INDIANA HEALTH DISPARITIES Task Force

Indiana State Department of Health
Office of Minority Health

Interagency State Council on Black and Minority Health

IMHC

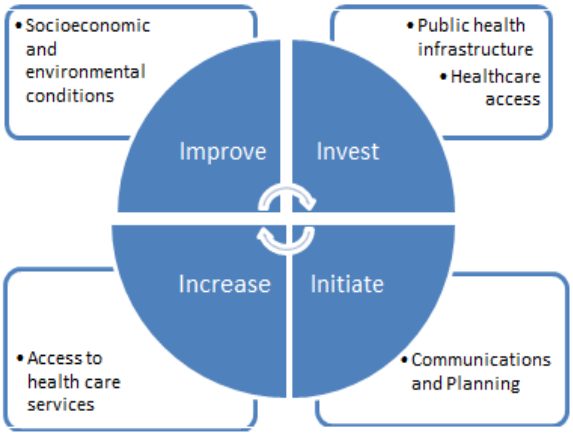
Executive Summary

The first case of COVID-19 in Indiana was confirmed by the Indiana State Department of Health on March 6, 2020, with the first death recorded on March 16, 2020. It was not long before published reports revealed that COVID-19 cases and deaths disproportionately impacted African American/Black ("Black") and Hispanic/Latino ("Latinx") populations in Indiana. On April 14, 2020, the Indiana Black Legislative Caucus (IBLC) sent a letter to Governor Holcomb recommending the establishment of the Indiana Health Disparities Task Force. The IBLC collaborated with the Interagency State Council on Black and Minority Health, the Indiana State Department of Health Office of Minority Health, and the Indiana Minority Health Coalition to create the Task Force. The Task Force was instructed to provide two deliverables, 1) a corrective action plan to address health disparities and the COVID-19 response, and 2) a plan to address the prison population, jails, and juvenile detention centers by June 30, 2020.

The Task Force created 8 committees to address different subject areas. It was composed of 70 individuals, including: members of the Indiana Black Legislative Caucus; racial and ethnic minority groups, community based organizations, gatekeepers, businesses, commissions and coalitions, medical organizations, and other entities representing vulnerable and marginalized populations in Indiana.

The Task Force developed a corrective action plan to respond to and mitigate the health disparities of COVID-19. The plan components include specific steps and recommendations, including policy changes and funding, for the following areas: COVID-19 response; social, economic, and environmental conditions; communications; racial, ethnic, and preferred language data; access to quality medical and behavioral health services; and Public Health Emergency/Disaster/Crisis Response Plan.

The Task Force developed recommendations to address and mitigate the impact of COVID-19 on our prison population, jails, and juvenile detention centers. The plan components include specific steps and recommendations, including policy changes and funding, for the following areas: providing a safe and protective environment within the correctional facility; provide COVID-19 testing, treatment, and support; reduce the population of incarcerated in correctional facilities; enhance reentry services; establish a process to assess the plan; and provide funding for services.



It is further recommended that the work of the Indiana Health Disparities Task Force continue through the establishment and action of workgroups operating under the Interagency State Council on Black and Minority Health to concentrate on the focus areas. The will secure subject matter expert and committee members to develop detailed work plans to outline the steps, take action, monitor progress, document outcomes, and report on each focus area.

Introduction

The novel coronavirus 2019 (COVID-19) is a virus that causes a respiratory illness with a higher risk of severe illness among people with certain underlying medical conditions (see Table 1). [1[In addition, certain socio-economic factors significantly increase the chances of contracting COVID-19, due to prolonged exposure in crowded physical environments. This environmental challenge is especially problematic for frontline healthcare workers, [2] food processing and service industry workers,[3] low-income, people who live in multiple family households, incarcerated populations, unhoused populations, and populations living or working in conditions that do not allow for adequate personal hygiene.

Table 1: Co-morbid health conditions increasing risk COVID-19 severe illness (CDC, June 2020)

Chronic kidney disease	Immunocompromised state (weakened immune system) from solid organ transplant	Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
COPD (chronic obstructive pulmonary disease)	Obesity (body mass index [BMI] of 30 or higher)	Sickle cell disease
		Type 2 diabetes mellitus

The first case of COVID-19 in Indiana was confirmed by the Indiana State Department of Health on March 6, 2020, with the first death recorded on March 16, 2020. This report is based on data with known race and ethnicity details. It was not long before published reports revealed that COVID-19 cases and deaths disproportionately impacted African American/Black ("Black") and Hispanic/Latino ("Latinx") populations in Indiana.

