

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES COVID-19 HEALTH EQUITY TASK FORCE

1st Meeting (Virtual) February 26, 2021

Members Present

Marcella Nunez-Smith, MD, MHS (Chair)
Marya Alvarez, MPH
Andrew Imparato, JD
Victor Joseph
Joneigh Khaldun, MD, MPH, FACEP
Octavio Martinez, MD, MPH, MBA, FAPA
Tim Putnam, DHA, EMS
Vincent Toranzo
Mary Turner, RN
Homer Venters, MD
Bobby Watts, MPH, MS
Haeyoung Yoon, JD

Members Absent

James Hildreth, PhD, MD*

Federal Staff

CAPT Samuel Wu, PharmD, Office of Minority Health
Sherice Perry, Senior Advisor, Office of Intergovernmental and External Affairs
Bonnie Mason, Program Assistant, Office of Minority Health

Invited Presenters

Jeff Zients, Counselor to the President, The White House
Norris Cochran, Acting Secretary, Department of Health and Human Services
David Kessler, MD, Chief Science Officer, HHS COVID-19 Response Team
Roslyn Moore, MS, Acting Director, HHS Office of Minority Health
Nancy Krieger, PhD, Professor of Social Epidemiology, Harvard T.H. Chan School of Public Health
Daniel Dawes, JD, Associate Professor, Executive Director, Satcher Health Leadership Institute, Morehouse School of Medicine

Call to Order, Welcome and Introductions

CAPT Samuel Wu
Designated Federal Officer, Office of Minority Health

* Dr. James Hildreth was present for the Oath of Office but left the meeting early due to his participation on the FDA Vaccines and Related Biological Products Advisory Committee that occurred on the same day.

CAPT Wu opened the inaugural meeting of the COVID-19 Health Equity Task Force (HETF) by welcoming the HETF chair as well as members and invited speakers. He reminded attendees that the meeting was open to the public and that an American Sign Language interpreter was available for the meeting.

Opening Remarks

*Marcella Nunez-Smith, MD, MHS
Chair, COVID-19 Health Equity Task Force*

Dr. Nunez-Smith underscored the urgency and importance of the work of the HETF. She noted that shortly after COVID-19 arrived in the United States, disparities emerged in testing, case rates, and mortality, and since then further disparities have emerged in rates of so-called “long-hauler” COVID-19 infection. These disparities implicate many factors including race, ethnicity, disability status, age, sexual orientation, and gender. Marginalized and minoritized groups not only experience disproportionately high infection rates, but also tend to face severe economic hardships that compound complications from COVID-19. Mental and behavioral health challenges are also noteworthy.

The HETF aims to help the United States achieve an equitable response to the COVID-19 pandemic. Its work must identify and remove structural barriers to the equitable distribution of therapeutics, vaccines, and personal protective equipment (PPE), while decreasing disproportionate infection and mortality rates among the hardest-hit and highest risk communities. Equity entails equal provision of high-quality health care as well as housing stability, food and nutrition security, and digital resource accessibility. Achieving equity will also require culturally responsive messaging that builds trust among communities disproportionately affected by COVID-19.

Dr. Nunez-Smith stressed that insufficient and poor-quality data have hindered efforts to address prevailing health inequities; this inaugural meeting of the HETF focused on how to address this challenge.

Welcome and Oath of Office

*RADM Felicia Collins, MD, MPH
Acting Assistant Secretary for Health*

RADM Collins thanked HETF members for convening to pursue the goal of mitigating health inequities and establishing policies, programs, and practices to address these issues. She shared the impact that COVID-19 has had on her family and friends and noted that similar experiences are widespread among communities of color and other minority communities.

RADM Collins highlighted Centers for Disease Control and Prevention (CDC) data showing inequities in hospitalization and mortality rates faced by Black and Latinx, as well as American Indian and Alaska Native communities, noting that these data demonstrate the urgent need for the HETF’s work. RADM Collins provided brief introductions of each task force member and then swore in the HETF chair and the 11 members present.

Charge of the Task Force

Marcella Nunez-Smith, MD, MHS

The HETF was established with the signing on January 21, 2021, of Executive Order 13995, Ensuring an Equitable Pandemic Response and Recovery. The Executive Order (EO) is part of a government-wide effort to identify and eliminate health disparities that result in heightened rates of illness, hospitalization, and death among minority and underserved communities. The HETF is charged with formulating specific recommendations to the President of the United States to help mitigate inequities caused or exacerbated by the COVID-19 pandemic, and to prevent these inequities from reemerging in the future. These recommendations should address how agencies, states, and local or tribal territorial officials can effectively allocate resources, perform outreach, and improve cultural responsiveness. Recommendations should also aim to close gaps in existing data by addressing shortcomings of data collection, analysis, and harmonization. Dr. Nunez-Smith emphasized that the function of the HETF is solely advisory. She provided a high-level outline of how the HETF members were selected, noting that each member was identified as a key individual in the fight against COVID-19.

Welcome from the White House

Jeff Zients

Counselor to the President

Mr. Zients emphasized the importance of the HETF's charge as illustrated by the fact that the EO creating the HETF was signed on President Joseph R. Biden's first full day in office. Mr. Zients noted that this EO represents only one of many actions taken by President Biden to ensure a safe, efficient, fair, and equitable COVID-19 response.

Welcome from HHS Acting Secretary

Norris Cochran

Acting Secretary, Health and Human Services

Mr. Cochran discussed the role that the U.S. Department of Health and Human Services (HHS) has played in responding to the COVID-19 pandemic, citing HHS's support for the development, procurement, and administration of vaccines, therapeutics, and diagnostics, as well as its efforts to provide a range of services to federal, state, and local organizations to help those in need access health care services. He emphasized that at this critical juncture, approximately 1 year into the pandemic response, challenges remain substantial and the work of the HETF is critical.

Welcome from HHS COVID-19 Response

David Kessler, MD

Chief Science Officer

Dr. Kessler noted that, during the year leading up to President Biden's inauguration, he worked closely with the President to plan for an equitable pandemic response. He shared his belief that equity is a primary social determinant of health and that any approach to the pandemic must be based in science and equity. He stressed that the HETF is poised to ensure that equity becomes embedded in distribution and administration of treatments and vaccines across the United States.

Welcome from HHS Office of Minority Health

Roslyn Moore, MS

Acting Director, Office of Minority Health

Ms. Moore noted that the mission and statutory obligation of the HHS Office of Minority Health (OMH) is to promote health and wellbeing of racial and ethnic minority populations, explaining that OMH is committed to forging pathways to achieve and sustain equity across all populations, conditions of life, and geographic locations. She emphasized that OMH will assist the HETF in generating recommendations to promote change and to ensure an equitable pandemic response.

Introductions of Members

Each HETF member present briefly introduced themselves, summarized their backgrounds, and highlighted any experiences relevant to the charge of the HETF.

Dr. Tim Putnam, President and CEO of Margaret Mary Health and a former emergency medical technician (EMT), brings to the HETF his experience as the head of a rural hospital dealing with the challenges of the COVID-19 pandemic.

Mr. Vincent Toranzo, State Secretary of the Florida Association of Student Councils, brings to the HETF his perspective as a student who works with his local government, advocating for the safety of students and foster children across the state of Florida, as well as his direct experience with the challenges that COVID-19 poses for Latinx Americans.

Ms. Mary Turner, an Intensive Care Unit (ICU) nurse at North Memorial Medical Center and President of the Minnesota Nurses Association union, brings to the HETF her perspective as a nurse working on the frontlines of the COVID-19 pandemic.

Dr. Homer Venters, a physician and epidemiologist working at the intersection of incarceration, health, and human rights, brings to the HETF his experience helping incarcerated populations to cope with the challenges of COVID-19.

Mr. Bobby Watts, CEO of the National Health Care for the Homeless Council, brings to the HETF his experience working with homeless Americans for the past 30 years, including during the pandemic, as well as a perspective gleaned from working with clinicians who treat homeless patients.

Ms. Haeyoung Yoon, Senior Policy Director at the National Domestic Workers Alliance, brings to the HETF 20 years of experience working with low-wage immigrant workers, who during the pandemic were largely labeled as essential workers but still face economic challenges of caring for themselves and their families.

Dr. Octavio Martinez, Executive Director of the Hogg Foundation for Mental Health at The University of Texas at Austin, brings to the HETF his experience as a psychiatrist concentrating on the mental health impact of the pandemic, as well as his perspective as a trained minority

health policy expert seeking to eliminate work force disparities and address social and political determinants of health.

Ms. Mayra Alvarez, President of The Children's Partnership, brings to the HETF her experience working with children and with a Latinx community that has been disproportionately affected by the pandemic, as well as her perspective as an immigrant and as a daughter of immigrants.

Mr. Andrew Imparato, a disability rights lawyer and the Executive Director of Disability Rights California, brings to the HETF his experience as a disability lawyer and as an advocate for the rights of the elderly and the disabled. As an individual diagnosed with bipolar disorder, he can also provide insight into the pandemic's impact on individuals who struggle with mental health.

Mr. Victor Joseph, former Tanana Chiefs Conference Chief/Chairman (March 2014-October 2020), brings to the HETF his experience as a former Chief of Native communities in Tanana to provide his perspective on the challenges faced by the American Indian and Alaska Native communities (e.g., lack of the basic supplies needed to adhere to safety guidelines).

Dr. Joneigh Khaldun, Chief Medical Executive for the State of Michigan and the Chief Deputy Director for Health in the Michigan Department of Health and Human Services, brings to the HETF her perspective as an emergency medical physician working on the frontlines of the pandemic and as the lead strategist for Michigan's response to the COVID-19 pandemic.

