Commissioner Malcolm and MDH Leadership,

The HEAL Council knows that dealing with a pandemic is no small feat, and the Minnesota Department of Health (MDH) has certainly been leading the response and the charge with grace and gusto. The impacts of COVID-19 morbidity and mortality have not been felt equally by all populations in Minnesota. The pandemic has exacerbated the underlying and persistent inequities among historically marginalized communities and those disproportionately impacted due to structural racism and other forms of systemic oppression. The current COVID-19 crisis has highlighted and given us even more clarity about our society's racial inequities and the impact of racism. Race in our state is directly linked to higher rates of homelessness, incarceration, and economic hardships for communities most severely impacted by inequities (CMI). It has become apparent, now more than ever, that racism is rooted and can be seen across systemic, institutional and interpersonal levels - all operating over the course of time and across generations. The lack of MDH's response with regard to George Floyd's murder and the disproportionate rates in COVID cases and deaths has prompted the Health Equity Advisory Leadership council to draft this call-to-action to MDH.

It is time for MDH to declare racism as a ***public health crisis*** in Minnesota and to recommit its full attention to improving the quality of life and health of its communities most severely impacted by inequities (CMI). HEAL wants MDH to honestly and directly address health inequities, including a systematic, data-driven focus on poverty, economic mobility, and other factors that impact the social determinants of health. American Indians, Black, and communities of color are impacted more greatly by challenges and inequities in many areas including but not limited to Crime, Social Capital, Education, Transportation, Employment, Food Access, Health Behaviors, Socioeconomic Status, Environmental Exposure, and Access to Health Services, Housing, and Public Safety. **The HEAL council requests MDH to identify clear steps and weave anti-racist strategies into its COVID response and current and future strategic plans; and create, implement, and measure a long-term equity response to address systemic and institutional racism.**

COVID-19 Issues Highlighted

While MDH has prioritized hospital systems, it has left behind communities that do not have access to these systems – American Indian, Black/Brown, and communities of color who carry the legacy of being turned away from health and health care, and whose health status and outcomes have earned Minnesota the ***second worse state*** in the nation for health disparities.

The coronavirus (COVID-19) pandemic has revealed deep-seated inequities in health care for American Indians, Blacks, and communities of color and amplifies social and economic factors that contribute to poor health outcomes. Recent CDC reports indicate that the pandemic disproportionately impacts communities of color, compounding longstanding racial disparities. As of July 1, 2020, case data from MDH show that in COVID-19 cases where race was specified, Blacks, who comprise 7 percent of the total MN population (U.S. Census Bureau-Minnesota, 2019), make up 21 percent of COVID-19 cases and 9 percent of deaths; Latinos, who make up 5.6 percent of the population (U.S. Census Bureau- Minnesota, 2019), account for 22 percent of COVID-19 cases and 3 percent of deaths; Asians, who make up 5.2 percent of the population (U.S. Census Bureau- Minnesota, 2019), account for 7 percent of COVID-19 cases and 3 percent of deaths; American Indian who make up 1.4 percent of the population (U.S. Census Bureau-Minnesota, 2019), account for 1 percent of COVID-19 cases and 2 percent of deaths.

According to CDC, as of June 12, 2020, age-adjusted hospitalization rates are highest among ***non-Hispanic American Indian, Alaska Native and non-Hispanic black persons, followed by Hispanic or Latino persons***.

- **Non-Hispanic American Indian or Alaska Native** persons have a rate approximately **5 times** that of non-Hispanic white persons,
- **Non-Hispanic Black persons** have a rate approximately **5 times** that of non-Hispanic white persons,
- **Hispanic or Latino persons** have a rate approximately **4 times** that of non-Hispanic white persons.

