Michigan Coronavirus Racial Disparities Task Force

Recommendations for Collaborative Policy, Programming and Systemic Change

State of Michigan's progress report on short- and long-term goals, and recommendations for collaborative policy and programming.

MDHHS
Michigan Department of Health & Human Services

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My fellow Michiganders,

In the initial months of the COVID-19 pandemic, our state measured and observed data that showed deeply disturbing racial disparities that negatively impacted Black, indigenous, and other communities of color: in a state where 14 percent of the population is Black, more than 40 percent of coronavirus deaths were Black Michiganders. Other communities experienced similar disparities. Governor Whitmer and I were not content to let this reality persist. That is why I committed to leading the Michigan Coronavirus Taskforce on Racial Disparities, the first and only of its kind in the nation.

This body assembled some of Michigan's greatest minds, including doctors, health experts, scientists, community organizers, and legislators, to flatten racial disparities in our COVID-19 response, as well as boost our broader effort to reduce disparities in health outcomes. I am continually grateful for each task force member's willingness to serve and create meaningful and lasting change.

This report details the Michigan Coronavirus Taskforce on Racial Disparities' progress on our short- and long-term goals, and it presents our recommendations for collaborative policy and programming work with the Michigan Department of Health and Human Services and other state departments and agencies. Our recommendations recognize that systemic problems require systemic solutions. We are pleased to show in this report that thanks to the actions we took in 2020 and 2021, we have achieved and maintained significant reductions in the initially observed racial disparities in COVID-19 deaths without losing sight of the very real need to reverse the generations of inequity that created those disparities.

Governor Whitmer and I will continue to listen to ideas and meet people where they are, so we can together continue overcome any obstacles. We will not stop working alongside the people of color fighting against the odds in order to lead safer, happier, healthier lives, and we will continue to support and promote strategies and tactics to provide equitable access to opportunity for everyone in Michigan.

Sincerely,

Lieutenant Governor Garlin Gilchrist II
State of Michigan

I. Executive Summary

The COVID-19 pandemic has disproportionately impacted communities of color. Black or African Americans have been the most impacted racial group during the pandemic, with the highest rate of cases and deaths during the first wave.[i] In April 2020, Governor Gretchen Whitmer established the Michigan Coronavirus Racial Disparities Task Force ("Task Force") to address the disproportionate toll of the pandemic amongst communities of color in Michigan.

The Task Force, chaired by Lt. Governor Garlin Gilchrist and led by Tommy Stallworth is comprised of state and federal legislators, leaders of community organizations, university partners, state government officials, and other key partners. The Task Force is made of three primary workgroups: Strategic Testing Infrastructure, Centering Equity, Primary Care Connections. These workgroups, along with experts from other key partner organizations, developed a series of recommendations that are either currently implemented, in progress, or are future recommendations to address racial disparities in Michigan's health care system.

The Task Force took immediate action to address racial health disparities and proposed solutions to address these disparities. Key actions implemented to address racial disparities of the COVID-19 pandemic included reducing barriers to testing in communities of color, expanding testing to the most at-risk for serious illness, developing culturally competent messaging for best practices of COVID-19 mitigation, improving racial data collection, and sharing, and improving access to health care for marginalized populations.

This progress report highlights key learnings from our response to COVID-19. This report is intended to help Michigan, and other states and localities, effectively prepare for addressing the next pandemic or public health crisis in a more racially equitable way that acknowledges and responds to the challenges that systemic racism presents. The pandemic has shown the disparate impact that social determinants of health have on marginalized populations and impacts their ability to access and receive quality health and social services. The pandemic has also shown how deep the distrust in government and other institutions and that responses must work to address this distrust. In addition, communities of color are overrepresented in the frontline workforce. Therefore, efforts must continue to be made to address these barriers.

II. Overview of the Coronavirus Racial Disparities Task Force

SCOPE OF THIS REPORT AND INTENDED AUDIENCE

It was not the Task Force's goal to write a report simply cataloging the problem of racial disparities in our health care system. To comprehensively summarize the multitude of issues discussed by or presented to the Task Force and its workgroups would require a report so voluminous that it would be of limited use. Further details of the Task Force's work can be found in the 2020 report, bit.ly/3GpuCTU.

The Task Force's purpose was instead to write a report easily understood by non-experts and experts alike, to guide future health equity work in Michigan and the rest of the country, both through the duration COVID-19 pandemic and beyond. The primary audience for this report is, correspondingly, those who must turn the Task Force's recommendations into action, including health equity advocates, state government agencies, nonprofit and private industry partners, and the state legislature.

This report focuses on this audience in several ways.

1. First, the report provides data and background information about how the COVID-19 pandemic has disproportionately impacted communities of color in Michigan.
2. Second, the report details action steps that the Task Force has implemented so far throughout the pandemic, in strong partnership with MDHHS and other key partners, to address health equity barriers. The report also presents key lessons and themes that have arisen throughout the work of the Task Force so far, which the Task Force hopes can better inform addressing the COVID-19 pandemic and future pandemics in a more racially equitable way.
3. Third, the report lays out a series of clear and understandable recommendations the Task Force believes will help address the problem of systemic racism in our health care system and move the needle on racial health disparities throughout the duration of the COVID-19 pandemic and beyond. The Task Force believes this report can be an effective tool for use by individuals and organizations within the State of Michigan and nationwide to be more effective advocates for changing racial health disparities.

At the time of writing this report, Michigan and many states across the country are experiencing a surge in COVID-19 cases associated with the Delta (B.1.617.2) and Omicron (B.1.1.529) variants. The Delta variant was first detected in India in October 2020 and later became the predominant strain in the United States in July 2021.

The Omicron variant was first detected in South Africa in November 2021 and has recently overtaken Delta as the predominant strain in the United States. These variants contains several mutations that make it much more

transmissible than the ancestral strain of SARS-CoV-2 and it also has potential mechanisms to reduce neutralization properties of monoclonal antibodies or post-vaccination sera (both are post-exposure prophylaxis treatments). With insufficient vaccination coverage and immune-naïve individuals resuming populated household mixing (e.g., return to in-person schooling, festivals/concerts, etc.) allowed the Delta and Omicron variants to rapidly spread nationally, including within Michigan. Comprehensive data was not yet available to assess the overall impact of this surge on racial disparities to include in this report, but the Task Force is committed to including additional information about racial disparities involved in this wave and potential others as the pandemic continues.

STRUCTURE AND MEMBERSHIP OF THE TASK FORCE

The Task Force was established in April 2020 by Governor Gretchen Whitmer. The Task Force, chaired by Lt. Governor Garlin Gilchrist, is comprised of state and federal legislators, leaders of community organizations, university partners, state government officials, and other health equity partners. Tommy Stallworth from the Executive Office of the Governor serves as lead staff for the Task Force. The Task Force consists of 23 members appointed by Governor Whitmer to bring a robust set of perspectives to address racial health disparities:

Full Task Force Membership

- Lieutenant Governor Garlin Gilchrist, Chair
- Honorable Thomas F. Stallworth III, Senior Advisor to the Governor and Director of the Task Force
- Director Elizabeth Hertel
- Chief Medical Executive Dr. Joneigh S. Khaldun

Governor Appointees

- Brandi Nicole Basket, D.O., Clinton Township; Chief Medical Officer for Meridian Health Plan Michigan Market
- Matthew L. Boulton, M.D. Ann Arbor; Senior Association Dean for Global Public Health and Director of the Minority Health and Health Disparities International Research Training Program at the University of Michigan
- Renee Branch Canady, Ph.D., Lansing; Chief Executive Officer of the Michigan Public Health Institute
- Denise Brooks-Williams, Detroit; Senior Vice President and Chief Executive Officer of the Henry Ford Health System North Market
- Sen. Marshall Bullock, Detroit
- Dessa Nicole Cosma, Detroit; Executive Director of Detroit Disability Power
- Connie Dang, Jenison; Director of the Office of Multicultural Affairs and Special Assistant for Inclusive Community Outreach at Grand Valley State University
- Marijata Daniel-Echols, Ph.D.; Farmington Hills; program officer at W.K. Kellogg Foundation
- Debra Furr-Holden, Ph.D., Flint; epidemiologist and associate dean for Public Health Integration at Michigan State University, and director of the Flint Center for Health Equity Solutions
- Audrey E. Gregory, Ph.D.; Franklin; Chief Executive Officer of the Detroit Medical Center
- Whitney Griffin, Detroit; Director of Marketing for the Downtown Detroit Partnership

- Bridget G. Hurd, Southfield; Senior Director of Diversity and Inclusion at Blue Cross Blue Shield of Michigan
- Curtis L. Ivery, Ph.D., Detroit; chancellor of Wayne County Community College District
- Solomon Kinloch Jr., Oakland Township; Senior Pastor at Triumph Church in Detroit
- Jametta Y. Lilly, Detroit; Chief Executive Officer of the Detroit Parent Network
- Curtis Lipscomb, Detroit; Executive Director of LGBT Detroit
- Mona Makki, Dearborn; Director of the ACCESS Community Health and Resource Center
- Alycia R. Meriweather, Detroit; deputy superintendent of the Detroit Public Schools Community District
- Randolph Rasch, Ph.D., East Lansing; professor and dean of the Michigan State University College of Nursing
- Celeste Sanchez Lloyd, Grand Rapids; community program manager for Strong Beginnings at Spectrum Health and a fellow in the W.K. Kellogg Foundation
- Jamie Paul Stuck, Scotts; Tribal Council chairman and member of the Nottawaseppi Huron Band of the Potawatomi Tribal Council
- Maureen Taylor, Detroit; state chair of the Michigan Welfare Rights Organization
- LaChandra White, Allen Park; director of the UAW Civil and Human Rights Department.
- M. Roy Wilson, M.D., Detroit; president of Wayne State University
- Representative Sherry Gay-Dagnogo
- Attorney General Dana Nessel
- Congresswoman Brenda Lawrence

In support of the Task Force, three working groups were established:

1. **The Centering Equity Workgroup** focuses on studying the cause of the COVID-19 racial disparities and recommending policies and practices that can be implemented in the present to respond to immediate needs and the future to combat racial disparities in possible new pandemics or health crises.
2. **The Primary Care Connections Workgroup** is charged with examining both short-term and long-term strategies to address the needs of uninsured Michiganders and to close the historical gap of relationships with primary care providers amongst communities of color.
3. **The Strategic Testing Infrastructure Workgroup** is tasked with implementing the infection testing and vaccine delivery infrastructure needed to effectively meet the needs of the Black or African American community and other marginalized communities during the public health emergency.

