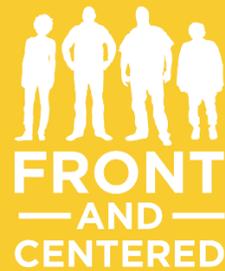


FRONT & CENTERED



COVID-19 Gap Analysis

AN INITIAL GLIMPSE AT WASHINGTON STATE



facebook.com/frontandcentered



[@frontandcentered](https://twitter.com/frontandcentered)



info@frontandcentered.org



frontandcentered.org



Front and Centered

Bullitt Center, 1501 E Madison St #250

Seattle, WA 98122

206-487-4303

info@frontandcentered.org

www.frontandcentered.org

MAIN AUTHOR: Isabel Carrera Zamanillo, Ph.D. for Front & Centered

Report published in February 2021.

Front and Centered is a statewide coalition of organizations and groups rooted in communities of color and people with lower incomes; we are on the frontlines of economic and environmental change. As thought leaders and organizers we build our agenda and strength with our grassroots community. Together we build power and capacity for a Just Transition that centers equity and is led by people of color.

ACKNOWLEDGEMENTS

We want to express our gratitude to all the community organizations and individuals that completed the survey and especially, we want to express our gratitude to WA-GRO and Julieta Altamirano-Crosby for their support in the distribution of the survey.

TABLE OF CONTENTS

Executive summary	3
Overview of the study	5
Objectives	5
Methodology	6
COVID-19 in Washington State	8
Social factors	8
Economic factors	15
Environmental factors	19
The COVID-19 crisis in the perception of Washingtonians	21
Washington State response to the COVID-19 crisis	25
Identified gaps during the COVID-19 crisis	29
Conclusion	30
References	32
Appendix I	39
Appendix II	41

EXECUTIVE SUMMARY

In recent months, dozens of studies have demonstrated the disproportionately higher rates of SARS-CoV-2 infection among black, indigenous, and people of color (BIPOC) and low-income communities. However, there is still a need to better understand the impact of this pandemic, not only from a public and environmental health perspective, but also from a more dynamic socioeconomic and environmental justice set of perspectives, so as to ensure that structural inequalities do not exacerbate the crisis.

COVID-19 MORTALITY RATE:

6X Hawaiian & Pacific Islander

4X Latinx & Native American

2X African American

*compared to Caucasian individuals
Rate calculated per 100,000habs, age-adjusted.
It varies per county

The current report represents an effort to raise awareness of the higher level of vulnerability and specific challenges faced by BIPOC and low-income communities in the state of Washington in order to identify potential gaps in the response to this ongoing crisis.

MAIN GAPS IDENTIFIED

➤ **Financial support**
*including unemployment benefits & fairly compensated work opportunities

➤ **Health services**
*including COVID-19 free testing and medical insurance

➤ **Food security**

➤ **Reliable access to internet**
*including affordable devices

➤ **Culturally responsive information and services**
*including translated material

Migratory status is a main barrier to all of these

It is important to bear in mind that the scope of this study is limited to the identification of some of the main elements of daily life in BIPOC communities that have been impacted by the COVID-19 pandemic, including but not limited to the effects of structural racism and particularly the unequal access to basic resources such as basic health care, fairly compensated and safe jobs, food, and affordable housing.

Furthermore, the findings of this report should be considered in the context of certain limitations inherent to the limited understanding of the SARS-CoV-2 virus, the existing gaps in publicly available data regarding other confounding variables in terms of space and time of collection (e.g. environmental disparities), and the scale of this study.

Among the main findings, the rural and urban divide plays an important role in the resources available for communities facing this pandemic. At the core of this division is an unequal distribution of resources that impact health care and social care factors.

Front and Centered strongly believes that the recognition of socioenvironmental determinants of health from different scales and perspectives is crucial to address the current crisis. Without elevating the voices of those who have been disproportionately affected there is a risk of developing inefficient policies and programs that superficially deal with some of the consequences of the pandemic, without solving the underlying problems. The solutions that will allow us to break from business as usual are those that prioritize equity and inclusion. There is no climate path forward that does not address the need to shift systems of governance, place, health/wellbeing, economy, and energy toward justice.

The current pandemic represents a triple threat; it encompasses a public health threat exacerbated by an economic recession and climate change. In order to effectively deal with this problem, we will need to develop a radical form of resilience rooted in the recognition of structural racism as the first step in transforming our institutions, public infrastructure, and securing a fairer distribution of resources. We have an excellent opportunity to explore a just zero-carbon transition that can create new job opportunities and bring health benefits, especially for those at the frontlines of the climate change threats.

In this context, *Front and Centered* demands place-based and people-centric strategies for assuring more equitable access to services emerging from intentional, inclusive, and long-term commitments that effectively address health, social, economic, and environmental disparities, to build resilience among the communities that live in Washington State. An equity-focused approach to solving the climate and pandemic crisis can dismantle institutionalized systems of oppression and replace them with regenerative models that serve everyone.



Figure 1- COVID-19 vulnerability depends on several social, economic, political, and environmental factors. This figure considers factors considered in the COVID-19 Community Vulnerability Index and the Social Vulnerability Index.

This report is intended to provide *Front and Centered*, our member organizations, and our allies an initial glimpse of the impacts of COVID-19 on black, indigenous, and people of color (BIPOC)

and low-income communities. As the interconnected crises continue to unravel, this report may serve as a jumping off point for additional questions to examine for the community leader, practitioner, and policy maker. How are communities filling-in the gaps in services and resources related to exposure, treatment, and death? What are the continuum of approaches being deployed to manage exposure, from the point of prevention to intervention and solution? How might the community access to basic needs and critical infrastructure (healthcare, education, transportation, water, energy, housing) determine their resiliency to the pandemic? To what extent do such factors correlate to their status as an at-risk essential worker? These are just some of the potential questions this report aims to initiate, by endeavoring to ask important questions about the pandemic through an equity framework.

SECTION ONE: OVERVIEW OF THE STUDY

OBJECTIVES

The current coronavirus crisis has made evident the devastating impact of structural inequities in black, indigenous, and people of color (BIPOC) communities, as well as low-income families. For many people, these inequities have become an issue of life or death. In fact, available data shows a disproportionately fast rate of SARS-CoV-2 infection in BIPOC communities. These communities are more vulnerable to an outbreak due to socio-economic factors and other socio-environmental determinants of health that are rooted in structural racism.

Researchers have demonstrated that geographic location and socioeconomic inequities are a main factor for imminent health disparities. The places people work, live, eat, play, and learn are shaped by the opportunities available to them, which are based on social class, gender, and/or race/ethnicity. Socio-environmental settings and how they shape people's living experiences are what the World Health Organization and the Centers for Disease Control define as social determinants of health. These determinants include access to adequate resources, including education, housing, food, job opportunities, transportation, public safety, technology, green spaces, and safe built environments. However, it is important to recognize that cultural differences also shape the needs of diverse communities; it is necessary to acknowledge these differences in order to develop better strategies to serve these groups.

This initial analysis is meant to provide some insight into potential socio-environmental determinants that can exacerbate the negative impact of the coronavirus pandemic, especially in BIPOC and low-income communities. The main sources of information are a literature review, publicly available data, as well as the results of surveys and focus groups conducted among community organizations affiliated with *Front & Centered*. The ultimate goal is to provide an

initial snapshot of whether and to what extent has COVID-19 exacerbated the inequities for BIPOC communities and to contrast statewide resources and other forms of support with community reported needs.

METHODOLOGY

The *COVID-19 Gap Analysis* report relies on a mixed-methods approach that combines quantitative and qualitative data. In terms of quantitative data, it looks at 86 social and environmental health datasets regarding the populations of each county in Washington state. This data has been correlated with information collected through a literature review, as well as with qualitative data collected via surveys held in collaboration with community organizations across the State to help contextualize the findings from the quantitative analysis.

For the surveys, two different surveys were designed (see Appendix II). The first survey was designed for individuals, offered in English and Spanish, and distributed by local community organizations to understand the needs at an individual and household levels. A second survey was designed for local community organizations, only in English, to share the perceived needs at a community level.

Google Forms was the platform used to distribute a 10-question¹ long questionnaire for 30 days. Following an informed consent section, the questionnaire asked participants to mark their personal identities from a provided list as a way to get some demographics. An open question asking for their zip code was included to know the geographic distribution of the participants. A couple of questions allowed participants to indicate some potential services and areas impacted by the current pandemic. All responses were kept anonymous. Frequencies were calculated based on selected areas for further statistical analysis, on a single-stage collection. No sampling weights were used, given that this was not a probabilistic sample of adults.

We strongly believe that this mixed-methods framework is necessary in that it gives meaning to the numbers by exploring the histories of communities impacted by COVID-19. Numbers and percentages will never substitute the richness of community-based information. In order to achieve truthfully inclusive assessments, the work has to begin on the ground and include community-based participatory research methods.

While the Washington State Department of Health dashboard looks into only five social determinants for health (poverty, limited education, limited English proficiency, unemployment, and lack of insurance) (WADOH 2020), the datasets analyzed for this report include social, economic and environmental factors as suggested by the World Health Organization and the U.S. Centers for Disease Control.

¹ Surveys included open- and closed-ended questions.

It is crucial to say that due to the novelty of this virus, existing literature and data is limited, requiring caution in the interpretation of the data. For example:

- Race and ethnicity are still not reported for a significant number of cases (30%). The Washington State Board of Health is currently working with county-level elected leaders to address this gap in information.
- The use of broad racial/ethnic reporting categories such as Black, Pacific Islanders, Asian, or Hispanic/Latinx overlooks the large diversity within communities, limiting our ability to truly understand the impacts of COVID-19 across smaller communities. The combining of distinct groups may limit our ability to recognize differences in COVID-19 impacts related to language, culture, or country of origin.
- Access to testing is, to a large degree, determined by the rural/urban divide, as well as by language and cultural barriers. This is partially related to the limited amount of culturally responsive material available, as well as by the digital divide.
- Although more data is being collected at the level of census tract, this report had to focus on the county level in order to be able to correlate the available data using the same geographic unit. However, this sort of approach can lead to certain generalizations that might not reflect the reality of many communities. This demonstrates the need to collect more data, at a more granular scale, and with higher frequency.

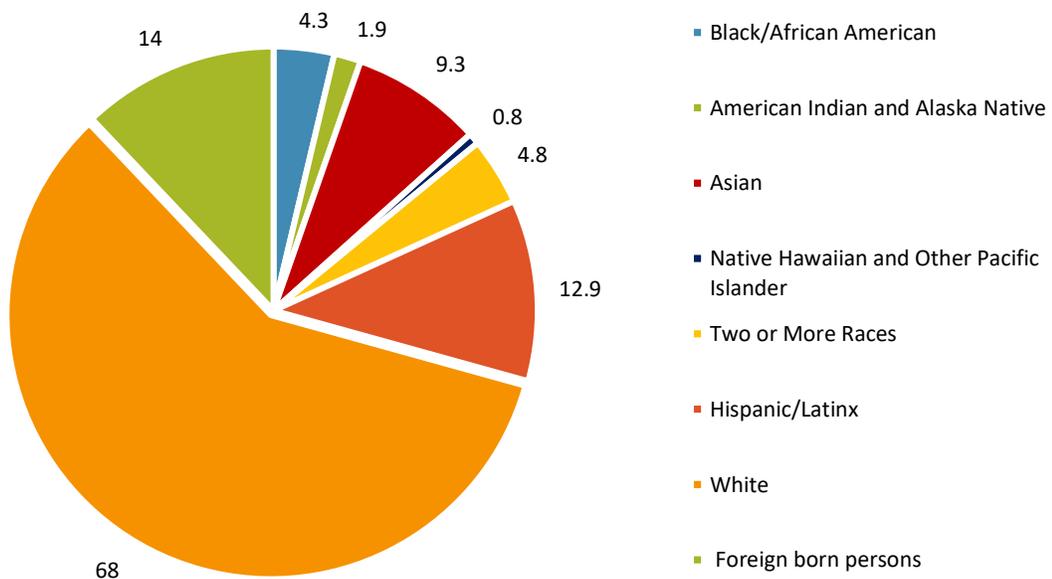
The main limitations to this study include the lack of updated and disaggregated publicly available data. This is an area of opportunity to create better and more inclusive systems of data collection that truly reflect the reality of the many diverse communities that live in the state of Washington. In the case of the distribution of COVID-19 cases in the state, it reflects how health disparities are socially determined and while the coronavirus does not discriminate, policies shaping social, economic, environmental, and health care systems do.

SECTION TWO: COVID-19 IN WASHINGTON STATE

SOCIAL FACTORS

Washington State is a region of deep social and environmental contrast. It is home for 7,614,893 people throughout 39 counties (U.S. Census Bureau 2020). It is the birthplace of some of the world’s biggest companies including Microsoft, Amazon, Boeing, Starbucks, and Costco. But it also has more than twenty thousand people experiencing homelessness (Washington State Department of Commerce 2019). It is home to 29 federally-recognized Indian tribes (Washington Indian Gaming Association 2020) and has become home to thousands of foreigners, from farmworkers to tech experts and academic researchers.

