



CRISIS STANDARDS OF CARE Issue Brief

COVID-19: Racial Disparities and Crisis Standards of Care

Introduction


Recent racial demographic data suggests huge racial disparities in COVID-19 infections and death. The COVID-19 pandemic has motivated states to develop Crisis Standards of Care (CSC) plans responsive to possible shortfalls in resources, such as ventilators. The emergence of these two circumstances (racial inequities) and CSC planning (anticipated resource shortfalls) raises the question of how CSC planning might incorporate growing racial justice concerns about COVID-19 and resource allocation. This issue brief examines evidence of racial disparities with respect to COVID-19 infections and deaths, possible causes, and legal protections against race discrimination. It also provides an overview of CSC planning, including key ethical features that may be utilized to ensure that CSC planning incorporates concerns about racial inequity.

Crisis Standards of Care: The Basics

According to the National Academy of Medicine (formerly the Institute of Medicine), CSC refers to “[a] substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive . . . or catastrophic . . . disaster.”¹ CSC plans are employed when demand exceeds medical or public health resource availability during such disasters.² With respect to COVID-19, this may include resources like ventilators or intensive care unit beds. States may formally trigger CSC plans through declarations of emergency or other legal mechanisms.³

CSC planning and implementation are grounded in a legal and ethical framework.⁴ Ethics and legality are “cornerstones” framing the steps to CSC planning and implementation.⁵ Multiple legal issues may arise including: coordination of services, allocation of resources (*e.g.*, doing so in a manner that does not violate civil rights laws), services reimbursement, licensure (*e.g.*, authority to waive licensure requirements), scope of practice, accounting for patients’ interests, duty of care owed to patients, implementation of uniform care, employer duties to provide personal protective equipment to healthcare workers (HCW), and liability issues for health care facilities, HCWs and volunteers.⁶

Ethics are directly implicated because CSC planning requires making difficult decisions about how to utilize scarce resources. As such, CSC plans “reflect underlying values.”⁷ Key ethical considerations include: fairness (ensuring different treatment is based on relevant differences), duties to care (including HCWs’ professional duties to a patient), and a duty to



steward resources (using scarce resources “prudently” during a disaster).⁸ Ethics also requires: transparency (e.g., engaging the public in CSC planning), consistency (striving to treat similarly situated groups the same, while recognizing the need for local flexibility in CSC planning), proportionality (e.g., formulating policies that are not unnecessarily burdensome but are proportionate to the disaster), and accountability (ensuring participants in disaster planning adhere to their responsibilities).⁹

In response to COVID-19, multiple states have updated and/or activated CSC plans.¹⁰ Community buy-in is essential. To this end, community engagement (sometimes referred to as public engagement) plays an important role in CSC development, by, for instance, increasing transparency and bringing in diverse perspectives as to what constitutes “fairness.” Community engagement can involve creating lasting and ongoing relationships with individuals or organizations and engaging them in CSC planning.¹¹ Inclusive ethical frameworks will be more responsive to diverse values and needs of different communities, including disadvantaged groups like many people of color during the current COVID-19 pandemic.

Although COVID-19 is new, concerns about racial equity in CSC plans are not. Community engagement is an important vehicle by which these concerns can be ethically addressed. Meaningful community engagement, however, cannot happen overnight or in the midst of a public health emergency. States should engage in this process in advance of a public health crisis so that their plans reflect the views of people of color and other potentially marginalized groups who may be disproportionately impacted. This will avoid plans that produce inequitable health burdens that then must be modified on an ad hoc basis to avoid unwarranted disparate racial impacts. Recent rapid guidance on implementing CSC during the COVID-19 pandemic reiterated the fundamental role of community engagement, education, and communication as key ethical dimensions of CSC planning.¹² This requires formulating inclusive and equitable principles that can adapt to a public health emergency in an equitable manner, and that allow for as much additional community participation as required to address any particular impact of a public health emergency. Such practices will increase much needed cultural competencies in emergency planning,¹³ and, as such, will be more like to generate buy-in across diverse populations.

