COVID -19
Response & Mitigation Strategies Targeting Racial & Ethnic Populations & Marginalized Communities

Office of Equity and Minority Health

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MDHHS
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Factors That Contribute to Disparities Experienced by Racial/Ethnic Minorities and Other Historically Marginalized Populations

Racial and ethnic minorities are shouldering a striking disproportionate number of COVID-19 cases and deaths. The factors of systemic inequity that contribute to the disproportionality of racial/ethnic and other historically marginalized populations are not new, they have been in existence for centuries.

The CDC created a COVID-19 in Racial and Ethnic Minority Groups page to explain factors that influence racial/ethnic group health, what can be done to address their needs, and what the federal government is doing.

1. **Racial and ethnic minorities have less access to health care.**
   a. No health coverage for the past 12 months due to costs reported by American Indian (20.9%), Arab (18.6%), Hispanic (17.3%), Black (16.3%) and White (11.7%) in MI 2015-2017.
   b. As of 2014, 18.4% of all Michigan immigrants were uninsured, compared to 9.6% of all state residents. In the same year, 46% of all undocumented immigrants in the state were uninsured.[1]
   c. No personal health care provider reported by American Indian (23.3%), Hispanic (21.3%)Black (17.6%), Arab

MARGINALIZED POPULATIONS

- People Over Age 65
- Racial and Ethnic Minorities
- Pregnant Women
- Parents of Extremely Young or Multiple Children
- Native Americans
- Residents with Disabilities
- Refugees, undocumented immigrants, migrant workers, and other individuals who have immigrated
- Those for Whom English is a Second Language
- Survivors of Interpersonal Violence
- Individuals Who Experience Short-Term or Persistent Housing Insecurity or Live in Congregate Housing
- Individuals Living with Mental Health and/or Substance Abuse Disorder
- Economically Disadvantaged Individuals (e.g. low wealth)
- Low-Wage Essential Employees
- The Un- and Underinsured
- The Incarcerated and Detained

Source: Ohio Health Department, Office of Health Equity. COVID-19 Risk Mitigation Resilience Report.

[1] *A Snapshot of Immigrants in Michigan*, January 2018. Michigan League for Public Policy.

(15.9%), Asian (15.8%) and White (15.3%) in MI 2015-2017.[2]

2. **Historically there has been mistrust in relationships between racial and ethnic minorities and disaster personnel, governmental entities and/or medical facilities.**
3. **Racial and ethnic minorities experience more discrimination and bias in health care.** In the 2002 Institute of Medicine Report, Unequal Treatment[3] evidence suggests that both socioeconomic differences and "direct and indirect consequences of discrimination" are at play. When people of color present with health concerns they do not receive the same standardized care as White people. Additionally, the Kirwan Institute's State of Science: Implicit Bias Review[4] reports, document bias in healthcare (e.g. perceptions of pain, differential treatment, medical education, etc.).
4. **Many organizations have not implemented National Standards for Culturally and Linguistically Appropriate Services (CLAS)[5].**
5. **Racial and ethnic minorities have higher rates of comorbid conditions (cardiovascular disease, diabetes, hypertension, chronic respiratory disease, cancer) which put them at greater risk for negative outcomes related to COID-19.**
    a. Ever told they had Cardiovascular Disease in MI 2014-2016: American Indian (15.6%), Arab (10.1%), Black (9.3%), Hispanic (9.2%) and White (8.2%).
    b. Ever told they had Diabetes in MI 2014-2016: Hispanic (13%), Black (12.6%), Arab (12.4%), Asian (12.3%) and White (8.6%).
    c. Ever told they had Chronic Obstructive Pulmonary Disease in MI 2014-2016: American Indian (14.4%), Black (10.2%) and White (7.2%).
    d. All Cancer Incidence Rate (per 100,000) in MI 2013-2015: Blacks (467.7), American Indian (462.5) and White (441.5).[6]
    e. According to the U.S. Department of Health and Human Services, African American adults are 60% more likely than non-Hispanic White adults to be diagnosed with diabetes, 40% more likely to have high blood pressure and are less likely to have those conditions under control.[7]

