



U.S. Department of Health and Human Services
Office of the Secretary

PROGRESS REPORT TO CONGRESS

HHS Office of Minority Health

2020 Update on the Action Plan to
Reduce Racial and Ethnic Health Disparities

FY 2020



Acronyms

AIM	Alliance for Innovation on Maternal Health
ARHQ	Agency for Healthcare Research and Quality
CDC	Centers for Disease Control and Prevention
CHIP	Children’s Health Insurance Program
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare & Medicaid Services
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
HRSA	Health Resources and Services Administration
HHS	U.S. Department of Health and Human Services
IHS	Indian Health Service
MMRC	Maternal Mortality Review Committee
NIH	National Institutes of Health
OCR	Office for Civil Rights
OMH	HHS Office of Minority Health
RHC	Rural Health Clinic
SAMHSA	Substance Abuse and Mental Health Services Administration

Summary

Included in the Manager’s Agreement to H.R. 1865, which became Public Law 116-94, the Further Consolidated Appropriations Act, 2020, was a request for an update of the Action Plan to Reduce Racial and Ethnic Health Disparities (page 119):

Within 180 days of enactment of this Act, HHS shall submit to the Committees an update of the Action Plan to Reduce Racial and Ethnic Health Disparities. The update should include barriers to full implementation and proposed remedies. The report should include the extent that HHS programs collect, report, and analyze health disparities data based on race, ethnicity, disability, and other characteristics for the population HHS programs serve. The updated report shall include specific efforts to improve birth outcomes for African-American women and children, including how to address implicit bias in healthcare delivery and the health impacts of trauma associated with racism. (Page 119, Managers Agreement)

The following report is an update on the HHS Action Plan to Reduce Racial and Ethnic Health Disparities.

PROGRESS REPORT

Overview

In 2011, the U.S. Department of Health and Human Services (HHS) published the [Action Plan to Reduce Racial and Ethnic Health Disparities, \(Disparities Action Plan\)](#) to strategically align HHS efforts to reduce and eliminate disparities in health and health care. The five primary goals of the Action Plan are listed below.

- I. Transform Health Care**
- II. Strengthen the Nation’s Health and Human Services Infrastructure and Workforce**
- III. Advance the Health, Safety and Well-Being of the American People**
- IV. Advance Scientific Knowledge and Innovation**
- V. Increase the Efficiency, Transparency and Accountability of HHS Programs**

The Disparities Action Plan featured select HHS programs and milestones to reinforce an integrated, data-driven approach for addressing health disparities and improving the access, use and outcomes of HHS initiatives. In 2015, HHS provided a [progress report](#) on the Disparities Action Plan to provide illustrative examples of important work to reduce health disparities.

The goals for the Disparities Action Plan continue to be relevant as HHS increases the impact of policies and programs to reduce health disparities in the context of emerging policies and conditions. This progress report highlights the implementation of the Disparities Action Plan elements in FY 2019 and FY 2020, with particular attention to the following three HHS priority areas.

- A. The Opioid Crisis**
- B. Maternal and Infant Health**
- C. COVID-19 Response and Recovery**

A. The Opioid Crisis

The opioid crisis is a nationwide public health challenge, and opioid misuse and opioid overdose mortality continues to affect racial and ethnic minority populations. Data from the Substance Abuse and Mental Health Services Administration (SAMHSA) shows that non-Hispanic Native Hawaiians and other Pacific Islanders have the highest rates of opioid misuse among those aged 18 and over.¹ According to the Centers for Disease Control and Prevention (CDC), from 2017 to 2018, small decreases occurred in all overdose deaths and

¹ SAMHSA Center for Behavioral Health Statistics and Quality. (2019). 2018 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration, Rockville, MD. Table 1.60B, accessed from: <https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2018-NSDUH>

in deaths involving all opioids, prescription opioids, and heroin. However, deaths involving synthetic opioids continued to increase in 2018 and accounted for two-thirds of opioid-involved deaths. Data show that from 2017 to 2018, Hispanics experienced the largest relative increases (27%) in synthetic opioid-involved overdose deaths compared to other racial/ethnic groups.² Non-Hispanic Asians/Pacific Islanders experienced the second largest increase (25%).³ Non-Hispanic Whites experienced the lowest relative increase (5.9%).⁴ Despite growing opioid misuse and overdose mortality issues, treatment utilization remains lower among racial and ethnic minority populations. The CDC also noted that increases in deaths among racial and ethnic minorities indicates the need for culturally tailored interventions that address social determinants of health and structural-level factors.

B. Maternal and Infant Health

According to the CDC, the maternal mortality [rate](#) in the United States for 2018 was 17.4 maternal deaths per 100,000 live births. CDC [data](#) show that racial/ethnic disparities in pregnancy-related mortality⁵ and severe maternal morbidity are striking. During 2011-2016, the pregnancy-related mortality⁶ ratios were:

- 42.4 deaths per 100,000 live births for non-Hispanic Black women.
- 30.4 deaths per 100,000 live births for non-Hispanic American Indian/Alaska Native (AI/AN) women.
- 14.1 deaths per 100,000 live births for non-Hispanic Asian/Pacific Islander women.
- 13.0 deaths per 100,000 live births for non-Hispanic white women.
- 11.3 deaths per 100,000 live births for Hispanic women.

Severe maternal morbidity⁷ rates are higher among racial and ethnic minority women compared to non-Hispanic white women. In 2017, the rate of severe maternal morbidity was 93% higher among Black/African American women when compared to white women.⁸ This variability in

² <https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a4.htm>

³ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a4.htm>

⁴ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a4.htm>

⁵ According to the CDC, Maternal Mortality is defined as “the death of a woman while pregnant or within 42 days of termination of pregnancy,” but excludes those from accidental/incidental causes. Source:

https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2020/202001_MMR.htm

⁶ According to the CDC, a Pregnancy Related Death is defined as “A pregnancy-related death is defined as the death of a woman while pregnant or within 1 year of the end of a pregnancy –regardless of the outcome, duration or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.” Source: <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#how>

⁷ Severe Maternal Morbidity includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. SOURCE:

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html#anchor_how

⁸ Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), 41 States and the District of Columbia, 2017 (from all states with reliable race reporting data in 2017 except Minnesota, Montana, North Dakota, Nebraska, Utah, and West Virginia) www.hcup-

the risk of severe complications of pregnancy and pregnancy related deaths by race/ethnicity indicates that more can be done to understand and reduce pregnancy-related deaths.