Furthermore, the Task Force received additional expertise and recommendations related to racial disparities in environmental justice and telemedicine.

The Environmental Justice Workgroup was established because environmental issues play a significant role in the health and welfare of communities of color as they are disproportionately exposed to air and water pollution and suffer from associated chronic health conditions. Access to clean water is a necessity, and as such efforts should include improving water affordability and accountability for

polluters. RDTF members will be asked to act as representatives in the already assembled Michigan Advisory Council on Environmental Justice to drive integration of coronavirus disparate impact considerations in the environmental justice problem solving process.

The Access to Telemedicine Workgroup was established because African Americans and communities of color disproportionately suffer from a shortage of doctors and primary care services. These shortages contribute to poor short- and long-term health outcomes and reduce the ability of community members to manage chronic conditions. Increased access to high-speed internet and telemedicine and other forms of remote medical care may contribute to overcoming obstacles, including transportation and physician shortages, that otherwise prevent or diminish care for communities of color. However, working through the issues with telemedicine is so complex that we referred this work to the much broader discussion about broadband expansion.

Public participation has been welcomed at every stage of the Task Force process. All meetings are open to the public, with dates, times, and locations of meetings posted online in advance. Time is also allocated for public testimonials at all full Task Force meetings. Both the full Task Force and workgroups bring in numerous experts and advocates to provide them information and advice on addressing racial disparities during the COVID-19 public health emergency.

NOTE ABOUT RACIAL/ETHNIC IDENTIFICATION TERMINOLOGY

We acknowledge the right of individuals who trace roots back to Latin America to self-identify as Latiné/Latinx/Hispanic/Latino or any other self-identity of meaning based on generation, place of birth, cultural ties, immigration status, amongst many other factors. While our priority is to elevate this right, we also understand our responsibility to align with federal Office of Management and Budget (OMB) data reporting standards and regulations. For this reason, we have opted to use Latino or Hispanic to represent this diaspora in this report.

The relationship between the State of Michigan and Native Americans is identified less through a racial/minority lens and more through a "Government to Government" relationship lens. Tribes are sovereign governments which provide health and other services directly to their citizens. MDHHS works in partnership with the state's 12 federally recognized Indian Tribes and American Indian Health and Family Services (Metro Detroit Area) to support those agencies' efforts to provide health services to Michigan's Native American population. Native American Health and Family Services serves Michigan's largest concentration of Native Americans that do not live in a specific tribe's geographic service area. Each of the 12 federally recognized tribes has one or more Health Clinics and MDHHS works continuously to help support all a variety of ways through multiple divisions of the department.

III. DATA

Over 2 million cases of COVID-19 have been confirmed in Michigan, claiming more than 30,000 lives.[ii] Racial and ethnic minorities have made up a disproportionate share of these cases and deaths. Michigan was hit especially hard during the first wave of the pandemic, and the first wave was particularly devastating to Black or African Americans, see **TABLES 1 AND 2**. African Americans had the highest rate of cases among all racial groups. More importantly, Black and African Americans had by far the highest death rate in Michigan.

Governor Whitmer's Executive Directive issued August 5, 2020, notes the rate of reported COVID-19 cases for Black or African American Michigan residents is more than three times higher than for White residents, and the rate of reported COVID-19 deaths for Black or African American Michigan residents is more than four times higher than for White residents.[iii] Since the launch of the Task Force, this disparity has declined.

To understand the impact of the COVID-19 on racial and ethnic minorities, it is critical to also understand the underpinning data. Epidemiologically, COVID-19 cases and deaths are identified and enumerated using national surveillance definitions.[iv] Through June 30, 2021, Michigan has experienced three waves of the COVID-19 pandemic – (1) the early spring wave between March 1, 2020 and June 15, 2020 [107 days], (2) the wave including the 2020 holiday season between June 16, 2020 through February 20, 2021 [250 days], and (3) the alpha variant (B.1.1.7) wave between February 21, 2021 through June 30, 2021 [130 days].[v] Trends over time show that each subsequent wave was higher than the previous wave. The all-time COVID-19 high was on April 11, 2021, and the all-time low was on June 26, 2021.[vi]

TABLE 1: The daily average case rates by rates adjusted for the duration of each of the waves

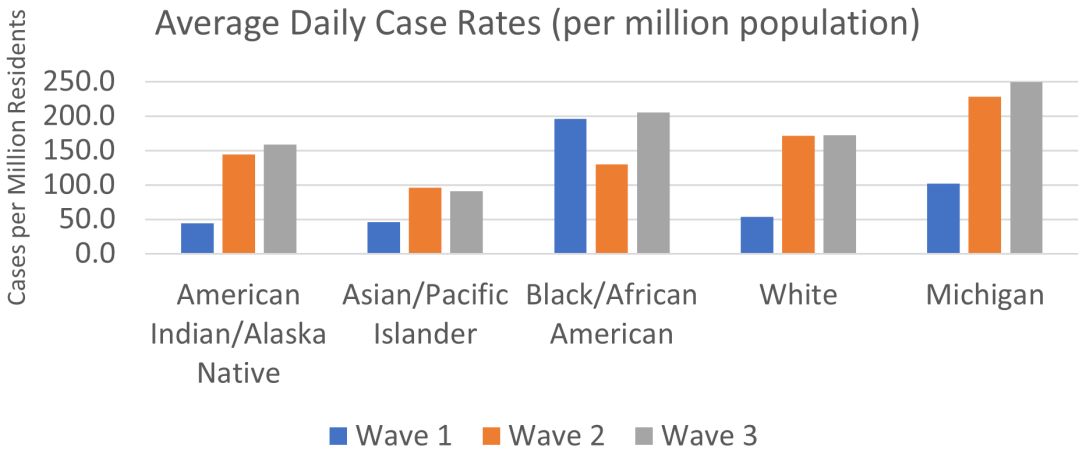


TABLE 2: The daily average death rates by rates adjusted for the duration of each of the waves

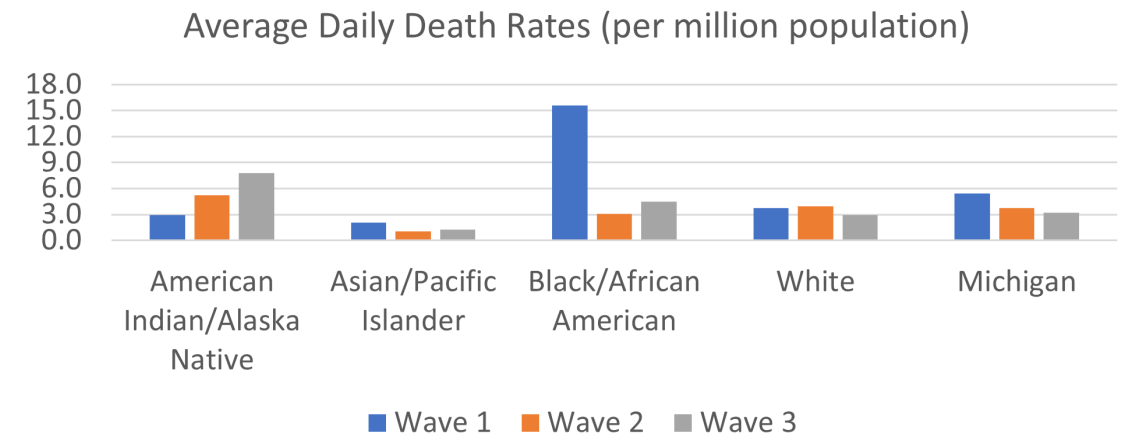
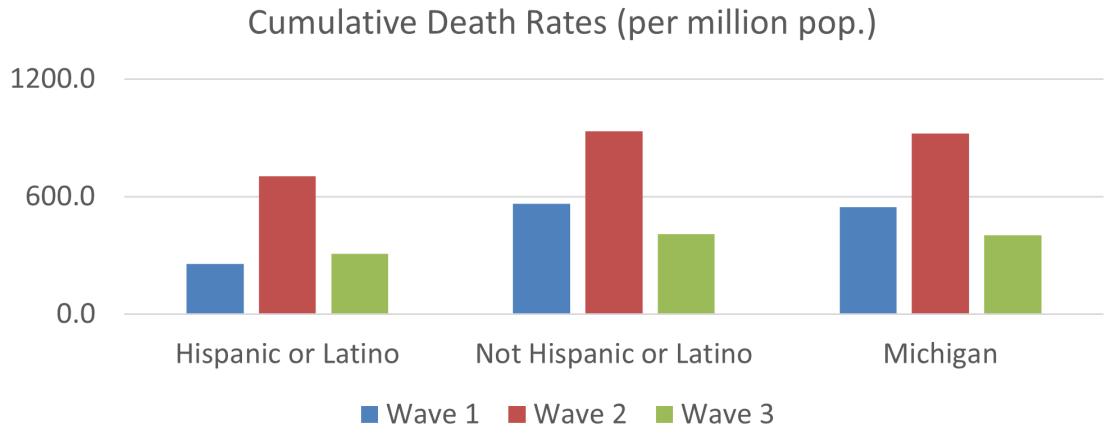


