



Presidential COVID-19 Health Equity Task Force

Final Report and Recommendations

October 2021



“This mission is important to me because, on a larger scale, it’s about how we currently ensure that everyone in the United States is receiving equitable care.

Equitable care is ... ensuring that all of us have fair access to resources and the best health outcomes possible.”

- COVID-19 Health Equity Task Force member

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Letter from the Chair

I am pleased to share the following report from the Presidential COVID-19 Health Equity Task Force with you. I thank President Biden and Vice President Harris for the opportunity to lead this historic Task Force. It has been an honor and privilege to serve in this role.

As we hold our work as a Task Force, we are mindful of the scores of families and communities across the country—including many people who are suffering symptoms of Long COVID—that are grieving the loss of loved ones to this pandemic. We also recognize the “grief gap”; loss has been disproportionately experienced in the most marginalized communities. As we continue to make progress in our pandemic response, we know the families who have lost loved ones have no “normal” to return to. And we must ensure this country does not return to our pre-pandemic “normal” either. Our “normal” policies and practices are inadequate to meet the needs of so many and have made marginalized communities the most vulnerable to the tragedies of COVID-19.

To honor the lives lost, we must continue to not only center equity in our response to and recovery from this pandemic, but also work to address the root causes of health disparities in this country. Achieving COVID-19 health equity is mission-critical for all of us, not simply because it’s the right thing to do, but also because there is no credible path to a new normal without it.

“This is our collective work. The reimagining of a different and better post-pandemic reality.”

The Task Force took its charge seriously. President Biden charged this Task Force with recommending actions to mitigate health inequities caused or exacerbated by the COVID-19 pandemic and to prevent such inequities in the future. Vice President Harris introduced legislation as a senator that provided a blueprint for the U.S. COVID-19 Health Equity Task Force. We were mindful of the broad lens necessary to center equity across the most affected groups—people with disabilities, those who are justice-involved, cherished elders, rural neighbors, mixed-status families, Queer people, Black and Brown people, Indigenous people, Asian/Asian American and Native Hawaiian and Pacific Islander people, those struggling on the margins of the economy—and, of course, the compounded challenges often found at the intersections of these identities.

While the events of the past 18 months have made us crucially aware of COVID-19's skewed toll on communities of color and other underserved populations, there has never been a time in which these communities have not suffered disproportionate burdens of death and disease. We know the communities that are first to be forgotten, especially when resources are in short supply. COVID-19 made it clear that, in this country, a person's zip code is a stronger driver of health than their genetic code. Inequity sickens our entire nation.

The imperative is clear—to advance health equity, we must name and urgently address the historical and contemporary underpinnings of these realities.

Equity requires full participation by each one of us.

I want to extend my deep appreciation to the remarkable Task Force members for their generativity, commitment, and thoughtful contributions. The 12 initial Task Force members were identified through conversations with stakeholder groups, on recommendation by organizations and individuals, and through the visible effort they lent to their communities in the fight against COVID-19. I also want to thank the Federal ex-officio members who informed this report, representing agencies and departments across the U.S. Government. In addition to the experience and expertise all of the members brought to this work, they collectively represented a range of key constituencies and corners of the country, providing diverse perspectives in the work.

It takes an entire team to support a Presidential Task Force. Thank you to the Federal staff team who worked tirelessly to elevate our vision, and to the CDC Foundation for its support. Finally, I extend my heartfelt appreciation to the more than 100 subject-matter experts and many guest speakers who joined us—thank you for your insights.

This report presents a case for change, proposed actions for the Biden-Harris administration to prioritize, and outcomes to set the vision for what the country can achieve. And, of course, this report holds the specific recommendations the Task Force has generated throughout many months—recommendations intended to disrupt the predictability of who is harmed first, and harmed worst in times of national crisis.

Equity never happens by default. I hold hope we will make personal choices and collective decisions that can get us *all* safely to the other side of this pandemic. Our nation has begun the hard work to recalibrate; we must stay the course and accelerate the health equity journey.

To a new and better normal,

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

Presidential COVID-19 Health Equity Task Force Chair



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Acknowledgements

The Task Force would like to give a special acknowledgement to:

- The Office of the Assistant Secretary for Health for hosting and staffing the Task Force
- Sherice Perry, *Senior Advisor*, for her time and contribution to the Task Force

The Task Force benefitted from the knowledge, stories, and perspectives shared by subject-matter experts, presenters, and others throughout this process. For a full list of these individuals, please see the appendices.

The following organizations provided instrumental support to the Task Force:

- The CDC Foundation
- KFF (Kaiser Family Foundation)
- The Commonwealth Fund
- Robert Wood Johnson Foundation

Throughout the report, we highlight programs that demonstrate our proposed outcomes in a series of vignettes. These relate to suggested outcome areas for the Task Force:

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

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

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

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

Spotlight on:

Connecticut Baby Bonds

Beginning July 1, 2021, every child in the state of Connecticut whose birth is covered by Medicaid started to receive a savings account with up to \$3,200, which is deposited into a trust and invested by the Office of the State Treasurer. When the child turns 18 and completes a financial education requirement, they will be able to use those funds for eligible purposes like educational expenses, retirement savings, purchasing a home in Connecticut, or investing in a Connecticut business. Research has shown that these actions can help close the racial wealth gap in the state. In a press release about the program, State Treasurer Shawn Wooden says, “Following a global pandemic, economic downturn, and racial reckoning, I don’t believe this program could have come at a more appropriate and important time. ...It’s moments like these that give me hope that I might see an equitable society in my lifetime. By investing directly in children born into poverty, Connecticut will not only help break the cycle of poverty for generations of families but can be seen as a model for the nation when it comes to diminishing long-standing wealth disparities.”

State of Connecticut Office of the Treasurer. “CT Makes History! Today, CT Baby Bonds Became Available For All CT Children Born Into Poverty; First State in the Nation to Pass Baby Bonds Program.” News release, June 30, 2021. <https://portal.ct.gov/-/media/OTT/Press-Room/Press-Releases/2021/PR070121----CtMakesHistoryTodayCtBabyBondsforCtChildrenintoPoverty.pdf>.

Thomas, Jacqueline Rabe. “CT Set to Give \$3,200 Bonds to Every Child Born into Poverty.” *The CT Mirror*. *The CT Mirror*, June 9, 2021. <https://ctmirror.org/2021/06/09/ct-to-give-baby-bonds-to-every-child-born-into-poverty/>.

Key Populations and Settings

For more information, please see the [appendices](#).

This report references various populations and settings of interest as **communities of color and other underserved populations**, considering where people live, work, and learn. This includes, but is not limited to:

Racial/Ethnic Groups

- Indigenous and Native Americans
- Asian/Asian Americans, Native Hawaiians, and Pacific Islanders
- Black/African American
- Hispanic/Latino

Other Marginalized Groups

- Immigrants, refugees, and asylees
- LGBTQIA+ people
- People with low income
- People experiencing homelessness
- Veterans or military personnel and their families
- Women and girls

Special Age Populations

- Children (younger than 12)
- Youth (12–17)
- Young adults (18–25)
- Older adults (65 and older)

Medically Underserved

- People with disabilities
- People with chronic medical conditions
- People with behavioral health conditions, including substance use disorder and mental health conditions
- People with long-term mental illness or long-term psychiatric disability
- People who require long-term services and supports
- People who are uninsured or underinsured

Workers

- Agricultural industry workers (includes migrant workers and meat packing/food processing industry)
- Essential workers
- Frontline workers

Geographic Areas

- Rural
- Remote
- Tribal
- Territorial

Congregate Settings

- Carceral settings (i.e., jails, prisons, detention centers)
- Homeless shelters (includes heating and cooling centers)
- Long-term care facilities (e.g., nursing homes, skilled nursing facilities)
- Shared housing (e.g., group homes, assisted living, dormitories)

Other Relevant Settings

- Businesses
- Childcare facilities (e.g., Head Start, Early Head Start, in-home daycare)
- Health care facilities and ambulatory care
- Schools (early childhood, K-12, and postsecondary educational institutions)
- Transportation (e.g., public transportation, private transportation, gig transportation, accessible/paratransit, emergency medical service, air travel, trains)



Spotlight on:

Using Vaccines to Preserve the Cherokee Language

Osiyo,

The Cherokee Nation lost at least 65 Cherokee speakers to COVID-19 as of this report's publication, leaving only approximately 2,000 fluent Cherokee speakers remaining. Tribal leaders recognized vaccination as a critical method of preserving the Cherokee culture, despite initial hesitancy toward the vaccine among Tribal citizens. The Cherokee Nation reserved vaccine doses specifically for Cherokee language speakers and began speaking to their community about the vaccine's benefits. One Cherokee speaker, Meda Nix, says, "I wasn't going to take it" but "felt a lot better about it" after listening to a call with COVID-19 specialists and Tribal Elders. She was eventually swayed to get the vaccine by her faith and her desire to protect her Nation's long and valuable history, an embodiment of the Cherokee belief in "Gadugi," or working together.

Wado, thank you.

Inskeep, Steve. "At First Wary of Vaccine, Cherokee Speaker Says It Safeguards Language, Culture." NPR. *NPR*, January 4, 2021. <https://www.npr.org/sections/coronavirus-live-updates/2021/01/04/953340117/at-first-wary-of-vaccine-choerokee-speaker-says-it-safeguards-language-culture>.