In the last two years, HHS has given added priority to improving maternal health outcomes in the United States. In 2019, HHS established a department-wide workgroup to coordinate and enhance the Department's work in this area, including addressing racial and ethnic disparities in maternal mortality and severe morbidity.

C. COVID-19 Response and Recovery

Data suggests that racial and ethnic minority populations bear a disproportionate burden of illness and death from COVID-19. As of August 18, 2020, Black/African American individuals accounted for 19.8% of confirmed cases (with known race/ethnicity) despite making up 13.4% of the U.S. population. Hispanic individuals accounted for 31.1% of confirmed cases but represent 18.5% of the U.S. population.^{9, 10} Data from some states and localities have suggested higher rates of deaths for racial and ethnic minority individuals than for white individuals. Among AI/AN populations, the Navajo Nation (located in Arizona, Utah and New Mexico) and the White Mountain Apache Tribe (located in Arizona) has been particularly affected. The Navajo Nation individuals accounted for over four times more deaths compared to the state of Arizona's COVID-19 death rate (267 vs. 63 per 100,000 population).^{11, 12} The White Mountain Apache Tribe individuals accounted for close to four times more deaths compared to the state of Arizona's COVID-19 death rate (245 vs. 63 per 100,000 population).^{6, 13} Racial and ethnic minorities are at greater risk for exposure to and adverse outcomes from COVID-19 due to social determinants of health and living and working conditions. A greater prevalence of underlying health conditions also put racial and ethnic minorities at higher risk for severe illness and death from COVID-19. Persistent disparities in access to healthcare pose challenges for racial and ethnic minority populations receiving COVID-19 services.

The following are examples of HHS's implementation of the five HHS Disparities Action Plan elements in these three priority areas.

Action Plan Implementation Updates

I. Transform Health Care

Transforming health care includes expanding access to culturally and linguistically appropriate health care services.

[us.ahrq.gov/sidoverview.jsp](https://www.us.ahrq.gov/sidoverview.jsp)

⁹ <https://www.cdc.gov/covid-data-tracker/index.html#demographics>

¹⁰ <https://www.census.gov/quickfacts/fact/table/US/PST045219>

¹¹ <https://us-covid19-per-capita.net/deaths.htm>

¹² <https://www.ndoh.navajo-nsn.gov/COVID-19>

¹³ <https://www.facebook.com/White-Mountain-Apache-Tribe-Emergency-Operations-Center-103417867996160>

A. The Opioid Crisis

- Expanding Treatment and Recovery Services for Diverse Populations: In FY 2019 and 2020, the SAMHSA Office of Behavioral Health Equity and Justice Involved (OBHE) funded the National Network to Eliminate Disparities in Behavioral Health (NNED) to support the expansion of treatment and recovery services for diverse populations affected by the opioid crisis through training in evidence-based prevention strategies, convening expert panels on effective clinical engagement strategies and disseminating informational resources on mental health and substance use issues.
- Strengthening Access to Treatments for Substance Use Disorders and Serious Mental Illnesses: Ensuring consistent and ongoing treatment for substance use disorders and serious mental illness is important, particularly as the COVID-19 pandemic has added significant new stressors that may be felt more acutely by the physically and financially vulnerable. SAMHSA released \$110 million to state, local, and tribal governments to continue to expand access to appropriate treatments for preexisting mental health conditions or for challenges arising during the COVID-19 pandemic.

B. Maternal and Infant Health

- Supporting Maternal and Infant Healthcare Coverage and Accountability: The Centers for Medicare & Medicaid Services (CMS) administer both Medicaid and the Children's Health Insurance Program (CHIP). These programs cover health services for women and children in families that meet certain income eligibility criteria. Medicaid plays a key role in providing maternity-related services for pregnant women, paying for slightly less than half (43%) of all births nationally in 2018. States can also provide CHIP-financed services for pregnant women. Because 21.4% and 38.7% of Medicaid or CHIP enrollees aged 0-18 and 21.5% and 24.7% of Medicaid or CHIP enrollees aged 19-64 are Black/African American and Hispanic, respectively, Medicaid and CHIP programs are well placed to address racial disparities in maternal and infant health. Medicaid covered a greater share of births in rural areas and among minority women.

CMS produces the Medicaid and CHIP Scorecard, an effort to increase public transparency and accountability for outcomes, including prenatal and postpartum care. CMS recently updated the Scorecard, which includes a maternal health measure on postpartum care with results presented by state. In addition, to support CMS's maternal and perinatal health-focused efforts, CMS identified a core set of 11 measures for voluntary reporting by state Medicaid and CHIP agencies. This Core Set, which consists of seven measures from CMS's Child Core Set and four measures from the Adult Core Set, will be used by CMS to measure and evaluate progress toward improvement of maternal and perinatal health in Medicaid and CHIP.

- Expanding Maternal Safety and Quality Improvement Efforts: The Alliance for Innovation on Maternal Health (AIM Program) is a national data-driven maternal safety and quality improvement initiative that strives to equip every state, Perinatal Quality Collaborative

(PQC), hospital, birth facility, and maternity care provider with the ability to significantly reduce severe maternal morbidity and maternal mortality in the U.S. AIM is part of the central effort of the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau to prevent maternal mortality and severe maternal morbidity in the clinical setting. Through AIM, HRSA partners with community, state and national organizations to implement maternal safety bundles in birthing facilities throughout the states. HRSA awarded the first AIM implementation funding to the American College of Obstetricians and Gynecologists in 2014 and works closely with CDC's funded PQCs and the National Network of PQCs to develop and disseminate AIM bundles. As of April 2020, 33 states are enrolled in AIM and approximately 1,400 hospitals are participating in the implementation of maternal safety bundles. Of the bundles that partners may chose, one specifically addresses racial/ethnic health disparities. In FY 2020, HRSA is working to reach all 50 states, D.C., U.S. territories, and tribal communities. HRSA is now supporting the development and implementation of maternal safety bundles to address preventable maternal mortality and severe maternal morbidity outside of hospital and other birthing facility settings.

