Rainbow PUSH Coalition and National Medical Association
Joint Statement on the Response to the Coronavirus/COVID-19 Pandemic: A Public Health Manifesto
Don't Panic, Prepare!

April 30, 2020

Just as the sun rises in the East and sets in the West, COVID-19 has emerged as a global threat. In the United States the effects of the disease have disproportionately impacted African Americans and other communities of color. According to state data currently available (and that includes demographic information), rates of infection and death amongst the African American population far exceeds the representation of African Americans in the overall population (in some instances by a multiple of more than 5).

This global pandemic has amplified the effects of pre-existing health disparities, structural impediments, and the ongoing harm done by inadequate strategies to address the dangers of COVID-19 in the African American community specifically, and communities of color overall.

This joint public health strategy proposed by the Rainbow PUSH Coalition1 and the National Medical Association2 addresses these concerns, and proposes viable, actionable steps that can be immediately implemented to reduce the possibility of irreparable harm due to COVID-19 on these at-risk communities.

THE JOINT PUBLIC HEALTH STRATEGY:

1. PREVENTION: Shelter-in-Place (at home) and Worship-in-Place (at home). Houses of worship and community organizations are encouraged to employ alternative, safe strategies for socialization and worship. As human interaction is essential for overall health, we encourage everyone to practice physical distancing (i.e., stay at least 6 feet from other people, avoid mass gatherings, wear cloth facial covering in public3, and do not host gatherings at home).

Engage in virtual internet meetings/gatherings, use phone/email/text capabilities for communicating, and ensure that regular hand-washing and surface cleaning are employed. Additionally, prevention messages and up to date information about the status of the pandemic must be communicated in culturally relevant and effective ways, consistent with the communication practices and languages of African American and other racial/ethnic communities.

2. DATA: State and local health departments and Centers for Disease Control and Prevention (CDC) must be required to collect and publicly report COVID-19 testing, emergency department visits, hospitalizations, and outcomes data, stratified by demographics (including race, ethnicity, gender, and 9-digit ZIP codes).

3. SCREENING: When screening questions are used to determine who will undergo diagnostic testing, high-risk groups including persons who are African American, Latinx, American Indian/Alaskan Native should be assigned a high priority risk score to enable testing.

4. ACCESS: To date, less than one percent (1%) of the population has been tested for COVID-19, and the numbers are skewed based on race and socioeconomic status (SES). Access to testing must be expanded, to ensure timely access to COVID-19 testing stations, and by prioritize testing in medically underserved areas, and with populations and neighborhoods impacted by limited/restricted access to public transportation.

The expanded use of mobile testing units and providing for "walk-up" testing at drive-up testing stations must be immediately employed to help ensure equitable access to testing for underserved populations. The walk-up capabilities must meet the following requirements:

a. Testing stations should be no more than 1/4th mile (5-minute walk) from nearest operating bus stop, train, or subway station.

b. Information concerning walk-up and drive-up testing stations must be widely disseminated, and must include multilingual, culturally sensitive, public service announcements within African American, Latinx, and American Indian/Alaskan Native communities.

Consider the use of public health emergency dollars received by Federally Qualified Health Centers (FQHCs) as a funding source for this community outreach. However, if these dollars are utilized for COVID-19 outreach, the expenditures must be immediately reimbursed to the FQHC to ensure ongoing liquidity for ongoing and future public health emergencies.

5. PROTECTION FOR CARE PROVIDERS: Require Personal Protective Equipment (PPE) for people at risk for COVID-19 that are performing duties in support of hospitals and nursing homes including (but not limited to) patient transport, environmental services, food service and maintenance staff, patient care assistants, nurses' aides, and pharmacy technicians. Provide cloth facial coverings, hand-washing soap and water or hand sanitizer for persons in homeless shelters and staff.