Spotlight on:

Healthy St. Landry Alliance

In the rural Louisiana parish of St. Landry, a community-focused alliance is doing everything it can to keep the parish's 90,000 residents safe and healthy, including setting up a communications and response system. The Healthy St. Landry Alliance, founded in 2018, brings together more than 25 local partners, including health care providers, local government, faith-based organizations, and community groups to help address social determinants of health and other health-related social needs. This alliance is managed by the parish's main health care provider, Opelousas General Health System (OGHS). OGHS CEO Ken Cochran says that when the pandemic hit, "The ongoing relationships and efforts of the Healthy St. Landry Alliance were a natural fit to ensure our health system connected with the community." Working together, OGHS and the Alliance were better able to understand and meet the needs of the community during a difficult time. Tracey Antee, executive director of the Alliance, notes the importance of this program: "In these times, it's important to develop a group focused on community health that is sustainable and continues to provide resources and information dissemination before, during, and after any type of public health crisis. The ability to activate a network that is community-based provides a significant opportunity to reach all sectors of the population by engaging on a more trusting and personal level."

American Hospital Association. "Case Study: Healthy St. Landry Alliance Leads a Coordinated Community Response: Opelousas General Health System." *Case Studies*. 2021. <https://www.aha.org/case-studies/2020-06-03-case-study-healthy-st-landry-alliance-leads-coordinated-community-response>.

Executive Summary

As of October 2021, COVID-19 has killed more than 700,000 people in the United States and has infected tens of millions.¹ COVID-19 has affected all Americans, but not equally.

Individuals from communities of color and other underserved populations have been disproportionately affected and, as a result, have borne the brunt of this pandemic.

Despite this tragedy, the pandemic has presented our nation with an opportunity to change the health narrative for communities of color and other underserved populations. On January 21, 2021, President Joseph R. Biden issued Executive Order 13995, which established the Presidential COVID-19 Health Equity Task Force (the “Task Force”). Following guidance from the Executive order, which was informed by legislation proposed by Vice President Kamala D. Harris during her time as Senator as well as the National Strategy for the COVID-19 Response and Pandemic Preparedness, the Task Force convened to recommend actions against long-standing and emerging health inequities exacerbated

by the pandemic. President Biden appointed Marcella Nunez-Smith, M.D., M.H.S. as chair of the Task Force and 12 other members with diverse backgrounds, lived experiences, and expertise. Eight ex-officio members from U.S. Federal agencies complete this Federal Advisory Committee.^a

The Task Force advocates for a health-justice-in-all-policies approach that calls for commitment and collaboration across all sectors.^b Only such an approach can disrupt the predictable pattern of who is harmed first and worst. The path to health equity requires a robust and sustained multisectoral response, genuine partnership, intentionality,

frequent review, and course-correction. To achieve this, the Presidential COVID-19 Health Equity Task Force presents two deliverables as part of the final report. 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 55 final recommendations.

“... COVID-19 has laid bare what has been the reality for so many in our country, who over generations have been minoritized and marginalized and medically underserved, and the pandemic took advantage of the legacy of intentional policies that have structurally disadvantaged communities over time.”

– COVID-19 Health Equity Task Force member

a **Health equity:** “The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.” We use the term “equity” instead of “equality” because equity acknowledges that communities require different support to achieve similar outcomes.

Office of Disease Prevention and Health Promotion. “Healthy People 2030 Questions & Answers.” Healthy People 2030, August 24, 2021. <https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers#q9>.

b **Health-justice-in-all-policies:** A health justice approach that combines a social justice lens with an approach to health considering the complex and interwoven social determinants of health. For more information, please see the appendices.

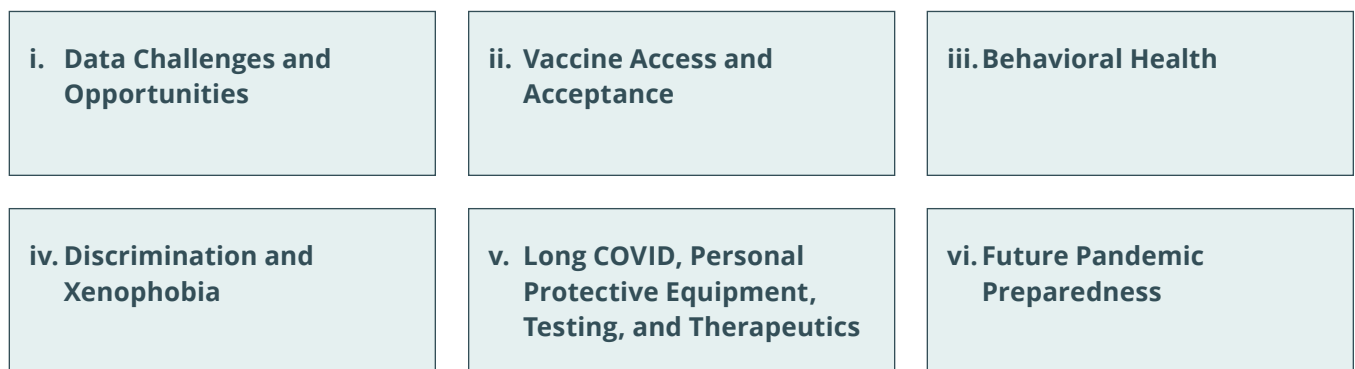
American Public Health Association. “Health in All Policies.” American Public Health Association. 2021. <https://www.apha.org/Topics-and-Issues/Health-in-All-Policies>.

The second deliverable includes a proposed implementation plan and suggested accountability framework to effect change and monitor progress to advance health equity for all.

Due to the urgent nature of the mission, Dr. Nunez-Smith organized the Task Force into four subcommittees that followed a monthly sprint cadence to address different key issues. Figure 1 on the next page overviews the designed three-phase process of the Task Force:

1. Formation of the Task Force
2. Task Force operations
3. Report development

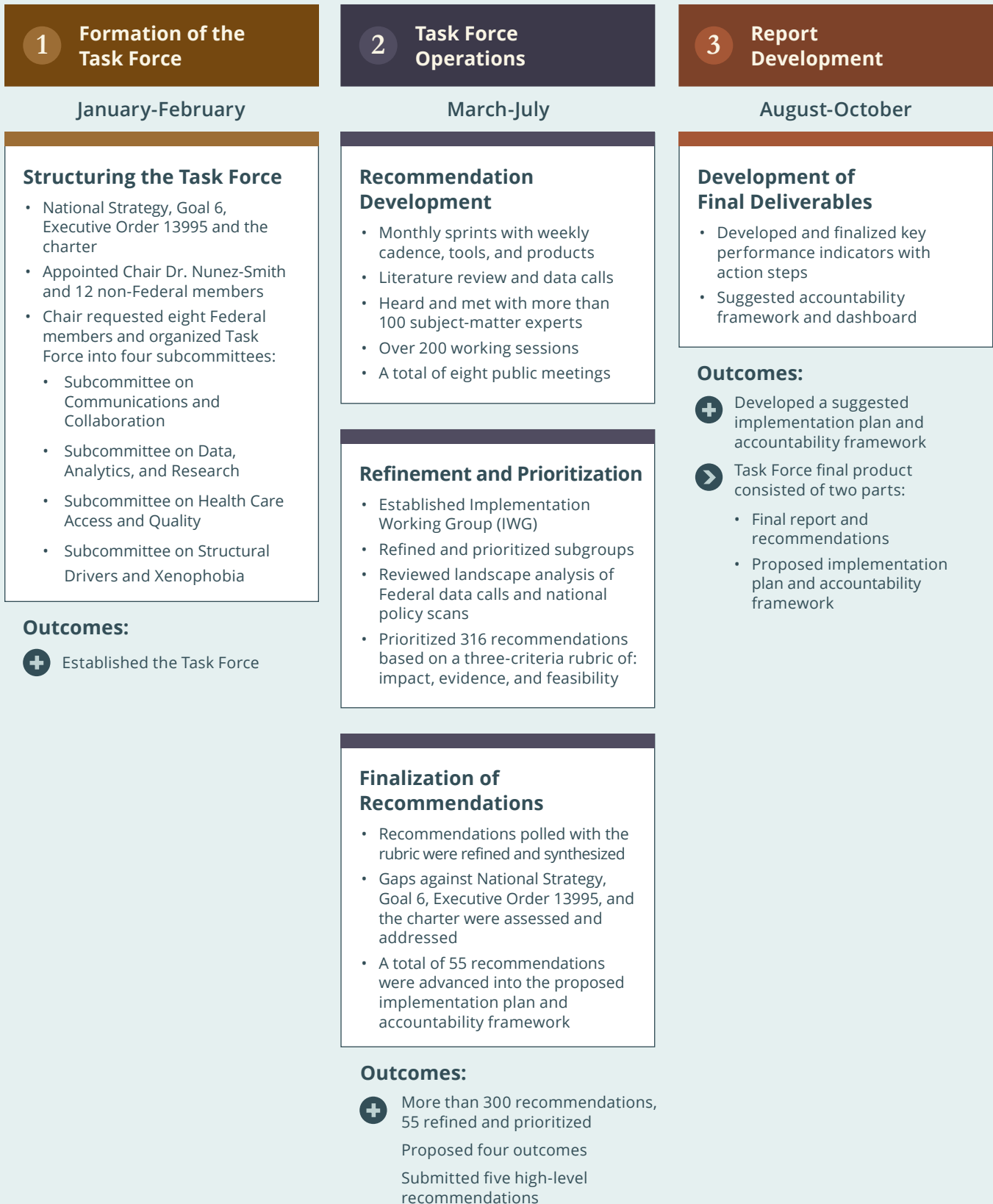
To operationalize the Task Force, the monthly sprints focused on priority topics from the National Strategy, Goal 6, Executive Order 13995, and the charter, which were:



Each sprint concluded with a public meeting, which included a vote on the slate of recommendations.

