

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)
COVID-19 HEALTH EQUITY TASK FORCE (HETF)**

7th MEETING (Virtual)

September 30, 2021

Members Present

Marcella Nunez-Smith, M.D., M.H.S. (Chair)
Mayra Alvarez, M.H.A.
Sara Bleich, Ph.D.*
Jessica Cardichon, Ed.D., J.D.*
Richard Cho, Ph.D., M.P.H.
Jamila Gleason
James Hildreth, Ph.D., M.D.
Andrew Imparato, J.D.
Jo Linda Johnson, J.D.*
Victor Joseph
Joneigh Khaldun, M.D., M.P.H., F.A.C.E.P.
Rachel Levine, M.D.*
Octavio Martinez, M.D., M.P.H., M.B.A., F.A.P.A.
Shannon Pazur, J.D.*
Tim Putnam, D.H.A., E.M.S.
Vincent Toranzo
Mary Turner, R.N.
Homer Venters, M.D.
Bobby Watts, M.P.H., M.S.
Haeyoung Yoon, J.D.

Members Absent

Pritesh Gandhi, M.D., M.P.H.*

*Federal ex-officio members

Federal Staff

Minh Wendt, PhD, Designated Federal Officer, Office of Minority Health
Martha Okafor, Ph.D., Executive Director, Office of the Assistant Secretary for Health

Call to Order, Welcome, and Introductions

Minh Wendt, Ph.D.

Designated Federal Officer, Office of Minority Health

Dr. Minh Wendt opened the seventh meeting of the COVID-19 Health Equity Task Force (HETF), noting that she was covering for CAPT Samuel Wu, who was on deployment. She shared that the focus of this meeting was future pandemic preparedness, mitigation, and resilience needed to ensure equitable response and recovery in communities of color and other underserved populations. Dr. Wendt explained that attendees would hear from Task Force members regarding the final set of refined recommendations. She reminded attendees that the meeting was being live streamed and recorded and that the recording would be available for viewing at a later time. Additionally, all materials presented at the meeting are available at minorityhealth.hhs.gov/hetf. Dr. Wendt noted that American Sign Language interpreter services were available for the meeting and closed captioning was available at both hhs.gov/live and the OMH YouTube channel. Dr. Wendt welcomed members of the public to provide comments as stated in the meeting notice published in the Federal Register by emailing COVID19HETF@hhs.gov no later than 7 days after the meeting.

Opening Remarks

Marcella Nunez-Smith, M.D., M.H.S.

Chair, COVID-19 Health Equity Task Force

Dr. Nunez-Smith welcomed everyone to the seventh public facing meeting of the U.S. COVID-19 Health Equity Task Force (“HETF”) and wished them a Happy Hispanic Heritage Month. She reminded everyone of the charge of the HETF—to provide recommendations for mitigating health inequities caused or exacerbated by the COVID-19 pandemic and to prevent such inequities in the future. Dr. Nunez-Smith shared that the preceding public facing meetings focused on several topics, including the data necessary to drive an equitable response and recovery, equity and vaccination access and building vaccine confidence, behavioral health recognizing the importance of mental health in this work, xenophobia and discrimination, long COVID, equitable access to PPE testing and therapies as well as future pandemic preparedness, all centered in equity. She advised that the purpose of the current meeting was to deliberate on the entire body of work of the Task Force and to vote on the refined recommendations in anticipation of the COVID-19 HETF final report.

The coronavirus pandemic affects all Americans but not equally. Dr. Nunez-Smith explained that we are dealing with a legacy of discriminatory and inequitable policies that have limited opportunity for positive health outcomes over generations. She shared that these structural inequities were exacerbated during the pandemic by shortfalls in data collection and reporting, and that crippled our ability to meet the moment and respond equitably in real time. To make equity actionable, she explained, we must establish a data ecosystem that promotes equity-driven decision making. Affected communities are expert in what is needed to advance health equity and, as such, we must invest in community-led solutions to identify and implement programs and processes that elevate this expertise. And to further advance equity we need a guiding framework, one that includes metrics, health equity impact statements, and processes that government entities can use to hold themselves and external grantees and vendors accountable to

health equity. The pandemic gives us an opportunity to disrupt patterns of harm to offer course correction and intervene to improve inequitable systems and practices.

Dr. Nunez-Smith pointed out that right now we have a once-in-a-generation opportunity for transformational change, and we must acknowledge that advancing health equity will take multisectoral commitment and collaboration. The inequities highlighted and experienced during the past 18 months put the onus on the government, the private sector, on community leadership, and on philanthropy, all together to achieve health justice. She stated that this is the work: to disrupt the predictable pattern of who is harmed first and harmed worst. That intentionality, that collaboration, that frequent review and course correction, is what is going to be required to achieve these goals.

Recent data from the Kaiser Family Foundation and the Centers for Disease Control and Prevention (CDC) noted that similar shares of adults are now reporting being vaccinated against all racial and ethnic groups. Dr. Nunez-Smith highlighted that this increase in vaccination rate and vaccination uptake and decrease in vaccination inequity would not have been possible without collaboration at every single level of society. However, gaps remain in vaccine uptake, and we continue to see hospitalizations and deaths from COVID-19 that are preventable. Dr. Nunez-Smith emphasized that while the challenges are significant, their correction is vital to the health of our nation; we need stamina and continued creativity, continued collaboration and commitment to get it done.

Dr. Nunez-Smith explained that in the HETF's work over these past 6 months, they generated more than 300 interim recommendations; and the Biden-Harris administration has already taken steps that address approximately 57% of these recommendations through a host of executive orders, memoranda, and agency-wide initiatives aimed at ensuring an equitable response to this pandemic. That's 57% of the Task Force recommendations already implemented or in progress. She then talked about the subcommittees and their general charge as well as summarized again the purpose of the meeting. Dr. Nunez-Smith shared that the refined recommendations will be synthesized into the Task Force final report, which will be delivered to the White House COVID-19 Response Coordinator.

Dr. Nunez-Smith ended by stating that systemic problems require systemic solutions and sustained efforts and the pandemic is not yet over; these are lessons and action for now and for moving forward. She noted we continue to hold out hope for a new and better normal. She thanked everyone involved over the past 6 months for their contributions, insights, expertise and time devoted to this effort.