TABLE 3: Death rate trends by ethnicity in Michigan



Throughout these waves, racial and ethnic minorities were disproportionately impacted by the pandemic. For example, as illustrated in Table 1, Blacks/African Americans had more COVID-19 cases than any other racial group during the first wave. The second wave a decline in racial disparities However, the third alpha wave saw the highest case rates among Blacks/ African Americans and those whose race was either unknown or multiracial/other (these latter two groups not shown). Hispanic or Latino populations have also been disproportionately impacted by the COVID-19 pandemic. Hispanic or Latino populations have had case rates greater than Not Hispanic or Latino populations for all three waves of the pandemic. While disparities in case rates were reduced in the second and third waves overall, in addition, nonwhite covid-19 patients were more likely to be readmitted a hospital within 60 days of release after release from an earlier COVID-19 hospitalization.[vii]

Table 2 illustrates the disproportionate death toll that COVID-19 had among Blacks/ African Americans during the first wave in Michigan. Blacks/African American COVID-19 deaths (15.6 per million) were four times higher than those for Whites (3.7 per million) in Michigan. Table 2 also demonstrates that American Indian and Alaskan Native had the highest rate of death during the second (5.3 per million) and third wave (7.8 per million) of the pandemic in Michigan.

TABLE 4: Daily case rates trends by ethnicity in Michigan

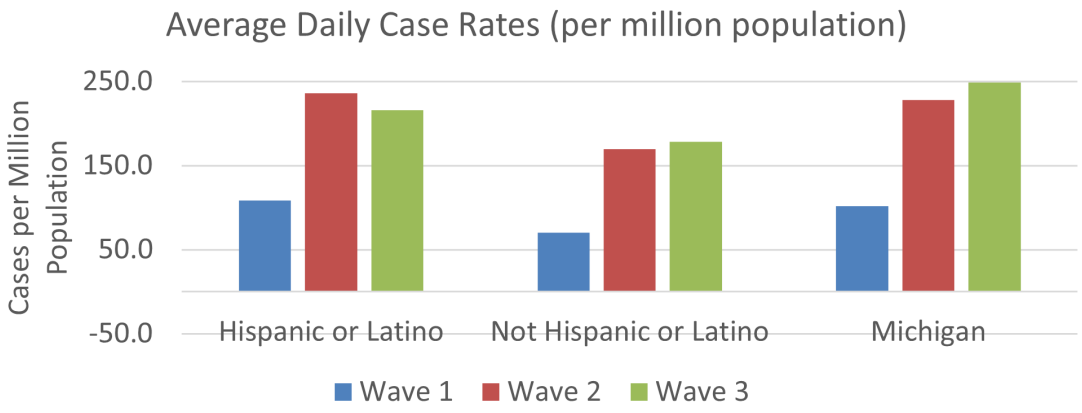


TABLE 5: Death rate trends by race

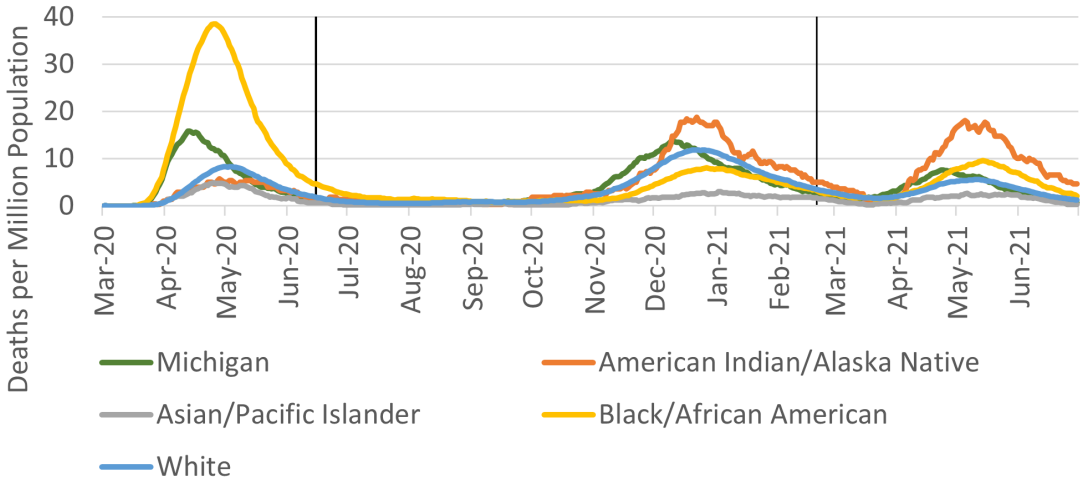
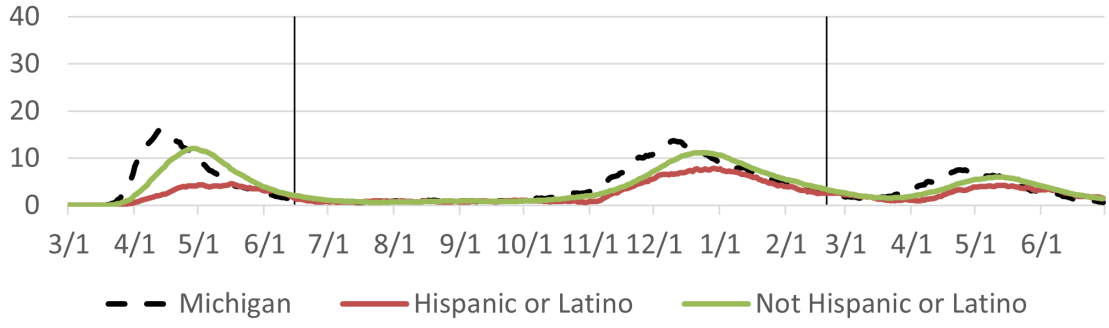


TABLE 6: Death rate trends by ethnicity



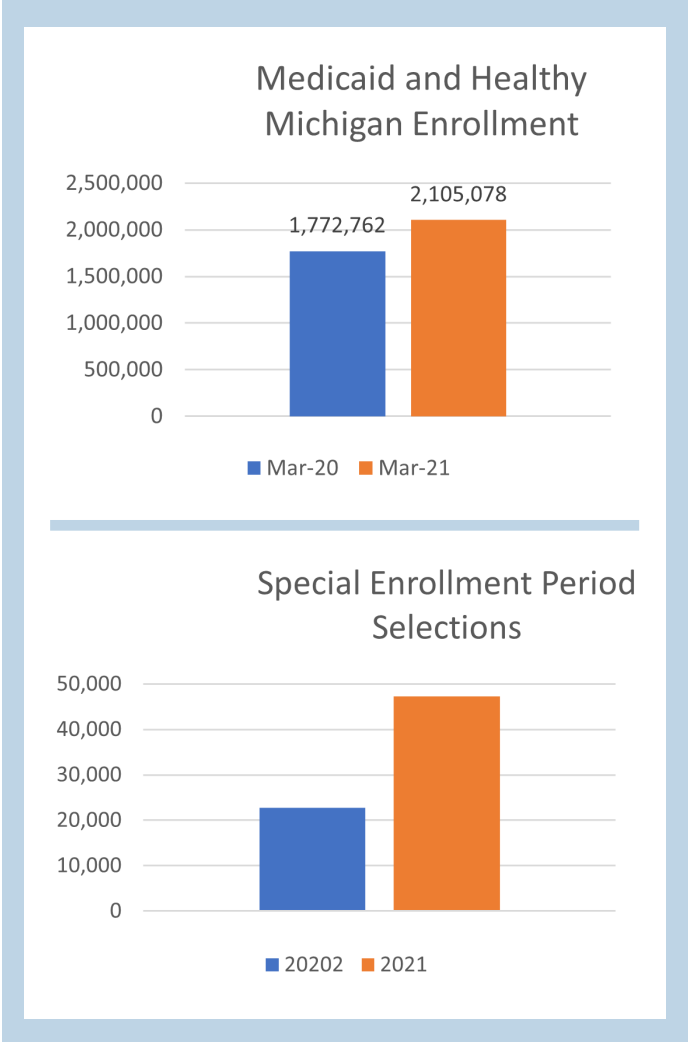
IV. Response

While Black or African American, American Indian or Alaska Native and Hispanic or Latino communities continue to be disproportionately impacted by the COVID-19 pandemic in Michigan, the Task Force has made significant progress in reducing disparities. The death rate in the first wave million was 15.6 per million and was reduced to 4.5 per million in the third wave. Michigan has been able to sustain its progress on flattening disparities, even in the face of the spread of COVID-19.Below are selected examples of work from the Task Force and key partners that have made an impact on the racial disparities exacerbated by the pandemic. While this section aims to provide a blueprint for adopting a racial equity lens in future and ongoing pandemic response work, it also highlights key areas for improvement.

