

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

**8<sup>th</sup> MEETING (Virtual)**

**October 28, 2021**

**Members Present**

Marcella Nunez-Smith, M.D., M.H.S. (Chair)  
Mayra Alvarez, M.H.A.  
Jessica Cardichon, Ed.D., J.D.\*  
Richard Cho, Ph.D., M.P.H.  
Pritesh Gandhi, M.D., M.P.H.\*  
Jamila Gleason  
Andrew Imparato, J.D.  
Jo Linda Johnson, J.D.\*  
Victor Joseph  
ADM 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**

Sara Bleich, Ph.D.\*  
James Hildreth, Ph.D., M.D.  
Joneigh Khaldun, M.D., M.P.H., F.A.C.E.P.

\*Federal ex-officio members

**Federal Staff**

CAPT Samuel Wu, Pharm.D., Designated Federal Officer, Office of Minority Health  
Martha Okafor, Ph.D., Executive Director, Office of the Assistant Secretary for Health

## **Welcome**

*CAPT Samuel Wu*

*Designated Federal Officer, Office of Minority Health*

CAPT Wu opened the eighth meeting of the COVID-19 Health Equity Task Force (HETF) and shared that the purpose of the meeting was to present and vote on the COVID-19 HETF Final Report. He 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 in the meeting would be available at [minorityhealth.hhs.gov/hetf](https://minorityhealth.hhs.gov/hetf). CAPT Wu noted that American Sign Language (ASL) interpreter services were available for the meeting and closed captioning was available at both [hhs.gov/live](https://hhs.gov/live) and the OMH YouTube channel. CAPT Wu welcomed members of the public to provide written comments as stated in the meeting notice published in the Federal Register by emailing [COVID19HETF@hhs.gov](mailto:COVID19HETF@hhs.gov) no later than Thursday, November 4<sup>th</sup>. As this was the last public meeting of the Task Force, CAPT Wu took the opportunity to thank the members of the Task Force for their work over the past 9 months and the Federal staff, led by Dr. Martha Okafor, for their dedication to the work of the Task Force. He also recognized the staff at the OMH who worked tirelessly behind the scenes for their support.

## **Opening Remarks**

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

*Chair, COVID-19 Health Equity Task Force*

Dr. Nunez-Smith welcomed everyone to the eighth meeting of the COVID-19 Health Equity Task Force. She acknowledged November as National Native American Heritage Month and shared that she was looking forward to celebrating the culture and heritage of American Indians and Alaska Natives. Dr. Nunez-Smith stated that she and the Task Force members were very pleased to share the final report from the Presidential COVID-19 Health Equity Task Force. She thanked President Biden and Vice President Harris for the opportunity to chair the group. She reminded the audience that Vice President Harris introduced legislation as a Senator that provided a blueprint for the Task Force and that on President Biden's first full day in office, he issued Executive Order 13995, which established the Presidential COVID-19 Health Equity Task Force. President Biden charged the Task Force with generating recommendations to mitigate health disparities caused or exacerbated by the COVID 19 pandemic and to prevent such inequities in the future.

Dr. Nunez-Smith shared how the HETF Task Force organized to address its charge. The Task Force split into four subcommittees and followed a monthly sprint cadence to address different key issues. These topics included the national strategy, executive order, and charter. Each sprint concluded with a public meeting, and each meeting concluded with a vote on a slate of recommendations. She shared that the Task Force systematically advanced 317 recommendations, and 55 of those are prioritized and highlighted in the body of the final report.

At this meeting, she noted, the Task Force would present two deliverables. The first deliverable includes four overarching suggested outcomes as the Task Force's vision for change, five

proposed priority actions to spur this change, and the 55 final prioritized recommendations intended to disrupt the predictability of who is harmed first and worst in times of national crisis. This work was unanimously approved and finalized at the September 28<sup>th</sup> HETF Task Force meeting.

Dr. Nunez-Smith clarified that while this was the final public meeting, the work is not done. To effect change, to monitor progress, to advance health equity for all, the Task Force would also present a second deliverable that includes a proposed implementation plan and suggested accountability framework, which would be discussed and voted upon at the meeting. She noted that this meeting would also provide the opportunity for Task Members to share their experiences and provide insights about their personal journeys over the last 18-plus months.

For families grieving the loss of a loved one or those suffering with Long COVID, Dr. Nunez-Smith explained, there is no “normal” to return to. The normal policies and practices in place were inadequate and made marginalized communities the most vulnerable; as a result, loss was disproportionately experienced in these communities. Dr. Nunez-Smith explained that achieving health equity is mission critical for all of us, not because it is simply the right thing to do but because there is no credible path to a new normal without it. She noted the Task Force was ever mindful to center equity across most affected groups and those struggling on the margins of the economy and the compounded challenges often found at the intersection of these identities.

While the COVID-19 crisis has made us aware of the toll on communities of color and underserved populations, Dr. Nunez explained that there has never been a time in which these communities have not suffered a disproportionate burden of death and disease. These communities are the first to be forgotten, especially when resources are in short supply. This pandemic has made it clear that a person’s zip code is a stronger driver of health than their genetic code. According to several national polls, significant progress has been made regarding increasing vaccination rates and decreasing vaccination inequity. This is the result of intentional work to address barriers at every level and reflects the collective work of community partners across the country to ensure access, confront misinformation, and prioritize vaccination. Yet there is more work to do. Gaps in vaccine uptake remain, and we continue to see new hospitalizations and deaths that are preventable. We need to push to keep our children safe, including vaccinating them once they are eligible.

Dr. Nunez-Smith extended her deep appreciation to Task Force members for their generativity, commitment, and deep and thoughtful contributions. She explained that the 12 original members were identified through conversations with stakeholder groups, recommendations by organizations and individuals, and through visible efforts led in their communities against COVID-19. She expressed gratitude for the Federal ex officio members who informed the work by representing agencies and departments across the Federal government and key constituencies, providing diverse perspectives. Dr. Nunez-Smith also thanked the Federal staff team, CDC Foundation, subject matter experts, and guest speakers for their contributions and insights.

She then turned to Chief Joseph for brief opening comments.

*Chief Victor Joseph*

Chief Joseph stated that he had put together a presentation, but in light of Dr. Nunez-Smith's comments and having recently lost a family friend, he decided instead to offer a word of prayer. He acknowledged the losses so many have experienced and asked for strength and encouragement for the grieving. Chief Joseph expressed gratitude for the Task Force and their work and asked that the recommendations be put into practice. He was appreciative that the President saw this as a priority issue and took action. He concluded by welcoming everyone to the meeting.

### **Member Roll Call**

*CAPT Samuel Wu*

After the opening remarks, CAPT Wu performed a roll call of the HETF members and announced a quorum for the meeting.

### **Final Report Walkthrough**

*Martha Okafor, PhD*

Dr. Okafor shared that the Task Force produced two deliverables—the Final Report and Recommendations and the proposed Implementation Plan and Accountability Framework—to address their charge to generate recommendations to mitigate health disparities caused or exacerbated by the COVID 19 pandemic and to prevent such inequities in the future. She then walked through a PowerPoint presentation that provided an overview of the report structure, including key elements of each section of the report. The PowerPoint presentation can be found on the OMH website. At the conclusion of her walkthrough of the Task Force's deliverables, Dr. Okafor congratulated the Task Force members for doing an excellent job.

### **Task Force Presentation 1: Reflections and Remarks**

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

Dr. Putnam expressed his pride at being part of this monumental effort and how the team came together for a united cause. He noted that so many of the deliberations focused on justice and the strength of our nation now and in the future. Dr. Putnam explained that to achieve both, we need to see disease as the true enemy and must unite to defeat it and to destroy the root causes of inequity. He highlighted that specific recommendations have been proposed to bridge the equity chasm in rural areas—equitable and affordable access to broadband, telemedicine, creating healthy food options, and curtailing closures of critical and essential rural hospitals. He also touched on the topic of diversity of workforce and the importance of having providers that reflect the nation as a whole. He specifically lifted up the recommendation for healthcare certifications that can be obtained in less than 2 years as an important step, highlighting EMTs in particular.

*Homer Venters, M.D.*

Dr. Venters thanked his fellow Task Force members and the staff for making this one of the most productive task forces he has been a part of. His comments related to how the HETF captured

important recommendations to promote health and start addressing health disparities faced by those involved with the justice system. He addressed how services and access to care for this population is grossly substandard and off the radar of most mainline public health structures like departments of health and even the CDC. Dr. Venters pointed out that COVID-19 created a situation where these entities are in prisons and detention centers to assist with the COVID response (testing, prevention, etc.), and the recommendations of the Task Force are important in shoring up what would otherwise be fleeting involvement to not only sustain the COVID response but also to address decades-long systemic racism that has led to these entities' absence. He also expressed that one of the most important recommendations from his perspective is to start thinking about release from incarceration as a public health tool.

*Mary Turner, R.N.*

Ms. Turner reflected on her work as an intensive care nurse in a COVID-19 unit. She stated that the work that the Task Force has done is the light at the end of a very dark tunnel. The recommendations of the Task Force will begin to repair the country's deep structural inequities that put people of color at a greater risk of infection, illness, and death during the pandemic. Ms. Turner explained that she has long advocated for on-the-job health and safety precautions as a nurse educator. As a result, she noted her pride regarding the recommendations calling for OSHA to develop permanent health and safety standards to protect all workers and to stockpile PPE and other essential supplies as well implement emergency production plans for equitable distribution.

Ms. Turner highlighted the dramatic funding increases recommended for infrastructure and the public health workforce that will reverse years of neglect. She also referenced recommendations regarding access to healthcare including eligibility at age 55 and expanding benefits to cover dental, vision, and hearing services. Ms. Turner drew attention to the recommendations regarding funding educational opportunities to create a more diverse and culturally competent workforce and the assessment of algorithms and clinical practice guidelines to correct for racial bias. Finally, she expressed her gratitude to President Biden for endorsing the Protecting the Right to Organize (PRO) Act and to the Task Force on the behalf of frontline workers across the country.

*Haeyoung Yoon, J.D.*

Ms. Yoon joined the chorus expressing gratitude to President Biden, Vice President Harris, and Chair Nunez-Smith for their generous and sustained leadership; the other Task Force members; Dr. Okafor for her clear guidance; and the rest of the HHS team. She noted that in 7 months the Task Force has accomplished so much, and she feels humbled, grateful, and empowered by their work. Ms. Yoon expressed that members of the Task Force reminded and affirmed to her that we need to be in close proximity to those who are most affected and experiencing harm and hardship to ground this work in and ensure equity.

*Bobby Watts, M.P.H., M.S.*

Mr. Watts expressed his gratitude that the Administration's commitment to health equity runs deep, even to the point of making sure the needs of people experiencing homelessness are considered in these deliberations. He noted that the answer to ending homelessness is housing and services, so he highlighted the recommendation that includes fully funding housing

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vouchers. Mr. Watts also reflected on the broad perspective of the Task Force members and how meaningful it was to him that some recommendations to help this population were raised by members other than himself. Finally, Mr. Watts identified what, in his opinion, was the largest obstacle in the response to this pandemic: the extent to which political considerations at the State, local, and Federal level overruled public health science. He noted that the Task Force has made a recommendation to help overcome this obstacle: the creation of an apolitical body that will help direct the nation's responses to counter political impulses that go directly against science and equity. Mr. Watts then expressed his gratitude to the Task Force and Chair Nunez-Smith.

