Thomas Dobbs, MD, MPH
State Health Officer
Mississippi State Department of Health
570 E. Woodrow Wilson Avenue
Jackson, MS 39216

April 14, 2020

Dear Dr. Dobbs,

The World Health Organization describes "equity in health" as an individual's fair and just opportunity to attain their full health potential with no one being disadvantaged from achieving this potential. There is a critical need to incorporate health equity into response efforts and all public policies enacted to combat the coronavirus disease (COVID-19) pandemic. As healthcare practitioners, public health professionals, policy makers, community advocates and community members, we are concerned by both the unacceptable racial disparity in COVID-19 deaths affecting Black people in Mississippi and the State's response to these observed disparities.

Historically, when health emergencies have occurred, the failure to acknowledge and address health equity generated persistent and preventable damage to those most at risk. We understand social injustices including the well-established legacy of structural racism, segregation and persistent explicit and implicit biases in healthcare create health inequities. The narrative about the disproportionately elevated rates of COVID-19 among Black people has been to blame pre-existing medical conditions, without consideration of healthcare quality, access to timely testing and treatment or biases in care that Black people may have faced. There has also been little recognition of the prolonged exposure essential workers and community members faced as the response to the pandemic evolved in our state. Learning recently that close to 70% of COVID-19 deaths were Black, came as both a shock and disappointment to many. This is now the time for action to prevent this disparity from widening and this disease from spreading in our community.

We urge serious consideration of the following recommendations to prioritize equity in the health department's response to the COVID-19 pandemic.

1. **Taskforce Representation**
   Ensure members of diverse populations are a part of decision-making and have a seat at the leadership table in planning and carrying out the COVID-19 response effort. This allows groups to share directly the insights needed to develop effective, sustainable strategies for and within their communities. This should include medical, public health, mental health and health equity experts.

2. **Prioritization of communities at greater risk**
   Prioritize the needs of diverse vulnerable populations at each stage of the response. These include, but are not limited to, communities of color, homeless persons, people in institutional settings, from skilled nursing facilities to prisons and detention centers, those who are income limited, as well as rural communities. Develop multiple prevention and intervention strategies that address the unique needs of marginalized groups. Recognize that the circumstances affecting vulnerable populations are multilayered. Accordingly, the solutions needed in these populations warrant greater initial investments than do the solutions needed in more advantaged communities.

3. **Specific, consistent and tailored messaging involving the Black community**
   Prevention of future COVID-19 cases requires that educational messaging about prevention is reflective of and sensitive to the needs and interests of diverse communities. We recommend that trusted messengers are featured to encourage individuals to employ recommendations. Various forms of communication beyond mobile, internet and media messaging are needed to reach populations with limited access to technology.

4. **Equity in the expansion of COVID-19 testing**
   Testing for COVID-19 should be expanded beyond the highly limited approach of only testing those with three or more significant symptoms. Anecdotally, many individuals have been turned away from testing at early stages in their illness, only to be tested within days of becoming severely ill. Given both the lack of access to coordinated care and the prevalence of high-risk comorbidities in the Mississippi population, the goal of testing should be to identify people prior to severe disease, particularly among older individuals or those with comorbidities of any age. Testing cannot be limited to those with access to a car during business hours. Consider local walk-up testing at grocery stores, bus stations, court houses and other accessible locations.

5. **Data analysis**
   Detailed assessment of COVID-19 cases is needed to first understand where and how members of the Black population were exposed to and acquired coronavirus. This is critical to strategize for primary prevention of new cases.

   Secondly, studying the circumstances surrounding testing (race, location) is critical for determining if testing is being performed equitably, without bias and leads to appropriate triage and treatment.

   Lastly, details surrounding COVID-19 deaths are important to determine the contributing factors to the death including the patient comorbidities, access to care, hospital and provided level factors like adequacy of equipment and availability of specialists, knowledge and preparation of staff. Narratives from family are also important to determine if there was any actual or perceived bias in care. While it is easy to attribute deaths to patient factors alone (“demographics”), neglecting other factors like explicit and implicit bias, care quality and access would be a lost opportunity for systems level improvement. *(See Appendix A for detailed proposed strategy for case evaluation and data analysis.)*

This moment makes it clear that each and every person's health is intertwined. To stop the spread of the virus, we can't afford to leave anyone out of our containment measures, no matter who they are and where they reside. For everyone's safety and well-being, we must ensure that our actions are equitable and extend to underserved and medically-disinvested people and communities, thus preventing additional harm.

Sincerely,

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APPENDIX A - PROPOSED STRATEGY FOR CASE EVALUATION & DATA ANALYSIS

The following is a proposed strategy for case evaluation and data analysis with a focus on racial disparities and health equity. This is modeled after mortality review guidance issued by the Centers for Disease Control and Prevention (CDC). All of these assessments may not be possible with currently available data but may be considered and expanded upon for future data collection and analysis.

(Black is intentionally capitalized in this document as this is preferred by members of the population, it represents a broad ethnic and cultural group and not a color, references here: https://apastyle.apa.org/style-grammar-guidelines/bias-free-language/racial-ethnic-minorities).

1. Race # and % of those tested, regardless of result.
2. Map of where Black patients were tested by county.
3. Average length of time from testing to result.
4. Among Black patient cases:
    a. age distribution
    b. Gender distribution
    c. Map
    d. # and % hospitalized-ever
    e. Trauma level of hospital
    f. # associated with Nursing home outbreaks
    g. Underlying health conditions
5. Among Black patient deaths
    a. age distribution
    b. gender distribution
    c. Map/county
    d. Location of death: residence vs hospital
    e. Level of hospital/ bed size
    f. # and % associated with nursing home
    g. Underlying health conditions including age distribution
6. Detailed information from case abstraction/ tracing. Qualitative or narrative descriptions preferred.
7. Level of detail required to understand severity of disease, cause of death, contributors to the death, quality of care and possible opportunities for prevention.
    a. Suspected location of exposure (travel, employment, event, family contact)
    b. Timing of testing from symptom onset
    c. Number of attempts to receive testing
    d. Timing of hospitalization from symptom onset
    e. Length of ICU admission
    f. Length of time on ventilator
    g. Treatments rendered
    h. Location of death
    i. Cause of death
8. Contact tracing- how many cases attributed to another known case?
9. Are there any common patterns for COVID-19 exposure among Black patients?
10. Where did early cases of COVID-19 in MS originate?
11. Can racial distribution be plotted by week since 3/1/2020?

Members of any analytic team should have expertise in health equity and disparities and include members of the communities being studied. Ideally, input from both professional and lay stakeholders should be included.

The intent of data analysis should be to mobilize swift solutions and action rather than for research alone. The goal should be utilizing and disseminating real time data to prevent COVID-19 cases and deaths in the immediate future.

While this document focuses on the Black population, other communities of color and marginalized populations should have specific focus and attention including those who are indigenous, undocumented and people in institutional settings, from detention centers to prison populations.