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[2] Michigan Department of Health and Human Services (MDHHS). Behavioral Risk Factor Surveillance System Survey Data. Lansing, Michigan: Michigan Department of Health and Human Services, 2015-2017.
[3] Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care; Smedley BD, Stith AY, Nelson AR, editors. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington (DC): National Academies Press (US); 2003. Retrieved here.
[4] *State of Science: Implicit Bias Reviews*, Kirwan Institute at Ohio State University. Retrieved here.
[5] National Standards for Culturally and Linguistically Appropriate Services (CLAS), U.S. Department of Health and Human Services – Think Cultural Health. Retrieved here.
[6] Michigan Health Equity Data Project. 2018 Update. MDHHS – Health Disparities Reduction and Minority Health Section. 2014-2016 Michigan Behavioral Risk Factor Survey, MDHHS
[7] Michigan's African American Community Hit Hardest by Coronavirus Pandemic. Retrieved here.

6. **Racial and ethnic minorities are more likely to be in lower paid positions and considered essential workers.[8]**
    a. Black people are more likely to represent nearly 30% of bus drivers and nearly 20% of all food services workers, janitors, cashiers and stockers.[9]
    b. Workers of color are far more likely to be paid poverty-level wages than White workers. The share of black workers earning poverty-level wages has consistently been 1.5 times that of white workers for the past 30 years. The ratio of the Hispanic poverty-wage rate to the white poverty-wage rate has grown since the 1980s. In 1986, the share of Hispanic workers earning poverty-level wages was 1.8 times that of white workers; in 2017, it was 2.2 times the share of white workers.[10]
7. **Racial and ethnic minorities are more likely to work in positions where they do not have personal and sick leave benefits and are not able to work from home[11].**
    a. Only 16.2% of Hispanic workers and 19.7% of black workers can telework; that is less than one in five black workers and roughly one in six Hispanic workers are able to work from home. [12]
8. **Racial and ethnic minorities are more likely to experience social, economic and environmental inequities, and social determinants of health have more negative impacts on their health outcomes.**
    a. Un/Employment
        i. Percent of Civilian Labor Force that is Unemployed in MI 2011-2015: Black (11.8%), American Indian (9.1%), Hispanic (8.4%), Arab (6.3%) and White (4.9%).[13]
    b. Poverty
        i. Percent of Population Living Below Federal Poverty Line in MI 2011-2015: Arab (35.3%), Black (34.6%), Hispanic (27.1%), American Indian (27%), Asian (14.5%) and White (12.6%).
    c. Housing
        i. Percent of Renters Paying More than 30% of Income on Rent in MI 2011-2015: Arab (60.5%), Black (57.7%), American Indian (52.3%), Hispanic (48%) and White (45.4%).
    d. Transportation

[8] Poverty USA. Accessed April 19, 2020. Retrieved here.
[9] *Why are Blacks Dying at a Higher Rate from COVID-19?* Retrieved here. April 2020.
[10] *Workers of color are far more likely to be paid poverty-level wages than White workers.* Economic Policy Institute. Retrieved here.
[11] *Black and Hispanic workers are less likely to be able to work from home*. CNN. Retrieved here.
[12] *Black and Hispanic workers are much less likely to be able to telework*. Economic Policy Institute. Retrieved here.
[13] *Michigan Health Equity Data Project*, 2018 Update. MDHHS – Health Disparities Reduction and Minority Health Section. American Community Survey, U.S. Census Bureau.

i. Percent of Households with No Vehicle Available for Use in MI 2011-2015: Black (20.8%), American Indian (12.2%), Hispanic (9.0%), Arab (7.3%) and White (5.8%).

e. Education
   i. Percent of Population 25 Years or Older with Less Than High School Diploma in MI 2011-2015: Hispanic (30.2%), Arab (23%), Black (15.8%), American Indian (13.8%), Asian (11.4%) and White (8.6%).
   ii. Health Literacy can impact a person's capacity to obtain, process and understand basic health information needed to make appropriate health decisions. Education may also impact health literacy. For example, in a nationally representative sample, almost half of adults who did not graduate from high school had low health literacy.[14]

[14] *Health Literacy*. Healthy People 2020. Retrieved here.