Race	% of Cases	% of Indiana population
White	45.2%	85.1%
Other Race ⓘ	18.1%	2.6%
Black or African American	12.3%	9.8%
Asian	1.5%	2.5%
Unknown	22.9%	0%

Ethnicity	% of Cases	% of Indiana population
Not Hispanic or Latino	33.3%	92.9%
Hispanic or Latino	11.4%	7.1%
Unknown	55.3%	0%

Note:

Other Race ⓘ "Included American Indian, Alaska Native, Asian, Native Hawaiian, Other Pacific Islander, two or more races, and those reported to ISDH as other race"

Source: Indiana State Department of Health; 2019 Novel Coronavirus (COVID-19), Indiana COVID-19 Data Report, 06/30/20; Demographic Distributions for Race and Ethnicity. Available from https://www.coronavirus.in.gov/

This is in part due to the fact that Black and Latinx populations are more likely to have the underlying medical conditions leading to severe COVID-19 illness and death.[4] Further, they disproportionately live and/or work in places and situations that combine to create risk for COVID-19 infection and transmission. COVID-19 has essentially illuminated the persistent disparities, inequities, and injustices in Indiana and across the nation faced by Blacks and Latinxs. COVID-19 has illuminated persistent disparities, inequities and injustices in Indiana and across the nation.

On April 14, 2020, the Indiana Black Legislative Caucus sent the aforementioned letter to Governor Holcomb recommending the establishment of the Indiana Health Disparities Task Force to address the inequitable impact of COVID-19 on race/ethnic minority communities in the state. The task force was charged to complete their work by June 30, 2020.

- A corrective action plan to address health disparities and the COVID-19 response.
- A plan to address the prison population and juvenile detention centers.

The IBLC collaborated with the Interagency Council on Black and Minority Health, the Indiana State Department of Health Office of Minority Health, and the Indiana Minority Health Coalition to work on the task force deliverables. Members of these organizations convened the inaugural meeting on May 18, 2020 to announce their call to action in order to focus on racial and ethnic minorities, discuss the current COVID-19 response, and introduce specific task force focus areas and committees.

The task force included the following: members of the Indiana Black Legislative Caucus; racial and ethnic minority groups, community based organizations, gatekeepers, businesses, commissions and coalitions, medical organizations, and other entities representing vulnerable and marginalized populations in Indiana. The task force conveners formed eight specific committees to address subject matter areas shown in Table 2.

Table 2. Committees of the Indiana Health Disparities Task Force, June 2020

1. Communication/Education/Comprehensive Campaign
2. Documented and Undocumented Immigrants
3. Frontline Workers
4. Incarcerated/Detained (prisons, juvenile detention centers, sheriff/local jail, etc.)
5. Nursing Home/Long Term Care/Assisted Living Facility
6. Pre-existing Underlying Conditions (Chronic Disease, Homelessness, and Pregnant Women); and
7. Special Interest Clusters (MHCs, FQHs, FBOs, CBOs, AAAs, etc.)
8. Uninsured/Underinsured

By way of background, health disparities are health *differences that systematically and negatively impact less advantaged groups.* [5] In Indiana and the U.S., health disparities among under resourced racial and ethnic minority populations existed long before the arrival of COVID-19.

For example, disparate health outcomes among black and minority populations were documented in the 1985 U.S. Department of Health and Human Services Secretary's Task Force report on Black and Minority Health (Heckler Report).[6] Health disparities among racial and ethnic minority populations include increased incidence of chronic disease, poorer health outcomes, and reduced mortality. Social, economic, and environmental challenges that enhance vulnerabilities such a less educational attainment, less family income, less access to healthy foods and health care, greater exposure to environmental hazards, and greater incidents of risky behaviors collude to create these disparate health outcomes. [7]

State efforts to begin to better address disparities among vulnerable populations in response to COVID-19 include:

- Indiana's COVID-19 response for the incarcerated/detained population has been to provide onsite testing at correctional facilities, PPE coordination and medical care. The state has collaborated in regional surge planning to reduce the disease burden in this population. The Indiana Department of Corrections (IDOC) and Indiana Sherriff's Association have been working to create a database to track jail daily census which will include charges and demographic information. Project is fully funded.

- In regards to the immigrant/migrant population in Indiana, the Indiana State Department of Health (ISDH) and other state agencies are working with businesses, farms and industries across the state to address the housing conditions, testing, health care access and isolation and quarantine if needed for COVID-19.

