

COVID-19 and Health Disparities in Maryland



An Advisory Memorandum of the
Maryland Advisory Committee to the
U.S. Commission on Civil Rights

February 2021

Advisory Memorandum

To: U.S. Commission on Civil Rights
From: Maryland State Advisory Committee
Date: February 2, 2021
Subject: COVID-19 and Health Disparities

In keeping with its responsibilities to the U.S. Commission on Civil Rights,¹ the Maryland Advisory Committee (Committee) held four virtual briefings in 2020 to examine disparities in health outcomes for people of color in Maryland during the COVID-19 pandemic.

Background

In early January 2020, the World Health Organization (WHO) announced a mysterious coronavirus-related pneumonia in Wuhan, China, which would be called SARS-CoV-2 (COVID-19). On January 21, the Centers for Disease Control confirmed the first case of Coronavirus in the United States after a Washington state resident came down with the virus after he returned from Wuhan. At the end of the January, WHO issued called it a global health emergency – the worldwide death toll was more than 200 and there was exponential jump to more than 9800 cases. Human-to-human transmission was quickly spreading and is found not only in the United States, Germany, Japan, Vietnam, and Taiwan. Three days later, on February 3, the United States declares a public health emergency.²

On March 11, WHO Declares COVID-19 a Pandemic; two days later President Trump declares COVID-19 a National Emergency.

In Maryland, on March 5, three Marylanders test positive for COVID-19. These residents had contracted the virus while traveling abroad. Governor Hogan put Maryland under a state of emergency that same day. On March 16, with 43 cases, Governor Hogan ordered all bars, restaurants, other recreational businesses to close. Seven days later, Governor Hogan ordered all non-essential businesses to close. At the time, there were 288 cases in the state.³

As 2020 ended, Maryland logged 276,662 total cases and 5,727 deaths. The United States surpassed 20 million infections from COVID-19, and more than 346,000 deaths. Globally, cases rose to 83,832,334 and 1,824,590 deaths.

¹ In conformance with 45 C.F.R. § 703.2, and per its statutory mandate, the U.S. Commission on Civil Rights establishes advisory committees and charges them with collecting and providing information, findings, and recommendations about civil rights matters in their states to the Commission. The Committee unanimously approved the Advisory Memorandum on February 2, 2021.

² A timeline of how pandemic evolved and progressed through 2020, “A Timeline of COVID-19 Developments in 2020,” is found at <https://www.ajmc.com/view/a-timeline-of-covid19-developments-in-2020>.

³ A timeline of the virus in Maryland, “TIMELINE: Coronavirus In Maryland, Tracking The Spread,” is found at <https://baltimore.cbslocal.com/timeline-how-the-coronavirus-spread-in-maryland/>.

In the beginning of January, like the rest of the United States, the state reported a record number of hospitalizations. As January came to a close, the South African variant was found in Maryland. The virus had mutated and various strains continued to infect people worldwide.

At the end of 2020, Maryland began vaccinations. The Committee has not received testimony on the efforts of vaccinations but is concerned that the racial disparities it learned about during its investigation will continue in the vaccination rollout.⁴

As the Committee releases its memorandum in April 2020, COVID-19 cases were again rising.⁵ At the end of March, Maryland had confirmed 411,344 coronavirus cases in the state since the pandemic began and 8,101 people died from the virus.⁶

Briefings

The Committee held four virtual briefings to hear testimony from elected officials, government officials, academicians, advocates, and others. The purpose of these briefings was to examine and gain a deeper understanding of the health disparities in Maryland during the COVID-19 pandemic. The Agendas and Summaries of the briefings are attached as appendix A and B. Presentations by the panelists are attached in Appendix C.

Recommendations

COVID-19 has revealed glaring racial disparities and the consequences these long-standing inequities have for communities and individuals of color, whereby regardless of income, people of color and marginalized groups have limited access to the resources that are both necessary for lifelong wellness and critical during emergencies, such as quality medical services, healthy food, childcare, education, technology, and secure housing. These long-standing inequities have led to inequitable health outcomes both in Maryland and nationally.

These inequities warrant a deeper examination by the Maryland state government and the United States government. The Committee encourages both to work in partnership with communities of color to ensure programs and policies reflect their experiences, needs, and support their long-term recovery.

⁴ See, e.g., Jayne Miller, “Maryland vaccination rate exposes racial disparity, Public health expert calls rollout of COVID-19 vaccines ‘halting, slow, challenging,’” WBAL-TV, Jan. 28, 2021, <https://www.wbal.com/article/covid-19-vaccine-distribution-racial-gap-maryland/35352491>;

Rebecca Tan, “A diverse suburb’s biggest pandemic challenge: Distributing the vaccine equitably,” Washington Post, Jan. 31, 2021, https://www.washingtonpost.com/local/vaccine-equity-montgomery-maryland/2021/01/31/3a1f2fe0-617f-11eb-9061-07abcc1f9229_story.html

⁵ <https://baltimore.cbslocal.com/2021/03/31/covid-in-maryland-more-than-1-3k-new-cases-reported-wednesday-hospitalizations-flat/>

⁶ Ibid.

The Committee groups its recommendations in two themes: Direct Provision of Health Care and Social Determinants of Health Care.

Direct Provision of Health Care

1. Theme: *Racial discrimination is systemic; it functions to segregate and suppress people of color and prevent equitable access to healthcare.*⁷

The committee recommends:

- a. Maryland develop an alternate housing program for infected individuals who may shelter and self-isolate in place similar to the COVID infected in Singapore and South Korea.
- b. The government increase the number of COVID testing sites and contract tracing in communities of color.
- c. The government provide essential public workers with PPE and facilitate access to PPE for private employers.
- d. Provide equitable distribution of healthcare resources, including vaccines.
- e. The State should use zip code data to prioritize access to quality health care for people of color and commit to equitable health standards that value individuals and populations.

2. Theme: *Communities of color mistrust doctors, hospital personnel, nurses, and health department officials.*⁸

The committee recommends:

- a. Public officials engage community organizations, leaders, church spokespersons, and other community members to build trust, understand community needs, change perceptions, provide information on how to access healthcare when needed, and engage with the healthcare community, including nontraditional care providers. This should be done while respecting the autonomy of individuals in the community.
- b. The Maryland Higher Education Commission and the Maryland Office of Minority Health and Health Disparities work with Maryland schools, boards, and commissions to incorporate training, such as cultural competency training and implicit bias training in medical and nursing education programs; training

⁷ Dr. Camara Phyllis Jones, Senior Fellow of the Satcher Health Leadership Institute and Cardiovascular Research Institute, Adjunct Associate Professor, Community Health & Preventative Medicine, Morehouse School of Medicine, testimony, *Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, July 7, 2020, transcript, p. 31

⁸ Dr. Stephen Thomas, Director of the Maryland Center for Health Equity, testimony, *Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, August 4, 2020, transcript, p. 6.

professional healthcare providers to become culturally aware and sensitive when caring for communities of color; and engage with communities of color to identify and address their respective needs.

3. Theme: *Immigrant communities' access to healthcare is adversely affected by social determinants and systemic discrimination.*⁹

The committee recommends:

- a. Local governments engage with members of immigrant communities, such as church groups, school officials, clubs, business and non-profit organizations and provide leaders with important health information in native languages.
- b. Government develop and execute a community relations communications outreach plan aimed at addressing health risks that affect immigrant communities and families.

4. Theme: *To improve health and longevity among people of color, it is essential that public health entities work in partnership with communities to foster trust, encourage cooperation, and inform communities about government guidelines with regard to COVID testing, tracing and vaccinations.*¹⁰

The committee recommends:

That as Maryland gears up for the distribution of the COVID vaccine, local public health departments, the medical community, local organizations, and the state government should devote adequate resources to create and sustain partnerships with communities of color. These partnerships would help identify volunteers willing to participate in the pre-trials and disseminate valuable health information to their communities. These individuals are potential health care ambassadors who can help build trust between health providers and communities of color.

Social Determinants of Health

5. Theme: *Children of color have been significantly disadvantaged due to a long history of racism that has undermined their education and COVID is exacerbating these preexisting issues of discrimination and educational attainment; and educational attainment will inevitably influence economic attainment and promote disparate outcomes.*¹¹

⁹ Dr. Michelle LaRue, Senior Manager, Health and Social Services, CASA de Maryland, testimony, *Web Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, September 1, 2020, transcript p. 10.

¹⁰ Brandon Scott, City Council President and Mayor-elect of Baltimore, testimony, *Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, November 10, 2020, transcript, p. 22.

¹¹ Dr. John B. King, President and CEO of The Education Trust and former Secretary of Education, testimony, *Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, August 4, 2020, transcript, p. 2.

The committee recommends:

The state, in partnership with communities, develop and implement a statewide recovery plan in advance, to support the long-term economic, health, and educational recovery of vulnerable teens and children of color post-pandemic. Planning stages for the statewide recovery plan should include, but not be limited to, members from various communities of color, state, federal and local government officials, religious community leaders, educators, health providers, and mental health professionals.

6. Theme: *The State of Maryland's research experts provide evidence of social determinants of racism.*¹²

The committee recommends:

- a. Federal and state government departments along with academic institutions develop a unified effort to focus on systemic racism and health inequities. Further research and data, as well as funding to support the studies are needed.
- b. Public health entities create a needs assessment and surveillance platforms that continuously monitor emerging health inequities; academic institutions could plan intervention strategies in communities that have data indicating high diabetes, for example, and academia could research systemic racism and disparities.
- c. Maryland agencies involved in diversity and inclusion initiatives and policymaking immediately begin disaggregating socio-demographic data collection to potentially better understand and address health disparities and health inequities in diverse communities of color in Maryland.

¹² Thomas, *supra* note 8 at p. 7.



**Maryland Advisory Committee
U.S. Commission on Civil Rights**

Tuesday, July 7, 2020; 12:00 p.m. (ET)

Agenda

1. Welcome/Opening
2. Briefing on COVID-19 Health Disparities

Dr. Camara Jones

Epidemiologist and Senior Fellow Morehouse College

Dr. David Mann

Epidemiologist, Maryland Department of Health

Angela Alsobrooks

County Executive, Prince Georges, Maryland

Question and Answer by Committee Members

Open Session

3. Other Business
4. Adjourn



**Maryland Advisory Committee
U.S. Commission on Civil Rights**

Tuesday, August 4, 2020; 12:00 p.m. (ET)

Agenda

1. Welcome/Opening
2. Briefing on COVID-19 Health Disparities

John B. King Jr.

President and CEO, Education Trust

Dr. Stephen B. Thomas

Director, Maryland Center for Health Equity

Karen B. Evans

Executive Director, Maryland Board of Nursing

Question and Answer by Committee Members

Open Session

3. Other Business
4. Adjourn



**Maryland Advisory Committee
U.S. Commission on Civil Rights**

Tuesday, September 1, 2020; 12:00 p.m. (ET)

Agenda

1. Welcome/Opening
2. Briefing on COVID-19 Health Disparities

Dr. Barbara Brookmyer, MD, MPH

Health Officer, Frederick County Health Department

Dr. Michelle LaRue

Senior Manager, Health and Social Services
CASA de Maryland

Ms. Danielle Weber

Administrative Deputy Health Officer
Somerset County Health Department

Dr. Noel Brathwaite

Director, Minority Health and Health Disparities
Maryland Department of Health

Question and Answer by Committee Members

Open Session

3. Next Steps
4. Other Business
5. Adjourn



Maryland Advisory Committee U.S. Commission on Civil Rights

Tuesday, November 10, 2020; 12:00 p.m. (ET)

Agenda

1. Welcome/Opening
2. Briefing on COVID-19 Health Disparities

Marc Elrich

County Executive, Rockville, Maryland

Maritza Solano

Education Director, CASA

Brandon M. Scott

City Council President, Mayor-Elect, Baltimore, Maryland

Question and Answer by Committee Members

Open Session

3. Next Steps
4. Other Business
5. Adjourn

Summary of Briefings

Briefing One: July 7, 2020

The purpose of this meeting was to examine and gain a deeper understanding of the health disparities in Maryland during the COVID-19 pandemic.

The speakers for Briefing One were: Prince George's County Executive Angela Alsobrooks; Dr. Camara Phyllis Jones, MD, MPH, PhD, Senior Fellow Satcher Health Leadership Institute and Cardiovascular Research Institute, Adjunct Associate Professor, Community Health & Preventative Medicine, Morehouse School of Medicine; Dr. David Mann, MD, PhD, Epidemiologist, Maryland Office of Minority Health and Health Disparities

COVID-19 exposed the lack of opportunity to equitable healthcare¹ and risk distribution available to people of color that already face existing health disparities in areas such as infant mortality, maternal mortality, diabetes rates, and hypertension². If opportunity and risk were equally distributed³, it is believed that the disparities would not exist today⁴.

People of color make up a large majority of the frontline workforce without added health benefits and are overrepresented in the unhoused community as well as jails and retention centers⁵.

Without wealth and resources, this population is susceptible to higher rates of death and disease⁶.

A Maryland SAC member asked how standards of care could be improved so that they are not racially discriminatory when it comes to COVID-19. Massachusetts Health Department, the first to establish that prioritization would not be determined based on race, language, zip code or prioritization status was given as an example of what is already being implemented.⁷ Suggested ways to improve standards of care include: 1) valuing individuals and population equally; 2) recognizing and rectifying historical injustices; and 3) providing resources according to need.⁸

Another member of the Maryland SAC asked what was the number one thing that the SAC could communicate to the United States Commission on Civil Rights (USCCR) and Marylanders about racial disparities in Maryland during COVID-19.

¹ Dr. David A Mann, Epidemiologist of the Office of Minority Health and Health Disparities (MHHD) of the Maryland Department of Health, testimony, *Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, July 7, 2020, transcript, pp. 15-17.

² Dr. Mann Testimony, *July 7, 2020 Briefing*, p. 18.

³ Dr. Camara Phyllis Jones, Senior Fellow of the Satcher Health Leadership Institute and Cardiovascular Research Institute, Adjunct Associate Professor, Community Health & Preventative Medicine, Morehouse School of Medicine, testimony, *Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, July 7, 2020, transcript, p. 2.

⁴ Dr. Mann Testimony, *July 7, 2020 Briefing*, p. 16.

⁵ Dr. Jones Testimony, *July 7, 2020 Briefing*, p. 6.

⁶ Ibid.

⁷ Dr. Jones Testimony, *July 7, 2020 Briefing*, p. 27

⁸ Ibid.

A follow up question asks what additional steps could be shared with Maryland and the USCCR to address these disparities.

The initial response was that addressing and acting on structural racism should be first priority.⁹ People need to be protected by making it easier for them to stay sheltered at home. This is especially true for people of color who are working the frontlines and also live in multigenerational households where they may risk potential exposure to their family members.¹⁰

Singapore and South Korea were cited as examples of countries that have isolation centers where people [presumably exposed to the virus] are checked regularly and sent to the hospital as soon as any form of sickness develops.¹¹

Secondly, improved and timely reports are needed to enable authorities to take immediate action to slow the rate of infection.¹² These reports need to include cases of infection and deaths in near real time, instead of after the fact. Previous reporting of data has often taken days to produce and largely represents symptomatic individuals.¹³

Prince Georges County was reported to have the most cases in Maryland despite the county being among the top 4% most affluent counties in the country.¹⁴ COVID-19 is severely impacting Prince Georges County, yielding as July 7th, 19,500 confirmed cases, 3,075 hospitalizations and 687 deaths.¹⁵ A majority of these deaths and hospitalizations have occurred amongst the Black population.¹⁶

One of the many reasons for the Prince Georges county statistics is that the county borders Washington D.C. and northern Virginia which means that the county is likely to experience higher rates of transient travel and likely transmission compared to other counties.¹⁷ The county has a large federal workforce¹⁸ and many of these workers navigate between the county and D.C. There are also many Prince Georges residents who are essential workers who continued to work during the COVID -19 crisis. This same data showed that the county had the largest number of imported cases compared to other counties.¹⁹

The differences between health disparities and health inequities are an important and distinct and needs to be understood as they are not interchangeable terms, but inter-related.²⁰ This was not always the case but has now been clarified to mean specific issues. Health disparity which

⁹ Ibid, 31.

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid. 32.

¹³ Ibid.

¹⁴ Angela Alsobrooks, County Executive of Prince George's County, testimony, *Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights, July 7, 2020*, transcript, p. 9

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Ibid., 10.

¹⁹ Ibid.

²⁰ Dr. Mann, Testimony, *July 7, 2020 Briefing*, pp. 15-16

originally meant having a health difference as a result of unfair/unjust disadvantage and discrimination now is used to identify differences agnostically, while healthy inequities refers to unjust differences.²¹ Examining health disparities in the connection with social determinants shows how they are related, in particular with regards to the COVID-19 pandemic.²²

This is where observations can be made to determine which disparities are a result of inequities based on social determinants such as education, employment, income and wealth, and lack of access to adequate housing, food security and transportation, environment, issues of violence in the community, and the justice system, all of which affect health and where health disparities often exist.²³ It is suggested that racism fuels many of these inequities.²⁴

People with higher prevalence of health disparities are more susceptible to developing disease and therefore yielding higher frequency of disease.²⁵ This also goes for severity of disease, death rates, emergency department and hospital visits, and healthcare costs.²⁶

In dealing with health inequities and developing interventions to address it, Dr. Mann stated that there are several important questions to answer: Who has the problem? Where is the problem located? How big or bad is it? And, how big are the differences across different groups? These questions are usually answered by academic partners who use research data.²⁷

An example given relates to frontline workers and their lack of access to adequate PPE, lack of access to appropriate healthcare, the risk posed to people living in multigenerational households in addition other social determinants (violence, poverty, and racism which yield higher levels of stress).²⁸

To date, the Maryland Office of Minority Health and Health Disparities has not conducted any research on infection and death rates of frontline workers in Maryland, who are likely people of color.²⁹ It is possible that this study will be taken up by academic researchers, but to date nothing is known to be available.³⁰

A request was made by a committee member to receive a side-by-side comparison of Prince George's County and Montgomery County data to analyze and compare health disparities and health inequities in the context of demographics, such as population diversity, socio-economic factors.

²¹ Ibid., 15.

²² Ibid., 16.

²³ Ibid.

²⁴ Ibid.

²⁵ Ibid., 17.

²⁶ Ibid.

²⁷ Ibid.

²⁸ Ibid., 18.

²⁹ Ibid., 29.

³⁰ Ibid.

A question was posed asking about COVID-19 co-morbidity and pre-disposing factors such as asthma, diabetes, and hypertension and how they are considered in the analysis of health disparities and health inequities. This is yet to be conclusively explained.³¹

Lastly, while data was presented on Black and White communities in Maryland, less attention or lack of mention of Hispanic and Asian communities was noticed.³² The reason given for this is the greatest disparities tend to be between White and Black communities.³³ The data being collected from the Hispanic and Asian communities are incomplete compared to the White and Black communities.³⁴

Briefing Two: August 4, 2020

The Maryland State Advisory Committee to the U.S. Commission on Civil Rights met virtually on August 4, 2020. The committee heard from three speakers followed by a brief public comment portion. The briefing covered various topics including the educational implications of COVID-19 as they intersect with the health consequences of COVID-19, the health aspects of COVID-19 involving racial disparities, community trust in the medical arena and building healthy communities.

The speakers for Briefing Two were: John B. King, Jr., President and CEO of The Education Trust and former Secretary of Education; Dr. Stephen B. Thomas, Director of the Maryland Center for Health Equity; Karen B. Evans, Executive Director, Maryland Board of Nursing.

The purpose of this meeting was to study the issue of racial disparities in Maryland and COVID-19, particularly deaths due to COVID-19 as well as implications and impact in the community.

The Committee first heard testimony from Dr. John B. King on the educational implications of COVID-19 as they intersect with the health consequences of COVID-19.³⁵ Both health consequences and economic consequences have important consequences for children.³⁶ From schools closing in the spring due to COVID-19, there was an immediate increase in food insecurity.³⁷ This estimates that 40% of black and Latino families with children are struggling to provide their kids with regular meals.³⁸

Families have become reliant on online learning, this also causing racial disparities.³⁹ 79% of white families have reliable internet access, only 66% black families, 61% of Latino families.⁴⁰

³¹ Ibid., 28.

³² Member, *Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, July 7, 2020, transcript, p. 30

³³ Dr. Mann Testimony, *July 7, 2020 Briefing*, p. 30

³⁴ Ibid.

³⁵ Dr. John B. King, President and CEO of The Education Trust and former Secretary of Education, testimony, *Web Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, August 4, 2020, transcript, p. 2.

³⁶ Ibid.

³⁷ Ibid.

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Ibid.

Therefore, families have a harder time accessing education.⁴¹ The lack of internet access also causes significant health consequences.⁴² Families are difficult accessing telehealth, tele mental health services, and kids who are not learning will see a long-term negative life consequence.⁴³ Dr. King emphasizes the need for the federal government to step up with significant resources to address stabilizing state budgets, to address food security, and to address learning loss and socio emotional needs of kids.⁴⁴

A Committee member asked can you talk a little more about the socio emotional impact, and talk about perhaps what we can advocate for as commissioners? Dr. King responded with when students are isolated from their relationship with school that can present a real challenge to their socio emotional wellbeing.⁴⁵ It is critical that we focus on relationships.⁴⁶ One of the schools in Arizona started a Every Student Everyday Campaign to make sure that there was an adult who worked with the school district.⁴⁷ Somebody was in touch with every kid every day to check on them.⁴⁸ So, counselors at school or it could be a mental health service provide that working with the school, but we have got to make sure that we are frequently offering those kinds of services.⁴⁹

Dr. Thomas asked if we have minorities living in areas that would be characterized as COVID-19 test deserts, the population is there, the disease is there, the deaths are there, but there is no testing, can that be viewed as in violation of civil rights? How might the levers of the Civil Rights Commission be used?

Dr. King responded with what we need is a level of federal leadership.⁵⁰ This is part of the challenge around addressing racial disparities in the use of exclusionary discipline.⁵¹ We are able to turn those recommendations in the Civil Rights Community and concerns into policy action, the current administration I would argue, is doing the opposite.⁵² Now there is also an opportunity for the commission to take recommendations to Congress.⁵³ I would love to see Congress in the next stimulus dedicate significant resources to address COVID related disparities.⁵⁴ We are not adequately investing in our healthcare sector, we see real disparities in the resources between hospitals, depending on who is served by those hospitals.⁵⁵ We also need

⁴¹ Ibid.

⁴² Ibid., 3.

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid., 10.

⁴⁶ Ibid., 11.

⁴⁷ Ibid., 10.

⁴⁸ Ibid., 10-11.

⁴⁹ Ibid., 11.

⁵⁰ Ibid., 21.

⁵¹ Ibid.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Ibid.

⁵⁵ Ibid., 22.

to address some of the social determinants of health.⁵⁶ So far, they have been unwilling to take on these issues in a meaningful way.⁵⁷

The Committee next heard testimony from Karen Evans, Executive Director of the Maryland Board of Nursing regarding the impact of health aspects of COVID-19 particularly when it involves racial disparities.⁵⁸ A lot of times, a lot of the patients feel that they are not wanted in that acute care arena.⁵⁹ There are also a lot of stereotypes.⁶⁰ She gave an example of how all African Americans ought to eat a certain food, little things like this causes someone not to trust their physician or to go to a new physician and sets up a barrier for healthcare.⁶¹ There are already barriers in more of the POCs, minority community for typically, access to health care.⁶² There has also been a long history of non-trust, when it comes to vaccines, and immunizations.⁶³ So, a lot of times, minorities do not seek out their physicians until it is too late.⁶⁴ She mentioned how cultural competence is not really being taught in regard to how to take of other minorities, it is usually watched over.⁶⁵ We not only have to change the mindset on the healthcare provider, but we also have to change the mindset on the minority end.⁶⁶ It would be nice if we have half a true percentage of all the minorities being truly presentative in healthcare.⁶⁷ We currently have 5 to 10 percent of all minorities in the healthcare, that does not represent as far as the number of percentages per ethnicity in the arena.⁶⁸

She also stated there has been an impact on workers in long term care.⁶⁹ They are not having the proper management of infection control policies and procedures in practices, which is causing a problem as well.⁷⁰ This is causing employees to have COVID-19, which they are then bringing home to their families.⁷¹ The one thing that we have no control over right now is that we still do not know everything there is to know about COVID-19.⁷² The majority of individuals who walk in certified nursing assistance or geriatric nursing assistants in the space are African American, or another set of minorities.⁷³ But they are not paid enough, on average they get paid \$11-\$15 an hour after they have been there about 20 years.⁷⁴ So, they are not paid sufficiently, they go on

⁵⁶ Ibid.

⁵⁷ Ibid.

⁵⁸ Karen B. Evans, Executive Director of the Maryland Board of Nursing, testimony, *Web Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, August 4, 2020, transcript, p. 4.

⁵⁹ Ibid.

⁶⁰ Ibid.

⁶¹ Ibid.

⁶² Ibid.

⁶³ Ibid.

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Ibid., 5.

⁶⁸ Ibid.

⁶⁹ Ibid.

⁷⁰ Ibid.

⁷¹ Ibid.

⁷² Ibid.

⁷³ Ibid.

⁷⁴ Ibid.

and be ill.⁷⁵ Karen Evans thinks that some clinicians do not believe that they are the cause of the problem as far as contributing to the access of COVID-19 back from the minority communities.⁷⁶ Individuals have to have trust in their medical arena, and we need to educate our communities so that they are able to get access when they need it.⁷⁷

A Committee asked the possibility or the future to resolve that issue in terms of what are those institutions doing about it, such as John Hopkins or some of the other schools in the State of Maryland? Karen Evans responded that the schools are opening scholarships and grants for minority students.⁷⁸ She thinks it really starts in the elementary school level, and it is critical first to have families that promote.⁷⁹ It would help if healthcare providers would go into elementary, middle school, high school, and just show them about healthcare, and how wonderful it really is.⁸⁰ It really would dispel a lot of myths that individuals have.⁸¹ So that others will help others within that arena understand how healthcare can improve their life.⁸² So, education is the key.⁸³ A part of this is you have to have an open heart and want to learn about another culture.⁸⁴ As everybody wants us to understand other culture, other cultures have to understand us as well.⁸⁵

A Committee member asked whether there was a demographic breakdown of the nurses in Maryland and whether it make sense that there are say enough black nurses in hospitals in PG county? Karen Evans responded with I really think that the number of nurses that we have in the State of Maryland need to mimic the percentage of demographics that we have for each.⁸⁶ I think it really needs to mimic what we have in our state.⁸⁷ We currently have 90,000 RNs and 12,000 LPNs⁸⁸. We have 10,000 what we call advanced practice nurses.⁸⁹ Approximately 150,000 certified nursing assistants or geriatric nursing assistants in the state.⁹⁰ She will work on getting better demographics and merging data.⁹¹

A Committee member asked if there is racial disparity data in Maryland that is accessible on those issues and if Ms. Evans thoughts about how to address cultural competence issues in community services for people of color. Ms. Evans asserted that she does not have that particular data and cultural competence issues in community services for people of color comes with access

⁷⁵ Ibid.

⁷⁶ Ibid.

⁷⁷ Ibid.

⁷⁸ Ibid., 6.

⁷⁹ Ibid., 11.

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² Ibid.

⁸³ Ibid., 12.

⁸⁴ Ibid.

⁸⁵ Ibid.

⁸⁶ Ibid., 13.

⁸⁷ Ibid.

⁸⁸ Ibid.

⁸⁹ Ibid.

⁹⁰ Ibid.

⁹¹ Ibid.

to healthcare.⁹² Karen Evans suggested we just need to begin with cultural competency with the healthcare providers and make that an annual education that everyone must do.⁹³

The Committee next heard testimony from Dr. Stephen Thomas, Director of the Maryland Center of Health Equity beginning with the theme in the Center for Health Equity—building bridges, building trust, and building healthy communities.⁹⁴ There are programs, training programs that address the community side of the distrust as well as the provider side of the history of distrust in our health care delivery system.⁹⁵ Our solution has to be more than an online training or a quick or cultural competence, it truly has to be culture change. Just like Dr. King resonates, we have to get out of a biological framework and address really these other social determinants of health, issues of poverty, issues of exposure to environmental toxins with our neighborhoods, many minority communities have suffered with this for decades⁹⁶. He makes a point that we need to recognize the lessons from our ancestors.⁹⁷ There is going to be tension here, many disagreements, but we have to be able to do so without being disagreeable, we also have to agree on things.⁹⁸ As of right now we can agree on what we mean when we say health disparities and health equity.⁹⁹ Health equity means everyone has fair and just opportunity to be as healthy as possible.¹⁰⁰ If the effort does not address poverty, if the effort does not address discrimination, and the consequences of discrimination on people who have been excluded, then it is not a health equity effort.¹⁰¹

Dr. Thomas shares an example of the basketball arena turned into an emergency dental clinic.¹⁰² People came for free dental care, they found that 1,769 people over 50% had prehypertension or hypertension.¹⁰³ This is one of the key underlying conditions for COVID.¹⁰⁴ We have not mounted the efforts needed to address it.¹⁰⁵ He also presents another data set, in terms of COVID patients per 10,000 people, Latinos and African Americans lead the way.¹⁰⁶ When you look at our country, we are the outlier.¹⁰⁷ Therefore, he mentions they have formed a commission, The Colors of COVID-19 Consortium Prevention, detection and treatment of African Americans and Hispanics in Maryland and across the country, in partnership with Let's Step, a rock build company.¹⁰⁸

⁹² Ibid., 16.

⁹³ Ibid.

⁹⁴ Dr. Stephen Thomas, Director of the Maryland Center for Health Equity, testimony, *Web Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, August 4, 2020, transcript, p. 4.

⁹⁵ Ibid., 6.

⁹⁶ Ibid., 7.

⁹⁷ Ibid.

⁹⁸ Ibid.

⁹⁹ Ibid.

¹⁰⁰ Ibid.

¹⁰¹ Ibid.

¹⁰² Ibid.

¹⁰³ Ibid.

¹⁰⁴ Ibid.

¹⁰⁵ Ibid.

¹⁰⁶ Ibid.

¹⁰⁷ Ibid.

¹⁰⁸ Ibid., 7-8.