Figure 2- Washington State Demographics



Source: U.S. Census Bureau

The federal Environmental Protection Agency defines “meaningful involvement” as:

- “People have an opportunity to participate in decisions about activities that may affect their environment and/or health;
- The public’s contribution can influence the regulatory agency’s decision;
- Community concerns will be considered in the decision-making process; and
- Decision-makers will seek out and facilitate the involvement of those potentially affected.”

According to the Washington State Department of Health, 23,442² people in the state have been infected by the SARS-CoV-2 virus. The five counties with the highest number of COVID-19 cases and deaths are King, Pierce, Snohomish, Yakima, and Benton, by the first week of June 2020. The following table summarizes data that characterizes these five counties in terms of reported number of cases, hospitalizations, and deaths, as well as the number of cases per 100K habitants, their COVID-19 community vulnerability, environmental risks (e.g. air and water pollution, vulnerability to heat waves, and exposition to toxic materials), and social vulnerability:

Table 1- Counties in Washington States with more COVID-19 reported cases

County	COVID-19 cases	COVID-19 hospitalizations	COVID-19 deaths	Cases per 100,000 people	CCVI ³	High risk, Environmental Disparities	SVI ⁴
King	8417	1659	576	378	0.28	~30%	0.09
Yakima	4366	337	100	1530.93	0.69	~90%	0.84
Snohomish	3025	566	152	379.73	0.19	~18%	0.1
Pierce	2019	366	85	226.79	0.26	~25%	0.26
Benton	906	152	66	423.86	0.63	~75%	0.3

Source: Washington State Department of Health 2020.

*The COVID-19 Community Vulnerability Index (CCVI) and the Social Vulnerability Index (SVI) consider 0 the lowest level of vulnerability and 1 the highest level of vulnerability.

When comparing the available COVID-19 demographic data for Washington State with other existing data such as the Community COVID-19 Vulnerability Index, the Social Vulnerability Index, and the Environmental Disparities displayed in the Disparities Map⁵, the overall socioeconomic disparities in Washington State become more evident. Special attention should be paid to what is happening in Yakima and Benton counties given that they show a high level of COVID-19

²As reported by June 6, 2020

³ It is important to mention that the COVID-19 Community Vulnerability Index incorporates the Social Vulnerability Index and correlates it with epidemiologic and healthcare system factors.

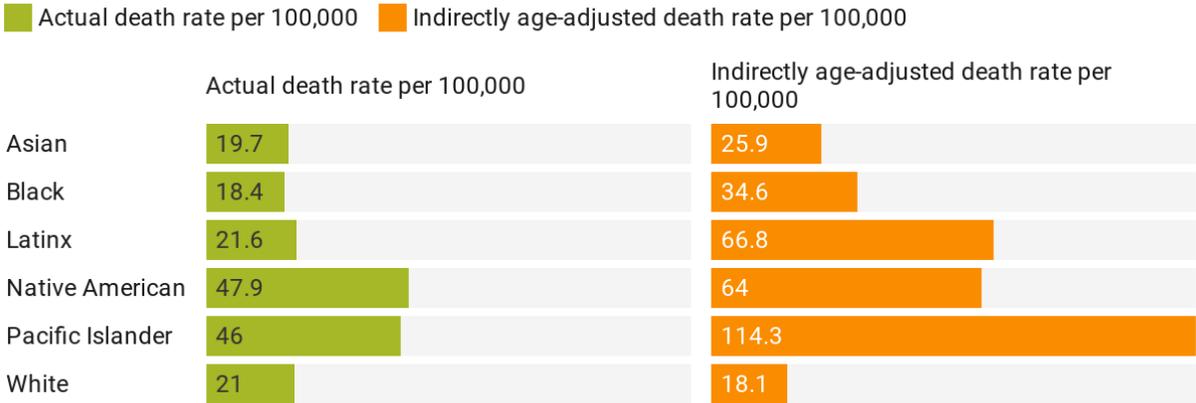
⁴ The Social Vulnerability Index incorporates data related to socioeconomic status, household composition and disability, minority status and language, housing type and transportation. Consider that the data available is for year 2018.

⁵ Co-created between Front & Centered, University of Washington researchers, and the Washington State Department of Health.

vulnerability; special care is needed so as to increase their resilience. More detailed information can be found in the coming pages.

In the current health crisis, data suggest a disproportionate rate of infection and death among BIPOC communities (CDC 2020). Across the United States, Blacks, Latinxs, and Native Americans people are getting infected with COVID-19 at alarmingly high rates relative to the percentage of the population they represent (Kendi 2020; Scott 2020; APM Research Lab 2020). Furthermore, the mortality rate, when calculated per 100,000 people and when indirectly adjusted based on age distribution (with emphasis on individuals 45 years of age or older), shows a much grimmer reality, especially for Native American and Pacific Islander individuals:

Figure 3- Washington State COVID-19 mortality rate per 100,000



Source: APM Research Lab. Data as reported by August 7, 2020. Created with Datawrapper

In terms of the demographic distribution of the disease in Washington State, Latinx, Native Hawaiian/Pacific Islanders, and Blacks have significantly higher rates of COVID-19 infection compared to Caucasians. This is also the case regarding the rates for American Indian and Asian communities based on their distribution among the population (APM Research Lab 2020; Kamb 2020). In the case of Yakima County, the rate of COVID-19 infection per capita is the highest in the state. It is important to remember that there is a high Latinx migrant community in this county working in the agriculture and food industry; the Latinx population in this area are more impacted in comparison with other groups (Berton 2020; Westneat 2020). It is important to consider that many cases go unreported, especially among immigrant and undocumented communities, who avoid healthcare services because of fear of current immigration policies and previous negative experiences due to discriminatory practices which have reduced their trust in health institutions. All these conditions, together with existing prejudices, have heightened the sense of uncertainty

for millions of non-White Americans who are also experiencing higher rates of stress, depression, and anxiety (Alfonseca 2020; Solis et al. 2020). In this sense, the current pandemic has unveiled the direct correlation between structural racism and “the unequal distribution of social, economic, environmental and other structural resources that put a substantial economic, clinical and human toll on communities and societies” (Kullar, Marcelin, et al. 2020).

The following table shows the percentages of COVID-19 related cases, hospitalizations, and deaths in the state of Washington based on their distribution among racial/ethnic groups and their representation in the State’s total population:

Table 2- COVID-19 reported cases and deaths in the state of Washington

Race/Ethnicity	Percent of Total WA Population	Percent of Cases	Percent of Hospitalizations	Percent of Deaths
<i>Unknown</i>	NA	29%	28%	5%
<i>Latinx/Hispanic</i>	13%	41%	26%	11%
<i>American Indian or Alaska Native</i>	1%	1%	1%	1%
<i>Asian</i>	9%	7%	9%	10%
<i>Non-Hispanic Black</i>	4%	6%	6%	3%
<i>Native Hawaiian or Other Pacific Islander</i>	1%	3%	2%	1%
<i>Multiracial</i>	4%	2%	1%	1%
<i>Other Race</i>	NA	2%	2%	2%
<i>White</i>	68%	38%	53%	71%

Source: Washington State Department of Health. Data as reported by June 7, 2020

For the purpose of this report, it is necessary to recognize that approximately 29% of the cases reported have not been correlated to a racial/ethnic group. However, reported cases have been confirmed via appropriate medical test but many more cases might never be reported, either for the lack of testing availability or the potential obstacles thousands of people face to access appropriate health care.

In this sense, the COVID-19 crisis is also exposing the deep inequities that thousands of migrant farmworkers face in the United States and Canada, including overcrowded living conditions, lack of access to clean water or sanitation facilities, lack of access to personal protective equipment (PPE), and lack of health benefits (Haley, et al. 2020). In addition, many of these farmworkers do not speak English and feel intimidated by American immigration policies, which often keeps them from seeking necessary medical attention (Kamb 2020).

In the case of those counties with larger urban areas (i.e. King, Pierce, Snohomish), higher rates of infection are related to higher levels of population density, including institutionalized living settings⁶. However, when compared to the ratio of infection per 100,000 people, Yakima and Benton counties show the largest infection rate, despite the fact that a large amount of the county is considered rural. This could be attributed in part to working and living conditions, especially for farmworkers and those laboring in packing/canning facilities.

It is important to mention that in King, Pierce, Snohomish, and Yakima counties, a larger number of BIPOC and immigrant communities live in these areas. These ethnic groups represent the largest number of workers in service, seasonal, and agricultural jobs.

Structural inequities are not only the root of racial/ethnic, education, and income disparities in the United States; they also directly impact health conditions and access to health services (CDC 2020; Gray, Anyane-Yeboah, et al. 2020; Solis et al. 2020).

According to the Centers for Disease Control and Prevention pre-existing health conditions such as diabetes, early pregnancy, asthma, chronic obstructive pulmonary diseases, cancer, cardiovascular diseases, obesity, and hypertension are risk factors that could lead to severe

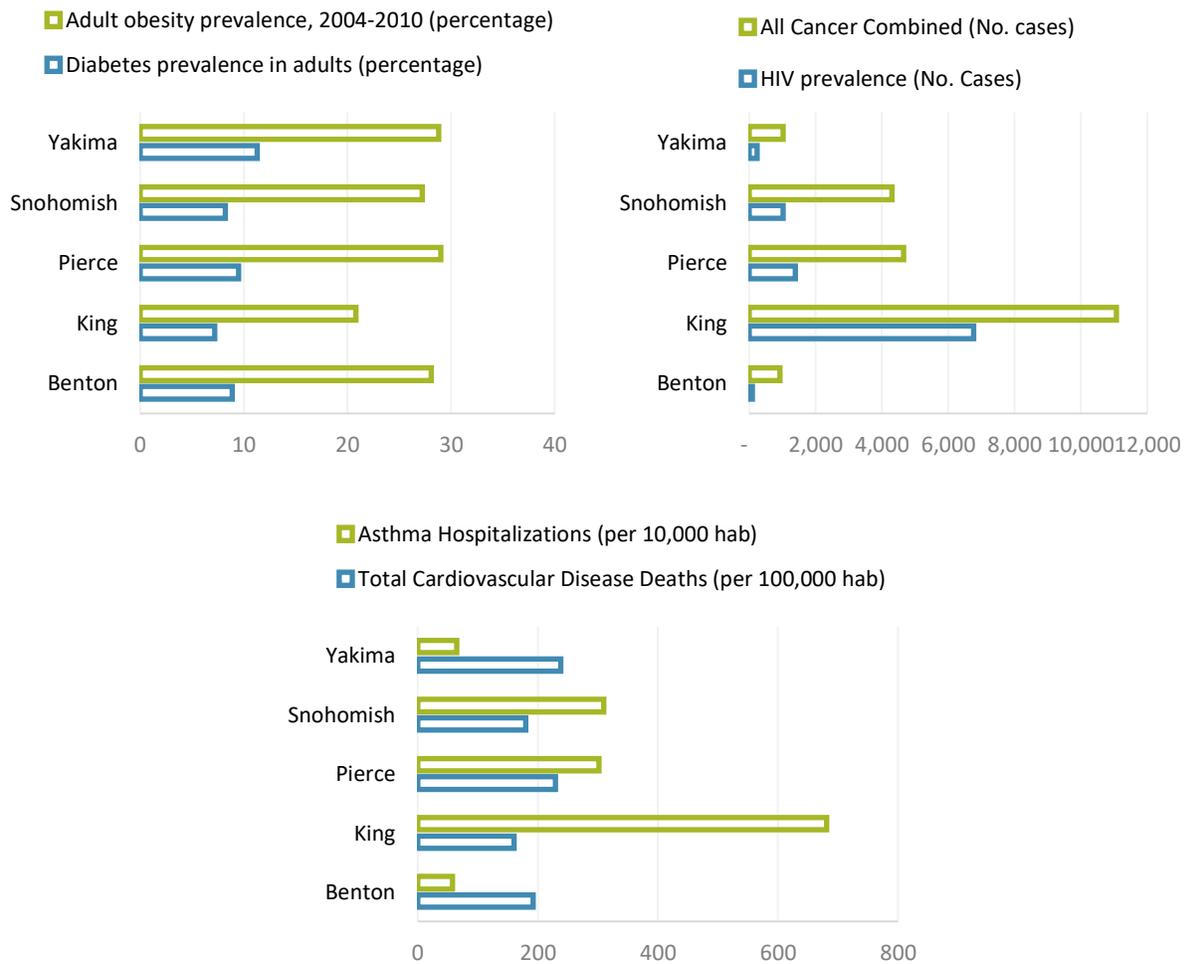


Immediate free, no-barriers access to the COVID-19 health services and workplace safety measures is important to protect worker health and safety.