- The Indiana Family and Social Services Administration (FSSA) has suspended all redetermination policies, copays, etc. to facilitate increased and sustained enrollment in state sponsored health insurance plans. The state, as well as many providers, also are not billing insurance or charging patients for COVID-19 testing

- A focus on long term care facilities in Indiana consists of providing resources and strike teams to provide education, PPE, infection control assessments, testing, isolation and quarantine of residents and staff; as well as assistance to enable communications between residents, loved ones, and their representatives; as well as to address loneliness.

- The FSSA designed the Safe Recovery Site to serve people experiencing homelessness and COVID-19 illness or exposure, and for others experiencing domestic violence or living in group homes. Participants are also connected to other resources including insurance, food, withdrawal management, counseling, and medical services.

- The Indiana OB Navigator program continued to contact pregnant women who are covered by Medicaid through virtual visits to connect them to services in their communities.

- The ISDH website has a "health equity and COVID-19" section in the public resources section. Information and links are organized by populations at risk; racial and ethnic minorities; mental health; elderly; language services; public assistance; domestic violence and disability services.

Methods

Community members, activists, and governmental officials were invited to participate in one or more of the eight focus committees. The committees identified issues and barriers that racial and ethnic minorities face in Indiana; recommended actions to respond to those issues and barriers; and determined the needs for funding and policy recommendations. The Indiana Minority Health Coalition staffed the process and led the writing of this report. Committee members reviewed the meeting notes and provided feedback for revisions. It was widely recognized that this Task Force effort was an initial, but important step toward addressing structural barriers facing racial and ethnic minorities in the state.

Between May 28 and June 11, 70 members of the eight committees met 2 to 3 times in zoom sessions. Audio and video from the online meetings were recorded. Meeting notes were drafted after each meeting and sent to the members for review and to provide feedback. Final versions of committee meeting notes were compiled and explored to determine common themes. Committee discussions were summarized and included this report. The following information presents the issues and barriers identified; recommendations for action, funding, and policy attention.

Issues and Barriers

Communication/Education/Comprehensive Campaign

The committee of subject matter experts outlined the following issues and barriers for communication/ education comprehensive campaign:

- Lack of communications and education designed to inform, increase awareness and engage the community about COVID-19 testing, contact tracing, serology testing, social services, insurance, and protective measures;
- Lack of information available in multiple languages;
- Lack of system to aggregate all public and private testing results;
- Lack of complete contract tracing information for racial and ethnic minorities; and
- Lack of sustained public communication campaign designed to reach racial and ethnic minorities.

Documented and Undocumented Immigrant

Documented Immigrants are legal permanent residents in the U.S. with the right to work without restrictions or attend school. Undocumented immigrants are non-citizens of the U.S. who have entered the country without proper documentation or stayed beyond their visa expiration. [8] Immigrant populations represent 5% of the state population. One-third were born in Mexico (32%); followed by India (9%), China (8%), the Philippines (3%), and Myanmar (3%). [9] About one in four immigrants in Indiana (92,000 of 350,000) are undocumented. [10]

Immigrants pay taxes, own businesses, and purchase products and services in our state. They are employed most frequently in manufacturing, hotel and food services, health and social assistance, educational services, and retail; and as such, are at greater risk of exposure to COVID-19. While 31 percent of Indiana immigrants have college degrees, 31 percent failed to obtain a high school diploma. In 2018, 26.2% of Indiana immigrant populations lived at or below 300% of the federal poverty threshold. [11]

It has been shown that negative health outcomes and the reporting of poor health and mental health issues by immigrant Latinx populations are related to their perceptions of living in states with unfavorable anti-immigration laws.[12] Such policies in Indiana have included, but are not limited to, the prohibition to enroll in Medicaid or the Children's Health Insurance Program.

The committee of subject matter experts outlined the following issues and barriers for the documented and undocumented immigrant population:

- Lack of awareness of COVID-19 testing, sites, process, isolation and quarantine procedures, and contact tracing;
- Barriers in accessing to testing sites, including transportation issues, language, and requirements for identification documents;
- Economic barriers, including cost of testing, lack of insurance, and lack of adequate housing or income;
- Cultural barriers such as language difficulties, stigma, victim-blaming, fear of the Immigrant and Naturalization Service (INS), and concerns about deportation;
- Behavioral Health issues such as anxiety, depression, self-harm, and substance use;
- Lack of self-efficacy skill, resilience, and support for grief and loss
- Lack of language appropriate education and communication materials and interpretation services;
- Lack of cultural competency of those involved in public health response, communications and medical services
- Social, economic, and environment challenges in the workplace;
- Lack of willingness to access assistance or public services due to the Public Charge rule in federal immigration laws that has led to increased fear of the INS, loss of future green card or loss of visa eligibility for self or family members;
- Preparedness plans lack cohesive, comprehensive and inclusive procedures; and
- Preparedness plans lack coordinated efforts, community engagement, and community partnerships to reach and serve the documented and undocumented immigrant populations and organizations.