After Dr. Nunez-Smith's opening remarks, Dr. Wendt performed a roll call of the HETF members and announced a quorum for the meeting.

Methods and Process

Dr. Martha Okafor spoke about the purpose and mission of the HETF. She highlighted that the members of the Task Force were called to perform a duty that normally takes, at a minimum, 2.5 years to do, and they did it in 7 months with excellence.

Dr. Okafor touched on why the Task Force’s work is important; the basis for the work; and where things currently stand. Executive Order 13995 charged the Task Force to study the factors that worsened inequities during the COVID-19 pandemic as well as propose recommendations on how the nation can equitably respond and recover from this pandemic and how to prevent such inequities in the future.

To tackle this effort, the work was divided into three phases:

1. Standing up the Task Force with appropriate leadership and members and defining its charge;
2. Crafting subcommittees, completing data and literature reviews, and holding meetings and working sessions with subject matter experts (SMEs) to generate interim recommendations; and
3. Refining and prioritizing the interim recommendations informed by data and then deliberating on a final set of recommendations.

Implementation of 170 of the approximately 300 interim recommendations made has already begun. Recommendations were then further refined.

Dr. Okafor explained that after doing this extensive work, the Task Force advanced 55 of their recommendations to present, deliberate on, and vote on publicly at this meeting. In October, they will wrap up this phase 3, and then come back to the public and present their final report, which will include the top priorities they are advancing and their suggested outcomes as well as their recommended implementation plan with an accountability plan.

Task Force Presentation 1: Suggested Outcomes, Proposed Priorities, and Discussion

Andy Imperato, J.D.

The Implementation Workgroup evaluated more than 300 recommendations over the past 6 months. Their challenge was how to distill them and answer the question for the president, vice president and leadership of what would make a big difference across many categories. These proposed priorities and suggested outcome statements are detailed in the COVID-19 HETF Deliberation and Vote on Final Recommendations PowerPoint Presentation on slide 7 and 8, which can be found [here](#).

The overarching message is to be bold and that the response must be proportional to the unprecedented scale of harm that we have been experiencing and are continuing to experience from this pandemic. As Dr. Nunez-Smith described, we want to disrupt the predictable pattern of who is harmed first and who is harmed worst. We want the President and the Administration to work hand in hand with communities of color and underserved populations to transform the status quo. We have a generational opportunity to create a reimagined national health landscape that is truly equitable. The priorities and suggested outcomes are detailed below.

Proposed Priorities:

Priority 1: Empower and Invest in Community-Led Solutions to Address Health Equity

Priority 2: Enforce a Data Ecosystem that Promotes Equity-Driven Decision-Making

Priority 3: Increase Accountability for Health Equity Outcomes

Priority 4: Invest in a Representative Health Care Workforce and Increase Equitable Access to Quality Health for All

Priority 5: Community expertise and effective communication will be valued in health care and public health.

Suggested Outcome Statements:

- Everyone will have equitable access to high quality health care.
- Data accurately represent our populations and their experiences to drive equitable decisions.
- Health equity will be centered in all processes, practices, and policies.
- Community expertise and effective communication will be valued in health care and public health.

Discussion

Dr. Martinez spoke about Priority 4. He noted that in creating a representative healthcare workforce, we need to be looking at our entire academic spectrum to make sure there is a pipeline for people to go into public health (including community health workers and those interested in administration), as well as recognizing support in residency programs and ongoing education for those already in practice. The educational pipeline also needs to infuse the right skillsets providing knowledge of cultural and linguistic providence, team-based care, trauma-informed approaches, social determinants of health and of mental health, and also what it means to have health disparities and how to eliminate those to begin to understand health equity. These are high-level priorities, and it will take a concerted, innovative, thoughtful process to make it happen.

Task Force Presentation 2: Prioritized Recommendations and Deliberation

Healthcare Access and Quality

Tim Putnam, D.H.A., E.M.S.

Dr. Putnam summarized the Healthcare Access and Quality Subcommittee's 25 final recommendations to the Task Force, providing background on each. The subcommittee's detailed recommendations begin on slide 10 of the COVID-19 HETF Deliberation and Vote on Final Recommendations PowerPoint Presentation, which can be found [here](#).

Discussion

Mr. Watts drew attention to homelessness and ensuring people experiencing homelessness are kept safe in this pandemic. He touched on the impact of CDC's and HUD's recommendations to States and localities on how to keep people experiencing homelessness safe, which resulted in many people who are homeless getting out of congregate shelters and encampments and into hotel rooms where they could recover and heal safely and get the care they needed.

Unfortunately, he noted, the funding for these programs is ending despite the pandemic continuing. Mr. Watts also mentioned the recommendation that States should have set-aside

vaccine allotments for hard-to-reach populations, such as people who are incarcerated and migrant workers, and the importance of this recommendation in preventing disease exposure to these high-risk populations and their communities.

Ms. Turner highlighted the importance of investing in public health infrastructure and staffing to ensure everyone has the right to the same quality healthcare. She explained that these services are the lifeblood of these communities, yet for over a decade, communities of color, low-income, and rural communities have seen hospitals and clinics being closed or services reduced; and now these closures and reductions are moving to the inner city. In relation to the pandemic, Ms. Turner noted, because of these closures, reliance has been on metro areas to handle the load, but there are not enough resources to accommodate the number of patients, and we are backed up. She asked to bring back community and inner-city hospitals so that everyone can have the same high-quality healthcare.

Mr. Toranzo emphasized the need for the recommendation to recognize and declare healthcare a human right. He expressed that after careful analysis of the many inequities caused or exacerbated by the pandemic, nearly every problem addressed has come back to the inequalities created by our profit-driven and unequal healthcare system. Mr. Toranzo noted that the Task Force's solutions for access and accountability in health would truly transform our healthcare system so that it is based on patient need and therefore guarantee a single, high-quality standard of health care for all as a right. The changes we make now will lead to stronger, more equitable health care system in the future.