Data Challenges and Opportunities

Two invited speakers, Dr. Nancy Krieger and Mr. Daniel Dawes, presented on the data challenges amplified by the COVID-19 pandemic and on potential opportunities to leverage data to reduce disparities. Each presentation was followed by a brief discussion period.

COVID-19, Health Inequities, Data Gaps, and Solutions

Nancy Krieger, PhD

Professor of Social Epidemiology, Harvard T.H. Chan School of Public Health

Dr. Krieger began her presentation on COVID-19 health inequities by highlighting four key points: (1) existing inequities reflect structural racism and social injustice due to preventable working and living conditions; (2) risk of dying from COVID-19 infection increases based on pre-existing social, economic, and health inequities; (3) inequities in vaccine roll-outs have been compounded by long-standing inequitable practices in medical and public health institutions that impede access and reduce trust; and (4) issues with how the data are reported around COVID-19 infection and vaccination make it difficult to see and address inequities. Rates of hospitalization and deaths are more than two times higher among non-Hispanic Blacks, Latinx, and indigenous populations compared to White non-Hispanic populations. However, White populations are more likely to receive vaccinations than Black and Latinx populations. Dr. Krieger noted that data are scarce regarding COVID-19 infection and death as related to occupation, education, income, disability, gender identity, and community context (e.g., incarceration).

Data are heavily influenced by the person who produces and controls them. Dr. Krieger noted that the United States has a long history of producing racialized data to support scientific racism

and eugenics and to counter social justice and equity, and emphasized that well-produced data should be used to secure health equity.

Dr. Krieger explained that missing data surrounding the inequities of COVID-19 have led to a denial that such inequities exist, and to the erasure of structural injustice. Early in the pandemic, racial and ethnic data were missing from most CDC data on cases, hospitalizations, and deaths. Then, in June 2020, new regulations mandated inclusion of racial and ethnic data in COVID-19 case, hospitalization, and death reporting. However, by September 2020, the CDC website was still missing racial and ethnic data for 43 percent of cases reported between August 28 and September 16, after the mandate took effect. When Dr. Krieger inspected data reported from December 2, 2020, to February 3, 2021, racial and ethnic data were still missing for 33 percent of COVID-19 cases. This lack of data has led to incomplete reports of which populations need to be prioritized for vaccination and prevention programs.

Dr. Krieger also noted that CDC's initial response to the public outcry over missing racial and ethnicity data was to focus on proportions, not rates. That is, CDC compared racial and ethnic composition of COVID-19 deaths to that of the total population. The data were originally hosted on two separate websites, making it difficult to determine whether the proportions differed. The data suggested that White non-Hispanics were overrepresented in COVID-19 deaths and that Black Americans were underrepresented, directly contradicting reports from other sources in the field. Dr. Krieger's team determined that CDC had made an error in weighting the COVID-19 deaths: CDC had provided a correct answer to a wrong question.

In response to its error, CDC has reverted to sharing proportions of case counts with no data on population composition and no weighting compared to total population. CDC also uses this approach with its vaccination data. Dr. Krieger's team has demonstrated, however, that it is feasible to collect the data needed to document health inequities; she gave three examples of how her team has cross-referenced data with other available metrics to document these inequities.

First, Dr. Krieger explained how her team reported U.S. COVID-19 mortality with county-level metrics of inequity, noting that the highest death rates occurred in the counties with the highest poverty rates, most crowded housing, and highest populations of color. Further data on racialized economic segregation showed a U-shaped curve. In addition, among COVID-19 infections and deaths, those individuals affluent enough to afford international travel and to live in low-poverty settings were more likely to contract COVID-19.

Next, Dr. Krieger discussed how her team reported on the surge of excess deaths by city/town and zip code metrics in Massachusetts. To create this measure, the team captured the number of deaths per 100,000 persons during a 2-week period and then compared those numbers to the mortality rate for the same 2-week period, based on the average deaths during that period each year from 2015 to 2019. This approach captured all the excess deaths categorized as COVID-19-related and not. The data show that the highest number of deaths occurred within communities that are also subject to the greatest economic, racial, and ethnic injustice.

Lastly, Dr. Krieger described how her team reported on national complaints to the Occupational Safety and Health Administration (OSHA) about COVID-19-related workplace risks as they

relate to COVID-19 death rates. The work illustrated that rises in workplace complaints related to COVID-19 correlated with the COVID-19 mortality curve. She also provided a heatmap that illustrates how infections and death rates among workers rose following workers' COVID-19-related complaints to OSHA.

Dr. Krieger stated that these examples illustrate that suppression of data can hide problems, and that such suppression can challenge efforts to organize for justice. She noted that these trends of data suppression are changing under the new administration, with new data being shared on the CDC website, including COVID-19 mortality rates stratified by education and race and ethnicity. More data are needed, however, to capture relationships such as those that can help to study the connections between racialized rates of COVID-19 infection and economic injustice.

Dr. Krieger concluded by emphasizing that better data are needed to inform action, noting that data should always present COVID-19 testing, cases, hospitalization, death, and vaccination by racial/ethnic and economic groups, and preferably also by age and gender. She recommended that the HETF (1) use informative contextual ZIP code data for all COVID-19 outcomes; (2) use individual-level education and occupation data for mortality data; (3) use real-time U.S. Census Household Pulse survey data for states and the 15 major metropolitan statistical areas (MSAs); and (4) create a real-time public roster of new social data that CDC is adding for COVID-19.

In terms of larger structural problems that require structural solutions, Dr. Krieger recommended that the HETF (1) ensure that data reveal problems tied to work conditions, crowded housing, lack of paid sick leave, lack of health care, and congregate living (including for incarcerated persons); (2) mandate that all racialized data be reported with contextualized social metrics, and allocate the funds needed (e.g., for people and technology) to do the work; and (3) expand data governance to ensure documentation of those with lived experiences of inequities.

Discussion

Dr. Nunez asked Dr. Krieger to expand on strategies to ensure quality and completeness of data by including contextualized social metrics. Dr. Krieger emphasized that it is increasingly easy for researchers to link to contextual metrics, noting that these data connections can be easily created when not readily available. Important variables such as education and income are often not captured in health surveys, despite being critical metrics for comparison. She also emphasized that governmental organizations often rely on funding and manpower of universities and other researchers to provide ways to make these data linkages.

Mr. Imperato asked Dr. Krieger what data are needed to determine whether individuals with disabilities are at increased risk for COVID-19 infection and poor outcomes. Dr. Krieger suggested that the HETF could correlate disability data referenced by geographic location with COVID-19 outcomes to illustrate how higher populations of disabled individuals affect COVID-19 outcomes in a given region, noting that public health students are a good resource for labor to create these connections to help solve these inequities.

Dr. Putnam asked Dr. Krieger how best to obtain real-time data to help predict outbreaks, particularly of emerging SARS-CoV-2 variants. Dr. Krieger noted that real-time data are only available for some outcomes. For example, data from the increasing genomic surveillance and

tracking of variants in the United States may enable tracking of SARS-CoV-2 variant epidemiology in real time. She also noted, however, that for COVID-19 case and mortality rates, which rely on the completion of health forms by frontline health care workers, these data may never be available in real-time format given the labor required to produce them. To determine whether an outbreak can be predicted, Dr. Krieger noted that the HETF would need to talk to data scientists working to predict the trajectory of the virus.

Health Data Transformation

Daniel Dawes, JD

Associate Professor, Executive Director, Satcher Health Leadership Institute, Morehouse School of Medicine

Mr. Dawes noted that during epidemics and pandemics, it is always the individuals with the least opportunity who are most impacted. He explained that the mission of the Satcher Health Leadership Institute (SHLI) is to create systemic change that will lead to a healthier, equitable, inclusive society. He quoted an article by Robinson et al. from *Biostatistics*, which stated that “structural racism is a critical body of knowledge needed for generalizability in almost all domains of health research.” He explained that structural racism is the totality of ways that society fosters racial discrimination enforcing an inequitable system, which in turn reinforces discriminatory beliefs, values, and resource distribution. Inequitable distribution of resources leads to the inequitable distribution of life saving materials. Combatting this inequity entails understanding the issues and designing appropriate solutions using accurate and complete data.

Mr. Dawes stressed that vulnerable communities are being harmed all across the United States. For example, of those individuals who died of COVID-19 in Washington, DC, 75 percent were Black, although Black residents only constitute 45 percent of the city’s population. Furthermore, in 2020, the total life expectancy in the United States dropped by 1.0 year, while life expectancy for Blacks dropped by 2.7 years and for Latinxs by nearly 2.0 years. American Indian and Alaska Natives are also facing a mortality rate 1.8 times higher than non-Hispanic Whites; and among children who have died of COVID-19, 75 percent were of color. Despite these inequitable death rates, only one U.S. state, New Mexico, has vaccinated at least 10 percent of its Black population. These inequitable responses result from a lack of data characterizing the issue, yet the current data collection regime renders collection of all of the necessary data infeasible.

Collaboration can enable collection of the data needed to achieve an equitable COVID-19 response. SHLI convened a brain trust with diverse leaders representing some of the most marginalized communities to formulate strategies to achieve health equity. The brain trust proposed creating a Health Equity Tracker, which will launch in April 2021 to help trace the existence of health inequities throughout the United States. It will establish an interactive and comprehensive Health Equity Data platform and help researchers to understand the health equity impact on mental/behavioral health, assess social determinants of health as they relate to COVID-19 and comorbidities, and examine political determinants of health. It will also provide technical assistance and policy recommendations to jurisdictions concerning data collection plans for inclusion of health equity indicators. The tracker will persist beyond the pandemic and continue to highlight the hardships faced by marginalized communities.