In addition, the COVID response has not taken into consideration the needs of the communities most severely impacted by inequities (CMI). Statistics show that CMI in Minnesota are:

- at increased risk for serious illness if they contract COVID-19 due to ***higher rates of underlying health conditions***, such as diabetes, asthma, hypertension, and obesity compared to Whites;
- more likely to be ***uninsured*** and to lack a usual source of care which is an impediment to accessing COVID-19 testing and treatment services;
- more likely to ***work in industries deemed "essential" and not amenable to teleworking*** such as health care, grocery stores, restaurants, retail, and hospitality that puts them at risk for exposure to COVID-19 and particularly at risk for loss of income during the pandemic;

- more likely ***not to have support/benefits*** such as mandated hazard pay, extended sick time, and child care options while school is out;
- more likely to live in ***housing situations***, such as multigenerational families or low-income and public housing that make it difficult to social distance or self-isolate; OR ***poor housing conditions*** where they are exposed to hazards such as carbon monoxide, allergens, leaky pipes (mold), lead in paint,; OR at ***increased risk for evictions/ losing housing***;

Moreover, HEAL is concerned about the increasing positive Covid-19 cases in communities with disabilities, increasing percentage of positive rates in essential workers, and the lifelong impacts on CMI after COVID-19 recovery.

HEAL recommends the following action steps to better serve communities most severely impacted by inequities:

HEAL RECOMMENDATIONS

Policy & Systems Changes

1. Data Disaggregation. Currently, Minnesota records/publishes the percentage of COVID-19 Cases and COVID-19 Deaths by race. However, it does not publish the percentage of COVID-19 Cases and COVID-19 Deaths by sexual orientation and gender identity (SOGI), or by race vs state population.

Recommendation: MDH start to disaggregate data related to COVID-19, such as testing, hospitalizations, ICU admissions, and deaths by race and ethnicity, sexual orientation and gender identity (SOGI), and state population. This additional information will inform MDH/policy leaders of the COVID-19 prevalence in our state by race /ethnicity, and by SOGI and identify opportunities to provide targeted resources/supports.

2. **Community Based Organizations for Federal Stimulus Opportunities**. The CARES Act provides economic stimulus for small businesses and individuals.

Recommendation: MDH—Center for Health Equity/ Community Engagement to a) develop and release a request for proposal (RFP) to engage culturally-appropriate and responsive community-based provider organizations serving historically marginalized populations; b) fund CBOs that will provide preventive care and COVID-19 education, building capacity, and address racial/geographical inequities; c) provide CBOs long term support.

3. **Expanded and Flexible Coverage for Uninsured**. DHS provides Medical Assistance (MA) coverage for COVID-19 testing during the peacetime emergency for individuals who are uninsured. However, this is limited to testing and diagnosis of COVID-19.

Recommendation: MDH to work with DHS to provide wraparound services to cover service not covered DHS' limited MA coverage or provide grant funding to organizations providing services.

4. Expand the Workforce. It is important for healthcare professionals to understand cultural differences in how patients interact with providers and the healthcare system. Given workforce demands, there is opportunity to tap previously unused health care talent.

Recommendation: consulting with/ bringing on BIPOC health associations that have been doing the work in community, and are equipped to work as conduits (i.e. MN Black Nurses Association, Nigerian Nurses Association, Filipino Nurses Association, Hmong Health Professionals Association, Somali Medical Association) to help create a policy that fast-tracks immigrant, refugee, and bilingual health care professionals who have until now been closed out of the health professions. Secondly, increase the recruitment of foreign-trained, international medical graduates into MN Health care systems (MDH, hospitals, clinics, community-based organizations, etc). HEAL sees an opportunity with health associations and foreign trained professionals in providing supportive and transitional services for individuals and families, post COVID discharge.

Communication, Health Literacy, and Public Awareness

1. **Language Translation**. With the rapidly changing knowledge about COVID-19, information is changing on a weekly, sometimes daily basis. Minnesota Department of Health posts notices and fact sheets in multiple languages. However, the English language materials are updated in real-time, creating lags in developing translated versions. Often materials are not translated correctly, resulting in confusion or misinformation especially as it relates to ASL interpretation.