COVID-19 and Emerging Racial Disparities

An Overview of the Disparities

An emerging issue is the existence of racial disparities in COVID-19 infections and deaths. Many states are failing to report essential racial data regarding COVID-19. Early indicators, however, suggest significant racial disparities in infection and morbidity with people of color faring significantly worse-off relative to their overall populations. This is especially the case for black people. Troubling disparities emerged in several states with respect to COVID-19 deaths in the month of April 2020. In Michigan, black people compose 14% of the state’s population, but accounted for 40% of COVID-19 deaths.¹⁴ In Louisiana, black people compose 32% of the population, but accounted for 70% of COVID-19 deaths.¹⁵ In Kansas, black people compose less than 6% of the population, but accounted for 32% of COVID-19 deaths.¹⁶

Recent analysis shows that relative to their population, black people composed a higher share of confirmed COVID-19 cases in 20 out of 31 states and deaths in 19 out of 24 states.¹⁷ Significant racial disparities in infections and/or deaths were also reported in: Chicago,¹⁸ New York City,¹⁹ Miami-Dade County,²⁰ Alabama,²¹ and Mississippi,²² among other jurisdictions. The available data shows that black people compose 13% of the national population and one-third of all COVID-19 deaths.²³ Latinos have also experienced disproportionate impacts.²⁴ For instance, NPR reported that black and Latino nursing home residents were disproportionately dying from COVID-19.²⁵ In New York City reported deaths were more closely linked to the percentage of residents of color, not the quality of nursing homes’ ratings from the federal government.²⁶ Native Americans, particularly in the Navajo Nation, have also experienced disproportionate COVID-19 deaths, relative to their population.²⁷



Possible Contributing Factors

“Social determinants of health” (SDOH) generally refers to social (e.g., norms, values, laws), economic, and physical conditions (e.g., neighborhood segregation) that individuals live in that impact health.²⁸ SDOH analyses often indicate that people of color are disadvantaged.²⁹ Racism, discrimination, job opportunities, and availability of transportation, for instance, have all been identified as SDOH. The goal of removing the negative effects of SDOH is to build “social and physical environments that promote good health for all.”³⁰

There are indicators that SDOH contribute to the apparent widespread racial disparities in the COVID-19 pandemic. For instance, some have observed that people of color are more likely to be limited in their ability to engage in social distancing measures. This is because, relative to whites, many people of color are more likely to be deemed “essential workers,” including in positions that require close contact,³¹ and less likely to be able to telework.³² According to recent analysis, women hold one in three jobs that states have deemed “essential” and women of color “are more likely to be doing essential jobs than anyone else.”³³


The underlying health conditions that appear to contribute to COVID-19 serious illness or death are also interlinked with SDOH. A recent study identified hypertension, diabetes, and obesity as the most common COVID-19 comorbidities.³⁴ The Centers for Disease Control and Prevention (CDC) has also identified diabetes and severe obesity as risk factors for severe COVID-19 illness.³⁵ People of color experience these conditions at disproportionately high rates. To illustrate, a 2019 study showed that black people were 60% more likely to be diagnosed with diabetes compared to whites.³⁶ In the same year, Hispanics and Latinos were more likely to develop type II diabetes (17%) compared to non-Hispanic whites (8%), and also have a greater likelihood of developing prediabetes.³⁷ Relative to other groups, black women have the highest rates of obesity and being overweight, and black people are 1.3 times more likely to be obese than non-Hispanic whites based on a 2019 study.³⁸ Despite the fact that obesity has increased for all groups, black people and Hispanics continue to experience the highest rates of obesity, according to CDC in February 2020.³⁹

Such underlying conditions cannot be separated from SDOH. For instance, food insecurity is a SDOH that has also been linked with obesity.⁴⁰ People of color who live in neighborhoods that are predominantly non-white tend to have less access to healthy food options,⁴¹ a factor that is in turn driven by racial segregation of neighborhoods. This is likely why race and zip code have been identified by some as key factors driving COVID-19’s disparate impact.⁴²

SDOH also include racism and discrimination.⁴³ Some have raised concerns that doctors are less likely to refer people of color for testing, raising questions of implicit bias.⁴⁴ Implicit bias includes failures or delays in referring people of color for testing or treatment because of certain stereotypes or beliefs. CDC has largely left testing decisions to the discretion of state and local health departments and health care providers.⁴⁵