*Victor Joseph*

Mr. Joseph shared his honor at working with so many committed people to address the health inequities that face the people of our nation simply because they are seen as less than. He has been a Tribal leader for over 30 years and was asked to extend his term as Chief/Chairman in the Interior region to help our 37 tribal communities prepare and respond to the pandemic. When he was a young man, he explained, elders shared stories of the Spanish Flu epidemic and how many families and communities were completely wiped out in Alaska, which caused the younger generations to grow up with a great fear of what a pandemic could do. Chief Joseph also shared a story about a diphtheria epidemic in January of 1925 and the related Great Race of Mercy. Children were dying in Alaska, and without the necessary antitoxin, diphtheria was sure to kill an entire population. Twenty mushers and their dog teams relayed the antitoxin the 674 miles to Nome in 5.5 days; many of the dogs lost their lives, and several mushers succumbed to frostbite. He noted his grandfather was one of those mushers. One man's hands were frozen to the reins and had to have warm water poured over them for him to let go. Chief Joseph used this example to explain the importance of the Task Force's work and the need to hold on tightly to the recommendations to make sure the changes are implemented.

*Andrew Imperato, J.D.*

Mr. Imperato lifted up Chair Nunez-Smith as someone who has made the members feel loved and valued throughout the process as well as Dr. Okafor and the contractors and interns. He expressed his pride for Vice President Harris and her call for the legislation that created the Task Force and his fellow Californians involved in the process. Mr. Imperato pointed out that people with disabilities are part of every underserved and minoritized community, so thinking about equity from a disability frame will help to deal with equity issues within all communities. Regarding crisis standards of care, he noted that Federal standards are needed regarding healthcare rationing. Mr. Imperato also stated that we need to move away from forcing people to live in congregate settings like nursing homes—this is a civil rights issue and has become a public health issue. Finally, Mr. Imperato raised up the need to build up disability competence and confidence to make good decisions in real time. Finally, he expressed his gratitude to the Task Force members for considering the patient perspective.

*Octavio Martinez, M.D., M.P.H., M.B.A., F.A.P.A.*

Dr. Martinez thanked President Biden and Vice President Harris for recognizing the need and creating the opportunity to address health equity during the pandemic and expressed his honor to be able to serve on the Task Force. He also thanked Drs. Nunez-Smith and Okafor for their

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guidance and leadership; the Federal task force support team and Federal partners for their dedication; and the many concerned individuals, subject matter experts, and health organizations that shared their knowledge and experiences. Dr. Martinez reflected on the pivot to recognize the effect that COVID-19 has on mental health. He noted that The Hogg Foundation for Mental Health, of which he is executive director, recognizes that mental health is not solely an individual responsibility but is a product of community conditions. Dr. Martinez pointed out that many of the inequities identified by the Task Force are structural in nature and will require concerted, intentional effort over time to address and mitigate. He explained that we are at an inflection point to build and improve upon our emergency response, public health and healthcare infrastructure to improve quality of care and quality of life for each and every one of us. That is health equity. Dr. Martinez expressed his hope that in 10 years he will look back at this report as the catalyst for structural changes that resulted in fair and just healthcare for all.

*Vincent Toranzo*

Mr. Toranzo shared that the day he was notified of his potential nomination to the Task Force, he was also notified that multiple family members had tested positive for COVID-19, including his grandmother, who has emphysema. He acknowledged the pain that the pandemic has brought to countless people worldwide who experienced much worse than he did and how that motivated him to accept the nomination to the Task Force. He noted that while his experience in government and working to include student voices contributed to his work ethic, he was inspired by the people who demanded change because they or their families were struggling. Mr. Toranzo stated that the HETF has lived up to the American Creed of a government of the people, by the people, and for the people through its deliberations and recommendations. The goal of the Task Force was not only to ensure a more equitable COVID-19 response and recovery but also lead the way for a brighter future and a stronger and healthier nation. He explained that this meant passing bold recommendations that would ensure people have widespread access to vaccinations and therapeutics, protecting children and educators so they can return to school safely, the prevention of dangerous and destructive disinformation motivated by politics influencing pandemic response and recovery, and finally, by making healthcare a human right. Mr. Toranzo expressed his gratitude to the Task Force for making him feel like he belonged and that the voice of the nation's youth is valuable. He also thanked the President and Vice President for making sure youth is represented in the Federal Government and Dr. Nunez-Smith for her leadership as Chair as well as the subject matter experts for their valuable insight and knowledge.

*Mayra Alvarez, M.H.A.*

Ms. Alvarez began by thanking President Biden and Vice President Harris for the honor of her appointment to the Task Force, Chair Nunez-Smith for her leadership, and the HHS staff for their support. As a proud daughter of Mexican immigrants, a resident of California, and a nonprofit executive of a child advocacy organization she noted the privilege she feels to have the opportunity to bring her personal and professional experiences to the critical work being done in advancing recommendations to ensure we have a more equitable response to COVID-19 and to future pandemics. She expressed how this work is very personal to her; when seeking how to address the data concerns, communications challenges, and potential solutions for structural drivers, she always centered the needs of her family. Ms. Alvarez pointed out that the recommendations made by the HETF are reflective of the systemic changes necessary to



improve the well-being of all Americans and especially those who have been historically marginalized. She noted that the Task Force kept at the forefront of their work the reality of this nation's racist, discriminatory, and unequal policies that limit opportunities for positive health outcomes for so many people today. Ms. Alvarez also highlighted the importance of ensuring that every kid has the opportunity to grow up healthy and thrive. There are recommendations that acknowledge schools and early learning centers are essential to our children's development and are critical partners in our equitable response, how to collect data in order to better capture the needs of diverse communities, and kids in particular, and finally, that draw attention to our responsibility to support children who have lost parents/caregivers to COVID. With the advancement of the report, the work of the Task Force truly begins, and Ms. Alvarez noted she looks forward to the good fight and bending the moral arc toward justice.

*James Hildreth, Ph.D., M.D.*

Via a video recording, Dr. Hildreth shared that he joined the HETF because the issues to be addressed were deeply personal to him. His journey started with his father's death from cancer; being born Black in a small town in the south, his father did not get much healthcare, and this is what initially drove Dr. Hildreth to want to become a physician. Another important part of Dr. Hildreth's work has been in HIV, a separate pandemic that disproportionately affects people of color all over the world. He expressed that being able to work on the Task Force has been particularly satisfying because his journey and life's work has been focused around trying to achieve equity when it comes to health and his 30-plus years of expertise working with a pandemic virus has been instructive and given him insights that have been very helpful. Dr. Hildreth also pointed out that his organization, Meharry Medical College, was founded to ensure that people of color would have access to healthcare and training in healthcare. One thing he noted as really important is expanding the definition of minoritized populations to include indigenous people, people with disabilities, people with behavioral and health challenges, etc. There are many things that define a minoritized population, and the Task Force has worked to show that minoritized populations does not just refer to people of color but people with disadvantages that are the result of stigma, xenophobia, and other challenges. He expressed that he has found the work important and gratifying and thanked the President for the opportunity to serve as part of the HETF.

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

Via a video recording, Dr. Khaldun expressed her honor at being appointed to the HETF with such esteemed colleagues and her gratitude for the leadership of Chair Nunez-Smith, the dedicated staff at HHS, and all of the partners who contributed to the effort. She noted how much she enjoyed speaking to those with lived experience and experts from all across the country. Over the past 9 months, the Task Force moved with boldness and intentionality to make sure no one is left out or left behind when it comes to COVID-19 and any current future health crisis. Dr. Khaldun highlighted how this work has been personal to her as a Black woman and ER doctor; she has seen up close what happens when the amount of money you make, the color of your skin, your disability status, or the zip code in which you live determines if you get infected or if you will die during a pandemic. The recommendations made by the Task Force are actionable items that could mean the difference between life and death for so many people. Dr. Khaldun was most excited about the charge to elevate the importance of data and noted that we cannot improve

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what we cannot measure. She urged that we cannot be complicit in worsening health inequities by omitting or ignoring the data that ensure every person in our society is seen and that we have a subsequently targeted and robust public health response. We must advance, with urgency, the building of a robust, interoperable data infrastructure so that we can advance policies and programs that address the needs of all communities and data gaps that have hindered our response and cost people their lives. Dr. Khaldun closed with hope that, as a country, we will work quickly and thoughtfully to implement the Task Force recommendations.

## **Task Force Presentation 2: Reflections and Remarks**

*ADM Rachel Levine, M.D.*

ADM Levine spoke about the honor of working with Task Force and ex officio members toward the same goal of mitigating the health inequities that have been exacerbated by the COVID-19 pandemic. She noted over the past months, Task Force members have worked diligently and deliberated and voted on recommendations to the President of the United States to help ensure that no one is left behind as we continue to tackle this most urgent health crisis. ADM Levine expressed how COVID-19 has taxed us all physically and mentally, but the fact remains that this pandemic has impacted some more than others; and this underscores the profound health disparities that have plagued our nation for far too long. She pointed out that equity is a key part of the mission of HHS. In fact, she stated, the department's mission is to enhance health of all Americans by providing effective health and human services and fostering sound, sustained advances in the sciences underlying medicine, public health, and social services. To do that effectively, ADM Levine explained, we must continue to collaborate and work together collectively as we strive to advance health equity and remove structural barriers including racism. The Biden-Harris Administration understands this and the need for action-driven efforts addressing health disparities and promoting equity for disenfranchised populations, and the time to act is now. She closed by thanking the Task Force members, Chair Nunez-Smith, and staff led by Dr. Okafor for their hard work and commitment to advance equity as we strive toward our new postpandemic reality.

*Jo Linda Johnson, J.D.*

Ms. Johnson expressed her appreciation to Dr. Nunez-Smith and Dr. Okafor for their leadership and her gratitude to her fellow HETF members as well as the ex officio members for sharing their knowledge and experience of challenges faced by different populations. She highlighted some of the work of the Federal Emergency Management Agency (FEMA) over the last 18 months providing support to every State, Tribe, and Territory and working to combat the pandemic and get shots into the arms of people in communities across the country. Ms. Johnson thanked her FEMA colleagues and congratulated them on a job well done. With regard to the HETF report, it represents extraordinary work and opportunity; universal healthcare, in Ms. Johnson's opinion, which is highlighted in several of the recommendations, represents the single biggest opportunity for progress for all. The work of this Task Force is a stark reminder that inequities in access and outcomes hurt us all; we can and must do better by the vulnerable and marginalized among us, all of our neighbors. She closed by thanking the HHS staff and contractors and looking forward to the response of the President and Vice President to the work the Task Force has done.

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

Dr. Gandhi talked about how he enjoyed his time on the Task Force, but it was cut a bit short when the Department of Homeland Security (DHS) became the lead Federal agency for Operation Allies Welcome in September and he had to leave the medical and public health effort to welcome Afghan allies here. He expressed how the time spend on the HETF was a humbling experience and many lessons were learned, noting that as of today, every Afghan evacuee coming to our country has the opportunity to receive the COVID vaccine, among others, particularly because we know and recognize the inherent inequities in access to healthcare when people get resettled. This effort was personal to him, living in a fairly divided city with a background as an internist and pediatrician and having co-led a federally qualified health center (FQHC), Dr. Gandhi saw the profound effect of inequity and race on health outcomes. He expressed his dismay at being part of a system than cannot provide core care to fellow humans, so the work of the HETF is mission critical for marginalized individuals and communities and those who have been on the fringes of access in our healthcare system. He echoed Mr. Toranzo's sentiment that the most important recommendation is Recommendation 55, to "recognize healthcare as a human right to include regardless of immigration status."