Immediate Strategies to Mitigate the Transmission of COVID-19 and Advocacy Recommendations

A renewed emphasis for health equity is needed that addresses the social, economic and environmental determinants that drive persistent health disparities. If seeking sustainable change, COVID-19 Task Force on Racial Disparities strategies (short and long-term) must be founded in principles of race equity (addendum A). Preamble Questions: Are the strategies…

- *Going directly to the people and communities who need it?*
- *Accessible regardless of ability or status?*
- *Being prioritized for communities already living on the margins (e.g. older adults, gender, ethnic, and racial minorities, urban and rural poor)?*
- *Rebuilding toward a just and sustainable and more equitable future?*[15]

The National Association for the Advancement of Colored People (NAACP), Coronavirus Equity Considerations. The NAACP has released a **resource** to guide officials responsible for addressing health, economic, and other impacts, in remediating some of the issues that are disproportionately affecting communities of color.[16]

1. ***Embed the use of a health equity lens and racial equity assessment tool being developed by the Michigan Department of Health and Human Services (MDHHS), Office of Equity and Minority Health (OEMH) to help assess, create and promote equitable decision-making, processes and policies to reduce and eradicate social disparities and inequities.*** Decision-making examples include:
    a. Use of ventilators
    b. Allocation of resources according to specific needs
    c. Budget cuts
    d. Layoffs: Prioritize most at need laid off workforce when reintegrating to regular functions. Ensure laid off staff, who are part of marginalized groups, have a social net of resources established.
2. ***Institutionalize the use of data mapping that OEMH is developing with the Bureau of Epidemiology and Population Health to guide testing and allocate resources.***
    a. Replicate a methodology shared by the Director of the Office of Health Equity at the Ohio Department of Health. MDHHS-OEMH is working with the Bureau of

[15] *GARE COVID-19 Racial Equity Rapid Response: Guidebook for Government*. Government Alliance for Race Equity.
[16] *Ten Equity Implications of the Coronavirus COVID-19 Outbreak in the U.S., The Imperative for Civil Rights Advocacy, Monitoring, and Enforcement.* National Association for the Advancement of People of Color.

Epidemiology and Population Health. The methodology will identify census tracts throughout the state that might be at the highest risk of COVID-19 outbreak.

i. This project combines the Center for Disease Control (CDC) Social Vulnerability Index. Social Vulnerability is a group of social-demographic factors that affect a community's ability to recover from major disasters which include socioeconomic status, household composition, minority status and language, housing and transportation.
ii. This map of social vulnerability across all zip codes in the state of Michigan will be overlaid with morbidity data taken from the Michigan Inpatient Hospital Database in the form of hospitalization rates for various chronic diseases that have been shown to increase the risk of severe complications of COVID-19
iii. Mortality data taken from the State of Michigan's Vital records department for these same diseases will also be mapped at the census tract level where feasible

b. By using a combination of Social Vulnerability, morbidity, and mortality data for Co-Morbidities of COVID-19 we can map areas where residents may be at increased risk of complications due to COVID-19
c. Use data to determine needs and facilitate decision making.

3. Collect, analyze and disseminate data by race, ethnicity, primary language, gender identity, age, disability status and other socioeconomic demographics

a. Data often highlights unmet needs and drives efforts. It is important to address root causes in data analysis and results. Mechanisms that can be leveraged to analyze data in addressing root causes include dominant culture, systems of oppression and implicit bias. Evidence-based methodology can be dominant culture. There is significant meta data available to suggest that dominant cultural biases are embedded in the way we collect, analyze and evaluate data and therefore perpetuate inequities. We must work towards uncovering the root causes of inequity and strategizing with this lens in mind.
b. Address concerns with gaps in data collection and analysis of COVID-19 cases and deaths by race, ethnicity, primary language, sex, disability state and other demographics. The unknown percentage of COVID-19 positive cases and deaths is staggeringly high. It's shockingly high when measuring ethnicity. Interventions will not be thorough until these numbers are more whole.
    i. We must anticipate issues like Arab/Chaldeans not being counted in Census and therefore left out in numerous data collection initiatives (ongoing challenge in Michigan), undocumented Latinos experiencing

fear of repercussions, small data size in Native American/Indian American communities, etc.