Institutional racism is also implicated in the COVID-19 pandemic. Institutional racism refers to laws, policies, or practices that are facially race neutral, but have a disproportionate adverse impact on people of color, irrespective of intent.⁴⁶ This may encompass the impact of laws, policies, or practices on their own or in combination. One pressing issue is the lack of national or statewide tracking with respect to the racial disparities in COVID-19 testing, morbidity, and mortality. The racial disparities are preliminary and based on limited data. The failure to report data on racial demographics, even though states report other data (e.g., age, sex), can make it more difficult to assess racial disparities because entities are working with incomplete information. Available data suggest that race appears to be just as significant a factor in COVID-19 serious illness or death as age, which is widely tracked and reported. The failure to track, report, and consequently understand racial disparities may be a race neutral practice that nonetheless has a devastating impact on communities of color.

CDC did not start providing provisional information on COVID-19 related deaths in the U.S. by race and Hispanic origin until April 17, 2020.⁴⁷ As of April 28, 2020, CDC is still missing demographic information on race for 68.1% of the COVID-19 cases in the U.S.⁴⁸ Further national data are not expected until May.⁴⁹ Only two states have released data on racial demographics and testing, 35 states provide information on racial demographics and confirmed cases, and 29 states provide information regarding COVID-19 related deaths.⁵⁰



A lack of data presents challenges for assessing the causes and scope of COVID-19 racial disparities. Nonetheless, preliminary data indicates sweeping and troubling disparities across several states.

Racial Justice Concerns as Applied to CSC

The same concerns discussed above have arisen in the context of CSC planning. A concern is that CSC plans will use criteria that covertly track race. To illustrate, Massachusetts issued CSC guidelines that directed medical staff not to use race as a factor to allocate resources when implementing a CSC plan.⁵¹ The guidelines, however, recommended a scoring system based on short-term and long-term comorbidities (the underlying health conditions that make COVID-19 worse). Patients with the lowest cumulative scores were given the highest priority regarding critical care services. Having a comorbid condition affecting long-term survivability generated more points, meaning such individuals were less likely to receive critical care resources. The guidelines immediately raised concerns about their disparate impact,⁵² potentially marking the difference between life and death, for people of color who have higher rates of chronic conditions and comorbidities due to racism and other SDOH.

After being criticized as discriminatory,⁵³ Massachusetts revised the guidelines in an attempt to address the “unconscious bias against people of color, people with disabilities and other community members who are marginalized.”⁵⁴ It eliminated any consideration of long-term survival, instead only including short-term survival. Two Massachusetts doctors emphasized that “a system that penalizes on the basis of comorbidities will undoubtedly and unfairly penalize the populations that are already more vulnerable to those conditions.”⁵⁵ They recommend that CSC plans include only comorbidities with a known short-term impact. This example demonstrates the complex ways in which race factors into CSC planning.


So far, CSC plans have been more commonly criticized as engaging in disability discrimination (*i.e.*, in Washington, Alabama, and Pennsylvania) under the Americans with Disabilities Act and other federal laws.⁵⁶ The Department of Health and Human Services (HHS) Office of Civil Rights (OCR) quickly reminded states that during the COVID-19 public health emergency the “civil rights statutes [that] OCR enforces, remain in effect.”⁵⁷ There are parallels between disability discrimination and race discrimination, but identifying race discrimination can be more challenging. Alabama’s plan to deny ventilators to persons with intellectual disabilities⁵⁸ clearly singled out individuals on the basis of disabilities that bore no relation to any medically relevant criteria in treating COVID-19. It is highly unlikely that a CSC plan would use racial classifications to ration care—in fact, Massachusetts’s guidelines explicitly forbid using race as a factor for allocating resources. These considerations underscore the challenges of identifying and combating racism in CSC plans.

Legal Protections That Explicitly Prohibit Race Discrimination

Despite the seeming racial disparities and concerns about racially discriminatory impacts, raising a legal challenge to CSC plans by invoking laws that explicitly protect against race discrimination will be difficult. Legal protections that forbid race discrimination are poorly equipped to address racial justice concerns in this context.

The U.S. Constitution, as applied to states and state agents under the 14th Amendment, guarantees equal protection under the law. Laws or policies that are facially racially discriminatory are subject to strict scrutiny, the most rigorous standard of review. In such cases, a state must show the law or policy is narrowly tailored to meet a compelling interest.⁵⁹ For instance, a COVID-19 policy that denied ICU beds to all Latinos would easily be challenged as a discriminatory race classification that is not narrowly tailored to meet the state’s compelling interest in rationing ICU beds if shortages arise.

