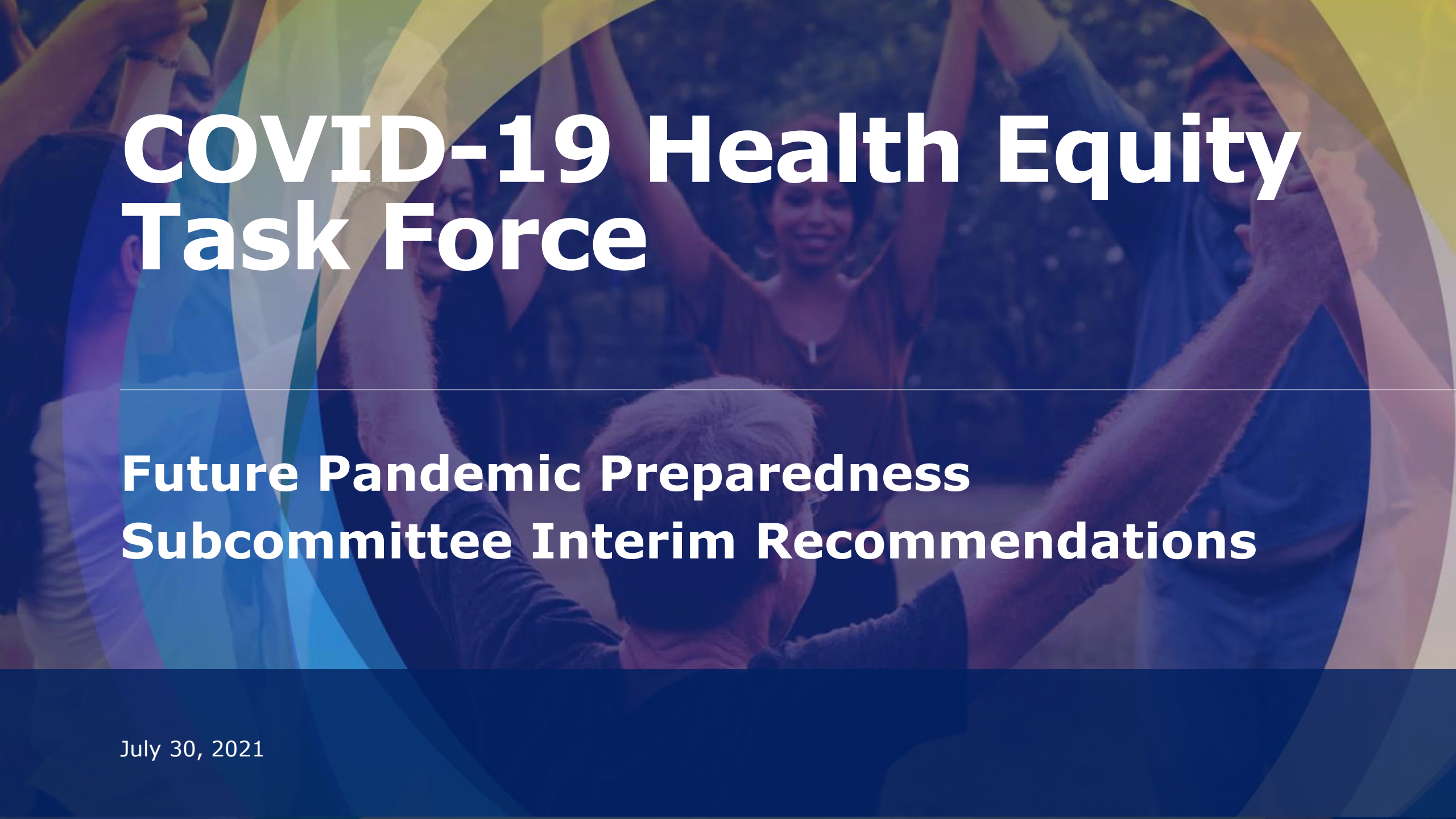

COVID-19 Health Equity Task Force

Future Pandemic Preparedness Subcommittee Interim Recommendations

July 30, 2021

Subcommittees and Task Force mission

This Task Force under the Executive Order ---- is responsible to make recommendations for mitigating the health inequities caused or exacerbated by the COVID–19 pandemic and for preventing such inequities in the future.

The four sub-subcommittees work intensely and effectively to provide:

A. Recommendations for how agencies and State, local, Tribal, and territorial officials can **best allocate COVID–19 resources**, in light of disproportionately high rates of COVID–19 infection, hospitalization, and mortality in certain communities and disparities in COVID–19 outcomes by race, ethnicity, and other factors, to the extent permitted by law;

B. Recommendations for agencies with responsibility for disbursing COVID–19 relief funding regarding **how to disburse funds in a manner that advances equity**; and

C. Recommendations for agencies regarding **effective, culturally aligned communication, messaging, and outreach to communities of color and other underserved populations** - In addition to addressing equity data shortfalls.

Thank you to our SMEs for engaging with the Task Force on Long COVID, PPE, Testing and Therapeutics!

Name	Institution
Jonetta J. Mpofu, PhD, MPH	Centers for Disease Control and Prevention (CDC)
Nikki Bratcher-Bowman	Assistant Secretary for Preparedness and Response (ASPR)
Matthew Payne, MPA	Assistant Secretary for Preparedness and Response (FEMA)
Kevin Bugin, PhD, MS	Food and Drug Administration (FDA)
Tracey D. Brown, MBA	American Diabetes Association (ADA)
Robert L. Trestman, PhD, MD	American Psychiatric Association (APP)
Joelle N Simpson, MD, MPH	American Academy of Pediatrics (AAP)
Timothy W. Farrell, MD, AGSF	American Geriatrics Society (AGS)
Maria Town	American Association of People with Disabilities (AAPD)
Mary Owen, MD	Association of American Indian Physicians (AAIP)
Scott Nass, MD, MPA, FAAFP, AAHIVS, Hector Vargas, JD	GLMA: Health Professionals Advancing LGBTQ Equality
Winston Wong, MD, MS, FAAFP	National Council of Asian Pacific Islander Physicians (NCAPIP)
Elena Rios, MD	National Hispanic Medical Association (NHMA)
Rachel Villanueva, MD FACOG	National Medical Association (NMA)

Interim Recommendations by Theme (1 of 4)

Incentivizing equity through data-and community-driven approaches to better prepare for future pandemics

- Incentivize equity in healthcare systems by encouraging data- and community-driven approaches focused on decreasing distrust in the healthcare system for marginalized, minoritized, and medically underserved communities.
- Create standardized expectations around disaggregated data collection and include incentives to collect and report disaggregated data.
- Develop and issue research grants focused on equity-related interventions that have been used in previous public health emergencies and grants
- Incentivize novel partnerships and data use (including administrative data) to better reflect these groups and address equity in preparedness.
- Practice, and incentivize healthcare companies to practice, bidirectionally engaging patients and community members, across race, gender, and cultural differences as equal partners in the work to develop appropriate sociodemographic and social-needs products and solutions.
- Assess opportunities to use data to close equity gaps in special pathogens care delivery.