The Task Force systematically advanced 316 recommendations, 55 of which are prioritized and highlighted in the body of this report. The Task Force also proposed five overarching priorities and four suggested outcomes. This work was unanimously approved and finalized in the September 2021 Task Force meeting.

Figure 1: COVID-19 Health Equity Task Force Process



Proposed Priorities

To take a bold step towards health equity, we, as a nation, must transform the status quo, hand in hand with communities and across sectors, with continued attention from the administration and Federal Government.

We recommend the administration prioritize the following actions to address the inequitable health outcomes that communities of color and other underserved populations have experienced during the COVID-19 pandemic:

- 1.** Invest in community-led solutions to address health equity

- 2.** Enforce a data ecosystem that promotes equity-driven decision making

- 3.** Increase accountability for health equity outcomes

- 4.** Invest in a representative health care workforce and increase equitable access to quality health care for all

- 5.** Lead and coordinate implementation of the COVID-19 Health Equity Task Force's recommendations from a permanent health equity infrastructure in the White House

Suggested Outcomes

Starting with these actions, we can create a nation where ...



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



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



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



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

In striving for these outcomes, the U.S. will advance health equity and the well-being of the nation. These outcomes offer a vision for a future in which all people living in the United States can live their healthiest, fullest lives; all communities thrive and flourish; and the disproportionate death and illness of communities of color and other underserved populations that took place during the COVID-19 pandemic becomes a hallmark of the past rather than a repeated pattern.

Spotlight on:

Beachwood Delivers

The city of Beachwood, Ohio (population: 14,040), started a food delivery-service to help restaurants stay afloat during the pandemic and give people access to safe food options. COVID-19 and the winter season made it necessary to provide delivery options to avoid exposure, but delivery-service companies can be incredibly expensive and take profits away from local businesses. The Beachwood administration realized the only way to help its restaurants and residents would be to provide that delivery service at no added cost to either group. Tod Bowen of the Ohio Restaurant Association praised the program and Beachwood for its ingenuity: “Beachwood Delivers is a great example of the city’s creativity and its commitment to its local restaurant community. We encourage every Beachwood resident to take advantage of this ingenious service and order from a great local restaurant ... every chance you get.” This program simultaneously ensured equitable food access and provided financial support to small businesses to keep them from losing their income. Originally scheduled to run December 21, 2020, through January 31, 2021, Beachwood Delivers was extended twice due to popular demand and ended March 31, 2021.

Wu, Annie. “Ohio City Temporarily Gets into the Food Delivery Business.” NPR, December 25, 2020. <https://www.npr.org/2020/12/25/950224177/ohio-city-temporarily-gets-into-the-food-delivery-business>.

Horansky, Andrew. “City of Beachwood Will Deliver Restaurant Meals for Free.” WKYC Studios, December 11, 2020. <https://www.wkyc.com/article/life/food/beachwood-deliver-restaurant-meals-free/95-0c10ad8f-577b-42e4-b38b-38692db82ad1>.

Piorkowski, Jeff. “Beachwood Offers Fee-Free Delivery from City Restaurants to Residents.” *Cleveland.com-Community News*, December 15, 2020. <https://www.cleveland.com/community/2020/12/city-of-beachwood-program-offers-fee-free-delivery-from-its-restaurants-to-residents.html>.

Case for Change

The COVID-19 pandemic has laid bare the human toll of pervasive structural and health inequities for communities of color and other underserved populations in the U.S.

Race, ethnicity, geography, income, ability, sexual orientation, gender and gender identity, immigration status, and other identities, either alone or in combination, should never stand in the way of equitable health. Unfortunately, this is a part of our nation's past and present. Health inequities did not begin with the COVID-19 pandemic, but we now have an opportunity to disrupt patterns of harm, offer course-correction, and transform inequitable systems, structures, practices, and processes. Health justice for all requires removing systematic limitations, promoting genuine partnerships across sectors, and establishing trustworthiness of public and private institutions responsible for supporting the well-being of *all* individuals and communities. The Task Force, chartered in response to the calamities of this pandemic, has seized this moment to build the foundation of intentionality, intersectionality, and justice to advance health equity in the U.S.

COVID-19 has affected all Americans, but not equally.

Communities of color and other underserved populations have experienced disproportionate rates of infection, hospitalization, and death due to COVID-19 and related complications.^{2,3} By the end of 2020, COVID-19 infected more than 20 million people in the U.S., disproportionately Black and Brown people and those with low income, and continues to infect Americans daily.^{4,5} For the first time since World War II, life expectancy in the U.S. fell by 1.5 years in 2020. This decrease was even more pronounced for Black/African American, Latino/Hispanic, and Indigenous and Native American people, whose communities have experienced reduced lifespan directly attributable to COVID-19.^{6,7} Asian/Asian American, Native Hawaiian, and Pacific Islander people have experienced worse COVID-19-related infection, hospitalization, and mortality rates than their white counterparts, which becomes more apparent when data are disaggregated.^{8,9} To this day, roughly one-half of the nationally reported data on cases and deaths have no associated race

or ethnicity data.¹⁰ Since August 2021, a sharp increase has occurred in the mortality rate outside of metropolitan areas and continues to increase.¹¹ Although data have been severely underreported, people with developmental and intellectual disabilities have also experienced increased mortality due to COVID-19.¹² Data limitations have hidden diagnosis, treatment, and mortality trends for communities of color and other high-risk communities, making many invisible, particularly those with intersectional identities.^{13,14,15,16}

“ ... [We must] push on the data that’s necessary. And we have to ... look at it through an intersectional view ... If we can’t talk about what it means to be a Black trans woman, then our data have failed us.”

– COVID-19 Health Equity Task Force member

Social and structural drivers of health inequities were exacerbated by the pandemic, hindering our ability to respond.

Even before the pandemic, many people of color, people with limited income, those with precarious employment, and those who are living in economically deprived areas had worse health outcomes than their white, financially-stable counterparts across numerous conditions, as well as overall physical and behavioral health.^{17, 18, 19, 20, 21} Many people from communities of color and other underserved populations experience barriers to care, including lack of affordable insurance and lack of accessible and affordable transportation.^{22, 23} In the U.S., a shortfall of almost 20,000 physicians stretched

thin hospital, primary care, and specialty care staff.²⁴ The current health workforce does not represent the diversity of our communities, which contributes to poorer health outcomes.^{25, 26} Rural hospitals across the country closed during the pandemic, while others overflowed with patients being cared for by a small and overworked group of health care providers.^{27, 28} When a vaccine became available, the public and private sectors did not have systems in place for equitable distribution, accessible services for people with disabilities, and information available in multiple languages.^{29, 30, 31}

Communities of color and other underserved populations face increased exposure to COVID-19 due to long-standing and current inequities beyond health.

Racist, discriminatory, and otherwise socially and economically inequitable policies limit opportunities for health.^{32, 33} Barriers to employment, familial wealth accumulation, and education result in Black and Brown people disproportionately holding essential occupations that carry higher risks of exposure to COVID-19, in part due to inadequate protective equipment.^{34, 35, 36} For some people with disabilities and serious illnesses, as well as populations unjustly concentrated in congregate

settings and crowded households, social distancing measures pose challenges and risks.^{37, 38, 39} Factors such as older age, limited access to economic resources, and geographic location can also contribute to increased exposure to environmental health risks such as air pollution, natural disasters, and lack of access to clean water and sanitation.^{40, 41} These factors must be addressed to mitigate these risks ahead of future pandemics.⁴²

“I never ever want to be in the situation where I’m handed one N95 and told that I need to wear it until it disintegrates on my face ... that can never happen again to us ... to be so unprotected, to feel so unsafe, to feel like we couldn’t go home to our families.”

– COVID-19 Health Equity Task Force member

COVID-19 triggered a confluence of health, educational, economic, and behavioral health crises.

Even as schools and facilities reopened in 2021, children, especially those in underfunded school districts, fell behind on their education.⁴³ Fifteen million people lost jobs within the first three quarters of 2020, most of whom—women and immigrants—were left unsupported by long-underfunded social services.^{44, 45} Housing insecurity and threat of rental eviction soon followed job loss.⁴⁶ Many communities of color and other underserved populations, such as the transgender and gender-expansive community,

“We need to recognize ... that a house divided against itself cannot stand when we face a pandemic, we have to ... recognize it as the enemy and put political differences aside and fight the enemy.”