Recommendation: MDH contracts with trusted agencies to provide timely and consistent translation of public health guidance.

2. **Culturally Tailoring Messages**. Public health concepts are not readily understandable across cultures. Concepts such as social distancing, flattening the curve, self-quarantining, face-masking, washing hands, and wiping down groceries need to be presented in a culturally-appropriate manner.

Recommendation: MDH to hire communication specialist from CMI and/or partner with CBOs, community health centers, cultural centers to produce culturally relevant materials. In addition, the information being shared by MDH needs to be synthesized into 1-3 important key message(s) to communities in lay man terms with follow up explanation as needed.

3. **Establish Communication Dissemination Strategies**. Messaging about COVID-19 testing, health services, and federal stimulus opportunities must be accurate, culturally understood, and disseminated through information channels that reach CMI. Trusted digital, print, media, and local leaders are important messengers.

Recommendation: MDH to use internal communications staff from the community or to partner with CBOs, community health centers, cultural centers, and community leaders to broadcast public service announcements in targeted communities (i.e., Hmong market, La Mercado, Somali mall, churches, etc.).

Partnerships with Communities: Leaders and Institutions

1. **Faith-based Leaders and Technology**. Faith leaders and places of worship play a key role in providing support, information, and spiritual leadership among communities most severely impacted by inequities. They are trusted messengers and influencers who often have a history of addressing health and mental health promotion. Places of worship are increasingly leveraging technology through radio broadcasts, Zoom sermons, Facebook Live, and podcasts.

Recommendation: MDH to partner with Faith-based organizations (FBOs) to disseminate information to their respective communities.

2. **Community-Based Organizations** (CBOs). Community-based organizations have established track-records in the community and are often multi-service providers that integrate health, behavioral health, and social services. They are well-positioned to convey COVID-19 information. They often have diverse partnerships and collaborations with schools, higher education, housing authorities, local businesses, and hospitals. Some CBOs host local town hall sessions.

Recommendation: 1) MDH to leverage their relationship with CBOs and tap into the audience on their social media platforms. MDH could be holding joint lives on Instagram and Facebook accounts so it's interactive and people can ask questions and engage. 2) MDH to create a locator to find CBOs serving communities most severely impacted by inequities.

3. **Identify Community-Accepted First Responders**. Due to fears of having children/family members taken out of the home, arrested, deported, and/or killed in some communities by law enforcement, some communities rely on faith leaders, neighbors, mental health professionals, and other community leaders to act as community first responders.

Recommendation: 1) MDH to identify these community determined first responders for disseminating critical information about COVID-19; 2) to develop a trauma-informed community first responders program and train free of cost; and 3) continue to build capacity within these communities.

Healthcare Workforce and Practice Efforts

1. **Virtual and Telehealth Opportunities**. Community health centers, CBOs, and urgent care centers have ramped up the use of telephone and video visits, and insurance companies are expanding coverage for these visits. These changes have eliminated transportation barriers to

accessing care. However, communities impacted by inequities may not have regular access to internet, making it harder to participate in telehealth.

Recommendation: MDH to release RFP to help community health centers, CBOs, and urgent care centers address the digital divide.

2. **Support Services**. Community Health Workers (CHWs) & Bilingual navigators are critical for outreach, engagement, and linking communities most severely impacted by inequities to support services. CHWs know the community, are familiar with resources, and are able to communicate effectively with their clients. While visits are usually in person, they can be virtual during the pandemic.

Recommendation MDH to create CHW program and train participants from CMI at no-cost.

Racism-related Issues Highlighted

In addition to the pandemic response, The HEAL Council is concerned about MDH's lack of response to the murder of Mr. George Floyd at the hands of law enforcement. Black communities in America have long experienced violence at the hands of police and law enforcement, and beyond this- experience significant systemic racism that leads to incredible health inequities and disease burden. In 2014, MDH made an incredible step in the release of the 2014 Advancing Health Equity Report to the Legislature where systemic and institutional racism impact the health of BIPOC communities and their health and well-being. However, MDH needs to implement more aggressive strategies to address structural and institutional racism. Our national public health organizations are making clear statements about racism as a public health crisis and police violence as a crisis and pointing to research and scholarship on the topic, including through the American Public Health Association and the American Journal of Public Health.