C. COVID-19 Response and Recovery

Making Testing More Accessible and Affordable

- [Expanding Testing at Federally Qualified Health Centers \(FQHCs\)](#): \$583 million was awarded to 1,385 HRSA-funded health centers, which are located in underserved communities and are often the main source of affordable and accessible healthcare, to expand COVID-19 testing. Over 22% of people served by health centers are Black/African American. [A large majority \(96%\) of FQHCs health centers are testing for COVID-19](#); these funds will support and expand that effort. In addition to the ongoing mandatory health center program funding, the Administration has invested a total of \$2 billion in community health centers to respond to COVID-19, ensuring that 28 million people living in medically underserved areas have access to the care and testing they need.
- [Getting Testing at Community-Based Retail Testing Sites](#): HHS supports a public-private partnership that established COVID-19 testing locations in certain CVS, Rite Aid, Walgreens, Walmart, Kroger, and Health Mart stores to accelerate testing for more Americans in communities across the country. The partnership continues to provide Americans with faster, less invasive and more convenient testing; protect healthcare personnel by eliminating direct contact with symptomatic individuals; and expand rapidly to areas that are under-tested and socially vulnerable.¹⁴ Approximately 70% of these sites are located in areas with high social vulnerability, as identified using the CDC Social Vulnerability Index.

¹⁴ Socially vulnerable groups refers to individuals, communities or populations that have characteristics that affect their capacity to anticipate, confront, repair, and recover from the effects of a disaster.

- Retail and Pharmacy Expansion: The pharmacy and retail partnership provides convenient access to COVID-19 testing, but it is also a bridge for retailers to implement new regulatory flexibilities and expanded reimbursement options HHS has provided through private insurance, Medicare, Medicaid, and the newly expanded authority given to pharmacists to order and administer COVID-19 testing. There are currently over 1960 sites (CVS and Walmart) that have taken advantage of these flexibilities.
 - State governments are developing partnerships with retail and pharmacy providers utilizing the best practices of the federal program and the new reimbursement mechanisms made possible by the federal government.

- Surge Testing: Surge testing efforts temporarily increase federal support to communities where there has been a recent and intense level of new cases and hospitalizations related to the ongoing outbreak. These sites will conduct up to 5,000 tests a day for a period of seven to 12 days with the intent to detect cases that would go undetected and could, in those middle size metropolitan areas, further help the states to flatten the curve.
 - Surge testing sites have been established in 8 states to date. To date over 208,000 tests have been conducted at these sites with positivity rates ranging from 6 to 15%.
 - Live sites - Surge testing is ongoing Birmingham, AL, Honolulu, HI, Baton Rouge/New Orleans, LA, Bakersfield, CA, Harris County/Houston, TX, Atlanta, GA, and Cococino Counties, AZ.
 - Closed sites - Surge testing has been completed in Edinburg, TX, Jacksonville, FL, Miami, FL, and Pima County/Yuma County/Phoenix, AZ.
 - 12% of individuals obtaining testing at the surge testing sites identified their ethnicity as Hispanic/Latino. 6.8% identified their race as Native Hawaiian or Other Pacific Islander and 5.2% identified their race as Black or African American.
 - There are three elements to the surge testing site operations: federal government support, federal contractor support, and state and local jurisdiction support.
 - The federal government provides personal protective equipment (surgical masks and gloves, cloth face coverings (five per person getting tested)), and community mitigation guidance (via CDC).
 - The federal contractor provides online registration, medical personnel (if requested by local jurisdiction), test kits (swabs, transport media, specimen bags), shipping containers, biohazard labels and mailing labels for shipping, the ordering physician for labs, specimen processing (turnaround time of 3-5 days), notification via email for individuals to log on to the contractor's portal to obtain results, and notification of lab results to the state and local health departments.
 - The state and local governments provide non-medical personnel, biohazard waste management, management of sites, storage of specimens (if operations extend after courier service arrives for daily pick-up), security/law enforcement/traffic control, durable non-medical equipment, such as tents, cones, tables, chairs,

sharpie markers, computers/iPads and Wi-Fi for onsite registration, blank vouchers or printers to print vouchers on site, printed educational and information materials, advertising and media relations.

- **Point of Care Testing:** HHS worked with eTrueNorth on a point-of-care testing pilot project in Broward County. The pilot provided rapid point-of-care tests from mobile units to high-risk communities in Broward County. The intent of the program is to go where people at high-risk for COVID-19 reside and test 2,000 (200 individuals per day) people and provide them with their results immediately using the Abbott ID Now rapid point-of-care testing platforms. Test results were provided to the individual within 15 minutes or less. The pilot was staffed by both local emergency management and public health staff and eTrueNorth medical personnel. This project ran for ten days from Thursday, August 13 through Saturday, August 22. 1617 individuals were tested. 54.7% of individuals tested at these sites identified their ethnicity as Hispanic/Latino and 21.5% of individuals tested identified their Race as Black or African American, <1% identified their race as Asian, and <1% identified their race as Native Hawaiian or Other Pacific Islander.
- **Helping States Protect Vulnerable Populations:** As of August 2020 CDC has awarded over \$872 million from the Coronavirus Preparedness and Response Supplemental Appropriations Act and then another \$631 million from the Coronavirus Aid, Relief, and Economic Security (CARES) Act to state and local jurisdictions to support contact tracing, surveillance and testing, all of which are fundamental to protecting vulnerable populations, particularly as communities take steps to reopen. CDC has awarded \$10.25 billion to states to increase testing in 64 state and local jurisdictions from the Paycheck Protection Program and Health Care Enhancement Act. In addition, CDC has awarded over \$206.4 million to tribal nations, consortia, and organizations for responding to COVID-19 across tribal communities.¹⁵

Making Treatment More Accessible and Affordable

- **Paying for Care of Uninsured Individuals:** HHS is using a portion of the Provider Relief Fund to pay for COVID-19-related care of uninsured Americans and using other funds provided to reimburse providers for conducting COVID-19 testing for the uninsured. Doctors, hospitals and other providers who have provided testing or treatment for uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020 can request claims reimbursement through the program and will be reimbursed generally at Medicare rates, subject to available funding.
- **Protecting Patients from Debt Collectors:** HHS also is protecting uninsured individuals coping with COVID-19 by requiring that the provider accept Provider Relief Fund payments for COVID-19 testing or treatment of an uninsured individual as payment in full. This guarantees that the uninsured will not have hospitals or other healthcare providers who receive funds from the Provider Relief Fund trying to collect for the care provided to support COVID-19 treatment and recovery.