– COVID-19 Health Equity Task Force member

already faced disproportionately high rates of homelessness, which have been intensified by COVID-19.⁴⁷ Until mid-August 2021, Federal and state data had not captured information as it relates to the experiences of LGBTQIA+ people.⁴⁸ Our outdated and underfunded public health infrastructure and health care system initially fell short on informing an equitable and real-time pandemic response.

People in the U.S who lost their jobs also lost employer-sponsored health insurance when they needed it most, not only for COVID-19 care, but also for pandemic-related anxiety, substance use, and depression. The financial strain of economic insecurity intensified the existing behavioral health crisis in the U.S., especially among women and youth.⁴⁹ For the more than 100,000 children who have lost caregivers, COVID-19 will have far-reaching

and lifelong effects.⁵⁰ Black and Brown people also reported alarmingly high rates of anxiety and depression.⁵¹ Social isolation and loneliness caused by COVID-19 social distancing requirements have been recognized to increase older adults' risk of anxiety, depression, cognitive dysfunction, heart disease, and mortality.⁵² COVID-19-related stress, anxiety, food insecurity, and economic insecurity also disproportionately affected LGBTQIA+ communities.^{53, 54} The opioid epidemic also worsened as a result of COVID-19, as overdoses spiked and those struggling with substance use disorders experienced isolation and barriers to treatment.⁵⁵ Between their limited ability to see providers in person due to stay-at-home orders and job-related loss of insurance, people could not access or pay for the behavioral health services they desperately needed.

Racist violence has harmed our communities, weighing heavily on those already suffering disproportionately from the pandemic.

Our nation continues to struggle with racism, homophobia, transphobia, Islamophobia, anti-Semitism, and other expressions of bigotry and hate. Throughout the past year, we have collectively experienced heartbreak and outrage at the increase in hate crimes witnessed in our communities. Asians/Asian Americans, Native Hawaiians, and Pacific Islanders became the targets of increased violence

and anger as xenophobia-related violence surged.⁵⁶ Widely publicized violence against Blacks, such as the murders of George Floyd and Breonna Taylor, exacerbated anxiety and depression experienced by Black and Brown people.^{57, 58} While structural inequity, police brutality, and racism existed prior to the pandemic, COVID-19 added to the significant burdens already faced by communities at high risk.⁵⁹

While inequities have plagued our health care and our governmental institutions, there is a once-in-a-generation opportunity for transformational change.

Our health care and public health infrastructure and workforce require renewed support to address health inequities. Our government, public sector, private sector, and health care institutions need continued creativity, collaboration, and commitment to change. Our nation must prioritize the care, vaccination, and lives of people in communities

of color and other underserved populations by expanding financial support for critically underfunded public health agencies.⁶⁰ Public-facing data should allow policy makers to direct resources to the hardest-hit groups and provide resource distribution information to communities in real time.

“... we are a country where inequities are really entrenched: racism, sexism, othering of communities, and basically othering [those who are] not white ... I’m excited that there is an opportunity ... [to] put out a set of recommendations to get on a path ... of moral progress, of building a more inclusive and multiracial democracy in this country.”

- COVID-19 Health Equity Task Force member

COVID-19 offered lessons on the importance of clear communication of scientific information to the public.

In addition to medical solutions, effective pandemic response relies on the trustworthiness of public health and medical institutions and the nation’s willingness to adopt safety measures. During 2020 and into the present, misinformation, conflicted messaging, and politicization of science undermined information from the government and the scientific community.^{61, 62} Historical traumas, everyday

discrimination, and medical racism—resulting in inequitable and ineffective care for communities of color and other underserved populations—are consistent demonstrations of a system that has not proven trustworthy.^{63, 64, 65, 66, 67, 68} Through tailored messages, trusted messengers, and meeting people “where they are,” our nation can better mitigate health inequities during public health emergencies.

In this report, the COVID-19 Health Equity Task Force presents a vision for transformational change that will help improve equity today and for years to come.

This report will shape the paths to transformation, offering key priorities and implementable solutions. Equity never happens by default. We must strive towards a new post-pandemic reality—one that puts data, clear communication, and community at the forefront of our pandemic response.





Spotlight on:

Rhode Island Health Equity Zones

Rhode Island is leading the way in advancing community-driven solutions with their Health Equity Zones. Each geographic area that is part of the initiative forms a collaborative of community stakeholders, conducts a needs and asset assessment, works with residents to prioritize what's important to the community and uses it to create and implement a data-driven plan of action. "A key feature of our Health Equity Zone initiative is that it puts the community's voice front and center, since residents understand the challenges facing their communities the best," says Rhode Island Director of Health Nicole Alexander-Scott. This initiative brings communities together to build solutions to their unique social, economic, and environmental challenges that are preventing people from being as healthy as possible. Ana Novais, Assistant Secretary of Rhode Island's Executive Office of Health and Human Services says, "This is truly a change in the way public health works. We usually are very disease-focused and this is a shift—stepping back and giving the power to the community, letting the community decide what health means, but really approaching it from a social determinants perspective." Over the course of the COVID-19 pandemic, Health Equity Zones across Rhode Island have distributed more than 2 million masks and 600,000 meals and administered more than 100,000 COVID-19 tests and 12,000 COVID-19 vaccines to the state's hardest-hit communities and residents. Rhode Island's Health Equity Zone initiative demonstrates how governments can value and benefit from collaborative partnerships with local communities.

Rhode Island Department of Health. "Health Equity Zones - Rhode Island." <https://health.ri.gov/publications/brochures/HealthEquityZones.pdf>. Rhode Island Department of Health. Accessed 2021. <https://health.ri.gov/publications/brochures/HealthEquityZones.pdf>.

Newman, Katelyn. "Health Equity Zones Offer Rhode Island Residents a Voice ... " *U.S. News & World Report*, February 18, 2020. <https://www.usnews.com/news/healthiest-communities/articles/2020-02-18/health-equity-zones-offer-rhode-island-residents-a-voice>.

Proposed Priorities

To take a bold step towards health equity, we, as a nation, must transform the status quo, hand in hand with communities, with continued attention from the administration and Federal Government. These priorities are necessary, concrete steps to begin the journey to a reimagined, equitable national health landscape.

We recommend the administration prioritize the following actions to address the inequitable health outcomes that communities of color and other underserved populations have experienced during the COVID-19 pandemic:

1. Invest in community-led solutions to address health equity

Establish dedicated resources for community-led solutions that improve health equity, drive timely actions, and are based in science and evidence. Communities hold expertise to identify and implement solutions that address their specific needs. Therefore, the government should invest in community-led solutions that offer communities in need funds that are easily accessible. Using innovative and community-based approaches and flexible funding mechanisms to design, mobilize, and implement solutions allows for better coordination, not only in public health emergencies, but also in everyday programs, policies, and practices. Individuals with lived experiences that can inform programming should lead these interventions, directing funding and other resources to the communities in which they live and work.

2. Enforce a data ecosystem that promotes equity-driven decision making

Government entities must collect, analyze, and share information on how people identify to make equity actionable. The Federal Government needs to establish and enforce equity-based standards for the collection of demographic and socioeconomic data in U.S. Census and health data, both at the individual and community level and that reflects residential and workplace location. After taking an inventory of available and relevant data and evaluating for accuracy and timeliness, government agencies should collaborate to expand data collection and data sharing efforts to perform disaggregated and intersectional analyses. Speed and timeliness of data collection and decision making can be achieved by continued innovations in rapid survey mechanisms and enhanced testing of real-time environmental biological data that are analyzed using community equity-oriented metrics. Government entities at all levels should support data sharing, but must establish and implement governance to protect confidentiality and personal information. With more robust data and a strengthened data infrastructure, the government can make more informed and timely decisions to meet the needs of highly affected populations during a pandemic.

3. Increase accountability for health equity outcomes

The United States must build health equity evaluation into funding, procurement, and grants processes to incentivize, measure, and improve public health and health care. Consistent and sustained attention to health equity measurement will enable the United States to assess and address widespread health inequities, preventing the repetition of these problems in the next pandemic. To address this, the Federal Government should develop a health equity framework, inclusive of metrics, health equity impact statements, and processes that government entities will use to hold themselves, external grantees, and vendors accountable to health equity outcomes.⁶⁹ This should include incorporating health equity measures and evaluation into funding, policies, practices, procurement, and grant-making processes to incentivize, measure, and improve equitable outcomes, and establishing penalties for failing to meet health equity measures.

4. Invest in a representative health care workforce and increase equitable access to quality health care for all

Government entities must significantly invest in the public health and health care workforce and incentivize equitable access and outcomes in health care delivery and public health preparedness, while prioritizing the highest risk populations in response, recovery, and resilience. Priorities should include designating sufficient resources for health care delivery and pandemic preparedness for communities of color and other underserved populations, promoting diversity and inclusivity in research, and increasing the size and representation of health care, public health, and emergency response workforces. Government entities should invest in the technical infrastructure needed for this work, as well as invest in those who carry out this work. These investments will reduce inequities in the capacity of public health agencies, public and private health care, emergency response, and educational institutions necessary to do this work. Funding will lift up institutions, programs, and groups that primarily represent and/or serve communities of color and other underserved populations or have a track record of training individuals from these communities.