Mr. Dawes also highlighted the Morehouse School of Medicine’s National COVID-19 Resiliency Network (NCRN), which links vulnerable communities with the resources they need to survive and thrive during the pandemic. The NCRN, which was developed as part of a \$40 million grant from OMH, has helped to expose data challenges and presented new opportunities to collect better data on health inequities.

Mr. Dawes emphasized four key data challenges: (1) lack of centralization and standardization of data; (2) lack of data sources analyzing the upstream factors as well as the “isms” that plague our society; (3) unreliable sources of and access to racial and ethnic data; and (4) federal government partners’ most restricted data being hidden behind restrictive barriers of the existing system. Furthermore, Mr. Dawes noted that racially biased algorithms may further disparities. For example, according to an article recently published in *Science*, an algorithm frequently employed by hospitals to predict which patients are most likely to need follow-up care identified only 18 percent of Black patients needing more care and 82 percent of White patients needing more care; the study team found that in fact 46 percent of Black patients and 53 percent of White patients needed more care. This example illustrates how deeply racial bias is entrenched in the health care process.

After reviewing data challenges, Mr. Dawes presented the SHLI team’s recommendations to the HETF: (1) provide resources for CDC to assemble/publish comprehensive COVID-19 outcomes and vaccine data; (2) compile a registry in primary care practice to identify/track patients with detailed demographic, social, and medical history; (3) create metrics for success and/or failure in vaccination efforts; (4) mandate requirements for granular race and ethnicity data fields; and (5) establish nationally standardized categories of race and ethnicity data fields and other identifying information.

Mr. Dawes concluded that the United States cannot return to the “normalcy” of a system in which marginalized communities are left without resources to survive and data needed to illustrate the inequities they face. He stressed that the United States should build on the lessons learned during the pandemic to strive for a new normal that achieves equity for all communities.

Discussion

Dr. Khaldun asked Mr. Dawes to expand on sources of data used by the Health Equity Tracker. Mr. Dawes explained that the Tracker will collect data from public and private data sources (e.g., from CDC and from insurance providers, hospital systems, and federally qualified health centers [FQHCs]). He encouraged task force members to suggest other partners for the initiative.

Ms. Turner asked whether the Health Equity Tracker will collect data on barriers to health care access. Mr. Dawes confirmed that identifying barriers limiting access to care is a key component of the Health Equity Tracker. The SHLI seeks to use the Tracker to create a “green book” of health care for vulnerable communities to provide locations where they can receive accessible and equitable services and testing. Furthermore, the SHLI wants to track how hesitancy to seek regular health care because of COVID-19-related fears affects outcomes. He invited task force members to provide feedback on other factors critical to tracking the impact of COVID-19 on the health of minority populations.

Mr. Toranzo asked whether the number of deaths among children of color would increase with the reopening of schools, particularly given the new virus variants. Mr. Dawes noted that from his experience the outcomes would likely be circumstantial, with different outcomes in different districts and schools. The largest factor of outbreaks in schools will be based on the resources available to protect children from contracting and spreading the virus. He explained that at the beginning of the pandemic schools had trouble accessing the necessary PPE to keep children safe.

Dr. Martinez asked whether the research community has accurately captured the proportion of deaths that have occurred due to COVID-19-related hesitancy to seek medical treatment for chronic illness or mental health, and whether medical examiners can record whether a death may have been COVID-19-related but not due to a COVID-19 infection. Mr. Dawes stressed the need to balance underreporting and overreporting of deaths related to COVID-19. He expressed his opinion that the United States currently underreports COVID-19-related deaths, adding that he did not possess enough information to fully address the question asked. However, he noted that during development of the Affordable Care Act, 62 provisions were written into law intended to elevate equity, and that one of those provisions called for increased data collection and reporting. This provision should be leveraged to increase and standardize data collection both for COVID-19-specific and general health data to help answer these key questions.

Mr. Dawes also noted that the impact of COVID-19 on mental health has been underappreciated. Recent studies show that one in three Black individuals know someone who has died of COVID-19, which illustrates the depth of the impact grief is having on the Black community. As such, the Health Equity Tracker will track five variables of mental health: anxiety, depression, suicide, substance addiction, and Alzheimer's disease. These factors will be tracked over the lifecourse and across geographic regions to track trends in real time. Mr. Dawes welcomed HETF members to propose additional mental health factors worth tracking for future inclusion.

In response to questions from Mr. Joseph, Mr. Dawes described efforts aimed at collecting data on American Indians, including liaising with the Indian Health Service (IHS). He noted that his team worked with IHS to determine what data points were accessible through their databases. His team also collaborated with CDC partners working with tribal nations, and individuals from various nations, beginning with the Navajo nation, at the grass-roots level. Mr. Dawes explained that this work informed the development of the NCRN. Mr. Dawes' team heard concerns from the American Indian communities regarding the sovereignty of the data collected and shared. Mr. Dawes assured HETF members that his team is working to ensure the sovereignty of the data collected while being as inclusive as possible.

Dr. Nunez-Smith invited Dr. Krieger to provide additional comments following Mr. Dawes' response. Dr. Krieger noted that large problems surround collection of data on American Indians and Alaska Natives, Native Hawaiians, and indigenous populations, adding that the number of cases are difficult to track because of inconsistent health coverage and the limited jurisdiction of the IHS, and that the Census data include problematic inconsistencies. She also noted that while linkages have been created to help solve these inconsistencies, these efforts are expensive and take time to create a better picture of the true size of the community. She emphasized that these data issues are not only related to COVID-19 and require larger structural changes. She

concluded that mitigation of elevated risks to a population that are due to structural conditions can only be achieved through better health data collection.

Group Discussion

Dr. Nunez-Smith began the group discussion by emphasizing that data present deep equity issues (i.e., what data are collected, how they are interpreted, and what action/inaction results from those interpretations). Missing data on race and ethnicity leads to denial of inequities.

Dr. Nunez-Smith discussed a data solutions model offered by Deloitte consisting of seven key lessons from the COVID-19 pandemic. First, the research and health care communities should react to data in real time. Second, data should be presented simply but powerfully to inform key choices. Third, data technology should be leveraged to increase connectivity across data systems. Fourth, data governance should be considered as important as data collection and reporting. Fifth, data security is a critical part of data sharing. Sixth, data sharing is required to create innovative solutions to long-standing problems. Seventh, the data collected must be used for decision making, which requires removing biases and strengthening data harmonization.

Mr. Watts emphasized the role that the HETF will play in providing recommendations to the government to create high data standards. He explained that the Bureau of Primary Healthcare establishes the data collection and reporting requirements and that HETF guidance may inform updates to these practices. However, he also cautioned that HETF members must consider the balance between collecting the data necessary to identify and resolve issues of inequality and not overburdening health care workers on the frontlines.

Dr. Putnam stressed the importance of standardizing data collection and data analysis to enable government officials at the federal, state, and local levels to make important decisions (e.g., resource allocation).

Mr. Joseph highlighted that good, reliable data are essential to respond to the COVID-19 pandemic. Lack of data and data access have been key drivers of persisting inequities experienced by minority populations. One key barrier to obtaining accurate data on the American Indian and Alaskan Native populations is that many surveys (e.g., the U.S. Census) categorize American Indians and Alaska Natives under the “Other” category, complicating harmonization across data sources. Moreover, IHS data on American Indians and Alaska Natives are limited because many individuals in these communities visit outside health care facilities in addition to IHS facilities. These challenges highlight the need to collaborate and coordinate with all entities providing health care services to ensure complete and accurate data collection.

Ms. Turner shared concerns from nurses about the lack of comprehensive disclosure, transparency, and reporting of COVID-19 infections and deaths. She emphasized that nurses need accurate data to assess risk, workplace safety, and patient needs. As of February 25, 2021, the National Nurses United found that at least 340 registered nurses and 3,336 health care workers have died of COVID-19. She stated that while one in four registered nurses are people of color, her union believes that at least 54 percent of the nurses who died of COVID-19 were people of color. These numbers were not easily obtainable because of the lack of access to accurate infection and death data. She stressed that access to accurate infection and death rates is

a matter of life or death for nurses on the frontlines. Furthermore, hospitals are still not providing health care workers with adequate PPE or testing, concluding that without accurate assessments of infection, deaths, and material distribution, governments, hospitals, and industry are not informed of how much PPE to produce and where to distribute it, or where to increase safety standards to prevent further infection and mortality.

Dr. Venters stated that the number of COVID-19 infections and deaths in the incarcerated population has not been well-documented. Small studies have suggested that rates of infection are higher among incarcerated individuals than among the general population, because detention centers lack the capacity to track rates of infections, deaths, or vaccinations. Dr. Venters highlighted the importance of creating a structure to understand the dynamics of the pandemic in these settings to help inform an equitable response.

Mr. Toranzo described the inequities faced by people of color that he has witnessed, and stressed the importance of collecting the data needed to determine whether children can safely return to a school, especially in the context of emerging SARS-CoV-2 variants.

Dr. Khaldun emphasized the need for a strong data collection infrastructure to assist government and health care workers at all levels to gather the information needed to prevent undue spread of, and death from, COVID-19.