⁶ Mental facilities, detention centers, nursing homes, and other facilities.

complications from COVID-19 infection (Gray, Anyane-Yebo, et al. 2020; Sun 2020). Historically, American Indian and Alaska Native, Black, and Latinx individuals in America have had higher rates of these pre-existing conditions in comparison to White Americans (Kent 2020; Raifman and Raifman 2020; Scott 2020). In addition, many individuals in these racial/ethnic groups do not have health insurance or they have access only to limited health services (CDC 2020).

Figure 4- Prevalence of chronic diseases in adults



Source: Washington State Department of Health

Disparities also exist in rates of health care coverage and health infrastructure (the number and distribution of hospitals and clinics, as well as the number of physicians per capita). These factors are crucial for making COVID-19 testing and treatment options more accessible.

In terms of available resources and infrastructure, Washington State is divided into 35 health jurisdictions that vary vastly in the quality of services they provide. The coronavirus crisis has made more evident the disparities between each one of these jurisdictions. In terms of the distribution of the public health budget among the counties in the state, the difference between the county with the highest health spending per capita (San Juan) and the county with the lowest health spending per capita (Snohomish) is almost \$240 per capita (Kroman 2020).

Table 3- Health spending per capita

<i>County</i>	<i>Dollars</i>
<i>Benton</i>	35
<i>King</i>	108.2
<i>Pierce</i>	38.9
<i>Snohomish</i>	19.8
<i>Yakima</i>	23.7

Source: Kroman 2020

King, Pierce, and Snohomish counties have the largest workforce in the state and they also have the largest concentration of physicians compared to other counties. On the other end of the spectrum is Yakima county, home to the largest group of non-English-proficient workers and one of the counties with the lowest median household income, the largest number of single-parent homes reported, and the largest amount of uninsured individuals. This reflects the direct impact of deep structural inequities on COVID-19 infection rates.

In regard to Medicaid coverage, in Washington State adults in financial need are covered, whether or not they have dependents. According to *Healthier Washington*, in 2018-2019, Medicaid coverage for the five counties most impacted by the SARS-CoV-2 outbreak looked as follows:

Table 4- Adult Access to Preventive/Ambulatory Health Services through Medicaid

County	Age			
	>20	20-44	46-64	>65
<i>Benton</i>	79%	78%	83%	95%
<i>King</i>	46%	73%	81%	88%
<i>Pierce</i>	76%	74%	80%	86%
<i>Snohomish</i>	80%	78%	83%	95%
<i>Yakima</i>	78%	76%	82%	81%

Source: Healthier Washington 2020

ECONOMIC FACTORS

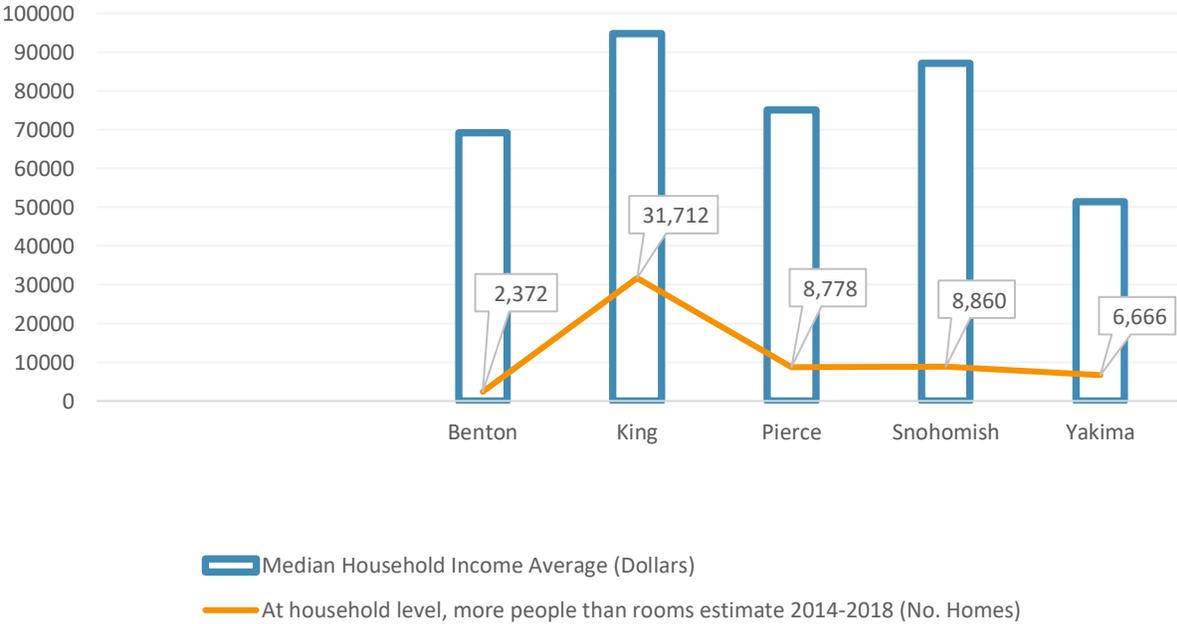
Research has demonstrated how economic factors impact not only individual, but also community access to space, and therefore, to different resources linked to place, “including food security; proximity to crucial services such as health care, parks, and open space; the social environment, including social capital, cohesion, [other] economic opportunities; and the physical environment including air quality, traffic density, and housing quality” (Front and Centered 2020).

It has been well documented that many BIPoC households do not have a cash cushion to support them during times of crisis (Keshner 2020). According to the Institute for Policy Studies, *the median White household has 41 times more wealth than the median Black household and 22 times more wealth than the median Latino household* (Collins, et al. 2019). In the state of Washington, the difference between the highest household income and the lowest household income exceeds \$230,000 (American Community Survey 2018). This wealth gap translates into the struggle that Black and Latinx households experience in paying their monthly bills in contrast to White households (Keshner 2020; Lopez, Rainie, Budiman 2020) and has a direct impact on their ability to afford other necessities such as food and medical care (WADOH 2018).



Front and Centered calls to create equitable, green revenue, and financing sources that support community scale, no-barriers support for basic needs and green job opportunities accessible to all.

Figure 5- Comparison of median income per household and number of people living in the household



Considering that in the United States about fifty percent of the population relies on job benefits to have health care coverage, the loss of work hours or a job can seriously limit the ability to access health services, including COVID-19 treatment options (Allsbrook 2020; Gray, Anyane-Yeboah, et al. 2020). In fact, a recent study by University of Washington showed that those without health insurance, especially BIPOC individuals, are about three times more likely to incur medical debt, augmenting the risk of homelessness and further health complications (Bielenberg, Futrell, et al. 2020).

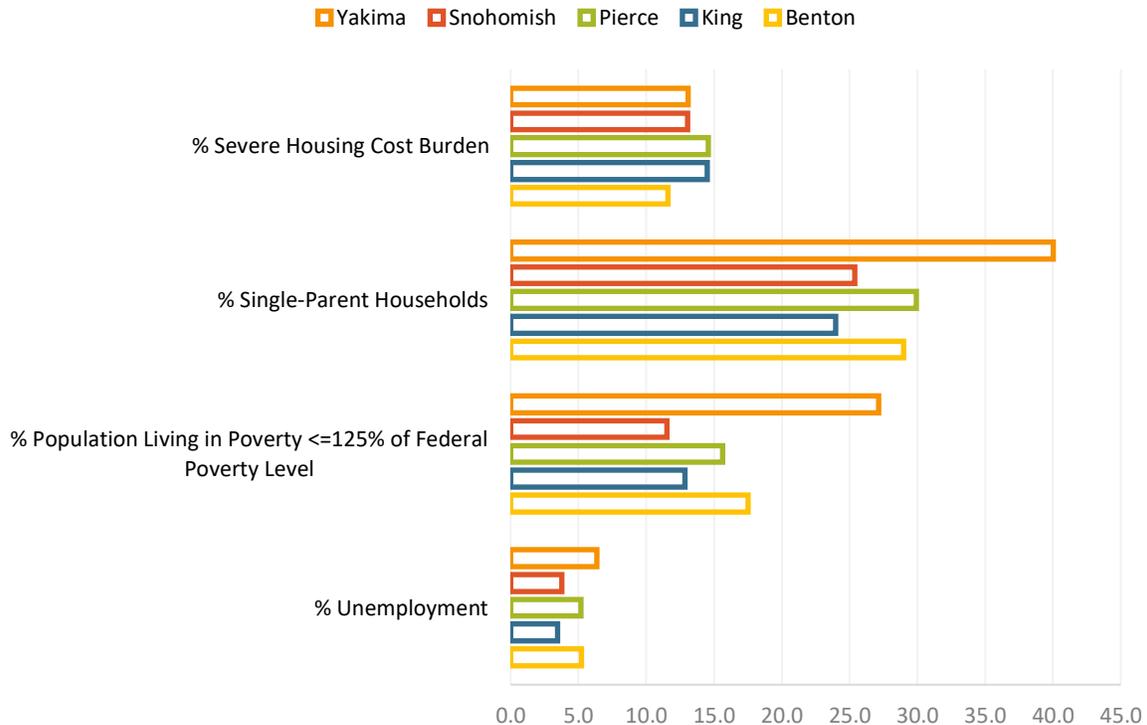
It is also important to consider that many of these communities tend to live in multigenerational and crowded households due to specific aspects of their cultures but also due to wealth disparities that impact entire households (CDC 2020; Raifman and Raifman 2020).

During the current health crisis, about half of the Latinxs surveyed expresses that they or someone in their household has taken a pay cut or lost a job because of the COVID-19 pandemic in contrast to about 30 percent of overall US households. This can be at least partially explained by the fact that more than 8 million Latinxs work in the service and hospitality sectors, including restaurants and hotels (Krogstad, Gonzalez-Barrera, Lopez 2020; Lopez, Rainie, Budiman 2020; Kamb 2020). Furthermore, many immigrants are undocumented, meaning that even though they contribute to the American economy with their work and by paying billions of dollars in taxes,

they are not eligible to receive any emergency financial or medical assistance funded by the federal government (Alfonseca 2020; Solis et al. 2020).

According to Washington STEM, just in King, County African American and black people make up 6% of the population in the county but make up 11% of the unemployment claims, while Latinxs make up 8% of the population in but make up 9% of the unemployment claims.

Figure 6- Some socioeconomic indicators showing disparities across counties

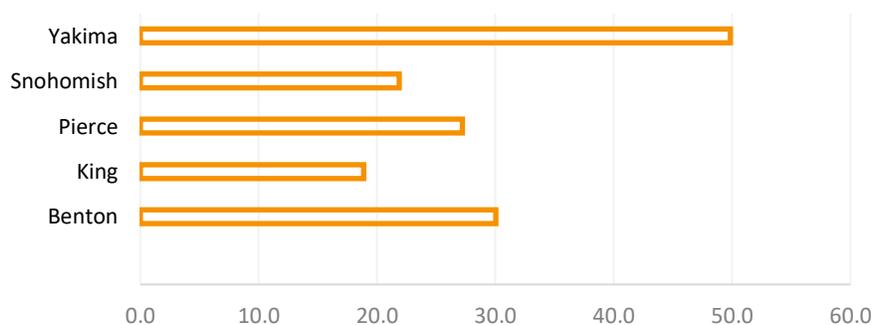


In addition, the COVID-19 crisis and the need to follow social distancing measures have transformed the daily lives of millions of people in the United States. Virtual environments have become part of the “new normal” but it has also uncovered a deep digital divide. For example, for many BIPOC and low-income communities, teleworking or social distancing is not an option since they are more likely to work in sectors considered “essential” during coronavirus-related closures, including grocery store clerks, nurses, farmworkers, warehouse workers, cleaners, and public transportation drivers, (Rho, Brown, Fremstad 2020; Scott 2020). Nevertheless, most of these “essential jobs” tend to be underpaid, do not offer sufficient protection for the workers, and do not offer the same quality of benefits in comparison to higher-paid jobs. Furthermore, people of color, immigrants, and women are overrepresented in these positions (Krogstad, Gonzalez-Barrera, Lopez 2020; Lopez, Rainie, Budiman 2020; Kamb 2020; Rho, Brown, Fremstad 2020).

According to a recent study from University of Washington, across the United States, only about 25% of U.S. workers have jobs in areas such as technology, administration, finance, academia, and engineering that can be done from home (Baker 2020). These statistics match with U.S. Bureau of Labor Statistics data that show that less than 20 percent of black workers and less than 16 percent of Latinx workers are able to telecommute (Nania 2020). Moreover, not having access to a reliable source of internet service represents a tangible obstacle to finding available resources, including medical services, legal advice, food distribution centers, and other forms of support. This digital divide also has an impact on individuals' ability to engage in remunerative and/or educational activities. This issue is exacerbated by the limited number of culturally (and particularly linguistically) responsive material (Alfonseca 2020).

In order to bolster public infrastructure in highly impacted communities, strengthen place-based communities and self-determination by supporting culturally-rooted community based organizations who respond to unique needs often overlooked by universal programs.

