

## HEALTH EQUITY: PUBLIC HEALTH EMERGENCY COVID-19

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Secretary Department of Health Nate Smith, MD

Arkansas Department of Health

4815 West Markham

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Re: COVID-19 Health Equity Response Team Recommendations to Advance Health and Racial Equity in Arkansas

Dear Dr. Patterson and Dr. Smith:

On behalf of the Arkansas COVID-19 Health Equity Response Team and the undersigned team members, we thank you for your timely response to the COVID-19 pandemic. We urge you to advance essential and critical additional state policies as well as monetary support, ensuring all children and families have a fair and just opportunity to be as healthy as possible during the novel coronavirus (SARS-CoV-2) pandemic. We continue to see increasing cases across the state, especially in our vulnerable communities, among them are significantly higher within Black, Hispanic and Marshallese communities, nursing homes, correction facilities, among others. The enclosed document outlines immediate and long-term recommendations for equity within the State of Arkansas.

There is still much we do not understand regarding the SARS-CoV-2 virus; such as viral transmission with varying  $R_0$  values in different regions/states, varying symptoms exhibited by infected individuals, varying antibody production in response to the infection, as well as the unknown long-term health impact of individuals who have been infected. Until a vaccine is available, our best defense is containment of the virus. As we move forward in opening our state economy, we must address the health inequities posing significant risks, particularly among our vulnerable populations.

The University of Arkansas Medical Sciences' predictive model is projecting a 30-50-fold increase in cases in Arkansas with a peak on September 30, 2020. This necessitates aggressively addressing testing, tracing, and supportive isolation to avoid overwhelming our healthcare systems. Supportive structures must be provided to vulnerable communities to mitigate the broad effects of this virus across the state.

Infections of essential medical and non-medical workers threaten the well-being of all, as this will also devastate our economy. We must continue to improve coordination across State agencies, the private sector, and community-based organizations. We must urgently address underlying causes of inequities that disproportionately affect communities of color and vulnerable groups in our state to minimize transmission across all our communities. Eventually, the impact of this pandemic on our vulnerable communities will take a toll, not only on our healthcare personnel and institutions but on the core infrastructure of our communities. A strategic and comprehensive approach to address these health care inequities will mitigate the impact on essential workers. They drive our economy in virtually every sector, such as health, food production and preparation, cleaning and sanitation services public services, and many more. We must protect essential workers and vulnerable communities to protect all Arkansans.

Collectively, our team offers a blueprint for the state, highlighting areas of need with recommendations for statewide solutions and needed resources.

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## Executive Summary

Arkansas is facing one of the worst public health crises in our lifetimes. COVID-19 is exposing a fragmented healthcare system and fragile social infrastructure. It underscores long-existing health disparities and demonstrates the increased social inequities which have led to the vulnerability of communities.

As of date, Arkansas cases by race are White 52%, Black 38%, Pacific Islanders 3%, Asian 1%, American Indian < 1%, and others 6%. Hispanics account for 11% of cases. Most recently, spikes in infections among Hispanics and Marshallese populations in NW Arkansas have been observed. Gender analysis demonstrates a male predominance of cases of 60%, with females comprising 39%. This is in stark contrast to the racial composition of the state population, which is 77.0% White Americans; 15.4% Black or African American; 0.8% American Indian and Alaska Native; Hispanics account for 7% of the state population.

As of date, Arkansas Infection Rates, with over 120,000 people tested, demonstrates a mean positivity rate of approximately 6.3%. As of June 20, 2020, there are 5,063 active cases and a total of 16,083 documented cases with 227 deaths. The top 3 counties in decreasing numerical rank are Washington 2531, Benton 2,087 & Pulaski, with 1531 cases. These statistics support that there is a disproportionate number of cases in people of color and other vulnerable populations. The Black, LatinX, and the Marshallese people are grossly disproportionately affected.