5. Lead and coordinate implementation of the COVID-19 Health Equity Task Force's recommendations from a permanent health equity infrastructure in the White House

The administration can sustain its commitment to health equity by coordinating at the highest level of government. The White House should create a permanent health equity infrastructure, which will coordinate effort among the Departments and Agencies whose missions contribute to health equity and pandemic preparedness and response.

Suggested Outcomes

Starting with these actions, we can create a nation where ...



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

Communities will have the resources to identify and implement solutions to address their health needs. Public health, science, research, and government institutions will take actions informed by the expertise that communities of color and other underserved populations bring about their experiences. Communities will lead the design and implementation of the programs, solutions, and resources meant to address situations they face where they live and work. By communicating evidence-based information in ways that are culturally and linguistically responsive and accessible to all people, organizations will build strong collaborations that support health and well-being.



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

Our data represent the diversity of our communities and the many ways people self-identify along multiple dimensions. We will make decisions on how to best support communities and their health based on comprehensive, high-quality data that enable coordination across sectors. Supported by a well-funded, robust infrastructure, these data will be standardized, timely, accurate, and interoperable to enable disaggregated and intersectional data analysis. We will use evidence to drive research, enable efficient pandemic responses, and inform Federal programs that truly see, engage, and support communities where they live and work. Equity will be at the center of decision making, community action, and coordination across all sectors, and everyone will be visible in the data.



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

Communities that have experienced long-standing oppression, discrimination, health inequities, economic insecurity, and occupational and environmental hazards in the past and present will achieve greater justice and thrive in the future. All people will receive the best possible health care, education, and economic opportunities. Communities of color and other underserved populations will no longer experience a disproportionate burden of adverse short- and long-term health outcomes related to COVID-19. As a nation, we will disrupt the predictability of who is harmed first and who is harmed worst. All communities will have the resources that enable them to prepare for and recover from pandemics. We will establish standardized metrics, benchmarks, and targets to drive accountability. We will use incentives, penalties, and additional levers to advance health equity.



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

The United States will have the people, skills, and resources it takes to maintain strong health care and public health systems. Communities that have experienced disproportionate illness, disability, and death in the past will access the high-quality physical and behavioral health care they need for their well-being. Providers will reflect the diversity of the communities they serve and understand the needs of different populations that have experienced inequities. We will fund health and the prevention of health inequities as a top priority, reflecting the value we place on the lives of current and future generations.

In striving for these outcomes, the United States will advance health equity and the well-being of the nation. These outcomes offer a vision for a future in which all people living in the United States can live their healthiest, fullest lives; all communities thrive and flourish; and the disproportionate death and illness of communities of color and other underserved populations that took place during the COVID-19 pandemic becomes a hallmark of the past rather than a repeated pattern.



Spotlight on:

COVID-19 Vaccine Outreach Program at UMSOM

Two departments at the University of Maryland School of Medicine (UMSOM) are partnering with community groups to address vaccine hesitancy in underserved groups across Maryland, Delaware, Virginia, and West Virginia. The program, funded by the Health Resources and Services Administration, uses a grassroots approach to provide culturally and linguistically tailored communications and outreach that meet the specific religious, ethnic, and socioeconomic needs of each community. Community health workers, outreach workers, and family peer specialists have been hired to go directly into communities. Some members of the community-based workforce are visiting hard-to-reach communities in a public health messaging truck; others are engaging with people experiencing homelessness using street-based outreach or connecting with post-penitentiary populations through behavioral health providers. Niharika Khanna, M.B.B.S., M.D., D.G.O., a professor at UMSOM, says, “It is critical to understand that the objections and concerns about getting vaccinated are real and valid in these communities in order to address them. We must acknowledge them and tailor our conversations accordingly.” This program is doing everything it can to help vaccines reach all communities and doing so in a way that is intentional and culturally aligned.

University of Maryland School of Medicine. “Grant Expands COVID-19 Vaccination Outreach.” *University of Maryland - Baltimore News*, September 3, 2021. <https://www.umaryland.edu/news/archived-news/september-2021/78m-grant-to-expand-covid-19-vaccination-outreach.php>.

Recommendations

After gathering input from government agencies, subject-matter experts, stakeholders, and members of the public, the Presidential COVID-19 Health Equity Task Force has developed and approved the following 55 recommendations to advance four suggested outcomes. The Task Force requests the administration act on all recommendations, acknowledging the need to prioritize action based on immediate, short-term, and long-term needs. For the full list of recommendations, please see the appendices.

Communications and Collaboration



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

1: Partner with communities to expand vaccination to underserved groups. The Federal Government should strengthen efforts to partner with local community-based organizations to collect, disseminate, and implement best practices to expand testing and vaccination efforts to reach communities of color and other underserved populations, where they live and work. Best practices, for example, for large immigrant/migrant populations, should include, but not be limited to, partnering with trusted faith and community organizations, avoiding a military or law enforcement presence, providing accurately translated information, employing trained interpreters, and advertising that services for people with limited English proficiency or who are more comfortable with another language are available. Innovative methods, such as mobile health care services to reach isolated or homebound populations, should be culturally, linguistically, and economically appropriate.

2: Fund organizations that work with communities of color and other underserved populations. The Federal Government should further strengthen collaboration with a diverse array of community-based organizations and public health providers by providing robust and sustainable funding for them to build capabilities, access technical assistance, and establish partnerships with communities of color and other underserved populations. This should be done through engagement with trusted entities to build coalitions for inclusion in public health emergency and pandemic preparedness, response, and recovery activities so that care is brought closer to the communities served and in settings that people trust.

“After seeing how badly this pandemic has impacted not only our health care system, but also ... our entire nation ... I think now’s the time to create ... [a] unified message that health care needs to be a human right.”

- COVID-19 Health Equity Task Force member

3: Conduct communications campaigns during public health emergencies. During any public health emergency, the Federal Government should lead a multi-pronged education, outreach, and communications campaign with additional specific campaigns tailored to targeted communities. These campaigns should use science-based, non-political sources by partnering with state, local, Tribal, and territorial health care institutions, community organizations, and other trusted sources to promote public health prevention behaviors, such as vaccine awareness and uptake, testing, contact tracing, masking, and social distancing, within local communities, paying particular attention to institutions and organizations that serve communities who have been hardest hit by COVID-19 exposure, illness, and death. The communications should be adapted to the cultural and linguistic context of communities of color and other underserved populations, and must also be accessible to people with diverse types of disabilities.

4: Partner with worker organizations for equitable health care access. The Federal Government should launch a formal partnership with trade unions and additional worker organizations representing farmworkers, frontline and essential workers, underserved immigrant and migrant workers, and those disproportionately affected due to their immigrant or refugee backgrounds for equitable access to health care services and inclusion in pandemic and public health emergency preparedness, response, and recovery activities. These partnerships should also work with the Federal Government authorities to inform development and enforcement of necessary occupational health standards and regulations relevant to pandemic control.

5: Execute a Long COVID communication campaign. The Federal Government should execute a robust communication campaign and establish an information resource center to educate the public on Long COVID in ways that are culturally and linguistically appropriate and accessible to people with disabilities. This campaign should include efforts to reach communities of color and other underserved populations, where they work and live, as well as health care workers that serve them.

6: Create a definitive pandemic response authority. The Federal Government should leverage Federal authorities for public health emergency, pandemic, and disaster response to establish a definitive Federal authority for coordinating and leading COVID-19 and future pandemic responses, inclusive of apolitical representatives with scientific and technical expertise that represent all vital stakeholders (including science, research, health care, communications, public health emergency, and disaster response) and expertise for centering equity for inclusion of communities of color and other underserved populations. This authority should coordinate, fund, research, and communicate response, diagnosis, and treatment.

7: Update the Crisis Standards of Care. The Federal Government should convene a multidisciplinary panel, including clinicians, civil rights attorneys, ethicists, health equity experts, and community members to assess and update the Crisis Standards of Care work produced by the National Academies of Science, Engineering, and Medicine for equity. The Federal Government should widely disseminate these standards, explaining their benefit, and incentivize adherence through accreditation and reimbursement requirements.

8: Collaborate with communities on research. The Federal Government should develop guidelines for engaging communities in research, including requiring reporting as part of the evaluation for ongoing funding. The Federal Government should incentivize community engagement in research and require grantees performing research to seek, incorporate, and report on community input. This feedback should be sought through culturally and linguistically responsive outreach to encourage communities to provide substantive input to research questions, research design, results, and publications.

9: Conduct a COVID-19 after action review. 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, Tribal, and territorial levels, including their respective roles in pandemic response, and make recommendations to improve preparedness and pandemic response in the future. The panel should seek input from diverse, non-governmental stakeholders and build on this Task Force report.

Data, Analytics, and Research



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

10: Use data to inform equity-centered pandemic response decisions. The Federal Government and state, local, Tribal, and territorial health departments should identify and leverage existing sources of quantitative and qualitative data, including location information, to make data-informed, timely, and accurate equity-centered decisions regarding outreach and planning activities and resource allocation (e.g., testing, vaccination allocation and distribution, monoclonal antibody treatment and other therapies). Incomplete health surveillance data should not prevent health authorities from prioritizing groups who have increased risks associated with their underlying health conditions or other risk factors.