In the current COVID-19 pandemic, racial justice concerns largely center on implicit bias and institutional racism. The U.S. Supreme Court has held, however, that laws or policies that are facially race neutral and have a discriminatory impact do not trigger strict scrutiny absent a showing of a discriminatory intent.⁶⁰ Instead, such laws receive rational basis review—the lowest level of judicial review, under which it is fairly easy for the government to prevail. Therefore CSC plans that



produce disparate impacts that are challenged as violating equal protection must prove that the state, or state agency, had a discriminatory intent. Otherwise, such constitutional challenges are unlikely to succeed.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in federally funded programs or activities.⁶¹ This can include HHS funded hospitals.⁶² The Supreme Court has held that Title VI protects against intentional discrimination, not merely discriminatory impacts. Title VI enforcement agencies, however, may issue regulations prohibiting HHS funded entities from enacting measures that have a discriminatory impact.⁶³ Even so, raising a Title VI challenge alleging a discriminatory racial impact may be difficult. Challengers would need to show that a CSC plan has no legitimate, non-discriminatory purpose.⁶⁴ So far no such challenge to CSC plans has been raised with respect to race.

In sum, laws directly prohibiting race discrimination will be unlikely to provide relief to those challenging CSC plans as having a discriminatory impact. It may therefore be crucial that CSC plans or (local, state, federal) emergency declarations generally incorporate specific protections against race discrimination. This can include explicit data requirements to track disparities in treatment and afforded outcomes, which will assist officials in better understanding and assessing any racial disparities in treatment or outcomes.

Ethical Decision Making in CSC Requires Accounting for Existing Racial Disparities

CSC planning is part of the broader social system that is impacted by SDOH. Resource allocation involves value-laden choices. CSC plans therefore can incorporate values that exacerbate or endeavor to mitigate structural racism. Ethical decision making is a core component of CSC planning, but while most would agree that fairness does not always require treating all equally, there can be genuine disagreements about what, in the alternative, constitutes a fair allocation of resources. The COVID-19 pandemic appears to be manifesting along the lines of familiar racial inequalities driven by well-known SDOH. Racial justice is therefore a core factor that should be incorporated when defining what constitutes fair resource allocation, which requires hard choices about dispensing care.

CSC planning may draw upon existing core principles to address concerns about racial inequities. It is crucial that CSC plans do not unnecessarily replicate existing disparities by failing to incorporate these concerns. Community buy-in has long been recognized as central to CSC planning. It requires the inclusion of diverse perspectives, particularly from communities of color who appear to be suffering the most serious effects from COVID-19. In short, community engagement is a racial justice issue.

Real time data in COVID-19 racial inequities, including infections, seriousness of illness, morbidity, differences in treatment, and other relevant data will only help better inform CSC plans. This will also build COVID-19 responses that are informed and responsive to local needs. CSC planning is part of a current social structure that contains pervasive racial inequalities with people of color faring poorly. Engaging in CSC planning that is just requires obtaining the right data and implementing inclusive processes.