Public Comments

The first member of the public invited to speak was **Kirsten Baker, CEO and Co-Founder of Jeenie**, a mobile interpreting service. Ms. Baker thanked the HETF chair and members for the work they are doing to lift the voice of marginalized communities. She introduced Jeenie, a mobile platform that connects users to video or audio calls with live interpreters for on-demand language assistance. She noted that health care providers across the country use Jeenie on mobile devices, landlines, and computers to ensure effective communication during in-person patient visits and telehealth consultations. Ms. Baker stressed that language is a basic human right and that her company seeks to eliminate language barriers and create equity and justice in the areas of health care, law, education, immigration, and refugee support. She noted the problem of misdiagnosis and mistreatment in health care that results from language discordance, stressing that this problem has been exacerbated by COVID-19 and social distancing requirements. Ms. Baker encouraged the task force to invest in eliminating these language barriers. She noted that FQHCs and other federally funded organizations need access to onsite interpreting at testing and vaccination centers to inform patients, meet health care needs, and build trust. She encouraged the creation of a vaccine dissemination strategy that includes onsite interpretation and translated materials to demonstrate the positive effect of language access on diagnosis, treatment, and overall health.

The next commenter was **Dr. Harald Schmidt, Assistant Professor of Medical Ethics and Health Policy at the University of Pennsylvania**. Dr. Schmidt raised several key points on using data for ventilator and vaccine rationing. First, in spring 2020 triage protocols were developed to capture data to ensure fair ventilator allocation. He noted that historical and structural models of clinical benefit that are used to guide resource allocation reduced the likelihood of disadvantaged populations receiving a ventilator. Despite major guideline revisions

in 2020, much of these structures remain in effect throughout the United States. Dr. Schmidt shared suggestions for reducing these inequities in his written comments. He added two points about vaccine allocation. First, allocating vaccines to states proportionate to population is inappropriate, because not all states contain the same proportion of disadvantaged individuals. Using CDC vulnerability data at the national level, Dr. Schmidt and colleagues illustrated that in 16 states more than 1 in 4 residents are among the most disadvantaged populations (e.g., New Mexico), while other states have a proportion closer to 1 in 10 (e.g., New Hampshire). Allocating by population alone increases scarcity of vaccinations for vulnerable populations. He encouraged the HETF to review the formula for allocating vaccines to states to identify ways to achieve equity. Dr. Schmidt added that he performed reviews of states' use of disadvantaged indices (e.g., social vulnerability index) and found that roughly half of all states used such a tool in 2020 to increase equitable allocation. Dr. Schmidt suggested that the HETF encourage those states not yet utilizing such tools to learn from states with successful implementation of these indices to make progress toward equitable distribution of vaccines.

The final commenter was **Dr. Eduardo Sanchez, Chief Medical Officer for Prevention at the American Heart Association**, who noted that in 2018 the American Heart Association formed an Office of Health Equity and in November 2020 it released a presidential advisory that examines structural racism as a fundamental driver of health disparities. He noted that the pandemic has re-exposed long-standing inequities in health care delivery and public health infrastructure that exacerbate disparities in health care access and outcomes. Since the pandemic began, the American Heart Association has worked to address equity challenges by providing credible information on COVID-19 to the public and to the research community, as well as by adjusting its research portfolio to establish a \$2.5 million rapid research fund to accelerate studies of heart and brain implications of COVID-19 infection. The American Heart Association also launched a COVID-19 cardiovascular disease registry to capture real-time data on patient characteristics, treatments, and outcomes for thousands of adults with COVID-19 across the country. Almost half of the registry is composed of Black and Latinx patients, and investigators have found significant racial and ethnic differences in the prevalence of comorbidities, clinical course, and outcomes. Dr. Sanchez noted that additional information regarding the registry can be provided to HETF members interested in learning more. He concluded with four recommendations for the administration: (1) continue to use trusted messengers to talk about prevention, the importance of getting a COVID-19 vaccine, and where and how to obtain one; (2) initiate dedicated efforts to ensure that vaccines are received by those least able to obtain them (e.g., via smaller vaccination sites closer to where people live, or house-to-house vaccination visits); (3) ensure that essential workers have adequate PPE and that their workplace environments are adjusted to better protect them; and (4) invest in/refortify the public health infrastructure, including data/data scientists.

CAPT Wu concluded the public comment period by announcing that any members of the public still wishing to provide comments for consideration may submit their comments in writing by Friday, March 5. Additional public comments submitted in writing are available in Appendix A.

Closing Remarks

Marcella Nunez-Smith, MD, MHS

Dr. Nunez-Smith thanked HETF members, speakers, and ASL interpreters for making this inaugural meeting a success. She noted that this meeting laid the groundwork for the HETF to provide future recommendations to address challenges and leverage opportunities surrounding the fair and equitable response to COVID-19. Before the next HETF meeting, HETF members will convene four subcommittee meetings focused on data, analytics and research, health care access and quality, structural drivers and xenophobia, and communications and collaborations. Subcommittee discussions will be presented during the next public HETF meeting.

Written Public Comments Submitted for the Meeting Records

1. Nargess Shadbeh, Oregon Law Center

Dear COVID-19 HEALTH EQUITY TASK FORCE:

I am Nargess Shadbeh, and the director of the farmworker program at the Oregon Law Center (OLC). Our organization helps access to justice for all low-income individuals and in my section agricultural workers.

For the past year, in my role with OLC, I have tried to focus attention on the issues of major concerns to our clients and COVID-19. I would like you to read these comments, so I am brief here:

Farmworkers living year-round in Oregon often work in seasonal jobs coupled with work in sheds, canneries, and fruit processing plants. These men and women with an average age of 30-50 do not fall into any particularly high category but for their work as essential workers. They must receive access to frequent testing and vaccination at the work sites because of difficulty in accessing these services elsewhere. We are concerned that with the variant and mutations of COVID-19 agricultural workers are in greater risk given the crowded spaces they work in with little chance for ventilation.

Even more difficult is the lack of coordination for testing and vaccination for workers who are migrant and seasonal workers at least registered housing across Oregon (never mind the thousands living in unregistered sites such as hemp workers). Currently, there are plans underway it appears for vaccination and possibly testing of arrival guestworkers and their counterpart domestic workers at the same labor camps. However, this is only a fraction of the labor housing in Oregon. We need your input to emphasize the testing and vaccination of the occupants of labor housing who are living in rooms as small as 4 people who could be unrelated in 160-200 square feet with little ventilation. **Please specify both domestic and guest workers across all labor housing in Oregon and not just tie it to guestworkers. Start now but must go with crops through at least August or September in Hood River and Southern Oregon.**

We appreciate the hard work that you and your organization do and the dedication of the outreach team and OHA. However, to change policy this information has to get to policymakers and we need action.

Nargess

Nargess Shadbeh
Oregon Law Center
522 SW Fifth Ave., Suite 812
Portland, OR 97204
(503) 473-8328

2. Benedict I. Truman, MD, MPH, Centers for Disease Control and Prevention

In 2015, the U.S. Community Preventive Services Task Force recommended client and family incentive rewards to increase vaccination rates in children and adults (see here: <https://www.thecommunityguide.org/findings/vaccination-programs-client-or-family-incentive-rewards>).

The recommendation was supported by sufficient evidence that small rewards, including money, food vouchers, gift cards, and lottery prizes are effective in reducing vaccine hesitancy and increasing vaccine coverage in underserved racial/ethnic minority populations.

To date, those incentive rewards are not being applied in systematic interventions to increase receipt of COVID-19 vaccines by racial/ethnic minority populations at highest risk for death and hospitalization.

The most potent incentive reward, receipt of a valuable COVID-19 vaccine, is not being applied by most COVID-19 vaccination clinics.

Instead, appointments for vaccination are being allocated preferentially to **tech-savvy people within priority groups based on their ability to compete for scarce appointments in online scheduling systems.**

And so racial/ethnic minority populations at highest risk of death or hospitalization from COVID-19, with less time and computing skills **within priority groups are being systematically pushed to the back of scheduling lines.**

Benedict I. Truman, MD, MPH | Associate Director for Science | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention | Centers for Disease Control and Prevention | Mail Address: 1600 Clifton Road, NE – Mailstop E-07, Atlanta, Georgia 30333 | Office Phone: (404) 639-8886 | Mobile: (404) 428-9128 | Fax: (404) 693-3125 | Email: bit1@[cdc.gov](mailto:bit1@cdc.gov) |

3. Barbara Alexander, IDSA and Rajesh Gandhi, HIVMA



February 25, 2021

Marcella Nunez-Smith, MD, MHS
Chair, White House COVID-19 Health Equity Task Force

Dear Dr. Nunez-Smith:

Congratulations on your appointment as the Chair of the White House COVID-19 Health Equity Task Force. On behalf of the Infectious Diseases Society of America (IDSA) and its HIV Medicine Association (HIVMA), we greatly appreciate your leadership in advancing health equity and specifically in mitigating the disproportionate impact of COVID-19 on Black, Indigenous, Latinx and other people of color.

IDSA and HIVMA represent over 12,000 infectious diseases physicians, scientists, public health professionals and other clinicians who have working on the front lines of coronavirus pandemic, and **we write to request a meeting with you and other members of the Task Force to share recommendations from Infectious Diseases (ID) and HIV physicians, public health professionals and researchers for addressing COVID-19 health inequities.**

While the intersection of structural racism and discrimination with health disparities have been brought to the forefront by the COVID-19 pandemic, our members have long recognized and worked to address these inequities in responding to other infectious diseases epidemics. We are particularly troubled to see the striking overlap in communities and populations that have been most heavily impacted by the COVID-19 pandemic with those that have been disproportionately affected by the HIV epidemic in the U.S.

