September 9, 2020

Dear HEAL Council,

Thank you for your letter lifting the importance to name racism a public health crisis and use this to drive systemic change, particularly as we respond to the pandemic. What I heard in your letter is a desire for MDH to provide more leadership, communication, and action in COVID-19 response with a racial equity lens. We agree that our response to the pandemic must be grounded in anti-racist strategies. We have done so in many ways, but more can be done. In your letter you put forth 12 recommendations for the agency, and a series of recommendations specifically tied to declaring racism a public health crisis. I will do my best to address what we have done or are currently doing to implement these recommendations and to identify opportunities we can do more work.

HEAL Recommendations:

Policy & Systems Changes

> ***1. Data Disaggregation****. Currently, Minnesota records/publishes the percentage of COVID-19 Cases and COVID-19 Deaths by race. However, it does not publish the percentage of COVID-19 Cases and COVID-19 Deaths by sexual orientation and gender identity (SOGI), or by race vs state population.*
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> ***Recommendation:*** *MDH start to disaggregate data related to COVID-19, such as testing, hospitalizations, ICU admissions, and deaths by race and ethnicity, sexual orientation and gender identity (SOGI), and state population. This additional information will inform MDH/policy leaders of the COVID-19 prevalence in our state by race /ethnicity, and by SOGI and identify opportunities to provide targeted resources/supports.*

MDH Response: We know that this virus is affecting populations of color disproportionately. We are continually working to improve our reporting to highlight this disparity. We have a Data and Forecasting section within our incident command. This section includes a health equity data group that is focused on equitable data analysis. In addition, the Governor's Office has a Community Resiliency and Recovery workgroup, led by Chris Taylor which focuses on the impact this pandemic is having on different communities in Minnesota.

We have made changes over time to the data reported on MDH's website and the Governor's Office website. If you review the MDH weekly web report, you will note that we do include race and ethnicity data with a comparison to their proportionate share of the state's

population. In addition, we show age-adjusted racial and ethnic data, to help demonstrate the disproportionate impacts of the virus. If you review the Governor's COVID Dashboard, you will see similar data with statewide comparisons.

We are also revising the information that the state collects at our community testing events and during our case investigation interviews to include disaggregated race/ethnicity and SOGI data. We are planning for this to go into effect later this month (September 2020). Unfortunately, MDH does not have oversight over what demographic data other test sites collect.

> *2.* ***Community Based Organizations for Federal Stimulus Opportunities****. The CARES Act provides economic stimulus for small businesses and individuals.*
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> ***Recommendation:*** *MDH—Center for Health Equity/ Community Engagement to a) develop and release a request for proposal (RFP) to engage culturally-appropriate and responsive community-based provider organizations serving historically marginalized populations; b) fund CBOs that will provide preventive care and COVID-19 education, building capacity, and address racial/geographical inequities; c) provide CBOs long term support.*

MDH Response:

MDH has distributed several rounds of funding to community based organizations (CBOs) in order to ensure that all who reside in Minnesota and the 11 Tribal Nations that share its geography – including residents from communities of color, American Indian residents, LGBTQ residents, and residents with limited English proficiency – have access to needed, culturally relevant resources and have the opportunity to be fully informed with culturally relevant, linguistically appropriate, accurate, and timely messages related to COVID-19. To date, the funding distributed to both CBOs and diverse media organizations has totaled nearly $4 million. A full list of all of the recipients of this funding can be found on the COVID-19 Contracts for Diverse Media Messaging and Community Outreach webpage.

Additionally, MDH has requested $10 million from the legislature to be distributed through the end of 2020 to CBOs to provide COVID resource coordination to POCI, LGBTQ, and disability communities across the state. We are working to secure additional funds through 2021.

While the source of funding is time limited (Federal CARES funding expires December 30, 2020), MDH is learning new ways to work in partnership with communities through our COVID outreach that will change the way we work into the future.

> *3.* ***Expanded and Flexible Coverage for Uninsured****. DHS provides Medical Assistance (MA) coverage for COVID-19 testing during the peacetime emergency for individuals who are uninsured. However, this is limited to testing and diagnosis of COVID-19.*

Recommendation: *MDH to work with DHS to provide wraparound services to cover service not covered DHS' limited MA coverage or provide grant funding to organizations providing services.*

MDH Response: As HEAL has articulated, this body of work falls under the authority of DHS. We can pass along the recommendation, but also encourage HEAL to make the request to DHS and coordinate with DHS' Cultural and Ethnic Community Leadership Council (CECLC).