Interim Recommendations by Theme (2 of 4)

Expand and diversify the healthcare workforce pipeline to address shortages and improve equitable treatment during pandemics

- Expand federally funded National Public Health Corps to address healthcare worker shortages. Prioritize training and hiring of members of vulnerable communities.
- Explore strategies that meet local and regional staffing needs during pandemic response to rapidly expedite staffing reinforcement and cross-training in areas with chronic health workforce shortages.
- Expand access to entry level and other positions with 2 years or less training programs for licensed and certified positions in healthcare while also maintaining quality of care in order to combat the shortage of healthcare workers and to increase the number of licensed health professionals from underrepresented populations.
- Dramatically increase funding for education in medical fields, graduate medical education, and first responders, to train future medical professionals from local, underrepresented, and first-generation populations from minoritized and underrepresented communities.
- Increase the amount of racial, ethnic, and disability data on the healthcare workforce and educational pipeline, across healthcare professions, and centralize it in an easy-to-access and financially-maintained database.
- Fund the National Health Care Workforce Commission to provide data on the healthcare workforce, train healthcare workers, and provide policy advice and recommendations to both Congress and the administration.
- Provide guidance to public health agencies on the collaboration between government and non-governmental entities that have stronger relationships with minoritized, marginalized and medically underserved communities, and work to build a pipeline for talent of individuals that come from these communities.

Interim Recommendations by Theme (3 of 4)

Encouraging science-based, evidence-based solutions

- Invest in evidence-based solutions, such as telemedicine and interdisciplinary approaches that expand telehealth specialist access to primary care, behavioral health, and specialty care services that combine in-person and virtual care for patients.
- Identify and establish partnerships with state and local policy organizations affiliated with other populations of focus to develop evidence-based strategies for reducing frontline and essential workers' exposure to the virus that causes COVID-19.
- Appoint an independent, Blue Ribbon panel to conduct a COVID-19 pandemic after-action analysis for the whole of government.
- Ensure equal representation and equal number of votes where relevant in government-led infectious disease guideline development

Mandate Standardized, Equitable, Data Collection through Research, Analysis & Reporting

- Develop a health equity framework, inclusive of formal metrics and processes to monitor factors including, but not limited to, social determinants of health, quality of care, and trust in the healthcare system, to effectively decrease health inequality throughout the healthcare delivery system.
- Develop standards and expectations to collect and require reporting of disaggregated data for all groups.
- Assess compliance with existing standards related to data capabilities, collecting feedback on challenges and barriers to compliance.
- Analyze data to improve both healthcare quality and the patient experience across these communities.
- Set more rigorous standards to protect against data misuse or political interventions that interfere with access to data.

Interim Recommendations by Theme (4 of 4)

Create Safety Nets for Healthcare to help communities equitably recover from pandemics

- Recognize healthcare as a human right and establish policies and funding to support this declaration via the use of an Executive Order.
- Create a comprehensive and effective health care systems that cover the costs of essential healthcare and provide quality of life services to address patient comorbidities, pre-existing conditions as well as the full scope of patient care to address healthcare needs during a pandemic.
- During a pandemic, expand access to COBRA coverage, ensure that it is affordable, and mandate that coverage cannot be terminated for those who have lost their jobs due to the economic impacts of the pandemic.
- Reduce the disproportionate reliance on employer-sponsored health insurance while increasing access to high quality care by doing the following:
  - Expand the eligibility criteria for federally sponsored or subsidized insurance programs (Medicaid, CHIP, etc.)
  - Reduce the age of Medicare eligibility to cover the 55-64-year-old age group to address health inequities driven by lack of insurance and underinsurance.
  - Expand all government health insurance programs to ensure that people currently uninsured, underinsured have equitable access to care.
  - In order to provide high quality health care during a pandemic, providers across every specialty should be available in their region and accept all forms of health coverage, including Medicaid plans.

Healthcare Access and Quality Subcommittee

- Chair: Tim Putnam
- Members: Mayra Alvarez, Pritesh Gandhi, Jamila Gleason, James Hildreth, Vincent Toranzo, Mary Turner, Homer Venters, Bobby Watts
- Staff: Martha Okafor, Phillip Blanc, Cheryl Levine, Shondelle Wilson-Frederick, Jamie Babin, Tag Quijano

OASH Office of the Assistant Secretary for Health

OMH U.S. Department of Health and Human Services Office of Minority Health

Problem Statements (1 of 4)

PROBLEM STATEMENT 1	Prior to the pandemic, existing disparities in physical and behavioral health, social determinants of health, healthcare access, coverage, and a variation in quality of care led to disproportionate rates of chronic disease in marginalized, minoritized, and medically underserved communities. During COVID-19, these chronic diseases led to worse outcomes for individuals who contracted the illness across these communities.
PROBLEM STATEMENT 2	The pandemic exacerbated a shortage of skilled healthcare workers, increased hospital closures and decreased access to primary care and behavioral health services in communities with the highest health needs, leading to a lapse in the continuation of care for marginalized, minoritized, and medically underserved populations. The lack of diverse providers who reflect the communities they serve is compounded in health professional shortage areas (HPSAs) and has led to a lack of confidence in the healthcare system across these communities.

Problem Statements (2 of 4)

PROBLEM STATEMENT 3	Congregate settings that struggle with providing isolation for disease outbreaks, including homeless shelters, migrant worker groups, and those under the control of law enforcement agencies such as jails, prisons and immigration detention facilities lack many of the basic elements of health care quality, transparency and pandemic preparedness. The lack of access to quality health care led to disproportionately higher and faster spreading COVID-19 outbreaks across these settings.