*Shannon Pazur, J.D.*

Ms. Pazur noted that it may not be intuitive that the Department of Justice (DOJ) would have a role to play in health equity, but equity cannot be siloed; health equity is inextricably linked to equity in all of its forms. She shared that the DOJ has a number of initiatives underway that overlap with the recommendations of the HETF, particularly those that relate to discrimination and hate crimes, improved data collection, community engagement, and carceral settings. The DOJ is taking steps to improve incident reporting, increase law enforcement training and coordination, prioritize community outreach and the Federal use of civil enforcement mechanisms. In addition, she explained that the department recently announced an internal review of its grant funding to ensure that public funds are not being used to finance illegal discrimination. Among other things, this review is expected to include recommendations aimed at strengthening grantees' data collection and reporting efforts. While grateful that a number of recommendations are already being implemented at the DOJ, there is much more they can do, and Ms. Pazur and the DOJ look forward to implementing the Task Force's recommendations and doing their part to ensure health equity for all. On a personal note, Ms. Pazur expressed that it was a privilege and a profound learning experience to serve on the HETF alongside such deeply dedicated experts and that the depth and breadth of the report stand as a testament to their passion, commitment, and expertise.

*Jamila Gleason*

Ms. Gleason thanked Chair Nunez-Smith, her colleagues on the Task Force, and the entire team responsible for shepherding this monumental effort and President Biden and Vice President Harris for having the vision to recognize how inequity has exacerbated the COVID-19 crisis. She expressed how she was honored to represent the Department of Labor (DOL) as an ex officio member of the HETF and that she will forever remember the talent, passion, and knowledge that each person brought to the effort. Ms. Gleason noted that the mission of the DOL is to foster, promote, and develop the welfare of wage earners, job seekers, and retirees of the United States, to improve working conditions, advance opportunities for profitable employment, and ensure

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work-related benefits and rights. She shared that the enthusiasm to change the tide against this disease that has ravaged so many of our communities is not just with DOL leadership and employees in program areas but goes directly to the Secretary of Labor's office and his commitment to diversity, equity, and inclusion in their work to ensure that when the department engages with the community it is thoughtfully, meaningfully, and informed. The problems giving rise to the need for this Task Force are longstanding and systemic. On a personal note, Ms. Gleason shared that her family has had to wonder if the color of their skin influenced quality of care they received or if they receive care at all. That anxiety and stress is real and something no one struggling with illness or battling COVID deserves. Equal access to health care—to health—is a fundamental human right, and Ms. Gleason expressed appreciation for the opportunity to have that conversation.

*Jessica Cardichon, Ed.D., J.D*

Dr. Cardichon expressed her thanks to Chair Nunez-Smith and Dr. Okafor for their guidance. She shared that she was honored to have been a part of this work on behalf of the Department of Education (ED) and that her participation in the Task Force has helped inform work at ED, which sees itself as a service agency whose role is to support States, districts, and schools in meeting the needs of the whole child—their social, emotional, and mental health as well as physical and academic needs. Dr. Cardichon pointed out that 9 of the 55 recommendations being advanced today touch on education and how that work begins in early education with making sure families have access to high-quality early childcare and education. She also noted that the work of the Task Force recognized the role of schools in supporting racial, cultural, linguistic, and disability status inclusion in early education through higher education and the diversity of our workforce and how we help our students learn and grow and work together. The HETF also recognized the importance of college affordability and making sure that we have a pipeline of diverse healthcare educators, which is a commitment of the administration that we want to make sure that our healthcare system looks like America, as we do with our teachers. Dr. Cardichon stated that it was clear from the first meeting of the Task Force that equity was not only at the center, it was the way they approached every recommendation and every conversation, and it is evident in the work the HETF has produced. This, she explained, is a result of the leadership maintaining focus on the mission at hand and not treating equity as an afterthought but as the guiding principle.

Dr. Nunez-Smith acknowledged and expressed her gratitude to two ex officio members who had been called away at the last minute and were unable to attend the meeting: Dr. Sara Bleich with the Department of Agriculture and Richard Cho with the Department of Housing and Urban Development.

### **Task Force Deliberation**

*Dr. Marcella Nunez-Smith*

Dr. Nunez-Smith shared that the Task Force had discussed and voted on the 55 prioritized recommendations that were included in the first deliverable during the September 2021 Task Force meeting. She explained that she wanted to focus on the second deliverable, the proposed Implementation Plan and Accountability Framework by posing a few questions for consideration

and group discussion to help bring others into some of the Task Force's thinking as to where there is potential and how to ensure that the process will lead to and yield success.

**Question 1:** Implementation will require coordination across Federal, State, local, Tribal, and Territorial levels as well as partnerships across diverse sectors with invited stakeholders from many disciplines and domains. Reflecting on this and your own personal and professional experiences, what particular sectors, what stakeholders should be engaged to get to success?

Dr. Martinez said everyone has a stake in health. Everyone can contribute to transform our healthcare system for the better. Community-based organizations speak very loudly, and he has seen movement in other sectors as well: nonprofits, the philanthropic sector, local and State governments, healthcare organizations, pharmaceutical companies, businesses, Fortune 500 companies, etc. Organizations are waiting for this report to give additional guidance; e.g., National Association of Latino Health Care Executives, American Psychiatric Association, Rand Corporation, American Heart Association Round Table, National Commission to Transform Public Health Data Systems. Dr. Martinez highlighted these many stakeholders are out there who are passionate and who will be able to look to this report, distill it, and identify what speaks to them in order to make a difference.

Ms. Gleason talked about legal aid organizations and how they assist in shoring up different areas where DOL doesn't have authority to handle. She brought up that while DOL handles matters like wage and hour rules, legal aid works with individuals to address eviction proceedings. Ms. Gleason also recently had the opportunity to travel to Alabama and talk to community leaders on the frontlines; one of these community leaders showed her a film about a waste water plant in a community where many residents weren't even hooked up to it. She pointed out the importance of engaging with community leaders who know and understand local issues.

Mr. Toranzo noted that throughout history young people have been a driving force in powerful movements. Involving young people in the implementation process is key to ensuring that the changes advocated for will move forward. Youth-led organizations have proved that the next generations are committed to promoting COVID-19 vaccinations and other causes as well. He suggested that the Federal Government partner with Statewide and national student government organizations, who have done incredible work in their communities. Working with brilliant young role models will ensure that equity is at the core of implementing the HETF recommendations.

Mr. Watts highlighted several recommendations involve people with lived experience. This has been especially important in his work with programs for people who have experienced homelessness. Mr. Watts explained that hearing from people with Long COVID provided more insight than he would have gained from reading journals for a month because those closest to the problem are best situated to help create a solution to the problem. In closing, Mr. Watts expressed hope that when calling for involvement of the community, we urge the healthcare system, human service system, and government to go against practice and gather input from these communities to formulate the proposed solution instead of asking for feedback after the fact.

Ms. Johnson followed up on Mr. Watts comment and encouraged local governments to work across different departments within their local government. From FEMA's vantage point, the emergency management community called upon to lead the response was not typically connected to public health officials or community-based organizations. Involving communities with individuals with lived experience when this country faces its next crisis will be important. She explained how it is imperative that public health officials for each State, emergency management communities across States and Territories, and local governments are connected to one another and community-based organizations that know the individuals who are most impacted, what is needed, and how to help in the best way; this collaboration was missing until recently and needs to be kept up going forward.

**Question 2:** Many of the additional action steps included in the second deliverable speak to data. Where are the opportunities for new, different, and diverse data sources in this work, and are there important lessons for us to consider moving forward?

Dr. Venters spoke about how we tend to focus on the logistics and technical aspects of how to analyze data, but whole groups of people are left out of our public health surveillance system not by accident but by design. In visiting jails and prisons, many of the people he encounters who had or have COVID-19 were never tested, so they are not on anyone's radar, not only for having the acute infection but for Long COVID and the problems that may persist afterward. We have to start by talking to the people who have the experience to find out what our data misses and then integrate their voices into designing new and better data platforms for COVID and subsequent health responses.

Ms. Alvarez also touched on the stories of lived experience as valuable data to inform a more equitable response. She noted that part of being equity-centered is lifting up and valuing the experiences of people who are going through these challenges. Some of the most inspiring, touching, and eye-opening discussions were with those who are living with Long COVID. She also highlighted the need to utilize the leadership and expertise of community partners to collect more accurate data because without them we don't necessarily have the trust and buy-in of the community to participate. Ms. Alvarez closed by mentioning a quote from a commission she is on: "we measure what we treasure." And that is what we need to really focus on as we think about including more of our diverse communities, people living with disabilities or people of color, or farm workers.

Ms. Johnson highlighted a difficulty in the trenches from the DHS and FEMA and called on partners across the Federal Government, local and State governments to be mindful of the importance of collecting data to comply with civil rights requirements. In order to demonstrate that we are serving communities equitably, it is not enough to simply say we are reaching everyone. When FEMA asserted its authority as a grantor, it was alone in collecting that data, but they were able to demonstrate that there were jurisdictions and States that were successfully reaching communities of color and plenty that were not despite assertions to the contrary. Data are critical to verify that efforts are accomplishing what they set out to accomplish and to validate outcomes. It is imperative that we continue to push forward with collecting information, and the more Federal departments can stand together in doing so, the better for everyone.

Mr. Imperato lifted up that in order to have the data that we need on people with disabilities we will need to spend money to collect those data and have budgets that support more robust data collection that will identify the disability population, which is very diverse. The LA Times published an article that morning stating that people with mood disorders are more at risk of contracting COVID-19. He pointed out the fact that data are not currently being collected on people with disabilities. This is an equity issue that gets compounded when people with disabilities are not prioritized to receive vaccines because there are not enough data to know whether they are at higher risk of contracting the illness.

Dr. Putnam stated we need is knowledge, wisdom, and data get us there. There is a need for better data and standardized data and the ability for data to flow. All of our cell phones can talk to every other cell phone in the country, but our electronic medical records cannot flow that information back and forth. It is not about getting more data from frontline staff; we need to standardize that data, we need to analyze it better, and we need to get it back to frontline staff so they can help their patients and help improve the health of the population.

Ms. Turner spoke from her experience on the frontlines where the first time a patient is seen is after they collapse and end up in the hospital. She urged that we need a better system of healthcare so that the first time she sees someone is not in the ICU.

## **Public Comments**

*Harald Schmidt, Ph.D., University of Pennsylvania*

Thank you very much. My name is Harald Schmidt. I am an assistant professor of medical ethics and health policy at the University of Pennsylvania. First, an enormous thank you again to the chair and the Task Force members, and especially also the staff for this outstanding work—just really so amazing.

As I followed the presentations today, I had to think about an instruction I came across, quite a while ago now, on a carved oak board on the wall of a workshop when I used to be a cabinet maker in Germany. Now cabinet making is not generally known for its rapid embrace of innovation, and this board expressed this by listing the three golden rules of German craftsmanship in case somebody would suggest doing things differently. And the rules were, first, we've always done it that way; secondly, we've never done it that way; and, third, anybody could say that.

The reason I'm bringing this up is that, regrettably, it seems pressing to consider alongside this landmark report the power of past dependency that these rules express. Here's one example: In a recent discussion paper by the National Academy of Medicine on Equity Lessons Learned in Crisis Standard of Care, the authors conclude that, "Protocols that will be used for making urgent allocation decisions in a disaster cannot be expected to remedy historic and structural inequity. However, they should not exacerbate underlying disparities."

Another example: At a recent national bioethics conference, Dr. Dawes highlighted in an inspiring keynote the linkage of health, place, and race, the political determinants of health, and how law and policy can be both sources of disparate outcome but also be used to accomplish the

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opposite. Yet, that was not the theme in any of the sessions focused on crisis center of care. Here, colleagues involved with establishing and implementing triage protocols all generally agreed that we now have clear evidence that the SOFA score erroneously assigns Black patients' lower priority in mental aid or access, but all things considered, still felt it was good enough to be used.