¹⁵ <https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/funding-update.pdf>

- **Supporting Hospitals that Serve Low-Income Communities:** As elective procedures were canceled, the continued financial viability of some hospitals has been threatened, specifically those that were already operating on thin margins because they serve rural populations or care for a disproportionately high number of Medicaid, Medicare, and uninsured patients. The [Federal Office of Rural Health Policy in HRSA received \\$150 million to assist hospitals](#) funded through the Small Rural Hospital Improvement Program to support capacity building in small hospitals to help them provide services to fight COVID-19. Because of the importance of these rural communities, [HHS further allocated](#) over \$11 billion from the Provider Relief Fund to support rural providers. HHS also targeted an additional \$2 billion from the Provider Relief Fund to hospitals based on their Medicare and Medicaid disproportionate share and uncompensated care payments and who provided care for 100 or more COVID-19 patients through April 10, 2020.

Expanding Telehealth Options to Ensure Access to Needed Care

- **Expanding Access to Telehealth Services:** Vulnerable populations can face any number of challenges accessing healthcare, including transportation and time. Telehealth helps provide necessary healthcare while minimizing transmission risk of COVID-19 to patients and healthcare personnel. The federal government, particularly CMS, has taken steps to make accessing care while at home or work through telehealth easier during the COVID-19 pandemic. CMS is helping people enrolled in Medicare to receive medical care using telecommunications technology (e.g., synchronous discussion over a telephone or exchange of information through video or image). CMS also announced a waiver allowing a range of providers such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers to provide telehealth and other services using communications technology wherever the patient is located, including at home and outside of designated rural areas, even across state lines. The types of telehealth that can be offered can also be flexible. Typically, devices must be equipped with audio and video capability to provide telehealth services. Now, during the public health emergency, some audio-only encounters can be reimbursed as telehealth visits. Further, IHS expanded telehealth services across IHS federal facilities.
- **Expanding Rural Health Clinic (RHC) and FQHC Flexibilities:** RHCs and FQHCs are essential parts of the healthcare system, particularly as it relates to underserved communities and the uninsured. To expand upon flexibilities to increase access to care, CMS released information for RHCs and FQHCs on Telehealth and Virtual Communications Flexibilities during COVID-19. Using telehealth protects at-risk patients from potential exposure to COVID-19, allows for the provision of healthcare to manage both chronic and acute health issues, and also helps those who may have transportation challenges in getting to their provider.
- **Expanding Funding for Telehealth Programs:** A key strategy for increasing access to care for both routine medical needs and treatment for COVID-related symptoms is through telehealth. HHS, through HRSA, has awarded money through several different programs to expand

telehealth availability. First, HRSA [awarded \\$11.5 million](#) through Telehealth Resource Centers. HRSA also [awarded \\$20 million](#) to increase telehealth access and infrastructure for providers and families to help prevent and respond to COVID-19.

- Increasing Access to Telehealth for Medicaid Substance Use Disorder Services: On April 2, 2020, CMS released an [Informational Bulletin](#) to states that identifies opportunities for telehealth delivery methods to increase access to Medicaid services for substance use disorder.

II. Strengthen the Nation's Health and Human Services Infrastructure and Workforce

Strengthening the nation's health and human services workforce includes incorporating cultural and linguistic knowledge in the health care and social services delivery system.

A. The Opioid Crisis

- Improving Cultural and Linguistic Competence Among Behavioral Health Providers: In FY 2019 and FY 2020, HHS created the e-learning program, *Improving Cultural Competency for Behavioral Health Professionals*. The free and accredited e-learning program is available via the HHS Office of Minority Health (OMH) [Think Cultural Health](#) website and helps to develop behavioral health providers' knowledge and skills related to culturally and linguistically appropriate services. The program was designed for certified counselors, nurses, psychiatrists, psychologists and social workers and is valuable for professionals working to address the opioid epidemic among racial and ethnic minority populations, which have low treatment rates and some of the highest rates of opioid misuse and overdose. In FY 2019 and FY 2020, more than 13,000 professionals completed at least one course in the program and 7,700 completed the entire program.

B. Maternal and Infant Health

- Improving Maternal Healthcare Quality Through Provider Cultural Competency Training: The OMH Think Cultural Health website offers free, accredited continuing education e-learning programs to provide training for health professionals and organizations in delivering culturally and linguistically appropriate care, which can be applied daily to better serve their clients. OMH expects completion of a maternal health program by FY 2021. The maternal health program focuses on culturally and linguistically appropriate care as a strategy for improving care quality and addressing disparities, to which factors like implicit bias, racism or discrimination may contribute. The curriculum includes content on implicit bias, trauma and patient-centered care. Current e-learning programs are tailored for disaster and emergency management personnel, nurses, oral health professionals, physicians, and behavioral health providers. In FY 2019 and FY 2020, more than 123,000 health professionals and students enrolled in the courses, earning an estimated 532,287 continuing education credits toward their licensure renewal requirements.