Problem Statements (3 of 4)

PROBLEM STATEMENT 4

The politicization of science, sub-optimal hospital system coordination and communication, and underinvestment in pandemic preparedness hindered the ability to execute an effective pandemic preparedness and response plan in the following ways:

a. The politicization of science and statutory agencies during the pandemic undermined public health, safety, and complicated the ability of these agencies to launch a nationally effective response and recovery plan for COVID-19.

b. The elevation of politics over science led to diminished trust in the healthcare system and willingness to comply with evidence-based measures to combat the spread of the virus.

c. The lack of hospital system coordination and investment in pandemic preparedness and response left health systems unavoidably overwhelmed and without the ability to mitigate capacity surges, leaving patients with limited access to care during the early stages of the pandemic.

Problem Statements (4 of 4)

PROBLEM STATEMENT 5

Healthcare coverage tied to employment led to a disproportionate impact of marginalized, minoritized, medically underserved communities losing access to quality healthcare. There is substantial evidence that a lack of insurance in the 55-64-year-old population led to more deaths associated with COVID-19. Despite government sponsored or subsidized insurance, there are documented disparities in quality of care across patient payer types. This exacerbated the impact of the pandemic by causing delayed diagnoses, treatment, and increased spread of the virus losing access to quality health care during the pandemic.

PROBLEM STATEMENT 1 Prior to the pandemic, existing disparities in physical and behavioral health, social determinants of health, healthcare access, coverage, and a variation in quality of care led to disproportionate rates of chronic disease in marginalized, minoritized, and medically underserved communities. During COVID-19, these chronic diseases led to worse outcomes for individuals who contracted the illness across these communities.

1. **The Federal Government should:**
   a. Develop a health equity framework, inclusive of formal metrics and processes to monitor factors including, but not limited to, social determinants of health, quality of care, and trust in the healthcare system, to effectively decrease health inequality throughout the healthcare delivery system.
   b. Incentivize equity in healthcare systems by encouraging data- and community-driven approaches focused on decreasing distrust in the healthcare system for marginalized, minoritized, and medically underserved communities.
   c. Analyze data to improve both healthcare quality and the patient experience across these communities.

PROBLEM STATEMENT 1 Prior to the pandemic, existing disparities in physical and behavioral health, social determinants of health, healthcare access, coverage, and a variation in quality of care led to disproportionate rates of chronic disease in marginalized, minoritized, and medically underserved communities. During COVID-19, these chronic diseases led to worse outcomes for individuals who contracted the illness across these communities.

2. **Invest in evidence-based solutions, such as telemedicine and interdisciplinary approaches** that expand telehealth specialist access to primary care, behavioral health, and specialty care services that combine in-person and virtual care for patients.
3. **The Federal Government should evaluate the link between the comorbidities** (e.g. diabetes, hypertension, and unhealthy cholesterol levels), which exist at a higher rate in minoritized populations and increased COVID-19 mortality and leverage the results to create targeted solutions to actively resolve these comorbidities. Additionally, the Federal Government should consider access to healthy food as a tool to combat these comorbidities by expanding access to affordable and healthy food options for all Americans, especially those in marginalized and rural communities that often have limited access to such options.

PROBLEM STATEMENT 2

The pandemic exacerbated a shortage of skilled healthcare workers, increased hospital closures and decreased access to primary care and behavioral health services in communities with the highest health needs, leading to a lapse in the continuation of care for marginalized, minoritized, and medically underserved populations. The lack of diverse providers who reflect the communities they serve is compounded in health professional shortage areas (HPSAs) and has led to a lack of confidence in the healthcare system across these communities.

1. **Expand federally funded National Public Health Corps** to address healthcare worker shortages. Prioritize training and hiring of members of vulnerable communities.
2. **Explore strategies that meet local and regional staffing needs during pandemic response to rapidly expedite staffing reinforcement and cross-training in areas with chronic health workforce shortages.** Standardize cross-training that allows traveling medical staff to effectively treat patients using emergency protocols at these temporary treatment sites, while maintaining evidence-based standards of care.

PROBLEM STATEMENT 2

The pandemic exacerbated a shortage of skilled healthcare workers, increased hospital closures and decreased access to primary care and behavioral health services in communities with the highest health needs, leading to a lapse in the continuation of care for marginalized, minoritized, and medically underserved populations. The lack of diverse providers who reflect the communities they serve is compounded in health professional shortage areas (HPSAs) and has led to a lack of confidence in the healthcare system across these communities.

3. **Expand access to entry level and other positions with 2 years or less training programs for licensed and certified positions in healthcare while also maintaining quality of care** in order to combat the shortage of healthcare workers and to increase the number of licensed health professionals from underrepresented populations. This will primarily increase inclusivity in the healthcare workforce so that staff and providers accurately reflect the needs of the communities that they serve and provide expanded career opportunities for these communities.

PROBLEM STATEMENT 2

The pandemic exacerbated a shortage of skilled healthcare workers, increased hospital closures and decreased access to primary care and behavioral health services in communities with the highest health needs, leading to a lapse in the continuation of care for marginalized, minoritized, and medically underserved populations. The lack of diverse providers who reflect the communities they serve is compounded in health professional shortage areas (HPSAs) and has led to a lack of confidence in the healthcare system across these communities.

4. **The Federal Government should dramatically increase funding for education in medical fields, graduate medical education, and first responders,** to train future medical professionals from local, underrepresented, and first-generation populations from minoritized and underrepresented communities. Increased funding should target people who speak languages other than English and first-generation populations. Increased funding distribution should go through diversity grants, scholarships, and loan forgiveness, prioritizing HBCUs, TCUs, and institutions that graduate licensed health professionals from minoritized communities equal to or greater than their share of the general population. The federal government should provide additional resources to US graduate schools that have a track record of graduating board eligible and licensed health professionals that represent the full diversity of the U.S. population.

PROBLEM STATEMENT 2

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5. **Form a federal commission to curtail hospital closures that negatively impact vulnerable populations. This commission shall do the following:**
    a. Perform a detailed analysis on every hospital serving vulnerable populations in urban and rural settings that have closed in the last decade. This analysis should determine the root cause, contributing factors, and impact on the health and economic viability of the region.
    b. Implement immediate short-term measures to curtail the imminent closure of hospitals serving vulnerable populations while long-term solutions are developed.

PROBLEM STATEMENT 2

The pandemic exacerbated a shortage of skilled healthcare workers, increased hospital closures and decreased access to primary care and behavioral health services in communities with the highest health needs, leading to a lapse in the continuation of care for marginalized, minoritized, and medically underserved populations. The lack of diverse providers who reflect the communities they serve is compounded in health professional shortage areas (HPSAs) and has led to a lack of confidence in the healthcare system across these communities.