The strategies recommended by IDSA and HIVMA members working on the frontlines of the coronavirus pandemic for reducing COVID-19 health inequities center around the following key themes:

- increasing engagement with community-based organizations and leaders;
- addressing barriers to COVID-19 services, including equitable access to therapeutics and vaccinations and thoughtful approaches towards reducing resistance to vaccines;
- improving national and state planning and coordination and data collection to strengthen the response;
- optimizing the clinical trial infrastructure to be more inclusive of key populations and community-based clinical trial sites (including in safety-net hospitals);
- fostering an inclusive and diverse clinical, public health and research workforce;

- strengthening the Food and Drug Administration’s emergency use authorization process for therapeutics.

We would welcome the opportunity to discuss our detailed recommendations with you and to learn more about how IDSA and HIVMA members can help advance your important work. Please contact us anytime through Amanda Jezek, IDSA’s Senior Vice President of Public Policy and Government Relations, at ajezek@idsociety.org and Andrea Weddle, HIVMA’s Executive Director, at aweddle@hivma.org.

Sincerely,

Barbara D. Alexander, M.D., MHS, FIDSA
President, IDSA

Rajesh T. Gandhi, M.D., FIDSA
Chair, HIVMA



Policy Recommendations for Addressing COVID-19 Health Inequities

Version: 2/25/21

This document was developed by IDSA and HIVMA to offer recommendations from infectious diseases and HIV physicians, scientists, public health professionals and other clinicians working on the frontlines of the coronavirus pandemic for Congress and federal agencies to reduce COVID-19 health disparities.

Key strategies for reducing COVID-19 health inequities are centered around the need to 1) increase engagement with community-based organizations and leaders; 2) address barriers to COVID-19 services, including vaccinations; 3) improve national and state planning, coordination and data collection to strengthen the response; 4) optimize the clinical trial infrastructure to be more inclusive of key populations and community-based clinical trial sites; 5) foster an inclusive and diverse research workforce and 6) strengthen the Food and Drug Administration's emergency use authorization process for therapeutics.

1) Increase Community Engagement and Education in All Aspects of the COVID-19 Response

- HHS: Increase support to directly fund community-based organizations (CBOs) serving populations at higher risk of experiencing health disparities to provide COVID-19 related public health education. These populations include Black, Indigenous and other people of color; Latinx; immigrant communities; people with substance use disorders, individuals who are experiencing homelessness, justice-involved populations and LGBTQ+ communities. These organizations also should be funded to provide health care services when appropriate, including vaccination, testing, contact tracing and providing support or coordination in accessing COVID-19 therapies or other COVID-19 related services. These efforts should be coordinated with local public health systems.
- Congress and HHS: Increase funding for local community providers, health centers and pharmacies to provide COVID-19 testing, vaccines and outpatient therapies with attention to ensuring sufficient funding to support an adequate public health workforce and sufficient funding for rural areas.
- HHS: Incentivize health systems to partner with CBOs and Indian Health Services/tribal entities serving Black, Indigenous, immigrant, Latinx and other underserved communities to support COVID-19 educational activities and provide COVID-19 related health care and public health services, including care coordination and other services, such as transportation, to support individuals seeking to access these services.
- HHS: Support culturally appropriate and linguistically accessible mass campaigns to educate community-based clinics and clinicians across the country on the availability of COVID-19 therapeutics and vaccines and how to encourage and assist their patients who are seeking access to them. Leverage partnerships with the IDSA, HIVMA and other

Professional associations to extend the reach of these campaigns. A significant increase in resources for translation services and to improve communications for non-English speakers will be critical to this effort.

1) Address Barriers to COVID-19 Services, including Vaccinations

- HHS: Support the expanded and regular use of mobile units to bring COVID-19 testing and vaccinations to underserved and rural communities and other vulnerable populations, such as people with disabilities and who are experiencing homelessness.
- HHS: Support the expanded use of peer-based community health worker programs to provide culturally relevant COVID-19 vaccination education, facilitate registration for vaccination appointments and provide information on COVID-19 testing sites and locations for outpatient treatment for COVID-19.
- HHS: Disseminate best practices and provide technical assistance for ensuring the use of non-internet-based mechanisms for vaccine education and registration to help address the inequities created by the digital and technology divide. For example, registrants should not be required to have an email address; allow registration by phone and ensure materials are accessible for individuals at all literacy levels.

2) Improve National and State Planning/Coordination/Data Collection to Strengthen the Response

- HHS: Support coordination at the state and local level regarding vaccine allocation, distribution plan and administration sites to ensure programs are implemented in a coordinated and thoughtful way to prioritize key populations.
- HHS: Incentivize complete reporting of public health data, including vaccine distributions and vaccines administered, and ensuring the collection of demographic data, such as race/ethnicity, age and zip code of residence. Urge states to require reporting of race/ethnicity data and urge health care systems to ensure they are collecting the information through their electronic health records. Provide funding to support the use of complementary databases to collect this information in areas where underreporting is present.
- HHS: Support and incentivize streamlined and centralized public health data reporting systems, including for vaccines and vaccinations.
- HHS: Ensure transparency in data reporting (including demographics) and the timely and regular public release of public health data.
- HHS: Support the use of data analytics and geospatial mapping to direct vaccine allocations to heavily impacted populations and communities, including people over 65 years of age, Black, Indigenous and other people of color and Latinx populations.
- HHS: Map outpatient treatment sites for monoclonal antibodies and other authorized COVID-19 therapies with COVID-19 case and death rates and provide technical assistance to expand access to these sites where needed.
- HHS: Disseminate information on therapies authorized for COVID-19 to primary care providers and health care facilities and on how and where to access them to increase use of treatment options in the most heavily impacted areas.

3) Optimize the Clinical Trial Infrastructure

- Congress: Increase federal funding for research to study and develop COVID-19 *outpatient* treatment options, to address barriers to timely identification of patients for trials and to support clinical trial engagement and outreach to those most vulnerable to COVID-19, including older individuals; Black, Indigenous and other people of color; Latinx communities; immigrants; LGBTQ+ individuals and other populations that are underserved and most heavily impacted by COVID-19 and other infectious diseases.
- HHS: Support collaborations between the Food and Drug Administration (FDA), the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC) and the clinical research community to strengthen and improve the clinical trial infrastructure. This should include expanded funding mechanisms, increased research staff, and development of better analytical and predictive tools to allow rapid start-up and to simplify enrollment.
- HHS: Provide an integrated framework to link individuals diagnosed with COVID-19 to appropriate trials and encourage large-scale collaboration across many different types of facilities. Strengthen and expand clinical trials sites to include safety-net and other community hospitals and clinics to increase access to promising therapeutics for populations that are typically omitted from studies. Including settings outside of traditional urban tertiary care academic centers provides opportunity for enrolling a more diverse study population more rapidly and increases patient access to treatments.
- HHS: Fund mobile units to allow equitable access to research for people in rural areas, many of whom live at considerable distance from any hospital or community health center.

4) Foster a More Inclusive and Diverse Research Workforce

- Congress: Increase funding for targeted biomedical research initiatives, adopt actionable policies and strategies to promote inclusivity through a diverse research workforce, and direct NIH to provide training and technical assistance to help funding recipients achieve diversity goals. This new funding should supplement, not supplant, existing appropriations and create sustainable and predictable funding for research agencies. Diversity policies that Congress and NIH promote for funding should ensure that:
 - Federal and private industry clinical trial sponsors prioritize a diverse research workforce, including Black, Indigenous and people of color and LBGBTQ+ individuals, and provide funding to facilitate partnerships between safety-net hospitals, community-based hospitals, clinics and well-established research centers;
 - Safety-net hospitals have the resources and education they need to value and participate in clinical trials;
 - Clinical trial sponsors ensure that research practices, trial designs and enrollment processes directly address the history of racism in clinical research by engaging Black, Indigenous and other people of color, Latinx communities and other underserved populations throughout the research process;

- Clinical trial sponsors engage with community leaders, including community-based participatory research groups, to support education about enrollment in research studies;
- Clinical trial sponsors ensure that study enrollment processes include comprehensive information about clinical trials and research studies with a transparent informed consent process;
- Clinical trial sponsors promote and expand access to the appropriate training on Good Clinical Research Practice (GCP), including medical ethics for medical and medical support staff;
- Clinical trial sponsors are encouraged to provide funding that would allow research sites to offer extended morning, evening and weekend hours to broaden access to people whose jobs or family responsibilities do not permit weekday participation;
- Federal clinical trial sponsors be allowed to cover trial participants' expenses related to participation, including transportation and childcare costs.

5) Strengthen the Emergency Use Authorization (EUA) Process for Therapeutics

- FDA: Require the sponsor of a therapeutic receiving an EUA to include plans for recruiting children, individuals who are pregnant and breastfeeding, and others who are immunocompromised, including people with HIV. In addition, require inclusion of populations heavily impacted by the pandemic, including Black, Indigenous and other people of color, immigrant, Latinx communities and other underserved populations.
- HHS: For therapeutics granted EUAs, facilitate and support collaborations with manufacturers, health care facilities, private and federal payers and other federal agencies to collect additional evidence to monitor utilization and outcomes by adapting existing COVID-19 registries and data platforms and, if necessary, create new data collection mechanisms.
- HHS: Develop and regularly update guidance and best practices for states and facilities to ensure access to outpatient COVID-19 treatment for older Americans, communities of color and other populations most heavily impacted by COVID-19.
- CMS: Increase payments to providers to better reflect the costs of administering COVID-19 therapeutics (particularly those requiring infusion) and to support data collection, including information on whether medications are being used equitably among disproportionately affected communities.