SUPPORTERS



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- ¹ INSTITUTE OF MEDICINE, *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situation: A Letter Report* (2009), <https://www.ncbi.nlm.nih.gov/books/NBK219953/>.
- ² INSTITUTE OF MEDICINE, *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* (2012), https://www.ncbi.nlm.nih.gov/books/NBK201072/#sec_0007.
- ³ INSTITUTE OF MEDICINE, *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situation: A Letter Report* (2009), <https://www.ncbi.nlm.nih.gov/books/NBK219953/>.
- ⁴ INSTITUTE OF MEDICINE, *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* (2012), https://www.ncbi.nlm.nih.gov/books/NBK201072/#sec_0007.
- ⁵ *Id.*
- ⁶ The Network for Public Health Law, COVID-19 Emergency Legal Preparedness Primer (As of April 21, 2020), <https://www.networkforphl.org/wp-content/uploads/2020/04/Western-Region-Primer-COVID-4-21-2020.pdf#page=26>; U.S. DEPARTMENT OF LABOR OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, *Guidance on Preparing Workplaces for COVID*, 14-17 (Last Visited April 24, 2020), <https://www.osha.gov/Publications/OSHA3990.pdf>.
- ⁷ INSTITUTE OF MEDICINE, *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*, Chapter 4 Cross Cutting Themes (2012), <https://www.ncbi.nlm.nih.gov/books/NBK201082/>.
- ⁸ *Id.*
- ⁹ *Id.*
- ¹⁰ The Network for Public Health Law, COVID-19 Emergency Legal Preparedness Primer (As of April 21, 2020), <https://www.networkforphl.org/wp-content/uploads/2020/04/Western-Region-Primer-COVID-4-21-2020.pdf#page=25>.
- ¹¹ This example comes from the Maryland CSC planning framework. *Maryland Framework for the Allocation of Scarce Life-sustaining Medical Resources in a Catastrophic Public Health Emergency* (August 24, 2017), https://www.law.umaryland.edu/media/SOL/pdfs/Programs/Health-Law/MHECN/ASR%20Framework_Final.pdf
- ¹² NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE. *Rapid Expert Consultation on Crisis Standards of Care for the COVID-19 Pandemic* (March 28, 2020), <https://www.nap.edu/download/25765>.
- ¹³ William F. Owen Jr., Richard Carmona, Claire Pomeroy, *Failing Another National Stress Test on Health Disparities*, JAMA (April 15, 2020), https://jamanetwork.com/journals/jama/fullarticle/2764788?guestAccessKey=23098ca6-8f80-47f5-9c57-744b65be5816&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=olf&utm_term=041520.
- ¹⁴ MICHIGAN.GOV, *Coronavirus Michigan Data* (April 17, 2020), https://www.michigan.gov/coronavirus/0,9753,7-406-98163_98173---00.html.
- ¹⁵ NPR, *Louisiana Sen. Cassidy Addresses Racial Disparities in Coronavirus Deaths* (April 7, 2020), <https://www.npr.org/sections/coronavirus-live-updates/2020/04/07/828827346/louisiana-sen-cassidy-addresses-racial-disparities-in-coronavirus-deaths>.
- ¹⁶ POLITICO, *Black doctors blast woefully anemic data on minority coronavirus cases* (April 20, 2020), <https://www.politico.com/news/2020/04/20/minority-cases-coronavirus-197203>.
- ¹⁷ Samantha Artiga, Kendal Orgera, Olivia Pham, Bradley Corallo, *Growing Data Underscore that Communities of Color are Being Harder Hit by COVID-19*, KAISER FAMILY FOUNDATION (April 21, 2020), https://www.kff.org/coronavirus-policy-watch/growing-data-underscore-communities-color-harder-hit-covid-19/?utm_campaign=KFF-2020-Medicaid&utm_source=hs_email&utm_medium=email&utm_content=86645517&hsenc=p2ANqtz--mit5Ds1AMpPlqNtkKL1A_7SbgKIkArMKQ5B-iA4lPnFM8x5PfkSm5i9lJnCiNLNzRV_81lpktZ1SwnsJfbnpYsLdJEG&_hsmi=86645517.