5. **Form a federal commission to curtail hospital closures that negatively impact vulnerable populations. This commission shall do the following:**
   c. Propose long-term solutions that make these critical and essential hospitals economically sustainable and capable of delivering quality care.
   d. Support preventive care, upgrading and building public hospitals, clinics, and treatment centers; community purchase of struggling or closed hospitals, clinics, and treatment centers; and financial and technical support to keep those that are essential open.

PROBLEM STATEMENT 2

The pandemic exacerbated a shortage of skilled healthcare workers, increased hospital closures and decreased access to primary care and behavioral health services in communities with the highest health needs, leading to a lapse in the continuation of care for marginalized, minoritized, and medically underserved populations. The lack of diverse providers who reflect the communities they serve is compounded in health professional shortage areas (HPSAs) and has led to a lack of confidence in the healthcare system across these communities.

6. **Fund the National Health Care Workforce Commission** to provide data on the healthcare workforce, train healthcare workers, and provide policy advice and recommendations to both Congress and the administration.

PROBLEM STATEMENT 3

Congregate settings that struggle with providing isolation for disease outbreaks, including homeless shelters, migrant worker groups, and those under the control of law enforcement agencies such as jails, prisons and immigration detention facilities lack many of the basic elements of health care quality, transparency and pandemic preparedness. The lack of access to quality health care led to disproportionately higher and faster spreading COVID-19 outbreaks across these settings.

1. **Expand adequate and evidence-based healthcare access** to treat patients in congregate settings.
2. **Fund infrastructure to build quarantine space** to house ill patients that reside in congregate settings.
3. **Implement policies that grant the release or reduction of sentence for low-risk individuals under the control of law enforcement agencies to reduce the high transmissibility of infectious disease** throughout congregate settings during a pandemic.

PROBLEM STATEMENT 3

Congregate settings that struggle with providing isolation for disease outbreaks, including homeless shelters, migrant worker groups, and those under the control of law enforcement agencies such as jails, prisons and immigration detention facilities lack many of the basic elements of health care quality, transparency and pandemic preparedness. The lack of access to quality health care led to disproportionately higher and faster spreading COVID-19 outbreaks across these settings.

4. **Expand access to hospital stepdown care during pandemics to provide adequate treatment and recovery** for patients that require treatment between general and intensive care that prevents them from residing in their residential congregate setting.
5. **Provide federal funding to ensure that contagious patients and those who are exposed and potentially contagious have the ability to isolate themselves** while receiving care or quarantining.
6. **Ensure that testing is accompanied from the start** by a robust system of contact tracing.

PROBLEM STATEMENT 4

The politicization of science, sub-optimal hospital system coordination and communication, and underinvestment in pandemic preparedness hindered the ability to execute an effective pandemic preparedness and response plan in the following ways:

A. The politicization of science and statutory agencies during the pandemic undermined public health, safety, and complicated the ability of these agencies to launch a nationally effective response and recovery plan for COVID-19.
B. The elevation of politics over science led to diminished trust in the healthcare system and willingness to comply with evidence-based measures to combat the spread of the virus.
C. The lack of hospital system coordination and investment in pandemic preparedness and response left health systems unavoidably overwhelmed and without the ability to mitigate capacity surges, leaving patients with limited access to care during the early stages of the pandemic.

1. **Create a pandemic preparedness team model to do the following:**
    a. Form a federal authority that will act as the definitive authority on the disease. Use the Federal Reserve Board as an apolitical model, inclusive of apolitical representatives with scientific and technical expertise that represents all vital stakeholders.
    b. Create the initial two-way communications plan based on their existing processes like the National Oceanic and Atmospheric Administration/National Weather Service model of information flow.
    c. Coordinate, fund, and communicate necessary and timely research to answer the most important questions regarding diagnosis, treatment, disease control, therapeutics, etc. that is fast and effective.

PROBLEM STATEMENT 4

The politicization of science, sub-optimal hospital system coordination and communication, and underinvestment in pandemic preparedness hindered the ability to execute an effective pandemic preparedness and response plan in the following ways:

A. The politicization of science and statutory agencies during the pandemic undermined public health, safety, and complicated the ability of these agencies to launch a nationally effective response and recovery plan for COVID-19.
B. The elevation of politics over science led to diminished trust in the healthcare system and willingness to comply with evidence-based measures to combat the spread of the virus.
C. The lack of hospital system coordination and investment in pandemic preparedness and response left health systems unavoidably overwhelmed and without the ability to mitigate capacity surges, leaving patients with limited access to care during the early stages of the pandemic.

1. Create a pandemic preparedness team model to do the following:

d. Ensure that research is ethical and inclusive of minoritized populations.

e. Support a permanent infectious disease standard by the end of 2021 that requires pandemic preparedness plans and funded science-based training.

PROBLEM STATEMENT 5

Healthcare coverage tied to employment led to a disproportionate impact of marginalized, minoritized, medically underserved communities losing access to quality healthcare. There is substantial evidence that a lack of insurance in the 55-64-year-old population led to more deaths associated with COVID-19. Despite government sponsored or subsidized insurance, there are documented disparities in quality of care across patient payer types. This exacerbated the impact of the pandemic by causing delayed diagnoses, treatment, and increased spread of the virus losing access to quality health care during the pandemic.

1. **The U.S. should recognize healthcare as a human right and establish policies and funding to support this declaration via the use of an Executive Order.** It should be enacted through legislation and regulations that leverage access and coverage as vital means to establish healthcare as a human right, regardless of immigration status, especially during a pandemic to reduce the possibility of infection.
    a. The government should engage the public and make the economic benefit case to support comprehensive healthcare reform for all.

PROBLEM STATEMENT 5

Healthcare coverage tied to employment led to a disproportionate impact of marginalized, minoritized, medically underserved communities losing access to quality healthcare. There is substantial evidence that a lack of insurance in the 55-64-year-old population led to more deaths associated with COVID-19. Despite government sponsored or subsidized insurance, there are documented disparities in quality of care across patient payer types. This exacerbated the impact of the pandemic by causing delayed diagnoses, treatment, and increased spread of the virus losing access to quality health care during the pandemic.

2. The Federal Government should **reduce the disproportionate reliance on employer-sponsored health insurance while increasing access to high quality care** by doing the following:
    a. Expand the eligibility criteria for federally sponsored or subsidized insurance programs (Medicaid, CHIP, etc.)
    b. Reduce the age of Medicare eligibility to cover the 55-64-year-old age group to address health inequities driven by lack of insurance and underinsurance.