Mr. Joseph recognized what Canada is doing today, a statutory holiday honoring lost children and survivors of residential schools for American Indians, Alaska Natives, and other native peoples. He offered a moment of silence for these victims and the root cause of inequities these communities face today. Mr. Joseph talked about the creation of the Indian Health Service and other programs created through treaties, statutes, and executive orders intended to help native peoples, including provisions for healthcare. He shined a light on underfunding of the Indian Health Services program and the unequal treatment of the American Indian and Alaska Native people and the subsequent higher rates of COVID-19 and the resulting disproportionate impact these communities have experienced. Mr. Joseph thanked the Task Force members for emphasizing the importance of appropriate funding for the Indian Health Service. He also noted the need to promote access to affordable, reliable internet and devices for telecommunications in communities with high poverty rates.

Dr. Martinez highlighted behavioral health as a crosscutting issue. He stressed that none of us are immune to the risk factors that can cause depression, anxiety, loneliness, and so forth. It's time to end the stigma against mental illness, substance use disorders, intellectual/developmental disabilities. To do this, he explained, we are going to have to eliminate the siloes that we have created due to financial streams and other methodologies to ensure a cohesive, collective, integrative approach to what it is to be a human being. The central nervous system cannot be separated from the rest of our human systems.

Dr. Khaldun elevated the priority around public health infrastructure and the workforce. She noted that in many cases the director of the local health department has multiple roles. The

director may also be the epidemiologist and the environmental health director. Oftentimes, there may be one epidemiologist for an entire jurisdiction, or multiple jurisdictions, or an entire State, and this person needs to look at data not just for the pandemic, but for other public health threats, environmental health threats, and maternal/infant health issues. Dr. Khaldun stressed how important it is that additional staffing and funding support are provided at State and local levels.

Dr. Hildreth talked about increasing capacity and diversity of the healthcare workforce. He noted that better outcomes result when providers are matched to the people they serve in terms of culture, race, and ethnicity. He stressed that even today, less than three percent of physicians are Black males, and there is a shortage of physicians estimated to be between 50,000 and 90,000. This is a great opportunity to bring diversity to the workforce by enrolling African American, Latinx, indigenous, and other minority students in medical schools to expand capacity. Dr. Hildreth referenced the large amount of money the country spends on “sick care” and how, if we took just a little of that money and redirected it to public health in training the healthcare workforce, we could change things for the better for everyone. There is a way to fund it by redirecting how we use our precious resources.

Dr. Imperato amplified Dr. Hildreth’s comment and encouraged the Task Force to think about people with lived experiences with disabilities, including behavioral health and other disabilities and people from the lesbian, gay, bisexual, transsexual, and queer communities when thinking about the diversity of the healthcare workforce. He expressed that sometimes the medical profession has different “isms” baked into how they approach training, and uncovering “isms” and welcoming all kinds of people into the workforce is going to be important moving forward.

Data, Analytics, and Research

Joneigh Khaldun, M.D., M.P.H., F.A.C.E.P.

Dr. Khaldun summarized the Data, Analytics, and Research subcommittee’s final recommendations to the Task Force. The subcommittee’s detailed recommendations begin on slide 39 of the COVID-19 HETF Deliberation and Vote on Final Recommendations PowerPoint Presentation, which can be found [here](#).

Discussion

Mr. Imperato mentioned that sometimes collecting data on disability can be expensive because you have to ask a lot of questions to get meaningful data that identify the population. Under the Clinton administration there was a disability supplement to the National Health Interview Survey that hasn’t been readministered since 1994. He noted a lot of very good, granular data came out of that supplement and suggested regular deep dives around disability data like it be used going forward.

Dr. Venters underscored the problems he sees with data gaps in carceral settings and crises around COVID-19 regarding a whole range of health outcomes, including deaths, and the answers to two crucial questions—did they receive the standard of care and did anything that happened behind bars, including medical neglect, contribute to the outcome of death. With the CDC and State and local health departments working more closely than ever with and in

correctional systems, he noted that there is an opportunity here to get these evidence-based structures involved in tracking health outcomes not just around COVID but around diabetes, around deaths, around injury, and build a system that is honest about the health risks of incarceration as well as the health of incarcerated people.

Dr. Hildreth noted the importance of data to good decision making and analyses and making the most efficient and best use of resources, particularly when resources are limited. The healthcare systems establish large databases of patient data and analytic capabilities with the hopes of improving outcomes and lowering costs, but many of these large data sets do not include enough records of people of color or underserved populations; and therefore the algorithms they will derive will not be beneficial to all of us. He emphasized that we can't achieve the goal of all of us having our best health unless information from everyone is available, collected, and assessed.

Mr. Joseph talked about Tribal Epidemiology Centers (TECs) and how they need access to public health data to assist Tribal management and to save lives and achieve health equity. He followed this by noting there should be a single interpretation of the Indian Health Care Improvement Act, specifically, defining the 12 TECs as public health authorities for the purpose of HIPAA privacy rules for data sharing that all HHS agencies should follow.

Ms. Johnson underscored and amplified the importance of data, citing how the Federal Emergency Management Agency's use of data during the early part of the vaccine rollout helped them to successfully reach communities of color, especially those that were hardest hit. Daily decisions guided where the outreach, popup clinics, and mobile clinics would go to make the greatest impact.

Ms. Turner expressed her frustration at what inequities have done to her patients and how looking into biases in these algorithms, guidelines, and technologies is very important because decisions should be patient focused and up to the individual practitioners who are making the observations.

Dr. Watts underscored the importance of collecting data and disaggregated data but noted that there are a lot of missing data on race, ethnicity, and language across healthcare settings. He quoted a previous presenter who stated that missing race data is a form of racial oppression. Incentivizing and perhaps rewarding for collecting data could help, but not all providers do this. Dr Watts stressed that the leadership needs to explain why collecting these data is so important for quality and equity, and we also need to have accountability so there are no missing data. Ms. Yoon amplified the importance of disaggregation. Often, aggregation masks diversity of experiences, which results in masking diversity of inequities that different communities experience. She explained that this came up as the Task Force looked at the rise of anti-Asian violence and xenophobia, citing the importance of disaggregation of data and making the connection to policy making.

Structural Drivers and Xenophobia

Haeyoung Yoon, J.D.

Dr. Yoon summarized the Structural Drivers and Xenophobia Subcommittee's final recommendations to the Task Force. The subcommittee's detailed recommendations begin on slide 52 of the COVID-19 HETF Deliberation and Vote on Final Recommendations PowerPoint Presentation, which can be found [here](#).