And another example: As highlighted at the last Task Force meeting, three States that activated crisis of standard of care last month all used the SOFA score and 2 years' earlier version of a point score system that its office revised that December due to important equity problems they found with it. Dr. Nunez-Smith regularly urged us all to work to reverse the predictable patterns of who gets harmed first and worst. In vaccine allocation, we've seen unprecedented movement in this regard, in particular through the widespread adoption of disadvantage and disease.

Yet, when it comes to currently active triage policy, to leading triage voices and bioethics, and expert committees tasked with assessing crisis of care equity, it seems we find agreement only on not exacerbating what is maintaining inequities. And in using the SOFA score and the knowledge that it is harmful to communities of color and people with disabilities, not even this threshold is met. Why is this so now and today?

A confluence of factors seems at play: the view that in an emergency the perfect can't be the enemy of the good; that, aside from ventilator triage a myriad of other crisis center care elements needs managing; that a triage framework is better than none; that while there may be alternative scores and modifications, they're cumbersome or complicated or just too new; or that we can just come back to this when we have to now that we finally seem to have turned a corner and are still busy with other related matters.

It's important to acknowledge pragmatic constraints, but these and related reasons are not good enough if we're sincere about equity. So, all to say that while path dependency and the role of competing and shifting priorities may seem banal, understanding and addressing the roles is crucial for the Task Force's next step and underscore a further facet of the critical relevance of the Implementation and Accountability Framework.

And it could be more important in some areas than others. For crisis standard of care, it requires proactive engagement of key stakeholders, including the State and Hospital Association level, to understand barriers and converts of real progress with health equity. Thank you, again, for opening a major new and urgent chapter with this landmark report.

*Lynn Todman, Ph.D., Spectrum Health*

Thank you very much. My name is Lynn Todman. I am Vice President of Health Equity at Spectrum Health, which is an integrated healthcare delivery system located in southwest Michigan. We're an \$8.3 billion enterprise with 31,000 employees, 5,000 in physicians and advanced care practitioners, and a dedicated \$100 million in funding for health equity work.

My thoughts about the final recommendations you've put forth, particularly focused on priority number five that references a permanent health equity infrastructure in the White House—it

shouldn't be lost on any of us that the last time we experienced a watershed moment like this was almost 50 years ago with the 1964 enactment of the Civil Rights legislation. That legislation outlawed discrimination based on race, color, religion, sex, national origin and, later, sexual orientation and gender identity.

It prohibited unequal application of voter registration requirements, racial segregation in schools, healthcare settings, and employment discrimination. And because of that legislation, as a nation we've made great strides. However, we all know that racism is a complex adaptive system. It has a way of reinventing itself and showing up despite policies, regulations, and reforms that have been intended to eliminate it.

And, as a result, we hadn't progressed as far as we might have thought we would, or hoped for, in 1964, and the disparities and social and economic conditions that impact health persist. They persist in education, employment, income, wealth, housing, food transportation, and so on. These disparities are predictably reflected in health inequities, such as pregnancy-related mortality, heart disease, hypertension, diabetes, obesity, and death from cancer.

These disparities and their underlying social and economic drivers fueled the harms the pandemic had on communities of colors. It is the persistence of these disparities, despite impressive historical efforts that inspire my comments. It's worth lifting up priority five that references a permanent health equity infrastructure in the White House and punctuating the many other references made throughout the document calling for this work to be institutionalized and embedded across all Federal agencies.

The institutionalization of health equity priorities and work across Federal bodies is mission critical. It's critical given the systemic and dynamic nature of racism, which has effectively muted past efforts to eliminate health inequities. We witnessed significant moments of hope and progress and promise that were subsequently thwarted by backlash, pivots, pauses, and redirects that robbed energy and focus from the work that we're all committed to. References in the documents to sustainable funding, regulatory reforms, and other types structural changes signal the intention of the recommendations.

I just want to take a moment to note that it's essential to hardwire this work into the institution's charge with shepherding the recommendations forward because, as we've learned over the decades and centuries in trying to advance health equity, the drivers of inequity persist, they adapt, they flex, they find holes, they push back. But I commend you for this work. I am so grateful for this work and everything you've done. And I am proud and I am hopeful. Thank you.

*Arthur Evans, Ph.D., American Psychological Association*

Okay, thank you. I'm the chief executive officer of the American Psychological Association (APA). APA is the largest professional association representing the practice and science of psychology in the United States, with over 122,000 clinicians, researchers, consultants, students as its members and affiliates. But really, importantly, our members reach hundreds of thousands of people each year providing direct services, conducting research, and training students.

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I want to first start by thanking the Task Force for your work in getting these 55 recommendations to this point. You've developed a strong roadmap that will position the nation to achieve the laudable health equity outcomes that we all want and desire. As the work now shifts to generating action, I want to share with you three points we see as essential to the successful implementation of the recommendations going to President Biden.

My first point is this, if the nation's behavioral health needs are not a central focus of our approach, our response to the pandemic will be incomplete and inadequate. Too often, mental health is treated as an afterthought, a luxury that we can get to after we've addressed people's physical health needs; but nothing could be further from the truth. We and others have highlighted the disease burden that behavioral health issues place on our nation.

And the data are clear. Our nation is experiencing a behavioral health pandemic like nothing we've ever seen before. Practically every survey illustrates the magnitude of the problem that we face. And our clinicians are telling us and seeing this as well. Our school psychologist colleagues are telling us that while many children are back in schools, many are disengaged unable to focus, using more substances, and are considering suicide at much higher rates.

Our organizational psychologist colleagues are telling us that issues like psychological safety, work-related stress, and burnout are having a disproportionate negative impact on frontline workers, many of whom are people of color. Our psychologist colleagues working primarily with indigenous communities are telling us that people are just exhausted and broken. Their energy is depleted from dealing with chronic and pervasive levels of stress and loss, not only due to the disproportionate impacts of the pandemic, but longstanding historical burdens like racism and discrimination. We just cannot afford to wait anymore. It is urgent that we address these issues now.

My second point is this, because human behavior is at the heart of most of the challenging aspects of managing and responding to the pandemic, we must use the science of human behavior to improve our response. For instance, psychological science helps us understand phenomena like attitude formation and persuasion that contribute to challenges like vaccine hesitancy.

Psychological science also helps explain why people do or do not engage in health behaviors. For years, health and pediatric psychologists have been at the forefront of helping patients with diabetes more consistently check their glucose levels and motivate those with kidney disease to stay on sodium-free diets. Similarly, we should be using this behavioral science to encourage people's uptake of COVID mitigation strategies.

My third and final point is this, given the complexity and the magnitude of the challenges related to achieving health equity, the Administration should utilize a population health framework to implement these recommendations. While we believe this is important for all of the recommendations, let me explain why it is so critical for behavioral health. The framework that we use must acknowledge the fact that our nation's approach to behavioral health was inadequate

prior to the pandemic, particularly for people of color, and that's only been exacerbated by the pandemic.

We can no longer afford to do more of the same thing and expect to get different results. So, what does it mean to use a population health framework for how we address our—the nation's behavioral health needs? It means that we don't only focus on people with a diagnosis or who are in crisis, but we also employ strategies to address people who are at greater risk to mitigate those risks or to intervene at the earliest possible moment. And we also must focus on people who are healthy to help keep them healthy.

We know a lot about the correlative of good psychological health, and we should be using that information to promote good mental health. This is the only way that we will be able to deal with the magnitude of the problems that we have or the challenges that we have. And this is what we mean by a whole-population approach, not just focusing on those who are sick.

One other point about that—we believe that this not only addresses the issues that we're seeing in the pandemic, but it [is] really is consistent with the President's imperative to build back better. I'd like to close by thanking you for this opportunity to speak on behalf of the American Psychological Association. We greatly appreciate your commitment to addressing the issues of health equity.

And if I could just say, on a personal note, this is a really a monumental moment for our country, and the roadmap that you have developed has the potential for enormous impact in the lives of millions of Americans. And I am personally grateful. And I am grateful for our association and for our discipline and profession. And we stand ready to help the Administration implement this roadmap to effectively achieve the goals that you've laid out. Thank you.

*Reva Singh, J.D., American Academy of Physical Medicine and Rehabilitation (AAPM&R)*

Hi there, thank you so much. My name is Reva Singh. I'm the director of advocacy in government affairs with the American Academy of Physical Medicine and Rehabilitation. I want to start off by thanking Dr. Nunez-Smith, the Task Force, and the staff for your diligent work, your recommendations, and today's insightful comments. AAPM&R is grateful for your attention to the massive issue of health equity and dedication to your inclusion.

Today, I'm focusing my comments on the Task Force's Long COVID recommendations. 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 are grateful to the Task Force's work and thoughtful recommendations to address this issue, but there is more work to be done beyond a communications campaign. AAPM&R believes that the most effective way to address the Long COVID crisis and 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 Long COVID presents. That includes healthcare infrastructure, equitable access to care, clinical research, but also the impacts of Long COVID on the economy, accessible education accommodations, workplace accommodations, disability evaluations, and

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many other issues that may arise from an estimated 12 million Americans and counting suffering from Long COVID symptoms.

We believe that this is imperative to ensure there are no gaps in access to care, benefits, or resources. And we believe this recommendation is aligned with the Task Force's work. AAPM&R's multidisciplinary collaborative of physician specialists, researchers, and patients is working to put out consensus guidance statements addressing some of the most commonly appearing symptoms of Long COVID. [A] 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 understand access to care barriers for patients and healthcare infrastructure concerns and gaps. We hope the health equity task force will recommend AAPM&R be considered a resource on Long COVID and include it in any stakeholder advisory group. And we look forward to seeing how the report recommendations are implemented. Thank you so much.

*Averi Pakulis, First Focus on Children*

Yeah, thank you, everyone. My name is Averi Pakulis. I am vice president for early childhood and public health policy at First Focus on Children. And First Focus, for those of you who don't know, is a bipartisan advocacy organization dedicated to making children of families the priority in Federal policy and budget decisions.

And First Focus would really like to thank the COVID-19 Health Equity Task Force, Dr. Nunez-Smith, and all the Task Force members for their work this year to address the inequitable impacts of COVID-19, which we view as being symptomatic of structural racism and historic inequities in our country. And they are felt by children, in addition to adults.

First Focus has worked over the last year and a half to draw attention to the inequitable burdens the pandemic has had on our children. You know many of these statistics, but over 6,000,000 child COVID-19 cases have been reported in the U.S., including 584 child deaths as of this week. All aspects of children's lives have been impacted by the pandemic, and they've carried some of the heaviest burdens throughout this time. And that's via childcare and school closures, over 140,000 children having lost a caregiver, increases in mental health needs, large numbers of homeless families, more children living in poverty, and increasing numbers of children going hungry.

Households with children have been more likely to experience job loss, decline in household income, and the loss of health insurance and other benefits during the pandemic. Children have experienced significant racial inequities through the pandemic as well, just like adults, with the rates of COVID-19 hospitalizations and deaths significantly higher for Black, Latino, and Hispanic children; the overrepresentation of Black and Hispanic youth in detention having

increased even further than prior to the pandemic; and children and ethnic minorities experiencing a disproportionate loss of a caregiver.

We thank the task force for recognizing children in so many of its recommendations to address health inequities, and we encourage the White House to now focus specifically and purposefully on health inequities in children when implementing these recommendations. We support the strong statement you all made to guarantee healthcare for everyone, regardless of immigration status, and to any exceptions made in health coverage based on immigration status significantly and negatively impact children.