ii. Growing data is evidencing high percentages of cases and deaths amongst Hispanic and Latinos/x, and Native American, Indian American and Pacific Islander communities across the nation, and other communities.
    - Navajo Nation reports more coronavirus cases per capita than all but 2 U.S. states. [17]

iii. Utilize CDC COVID Data Tracker. This resource provides maps, charts, and data on a state and federal level.

c. Refer to April 8, 2020 letter to Secretary Azar and Director Redfield, from The Congressional Hispanic Caucus (CHC), the Congressional Asian Pacific American Caucus (CAPAC), and the Congressional Black Caucus (CBC), collectively known as the Tri-Caucus regarding collection of data by race and ethnicity.

d. Make changes to reporting systems to include collection by race, ethnicity, primary language, gender identity, age, disability status and other socioeconomic changes

e. Disaggregate data by race, ethnicity, primary language, gender identity, age, disability status and socioeconomic status in line with, at least, the Section 4302 promulgated standards under the Affordable Care Act (ACA).

f. Develop data sharing agreements to provide data to tribal nations.

i. Native Americans are being left out of the demographic data and labelled as "other" on the impact of the coronavirus across the U.S. [18] Misclassification leads to inequitable strategies.

4. Design and Implement Testing Infrastructure

a. Identity the level of testing that is needed, specific to racial and ethnic minorities prior to ending the state's Stay Home order.

b. Use mapping or other projections to identify optimal testing numbers

i. Number tested vs recommend number to be tested

c. Incorporate strategies to make testing readily available in the community

i. Prioritize most in need neighborhoods.

ii. Identify and implement testing for homebound individuals

iii. Testing should be made available in the neighborhood-specific predominant language/s. Recruit staff who speak the language or have medically qualified interpreters on testing sites at all times.

d. Assess the effectiveness for current methods of testing

[17] Navajo Nation reports more coronavirus cases per capita than all but 2 U.S. states. Retrieved here.

[18] Native Americans being left out of US coronavirus data and labelled as "other". Retrieved here.

i. Determine the number of primary care providers who are not seeing patients and referring to other entities for testing.
ii. Determine local heath departments ability to provide testing.
iii. Get the best information, resources and processes to individuals needing testing.

e. Develop new messaging for residents who are frustrated with being turned away from testing
f. Enhance community-based COVID-19 testing for families, especially those living in multi-unit dwellings or crowded households. Protocols and testing must be accessible to people with limited English proficiency and disabilities and accommodate reasonable modifications to procedures.
g. Follow code of ethics and racial equity principles when conducting pilot testing or research experiments with marginalized populations, including those who were unethically used as human subjects in history: [19]Black/African American people, Latinos/x and Hispanic people, Indian and Native American people, people with disabilities[20], incarcerated people, etc.

5. Provide Quality Treatment

a. Enhance access to and create community-based telehealth programs for technologically marginalized groups.
b. Develop and disseminate COVID-19 Risk Mitigation Kits (masks, hand sanitizer, gloves, acetaminophen) to distribute in communities where COVID-19 morbidity is disproportionately high.
c. Provide access to resources and tools to support mental health and wellness needs of minority communities.

6. Design and Implement Contact Tracing Procedures

a. Implement strategies included under treatment section.
b. Prioritize racial and ethnic populations for contract tracing due to disparate impacts of inequities in poverty, racism and social determinants of health.
    i. Concern with more exposure and extensive corresponding implications
        - More people of color makeup the line of essential workers
        - More significant risk for incarcerated people
        - Increased risk at Immigrant detention centers

[19] S. Reverby. *Ethical Failures and History Lessons: The U.S. Public Health Service Research Studies in Tuskegee and Guatemala.* Public Health Reviews, Vol. 34, No 1.
[20] New Jersey's Five Developmental Centers conduct pilot swab testing with institutionalized developmentally disabled populations. Retrieved here.