11: Track and report on health outcomes for people in congregate and high-risk settings. The Federal Government should work with state, local, Tribal, and territorial health departments to establish efforts to track and report the health and health status and outcomes of people in congregate settings (e.g., carceral settings, nursing and long-term care, foster care facilities and group homes, homeless shelters) and other settings with increased risk of exposure in real time and develop and research evidence-based interventions, such as early release/decarceration or voluntary stepdown care from an assisted living center, to protect health and prevent death. Efforts should result in the safe relocation of people who are most at risk of dying in a congregate setting due to a pandemic-related illness.

12: Standardize demographic and socioeconomic categories in data. Federal entities with authorities to set data standards should establish standardized socioeconomic and demographic categories (individual level and area-based) to improve the timeliness, accuracy, and disaggregation of data elements. Federal agencies and programs should be granted approval to collect this disaggregated data on their programs. The Federal Government should enhance public access to the most timely, accurate, and disaggregated data for Federal programs and funding while developing policies to prevent the misuse of these data. The Federal Government should develop a COVID-19 equity dashboard using these data.

13: Support equity-centered data collection. The Federal Government should fund an equity-centered approach to data collection, including ensuring sufficient funding to collect data for groups that are often left out of data collection (e.g., people with disabilities, those in congregate settings, LGBTQIA+ people, etc.). The Federal Government should remove administrative barriers, approve and support all agencies to comply with collection and reporting of expanded health equity data elements based on standard disaggregated sociodemographic data and health equity metrics to achieve outcomes.

“Suppression of data can hide problems, and that such suppression can challenge efforts to organize for justice. More data are needed to capture relationships ... that can help to study the connections between racialized rates of COVID-19 infection and economic injustice.”

- Public meeting guest speaker

14: Research COVID-19 interventions in educational settings. As schools reopen, the Federal Government should support equity-centered implementation research around the effectiveness of social distancing, masking, respirators, and other interventions on mitigating transmission risk within educational settings and the impact on educational outcomes for children. The Federal Government should work with state, local, Tribal, and territorial school districts as well as postsecondary education institutions in developing and enforcing plans and policies using these evidence-informed measures. Based on this research, the Federal Government should develop clear and implementable standard guidelines for action and tie their adherence to funding incentives to further support educational agencies.

15: Research and collect data on behavioral health. Federal, state, local, Tribal, and territorial governments should invest in data infrastructures to collect, integrate, and share data related to behavioral health, including continuum of prevention, testing, treatment, including hospitalizations, prescriptions, utilization of community-based therapy, intensive care unit admissions, recovery support services, and fatalities. Data should be disaggregated by a core set of standardized socioeconomic and demographic characteristics to help understand the impact of COVID-19 on local communities and guide improvement and expansion of resources for behavioral health supports and services especially for communities of color and other underserved populations.

16: Further promote and invest in research to understand and eliminate structural racism in health care systems. The Federal Government should fund, incentivize, promote, and apply practice-based research aimed to develop and evaluate solution-oriented interventions to minimize and/or eliminate structural racism, sociocultural, economic structural, institutional, and interpersonal discrimination in health care systems, including, but not limited, to structural racism that results in negative health impacts and disparities in outcomes for communities of color and other underserved populations. This should include assessment of clinical practice guidelines, health-related algorithms and artificial intelligence, and health information technology to correct for racial and other types of social and economic discrimination in these technologies, and biased foundational principles and practices.

17: Set a national research agenda on health equity and COVID-19. The Federal Government should expand on existing efforts to set a national research agenda centered on health equity and COVID-19 that strengthens population health monitoring and analysis of population health data. The government should lead and promote public-private partnerships and investments with a special emphasis on community-based participatory research and population-based inclusive health surveillance (with overrepresentation of underrepresented at-risk groups). The government should require that participants are representative of communities of color and other underserved populations from pediatric to geriatric populations to gather disaggregated data for these high-risk populations.

18: Improve clinical trial best practices. The Federal Government should develop standards and recommendations to improve representation from communities of color and other underserved populations in clinical trials related to special pathogens, including setting diversity enrollment targets in clinical trials.

19: Fund data modernization for health settings. The Federal Government should provide funding/incentives to advance data modernization initiatives for hospitals (including Veterans Affairs hospitals), community health centers, and state, local, Tribal and territorial departments to update data systems centered on equity and to ensure interoperability and automatic electronic lab reporting of a robust set of disaggregated, standardized socioeconomic and demographic data elements to ensure real-time information can be shared quickly. The Federal Government should create health surveillance surveys with intersection of race and ethnicity, education, economic and linguistic diversity to inform health equity decision making and actions.



Structural Drivers and Xenophobia



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

20: Strengthen affordable broadband access. In the short term, the Federal Government should strengthen access to affordable broadband internet in medically underserved communities, including rural, Tribal, and territorial communities, to minimize barriers to accessing medical, mental health, and substance use disorder services via telehealth and telemedicine. This includes creating funding and incentives to research, identify, and implement interventions to address internet deserts.

21: Support schools in meeting family needs. The Federal Government should expand schools' ability to meet children's and families' holistic needs, including those related to COVID-19. Strategies include investing in Full-Service Community Schools that provide one-stop shop access to social services (e.g., educational, social and emotional development, physical health, and behavioral health) and expanding programs that provide students access to free meals and other support services, even during school closures.

22: Create protections for workers. The Federal Government should use the Occupational Safety and Health Administration and other authorities to protect all workers from occupational exposure during pandemics by developing temporary and permanent health and safety standards for long-standing infectious diseases, as well as new and emerging infectious disease threats (including COVID-19), and updating relevant agency guidance. The Federal Government should develop an emergency response plan to assess and quickly meet the needs of health care and essential workers in future pandemics to protect from aerosol or other modes of transmission. The Federal Government should incentivize employers to provide paid time off and wage replacement programs to account for future pandemic-related testing, vaccine administration, and recovery.

“When we say that not enough people speak a specific language to reach out to members of that community, we are marginalizing and effectively discriminating against that community.”

- Public meeting guest speaker

23: Invest in workers and working families. The administration should work with Congress to rebuild and invest in our nation by creating jobs with family sustaining wages and benefits, developing mechanisms to protect and empower workers in the workplace, and investing in childcare, early learning, home and community-based care, and other family support needs to support returning to the workforce, and especially for women, communities of color and other underserved populations overburdened by COVID-19.

24: Ensure safe ventilation practices in congregate settings. The Federal Government should work with regulators, policy makers, and suppliers to ensure safe ventilation practices and regularly evaluate such practices in congregate settings.

25: Increase affordable, accessible housing. The Federal Government should take action to increase the supply of high-quality, affordable, accessible, and supportive housing and expand the effectiveness of programs that enable people to remain housed during a public health emergency, including renewing the eviction moratorium, funding assistance for missed rent and legal services to those facing eviction, expanding housing-first programs, strengthening housing and lending anti-discrimination laws, and prohibiting disqualification for U.S. Department of Housing and Urban Development vouchers based on criminal drug history.

26: Invest in a virtual education infrastructure. The Federal Government should provide sufficient funding for appropriate technology, training, and support to students, educators, and faculty to enable the continuation of quality education and related services in instances where schools must dynamically shift between in-classroom and remote learning contexts, as may be required by future pandemics.

27: Provide safety nets during public health emergencies. During public health emergencies, the Federal Government should use its full executive authority and work with Congress to provide safety nets and monitor the need for and provision of them to ensure people experience food, housing/shelter, and economic and workplace security and receive support with health care-related travel, lodging, and caregiving needs.

28: Make postsecondary and workplace training more affordable. The Federal Government should increase funding for financial aid programs and implement loan repayment pause programs during future pandemics to address attrition and affordability of postsecondary and workplace training programs for students from communities hardest hit by COVID-19.



29: Advance cultural responsiveness and language access for Asian/Asian Americans, Native Hawaiians, Pacific Islanders, and other populations facing pandemic-fueled discrimination and xenophobia. The Federal Government should advance cultural responsiveness to language access and increase awareness of different experiences of Asian/Asian Americans, Native Hawaiians, Pacific Islanders, and other populations facing pandemic-fueled xenophobia and discrimination by:

- Requiring Federal agencies to make communication transparent, culturally and linguistically inclusive.
- Allocating sufficient funding to Federal agencies to review enforcement of anti-discrimination protections and implementing solutions to address gaps in investigating and prosecuting allegations of discrimination.
- Enforcing anti-discrimination protections for Asian/Asian American, Native Hawaiian and Pacific Islander health care workers.
- Supporting education about Asian/Asian Americans, Native Hawaiians, Pacific Islanders, and other communities facing xenophobia and discrimination related to the pandemic history in schools and postsecondary education.
- Mobilizing action plans to quickly respond to discrimination and hate crimes.
- Using an equity-centered approach to create future pandemic plans to combat discrimination.

30: Fund access to healthy food options. Create funding and incentives to research, identify, and implement interventions to support communities that have limited access to healthy food options, including by expanding Federal nutrition safety net programs and using technology to make those programs more accessible.

