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COVID-19 is Out of Proportion in African Americans. This Will Come as No Surprise . . .

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As the COVID-19 crisis unfolds, it is clear that the disease is affecting African American populations disproportionately. For example, in our home state of Alabama, African Americans comprise 37.5% of laboratory-confirmed cases and 47.4% of deaths, despite only being 26.8% of the population, according to publicly available statistics on April 21, 2020. In Louisiana, 56.25% of COVID-related deaths were among Blacks, even though only 32.7% of the population is black. In Michigan, while 14.1% of the population is black, 33% of COVID-19 cases are among Blacks and African Americans, as are 40% of the deaths. However, none of this should come as a surprise.

Health Disparities are an Old and Enduring Story

We have understood for decades that health status and outcomes differ widely among racial/ethnic and socioeconomic groups, especially for chronic conditions such as hypertension, cardiovascular disease, diabetes, and obesity – some of the very conditions that appear to contribute to poor COVID-19 outcomes. For example, 54% of black adults have hypertension as compared to only 46% of white adults[1]. While 16.4% of black adults have diabetes, among white adults the rate is 11.9%[2]. And, although 38.4% of black adults fit the criteria to be considered obese, only 28.6% of white adults do[3]. Overall, minority and low-income groups tend to have worse outcomes in terms of morbidity and mortality[4]. We knew early on that these conditions which are more prevalent in minority populations were markers of high risk for poor COVID-19 outcomes, yet we did not use this to inform our prevention and testing efforts. Doing so could have helped reduce transmission among higher risk populations, ultimately reducing the burden on our healthcare systems.

From the beginning of the crisis, we have compounded disparities by not heeding lessons learned from years of research into health disparities. Even now, as COVID-19 disparities become clear, the discussion seems to center on co-morbid conditions as the driver of disparities. But health disparities researchers have known all along that chronic disease disparities are symptomatic of larger

causes. Social and structural differences in our communities and society make it easier for some to stay healthy and harder for others[5]. Policies, systems, and environments all combine to limit opportunities for health equality. Low education levels, poverty, food insecurity, low-quality housing, limited transportation options, the threat of crime, and a host of other "social determinants" all contribute to health disparities. Such unfavorable conditions are especially prevalent among many majority African American communities.

Knowing that African Americans suffer from high rates of chronic diseases, coupled with disadvantaged socioeconomic circumstances, we could have anticipated that COVID-19 would likely hit low-income African American communities harder than others, compounding existing disparities in health and health outcomes. But we seem to have treated the coronavirus as novel in one too many ways, looking past evidence and experience that would have foreshadowed the disparities to come. That said, there is still time to make sure this disparities story has a different outcome.

What We Can Do

Although we have missed the opportunity to get ahead of racial disparities with COVID-19, we can begin to change them now by addressing each opportunity that we have so far overlooked. We know what to do. We just have to start doing it.

First, we must ensure *appropriate and culturally sensitive messaging*. While health authorities and many organizations from non-profits to health systems are disseminating information to help people stay safe from coronavirus and prevent spread to others, much of it is one-size-fits-all. In our own work in minority and rural communities around the state of Alabama, we have learned through virtual meetings that much of the messaging misses the mark. The low-income and traditionally underserved people we work with have found the COVID-19 messages confusing, seemingly irrelevant, or even untrustworthy.

By not tailoring our messaging, we have left a population at high risk of hospitalization and poor outcomes at an information disadvantage. We can start to change that now with customized messages, appropriate communications channels (including telephone, text, flyers, and yard signs), and culturally relevant advice for social distancing and coronavirus avoidance.

Second, we must *ensure equitable testing*. Cities around the US have established drive-through testing sites. However, anecdotal evidence suggests that these sites are not accessible by many members of traditionally underserved communities, due to lack of a physician referral, lack of reliable transportation, or lack of communication options such as a mobile phone to communicate with testing personnel while in line. We must address these issues to ensure that testing is available and accessible to those who seem to be at highest risk of ending up hospitalized and needing intensive care.

For example, hybrid walk-up/drive-through testing sites closer to or located in underserved communities would provide a greater opportunity for those at highest risk to be tested and receive *earlier* care. In addition, implementation of "navigator" programs at these sites would allow those without transportation or mobile phones to work directly with a properly protected, trained lay-person to determine whether a test is needed and, if so, to schedule one. Navigators can also help patients receive and interpret results through a communication channel that works for the patient.

Third, we must *ensure that therapeutic and vaccine clinical trials are representative* of those at highest risk. Owing to a combination of historic African American distrust in the medical profession and traditional lack of emphasis on underrepresented minorities, minority representation in clinical trials has long been an issue. However, our own research has shown that the use of navigators (representative individuals who can guide patients), combined with a special emphasis on recruitment, can dramatically increase minority enrollment and retention in clinical trials[6].

Fourth, it is vital that we *ensure follow-up and access to appropriate care*. Low-income Black and African American communities, especially in rural areas, have long lacked the ready access to quality healthcare that many others enjoy. It is vital that we ensure that people do not yet again "fall through the cracks" – get tested, but receive no care or get care, but then receive no follow up. This means developing personal relationships, perhaps through navigators, and maintaining long-term contact with patients to follow their progress and understand their outcomes.

Finally, we must *commit to ensuring that COVID-19 does not widen the health disparities* that already exist. The long-term effects of COVID-19 on individuals and communities remain to be seen. Without careful attention, however, we can fully expect disparities here as well. This is why follow-up is so important. Should COVID-19 turn out to be a condition with long-term effects, we should expect that those effects will fall disproportionately on populations that have traditionally borne a larger share of the burden of chronic disease.

Learning from COVID-19

Much as healthier bodies are better able to rid themselves of the coronavirus, healthier neighborhoods, communities, and societies will be better able to decrease the burden of chronic diseases, making them, in turn, better able to respond to the next pandemic. It is vital for us to ensure that underrepresented populations are adequately represented as we work to understand and address COVID-19. Let us make this crisis a turning point and use what we learn to ensure that we reduce health disparities rather than widening them.

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