Discussion

Dr. Khaldun elevated the importance of the priority of a high living wage. She cited the extended consequences of not providing a high living wage not just to the healthcare system but to the entire behavioral health system and how this actually exacerbates the disparities we see.

Ms. Johnson expressed how she was struck by the breadth of the recommendations. She noted how the pandemic revealed structural fissures in the foundations of our country that have to be attacked head on. Ms. Johnson went on to explain that systemic failures require systemic fixes and the recommendations made get to what matters most, supporting families, workers, individuals, and communities to move forward more effectively.

Dr. Martinez highlighted how telemedicine and telehealth have come to the forefront. The pandemic elevated their utilization, but infrastructure is still needed for broadband. He stressed that broadband should be a basic utility like water or electricity. This is not just integral to healthcare but also to education and commerce. The bump in telehealth and telemedicine during the pandemic increased access geographically as well as to certain sectors, but more needs to be done to build the infrastructure to reach every corner of the United States.

Mr. Watts emphasized the importance of the recommendation on increasing affordable, accessible housing long term as well as helping to keep people in their homes during a pandemic, as housing is one of the strongest social determinants of health. He noted that on October 3, the eviction moratorium is scheduled to end and millions of people are potentially facing eviction. This is a public health crisis, a human crisis, he explained. We need to keep people in their homes during the pandemic, which is not over, and increase the long-term supply of affordable housing.

Ms. Turner expressed her appreciation for the recommendations to strengthen the worker's health and safety protections. She explained the importance of bringing forth enforceable OSHA standards to benefit all workers and how many lives could have been saved had these standards been in place from the beginning of the pandemic.

Mr. Joseph talked about the importance of clean water and utilities as well as supporting essential workers. He shared information specific to Alaska regarding the costs of water and fuel oil and how they are much higher than the national average. Some American Indian/Alaska Native households lack access to running water completely. Mr. Joseph noted that especially during pandemics, where washing hands is so important, access to clean water is an essential need. He stressed the importance of having steady employment in these communities because, if

people lose their job in the middle of winter and they're not able to afford to pay the electric bill, let alone their internet connection, they will have to make some really tough choices.

Dr. Hildreth also emphasized the importance of broadband access and how it is not just an issue in rural areas and Tribal communities but also for poor and urban communities in certain cities. He also agreed that broadband should be considered a utility because the education gap, the medicine gap, the healthcare gap—these are not going to close without this access.

Ms. Gleason expressed appreciation of support of a Federal minimum wage, a living wage, that will help to stem the tide of the evictions and help people to be able to afford access to care and its potential to resolve many of the inequities we are seeing.

Ms. Alvarez commended the group for sticking to their commitment to addressing the inequities involved. She also emphasized the importance of supporting schools and meeting the comprehensive needs of our families and our children. She highlighted the important role that the Government, working in partnership with States and communities, has in making schools the comprehensive family resource centers that they are.

Communications and Collaborations

Mayra E. Alvarez, M.H.A.

Dr. Alvarez summarized the Communications and Collaboration Subcommittee's final recommendations to the Task Force. The subcommittee's detailed recommendations begin on slide 68 of the COVID-19 HETF Deliberation and Vote on Final Recommendations PowerPoint Presentation, which can be found [here](#).

Discussion

Dr. Putnam highlighted the definitive pandemic response authority recommendation, noting the need for a diverse group; people with expertise in logistics, people with knowledge regarding expansion of inpatient capabilities of hospitals, virologists, and other experts in the medial field. To grow that credibility, he explained, it's going to take years, if not decades, so the work needs to be purposeful and continual and led by scientists and people who understand how best to deliver care in the nation and respond to a pandemic.

Dr. Martinez highlighted collaborating with communities in terms of research. These communities should be looked at as SMEs in their domain; think of them as citizen scientists, from brainstorming through translation to implementation to ensure no one is left out. Community-based participatory research is out there, and The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care have been around for a while, lets implement them across the board. He noted that this framework can help us to improve healthcare quality and advance health equity.

Mr. Toranzo reiterated that the key to ending the pandemic is getting vaccinated. He acknowledged the long debates on whether ongoing issues with achieving higher numbers are due to hesitancy or access. Hesitancy can be a result of lack of access to information and

knowledge needed to make the important decision to get vaccinated. Outreach efforts from State, municipal, Tribal, and Territorial health organizations is vital to address this issue. Mr. Toranzo also noted that partnering with community health centers, nonprofits, and universities could also make a big difference, especially when trying to reach younger audiences.

Mr. Imparato lifted up the recommendation related to crisis standards of care and the importance of having the perspectives of people who understand disabilities, civil rights, and the rights of elders as part of the development of crisis standards of care. He shared that we don't really know all the different ways that healthcare rationing has affected specific populations during this pandemic, especially in carceral and other congregate settings. As a result, Mr. Imparato encouraged the analysis of deaths due to rationing, including people that could not access non-COVID-related healthcare.

Dr. Khaldun elevated the importance of proactively engaging with the community in advance of a crisis. She explained that if these relationships with community-based organizations, schools, and businesses were established before the pandemic, we may have seen fewer inequities in outcomes. Bringing these other entities to the table in preparedness planning will improve implementation and response going forward.

Mr. Watts highlighted the recommendation regarding a thorough after-action review including input from diverse nongovernmental stakeholders. He expressed that the focus on the effects of mandates, how to promote equity, where they do not promote equity, what can be done to tailor them, when they should be deployed, etc., will be extremely important for an equitable response in the future.

Public Comments

Reva Singh, American Academy of Physical Medicine and Rehabilitation (AAPM&R)

Good afternoon. My name is Reva Singh. I'm the director of advocacy and government affairs with the American Academy of Physical Medicine and Rehabilitation. I want to start off with thanking you, Dr. Nunez-Smith, and the Task Force for all of your thoughtful work and for your recommendations. We are so grateful for your attention to this massive issue of health equity and to Long COVID.

Earlier this year, AAPM&R put out a call to action to create a comprehensive national plan to meet and defeat the Long COVID crisis. This crisis is only getting larger as time goes on. We appreciate what has been done so far and are particularly thankful for the large collection of resources and supports that the administration released on July 26 clarifying that Long COVID may rise to the level of a disability. But there's more work to be done.