Explaining the data 60% of African Americans live in vulnerable census tracks versus only 34% of white.¹⁰⁹ Many of these tracks are also part of the non-vulnerable counties, and only 22% of African Americans live in these vulnerable countries.¹¹⁰ With geography we can tell you where its vulnerable and where its growing. We have testing deserts around the country where the people of color have less access to testing. This shows the gap for African Americans, its 2.7 times higher in terms of vulnerable countries and increasing COVID deaths and no test sites.¹¹¹

Once things started to open back up, we have a very high steep curve on the vulnerable counties that are 40% higher than those in the low vulnerable zip codes and census tracks.¹¹² For people living in vulnerable areas, it is 19 miles on average to get to a test site verses 9.7 miles for people who are not in the vulnerable area, in rural, and only 2.9 miles for urban people who are not in vulnerable areas.¹¹³ Making context with the Tuskegee syphilis study, this is the part of the cultural memory in many African American Communities.¹¹⁴ Therefore, they are hesitant to get involved in vaccine trails and many other things that could save their lives.¹¹⁵ We need to move towards atonement.¹¹⁶ It is in that atonement that the national campaign to eliminate the racial ethnic and health disparities operating.¹¹⁷ It is in the atonement that we allow COVID-19 to enable us to see where the challenges are, where the gaps are, and where we can close those gaps for our most vulnerable citizens.¹¹⁸

Using the example of what is being worked on the black barbershops and beauty salons, you can see that the community wants to be involved in the planning, the design, every step of the way.¹¹⁹ Lastly, never influence any person, allow any person to dampen or diminish your light—our light right now in this public health catastrophe is to finally make a commitment to address racial and ethnic health disparities and the underlying root causes that have been driving them all this time.¹²⁰

A Committee member asked whether there was racial disparity data in Maryland that could be accessed on minority communities being disproportionately served in institutional settings rather than community settings and excluded from community services.¹²¹ Dr. Thomas responded by asserting that there has been the COVID pandemic and we also have the aftermath of George Floyd's murder that everyone witnessed.¹²² That was the spark in the dry grass of racism that went around the world.¹²³ Dr. Thomas asserts it is in the space of COVID-19 public health

¹⁰⁹ Ibid., 8.

¹¹⁰ Ibid.

¹¹¹ Ibid.

¹¹² Ibid.

¹¹³ Ibid.

¹¹⁴ Ibid., 9.

¹¹⁵ Ibid. 9.

¹¹⁶ Ibid., 9.

¹¹⁷ Ibid.

¹¹⁸ Ibid.

¹¹⁹ Ibid.

¹²⁰ Ibid., 10.

¹²¹ Ibid., 16

¹²² Ibid., 17.

¹²³ Ibid.

emergency is the space where we can come back together.¹²⁴ Let us make sure that we acknowledge that the explosion of COVID many people of color has just as much to do with them being in employment positions that now make them essential.¹²⁵ He states this so that we do not run the risk of blaming people of color for their own risk.¹²⁶

A Committee member asked whether Dr. Thomas was thinking in advance about disparities that may arise in vaccine availability and discrimination here in Maryland once we have a viable vaccine.¹²⁷ Dr. Thomas answered with absolutely, Maryland should be leading the nation.¹²⁸ Our minority communities have been seeded already with disinformation saying COVID is a hoax and do not take the test.¹²⁹ My concern is that our communities are already predisposed to not want to be involved.¹³⁰ So, we need trusted opinion leaders.¹³¹ They do not have to have MDs and degrees, these opinion leaders might be the local store owner, the minister, the barber.¹³² We need to ensure communities know that we care about them, that we are not treating them like guinea pigs, that we are going to respect them.¹³³

A Committee member spoke about his concern of if there is no consideration of what kind of side effects or aftereffects that may affect people of color specifically, that could be another disaster in the making in which the cure is worse than the actual COVID-19.¹³⁴ Dr. Thomas asserted the side effects are one of the areas where minorities are really concerned with the existing drug, let alone that brand new vaccine.¹³⁵ If there is anything we should be doing right now, it should be making sure that we do get much better uptake of the flu vaccine.¹³⁶ All preparation needs to be happening right now.¹³⁷ I do not see that kind of urgency in the very neighborhood that we now know are vulnerable for this virus.¹³⁸

A Committee member inquired as to how this kind of urgency is created.¹³⁹ Dr. Thomas responded by asserting that this is a Civil Rights issue.¹⁴⁰ There is history of this kind of racism in our healthcare delivery system that has been addressed through civil rights laws.¹⁴¹ I am hoping that the Civil Rights Commission, the very members of this board us their voices, their

¹²⁴ Ibid.

¹²⁵ Ibid., 18.

¹²⁶ Ibid.

¹²⁷ Ibid.

¹²⁸ Ibid.

¹²⁹ Ibid.

¹³⁰ Ibid., 18.

¹³¹ Ibid.

¹³² Ibid.

¹³³ Ibid.

¹³⁴ Ibid., 19.

¹³⁵ Ibid., 20.

¹³⁶ Ibid.

¹³⁷ Ibid.

¹³⁸ Ibid.

¹³⁹ Ibid.

¹⁴⁰ Ibid.

¹⁴¹ Ibid.

imprimatur, and use the civil rights laws to rectify many of the things that we have exposed in this presentation.¹⁴²

A Committee member then shared views that within the Asian community, there is a deep resentment brought on by the complete ignorance of Asians in any research you have presented.¹⁴³ I would ask that you please be aware that this is promoting a secondary systemic racism by not even being measured or included.¹⁴⁴ Dr. Thomas responded with thank you for your observation, your observation should be echoed loudly to the federal government because there is only a patchwork of data on COVID-19 being released by race, ethnicity—it is not national assets.¹⁴⁵ Early on our President was talking about the Chinese virus, so there is an anti-Asian pandemic related racism and fear mongering that been going on from the very beginning, we all need to acknowledge that and address it.¹⁴⁶

Dr. King agreed with those sentiments and added that one useful thing that the commission could do is to recommend not only that there be a more systemic effort to report data for Asian Americans in both the healthcare and education context, but something that was set forth during the Obama administration—trying to obtain better disaggregated data within the Asian American, Pacific Islander Community because often times there are specific communities with that data that are particularly impacted.¹⁴⁷

Briefing Three: September 1, 2020

The Maryland State Advisory Committee to the U.S. Commission on Civil Rights met virtually on September 1, 2020. The committee heard from three speakers followed by a brief public comment portion. The briefing covered various topics including lack of access to healthcare, transportation issues, housing issues, the impact of COVID-19 on the immigrant community.

The speakers for Briefing Three were Dr. Michelle LaRue, Senior Manager, Health and Social Services of CASA de Maryland; Dr. Barbara Brookmyer, MD, MPH, Health Officer, Frederick County Health Department; Dr. Noel Brathwaite, Director, Minority Health and Health Disparities, Maryland Department of Health; Danielle Weber, Administrative Deputy Health Officer at the Somerset County Health Department.

The purpose of this meeting was to study the issue of racial disparities in Maryland and COVID-19, particularly deaths due to COVID-19 as well as implications and impact in the community.

¹⁴² Ibid., 20.

¹⁴³ Ibid., 12.

¹⁴⁴ Ibid.

¹⁴⁵ Ibid., 14.

¹⁴⁶ Ibid.

¹⁴⁷ Ibid.

The Committee first heard from Dr. Barbara Brookmyer, Health Officer with the Frederick County Health Department.¹⁴⁸ The data that has been collected in Frederick County indicates that cases have been fairly evenly distributed among race, but deaths have been proportionally higher in the black population.¹⁴⁹ Cases by ethnicity suggest proportionally higher cases in the Hispanic population but proportionally lower deaths.¹⁵⁰ For both data sets, about 20-25% of the cases have unreported race or ethnicity data, so conclusions are uncertain.¹⁵¹ In the beginning, most cases were in the white population, but as the pandemic has progressed there has been an increase of cases in the black and Hispanic populations.¹⁵²

Dr. Brookmyer emphasizes that the risk of exposure through housing and access to healthcare is key for contracting COVID-19, and that minority populations are at increased risk because of the necessity to continue to work essential jobs throughout the pandemic, lack of access to healthcare, transportation issues, and housing issues.¹⁵³ Transportation issues are particularly important because they include the ability to access healthcare and ability to get to work.¹⁵⁴ As carpooling has been, and continues to be, utilized, it increases minorities' risk of exposure by frequently putting individuals in close proximity with other potentially infected adults, and is used for everything from accessing healthcare and testing sites to getting to work every day.¹⁵⁵ Housing is also a broad issue as it addresses the quality of housing, such as the ventilation and hygiene of the building, as well as the living situation of the occupants, such as the number of adult occupants.¹⁵⁶ The more adult occupants within a living space, the higher the risk of exposure as the adults are likely out working.¹⁵⁷

Dr. Brookmyer has also seen shifts from high case numbers in the populated areas of Frederick County to high case numbers in the less populated areas.¹⁵⁸ She attributes this to the corresponding lack of access to opportunity in lower population areas.¹⁵⁹ The Frederick County Health Department has partnered with various organizations to increase the number of free testing sites to address some of these transportation and healthcare access issues.¹⁶⁰ Most recently they have partnered with the Housing Authority of the City of Frederick to facilitate free on-site testing.¹⁶¹ They are also reaching out to the community to find more Spanish speaking staff to

¹⁴⁸ Dr. Barbara Brookmyer, MD, MPH, Health Officer, Frederick County Health Department, testimony, *Web Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, September 1, 2020, transcript, p. 2.

¹⁴⁹ *Ibid.*, 3.

¹⁵⁰ *Ibid.*, 4.

¹⁵¹ See Appendix C, Brookmyer PowerPoint Presentation, p. 9.

¹⁵² *Ibid.*, 10-11.

¹⁵³ *Ibid.*, 16.

¹⁵⁴ *Ibid.*, 19.

¹⁵⁵ Brookmyer Testimony, *Web Briefing*, p. 25.

¹⁵⁶ *Ibid.*, 8.

¹⁵⁷ *Ibid.*

¹⁵⁸ *Ibid.*, 6.

¹⁵⁹ *Ibid.*

¹⁶⁰ Appendix C, Brookmyer PowerPoint Presentation, p. 26.

¹⁶¹ *Ibid.*

work testing locations, though Dr. Brookmyer acknowledges that this effort is more tertiary prevention and they want to move to more primary prevention methods.¹⁶²

A Committee member asked what the factors were that were impacting the current uptick in cases in the Frederick County area and how that is impacting the flattening curve that was present.¹⁶³ Dr. Brookmyer responded that the flattening curve has more to do with hospitalizations, which have been decreasing, but there have been recent increases in the positivity rate.¹⁶⁴ She says they are still not quite sure why, but they have some ideas.¹⁶⁵ She says it could be because of a change in the pattern of people's activities such as holidays like the 4th of July and vacations where the case proportions seemed artificially lower because everyone was getting tested before leaving for vacation when they had not been at risk of exposure, so the current uptick could be a return from the artificially lower number.¹⁶⁶ Dr. Brookmyer also mentions the effect the local colleges played when students returned but says that she does not think that the colleges contributed to the increase in percent positivity.¹⁶⁷

A Committee member asked whether Dr. Brookmyer found any solutions for carpooling and transportation issues or whether it remained an unsolved problem.¹⁶⁸ Dr. Brookmyer states that testing essential workers has been somewhat challenging because employers do not want their workforce impacted by the testing.¹⁶⁹ As of June, Frederick County's local hospital was testing everyone who came in the doors and found 40% of the positive cases were asymptomatic, which is highly problematic for something like carpooling because people do not know that they should be isolating and continue to carpool in a small space with others.¹⁷⁰ Dr. Brookmyer suggests larger shared vehicles such as vans could be used at a very low capacity to increase distancing and opening windows to increase airflow.¹⁷¹ She says creating incentives for employers to provide this type of transportation may be a solution, particularly with a number of large vehicles like buses not being used right now.¹⁷² She says that these solutions are not ideal, but they would reduce risk.¹⁷³

Dr. LaRue adds that there is a big difference between what is ideal and what the reality is for many of these communities.¹⁷⁴ She says the efficacy needs to be studied, but things like wearing masks in the car, opening windows and blasting the air conditioning could help to decrease risk by increasing air circulation.¹⁷⁵ Further, she states that ideal situations continue to be discussed,

¹⁶² Ibid., 27.

¹⁶³ Brookmyer Testimony, *Web Briefing*, p. 22.

¹⁶⁴ Ibid.

¹⁶⁵ Appendix C, Brookmyer PowerPoint Presentation, p. 23.

¹⁶⁶ Ibid.

¹⁶⁷ Ibid., 24.

¹⁶⁸ Ibid.

¹⁶⁹ Ibid.

¹⁷⁰ Ibid., 25.

¹⁷¹ Ibid.

¹⁷² Ibid.

¹⁷³ Ibid., 25-26.

¹⁷⁴ Dr. Michelle LaRue, Senior Manager, Health and Social Services, CASA de Maryland, testimony, *Web Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, September 1, 2020, transcript, p. 2.

¹⁷⁵ Ibid., 26.

but they are not realistic to apply, and we need to do something for the members of the communities to keep them as safe as we are able while new solutions are thought up.¹⁷⁶

A Committee member asked Dr. Brookmyer to comment on the relationship with the Burmese community in Frederick County.¹⁷⁷ Dr. Brookmyer says that for the past 10-20 years Frederick has been the location of Burmese refugee resettlements, especially for a group that speak the Chin dialect of Burmese.¹⁷⁸ She says they have been lucky to find staff that speak Chin and have been able to create a long-standing relationship with the Burmese population starting with their refugee health screening program where it was ensured that the results did not affect their ability to stay.¹⁷⁹

David Kim asked of everyone to comment on the CDC statistic that 94% of COVID deaths were supplementary, meaning the individual had comorbidities.¹⁸⁰

A presenter clarified that comorbidities were preexisting conditions, especially chronic diseases.¹⁸¹ They continue that with Hispanics, this is not necessarily what they are finding and say that the Hispanics hospitalized tend to be younger and to have fewer preexisting conditions, but the mortality rate is lower.¹⁸² Dr. Brookmyer adds that the data is of great quality and that she hopes that it does not lead to victim blaming or individuals thinking that they are not at risk because they do not have preexisting conditions.¹⁸³ She further states that she does not find that statistic reassuring because it may mislead people into thinking they are not at risk and will not worry about infecting others.¹⁸⁴

The next speaker was Dr. Michelle LaRue, Senior Manager for Health and Human Services at CASA of Maryland.¹⁸⁵ Dr. LaRue concurred with Dr. Brookmyer's findings and added that working conditions for immigrant populations such as lack of paid sick leave, working essential jobs like construction and cleaning, that never closed throughout the course of the pandemic, and working service jobs with no PPE, have greatly increased their risk of exposure.¹⁸⁶ It also complicates their ability to access public programs for fear of public charge.¹⁸⁷ This is a major problem in the immigrant communities where existing issues of food and housing insecurity have been made worse during the pandemic, particularly because much of this population was left out of the stimulus.¹⁸⁸ Language barriers are also an ever-present issue as most information

¹⁷⁶ Ibid.

¹⁷⁷ Brookmyer Testimony, *Web Briefing*, p. 28.

¹⁷⁸ Ibid., 29.

¹⁷⁹ Ibid.

¹⁸⁰ Ibid., 29-30.

¹⁸¹ Presenter Testimony, *Web Briefing*, p. 30.

¹⁸² Ibid., 29.

¹⁸³ Brookmyer Testimony, *Web Briefing*, p. 30.

¹⁸⁴ Ibid.

¹⁸⁵ LaRue Testimony, *Web Briefing*, p. 10.

¹⁸⁶ Ibid.

¹⁸⁷ Ibid.

¹⁸⁸ Ibid., 12.

about COVID-19 has been in English.¹⁸⁹ This again is a situation where COVID-19 has exacerbated preexisting issues such as food and housing insecurity.¹⁹⁰

The next speaker was Danielle Weber, Administrative Deputy Health Officer of the Somerset County Health Department.¹⁹¹ The experience of Somerset County is somewhat different because it is a small rural population, half of the population is minority, 23% are below the poverty line, and unemployment and Medicaid numbers were already fairly high.¹⁹² Within the county there is a university and a prison, so there is a high proportion of essential employees.¹⁹³ The Somerset County Health Department has a good relationship with the long-term Hispanic community built over a long history of community events, but there is a seasonal migrant camp that is less trustful of public health workers.¹⁹⁴ Unfortunately, COVID-19 prevents the use of community events to build a more trustful relationship with the migrant communities.¹⁹⁵ Because of COVID-19, there are now two migrant camps present in the county, and communication with both groups has been challenging.¹⁹⁶ Contact tracing is a major challenge here because the migrant populations and the Black populations are both mistrustful of public health and healthcare workers.¹⁹⁷ Transportation is a big issue throughout the county, so testing and vaccine services would need to be brought to them.¹⁹⁸ Trust is a major factor here also with getting services to the minority populations.¹⁹⁹

A Committee member asked Danielle Weber what her impressions were of Somerset County's experience being typical for other counties in the Eastern Shore. Ms. Weber asserted that Somerset County has actually had much lower rates than neighboring counties.²⁰⁰ She also stated that they have been able to create some avenues of communication with the migrant population even before they arrived this year, so the rates have not been very affected by the camp.²⁰¹ As far as other travel, Danielle Weber states that there is not a lot of travel in and out of the county.²⁰² The travel that does exist is mostly residents who travel to neighboring counties for work.²⁰³ She also says that many of Somerset County's cases have been linked to this out of county travel.²⁰⁴

¹⁸⁹ Ibid.

¹⁹⁰ Ibid., 10.

¹⁹¹ Danielle Weber, Administrative Deputy Health Officer of the Somerset County Health Department, testimony, *Web Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, September 1, 2020, transcript, p. 2.

¹⁹² Ibid., 14.

¹⁹³ Ibid.

¹⁹⁴ Ibid.

¹⁹⁵ Ibid., 15.

¹⁹⁶ Ibid., 14.

¹⁹⁷ Ibid., 15.

¹⁹⁸ Ibid., 28.

¹⁹⁹ Ibid., 16.

²⁰⁰ Ibid., 27.

²⁰¹ Ibid., 28.

²⁰² Ibid.

²⁰³ Ibid.

²⁰⁴ Ibid.

The next speaker was Dr. Noel Brathwaite, Director of Minority Health and Health Disparities at the Maryland Department of Health.²⁰⁵ Dr. Brathwaite stated that state-wide data is showing disproportionate rates of cases and deaths in minorities and he stresses the correlation between trust in government agencies and the degree of compliance to guidelines.²⁰⁶ He says that there is very low trust in these agencies for minority communities, and so compliance with recommendations is correspondingly low.²⁰⁷ He provides the example of the Haitian community on the Eastern Shore where individuals have been moved to hotels to be quarantined and some have still not been reunited with their families.²⁰⁸ Because of this, many in the Haitian community are afraid of being separated from their families and never being reunited.²⁰⁹ He emphasizes that trust and fairness need to be restored in order to increase compliance within minority communities.²¹⁰ He gives several ways to begin to restore trust that include the following: apologies from large hospitals and organizations, including the community in planning and implementing initiatives within their community from the outset and not only once you need them, acknowledging the reality of citizen status and civil rights of minority groups, and not invading their privacy by collecting personal data like immigration status.²¹¹

A Committee member asked Dr. Brathwaite what the state-wide data for the racial breakdown of COVID-19 infections and deaths was. Dr. Brathwaite stated that there is a marked disproportionality that is continuing throughout the state.²¹² In Maryland, 30% of the population is made up by African Americans and 10-11% of the population is Hispanic.²¹³ African Americans and Hispanics make up much more of positive cases and hospitalizations than is proportional to population.²¹⁴ We hope that by contact tracing, and also by social determinants of health metrics in terms of meeting some of the social needs, that we will be able to reduce the disparity.²¹⁵

Briefing Four: November 10, 2020

The purpose of this meeting was to examine and gain a deeper understanding of the health disparities in Maryland during the COVID-19 pandemic with a particular interest in understanding the challenges and initiatives being undertaken to address these challenges in Montgomery County, Baltimore City and the perspectives from a Hispanic community-based organization in Maryland.

²⁰⁵ Dr. Noel Braithwaite, testimony, *Web Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights*, September 1, 2020, transcript, p. 17.

²⁰⁶ *Ibid.*, 18.

²⁰⁷ *Ibid.*

²⁰⁸ *Ibid.*, 20.

²⁰⁹ *Ibid.*

²¹⁰ *Ibid.*

²¹¹ *Ibid.*

²¹² *Ibid.*, 26.

²¹³ *Ibid.*

²¹⁴ *Ibid.*

²¹⁵ *Ibid.*, 27.

The speakers for Briefing Four were: Montgomery County Executive Marc Elrich; Martiza Solano, Education Director, CASA-Maryland; Baltimore City Council President and Mayor-elect Brandon M. Scott.

This briefing focused on the efforts and challenges that leaders of Maryland's largest county, Maryland's largest city and a prominent Hispanic community-based organization located in Montgomery County face in addressing disparities in communities of color that have been exacerbated by the pandemic.

Issues such as pre-existing health conditions, inadequate housing, and pre-pandemic lack of access to healthcare were some of the factors identified as presenting significant challenges to minimizing the pandemic impact in Montgomery County, especially in communities of color, like many other places in the US.²¹⁶

Second to the health impact, is the economic impact that disproportionately affects people of color because of the larger number of minority-owned small businesses in Montgomery County.²¹⁷ These businesses, many of which serve the respective communities where they are located, manage to get by in good times, but without reserves continue to struggle to pay rent and bills during the pandemic.²¹⁸

Financial help from Montgomery County, the state and the Federal government is either insufficient or simply not forthcoming therefore unable to undo or offset the financial damage to these businesses.²¹⁹ The postponement of evictions does not forgive many of the obligations once lifted which means paying back what was owed and likely accrued will be an extraordinary challenge.²²⁰

Montgomery County has been trying to help the frontline or central workers who are the most vulnerable, likely least paid, least respected, and least cared for.²²¹ Another term used for this category of workers has been "essential workers" which often, if not typically refers to minorities. Those who are from immigrant communities often are not citizens, do not have insurance, and do not qualify for medical care are unable to get help from anyone.²²² This is further exacerbated by the digital divide where many of these people don't have access to the internet or internet service fast enough to handle multiple computers or devices in a household.²²³

²¹⁶ Marc Elrich, County Executive of Montgomery County, testimony, *Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights, November 10, 2020*, transcript, p. 2

²¹⁷ Ibid.

²¹⁸ Ibid.

²¹⁹ Ibid., 3

²²⁰ Ibid.

²²¹ Ibid.

²²² Ibid.

²²³ Ibid., 4.

County efforts to reach out to these communities are not enough and did not reach deep enough into the communities of color, so efforts are being made to move programming into these communities in order to ease and open access to government services.²²⁴

Latino non-profit organizations have been contracted to provide testing, contact tracing, counseling for mental and other health issues, as well as connecting the community to housing programs.²²⁵ African Americans in Montgomery County are being provided with testing and social support services through non-profit partners because more importantly, in addition to convenience, these services and activities are being conducted by trusted entities.²²⁶

Latinos in Montgomery County are being helped deal with the social determinant disparities that have been exacerbated by the pandemic by organizations such as CASA.²²⁷ Of the many challenges previously mentioned such as access to food and stable housing, access to the internet has been pointed out as having a significant impact on students because of the altered learning situation and environment.²²⁸ The lack of computers and tablets has meant students have no choice but to learn from their phones or from a family member's phone and seek public wi-fi hot spots in order to attend classes.²²⁹

The social environment for these students, many of whom are from low income and/or immigrant families has also changed dramatically as many of them have parents who are essential workers and the routine of dropping off children at school has been completely disrupted.²³⁰ With many of the parents having to stop work because they need to take care of their children who have to take classes at home virtually, household income has dropped which has triggered additional challenges such as the ability to complete school work and the effect on academic progress.²³¹

Many of these families have depended upon the school to provide resources and connections to help them navigate the communities in which they live.²³² With schools closed down, being able to meet with a community school coordinator or social worker has become more difficult, but some school districts are doing an excellent job of finding ways to reconnect parents and families with the schools.²³³

CASA points to the best practices of working closely with the community school coordinators in Prince George's County.²³⁴ In addition to helping families navigate food access challenges,

²²⁴ Ibid.

²²⁵ Ibid.

²²⁶ Ibid.

²²⁷ Maritza Solano, Education Director of CASA, testimony, *Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights, November 10, 2020*, transcript, p. 8.

²²⁸ Ibid.

²²⁹ Ibid.

²³⁰ Ibid.

²³¹ Ibid.

²³² Ibid., 9.

²³³ Ibid.

²³⁴ Ibid.

virtual learning issues and technology access, social services that have been provided include hosting legal clinic to address eviction issues.²³⁵

Montgomery County schools have created equity hubs which allow folks access to safe and affordable childcare which is critical for essential workers to be able to drop off their children and go to work.²³⁶

School districts willing to work with community organizations have played a key part in successful collaborations.²³⁷ More funding to community organizations would help reduce the impact of COVID-19 in these vulnerable communities.²³⁸ These collaborations may play a key part of any recovery plans addressing educational, social, and emotional aspects post-pandemic.²³⁹

The effectiveness of any policy, strategy or activity implemented to mitigate the challenges faced by communities of color during this pandemic often rests on the quality of the data that is collected, analyzed and used to develop appropriate responses.

Montgomery County has been limited in its ability to collect and compile comprehensive data, especially regarding communities of color.²⁴⁰ Legal limitations prevent several questions related to race, which stymie narrow efforts to create deliberately targeted programs.²⁴¹ Incomplete data sets that may identify certain races/ethnicities are wholly inconclusive. Lack of coordinated infrastructure prevents integration of data across several systems though some efforts are being considered.²⁴²

Similarly, data on evictions has been scant, except for the cases that have been backlogged prior to the pandemic.²⁴³ Current state law also allows landlords to evict tenants at the end of a lease without any reason. Montgomery County has no authority to ban such action.²⁴⁴

The issue of school re-openings in Montgomery County is pivotal to communities of color.²⁴⁵ The process to achieve this outcome will begin with a parent survey to assess level of comfort in sending students back into classrooms, back to a structured academic environment.²⁴⁶ However, discussions between County officials and school superintendents and parents has meant working more closely to address issues of potential virus spreading, long-term health impacts, uneven mask policies and compliance, abatement forecasts, air conditioning systems and even contemplate longer-term structural changes for the physical environments.²⁴⁷

²³⁵ Ibid.

²³⁶ Ibid.

²³⁷ Ibid.

²³⁸ Ibid., 10.

²³⁹ Ibid.

²⁴⁰ Elrich Testimony, *November 10, 2020 Briefing*, p. 11.

²⁴¹ Ibid.

²⁴² Ibid., 12.

²⁴³ Ibid., 13.

²⁴⁴ Ibid.

²⁴⁵ Member, *November 10, 2020 Briefing*, p. 13.

²⁴⁶ Ibid.

²⁴⁷ Elrich Testimony, *November 10, 2020 Briefing*, p. 16.

Moving the discussion from Maryland's largest county to Maryland's largest city, the picture is vastly different with a 77% increase in COVID patients over the previous month.²⁴⁸ To date there have been 475 deaths and 22,000 who have contracted the virus.²⁴⁹

Baltimore City Council recognized the crucial need for data and looked at zip codes to the focus on.²⁵⁰ The 21215 zip code area is not only a local COVID hotspot but one of the state's hotspots.²⁵¹ Coincidentally, this zip code was where the current Mayor-elect was born and raised.

The dissemination of necessary information regarding the pandemic was done through several old and new forms, from teleconferences with seniors to social media such as Instagram aimed at the younger generations, as well as physically handing out information in hard hit neighborhoods.²⁵²

A Baltimore COVID-19 asset map was created to allow residents to access all of the available resources, where to get tested, where to get food, etc.²⁵³

Regarding coordination of communications, the health department was designated the lead agency for the COVID command, which was comprised of representatives of all agencies. The City Council health committee chair represented the City Council.²⁵⁴

Actions taken by the City Council included allocating funding to help children and youth get laptop computers, access to the internet as well as food.²⁵⁵

Working with hospitals including Johns Hopkins has been key to preparing and responding to new outbreaks and is an example of the importance of public-private partnerships with hospitals around the city.²⁵⁶ Best practices and integrated communications through credible messengers are also key outputs from working with and partnering with community organizations and churches, especially for outreach to hard-to-reach populations.²⁵⁷ Mobile testing is one example of this.²⁵⁸

²⁴⁸ Brandon Scott, City Council President and Mayor-elect of Baltimore, testimony, *Briefing Before the Maryland State Advisory Commission to the U.S. Commission on Civil Rights, November 10, 2020*, transcript, p. 17.

²⁴⁹ Ibid., 18.

²⁵⁰ Ibid.

²⁵¹ Ibid.

²⁵² Ibid.

²⁵³ Ibid.

²⁵⁴ Ibid., 20.

²⁵⁵ Ibid., 18.

²⁵⁶ Ibid., 22.

²⁵⁷ Ibid.

²⁵⁸ Ibid.

Appendix C

Presentations from Briefings

Dr. David Mann

Epidemiologist, Maryland Department of Health

Dr. Stephen B. Thomas

Director, Maryland Center for Health Equity

Dr. Barbara Brookmyer, MD, MPH

Health Officer, Frederick County Health Department

Dr. Noel Brathwaite

**Director, Minority Health and Health Disparities,
Maryland Department of Health**



Maryland State Advisory Committee to U.S. Commission on Civil Rights Health Equity, Social Justice, and COVID-19

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Office of Minority Health and Health Disparities

Maryland Department of Health

July 7, 2020

Outline of Presentation

- **Health Disparity Data Basics: Social Determinant Role**
- **Some Maryland COVID-19 Data by Race/Ethnicity**
- **Data on Disparity in Some Relevant Co-morbidities**
- **Data on Social Determinants and Comorbidities**

Health Equity and Health Disparity Basics

- **Original concept of health disparity:**
 - A health difference due to disadvantage and discrimination
 - Therefore, unjust and unfair, and in need of resolution
 - Disparity and Health Inequity were synonymous terms
 - See <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>
- **More recent usage:**
 - Disparity is being used to mean any difference
 - Inequity is being used to mean those that are unjust
 - Disparity and Inequity no longer synonymous


Health Equity and Health Disparity Basics (2)

- **Health Equity: equal opportunity to achieve optimal health**
 - Focus on the social determinants of health:
 - Education, employment, income, wealth distributions
 - Housing, food security, transportation, environment, violence, justice system, etc.
- **Health Disparities includes both**
 - Health status disparities (next slide)
 - Health care disparities (differences in access and quality)
 - A process disparity

Health Equity and Health Disparity Basics (3)

Causal Chain of Health Disparities from Social Determinants to Ultimate Outcomes

<div><div>Social Determinants of Health</div><div>Education</div><div>Employment</div><div>Income</div><div>Wealth</div><div>Health Insurance</div><div>Housing</div><div>Transportation</div><div>Food security</div><div>Safety/Violence</div><div>Environment</div><div>Racism</div><div>Etc.</div><div>(Many of these vary by place)</div></div>	Prevalence of Causes of Disease (“risk factors”)	<div>Frequency of Disease:</div> <div>Number of Cases</div> <div>New cases = incidence</div> <div>All cases = prevalence</div>	<div>Ultimate Outcomes:</div> <div>Death, Disability, Amputations, ED Visits, Hospital Admissions, and Costs</div>
	Access to and quality of <u>prevention</u> services		
	Severity of Causes of Disease (“risk factors”)	<div>Severity of Disease:</div> <div>Rate of adverse events per case</div>	
	Access to and quality of <u>treatment</u> services		



Maryland

DEPARTMENT OF HEALTH

Three Roles of Data in Health Equity

- Needs assessment: who has the problem, where, and how big or bad is the problem?
 - Usually done by public health using surveillance data
- Intervention Planning: why do we see this (causes) and how do we fix it (evidence-based interventions)?
 - Usually done by academia using research data
- Evaluation: are we making progress?
 - Repeat the needs assessment analysis over time

Reasons for Minority Excess COVID Events

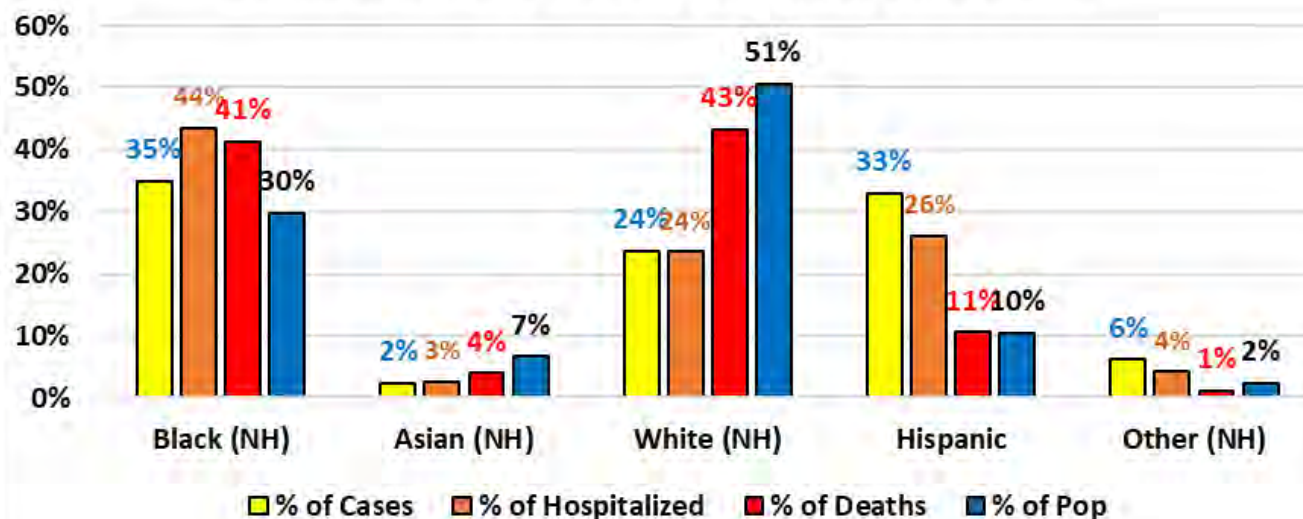
- **Reasons for higher minority incidence (more cases):**
 - More employment in essential occupations
 - Less ability to telework (*between household spread*)
 - More likely to be in larger, high density, multigenerational households (*within household spread*)
- **Reasons for higher minority severity once infected:**
 - Higher general stress due to violence, poverty and racism
 - Less access to resources due poverty and racism
 - Higher preval/sever of comorbids (HTN, Diabetes, Asthma, etc.)