ADDRESSING SYSTEMIC RACISM IN THE HEALTH CARE SYSTEM

Key Takeaway: Expand access to care and increase implicit bias training to improve the health of minority communities.

The Task Force, and particularly the Centering Equity Workgroup, focused on how to put in place policies, programs, and practices that mitigate unintentional negative impact and contribute to the ending of systemic racism. For example, the Task Force was instrumental in advocating for Executive Directive 2020-7 which directs the Department of Licensing and Regulatory Affairs (LARA) to begin developing rules that will require implicit bias training as part of the knowledge and skills necessary for licensure, registration and renewal of licenses and registrations of health professionals in Michigan. In addition, launched a Racial Equity Impact Assessment (REIA). A REIA can help to develop strategies and actions that reduce racial inequities and improve outcomes for all groups. One of the most significant contributors to racial disparities in the COVID-19 pandemic was the already existing disparity of being uninsured or underinsured, and the widespread lack of access to health care. A persistent ongoing commitment to providing health coverage for all is a strategic necessity.



Cross functional teams (DHHS & DIFS) were established to integrate outreach for Medicaid and market enrollments. Medicaid and Healthy Michigan enrollment increased 1,772,762 in March 2020 to 2,105,078 in March 2021. The 2021 Special Enrollment Period for Marketplace coverage led to 47,306 Michigan residents obtaining health insurance coverage.

SUPPORTING MOTHERS AND INFANTS

In the early stages of the pandemic, pregnant people were categorized as high-risk and advised to limit social interactions to protect themselves against contracting the virus. While health care services were disrupted for many Americans during the pandemic, these disruptions to care were particularly concerning for pregnant and postpartum people because limited access to services increase the risks of adverse health outcomes for both mother and baby. This challenge compounded existing challenges pre-pandemic that many Black/African American, American Indian or Alaska Native, and Hispanic/ Latino mothers face in obtaining access to affordable, quality prenatal and postpartum care.

In Michigan, pregnancy-related mortality is 2.4 times higher among Black/African American women compared to white women.[viii] Black/ African American mothers also endure a greater burden of morbidity and other complications related to pregnancy. While in general, many health disparities may be largely explained by factors like socioeconomic status, immense disparities in maternal health persist even among Black/ African American women with a college degree and/or higher income levels.

The Task Force was concerned about the disparate negative health outcomes experienced by Black/African American moms and dedicated attention on how to help moms navigate the challenges presented by the pandemic. After the Task Force identified mothers and infants as a group particularly susceptible to exacerbation of racial disparities during the pandemic, the Task Force set out to enact meaningful policy changes that could be accomplished quickly at the executive level to better support this population. The Task Force met with MDHHS staff to help the Executive Office of the Governor secure extended healthcare coverage for low-income new moms to a full year after giving birth and move a woman's first postpartum visit to within three weeks, with a comprehensive visit within twelve weeks.

IMPROVEMENTS TO INDOOR AIR QUALITY IN SCHOOLS

Communities near environmental hazards and those who experience impact from those hazards are at greater health risk for respiratory disease, including COVID-19. Air quality can be impacted by proximity to certain industries, air pollution, and building ventilation. These factors are particularly concerning for school-aged children in certain areas of the state, where rates of childhood asthma are already elevated.

Due to the racial disparities present in environmental hazards, assessments were conducted in schools to ascertain indoor air quality standards. Michigan is targeting to complete 200 air quality assessments in schools. Furthermore, assessments are only the first step. Many schools need funding for infrastructure changes to upgrade air filtration and HVAC systems to protect marginalized students from susceptibility to COVID-19 and other respiratory illnesses, such as asthma.

TESTING AND VACCINATION INNOVATION

Key Takeaway: Invest in the infrastructure to meet marginalized communities where they are, including strategically located neighborhood sites, school health centers, and mobile health units.

Early in the pandemic, COVID-19 testing was not widely available. Even when testing was available, it was not located in areas easily accessible to those most impacted by the pandemic, including amongst communities of color. Furthermore, data was not easily available to identify historically underserved communities and track progress in testing efforts. In addition, there was not clear messaging on the importance of public health mitigation measures for communities of color to minimize COVID-19 risk.

This exacerbated the disparities that already existed among racial and ethnic minorities. To address these barriers, the Strategic Testing and Infrastructure Workgroup was formed with the mission of eliminating barriers to testing for marginalized communities. The Strategic Testing and Infrastructure Workgroup quickly developed recommendations to address these barriers to testing. This work involved expanding eligibility for testing, better targeting marginalized communities to receive testing, tailoring public health messaging toward communities of color, and improving collection and use of data.

As a result of substantial community engagement and extensive expertise of Task Force members, MDHHS and community partners were able to use a data driven strategy to identify communities to expand COVID-19 testing services once testing became more available, see 2020 report for more details. This resulted in the implementation of a Neighborhood Testing Strategy within MDHHS.

Under a rapid timeline, vendors were secured to provide medical staff, supplies, and reporting services in partnership with trusted community organizations to provide testing in 22 high need areas identified by the data driven strategy. Thanks to this initiative, over 247,594 tests were administered at 22 neighborhood testing sites in communities across the state. Most of the sites are in high-risk census tracks where a high percentage of minority populations reside across the state. These sites can be found here: Coronavirus - Community Based Pop-Up Rapid Antigen Testing Events (michigan.gov).

Furthermore, this initiative promoted services to eliminate barriers at testing sites by providing culturally and linguistically competent, accessible services for all, including individuals with physical, intellectual, and developmental disabilities; the deaf, blind, and hard of hearing; those who speak a foreign language; and individuals without government-issued identification.

Key actions for disabled populations include developing the following resources: Best Practices for Accessibility at Michigan Testing Sites and Guidelines and Best Practices for Accessibility and Michigan Vaccination Sites. Additionally Migrant services agencies in state government partnered with community agencies to establish a testing program among migrant workers. Migrant workers are at higher risk of infection and serious health complications from COVID-19, as they often live in congregate settings and have higher rates of high-risk health conditions. Since the start of the Migrant testing program, over 15,000 tests and 4,000 vaccines have been administered in this effort. The COVID-19 testing program for migrant workers helped to reduce outbreaks among this community.

Once COVID-19 vaccines became available, Neighborhood Testing Sites pivoted to employ their strategic community testing sites and strong trust within those communities to offer vaccines to some of Michigan's most marginalized citizens. Because these sites were already embedded into communities and providing trusted support during the pandemic, such as follow-up care for all residents that tested positive and resources to safely quarantine, these sites were extremely successful at providing a spectrum of COVID-19 prevention and care services, including vaccinations. These trusted, consistent services will continue to be crucial in vaccinating more Black or African American Michiganders and delivering booster shots to those who are eligible to curb the impacts of more contagious variants. MDHHS also

collaborated with the federal Indian Health Services and American Indian Health and Family Services to stand up and publicize large vaccine clinics. Furthermore, Neighborhood Testing Sites began to offer non-COVID related social supports and services as well, such as offering the 2020 census questionnaire at the time of testing.

Key Takeaway: Partner with impacted communities to respond to the crisis and reduce disparities.

With the guidance and expertise of the Task Force, MDHHS was able to be intentional about community engagement and sharing power and decision making with communities experiencing inequities during the COVID-19 pandemic. Nowhere was this more evident than the work of the Neighborhood Testing Sites, where the Task Force and MDHHS built strategic partnerships to build capacity with trusted local organizations to conduct COVID-19 testing, and eventually vaccinations. This model can be applied more broadly to other health services, as several of the Task Force Workgroups recommended, to help decrease disparities in access to resources for health in communities where trust and access to the traditional health care is lacking.

Because this approach is targeted for groups experiencing the effects of structural racism, a significant focus was placed on bringing these resources to Detroit and Wayne County, but the benefits are expected to radiate across the state. The team at MDHHS who implemented this program were able to embed a community-driven approach in several important ways. First, hiring for on-site positions needed at the Neighborhood Testing Sites were offered to local community partners first. This intentional hiring process allowed qualified candidates to come from the specific community where the site was located, which inserted another layer of trust into the work at the site.

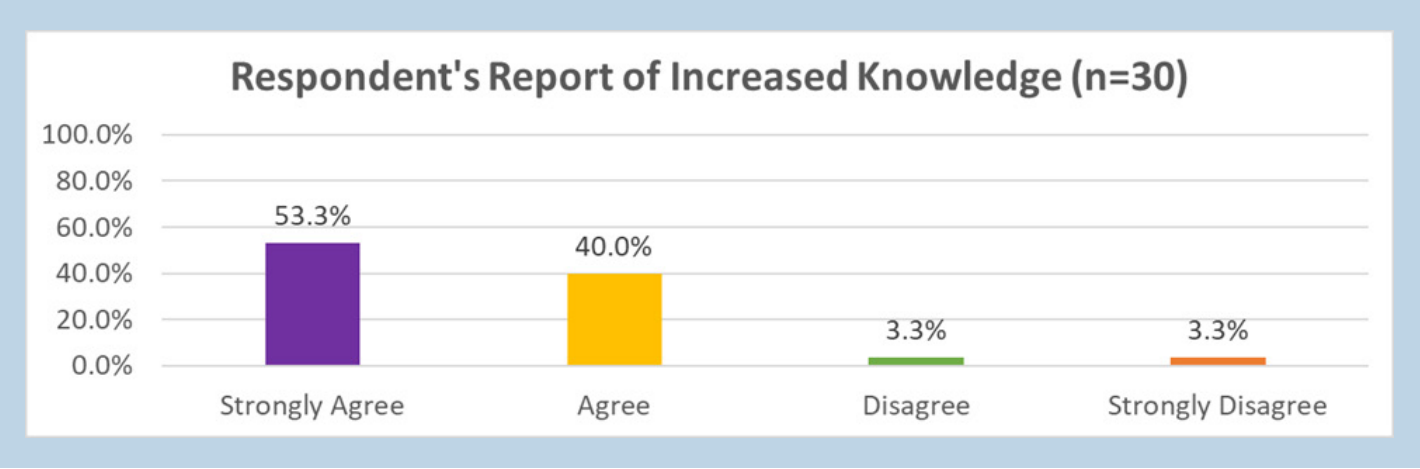
Furthermore, this hiring practice served as an economic empowerment tool for the community, one of several that the MDHHS team employed. Another example of this is demonstrated in that MDHHS rents space at the Neighborhood Testing Sites, which plays a significant role in the sites being able to operate testing and vaccination services to their community. Financial investment and empowerment have been important to demonstrate that the state places value in the work occurring at these sites to address racial disparities during the pandemic.