PROBLEM STATEMENT 5

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2. The Federal Government should **reduce the disproportionate reliance on employer-sponsored health insurance while increasing access to high quality care** by doing the following:

   c. Expand all government health insurance programs to ensure that people currently uninsured, underinsured have equitable access to care.

   d. In order to provide high quality health care during a pandemic, providers across every specialty should be available in their region and accept all forms of health coverage, including Medicaid plans.

PROBLEM STATEMENT 5

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3. The government should **create comprehensive and effective health care systems that cover the costs of essential healthcare and provide quality of life services** to address patient comorbidities, pre-existing conditions as well as the full scope of patient care (e.g., medical, dental, vision services, and home and community-based long-term services and supports) to address healthcare needs during a pandemic.
4. **During a pandemic, expand access to COBRA coverage, ensure that it is affordable, and mandate that coverage cannot be terminated for those who have lost their jobs** due to the economic impacts of the pandemic.

Additional Research

The Task Force is conducting additional research around recommendations:

- *Addressing needs in long term care and assisted living settings*
- *Expanding access to people in home and community-based support services in lieu of congregate care settings*

These recommendations will be included in the Final HETF Report.

Discussion

Structural Drivers and Xenophobia Subcommittee

- Chair: Haeyoung Yoon
- Members: Mayra Alvarez, Sara Bleich, Jessica Cardichon, Richard Cho, Jamila Gleason, Jo Linda Johnson, Victor Joseph, Octavio Martinez, Shannon Pazur, Mary Turner, Bobby Watts
- Staff: Martha Okafor, Phillip Blanc, Cheryl Levine, Shondelle Wilson-Frederick, Jamie Babin, Sydney Gray

Problem Statements (1 of 3)

PROBLEM STATEMENT 1	Pandemics underscored the need for robust government-provided safety nets — food, transportation/travel, housing/shelter, education, income support, and family care — to protect working families, and the most high-risk populations. Programs rolled out in response to COVID-19 took time to develop and launch; moving forward we must anticipate the most basic needs before a crisis begins.
PROBLEM STATEMENT 2	There are institutionally-driven increases in pandemic-related health risks and worsened health outcomes, including deaths, potentially resulting from climate change as well as: lack of quality control; inequitable access to clean natural resources such as water and air; and mismanagement and/or lack of public utilities such as modern waste management.
PROBLEM STATEMENT 3	The continued practices and legacy of systemic racism, sexism, violence, and betrayal by American medicine and research have contributed to disparities in health outcomes as well as decreased institutional engagement and collaboration which will be necessary in responding to future pandemics.

Problem Statements (2 of 3)

PROBLEM STATEMENT 4	There is a clear lack of minoritized, marginalized, and medically underserved populations within the healthcare pipeline, educational, and mentorship programs, leading to a gap in the healthcare workforce. The current demographics of the healthcare workforce do not encapsulate the diversity of the United States and are even less representative of the minority populations – particularly for Black, Latinx, American Indian/Alaska Native, and disability communities – who historically experience worse outcomes during pandemics. Because concordance between patients and their care providers has been repeatedly associated with superior clinical outcomes, developing and retaining a diverse scientific workforce has been encouraged as a key strategy for resolving health disparities during COVID-19 and future pandemics.

Problem Statements (3 of 3)

PROBLEM STATEMENT 5	There is a clear lack of minoritized, marginalized, and medically underserved populations within the healthcare pipeline, educational, and mentorship programs, leading to a gap in the healthcare workforce. The current demographics of the healthcare workforce do not encapsulate the diversity of the United States and are even less representative of the minority populations – particularly for Black, Latinx, American Indian/Alaska Native, and disability communities – who historically experience worse outcomes during pandemics. Because concordance between patients and their care providers has been repeatedly associated with superior clinical outcomes, developing and retaining a diverse scientific workforce has been encouraged as a key strategy for resolving health disparities during COVID-19 and future pandemics.

PROBLEM STATEMENT 1

Pandemics underscored the need for robust government-provided safety nets — food, transportation/travel, housing/shelter, education, income support, and family care — to protect working families, and the most high-risk populations. Programs rolled out in response to COVID-19 took time to develop and launch; moving forward we must anticipate the most basic needs before a crisis begins.

1. Building on the COVID-19 response strategies in a future pandemic the federal government should use its full executive authority and work with Congress to **provide safety nets to ensure people are experiencing food, housing/shelter, and job security as well as having support with healthcare, travel, and lodging as well as family care needs**.

PROBLEM STATEMENT 2 There are institutionally-driven increases in pandemic-related health risks and worsened health outcomes, including deaths, potentially resulting from climate change as well as: lack of quality control; inequitable access to clean natural resources such as water and air; and mismanagement and/or lack of public utilities such as modern waste management.

1. Institute a national **moratorium on water and utility shutoffs to improve sanitation efforts** and address immediate, emergency needs in future pandemics.

2. Allocate federal funding for **grants and funding for cities, states, and tribes and technical assistance to replace household plumbing and lead services lines** in advance of a future pandemic.

3. **Establish a permanent low-income utility — water, electricity, waste management** — assistance program akin to the Low-Income Home Energy Assistance Program.

PROBLEM STATEMENT 2 There are institutionally-driven increases in pandemic-related health risks and worsened health outcomes, including deaths, potentially resulting from climate change as well as: lack of quality control; inequitable access to clean natural resources such as water and air; and mismanagement and/or lack of public utilities such as modern waste management.

4. The federal government must ensure that, through public utilities, every dwelling in the US has access to clean water and sanitation. They should also:

   a. **Use a reliable indicator — such as the Health Social Vulnerability Index (SVI) and/or CDC SVI — to accurately assess the level of exposure to hazards within our most at risk communities, including but not limited to Tribal Nations.**

   b. **Establish and adjust national standards as well as strategically target funding for water, sewage, and air quality to where it's needed, based on data from reliable equity indicators.**

PROBLEM STATEMENT 3 The continued practices and legacy of systemic racism, sexism, violence, and betrayal by American medicine and research have contributed to disparities in health outcomes as well as decreased institutional engagement and collaboration which will be necessary in responding to future pandemics.

1. The federal government should both **practice, and incentivize healthcare companies to practice, bidirectionally engaging patients and community members, across race, gender, and cultural differences as equal partners in the work to develop appropriate sociodemographic and social-needs products and solutions**, including: screening methods, valid healthcare data, surveillance and risk reduction strategies, as well as medical tools, devices, and technologies.