Frontline Workers

Frontline workers are a group of essential workers who are required to be at their worksites due to the nature of the job. They work in jobs from several business sectors representing 62% of the total workforce. Examples include (but are not limited to) community and government operations, medical services, public health, public transit, critical manufacturing, food and agriculture, retail, and services industries. In the U.S., 50 million people qualify as frontline workers. [13]

Frontline workers generally earn less pay, have lower educational attainment, are disproportionately under resourced racial and ethnic minorities, and live in low income neighborhoods, often near hazardous materials. Frontline workers also tend to have small living quarters and many live in multigenerational family units. They often lack personal protective equipment ("PPE"), insurance coverage, sick leave, and hazard pay. [14] They tend to also work in public-facing jobs where physical distancing is normally not possible. The lack of protection for frontline workers increases their risk of poor health outcomes in this COVID-19 environment. Thus, they are at the greatest risk of infection from COVID-19. Frontline workers stand at the intersection of race/ethnicity, immigration status, and low income status. Over 40% frontline workers in the U.S. are Black, Latinx or Asian-American/Pacific Islander. [15]

The committee of subject matter experts outlined the following issues and barrier for the other frontline workers:

- Fear of the infections, illnesses, and concerns about the lack of institutional support from employers;
- Lack of access to testing services due to locations, time of operation, and lack of funds;
- Lack of insurance coverage , lack of sick pay, and low wages;
- Lack of access to PPP in their workplace
- Inability to do social distancing due to the nature of their work; and
- Living conditions that often make it difficult to practice social distancing, including lack of physical space and multiple family living arrangements.

Incarcerated/Detained

Adults and youth with lower incomes and communities of color are disproportionately represented in the incarcerated population. [16] Individuals who are incarcerated have higher rates of chronic health conditions compared to the public with particularly high rates of high blood pressure, heart disease, asthma, diabetes, and obesity. [17]

The incarcerated / detained population in Indiana includes 27,268 adults and 350 youth held in Indiana prisons and detention facilities. There are also 6,132 adults and 44 youth on parole. Thirty-two percent of incarcerated adults and 33 percent of incarcerated youth were African American/Black, [18] but Blacks account for only 10 percent of the Indiana population. The situation is worse among the estimated 21,300 people in Indiana county jails. In Indiana jails, the rate of Black incarceration is five times higher than whites. [19]

Individuals face many challenges while incarcerated in facilities and upon reentry into the community. Incarcerated individuals often experience overcrowding, confined spaces, limited hygiene supplies, strict social groups, lack of control over their movements, limited outdoor time, trauma, limited access to treatment for medical conditions, behavioral health and substance use disorders, isolation from family and community, and costly phone, email and video contact outside of the facility. [20] Challenges faced by individuals released from incarceration include difficulty securing employment, housing, access to medications, access to adequate medical services, and behavioral health and substance use disorder services. [21] The high risk of death among formerly incarcerated people has been well documented. [22]

The committee of subject matter experts outlined the following issues and barriers for the incarcerated/detained population:

- Due to the size of the population behind bars, there are challenges related to COVID-19 testing of all inmates;
- Lack of ample space within confined environments to isolate or quarantine infected individuals;
- Lack of consistent testing before releasing inmates into the general populations to determine the need for quarantine upon release;
- Infected staff passing the virus to inmates;
- Limited communications between prisons/jails and community-based reentry organizations;
- Challenges of sharing medical records and providing care coordination between the prison/jails and community sites; and
- Lack of available reentry housing in the community.

Nursing Home/Long Term Care/Assisted Living Facility

Individuals with underlying health conditions, who are, therefore, at higher risk for serious illness from COVID-19 infections [1] tend to make up a larger percentage of those living in nursing homes, long-term care, assisted living facilities. An estimated 41,500 Hoosiers live in Indiana's 200 nursing homes or skilled nursing facilities, where there are more than 20,000 assisted living beds. Ten percent of facility residents are Black and 1 percent are Latinx. [23]

The communal nature of these facilities, the need for personal care and assistance, and other medical conditions create several challenging issues for these residents who are at increased risk of infection, serious illness and death. [24] Further, as there is now evidence of asymptomatic transmission of COVID-19, nursing home and long term care facility residents face additional risk of transmission from staff and visitors. [25] To date the cases of COVID-19 among Indiana nursing home and long term care residents remains unclear, despite widely reported outbreaks. [26]