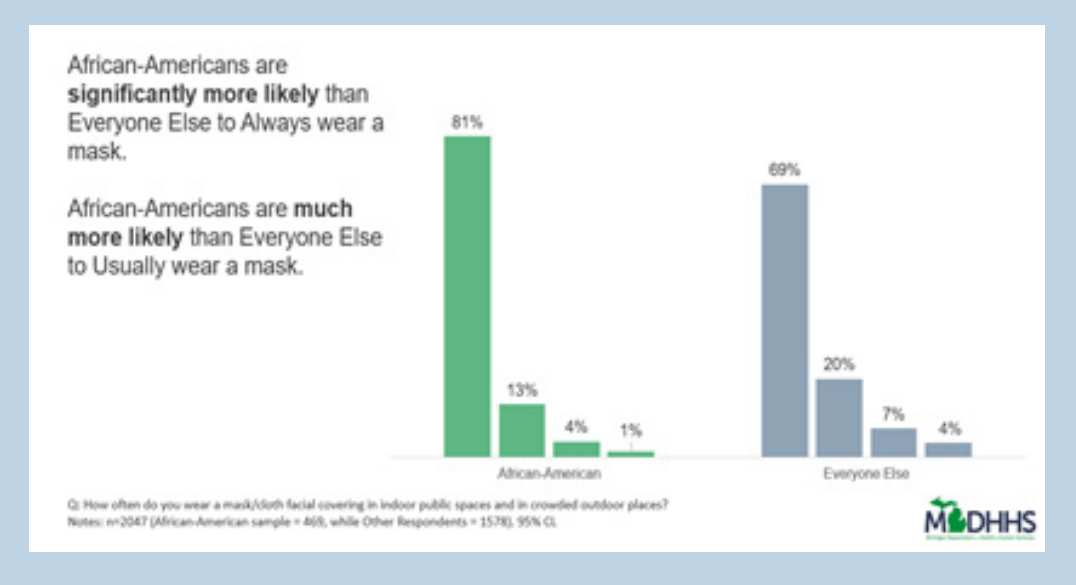
By taking an authentic, community-driven approach, the state government acknowledges that community members are the authority on their needs. In that vein, communities should be supported to define success and impact and identify metrics. Communities can create local evaluation plans to capture systemic change and success stories to be incorporated in evaluation of health equity work they pursue.

RACE EQUITY IMPACT ASSESSMENT PILOT AT MDHHS

Without intentional intervention, institutions and structures continue to perpetuate racial inequities. The Race Equity Impact Assessment is designed to help transform government structures that contribute to inequities by normalizing conversations about race and health equity, operationalizing new equity-decisions, and organizing around data driven strategies and structures of sustainability that center equity. Routine use of a race equity impact assessment explicitly integrates race and health equity principles and develops strategies and actions that reduce racial disparities and improve outcomes for racial/ethnic minorities and other marginalized groups.

In response to Governor Whitmer's Declaration of Racism as a Public Health Crisis in September 2020, MDHHS was charged with developing a Race Equity Impact Assessment (REIA) pilot to: (1) develop or amend policies, practices, procedures, and programs that are responsive to root causes of health disparities and inequality, and (2) advance race equity by reducing historical and contemporary harm done to racial/ethnic





and other marginalized populations. The pilot is designed to integrate explicit racial equity consideration in decisions, including policies, practices, procedures, and programs.

The REIA pilot is taking place in three key areas within MDHHS: Medical Medicaid Services Administration, Economic Stability Administration, and Behavior Health Development Disabilities Administration. At the time of writing this report, each pilot area in MDHHS has had two leadership meeting, completed all three foundational REIA trainings and three (of six) technical assistance sessions, and begin part one of two more sessions. Each pilot area collected and interpreted disparity data, developed a problem statement and root cause analysis to address the selected disparity affecting a Michigan racial/ethnic group and is working on engaging with directly impacted community to gather qualitative data.

Based on evaluation of these initial trainings, it is evident that REIA increases knowledge. The goal of the REIA is to standardize a process that can help decision makers make more objective, data driven interventions by authentically engaging state governmental leaders with community stakeholders to co-create and increase equitable outcomes for racial/ethnic and other marginalized populations. The REIA pilot process is being thoroughly evaluated. A theory of change and logic model have been established to assess its effectiveness. Thus far, participating pilot areas widely report an increase in REIA knowledge. Topics covered in the REIA include disparities vs inequities, equity framework, social determinants of equity, cultural competence, and the four systems of advantage and disadvantage. This process will help state government better respond to coronavirus racial disparities.

COMMUNICATIONS APPROACH

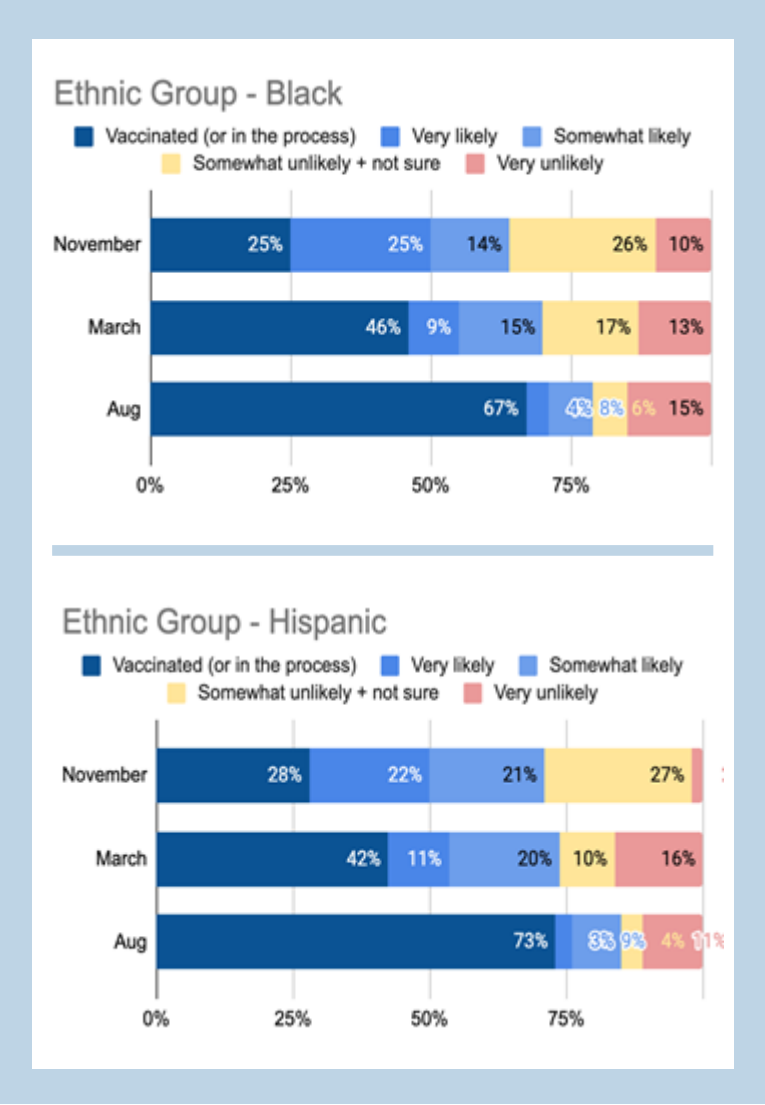
Key Takeaway: Invest in targeted and culturally effective messaging to impacted communities.

A significant barrier to implementing a variety of measures to reduce the impact of COVID-19 among Michigan's communities of color – from prevention methods to testing strategies – was public messaging. Therefore, the Task Force collaborated with the MDHHS Communications Team and other partners to develop public awareness efforts focused on communities of color. This effort to promote testing, mitigation strategies, and vaccination was developed by extensive polling, focus grouping, and community engagement. The work was not limited to one community, but narrowly tailored to impacted communities throughout the state. This included messages targeted Black or African American, Hispanic or Latino, and Middle Eastern populations across the state.

These messages were translated into Spanish and Arabic to better reach these populations. This work allowed for the most effective messages to drive communications. Three months into the campaign, the Communications Team conducted in-depth research with over 2,100 Michiganders to determine efficacy of messaging and areas of improvement.