PROBLEM STATEMENT 4

Many US — state, territories, Tribal Nations — Pre-K-12 schools and postsecondary institutions lack infrastructure and adequate funding to support quick, frequent, or sustained shifts to virtual classes that future pandemics may demand, as evidenced by disparities in broadband, internet, and technology access during the COVID-19 pandemic, particularly for Black, Latinx, and American Indian/Alaska Native communities. Diminished access to education because of this digital divide may further reinforce educational disparities by race and/or ethnicity.

1. The federal government should **provide for appropriate technology and training to students, teachers, and faculty in order to enable and assure quality education and related services, as well as dynamically shift between in-classroom and remote teaching contexts** as required by future pandemics. This should include training on the use of and best practices for both hardware and software, as well as providing a home internet stipend that covers the total cost during any stay-at-home order issued in response to a pandemic, and other essential educational materials.

PROBLEM STATEMENT 5

There is a clear lack of minoritized, marginalized, and medically underserved populations within the healthcare pipeline, educational, and mentorship programs, leading to a gap in the healthcare workforce. The current demographics of the healthcare workforce do not encapsulate the diversity of the United States and are even less representative of the minority populations – particularly for Black, Latinx, American Indian/Alaska Native, and disability communities – who historically experience worse outcomes during pandemics. Because concordance between patients and their care providers has been repeatedly associated with superior clinical outcomes, developing and retaining a diverse scientific workforce has been encouraged as a key strategy for resolving health disparities during COVID-19 and future pandemics.

1. **Increase the amount of racial, ethnic, and disability data on the healthcare workforce and educational pipeline, across healthcare professions, and centralize it** in an easy-to-access and financially-maintained database. Doing so may facilitate research into factors contributing to increased workforce diversity as well as understanding the association between these factors and health outcomes.

Discussion

Communications and Collaborations Subcommittee

- Chair: Andy Imparato
- Members: Mayra Alvarez, Jo Linda Johnson, Rachel Levine, Octavio Martinez, Vincent Toranzo
- Staff: Martha Okafor, Phillip Blanc, Cheryl Levine, Shondelle Wilson-Frederick, Jamie Babin, Swathi Srinivasan

OASH Office of the Assistant Secretary for Health

OMH U.S. Department of Health and Human Services Office of Minority Health

Problem Statements (1 of 3)

PROBLEM STATEMENT 1	The inadequate communication and collaboration between public health officials and public emergency management, coupled with shrinking budgets for public health, led to inefficiencies in emergency response.
PROBLEM STATEMENT 2	Pandemic preparedness is a core function of federal and state governments and requires global coordination with the international system and private sector at the highest level. It is not a responsibility of the health sector alone to prepare and respond to pandemics.
PROBLEM STATEMENT 3	Due to chronic underfunding of public health and disjointed federal, state and regional response, COVID-19 demonstrated a lack of coordinated equitable response from acute care delivery, long-term care, EMS, public health, pharmaceutical companies, healthcare equipment manufacturers, resulting in an inequitable distribution of treatment resources.

Problem Statements (2 of 3)

PROBLEM STATEMENT 4	Lack of a unified, science-based, non-political, trusted voice to educate the public about PPE, therapeutics and testing contributed to inconsistent communications that increased risk for front line workers and minoritized, marginalized and medically underserved populations.
PROBLEM STATEMENT 5	Chronically underfunded national pandemic preparedness complicates efficient pandemic detection and response. The impact of these deficits disproportionally impacts minoritized, marginalized, rural, and medically underserved communities.
PROBLEM STATEMENT 6	Public messaging does not adequately consider the cultural, linguistic, and geographic context for minoritized, marginalized and medically underrepresented communities, especially Indigenous populations.

Problem Statements (3 of 3)

PROBLEM STATEMENT 7	Unfamiliarity and/or lack of trust between public health officials and the communities they serve results in significant emergency response challenges.

PROBLEM STATEMENT 1 The inadequate communication and collaboration between public health officials and public emergency management, coupled with shrinking budgets for public health, led to inefficiencies in emergency response.

1. **Foster a culture of collaboration between public health officials and public emergency management at every level of government.** Leveraging these collaborations, develop an adaptive pandemic preparedness and response plan and commit to exercising it at appropriate intervals and against various scenarios. Ensure adequate funding for the planning process, steady-state collaboration, and exercises.

PROBLEM STATEMENT 2 Pandemic preparedness is a core function of federal and state governments and requires global coordination with the international system and private sector at the highest level. It is not a responsibility of the health sector alone to prepare and respond to pandemics.

1. **The U.S. should take an active leadership role in bringing an equity lens to international pandemic preparedness efforts and should encourage American healthcare leaders to take a global approach to global problems**. The U.S. should develop a policy point-of-view on the international proposals (ex. The U.S. should review and identify appropriate recommendations from the Independent Panel for Pandemic Preparedness and Response).

PROBLEM STATEMENT 3

Due to chronic underfunding of public health and disjointed federal, state and regional response, COVID-19 demonstrated a lack of coordinated equitable response from acute care delivery, long-term care, EMS, public health, pharmaceutical companies, healthcare equipment manufacturers, resulting in an inequitable distribution of treatment resources.

1. **The Federal Government should appoint an independent, Blue Ribbon panel to conduct a COVID-19 pandemic after-action analysis for the whole of government**. This analysis should include a review of performance of public authorities at the federal, state, local and tribal levels, their respective roles in pandemic response, and should seek input from diverse, non-governmental stakeholders.

PROBLEM STATEMENT 4 Lack of a unified, science-based, non-political, trusted voice to educate the public about PPE, therapeutics and testing contributed to inconsistent communications that increased risk for front line workers and minoritized, marginalized and medically underserved populations.

1. **In future pandemics, the Federal Government should establish consistent communication to educate the public about PPE, therapeutics and testing using science-based, non-political sources.** The federal government should create a unified, national response that may involve directing a lead agency to work in close collaboration with trusted state, local leaders and trusted private sector entities to ensure the message is clear, credible, consistent and adapted to the cultural context of marginalized populations.

PROBLEM STATEMENT 5 Chronically underfunded national pandemic preparedness complicates efficient pandemic detection and response. The impact of these deficits disproportionally impacts minoritized, marginalized, rural, and medically underserved communities.