C. COVID-19 Response and Recovery

Tailored Guidance for Individuals & Communities At Increased Risk

- Strengthening the Infrastructure for Disseminating Culturally and Linguistically Diverse Public Health Information: In 2020, HHS launched the [National Infrastructure for Mitigating the Impact of COVID-19 within Racial and Ethnic Minority Communities Initiative](#). The \$40 million initiative will help OMH establish a network of national, state, territorial, tribal and local public and community-based organizations. This network will deliver vital culturally and linguistically diverse information on COVID-19 testing and vaccination, and other healthcare and social services to racial and ethnic minority, rural and socially vulnerable communities, including those hardest hit by the pandemic. In addition, the award will support linkages to COVID-19 testing, vaccination, other healthcare services and social services in communities highly impacted by or at greater risk for COVID-19. The network will be active in all states and territories, and the initiative will be enhanced by a multi-media campaign in the geographic areas highly-impacted by COVID-19 and with a heightened risk for adverse outcomes.
- CDC COVID-19 Health Equity Strategy: CDC is implementing four strategic priorities to reduce the disproportionate burden of COVID-19 among populations at increased risk for infection, severe illness, and death. These strategies aim to broadly address health disparities and inequities related to COVID-19 with a holistic, all-of-response approach. To reach populations that have been put at increased risk, Priority Strategy 2 seeks to expand programs and practices for testing, contact tracing, isolation, healthcare, and recovery from the impact of unintended, negative consequences of mitigation strategies. This will be accomplished, in part, by building community capacity to reach disproportionately impacted populations with effective culturally and linguistically tailored programs and practices in place-based settings.
- Offering Guidance for People at Increased Risk: Through data collected by doctors and epidemiologists across the country, we know that people with underlying health conditions, as well as older adults and others, are at elevated risk for complications from COVID-19. CDC has published information for people who need to take extra precautions. Conditions like diabetes, hypertension, cancer, and other chronic health conditions that are prevalent at higher rates in some minority communities can [elevate the risk for complications due to COVID-19](#). The published information offers guidance on how those at highest risk can protect themselves. It also offers important information about reducing the risk of severe illness from COVID-19 infection.
- Advancing Diversity in Clinical Trials: During the COVID-19 pandemic, the Food and Drug Administration (FDA) Office of Minority Health and Health Equity (OMHHE) continues to support efforts to advance racial and ethnic minority representation in clinical trials. FDA OMHHE has increased amplification of clinical trial diversity messages, and provided tailored FDA COVID-19 communications to members of racial and ethnic minority groups. They also held a listening session with diverse stakeholders to learn more about the gaps and needs of racial and ethnic minority communities and to share information on FDA's COVID-

19 activities. FDA OMMHE has increased outreach by disseminating COVID-19 health education materials for consumers in multiple languages. The agency's official COVID-19 webpage has been translated into Spanish and includes a page for FDA's COVID-19 Frequently Asked Questions (available in English and Spanish). FDA has also created a COVID-19 Multilingual Resources webpage that features a growing collection of educational materials in Spanish, Simplified Chinese, Korean, Vietnamese, Tagalog, among other languages. To further enhance outreach and dissemination, FDA launched a COVID-19 Bilingual (English/Spanish) Social Media Toolkit that features consumer friendly messages and culturally appropriate graphics.

- [Enforcing Civil Rights Laws During the COVID-19 National Public Health Emergency](#): In March 2020, the HHS Office for Civil Rights (OCR) issued a bulletin to ensure that entities covered by civil rights authorities, including Section 1557 of the Affordable Care Act, are aware that their obligations under laws and regulations that prohibit discrimination on the basis of race, color, national origin, disability, age, sex, religion and exercise of conscience in HHS funded programs are not suspended in the provision of health care services during COVID-19.
- [Ensuring Access to Language Assistance Services During the COVID-19 National Public Health Emergency](#): In May 2020, OCR issued a bulletin to covered health entities to ensure they continue to serve individuals with limited English proficiency (LEP) during the COVID-19 emergency. Under regulations implementing Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act, recipients, including hospitals and other health care providers, must take reasonable steps to provide meaningful access to individuals with LEP in their health programs and activities. The requirement to take reasonable steps to provide meaningful access to LEP persons is enforced by OCR through the procedures identified in the Title VI implementing regulations. These procedures include complaint investigations, compliance reviews, efforts to secure voluntary compliance, and technical assistance. Individuals or organizations may file a complaint via the [OCR Complaint Portal](#), for which language assistance is provided.
- [Connecting Community-Based Organizations Through the National Network to Eliminate Disparities \(NNED\) in Behavioral Health](#): SAMHSA continues to operate the NNED, which is a network of over 1,100 community-based organizations across the country serving primarily underserved racial and ethnic minority populations. The NNED provides training and informational resources, and during the COVID pandemic has accelerated informational materials, including information on CARES Act provisions, to these communities. It has hosted virtual webinars and roundtables focusing on strategies to address mental health and substance use issues exacerbated by the pandemic in minority communities.

III. Advance the Health, Safety and Well-Being of The American People

Advancing health, safety and well-being includes promoting public health measures that support health.

A. The Opioid Crisis

- Addressing Opioid-Related Disparities in Disproportionately Impacted Communities: In 2019 and 2020, OMH continued to fund 12 projects focused on communities disproportionately impacted by the opioid crisis through the Empowered Communities for a Healthier Nation Initiative. The Initiative aims to reduce significant health disparities impacting racial and ethnic minorities and/or disadvantaged populations through demonstrating the effectiveness of implementing evidence-based strategies. Project activities included community-level strategies to prevent opioid abuse and increase access to treatment and recovery services and overdose reversal capacity, such as training and education of providers, pharmacists, and the public about opioid overdose prevention and reversal using naloxone; training of primary care providers in screening and diagnosis of opioid misuse and engagement in treatment, including MAT; supporting partnerships across multiple sectors; and reaching people who inject drugs and addressing infectious disease transmission.

B. Maternal and Infant Health

- Serving Pregnant and Postpartum Women with Opioid Use Disorder (OUD): In April 2019, the CMS Innovation Center announced the Maternal Opioid Misuse model. It is designed to address fragmentation in the care of participating pregnant and postpartum Medicaid and CHIP beneficiaries with OUD through state-driven transformation of the delivery system surrounding this vulnerable population. The primary goals of the model are to: (1) improve quality of care for pregnant and postpartum women with OUD as well as their infants; (2) expand access service delivery capacity and infrastructure based on state-specific needs; and (3) create sustainable coverage and payment strategies that support ongoing coordination and integration of care and reduce costs. The model requires that women with OUD receive a comprehensive set of services such as maternity care, medication-assisted treatment, and mental health screening and treatment delivered in a coordinated and integrated approach by a team of health care professionals who work in different specialties.
- Addressing Behavioral Health Issues Among Pregnant and Postpartum Women: HRSA's Screening and Treatment for Maternal Depression and Related Behavioral Disorders program, authorized by the 21st Century Cures Act, supports states to integrate behavioral health in primary care through programs that expand health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for maternal depression and related behavioral disorders, such as anxiety and substance use disorder, especially in rural and medically underserved areas. Specifically, the program helps offer real-time psychiatric consultation, care coordination support, and training to front-line providers to improve the mental health of pregnant and postpartum women and, thereby, their infants' social and emotional development.
- Improving Access to Fetal Alcohol Spectrum Disorder (FASD) Screening and Treatment: HRSA announced in April 2020 a new funding opportunity for up to \$1 million per year for