The research revealed that Black or African Americans were among the most compliant mask wearers and their cases were going down dramatically. When asked the question, "How often do you wear a mask/cloth facial covering in indoor public spaces and in crowded outdoor places?" 81% of Black or African American adults responded "Always" with another 13% responding "Usually," compared to 69% and 20% for the rest of the population. This showed targeted messaging likely impacted behavior.

Furthermore, the Communications Team conducted research to gauge attitudes toward vaccination throughout the vaccine rollout. In November 2020, only 50% of Black or African Americans said they were very likely or somewhat likely to get the vaccine. After this research, messages focusing on Black and African Americans were launched. By March 2021, this percentage increased to 70%. By August 2021, those same categories of vaccine adoption increased to 79%. For the Hispanic population, those same numbers went from 50% in November 2020 to 73% in March 2021 and 85% in August 2021.



MDHHS Communications worked with local leaders in communities of color to develop the "My Why" campaign, which includes narratives and experiences from Michiganders regarding getting the vaccine and why, as well as information from providers about why it is so important. Furthermore, the MDHHS Communications Team coordinated a statewide campaign targeted toward low coverage, high Social Vulnerability Index (SVI) areas via door-to-door outreach to share information and encourage Michiganders to get vaccinated.

This initiative is in conjunction with the Protect Michigan Commission and efforts to expand community clinics to increase access and convenience. These efforts are also coordinated with faith-based and community leaders in each of these geographic areas. In addition to these grassroots projects, MDHHS is frequently fielding surveys to measure Michiganders' attitudes, perceptions, and intentions when it comes to vaccination and mitigation

efforts. The data collected is used to tailor messaging from both an earned and paid media standpoint. Since the launch of this work, there has been a significant increase in willingness to get vaccinated in minority communities. This work can help improve health literacy in minority communities. In addition, this effort can help address misinformation that exist regrading vaccinations and other health related issues.

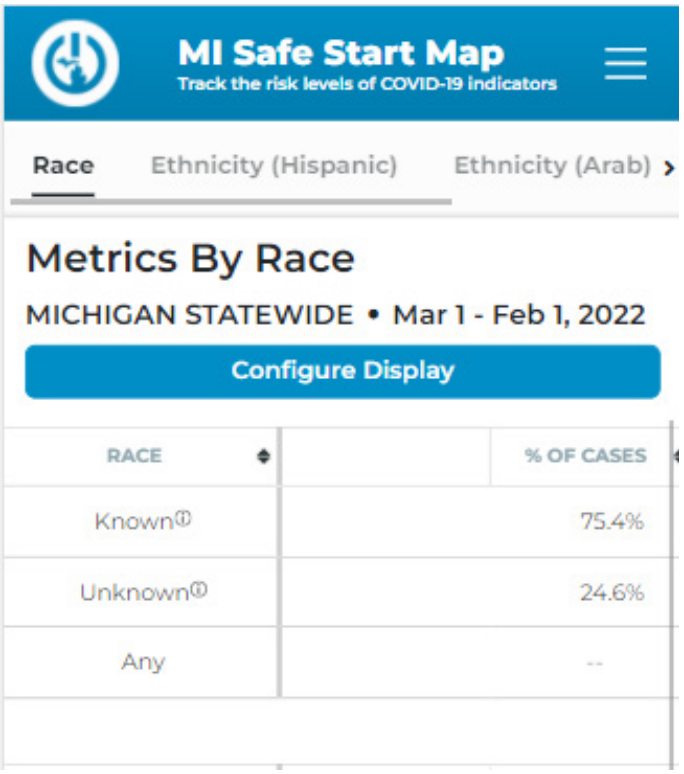
COLLECTING RACIAL DATA

Key Takeaway: Improve the timeliness and accuracy of disparities data to better target actions and to measure progress.

The collection, analysis, and use of race and ethnicity and SDOH is critical to understand disparities, inform policies and practices, and track progress to reducing health inequities. Unfortunately, the data necessary to track COVID-19 cases, hospitalizations, and deaths often has been incomplete and/or not culturally competent, which inhibits policymakers, state agencies, and health care systems to make decisions that may increase health inequity and racial disparities. Limitations in the availability and analysis of data prevent us from having complete data disaggregated by race at the county level or smaller geographies.

Driven by the Task Force's recommendations, MDHHS has collaborated with several internal and external partners to develop several dashboards to geographically display COVID testing. These dashboards include: public county level testing data (MiStartMap.info), dashboards for local health departments to better deploy their resources (e.g, MILighthouse), statewide coronavirus vaccination dashboard, bit.ly/3uBYFWj, and dashboards for state leadership to allocate resources.

These dashboards incorporate SVI; counts and rates for cases, hospitalizations, and deaths;



locations of testing centers; and data by census tract. In preparation for the next phase of the pandemic, an MDHHS team is working to develop a smaller but representative sentinel surveillance program to provide similar measures with indicators and trends that do not require massive daily updates from the entire state. While state government agencies have a significant role to play in improving racial data collection, a successful effort will also require commitment from health care systems – hospitals and insurers – to accurately capture many health equity metrics.

In the short-term, hospitals and MDHHS should continue to improve racial data collection as it relates to COVID-19 hospitalizations and deaths. This includes continuation of federal, state, and local public health efforts that began in the pandemic. System-wide reform and innovative strategies to collect comprehensive racial data will require more resources beyond current pandemic funds, especially for certain time-intensive tools like data dashboards.

V. Task Force Recommendations

Addressing racial disparities exacerbated by COVID-19 requires implementing strategies in the immediate short-term as well as building long-term strategies. Therefore, some of the recommendations included in this report are immediately actionable ways to remediate the impact of systemic racism. However, most of the recommendations focus on how to make sustainable change within existing systems. Many of the recommendations build on the Task Force's successes and iterate further work necessary to reduce systemic racism within government agencies and among the many organizations that partner with those agencies to provide more equitable services to Michigan residents.

STRATEGIC TESTING INFRASTRUCTURE WORKGROUP

1. Improve racial and ethnic data collection and use to address racial and ethnic disparities. The collection, analysis, and use of race and ethnicity data is critical to understand disparities, inform policies and practices, and track progress to reducing health inequities. Unfortunately, the data necessary to track COVID-19 cases, hospitalizations, and deaths often has been incomplete and/or not culturally competent, which inhibits policymakers, state agencies, and health care systems to make decisions that increase health inequity and racial disparities.

2. Continue to fund neighborhood testing and vaccination sites and mobile health units to provide new and existing health and social services to marginalized communities. The Neighborhood and Mobile COVID-19 Testing sites in Michigan have brought COVID-19 tests and vaccinations to regions of the state hardest hit by racially disparate impacts of the pandemic and eliminated barriers at testing sites by providing culturally and linguistically competent, accessible services. MDHHS should fund community partners to create "health hubs" (e.g., via mobile units and neighborhood testing and vaccination sites). Health Hubs are a central location where one can receive multiple different services, including COVID testing/vaccination, as well as linkage to health care and social services.

3. Require adherence to and monitor compliance of federal requirement to assist with meaningful language access. Marginalized racial and ethnic groups are susceptible to experiencing language

barriers when receiving health care, included COVID-19 care. The Task Force recommends that providing more robust translation of materials and interpretation assistance can reduce or eliminate those barriers to care.

4. Establish a process and infrastructure to send alerts to key community partners and/or residents regarding COVID-19 infection rates and problem areas. This allows trusted community partners to quickly provide updated messaging to residents living in marginalized communities and reduce the lack of prompt and culturally appropriate information needed to influence behavior. These community partners can effectively share messaging on mitigation strategies and where/how to secure needed services.

PRIMARY CARE CONNECTIONS WORKGROUP

1. Decrease the number of uninsured and underinsured Michiganders. The historical disproportionate number of uninsured and underinsured people has exacerbated underlying chronic health conditions in communities of color. These conditions increased the risk of contracting severe COVID-19, and in turn increased the risk of death from COVID-19 in communities of color.

2. Fully leverage Health Information Technology and data to reduce racial health disparities. Current gaps in Health Information Technology (HIT) and technology barriers have led to challenges in patient care. For example, different healthcare providers use different platforms which makes it difficult to consolidate data to best serve patients. The Task Force identified ongoing issues with interoperability between systems, which prevents adequate and effective sharing of patient data. Improving access to data would better allow providers and policy makers to identify and address disparities. However, the lack of consistent data reinforces racial disparities. Therefore, the PCC Workgroup recommends the development of a central repository of data to share Electronic Health Records and other social service organizations.

3. Implement quality criteria to incentivize primary care. Consistent, quality primary care services can dramatically improve individual's overall health and wellbeing. Ultimately, consistent connection to quality primary care will result in closing the racial disparity gap in our health care system in Michigan. Therefore, the Task Force recommends adoption of efforts to improve the number of well visits a patient has per year,

4. Maximize the use of school-based clinics for expanded care delivery. Child and Adolescent Health Center Program care facilities ("CAHC", also referred to as school-based health clinics) offer primary care services to adolescents in school settings, allowing patients to receive crucial care without barriers such as transportation or health care coverage.

5. Educate the public about mental health services. Stigma still surrounds mental health care in Michigan, particularly among many communities of color. The Task Force recommends the development and launch of a "Let's Talk About It" campaign to promote the importance of talking about mental health and support services.