We support the expansion and strengthening of Medicaid and the Children's Health Insurance Program, which will benefit children of color and their families. Prioritizing vaccine distribution, testing, and treatment in communities of color and underserved communities, as you all suggest, will also benefit children, as we consider children to be an underserved population.

The COVID-19 pandemic has exposed and exacerbated great needs in behavioral health services, as was just mentioned, for children that must be addressed and are recognized here. And we also appreciate the recognition that homeless youth face significant obstacles and for you including housing supports in recommendations.

We appreciate the attention you paid to the needs of children in cultural settings and those in congregate care and the recognition that early learning settings in schools play an important role in caring for [and] in creating equity for children and their families and their health. The recommendation to provide paid time off for COVID-19 testing, vaccination, and recovery is vital. And we urge the Administration to ensure that this kind of time off also allows caregivers to get their children tested and vaccinated, and for their children to recover, as we recently urged the Department of Labor to do.

And finally, we urge the administration to include people representing the specific needs of children in any pandemic response authority that it creates based on your recommendations. First Focus on Children thanks you again for this important equity work, and we urge you to continue considering the unique needs of children as you move forward toward implementation. Thank you so much.

*Joe Nahra, Powers, Pyles, Sutter, & Verville, PC*

Thank you, Captain Wu. And thank you to the Task Force for the opportunity to comment today. My name is Joe Nahra, and I am one of the coordinators for the Disability and Rehabilitation Research Coalition, or the DRRC. The DRRC is a coalition of more than 25 national research, clinical, and consumer nonprofit organizations committed to improving the science of rehabilitation, disability, and independent living.

The DRRC seeks to leverage the Federal investment in these areas to improve the ability of Americans with disabilities to live and function as independently as possible following an injury, illness, disability, or chronic condition. As you might expect, over the past 2 years the DRRC has



focused on addressing the disparate impact of COVID-19 on the populations we represent, particularly through the lens of research and data.

I'd like to say that we greatly appreciate the Task Force's work over the past year on advancing health equity for underserved populations, including people with disabilities. And I'd like to personally congratulate all the Task Force members on the completion of the final report today. Earlier this year, members of the DRRC Steering Committee had the opportunity to meet with Dr. Nunez-Smith and other representatives from the Task Force and discuss our recommendations for their work. We are so glad to see that many of these concepts are incorporated throughout today's report.

We have particularly appreciated the Task Force's recognition of the importance of robust demographic data collection, including disability status data. As the members of the Task Force well know, demographic data collection is critical, not only to support traditional research endeavors but to better identify and understand disparities and inequities and to develop both and evaluate policy solutions to address the needs of people with disabilities and other underserved populations.

COVID-19 pandemic has laid bare and exacerbated not only the health disparity and inequities that these populations face, but the inadequacies of the current data collection regime. For far too long there has been a lack of reliable information on how people with disabilities are impacted by any number of factors. And these gaps are replicated to varying degrees across other demographic categories as well.

We've also seen that the administration has led the charge in placing a greater focus on equity and social determinants in health policy discussions, which we strongly support. However, too often, disability is omitted or only included as an afterthought despite the inclusion of people with disabilities in the President's Executive Order on advancing racial equity and support for underserved communities. Disability status needs to be explicitly recognized as a mandatory category for demographic data collection across all Federal efforts. We appreciate that the Task Force has recognized this need and hope the recommendations in today's report are taken into consideration by other Federal agencies.

We have a task force and an interagency working group on equitable data. The Administration's commitment to improving and standardizing demographic data is clear, and we look forward to seeing these recommendations implemented throughout the Federal Government. Today's report is an important first step. Policy makers and external stakeholders need to continue working together to ensure that they are appropriately acted upon. The inclusion of the Implementation Plan and Accountability Framework in today's report is crucial to accomplishing this goal. And we thank the Task Force for recognizing this important piece of the report.

Thank you again for all your work over the past year. We look forward to continuing to work with you and your colleagues on these issues. And the DRRC serves as a resource for this Task Force, the Administration, and Congress going forward. Thank you very much.

*Jayne Morgan, M.D., Piedmont Healthcare (comments read by CAPT Wu)*

Hello, my name is Dr. Jayne Morgan. I am a cardiologist and the Executive Director of the COVID Task Force for the Piedmont Healthcare System in the State of Georgia. We are the largest healthcare system here in the State, covering over 70 percent of the geography. I am here today to talk with you about the importance of clinical trials and improved minority enrollment in these clinical trials and the direct correlation to decreasing the gap in health inequities via clinical trials.

Clinical trials offer all the best and our brightest thinking. And yet, African American and other minority groups as well participate at low levels in these trials. The Black of population specifically has a historical context of atrocities committed against their body in the name of the advancement of medicine and science. And so, clinical trials and the research by and large is not a safe place for them to be. And yet, as we grapple with health inequities, we must begin to change the paradigm of that thinking from exploitation to representation.

Clinical trials offer more touchpoints with the medical system. If you are uninsured or underinsured, by and large your medical care is taken care of while you are enrolled in these clinical trials. You have a research coordinator and both a local and regional physician who are looking after you. I posit that you are receiving better healthcare when you are enrolled in a clinical trial.

Additionally, when we look at oncology trials, specifically in cancers where Blacks have the higher incidence, we see that participation in these trials is still low. This is despite oncology trials being the only trials that have shown to increase the rates of remission with the trials themselves and not the subsequently approved therapeutics. And yet, participation remains low.

I would argue that African Americans receive optimal care when seeing their physicians, so are treated to the top level of the approved drugs, but do not receive the maximal care. They do not have access to tomorrow's drugs today. There is—this is largely because they are not approached by a trusted physician and asked about the enrollment into these trials. Eighty percent of African Americans are seen by African American physicians. African American physicians are not recruited as principal investigators of clinical trials. Therefore, since they are not involved in these trials, these crucial and personal conversations with their patients regarding trial enrollment are not had. In closing, I would like to thank Dr. Nunez-Smith for all the work that you have done, not only on this Task Force, but for the United States of America.

*Dr. Melinda Wood, Ph.D., San Jose State University*

Thank you so much. I want to applaud the Health Equity Task Force for their remarkable work and to suggest a possible pathway to help achieve priority number four, invest in a representative healthcare workforce and increase equitable access to quality health for all in a way that will also support recommendations to invest in workers and working families and sustainable funding of the public health workforce and emergency response.

From my perspective as a faculty member teaching undergraduate public health at a majority/minority serving public institution during the pandemic, I saw my very diverse college students in health science lose their poorly paid jobs in retail, food services, and other service sectors. My linguistically and culturally diverse students, many the children of immigrants or immigrants themselves, have so much to offer this country and our public health and healthcare workforce.

The moment seems ripe to me for the Federal Government to invest in a works progress administration–style hiring of community health workers and to pay them a living wage. While these roles can be career destinations for some, such an investment by the Federal Government could also create a ladder for poor and BIPOC young people to get paid clinical and public health experience, thus making them more competitive for professional schools to get their health credentials as health professionals.

I see such an effort of not only creating a pathway for achieving the Task Force’s priority, but also as a way to bring deeply important lived experience and cultural knowledge into the healthcare space that, if done in an inclusive way, could help achieve other health equity recommendations put forth by the Task Force as well. Thank you so much for this wonderful report. And I look forward to seeing the evidence of these outcomes in the years to come. Thank you.

*Angela Meriquez Vasquez, M.S.W., Body Politics*

Hello, Task Force members. Thank you so much for the opportunity to address you today. My name is Angela Vazquez. I am the President of Body Politic. Body Politic is a patient-led organization at the forefront of the Long COVID movement with over 15,000 global patient and caregiving members of our support group and advocacy efforts. We were also the first COVID-19 support group to research and advocate for this serious illness, regarded as the largest mass disabling event in modern history.

Long COVID is a new and highly debilitating multiorgan-impacting illness that’s estimated to affect at least 37 percent of all COVID-19 survivors, regardless of acute illness severity and irrespective of a person’s prior health before their exposure to COVID-19. Due to the serious nature of this chronic illness, we applaud the administration for acknowledging the potential disabling impacts of getting Long COVID with recent announcements acknowledging the disabilities that are the result of a Long COVID patient’s experience. We also applaud Congress for providing \$1.15 billion in funding to the NIH for Long COVID research.

Long COVID has no treatment, no known prognosis, and with over 86.2 percent of surveyed patients reporting being mildly to severely unable to work. Many are battling mental health challenges as a result of the lacking medical and societal support. It’s a crisis that extends far beyond the hospital setting and is one [that] not only the Federal but State and local governments mustn’t overlook.

As others on this commission have said, we must now look ahead to implementation of these efforts, as implementation is where existing inequities calcify. For example, for low-income immigrants and BIPOC communities, their lack of access to high-quality healthcare means they are unlikely to be counted as suffering from Long COVID; unlikely to be counted as disabled; and unlikely to receive work and school accommodations, disability benefits, meaningful treatments, and supportive therapies as they emerge.

If you care about them, you count them. To that end, we absolutely must count Long COVID at the Federal level. Just this week, a preprint paper was released that showed compelling data that vaccines provide no meaningful benefit in prevention of Long COVID in those who get infected. This data is alarming and it is thoroughly disappointing that it has not come from our own public health agency, the CDC.

The CDC does not currently collect any data on Long COVID, nor does it require local or State public health agencies to collect this data. This data collection on breakthrough infections is already woefully inadequate, as it is intentionally restricted to only reporting on hospitalizations, in addition to not tracking patients who are experiencing long-term symptoms, and protracted recoveries. We must remedy this and count Long COVID at the national level immediately.

We also know that electronic health record surveys are inadequate due to the—due to the access issues that I mentioned before from historically marginalized populations. I also wanted to take my last 30 seconds to let you all know how grateful I am for this Task Force intentional engagement with patients such as myself who have Long COVID. I am so grateful to be here and would like to just let you know that what you see here is an outlier.

I am an outlier in the patient experience. I work more than full time. And it is because the exceptional amount of privilege that I have, and a supportive partner at home who has taken on the vast majority of household tasks and caregiving. I have a job that allows me to telecommute and work from home. I don't have to spend my limited energy on a commute or interacting with office members who may or may not be an exposure risk to me getting this infection again.

And so, just really wanted to, again, thank the Task Force but also remind folks that what you see here I, yes, I am a Long COVID patient but I am highly functional and well, well supported and come with a lot of privilege that allows me to speak for you today. And I speak on behalf of those who are too sick to be here, who are bed bound, who have no support system at home who are working and progressively getting worse because they are working because they do not have access to the healthcare disability benefits and work accommodations to not continue to work. And so, again, thank you so much to this Task Force for your intentional engagement of patients. And we look forward to being partners in the work ahead. Thank you.

*Dr. Uzma Syed, Faiths For Vaccines*

Good afternoon, everyone. Thank you so much, Dr. Nunez-Smith. It is my honor to be speaking at the COVID-19 Health Equity Task Force Meeting as a core group member of Faiths for Vaccines. Since the onset of the vaccine distribution, faith communities have outwardly

expressed their willingness and ability to support equitable vaccine distribution, and to increase vaccine acceptance.

In understanding the critical role of faith actors, prominent national faith leaders, and medical professionals convened a roundtable consultation in early February to decide how to best address the gap between the role and capacity of faith leaders and the Biden Administration's goal to vaccinate the U.S. population. It was mutually agreed that this would only be achieved if we utilized trusted locations, such as houses of worship, and trusted messengers.

Faiths for Vaccines is an inclusive multifaith movement comprised of local and national U.S. religious leaders, as well as medical professionals who are working together to identify and resolve current gaps in vaccination, mobilization, outreach, and uptake. We formed a strong collaboration with the Biden Administration. Faiths for Vaccines was honored to partake in a White House webinar on the topic of partnering with community and faith organizations.