Figure 7- Digital divide index showing access to internet



Source: Purdue University
 * 100 indicates the highest digital divide

In the case of business ownership, although women/BIPoC/immigrant-owned businesses still represent a small fraction of all the business in the United States, the COVID-19 crisis has disproportionately impacted this small sector. As a matter of fact, as shown by federal census

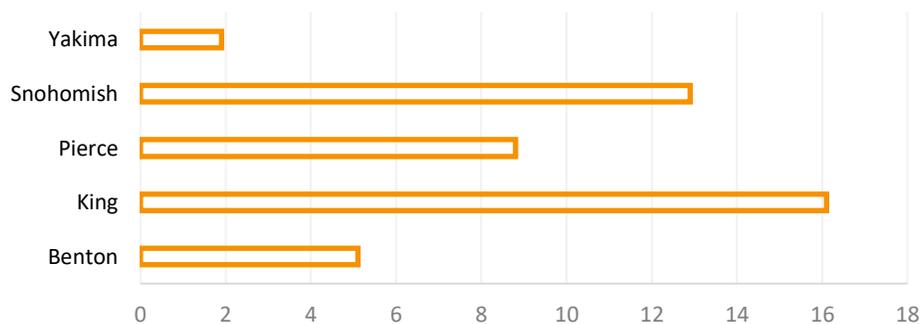
data, the number of women/BIPoC/immigrants-owned business forced to shut down by the pandemic exceeded almost by four times the number of white-owned that shut down (Dubb 2020). This has had a devastating effect in already harshly impacted communities.

ENVIRONMENTAL FACTORS

There is a vast amount of literature exposing the negative effects of air pollution on human health, including higher infant mortality rates, low-birth-weight births, and premature mortality in the presence of preexisting cardiovascular and respiratory conditions (Bashir et al. 2020, WADOH 2018). In the past couple of months, several scientific articles that establish an association between long-term air pollution exposure (particularly, to PM2.5 -fine particulate matter) and higher mortality rates for individuals infected by COVID-19 have been published (Bagley 2020; Bashir et al. 2020). Part of these findings is being analyzed to better understand the higher rates of mortality due to COVID-19 in patients with these kinds of conditions.

Initial research findings suggest that there could be a potential correlation between COVID-19 incidence rates in areas that have reported larger amounts of diesel emissions and higher percentages of paved surfaces. It is well known that people living in highly polluted areas have a higher risk of developing asthma (Cecchi 2018; Khreis et al. 2017; Orellano 2017; Wu et al. 2020). In the case of Washington State, data regarding certain aspects of this issue such as overall diesel emissions, the population living close to high-traffic areas, and even exposure to pesticides, support these findings.

Figure 8- Population living close to high traffic in 2017 (percentage)



Source: Washington State Department of Health

Deepening the rural-urban divide is the unsustainable land-use planning and policies of segregation that lead to high dependency on vehicles (contributing with greenhouse gases emissions) as a result of the long distances between homes, workplaces, services, community institutions, and even health care facilities. These emissions, together with the increasing number of wildfires, especially in the eastern part of Washington state, reduces the air quality, but also contributes to global warming and ocean acidification.

The differential pollution burden across racial/ethnic groups results from higher rates of exposure among people of color generally than white communities and leads to several health conditions and therefore, in a differentiated life expectancy. Some studies had demonstrated that White adults live an average of ten years longer than Black adults, 12 years longer than Latinx adults, and three years longer than Asian/Pacific Islander adults (Front & Centered 2016). As mentioned before, this plays an important role in the rate of vulnerability to COVID-19.

The social and environmental context in which people live has a direct impact on their health. It is necessary to recognize that structural inequities are the reason many BIPOC and low-income communities live in highly polluted areas (Bagley 2020; CDC 2020; Dalzell 2020; Frazin 2020). Other factors such as lack of access to potable water or lack of access to the green spaces that reduce heatwaves worsen the vulnerability of these communities to COVID-19 (Frazin 2020). In fact, the effects of climate change and water availability will also affect the



Community organizations working at the intersection of equity and environmental and climate change believe in a just transition -- from extractive resources toward universal access to clean water and energy sufficiency. This means prohibiting shutoffs, expanding energy assistance and weatherization along with clean, community-produced energy, and strengthening regulations and enforcement on major sources of pollution to ensure clean air and water gets cleaner throughout recovery.

rates of infection, creating more challenges in the coming months (Global Heat Health Information Network 2020; WADOH 2018).

“The COVID-19 crisis and the rise of Black Lives Matter movement have only amplified the need for Washington state to take a comprehensive approach to climate justice through a transition that is just and transformative. Washington was the first state in the United States to be struck by the COVID-19 pandemic. We were the first state forced to respond to the crisis. If we act thoughtfully and comprehensively take action, we can be the first to demonstrate pathways to a just recovery and just transition, not just from a pandemic but to our vision of a just, sustainable, and resilience society” (Front & Centered 2020).

PRINCIPLES OF CLIMATE JUSTICE

1. Racial and economic analysis should drive decisions (*Structural Equity*)
2. Follow the leadership, knowledge and expertise of communities disproportionately impacted (*Procedural Equity*)
3. Use targeted strategies to create net environmental and economic outcomes for Black, Indigenous, People of Color and low-income communities (*Distributional Equity*)

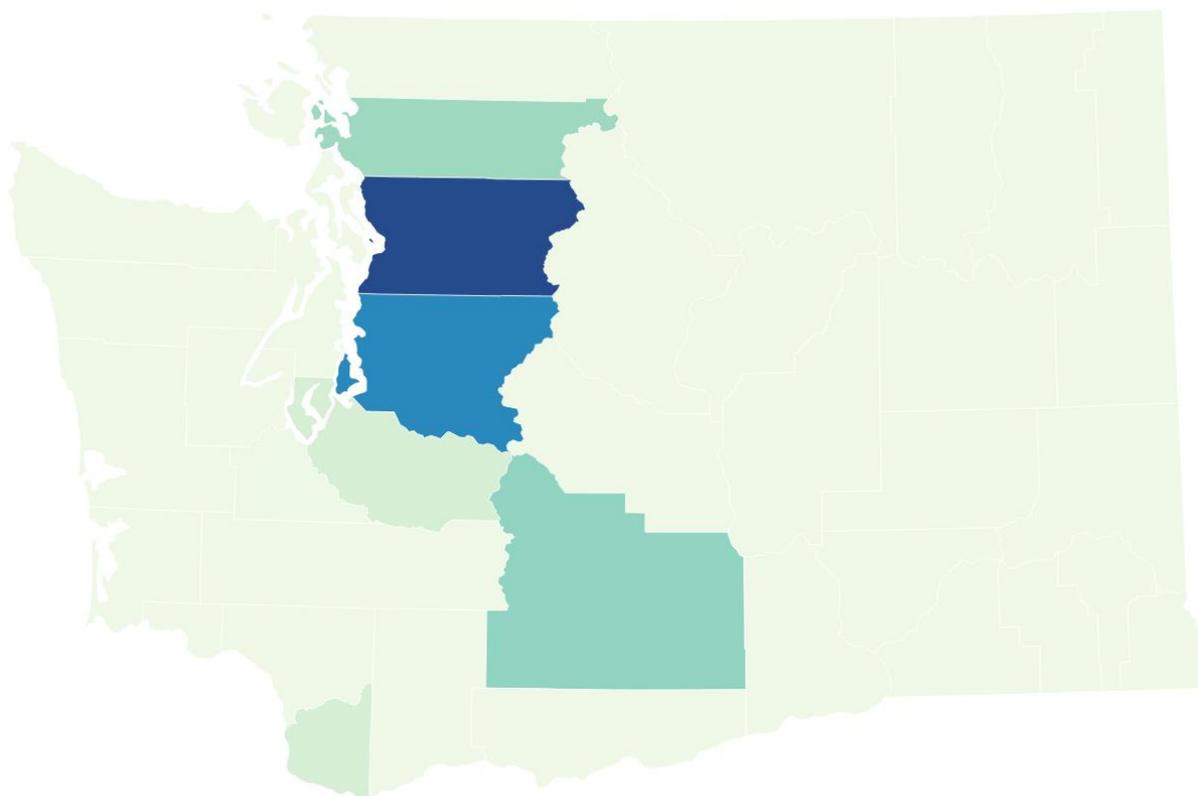
THE COVID-19 CRISIS IN THE PERCEPTION OF WASHINGTONIANS

In order to contextualize the previous data into the reality of many Washingtonians impacted by COVID-19, it was triangulated with a series of surveys distributed through Front & Centered and some allies, to better understand the impact of COVID-19 on Washingtonians based on lack of access to resources and perceived needs.

In total, eighteen community organizations responded the survey, from which 81 percent serve more than five hundred individuals per year, while the rest 19 percent serve between a hundred and five hundred individuals per year. In terms of coverage, half of the organizations serve communities statewide, while the rest of organizations serve BIPOC and vulnerable populations in some of the counties with more COVID-19 cases, including King, Snohomish, Skagit, Pierce, and Yakima counties. On the other hand, most of the individual respondents to the survey live in the counties in the corridor I-5.

Regarding the individual surveys, a total of 293 people answered the survey, from which 212 were completed online, while 81 were completed in paper. In terms of language, 219 were answered in Spanish and 74 were answered in English. Limitations in the sampling limited the geographic distribution and race/ethnicity of the respondents.

Figure 9- Distribution of survey responses across the state of Washington. Consider that half of the organizations who answered the survey provide services and support to people across the state.

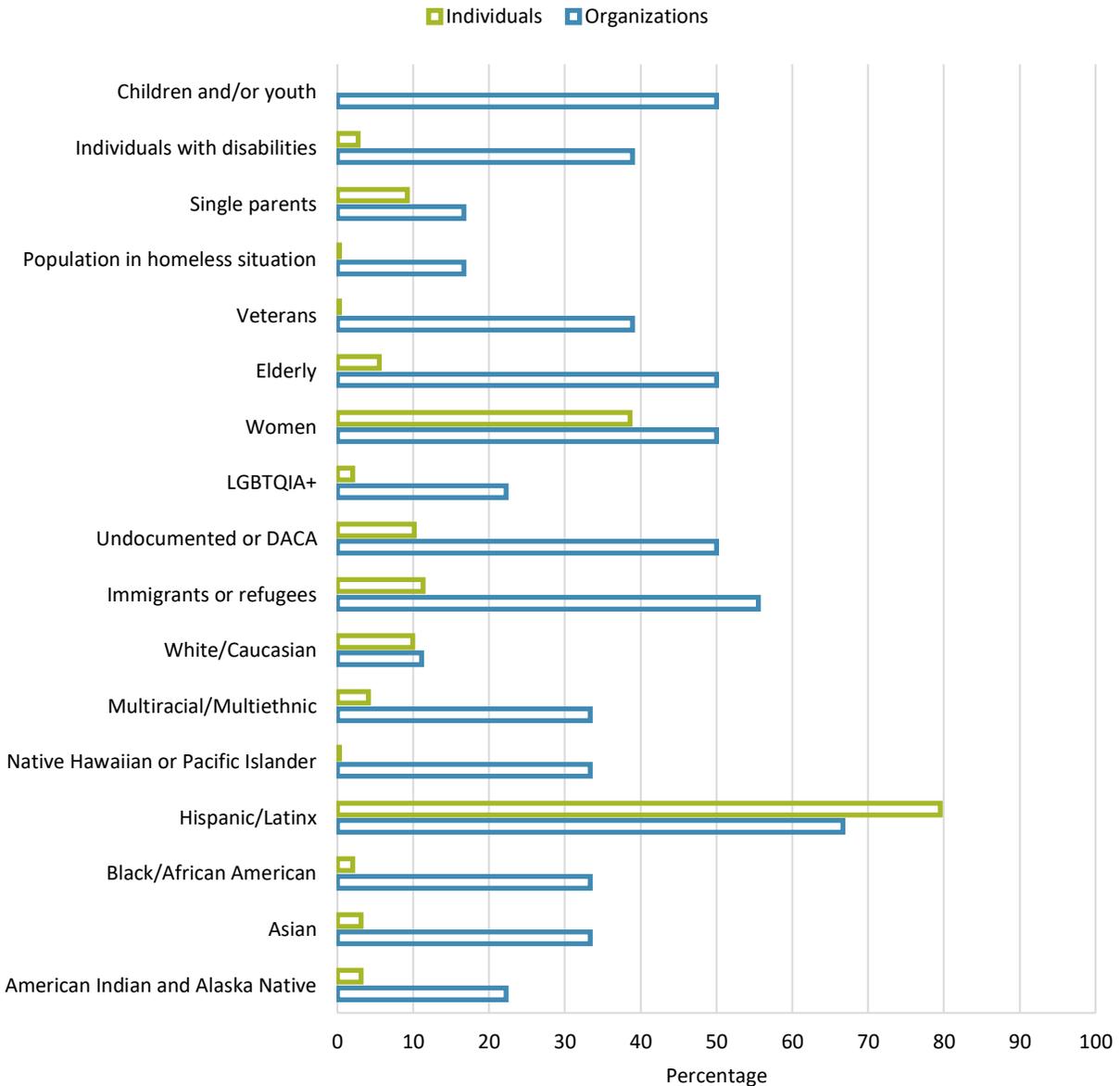


Created with Datawrapper.