31: Commit to improve environmental justice. The Federal Government must advance and extend its commitment to environmental justice during pandemics and future health-related emergencies by ensuring access to clean water and sanitation, establishing a low-income utility assistance program, using disaggregated data to assess exposure to hazards and allocate utilities, developing and modifying water, sewage, and air quality standards, and instituting a moratorium on water and utility shut-offs during pandemics.



Health Care Access and Quality



Everyone has equitable access to high-quality health care.

32: Improve health equity through measurement and incentives. The Federal Government should improve health equity in care delivery through measurement, incentives, and accountability by:

- Developing a health equity framework, inclusive of formal metrics, equity impact statements, and process to monitor factors such as social determinants of health, quality of care, and health care discrimination, at a range of geographic levels from national to local.
- Supporting the development of reimbursement models that encourage data- and community-driven approaches focused on improving equity-centered health care delivery for communities of color and other underserved populations where they live and work.
- Providing payment incentives to providers that improve metrics of health care quality and patient experience in communities of color and other underserved populations.

“Health is the interplay of so many other social factors... we have not ... acknowledged that reality sufficiently in our policies and practices and procedures to date ... what it makes clear is that health care is vital. Access to high-quality health care is a must, but so is access to stable housing, so is nutritious food ... economic stability, and ... education... One of the truths that COVID-19 made clear is that there’s an opportunity to center health in all policies in a way that we perhaps haven’t achieved before.”

- COVID-19 Health Equity Task Force member

33: Support Long COVID insurance coverage and treatment. Given our limited understanding of Long COVID, the Federal Government should take steps to address needs of people with Long COVID and to mitigate future inequities by:

- Communicating unified ICD-10 for Long COVID so that medical providers can accurately classify the diagnosis, treatment, and billing for Long COVID. This is intended to prevent patients from being denied coverage for the diagnosis and treatment of Long COVID and support the growing body of real world evidence on care.
- Creating more inclusive health insurance and temporary disability policies and benefits that recognize Long COVID as a health condition with a diagnostic schema that identifies people who have Long COVID without a positive COVID-19 test.
- Banning coverage limits for Long COVID and ensure treatment regardless of insurance status to extend existing protections during the pandemic.
- Continuing to update and disseminate standards and protocols for diagnosis and management of Long COVID.

34: Prioritize vaccine, testing, treatment, and personal protective equipment access to underserved communities. Federal, state, local, Tribal, and territorial governments should prioritize vaccine distribution, testing, treatment, and personal protective equipment access to communities of color and other underserved populations, including those who face mobility, geographic, or other barriers to access. These barriers should be eliminated through accessible distribution locations, transportation, and communication campaigns tailored to specific groups (e.g., young adults, Veterans, people with disabilities, rural communities) in multiple languages.

35: Expand telehealth and telemedicine access and reimbursement. Expand access and reimbursement for telehealth and telemedicine, including telephone visits when effective video-based telehealth and telemedicine are unavailable, to reduce barriers to access for appropriate health services due to loss of wages, stigma, trauma, and safety during a pandemic.

36: Collect best practices on culturally and linguistically responsive contact tracing. The Federal Government should work with state, local, Tribal, and territorial health departments to collect best practices on culturally and linguistically sensitive approaches to contact tracing to improve policies and implementation and ensure testing is accompanied by effective contact tracing and support services.

37: Mitigate risk of COVID-19 infection in carceral settings. To mitigate the increased risk of COVID-19 and other airborne contagions in carceral settings, the Federal Government should ensure access to equity-centered preventative adult and pediatric vaccination, testing, treatment, and recovery in carceral settings as well as continuity of Medicaid coverage after release for those previously enrolled.



38: Accept all patients and offer community resources at Long COVID care centers.

The Federal Government should require multidisciplinary Long COVID care centers it funds to:

- Accept patients—from pediatric to geriatric—regardless of insurance coverage, when or how they have been diagnosed, and whether or not they have been hospitalized.
- Offer equity-centered resources, information, and training to safety net health systems (e.g., Federally Qualified Health Centers, Indian Health Service, Rural Health Clinics) and disseminate best practices and treatment approaches that enhance access to high-quality care to everyone where they live.

39: Implement solutions for those at increased risk of death from COVID-19.

The Federal Government should identify comorbidities linked with increased risk of death from COVID-19, which exist at a higher rate among communities of color and other underserved populations, and develop and fund innovative, equity-centered interventions to reduce those comorbidities, such as healthy food, better air quality, and places for safe physical activity where people live and work.

40: Reduce barriers to testing, vaccinations, and treatment. The Federal Government should reduce barriers for communities of color and other underserved populations, including uninsured individuals, to accessing testing, vaccinations, and treatment/therapeutics as standard practice during a pandemic by:

- Not requiring insurance coverage for testing, vaccination, and treatment during a pandemic.
- Removing billing information barriers to those administering tests, vaccines, and treatment.
- Reimbursing testing, vaccination, and treatment for uninsured individuals.

41: Fund the public health workforce and emergency response. The Federal Government should increase and sustain funding for equity-centered pandemic and public health emergency activities and infrastructure at the Federal, state, local, Tribal, and territorial levels. This should include long-term investment in building a workforce dedicated to public health emergency preparedness, response, recovery, and disaster-related behavioral health services to support communities with the greatest health care inequities. Funding must be sustained and implementers held accountable to maintain the public health infrastructure and workforce.

42: Stockpile and distribute sufficient personal protective equipment. The Federal Government must maintain an adequate stockpile of personal protective equipment and other essential supplies for equitable distribution to disproportionately affected communities in sufficient quantities. The Federal Government should also create a rapid emergency production plan across public and private sector manufacturers and distributors that enforces standards used to produce and disseminate personal protective equipment for health care providers and frontline and essential workers.



43: Strengthen the care continuum for older adults and people with disabilities.

To support the health of elders and those living with disabilities, the Federal Government should strengthen the care continuum across the many settings of care (e.g., post-acute, long-term care, assisted living, senior centers, and home). This investment should strengthen the infrastructure that supports care in home and community-based settings. The Federal investment should include greater financial support for home and community-based long-term services and supports, disaster and pandemic response that helps people in congregate settings transition successfully to safer settings, plans for stepdown between settings, and improved wages and benefits for the direct care workforce. As part of pandemic preparedness and planning, consistent with the integration mandate in the Americans with Disabilities Act, the Federal Government should reduce overreliance on congregate settings as the default housing for people with disabilities across the age spectrum and help expand access to home and community-based long-term services and supports.

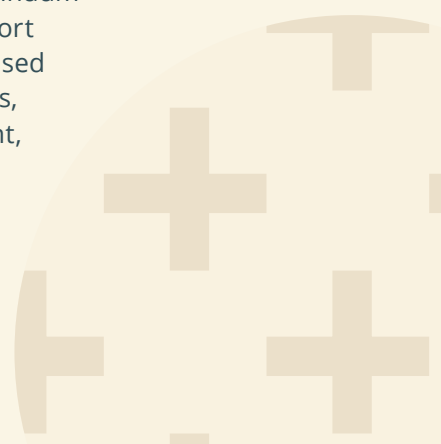
44: Increase support for equity-centered public provision of health insurance.

The Federal Government should increase access to equity-centered, high-quality care by:

- Expanding eligibility criteria for Federally sponsored or subsidized insurance programs (Medicaid, Children’s Health Insurance Program, etc.) and ensuring these criteria are equity-centered.
- Expanding access to Consolidated Omnibus Budget Reconciliation Act coverage, ensuring that it is affordable, and mandating that coverage cannot be terminated for those who have lost their jobs due to the economic impacts of the pandemic.
- Reducing the age of Medicare eligibility to 55 to address health inequities driven by lack of insurance and underinsurance.
- Expanding all government health insurance programs to ensure that people currently uninsured or underinsured have equitable access to care.

45: Expand care access to students and families. The Federal Government should develop a comprehensive plan to expand access to affordable, high-quality, equity-centered health care including medical, vision, dental, and behavioral health services for students and their families in communities of color and other underserved populations, especially in K-12 schools serving a significant number of students of color. The plan should include early childhood, K-12, and postsecondary educational institutions (as appropriate).

46: Increase access to behavioral health care. Federal, state, local, Tribal, and territorial governments should increase investment in and access to comprehensive, care continuum and equity-centered behavioral health interventions, treatments and recovery support for communities during the COVID-19 pandemic, including expanding community-based behavioral health services that include prevention, effective community-based models, integrative care - collaborative case management models, mobile crises management, effective jail diversion, harm reduction, and innovative treatment for substance use disorder instead of incarceration.



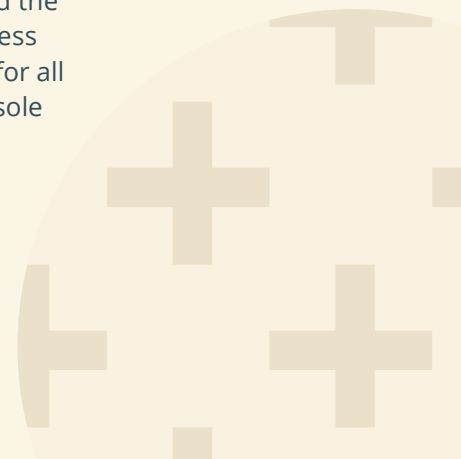
47: Curtail hospital and health facility closures. The Federal Government should curtail hospital and health care facility closures that negatively affect communities of color and other underserved populations (e.g., Critical Access Hospitals, sole community hospitals, hospitals with a high population of Medicare and Medicaid beneficiaries) in the short term, while developing long-term solutions that make these facilities economically sustainable and capable of delivering equity-centered quality care.