6. DO NOT RESUSCITATE (DNR) ORDERS: Do Not Resuscitate (DNR) orders enable patients to pre-determine care decisions concerning the use of life sustaining/life maintaining therapies. Public health emergency provisions allow for involuntary DNR protocols whereby a clinician or staff member (without prior consent of patient, family, or health advocate) makes the decision to withhold Basic Life Support (BLS),

Advanced Cardiac Life Support (ACLS) or other extraordinary measures for acute, life-threatening, or deteriorating health. When a public health emergency has been declared, it is to be required that state and local health departments collect and report all involuntary DNR orders, including data according to race, ethnicity, gender, and age. This data will be monitored by an appointed Community Advisory Board, the responsibility of which will include evaluation for any trends in the data, especially related to race or ethnicity.

7. PROTECTION OF VULNERABLE POPULATIONS: Immediately halt inclusion of persons who are a) incarcerated, b) reside in a mental institution, or c) institutionalized with intellectual or physical disabilities as human subjects for clinical trials and experiments involving off-label use of medications and vaccines.

8. PROTECTION OF INCARCERATED PERSONS: Due to the emerging and ongoing challenge of rising numbers of confirmed cases of COVID-19 in jails and prisons, and a recently confirmed death of at least one inmate from COVID-19, every effort to depopulate jails and prisons of non-violent detainees and persons convicted of nonviolent offences must be employed to eliminate close contact, and to ensure the ability to quarantine persons requiring separation from other inmate populations.

This includes the use of personal recognizance, appropriate home monitoring, community release, and enhanced follow-up with offices of parole and probation to the maximum extent possible. Additionally, all inmates and staff should be provided cloth facial coverings, hand-washing soap and water or hand sanitizer.*

9. CARE COSTS: Ensure full implementation of the provisions of the CARES Act, to include no cost for screening and treatment for COVID-19 and related conditions. This should include medical follow-up for related worsening or unmasking of underlying disease, and aftercare (i.e. skilled nursing facility).

10. AFFIRMATIVE ACTION: Rescind, effective immediately, the U.S. Department of Labor suspension of certain Affirmative Action guidelines, as provided for in the March 17, 2020 memorandum from the director of the Office of Federal Contract Compliance Programs. By carving out exceptions to essential equal opportunity policies as related to federal contracting during the COVID-19 response, some will be denied opportunities at the very time when everyone should be allowed to fully engage in addressing the current public health emergency. There can be no “whole of America” response if ALL of America cannot equally participate in the response.

11. AID TO AFRICAN COUNTRIES FOR COVID-19 RESPONSE: An aggressive deployment of essential medical resources, to include testing kits, PPE, ventilators, and the like be activated to mitigate further global spread and deaths in African countries due to novel coronavirus, as well as the potential for re-emergence in African immigrant communities in the United States where persons may return to their homes of origin, and then return to the United States.

This includes needed CDC resources and consultation, additional budget appropriation for funding support for public health infrastructure and nongovernmental organizations (NGOs), including reinstatement of World Health Organization (WHO) funding, in order to mitigate impact of COVID-19 on indigenous populations on the African continent.

12. ADDRESSING THE CRITICAL SHORTAGE OF AFRICAN AMERICAN MEDICAL PROFESSIONALS: The effects of the COVID-19 pandemic in the United States has revealed a severe shortage of highly trained, culturally competent medical professionals in communities of color and rural communities across the country. There must be funding, and resources made available to support the recruitment, training, and deployment of African American medical professionals in the United States.

This includes partnering and supporting African American schools of medicine, nursing, and health sciences, reducing the debt burden on students of color attending medical/nursing schools, and beginning earlier in the K-12 educational process to expose students of color to the medical profession, and the opportunities available within the profession.

For more information about this agenda, please contact:
National Medical Association President Oliver Brooks, MD
olibro@aol.com

National Medical Association President-elect Leon McDougle, MD, MPH
Leon.McDougle@osumc.edu

Rev. Dr. Janette Wilson, Esq., Special Asst. to Rev. Jesse Jackson, Rainbow PUSH Coalition
revjwilson@rainbowpush.org

Rev. S. Todd Yeary, JD, PhD, Senior Vice President & Chief of Global Policy, Rainbow PUSH Coalition
styeary@rainbowpush.org