The HEAL Council requests a public statement from MDH leadership naming racism as a public health crisis and present a plan for how MDH will address institutional racism internally and structural racism across the agency and throughout Minnesota, as well as a timeline for these efforts.

HEAL requests MDH leadership to address the above concerns including a commitment to health and racial equity in a bold and transparent way. Commissioner Malcolm, HEAL requests you to:

- **Declare racism as a public health crisis** in Minnesota and create an equity and justice-oriented public health department identifying specific activities to embrace diversity

and establish **anti-racism principles** across MDH, leadership, staffing and contracting , other government agencies, and community partners;

- Work to build alliances and partnerships with local, state, regional, and national entities organizations that are confronting racism and encourage other agencies to join the fight against racism;
- Develop and implement routine health equity/racial equity impact assessment process to help leaders/MDH staff understand the racial equity implications to existing and/or new policy, programs and/or institutional practices;
- Promote racially equitable economic and workforce development practices;
- Proactively identify and address existing policy for racial equity gaps while advocating for further local, state, federal or national support;
- Include in any decision making the people most affected by health and economic challenges and benchmark progress on these outcomes;
- Incorporate into the organizational structure a plan for educational efforts to understand, address and dismantle racism, in order to undo how racism affects individual and population health and provide community-developed tools to assist MDH staff, contractors, and its partners on how to engage actively and authentically with CMI;
- Ensure the consistent collection, analysis and reporting of disaggregated data for all public health efforts (age, race, ethnicity, gender, disability, neighborhood, sociodemographic characteristics and impact to health status) with data visualization and storytelling of said data;
- Create an internal task force with diverse members and Human Resources to address and create a pipeline for the retention and advancement of CMI associates to and beyond the Director levels.
- Commit to conduct all human resources, vendor selection and grant management activities with a racial equity lens including reviewing all internal policies and practices such as hiring, promotions, leadership appointments and funding;
- Always promote and support all policies that prioritize the health of all people, especially people of color by mitigating exposure to adverse childhood experiences, trauma in childhood and ensuring implementation of Health and Equity in All Policies throughout the state;
- Support efforts to invest in strengthening public health, health care and social infrastructure to foster resilience, with much emphasis on protecting the safety of essential workers and their families through PPE, paid sick leave, child care services and more;
- Train all MDH Leadership, staff, funders and grantees, contractors on workplace biases and how to mitigate them;
- Encourage community partners and stakeholders in the education, employment, housing, criminal justice and safety arenas to recognize racism as a public health crisis and to implement portions or all of this declaration;

- Promote community engagement, actively engaging community members on issues of racism, and providing tools to engage actively and authentically with communities of color;
- Identify clear goals and objectives, including specific benchmarks, to assess progress and capitalize on opportunities to further advance racial equity; and
- Establish alliances and secure adequate resources to successfully accomplish the above activities;
- Conduct an assessment of internal policy and procedures to ensure racial equity is a core element of MDH, supported by the MDH leaders in collaboration with the Management Team and the Center for Health Equity team;
- Develop an equitable framework around decision-making as it relates to prioritization, budgeting, and resource allocation during COVID-19 and beyond (i.e. PPE distribution, vaccine distribution, testing resources, etc.)
- Proactively collaborate with the MN Legislator to secure robust and long-term funding streams to expand continuation of both COVID response and ongoing vital MDH programming in areas such as: maternal child health, women's health, infant mortality, disease prevention and more.

Lastly, HEAL recommends MDH to create a stronger Strategic Plan that explicitly weaves racial and health equity into all areas of growth, and proposes that the next Statewide Health Assessment focus on the impacts of institutional and structural racism on disease burden.