AAPM&R believes that the most effective way to address the Long COVID crisis efficiently and comprehensively is through the designation of a coordinated interagency group at the Federal level that works together on a plan to address the myriad of issues that Long COVID presents. There's healthcare infrastructure, equitable access to care, clinical research—but beyond healthcare, there's also the impact on the economy, accessible education, and workplace

accommodations; disability evaluations; and other issues that may arise from an estimated 12 million Americans and counting suffering from Long COVID.

We believe that this coordinated body and comprehensive plan is imperative to ensure that there are no gaps in access to care, benefits, or resources. And we believe that this recommendation is aligned with recommendations coming from this Task Force. AAPM&R is a multidisciplinary collaborative of physician specialists, researchers, and patients is working to put out consensus guidance statements addressing the most commonly appearing symptoms of Long COVID.

Our fatigue consensus guidance statement was recently released, but additional statements are in the works, including statements on cognitive impairment, breathing, discomfort, cardiac and autonomic issues, neuropsychology, and pediatrics. This collaborative is a wealth of knowledge not only clinically but also to better understand access to care barriers and healthcare infrastructure concerns. We hope the HETF will recommend AAPM&R and its collaborative be considered a resource on Long COVID and included in any stakeholder advisory group.

Again, thank you so much for all of your hard work and for the opportunity to speak today.

Terri L. Wilder, #ME Action New York

Thank you for allowing me to speak with you today. My name is Terri Wilder, and I will be reading my remarks as I have brain fog. I realize that you've been working on your recommendations for some time, and I'd like to highlight a few recommendations that myself and others find important.

In March of 2016 I was diagnosed with myalgic encephalomyelitis, or ME. This disease is a complex chronic disease. It's a neurological disease according to the World Health Organization. It cannot be treated or cured by graded exercise therapy and is not a psychiatric illness. It's often referred to as chronic fatigue syndrome, which I find to be highly stigmatizing and limiting to what morality is and encourage you to avoid that label.

The reason why I'm sharing this is because the ME community saw Long COVID coming from a mile away. We predicted that Long COVID would happen to a percentage of people who got COVID. Why? Because many of us have had the same experience. It means a common chronic consequence of viruses. They're estimated 1 to 2.5 million in the United States with ME. The number is growing because of Long COVID.

In August of 2021, the New England Journal of Medicine published a perspective article titled *Confronting Our Next National Health Disaster, Long-Haul COVID*. In the article, the author states that factoring in new infections in unvaccinated people, we can conservatively expect more than 15 million cases of Long COVID resulting from this pandemic, and then the data are still emerging. The average age of patients with Long COVID is about 40. Given these demographics, Long COVID is likely to cast a long shadow in our healthcare system and economic recovery.

This is not a new phenomenon. Like I said, the ME community saw it coming from a mile away. If the government had invested resources, research, healthcare, and social services for people with ME 40 years ago, we wouldn't be here today with Long COVID. The relationship of Long COVID to ME has been discussed by the CDC, National Institutes of Health (NIH), and other groups.

In July of 2021, I asked Dr. Tony Fauci his thoughts about this connection during a press conference I attended. And in his response, he stated that Long COVID is highly suggestive of ME. I should tell you that the ME community has never had equitable access to high-quality healthcare. It didn't exist in our world, and it won't exist for people [with] Long COVID without the right resources. I believe that healthcare is a right, so my recommendation is to put serious funding into medical education around ME and Long COVID and unconscious bias.

This medical education intervention should include webinars, conferences, and preceptorships, Project ECHO, clinical diagnostic tools, as well as resources to get real experts to publish articles and medical journals that give the message that these are real diseases and that it is malpractice to deliver healthcare from a place that they are not.

My second recommendation is to demand that the NIH, and Dr. Francis Collins in particular, make ME and Long COVID research a priority and, in particular, fund ME research at a level that is proportional to the disease burden. Because according to their numbers, my life in National Institute of Health research dollars is somewhere around \$7. I support any recommendation that ensures meaningful participation by people with lived experience. That is not happening at all levels of government.

Health and Human Services must bring back the Chronic Fatigue Syndrome Advisory Committee that was disbanded under the Trump administration. I'm begging you to add this to your recommendations. Under the last administration, we were told that we had met our goals in this committee and that there was no need for us to meet anymore. Clearly, that was wrong. It must be brought back with a different name under a new charter with bold leadership and resources and with representatives from all key stakeholder groups including government.

I'm available to help, and I hope that Dr. Rachel Levine will help this as well. We need data. We have no idea how many people have ME in this country or Long COVID. In the case of ME, it has been over 40 years. We need a case definition so that we can be counted. The CDC needs to get on this immediately. We must confront systemic bias, including sexism and racism, in the Long COVID and ME response. The majority of people with ME are women, so sexism is killing us. And for people of color and specifically Black people, they are consistently underdiagnosed or not diagnosed at all. Racism and conscious bias, sorry, racism and unconscious bias is killing them. This is criminal.

We must, must leverage existing postviral disease knowledge and infrastructure. Basically, reach out to our community and pick our brains. We are familiar with this. We must expedite public-private partnerships. Pharma is never interested in us. Why? Because nobody ever takes our disease seriously. There would be interest in treatment discovery if the message was delivered that this is a public health crisis. And finally, we must deliver evidence-based treatments to

people with these diseases immediately. We can't wait any longer. Some of us have been waiting for decades.

And one final bonus recommendation, please be sure to have an implementation plan in place for these recommendations. As a person who has served in millions of committees and task forces, nothing is as frustrating as working hard to find out nothing is implemented and no one was monitoring the workflow. Make sure that happens.

So, in conclusion, I'm begging you to use your influence to save our lives. As you're looking over your final recommendations and making your last edits, please connect the dots and save two communities, the Long COVID community, and the ME community. Vaccines alone will not end this epidemic. People are sick now and have a life of illness ahead of them. When you're writing about Long COVID, include ME in the recommendations in healthcare research communication plans. It is critical to those of us who've been suffering for 40 years and will be to those who have been suffering for the past 19 months.

And please don't forget my name, Terri Wilder.