6. Increase inoculation rates across ages through statewide messaging campaigns. The In January, MDHHS Communications launched a statewide vaccine campaign through television, connected TV, streaming, print, YouTube, digital and social media based on customized messaging of diverse populations. The PCC Workgroup recommends continuation of this work, especially as the delta variant continues to impact communities of color in Michigan. In addition, this messaging campaign should include implementing a word-of-mouth and canvassing campaign

for individuals that have been vaccinated to share information on why they decided to get vaccinated and share their experiences.

Sharing personal stories about why an individual chose to get vaccinated against COVID-19 can have a significant impact in assisting vaccine-hesitant individuals make an informed decision with additional insights from individuals they trust, particularly among communities with history of systemic racism and mistrust in the medical establishment. A community canvassing is critical to address racial disparities by bringing information from trusted sources directly to the most disenfranchised populations. With culturally competent and well-funded efforts we can influence attitudes and decisions.

CENTERING EQUITY WORKGROUP

1. Increase culturally competent data collection. Incorporating a thoughtful and consistent emphasis on cultural competence when performing all essential public health functions, including data collection, creates a necessary foundation for efforts to reduce health disparities and enables professional to adapt programs to benefit individuals and groups from varying cultural backgrounds. Furthermore, improving cultural competence among public health practitioners could help reduce health disparities and improve the quality of care and health for everyone.[ix]

2. Support implementation of the Maternal Infant Health & Equity Improvement Plan's (MIHEIP) strategic vision of Zero preventable deaths - Zero health disparities across its six primary priorities. Disparities that show up in every facet of maternal and infant health are rooted in long standing systemic inequities, often based on race. Women of color are more likely to die from pregnancy-related causes than White women, and infants born to women of color are more likely to die before they reach their first birthday.[x] While improvements have been realized since the start of the MIHEIP, persistent challenges remain and must be addressed.

ADDITIONAL RECOMMENDATIONS

1. Reduce COVID-19 exposure risks in environmental justice communities related to air quality. Increase air quality assessments, HVAC improvements, and communications around updates to indoor air quality to reduce COVID-19 risk.

2. Ensure that every home and business in Michigan has access to an affordable, reliable high-speed internet connection that meets their needs. Early in the COVID-19 pandemic, this task force recognized the need to close the digital divide in telehealth and virtual learning to ensure equitable access for all Michiganders. Data show that Black and Hispanic patients, particularly senior citizens, are less likely than their white counterparts to access telemedicine. Similarly, Black and Hispanic students are less likely to have computers, a home broadband connection, or access to the internet at all when compared to white students. These barriers can be overcome through targeted and strategic investments in infrastructure, devices, digital literacy, and an overall focus on connectivity.

VI. Conclusion and Next Steps

The Task Force views this report as only the end of the beginning. It will be up to lawmakers, agencies with rulemaking authority, advocates, and other policymakers, including not least the Executive Office of the Governor of Michigan, to continue to advocate for and lend their expertise to turning the Task Force's recommendations into action. Only if all stakeholders act with the urgency that this issue requires will the spotlight remain appropriately focused on the life-or-death issue of lowering racial disparities impacting the health of Michiganders.

In addition, the delta and omicron variants has shown that the pandemic is far from over. The strategies used to address racial disparities so far in the pandemic must continue to be utilized and must continue to evolve to fit the needs of the crisis. This will help ensure that Michigan continues to make progress on addressing racial disparities resulting from and exacerbated by COVID-19. However, with low vaccine rates in African American communities there is a risk of another deadly wave in the African American community. Improving vaccine rates will be a priority in 2022 for the Task Force.

The Task Force is committed to continuing to work with MDHHS on leading state initiatives that address health disparities in the face of the COVID-19 pandemic and beyond. There is widespread recognition about the need to address Social Determinants of Health (SDOH) - factors like housing, transportation, employment, education, and food security that affect individuals' lives and health outcomes, going upstream to the root causes and not just the symptoms. MDHHS has taken the approach of developing a targeted SDOH strategy that will allow the Department, other state agencies, and external partners which may include health organizations, community-based partners, and local health departments to align for a greater impact.

The 2022-2024 MDHHS SDOH Strategy outlines an innovative, collaborative approach to advance health equity and bolster impact. The development of the SDOH Strategy will be an iterative process allowing the Department to build on existing efforts while considering Michigan's ever-changing landscape. Innovative strategies will be developed and refined based stakeholder engagement and national best practices with the goal of moving more upstream with a more holistic approach to supporting Michigan residents. In 2022, the MDHHS SDOH Strategy, which will address housing stability, food security, and health equity, will have significant overlap with many of the Task Force's recommendations.

VII. Appendix

1. TASK FORCE WORKGROUP MEMBERS

Strategic Testing Infrastructure

Task: Implement the infection testing and vaccine delivery infrastructure needed to effectively meet the needs of the Black or African American community and other marginalized communities during the public health emergency.

Members:

- Brenda Jegede – Michigan Department of Health and Human Services Policy Staff Lead and Chair
- Charles Stanley
- Curtis Ivery
- Philip Levy
- Mona Makki
- Whitney Griffin
- Denise Fair
- Alfredo Hernandez
- LaChandra White
- Teresa Branson
- Larry Lewis Jr.
- Kimberly Trent
- Tiffany King
- Rev. Solomon Kinloch
- Congresswoman Brenda Lawrence
- Chris Kolb
- Linda Little
- Tonya Thompson
- Rep. Sherry Gay-Dagnogo
- Marijata Daniel-Echols
- Maureen Taylor
- Karen Philippi
- David Sanchez
- Roy Wilson
- Andrea Taverna
- Yesenia Murillo
- Jessie Marshall
- Jacquetta Hinton
- Shronda Grigsby
- William Marshall
- Sharon Freeman
- Mariah Martin
- Aisha Benton
- Robert Orellana

Centering Equity

Task: Recommend how to put in place policies, programs, and practices that mitigate unintentional negative impact and contribute to the ending of systemic racism.

Members:

- Renée Canady – Workgroup Co-Chair
- Marijata Daniel-Echols – Workgroup Co-Chair
- Yesenia Murillo – Michigan Department of Health and Human Services Policy Staff Lead
- Alize Asberry-Payne
- Ken Borkowski
- David Brown
- Lonias Gilmore
- Alfredo Hernandez
- Brenda Jegede
- Dionne M. Smith
- Janee Moore
- Yesenia Murillo
- Karen Phillippi
- Cherie Ross-Jordan
- Tari Muniz
- Tedra Jackson
- Bridget Hurd
- Tonya Bailey
- Lauren Bealore
- Megen Miller
- Teresa Branson
- Lilianna A. Reyes
- Cynthia Taueg
- Aletha Carr
- Marlon Brown
- LaChandra White
- CJ Eason
- Phyllis Meadows
- Mariah Martin
- Myra Lee
- Sandra Bitonti Stewart
- Robert Orellana

Primary Care Connections

Task: Examine both short-term and long-term strategies to address the needs of the uninsured and close the historical gap of relationships with primary care providers amongst communities of color.

Members:

- Randolph Rasch – Workgroup Chair
- Danielle El-Amin – Executive Office of the Governor Policy Staff Lead
- Randolph Rasch – Workgroup Chair
- Brandi Basket
- Denise Brooks-Williams
- Bridget Hurd
- Jametta Lilly
- Audrey Gregory
- Tawana Nettles
- Zaneta Adams
- Celeste Sanchez Floyd
- Connie Dang
- Jacquetta Hinton
- Alize Asberry Payne
- Wenona Singel
- Crystal Brown
- Kathleen Oberst
- Jon Breems

2. RACIAL DISPARITIES TASK FORCE ACCOMPLISHMENTS

	Recommendation	Actions/Accomplishments
1	Expanded testing criteria to include testing household members when someone tests positive. Asymptomatic household members should be tested.	■ Testing criteria expanded ■ Accomplishments listed in the interim report.
2	Used a data driven strategy to identify communities to expand testing services. Utilize Social Vulnerability Index, co-morbidity mortality data, COVID-19 cases and deaths, distance to testing location. Finalize census tracts and zip codes after discussing with local leadership and stakeholders.	■ Used this strategy in the establishment of the neighborhood sites and mobile units ■ MDHHS collaborated with several internal and external partners to develop several dashboards to geographically display COVID testing. These dashboards include public county level testing data (www.MiStartMap.info), dashboards for local health departments to better deploy their resources (e.g, MILighthouse), and dashboards for state leadership to allocate resources. These dashboards incorporate SVI; counts and rates for cases, hospitalizations, and deaths; locations of testing centers; and data by census tract.
3	Implemented Neighborhood Testing Strategy. Secure vendor(s) to provide medical staff, supplies, lab, reporting services and partner with trusted community organizations to provide testing in 20 high need areas identified by data driven strategy (COVID-19 cases/deaths, CDC's Social Vulnerability Index, co-morbidity deaths, distance to nearest testing locations).	■ Set up 22 neighborhood locations with churches and community colleges Detroit (7), Ecorse, Roseville, Wayne, Warren, Flint (2), Grand Rapids, Albion, Mt. Morris, Graying, Saginaw, Muskegon, Niles, Lansing, and Benton Harbor. ■ Over 247,594 tests have been administered at Neighborhood Testing Sites ■ All locations offering vaccinations. ■ MDHHS/REDI/OEMH secured $1.5M to support services at Neighborhood testing and vaccination sites via CDC Health Disparities Grant (June 2021-May 2023)