The committee of subject matter experts outlined the following issues and barriers for the Nursing Home/Long Term Care/Assisted Living Facility;

- Details on testing and reporting of COVID-19 cases and deaths among residents and staff is not reported by individual facilities;
- Added stress of the love ones in these facilities due to lack of knowledge about the spread of COVID-19 in the facility where there loved one resides;
- Residents lack adequate emotional support because they are isolated from family, friends and other residents due to social distancing restrictions;
- Isolation contributes to loneliness, fear, and distress;
- Lack of availability of PPE for staff and visitors
- Staff concerns about the risk related to the work environment, including the work setting, facility safety, and close contact with residents; and
- Individuals living in these facilities are at greater risk of serious illness from COVID-19 due to chronic health conditions and close quarters.

Pre-existing Underlying Conditions (Chronic Disease, Homelessness, and Pregnant women)

Underlying conditions contribute to increased risk of infection and illness severity. The following information details some of the factors that may increase risk for people with underlying conditions.

Chronic disease

As shown in Table 1 on page 2 of this Report, on June 25, 2020, the Centers for Disease Control and Prevention (CDC) identified people of any age with specific underlying health conditions to be at higher risk of severe illness from a COVID-19 infection. [1] In addition, the CDC indicated that currently there is limited data and information about the impact of other underlying medical conditions and whether they increase the risk for severe illness from COVID-19. Evidence continues to emerge based on the evolution of science about COVID-19. Current studies suggest that people with the following conditions might be at an increased risk for severe illness from COVID-19 (Table 3). [27]

Table 3. Additional health conditions which may impact risk of COVID-19 related illness or severity
Asthma (moderate-to-severe)
Cerebrovascular disease (affects blood vessels and blood supply to the brain)
Cystic fibrosis
Hypertension or high blood pressure
Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines
Neurologic conditions, such as dementia
Liver disease
Pregnancy
Pulmonary fibrosis (having damaged or scarred lung tissues)
Smoking
Thalassemia (a type of blood disorder)
Type 1 diabetes mellitus

Homelessness

The homeless or unhoused population in Indiana is estimated to be nearly 5,500 individuals, of which, 10% were veterans, 10% are homeless families; 7% are considered to be chronically homeless, and 5% are young adults. [28] The homeless population in Indiana faces a heightened vulnerability during the public health crisis because of the lack of stable housing, having to live in unsafe/insecure environments, being exposed to poor weather conditions, lack of access to usual sources of medical services, [29] and living in group conditions that do not provide safe distancing or hygiene. [30] As a result, many people who are unhoused suffer a range of poor health conditions, including behavioral health issues (depression, substance use disorder, and trauma), chronic health conditions (asthma, diabetes, heart disease, and high blood pressure), poor nutrition, exposure to infections, and lack of personal hygiene supplies and medications. [31]

Pregnant women:

Pregnant women may be concerned about accessing medical services due to fear of potential exposure to COVID-19, lack of insurance coverage or medical provider, and/or lack of care for other children. Pregnant women may lack PPE. They may also not be able to practice social distancing, handwashing, and frequent cleaning of surfaces due to their living conditions. [32] A recent CDC study suggests that pregnant women with COVID-19 are more likely to be hospitalized and are at increased risk for intensive care admissions and receipt of mechanical ventilation than non-pregnant women. [33]

The committee of subject matter experts outlined the following issues and barriers for underlying conditions:

- Pregnant women worry about accessing services due to risk of COVID-19; this includes specific concerns regarding access to doula services;
- Pregnant women have concerns about medical systems limiting support personnel during the birthing process;
- Concerns about a significant number of prenatal visits being conducted via telehealth with severely limited in person visits;
- Lack COVID19 testing for pregnant women with limited mobility;
- Lack of easy access and availability of the Indiana In-Home Support Services (C.H.O.I.C.E.);
- Lack of providers with expertise in care, treatment, and pain crisis for Sickle Cell Disease clients;
- Lack of access to healthy foods, fresh fruits and vegetables in food deserts;
- Evictions may contribute to an increase in homelessness;
- Homeless population lacks access to hygiene supplies, PPE, and safe secure shelter; and
- Chronic diseases going untreated due to lack of insurance coverage, affordable treatment options and transportation

Special Interest Clusters (MHCs, FQHCs, FBOs, CBOs, AAAs, etc.) – Local efforts

The committee of subject matter experts outlined the following issues and barriers for special interest clusters:

- Lack COVID-19 testing supplies, equipment, and community test sites;
- Lack of access to telephone, internet, computer, and reliable bandwidth for telemedicine visits;
- Lack of familiarity and comfort with the use of computers, technology and social media;
- Lack of resources and access to PPE;
- Lack of face mask use in public places;
- Need for multiple language community education on COVID-19 risks and protective actions;
- Lack of Spanish speaking individuals at the community level to deliver test results and conduct contact tracing activities;
- Lack of transportation and childcare to address the needs of community members; and
- Lack of community member access through faith-based organizations due to COVID-19 closures.