Arkansas Mortality Rates are 1.9%, with 54% of cases white, 38% African American, Pacific Islanders 3%, Asian 1%, and others 5%. Older aged individuals accounted for the majority of deaths persons >65+ years of age accounted for 73% of cases, individuals 45-64 years of age accounted for 23%, while younger individuals comprised a minority of cases: 24-44 accounted for 3% and no deaths in the under 24 years of age group. Again, Black, LatinX, and the Marshallese people mortality rates are also grossly disproportionately affected.

[The RWJF brief on “Health equity for state and local leaders Responding to, Reopening and Recovery from COVID-19”](#) underscore that

*“Our health is inextricably linked to that of our neighbors, family members, child- and adult-care providers, co-workers, school teachers, delivery service people, grocery store clerks, factory workers, and first responders, among others;*

*Our current health care, public health, and economic systems do not adequately or equitably protect our well-being as a nation.*

*Every community is experiencing harm, though certain groups are suffering disproportionately, including people of color, workers with low incomes, and people living in places that were already struggling financially before the economic downturn.”*

Arkansas must center equity in every stage of its COVID-19 relief. Enhanced coordination is needed to implement long-term relief and recovery, as well as future risk reduction. This must include immediate/short-term, medium, and long-term goals; if not, we risk exacerbating infection rates and creating a cascade of additional problems to solve. Our current crisis presents a public health opportunity to develop and implement policies, address broadband infrastructure, socially promote healthy behavior, invest in the public and private healthcare industry to better serve vulnerable communities and remove silos among all sectors to address the health of our state.

We must expand access to preventive care, chronic disease management, treatment, and recovery services, including behavioral health and substance use disorders to address the wave of chronic disease & mental health issues (Figure 1), resulting from the barriers to access, physical, emotional and socioeconomic stressors related to COVID-19.

The [COVID-19 Vulnerability Index](#) underscores the areas in Arkansas, which have the greatest risk of worst outcomes. This vulnerability index should guide where additional critical resources are allocated to reduce the spread of the virus.

Arkansas leadership must not only address the current pandemic, but create an infrastructure for sustainability and resiliency among our communities. This can be done by comprehensive needs assessments, that is holistic by including social determinants of health, enhance coordination among public health agencies and community-based organizations, supporting local health entities, and strategic campaigning specific to the needs of vulnerable populations. Policymakers, along with public and private organizations, must work collectively to address the needs of vulnerable people.

This document reflects the following priorities in addressing health disparities reflected by this body of stake holders.

1. Improve State effort outreach and awareness through effective campaigning regarding COVID-19 prevention and mitigation.
  - a. Expand public health service campaigns to become culturally and linguistically appropriate across all communities, repeatedly providing education and instructions to reach all vulnerable populations.
2. Increase COVID-19 testing, treatment, and related care
  - a. Widespread testing, minimum 10% in each vulnerable group, contact tracing and supportive isolation are crucial steps to mitigate the spread of infection according to [Harvard's Roadmap to Pandemic Resilience](#).
  - b. Policy and monetary support to provide COVID – 19 related care at no cost to the individuals
3. Strategic sustained engagement to support community-based organizations and efforts in their service that affect the health and well-being of their communities.
  - a. Continue and expand support needed by non-profits, community or faith-based organization's mission to serve the communities. Many of their services are in higher demand due to COVID-19 at a time when the organizations are struggling. Their services often address the gaps caused by social determinants of health.
  - b. Utilizing key trusted sources in each community is key to how messages are delivered, received, and accepted.