4. Expand the Workforce*. It is important for healthcare professionals to understand cultural differences in how patients interact with providers and the healthcare system. Given workforce demands, there is opportunity to tap previously unused health care talent.*

Recommendation: *consulting with/ bringing on BIPOC health associations that have been doing the work in community, and are equipped to work as conduits (i.e. MN Black Nurses Association, Nigerian Nurses Association, Filipino Nurses Association, Hmong Health Professionals Association, Somali Medical Association) to help create a policy that fast-tracks immigrant, refugee, and bilingual health care professionals who have until now been closed out of the health professions. Secondly, increase the recruitment of foreign-trained, international medical graduates into MN Health care systems (MDH, hospitals, clinics, community-based organizations, etc). HEAL sees an opportunity with health associations and foreign trained professionals in providing supportive and transitional services for individuals and families, post COVID discharge.*

MDH Response:

MDH's Office of Rural Health and Primary Care (ORHPC) collects some of this information in its workforce surveys. ORHPC is doing a review of its outreach for workforce-related grant and loan forgiveness programs and working on ways to make sure they are reaching a more diverse workforce.

ORHPC also houses the International Medical Graduates (IMG) program, whose purpose is to address barriers to practice and facilitate pathways to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state. The program is exploring ways to promote the opportunity among residency programs and to create more openness to IMGs in matching residents into residency programs. IMGs have also been hired by MDH as COVID case investigators and is exploring ways to increase collaboration.

Communication, Health Literacy, and Public Awareness

1. ***Language Translation****. With the rapidly changing knowledge about COVID-19, information is changing on a weekly, sometimes daily basis. Minnesota Department of Health posts notices and fact sheets in multiple languages. However, the English*

language materials are updated in real-time, creating lags in developing translated versions. Often materials are not translated correctly, resulting in confusion or misinformation especially as it relates to ASL interpretation.

Recommendation: *MDH contracts with trusted agencies to provide timely and consistent translation of public health guidance.*

MDH Response: MDH currently contracts with professional translation companies to translate many of our materials into 10+ languages consistently, and additional languages as needed. We also create videos with ASL interpreters and closed captions. Accessibility is foundational to our approach to public health and our COVID response. We also have an internal team of staff that are providing review of 9+ languages in house after the professional translation company send us documents. Even so, when errors are found once materials are published, we work to quickly fix the errors. Further, we have contracted with 80+ trusted, diverse community-based partners and diverse media to provide timely updates to their respective communities. We trust them to translate materials and adapt them to be culturally and linguistically relevant to their communities.

Further, HEAL had raised to MDH that during the Governor's press conferences, the ASL interpreter on screen was at times being blocked by text or images depending on the local news stations broadcasting the press conference. MDH took swift action to notify the Governor's office and this issue was resolved immediately. If there are additional concerns that have not been addressed, please let us know.

2. ***Culturally Tailoring Messages****. Public health concepts are not readily understandable across cultures. Concepts such as social distancing, flattening the curve, self-quarantining, face-masking, washing hands, and wiping down groceries need to be presented in a culturally appropriate manner.*

Recommendation: *MDH to hire communication specialist from CMI and/or partner with CBOs, community health centers, cultural centers to produce culturally relevant materials. In addition, the information being shared by MDH needs to be synthesized into 1-3 important key message(s) to communities in lay man terms with follow up explanation as needed.*

MDH Response: As mentioned above, MDH has current P/T contracts with close to 90 trusted, diverse community-based partners and diverse media to provide timely updates to their respective communities. To date we have put out nearly $4 million to our contractors to deliver messages and adapt them to be culturally and linguistically relevant to CMI across the state. Examples of how our contractors have tailored messaging can be found on the COVID-19 Examples of Contractor Materials and Messages webpage.

In just the first couple months of their contracts, 17 community-based organization contractors reported that together they had provided direct COVID-19 information or services to more than 25,000 community members. Another 19 contractors reported that they had provided COVID-19 information or services to nearly 900 community leaders to then disseminate to their

respective communities. Five contractors were responsible for more than 50 translations of COVID-19 messages. These numbers reflect only the first half of their contract work. As a portion of these contracts ended at the end of August 2020, we will have additional numbers to share in the fall.