Maryland Disparities in COVID Cases, Hosp, Deaths

Race/Ethnic Distribution of Cumulative COVID Cases, Hospitalizations, Deaths and Population, Maryland 6/16/2020

(Percent of Events of Known Race)

Missing race: 18% of cases, 1% of Hosp, 1% of deaths)



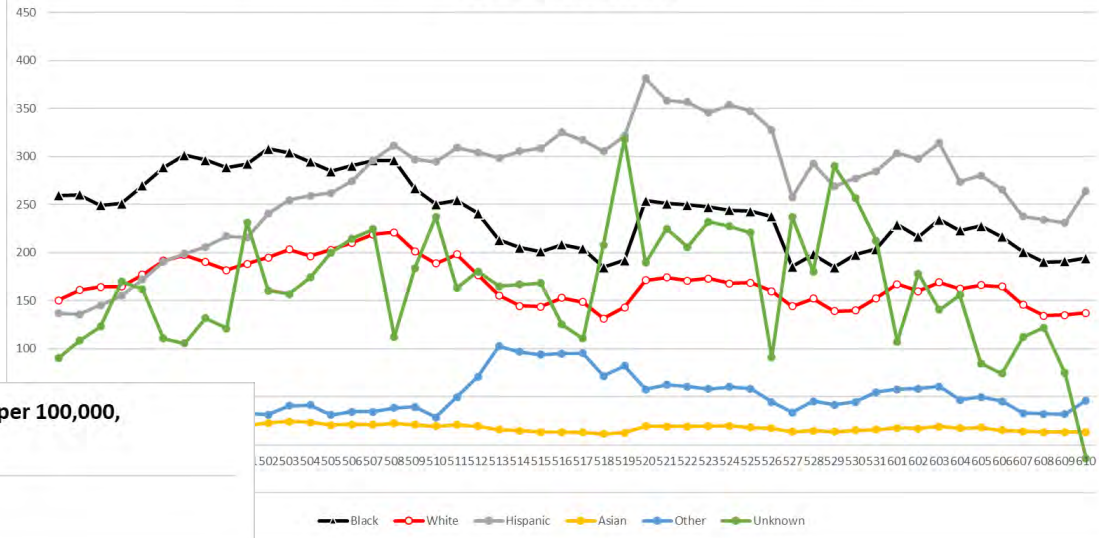
Black excess in all three metrics vs population.

Whites low in all three metrics vs population, deaths high for case and hospital share.

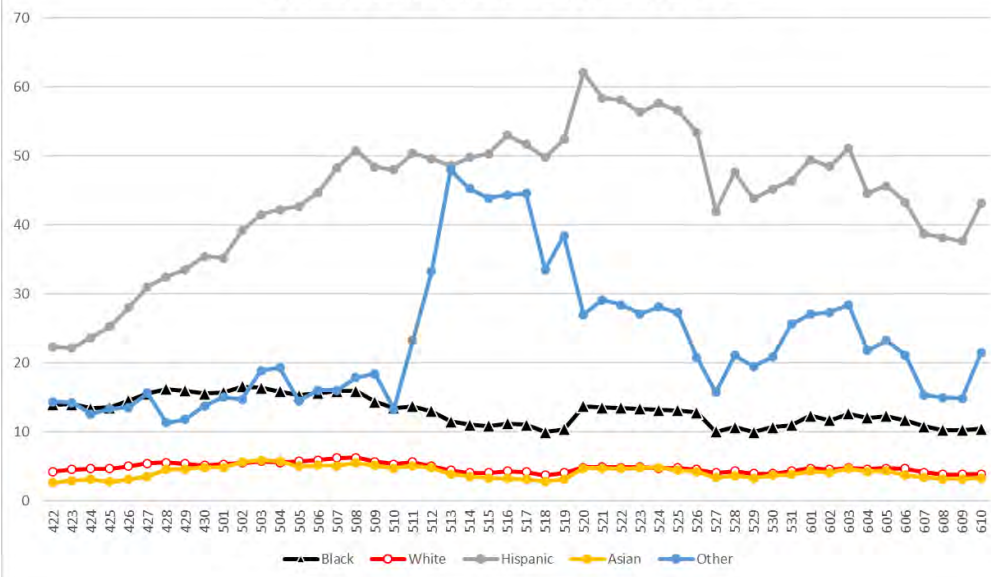
Hispanics high in cases and hospital but not deaths

Maryland New Case Trends by Race/Ethnicity

Prior 7-Day Ave Daily Positive SARS-CoV-2 Viral RNA Tests, By Race/Ethnicity, Maryland 4/22 to 6/10 2020



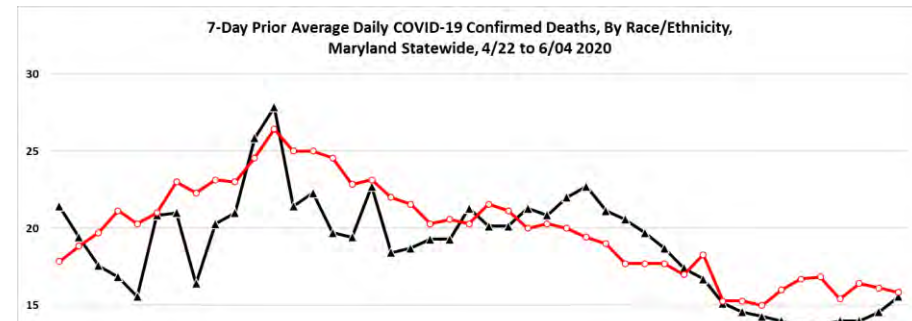
Prior 7-Day Ave Daily Positive SARS-CoV-2 Viral RNA Test Rate per 100,000, By Race/Ethnicity, Maryland 4/22 to 6/10 2020



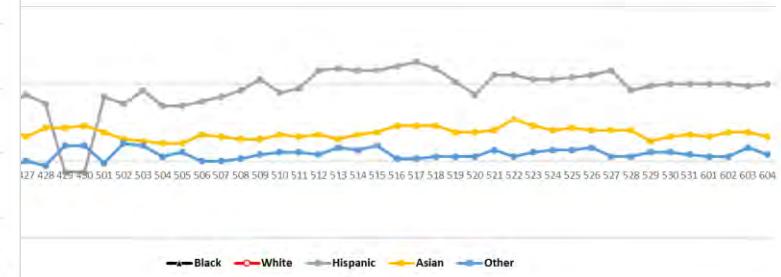
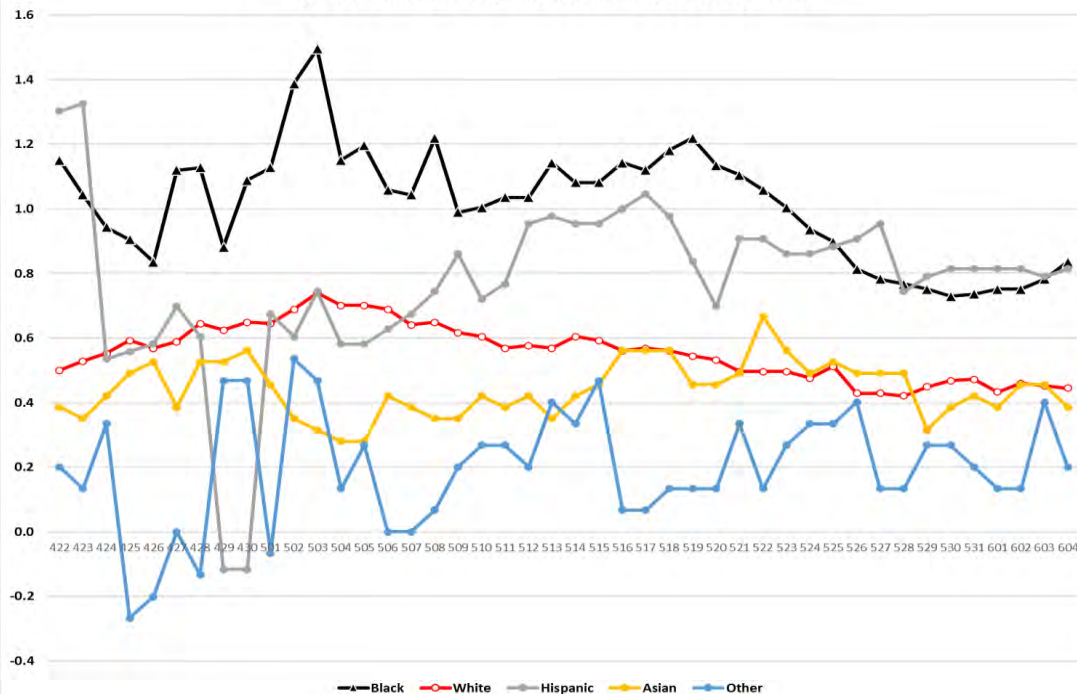
Interpretation of Case Trend Data

- Asian daily rate and trajectory matches White rate
- Black daily rate is higher than the White rate
 - Black daily rate trajectory is parallel to White trajectory
 - “Curve-bending” is similar for Blacks and Whites
- Hispanic daily rate is dramatically higher than any other
 - Hispanic trajectory rose much higher and peaked much later
 - The epidemic has penetrated more deeply and densely into the Hispanic community in terms of rate of cases.

Maryland COVID Death Trends by Race/Ethnicity



7-Day Prior Average Daily COVID-19 Confirmed Death Rates per 100,000, By Race/Ethnicity, Maryland Statewide, 4/22 to 6/04 2020



Interpretation of Death Trend Data

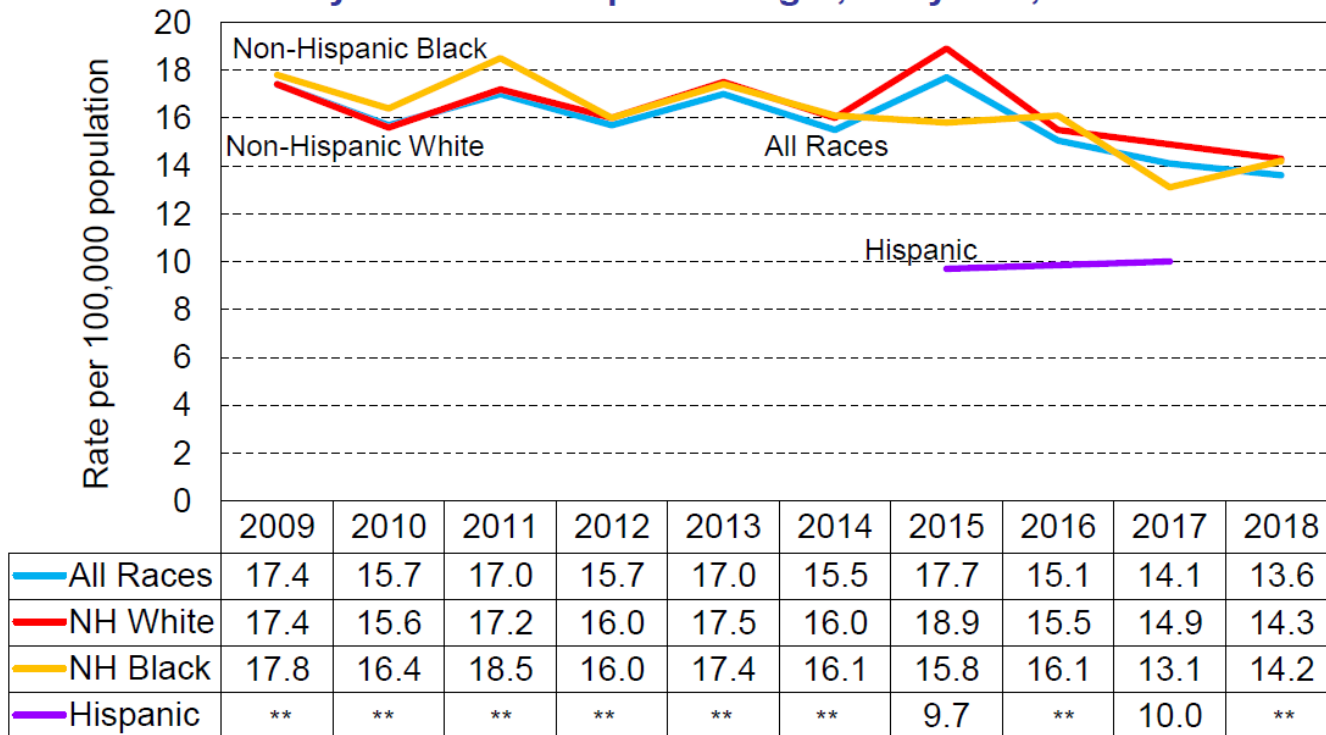
- **Asian daily rate is at or below the White rate**
 - Asian daily rate trajectory is generally similar to White
- **Black daily rate is higher than the White rate**
 - Black daily rate trajectory is parallel to White trajectory
 - “Curve-bending” is similar for Blacks and Whites
- **Hispanic daily rate started out similar to the White rate and ended up similar to the Black rate**

Flu and Pneumonia Mortality Rate

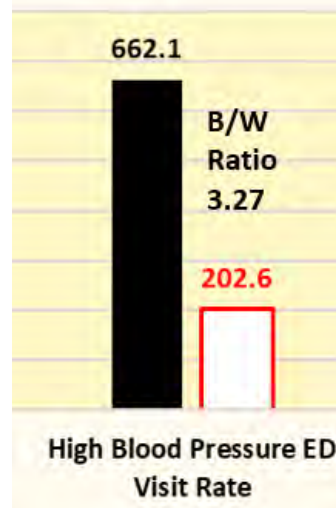
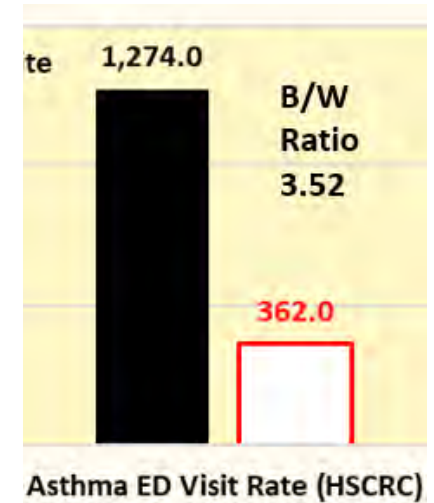
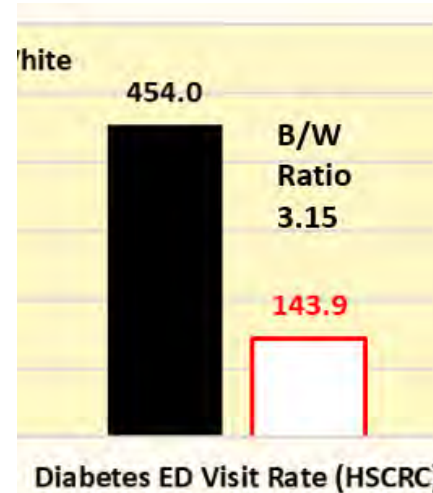
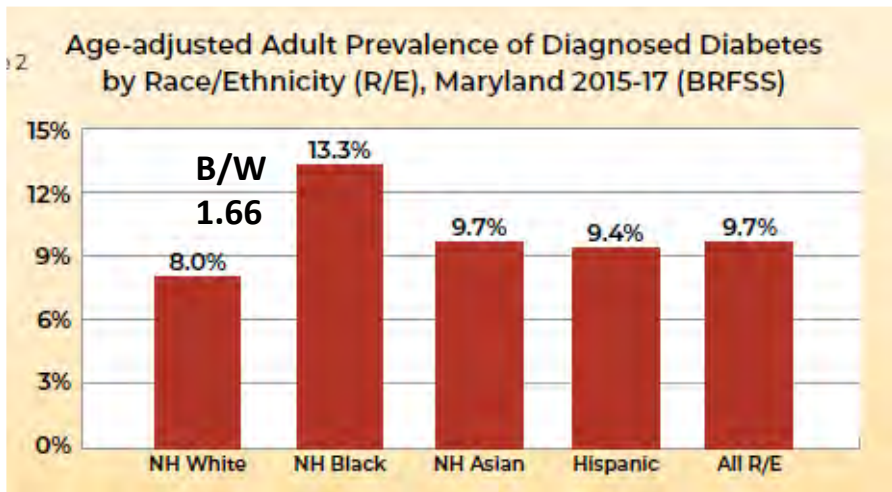
Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

**Age-Adjusted Death Rate* for Influenza and Pneumonia
by Race and Hispanic Origin, Maryland, 2009-2018.**



Maryland Disparities in COVID-19 Relevant Comorbidities



Age-adjusted rate per 100,000 population, 2017 data, HSCRC

Minorities have higher disease prevalence for several relevant high-risk COVID comorbidities

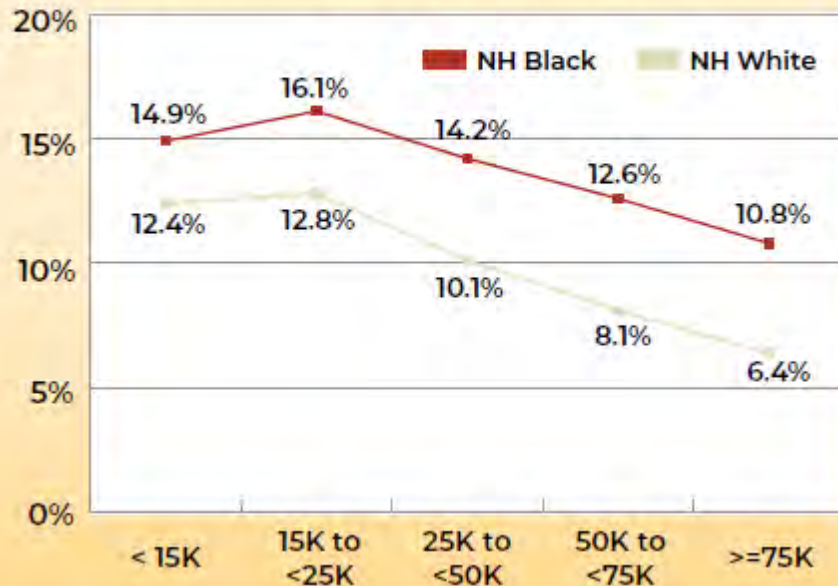
And higher severity (seen in the huge ED visits disparities that exceed prevalence disparities)

Role of Social Determinants: Diabetes Example

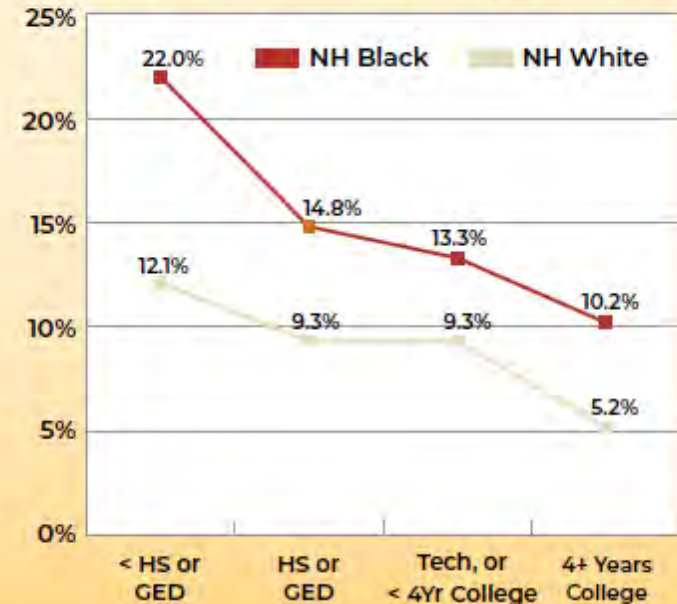
Maryland Diabetes Action Plan

<https://phpa.health.maryland.gov/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf>

Age-adjusted Adult Prevalence of Doctor Diagnosed Diabetes, by Income and Race, Maryland 2015-17 (BRFSS)



Age-adjusted Adult Prevalence of Diagnosed Diabetes, by Education and Black or White Race, Maryland 2015-17 (BRFSS)

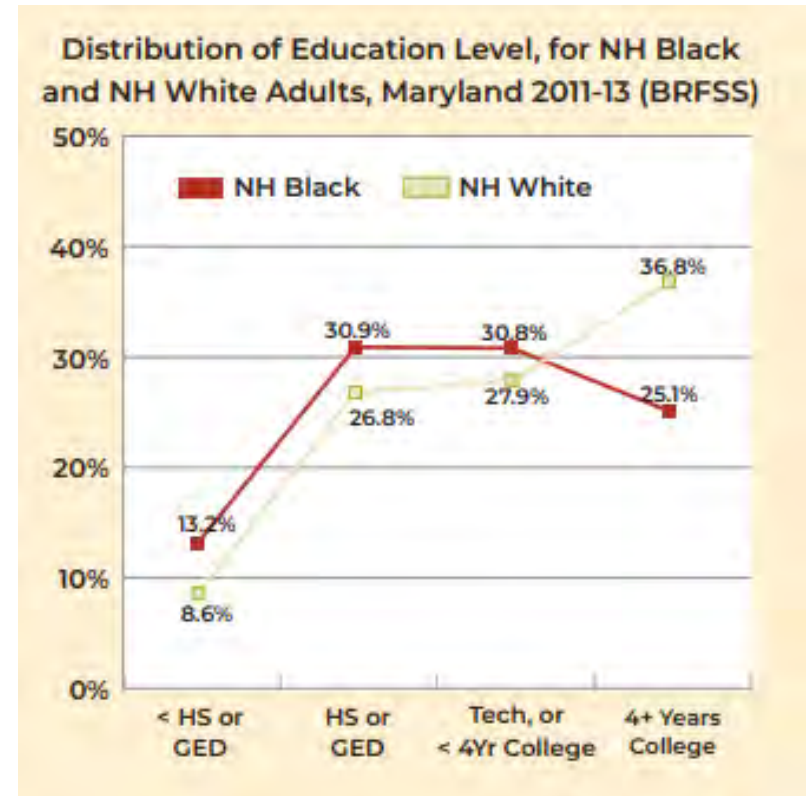
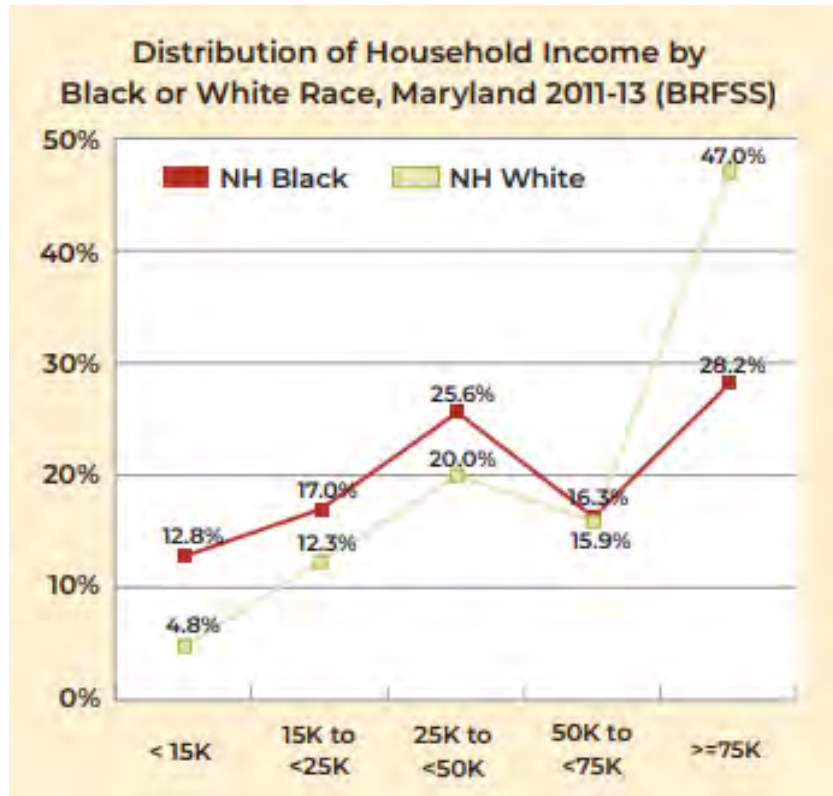


Income/Education matters regardless of race,
Race matters regardless of income/education.
Minorities have lower income/education, and
do worse at every level of income/education.

Role of Social Determinants: Income and Education

Maryland Diabetes Action Plan

<https://phpa.health.maryland.gov/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf>



Blacks are more likely to be at low income or education, and less likely to be at high income or education.

End of Presentation

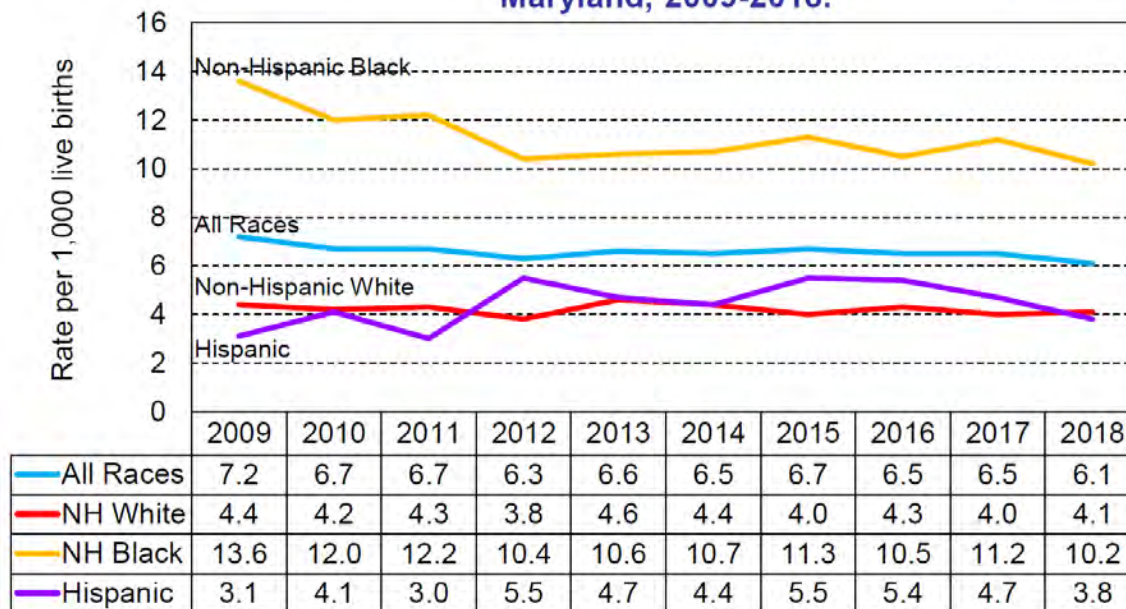
Supplemental Data Slides

Infant Mortality Rate

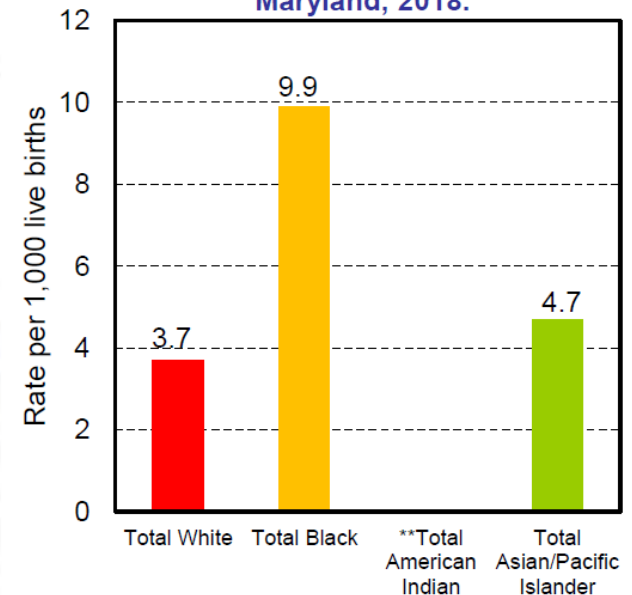
Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

Infant Mortality Rate by Race and Hispanic Origin, Maryland, 2009-2018.



Infant Mortality Rate by Race, Maryland, 2018.