There's a level of urgency in our request to: provide adequate and culturally appropriate resources to CMI to fight COVID, to eliminate health disparities, and declare racism as a public health crisis.

Commissioner Malcolm, we appreciate your leadership, and we look forward to advancing this critical work with you.

Sincerely,

The HEAL Council:

Dr. Jokho Farah, co-chair
Va Yang, co-chair
Dr. Tracine Asberry
Anita Buel
Callie Chamberlain
Zitlali Chavez Ayala

Jessica Coleman
Therese Genis
Sue Grafstrom
Talia Miracle
Ayah Mohammed
Jennifer Nguyen Moore
Samuel Moose
Laurelle Myhra
Cassandra Silveira
Jeremy Hanson Willis

(list of organizations that will be signing onto this letter—ie People's Center Clinics & Services

Appendix 1: https://mn.gov/covid19/data/data-by-race-ethnicity/index.jsp

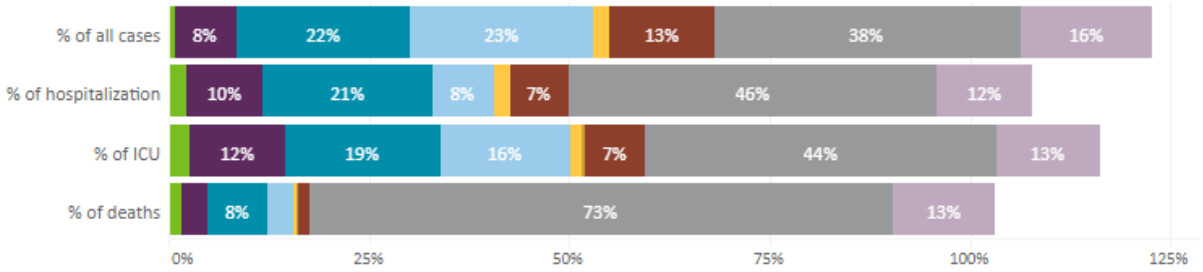
Appendix 2: Demographics of Twin Cities Community Testing

SUMMARY

SUMMARY OF CASES, HOSPITALIZATION, ICU, AND DEATHS

BY RACE/ETHNICITY WITH STATE OF MN COMPARISON

AMERICAN INDIAN/ALASKA NATIVE | ASIAN | BLACK | LATINX | MULTI | OTHER | WHITE | UNKNOWN



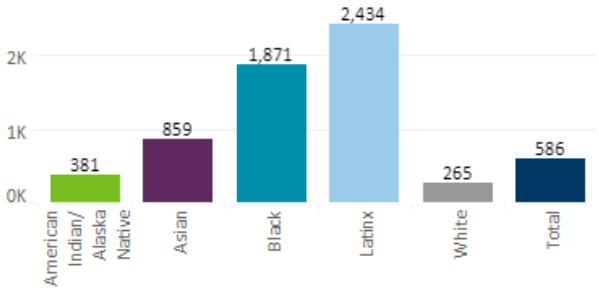
The cumulative case rate shows COVID-19 cases per 100,000 because it allows us to compare rates for racial, ethnic, and Indigenous identity groups that have very different population numbers.

Latinx individuals may be of any race and all race groups include Latinx individuals. For this reason, the summary bars sum to more than 100 percent.