- 18 NPR, *In Chicago, COVID-19 Is Hitting the Black Community Hard* (April 6, 2020), <https://www.npr.org/sections/coronavirus-live-updates/2020/04/06/828303894/in-chicago-covid-19-is-hitting-the-black-community-hard>.
- 19 NEW YORK TIMES, *Virus is Twice as Deadly for Black and Latino People than Whites in N.Y.C.* (Updated April 14, 2020), <https://www.nytimes.com/2020/04/08/nyregion/coronavirus-race-deaths.html>.
- 20 Daniel Chang, C. Isaiah Smalls II, *Black people in Miami die of COVID-19 at a greater rate than whites, state data shows*, MIAMI HERALD (Updated April 19, 2020) <https://www.miamiherald.com/news/coronavirus/article242039576.html>.
- 21 TIMES DAILY, *Alabama numbers show disparity in COVID-19 deaths* (April 12, 2020), https://www.timesdaily.com/news/state/alabama-numbers-show-race-disparity-in-covid-19-deaths/article_e987cdf3-a8d3-57b0-80b7-2b082bc66e8a.html.
- 22 KAISER HEALTH NEW, *The Other COVID Risks: How Race, Income, Zip Code Influence Who Lives or Dies* (April 22, 2020), https://khn.org/news/covid-south-other-risk-factors-how-race-income-zip-code-influence-who-lives-or-dies/?utm_campaign=KHN%3A%20First%20Edition&utm_source=hs_email&utm_medium=email&utm_content=86847279&hsenc=p2ANqtz-zH9gitnlWT05uZOtnpSzFvxB7ebsoXyp8_-255ay2DzjwnnNv5Yxbw_HhlMmMAN8HtJumqd2rgLBc72_2MYQVz8lDeA&hsmi=86847279.
- 23 NPR, *White House: Data on COVID-19 and Race Still Weeks Away* (April 20, 2020), <https://www.npr.org/sections/coronavirus-live-updates/2020/04/20/838745546/white-house-data-on-covid-19-and-race-still-weeks-away>.
- 24 Samantha Artiga, Kendal Orgera, Olivia Pham, Bradley Corallo, *Growing Data Underscore that Communities of Color are Being Harder Hit by COVID-19*, KAISER FAMILY FOUNDATION (April 21, 2020) https://www.kff.org/coronavirus-policy-watch/growing-data-underscore-communities-color-harder-hit-covid-19/?utm_campaign=KFF-2020-Medicaid&utm_source=hs_email&utm_medium=email&utm_content=86645517&hsenc=p2ANqtz--mit5Ds1AMpPlqNtkKL1A_7SbgKlArMKQ5B-iA4IPnFM8x5PfkSm5i9lJnCiNLNzRV_81lpktZ1SwnsJfbbpYsLdJEq&hsmi=86645517.
- 25 NPR, *In New York Nursing Homes, Death Comes to Facilities With More People of Color* (April 22, 2020), <https://www.npr.org/2020/04/22/841463120/in-new-york-nursing-homes-death-comes-to-facilities-with-more-people-of-color>.
- 26 *Id.*
- 27 For example, the Navajo Nation has experienced about 13% of Arizona's COVID-19 cases, yet it makes up only 1.4% of Arizona's population. PHOENIX NEW TIMES, *Navajo Nation and Arizona's Rural North Bear the Brunt of its COVID-19 Deaths* (April 2020), <https://www.phoenixnewtimes.com/news/navajo-nation-azs-rural-north-bear-the-brunt-of-covid-19-deaths-11463856>. Although the data on racial demographics is incomplete, Arizona recently reported that 16% of the state's COVID-19 deaths were Native American, despite this group composing 6% of the population. INDIAN COUNTRY TODAY, *Arizona: 16 percent of COVID-19 deaths are Native Americans* (April 13, 2020), <https://indiancountrytoday.com/news/arizona-16-percent-of-covid-19-deaths-are-native-americans-b-n3zYNsgUGFHIFSZpzPqx>.
- 28 HEALTHY PEOPLE.GOV, *Social Determinants of Health* (Last Updated April 22, 2020), <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.
- 29 For example, residential segregation has been identified as adversely impacting health. See Donald F. Schwartz, *What's the Connection Between Residential Segregation and Health?*, ROBERT WOOD JOHNSON FOUNDATION CULTURE OF HEALTH BLOG (April 3, 2018) <https://www.rwjf.org/en/blog/2016/03/whats-the-connection-between-residential-segregation-and-health.html>.
- 30 HEALTHY PEOPLE.GOV, *Social Determinants of Health* (Last Updated April 22, 2020), <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.
- 31 WASHINGTON POST, *4 reasons coronavirus is hitting black communities so hard* (April 10, 2020) <https://www.washingtonpost.com/politics/2020/04/10/4-reasons-coronavirus-is-hitting-black-communities-so-hard/>.
- 32 Elise Gould, Heidi Shierholz, *Not everybody can work from home*, ECONOMIC POLICY INSTITUTE (March 19, 2020), <https://www.epi.org/blog/black-and-hispanic-workers-are-much-less-likely-to-be-able-to-work-from-home/>.
- 33 NEW YORK TIMES, *How Millions of Women Became the Most Essential Workers in America* (April 18, 2020) <https://www.nytimes.com/2020/04/18/us/coronavirus-women-essential-workers.html?smid=nytcore-ios-share>.
- 34 Safiya Richardson, Jamie S. Hirsch, Mangala Narasimhan, *Presenting Characteristics, Comorbidities, and Outcomes Among 5700 Patients Hospitalized With COVID-19 in the New York City Area*, JAMA (April 22, 2020), <https://jamanetwork.com/journals/jama/fullarticle/2765184>.
- 35 CENTERS FOR DISEASE CONTROL AND PREVENTION, *People Who Are at Higher Risk for Severe Illness* (April 15, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>.