4. Designate and support lay health workers as health champions in these efforts. They are integral to targeted campaigning, education, screening, guidance to wrap-around services, and social support.
  - a. Provide funding for training and employment (including hazard pay) for community lay health workers with language translations and disability accommodations to deploy statewide (NW, NE, Central, SW & SE)
5. Holistic responses to COVID-19 by addressing social determinants of health
  - a. Effective coordination and funds are needed for wrap around services needed among vulnerable groups
6. Targeted support of health care providers, independent clinics, primary care offices, federally qualified health centers (FHQC), and other health care systems to respond to COVID-19 and the expected rises of morbidity due to delayed care
  - a. Reports from the Primary Care Collaborative estimates 35% of primary care practices may close post-COVID-19. This will clearly increase barriers to access to care. The lack of chronic disease management during the pandemic is projected to create a separate and independent wave of morbidity and mortality, creating added stress to an already over-burdened system.
  - b. Already clinics have closed in the State of Arkansas in areas of greatest need
7. Increase and targeted efforts to effectively address health-related workforce issues
  - a. Essential workers are among the groups with chronic disease inequities before the pandemic, leading to higher numbers of severe cases of COVID-19. This results in a disproportionate number of hospitalizations and deaths. Groups such as those in health, food production and preparation, factory and plant workers, cleaning and sanitation services, public services, and many more are counted as those disproportionately affected by the pandemic.
8. Representation of vulnerable populations in COVID-19 related policy decisions and appropriations
  - a. According to the [RWJF Health Equity Principles](#), policymakers should create space for leaders from these communities to be at decision-making tables regarding the matter of COVID -19 across all sectors and should regularly consult with community-based organizations that can identify barriers to accessing health and social services, lift up grassroots solutions.
9. Data
  - a. We recommend the adoption of best practices and guiding principles noted by [Policy Link](#), a national research and action institute advancing racial and economic equity funded by the Robert Wood Johnson Foundation. ( Rubin et al., Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to Advance a Culture of Health )

## EQUITY STAKEHOLDERS

The AR Health Equity Response team comprises of individuals/organizations that work closely in and represent communities from all geographical areas across the state that have been disproportionately affected. The committee is racially and ethnically diverse representing healthcare providers from academics, Arkansas Health Department, federally qualified health centers and private practices, community-based organizations (CBOs), policy advocates from various regions across the state, dedicated to improving the health and well-being of the state's diverse populations. Many of our partners work directly with constituents across Arkansas and play a crucial role in bridging the gaps between community needs and institutional responses. These groups are trusted messengers and gatekeepers and often the only organizations in their area with service and specific cultural or language capacity.

|   |   |   |
|---|---|---|
| <i>Accountable Care Organizations</i>             | <i>Arkansas United</i>                      | <i>Disability Rights of Arkansas</i>        |
| <i>Arkansas Advocates Children &amp; Families</i> | <i>Arkansas Department Veteran Affairs</i>  | <i>East Arkansas Family Health Center</i>   |
| <i>Arkansas Department of Corrections</i>         | <i>Blue Cross Blue Shield</i>               | <i>NYIT College of Osteopathic Medicine</i> |
| <i>Arkansas Department of Health</i>              | <i>Children's International</i>             | <i>UA Medical Sciences</i>                  |
| <i>Arkansas Minority Health</i>                   | <i>Community Health Centers of Arkansas</i> | <i>Walgreens</i>                            |
|   | <i>Delta Population Health Institute</i>    | <i>Winthrop Rockefeller Foundation</i>      |

### COVID-19: Disproportionately Impacting Our Communities

Social Determinants of Health (SDH), *defined by the [Office of Disease Prevention and Health Promotion](#)*, are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as “place.”

Arkansas populations of color have a larger portion of lower socioeconomic status, lower hourly wage, essential workers with higher unemployment and uninsured rates. These communities are more reliant on public assistance for food, shelter, and transportation. All of these factors contribute to an increase in vulnerability for these communities.

SDH and chronic stresses contribute to disproportionate rates of hypertension, obesity, diabetes, cancer, strokes, etc. This is the general data that highlights health inequities and the basis for our committee submitting guidelines to mitigate against these inequities.

These communities have long been disenfranchised from our health and social systems. The ongoing outbreak compounds the lack of access to quality, culturally and linguistically appropriate healthcare, and access to fair distribution of resources, which magnifies the higher prevalence of non-communicable conditions including diabetes, hypertension, asthma and depression in these communities. Arkansas' low-income Black, Indigenous and Persons of Color (BIPOC) and immigrants, overrepresented in low-

wage and non-medical essential workforce, jails, homeless shelters, and immigration centers are at heightened risk of directly contracting COVID-19.