Based on demographic information, there seems to be an overrepresentation of organizations that serve Hispanics or Latinxs and individuals that self-identify as such. This can be partially explained by the fact that Washington has a still growing Latinx population employed in agriculture, packing, construction, and forestry; however, many of these individuals are still marginalized and many community organizations have move to attend the needs of these communities due to the lack of appropriate support from state and federal agencies.

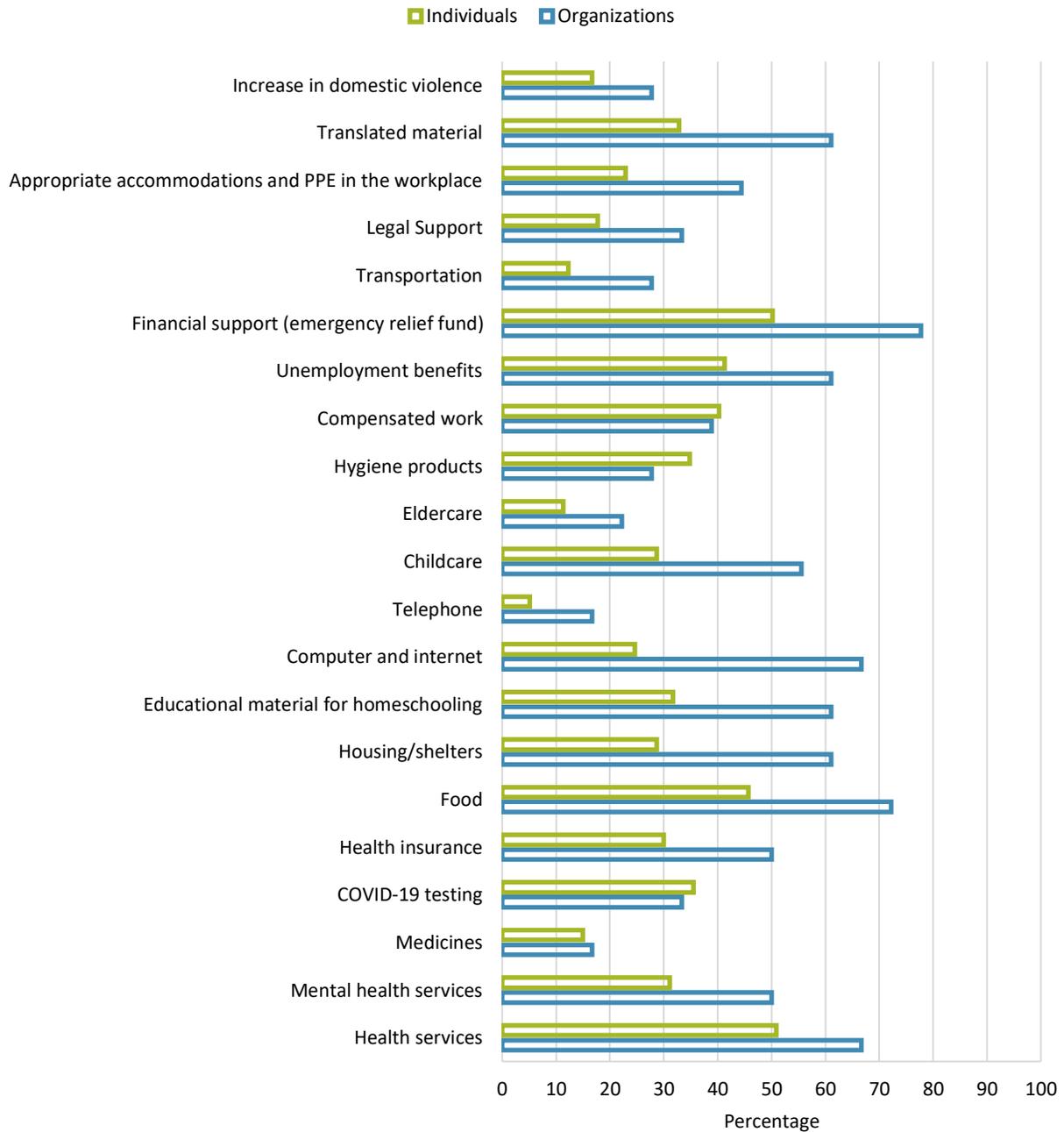
The high number of responses from women is also something to notice, especially when correlated with the number of single parents.

Figure 10- Comparison of demographic information regarding the survey responses passed to community organizations and individuals. The individual survey was open only to 18 years old or older people.



Among the more tangible areas of need that respondents expressed to be facing during this pandemic, health services, financial support, food, unemployment benefits, and compensated jobs stand out. All of these are basic needs and clearly show the negative role of structural inequities in the ability of individuals to cover them. As a direct result, problems in mental health and domestic violence have increased in the past months, becoming then new areas of attention.

Figure 11- Comparison between perceived responses regarding the most significant service needs and gaps identified based on the impact of COVID-19.



Some additional needs mentioned include high costs of living that combined with low paid jobs or unemployment have contributed to additional forms of stress; social isolation; poor basic services such as public restrooms and drinking water; and difficulty knowing how to navigate online settings.

In relation to the main barriers to resources, lack of translated material and culturally appropriate services, as well as lack of support and resources due to migratory status were recognized as factors that have increased a sense of fear and lack of trust in many immigrant and refugee communities.

There is no doubt that further analysis is needed to better understand the needs in other BIPOC communities. Nevertheless, Hispanics/Latinxs are currently one of the population in the state most heavily affected by the coronavirus in terms of the distribution of number of cases and deaths in the state.

WASHINGTON STATE RESPONSE TO THE COVID-19 CRISIS

Improving access to health care has been one of the first response actions to the current pandemic in Washington State. As a way to address societal inequities, the Washington State Department of Health and the Office of the Insurance Commissioner (OIC) issued an emergency order regarding state-regulated health plans on March 5, 2020 meant to reduce financial barriers linked to COVID-19-related expenses by covering testing (including any lab fees) and hospital visits for COVID-19. However, this order does not regulate self-funded employer plans, Medicaid, Medicare, or health plans for federal employees, members of the military, or veterans (Washington State Department of Health 2020).

Normally, many low-income and undocumented immigrant Washingtonians are not eligible for health care through public programs such as Medicaid, Medicare, and subsidized health insurance under the Affordable Care Act (ACA), even though their children are eligible for health coverage via the Washington Apple Health program regardless of immigration status. As a way to support these communities, the Washington State Department of Health has partnered with community clinics to offer COVID-19 testing and treatment options either at no cost or by providing a sliding-scale fee and additional payment plan options. Moreover, USCIS announced that the use of Medicaid for testing, treatment, and preventative care related to COVID-19 will not be considered a public charge (Washington State Department of Health 2020).

For those not eligible for health insurance coverage, many health centers across the state have waived some fees for COVID-19 and have also created telehealth options for individuals as a way to lower the burden on hospitals. In addition, the Alien Emergency Medical (AEM) program has been temporarily extended to cover COVID-19-related testing and treatment, while the Washington State Department of Social and Health Services established a disaster cash assistance program with no immigration status requirements. For those who have lost their jobs, the

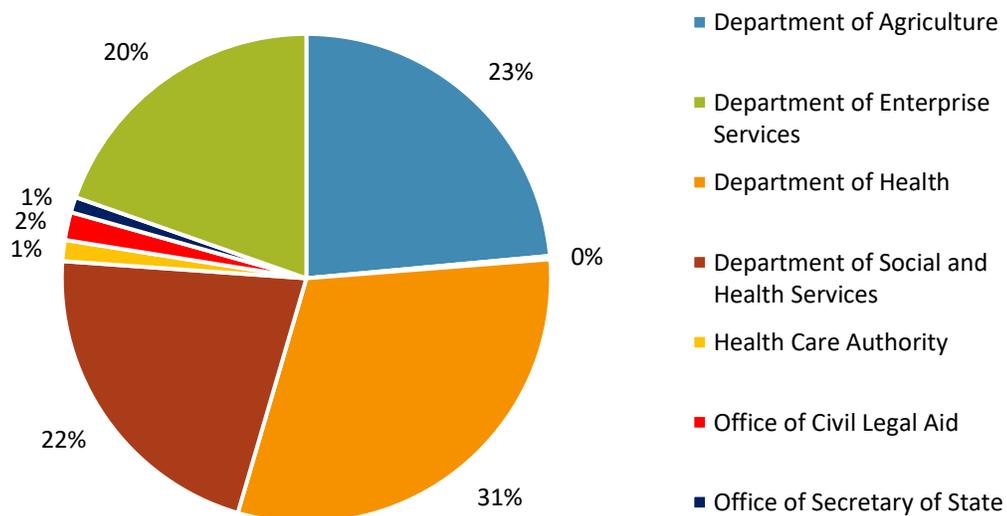
Washington State Health Benefit Exchange and Medicaid have extended open enrollment with no coverage gaps (Washington State Department of Health 2020).

In order to alleviate the health care gap in rural areas, the state created a \$2 million Rural Health Hospital Emergency Fund for the smallest and most financially vulnerable clinics to supplement Medicare payment relief programs and to provide necessary funds to rural communities (Birch, Lindeblad and Cody 2020). However, healthcare infrastructure in rural areas across the United States suffers from a limited allocation of resources, restricting their capacity to provide acute and critical care to thousands of people at risk of not receiving proper care if infected with the SARS-CoV-2 virus (Miller, Becker, et al 2020).

In the past weeks, the U.S. Department of Housing and Urban Development designated \$5.7M for the Lummi Nation Housing Authority; the Muckleshoot Housing Authority, the Nisqually Indian Tribe, the Squaxin Island Tribe and Tulalip Tribes, mainly to provide rental and utility assistance for families financially hurt by the COVID crisis (Mapes 2020).

In addition, to fight the current COVID-19 crisis, the State has distributed \$172.5 million as of June 2020, from a total of \$200 million in funds budgeted by the Legislature in Engrossed House Bill 2965, among state agencies and institutions (a detailed table with information on how this money has been distributed can be found in *Appendix I*) (Goldberg 2020; Office of Fiscal Management 2020).

Figure 12- Washington State agencies COVID-19 funds allocation



Source: Washington State Office of Fiscal Management

In addition, our organization was able to identify close to 300⁷ COVID-19-related financial support and emergency relief funds managed and distributed by state agencies, community-based organizations, philanthropic institutions, professional groups, and private industry. However, the total amount of support given was not possible to determine. In addition, 38 support funds were identified as available to the entire United States, while 46 funds were identified as available to any county in Washington State.

Figure 13- COVID-19-related financial support and emergency relief funds, geographic distribution, type of resources

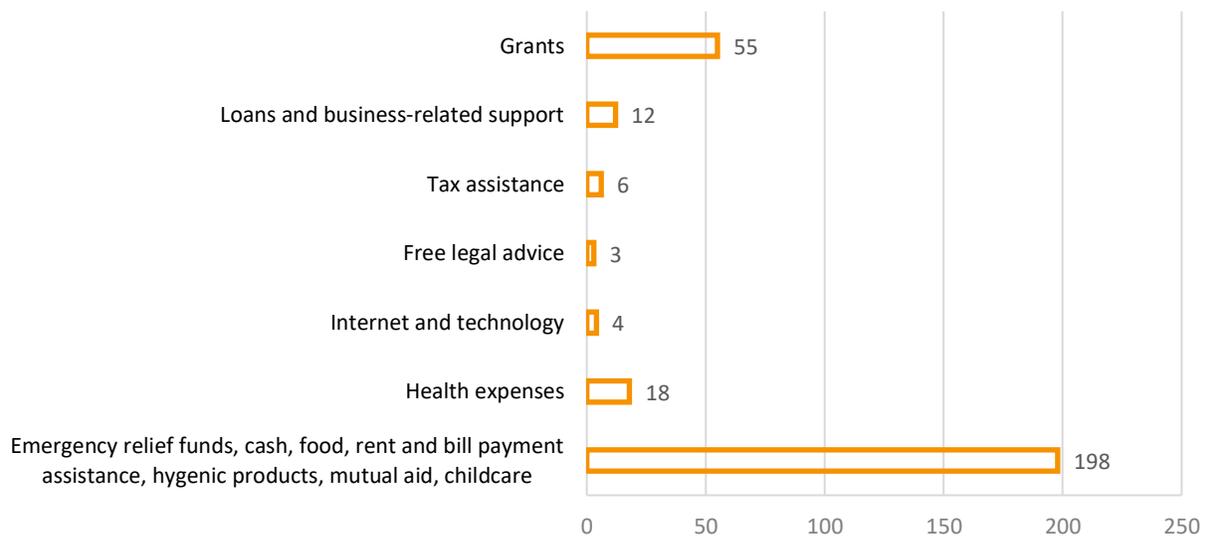
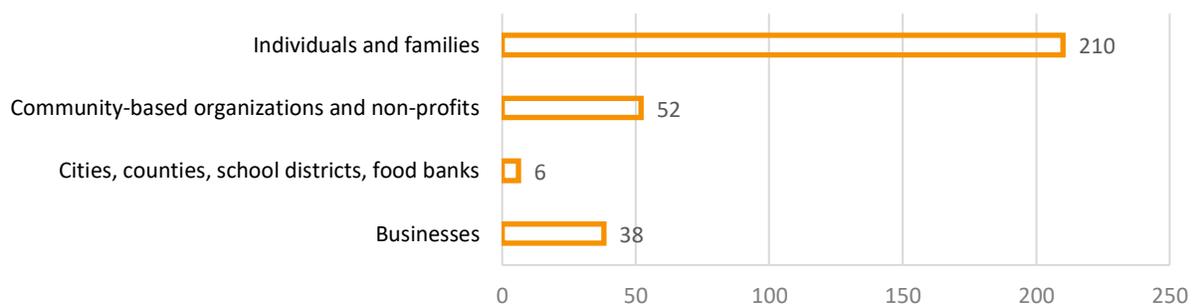


Figure 14- COVID-19-related financial support and emergency relief funds, per type of recipient



⁷ This number does not include funds distributed through the CARES Act or by FEMA.