Harald Schmidt, University of Pennsylvania

Dr. Harald Schmidt, an assistant professor of medical ethics and health policy of the University of Pennsylvania, spoke about the recommendations on Federal guidance for crisis standard of care. A copy of his written public comments can be found in Appendix A of this summary.

Jennifer Stoll, OCHIN

Hello there, Chair Dr. Nunez-Smith, members of the COVID-19 Equity Task Force. Thank you for the opportunity to comment. For the record, I'm Jennifer Stoll, executive vice president of government relations for OCHIN. OCHIN is a national nonprofit health technology and research organization with over two decades of experience providing leading-edge technology, data analytics, and support services for over 1,000 community healthcare sites reaching nearly 6 million patients, [and] 21,000 providers in underserved communities: predominantly low income, uninsured, medically complex, and those with significant—facing significant structural inequalities.

OCHIN members and patients know firsthand the negative disparate impacts of COVID-19 and structural inequality. And during the pandemic, OCHIN has been sharing our data and learnings to policymakers, including the Administration, on what we've been seeing about health inequities during the pandemic for the last 2 years. OCHIN has submitted formal comments consistent with the incredible findings of this committee, and we strongly support and admire the recommendations in the work of this Task Force.

So, it is with deep respect that we would like to highlight a couple of key items as it relates to data and the ability to capture data for the purpose of this work. Number one, it is very, very important and data will only be aspirational without the investments to modernize health technology and the technical support for providers, public health agencies, justice organizations,

and community service organizations. This was a foundational problem during the pandemic—not having good quality systems to capture the data is a key problem still.

The second thing is workforce. The expanding workforce in health technology and making this a key priority is very, very important. Our workforce in health technology is not reflective of those communities we serve, and we stand ready to support you in this effort. And finally, permanent access to telehealth and virtual modalities through the extension of current public health emergencies is foundational in being able to continue to reach patients, especially those with social determinants of health and other challenges facing our communities.

So, OCHIN stands ready to be a resource to this committee and to HHS as you further implement these recommendations. We thank you and admire so much all of the work that each and every one of you have done. And I'm happy to stand ready to support you. Thank you.

Final Recommendations Vote

Dr. Nunez-Smith introduced the voting phase, asking the HETF members to vote sequentially on the full set of final recommendations, suggested outcomes, and proposed priorities. Each slate received a motion to approve that was seconded. Each motion carried with a majority vote to approve. Dr. Nunez-Smith congratulated the Task Force members for advancing the full final slate of recommendations, outcomes, and priorities that will be included in the final report.

Closing Remarks and Next Steps

Marcella Nunez-Smith, M.D., M.H.S.

Dr. Nunez-Smith thanked everyone for their participation and/or support of the HETF work. She shared that we are moving boldly toward a new post-pandemic reality that will put science, reliable communication, community health, racial, ethnic, and social equity all at the forefront of our pandemic response. Dr. Nunez-Smith stated that the COVID-19 HETF's final report will be presented and discussed next month. The HETF meeting time and date will be published in the Federal Register.

Appendix A. Written Public Comments



October 7, 2021

Samuel Wu
Designated Federal Officer for the Task Force
Office of Minority Health
Department of Health and Human Services
Tower Building
1101 Wootton Parkway, Suite 100
Rockville, Maryland 20852

Dear Officer Wu and members of the Health Equity Task Force,

Centro de los Derechos del Migrante (CDM) is a binational migrant workers' rights organization that has been working to improve conditions for low-wage migrant workers in the United States for over 16 years. Nearly 300,000 migrant workers with H-2A or H-2B temporary work visas travel to the United States each year¹ to work in agriculture, food processing industries and other industries deemed as essential during the pandemic. Even before the pandemic, migrant workers experienced highly unsafe and dangerous working conditions. As we know, the COVID-19 exacerbated the challenges faced by migrant workers. **Improving workplace protections and health care access for these workers, who are overwhelmingly Latinx, is an urgent matter of racial equity.**²

Challenges faced by migrant workers in temporary visa programs

Migrant workers have served as essential frontline workers throughout the COVID-19 pandemic, supporting key industries like agriculture and food processing, and yet their health and safety is continually at risk. These workers often work in overcrowded and unsanitary labor sites, where social distancing is virtually impossible. From our experience, employers rarely provide personal protective equipment (PPE) to migrant workers, with some employers even charging employees for PPE or making employees purchase their own.³ When workers do contract COVID-19, their access to healthcare is also often limited because many work in isolated, rural areas and depend on their employers for transportation.

Additionally, migrant workers in temporary visa programs often depend on their employer for housing. It is common for workers to live in crowded barracks, deteriorated housing, and shared rooms, making

¹ U.S. Department of State, *Nonimmigrant Visas Issued by Classification Fiscal Years 2016–2020* (2020), <https://travel.state.gov/content/dam/visas/Statistics/AnnualReports/FY2020AnnualReport/FY20AnnualReport-TableXVB.pdf>.

² Over 92% of H-2A workers and over 74% of H-2B workers are Mexican. U.S. Department of State, Bureau of Consular Affairs, *FY 2020 Nonimmigrant Visas Issued*, <https://travel.state.gov/content/dam/visas/Statistics/Non-Immigrant-Statistics/NIVDetailTables/FY20NIVDetailTable.pdf>.

³ "Ripe for Reform." Centro de los Derechos del Migrante, Inc., (2020), (<https://cdmigrante.org/wp-content/uploads/2020/04/Ripe-for-Reform.pdf>).

self-isolation to prevent the spread of COVID-19 nearly impossible. Lastly, under most temporary work visa programs, workers' immigration status and employment are tied to a single-employer. Under the law, workers can only be employed by the employer listed on their visa, making it practically impossible for workers to find alternative jobs. This also means that when migrant workers speak out, they face the risk of retaliation, losing their jobs, and simultaneously falling out of immigration status. Such was the case of [Maribel and Reyna](#), two Mexican H-2B crawfish workers in Louisiana, who faced retaliation from their employer and lost their jobs when they sought necessary medical treatment for COVID-19.

Recommendations

CDM appreciates the work of the Health Equity Task Force to ensure improved access to health care and stronger workplace protections for the workers who have borne the brunt of COVID-19's impacts. To ensure that the recommendations of the Task Force are inclusive of migrant workers, CDM suggests the following measures, organized by outcome in alignment with the structure of the Task Force's final recommendations:

Everyone will have equitable access to high quality health care.