### National Models and Committee Recommendations

Harvard's Roadmap to Pandemic Resilience recommends 3 things: widespread testing, contact tracing and supportive social isolation to contain the spread of COVID-19 while re-opening our economy. The committee supports the ideology that COVID-19 initiates seismic waves within patient care. Therefore, prevention and supportive action for patient care must be addressed. Fig. 1 illustrates the four waves of patient care.

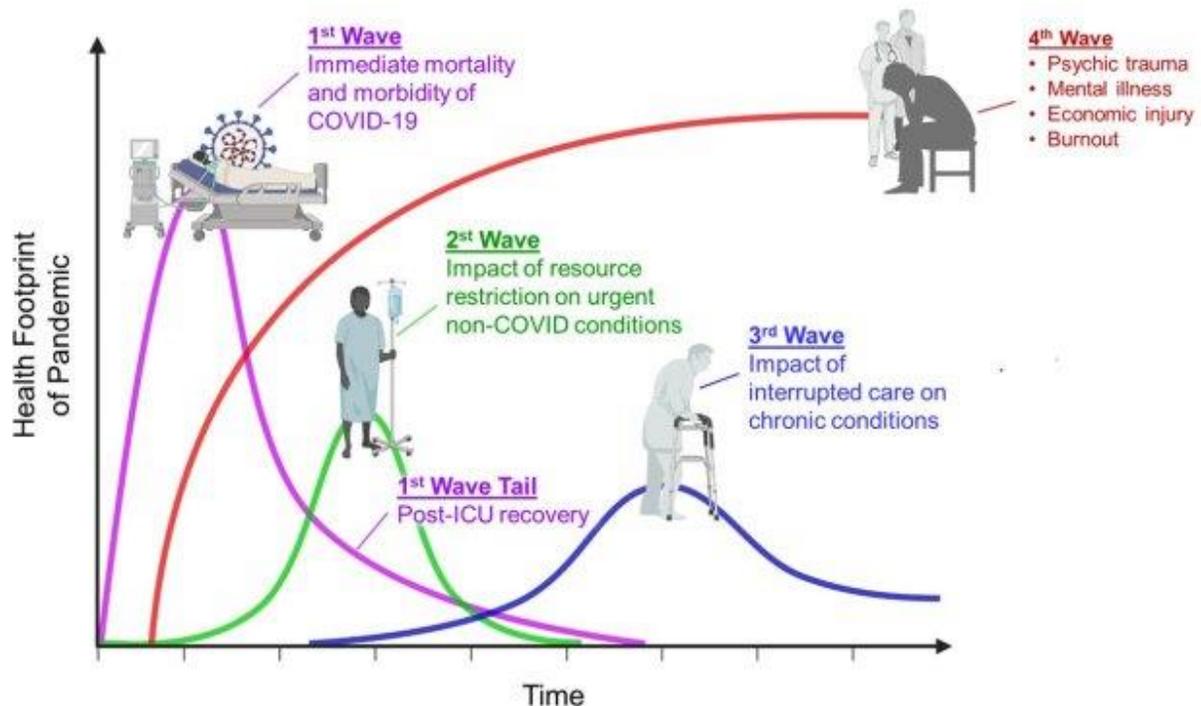


Figure 1

Tseng [@VectorSting](#)

<https://hldr.wordpress.com/2020/04/07/the-pandemics-4th-wave/>

Healthcare Leadership Blog

- 1st Wave: Immediate mortality and morbidity of COVID-19.
- 1st Wave Tail: Post-ICU and admission recovery for many patients.
- 2nd Wave: Impact of resource restrictions on non-COVID conditions – all the usual urgent things that people need immediate treatment for in acute circumstances.
- 3rd Wave: The impact of interrupted care of chronic conditions (people stayed home).
- 4th Wave: Psychic trauma, mental illness, PTSD, economic injury, burnout, and more.