We also collaborated with national health groups, such as Association of State and Territorial Health Officials, and the National Association of County Health Officials, as well as many private health entities. Through months of advocacy, we were delighted when pharmacies announced that they would partner directly with local faith communities to bring all vaccination resources directly to houses of worship.

In May, we hosted a national summit which convened faith leaders, medical professionals, and government officials to engage in dialogue to identify and address key issues, areas of vaccine distribution, and acceptance. We also recognized a critical role of youth in supporting vaccination efforts. In June, we held a youth developed and led roundtable discussion. The youth provided an overview of the critical work they are doing in their local communities to ensure vaccine acceptance.

While we have made significant strides, there is still so much untapped potential surrounding the engagement of faith communities and vaccination efforts. In looking to the near future, we continue to support COVID-19 vaccination efforts, but we also intend to use the strong multifaith platform to address other issues, such as health inequity. We are partnering with local faith organizations and multilateral institutions to support global vaccine distribution and advance the role of faith communities in different regions of the world.

We are truly grateful for all of those with whom we have partnered within the past year. And we look forward to continuing our collaboration between the faith community and different levels of society, at both the national and a global level. And I really want to take this time to thank the entire Task Force for all of the hard work that you're doing on behalf of all Americans. Thank you.

*Margie Scott, Patient Advocate*

Good afternoon, I am Marjorie R. Scott and I am honored to speak to you today. I'm an attorney by practice, and political strategist by trade, who is here as a patient advocate for a unique group

of vaccine recipients. Thank you, Health Equity Task Force, for your service. Your work has been paramount. And Dr. Nunez-Smith, while a White House appointment is full of fame and glamour, I can only imagine the sacrifices you've made to serve our country, thank you.

I am a provaccine advocate who received an mRNA vaccine. Within days of my second shot, I experienced several unanticipated symptoms, which I now know are vaccine-related. First, I experienced extreme blurry vision, followed by tremors, loss of mobility, and difficulty breathing. After seeing an ophthalmologist, I then experienced rapidly decreasing mobility. I ended up in urgent care, was then referred to a hospital, and finally to different medical specialists.

My symptoms were questioned with dubious overtones, even though I had visible physical limitations. I was unable to perform my—I was unable to function in a normal capacity. I missed work. I was unable to take care of my most basic activities of daily living. And the out-of-pocket medical expenses destabilized by family's income and finances. But for the grace of God, my support system stood in the gap and covered me with grace.

Before taking the vaccine, I researched, I read, and studied in order to make the best, most informed decision about my vaccine selection. Now, I am—now, I am left as a recently married 35-year-old lawyer wondering if my aspiration to become a mother has been compromised. This is not because of my decision to be vaccinated but, rather, not knowing what potential side effects I might experience. The unintended consequences of the vaccine have left me afraid. Even when I seek answers about my health, the data and information either does not exist or is not public.

I am left with the impression that we are making this up as we go along. If I, as a lawyer, am having difficulties finding answers, what about the essential workers who are affected like me feeling, experiencing, and thinking? I'm not talking about long-haulers syndrome. I'm talking about being a healthy 35-year-old practicing attorney who was never COVID-19 positive. I campaigned to get American vaccinated. I did what I was supposed to do.

I have experienced pain and incapacitation. I've had my integrity questioned. And I am still managing health issues while feeling abandoned. We are suffering in silence with no help, no resources, or guidance to manage our health. Now, I need America to do something for me and the others who did the right thing but ended up in this unique population.

My first ask is that the vaccine—is that vaccine informed consent with true disclosures be provided prior to administration of the shot. Secondly, resources be made available for individuals like me who've experienced adverse reactions to COVID-19 vaccines. Again, thank you for the opportunity to be here.

*Dr. Cheryl Grills, Loyola Marymount University*

Thank you. I am Dr. Cheryl Grills, Loyola Marymount University, speaking today on behalf of the National Urban League, and the Alliance of National Psychological Associations for Racial



and Ethnic Equity. This includes the Asian, Black, indigenous, and Latinx Psychological Associations, and the APA.

Thank you for this opportunity to express appreciation to the chair and the Task Force for your valiant efforts in this important work. Based on the findings from our national COVID-19 Impact on Communities of Color Study with over 25,000 respondents, we respectfully offer additional considerations to maximize effective implementation of your recommendations for various racial and ethnic groups.

With respect to increasing data collection and reporting for high-risk groups, we implore you to, one, ensure that this data collection disaggregates data on Asian-American, Native Hawaiian, and Pacific Island Americans by national origin and language. Further, the CDC's COVID-19 surveillance system currently depends on reporting from local and State health agencies that represent an inconsistent patchwork of data collection and reporting practices. The lack of uniformity and representation presents serious challenges to accurately determining the depth of COVID's impact.

Second, ensure that data collection and research efforts require partnership with community organizations. Third, directly fund community-based organizations to build infrastructures to conduct community engaged research to ensure research and data are from a community-centered and community-driven lens. Fourth, fund and direct the National Academy of Sciences, Division of Behavioral and Social Sciences and Education Committee on Populations to conduct five consensus panels. An Asian, Black, Latinx, indigenous, and fifth Native Hawaiian and Pacific Island American panel. Reports on three of these groups have been conducted in the past, but they are dated. No previous reports have been conducted for Asian Americans and Native Hawaiians and Pacific Islanders.

With respect to expanding clinical, public health, and community-based organization workforce, among others, we recommend, one, a moratorium on restricting mental health services to evidence-based practices only. They limit services that resonate with the community and its culture, context, and history. Secondly, funding for informal support networks is necessary to provide community-initiated and -led peer education and support services that increase access and culturally responsive mental health and prevention early intervention services.

With respect to strengthening the social service safety net to address unmet basic needs, please consider, one, extending benefits and eligibility through the agriculture appropriations process to include a Tribal set aside for SNAP, special supplemental nutrition programs for WIC to increase participation and improve benefits for Tribes and communities of color. Second, engage community-based organizations with a track record of serving communities of color to help identify the educational and mental health needs of students and to deploy resources to them.

Third, galvanize relationships between community, local farmers, and small business owners to provide culturally appropriate and appealing produce options, and support people of color-owned businesses in this process. And this is in response to the high rates of food insecurity found in our survey. Fourth, develop new discretionary grant opportunities to support Tribal and

urban native programs to design and test demonstration projects using community-driven solutions. And this is also relevant for other communities of color.

And fifth, increase benefits to the current Native American Housing Programs, and the Tribal HUD-VASH Program for rental assistance for Native American veterans that are homeless or at risk of homelessness. We have far—quite a few more recommendations. Time does not permit me to share them, but I will provide a written summary with the additional recommendations. Thank you and congratulations on the completion of your work.

*Dr. Ruby Long, B3 Equity Helix*

Thank you so much. I am a board-certified emergency medicine physician, and I am honored to represent the B3 Equity Helix. We are a cohort of Black women with expertise in health law research, substance use disorder, behavior health, and community engagement. Our focus is to address health inequities and disparities in BIPOC communities.

Thank you, Dr. Nunez-Smith. Your leadership of the Health Equity Task Force has been powerful and assuring, so assuring to have you at the helm of this endeavor. Task Force, thank you all for embracing the challenge of President Biden’s Executive Order. Our Constitution reads that, “All men are created equal.” Unfortunately, vaccine hesitancy is not.

American is not a homogenous society. Each culture and socioeconomic group are living with vaccination and COVID-19 in their own way. The truth of this must be considered when establishing health-related policies and procedures. Without consideration of these cultural nuances, marginalized communities will continue to experience increased conflict [and] distress while trying to navigate standards that don’t take their perspectives into account.

The pandemic has been an accelerator of inequities imbedded within the healthcare system. B3 Equity Helix considers that policy now practiced to continue to allow barriers to exist, and we make the following five recommendations. Shortages of monoclonal antibodies are killing people; access to this resource is a major barrier. Two, Long COVID is impacting GDP, robbing our citizens of their productivity, quality of life, and action must be taken to mitigate excess disease burden.

Three, informed consent with true disclosure of side effects, neurologic syndromes, and allergic reaction must be provided before vaccination; and a public avenue for clinical and legal recourse must be provided beyond documentation of VAERS. Our healthcare system—the infrastructure is fragile. Providers have left and are leaving. It is in a critical state. And to address these long-term consequences, we must be proactive in managing additional stressors.

The colliding pandemics of COVID-19 and social determinants of health have stifled routine health maintenance, making all healthcare all the more challenging. The pandemic is not over. And before the holidays, strong messaging is essential to mitigate a resurgence. And at the heart of the matter, when we sit down with our loved ones during this holiday season, we want them to be their best physically, mentally, and emotionally. Removing barriers to access to equitable care

is a first huge step in achieving health outcomes and achieving the promise of health equity. Thank you so much.

### **Vote on Deliverables**

Dr. Nunez-Smith introduced the voting phase for HETF members to vote on the following deliverables:

1. Final Report and Recommendations
2. Proposed Implementation Plan and Accountability Framework

Each item received a motion to approve that was seconded. Each motion carried with a majority vote to approve.

### **Closing Remarks and Next Steps**

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

Dr. Nunez-Smith took a moment to recognize the incredible amount of dedication, work, commitment, passion and how she would not want to be on this march with anybody else. She thanked everyone who helped to stand up the meeting, including the ASL interpreters. As the report, proposed implementation plan, and accountability framework have been approved, it is time to turn these words into action. There are so many people and communities who have brought innovation to this space and figured out ways to be protective and supportive and have inspired us and our work. We are calling now for the support and resources needed to continue to make these communities strong.

Dr. Nunez-Smith emphasized that it is a core belief of the HETF that communities are expert in knowing what is needed to advance health equity, and we can no longer allow them to shoulder that burden alone. We have to give back through sustained investment, community-led solutions and a commitment to equity-driven decision making across all sectors. Equity never happens by default; it always takes intentionality. We have the power to make it to the other side of the pandemic, but we have to stay the course and accelerate the journey toward health equity.

CAPT Wu gave a shoutout to Dr. Minh Wendt for covering while he was deployed and thanked everyone for the opportunity to work with the Task Force.

Dr. Nunez-Smith adjourned the meeting.

## Appendix A. Written Public Comments



November 1, 2021

Dr. Marcella Nunez-Smith  
Chair  
COVID-19 Health Equity Task Force  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Dr. Nunez-Smith:

Thank you for the leadership that you and the Biden Administration have shown in bringing health equity into the national dialogue. Your integration of the federal response to the COVID-19 pandemic with awareness and response to issues that face communities like South Los Angeles is key to our work going forward.

For too long, our nation has offered separate and unequal systems of health care. Extensive research and data analysis underscore the same conclusion: people of color in the United States are more likely to experience healthcare access and quality challenges and, as a result, worse health outcomes.

The COVID-19 pandemic has provided an unprecedented opportunity to see the impact of these disparities. Communities of color were – and continue to be – disproportionately impacted by the COVID-19 pandemic. This is the outcome of a health care system that fails to meet the needs of Americans on an equal basis. Without change, the outcome will be the same in the next pandemic.

The COVID-19 Health Equity Task Force has brought badly needed federal focus to the disparities plaguing our nation's health care system. Its recommendations acknowledge how federal policy affects systemic inequalities in the health care system and are an important step forward. Investment and action are now critical.

I am greatly encouraged by recommendations the COVID-19 Health Equity Task Force has put forward that include cost-based reimbursement and acknowledge the crux of the challenge before us.