Uninsured/Underinsured

In 2018, it was estimated that 8.3 percent of the population in Indiana did not have health insurance coverage. The lack of health insurance varies by race and ethnicity. In Indiana, the uninsured population includes 21% of the Latinx population; followed by Native Hawaiian/Other Pacific Islander (17%), American Indian/Alaska Native (15%), Black (11%), Asian (10%), and white, Non-Hispanic (8%). [34] According to results from The Commonwealth Fund's 2018 Biennial Health Insurance Survey, 29 percent of the U.S. population is under-insured. Being under-insured is defined as having health insurance coverage with a high deductible, high out of pocket costs compared to personal income, and being more likely to have difficulty paying for medical services or choosing not to receive medical services due to cost. COVID-19 complicates insurance coverage, as more than 11% of the U.S. labor force was unemployed as of June 2020. The Commonwealth Fund's recent survey among U.S. adults found that two in five had health coverage through a job that was now lost or furloughed due to COVID-19. [35]

The committee of subject matter experts outlined the following issues and barriers for the uninsured/underinsured populations:

- Loss of insurance due to loss of employment or furlough particularly among the American Indian population, frontline workers, and low-wage workers;
- Lack of social security numbers and insurance to cover COVID-19 testing and treatment;
- Lack of Indian (Tribal Enrolled Natives) Health Services providers, clinics, and services in Indiana;
- Lack of availability and understanding of insurance coverage and social services by under resourced minority communities;
- Lack of affordable insurance and medical services
- Lack of trust of medical systems and medical providers
- Lack of data on health disparities of American Indians; and
- Lack of accurate insurance information provided by government agencies and employees.

DELIVERABLES

The following section details the Indiana Health Disparities Task Force recommendations to fulfill the deliverables.

Deliverable 1) A corrective action plan to address health disparities and the COVID-19 response

The Indiana Health Disparities Task Force recommend the following Action Plan to Strengthen the Response to COVID-19 to include, engage and serve racial ethnic minorities and other vulnerable populations in Indiana. The plan components address COVID-19 response; social, economic, and environmental conditions; communications; racial and ethnic, and preferred language data; access to quality medical services and behavioral health services; Public Health Emergency / Disaster / Crisis Response Plan; funding needs; and policy needs.

COVID-19 response

- Conduct contact tracing in partnership with local leaders and trusted community organizations that will allow for establishing proper communication, obtaining accurate contact lists, and offering information, support, and resources;
- Establish mobile testing sites in collaboration with community-based and faith-based organizations;
- Set up procedures to ensure timely delivery of test results with instructions for isolation, quarantine, and preventive actions;
- Engage and partner with local community health workers to share details and navigate local medical system
- Inform public about the impact of COVID-19; and
- Offer free testing services at accessible community locations in partnership with trusted community-based organizations and community leaders.

Social, economic, and environmental conditions

- Ensure that employers provide safe work environments that are clean, maintain physical distancing, isolation and quarantine spaces;
- Educate employees and employers on rights of workers;
- Increase hourly minimum wage;
- Provide hazard pay to frontline workers;
- Expand insurance eligibility and coverage; and
- Provide financial assistance for medical debt, rent, utilities, medication, childcare, and other important needs.

Communications

- Develop culturally and linguistically appropriate messages and materials to inform diverse populations about COVID-19 testing, safety, isolation, care, quarantine procedures, contact tracing, protective actions, and reducing stigma and blame;
- Include trauma-informed approach in all communication and actions;
- Implement, monitor and evaluate the communication, education, and statewide campaign materials that are tailored to specific audiences, including
    - collaborating with trusted community members who are in and of the cultural, faith and language community to develop and share culturally relevant linguistically appropriate communications; and
    - medical system services, behavioral health and substance use services;
- Provide information and training that is culturally relevant and linguistically appropriate, including
    - regular trainings required for state agencies, medical systems and providers, businesses, and employees on topics of cultural competency, diversity, equity, inclusiveness, and bias;
    - culturally relevant training in multiple languages on self-efficacy and resilience; and
    - culturally relevant training in multiple languages on grief and loss support services.
- Provide information that is linguistically appropriate, including
    - Verbal, audio, visual and written materials in relevant preferred languages;
    - engage minority owned business in communication development, delivery, and monitoring, distribution of information; and
    - adopt, implement, monitor, and evaluate Language Access Plans for state and local health departments, and social and service organizations; and
- Require communications messages and materials to clearly explain and guarantee that the confidentiality of personal information collected for public health emergency purposes will not be shared with the federal government under any circumstances.