Based on the aforementioned priorities, the following are administrative recommendations:

1. Improve State effort for outreach and awareness regarding COVID-19 prevention and mitigation
  - a. Timely communication to all Arkansans in appropriate literacy level and culturally appropriate language is critical to achieving compliance of recommended guidelines, i.e., mask wearing and social distancing.
  - b. Further expand public health service campaigns to become culturally and linguistically appropriate across all communities, repeatedly providing education and instructions to reach all vulnerable population. Utilizing key trusted sources in each community is key to how messages are delivered, received and accepted through multi-media modalities.
  - c. Increase public awareness of no personal cost testing and other policies of specified coverage related to COVID-19.
  - d. Collect, analyze and report data by sociodemographic markers and co-morbidities in addition to disaggregated data of age, race, ethnicity, gender, disability, neighborhood. This will serve to inform the allocation of resources to areas of most need.
2. Continue increased COVID-19 testing, treatment, and related care
  - a. Wide-spread testing, contact tracing and supportive isolation are crucial steps to mitigate spread of COVID-19 infection according to Harvard’s Roadmap to Pandemic Resilience.
  - b. Wide-spread testing must reach all vulnerable communities universally at no cost.
  - c. Train adequate numbers of contact tracers from vulnerable communities to obtain information from COVID-19 positive individuals and contact all potentially exposed individuals with instructions for testing and quarantine.
  - d. Provide supportive isolation once individuals are identified as being positive or exposed. Supportive services are essential to ensure they can comply with recommended quarantine guidelines.
  - e. Create a “Testing and Manage in Place Teams” consisting of various health related stakeholders. These teams will go into facilities – may it be homeless shelters, assisted living facilities, or at-risk neighborhoods – where there might be concerns about residents being able to access healthcare. The teams can conduct health screenings, connect individuals to social resources, and administer COVID-19 tests. With this approach, we are targeting our efforts to reduce the burden on healthcare systems across the state.
  - f. Policy is needed to cover the entire cost of testing and treatment related to acute COVID-19 infections. There also needs to be policies addressing coverage for the long-term sequelae of disease, i.e. repeat infection risks, damage to lungs, heart, kidneys and other organ systems that are yet unknown, but evolving.
3. Support and fund community-based organizations that provide social and wrap-around services
  - a. Continue and expand support needed non-profits, community or faith-based organization’s mission to serve the communities. Many of the services are in higher demand due to COVID-19 at a time when the organizations are struggling.