POSITIVE CASES

CASE INCIDENCE PER 100,000 RESIDENTS

BY RACE/ETHNICITY

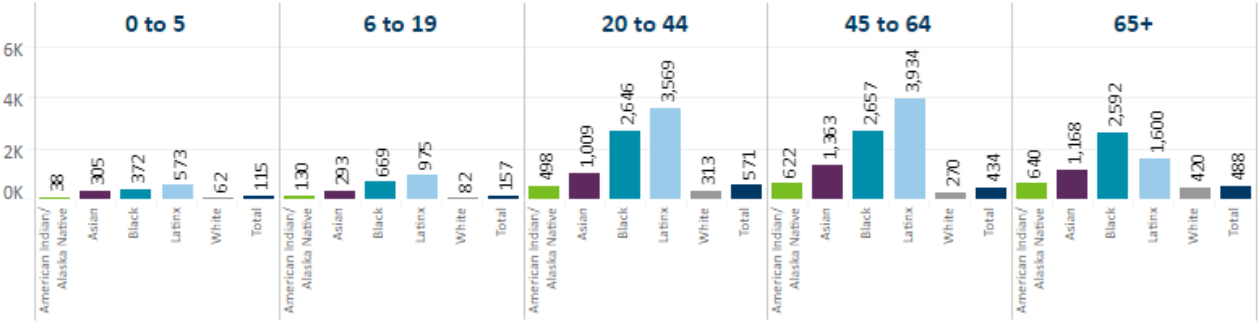


Latinx Minnesotans are testing positive at more than four times the overall population and more than nine times higher than white Minnesotans.

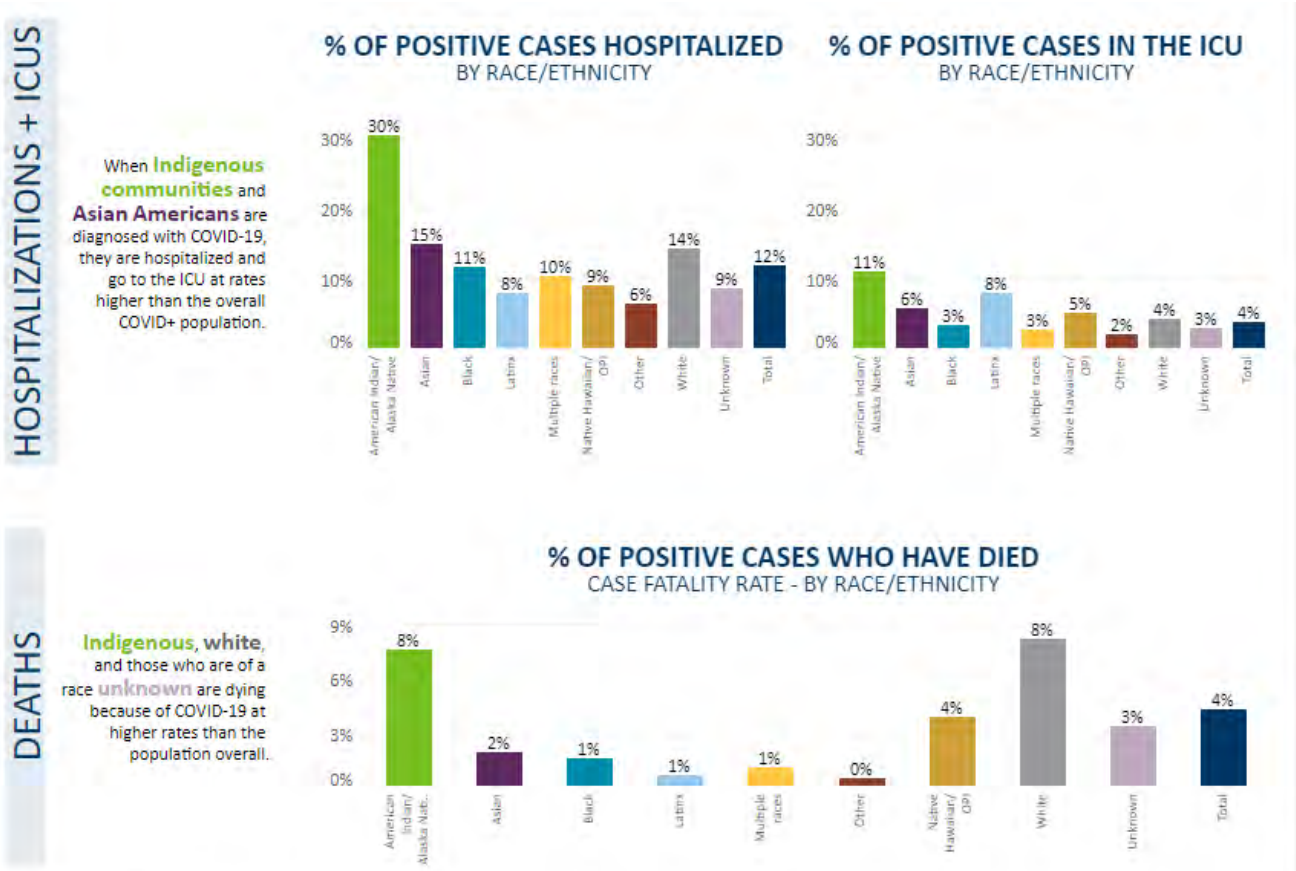
Black Minnesotans are testing positive for COVID-19 at more than three times the rate of the overall population and more than seven times higher than white Minnesotans.