Racial and ethnic, and preferred language data

- Collect, document, and provide race, ethnicity, and preferred language data to identify, understand and act on disparities;
- Conduct thorough analyses of all available data using cross-cultural research methods to examine the social, cultural and systemic factors contributing to differences and disparities in health outcomes;
- Release and report data by race, ethnicity and preferred language; and
- Provide resources to take action to address the disparities identified.

Access to quality medical services and behavioral health services
- Establish and maintain Emergency Department (ED) follow-up clinics to monitor health and provide information on resources
- Implement standard protocols to inform client of rights; including their ability to opt-out of sharing information;
- Utilize benefit coordinators to assist clients in navigating and understanding benefits, services, and billing processes;
- Educate providers to engage, serve, and build relationships and trust;
- Provide medical interpretation services to improve communication, increase understanding, and inform client and family to enhance access to services
- Educate medical service providers on safe and effective care and treatment of Sickle Cell Disease clients;
- Educate providers and clients about equity, inclusion, diversity, and bias; and
- Include housing security as part of medical services.

Public health Emergency/Disaster/Crisis Response Plan
- Develop coordinated and comprehensive public health efforts across the state;
- Include racial and ethnic minority and vulnerable population subject matter experts throughout planning, implementation, monitoring and evaluation of the plan;
- Develop communication plans to include coordinated actions to offer effective and comprehensive outreach to racial and ethnic minority and vulnerable populations;
- Include communication plan that involves coordinated actions and comprehensive outreach to racial and ethnic minority and vulnerable populations;
- Increase workforce diversity and cultural competence throughout government agencies and employers
- Conduct self-assessments for racial equity impact of policies, practices and procedures; and
- Review and revise the public health Home Rule as needed to work with the plan,

Needed Investments
- Increase funding for public health infrastructure and services;
- Fund local leaders and trusted community organizations to conduct contract tracing, obtain accurate contact lists, and offer information, support and resources;
- Funding for medical insurance enrollment outreach, support and assistance;
- Fund the communication plan and campaign development
- Fund implementation, monitoring, and evaluation of communication plan and campaign development;
- Fund PPE, Plexiglas shields, cleaning supplies for the faith-based community organizations and small businesses;
- Increase funding for community health worker services provided in community and medical systems;
- Increase funding to Federally Qualified Health Centers that serve uninsured/underinsured; and
- Fund access to healthy foods and fresh fruits and vegetables in food deserts.

Needed Policy

Overall

- Require written policies and procedures to place inclusion, diversity, equity, anti-racism, and implicit bias into practice in government agencies;
- Require annual training on racism, inclusion, equity, and bias;
- Require written policies and procedures to place inclusion, diversity, equity, anti-racism, and implicit bias into practice in government agencies;
- Require state agencies to conduct annual self-assessment of racial equity impact policies, practices and procedures, monitor progress, and report outcomes annually;
- Require state public health agencies to develop and distribute communications to explain that accessing assistance, public health and other services are not penalized under the new Public Charge rule;
- Require employers to provide safe work environments and protective equipment;
- Require annual training on employee rights and employer responsibilities;
- Address youth aging out of the foster care system and needing secure housing;
- Protect personal health information for all including undocumented populations;

Communications

- Require written procedures to include engagement, partnership, outreach, and language access for Limited English Proficiency (LEP) populations
- Require state and local health departments to develop, implement and evaluate language services and Language Action Plans;
- Require written communication policies and procedures;
- Incorporate trauma-informed approach in all communication plans and campaigns;
- Require action plans and annual outcome reports;

Data

- Require collection, stratification, analysis and reporting of race, ethnicity and preferred language;
- Require action plans and annual reports of race, ethnicity and preferred language outcomes;

Economic

- Increase the hourly minimum wage;
- Require a comprehensive, permanent paid sick leave for wage protection;

Insurance coverage

- Revise Indiana Medicaid flexibility and payment of Telemedicine visits to improve access;
- Expand Medicaid coverage of women for one year after child's birth;
- Increase the number of community health workers hours reimbursed per month;

Medical systems

- Declare Doulas as members of the birthing teams in all Indiana hospitals;
- Require COVID-19 testing as part of standard pregnancy tests and covered by insurance;
- Include transportation as part of dialysis wrap around services;
- Require medical service systems to have comprehensive written financial assistance policies and procedures; and publicly report results;

Deliverable 2) A plan to address the prison population and juvenile detention centers

Plan to address the prison population, jails and juvenile detention centers. [36] The plan components include providing a safe and protective environment within the correctional facility; provide COVID-19 testing, treatment and support; reduce the population of incarcerated in correctional facilities; enhance reentry services; provide funding for services; and policy to assess the plan.