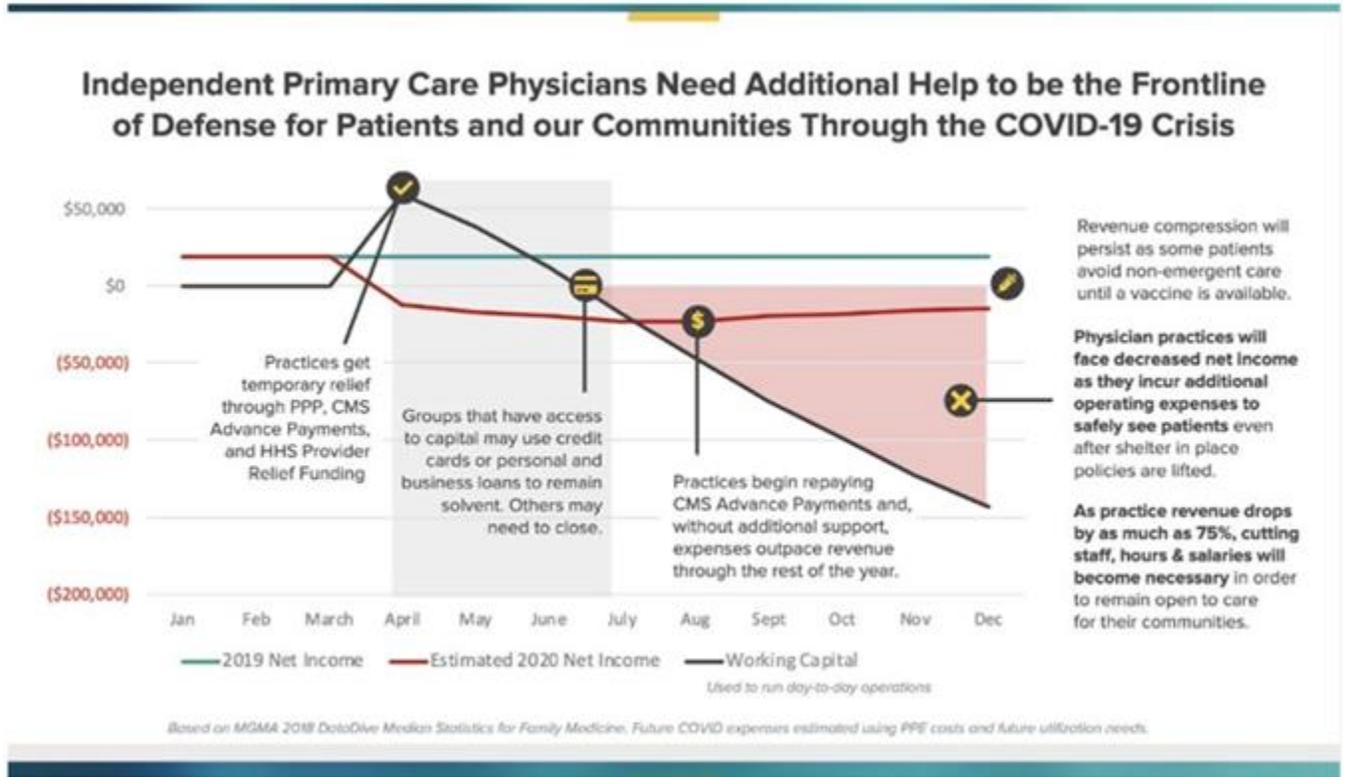
- b. Provide CARES funding and employment (including hazard pay) for Lay Health Workers with language translations and disability accommodations to deploy statewide (NW, NE, Central, SW & SE).
  - c. Support organizations, such as food banks, mobile food markets, farmer's markets or delivery services that are providing critically needed basic services.
  - d. Support homeless and domestic violence shelters that are in urgent need and in short supply. Domestic violence and child abuse have increased during the pandemic.
  - e. Create facilities for quarantine of individuals that cannot quarantine at home or have no home.
4. Provide support of health care providers, independent clinics, [primary care offices](#), federally qualified health centers (FHQC), and other health care systems to respond to COVID-19 and the expected rise of morbidity due to delayed care. Already clinics have closed in the State of Arkansas in areas of greatest need. Reports from the Primary Care Collaborative estimates 35% of primary care practices may close post COVID-19. This will increase barriers to access to care. The lack of chronic disease management during the pandemic is projected to create a separate and independent wave of morbidity and mortality, creating added stress to an already over-burdened system. (figure 2)
- a. Sufficiently subsidize and support health care providers, including independent primary care offices, Accountable Care Organizations, as well as federally qualified health centers (FHQC) that have experienced patient volume decline after closures due to COVID-19.
  - b. Support existing policies, practices, payment structures to ensure that the current health care services delivered through telemedicine during COVID-19 can be continued beyond this pandemic and the state of emergency.
    - i. Support reimbursement for current telemedicine services specifically for video and phone.
    - ii. Identify and remove barriers for continuity of care, medication refills, initiation of care, and treatment regarding telemedicine services.
  - c. Work with financial institutions to improve the lending process for small practices. Provide relief funding for small practices with a high volume of low-income clients to make COVID adjustments in care.
  - d. Statewide coordination and monetary support of Mobile Health Units in Arkansas for preventive services/ supportive care for chronic illnesses and connecting care to local clinics.
  - e. Expand the availability and accessibility of other essential health services.
  - f. Expand access to behavioral health prevention, treatment, and recovery services to address the wave of mental health issues (Figure 1) resulting from the physical, emotional, and socioeconomic stressors related to COVID-19.
  - g. Establish a reporting mechanism to report the closure of practices to assess statewide community health care needs.