CASE INCIDENCE PER 100,000 RESIDENTS

BY RACE/ETHNICITY AND AGE



Disparities persist across age groups. Adults (20 – 64) and older, **Black**, **Latinx**, and **Asian Americans** are testing positive for COVID-19 at higher rates than the overall population.



To access underlying data for the visualization above use a mouse or keyboard to select the visualization and then press Ctrl + Shift + Enter. Full functionality may not be available with Internet Explorer browser.

DEPARTMENT OF HEALTH

Demographics of Twin Cities Community Testing

UPDATED 6/23/20

Based on testing completed on June 9, 10, 16 & 17 at Jimmy Lee, Sabathani, Holy Trinity and New Salem

Race/Ethnicity of All Tested

	#	%
White	4367	57%
Asian	1121	15%
Black	764	10%
Unknown	496	6%
Latinx	489	6%
Multiple	377	5%
AI	51	1%
Mid East*	23	0%
NHPI**	18	0%
Total	**7706**	

**Middle Eastern/North African*

***Native Hawaiian Pacific Islander*

Race/Ethnicity of All Positives

	#	%
Asian	57	48%
Latinx	36	30%
Black	10	8%
White	9	8%
Multiple*	4	3%
Unknown	3	3%
Mid East	1	1%
AI	0	0%
NHPI	0	0%
Total	**120**	

**"Multiple" race category includes: Black, White, Latinx, American Indian*

Positivity Rate by Race/Ethnicity

	%
Latinx	7.36%
Asian	5.08%
Mid East	4.35%
Black	1.31%
Multiple	1.06%
Unknown	0.60%
White	0.21%
AI	0.00%
NHPI	0.00%

Positives by Test Site

	Positives	Total Tests	+ Rate
Holy Trinity	14	1692	0.83%
Jimmy Lee	79	3163	2.50%
Sabathani	12	1747	0.69%
New Salem	15	1104	1.36%
	120	**7706**	**1.56%**