Figure 15- COVID-19-related financial support and emergency relief funds, per final recipient⁸

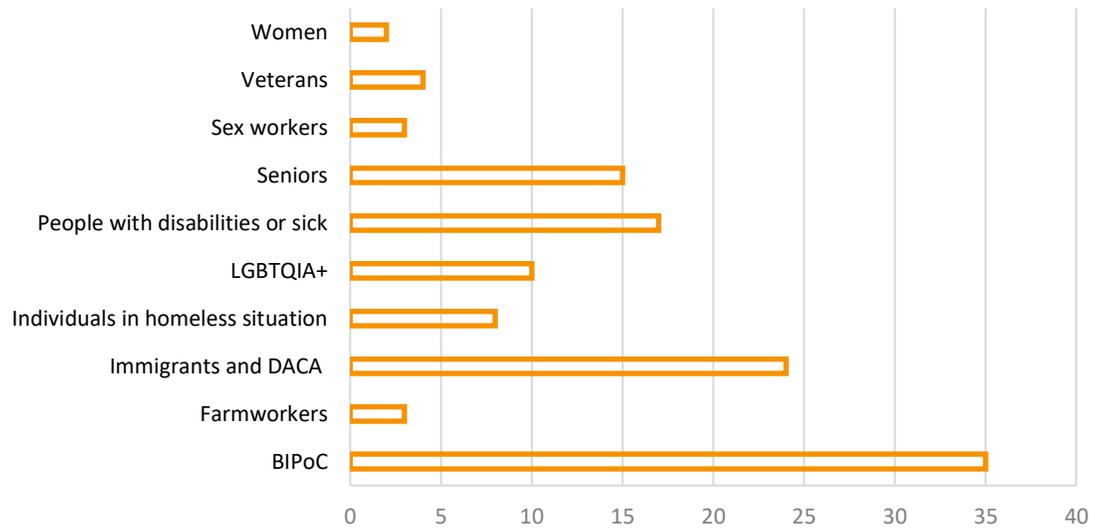
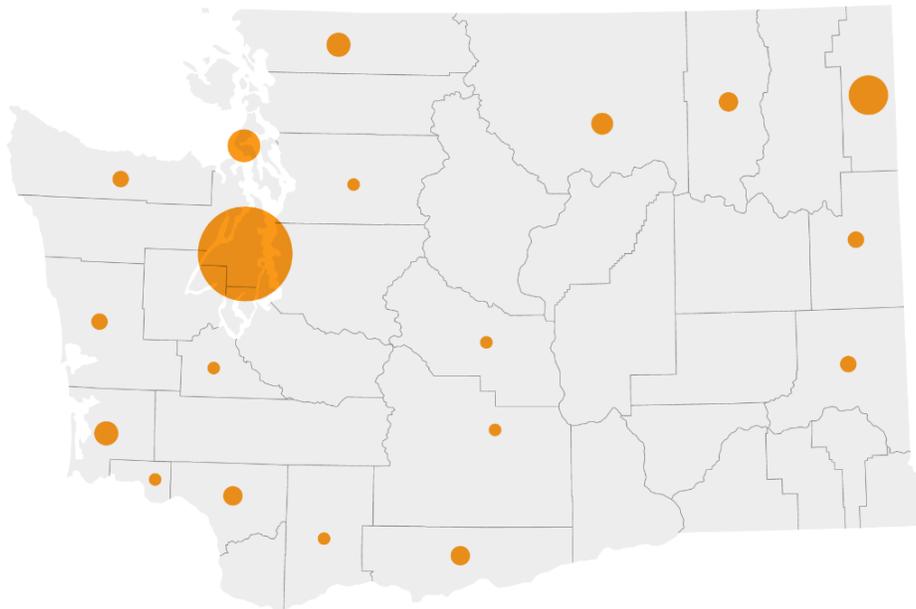


Figure 16- COVID-19-related financial support and emergency relief funds, geographic distribution



The size of the circle describes the number of sources identified. 33% of the resources were concentrated in King County, while Pierce and Snohomish County concentrated 5% of the resources each. This unequal distribution of funds only exacerbates existing inequities. Created with Datawrapper

⁸ This was calculated based on an initial compilation of information of funds and grants. Categories used in this figure depend on the ones explicitly reported by the groups proving the funds or grants.

INITIAL MAIN IDENTIFIED GAPS DURING THE COVID-19 CRISIS

- Food security
- Access to adequate health services
- Health insurance coverage
- Limited access to information due to lack of culturally and linguistically appropriate material
- Adequate work accommodations and personal protective equipment for “essential workers”, especially farmworkers and workers in packing facilities
- Adequate housing and living conditions
- Abuse from landlords and work managers/business owners, especially threatening immigrant families and not complying with rent moratorium orders
- Limitations to the ability to organize due to restrictive unionizing laws
- Undertesting and underreporting of COVID-19, especially among undocumented immigrants and refugees
- Distance to health centers (rural communities)
- Fear of becoming “visible” or to incur in State burden (especially for immigrants, refugees, and undocumented people)
- Lack of appropriate mental support resources (linked to increase in domestic violence)
- The digital divide limiting the access to resources
- Unequal exposure to air pollutants, leading to chronic conditions
- Heat waves (linked to paved surfaces) exacerbating respiratory illnesses
- Access to drinking water, especially in rural areas
- Ongoing redlining practices that limit access to services and resources

Although the findings in this study are preliminary, they seem consistent with other studies, showing the clear role of longstanding structural inequities that especially affect BIPOC communities and put them at a higher risk to the coronavirus. Furthermore, considering that COVID-19 vulnerability is aggravated by pre-existing conditions related to environmental factors (e.g. asthma, cancer, limited access to water or food) and socioeconomic disparities, it is imperative that the state ensures that these communities are at the center of the decision-making process and the evaluation of COVID-19 response and recovery strategies.

CONCLUSION

“Our state is facing a public health and economic crisis at an unprecedented scale. The impacts of both the COVID-19 pandemic and the climate crisis are disproportionately impacting working, lower-income, and communities of color. Similarly, many of the solutions needed to recover from the health and economic impacts of COVID-19 will also ease the transition to climate justice. If Washington State Takes bold and comprehensive action now, we can demonstrate pathways to a Just Transition, not only beyond this pandemic but to achieve our vision of a just, sustainable, and resilient society”. -Front and Centered COVID-19 Response Policy Priorities

Understanding the disparities in the impact of COVID-19 between racial/ethnic groups is important for allocating resources meant to prevent, identify, and treat COVID-19 cases. Furthermore, this pandemic also represents an opportunity to analyze the resilience of our communities. For this purpose, it is necessary to look into the context in which different communities live, work, study, and play in order to better understand the roots of these disparities.

About half of the COVID-19 cases are concentrated within the three largest counties in the state (King, Pierce, and Snohomish) than in any of the others. King County has a stronger health infrastructure than any other in the state, and yet it has received many more economic resources than rural counties such as Benton and Yakima, where there is a large proportion of undocumented and non-English speaking communities. These inequities have a negative impact on the capacity for many communities to respond to economic and environmental disasters, increasing their level of vulnerability to COVID-19. Addressing structural inequities that limit the ability of working, lower-income, and BIPOC communities to cope with disasters is fundamental to increasing their resilience.

At the end of July, more cases were reported across the state, but counties like Okanogan, Benton, Spokane, and Grant are becoming the new centers of infection, making the COVID-19 burden larger in counties located in the eastern side of the state. However, we cannot think only about numbers and statistics; each one of the reported cases, hospitalizations, and deaths is a community member, an individual with a story. All individuals should have the right to a healthy life, regardless of their location, race, ethnicity, gender, or country of origin.

One of the main limitations of this study is the lack of updated and disaggregated publicly available data. This is an area of opportunity to create better and more inclusive systems of data collection that truly reflect the reality of the many communities that live in the state of Washington. *Front & Centered* pledges for the creation of better data collection systems to identify and better understand health disparities, risk factors, and environmental risks. These systems must accurately reflect what is happening at regional and local levels, while differentiating populations by race and ethnicity, gender, age, income, education, social and

physical environments, and geographic factors, to better understand differentiated risks and vulnerabilities.

If we are going to start creating plans for what the new reality might look like, before an effective vaccine is developed, we need to understand how structural inequities and structural racism in general play a crucial role, not only in this pandemic, but in determining who has access to health services as well as safe work and living environments. Without an honest consideration of these factors, we will continue to see a disproportionate impact of all kinds of disasters on BIPOC and low-income communities.

In order to effectively build resilience among these communities there needs to be a planned effort to better understand the impact of structural inequalities in the wellbeing of BIPOC individuals. Only then it will be possible to prioritize strategies to increase their capacity to deal with circumstances such as the current pandemic or climate change, as well as to implement better coordinated and more effective programs across regional and social boundaries.

Front and Centered demands place-based and people-centric strategies for assuring more equitable access to services emerging from intentional, inclusive, and long-term commitments that effectively address health, social, economic, and environmental disparities. Risk management cannot be done under an individual approach that forces people to comment on their own social and structural inequities. There needs to be a stronger collaboration between government and local communities to ensure that the voices of those who have been historically silenced are heard and considered in the decision-making processes. However, this requires an open dialogue and culturally responsive strategies of engagement.

Even though the “stay home orders” are being lifted, the COVID-19 health crisis is not over yet. In the coming months, we will all face a triple threat: Climate Change + Economic Recession + COVID-19. In order to effectively deal with this threat, we will need to develop a radical form of resilience rooted in the recognition of structural racism as the first step in transforming our institutions and securing a fairer distribution of resources. But we cannot wait for this change to come from the top, we need to assume individual responsibility and engage in action.

REFERENCES

1. Airhihenbuwa, C. O. (2020). Culture Matters in Communicating the Global Response to COVID-19. *Preventing Chronic Disease*, 17.
2. Alfonseca, K. (2020). How Coronavirus is Affecting the Latinx Community's Mental Health. *HuffPost*. Available at https://www.huffpost.com/entry/coronavirus-impact-latinx-mental-health_I_5ea9b743c5b6acde47fe7599?ncid=APPLENEWS00001&guccounter=1
3. Allsbrook, J.F. (2020). The Coronavirus Crisis Confirms That the U.S. Healthcare System Fails Women. *Center for American Progress*. Available at <https://www.americanprogress.org/issues/women/reports/2020/04/23/483828/coronavirus-crisis-confirms-u-s-health-care-system-fails-women/>
4. APM Research Lab. (2020). The color of coronavirus: COVID-19 deaths by race and ethnicity in the U.S. Available at <https://www.apmresearchlab.org/covid/deaths-by-race>
5. Baker, M. G. (2020). Nonrelocatable Occupations at Increased Risk During Pandemics: United States, 2018. *American journal of public health*, (0), e1-e7.
6. Bashir, M., Bilal, B., & Komal, B. (2020). Correlation between environmental pollution indicators and COVID-19 pandemic: A brief study in Californian context. *Environmental Research*, 109652.
7. Bernton, H. (2020). In Yakima County, Tensions Grow as Some Want Life Back to Normal While Agricultural Workers Want More Protection Amid Coronavirus. *The Seattle Times*, May 10, 2020.
8. Bielenberg, J. E., Futrell, M., Stover, B., & Hagopian, A. (2020). Presence of Any Medical Debt Associated with Two Additional Years of Homelessness in a Seattle Sample. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 57, 0046958020923535.
9. Birch, S., Lindeblad, M., and Cody, E. (2020). On the Front Lines of COVID-19: A Blueprint for Health and Human Services from Washington State, Milbank Memorial Fund. Available at <https://www.milbank.org/publications/on-the-front-lines-of-covid-19-a-blueprint-for-health-and-human-services-from-washington-state/>
10. Braveman, P. A., Cubbin, C., Egerter, S., Williams, D. R., & Pamuk, E. (2010). Socioeconomic disparities in health in the United States: what the patterns tell us. *American journal of public health*, 100(S1), S186-S196.
11. Cecchi, L., Annesi-Maesano, I., & d'Amato, G. (2018). News on climate change, air pollution, and allergic triggers of asthma.
12. Centers for Disease Control and Prevention. (2018). Social Vulnerability Index. ArcGIS Map. Available at <http://www.arcgis.com/home/webmap/viewer.html?webmap=d9a0e0a262fc4ce48ae39c770a34af29>
13. Centers for Disease Control and Prevention. (2019). Total Cardiovascular Disease Death Rate per 100,000, All Ages, All Races/Ethnicities, Both Genders, 2016-2018. Available at <https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx>
14. Centers for Disease Control and Prevention. (2020). Assessing Risk Factors for Severe COVID-19 Illness. Available at <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/assessing-risk-factors.html>
15. Centers for Disease Control and Prevention. (2020). COVID-19 in Racial and Ethnic Minority Groups. Available at <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>
16. Centers for Disease Control and Prevention. (2020). COVID-19-Associated Hospitalization Rates (per 100,000 population) for the COVID-NET Network. Available at https://gis.cdc.gov/grasp/covidnet/COVID19_3.html
17. Centers for Medicare and Medicaid Services. (2019). Medicare Disparities, difference between national average cost and county average cost. Available at <https://data.cms.gov/mapping-medicare-disparities>