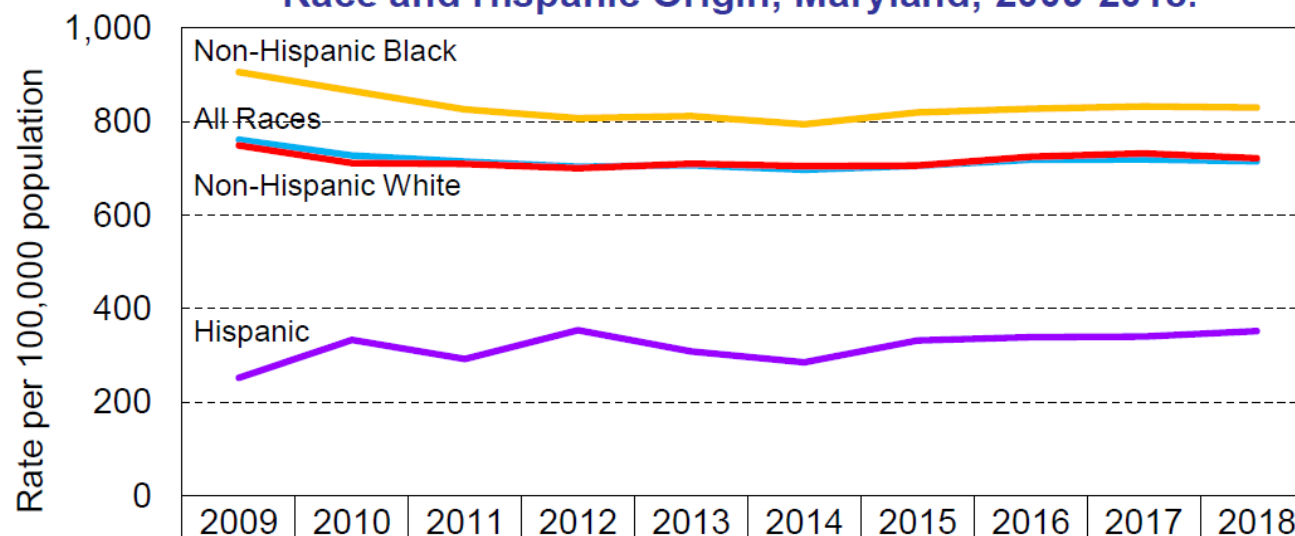
**Rates based on <5 events in the numerator are not presented since such rates are subject to instability.

All-cause Mortality Rate

Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

Age-Adjusted Death Rate* for All Causes of Death by Race and Hispanic Origin, Maryland, 2009-2018.



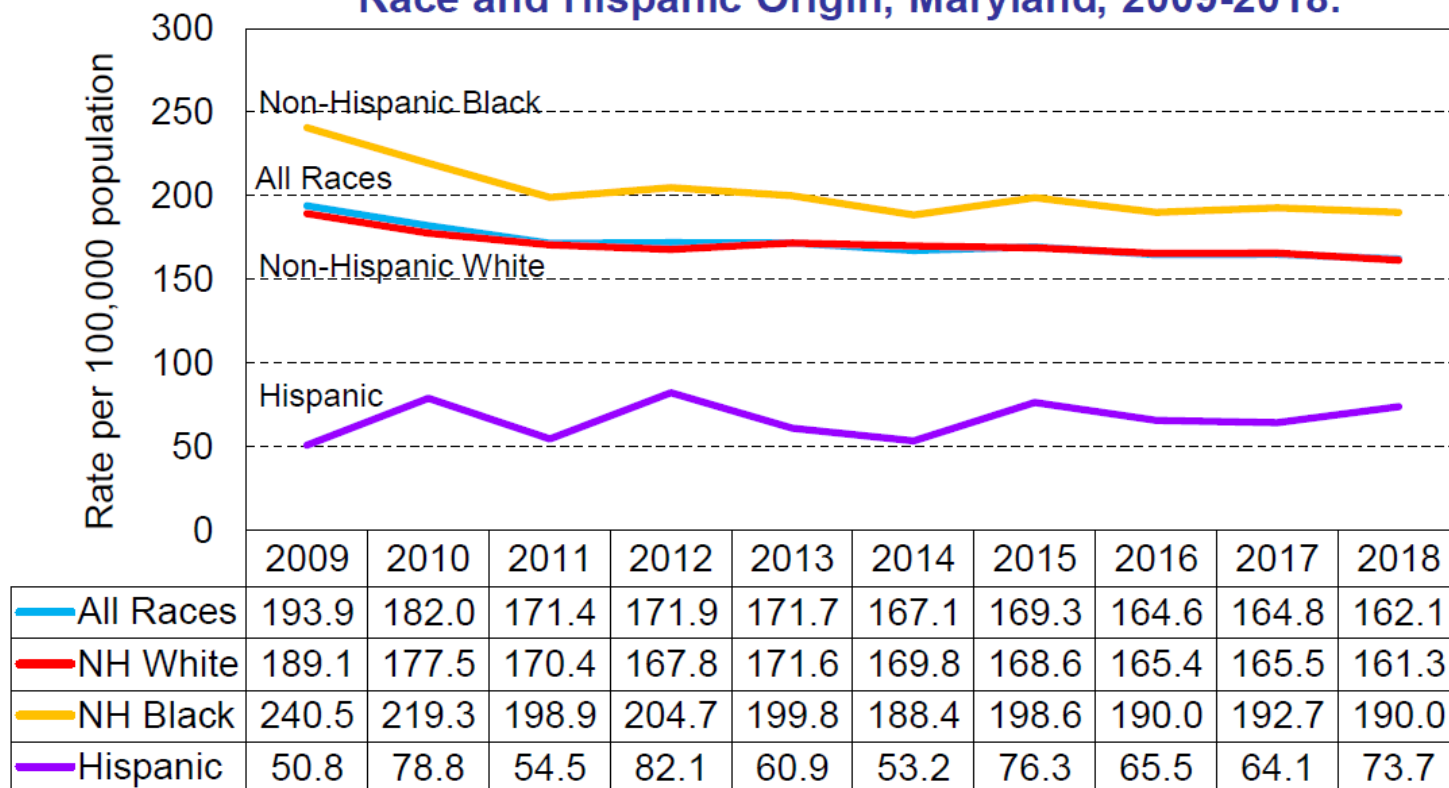
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All Races	761.3	727.4	714.3	703.2	706.5	696.8	705.6	718.4	719.1	715.4
NH White	748.7	711.5	709.1	700.3	709.7	704.8	706.2	725.1	731.9	721.9
NH Black	905.7	865.4	826.0	807.1	811.6	794.2	819.2	827.3	832.8	829.9
Hispanic	252.1	333.2	292.4	354.1	308.8	285.1	331.6	339.2	340.0	352.2

Heart Disease Mortality Rate

Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

Age-Adjusted Death Rate* for Diseases of the Heart by Race and Hispanic Origin, Maryland, 2009-2018.

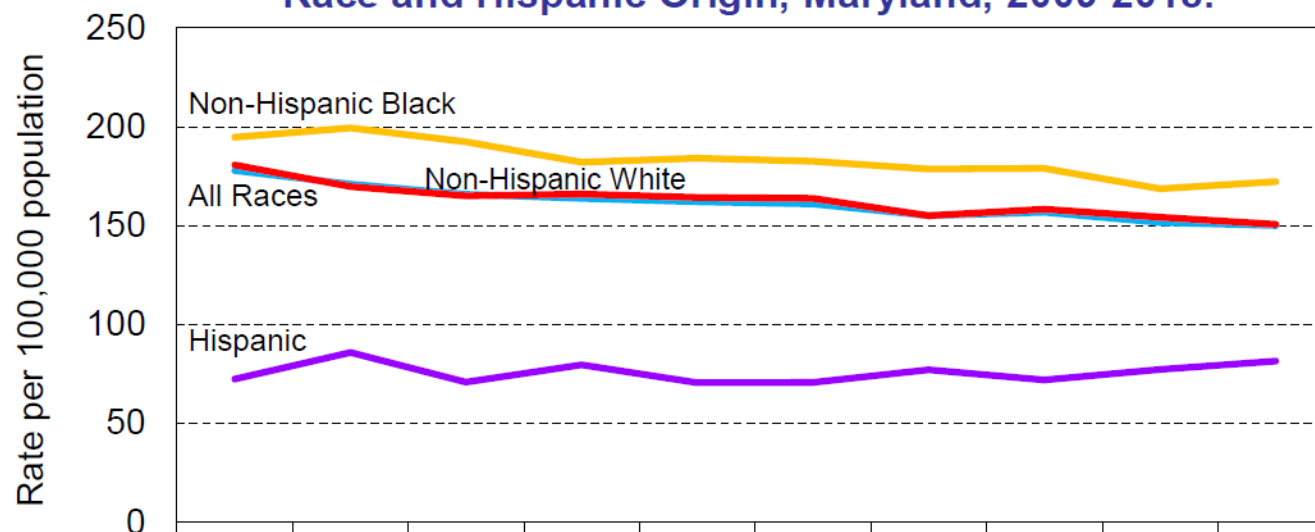


Cancer Mortality Rate

Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

Age-Adjusted Death Rate* for Malignant Neoplasms by Race and Hispanic Origin, Maryland, 2009-2018.



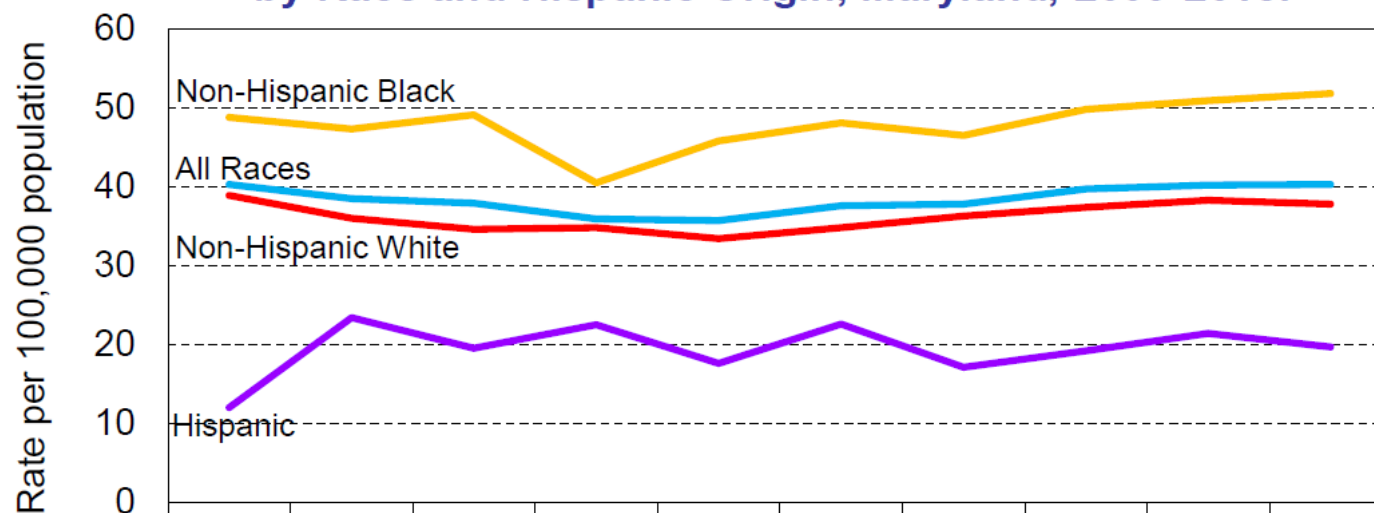
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All Races	177.7	170.9	165.7	163.7	161.9	160.9	155.0	156.6	151.5	150.0
NH White	180.5	169.6	165.0	165.9	164.1	163.7	155.0	158.2	154.2	150.6
NH Black	194.7	199.3	192.3	181.9	184.0	182.5	178.5	178.8	168.6	172.1
Hispanic	72.3	85.7	70.8	79.5	70.5	70.6	77.0	71.9	77.1	81.4

Stroke Mortality Rate

Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

**Age-Adjusted Death Rate* for Cerebrovascular Diseases
by Race and Hispanic Origin, Maryland, 2009-2018.**



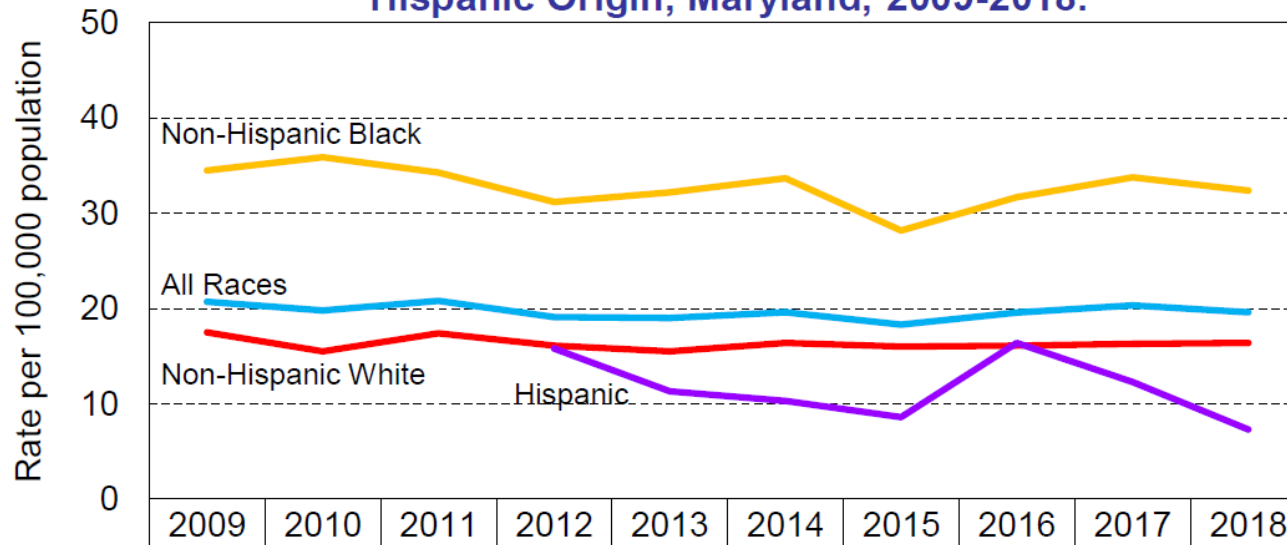
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All Races	40.3	38.5	37.9	35.9	35.7	37.6	37.8	39.7	40.2	40.3
NH White	38.9	36.0	34.6	34.8	33.4	34.8	36.3	37.4	38.3	37.8
NH Black	48.8	47.3	49.1	40.5	45.8	48.1	46.5	49.8	50.9	51.8
Hispanic	12.0	23.4	19.5	22.5	17.6	22.6	17.1	19.2	21.4	19.7

Diabetes Mortality Rate

Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

Age-Adjusted Death Rate* for Diabetes by Race and Hispanic Origin, Maryland, 2009-2018.



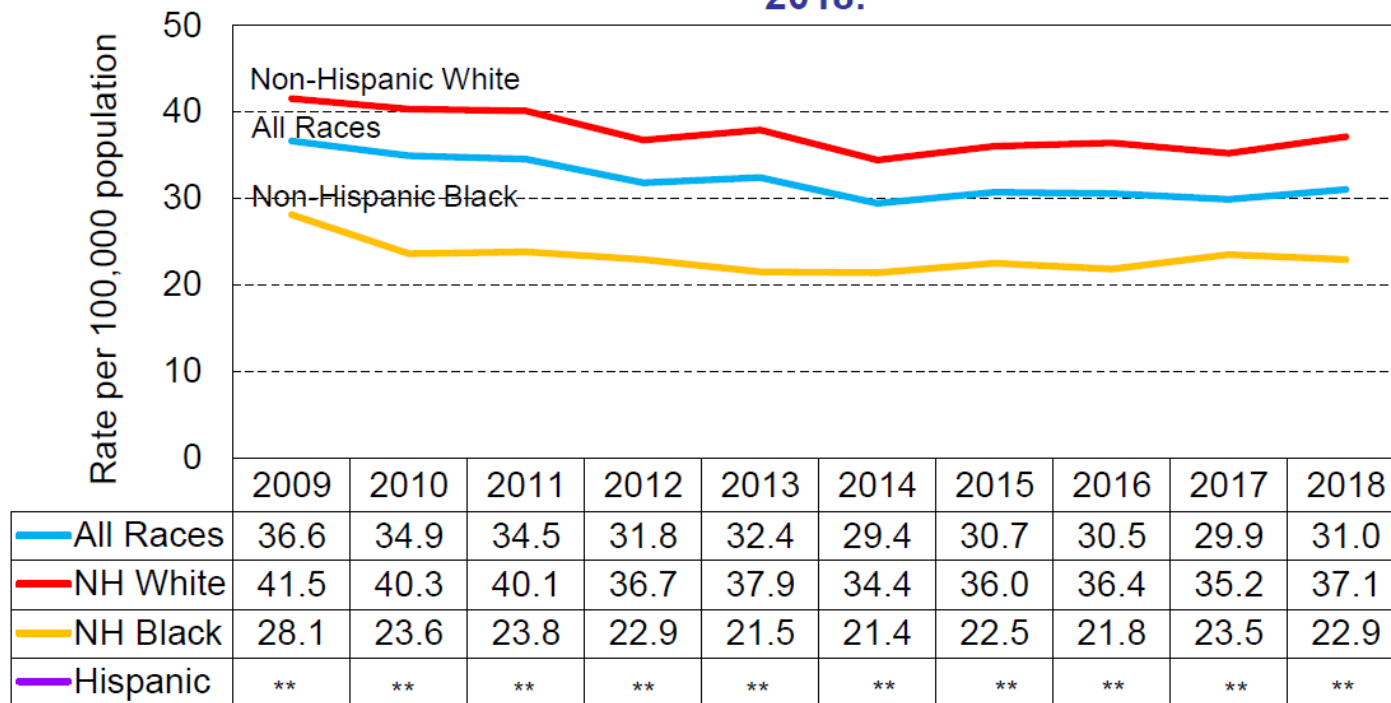
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All Races	20.7	19.8	20.8	19.1	19.0	19.6	18.3	19.6	20.3	19.6
NH White	17.5	15.5	17.4	16.1	15.5	16.4	16.0	16.1	16.3	16.4
NH Black	34.5	35.9	34.3	31.2	32.2	33.7	28.2	31.7	33.8	32.4
Hispanic	**	**	**	15.8	11.3	10.3	8.6	16.4	12.3	7.3

Chronic Lung Disease Mortality Rate

Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

Age-Adjusted Death Rate* for Chronic Lower Respiratory Diseases by Race and Hispanic Origin, Maryland, 2009-2018.

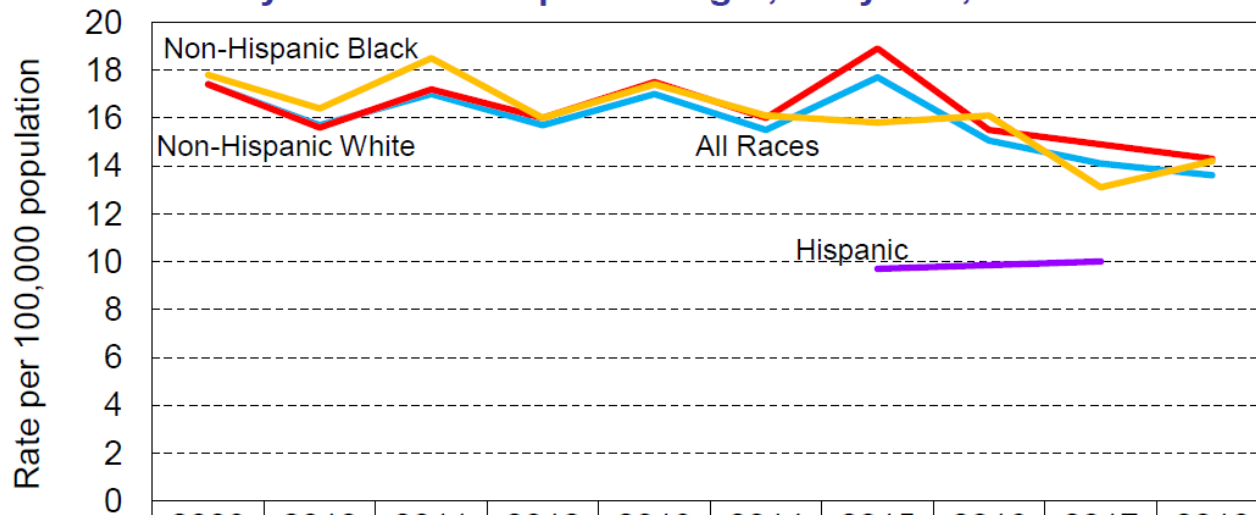


Flu and Pneumonia Mortality Rate

Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

**Age-Adjusted Death Rate* for Influenza and Pneumonia
by Race and Hispanic Origin, Maryland, 2009-2018.**



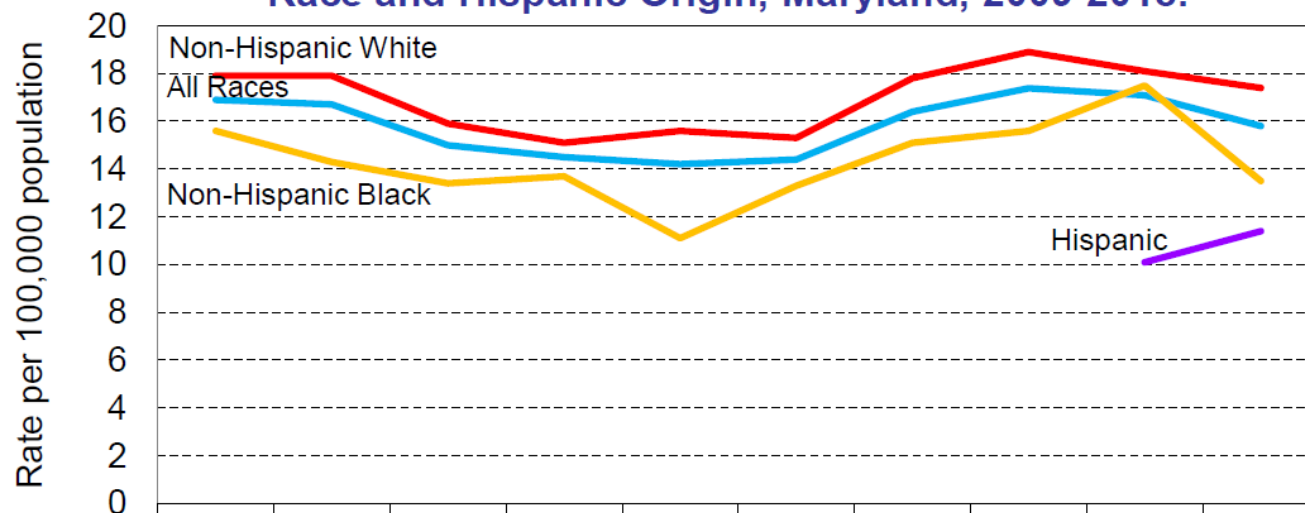
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All Races	17.4	15.7	17.0	15.7	17.0	15.5	17.7	15.1	14.1	13.6
NH White	17.4	15.6	17.2	16.0	17.5	16.0	18.9	15.5	14.9	14.3
NH Black	17.8	16.4	18.5	16.0	17.4	16.1	15.8	16.1	13.1	14.2
Hispanic	**	**	**	**	**	**	9.7	**	10.0	**

Alzheimer's Disease Mortality Rate

Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

Age-Adjusted Death Rate* for Alzheimer's Disease by Race and Hispanic Origin, Maryland, 2009-2018.



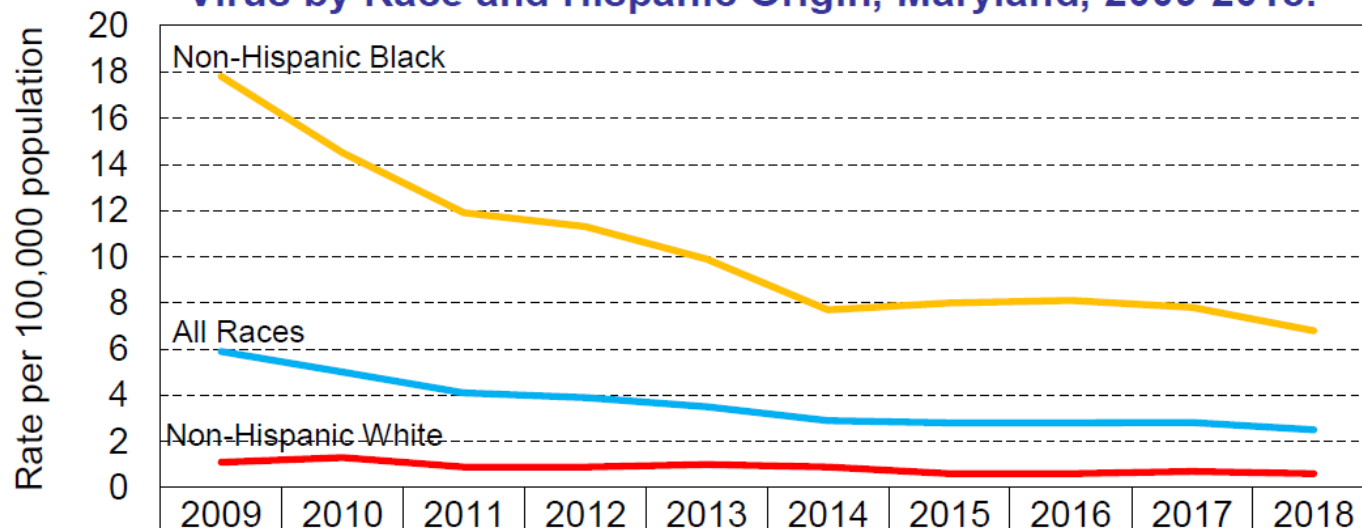
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All Races	16.9	16.7	15.0	14.5	14.2	14.4	16.4	17.4	17.1	15.8
NH White	17.9	17.9	15.9	15.1	15.6	15.3	17.8	18.9	18.1	17.4
NH Black	15.6	14.3	13.4	13.7	11.1	13.3	15.1	15.6	17.5	13.5
Hispanic	**	**	**	**	**	**	**	**	10.1	11.4

HIV/AIDS Mortality Rate

Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

Age-Adjusted Death Rate* for Human Immunodeficiency Virus by Race and Hispanic Origin, Maryland, 2009-2018.



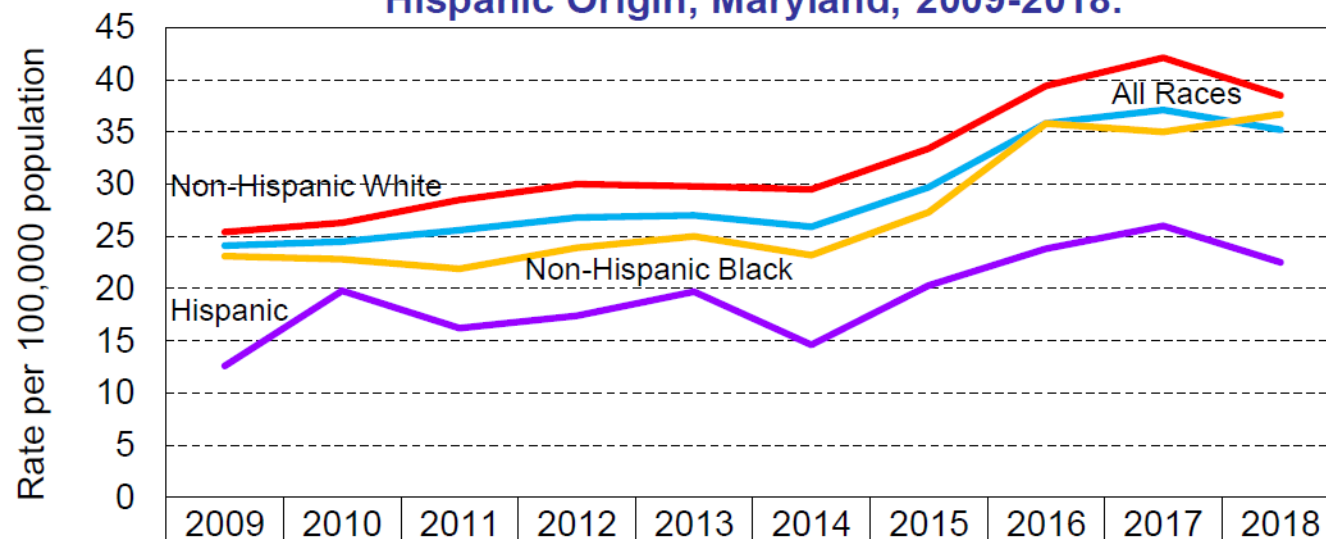
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All Races	5.9	5.0	4.1	3.9	3.5	2.9	2.8	2.8	2.8	2.5
NH White	1.1	1.3	0.9	0.9	1.0	0.9	0.6	0.6	0.7	0.6
NH Black	17.8	14.5	11.9	11.3	9.9	7.7	8.0	8.1	7.8	6.8
Hispanic	**	**	**	**	**	**	**	**	**	**

Accidents (includes Drug Overdose) Mortality Rate

Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

Age-Adjusted Death Rate* for Accidents by Race and Hispanic Origin, Maryland, 2009-2018.



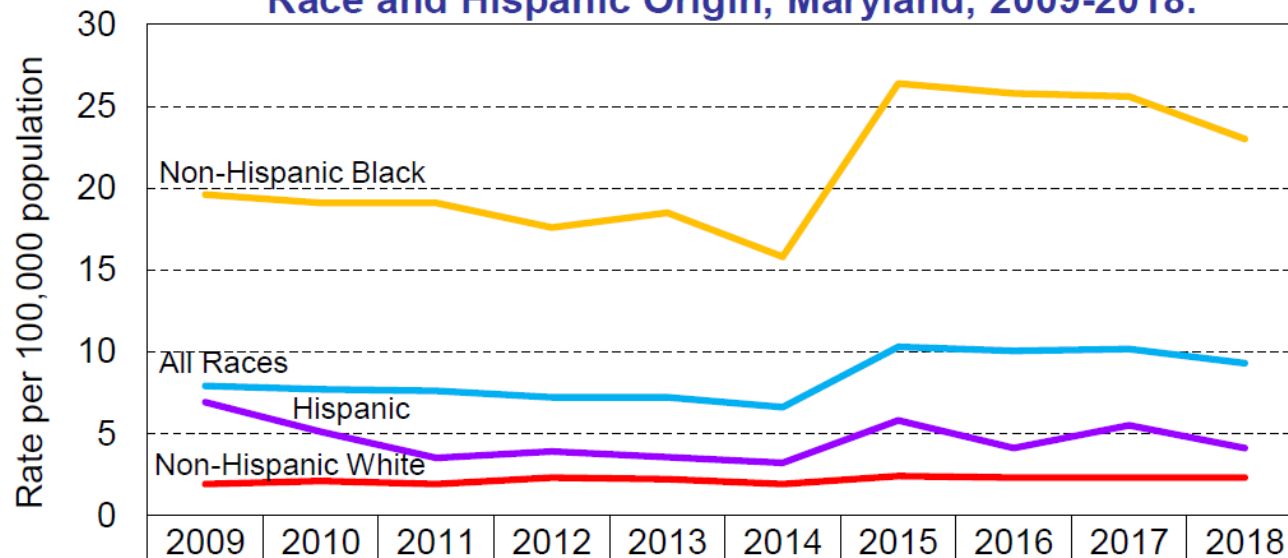
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All Races	24.1	24.5	25.6	26.8	27.0	25.9	29.7	35.8	37.1	35.2
NH White	25.4	26.3	28.5	30.0	29.8	29.5	33.4	39.4	42.1	38.5
NH Black	23.1	22.8	21.9	23.9	25.0	23.2	27.3	35.8	35.0	36.7
Hispanic	12.6	19.8	16.2	17.4	19.7	14.6	20.3	23.8	26.0	22.5

Homicide Mortality Rate

Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

Age-Adjusted Death Rate* for Assault (Homicide) by Race and Hispanic Origin, Maryland, 2009-2018.