For questions, contact Amanda Jezek, IDSA Senior Vice President, Public Policy and Government Relations at ajezek@idsociety.org or Andrea Weddle, HIVMA Executive Director at aweddle@hivma.org.

4. Vivian Bradley Johnson, Clinical Services Parkland Health and Hospital System



Statement of Dr. Vivian Bradley Johnson to the COVID-19 Health Equity Task Force:

February 26, 2021

Dr. Nunez-Smith and Members of the Task Force:

The Parkland Health & Hospital System appreciates the opportunity to provide input on the work our system is actively doing to help underserved communities affected by COVID-19. Parkland provides care to indigent, uninsured and underinsured residents of Dallas County, averaging more than 60,000 hospital discharges and 1 million outpatient visits annually. Parkland's patient payor mix is approximately 30% charity, 30% Medicaid, 20% Medicare and 10% self-pay.

Throughout the pandemic the Dallas County community has relied heavily on us to provide care to an increasing number of individuals diagnosed with COVID-19. In order to handle the increasing volume of patients, Parkland has transformed surgical operating suites into a designated tactical care unit to increase capacity for critically ill COVID-19 patients. Additionally, mega drive-through and walk-up sites were established in vulnerable communities to improve access to COVID-19 testing, and, once available, vaccinations were provided at the drive-through locations as well. On top of this effort, two on-campus clinics were opened to increase capacity for individuals eligible to receive vaccinations based on criteria established by the Centers for Disease Control (CDC) and our state and local health departments.

Of the 256,072 COVID-19 tests administered by Parkland to date, 62% were provided at community testing sites located in ZIP Codes identified with vulnerable populations. Approximately 43,000 of these patients tested positive for COVID-19 (66% Hispanic, 20% Black, and 9% White) with 11% of them hospitalized at Parkland. Out of the 1% of patients who died due to COVID-19, 72% were Hispanic, 15% Black, and 10% White.

For many individuals, including those facing the challenges associated with health inequities, their local pharmacist provides a trusted source of health information. Whether practicing in a neighborhood retail pharmacy or serving a large population through a safety-net provider such as Parkland, pharmacists are a trusted source of vaccine safety and efficacy information. They are uniquely positioned to offer expertise on the handling and distribution of vaccines along with additional insight into the barriers of care.

In an effort to eliminate barriers such as lack of information or dispelling misinformation, Parkland has launched a multi-faceted approach to marketing and outreach to vulnerable populations. Parkland's targeted communications, which provide education and encourage individuals to get vaccinated, include

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214.590.8000 | fax 214.590.8096
www.parklandhospital.com

5. Paul Abramowitz, American Society of Health-System Pharmacists



Statement of Dr. Paul W. Abramowitz to the COVID-19 Health Equity Task Force: Our Nation Should Fully Utilize Pharmacists to Help Address Disparities in Access to Care

February 26, 2021

Dr. Nunez-Smith and Members of the Committee:

ASHP represents pharmacists who serve as patient care providers in hospitals, health systems, ambulatory clinics, and other healthcare settings spanning the full spectrum of medication use. The organization's nearly 58,000 members include pharmacists, student pharmacists, and pharmacy technicians. ASHP also hosts the largest gathering of pharmacists in the world, the Midyear Clinical Meeting, with over 25,000 attendees each year. For 79 years, ASHP has been at the forefront of efforts to improve medication use and enhance patient safety, providing critical practice resources such as an extensive publicly-accessible COVID-19 resource center, including an evidence table for COVID-19 treatments and health system pharmacy surge toolkit. As the pandemic enters its second year, ASHP remains fully committed to helping ensure equitable access to COVID-19 vaccination, testing, and treatment for our members and their patients. In the weeks leading up to the approval of a COVID-19 vaccine, ASHP developed [principles on COVID-19 vaccination](#), specifically calling for equitable access to COVID-19 vaccines, and we have continued to update policymakers with recommendations for improving the rollout drawn from our members' experiences in the field.

Across the country, our pharmacist, pharmacy technician, and pharmacy student members are providing essential patient care in hospitals, health systems, ambulatory clinics, and other healthcare settings spanning the full spectrum of medication use. They are on the front lines of the COVID-19 response and they have been a lifeline for patients seeking testing, immunizations, and medications. They are also the leaders managing fragile drug supply chains on behalf of patients and the healthcare enterprise. I urge you to include their voice and expertise in decisions you make.

Pharmacists are Among the Nation's Most Accessible Providers in Underserved Communities

Pharmacists are the most accessible providers in otherwise underserved communities. In fact, 90% of all Americans live within five miles of a community pharmacy.¹ In rural and underserved communities and in communities experiencing physician shortages, pharmacists may be the only healthcare provider that is immediately available to patients. A recent report from the University of Pittsburgh School of Pharmacy highlighted the gaps in access to care experienced by Black Americans.² The report found that 37% of U.S. counties had two or fewer healthcare facilities per 10,000 residents and 9% had less than one facility per 10,000 residents. In the study, 69 counties, including 23 urban counties, were identified where Black residents had a significantly higher risk than white residents of having to drive greater than one mile to the closest COVID-19 vaccine administration facility. A further 94 counties were identified where Black residents had a significantly higher risk than white residents of having a driving distance greater than 10 miles to the closest facility. The findings also highlight that pharmacists and pharmacies are the most accessible healthcare providers in otherwise underserved communities, and highlight the need to leverage non-traditional access points to

¹ See NCPDP Pharmacy File, ArcGIS Census Tract File. NACDS Economics Department.

² Berenbrok, Lucas A, et al. Access to Potential COVID-19 Vaccine Administration Facilities: A Geographic Information Systems Analysis. 2 Feb. 2021, s8637.pcdn.co/wp-content/uploads/2021/02/Access-to-Potential-COVID-19-Vaccine-Administration-Facilities-2-2-2021.pdf.

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increase availability of vaccination and testing in underserved communities. They also highlight the need to fully leverage the existing healthcare providers, notably pharmacists and pharmacies that are already available to provide access in these communities.

Remove Barriers to Pharmacist Care Harm Underserved Communities

Pharmacists practicing in health systems have led the coordination of COVID-19 vaccination efforts across our country, and while I am pleased that the government is beginning to roll out vaccinations through community pharmacies as well, there are significant federal barriers to pharmacists providing care in the communities they serve. While several states currently reimburse pharmacists as healthcare providers, the Medicare program does not. As a result, many pharmacies are unable to be reimbursed for providing COVID-19 testing, nor are they able to receive reimbursement to provide patient assessment and counseling for Medicare beneficiaries receiving COVID-19 testing. This creates a financial barrier that undermines access to care in the communities pharmacists serve, which is very concerning given pharmacies are often the only point of care that exists in underserved communities. These barriers can be overcome if we have the will to fully leverage pharmacists as healthcare providers in these otherwise underserved communities. COVID-19 has exposed deep disparities in care across our country. Taking steps today to fully leverage pharmacists to provide care in the communities they serve will increase care access well beyond the span of the COVID-19 pandemic.

Enhance Support for Safety Net Providers

Our government has long recognized the role that safety-net hospitals play in serving patients in both rural and urban communities. These hospitals often serve as the only source of acute care services, including inpatient care for COVID-19 patients, in underserved communities. Yet, for the past several years, the Centers for Medicare & Medicaid Services has undermined a critical safety net program, the 340B Drug Pricing Program, by targeting 340B eligible hospitals for Medicare cuts and by failing to enforce 340B drug discount requirements for drug manufacturers. The savings generated by the 340B program support many vital programs hospitals could not otherwise provide to underserved patients, such as transportation and clinical services. To protect communities' access to services, the government should immediately reverse these harmful policies. Further, given COVID-19's toll on providers, particularly those that were under-resourced before the pandemic, additional support is needed. The Provider Relief Fund, which was established by Congress to support providers struggling to serve patients as a result of the COVID-19 pandemic, is nearly depleted, but the pandemic continues. We urge the COVID-19 Health Equity Task Force to recommend that Congress replenish the Provider Relief Fund to make funds available for safety-net hospitals and other providers on the front lines of COVID-19 care.

Immediately Appoint a Pharmacist to the COVID-19 Health Equity Task Force

I am greatly concerned that despite the role pharmacists are playing in COVID-19 vaccination and treatment, and the relative accessibility of pharmacists in otherwise underserved communities, this Task Force does not have a single pharmacist among its members. This deprives the Task Force of insights from medication use experts who are also the most accessible providers in underserved communities. The leadership of this Task Force and the Biden administration should move swiftly to add a pharmacist to the COVID-19 Health Equity Task Force. The national pharmacy organizations, including ASHP, have jointly recommended including Dr. Vivian Bradley Johnson, Pharm.D., M.B.A., FASHP, senior vice president of clinical services for Parkland Health and Hospital System, and Dr. Lakesha Butler, PharmD, BCPS, immediate past president of the National Pharmaceutical Association. Both of these pharmacists have a history of serving as healthcare providers in Black and Brown communities, and both are well qualified to provide insights that will help this task force address disparities in COVID-19 care. I strongly urge that a pharmacist with experience addressing health disparities be added to this task force.

Page 3

Thank you for your consideration of these recommendations.