18. City of Seattle. (2016). Digital equity and inclusion. Available at <https://www.kingcounty.gov/depts/it/initiatives/digital-equity.aspx>
19. Collins, C., Asante-Muhamend, D., et al. (2019). Dreams Deferred. How Enriching the 1% Widens the Racial Wealth Divide. *Institute for Policy Studies*.
20. Dalzell, N. (2020). MA Attorney General Highlights Link Between Environmental Justice and COVID-19. ClimateXChange. Available at <https://climate-xchange.org/2020/05/14/ma-attorney-general-highlights-link-between-environmental-justice-and-covid-19/>
21. Dubb, S. (2020). Study Maps Business Closure Effects on People of Color, Women & Immigrants. *Non-Profit Quarterly*, June 2020. Available at <https://nonprofitquarterly.org/study-maps-business-closure-effects-on-people-of-color-women-immigrants/>
22. Front and Centered. (2016). The Disproportionate Burden of Fossil Fuel Air Pollution on Communities of Color in Washington. Available at <https://frontandcentered.org/wp-content/uploads/2016/08/Fossil-Fuel-Pollution-Communities-of-Color.pdf>
23. Front and Centered. (2020). Accelerating a Just Transition in Washington State: Climate Justice Strategies from the Frontlines.
24. Global Heat Health Information Network. (2020). Heat and COVID-19. Available at <http://www.ghhin.org/heat-and-covid-19>
25. Goldberg, M. (2020). How much agencies and institutions have received in state funds for COVID-19 response. *The Washington State Wire*. Available at <https://washingtonstatewire.com/how-much-agencies-and-institutions-have-received-in-state-funds-for-covid-19-response/>
26. Gray, D. M., Anyane-Yeboah, A., Balzora, S., Issaka, R. B., & May, F. P. (2020). COVID-19 and the other pandemic: populations made vulnerable by systemic inequity. *Nature Reviews Gastroenterology & Hepatology*, 1-3.
27. Haley, E., Caxaj, S., George, G., Hennebry, J., Martell, E., & McLaughlin, J. (2020). Migrant farmworkers face heightened vulnerabilities during COVID-19. *Journal of Agriculture, Food Systems, and Community Development*, 9(3), 1-5.
28. Harvard Global Health Institute. (2020). U.S. Hospital Capacity per State. Available at <https://globalepidemics.org/our-data/hospital-capacity/>
29. Healthier Washington. Adult Access to Preventive/Ambulatory Health Services 2018-2019. *Medicaid Population Explorer*: <https://hca-tableau.watech.wa.gov/t/51/views/HealthierWashingtonDashboard/MeasureMaps?%3AisGuestRedirectFromVizportal=y&%3Aembed=y>
30. Henry J. Kaiser Family Foundation. (2019). U.S. Distribution of the Nonelderly Uninsured by Race/Ethnicity per state in 2018. Available at <https://www.kff.org/uninsured/state-indicator/distribution-by-raceethnicity-2/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
31. Kamb, L. (2020). King County has Big Racial Disparities in Coronavirus Cases and Deaths, According to Public-Health Data. *The Seattle Times*. May 1, 2020.
32. Kendi, I. X/ (2020). What the Racial Data Show. The pandemic seems to be hitting people of color the hardest. *The Atlantic*. April 6, 2020.
33. Kent, J. (2020). County-Level Data Shows Racial, Ethnic Disparities in COVID-19 Cases. Health IT Analytics, Xtelligent Healthcare Media. Available at <https://healthitanalytics.com/news/county-level-data-shows-racial-ethnic-disparities-in-covid-19-cases>
34. Kent, J. (2020). Levering COVID-19 Data to Eliminate Healthcare Disparities. Health IT Analytics, Xtelligent Healthcare Media. Available at <https://healthitanalytics.com/news/leveraging-covid-19-data-to-eliminate-healthcare-disparities>

35. Keshner, A. (2020). 'The floor was taken out from under them': April's massive job losses are hitting these Americans more than others. *MarketWatch*. May 9, 2020.
36. Khreis, H., Kelly, C., Tate, J., Parslow, R., Lucas, K., & Nieuwenhuijsen, M. (2017). Exposure to traffic-related air pollution and risk of development of childhood asthma: a systematic review and meta-analysis. *Environment international*, 100, 1-31.
37. Krogstad, J. M., Gonzalez-Barrera, A., & Noe-Bustamante, L. (2020). US Latinos among hardest hit by pay cuts, job losses due to coronavirus. *Pew Research Center*.
38. Kroman, D. (2020). Coronavirus has no borders, but your county's health funding does. Crosscut. Available at <https://crosscut.com/2020/04/coronavirus-has-no-borders-your-countys-health-funding-does>
39. Kullar, R., Marcelin, J. R., Swartz, T. H., Piggott, D. A., Macias Gil, R., Mathew, T. A., & Tan, T. (2020). Racial Disparity of Coronavirus Disease 2019 (COVID-19) in African American Communities. *The Journal of infectious diseases*.
40. Lopez, M.H., Rainie, L., Budiman, A. (2020). Financial and Health Impacts of COVID-19 Vary Widely by Race and Ethnicity. *Pew Research Center*.
41. Mapes, L. (2020). Grants provide \$5.7M for Washington tribes for COVID relief. The Seattle Times. July 20, 2020. Available at: <https://www.seattletimes.com/seattle-news/grants-provide-5-7m-for-washington-tribes-for-covid-relief/>
42. Miller, I. F., Becker, A. D., Grenfell, B. T., & Metcalf, C. J. E. (2020). Disease and healthcare burden of COVID-19 in the United States. *Nature Medicine*, 1-6.
43. Nania, R. (2020). Blacks, Hispanics Hit Harder by the Coronavirus, Early U.S. Data Show. *American Association of Retired Persons*. May 1, 2020.
44. National Health Service Corps. Washington Health Professional Shortage Area. Available at <https://data.hrsa.gov/tools/shortage-area/hpsa-find>
45. Office of Disease Prevention and Health Promotion. (2020). Social Determinants of Health. Available at <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>
46. Office of Financial Management. (2020). State funds distributed for COVID-19 outbreak response. Available at <https://www.ofm.wa.gov/about/news/2020/05/state-funds-distributed-covid-19-outbreak-response>
47. Orellano, P., Quaranta, N., Reynoso, J., Balbi, B., & Vasquez, J. (2017). Effect of outdoor air pollution on asthma exacerbations in children and adults: systematic review and multilevel meta-analysis. *PLoS one*, 12(3), e0174050.
48. PBS NewsHour. COVID-19 Worsens the Role Environmental Injustice Already Plays in Marginalized Communities. May 12, 2020. Available at <https://www.pbs.org/newshour/health/covid-19-worsens-the-role-environmental-injustice-already-plays-in-marginalized-communities>
49. Plan Washington. (2014). Washington Obesity Rates. Available at <http://planwashington.org/blog/archive/data-visualization-obesity-in-washington-state-counties/>
50. Public Health Insider. (2020). New Analysis Shows Pronounced Racial Inequities among COVID-19 Cases, Hospitalizations and Deaths. Available at <https://publichealthinsider.com/2020/05/01/new-analysis-shows-pronounced-racial-inequities-among-covid-19-cases-hospitalizations-and-deaths/>
51. Purdue University. (2020). Digital Divide Index. *Center for Regional Development*. Available at <https://pcrd.purdue.edu/ruralindianastats/broadband/ddi.php?variable=ddi-overview&county=Adams> (A special report for Washington State was kindly provided for this study by Dr. Roberto Gallardo).
52. Raifman, M., & Raifman, J. (2020). Disparities in the population at risk of severe illness from covid-19 by race/ethnicity and income. *American Journal of Preventive Medicine*.
53. Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. (2020). County Health Rankings for Washington. Available at <https://www.countyhealthrankings.org/app/washington/2020/downloads>

54. Rho, J. H., Brown, H., & Fremstad, S. (2020). A Basic Demographic Profile of Workers in Frontline Industries. *Center for Economic and Policy Research*.
55. Rudowitz, R. and Hinton, E. (2020). Early Look at Medicaid Spending and Enrollment Trends Amid COVID-29. *Kaiser Family Foundation*. Available at <https://www.kff.org/coronavirus-covid-19/issue-brief/early-look-at-medicaid-spending-and-enrollment-trends-amid-covid-19/>
56. Scott, D. (2020). COVID-19's Devastating Toll on Black and Latino Americans, in One Chart. *Vox*. April 17, 2020.
57. Solis, J., Franco-Paredes, C., Henao-Martínez, A. F., Krsak, M., & Zimmer, S. M. (2020). Structural Vulnerability in the United States Revealed in Three Waves of Novel Coronavirus Disease (COVID-19). *The American Journal of Tropical Medicine and Hygiene*, tpm200391.
58. Sun, L. (2020). Patients with underlying conditions were 12 times as likely to die of covid-19 as otherwise healthy people, CDC finds. *The Washington Post*. June 15, 2020.
59. Surgo Foundation. (2020). COVID-19 Community Vulnerability Index. Available at <https://www.precisionforcovid.org>
60. United States Census Bureau. (2020). Income Inequalities per county in Washington State. Available at <https://data.census.gov/cedsci/table?q=B19080&g=0400000US53.050000&hidePreview=false&table=B19080&tid=ACSDT5Y2018.B19080&vintage=2018&lastDisplayedRow=0&moe=false&y=2018&tp=true>
61. United States Census Bureau. (2020). Washington State Quick Facts. Available at <https://www.census.gov/quickfacts/fact/table/WA/POP645218#POP645218>
62. United States Department of Agriculture. (2019) Food Atlas. Available at <https://www.ers.usda.gov/data-products/food-environment-atlas/data-access-and-documentation-downloads/>
63. Washington Indian Gaming Association. (2020). Washington Tribes. Available at <https://www.washingtontribes.org/>
64. Washington State Department of Commerce. (2019). Final results for 2019 Point-in-Time count of homeless in Washington show net decrease. Available at <https://www.commerce.wa.gov/news-releases/community-programs-facilities/final-results-for-2019-point-in-time-count-of-homeless-in-washington-show-net-decrease/>
65. Washington State Department of Ecology. (2020). Washington State Water Pollution- Oil spills 2015-2020. Available at https://fortress.wa.gov/ecy/coastalatlant/storymaps/spills/spills_sm.html?&Tab=nt3
66. Washington State Department of Health. (2020). Air Stagnation. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
67. Washington State Department of Health. (2020). Cancer Incidence. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
68. Washington State Department of Health. (2020). Children's Access to Park, 2015. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
69. Washington State Department of Health. (2020). COVID-19 Data Dashboard. Available at <https://www.doh.wa.gov/Emergencies/NovelCoronavirusOutbreak2020COVID19/DataDashboard>
70. Washington State Department of Health. (2020). Diesel Emission Levels of NOx, 2014. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
71. Washington State Department of Health. (2020). Life Expectancy at Birth, 2015-2018. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>