up to three years to implement the Supporting Fetal Alcohol Spectrum Disorders Screening and Intervention program. The program is intended to reduce alcohol use among pregnant women, and to improve developmental outcomes for children and adolescents with a suspected or diagnosed FASD in parts of the country that have high rates of binge drinking among pregnant women. The specific goals of the program are to improve the ability of primary care providers (1) serving pregnant women to screen their patient population for alcohol use, provide brief intervention, and refer high-risk pregnant women to specialty care and (2) serving children and adolescents to screen their patient population for prenatal alcohol exposure among those suspected of FASD, and manage and provide referrals to necessary services.

C. COVID-19 Response and Recovery

- Sharing Critical Public Health Information: In FY 2019 and 2020, HHS has supported the national response to the COVID-19 pandemic by amplifying vital information and CDC-recommended public health measures to help slow the spread of the disease. The CDC has also published the [Health Equity Considerations and Racial & Ethnic Minority Groups](#) COVID-19. OMH helped to amplify CDC resources in four languages (Spanish, Chinese, Vietnamese and Korean) by making links to the resources available on its homepage and promoting the materials via its communications platforms, including its newsletters. OMH also provided translation of COVID-19 materials into the Pacific Island languages of Tongan and Chuukese.

IV. Advance Scientific Knowledge and Innovation

Advancing scientific knowledge and innovation includes the collection of race and ethnicity data.

A. The Opioid Crisis

- Collecting and Reporting Opioid-Related Data by Race and Ethnicity: In FY 2019 and 2020, HHS sponsored a number national-level surveys and data collection systems to monitor the opioid epidemic and track the health of populations across a range of demographic characteristics, including racial and ethnic minorities. The Agency for Healthcare Research and Quality (AHRQ), CDC and CMS provide online data portals to allow interactive access to their data, including [dashboards on drug poisoning mortality](#) (CDC), [opioid-related hospital use data](#) (AHRQ), and [Medicare Part D opioids prescriptions](#) (CMS). CDC provides a data portal, [WONDER](#), for epidemiologic research with a wide array of public health information, including detailed mortality, compressed mortality, multiple cause of death, and infant deaths. SAMHSA uses data collected through the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and [National Mental Health Services Survey](#) (N-MHSS) to update its Behavioral Health Treatment Locator, an online tool for persons seeking treatment facilities in the United States or U.S. Territories for substance abuse/addiction and/or mental health problems.

Recent HHS publications on opioids and minority populations include the following.

- SAMHSA published *The Opioid Crisis and the Black/African American Population: An Urgent Issue* in April 2020. This issue [brief](#) provides recent data on prevalence of opioid misuse and opioid overdose death rates in the Black/African American population in the U.S; discusses contextual factors that impact the opioid epidemic in these communities, including challenges to accessing early intervention and treatment; highlights innovative outreach and engagement strategies that have the potential to connect individuals with evidence-based prevention, treatment, and recovery; and emphasizes the importance of ongoing community voice and leadership in the development and implementation of solutions to this public health crisis.
- SAMHSA published *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue* in July 2020. This issue brief provides an overview of the contextual factors influencing opioid misuse and opioid use disorder in Hispanic/Latino communities, highlights outreach and engagement strategies for prevention, treatment, and recovery interventions, and illustrates the importance of ongoing community voice and leadership in addressing the opioid crisis.
- The CDC Morbidity and Mortality Weekly Report (MMWR) published *Racial/Ethnic and Age Group Differences in Opioid and Synthetic Opioid-Involved Overdose Deaths Among Adults Aged ≥18 Years in Metropolitan Areas – United States, 2015-2017* in November 2019. This [report](#) examines the variation in synthetic opioid involvement in these deaths among racial/ethnic age groups across different metropolitan areas. The findings underscore the changing demographics and populations affected by the opioid overdose epidemic likely driven by the proliferation of illicitly manufactured fentanyl or fentanyl analogs. The March 2020 MMWR [report](#) highlights decreases from 2018 to 2017 in overdose death rates involving all opioids (2% decline), prescription opioids (14% decline), and heroin (4% decline); rates involving synthetic opioids increased 10%.

B. Maternal and Infant Health

- Improving Maternal Mortality Data Collection and Surveillance: State and local Maternal Mortality Review Committees (MMRCs) have the potential to get the most detailed, complete data on maternal mortality necessary for developing effective recommendations for prevention. Review Committees have access to multiple sources of information that provide a deeper understanding of the circumstances surrounding a death. In FY 2019, CDC made 24 awards, supporting 25 states for the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program. This funding directly supports agencies and organizations that coordinate and manage Maternal Mortality Review Committees to identify, review, and characterize maternal deaths; and identify prevention opportunities. To help facilitate standardization of data collection across states, CDC developed and maintains the Maternal Mortality Review Information Application (MMRIA), which is available to all MMRCs. MMRIA facilitates MMRC prevention recommendations that often include strategies to address social determinants of health, such as prioritizing pregnant and postpartum women for temporary housing programs; strengthening or building systems to

link persons to affordable transportation, or provide transportation vouchers to medical appointments; and ensuring access to interpreter services when needed. CDC has also incorporated into MMRIA the ability to capture information on discrimination, interpersonal and structural racism when identified as factors in pregnancy-related deaths.