1. **The Federal Government should establish consistent funding for pandemic response.**

PROBLEM STATEMENT 6 Public messaging does not adequately consider the cultural, linguistic, and geographic context for minoritized, marginalized and medically underrepresented communities, especially Indigenous populations.

1. **The Federal Government should provide guidance to state, local, tribal, and territorial government as well as Federally Qualified Health Centers, on health communications strategies** with culturally and linguistically responsive materials and messengers. These communicators should disseminate accurate information in plain language and minimize the harms associated with miscommunication.
2. **The Federal government should provide guidance on the creation of preparedness plans** and the involvement of community-based providers and organizations that are familiar with minoritized, marginalized and underrepresented communities, their family communication and social network dynamics.
3. **The Federal Government should identify and establish partnerships with state and local policy organizations** affiliated with other populations of focus to develop evidence-based strategies for reducing frontline and essential workers' exposure to the virus that causes COVID-19.

PROBLEM STATEMENT 7

Unfamiliarity and/or lack of trust between public health officials and the communities they serve results in significant emergency response challenges.

1. **The Federal Government should provide guidance to public health officials on establishing expectations that staff and management engage in activities designed to advance health equity** (e.g., training requirements, workgroup participation)The Federal government should provide guidance on the creation of preparedness plans and the involvement of community-based providers and organizations that are familiar with minoritized, marginalized and underrepresented communities, their family communication and social network dynamics.
2. **The Federal Government should provide guidance to public health officials on establishing and maintaining strong and authentic relationships** with communities experiencing health inequities before funding opportunities arise or urgent health issues develop.
3. **The Federal Government should provide guidance to public health agencies on the collaboration between government and non-governmental entities** that have stronger relationships with minoritized, marginalized and medically underserved communities, and work to build a pipeline for talent of individuals that come from these communities.

Discussion

Data, Analytics, and Research Subcommittee

- Chair: Joneigh Khaldun
- Members: James Hildreth, Andy Imparato, Victor Joseph, Homer Venters
- Staff: Martha Okafor, Phillip Blanc, Shondelle Wilson-Frederick, Jamie Babin, Cheryl Levine, Beverly Udegbe, Maya McCoy

OASH Office of the Assistant Secretary for Health

OMH U.S. Department of Health and Human Services Office of Minority Health

Problem Statements (1 of 4)

PROBLEM STATEMENT 1	Structures, related to real time data systems, created in the immediate response to Ebola Virus, H1N1, and other recent outbreaks were not sufficient and/or have not been sustained afterwards due to inconsistent funding and an inconsistent governmental commitment to preparedness.
PROBLEM STATEMENT 2	Many healthcare professionals, medical providers, social service workers, and essential workers lacked adequate PPE and necessary supplies during the COVID-19 pandemic. Data infrastructure is needed to track PPE availability, supply chain shortages of resources and materials, expiration of PPE, ensure adequate training in donning and doffing of PPE for different types of pathogens, and equitable access to PPE for all facilities impacted by the CMS emergency preparedness rule.
PROBLEM STATEMENT 3	There are few systems and expectations in place to gather disaggregated, quality data, whether that's based on research from other countries or from within the US, or outcomes that could inform special pathogen preparedness at the state, local, tribal, and/or territorial (SLTT) level. The general lack of a timely, reliable, data dashboard at the SLTT levels as well as the absence of standardized, real-time threat information-sharing, case investigation, and contract tracing data has hindered an effective and trusted special pathogens response.

Problem Statements (2 of 4)

PROBLEM STATEMENT 4	Data remain largely unavailable for demographic subgroups, including people who are American Indian or Alaska Native (AI/AN) and Native Hawaiian or Other Pacific Islander (NHOPI), or veterans, or people with disabilities, or people in carceral settings, limiting the ability to identify impacts for these populations. Certain groups are also siloed from data collection and reporting chains like AI/AN and veterans, who receive care in siloed medical delivery systems, like the Indian Health Service and the Veteran's Administration. Thus, data often collected does not provide for a complete understanding of impacts for these groups.
PROBLEM STATEMENT 5	Standards for data capabilities exist but they are not often executed. Trainings and exercises for special pathogen events remain largely focused on direct medical preparedness, leaving out opportunities to test and proactively improve execution of data standards, and overall data sharing and data collection capabilities.

Problem Statements (3 of 4)

PROBLEM STATEMENT 6	Data systems are not integrated at the federal, state, local, tribal, territorial government level as well as between providers, health systems, labs etc. This causes duplicative data requests and collection efforts, unclear expectations, and an overall slower response or nonresponse. The type of data (e.g., capacity data, operational data etc.) is not centrally collected, understood, or utilized. This inhibits collaboration, collective awareness, data sharing, and data streamlining.
PROBLEM STATEMENT 7	Systematic lack of inclusion of minoritized, marginalized, and medically underserved individuals in biomedical, health systems, clinical, and public health research, from research subjects to researcher leads, coupled with insufficient and unsustained funding devoted research on equity-related interventions has resulted in greater vulnerability of these communities in future pandemics of every kind.

Problem Statements (4 of 4)

PROBLEM STATEMENT 8	Clinical trials pools for COVID-19 therapeutics and vaccines lacked representative diversity from minoritized, marginalized, and medically underserved groups, which leaves gaps in understanding around how various people (especially racial/ethnic minorities) may respond. For future special pathogen responses, gaps in research such as these could leave vulnerable populations without adequate information regarding their treatment and prevention options.
PROBLEM STATEMENT 9	The COVID-19 pandemic has brought to light the dangers of congregate living settings as the risks of disease transmission can increase based on proximity, size of groups, and practices (i.e., communal dining) that are associated with congregate living. There is a lack of understanding and data related to the factors that led to adverse outcomes in these settings and the effectiveness of strategies, including release and reduction, to mitigate

PROBLEM STATEMENT 1

Structures, related to real time data systems, created in the immediate response to Ebola Virus, H1N1, and other recent outbreaks were not sufficient and/or have not been sustained afterwards due to inconsistent funding and an inconsistent governmental commitment to preparedness.

1. **Invest in national special pathogen preparedness and response and specifically invest in data sharing solutions and data capabilities as the new care delivery network is stood up.**
2. **Assess opportunities to use data to close equity gaps in special pathogens care delivery.**

PROBLEM STATEMENT 2

Many healthcare professionals, medical providers, social service workers, and essential workers lacked adequate PPE and necessary supplies during the COVID-19 pandemic. Data infrastructure is needed to track PPE availability, supply chain shortages of resources and materials, expiration of PPE, ensure adequate training in donning and doffing of PPE for different types of pathogens, and equitable access to PPE for all facilities impacted by the CMS emergency preparedness rule.