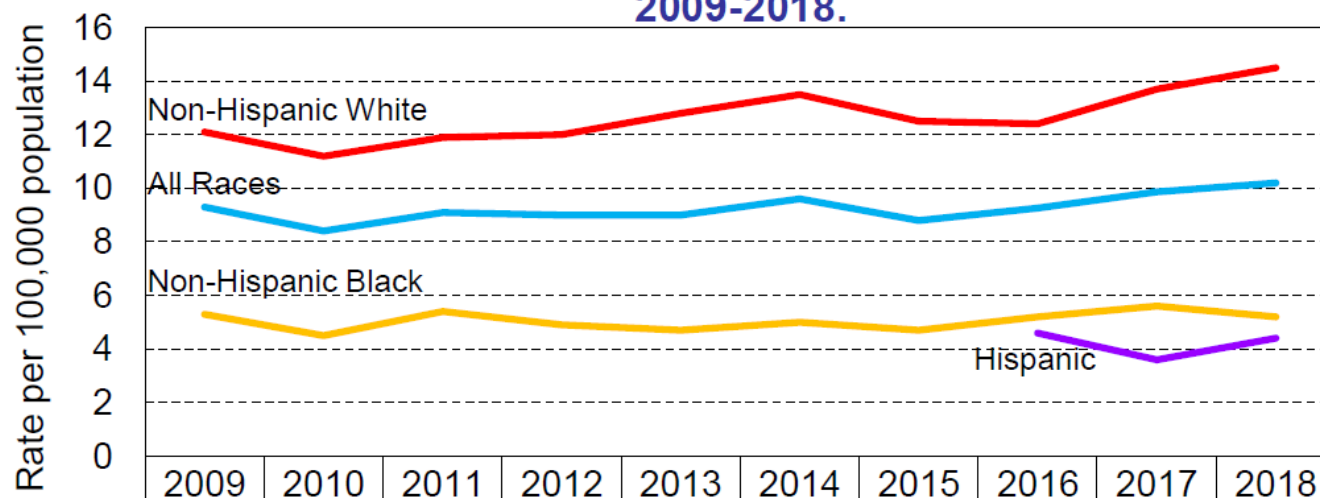
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All Races	7.9	7.7	7.6	7.2	7.2	6.6	10.3	10.1	10.2	9.3
NH White	1.9	2.1	1.9	2.3	2.2	1.9	2.4	2.3	2.3	2.3
NH Black	19.6	19.1	19.1	17.6	18.5	15.8	26.4	25.8	25.6	23.0
Hispanic	6.9	5.1	3.5	3.9	**	3.2	5.8	4.1	5.5	4.1

Suicide Mortality Rate

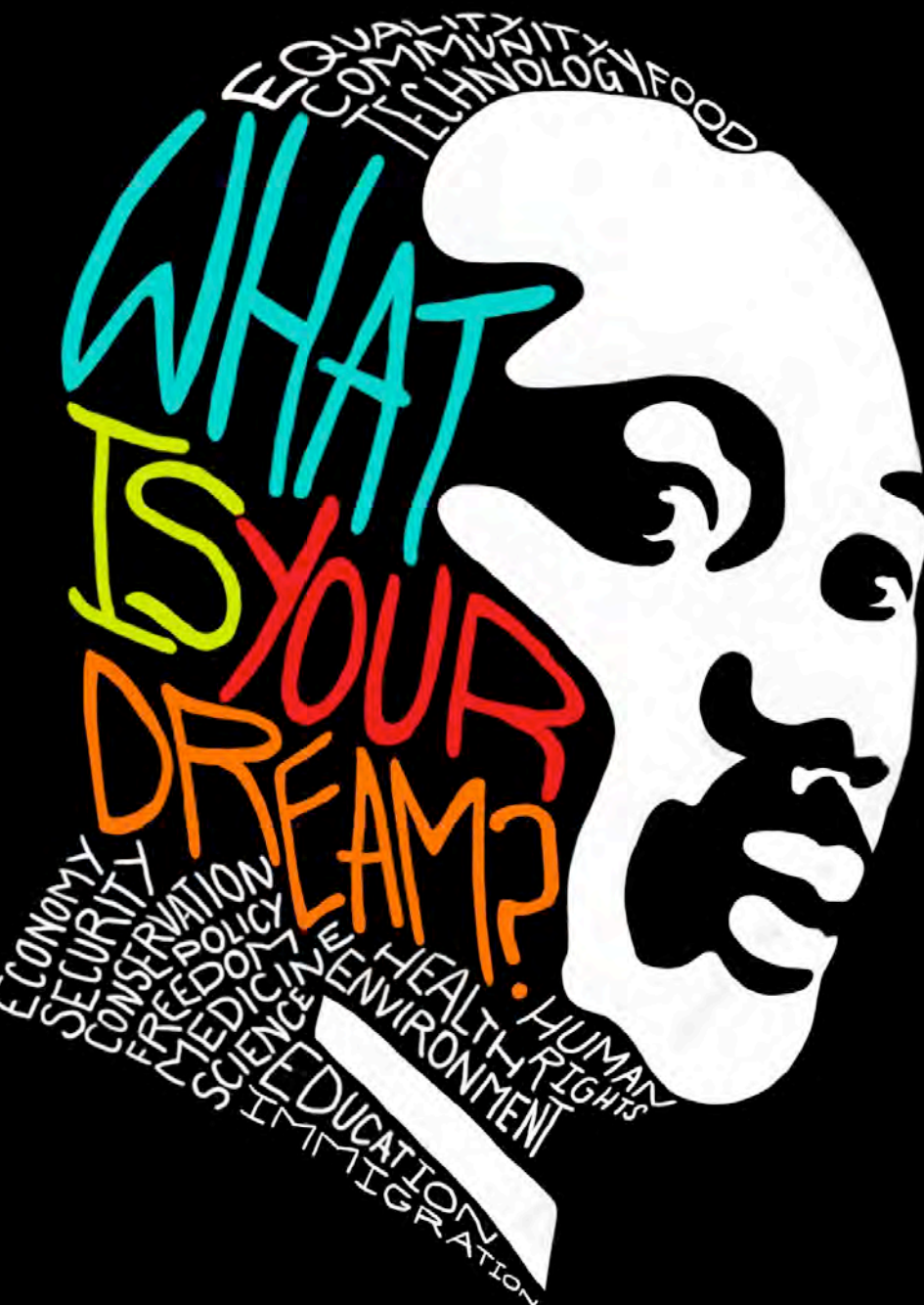
Maryland Vital Statistics Annual Report 2018

https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2018annual_rev3.pdf

**Age-Adjusted Death Rate* for Intentional Self-Harm
(Suicide) by Race and Hispanic Origin, Maryland,
2009-2018.**



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All Races	9.3	8.4	9.1	9.0	9.0	9.6	8.8	9.3	9.9	10.2
NH White	12.1	11.2	11.9	12.0	12.8	13.5	12.5	12.4	13.7	14.5
NH Black	5.3	4.5	5.4	4.9	4.7	5.0	4.7	5.2	5.6	5.2
Hispanic	**	**	**	**	**	**	**	4.6	3.6	4.4



The Colors of COVID-19: Confronting Health Disparities During Global Pandemic

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U.S. Commission on Civil Rights
State of Maryland
August 4, 2020
Virtual Zoom



**MD SAC Briefing Panel 2 -
COVID-19 Health
Disparities**



UMD President Daryl Pines Visits UMD SPH on his First Day in Office



MONA CENTER SERVICES



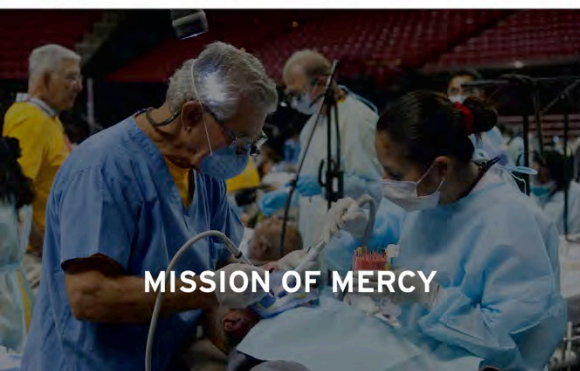
MONA CENTER
COMMUNITY GARDEN



BARBERSHOP HEALTH
INITIATIVES



COMMUNITY RESEARCH
ADVISORY BOARD



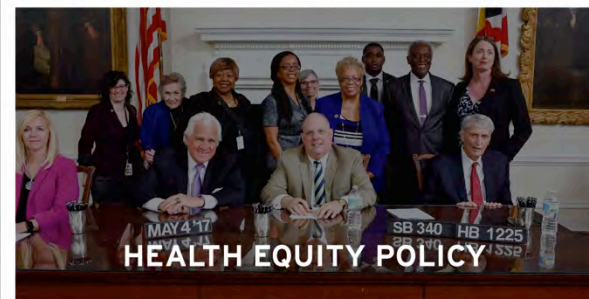
MISSION OF MERCY



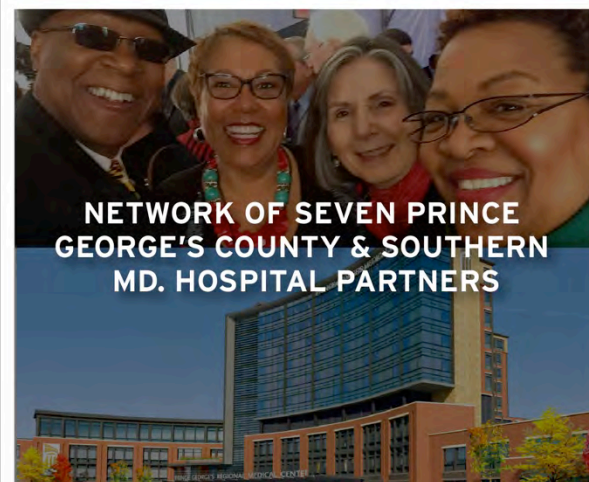
SCHOOL OF
PUBLIC HEALTH

CENTER FOR HEALTH EQUITY

BUILDING BRIDGES
BUILDING TRUST
BUILDING
HEALTHY COMMUNITIES



HEALTH EQUITY POLICY



NETWORK OF SEVEN PRINCE
GEORGE'S COUNTY & SOUTHERN
MD. HOSPITAL PARTNERS

The Social Context of Health Disparities

The ultimate aim is to uncover social, cultural and environmental factors beyond the biomedical model and address a broad range of issues. This approach includes, but not limited to, breaking the cycle of poverty, increasing access to quality health care, eliminating environmental hazards in homes and neighborhoods, and the implementation of effective prevention programs tailored to specific community needs.



Charles Moore/Black Star

The Historical Context of Health Disparities

“..If there is no **struggle**, there is no progress. Those who profess to favor freedom, and yet depreciate agitation, are men who want crops without plowing up the ground. They want rain without thunder and lightning. They want the ocean without the awful roar of its many waters...”

(Frederick Douglass)



Defining Health Disparities and Health Equity

“Health equity
means that
everyone has a fair
and just opportunity
to be as healthy as
possible...”


... if an effort does not address poverty, discrimination, or their health-damaging consequences for groups of people who have historically been excluded or marginalized – it's probably not a health equity effort.

RESEARCH ARTICLE

Open Access



Mission of Mercy emergency dental clinics: an opportunity to promote general and oral health

Devlon N. Jackson^{1*} , Susan Passmore^{1,2}, Craig S. Fryer^{1,3}, Jie Chen^{1,2}, Dushanka V. Kleinman^{4,5}, Alice M. Horowitz^{3,4}, James Butler III^{1,3}, Mary A. Garza^{1,3}, Sandra C. Quinn^{1,6} and Stephen B. Thomas^{1,2}

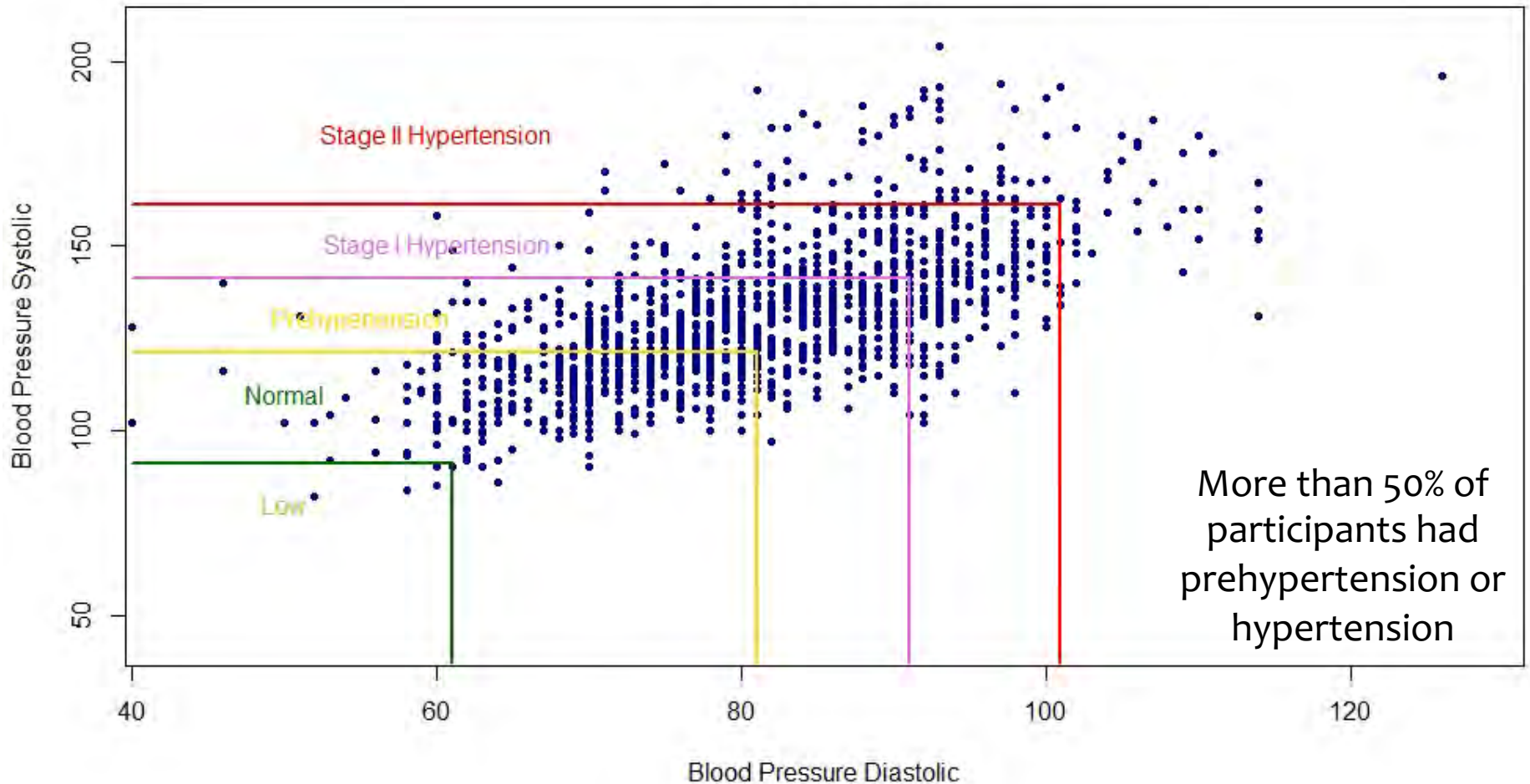
Abstract

Background: Mission of Mercy (MOM) emergency dental clinics are a resource for populations lacking access to dental care. We designed a MOM event incorporating health equity components with established community partners who shared a common vision of addressing the oral health, physical health, and social service needs of Maryland and Washington, DC area residents. Although studies have explored associations between oral and chronic health conditions, few studies to our knowledge have examined the relationship between these conditions and receipt of dental services. Therefore, this study explored these associations and the opportunity for better care coordination.

Methods: Oral health data from the 2014 Mid-Maryland Mission of Mercy and Health Equity Festival event was analyzed. A descriptive analysis assessed frequencies and percentages of participant sociodemographics characteristics, oral health and chronic disease risk(s), and dental services delivered. Chi-square tests and multivariate logistic regression were conducted to determine the associations between 1) oral health and chronic disease risk(s) and dental services; and 2) oral health and chronic disease risk(s) and participant characteristics.

Mid-MOM Participants by Blood Pressure 2014 and 2017 Combined (N= 1,769)

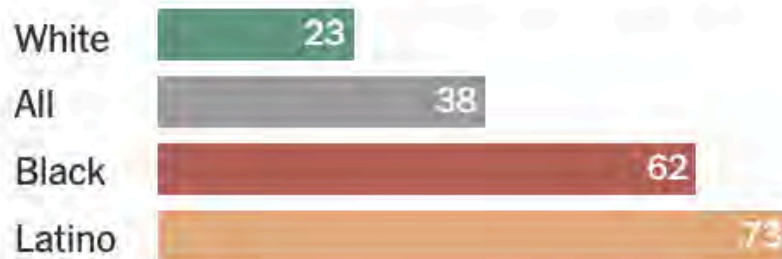
Blood Pressure Reading with National Guideline
MOM 2014 2017



Warning

The following data
represents real people,
your friends and family

Coronavirus cases per 10,000 people



The Fullest Look Yet at the Racial Inequity of Coronavirus

By [Richard A. Oppel Jr.](#), [Robert Gebeloff](#), [K.K. Rebecca Lai](#), Will Wright and [Mitch Smith](#) July 5, 2020

Teresa and Marvin Bradley can't say for sure how they got the coronavirus. Maybe Ms. Bradley, a Michigan nurse, brought it from her hospital. Maybe it came from a visiting relative. Maybe it was something else entirely.

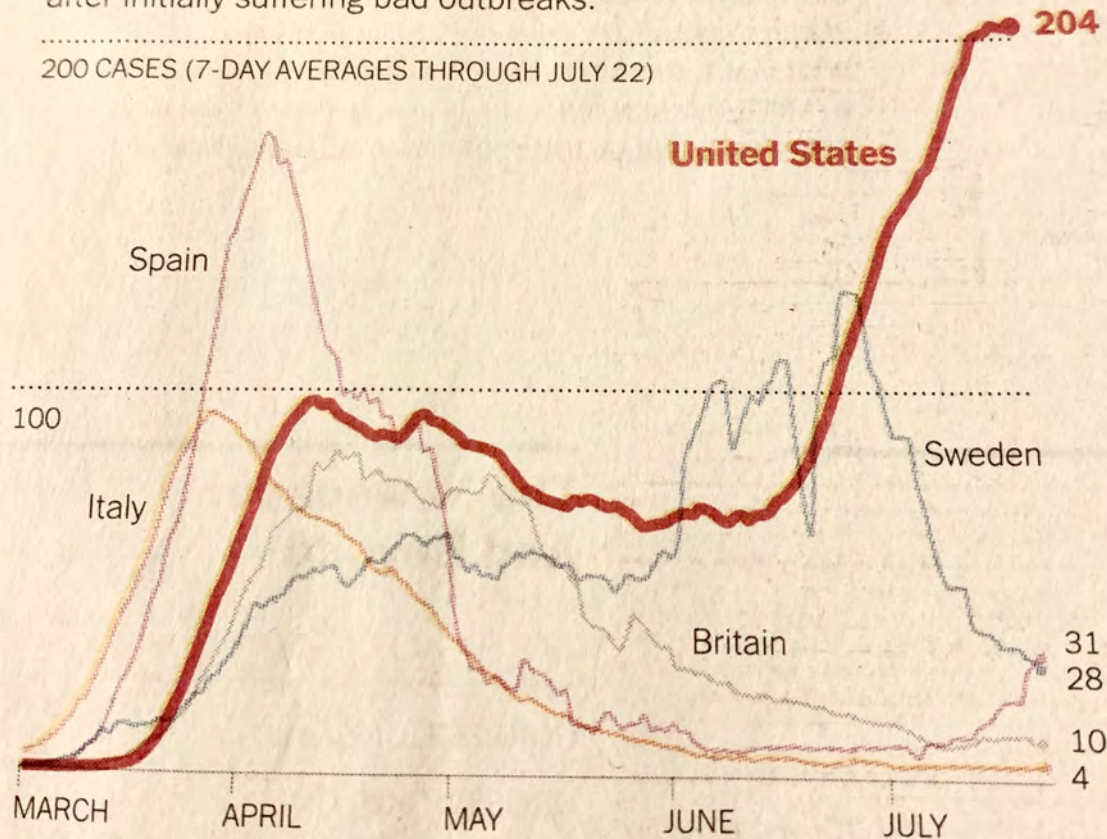
U.S. Ranks Among Nations Hit Hardest by the Virus. And 10 States Outrank Them All.

Comparing new daily coronavirus cases, per one million residents

RICH COUNTRIES WITH SEVERE OUTBREAKS

These European countries flattened their caseloads after initially suffering bad outbreaks.

200 CASES (7-DAY AVERAGES THROUGH JULY 22)



RICH COUNTRIES WITH BETTER-CONTROLLED OUTBREAKS

Their case rates are a small fraction of the U.S. rate.
Canada's border with the United States remains closed.

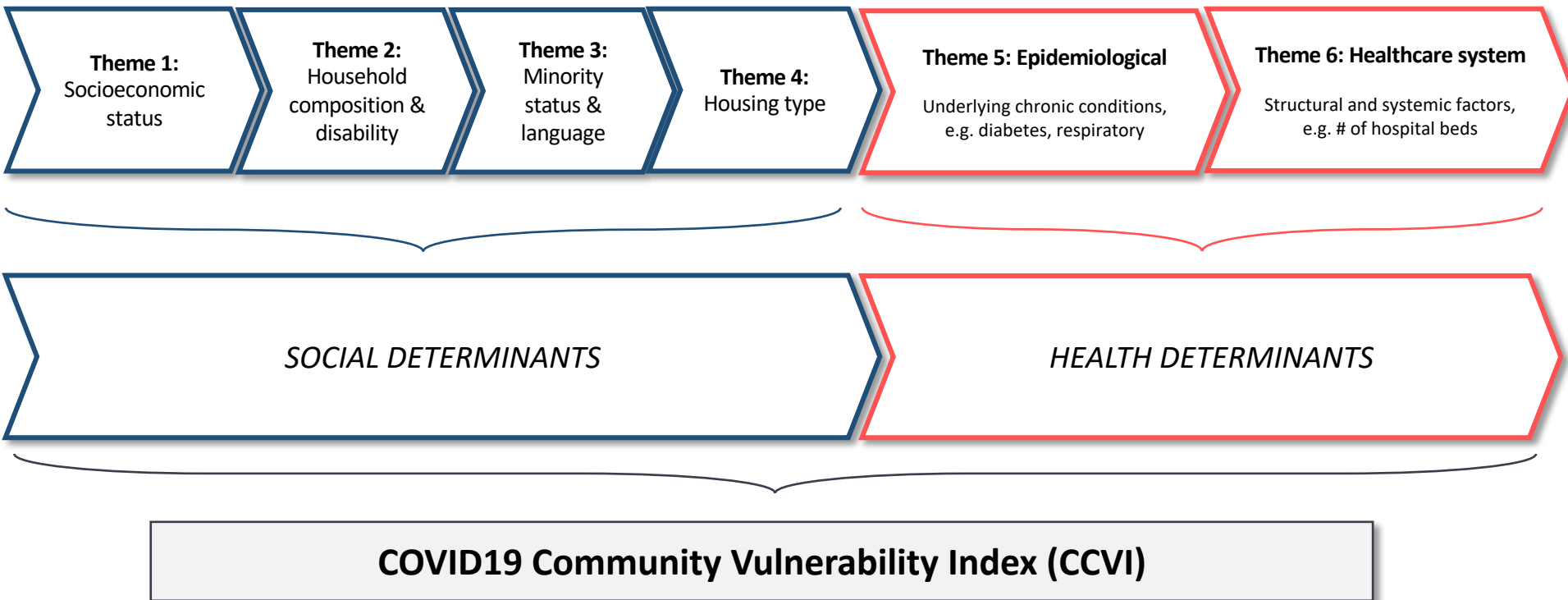
***Colors of COVID (CC19) Consortium:
Prevention, Detection, and Treatment
of African American and Hispanic Communities in
Maryland and across the U.S.***

The Leadership Team

The University of Maryland, Center for Health Equity

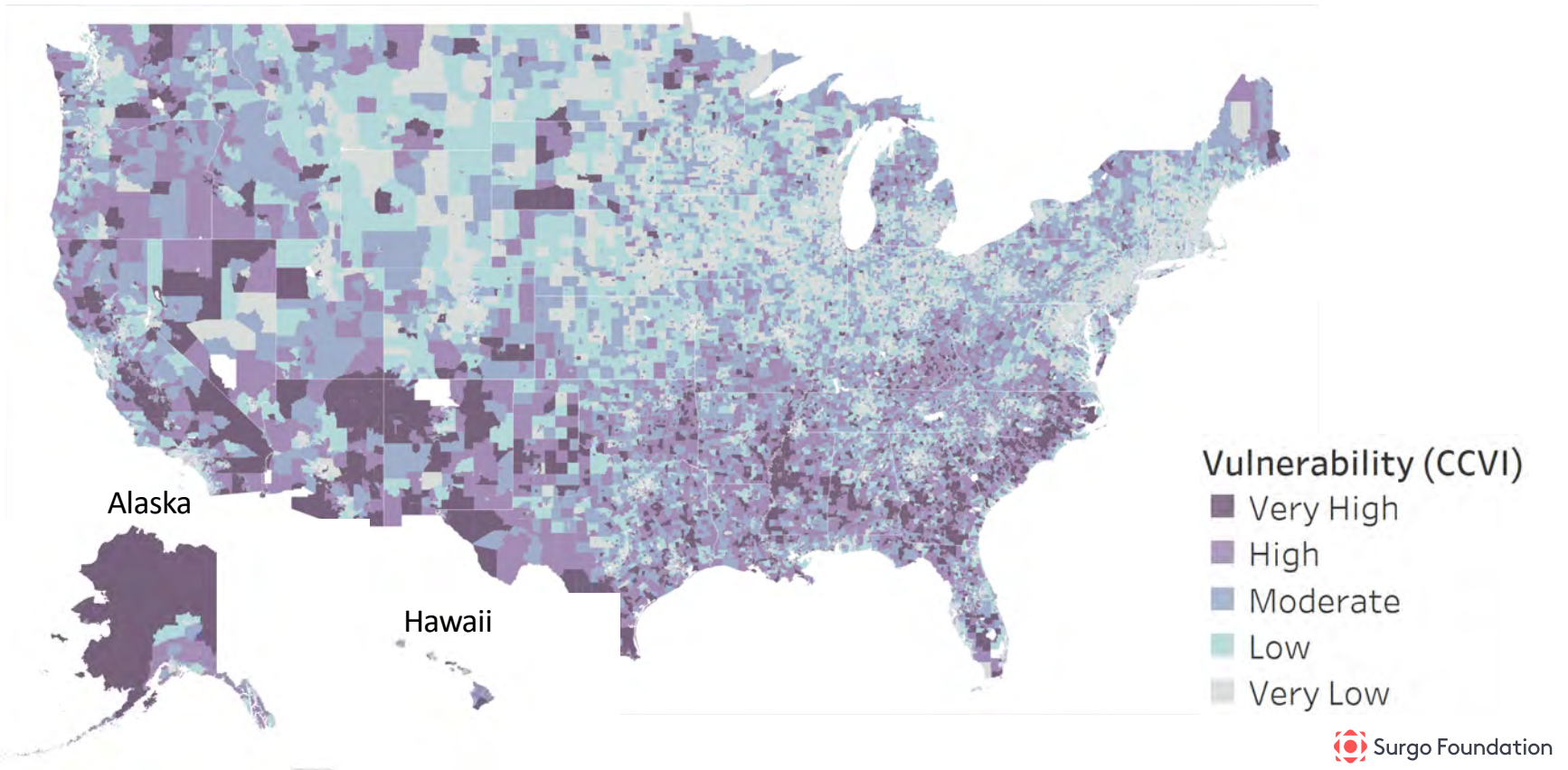
Westat, Inc.

We built a modular index tailored to the unique characteristics of COVID



34 factors equally weighted across 6 themes. Themes 1-4 from CDCs SVI. Factors represented as percentiles in each geographic level (e.g. census tract) and ranked against all others. Each variable aggregated into individual themes and each theme is aggregated to the final CCVI.

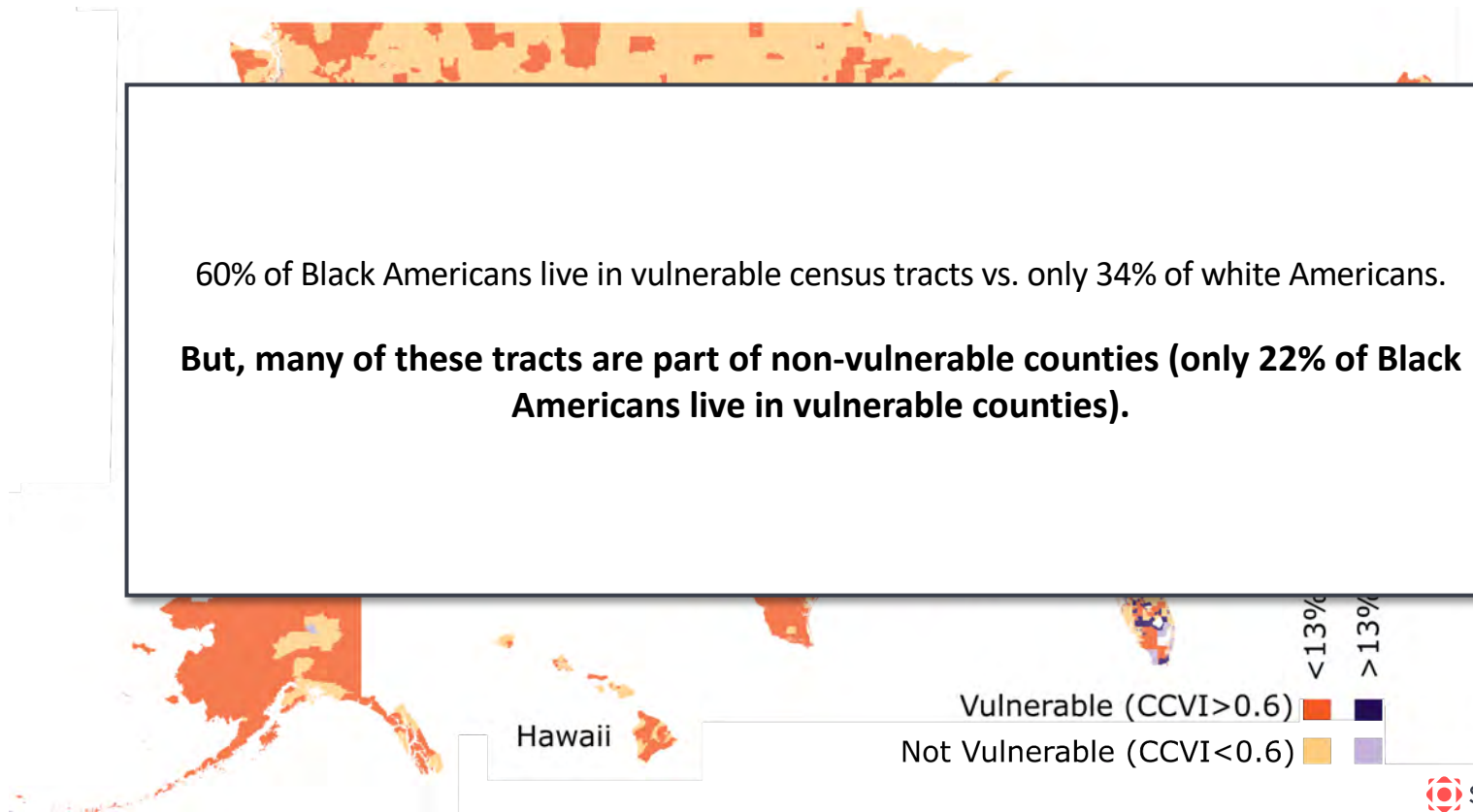
To give us a census-tract level view of vulnerability across the country







This index exposes how racial inequities contribute to vulnerability to COVID-19

60% of Black Americans live in vulnerable census tracts vs. only 34% of white Americans.