5. Promote and fund safety and well-being of most disadvantaged communities, long-term investments, systemic solutions
  - a. Include in decision-making task forces the people most affected by health and economic challenges related to COVID-19 and benchmark progress based on their outcomes.
  - b. Establish and empower a task force dedicated to promoting racial equity in response and recovery efforts.
6. Work Place Issues
  - a. Education/awareness campaign by the state Department of Human Services to inform parents who lost employment how to register their children for Medicaid
  - b. Education/awareness by state Insurance Department to inform adults concerning the rules to obtain insurance via the marketplace.
  - c. Improve efforts by Arkansas Department of Labor to inform employees concerning rights for sick leave policy changes under the Families First Coronavirus Response Act (FFCRA) with increased access and transparency of DOL website highlighting Paid Leave and Sick Leave policies.
  - d. Support legislative efforts to ensure essential employees receive workers' compensation due to the risk of exposure to COVID-19.
  - e. Support legislative efforts to ensure all workers, regardless of status, industry, or form of employment, are able to earn paid sick leave due to exposure to COVID-19.
  - f. Support legislative efforts to provide whistleblower protections for employees filing complaints against employers failing to comply with public health orders related to COVID-19.
  - g. Improve oversight by the Arkansas Department of Labor to ensure workplace safety.
  - h. Ensure adequate and safe childcare for essential workers.
  - i. Mitigate disease spread by providing rental assistance preventing evictions.
7. Broadband Access & Connectivity
  - a. Improve infrastructure and access to all underserved areas of state.
  - b. Involve local health providers in the planning and distribution of service in rural areas.
  - c. Improve connectivity (Wi-Fi) possibilities with economic development by creating Medical Zones.

The Health Equity Response Team recommends the following legislative items for the 2021 session:

- Support legislative efforts to ensure essential employees receive workers' compensation due to the risk of exposure to COVID-19.
- Support existing campaigns to ensure all Arkansas workers, regardless of status, industry, or form of employment, can earn paid sick leave.
- Support existing campaigns to provide whistleblower protections for all Arkansan employees filing complaints against employers failing to comply with public health orders.
- The Health Equity Response Team wants to ensure that the communities who are being disproportionately impacted by COVID-19 are prioritized during the 2021 legislative session. In addition, the equity response team wants to ensure that Arkansas workers are protected.

Figure 2



References:

- <https://www.rwjf.org/en/library/research/2020/05/health-equity-principles-for-state-and-local-leaders-in-responding-to-reopening-and-recovering-from-covid-19.html>
- <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00794>

## COVID-19 CARES ACT EMERGENCY FUNDS REQUEST

Direct support to the public and private sector is needed. Small private practices and community-based organizations are vital to meeting the needs of vulnerable populations; however, COVID-19 barriers and limited resources have impeded their ability to serve their communities.

It will take some time for most to be back to full capacity, if ever. Reports from the Primary Care Collaborative estimates 35% of primary care practices may close post COVID. This will greatly widen the gaps of access to care. The lack of chronic disease management during the pandemic is projected to create a separate and independent wave of morbidity and mortality creating added stress to an over-burdened system.

It is imperative that we protect the safety and well-being of our most disadvantaged communities and invest in long-term, systemic solutions that will enhance the health of our communities beyond the COVID-19 crisis with the inclusion of people most affected by health and economic challenges on task forces. Progress should be benchmarked based on their outcomes.

This budget narrative outlines the proposed programs and supplies. Budget activities shall operate through December 30, 2020.

### Direct support for non-profits, small practices focused on vulnerable communities, & Federally Qualified Health Centers

We request 5 million in funding supports. Funding shall provide PPE, wrap-around services such as transportation, delivery for quarantined citizens (food, medications, etc.). Point of Care testing for twelve sites statewide by region. Point of Care testing includes staff, training, equipment, and supplies.

### Chronic Care Management & Support Mobile Health Units

We request \$10 million in funding supports. Chronic Care Management program to assist small practices statewide. Programming links Certified Health Education Specialists contracted/employed by Federally Qualified Health Centers to small primary care physician practices to provide patient outreach and follow-up. Costs include training, salary, and equipment.

Mobile health units shall provide preventive services and care for chronic illnesses. Funds support daily operation, decontamination, and equipment.