Sincerely,

Paul W. Abramowitz, PharmD, Sc.D. (Hon), FASHP
Chief Executive Officer
American Society of Health-System Pharmacists (ASHP)

6. Chrissie Juliano, Big Cities Health Coalition



March 5, 2021

Marcella Nunez-Smith, MD, MHS
Chair, COVID-19 Health Equity Task Force

Re: Comments in Response to the February 26, 2021 COVID-19 Health Equity Task Force Meeting

Dear Dr. Nunez-Smith:

I write to you on behalf of the Big Cities Health Coalition (BCHC), a forum for leaders of America's largest metropolitan health departments to exchange strategies and collaboratively address issues to promote and protect the health and safety of the nearly 62 million people they serve. Our members have been on the frontline of the COVID-19 response for over a year now. In that time, they have seen and experienced firsthand the vast inequities that the COVID-19 Health Equity Task Force is charged with addressing. We thank you and your colleagues on the Task Force for your service and for this opportunity to provide comments and information on our members' behalf.

It is now well known that COVID-19 disproportionately exposes, sickens, and kills people of color and those of lower socioeconomic status at rates far higher than their white, wealthy non-immigrant counterparts. These inequitable exposures and outcomes are the result of a long history of systemic racism that has influenced policies and practices related to employment, housing, transportation, health, and other societal issues. These inequities persist today and have been exacerbated by the pandemic. As illustrated by Dr. Nancy Krieger and her colleagues, compared to the non-Hispanic white population, there have been excess COVID-19 deaths among people of color across all age groups. In particular, [there has been a striking loss of life among people of color younger than age 65](#).

Throughout the vaccine rollout, our members have been on-the-ground trying to balance efficiency with equity each day, which has proved challenging given their lack of authority in many places around who should get access to life-saving vaccine when. **Despite the best intentions of the White House and federal health agencies, the current vaccine distribution process across the country has been anything but equitable.** For example, some of our members have attempted to mass vaccinate individuals ages 50-64 in low-income communities of color that have seen disproportionate COVID-related hospitalizations and deaths. Others have attempted to target vaccine distribution by zip code to reach those most at risk. However, in each of these cases, they have been told to stand down their plans by state authorities.

Additionally, in many jurisdictions, local health department staff have had to work to re-route vaccine doses from hospitals – which tend to serve white suburbanites – to community-based locations that serve those living in the heart of their cities. As is longstanding practice, city vaccination sites must also serve large numbers of people who work in their jurisdictions, but live in areas outside of the city. To that end, **big cities should receive additional doses from state or federal authorities to allow them to serve those who work in their jurisdictions without negatively impacting those that live within their jurisdictions as well.**

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In the face of these challenges, big city health officials are working diligently to direct vaccines where they are most needed: to low-income communities and communities of color that have been decimated by the pandemic and whose residents are more likely to be hospitalized by or die from COVID-19. Right now, the vast majority of vaccine doses have been routed from the federal government to states, which then distribute them to local communities. *However, this is not the best way to ensure equity at the local level.* Many cities that have large populations of those most at risk of COVID-19 infections and deaths are often not getting a sufficient share of doses to address these inequities. We also understand that vaccine doses are being sent directly from the federal government to retail pharmacies and Federally Qualified Health Centers (FQHCs) in the name of equity and in an attempt to access “hard to reach” populations. Even still, we are not yet close to achieving our equity goals.

We believe this is not just an issue of limited supply; even when vaccine is readily available, without an intentional and proactive focus on getting vaccines into arms within underserved communities, they will continue to be left behind. **Our members – leaders of big city health departments – have shown that both equity and speed can be simultaneously achieved when efforts are made to actively and honestly engage communities, and when local jurisdictions have a voice in where vaccine is directed.** We urge you and your colleagues to support this critically important local authority and the highly valued relationships our members have with their communities.

Achieving equity requires that we value all individuals and populations equally, recognize and rectify historical injustices, and provide resources according to need. To that end, **every federal policy and funding decision – particularly those related to the pandemic response and recovery – must utilize an equity lens.** Late last year, in partnership with Human Impact Partners, and at the request of our membership, we developed a [Health Equity Lens Tool](#) that helps health departments engage communities to ensure that all policy decisions are made with equity as the forefront.

To achieve a more equitable COVID-19 response, we recommend that the White House and the federal government ensure:

- **Disaggregated data that are collected and linked across federal, state, and local governmental agencies to help identify connections between COVID-19 risk, race/ethnicity, and the social determinants of health,** including (but not limited to): employment status and work conditions; housing affordability and stability; neighborhood location; health insurance status and access to primary care; carceral status; and availability (or lack of) paid sick leave.
- **Clear, consistent, and data-informed guidance to state and federal agencies about the populations that are most at-risk, where they are located, and why it is critical that they be placed “at the front of the line” for vaccinations.** Federal guidance to states about the populations we know are most at risk of COVID-19 infection, hospitalization, and death would help communicate how vaccines can and should be distributed in ways that are just and fair. Additionally, this federal guidance can help states and jurisdictions collaborate more effectively to utilize hyperlocal data and community engagement strategies to distribute allocated vaccine doses quickly and equitably. The federal guidance should also allow for “innovation” in local distribution strategies, making exceptions for those ideas meant to close gaps in risk and burden profiles among people of color in local communities.

- **Sustained and long-term access to funding, human resources, and supplies necessary to reach areas and populations that are most in need.** Specifically, big city health departments need long-term and sustained funding to provide ongoing vaccination, testing, and contact tracing services in neighborhoods that are highly impacted by COVID-19 and difficult to access. This often requires having local health department staff available to personally visit neighborhoods and knock on doors to conduct testing and administer vaccines. Furthermore, while emergency funding is important, we cannot continue the “boom and bust” cycles that have resulted in chronically underfunding the public health system that hampers our pandemic response today. *Looking toward the future, long-term and dependable investments will be needed to help local health departments provide ongoing support to communities that have been hardest hit as they work to recover from the pandemic, as well as the decades of inequity that predated it.*
- **Ongoing and well-tested messaging about the critical importance of being vaccinated against COVID-19.** Given the current (and forthcoming) approval of new vaccines, local health departments continue to need messages to support their work and to help convey the effectiveness and safety of vaccination, particularly within communities that are targeted and systematically disenfranchised by medical racism and disinformation campaigns.

Finally, as you are aware, there is no government agency at any level that is officially charged with seeing “the big picture” and addressing the many complex and interconnected issues that contribute to inequity and the health of the public overall. Big city health departments are often the only agencies that have the understanding, vision, and courage to take on this critical role. The Task Force’s recommendations and support can help them and their colleagues guide the millions of people that are depending on governmental public health throughout the pandemic. They are depending on you to help them create communities that build resilience, advance equity, and move closer to our collective vision in which everyone can live healthier, longer lives.

We again thank you for your work on these critical issues, and we appreciate the opportunity to comment. We also welcome the opportunity to discuss these issues further. Please do not hesitate to reach out to us as you move forward. You may reach BCHC staff or our members collectively by contacting me at 202-557-6507 or juliano@bigcitieshealth.org.

Regards,

Chrissie Juliano, MPP
Executive Director
Big Cities Health Coalition

7. Nicole McCann-Davis, National Hospice and Palliative Care Organization



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March 5, 2020

Dr. Marcella Nunez-Smith
Chair, COVID-19 Health Equity Task Force
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

RE: 2/26/2021 Biden-Harris COVID-19 Health Equity Task Force Meeting Regarding
Data Needs to Close Health Inequities

Dear Dr. Nunez-Smith:

On behalf of the National Hospice and Palliative Care Organization (NHPCO) and the NHPCO Diversity Advisory Council, we thank you for your continued leadership in addressing health and social inequities exacerbated by the COVID-19 pandemic. NHPCO is the largest membership organization representing the entire spectrum of not-for-profit and for-profit hospice and palliative care programs and professionals in the United States. NHPCO is comprised of over 4,000 hospice locations with more than 57,000 hospice staff and volunteers, as well as 48 state hospice and palliative care organizations. The NHPCO Diversity Advisory Council provides information, guidance, and technical expertise related to serving diverse populations and achieving equitable access to hospice and palliative care services.

We greatly appreciate the public meetings that the Biden-Harris COVID-19 Health Equity Task Force is convening to promote transparency and ensure that stakeholder feedback is collected on these important issues. We attended the February 26, 2021 meeting, and in response to your call for comments, we submit the following recommendation:

While the disproportionate physical health toll of the COVID-19 pandemic on communities of color has been well documented, we have less information on the emotional health needs of these vulnerable communities.

To help to ensure equitable access to social and emotional support, we recommend appropriate mental health screenings for communities impacted by COVID-19 to assess the emotional wellbeing of individuals who may be grieving the death and/or suffering of loved ones impacted directly by the coronavirus as well as connecting those in need to bereavement services. The Biden-Harris COVID-19 Health Equity Task Force should recommend that these screenings are offered broadly across the nation including at COVID-19

1 | NHPCO

testing and vaccination sites. This systematic approach would support essential data collection efforts and help policymakers determine how to better target resources for services including bereavement and grief counseling.

We thank you for your service and consideration of our recommendation. The hospice and palliative care community stands ready to assist you with screening, data collection, and grief and bereavement support as we work together to serve our most vulnerable and underserved communities during this national public health emergency and beyond.

Sincerely,

Edo Banach, President & CEO
NHPCO

Nicole McCann-Davis, Chair
NHPCO Diversity Advisory Council

cc: Cedric Richmond, Senior Advisor and Director of the Office of Public Engagement
Christen Linke Young, Deputy Director of the Domestic Policy Council for Health and Veterans
Zach Butterworth, Director of Private Sector Engagement
Trey Baker, Senior Advisor for Public Engagement

8. Ruby Long, Medical College of Wisconsin

Subject: Attention Health Equity Task Force. Public comment attached.