But, many of these tracts are part of non-vulnerable counties (only 22% of Black Americans live in vulnerable counties).

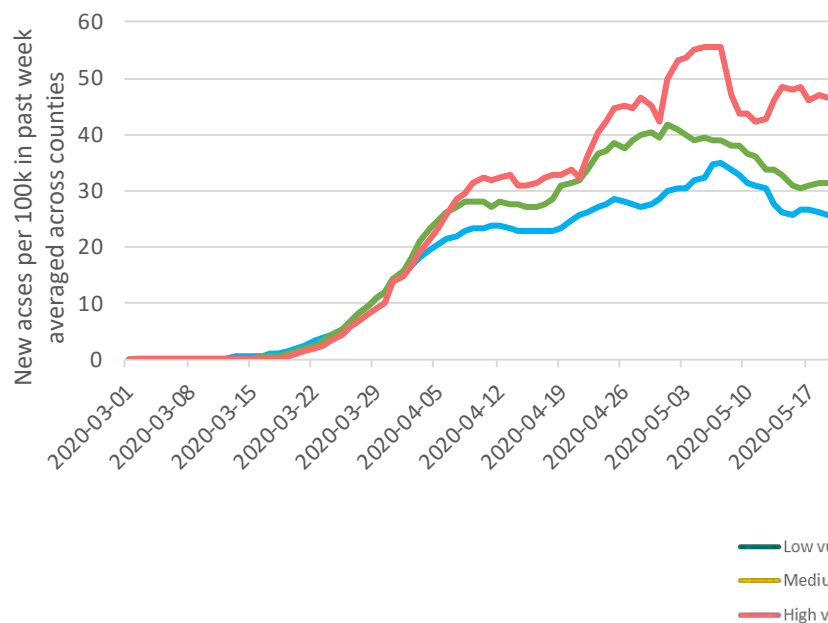


Vulnerable (CCVI>0.6)  
Not Vulnerable (CCVI<0.6)  

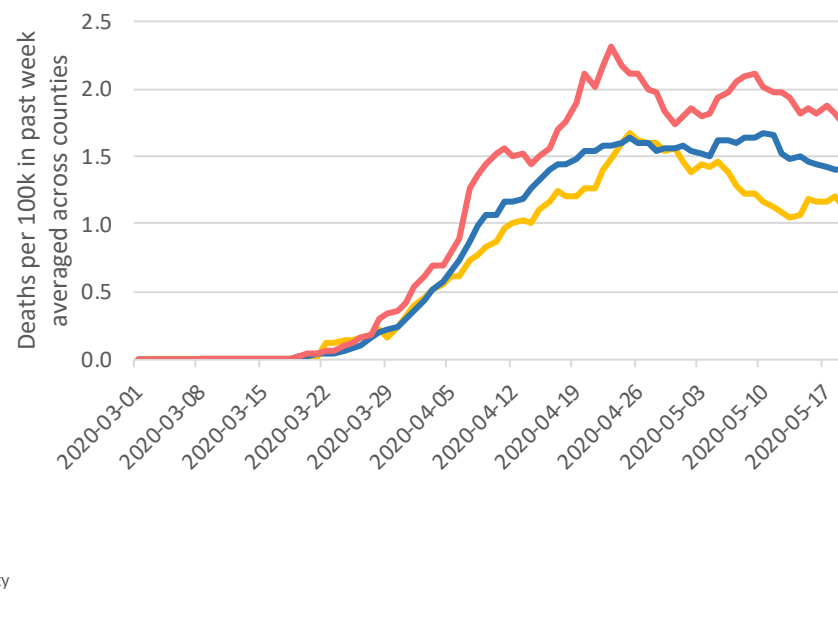
<13%
>13%

And shows us that the virus grows more quickly in vulnerable areas

Case growth rate



Death rate



Data source is JHU supplemented with USAFacts for NYC boroughs. Cases and deaths per 100k are computed at county level, then averaged across counties without weighting for the population of each county. Data retrieved on May 20, 2020

Our insights allowed the media to bring attention to ‘testing deserts’ and racial disparities in access

“nearly two-thirds of rural counties — home to some 21 millions of people — have no testing sites at all, according to an analysis by the nonprofit Surgo Foundation.”

*-People of color have less access to Coronavirus testing, **Axios**, June 23, 2020*

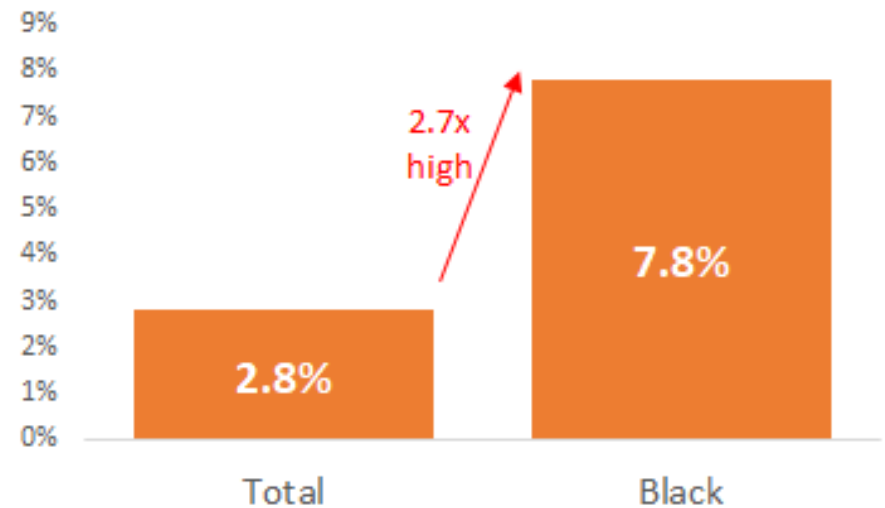
“and people of color are disproportionately represented in those counties without testing sites, the Surgo Foundation reported this week..”

*-Why the U.S. still hasn't solved its testing crisis, **Politico**, July 5, 2020*

“In rural counties without testing sites, cases and deaths are growing much faster than they in their rural counterparts with sites. The analysis also shows that compared to the average rural American, Black Americans are 2.7 times more likely to live in these testing deserts.”

*-Most rural US counties are in COVID-19 “testing deserts”, analysis finds, **Becker's Hospital Review**, June 23, 2020*

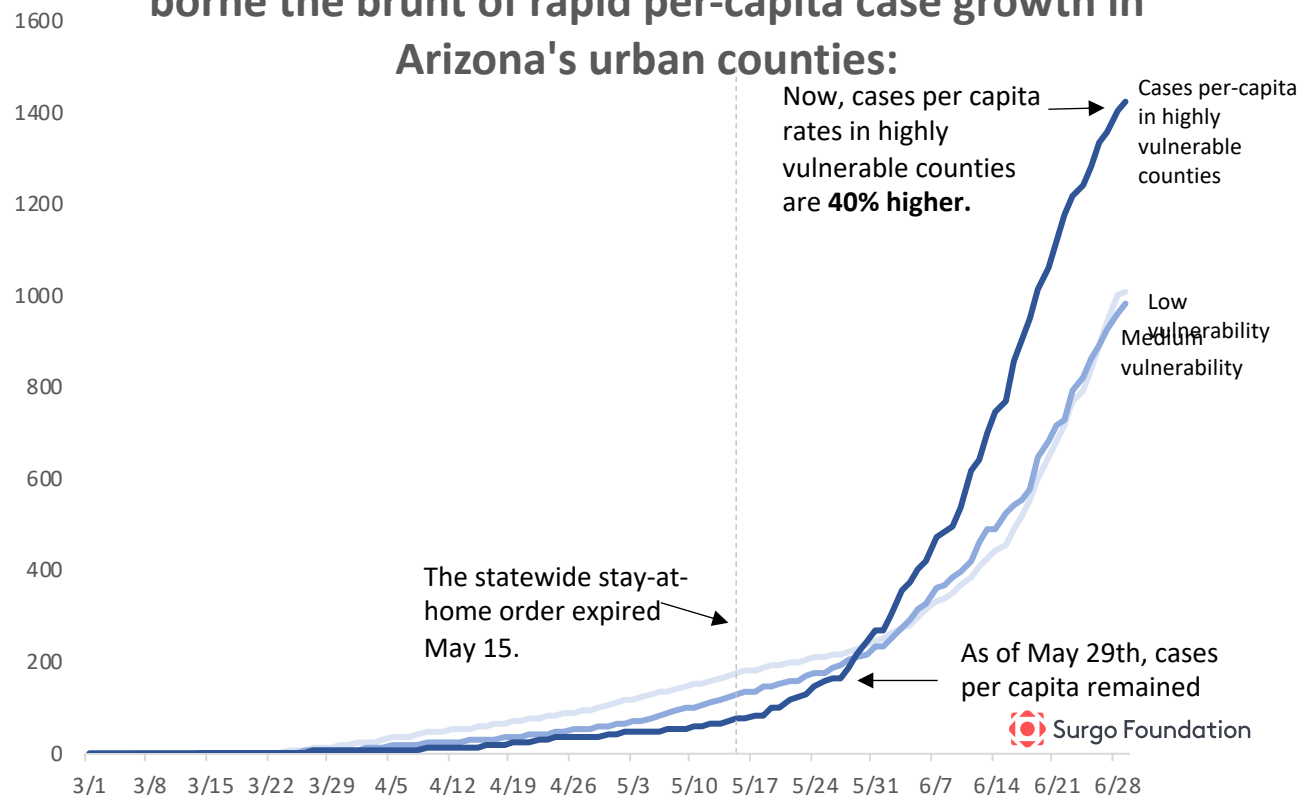
Proportion of rural Americans living in vulnerable counties with increasing COVID deaths and no test site



A deep dive into the latest 'hot spot' demonstrates how vulnerability can predict pandemic impact

As the crisis reaches a fever pitch in Arizona, we are now well-equipped to rapidly analyze data and provide tools to the public uncovering the trends in the pandemic as well as the public response. Our data illuminates troubling, unique trends:

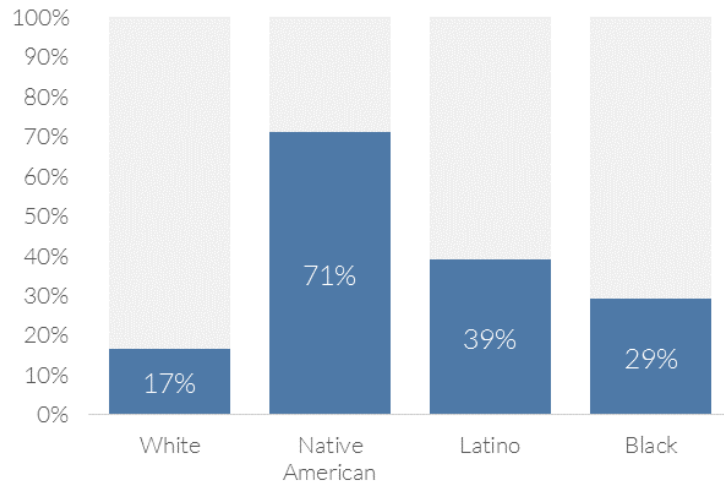
Urban counties identified as *highly vulnerable* have borne the brunt of rapid per-capita case growth in Arizona's urban counties:



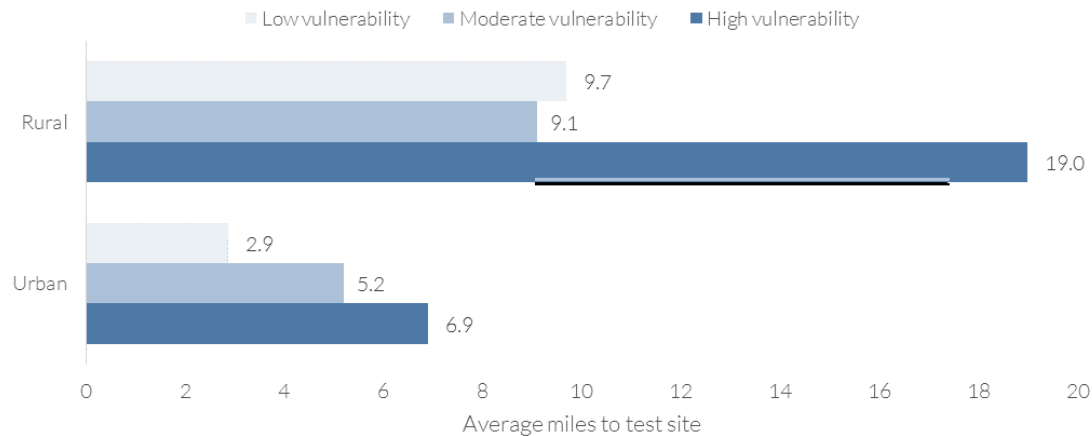
And the public response expounds on these discrepancies, disproportionately impacting minorities

And further analysis highlights that there is an inequitable public health response and a strong racial dynamic to vulnerability:

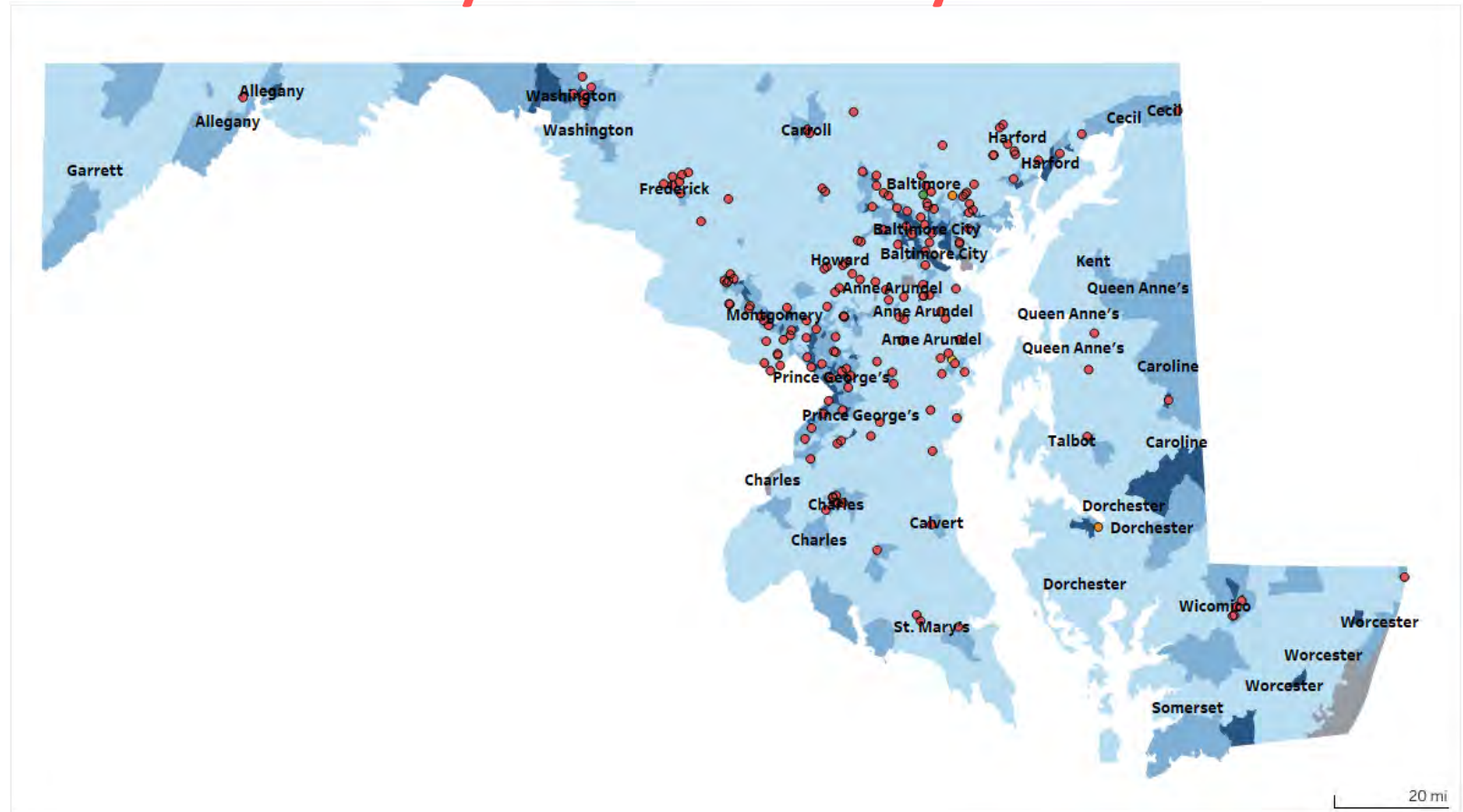
Proportion of each racial group living in a vulnerable community



Average distance to test site, among urban and rural populations (comparison by vulnerability)



With detailed data in Maryland, we can analyze the underlying patterns of accessibility and vulnerability



History Matters

Civil Rights Act 1957

- ❖ Included a number of important provisions to protect voting rights.
- ❖ It established the Civil Rights Division in the Justice Department, & empowered federal officials to prosecute individuals that conspired to deny or abridge another citizen's right to vote.
- ❖ Created a U.S. Civil Rights Commission charged with investigating allegations of voter infringement.
- ❖ Signaled a growing federal commitment to the cause of civil rights.



U.S. Public Health Service Syphilis Study done at Tuskegee (1932-1972)



The Tuskegee Syphilis Study, described as arguably the most infamous biomedical research study in U.S. History

A doctor draws blood from one of the Tuskegee test subjects



“...The people who ran the study at Tuskegee diminished the stature of man by abandoning the most basic ethical precepts. They forgot their pledge to heal and repair. They had the power to heal the survivors and all the others and they did not. Today, all we can do is apologize....”

President William Jefferson Clinton

The White House

May 16, 1997

<http://www.cdc.gov/tuskegee/clintonp.htm>



**WHAT BLACK BARBERS &
STYLISTS SAY TO SCIENTISTS:
NO RESEARCH ON US WITHOUT US!**

*An Innovation Design Studio on Biomedical
Clinical Trials and the Role of Black Barbershops
and Salons in Recruitment and Retention of
African Americans*

Monday, December 9, 2019

The Hotel at The University of Maryland
7777 Baltimore Ave, College Park, MD 20742



Stephen B. Thomas, Ph.D.
Professor Health Policy &
Management
Director, Maryland Center for
Health Equity
School of Public Health
University of Maryland
College Park, MD
sbt@umd.edu

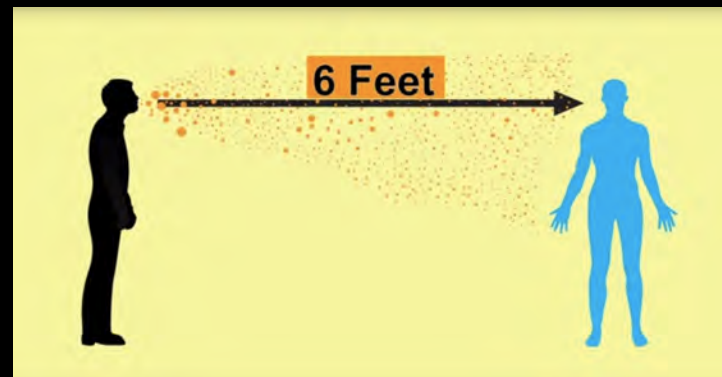


Craig S. Fryer, DrPH
Associate Professor
Behavioral & Community Health
Associate Director
Maryland Center for Health Equity
School of Public Health
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csfryer@umd.edu

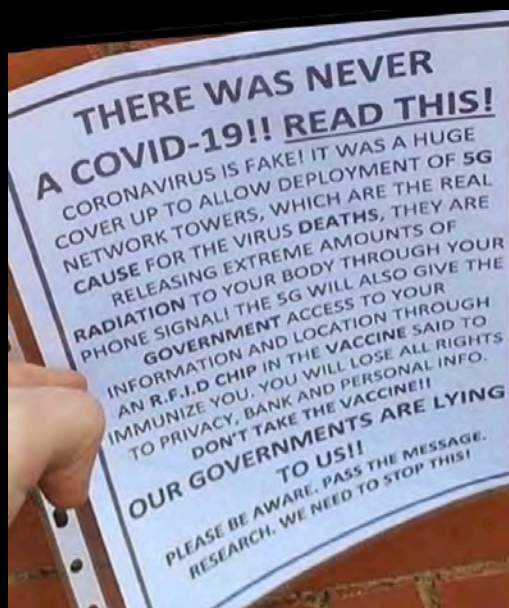
1:03:06

Where do we go from here: Chaos or Community

What Works



What Does Not Work



***Colors of COVID Consortium:
Prevention, Detection, and Treatment
of African American and Hispanic Communities in
Maryland and across the U.S.***

The Leadership Team

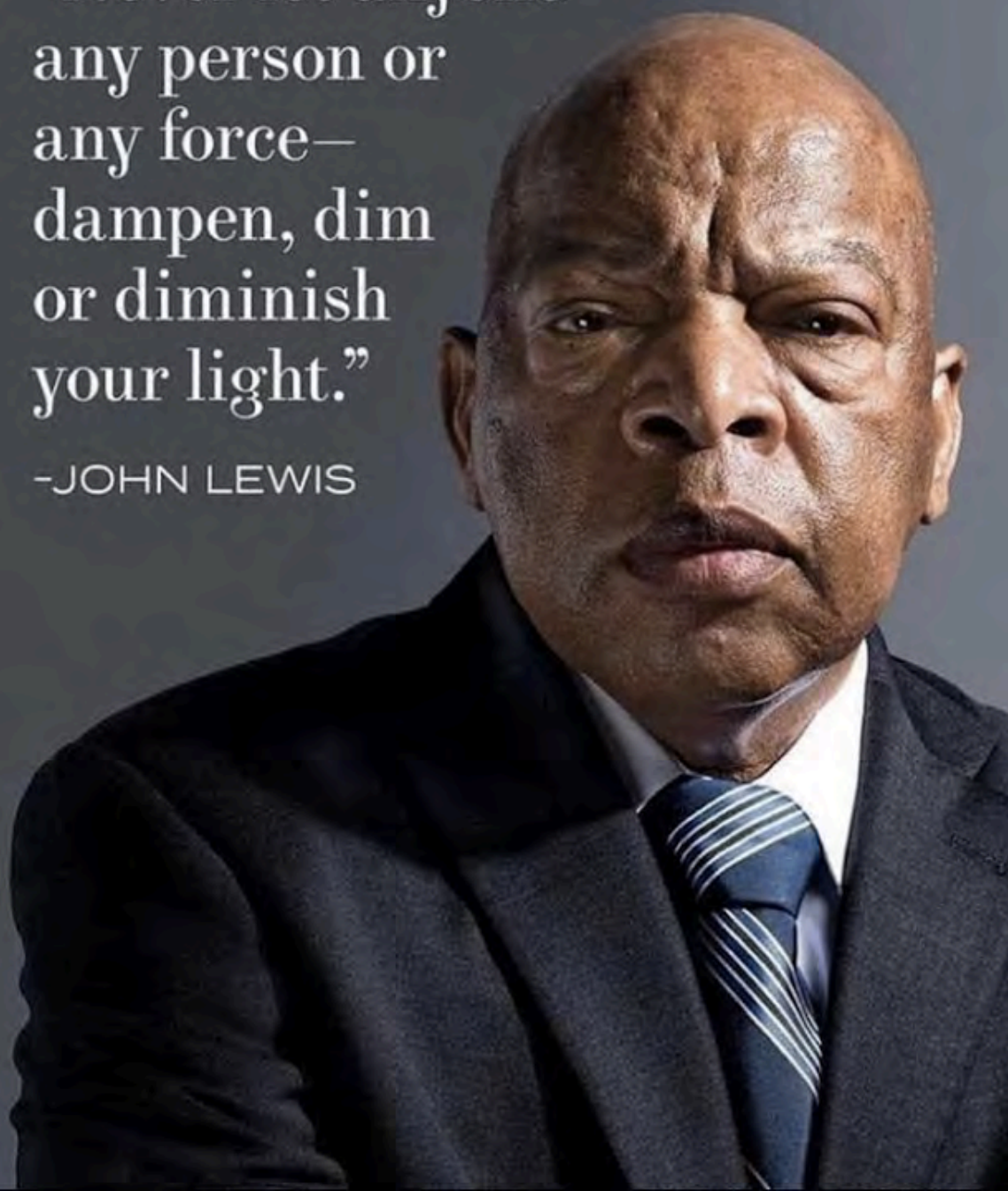
The University of Maryland, Center for Health Equity

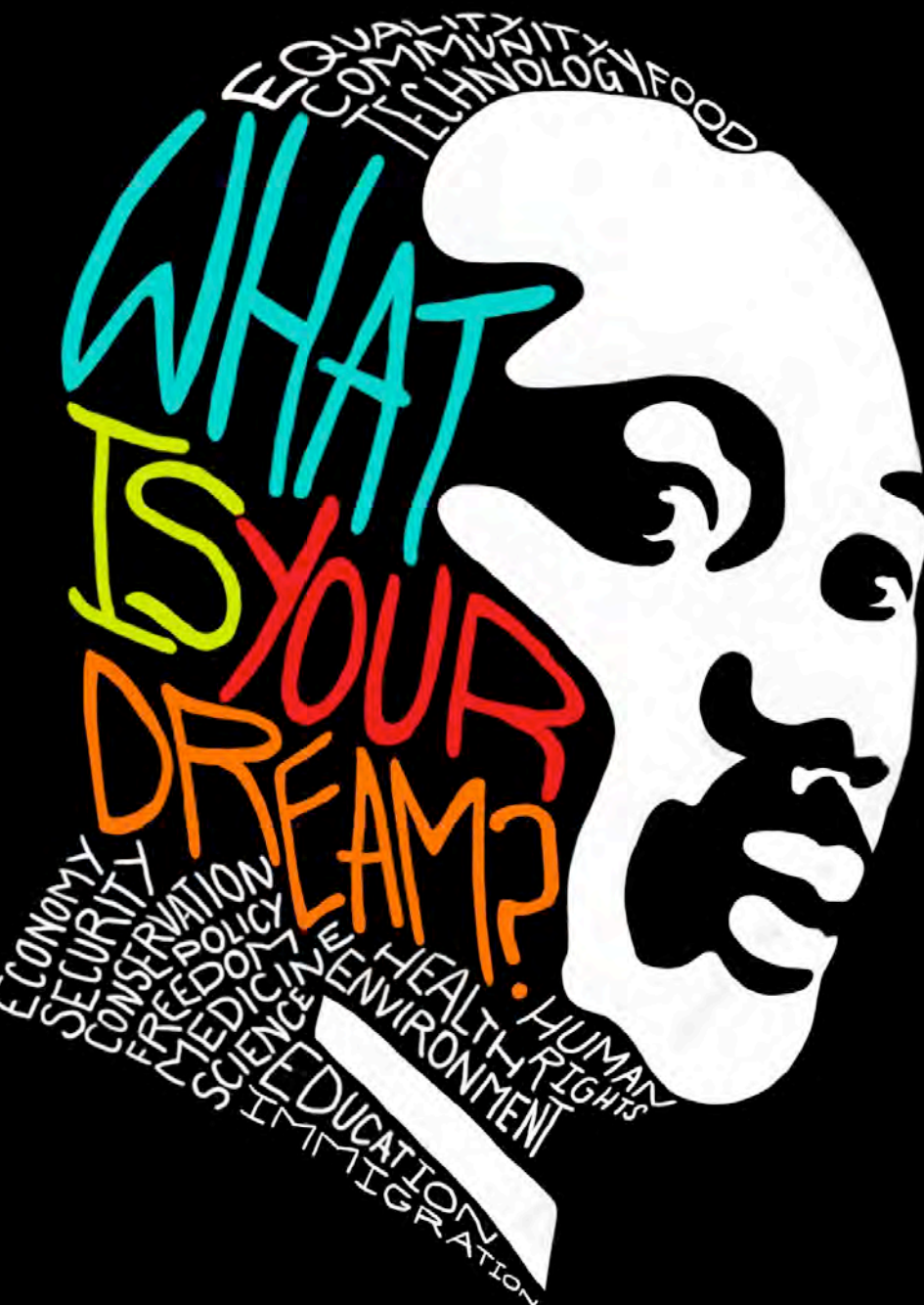
Westat, Inc., and

July 17, 2020

“Never let anyone—
any person or
any force—
dampen, dim
or diminish
your light.”

—JOHN LEWIS





The Colors of COVID-19: Confronting Health Disparities During Global Pandemic

Stephen B. Thomas, Ph.D.

Professor Health Policy & Management
School of Public Health
Director, Maryland Center for Health Equity
University of Maryland
College Park, MD
sbt@umd.edu

U.S. Commission on Civil Rights
State of Maryland
August 4, 2020
Virtual Zoom



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NOVEL CORONAVIRUS (COVID-19)

For

Maryland Advisory Committee to the U.S. Commission on Civil Rights

Barbara Brookmyer, MD, MPH
Frederick County Health Officer
September 1, 2020

Risk of Infection

- If you are not exposed, then there is no risk of infection
- Who was and is able to stay home and thrive?