Dr. Marcella Nunez-Smith  
Page 2

The recommendation related to developing long-term solutions that put providers serving underserved populations in a position to deliver “equity-centered quality care” is particularly critical—it calls out the need for provider payment models that are designed to create equitable health outcomes for patients, regardless of their insurance. In California, a state that ranks third lowest in the nation for Medicaid provider reimbursement, providers are paid .48/\$1.00 for the cost of providing care. Equitable health outcomes are simply not possible within this model.

The task force recommendations can provide the foundation for badly needed investments in those who care for the nation’s Medicaid beneficiaries—providers like MLK Community Healthcare in South Los Angeles—and support those providers in offering the kind of care all communities deserve. Change is not possible without elimination of the disparate payment system that disadvantages the poor. Health equity cannot be achieved without addressing payment disparities.

In the hospital, outpatient practice sites and programs of MLK Community Healthcare, we take pride in bringing care to a chronically underserved community. Our residents of Watts and Compton, Lynwood and Southgate are all people of color. Our patients rely heavily on the safety net, with 80% insured through Medicaid or uninsured.

Our mission is to provide quality care for our patients and, importantly, to improve the health of our community. We started a nonprofit, multi-specialty medical group in 2016 with the goal of creating an integrated system of care. Improving health outcomes requires this work – but poor Medicaid reimbursement undermines and, over time, fatally limits it.

Recommendations are an initial step. Implementation of the recommendations is critical—and will no doubt be challenging. Please consider us an ally and invested stakeholder in this work.

Sincerely,



Elaine Batchlor, MD, MPH  
Chief Executive Officer  
Martin Luther King Community Healthcare  
Martin Luther King, Jr. Community Hospital

1680 E. 120th Street, Los Angeles, CA 90059 | mlkch.org





November 1, 2021

Dr. Marcella Nunez-Smith  
Chair, COVID-19 Health Equity Task Force  
Office of Minority Health  
U.S. Department of Health and Human Services

**Re: Disability and Rehabilitation Research Coalition Comments on Final Health Equity Task Force Report and Recommendations**

On behalf of the Disability and Rehabilitation Research Coalition (DRRC), we thank the COVID-19 Health Equity Task Force for its work over the past ten months and for the opportunity to comment on the Task Force’s final report and recommendations. We greatly appreciate the Task Force’s efforts to advance health equity for underserved populations, including people with disabilities, and congratulate the members of the Task Force on the completion of the final report.

The DRRC is a coalition of more than 25 national research, clinical, and consumer non-profit organizations committed to improving the science of rehabilitation, disability, and independent living. The DRRC seeks to maximize the return on the federal investment in these areas with the goal of improving the ability of Americans with disabilities to live and function as independently as possible following an injury, illness, disability, or chronic condition. The coalition plays a leadership role in coordinating the activities of stakeholders to increase and leverage federal resources devoted to research and development in these domains.

Earlier this year, members of the DRRC Steering Committee had the opportunity to meet with Dr. Nunez-Smith and other representatives from the Task Force and discuss recommendations for the Task Force’s mission from a disability perspective. We are glad to see that many of these concepts are incorporated throughout the final report. In particular, we appreciate the Task Force’s recognition of the importance of robust demographic data collection, especially disability status data.

As the members of the Task Force well know, demographic data collection is critical to advancing equity, not only to support traditional research endeavors, but to better identify and understand the disparities and inequities faced by people with disabilities and underserved populations. Furthermore, accurate and comprehensive data, disaggregated by disability status and other demographic factors, allows policymakers and other stakeholders to more appropriately develop and evaluate policy solutions addressing the needs of people with disabilities and other underserved populations.

The COVID-19 pandemic has laid bare and, in many cases, exacerbated not only the health disparities and inequities that these populations face, but the inadequacies of the current data

1501 M Street NW, 7<sup>th</sup> Floor • Washington, DC 20005 • [www.drcc-coalition.org](http://www.drcc-coalition.org) • 202-466-6550



collection regime at the federal, state, and local levels. For too long, there has been a lack of reliable information on how people with disabilities are impacted by any number of factors. During the pandemic in particular, it has been incredibly difficult to accurately gauge the extent to which people with disabilities are facing disproportionately higher risks of COVID-19 exposure, infection, serious and life-threatening symptoms, hospitalization, and death. The gaps in disability data collection are replicated to varying degrees across other demographic categories as well. It is also critical to understand the intersectionality of race, age, disability, geography, chronic illness, and other identities; without improved data collection including disability status, the impact of these intersections will remain opaque.

We have also seen that the Biden Administration has led the charge in placing a greater focus on equity and social determinants in health policy discussions, which we strongly support. The President's Executive Order 13985 made it a goal across the federal government to advance equity and support for underserved communities, including people with disabilities. We fully support the recognition that the government's goal in advancing equity is "to provide everyone with the opportunity to reach their full potential," and recognize that the Task Force's recommendations are essential to carrying out this charge. This Order also established an Interagency Working Group on Equitable Data. We believe that that mandating and standardizing the collection of disability status data along with other demographic data regarding the COVID-19 pandemic and public health efforts more broadly would be an important first step towards fulfilling the mission of this Executive Order.

Unfortunately, we have seen that too often disability communities are omitted from these discussions or only included as an afterthought, despite the inclusion of people with disabilities in the Executive Order. Disability status must be explicitly recognized as a mandatory category for demographic data collection across all federal efforts. We thank the Task Force for recognizing this need and hope the recommendations in today's report are taken into consideration by other federal agencies.

Between the Task Force's report and the ongoing work of the Interagency Working Group on Equitable Data, the Administration's commitment to improving and standardizing demographic data is clear, and we look forward to seeing these recommendations implemented throughout the federal government. Today's report is an important first step, but policymakers and external stakeholders need to continue working together to ensure they are appropriately acted upon. The inclusion of the Implementation Plan and Accountability Framework in the report is crucial to accomplishing this goal, and we look forward to working with your colleagues across the Administration and Congress to help ensure these recommendations are implemented.

\*\*\*\*\*

We greatly appreciate your consideration of our comments and our recommendations as the Task Force conducted its work. The DRRC stands ready to serve as a resource for the members of the Task Force and the rest of the Biden Administration to answer any questions that may arise and provide technical expertise on behalf of the field as the implementation process for the Task Force's recommendations unfolds. If we can be of any further assistance, please do not hesitate

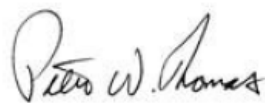
to contact the DRRC coordinators, Peter Thomas, Joe Nahra, and Bobby Silverstein, at 202-466-6550 or by email at [Peter.Thomas@PowersLaw.com](mailto:Peter.Thomas@PowersLaw.com), [Joseph.Nahra@PowersLaw.com](mailto:Joseph.Nahra@PowersLaw.com), and [Bobby.Silverstein@PowersLaw.com](mailto:Bobby.Silverstein@PowersLaw.com).

Sincerely,

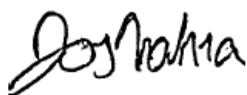
**The Disability and Rehabilitation Research Coalition (DRRC)**



Bobby Silverstein, DRRC Coordinator  
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**From:** Melissa Lynch Long Covid Kids USA Global Ambassador <lckusa2021@gmail.com>  
**Sent:** Friday, October 22, 2021 12:23 PM  
**To:** COVID-19 Health Equity Task Force (OS/OASH) <COVID19HETF@hhs.gov>  
**Subject:** Submission of Public Comment

First Thank you all for what you do, and for this opportunity to speak on behalf of Children with Long Covid and their families.

My name is Melissa Lynch, I'm the Lead Representative for The United States of America for the International Charity Long Covid Kids and a Mother of a 12yo daughter 13mo Long Covid (DX 10/1/20).

Within the United States alone, we represent within our Private Parent Support Group close to 600 Long Covid Kids and their Families, 1,850 across all social media networks & Globally between all countries, we support a little over 29,500 across all social media networks. Many as you know, 11y and under, rely solely upon mitigations to provide protection. 12yo to 17yo are the lowest percentage within the United States fully vaccinated. The AAP quoted 6 million children have tested positive since the pandemic began and that number is growing rapidly. According to the CloCK study out of UK published 08/26/21 in BMJ found 1 in 7 children will contract Long Covid and continue with Symptoms past 15w. So, I would hardly consider this disease a "rarity in children". This is not even including MIS-C.

What we need?

\*Expanded Medicaid in all states, w/o the refusal of pre-existing or denial of coverage for PASC and Sars-Cov-2 related services. The ICD-10 codes are released now to bill and DSS qualifications for assistance are outdated.

\*Funding for additional research for PASC in the Pediatric population, along with guidelines, databases like CDC has for MIS-C, and for ALL states, counties and communities to report 0-21 on diagnosed PASC, Sars-Cov-2 case positivity, ethnicity, hospitalization, PICU, and mortality rates. You Cannot make accurate decisions on vaccination percentages, mitigations, schools, etc... if the data is not being revealed.

\*Updates to all DOE/ DPI on the medical affects of PASC needed to assess properly for accommodations within schools. Education on PICU levels and how Diversion works also.

\*Reformation of Special Education. Let's face the facts, the system is set up no matter what disability a child has for the parent to fail. Much less the struggle of a new, little known disease. With additional resources for parents to learn parent rights, obtain a parent Advocate, or legal representation when needed.

\*Funding allocated for Covid-19 in schools, must be only for schools and not to be redirected for example, to infrastructure.

Lastly, this is a multi-faceted problem with disparity intertwined. We must reach all children to support with Medical care, mitigations, resources for they are in the "Time of Their Lives", they are impressionable, learning sponges. They should not have to worry about health, education, discrimination, or if mom and dad need to not pay the light bill or obtain them care.

Thank you,

Melissa Lynch  
Representative for United States  
Long Covid Kids Charity #119617  
Long Covid Kids USA  
[lckusa2021@gmail.com](mailto:lckusa2021@gmail.com)  
704-240-2436

[www.longcovidkids.org](http://www.longcovidkids.org)

@MomOfLongCovKid @LckUsa



October 28, 2021

Dear Chairwoman Dr. Nunez-Smith,

On behalf of the National Rural Health Association, I want to express our sincere gratitude to you and the members of the Biden-Harris COVID-19 Health Equity Task Force for your work on identifying and eliminating health and social disparities related to COVID-19.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care infrastructure, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through advocacy, communications, education, and research.

Nationwide, but particularly in rural America, the COVID-19 pandemic ravaged communities. Rural residents bore a disproportionate burden from the pandemic, most notably in terms of per capita case and death rates. We know that the pandemic will have long-lasting effects on overall health and well-being for rural residents. NRHA supports the Task Force's vision for achieving investments related to a data ecosystem, empowering community-led solutions, developing a representative health care workforce, and increasing equitable access to health for all.

NRHA celebrates the important recommendations the Task Force has prepared for the White House to improve COVID-19 health equity. In particular, we applaud the swiftness of your efforts, preparing thoughtful, impactful recommendations in less than one year. The Task Force's final report lifts up efforts that will mitigate health inequities caused or exacerbated by the COVID-19 pandemic and prevent such inequities in future pandemics in rural communities, including:

- Increasing affordable access to broadband, as functional broadband is critical to health and economies in rural areas and critical to the success of telehealth for rural residents.
- Standardizing demographic and socioeconomic categories in data and support equity-centered data collection, especially that which is inclusive of geographic disparity.
- Investing in a diverse rural workforce, acknowledging the importance of a workforce reflective of the population it serves, to ensure equitable health care access.

We understand that addressing the challenges resulting from the COVID-19 pandemic and preparing for future pandemics will require a multifaceted, all-of-government approach. NRHA looks forward to working with the Biden-Harris Administration to assist rural parts of our country with implementing these solutions.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", is written over a light blue horizontal line.