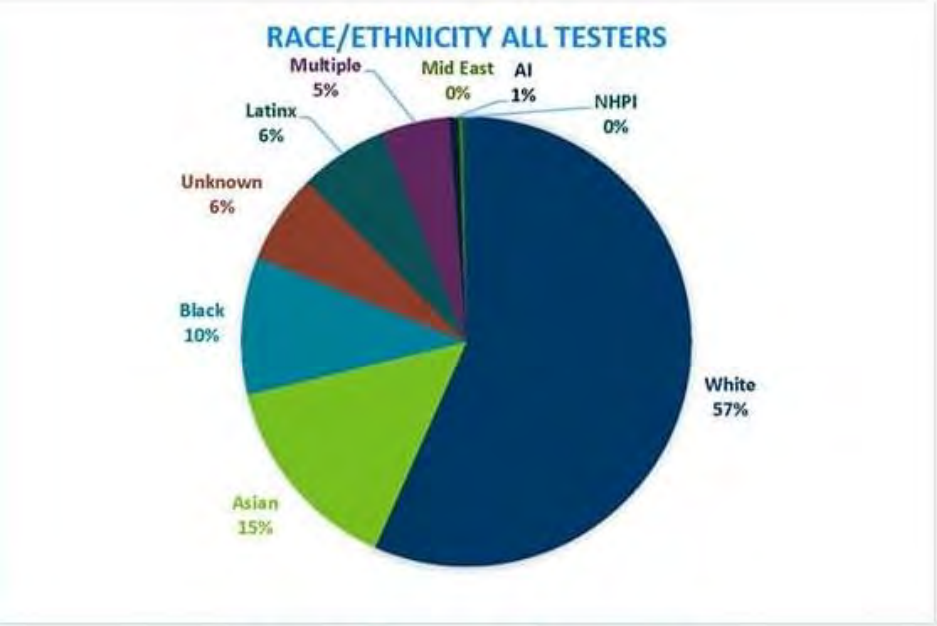
1

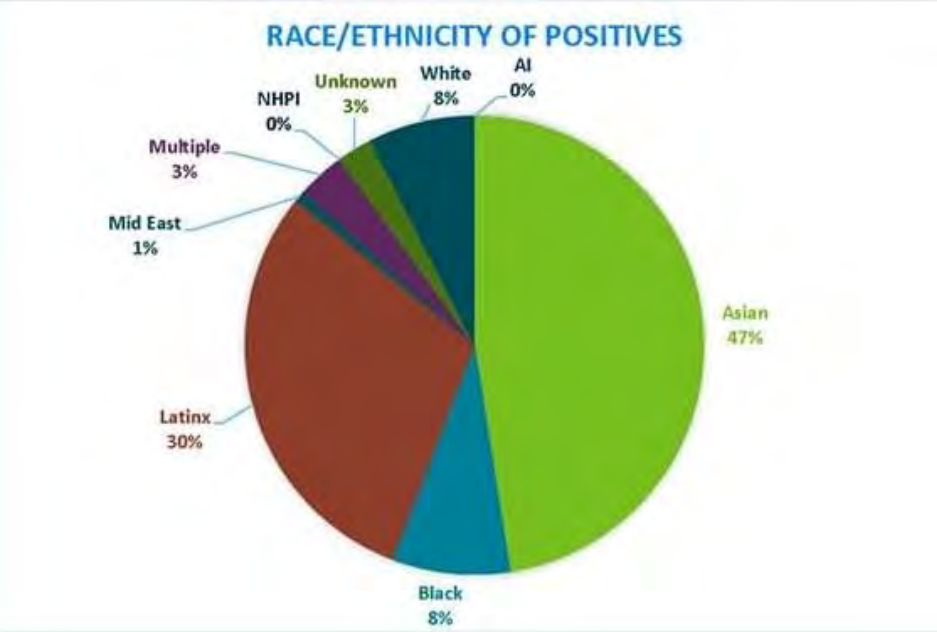
Gender of All Tested

	#	%
Male	3058	40%
Female	4132	54%
Transgender	34	0%
Cisgender	24	0%
Gender queer	38	0%
Non Binary	149	2%
Other	9	0%
Unknown	263	3%
Total	**7707**	

Gender of All Positives

	#	%
Male	55	46%
Female	62	52%
Transgender	0	0%
Cisgender	0	0%
Gender queer	0	0%
Non Binary	0	0%
Other	0	0%
Unknown	3	3%
Total	**120**	


RACE/ETHNICITY ALL TESTERS
Multiple 5%
Mid East 0%
AI 1%
NHPI 0%
Latinx 6%
Unknown 6%
Black 10%
White 57%
Asian 15%


RACE/ETHNICITY OF POSITIVES
NHPI 0%
Unknown 3%
White 8%
AI 0%
Multiple 3%
Mid East 1%
Asian 47%
Latinx 30%
Black 8%

2