1. Including health care as a human right, regardless of immigration status, is a crucial first step toward ensuring the health and safety of workers during the COVID-19 pandemic and beyond. Health care access should be inclusive and guaranteed for all workers, including workers on temporary work visas.

All essential workers, regardless of immigration status, who contract COVID-19 while working in the U.S. should be able to access free health care and be allowed to remain in the US to receive treatment. Workers' compensation laws should cover workers holding temporary visas in the event that they fall ill with COVID-19.

For H-2A and H-2B workers, whose immigration statuses are tied to their employer, the U.S. government should extend non-employment-based immigration relief to migrant workers so they can access care for COVID-19, particularly for long COVID, without losing immigration status if their employment is terminated when they become ill.

2. Community collaboration is essential to equity in healthcare access and migrant workers' health and safety. Our years of experience have demonstrated that partnership with on-the-ground organizations will enable hard-to-reach populations like temporary workers to access critical resources and information. Access to information about vaccines, testing and PPE continue to be challenges for temporary workers. Workers who we do outreach with are more likely to assert their rights.

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CDM is currently engaged in a cooperative agreement with the Centers for Disease Control (CDC) for the [Protein Processing Workers Project](#), which in its first year has facilitated the transmission of CDC-backed information and materials to hundreds of thousands of immigrant and migrant workers and their communities in multilingual, multimedia formats. State, local, and territorial recipients of federal funds should be incentivized to engage in similar partnerships to maximize outreach and resource access and to ensure future pandemic preparedness.

3. The expansion of health care infrastructure, including increased rural health services and additional providers with diverse linguistic and cultural competencies, is also critical to protecting workers' health. CDM and its partners work in the Delmarva region where migrant workers speak Spanish, Haitian Creole, and indigenous languages like Mixtec. Making health equity a reality means that language must not be a barrier to healthcare access. The migrant workers we serve in the Delmarva region face further challenges in accessing health care because their worksites are often extremely remote. While some workers are able to access care through mobile services, these services are irregular and limited in scope.⁴ Migrant workers need expanded affordable rural health care options in order to remain healthy at work.

Data accurately represent all populations and their lived experiences to drive equitable decisions.

1. The Task Force should include questions about language within the standardized demographic categories that it recommends. Collecting this data would provide government agencies and advocates with a more nuanced view of health impacts and outcomes in migrant communities. Additionally, language data would assist the federal government in ensuring that recipients of federal funds are complying with Title VI of the Civil Rights Act of 1964's prohibition on discrimination based on national origin, which includes the failure to provide language access services.

Health equity will be centered in all processes, practices, and policies.

1. CDM supports the Task Force's call for an increased supply of safe and affordable housing. The H-2 visa program regulations require employer-provided housing to be inspected for safety. However, these inspections are inconsistently implemented across jurisdictions, and housing conditions are often overcrowded and unsanitary. During the pandemic, many workers have shared with CDM that OSHA failed to conduct needed inspections, even after workers contacted the agency with complaints. These conditions have put migrant workers at particular risk during the pandemic because their housing does not allow for adequate self-isolation and recuperation. CDM recommends that the Task Force's call for an increased supply of housing be coupled with

⁴ "Breaking the Shell," Centro de los Derechos del Migrante, Inc., Georgetown University Law Center Federal Legislation Clinic, & American University Washington College of Law Immigrant Justice Clinic, (September 2020), <https://cdmigrante.org/wp-content/uploads/2020/09/Breaking-The-Shell.pdf>

consistent, detailed inspections of existing housing and strengthened tenants' rights.

2. The Task Force's recommendation to develop "mechanisms to protect and empower workers in the workplace" is particularly crucial for migrant workers. An effective complaint mechanism must include robust protections for all workers from employer retaliation as well as immigration relief for whistleblower migrant workers who are fired for speaking out about unsafe and unhealthy workplace conditions.
3. CDM agrees with the Task Force's recommendation that OSHA establish health and safety standards to limit workplace disease transmission. In order to effectively limit transmission, these standards must be enforceable, permanent, and fully funded so that OSHA can fulfill its public mandate and thoroughly investigate violations in a timely manner. The current OSHA Emergency Temporary Standard (ETS) excludes the vast majority of workers, especially frontline workers from industries with documented high infection and mortality rates, such as protein-processing industries, where Black, Indigenous and Latinx workers are disproportionately represented.

CDM is aware of OSHA's forthcoming emergency temporary standard regarding vaccination in the workplace. Accordingly, in addition to any rule requiring employers with more than 100 employees to require employees to be vaccinated against the virus causing COVID-19, or submit to weekly testing, OSHA should *also* require all employers using temporary visa programs, including the H-2 program, to:

- develop and implement a comprehensive written COVID-19 preparedness and response plan addressing both the workplace and employer-providing housing;
- maintain records and, upon request by OSHA inspectors, provide proof of social distancing implementation, proof of sufficient sanitizing and handwashing supplies at the housing and at worksites, and proof of sufficient masks for all workers; and
- provide all workers with the necessary personal protective equipment (PPE) required to limit the transmission of COVID-19 and other infectious diseases in employer-provided housing and in the workplace.

Community expertise and effective communication will be valued in health care and public health.

1. CDM supports the Task Force's call for a "formal partnership with trade unions and additional worker organizations representing farmworkers, frontline and essential workers, underserved immigrant and migrant workers, and those disproportionately affected due to their immigrant or refugee backgrounds" and the federal government. As previously mentioned, CDM is currently engaged in a cooperative agreement with the CDC for the Protein Processing Workers Project, and federal, state, local, and territorial governments should seek to expand and maintain such partnerships. These partnerships allow for bidirectional feedback: organizations like CDM and our partners are able to share information and resources with workers, receive direct feedback

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from workers on the ground, while government partners can use the feedback CDM gathers from workers to modify their resources and programs.