Provide for safe and protective environment within the correctional facility

- Follow the CDC guidance for COVID-19 management in correctional facilities;
- Educate incarcerated individuals and staff on preventive practices;
- Provide PPE and personal hygiene products at no cost;
- Practice physical distancing;
- Perform regular cleaning and disinfecting of facilities; and
- Conduct routine symptom screening of incarcerated individuals and staff.

Provide COVID-19 testing

- Provide resources, materials, supplies, equipment and providers to offer testing;
- Test incarcerated or detained individuals with COVID-19 symptoms;
- Test incarcerated individuals according to CDC guidelines for correctional facilities;
- Test individuals newly incarcerated/detained individuals upon entry to the system, movement between facilities, and prior to release from the correctional system; and
- Provide test at no cost to incarcerated/detained individuals.

Provide treatment

- Eliminate the standard co-pay fees for medical services when responding to complaints of COVID-19 symptoms for incarcerated/detained individuals;
- Offer Medicaid coverage of medical services for individuals in the criminal justice system;
- Provide access to quality medical services; and
- Quarantine incarcerated individuals and staff exposed to COVID-19 infected individuals.

Provide support

- Enhance behavioral health services to meet the needs of incarcerated population;
- Increase access to family phone calls at no cost; and
- Provide family video visitation at no cost.

Reduce the population of incarcerated in correctional facilities

- Reduce risk of exposure and virus transmission through the decreased overcrowding at facilities;
- Promote physical distancing, with fewer individuals in the same amount of space; and
- Prevent overwhelming the medical systems within the correctional system and external sites.

Enhance reentry services

- Educate and inform families and communities about the release and how they may assist;
- Enroll individuals in Medicaid;
- Establish housing to provide for safe location for quarantine with medical monitoring;
- Secure appropriate housing, food, workforce development and transportation;
- Support reentry individuals to obtaining health insurance coverage, medical home, behavioral health services, substance use disorder services, and harm reduction assistance;
- Enhance communication and collaboration with community-based reentry organizations; and
- Provide case management to coordinate reentry.

Provide Funding for Services

- Provide resources to support wrap around reentry services;
- Enhance funding for Community Behavioral Health Centers to increase capacity;
- Provide incentives to private sector Behavioral Health Providers to serve Medicaid recipients;
- Provide resources to reentry community organization [such as Public Advocates in Community Reentry (PACE)] to enable them to provide services recently released that may include quarantine and monitoring, access to medical service and behavioral health providers, medication supplies, and substance use disorder access to Medically Assisted Treatment; and
- Follow up and support for transition of the recently released back into the community.

Policy

- Policy needed to implement the action plan, monitor and evaluate outcomes

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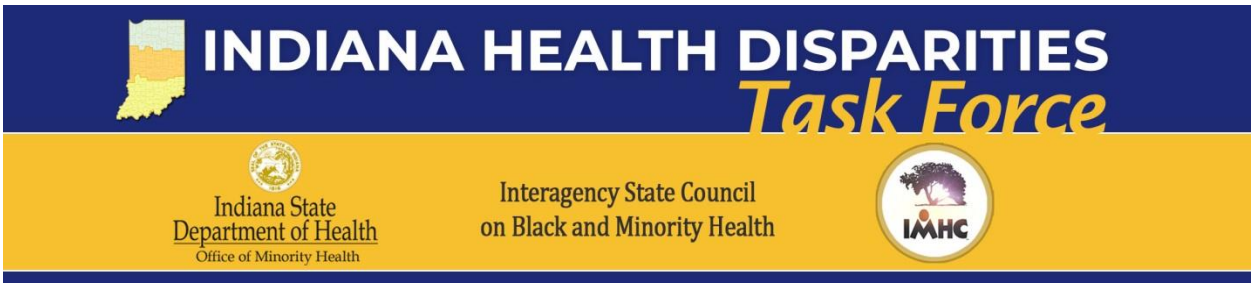
Exhibit A



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