ii. More people of color utilize public transportation – concern with sanitation and exposure. Sanitation wipes should be available on public transportation, buses, rails, etc.

iii. More people of color live in intergenerational housing – due to housing discrimination, lending disproportionality, etc. Level of stress has peaked in communities of color – concern about family members being exposed, dying, etc.

c. Contract the services of minority media, communication firms, and respected community leaders to develop targeted health messaging for and to create awareness about specific marginalized populations in print, video and at press conferences. The information should also include pertinent culturally accurate questions and answers that is sure to address common misconceptions/myths. Include regular testimonials of racial and ethnic minorities' trusted leaders to drive a message of urgency and importance to add validity and support the Medical Executive and the Governor's comments and broadcast these messages statewide or regionally.

d. Identify and address training needs. Including culturally and linguistically competent training for staff involved with the contact tracing process.

e. Identify needs and connect with to resources (I.e. isolation hotels/facilities).

f. Consider CDC Contact Tracing Principles to stop COVID-19 transmission: Part of a Multipronged Approach to Fight the COVID-19 Pandemic.

7. Establish protocol to protect prisoners, detainees and larger community from COVID-19 spread. Isolation housing opportunities (e.g. hotels) must be made available upon release until individuals test negative for the virus.

a. Detention centers, juvenile institutions and prisons/jails may act as incubators for COVID-19. As many as 99,000 more people could die in the US as a result of the virus being contracted behind jail walls. Of those, 23,000 are projected to succumb behind bars and 76,000 in surrounding communities as a result of inmates spreading the virus upon release[21].

8. Government response to COVID-19 must include immigrants and refugees [22]

a. 6.4% of Michiganders are immigrants and 6.9% of native-born children (under the age of 6) had at least 1 immigrant parent in 2015.

b. Michigan is a refugee resettlement state. The 2018 Fiscal Year tracked approximately 650 refugees who were resettled in Michigan. This is in comparison to past years where resettlement numbers were 3,000-4,000 across the state.

[21] Mass incarceration could add 100,000 deaths to US coronavirus toll. ACLU/The Guardian. Retrieved here.
[22] *COVID-19 & Race, Actions*. Policy Link. Retrieved here.

c. Michigan is home to the 2nd largest agricultural industry in the U.S. Much of our agricultural work is done by migrant workers.
    - Working Conditions of Migrant Laborers Leave Them Uniquely Vulnerable to Catching, Spreading COVID-19.[23]

d. While in 2015, undocumented immigrants in Michigan paid $86.6 million in state and local taxes[24], stimulus checks are denied to undocumented immigrants and those individuals married to undocumented immigrants. [25]

9. Develop, disseminate and monitor minimum requirements for business to have in place to reopen

a. Check temperatures, provide PPE and disinfectants, etc.
b. Flexibility with staff hours/needs for self-care or to care to ill family or children at home.
c. Require social distancing within business establishments.
d. Business to establish clear polices for connecting employees to testing, treatment and social determinants of health services.

10. Provide financial relief for small and minority owned businesses.[26]

a. Implement policy and guidance to provide financial relief for businesses, particularly small and minority owned businesses, that allow for sick days and provide paid leave for ill employees and/or their dependents/family members.
b. Provide hazard pay to essential workers. Racial and ethnic minority groups in the workforce are prone to higher rates of workforce-related diseases, injuries, and psychological distress than members of the dominant group. The severity and types of hazards minorities face are different because they may work in more physically demanding, labor-intensive jobs…[27]

11. Use evidence-based and promising practices for reducing racial and ethnic disparities

a. OEMH contracted with Public Research and Evaluation Services to conduct a literature review of evidence-based strategies to reduce racial and ethnic health disparities. Most of the literature demonstrate results when:
    i. Utilizing Culturally competent services tailored to specific populations.
    ii. Use of Community Health Workers, peer-led education, social workers, etc.
    iii. Increasing the number of racial and ethnic providers.