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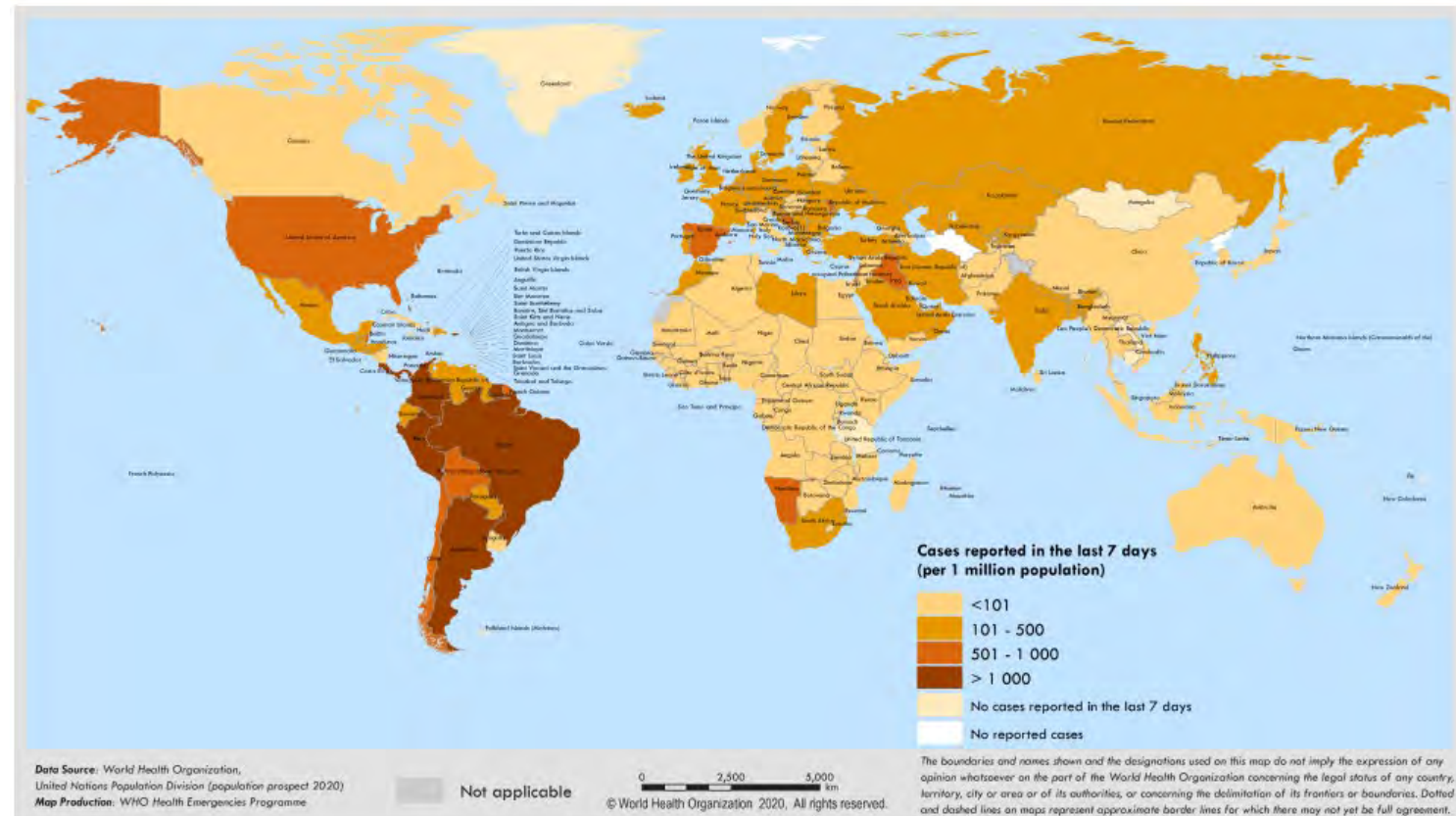
Worldwide: COVID-19 (as of 8/31/2020)

■ Cases

- *Total: 25,118,689*
- *24 hrs: 264,107*

■ Deaths:

- *Total: 844,312*
- *24 hrs: 5,385*



July 30 marks 6 months since WHO declared COVID a Public Health Emergency of International Concern.



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Coronavirus / COVID-19

	U.S	Maryland	Frederick County
First Case	Jan. 20, 2020 (WA)	March 5, 2020	March 16, 2020
First Death	Feb. 6, 2020 (CA)	March 18, 2020	March 31, 2020
Current Cases (as of 8/31/20)	5,972,356	108,249	3,492
Confirmed Deaths (as of 8/31/20)	182,622	3,612	118
Trend	Cases still accelerating in some states, overall decline	Cases peaked in May and end of August, starting to trend down	Cases peaked in May, little peak in July, starting to trend up again



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Frederick County Health Department began local response on January 28, 2020.

U.S.: COVID-19

Trends in Number of COVID-19 Cases in the US Reported to CDC, by State/Territory

USA
5,972,356
TOTAL CASES
CDC | Updated: Aug 31 2020 2:02PM

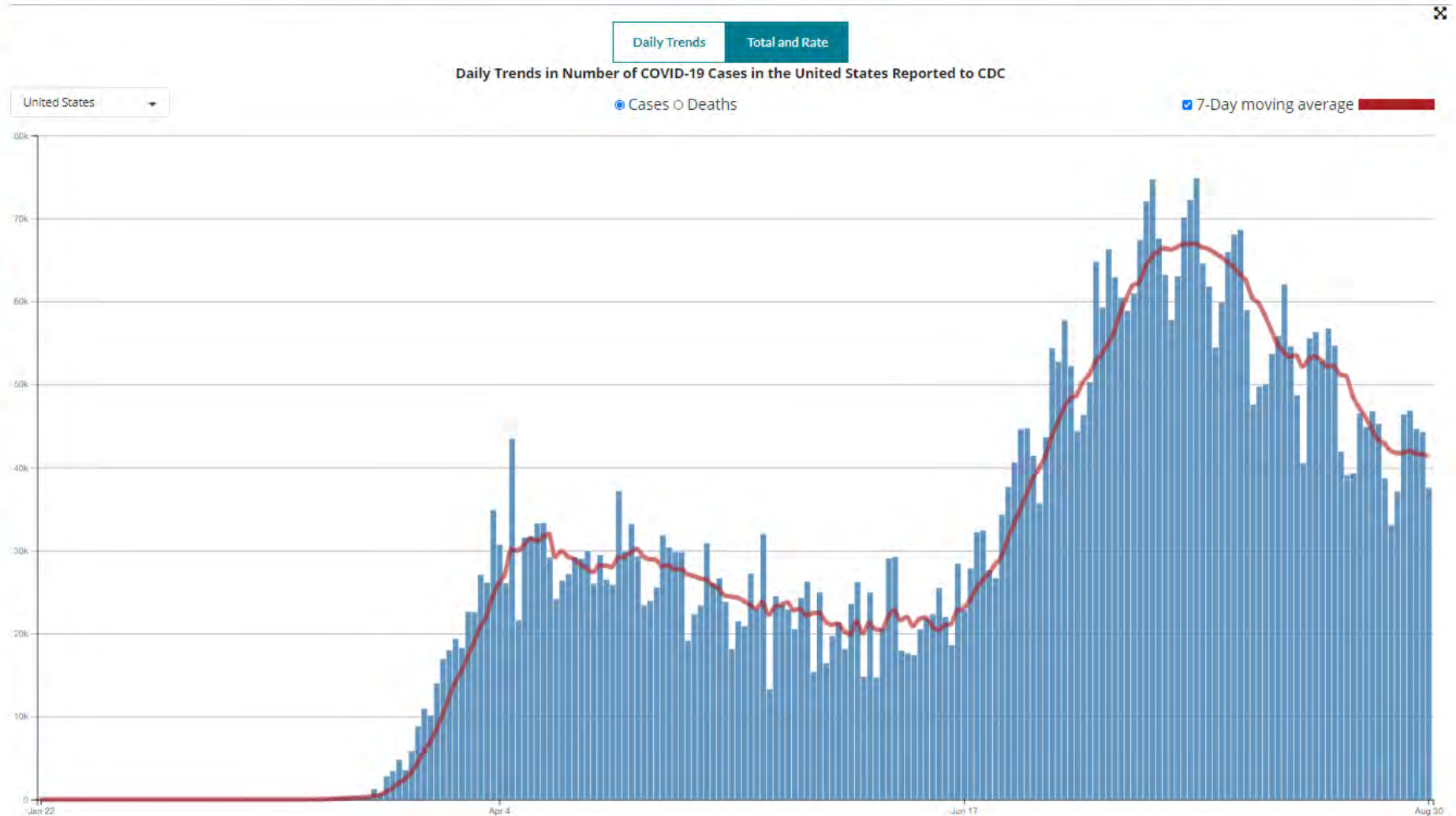
USA
182,622
TOTAL DEATHS
CDC | Updated: Aug 31 2020 2:02PM

USA
1,822
Cases per 100,000 People
CDC | Updated: Aug 31 2020 2:02PM

Case Daily Trends - United States

Date	New Cases	7-Day Moving Avg
Aug 30 2020	37532	41409
Aug 29 2020	44292	41573
Aug 28 2020	44656	41712
Aug 27 2020	46830	42011
Aug 26 2020	46393	41731
Aug 25 2020	37086	41746
Aug 24 2020	33076	42065

CDC | Updated: Aug 31 2020 2:02PM



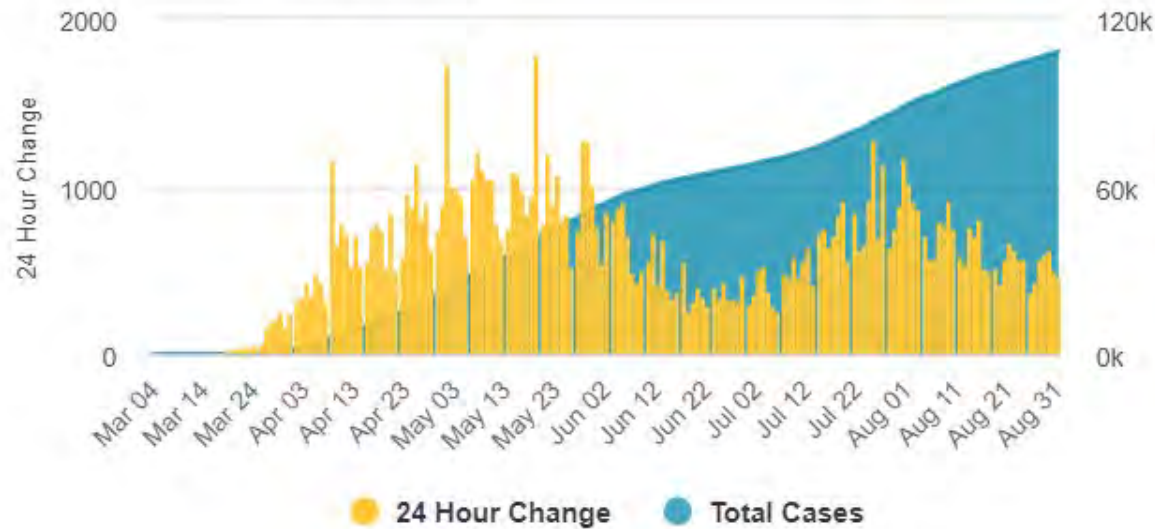
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Current Trends in Maryland

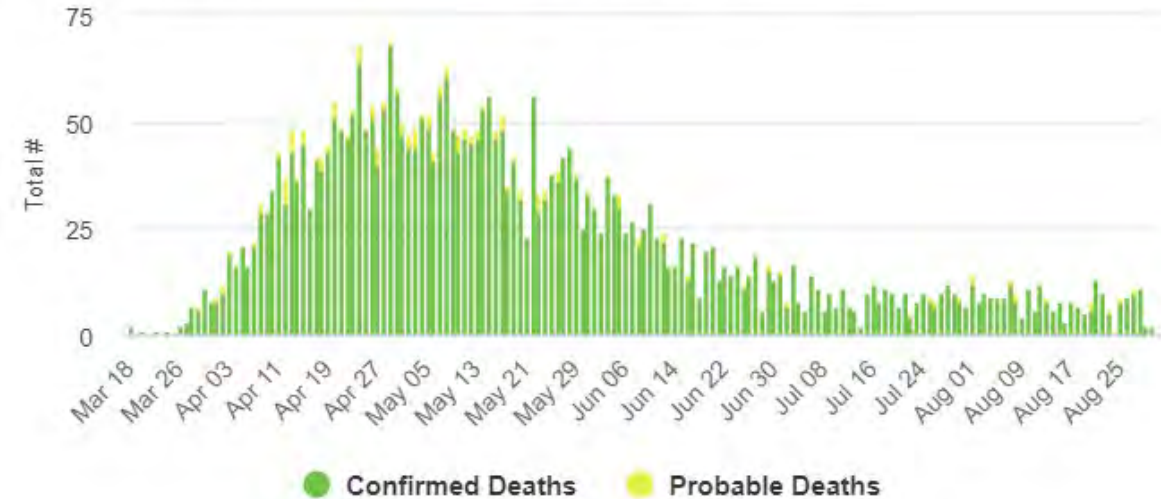
Cases in Maryland

Confirmed Cases, Total over Time



Deaths

Confirmed and Probable Deaths, Totals by Date of Death



Note: different scales on graphs.



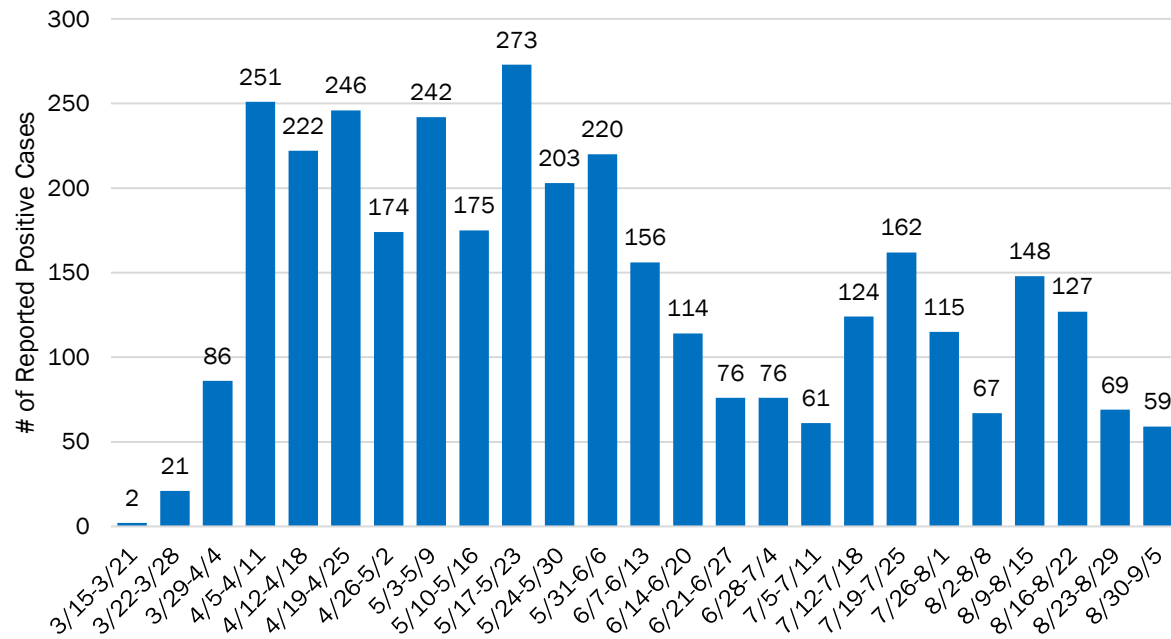
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Current Trends in Frederick County

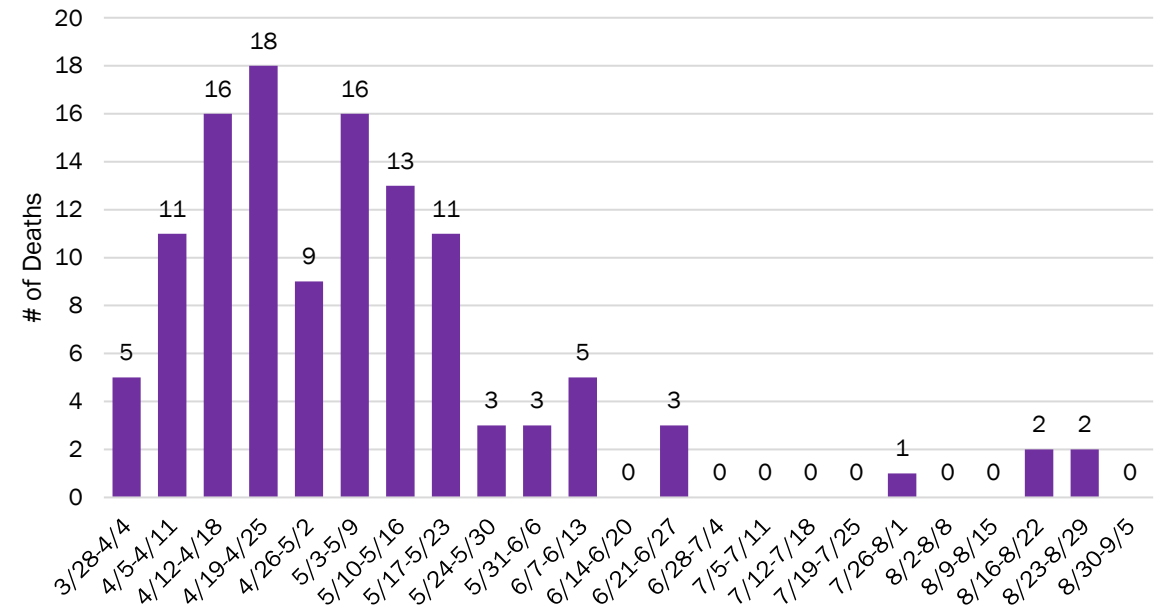
Cases

Frederick County, MD COVID-19 Cases by Week
(Date Received)



Deaths

Frederick County COVID-19 Deaths by Week



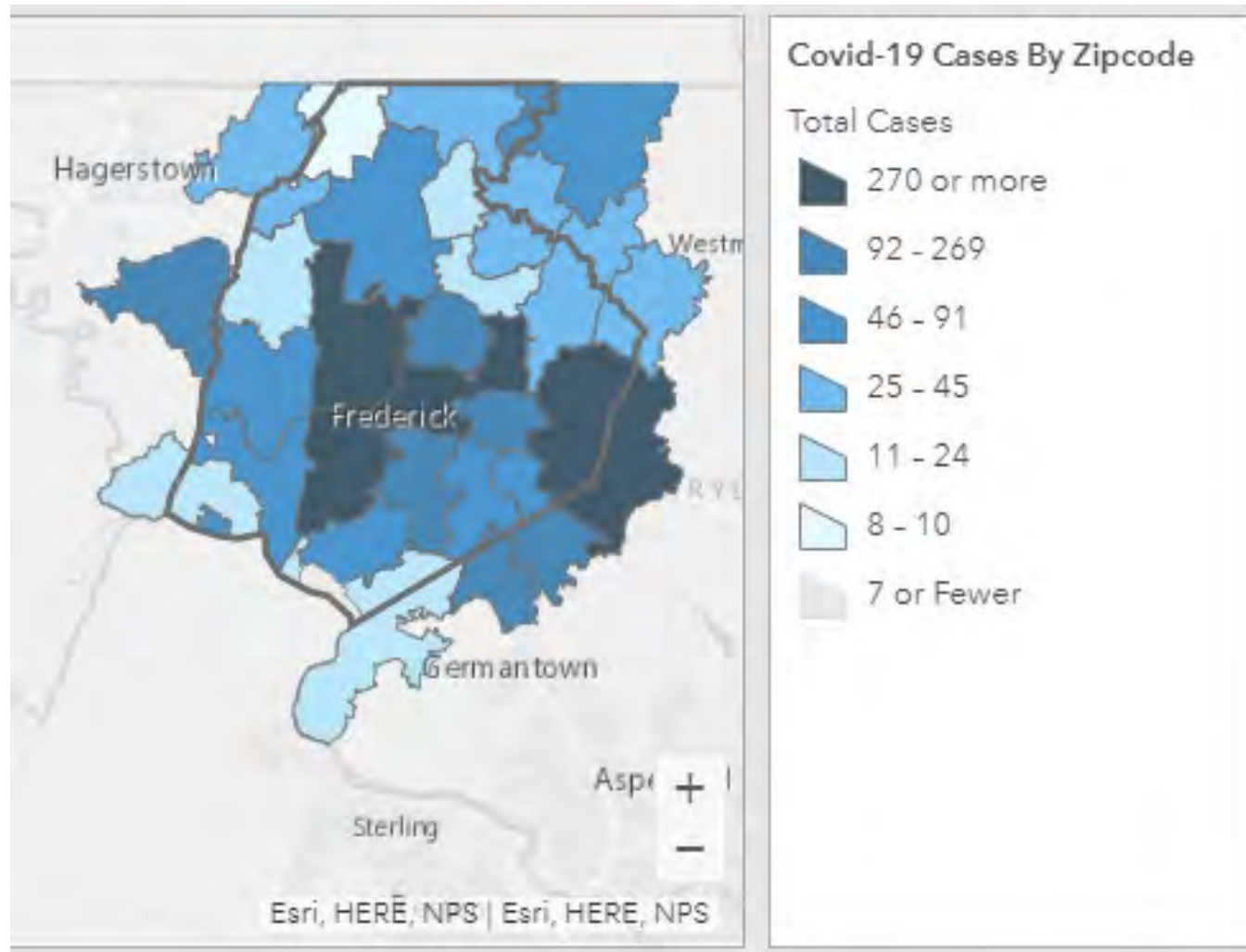
Note: different scales on graphs.



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Frederick County Data by Zip Code



- Data for ZIP codes with 7 or fewer cases are suppressed according to Maryland Department of Health guidelines.

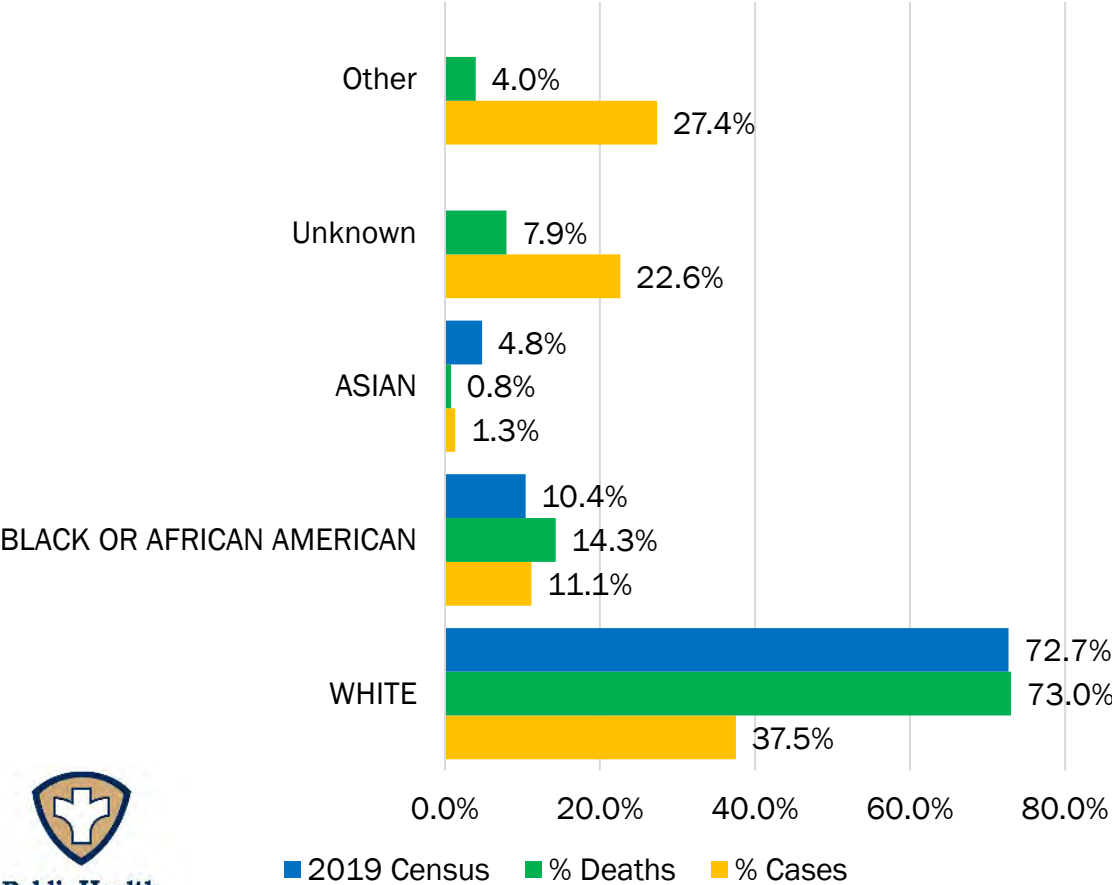


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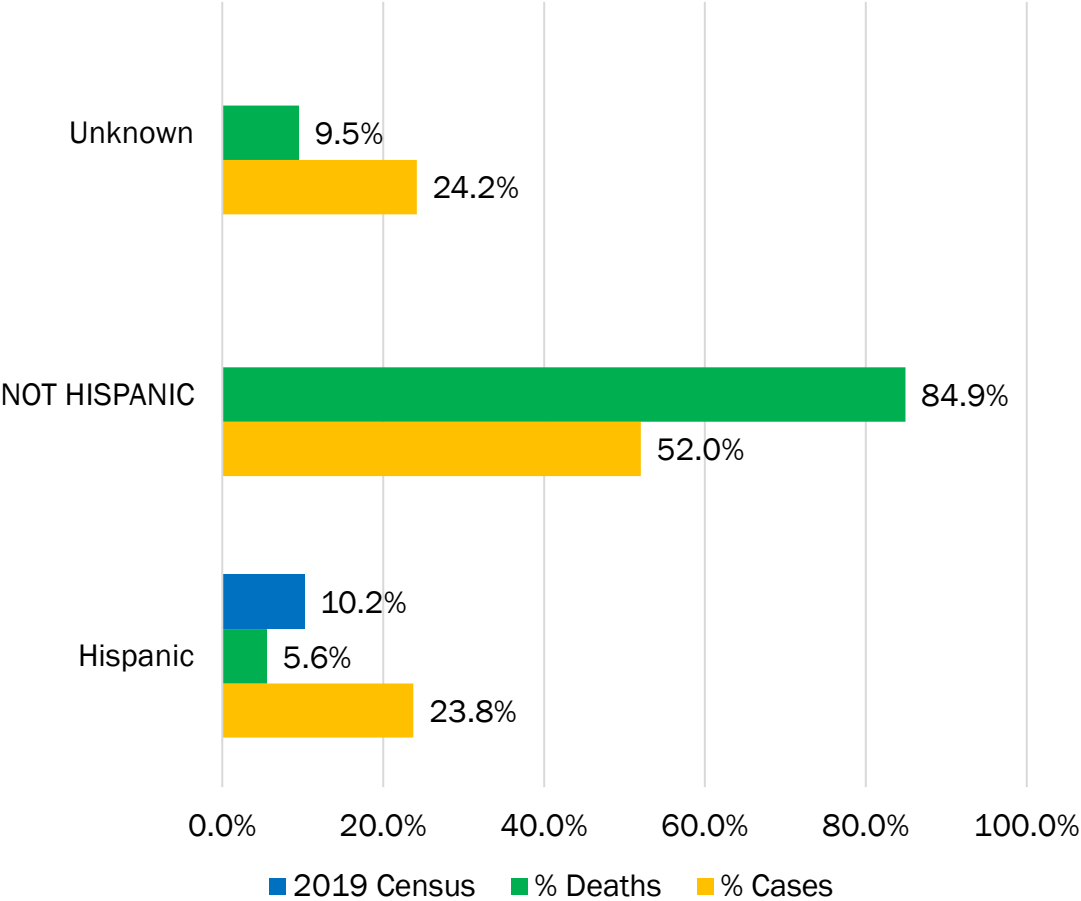
Frederick County Health Department

Frederick County COVID-19 YTD, Race & Ethnicity

Frederick County, MD COVID-19 Cases and Deaths by Race



Frederick County, MD COVID-19 Cases and Deaths by Ethnicity



Frederick County COVID-19 Race by Week

7 Day Moving Average of Confirmed Cases by Race by Day

Measure Description: All COVID-19 confirmed cases by date reported to MDH

Chart Type: 7-Day moving average by day of the raw count of the selected measure

Data Source: Maryland Department of Health Confirmed Cases Panel;

Data Available Through: 8/30/2020



Chart Type

- ☒ Count
- ☐ Percent of Total
- ☐ Population Adjusted

Measure

- ☐ All Tests
- ☐ Positive Tests
- ☐ Positive Test Percent
- ☒ Confirmed Cases
- ☐ Admissions
- ☐ Deaths

Chart Lines

- ☐ None
- ☐ Age Group
- ☐ Gender
- ☒ Race
- ☐ Ethnicity
- ☐ Region
- ☐ County

Separate Charts

- ☒ None
- ☐ Age Group
- ☐ Gender
- ☐ Race
- ☐ Ethnicity
- ☐ Region
- ☐ County

Age Group

(All)

Gender

(All)

Race

(All)

Ethnicity

(All)

Region

(All)

County

FREDERICK



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CRISP

Frederick County COVID-19 Ethnicity by Week

7 Day Moving Average of Confirmed Cases by Ethnicity by Day

Measure Description: All COVID-19 confirmed cases by date reported to MDH

Chart Type: 7-Day moving average by day of the raw count of the selected measure

Data Source: Maryland Department of Health Confirmed Cases Panel;

Data Available Through: 8/30/2020



Chart Type

- ☒ Count
- ☐ Percent of Total
- ☐ Population Adjusted

Measure

- ☐ All Tests
- ☐ Positive Tests
- ☐ Positive Test Percent
- ☒ Confirmed Cases
- ☐ Admissions
- ☐ Deaths

Chart Lines

- ☐ None
- ☐ Age Group
- ☐ Gender
- ☐ Race
- ☒ Ethnicity
- ☐ Region
- ☐ County

Separate Charts

- ☒ None
- ☐ Age Group
- ☐ Gender
- ☐ Race
- ☐ Ethnicity
- ☐ Region
- ☐ County

Age Group

(All)

Gender

(All)

Race

(All)

Ethnicity

(All)

Region

(All)