Alan Morgan  
Chief Executive Officer  
National Rural Health Association

**RuralHealthWeb.org**

50 F. St., N.W. Suite 520

Washington, DC 20001 | 202 639 0550



November 4, 2021

Dr. Marcella Nunez-Smith  
Chair of the COVID-19 Health Equity Task Force  
Office of Minority Health  
U.S. Department of Health and Human Services

Re: Response to final recommendations and priorities of the COVID-19 Health Equity Task Force

Dear Chair Nunez-Smith,

The Center for American Progress (CAP) is an independent non-partisan think tank committed to conducting evidence-based research and advocating for the advancement of health equity for underserved communities. We recognize the COVID-19 Health Equity Task Force's ("the Task Force") commitment to advancing equitable health in response to the pandemic and appreciate its dedication to engaging directly with a wide range of community stakeholders throughout its tenure. We support the Task Force's five suggested priority actions for the Biden-Harris Administration and four overarching outcomes aimed at disrupting the predictable pattern of which communities are harmed first and harmed worst during times of national crisis. While the Task Force generated a wide range of recommendations, our comment today is limited in its focus on a few select priorities that fall under the umbrella of its four outcome statements.

## 1. Everyone will have equitable access to high-quality health care

The pandemic has had a disproportionate impact on the physical and mental health of Black, Latinx, Indigenous and LGBTQ+ people, and people with disabilities. CAP supports the Task Force's recommendations for increasing coverage and reimbursement for health and well-being services, including investment in and access to comprehensive and equity-centered long COVID care; behavioral health interventions, treatment, and recovery support; telehealth services; and home and community-based services to support disabled and elderly individuals with in-home services, enabling them to stay healthy in their homes.

Embedding equity in health care payment and delivery approaches, regulations, and demonstrations; eligibility and enrollment systems; health care research; and public health infrastructure development will advance equity in federal policies, programs, services, processes, and operations. An additional important step to promote equitable access to care for underserved communities is to restore and enforce nondiscrimination protections - including those based on sexual orientation and gender identity - among service providers, grantees, and contractors that receive federal funding through the U.S. Department of Health and Human Services.



During the COVID-19 pandemic, decades of chronic underfunding of public health systems became apparent in critical activities, including disease surveillance, contact tracing, vaccine delivery, and communications. COVID-19 emergency funding, critical to the pandemic response, does not compensate for this chronic underinvestment. All efforts to address the ongoing pandemic and create sustainable systems that ensure preparedness for future and emerging health threats must prioritize advancing health equity, and provide adequate funding for research to promote innovation, development of the public health data infrastructure, and capacity building for public health staff.

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

To support equity-centered data collection, it is essential to invest in improving data collection and disaggregation by a core set of standardized socioeconomic and demographic characteristics, including race and ethnicity and sexual orientation and gender identity (SOGI). Collecting and reporting these disaggregated data, including identification beyond broad race categories, will provide researchers and policymakers with the tools to better understand the experiences of LGBTQ+ people, including LGBTQ+ people with disabilities, people of color, and transgender individuals. These data are crucial to inform evidence-based decision-making necessary for an equity-centered response to the pandemic; to address health disparities that predate the pandemic but that have also been exacerbated by it; and to eliminate structural barriers and discrimination in our health care systems. Uniform collection standards would improve disease surveillance, understanding of the impact of health conditions and interventions for various subpopulations, and data sharing between various health and social services providers to enhance equity-centered care and service coordination.

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

Our policy landscape, and the processes and practices that flow from it, creates the conditions that lead to good or bad health. Addressing social determinants of health such as income, education, housing, employment, transportation, and neighborhood conditions improves health, reduces disparities, and creates more accessible, affordable, and equitable systems. An intentional focus on social and structural determinants of health, structural and institutional racism and discrimination, and access to high quality health care is critical to eliminating disparities in health outcomes. This requires strategic financial investment in social supports, alongside investments in health coverage and public health. Improving the social conditions in which people live not only improves health outcomes through upstream prevention, but also facilitates access to needed health care services. Together, these interventions advance health equity.

Alignment of eligibility and benefit policy across federal health, nutrition, housing, and social support programs that address these social determinants would ensure that people are connected to the full range

of assistance needed to improve health. This includes sustaining authorities linked to the public health emergency that provided pathways for streamlining eligibility and enrollment processes.

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

Health care programs should employ patient-centered practices and cultural humility models to advance health equity. It is crucial that public health and other government institutions partner with, and take actions informed by, the expertise of underserved communities. Communication strategies to raise awareness and share evidence-based public health information should include culturally and linguistically responsive materials and be delivered by trusted community-based messengers to address concerns and dispel mistrust rooted in historical and ongoing mistreatment and abuse in health care settings.

Increased and targeted resources, services, funding, outreach, and collaboration with community-based organizations representing underserved communities hit hardest by COVID-19 exposure, illness, and death, and with communities that are most vulnerable and historically disadvantaged, will be vital to fostering more inclusive public health emergency and pandemic preparedness, response, and recovery activities.

Last, we support the recommendation to establish a federal authority for coordinating, funding, researching, communicating, and centering equity in the response to COVID-19 and emerging threats.

We believe adopting these recommendations is crucial for the Biden-Harris administration to fulfill the aims of Executive Order 13995, *Ensuring an Equitable Pandemic Response and Recovery*, mitigate inequities resulting from and amplified by the COVID-19 pandemic, and prevent such inequities in the future.

Thank you for your consideration. Please do not hesitate to contact Jill Rosenthal at [jrosenthal@americanprogress.org](mailto:jrosenthal@americanprogress.org) if you need any additional information.

Sincerely,

*Nicole Lee Ndumele*

Nicole Lee Ndumele  
Senior Vice President, Rights and Justice  
Center for American Progress

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**Sent:** Tuesday, November 2, 2021 7:07 PM  
**To:** COVID-19 Health Equity Task Force (OS/OASH) <COVID19HETF@hhs.gov>  
**Cc:** krista.drobac@connectwithcare.org  
**Subject:** Public Comment on Telehealth Recommendation

Good evening,

On behalf of the Alliance for Connected Care and its members, I write to first thank the COVID-19 Health Equity Task Force for its tremendous work over the last few months to develop recommendations to mitigate the inequities caused or exacerbated by COVID-19 to ensure an equitable response to the current pandemic and future public health emergencies.

The [Alliance for Connected Care](#) (the Alliance) is an advocacy organization dedicated to facilitating the delivery of high-quality care using connected care technology. Our members are leading health care and technology companies from across the spectrum, representing health systems, health payers, and technology innovators. The Alliance works in partnership with an Advisory Board of 40 patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth.

In tuning in to the last meeting of the Task Force on October 28, it was noted that the final day to provide public comment is November 4. As such, we write today in regard to the telehealth recommendation put forward in the [final slate of recommendations](#) (on page 22) developed by the Task Force. Below, we offer feedback on the language used in the recommendation for your consideration.

The definition of ‘unavailable’ used in the recommendation could mean many things and has potential to be overly burdensome to prove and/or document. Our members are finding that either for patient preference or clinical acuity, telehealth services delivered via telephone can be very sufficient for some visits. For example, while the majority of virtual visits at Stanford Health Care are delivered using video (phone represents <2% of total ambulatory visits), telephone remains an important and clinically appropriate access point for Stanford Health Care patients. Additionally, the percentage of visits conducted via phone is much higher for FQHCs and community providers. As another example, telehealth services delivered via audio-only care represent 18% of total scheduled video visit care across Johns Hopkins Medicine, but use of audio-only care is not distributed equally, nor has changes in audio-only care evolved equally over the course of the pandemic. Please see Figure 1 below for more data on this, with the top half of the chart showing Johns Hopkins Medicine total telehealth services delivered via audio-only and the bottom health showing telehealth services delivered via audio-only for mental health only.

The feedback our members receive from clinicians and patients is that telehealth services don’t always *have to* be delivered via video. Regulators should leave the decision on the most appropriate modality for that visit to the provider and the patient. As such, we recommend the following change to the telehealth-specific recommendation, originally put forward by the Healthcare Access and Quality Subcommittee, in the final slate of recommendations:

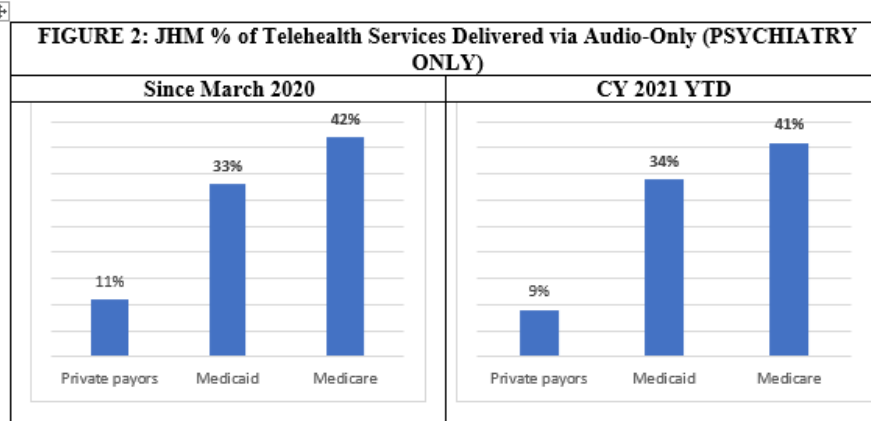
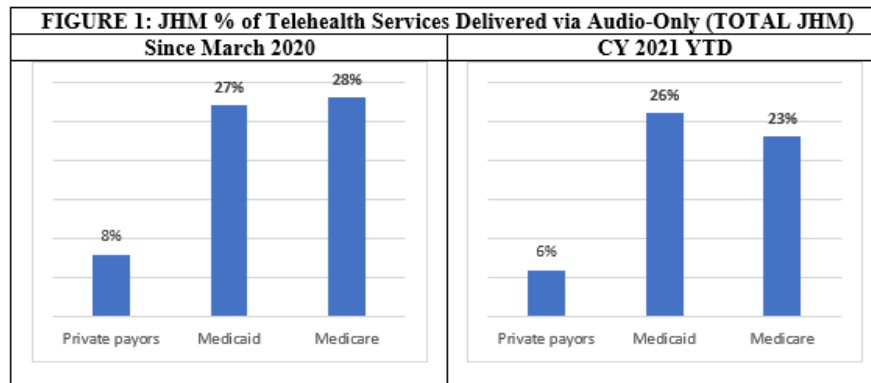
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**“Expand Telehealth & Telemedicine Access and Reimbursement** – Expand access and reimbursement for telehealth & telemedicine, including telephone visits when effective video-based telehealth & telemedicine is unavailable, to reduce barriers to access for appropriate health services due to loss of wages, stigma, trauma, and safety during a pandemic.”

For further consideration, the CMS Calendar Year 2022 Medicare Physician Fee Schedule [proposed rule](#) contained language (on page 45 of the linked PDF) that our members see as relatively good language that creates flexibility for providers and patients to choose the appropriate modality for a visit: “We are also proposing to limit payment for audio-only services to services furnished by physicians or practitioners who have the capacity to furnish two-way, audio/video telehealth services but are providing the mental health services via audio-only communication technology in an instance **where the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology.**”

We are happy to discuss this information further should you have any questions, and are happy to serve as a resource to you and the Biden-Harris Administration on this effort. Thank you in advance for your consideration. We look forward to viewing the final report, implementation plan, and accountability framework once available.

Many thanks,  
Casey Osgood



**Casey Osgood**

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