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[23] *Advocates Raise Alarm about Migrant Worker Safety Amid COVID-19*. Retrieved here.
[24] *A Snapshot of Immigrants in Michigan*, January 2018. Michigan League for Public Policy.
[25] *Lawsuit filed against Trump over stimulus checks denied to those married to immigrants*. Retrieved here.
[26] *Black Businesses Left Behind in COVID-19 Relief*. Retrieved here.
[27] *Occupational Health Disparities: Improving the Well-Being of Ethnic and Racial Minority Workers.* American Psychological Association. Retrieved here.

b. Minnesota Department of Health (MDH), Center for Health Equity, Office of Minority & Multicultural Health provided grants to community-led non-profits to take materials and tailor them in culturally/linguistically appropriate ways for diverse communities. Allocated about $1 mil from emergency funds for about 40 grants and MDH plans to request more funding as the need is so high. Staff work closely with partners on adaptation and relaying concerns/needs between communities and MDH.

12. Identify and Codify Trust-Building Efforts with Communities

a. Historically, communities' distrust local and state government. How can we ensure efforts are intentional in rebuilding trust, in having transparency and accountability, in elevating the voice and value of community members?
b. Develop plan and structure to sustain collaborative and trust-building efforts with community stakeholders beyond COVID-19.

Long-term Strategies and Advocacy Recommendations

Response, recovery, reemergence. The combined costs of racial and ethnic disparities in health and health care are estimated in more than a trillion dollars. Eliminating health disparities is not only the right humane thing to do, but it will also reduce direct medical care expenditures by $230 billion dollars and indirect costs associated with illness and premature death by more than a trillion dollars. [28]

1. ***Fund and implement Public Act 653[29] (Minority Health Bill) provisions***
    a. Minority health bill passed in 2006.
    b. Rev. Dr. Michael Murphy - Former Michigan State Representative and original author of Michigan Public Act 653
    c. Gov. Whitmer was one of the representatives that introduced the bill
    d. Public Act 653 Provisions (see full list here)
        i. MDHHS to create a structure and policies to address health disparities
        ii. Establish minority health policy
        iii. Statewide strategic plan
        iv. Utilize federal, state, and private resources, as available and within the limits of appropriations, to fund minority health programs, research, and other initiatives.
        v. Racial and ethnic specific data including, but not limited to, morbidity and mortality.
        vi. Develop and implement recruitment and retention strategies to increase the number of minorities in the health and social services professions.
        vii. Develop and implement awareness strategies targeted at health and social service providers in an effort to eliminate the occurrence of racial and ethnic health disparities.
        viii. Identify and assist in the implementation of culturally and linguistically appropriate health promotion and disease prevention programs that would emphasize prevention and incorporate an accessible, affordable, and acceptable early detection and intervention component.
        ix. Provide funding, within the limits of appropriations, to support evidence-based preventative health, education, and treatment programs that include outcome measures and evaluation plans in minority communities.

[28] LaVeist TA, Gaskin D, Richard P. *Estimating the Economic Burden of Racial Health Inequalities in the United States*. Int J Health Serv. 2011;41(2):231-8.
[29] *State of Michigan, Public Act 653 (Minority Health Bill)*. Retrieved here.

x. Provide technical assistance to local communities to obtain funding for the development and implementation of a health care delivery system to meet the needs, gaps, and barriers identified in the statewide strategic plan for eliminating racial and ethnic health disparities