County

FREDERICK

Legend

- DATA NOT AVAIL...
- HISPANIC
- NOT HISPANIC



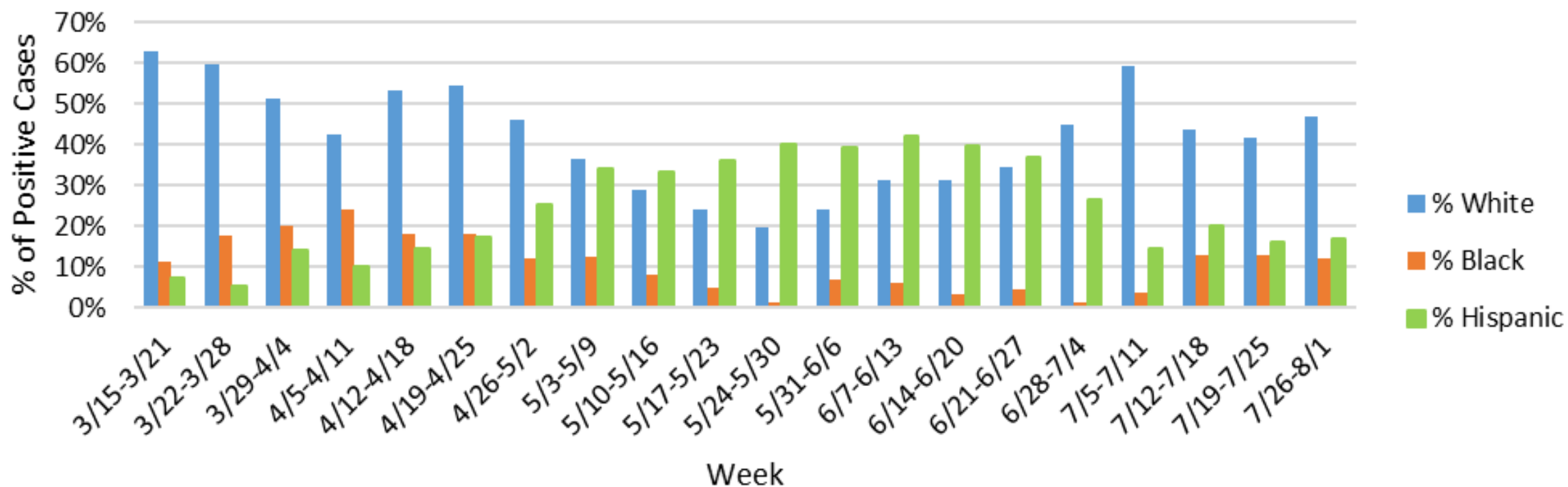
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CRISP

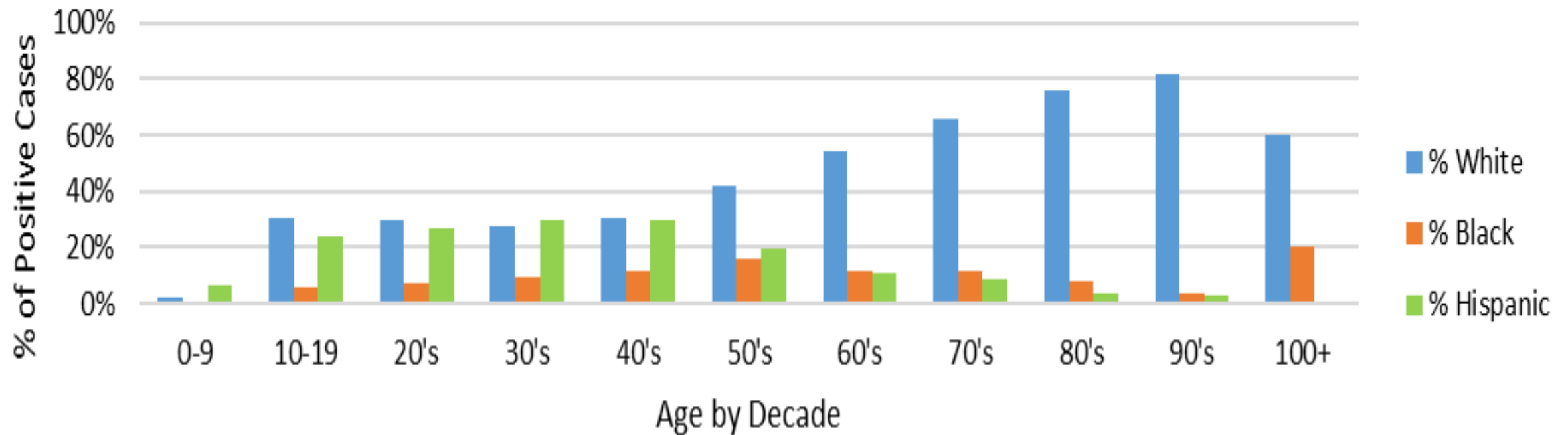
Frederick County, MD COVID-19 Cases: By week and Select Race/Ethnicities (%)



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Frederick County, MD COVID-19 Cases: By Age and Select Race/Ethnicities (%)

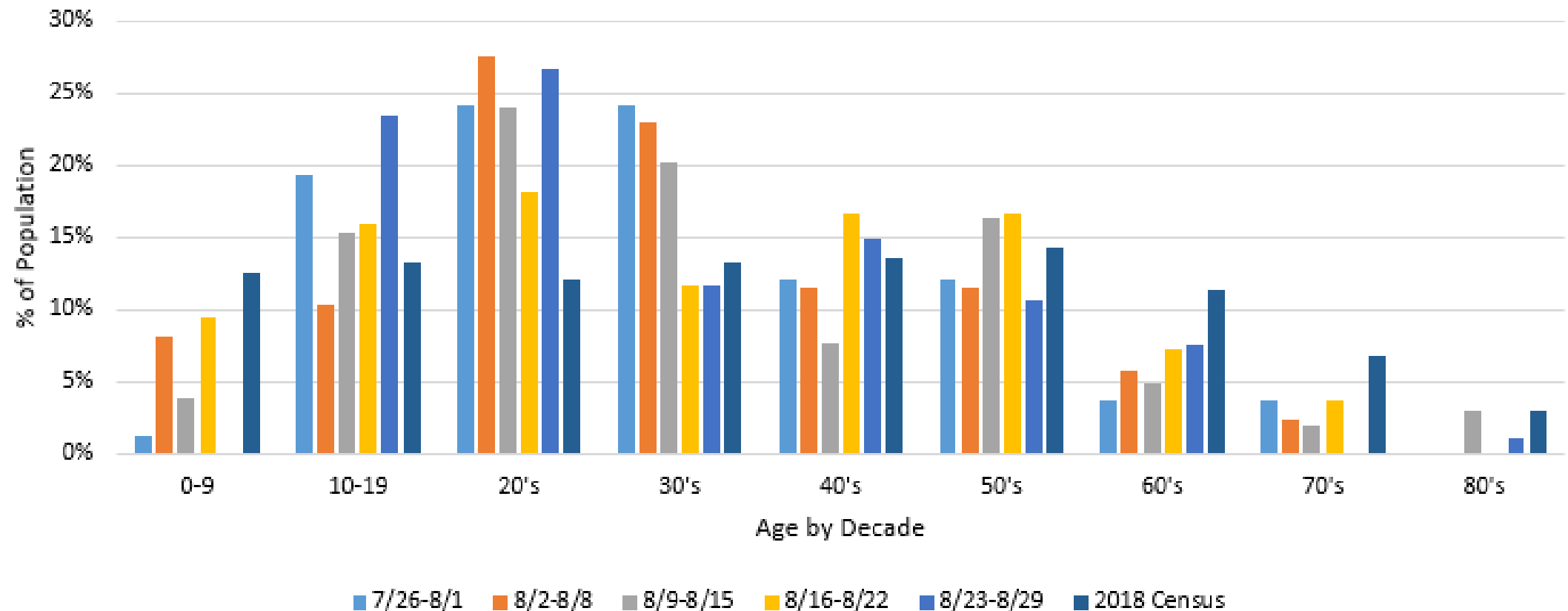


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Frederick County COVID-19 YTD, Age

Frederick County, MD COVID-19 Percent of Weekly Cases by Age,
Compared to Census Population



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Frederick County COVID and Underlying Medical Conditions

Frederick, Maryland :

Any condition is defined as BRFSS respondents who answered "yes" to any of the following questions: "Have you ever been told by a doctor, nurse, or other health professional that you have: chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; heart disease (angina or coronary heart disease, heart attack or myocardial infarction); diabetes;

Any condition
40.7 %

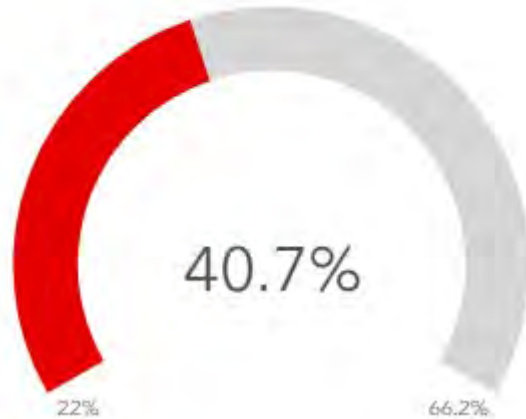
estimated number: 80,034

2018 county population estimate for adults 18 years and above was 196,468.

Frederick, Maryland:

2018 county population estimate for adults 18 years and above was 196,468.

Any condition
prevalence



Frederick, MD

Chronic kidney disease

2.6 %

estimated number: 5,073

Frederick, MD

COPD

6.2 %

estimated number: 12,099

Frederick, MD

Heart disease

5.9 %

estimated number: 11,556

Frederick, MD

Diagnosed diabetes

10.1 %

estimated number: 19,821

Frederick, MD

Obesity (BMI ≥ 30)

31.6 %

estimated number: 62,084

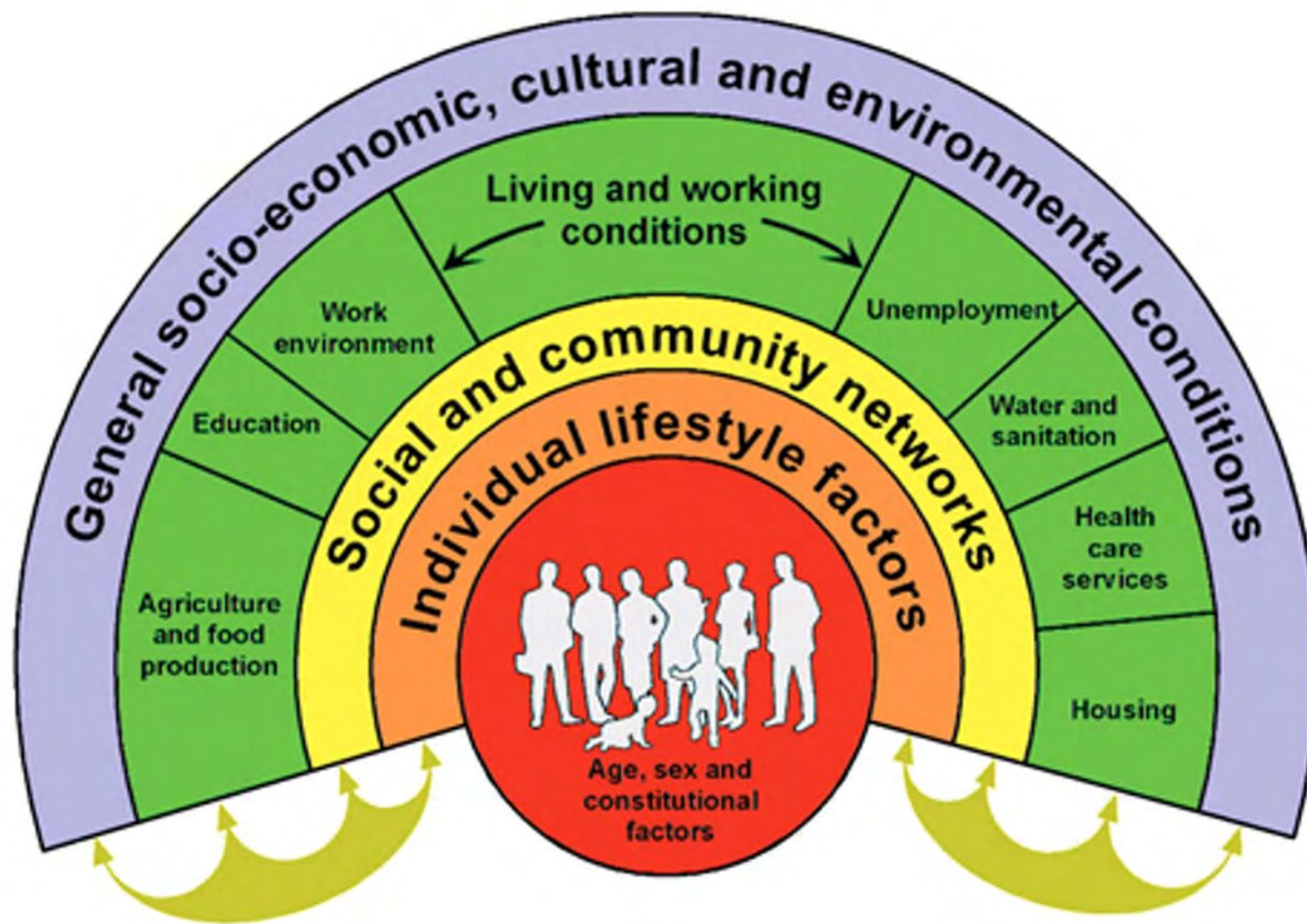


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<https://covid.cdc.gov/covid-data-tracker/#underlying-med-conditions>

Social Determinants of Health



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New data from MWCOCG report



- At first glance, the health of this population is excellent, well above the national average.
- But the health status of the local population is not uniform across the region and health varies greatly from one neighborhood to the next.

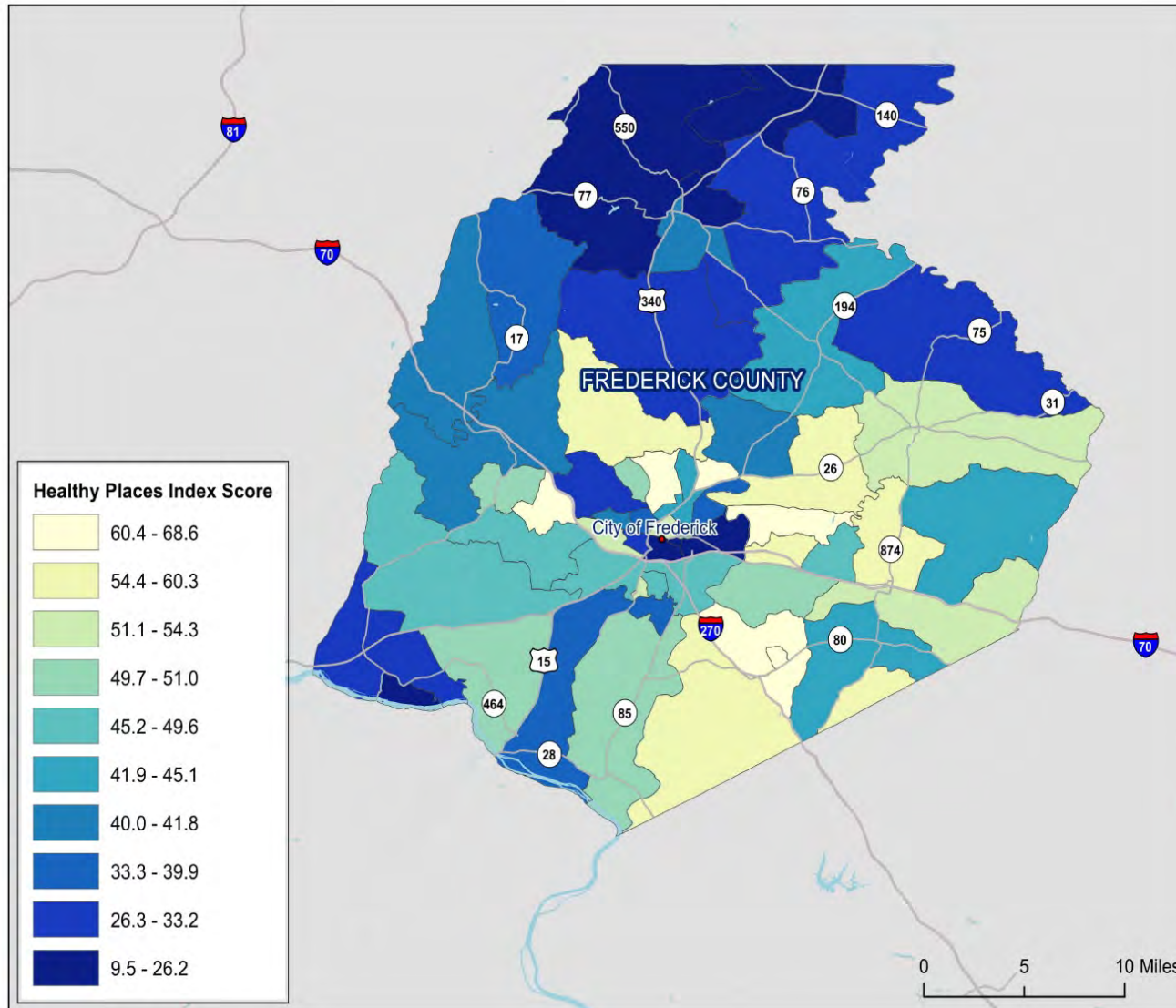


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<https://www.mwcog.org/documents/2018/10/26/uneven-opportunities-how-conditions-for-wellness-vary-across-the-metropolitan-washington-region-health-health-data/>

Healthy Places Index from MWCOCG



Local factors influence health:

- Air quality
- Education
- Economic/household resources
- Healthcare access
- Housing
- Transportation

Useful starting point to understand health of communities

Frederick Specific Data from MWCOG

Census Tract Data on:

Domain	Topic	Domain	Topic	Domain	Topic
Air Quality	Cancer risk	Health Care Access	Private insurance	Race/Ethnicity/Country of Birth	Asian population
Air Quality	Environmental hazards	Health Care Access	Public Insurance	Race/Ethnicity/Country of Birth	NH black population
Air Quality	Respiratory risk	Health Care Access	Mental health provider access	Race/Ethnicity/Country of Birth	African immigrants
Economic	Poverty (adult)	Health Care Access	OB/GYN provider access	Race/Ethnicity/Country of Birth	Asian immigrants
Economic	Poverty (child)	Health Care Access	Primary care provider access	Race/Ethnicity/Country of Birth	European immigrants
Economic	Income inequality	Health Care Access	Uninsured adults	Race/Ethnicity/Country of Birth	Latin American immigrants
Economic	Low food access	Health Care Access	Uninsured children	Race/Ethnicity/Country of Birth	Immigration 2010+
Economic	Low food access (overall)	Housing	Housing cost burdened (overall)	Race/Ethnicity/Country of Birth	Immigration 1990s
Economic	Marital status	Housing	Extremely housing cost burdened (overall)	Race/Ethnicity/Country of Birth	Immigration 2000s
Economic	Median household income	Housing	Older age of housing	Race/Ethnicity/Country of Birth	Immigration pre-1990
Economic	Low income (adult)	Housing	Overcrowding	Race/Ethnicity/Country of Birth	Foreign born population
Economic	Public assistance	Housing	Median home value	Race/Ethnicity/Country of Birth	Hispanic population
Economic	Single-parent households	Housing	Median rent	Race/Ethnicity/Country of Birth	Multi-race population
Economic	Unemployment rate	Housing	Housing moves	Race/Ethnicity/Country of Birth	NH white population
Education	High school diploma/higher	Housing	Housing cost burdened (homeowners)	Transportation	Commute by motor vehicle
Education	Lack of English proficiency	Housing	Extremely housing cost burdened (homeowners)	Transportation	Commute by public transit
Education	Preschool enrollment	Housing	Poor housing conditions (homeowners)	Transportation	Commute by walking/cycling
Education	Some college/higher	Housing	Renter housing cost burdened	Transportation	Travel time to work
		Housing	Extremely housing cost burdened (renters)	Transportation	No access to vehicle
		Housing	Renter occupied		
		Housing	Poor housing conditions (renters)		
		Housing	Housing stability		
		Housing	Housing vacancies		



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MWCOG report takeaway messages

“Health care is a necessary but insufficient solution to address these health inequities.”

“Solutions to improving health are also vital to improving the economy and growth of the region.”

“The Healthy Places Index... can help identify “hot spots” for targeting efforts at community and economic development.”

“Everyone benefits from this approach, not only the residents in low-income neighborhoods.”



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Current Trends in Frederick County

- We successfully “flattened the curve” of hospital beds use, ICU bed use, and deaths, but starting to see uptick
- Our cases started out older, then trended younger, now seeing more 40s/50’s.
- Of the Frederick County cases who have died:
 - *92% of deaths have been in people 60+ years old*
 - *79% were in a long term care facility*



Current Local Efforts

- Liaisons working with High Risk Facilities
- Contact Tracing
- Community Testing Locations throughout the County
 - *Recurring at Brunswick, Thurmont, Frederick (Rescue Mission, Rt. 40, Asbury United Methodist Church, South Street.)*
 - *Additional pop-up/closed clinics*
- Wastewater Study

5 simple ways to stay safe and healthy

- wear a face covering properly
- keep a 6 feet distance
- wash your hands often
- opt for the outdoors
- avoid crowds



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Key Messages

How should I wear my face covering?
So it covers your mouth and nose!

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You Can Help Stop the Spread.

When you see MD COVID:

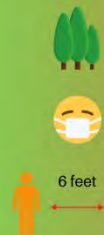
1. pick up the phone.
2. follow the instructions.
3. spread the word.

covidLINK



LOWER YOUR RISK & PROTECT OTHERS

LOWER RISK



Outdoor Activities

Face Coverings

Physical Distancing

HIGHER RISK



Indoor Activities

No Face Coverings

No Physical Distancing



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health.frederickcountymd.gov/coronavirus



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Only You Can Keep Frederick County Open For Business



Avoid crowds.



Wear a face covering.



Wash your hands.



Get tested.



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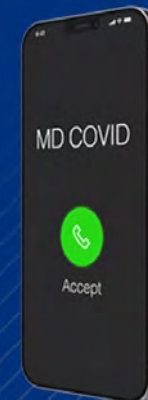
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Contact Tracing in Frederick County

- Frederick County is currently using the Maryland covidLINK system
- Maryland Department of Health has a bank of contact tracers calling cases and contacts
- Frederick County Health Departments also have contact tracers making calls, some school health staff, some new hires

covidLINK
Respond. Connect. Recover.



Challenges and Immediate Solutions

Situation

- Drive-thru clinics
- 24% of cases are Hispanic
- Majority of public messaging is in English on social media
- Misinformation and lack of trust in government

Problem

- Not everyone has car
- Not enough Spanish speaking Case Investigators
- Not everyone gets information in English on social media
- People won't follow guidelines for masks, testing, or isolation

Current Solution

- Hold walk-up community clinics in
- Trying to hire more bilingual
- Include Spanish infographics on social media, distribute flyers in Spanish thru community partners
- Repeat simple, positive messages including FAQs, work to be trusted presence, ask community about fears

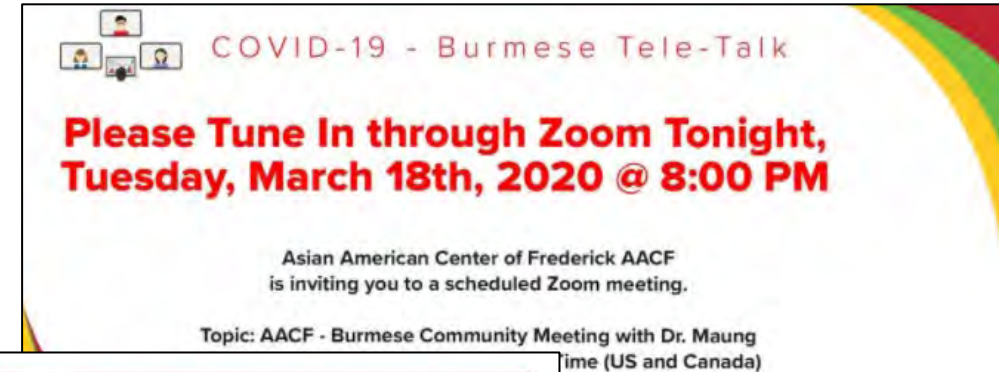


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Reaching our Immigrant Community

- Joint Information Center (JIC) working closely with trusted community partners to learn FAQs and vet messaging.
- Produced materials in Spanish, for homeless, seniors
- Worked with partners to create videos in English, Spanish, and Burmese



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14 de Abril, 2020

10 de Abril, 2020

Risk Reduction – Social Determinants of Health

- Education
- Economics
- Safe and stable housing
- Adequate nutrition
- Physical activity/recreation
- [new report](#) from the National Academies of Sciences, Engineering, and Medicine
 - *While it will be impossible for schools to entirely eliminate the risk of COVID-19, the report says, young children in particular will be impacted by not having in-person learning and may suffer long-term academic consequences if they fall behind as a result. In grades K-3, children are still developing the skills to regulate their own behavior, emotions, and attention, and therefore struggle with distance learning. Schools should prioritize reopening for grades K-5 and for students with special needs who would be best served by in-person instruction.*
 - *“This pandemic has laid bare the deep, enduring inequities that afflict our country and our schools,” said Enriqueta Bond, chair of the committee that authored the report. “Many of the communities hardest hit by the virus are also home to schools with the least resources and the greatest challenges. Education leaders need to be careful when making the decision to reopen to not exacerbate these inequities.”*



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What Comes Next?

- Data – continued pursuit of more granular data for all test samples collected, not just the positive cases, by zip code, by race, by ethnicity, by age, and by collection location type to enable calculation of a rate and then the same for vaccination
- COVID-19 Vaccination - ??
- Economic impact response - ???!
- Educational impact response - ???!
- Psychosocial and Social impact response - ???!



Equality



In the first image, it is assumed that everyone will benefit from the same supports. They are being treated equally.

Equity



In the second image, individuals are given different supports to make it possible for them to have equal access to the game. They are being treated equitably.

Remove barriers



In the third image, all three can see the game without any supports or accommodations because the cause of the inequity was addressed. The systemic barrier has been removed.



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Summary

- The choices we make are limited to the choices we have
- The choices families make are limited to the choices they have
- The risk of infection is based upon risk of exposure
- The risk of dying is impacted by pre-existing conditions (health, economic, education, social, and etc.)



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Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Noel Brathwaite, PhD, MSPH, Director
Minority Health and Health Disparities
201 W. Preston Street, Room 500
Baltimore, MD 21201

PRESENTATION
Maryland State Advisory Committee
United States Commission on Civil Rights
NOEL BRATHWAITE, PhD
SEPTEMBER 01, 2020

INTRODUCTION

Objective

Explore trust building steps for protecting adherence and opportunity for increasing wellbeing during COVID-19

Q1: How will the State obtain trust in minority communities when the COVID vaccine is developed? You'll recall the Tuskegee Experiment, etc.

Q2: Access to COVID test sites and contact tracing continues to be difficult for minority communities around Maryland and could become a civil rights issue.

A. Erosion of Trust, Fairness and Civil Rights

Trust, perceived fairness and access are very important in terms of protecting adherence:

¹https://statesville.com/news/world/elites-are-flouting-coronavirus-restrictions----and-that-could-hurt-us-all/article_bf7baeec-776a-512d-8edc-9a6c1905adf5.html This mantra is critical as we face and deal with the COVID-19 pandemic that has disproportionately affected minorities in Maryland and nationally where data by race and ethnicity is known ²<https://coronavirus.maryland.gov/>
³<https://pubmed.ncbi.nlm.nih.gov/32562416/>

Actions to contain COVID-19 is often government led including funding and other resources. And when countries impose restrictions to combat coronavirus, there's an implicit pact between the government and people: we're all in this together¹.

In the past some actions of government to address health conditions and outcomes have gone from initial trust to erosion of trust and to distrust and injustice or unfairness. The most cited and notable example is the Tuskegee syphilis study which resulted in the erosion of trust and is still cited as a contributor to today's responses by minorities. In this example not only was [trust diminished significantly](#) but so did

fairness and adherence. From a historical perspective, the Tuskegee syphilis study is widely recognized as a reason for mistrust because of the extent and duration of deception and mistreatment and the study's impact on human subject review and approval.

⁴<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4354806/#:~:text=From%20a%20historical%20perspecti,ve%2C%20the,human%20subject%20review%20and%20approval.>

Distrustful also due to other long-running racial inequities in the health care system.

Now that we are in this COVID-19 era with its negative impact on minorities in terms of positive cases, hospitalizations and deaths, how do we restore trust and fairness in order to improve compliance to efforts for containing the spread of the virus including testing, isolation, contact tracing, social distancing, mask wearing as well as clinical trials and vaccine? The memory of the horrific Tuskegee syphilis study makes some African Americans suspicious of a coronavirus vaccine.

For many Hispanics, the reluctance to get tested or seek treatment stems from fear of deportation. That distrust could discourage people from getting treatment or from cooperating with government contact tracers trying to identify who an infected person had come into contact with. This information is needed, and there needs to be a guarantee of its privacy.

⁵<https://www.nbcnews.com/news/amp/ncna1236732>

It should be noted that In times of nationwide crisis the people turn to the state and its institutions for leadership and unified action. Ironically, it is during a crisis too that the capabilities of the state and its institutions get challenged most. This is the case during the on-going COVID-19 pandemic.

⁶<https://www.un.org/development/desa/dpad/publication/un-desa-policy-brief-75-covid-19-reaffirming-state-people-governance-relationships/>

B. Restoring Trust

A number of strategies have been mentioned to restore trust while mitigating the virus. My seven point plan should be imbedded in COVID response and recovery.

- Affirming and acknowledging the problem highlighted by data and also apologizing for it as former President Clinton did for the Tuskegee study ⁸<https://www.cdc.gov/tuskegee/clintonp.htm>
- Building pre-action relationships with trusted members of the community. This include respect (See Figure 1)
- Communicating and engaging communities in planning initiatives not waiting until for example two weeks to call for recruitment of minorities per COVID-19 vaccine clinical trials
- Acknowledging the mix-status and civil rights of residents who may be reluctant to provide reliable information to contact tracers for fear of isolation thus depriving family members of financial support (eco dependent) during isolation and future negative immigration action and reprisals
- Be sure not to invade privacy despite immigration status and explain what data is collected about them

- Be prepared to provide resources/investment (short and long term)
- Sustaining efforts through maintaining post-crisis engagement, appreciation and a seat at the table

C. Conclusion

Trust is the connective tissue that binds together everything that we do: our relationships, our actions, our expectations of others. We expect institutions, businesses, and other organizations to deliver on their promises and behave responsibly. Trust is easy to lose, and difficult to build up.

We can restore trust by addressing long-standing issues of medical racism and current distrust and perceived injustice surrounding COVID-19 and COVID vaccine. These strategies can be a start in correcting the centuries of medical racism and injustice inflicted upon the minority community.

Notes

The meaning of trust

Trust is defined as “our willingness to be vulnerable to the actions of others because we believe they have good intentions and will behave well toward us.” We are willing to put our trust in others because we have faith that they have our best interests at heart, will not abuse us, and will safeguard our interests—and that doing so will result in a better outcome for all.

⁷<https://www2.deloitte.com/us/en/insights/economy/covid-19/building-trust-during-covid-19-recovery.html>

Figure 1: Trust Model



⁸<https://levelupleadership.com/category/workplace-culture/>

Table 1: Percent of U.S. adults who say...

Survey Items	Response % Black	Response % Hispanic	Response % White	Response % USA
Benefits outweigh the risks of allowing more access to experimental treatments before completion of clinical trials	41%	53%	63%	59%
They would definitely/ probably get a COVID-19 vaccine if it were available today	54%	74%	74%	72%

Survey conducted April 29-May 05, 2020 Pew Research Center

Findings: Black Americans are more skeptical of experimental treatments and potential COVID-19 vaccine than Hispanics and Whites

⁹https://www.pewresearch.org/fact-tank/2020/06/04/black-americans-face-higher-covid-19-risks-are-more-hesitant-to-trust-medical-scientists-get-vaccinated/ft_20-06-01_covidracehealth_2/