	Recommendation	Actions/Accomplishments
4	Expanded WSU/ACCESS/Ford mobile testing pilot from 4 to 10 vehicles to provide testing in high need areas of the state identified by data driven strategy (COVID-19 cases/deaths, CDC's Social Vulnerability Index, co-morbidity deaths, distance to nearest testing locations).	■ Nine mobile health units were purchased to support testing, vaccination, and linkage to services » Partnerships with WSU/Wayne Health – 6 units servicing Wayne, Oakland, Macomb, and Washtenaw Counties. WSU received the vehicles in December 2020. » Partnership with Genesee Health Systems. Support for staffing and resources for their existing mobile units. Supported since January 2021. » Partnerships with Ingham and Kent LHDs. Each received one unit in April 2021. » Partnership with Muskegon LHD who received their unit in May 2021. » 44,950 COVID-19 tests and 19,045 COVID-19 vaccinations provided with mobile units. ■ MDHHS/REDI/OEMH secured $4.2M to support mobile health units via ELC EDX (the expansion grant - 10/15/21-7/31/24)
5	Eliminated barriers at testing sites by providing culturally and linguistically competent accessible services for: ■ Residents with physical, intellectual, and developmental disabilities ■ Deaf, blind, and hard of hearing ■ Those who speak a foreign language ■ Those without government-issued identification	■ Utilized translators (specifically Spanish and Arabic speaking). Additionally, surveys and signage have been translated into Spanish and Arabic. ■ Moving the mobile clinics close to the vicinity to assist people with disabilities or going door to door. ■ Protect Michigan Disability network is working to identify various regions across the state to assist with population density with people who has a disability, to set up mobile testing units.

	Recommendation	Actions/Accomplishments
5	Eliminated barriers at testing sites by providing culturally and linguistically competent accessible services for: ■ Residents with physical, intellectual, and developmental disabilities ■ Deaf, blind, and hard of hearing ■ Those who speak a foreign language ■ Those without government-issued identification	■ Enhanced testing access and collaboration with Wayne County Community Colleges ■ WSU/Wayne Health reached 1000 people with mentally handicap and developmental delayed disabilities. We eliminated barriers to get individuals vaccinated. ■ Between 02/10/2021 and 02/19/2021, Wayne Health collaborated with DWIHN and DHD to vaccinate 1,113 people, which are part of the MHDD (Mentally Handicapped, Developmentally Delayed) population. ■ WSU/Wayne Health provide social services through community health workers and patient navigators. Many individuals have struggled with housing, food security, childcare, etc. during the pandemic. By linking patients up with various community resources, we can eliminate barriers to healthcare and improve health outcomes. Their partner, Detroit Parent Network provided 2,525 referrals to community resources. ■ Offer linkage to primary care providers. Many individuals in the city of Detroit and surrounding communities have not seen a provider within the past year. Molina, the insurance plan, provided Wayne Health with a list of over 40,000 members that have not had a claim in the past year. Using a data driven approach, Wayne Health identified partners to host the MHUs in areas where there are Molina clients not utilizing their insurance plan. ■ Collaboration with the Detroit caucus has aided with connection in low vaccination communities.

	Recommendation	Actions/Accomplishments
5	Eliminated barriers at testing sites by providing culturally and linguistically competent accessible services for: ■ Residents with physical, intellectual, and developmental disabilities ■ Deaf, blind, and hard of hearing ■ Those who speak a foreign language ■ Those without government-issued identification	■ Pull data out of Michigan Care Improvement Registry (MCIR) and break it down into census tracks, with 25/50 percent vaccination rates. ■ Establishing trust and building trust in faith-based communities. ■ Pulling safe graph data in low-density areas and being visible in those areas.
6	Prioritized and provided testing and contact tracing for high-risk subgroups including: ■ Racial and ethnic minorities ■ Michigan's 12 sovereign Indian nations ■ Undocumented ■ Homeless ■ Returning residents	Accomplishments listed in the interim report.
7	Provided follow-up care for all residents that test positive. Provide resources needed to quarantine including connection to shelter, food, cleaning materials, masks, and other supplies. Repeat testing at two weeks.	Accomplishments listed in the interim report.

	Recommendation	Actions/Accomplishments
8	Identified and tested homebound residents (i.e., residents not living in congregate living facilities, seniors, individuals with severe mobility issues, etc.)	Wayne State University/Wayne Health MHUs started to partner with Wayne County Health Department in May 2021 to offer in-home services homebound individuals wanting the vaccine.
9	MDHHS testing plan to include active surveillance and on-going strategic guidance regarding duration of testing, testing type (molecular +/- serologic), and frequency of re-testing. Testing plan to prioritize racial and ethnic minorities and other high-risk populations.	Prioritized testing to high-risk populations.
9	Provided requirements or guidance for testing sites to collect and report minimum demographic data: full name, date of birth, sex, gender, working phone number, full address, race/ethnicity, primary language, disability status, whether the person was symptomatic; whether the person was exposed to a known case of COVID-19, and if they are in a high-risk occupation for exposing others to COVID-19.	MDHHS order for labs and testing sites to collect and report demographic information along with submitted specimens. A data quality workgroup was established to follow-up with underperforming labs. The public can view the data using the public-facing dashboard at: waynehealthcares.org/mobile-health-unit.
10	Offered residents to complete the 9-question 2020 census questionnaire at the time of testing at the Neighborhood Testing sites.	Census 2020 ads were served to 21,811 people on Facebook & Instagram, resulting in 51,860 impressions — so each person received between 2-3 ads. The ads generated 749 clicks to the 2020 Census form. Watch the video of the ad: youtu.be/fZoex6oUcm8.
11	Supported successful implementation of MIHEIP, and the Governor's Healthy Moms Healthy Babies plan.	Workgroup members met with MDHHS staff to help the EOG secure extended healthcare coverage for low-income new moms to a full year after giving birth and move a woman's first postpartum visit to within three weeks, with a comprehensive visit within twelve weeks.

	Recommendation	Actions/Accomplishments
11	Supported best practices recommendations for race equity impact assessment.	Workgroup members helped refine the selected tool, its supporting materials and the plan for pilot testing an Equity Impact Assessment process within MDHHS.
12	Supported operationalization of declaration of racism as a public health crisis the workgroup.	■ Advocated for lifetime medical benefits for sickle cell patients, which is now in deliberation on the senate floor. ■ Endorsed requiring health practitioners to be trained in implicit bias. ■ Endorsed the requirement that Michigan state employees and contractors complete implicit bias training.
13	Rapid Response grant initiative	■ The task force identified 30 community organizations and an evaluation project led by a state university to receive a total of $20 million in funding under the Michigan Rapid Response Initiative. These organizations are using funds to respond to needs associated with the disparate impacts that the virus has on communities of color. ■ Efforts are focused on health services, non-medical resources, education and livelihoods, and data improvement.

3. RACIAL DISPARITIES TASK FORCE RECOMMENDATIONS

Workgroup	Recommendation
Strategic Testing Infrastructure	■ Improve racial and ethnic data collection and use to address racial and ethnic disparities. ■ Support infrastructure needed to continue the health and social services being provided in the community. ■ Continue to fund neighborhood testing and vaccination sites and mobile health units to provide new and existing health and social services to marginalized communities. ■ Require adherence to and monitor compliance of federal requirement to assist with meaningful language access. ■ Require mandatory routine testing for unvaccinated individuals. ■ Create and implement a word-of-mouth campaign for individuals that have been vaccinated to share information on why they decided to get vaccinated and share their experiences. ■ Establish a process and infrastructure to send alerts to key community partners and/or residents regarding COVID-19 infection rates and problem areas.
Primary Care Connections	■ Decrease the number of uninsured and underinsured Michiganders. ■ Fully leverage Health Information Technology and data to reduce racial health disparities. ■ Implement quality criteria to incentivize primary care. ■ Maximize the use of school-based clinics for expanded care delivery.

Workgroup	Recommendation
Primary Care Connections	■ Educate the public about mental health services. ■ Increase inoculation rates across ages through statewide messaging campaigns.
Centering Equity	■ Increase culturally competent data collection. ■ Support implementation of the Maternal Infant Health & Equity Improvement Plan's (MIHEIP) strategic vision of Zero preventable deaths - Zero health disparities across its six primary priorities.
Environmental Justice	■ Reduce COVID-19 exposure risks in environmental justice communities related to air quality.
Internet Access	■ Ensure that every home and business in Michigan has access to an affordable, reliable high-speed internet connection that meets their needs.

ENDNOTES

i. Michigan Disease Surveillance System
ii. https://www.michigan.gov/coronavirus
iii. Exec. Directive No. 2020-9, sections 1 and 8 of article 5 of the Michigan Constitution of 1963 (2020). https://www.michigan.gov/whitmer/0,9309,7-387-90499_90704-535748--,00.html
iv. National Notifiable Diseases Surveillance System. Coronavirus Disease 2019 (COVID-19) 2020 Interim Case Definition, Approved August 5, 2020. Coronavirus Disease 2019 (COVID-19) | CDC
v. MI COVID response Data and modeling update (michigan.gov)
vi. MI COVID response Data and modeling update (michigan.gov)
vii. Black COVID patients: Less medical follow-up, longer return-to-work delays, more hospital readmissions | University of Michigan News (umich.edu)
viii. https://www.michigan.gov/documents/mdhhs/MMMS_2013-2017__Pubapproved_712422_7.pdf
ix. https://www.cdc.gov/dhdsp/docs/cultural_competence_guide.pdf
x. https://www.michigan.gov/mdhhs/0,5885,7-339-71550_96967_97025---,00.html