MDH also created new internal communications review processes to get input from staff from CMI in the development process of new MDH materials and messages. For example, when new video or infographic is created that might resonate with different communities in different ways, our COVID-19 community liaison team of about 20 staff is often the first to review and give feedback on drafts to make sure the messages/images are understandable and appropriate for different groups.

> *3. **Establish Communication Dissemination Strategies**. Messaging about COVID-19 testing, health services, and federal stimulus opportunities must be accurate, culturally understood, and disseminated through information channels that reach CMI. Trusted digital, print, media, and local leaders are important messengers.*
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> ***Recommendation:** MDH to use internal communications staff from the community or to partner with CBOs, community health centers, cultural centers, and community leaders to broadcast public service announcements in targeted communities (i.e., Hmong market, La Mercado, Somali mall, churches, etc.).*

MDH Response: MDH has established several communication channels with the dozens of contracted diverse community-based partners and media vendors mentioned above in order to ensure they have the accurate, timely, and relevant information they need to act as trusted messengers in their communities. All of our contractors receive a weekly curated list of new resources and messages related to COVID-19 and CMI, in addition to at least weekly GovDelivery emails with additional resources, videos, infographics, funding opportunities, and other important messages. Our media contractors also participate in media briefings with MDH and the Governor's Office to receive information directly from the source. While timely announcements – such as the announcement of a new free community testing site – are sent via email immediately to all contractors.

From this wealth of information, the contracts are set up in a way that allows contractors the flexibility to choose which of the message from that day or week are most important and relevant to their communities and to then adapt and disseminate them through their trusted channels. For example, Black Family Blueprint has created a weekly video campaign that speaks to the cultural needs and awareness for African American families and constituents, as well as a social media and print campaign using imagery reflecting the cultural health of African American families. Another contractor, Somali TV of Minnesota, has filmed video interviews with religious leaders and local artists/celebrities that highlight COVID-19 messages through the Somali cultural lens, and distributed the videos widely through social media. As a final example, MLatino Media has adapted many MDH messages to be more culturally appropriate for a Latinx audience and posted billboards, digital banner ads, and Spanish-language radio spots on both local radio and Pandora Online. More examples of contractor work can be found on the COVID-19 Examples of Contractor Materials and Messages webpage.

Since our pandemic response work began in early spring, MDH has distributed three rounds of funding for diverse media vendors to share COVID-19 information with their communities. The first consisted of small, fee-for-service based contractors with ethnic media vendors we were already working with for other health campaigns in order to get information out fast and efficiently. The second and third rounds were expedited competitive processes that were released in April and May, where we recruited staff and partners who identify as POCI and/or LGBTQ to review and score applications and make final decisions as a group about where funding should be directed. The organizations who were funded in the second round will wrap up their work at the end of August, and we hope to be able to share more deliverables and data from their work – including some reach data – soon. The remaining contractors will work with us through the end of 2020.

Partnerships with Communities: Leaders and Institutions

> *1. **Faith-based Leaders and Technology**. Faith leaders and places of worship play a key role in providing support, information, and spiritual leadership among communities most severely impacted by inequities. They are trusted messengers and influencers who often have a history of addressing health and mental health promotion. Places of worship are increasingly leveraging technology through radio broadcasts, Zoom sermons, Facebook Live, and podcasts.*
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> ***Recommendation**: MDH to partner with Faith-based organizations (FBOs) to disseminate information to their respective communities.*

MDH Response: Within MDH's COVID response there is a dedicated team to engage faith-based organizations and disseminating information. The group continues to reach out to diverse faith group leaders across Minnesota, including faith leaders providing services in Hmong, Vietnamese, Spanish, Karen, and Somali. They regularly share updates to various faith groups, including African American church leaders and the calls held by the MN Council of Churches, which includes leaders of many faiths. Some examples of collaboration include working with Karen faith leaders on messaging about gatherings, working with Islamic leaders to release Ramadan guidance, and creating PSAs for the African American community around Easter with Pastor Babington. Several faith networks and organizations have been funded by MDH in this COVID response and have participated in regular weekly calls to share information in a bi-directional way and create messaging, including the StairStep Foundation / His Works United, IANA, and Islamic Civic Society/Open Path Resources.