Once again, CDM thanks the Task Force for their recommendations to improve health equity nationwide. Our comments provide specific guidance as to how these recommendations can be implemented in a manner that is inclusive of migrant workers who have been impacted by COVID-19. CDM looks forward to ongoing partnerships that will protect and empower all workers as we respond to and recover from the current pandemic. Please direct any questions related to this comment to Mari Perales Sánchez, Senior Policy Manager at CDM (mariap@cdmigrante.org).

Sincerely,

Mari Perales Sanchez
Senior Policy Manager
Elizabeth Mauldin Memorial Advocate for Migrant Women
Centro de los Derechos del Migrante

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Health Equity Task Force
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Philadelphia, October 8, 2021

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

Public comment – Crisis Standards of Care

I would like to congratulate the Chair, the task force members, and especially also the staff, for the truly herculean effort that went into the final recommendations, and that could hardly be more timely or important.

I would also like to thank you for the opportunity to provide public comment at the September meeting, and am following up with a written version of my comments and sources that I mentioned.

My comments have to do with a simple, but deep issue that is directly connected to the Task Force charge under Goal 6 of the National Covid Strategy, as well as the recommendation that:

The federal government should convene a multidisciplinary panel, including clinicians, civil rights attorneys, ethicists, health equity experts, and community members to assess and update the Crisis Standards of Care work produced by the National Academy of Science and Medicine for equity. Widely disseminate these standards, explaining their benefit, and incentivize adherence through accreditation and reimbursement requirements namely recommendations on federal guidance for crisis standards of care (CSC).

And the recommendation that:

The federal government should appoint an independent, Blue Ribbon panel to conduct a COVID-19 pandemic after action analysis for the whole of government. This analysis should include a review of performance of public authorities at the federal, state, and local levels, their respective roles in pandemic response, and make recommendations to increase preparedness. The panel should seek input from diverse, non-governmental stakeholders and build on this report.

As well as comments during the meeting that it will be important to establish to what extent rationing happened formally and informally.

The issue is this: Three states that have activated Crisis Standards of Care (CSC) in recent weeks are basing their rules on now outdated algorithms that mean Black patients face far worse chances at receiving a ventilator, compared to white patients.

Based on joint work with my colleagues Dorothy Roberts and Amaka Eneanya, (already published in the *Journal of Medical Ethics*¹ as well as forthcoming there²) I would like to suggest that this injustice should not stand:

1. and most importantly, right now, we knowingly and erroneously disadvantage Black people in ventilator access
2. we need to understand how and why this happened there and likely elsewhere
3. we need to identify clear measures that avoid repeats in this pandemic, as well as future ones.

Idaho,¹ Montana² and Alaska³ all recently activated CSC, and all three states draw centrally on the SOFA score, a measure to predict the likelihood of ICU survival.

The first major problem is that SOFA is not fit for purpose.

To be clear, this is not my personal assessment, but the conclusion of a joint Expert Panel by the Task Force for Mass Critical Care and the American College of Chest Physicians who state that the SOFA score is unlikely to predict critical care outcomes with sufficient accuracy, and is not a useful basis for triage decisions.³

The groups published their report in Spring 2020, and a Discussion paper on equity lessons learned from Covid-19 that was published August 30, 2021 by the National Academy of Medicine directly echoes this: “Limitations of the SOFA score have been recognized and publicized prior to COVID-19 [42,43,44]. The SOFA score should not be used as a significant variable for COVID-19 or other primarily respiratory diseases, as scores are significantly lower than for disease states such as sepsis [45,46,47].”

Yet the 3 mentioned states use SOFA, right now.

But SOFA is not only bad science—it is also inequitable.

4 robust studies now all confirm that both SOFA alone, as well as when embedded in triage guidance such as that used by Idaho and Montana, assigns disproportionate numbers of Black patients to lower priority tiers, and erroneously excludes them from the highest prioritization.

Looking at data of more than 100,000 patients, Deepshikha Ashana and colleagues found that “81.6% of Black patients [were] included in lower priority.. categories, and 9.4% of all Black patients were erroneously excluded from receiving the highest prioritization”.⁴

In a Cohort study of more than 95,000 patients by William Miller and colleagues it was established that SOFA “overestimated mortality among Black patients” and misclassified more than 15% from the highest to the intermediate priority.⁵

Sivasubramaniam Bhavani, Yuan Luo and colleagues found that “SOFA-only and multi-principle protocols saved fewer lives than youngest-first and reduced ventilator allocation and survival in Black patients.”⁶

¹ <https://healthandwelfare.idaho.gov/health-wellness/emergency-planning/emergency-preparedness>

² <https://dphhs.mt.gov/publichealth/cdepi/diseases/CoronavirusMT/MontanaCrisisCareGuidanceOverviewMaterials.pdf>

³ https://dhss.alaska.gov/dph/Epi/id/SiteAssets/Pages/HumanCoV/SOA_DHSS_CrisisStandardsOfCare.pdf

A study by Shireen Roy and colleagues found that “Black patients had higher SOFA scores compared to patients of other races [but] did not have significantly greater in-hospital mortality or ICU admission. [If the] SOFA score had been used to allocate care, Black COVID patients would have been denied care despite having similar clinical outcomes to white patients.”⁷

Further, the authors of the model guidance that Idaho and Montana, as well as many other states adopted, published a revised version in December 2020,⁸ in which they acknowledged “important equity problems” of guidance, including their own, and offered a number of revisions, including dropping the SOFA score.

Unfortunately, 10 months after publication, policy maker in Idaho and Montana seem unaware, as both states incorporate an earlier, and more inequitable, version of the model guidance.

None of the 3 mentioned states, nor any other state or hospital, should ration ventilators on outdated and more inequitable guidance. Two things could help to change this:

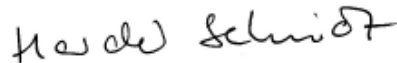
First, appropriate units within HHS should contact all state health departments, to share the evidence on the harmful consequences of using the SOFA score, and discourage use.

Second, going forward, a systematic inventory of state level and other triage protocols should be created and maintained within HHS.² Whether public or non-public, even a non-public version would create incentives for states and hospitals to establish triage protocols and keep them up to date.

I thank you again for the opportunity to provide a comment and for all the amazing work the Chair, the task force members, and the staff have accomplished.

If there would be anything that you would like to discuss further, please feel free to reach out via schmidth@upenn.edu.

Sincerely,



Harald Schmidt, PhD

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