- 36 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF MINORITY HEALTH, *Diabetes and African Americans* (Last Modified December 12, 2019), <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18>.
- 37 CENTERS FOR DISEASE CONTROL AND PREVENTION, *Hispanic/Latino Americans and Type 2 Diabetes* (Last Reviewed September 15, 2019) <https://www.cdc.gov/diabetes/library/features/hispanic-diabetes.html>.
- 38 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF MINORITY HEALTH, *Obesity and African Americans* (Last Modified March 26, 2020), <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=25>.
- 39 CENTERS FOR DISEASE CONTROL AND PREVENTION, *Adult Obesity Facts* (Last Reviewed February 27, 2020) <https://www.cdc.gov/obesity/data/adult.html>.
- 40 <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity>
- 41 Leonard Jack Jr., Nkenge H. Jack, Sandra C. Hayes, *Social Determinants of Health in Minority Populations: A call for Multidisciplinary Approaches to Eliminate Diabetes-Related Health Disparities*, DIABETES SPECTRUM, Vol. 25, Issue 1 (2012)<https://spectrum.diabetesjournals.org/content/25/1/9>.
- 42 KAISER HEALTH NEWS, *The Other COVID Risks: How Race, Income, Zip Code Influence Who Lives or Dies* (April 22, 2020), https://khn.org/news/covid-south-other-risk-factors-how-race-income-zip-code-influence-who-lives-or-dies/?utm_campaign=KHN%3A%20First%20Edition&utm_source=hs_email&utm_medium=email&utm_content=86847279&hsenc=p2ANqtz-zH9gitnlWT05uZOtnpSzFvxB7ebsoXyp8_-255ay2DzjwnnNv5Yxbw-HhlMmMAn8HtJumqd2rgLBc72_2MYQVz8lDeA&hsmi=86847279.
- 43 HEALTHY PEOPLE.GOV, *Social Determinants of Health* (Last Updated April 22, 2020), <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.
- 44 NEW YORK TIMES, *Black Americans Face Alarming Rates of Coronavirus Infection in Some States* (Updated April 14, 2020), <https://www.nytimes.com/2020/04/07/us/coronavirus-race.html?referringSource=articleShare>; Kristen Jordan Shamus, *Family Ravaged by coronavirus begged for tests, hospital care but was repeatedly denied*, USA TODAY (April 20, 2020), <https://www.usatoday.com/story/news/nation/2020/04/20/coronavirus-racial-disparity-denied-tests-hospitalization/5163056002/>.
- 45 CENTERS FOR DISEASE CONTROL AND PREVENTION, *Testing for COVID-19* (April 15, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html>.
- 46 For example, an algorithm widely used by hospitals that used health care costs to predict who would benefit from further care produced racially biased results because black people spend less on care as a result of poverty, not medical need. HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH, *Study: Widely used health care algorithm has racial bias* (2019), <https://www.hsph.harvard.edu/news/hsph-in-the-news/study-widely-used-health-care-algorithm-has-racial-bias/>.
- 47 CENTERS FOR DISEASE CONTROL AND PREVENTION, *Provisional Death Counts for Coronavirus Disease (COVID-19): Weekly Updates by Select Demographic and Geographic Characteristics* (April 21, 2020), https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/.
- 48 CENTERS FOR DISEASE CONTROL AND PREVENTION, *Cases of Coronavirus Disease (COVID-19) in the U.S.* (Site last visited April 22, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>.
- 49 NPR, *White House: Data on COVID-19 and Race Still Weeks Away* (April 20, 2020), <https://www.npr.org/sections/coronavirus-live-updates/2020/04/20/838745546/white-house-data-on-covid-19-and-race-still-weeks-away>.
- 50 JOHN HOPKINS UNIVERSITY & MEDICINE, *Racial Data Transparency: States that have released breakdowns of COVID-19 data by race* (April 21, 2020) <https://coronavirus.jhu.edu/data/racial-data-transparency>.
- 51 WBUR, *Thinking Through The Unthinkable: How Mass. Hospitals May Decide Who Gets a Ventilator in the COVID-19 Surge* (Updated April 8, 2020), <https://www.wbur.org/commonhealth/2020/04/07/icu-ventilator-triage-massachusetts-covid-19-coronavirus>.
- 52 WBUR, *Pressley Says ICU, Ventilator Guidelines Negatively Affect Minorities and Wants Baker To Rescind Them* (April 14, 2020), <https://www.wbur.org/commonhealth/2020/04/14/ayanna-pressley-critical-care-state-guidance-governor-letter>
- 53 *Id.*
- 54 WBUR, *After Uproar, Mass. Revises Guidelines on Who Gets An ICU Bed or Ventilator Amid COVID-19 Surge* (Updated April 22, 2020), <https://www.wbur.org/commonhealth/2020/04/20/mass-guidelines-ventilator-covid-coronavirus>.
- 55 NPR, *Opinion: U.S. Must Avoid Building Racial Bias into COVID-19 Emergency Guidance* (April 21, 2020), <https://www.npr.org/sections/health-shots/2020/04/21/838763690/opinion-u-s-must-avoid-building-racial-bias-into-covid-19-emergency-guidance>.