- Supporting Research on Racial Disparities in Maternal Mortality and Morbidity: In April 2020, the National Institutes of Health (NIH) released a funding opportunity announcement (FOA), “Addressing Racial Disparities in Maternal Mortality and Morbidity.” It is sponsored jointly by the National Institute on Minority Health and Health Disparities, the National Heart, Lung, and Blood Institute, the National Institute of Nursing Research, and the NIH Office of the Director. This FOA will support original, innovative, multidisciplinary research aimed at advancing the understanding, prevention, and reduction of maternal mortality or morbidity among racial and ethnic minority women and socioeconomically disadvantaged women including those in rural settings. As stated in the FOA, research projects can focus on any point across the continuum of care, from preconception care to postpartum care up to 1 year after labor or delivery. Research projects are expected to provide a theoretical framework that addresses the intersection of domains of influence (biological, behavioral, physical, sociocultural, psychosocial, and health care system) and levels of influence (individual, interpersonal, community, and societal). Examples of individual-level factors include pre-pregnancy obesity, maternal hypertension, gestational weight gain, peripartum obesity, pre-eclampsia, pre-diabetes, and gestational diabetes on maternal post-partum health outcomes in women from racial and/or ethnic populations. Other examples at higher levels of influence include, but are not limited to, patient-clinician communication; clinician implicit and explicit bias, availability or accessibility of healthcare; healthcare insurance and reimbursement policies; structural factors in the healthcare settings; availability of social services; social, family, and peer support; interpersonal, community, or societal-level discrimination or violence exposure; the local food environment; and the physical and chemical environment in the home, workplace, and community.
- The HHS Office of Minority Health website hosts the [Compendium of Federal Datasets Addressing Health Disparities](#). The Compendium of Federal Datasets Addressing Health Disparities is a free resource of publicly available data relevant to research and programs aiming to reduce health disparities by exploring the relationship between socioeconomic factors and the social determinants of health. The Compendium, an initiative of the Interdepartmental Health Equity Collaborative (IHEC), includes data and data-related resources from various federal agencies within the U.S. Department of Health and Human Services (HHS). The Compendium provides information on federal resources related to the Opioid Crisis and Maternal Health.
- Understanding the Impact of Substance Use during Pregnancy on Maternal and Infant Health: CDC works to address the impact of substance use during pregnancy by collecting data that drive public health action to support the health of pregnant women and their children. CDC assesses trends in alcohol and polysubstance use in pregnancy, conducts

surveillance of neonatal abstinence syndrome (NAS), and monitors healthcare provider behaviors related to alcohol screening and brief intervention (SBI). Through funding from an interagency agreement with the HHS Assistant Secretary for Planning and Evaluation's Patient-Centered Outcomes Research Trust Fund, CDC also recently established MAT-LINK. This system will monitor maternal, infant, and child health outcomes associated with treatment of opioid and substance use disorder during pregnancy. Through each of these activities, data on race and ethnicity are collected and help identify potential disparities and provide information to help address the impact of substance use during pregnancy so that pregnant women and their babies can thrive.

- Providing Critical Data on Emerging Threats to Mothers and their Babies: Pregnant women and babies are uniquely vulnerable to infectious disease outbreaks, harmful substances, natural disasters, and environmental hazards. Rapid data collection among these populations is essential to inform public health action. CDC's Surveillance for Emerging Threats to Mothers and Babies was established in 2019 and adapts the mother-baby linked surveillance approach from the Zika outbreak to detect the impact of other known and emerging health threats during pregnancy, like hepatitis C, syphilis, and COVID-19. Data on race and ethnicity are collected and help identify potential disparities and inform the medical care of pregnant women and babies affected by these emerging infectious diseases.

C. COVID-19 Response and Recovery

- Improving COVID-19 Data Collection and Reporting by Race/Ethnicity: The collection and reporting of race and ethnicity data is essential to address targeted needs of racial and ethnic communities impacted by COVID-19. In addition, reliable and timely data to identify the populations that are most vulnerable to COVID-19 or any infectious disease is critical. As of August 11, 2020, CDC has received a total of 3,822,986 case reports. Among these case reports, 60% contain race data, 50% contain ethnicity data, and 48% contain race and ethnicity data. Overall, from April 2 to August 11, there was an improvement in completeness of race and ethnicity in the case reports, from 21% to 60% for race and from 18% to 50% for ethnicity. Additionally, on June 4, 2020, HHS issued new guidance under the CARES Act that specifies laboratories must report additional demographic data, including patient race and ethnicity, to state and local health departments for all COVID-19 test results beginning in August 2020. Under this new guidance, we expect to gain critical information about people who test positive for COVID-19, including data on race and ethnicity. In addition, CDC reports and advises on the disproportionate impact of COVID-19 among racial and ethnic minority groups in the following ways.
 - Social Vulnerability Index: The CDC constructs and maintains the [Social Vulnerability Index \(SVI\)](#), which uses U.S. Census variables that reflect at-risk populations to identify and map vulnerable areas. The SVI also provides prepared maps that show geographic patterns of potential vulnerability of local areas, arranged by four themes: socioeconomic status; household composition and disability; minority status and language; and housing and transportation. OMH has been working with the Geospatial Research, Analysis, and

Services Program (GRASP) team at CDC to develop a COVID-19-specific SVI that will add more granular race/ethnicity categories, English language proficiency and languages spoken, internet access, and some measures of medical vulnerability such as chronic health conditions, hospital beds, ICUs, and ventilator availability.

- COVID-NET: The CDC maintains the Coronavirus-Associated Hospitalization Surveillance Network ([COVID-NET](#)), which is a population-based surveillance system that collects data on laboratory-confirmed COVID-19-associated hospitalizations among children and adults through a network of over 250 acute-care hospitals in 14 states. COVID-NET is CDC's source of important data on hospitalization rates associated with COVID-19. COVID-NET also provides important clinical information on COVID-19-associated hospitalizations, including age group, sex, race/ethnicity and underlying health conditions. COVID-NET covers approximately 10% of the U.S. population. The counties covered are located in all 10 HHS regions.
- NCHS death certificate reporting: The CDC National Center for Health Statistics (NCHS) uses incoming data from death certificates to produce provisional COVID-19 death [counts](#) that occur within the 50 states and the District of Columbia. While death certificates are the best source of mortality data since they are reviewed by medical examiners, it takes some time to be processed, coded, tabulated, and reported through the National Vital Statistics System. NCHS also provides summaries that examine deaths in specific categories and in greater geographic detail, such as deaths by county, by race and Hispanic origin.
- Morbidity and Mortality Weekly Report (MMWR): CDC has published several MMWRs reporting COVID-19 data by race/ethnicity, including county-level incidence disparities, cases among AI/ANs, differences in mortality, and hospitalizations.

