcendor DJ, et al. An analysis of COVID-19 mortality during the dominancy of alpha, delta, and omicron in the USA. Journal of Primary Care & Community Health. 2023; 14:21501319231170164.

12. Paul P. Genomic surveillance for SARS-CoV-2 variants circulating in the United States, December 2020–May 2021. MMWR. Morbidity and Mortality Weekly Report. 2021;70.

13. Grint DJ, Wing K, Houlihan C, Gibbs HP, Evans SJW, Williamson E, et al. Severity of severe acute respiratory system coronavirus 2 (SARS-CoV-2) alpha variant (B. 1.1. 7) in England. Clinical Infectious Diseases. 2022;75(1): e1120–7.

14. Pascall DJ, Mollett G, Vink E, Shepherd JG, Williams T, Wastnedge E, et al. The SARS-CoV-2 Alpha variant caused increased clinical severity of disease in Scotland: a genomics-based prospective cohort analysis. MedRxiv. 2021;2021–8.

15. Lauring AS, Tenforde MW, Chappell JD, Gaglani M, Ginde AA, McNeal T, et al. Clinical severity of, and effectiveness of mRNA vaccines against, covid-19 from omicron, delta, and alpha SARS-CoV-2 variants in the United States: prospective observational study. BMJ. 2022;376.

16. Iuliano AD. Trends in disease severity and health care utilization during the early Omicron variant period compared with previous SARS-CoV-2 high transmission periods—United States, December 2020–January 2022. MMWR. Morbidity and Mortality Weekly Report. 2022;71.

17. Omicron, Delta, Alpha, and More: What to Know About the Coronavirus Variants > News > Yale Medicine [Internet]. [cited 2024 Oct 3]. Available from: https://www.yalemedicine.org/news/covid-19-variants-of-concern-omicron

18. Update on Omicron [Internet]. [cited 2024 Oct 3]. Available from: https://www.who.int/news/item/28-11-2021-update-on-omicron

19. Florensa D, Mateo J, Spaimoc R, Miret C, Godoy S, Solsona F, et al. Severity of COVID-19 cases in the months of predominance of the Alpha and Delta variants. Scientific Reports. 2022;12(1):15456.

20. Whittle RS, Diaz-Artiles A. An ecological study of socioeconomic predictors in detection of COVID-19 cases across neighborhoods in New York City. BMC Medicine. 2020; 18:1–17.

21. Chen JT, Krieger N. Revealing the unequal burden of COVID-19 by income, race/ethnicity, and household crowding: US county versus zip code analyses. Journal of Public Health Management and Practice. 2021;27(Supplement 1): S43–56.

22. KC M, Oral E, Straif-Bourgeois S, Rung AL, Peters ES. The effect of area deprivation on COVID-19 risk in Louisiana. PLoS One. 2020;15(12): e0243028.

23. Hatef E, Chang HY, Kitchen C, Weiner JP, Kharrazi H. Assessing the impact of neighborhood socioeconomic characteristics on COVID-19 prevalence across seven states in the United States. Front Public Health. 2020; 8:571808.

24. Yancy CW. COVID-19 and African Americans. JAMA. 2020;323(19):1891–2.

25. Laurencin CT, McClinton A. The COVID-19 pandemic: a call to action to identify and address racial and ethnic disparities. Journal of Racial and Ethnic Health Disparities. 2020; 7:398–402.

26. Tung EL, Peek ME, Rivas MA, Yang JP, Volerman A. Association of Neighborhood Disadvantage with Racial Disparities In COVID-19 Positivity in Chicago: Study examines the association of neighborhood disadvantage with racial disparities in COVID-19 positivity in Chicago. Health Affairs. 2021;40(11):1784–91.

27. Knighton AJ, Savitz L, Belnap T, Stephenson B, VanDerslice J. Introduction of an area deprivation index measuring patient socioeconomic status in an integrated health system: implications for population health. EGEMs. 2016;4(3).

28. Singh GK. Area deprivation and widening inequalities in US mortality, 1969–1998. American Journal of Public Health. 2003;93(7):1137–43.

29. Adjei-Fremah S, Lara N, Anwar A, Garcia DC, Hemaktiathar S, Ifebirinachi CB, et al. The effects of race/ethnicity, age, and area deprivation index (ADI) on COVID-19 disease early dynamics: Washington, DC case study. Journal of Racial and Ethnic health Disparities. 2023;10(2):491–500.

30. Harris R, Rosser M, Chowdhury AM, Ohnuma T, Raghunathan K, Haines KL, et al. Association of Area Deprivation Index with Mortality in Critically Ill Adults With COVID-19. American Journal of Critical Care. 2024;33(6):446–54.

31. Manabe YC, Sharfstein JS, Armstrong K. The need for more and better testing for COVID-19. JAMA. 2020;324(21):2153–4.

32. Why COVID-19 testing is the key to getting back to normal | National Institute on Aging [Internet]. [cited 2024 Oct 3]. Available from: https://www.nia.nih.gov/news/why-covid-19-testing-key-getting-back-normal

33. SHIELD - University of Illinois System [Internet]. [cited 2024 Oct 16]. Available from: https://www.uillinois.edu/shield

34. About Us | Loyola Medicine [Internet]. [cited 2024 Oct 16]. Available from: https://www.loyolamedicine.org/about-us

35. Loyola University Medical Center | Loyola Medicine [Internet]. [cited 2024 Oct 16]. Available from: https://www.loyolamedicine.org/location/loyola-university-medical-center-0

36. Vassilaki M, Aakre JA, Castillo A, Chamberlain AM, Wilson PM, Kremers WK, et al. Association of neighborhood socioeconomic disadvantage and cognitive impairment. Alzheimer’s & Dementia. 2023;19(3):761–70.

37. Hu J, Kind AJH, Nerenz D. Area deprivation index predicts readmission risk at an urban teaching hospital. American Journal of Medical Quality. 2018;33(5):493–501.

38. Area Deprivation Index [Internet]. [cited 2024 Oct 3]. Available from: https://www.nrpa.org/publications-research/data-and-mapping-resource-library/area-deprivation-index/

39. Singh GK, Lin CCC. Area deprivation and inequalities in health and health care outcomes. Annals of Internal Medicine. 2019;171(2):131–2.

40. Zeng S, Pelzer KM, Gibbons RD, Peek ME, Parker WF. Association of zip code vaccination rate with COVID-19 mortality in Chicago, Illinois. JAMA Network Open. 2022;5(5): e2214753–e2214753.

41. Hedberg P, Parczewski M, Serwin K, Marchetti G, Bai F, Jensen BEO, et al. In-hospital mortality during the wild-type, alpha, delta, and omicron SARS-CoV-2 waves: a multinational cohort study in the EuCARE project. The Lancet Regional Health–Europe. 2024;38.

42. Buchan SA, Chung H, Brown KA, Austin PC, Fell DB, Gubbay JB, et al. Estimated effectiveness of COVID-19 vaccines against Omicron or Delta symptomatic infection and severe outcomes. JAMA Network Open. 2022;5(9): e2232760–e2232760.

43. Saidani M, Kim H, Kim J. Designing optimal COVID-19 testing stations locally: A discrete event simulation model applied on a university campus. PLoS One. 2021;16(6): e0253869.

44. Holman EJ, Winfield CM, Borkowf CB, Kauerauf J, Baur C, Ahmed S, et al. Evaluation of Serial Testing After Exposure to COVID-19 in Early Care and Education Facilities, Illinois, March–May 2022. Public Health Reports. 2023;138(4):664–70.

45. Ivanov A, Mukherjee U, Bose S, Seshadri S, Watkins R, England III AC, et al. COVID-19 Test-to-Stay Program for K-12 Schools: Opt-In Versus Opt-Out Policies. Available at SSRN 4428747. 2023.

46. U.S. Census Bureau QuickFacts: Cook County, Illinois [Internet]. [cited 2024 Oct 16]. Available from: https://www.census.gov/quickfacts/fact/table/cookcountyillinois/POP010220

**Appendix 1: ICD-10 codes related to COVID-19**

Table A.1 shows a list of ICD-10 codes used to classify COVID-19-related conditions and diagnoses. Each code represents a specific health condition directly associated with COVID-19, ranging from exposure to the virus to post-COVID complications.