72. Washington State Department of Health. (2020). Limited Access to Healthy Food, 2009. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
73. Washington State Department of Health. (2020). Ozone Concentration, 2009-2011. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
74. Washington State Department of Health. (2020). Paved-surfaces, 2011. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
75. Washington State Department of Health. (2020). Percent of adults who reported having a personal health care provider, 2012-2016. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
76. Washington State Department of Health. (2020). Pesticide Illness- Rate per 100,000, 2016-2018. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
77. Washington State Department of Health. (2020). PM2.5 Concentration, 2009-2011. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
78. Washington State Department of Health. (2020). Population Living in Poverty <=125% of Federal Poverty Level (%), 2013-2017. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
79. Washington State Department of Health. (2020). Populations Near Heavy Traffic Roadways - Census Tract 2017. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
80. Washington State Department of Health. (2020). Population Unemployed, 2013-2017. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
81. Washington State Department of Health. (2020). Proximity to Hazardous Waste Treatment Storage and Disposal Facilities, 2017. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
82. Washington State Department of Health. (2020). Public Water Systems, 2017. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
83. Washington State Department of Health. (2020). Social Determinants of Health Dashboards. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards>
84. Washington State Department of Health. (2020). State Waives Costs for COVID-19 Testing. Available at <https://www.doh.wa.gov/Newsroom/Articles/ID/1120/State-waives-costs-for-COVID-19-testing>
85. Washington State Department of Health. (2020). Toxic Release from Facilities, 2012-2014. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>

86. Washington State Department of Health. (2020). Washington State Capability Assessment for Emergency Operations Coordination. Available at <https://fortress.wa.gov/doh/wtn/WTNPortal/home/#!q0=1143>
87. Washington State Department of Health. (2020). Wastewater Discharge, 2015. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
88. Washington State Department of Health. (2020). Wildfires, 2018. Available at <https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/SocialDeterminantsofHealthDashboards/CountySocialDeterminantsofHealth>
89. Washington State Department of Social and Health Services. (2020). Alcohol and Drug Related Deaths. Available at <https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state>
90. Washington State Department of Social and Health Services. (2020). Arrests for Violent Crime. Available at <https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state>
91. Washington State Department of Social and Health Services. (2020). Cases of Child Abuse or Neglect Referrals. Available at <https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state>
92. Washington State Department of Social and Health Services. (2020). Child Mortality. Available at <https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state>
93. Washington State Department of Social and Health Services. (2020). Infant Mortality (under 1yo). Available at <https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state>
94. Washington State Department of Social and Health Services. (2020). High School Dropouts. Available at <https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state>
95. Washington State Department of Social and Health Services. (2020). Low Birthweight Babies. Available at <https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state>
96. Washington State Department of Social and Health Services. (2020). State-Funded Alcohol and/or Drug Related Services. Available at <https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state>
97. Washington State Department of Social and Health Services. (2020). Students Eligible for Free and Reduced Lunch. Available at <https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state>
98. Washington State Department of Social and Health Services. (2020). Temporary Assistance to Needy Families (TANF), child recipients. Available at <https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state>
99. Washington State Department of Social and Health Services. (2020). Total Adolescent Arrests. Available at <https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state>
100. Washington State Office of Financial Management, Forecasting and Research Division. (2020). Adjusted Census 2000 Population and Housing by Type of Structure and Group. Available at <https://www.ofm.wa.gov/washington-data-research/population-demographics/population-estimates/adjusted-2000-population-and-housing-structure-type-and-group-quarters-state-counties-cities-and-towns>
101. Washington State Office of Financial Management, Forecasting and Research Division. (2020). Estimates of Population with Limited English Proficiency (LEP), 2016. Available at <https://www.ofm.wa.gov/washington-data-research/population-demographics/population-estimates/special-subject-estimates>
102. Washington State Office of Financial Management, Forecasting and Research Division. (2020). Percentage of state physicians per county, 2019. Available at https://www.ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician_supply_2018-19.pdf
103. Washington State Office of Financial Management, Forecasting and Research Division. (2020). Population Density and Land Area by County. Available at <https://www.ofm.wa.gov/washington-data-research/population-demographics/population-estimates/population-density>

104. Washington State Office of Financial Management, Forecasting and Research Division. (2020). Washington State Small Area Demographic Estimates (SADE) by Age, Sex, Race and Hispanic Origin, 2000. Available at <https://www.ofm.wa.gov/washington-data-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin>
105. Washington STEM. (2020). Shared Crisis, Uneven Impact. Available at: <https://washingtonstem.org/shared-crisis-uneven-impact/>
106. Westneat, D. (2020). No, We're Not All in This Together- Look at What's Happening with Coronavirus in Yakima. *The Seattle Times*. May 20, 2020.
107. Wiesman, J. and Lofy, K. (2018). 2018 Washington State Health Assessment. *Washington State Department of Health*.
108. World Health Organization, Commission on Social Determinants of Health. Closing the Gap in a Generation: Health equity through action on the social determinants of health. Available at http://www.who.int/social_determinants/en
109. Wu, X., Nethery, R. C., Sabath, B. M., Braun, D., & Dominici, F. (2020). Exposure to air pollution and COVID-19 mortality in the United States. *medRxiv*.

APPENDIX I- WASHINGTON STATE FUNDS DISTRIBUTED FOR THE COVID-19 CRISIS AS FOR JUNE 2020

Recipient	Amount	Purpose
Dept. of Agriculture	\$10 million	To purchase food and food distribution supplies for food banks and other non-profit organizations.
Dept. of Commerce	\$5 million	To distribute to the 29 federally recognized tribes in Washington to assist them in responding to the COVID-19 outbreak.
Dept. of Commerce	\$250,000	For Consolidated Technology Services (WaTech) and Washington State University to install infrastructure hardware for drive-in WiFi locations at schools and libraries.
Dept. of Commerce	\$5 million	To continue the Working Washington Small Business Grant program administered by the Department of Commerce.
Dept. of Commerce	\$5 million	To distribute to the 29 federally recognized tribes in Washington to assist them in responding to the COVID-19 outbreak.
Dept. of Commerce	\$23 million	To address the public health needs of individuals experiencing homelessness, including social distancing measures, sanitation efforts, and shelter staffing needs.
Dept. of Enterprise Services	\$360,000	To translate COVID-19 documents into 37 languages for 40 state agencies.
Dept. of Health	\$11.7 million (GF-Federal)	To pay for costs associated with the state and local government response to the coronavirus outbreak in Washington.
Dept. of Health	\$30 million	To pay for costs associated with the state and local government response to the coronavirus outbreak in Washington.

Dept. of Health	\$20 million (Disaster Response Account) + \$13.3 million (General Fund-Federal)	To pay for costs associated with the state and local government response to the coronavirus outbreak in Washington.
Dept. of Social and Health Services	\$15.6 million	To address various needs related to the coronavirus pandemic, including to reduce non-compliance sanctions for TANF recipients in April while many WorkFirst services are suspended due to the coronavirus. It also temporarily extends the 60-month lifetime limit during the outbreak. Also to provide assistance to individuals and families without children in April, pursuant to Governor's Proclamation 20-18 which expanded eligibility for the Family Emergency Assistance Program. Also to fund the required match for the Food Assistance Program in March and April for the benefit level of the Supplemental Nutrition Assistance Program (SNAP).
Dept. of Social and Health Services	\$19.5 million	To pay for costs associated with moving patients from hospitals to long-term care settings (\$6.0 million) and purchasing a long-term care facility (\$13.5 million).
Health Care Authority	\$260,000	To pay the sales tax portion of the Washington State Hospital Association's purchase of personal protection equipment for hospitals, long-term care facilities, and other providers of services to vulnerable populations.
Health Care Authority	\$2 million	To establish a rural hospital emergency fund.
Office of Civil Legal Aid	\$3 million	To pay for legal assistance for unemployment insurance claimants whose claims have been lost or denied and for tenants who face eviction upon termination of federal, state, and local eviction moratoria.
Office of the Secretary of State	\$1,668,755	To provide the required 20 percent state match for the \$8.3 million Help America Vote Act (HAVA) CARES Act grant received by the State of Washington. In accordance with the federal grant requirements, these matching funds must be used to prevent, prepare for, and respond to coronavirus, domestically or internationally, for the 2020 federal election cycle.
University of Washington	\$21,875,000	For UW Medicine to mitigate the spread of COVID-19, including managing an emergency operations center; procuring personal protective equipment, medical supplies and other equipment; disposing medical waste; cleaning and

		disinfecting state-owned facilities and equipment; disseminating information to the public; making temporary modifications to health care facilities; and developing triage, intake and testing facilities.
University of Washington	\$10 million	To pay solely for the costs incurred by University of Washington Medicine for coronavirus testing.

Source: Office of Financial Management, 2020.

APPENDIX II- SURVEYS

DISTRIBUTED AMONG ORGANIZATIONS

1. Describe the population(s) with which your organization works mostly *[select all that apply]*

- | | |
|--|---|
| <input type="checkbox"/> American Indian and Alaska Native | <input type="checkbox"/> Immigrants |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Undocumented |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> LGBTQIA+ |
| <input type="checkbox"/> Hispanic/Latinx | <input type="checkbox"/> Women |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Children and/or youth |
| <input type="checkbox"/> White | <input type="checkbox"/> Elderly |
| <input type="checkbox"/> Multiracial | <input type="checkbox"/> Veterans |
| | <input type="checkbox"/> Population in homeless situation |
| | <input type="checkbox"/> Other: |

2. What geographic area do you cover? *[indicate city and/or county]*

3. How many people does your organization serves per year (approximately)?

- Less than 100 individuals
- 101-500 individuals
- More than 500 individuals

4. Given the public health crisis and the many different social and economic impacts on communities, how would you describe your organization's most important goal(s) during this time?

5. What are the most significant service needs and gaps you have identified in your community based on the impact of the coronavirus/COVID-19? *[select all that apply]*

- | | |
|---|---|
| <input type="checkbox"/> Health services | <input type="checkbox"/> Medicines |
| <input type="checkbox"/> Health insurance | <input type="checkbox"/> COVID-19 testing |

- Food
- Educational material for home schooling
- Computer and internet
- Telephone
- Hygiene, cleaning products
- Compensated work
- Unemployment benefits
- Financial support (emergency relief fund)
- Housing/homelessness
- Childcare
- Eldercare
- Transportation
- Legal support
- Appropriate accommodations in the workplace, including PPE
- Increase in domestic violence
- Other:

6. What are the most significant barriers to accessibility of these services in this community?
7. How would you prioritize funding to continue addressing community needs and/or sustain your organization?
8. Do you have any other feedback that may help us understand community needs, service gaps and priorities?

DISTRIBUTED AMONG INDIVIDUALS (IN ENGLISH AND SPANISH)

1. Describe the how you self-identify *[select all that apply]*

- American Indian and Alaska Native
- Asian
- Black/African American
- Hispanic/Latinx
- Native Hawaiian or Pacific Islander
- White
- Multiracial/Multiethnic
- Immigrant or refugee
- Undocumented or DACA
- LGBTQIA+
- Women
- Elderly
- Veteran
- Living in homeless situation
- Single parent
- Individual with disabilities
- Other

[SP] Describa cómo se identifica *(seleccione todas las opciones que usted considere aplican)*

- Indígena o nativo americano
- Asiático
- Afrodescendiente/Afroamericano
- Hispano/Latinx
- Nativo de Hawaii o de las Islas del Pacífico
- Caucásico (blanco)
- Multiracial/Multiétnico
- Inmigrante o refugiado
- Indocumentado o DACA
- LGBTQIA+
- Mujer
- Adulto mayor (+65 años)

- Veterano
- En situación de calle
- Padre/madre soltero/a
- Con capacidades diferentes
- Otro:

2. What is your zip code?// [SP] ¿Cuál es su código postal?

3. What are the most significant service needs and gaps in your community you have seen based on the impact of the coronavirus/COVID-19? *[select all that apply]*

- Health services
- Mental health services
- Medicines
- Health insurance
- COVID-19 testing
- Food
- Housing/shelters
- Educational material for homeschooling
- Computer and internet
- Telephone
- Childcare
- Eldercare
- Hygiene, cleaning products
- Compensated work
- Unemployment benefits
- Financial support (emergency relief fund)
- Transportation
- Legal support
- Appropriate accommodations in the workplace, including PPE
- Translated material
- Increase in domestic violence
- Other

[SP] ¿Cuáles son las necesidades en servicios en su comunidad que ha visto han sido impactados negativamente por el coronavirus/COVID-19? (seleccione todas las opciones que usted considere aplican)

- Servicios de salud
- Servicios de salud mental
- Medicinas
- Seguro médico
- Pruebas de COVID-19
- Comida
- Casa/albergue
- Material educativo para estudiar en casa
- Computadora y acceso a internet
- Teléfono
- Cuidado infantil/guardería
- Cuidado de adultos mayores
- Productos higiénicos y de limpieza
- Trabajo pagado
- Beneficios de desempleo
- Apoyo económico (fondos de emergencia)
- Transporte
- Apoyo legal
- Condiciones apropiadas de trabajo, incluyendo equipo de protección personal
- Material en español/otros idiomas
- Incremento en violencia doméstica
- Otro:

4. What are the most significant barriers to access these services or resources you have seen or experienced?

[SP] ¿Cuáles cree ud. que sean los principales obstáculos para acceder a estos servicios o recursos?

5. Do you want to share anything else regarding your experience during this crisis?

[SP] ¿Quiere compartir algo más acerca de su experiencia durante esta crisis?