V. Increase the efficiency, transparency and accountability of HHS programs

To ensure that programs and policies are efficient, transparent, and accountable, HHS has established systems to support information sharing across agencies and minimize duplication of efforts. HHS also has implemented processes to track, assess, and report on the impact of programmatic and policy efforts to address health disparities. These processes include tracking existing performance measures and other government data on health system indicators and making them available to the public.

[Healthy People](#) provides a strategic framework for a national prevention agenda that communicates a vision for improving health and achieving health equity; identifies science-based, measurable objectives with targets to be achieved by the end of the decade; requires tracking of data-driven outcomes to monitor progress and to motivate, guide, and focus action; and offers a model for program planning at the international, state, and local level. For three decades, Healthy People has established benchmarks and monitored progress over time to:

- Encourage collaborations across communities and sectors;
- Empower individuals toward making informed health decisions; and
- Measure the impact of prevention activities.

HHS provides data to track progress on the Healthy People 2020 goals and objectives, which include objectives related to maternal and infant health and substance use. OMH, the Office of Disease Prevention and Health Promotion and NCHS also developed a tool that shows health disparities information for measurable, population-based objectives where data are available. The framework, goals and objectives for Healthy People 2030 have been released.

The HHS [2018-2022 Strategic Plan](#) outlines Departmental goals and objectives, which are aligned with performance measures. HHS publishes an annual performance plan and report to provide information on HHS's progress toward achieving the Strategic Plan goals and objectives. Performance measure information is also provided on [Performance.gov](#), including information on the HHS agency priority goal on reducing opioid morbidity and mortality.

Addressing Barriers to Reducing Racial and Ethnic Health Disparities

The Opioid Crisis

A number of challenges act as barriers to reducing racial and ethnic disparities in opioid misuse, overdose-related mortality, and treatment including stigma related to substance issues and treatment, lack of access to affordable services, lack of availability of culturally and linguistically appropriate services and culturally competent providers, lack of knowledge about medication-assisted treatment (MAT), bias and discrimination in treatment delivery, and criminalization of substance misuse. HHS has worked to address these barriers by supporting efforts to increase awareness and education about opioid-related risks, MAT and overdose prevention; to increase workforce capacity to improve access to MAT by providing training and certification guidance; to increase treatment capacity through funding to behavioral health agencies and integrated care settings; to improve cultural competency among behavioral health professionals through training; and to improve coverage of substance use disorder treatment services through Medicaid and Medicare.

Maternal and Infant Health

Barriers to reducing racial and ethnic health disparities in maternal and infant health outcomes include the multi-factorial etiology of such disparities, including the social determinants of health, such as socioeconomic factors, access to cultural and linguistically appropriate care, disrespectful treatment, housing, transportation, and education; as well as discrimination and institutional racism and access and quality of care. Although the factors that contribute to these disparities cannot be entirely addressed by the federal government, the HHS agencies/offices are working together to develop strategies to transcend these barriers and make America one of the safest nations for any woman to give birth.

COVID-19 Response and Recovery

Barriers to reducing COVID-19 disparities among racial and ethnic minority individuals are associated with a number of potential contributing factors, including lack of knowledge about COVID-19, lack of availability of healthcare services in the community, inability to pay for services, and lack of culturally and linguistically appropriate services (including language access services and culturally competent and/or bilingual providers). A recent study found that persons living in communities with higher proportion of racial and ethnic minority population were more likely to have more than 20 minutes travel time to a COVID-19 testing site.¹⁶ The difference in travel time may limit access to and utilization of testing services for those who have limited access to transportation and those who live in areas with fewer public transit services and schedules. Other factors that may affect access to and utilization of testing services include lack of healthcare insurance, concern about the costs or co-pays, occupational factors such as not being able to take time off of work, lack of paid leave, and distrust of the government and healthcare systems.^{17,18,19,20} Strategies to address barriers to reducing disparities include improving the development and dissemination of culturally and linguistically appropriate messaging and information about COVID-19 testing and healthcare services; working with community partners to support outreach, education and linkages to services; using data to identify socially vulnerable/high-need areas in which to place COVID-19 testing sites; continuing to increase the capacity of IHS facilities and health centers to provide COVID-19 testing and healthcare services; disseminating CMS information about Medicare and Medicaid coverage of COVID-19 testing and services; and promoting cultural competency training and workforce diversity programs. Addressing these barriers are important for the COVID-19 response and to address disparities more broadly.

Conclusions

The U.S. Department of Health and Human Services will continue to lead the implementation of strategic policies and programs with the goals of improving health and reducing health disparities for racial and ethnic minority populations. Unfortunately, the impacts of COVID-19 have likely exacerbated many of the factors that are associated with health disparities. However, the current challenging circumstances have galvanized HHS' steadfast commitment to address disparities in access to and quality of care, strengthen cultural and linguistic knowledge in health care systems, promote public health measures that support health, and advance data collection

¹⁶ Rader B, Astley CM, Therese K, et al. Geographic access to United States SARS-CoV-2 testing sites highlights healthcare disparities and may bias transmission. *Journal of Travel Medicine*. 2020. <https://doi.org/10.1093/jtm/taaa076>

¹⁷ Berchick, Edward R., Jessica C. Barnett, and Rachel D. Upton Current Population Reports, P60-267(RV), Health Insurance Coverage in the United States: 2018, U.S. Government Printing Office, Washington, DC, 2019.

¹⁸ Institute of Medicine (US) Committee on the Consequences of Uninsurance. *Care Without Coverage: Too Little, Too Late*. Washington (DC): National Academies Press (US); 2002. DOI: <https://doi.org/10.17226/10367>external icon.

¹⁹ Economic Policy Institute. Black workers face two of the most lethal preexisting conditions for coronavirus—racism and economic inequality [online]. 2020 [cited 2020 Jun 28]. Available from URL: <https://www.epi.org/publication/black-workers-covid/>external icon

²⁰ Institute of Medicine. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press. DOI: <https://doi.org/10.17226/10260>external icon.

and research consistent with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities.