HHS Initiatives to Address the Disparate Impact of COVID-19 on African Americans and Other Racial and Ethnic Minorities

PRESIDENT TRUMP IS COMMITTED to equipping racial, ethnic, and underserved communities with the healthcare resources needed to combat the COVID-19 pandemic. The information below outlines some of the immediate steps underway to improve prevention, testing, and treatment of COVID-19 in minority populations and reduce racial and ethnic disparities.

The Administration recognizes that effectively addressing the underlying issue of overall poorer health status in some racial, ethnic, and other underserved communities requires both short- and long-term strategies. Broader initiatives that address both economic opportunity and healthcare disparities are critical and the Administration has multiple such initiatives underway, including the creation of Opportunity Zones, the White House Council on Eliminating Barriers to Affordable Housing, and HHS's targeted efforts on chronic underlying health conditions such as diabetes, hypertension, maternal morbidity, and tobacco use, all of which are more prevalent among some minorities. This fact sheet is focused on the immediate steps the U.S. Department of Health and Human Services (HHS) has taken to address the disparate impact of COVID-19 on African Americans and other racial and ethnic minorities.

Improving our Understanding of COVID-19's Impact on Minorities

Reliable and timely data is critical to identify the populations most vulnerable to COVID-19 or any other infectious disease. Currently, however, only a small proportion of data reported to the Centers for Disease Control and Prevention (CDC) includes information on a patient's race or ethnicity. Efforts are ongoing to improve completeness of reporting from public health departments and laboratories, such as developing modernized systems to enable complete and timely reporting that will be used for COVID-19 but will be adaptable to any specific health issue in the future. The CDC continues to collaborate with hospitals, academic institutions and state, local, territorial, and tribal public health partners to gather and report more racial/ethnic data. These collaborations will allow CDC to get more complete data on race/ethnicity, reflected in preliminary data and can inform and improve clinical management of patients, allocation of resources, and targeted public health information.

CDC Is Strengthening Data Collection and Reporting on Racial and Ethnic Minority Populations: The CDC is publishing and updating daily available race/ethnicity data received through case-based reporting from public health departments on the CDC website. HHS has standardized reporting to ensure that public health officials have access to comprehensive and nearly real-time data to inform decision making in their response to COVID-19. Laboratory testing data, in conjunction with case reports and other data, also provide vital guidance for mitigation and control activities and is a critical piece to better understanding the impact on socially vulnerable populations.

CDC's COVID-NET Is Publishing Data on Hospitalizations by Race and Ethnicity: The COVID-NET surveillance system collects data from a network of over 250 acute-care hospitals in 14 states and publishes COVID-19-associated hospitalization rates on a weekly basis. Data are also displayed by age, gender, and underlying condition. From March 1 to May 16, 2020, 82 percent (18,136) of laboratory-confirmed COVID-19-associated hospitalizations reported to COVID-NET included data on race/ethnicity.

CDC Shows Higher Hospitalization of African Americans for COVID-19: In March 2020, the CDC outlined characteristics and clinical outcomes of hospitalized COVID-19 patients in Georgia, documenting that African American patients were overrepresented in hospital admissions relative to other racial groups.

CDC Is Using Surveillance and Epidemiology to Assess Risk Factors: CDC is complementing its work to gather more real-time demographic data by using surveillance networks and epidemiologic investigations to better understand risk factors for severe COVID-19 disease. These surveillance networks and investigations will allow CDC to gather and analyze data over time to build an evidence base about COVID-19 and how demographics like race/ethnicity, age, sex, occupation and others may increase a person's risk.

CDC Is using Electronic Health Records: CDC is actively working with multiple vendors and aggregators of electronic health records data (EHR). EHR data are a rich, timely source of detailed clinical and demographic data that can provide insight into COVID-19 and its impact on our communities and families. Further, these data can help us understand and address the impact of COVID-19 on minority and vulnerable communities.

Making Testing More Accessible and Affordable

Expanding Testing at Federally Qualified Health Centers (FQHCs): In May, $583 million was awarded to 1,385 FQHCs, many of which are located in medically underserved communities and are often the main source of affordable and accessible healthcare in those communities. Over 22 percent of people served by FQHCs are African American.

A large majority (91 percent) of FQHCs are testing for COVID-19: these funds will support and expand that effort. In addition to the ongoing health center program funding, the Administration has invested a total of $2 billion in community health centers to respond to COVID-19, ensuring that the 28 million served by FQHCs in a given year have access to the care and testing they need.

Getting Testing at Community-Based Retail Testing Sites: HHS supports public-private partnerships that established COVID-19 testing locations by CVS, Rite Aid, Walgreens, Walmart, Kroger, and Health Mart to accelerate testing for more Americans in communities across the country. The partnerships provide Americans with faster, less invasive, and more convenient testing; protect healthcare personnel by eliminating direct contact with symptomatic individuals; and have expanded rapidly to areas that are under-tested and at highest risk of COVID-19. Approximately 70 percent of these sites are located in areas with high social vulnerability, according to the CDC.

Helping States Protect Vulnerable Populations: The CDC awarded $186 million from the Coronavirus Preparedness and Response Supplemental Appropriations Act and an additional $631 million from the CARES Act to state and local jurisdictions to support contact tracing, public health surveillance, and testing, all of which are fundamental to protecting vulnerable populations, particularly as communities take steps to reopen. In addition, from the funds appropriated by the Paycheck Protection Program and Health Care Enhancement Act, the CDC has awarded $10.25 billion to states to increase testing in 64 state and local jurisdictions, and the Indian Health Service (IHS) will be allocating $750 million to increase testing.

Making Treatment More Accessible and Affordable

Paying for Care of Uninsured Individuals: HHS is using a portion of the $175 billion Provider Relief Fund to pay for COVID-19-related care of uninsured Americans. Doctors, hospitals, and other providers who have provided testing or treatment for uninsured individuals with a COVID-19 diagnosis can request 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 prohibiting providers from seeking to collect out-of-pocket payments from a patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider. This guarantees that uninsured individuals will not have hospitals or other healthcare providers who receive funds from the Provider Relief Fund attempting to collect additional sums for the care provided to support COVID-19 treatment and recovery.

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 pandemic has added significant new stressors that may be felt more acutely by the physically and financially vulnerable. The Substance Abuse and Mental Health Administration (SAMHSA) released $110 million to state, local, and tribal governments to continue to expand access to appropriate treatments. Whether for preexisting mental health conditions or for mental health challenges arising during this emergency, making sure there are enough resources for communities is an essential role for which states can use this funding.

Supporting Hospitals That Serve Low Income Communities: As elective procedures were canceled, the continued financial viability of some hospitals has been threatened—especially 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 Health Resources and Services Administration (HRSA)'s Federal Office of Rural Health Policy awarded $150 million to assist hospitals funded through the Small Rural Hospital Improvement Program (SHIP) to assist 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 $10 billion to support rural providers and targeted an additional $2 billion to hospitals with a disproportionate share of uncompensated care and seeing 100 or more COVID-19 patients.

Tailored Guidance for Individuals & Communities Most At Risk

CDC Offers Guidance for At-Risk Populations: Through data collected by doctors and epidemiologists across the country, we know that people with underlying health conditions are at elevated risk for complications from COVID-19. The CDC has published information for people who need to take extra precautions. Conditions like diabetes, hypertension, cardiovascular disease, asthma, 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 to protect those most vulnerable populations and important information about reducing the risk of severe illness from COVID-19 infection.

Expanding Telehealth Options to Ensure Access to Needed Care

Expanding Access to Telehealth Services: At-risk populations can face additional challenges accessing healthcare, including transportation and a higher risk for infection. The federal government, particularly the Centers for Medicare & Medicaid Services (CMS), has taken steps to make accessing care through telehealth services easier. For example, CMS is helping people enrolled in Medicare to receive medical care using telecommunications technology. CMS also announced a waiver allowing doctors 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, some telehealth visits can be billed for audio-only encounters. The HHS Office for Civil Rights (OCR) also issued a Notification of Enforcement Discretion to empower covered health care providers to use widely available communications applications without the risk of penalties imposed by OCR for violations of Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules for the good faith provision of telehealth services.

Rural Health Clinic (RHC) & FQHC Flexibilities: RHCs and FQHCs are essential parts of the healthcare system, particularly for 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 patients at highest risk 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: 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.

Telehealth for Medicaid Substance Use Disorder Services: CMS released an Informational Bulletin to states that identifies opportunities for telehealth delivery methods to increase access to Medicaid services for substance use disorder.

Strengthening Outreach & Effective Communication on COVID-19 to Minority Communities

Improving Outreach & Communication on COVID-19 to Minority Communities: HHS's Office of Minority Health announced a competitive funding opportunity to invest up to $40 million for the development and coordination of a strategic network of national, state, territorial, tribal, and local organizations to deliver important COVID-19-related information to racial and ethnic minority, rural and socially disadvantaged communities 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.

Enforcing Civil Rights Laws During the COVID-19 National Public Health Emergency: In March 2020, 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 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 eligible to be served or likely to be encountered in their health programs and activities.

National Network to Eliminate Disparities (NNED) in Behavioral Health: SAMHSA continues to operate the NNED in Behavioral Health, which is a network of over 1,100 community-based organizations across the country serving primarily ethnic minority populations. The NNED provides training and informational resources. During the COVID-19 pandemic, the NNED has accelerated the development and release of informational materials, including 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.

Multilingual COVID-19 Information: The Food and Drug Administration (FDA) has increased outreach by developing and 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 the FDA COVID-19 Frequently Asked Questions (available in English and Spanish). The 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, the FDA launched a COVID-19 Bilingual (English/Spanish) Social Media Toolkit that features consumer friendly messages and culturally appropriate graphics.