For details of some of the information provided to faith-based organizations, visit: https://www.health.state.mn.us/diseases/coronavirus/communities.html#comm

*2. **Community-Based Organizations** (CBOs). Community-based organizations have established track-records in the community and are often multi-service providers that integrate health, behavioral health, and social services. They are well-positioned to convey COVID-19 information. They often have diverse partnerships and collaborations with schools, higher education, housing authorities, local businesses, and hospitals. Some CBOs host local town hall sessions.*

***Recommendation**: 1) MDH to leverage their relationship with CBOs and tap into the audience on their social media platforms. MDH could be holding joint lives on Instagram and Facebook accounts so it is interactive and people can ask questions and engage. 2) MDH to create a locator to find CBOs serving communities most severely impacted by inequities.*

MDH Response: Our current contracts with CBOs encourages them to use the mechanisms that will best reach their communities. For many, this includes social media. We participate in virtual town halls whenever requested from community partners, and many of our contractors have conducted interviews with MDH staff – including Director of Infectious Diseases and Epidemiology Kris Ehresmann – and shared those live on the radio, on Facebook, or through other channels.

In just the first few months of work, 14 of our community based organization contractors reported that they created and disseminated/posted more than 250 unique online communications, and another 16 reported that they had more than 1 million hits on social media on their COVID-19 messages combined. Nine of our community-based organization contractors also reported that together they contributed to 20 radio or TV broadcasts related to COVID-19. Six of those contractors were able to estimate the radio or TV audience, with close to 400,000 views/listens. Again, these numbers reflect only the first half of their contractor work (and does not include our media contractors); as a portion of these contracts come to a close at the end of August 2020, we will have additional numbers to share in the fall.

Further, within our COVID response team, we have over 40 staff involved in outreach and engagement of communities most impacted by inequities, including:

- Asian American and Pacific Islander
- African American
- African Immigrant
- Latinx
- American Indian and Tribal
- Disability communities
- LGBTQIA
- Faith-based communities
- Rural communities
- Recently arrived refugees
- Higher education/childcare
- Migrant and seasonal workers
- Housing/high-rises

There are currently a few different ways to identify CBOs serving communities:

1) MDH COVID Community Outreach Contractors - https://www.health.state.mn.us/communities/equity/funding/covidcontracts.html
2) Disability Hub – https://disabilityhubmn.org/health/coronavirus-resources
3) Refugee-resettlement agency Hub - https://mn.gov/dhs/people-we-serve/adults/services/refugee-assistance/resettlement-programs-office-agency-contract-list/

3. **Identify Community-Accepted First Responders**. Due to fears of having children/family members taken out of the home, arrested, deported, and/or killed in some communities by law enforcement, some communities rely on faith leaders, neighbors, mental health professionals, and other community leaders to act as community first responders.

Recommendation: 1) MDH to identify these community determined first responders for disseminating critical information about COVID-19; 2) to develop a trauma-informed community first responders program and train free of cost; and 3) continue to build capacity within these communities.

MDH Response: This is very much outside of MDH's purview. We agree that having first responders that have been trained in trauma-based care is desirable.

Healthcare Workforce and Practice Efforts

*1. **Virtual and Telehealth Opportunities**. Community health centers, CBOs, and urgent care centers have ramped up the use of telephone and video visits, and insurance companies are expanding coverage for these visits. These changes have eliminated transportation barriers to accessing care. However, communities impacted by inequities may not have regular access to internet, making it harder to participate in telehealth.*

***Recommendation:** MDH to release RFP to help community health centers, CBOs, and urgent care centers address the digital divide.*

MDH Response:

In March, the Minnesota Legislature approved $200 million for health care grants to support costs related to planning for, preparing for, or responding to the COVID–19 outbreak. A $50 million COVID–19 Response Grant for Short Term Emergency Funding was available on an emergency basis to provide cash flow relief to health care organizations to cover their priority needs. This grant is now **closed**. View the COVID–19 Short Term Emergency Funding webpage for a list of organizations that received funding through this program.

The $150 million COVID–19 Health Care Response Grant was intended to cover longer-term costs related to planning for, preparing for, or responding to the COVID–19 outbreak. These funds were awarded through a Request for Proposal (RFP) process. This funding opportunity

also recently closed. MDH awarded grants to roughly 700 providers around the state through this program, ranging from large health systems to assisted living facilities and small community ambulance systems. A list of grantees from this program is available here: https://www.health.state.mn.us/facilities/ruralhealth/funding/grants/covidlong.html.