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- ⁵⁶ DISABILITY RIGHTS WASHINGTON, Complaint (March 23, 2020), https://www.centerforpublicrep.org/wp-content/uploads/2020/03/OCR-Complaint_3-23-20-final.pdf; HHS, *OCR Reaches Early Case Resolution with Alabama After It Removes Discriminatory Ventilator Triaging Guidelines* (April 8, 2020), <https://www.hhs.gov/about/news/2020/04/08/ocr-reaches-early-case-resolution-alabama-after-it-removes-discriminatory-ventilator-triaging.html>; HHS, *OCR Resolves Civil Rights Complaint Against Pennsylvania After it Revises its Pandemic Health Care Triaging Policies to Protect Against Disability Discrimination* (April 16, 2020) <https://www.hhs.gov/about/news/2020/04/16/ocr-resolves-civil-rights-complaint-against-pennsylvania-after-it-revises-its-pandemic-health-care.html>.
- ⁵⁷ HHS OFFICE OF CIVIL RIGHTS IN ACTION, *Bulletin: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19)*, <https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf>.
- ⁵⁸ HHS, *OCR Reaches Early Case Resolution with Alabama After It Removes Discriminatory Ventilator Triaging Guidelines* (April 8, 2020), <https://www.hhs.gov/about/news/2020/04/08/ocr-reaches-early-case-resolution-alabama-after-it-removes-discriminatory-ventilator-triaging.html>.
- ⁵⁹ *Korematsu v. U.S.*, 323 U.S. 214 (1944) (holding racial classifications are subject to highest level of scrutiny).
- ⁶⁰ *Washington v. Davis*, 426 U.S. 229 (1976).
- ⁶¹ HHS, *Civil Rights Requirements-A. Title VI of the Civil Rights Act* (Last Visited April 23, 2020) <https://www.hhs.gov/civil-rights-for-individuals/special-topics/needy-families/civil-rights-requirements/index.html>.
- ⁶² NATIONAL HEALTH LAW PROGRAM, *Your Civil Rights to Health Care. Your Rights Under Title VI of the Civil Right* (July 23, 2013), <https://healthlaw.org/resource/your-civil-rights-to-health-care-your-rights-under-title-vi-of-the-civil-right/>.
- ⁶³ CONGRESSIONAL RESEARCH SERVICES, *Civil Rights at School: Agency Enforcement of Title VI of the Civil Rights Act of 1964*, pages 8-10, (April 4, 2019), <https://fas.org/sqp/crs/misc/R45665.pdf>.
- ⁶⁴ HHS, *Civil Rights Requirements-A. Title VI of the Civil Rights Act* (Last Visited April 23, 2020) <https://www.hhs.gov/civil-rights-for-individuals/special-topics/needy-families/civil-rights-requirements/index.html>.