2020

Actions for an Equity-Centered Response to COVID-19

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Guiding Principles ~ Data Collection ~ COVID-19 Testing ~ Access to Care and Treatment
Economic Resilience

The purpose of this document is to provide specific details on how equity can be the focus in the next phases of the response to COVID-19, including communication, testing, active surveillance and recovery and resilience.

Health Equity Definition

The Oregon Health Authority (OHA) has an established definition of health equity which should lead the work of the agency. This definition is particularly important during a time of crisis. It is during this time that we must be guided by the agency's definition of Health Equity. Oregon's health equity definition is:

> Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address:
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> - The equitable distribution or redistribution of resources and power; and
> - Recognizing, reconciling and rectifying historical and contemporary injustices.

Background

Roots of Inequity: Social Determinants of Health

People's health depends on much more than just their biology. The conditions in which people are born, grow, live, work and age have a profound effect on how healthy they can be. These conditions are known as the social determinants of health.

They are not typically within an individual's control, but are a product of policies and practices that create an unfair distribution of resources and opportunities. Those with limited access to these resources and opportunities are placed at a disadvantage; they

experience worse health outcomes and reduced lifespans. The legacy of racism is that people of color, due to historical and current unequal distribution of resources, experience overall worse health outcomes. This is true in times of relative calm, and it is further compounded during times of crisis.

Everyone is experiencing the impacts of COVID-19, but not all are experiencing this pandemic in the same way. Physical distancing with adequate space and resources is different than physical distancing in a densely populated neighborhood, in a food desert, or in industries where individuals are still required to put themselves at risk in order to support their families.

Communities of Color are Disproportionately Affected by COVID-19

Inequity Is Not New

The inequitable burden of disease and other negative health conditions on communities of color and indigenous and American Indian/Alaska Native communities are not new. COVID-19 has simply highlighted this inequity at a time when more people are paying attention to illness and health. The fact that it is being reported as "news" does not consider the experiences of people of color who live with this reality every day.

COVID-19 has compounded the ongoing burden of living in a racist society.

It is widely known that people with underlying medical conditions are at high risk of severe complications and potential death if exposed to COVID-19. Obesity is related to a variety of health issues, including diabetes and high blood pressure. Science has also shown immune cells do not function as well for people experiencing obesity.[1]

The CDC found that 33% of people who have been hospitalized with COVID-19 are African American, yet only 13% of the U.S. population is African American.[2] There are several factors that may make African Americans more vulnerable to COVID-19:

Racial discrimination: chronic stress and trauma caused by societal and institutional racism

[1] Milner, J., & Beck, M. (2012). The impact of obesity on the immune response to infection. *Proceedings of the Nutrition Society, 71*(2), 298-306. doi:10.1017/S0029665112000158,

[2] "COVID-19 in Racial and Ethnic Minority Groups." April 2020, Centers for Disease Control and Prevention (CDC). Retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html

- Chronic stress and discrimination are linked to higher levels of inflammation among black adults.[3] Chronic stress can lower a body's ability to fight infection.
- Black, Latino and American Indian/Alaska Native workers are more likely to hold jobs that cannot be done from home, making them more likely to be exposed to the virus.
- Racial discrimination in health care often leads to fewer medical procedures and lower quality care for people of color than whites.[4]

"People of color are disproportionately likely to be in low-paying or hourly-wage jobs that make them unable to provide care or interrupt work. They are also more likely to have limited access to affordable healthcare, childcare, and transportation. People of color are more likely to face unsanitary conditions inside prisons, jails, and detention centers. Funding disparities in communities of color have led to hospital closures; shortages of frontline doctors and nurses; higher incidences of chronic conditions, such as hypertension, diabetes, and heart disease; housing overcrowding; and lack of quality elder care." -**Race Forward**

Communications

The Americans with Disabilities Act (ADA) requirements must be met or exceeded during the COVID-19 response. This includes:

- **Ensuring that communication with people with disabilities is as effective as communication with people without disabilities and**
- **Providing reasonable modifications by adjusting policies, practices, and procedures, to ensure the provision of goods and services to people with disabilities.**

Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act require that OHA provides meaningful access to services to individuals who have limited English proficiency. OHA must make sure that when communicating health information in a clinical setting, Oregon certified and qualified interpreters across all platforms are being used to ensure meaningful communication is occurring. Moreover, OHA must continue to make information available across multiple social media platforms and print in at least the

[3] Thames, AD et al. "Corrigendum to "Experienced discrimination and racial differences in leukocyte gene expression." (2019 Sep 10). Psychoneuroendocrinology. Retrieved from: https://coronavirus.jhu.edu/data/us-state-data-availability

[4] Aubrey, Allison, "Who's Hit Hardest By COVID-19? Why Obesity, Stress and Race All Matter," NPR, 18 April 2020, https://www.npr.org/sections/health-shots/2020/04/18/835563340/whos-hit-hardest-by-covid-19-why-obesity-stress-and-race-all-matter.

top 11 languages, indigenous languages, ASL and provide accurate captioning for all events involving the public.

For all COVID-19 written materials, regardless of whether they are internal or external, the following statement must be included.

"You can get this document free of charge in other languages, large print, braille or a format you prefer. Contact Mavel Morales, Office of Equity and Inclusion at 1-844-882-7889, 711 TTY or OHA.ADAModifications@state.or.us."

For All COVID-19 meetings, including webinars, the following language must be on invitations:

"Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- **Written materials in other languages**
- **Braille**
- **Large print**
- **Audio and other formats**

If you need help or have questions, please contact: [Program Contact] at [phone number, 711 TTY] at least [amount of time, at least 48 hours] before the meeting.''

The contact person for these meetings/webinars should be whoever is responsible for setting up the meeting. If the contact person needs help in meeting the request please contact Mavel Morales, OHA Office of Equity and Inclusion at 1-844-882-7889, 711 TTY or **OHA.ADAModifications@state.or.us**

Data Collection

OHA has several highly trained data analysts who understand and can deploy strategies for REALD implementation for COVID-19.

Where OHA does not have demographic data for confirmed cases, OHA should develop a plan to follow-up and obtain these data. The plan should include:

- Providing training to local public health authorities on collection of REALD data during case interviews.

- Providing feedback on REALD data collection to prompt timely completion of demographic fields in case reports.

OHA may employ other methods for obtaining or estimating race/ethnicity case data when data are missing.

COVID-19 Testing

In order to ensure that communities with higher risks of exposure to COVID-19 and at risk for more severe complications have access to testing for COVID-19, OHA's testing guidance, updated April 30, 2020, specifically names the following groups:

People who identify as Black, African American, Latino, Latina, Latinx, Hispanic, American Indian/Alaska Native, or Asian/Pacific Islander; linguistically diverse populations; or those with a disability. Data indicate that these communities are at higher risk for COVID-19 and associated complications due to longstanding social and health inequities.

In addition to being prioritized for testing, communities of color and disability communities can learn more about how they are prioritized for COVID-19 testing through regular culturally and linguistically responsive communications.

Providers can also learn more about these new testing guidelines as they are implemented in a way that promotes care and does not stigmatize communities of color or people with disabilities.

COVID-19 testing sites must be chosen in accordance with ADA requirements to ensure access for people with disabilities.

Nontraditional testing sites, such as mobile vans, pop-up clinics or the use of point of care instruments in alternative settings, should be implemented to the extent possible to reach communities where they are.

Patients who test positive must be supported across disciplines; housing, food, and medical attention must be anticipated and resources must be provided in a clear, simple and trauma informed manner. See: Trauma Informed Oregon. **Services must be coordinated between nonprofit organizations and partner agencies, such as DHS.**

Case Investigation and Contact Tracing

As Oregon begins to reopen, the state must suppress the transmission of COVID-19 in Oregon communities and protect those at the highest risk of exposure for severe disease.

To accomplish this critical task, OHA, in cooperation with local and Tribal public health authorities and the healthcare system, must initiate active surveillance statewide. Active surveillance includes a combination of expanded testing, rapid identification and isolation of cases, identification of clusters of cases, and broad contact tracing and quarantine of those exposed.

To successfully implement active surveillance, Oregon must strengthen the existing public health infrastructure. OHA hopes this effort will ultimately allow Oregonians to return to their normal routines. With everyone's cooperation, the state can begin to restore services and lift physical distancing measures.

In order to accomplish this task, new staff will be needed to conduct the steps of active surveillance. This new public health workforce must reflect Oregon's diverse communities and include staff with lived experience as well as individuals with fluency in the top languages other than English spoken in Oregon. Staff that share the same background as individuals impacted by COVID-19 are better able to quickly build trust, leading to improved health outcomes and adherence to recommended isolation and quarantine measures.

Furthermore, rapid scale-up of a public health workforce can provide relief to communities disproportionately impacted by layoffs while building a culturally and linguistically responsive pipeline into Oregon's public health system.

The staffing needs created by COVID-19 also allows for timely, hands-on experience by students in health care, social service and public health – in addition to members from the communities experiencing the disparities.

It is critical to be mindful about the vocabulary that is used for contact tracing. Words like surveillance and tracing are likely to result in reduced compliance and participation in locating people who may have come into contact with COVID-19 infection.

Communication about possible community exposure and the process for finding individuals who may have been exposed to COVID-19 must be created by prioritizing the needs of those experiencing the greatest health inequities. OHA must invert its typical process and start by creating information for those individuals the agency may have the hardest time reaching such as:

- People who are LGBTQ+;
- People who are HIV+;

- People who are living outdoors or in shelters;
- People who do not have access to the internet;
- Farmworkers;
- Indigenous language speakers;
- People whose primary language is not English;
- People who cannot read;
- People who are deaf, blind, and/or hard of hearing;
- Agricultural workers

Access to Care and Treatment

As communities continue to need care for COVID-19, a network of culturally and linguistically responsive providers and traditional health workers can support communities of color and people with disabilities in accessing services by:

- Linking individuals without a care provider to health services.
- Supporting community health centers.
- Developing raining modules for the provider community and traditional health workers about health inequities and the impact of institutional racism on health outcomes.
- Supporting providers in whole-person care, particularly as individuals manage the impacts of COVID-19 on their mental, physical and economic well-being.

Economic Resilience

> *"The impacts of this pandemic are being compounded by our state's historic and ongoing disenfranchisement of people of color—at the individual, institutional, and structural levels. Decades of discrimination in land use, health care, education, housing, law enforcement, financing, employment, and pay are still very much being felt today, and mean that it's both harder for POC folks to start businesses, as well as to keep them afloat.*
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> *Public policy played a major role in creating the inequities that make POC communities and businesses more vulnerable to this crisis—public policy must now play a role in correcting those injustices."* -**Excerpt, Community Chamber Coalition of Oregon and Alliance Partners Letter to the Governor, April 20, 2020**

Equitable communities are more resilient communities. When we reduce the disproportionate burden of trauma, discrimination, and chronic disease experienced by many communities in Oregon, we are reducing the risk of poor health and early death—not just from pandemics—but on a daily basis.

Last year, OHA started development of the 2020-2024 State Health Improvement Plan (SHIP). With input from over 2500 people across our state, five priority areas were identified for the 2020-2024 SHIP: institutional bias; adversity, trauma and toxic stress; behavioral health; economic drivers of health (to including housing, food security and living wage); and access to equitable preventive health care. At the time, these priorities were identified because they impact a lot of people, are root causes of health problems, and impact some communities more than others. With absolute certainty, these priorities have only been exacerbated by COVID-19, and inequities have worsened. With a primary goal of achieving health equity, the SHIP is a timely tool for our state's recovery from COVID-19.

Despite the interruptions of COVID-19, OHA is on track to launch the 2020-2024 SHIP this August. Nearly 75 strategies have been identified by subcommittees consisting of over 100 partners from local and tribal public health, Coordinated Care Organizations, community-based organizations, state agencies (including DHS, ODOT, ODE, OHCS and DCBS), and people with lived experience. Strategies have been identified across all five priority areas to enact change at the community, system and policy level. Examples of strategies include:

- Ensure state agencies engage priority populations to co-create investments, policies, projects and agency initiatives.
- Integrate racial equity as a key criterion in state agencies' planning, policy, and investment.
- Strengthen economic development, employment, and small business growth in underserved communities.
- Ensure access to and resources for family friendly policies, such as affordable, high quality, culturally responsive childcare and paid family leave.
- Expand recommended preventive health related screenings in schools.
- Increase supports that address food insecurity, like SNAP, WIC and school-based food programs.
- Strengthen agency partnerships in education, law enforcement, housing, social services and health care to improve mental health among people of color.
- Implement anti-racist and anti-oppression policies and cross-system initiatives.

- Locate support services for low income people and families at or near health clinics.
- Expand use of telemedicine in rural areas.
- Expand programs that address loneliness and increase social connection in older adults.
- Conduct behavioral health system assessments at state, local and tribal levels.

Strategies are in the process of being finalized with input from community partners and state agencies. For more information, visit healthoregon.org/2020ship or email christy.j.hudson@state.or.us