2. ***Increase funding for the OEMH and elevate the section to an office reporting directly to the director of MDHHS or the Governor so all issues concerning health disparities, health equity, SDOH, etc. will be at the forefront policy considerations.***
3. ***Focus on reemergence of the problem or next emergence***
    a. What structural impediments are in place that disables government to respond?
    b. Highlight structural issues in our agencies that inhibits MDHHS and OEMH to do needed work.
    c. What public health changes are necessary, and which are we willing to make?
    d. How do recovery efforts address the needs of marginalized populations and not as an afterthought?
    e. Identify specific strategies to address the needs of marginalized populations.
    f. What is in our polices and process to make us react vs be prepared?
4. ***Structure Health Equity Immersion into Crisis Response[30]***
    a. Community Health Emergency Coordination Center (CHECC) and the State Emergency Operations Center (SEOC)
        i. OEMH should be a part of Community Health Emergency Coordination Center (CHECC) and daily Leadership Updates and strike teams.
    b. The rapidity of spread of COVID-19 requires that decisions be implemented immediately. Current processes for decision-making should be modified to consider the potential impact and possibility of unintentional harm for marginalized populations as follows:
        a. Place a health equity subject-matter expert within the CHECC who participates in all major briefings in the crisis response and loops in other subject matter experts when appropriate.
        b. Establish a team of health equity subject matter experts to immediately review proposed solutions prior to implementation.
        c. Establish marginalized populations report-out sections for all areas of the State emergency response process by Emergency Support Function.
    b. Build on established relationships with OEMH, MDHHS Communications, Emergency Preparedness and Behavior Health to create culturally competent messaging and tools to address racial and ethnic populations during a crisis, pandemic, etc.

[30] State of Ohio Health Equity Response to COVID-19. COVID-19 Risk Mitigation & Resilience Report. Targeting Populations Made Most Vulnerable Through COVID -19 Response and Containment.

5. ***Prioritize inclusion of racial and ethnic minorities in COVID-19 related research***
    a. Assure adherence to legal and ethnical protocols, while staying conscientious of historical misuse of human subjects, especially amongst marginalized communities.
6. ***Develop a plan to address Mental Health and Substance Use and Abuse Needs***[31]
7. ***Develop a plan to reduce structural racism and bias in systems – healthcare***
8. ***Develop a plan to address social determinants of health***
    a. Revise Michigan's paid sick leave law to cover workers at businesses with fewer than 50 employees.
    b. Extend paid sick leave coverage to all workers, regardless of how long or the number of hours they have worked for their current employer, or full or part-time status, or of overtime exemption status.
    c. Allow workers to earn and use up to 72 hours of sick time in a year.[32]
9. ***Develop a plan to address gaps in educational achievement***
10. ***Develop plan to address digital divide***
    a. According to the Pew Research Center, 29% of adults with household incomes less than $30,000 a year don't own a smartphone, while 44% don't have home broadband and 46% lack a "traditional" computer either. Pew also noted that 35% of lower-income households with school-age children don't have a home-based broadband internet connection.[33]

[31] The Implications of COVID-19 for Mental Health and Substance Use. Retrieved here.
[32] Public Policy Response to the COVID-19 Response in Michigan: Paid Leave. Michigan League for Public Policy. Retrieved here.
[33] Pandemic response lays bare America's digital divide. Retrieved here.

Addendum A – Racial Equity Principles

We recommend using the following racial equity principles[34] in any short-term and long-term strategy or response to COVID-19.

1. *Participatory Practice:* Leadership, staff and community members are collectively accountable for identifying, collecting, and using data in a participatory process. Strategies and evaluation efforts get developed collectively or by those affected.
2. *Data Culture:* Transforming the usual punitive data culture to transparent, non-punitive data analysis and use culture. We must seek the story behind data and identify white dominant data.
3. *Self-Reflection:* A practice that doesn't "prove" or blame communities for our institutional and systems failure. Turning individual blaming to identifying systemic/institutional reasons for the failure.
4. *Sharing Data:* Data is shared with the community regardless of outcome; for transparency, trust, and most importantly because community is the best knower of the problem and solution.
5. *Data Informs Practice:* Data is used consistently to inform practice. Data can claim success as soon as we see substantial evidence. However, data is a proxy for information, and we must go deeper and ask why to uncover deeper messages.
6. *Eye to Root Cause:* Identify potential solutions with an eye to root cause so that they will disrupt and address racially disproportionate outcomes. Ask yourself: What root problem are we solving for as we're thinking of this strategy.
7. *Authentic Relationships:* Build authentic, trusting relationships so that when data goes in a scary direction, the group will seek solutions. Authentic groups name the impact desired and hold each other accountable. The impact is codefined internally or externally (depending on the intended audience).

[34] The People's Institute for Survival and Beyond. Retrieved here.
Equity and Results, Results Based Accountability. Retrieved here.