Dear Officer Wu,

I am writing to highlight opportunities for promoting health equity. I am a Fellow of the American College of Emergency Physicians currently appointed Assistant Professor of Emergency Medicine at the Medical College of Wisconsin. As a frontline worker during this pandemic and a health equity advocate and scholar, I am repeatedly confronted by the traumatic impacts of COVID-19 on patients and colleagues due to inequitable resource allocation. The emotional, physical, and mental health tolls of COVID-19 have been grave, and the depths of the sequelae are still largely unknown. Despite these tragedies, I continue to believe that the national application of trauma-informed care shaped by restorative practices can promote communal healing and buy-in for future initiatives to manage COVID-19.¹

I believe that the Health Equity Task Force will build public trust without inadvertently fostering health inequities by addressing the needs of Americans through a lens of acknowledging the hurts of COVID-19. To this end, I recommend the following initiatives:

- Immediately circulate continuing medical education reflecting current best management practices for mild to moderate COVID-19 cases among medical providers, including physicians, advancing practice providers, and nurses. Included with this training is provider education that equips providers with tools to engage patients in a restorative/trauma-informed approach to reduce retraumatizing patients at the point of care.
- Limit or eliminate the need to pre-register for COVID-19 testing and vaccination services. The digital divide, particularly amongst the at-risk aging community, is contributing to barriers with accessing services. Additionally, creating clarity and efficiency with the current telephone registration systems would yield higher numbers of vaccinated citizens by optimizing the process.
- Increase access to monoclonal antibody treatment and provide this therapy at the time of diagnosis for eligible patients. This would reduce the burden of patients shuttling to an infusion site after initial assessment. There is precious time lost in coordinating infusion center appointments for people with mobility, transportation, and social support issues.

I am happy to expand on my comments as a provider in the Emergency Department, which is acting as our country's safety net. I believe that my perspective could be instrumental in promoting health equity, if I were to serve as a citizen contributor to the Task Force. I look forward to your response to this letter. You can contact me at rulong@mew.edu.

Thank you for allowing public opinion for the recent Health Equity Task Force Meeting. Please consider extending this opportunity for the additional meetings to come.

Reference

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9. Harald Schmidt, University of Pennsylvania



Harald Schmidt, PhD
Assistant Professor, Department of Medical Ethics and Health Policy
Research Associate, Center for Health Incentives and Behavioral Economics
Senior Scholar, Leonard Davis Institute of Health Economics

Health Equity Task Force
Office of Minority Health
Tower Oaks Building
1101 Wootton Parkway
Suite 100
Rockville, MD 20852

Philadelphia, March 4, 2021

Dear Dr. Nunez Smith and members of the Health Equity Task Force,

Public comment – improving equity in ventilator and vaccine allocation

As countless others in the country, I am grateful for the wisdom of the Biden-Harris administration to establish the Health Equity Task Force, and thrilled about its all-star membership. While the missions ahead are daunting to say the least, it is hard to think of a group of people in which one would have more confidence that they will accomplish meaningful progress.

I am grateful for the opportunity to provide oral public comment and the Task Force's inaugural meeting. In support of the group's work focused on ensuring that data promoting health equity are available and used in ways that are genuinely conducive towards this end, I am offering here some brief thoughts relating to the use of data and evidence in ventilator and vaccine allocation.

1. Ventilator rationing

In Spring 2020, across the country, triage protocols were adopted that aimed to integrate objective data in ways that enabled fair ventilator allocation. While there is a clear public interest in transparency about the criteria used to decide who should receive a ventilator when not all can, regrettably, an important systematic review found that as of May 10, 2020—when in many states the needs from the first wave had already peaked—only 26 states had publicly available guidelines.¹ Rightly, the concern underlying the development of triage guidance was that in the vast majority of cases, the default of a first-come-first served approach would lead to highly inequitable outcomes. However, in focusing on maximizing overall benefits, dominant guidance models paid insufficient attention to the distribution of benefits. While striving for the greatest benefit can be entirely understandable in a number of ways, it was, and is, problematic, as the way data were frequently integrated means that historically and structurally disadvantaged populations, especially disabled and Black communities, had lower chances of receiving a ventilator. Moreover, the approach risked exacerbating further Covid-19's vastly disparate impact across income, racial and ethnic groups.² Despite an intense reckoning with social and racial justice in the Summer of 2020; considerable reorientation in bioethics debates; and major guideline revisions in late 2020,³ much of this guidance remains, some legally binding,⁴ for

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example, in the form of New Jersey's *Directive Regarding Non-Prosecution of Healthcare Facilities and Professionals Adhering to Triage Protocols During COVID-19 Pandemic – Attorney General Law Enforcement Directive No. 2020-03* (For your information, I have raised this fact with the office of New Jersey's Attorney General by email on January 7, 2021, after publication of a related analysis with my colleagues Drs. Dorothy Roberts and Amaka Encanya).⁴

It appears that we are currently on a far less concerning Covid-19 incidence trajectory, but we still cannot be sure that we will be able to continue to avoid having to ration ventilators. Moreover, even if not used in this pandemic, adopted guidance carries important expressive value, and may be seen by future analysts, policy makers or practitioners as expressing consensus benchmarks, when, in fact the debate has moved on considerably during 2020.³

It is therefore very welcome that the Task Force will provide recommendations on federal crisis standards of care guidance. I hope that the group's members and staff will find six concrete options helpful, that Drs. Dorothy Roberts and Amaka Encanya and myself recently set out as in-principle available ways of reducing inequitable consequences from reliance on widely used SOFA score data within dominant triage frameworks. Chiefly, these strategies are: 1. improving diversity in decision processes; 2. adjusting creatinine scores, by using race-and ethnicity specific averages, rather than one general one; 3. dropping creatinine from the SOFA score; 4. using alternative measures, such as cystatin, instead; 5. adding equity weights, that can be constructed with metrics such as the Area Deprivation Index (ADI); or 6. rejecting the dominant SOFA model altogether.⁴ Our paper is attached here. On a closely related note, I am also enclosing a study lead by Whitney Kerr, in which we reviewed what is known about the views of vulnerable minority populations on principles underlying dominant ventilator allocation models.⁵ We found only six studies, and that involvement of disadvantaged minority populations in eliciting preferences is very limited (of a total of 10, 591 participants, 1,247 were from disadvantaged populations). This is concerning, as despite a relatively small number of studies; small share of disadvantaged participants; and framing effects in the way studies were designed, there is an observable and plausible trend suggesting that disadvantaged groups worry that dominant principles reduce their chances of receiving a ventilator.

2. Vaccine rationing – allocating to states/CDC jurisdictions

Former Health Secretary Alex Azar explained that allocating vaccines to states proportionate to population is 'fair, simple and consistent.'⁶ However, it is not clear that that is the case, as not all states have the same number of disadvantaged people. Using the CDC's Social Vulnerability Index (SVI) at the national level, colleagues Parag Pathak, Michelle Williams, Tayfun Sönmez, Utku Ünver, Lawrence O. Gostin and I showed that in 16 states—half blue, half red—more than 1/4 of the population are among the nation's most disadvantaged (see enclosed study).⁷ For example in New Mexico more than 3 in 10 people are among the most disadvantaged nationwide, but in New Hampshire, just over 1 in 10 are in this group. Allocating by population alone therefore means that disadvantaged groups—and by extension, more disadvantaged minorities—face increased scarcity in states in which they account for a larger population share. But this is not their fault, and it is not fair. It would therefore be helpful if the Task Force reviewed the formula for allocating vaccines to states and thought about ways of mitigating inequitable impact, such as adjusting quotas.

3. Vaccine rationing – improving equitable allocation within states through different ways of using disadvantage indices

In another study, Rebecca Weintraub, Michelle Williams, Alison Buttenheim, Emily Sadecki, Helen Wu, Aditi Doiphode, Lawrence Gostin, Angela Shen, and I reviewed states' use of disadvantage indices such as the SVI. Last year, we found roughly 1/3 of the CDC's 64 jurisdictions used this data tool, as described in their initial allocation plans. Updating the search in mid-January, we found a considerable increase, in that 1/2 of jurisdictions, and the majority states (N=29) use such an index for the purposes of: 1) prioritizing disadvantaged groups through larger shares of vaccines; 2) defining priority groups in phased systems; 3) planning tailored outreach and communication; 4) planning the location of dispensing sites; and 5) monitoring uptake, all of which directly increase equitable allocation.⁸ We have not yet published the updated review, but I will share it as soon as it is available. It would be useful if the Task Force found a way of enabling states and cities still contemplating using a disadvantage index to learn from their peer leaders. There are countless ways in which we can make real progress with equitable allocation, and importantly none need to sacrifice equity for efficiency in terms of reaching meaningful herd immunity.

4. Vaccine rationing – pragmatic targets for continued progress toward equity

Finally, while poorly conceptualized or implemented targets can become distractions in public health and elsewhere, in principle, targets are able to provide orientation, focus and clarity. The National Covid strategy helpfully includes the recommendations that states should “update their pandemic plans to describe how they have or will provide equitable access to Covid-19 resources.... using CDC’s Social Vulnerability Index [SVI] or other indices as appropriate”. Beyond descriptive uses of disadvantage indices, these metrics also offer a unique opportunity: It would be helpful if the Task Force considered a pragmatic target for states, such that they should strive for vaccine uptake in a way that there are no differences across the disadvantage index spectrum. This would help simultaneously promote public health,^{9,10} social, and racial justice.¹¹

I wish the Task Force every success for its endeavors. If there would be anything that you would like to discuss further, please let me know either by email schmidth@upenn.edu or by phone: 215-573-4519.

Sincerely,

Harald Schmidt, PhD

References

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