Some of the distributed funds were targeted to telehealth; it was an eligible expense under the grants, and a number of organizations requested funds to expand their telehealth capacity via new equipment or to conduct training on effective use of telehealth. We also have some data from the ORHPC workforce survey that over 50% of providers had used some form of telemedicine and around 90% of those expect to continue to use it going forward. There is also a broadband grant program that DEED is administering that will help promote telemedicine. The upcoming legislative session is an opportunity to keep the flexibility of telehealth services in place once COVID emergency authorization timelines expire.

> *2. **Support Services**. Community Health Workers (CHWs) & Bilingual navigators are critical for outreach, engagement, and linking communities most severely impacted by inequities to support services. CHWs know the community, are familiar with resources, and are able to communicate effectively with their clients. While visits are usually in person, they can be virtual during the pandemic.*
>
> ***Recommendation** MDH to create CHW program and train participants from CMI at no-cost.*

MDH Response: CHWs and Community Paramedics (CP) are valuable in reaching more isolated members of a community. ORHPC is exploring a training program for CPs. MDH's Refugee and International Health Program is exploring collaborations with CHWs and COVID response as well.

Racism-related Issues

> *The HEAL Council requests a public statement from MDH leadership naming racism as a public health crisis and present a plan for how MDH will address institutional racism internally and structural racism across the agency and throughout Minnesota, as well as a timeline for these efforts. HEAL requests MDH leadership to address the above concerns including a commitment to health and racial equity in a bold and transparent way.*

MDH Response: We appreciate HEAL raising this important issue. MDH agrees that institutional and structural racism is one of the greatest barriers to advancing health equity and must be addressed both within the agency and broadly across the state. Our 2014 Advancing Health Equity report boldly articulated this and very clearly laid out recommendations, which paved a foundation for our 2015-2019 strategic plan. Within the plan was a focus on changing the way we do business and addressing structural racism within the agency.

We have made significant strides to address this within the past decade. There are many accomplishments we are very proud of, such as requiring training on racial equity, institutional

racism and bias, embedding metrics within the agency assessing staff, manager and supervisor understanding of health and racial equity, creating the HEAL and I-HEALTH councils, requiring all policies, procedures and standards undergo health equity review, implementing health equity review of programs across the agency, and standing up an equity in grants work group which has implemented several initiatives to forefront equity in our grantmaking process. We know that this is only the beginning of the immense work ahead of us to achieve equity. We are committed to the long haul.

I appreciate and agree that a public declaration of racism as a public health crisis would be an effective public message, however, it is not within the authority of the Commissioner of Health to make this declaration. Such a declaration would need to come from the Governor. We understand the urgency of the matter and are working closely with the Governor's office to explore how this declaration could be made. Many of the recommendations HEAL has put forward under this category are items we are discussing with the Governor's office. Such a declaration will require swift action, collaboration and coordination beyond MDH, to include all sectors, and all levels of government from city, county, state and tribal.

> ***Lastly, HEAL recommends MDH to create a stronger Strategic Plan that explicitly weaves racial and health equity into all areas of growth, and proposes that the next Statewide Health Assessment focus on the impacts of institutional and structural racism on disease burden.***

MDH Response: As HEAL is aware, MDH was in the process of creating our new strategic plan before COVID. It is on hold as we respond to the pandemic. We are still committed to embedding racial and health equity throughout the plan in consultation with HEAL. To that end, I have charged a small team of MDH leaders to complete an action plan for the next 12 months that builds upon the foundational racial equity work MDH has done over the past decade and hones in on the immediate actions necessary to make our workplace a more diverse, equitable, and inclusive environment for all.

Regarding the next statewide health assessment, I am aware that Jeannette Raymond has been participating in HEAL meetings and is planning to present to HEAL about the upcoming statewide health assessment. We welcome recommendations and guidance on how to ensure the assessment centers the impacts of institutional and structural racism.

I would like to meet with HEAL and I-HEALTH to discuss the letter, my response, and identify opportunities to ensure the work of the agency and our response to COVID continue to center racial equity and that there is greater communication, transparency and accountability. I look forward to continuing to work closely with HEAL and I-HEALTH to address these concerns.

Sincerely,

Jan K. Malcolm
Commissioner