1. **Develop a tool for facilities and health systems to help track PPE and other essential supplies availability.**
2. **Strengthen, streamline, and make more transparent data collection processes to enable reporting on PPE and other essential supplies availability to SLTT and federal public health authorities to support tracking of local supplies.**
3. **Properly maintain PPE and other essential supplies in local stockpiles and using sharing agreements.**
4. **Incentivize training on PPE donning and doffing on a regular schedule and monitor training compliance.**
5. **Conduct a retrospective analysis to determine recommendations for federal and STTL stockpiles.**
6. **Leverage existing frameworks that explore the equity gap between PPE supply and demand and distribute the resources to those who lack protection in pandemic response.**

PROBLEM STATEMENT 3

There are few systems and expectations in place to gather disaggregated, quality data, whether that's based on research from other countries or from within the US, or outcomes that could inform special pathogen preparedness at the state, local, tribal, and/or territorial (SLTT) level. The general lack of a timely, reliable, data dashboard at the SLTT levels as well as the absence of standardized, real-time threat information-sharing, case investigation, and contract tracing data has hindered an effective and trusted special pathogens response.

1. **Create standardized expectations around disaggregated data collection and include incentives to collect and report disaggregated data.**
2. **Leverage existing SLTT and federal data to create a centralized dashboard that displays timely, reliable, transparent, and accessible data.**
3. **Invest in SLTT data and surveillance infrastructure to ensure real time threat information can be shared quickly.**
4. **Promote robust information sharing transnationally** that allows for better design of health information systems that will help with data sharing, understanding risks for vulnerable communities, and enable a more comprehensive response.

PROBLEM STATEMENT 4

Data remain largely unavailable for demographic subgroups, including people who are American Indian or Alaska Native (AI/AN) and Native Hawaiian or Other Pacific Islander (NHOPI), or veterans, or people with disabilities, or people in carceral settings, limiting the ability to identify impacts for these populations. Certain groups are also siloed from data collection and reporting chains like AI/AN and veterans, who receive care in siloed medical delivery systems, like the Indian Health Service and the Veteran's Administration. Thus, data often collected does not provide for a complete understanding of impacts for these groups.

1. **Incentivize novel partnerships and data use (including administrative data) to better reflect these groups and address equity in preparedness.**
2. **Develop standards and expectations to collect and require reporting of disaggregated data for all groups.**
3. **Set more rigorous standards to protect against data misuse or political interventions that interfere with access to data (e.g., for undocumented people, mixed-status families, or people with histories of incarceration).**

PROBLEM STATEMENT 5

Standards for data capabilities exist but they are not often executed. Trainings and exercises for special pathogen events remain largely focused on direct medical preparedness, leaving out opportunities to test and proactively improve execution of data standards, and overall data sharing and data collection capabilities.

1. **Assess compliance with existing standards related to data capabilities, collecting feedback on challenges and barriers to compliance**
2. **Include the interest and/or priorities of community organizations and leaders outside of the traditional medical setting to ensure that trainings and exercises for special pathogen events identify subpopulations that may be underserved.**

PROBLEM STATEMENT 6

Data systems are not integrated at the federal, state, local, tribal, territorial government level as well as between providers, health systems, labs etc. This causes duplicative data requests and collection efforts, unclear expectations, and an overall slower response or nonresponse. The type of data (e.g., capacity data, operational data etc.) is not centrally collected, understood, or utilized. This inhibits collaboration, collective awareness, data sharing, and data streamlining.

1. **Conduct an environmental scan to understand various reporting requirements and find areas for potential standardization and alignment.**
2. **Leverage existing data reporting processes on specific data types and set expectations and create new process to enable real time data reporting in a centralized and standardized manner.**
3. **Use improved data to improve collaboration, care coordination, and resource allocation in future pandemics.**
4. **Streamline data requests and collection efforts to make informed decisions about addressing health needs.**

PROBLEM STATEMENT 7

Systematic lack of inclusion of minoritized, marginalized, and medically underserved individuals in biomedical, health systems, clinical, and public health research, from research subjects to researcher leads, coupled with insufficient and unsustained funding devoted research on equity-related interventions has resulted in greater vulnerability of these communities in future pandemics of every kind.

1. **Conduct an analysis to determine inequities in research funding and structural barriers to access for different types of individuals and organizations.**
2. **Develop a research network that enables a timely sharing of research that is accessible to all, promoting greater understanding in a rapidly changing environments, and enabling more research to be conducted specifically on minoritized, marginalized, and medically underserved groups.**
3. **Require federally supported biomedical research to include individuals from marginalized communities in ethical research design and as subjects of ethical research.**
4. **Develop and issue research grants focused on equity-related interventions that have been used in previous public health emergencies and grants focused on intersectionality aspects that incorporate a syndemic framework highlighting vulnerability among minoritized, marginalized, and medically underserved groups that result from collective (or cumulative) exposure to health risks.**

PROBLEM STATEMENT 8

Clinical trials pools for COVID-19 therapeutics and vaccines lacked representative diversity from minoritized, marginalized, and medically underserved groups, which leaves gaps in understanding around how various people (especially racial/ethnic minorities) may respond. For future special pathogen responses, gaps in research such as these could leave vulnerable populations without adequate information regarding their treatment and prevention options.

1. **Conduct a retrospective analysis to determine inequities in the COVID-19 clinical trials for therapeutics and vaccines and understand barriers and challenges for those who wanted to participate in trials but couldn't.**
2. **Develop standards and recommendations for future clinical trials for special pathogens treatments and vaccines that breaks down barriers and enables more equity.**
3. **Include diversity enrollment targets in clinical trials that are related to special pathogens and oversample for populations hit hard by a special pathogens event.**

PROBLEM STATEMENT 9

The COVID-19 pandemic has brought to light the dangers of congregate living settings as the risks of disease transmission can increase based on proximity, size of groups, and practices (i.e., communal dining) that are associated with congregate living. There is a lack of understanding and data related to the factors that led to adverse outcomes in these settings and the effectiveness of strategies, including release and reduction, to mitigate adverse outcomes.

1. **Study the overall risks of congregate settings to any infectious disease and the implications of those risks for considering how federal resources are used to prepare for and respond to infectious disease outbreaks in these settings.**

Discussion