**Table A.1:** ICD-10 codes related to COVID-19

|  |  |
| --- | --- |
| COVID-19-relatedICD-10 code | Description |
| Z11.52 | Contact with and (suspected) exposure to COVID-19 |
| M35.81 | Multisystem Inflammatory Syndrome (MIS) |
| J12.82 | Pneumonia due to Coronavirus disease 2019 |
| U07.1 | COVID-19 |
| U09.9 | Post-COVID-19 condition, unspecified |
| B97.29 | Other Coronavirus as the cause of disease classified elsewhere |
| J20.8 | Acute bronchitis confirmed as due to COVID-19 |
| J22 | Lower or acute respiratory infection due to COVID-19 |
| J98.8 | Respiratory infection due to COVID-19 |
| J80 | Acute Respiratory Distress Syndrome (ARDS) due to COVID-19 |

**Appendix 2: Quantifying the Effective Coverage of SHIELD Test Centers**

In this model, represents the index for each SHIELD test center, corresponds to each zip code, and denotes time. The variable ​ is the number of COVID-19 samples collected from zip code by test center in time , while ​ represents the total number of samples collected from zip code by all test centers in in time . The proportion of samples collected by test center iii from zip code in time , denoted as ​. The effective number of SHIELD test centers serving zip code in time , denoted as , is then determined by summing these proportions across all test centers, capturing the distribution of service provided by the centers in relation to the zip code. This approach quantifies the contribution of multiple centers in testing coverage for each zip code.

**Appendix 3: Mathematical Calculation of COVID-19 ICU Admission Rate**

The total number of ICU admissions in zip code during time is represented by , and the population of zip code is denoted as ​. The COVID ICU admission rate for zip code during time , denoted as , is calculated as the ratio of the total ICU admissions to the population of the zip code. This rate captures the proportion of ICU admissions related to COVID-19 in a given zip code relative to its population, providing a standardized measure of the ICU burden on the local healthcare system. The formula is:

This formula calculates the number of ICU admissions per 1,000 people for a given zip code in time

**Appendix 4: Trends of SHIELD test centers and effective number of SHIELD centers over time**

Figure A.1 shows the trends of the number of SHIELD test center versus effective number of SHIELD test centers for all zip codes over time.

**Figure A.1:** Trends of SHIELD test centers and effective number of SHIELD centers over time for all zip codes

**Appendix 5: Comparison of LUMC ICU Cohort with Cook County and National Averages** (46).

Table A.2 compares demographic characteristics of the LUMC ICU cohort with Cook County and national averages, highlighting differences in race, gender, language, and socioeconomic factors.

**Table A.2:** Demographic Comparison of LUMC ICU, Cook County, and National Averages

|  |  |  |  |
| --- | --- | --- | --- |
| Characteristic | LUMC ICU Cohort | Cook County | National Average |
| Black/African American Patients (%) | 19 | 23.8 | 13.4 |
| Female Patients (%) | 43.3 | 51.4 | 50.8 |
| Non-English Speakers (%) | 35 | 35 | 21.5 |
| Hispanic Population (%) | - | 26.1 | 18.5 |
| Poverty Rate (%) | - | 13 | 11.4 |

**Declarations**

**Ethics approval and consent to participate**

Not Applicable

**Consent for publication**

The authors affirm that all participants involved in this study, or their legal guardians, have given their consent for the publication of any potentially identifying information contained within the manuscript. No personal or sensitive data (such as images, personal health information, or identifiable demographics) will be included that could compromise the privacy or anonymity of the participants. Where applicable, participants provided informed consent in accordance with ethical guidelines and institutional policies. Furthermore, this manuscript does not contain any individual-level data or other content requiring consent for publication.

**Availability of data and materials**

Not Applicable

**Competing interests**

The authors declare no competing interests.

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A.K. was responsible for design of the study, data analysis, and manuscript writing. A.W. contributed valuable insights into the results and analyses and assisted in reviewing and editing the manuscript. F.I. and M.S. played key roles in data preprocessing and graphic design. W.P., M.S., S.A., and S.T. conceptualized the study, reviewed the manuscript, provided critical feedback, and contributed to funding acquisition (PI: S.T.) Additionally, S.A. and S.T. contributed to manuscript editing and analysis insights.

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