48: Fund the Indian Health Service. The Federal Government should fully fund the Indian Health Service and self-determined Tribes as recommended by the Indian Health Service budget formulation committee for health care and health services for Indigenous persons who receive care through the Indian Health Service and other facilities. Additionally, the Federal Government should consider commitment of future funding through the Indian Health Service to establish capabilities for public health emergency and pandemic preparedness, response, and recovery for all Indigenous persons, whether on or off Federally-recognized reservations or other Tribal lands. This funding should be directed to:

- Reduce administrative burden.
- Address cultural and linguistic barriers to health care.
- Combat the high incidence of disability.
- Expand and enhance the culturally responsive workforce to address the health professional shortage.
- Provide sustained and increased funding to Tribes for environmental health, sanitary, utility, and transportation infrastructure to address community needs and prioritize delivery of necessary supplies related to COVID-19 or future pandemics.

49: Incentivize COVID-19 treatment by homeless service providers. The Federal Government should encourage and incentivize state homeless service providers and state, local, Tribal, and territorial service providers to address COVID-19 and Long COVID in people experiencing homelessness (e.g., special populations such as homeless youth or veterans) or anyone unable to quarantine safely (e.g., those living in multigenerational housing). Strategies include funding medical respite programs, extending shelter hours, minimizing barriers to care, improving quarantine capabilities, increasing shelter capacity, and providing health care access to people in congregate settings.

50: Expand essential health benefits and coverage. The Federal Government should work to expand the definition of essential health benefits to include coverage and reimbursement for health and well-being services to address patient comorbidities, home- and community-based long-term services and supports, pre-existing conditions, and the full scope of patient care (e.g., medical, dental, auditory, and vision services) to address health care needs during a pandemic. These should be reimbursed at the same rate for all people, including requiring all Medicaid plans to reimburse Critical Access Hospitals, sole community hospitals, and hospitals with a high population of Medicare and Medicaid beneficiaries and/or vulnerable patients at a minimum of the Medicare cost-based reimbursement rate.



51: Improve Medicare and Medicaid payment parity for behavioral health. The Federal Government should identify and address barriers to the Medicare and Medicaid payment system from a perspective of equity to ensure that there are equitable rates, and that parity exists between behavioral health and physical health payment across Medicare and Medicaid and other government health insurance programs.

52: Develop standards for behavioral health equity. The Federal Government should collaborate with trusted national partners and state, local, Tribal, and territorial experts to develop both steady state and disaster behavioral health standards to ensure access to equity-centered behavioral health care for communities of color and other underserved populations, as well as health care providers, youth, Veterans, childcare workers, and community leaders. These standards should increase access to comprehensive treatment options, intellectual and developmental disabilities services, prevention, recovery and peer support services, and substance use disorder interventions and services.

53: Fund equity-centered training in health education programs. The Federal Government should increase funding to provide equity-centered education and training at all levels of the health care and public health workforce that incorporates social determinants of health, and ways of addressing systemic, structural, institutional, and interpersonal social and economic biases adversely affecting public health and health care practices. This training and education should encompass equity-centered pandemic response and routine care delivery.

54: Increase capacity and representation of the health workforce. The Federal Government should fund the equity-centered development of a racially, ethnically, culturally, and linguistically diverse and representative health workforce across all fields (e.g., acute care, behavioral health) and at all levels who live in or are from communities of color and other underserved populations, as well as first-generation populations and people who speak languages other than English.

55: Recognize health care as a human right. The U.S. should recognize and establish health care as a human right, regardless of immigration status, by enacting legislation and regulations with sufficient and sustainable funding that provide health care access and coverage for all.



Conclusion

The recommendations outlined in this report set the stage for changes needed to improve health equity and pandemic response. This report includes companion material that proposes next steps for this work: an implementation plan and an accountability framework. The former suggests action steps for implementers to use when advancing these recommendations. The latter consists of a logic model and evaluation framework with suggested key performance indicators and dashboards for tracking progress.

The Task Force urges government agencies at all levels and non-governmental actors alike to review these recommendations and use the resources provided to begin implementation. Together we can transform the status quo and achieve the equitable national health future that we imagine.



Spotlight on:

California Broadband Services

As being connected to the internet becomes a key part of the way we work, learn, and connect, California has taken steps to provide increased broadband access to low-income individuals. The California Public Utilities Commission (CPUC) updated the California LifeLine Program to include low-cost and no-cost mobile data services. Genevieve Shiroma, CPUC Commissioner, notes how the program will make the pandemic less burdensome for many, “The COVID-19 pandemic has underscored that broadband is a critical service and laid bare the depth of the digital divide in California and across the country. The LifeLine Program must support affordable choices for Californians across the state, including rural and urban Californians, households and individuals who need no-cost wireless services, and struggling families who need mobile family plans or fixed voice or broadband services. This decision brings broadband service for the first time into our LifeLine proceeding as the COVID-19 pandemic has emphasized the importance of broadband access for all Californians to support distance learning, telehealth, and working from home.”

“CPUC Revises California Lifeline to Better Serve Low-Income Customers amid the COVID-19 Pandemic.” California Public Utilities Commission, October 8, 2020. <https://www.cpuc.ca.gov/news-and-updates/all-news/cpuc-revises-california-lifeline-to-better-serve-low-income-customers-amid-the-covid-19-pandemic>.



Spotlight on:

UAMS Geriatric Buddy Program

The University of Arkansas for Medical Sciences (UAMS) is preventing social isolation and loneliness for older adults during the COVID-19 pandemic with their Geriatric Buddy Program. Medical residents, fellows, and third- and fourth-year students from several UAMS colleges can volunteer to virtually visit with nursing home residents or older adults living by themselves. Buddies can engage in several activities together over virtual platforms, including playing games, reading books, and listening to music. This increases social interaction for older adults and helps ensure their social and health needs are being met. UAMS geriatrician Priya Mendiratta, M.D., one of the program's leaders, says, "Isolating the elderly might reduce transmission of the virus, but we have to look into strategies to help them stay mentally and physically well. ... We all need to reach out to older neighbors in our neighborhoods. We all need to take those small steps."

"Geriatric Buddy Program Eases Social Isolation during COVID-19: AHA." American Hospital Association. <https://www.aha.org/other-resources/2020-11-11-geriatric-buddy-program-eases-social-isolation-during-covid-19>.

Appendices

Acronyms

ACF	Administration for Children and Families (within HHS)	EVCTF	Equity and Vaccine Confidence Task Force	PASC	Post-acute sequelae SARS-CoV-2 infection, or Long COVID
ADA	Americans with Disabilities Act	FEMA	Federal Emergency Management Agency	PCC	Poison Control Center
AHRQ	Agency for Healthcare Research and Quality	FSIS	Food Safety and Inspection Services	PPP	Paycheck Protection Program: offered forgivable low-interest loans to small businesses facing uncertainty due to the COVID-19 pandemic
ARPA	Advanced Research Projects Agency	FYSB	Family and Youth Services Bureau (within the ACF)	PUF	Public Use File
CARES Act	Coronavirus Aid, Relief, and Economic Security Act	HHS	Department of Health and Human Services	RHY	Runaway and Homeless Youth
CCDF	Child Care and Development Fund	HRSA	Health Resources and Services Administration	SLTT	State, local, Tribal and territorial
CDC	Centers for Disease Control and Prevention	HUD	Department of Housing and Urban Development	SOGI	Sexual orientation, gender identity
CMS	Centers for Medicare & Medicaid Services	IA	Individual Assistance	USDA	United States Department of Agriculture
CSAT	Center for Substance Abuse Treatment (within the DPT)	MCBS	Medicare Current Beneficiary Survey	USFDA	United States Food and Drug Administration
DHS	Department of Homeland Security	OCC	Office of Child Care (within the ACF)		
DoED	Department of Education	OCR	Office of Civil Rights		
DOJ	Department of Justice	OEDA	Office of Enterprise Data and Analytics (within CMS)		
DPT	Division of Pharmacologic Therapies	OTIP	Office on Trafficking in Persons		
ED visit	Emergency department visit	OTP	Opioid Treatment Programs (within the DPT)		

Glossary of Terms

TERM	DEFINITION
Ableism	Ableism is “the discrimination of and social prejudice against people with disabilities based on the belief that typical abilities are superior. At its heart, ableism is rooted in the assumption that disabled people require ‘fixing’ and are defined by their disability. Like racism and sexism, ableism classifies entire groups of people as ‘less than,’ and includes harmful stereotypes, misconceptions, and generalizations of people with disabilities.” ⁷⁰
Ageism	“Ageism refers to the stereotypes (how we think), prejudice (how we feel), and discrimination (how we act) towards others or oneself based on age ... Ageism affects everyone. Children as young as 4 years old become aware of their culture’s age stereotypes. From that age onwards they internalize and use these stereotypes to guide their feelings and behavior towards people of different ages. They also draw on culture’s age stereotypes to perceive and understand themselves, which can result in self-directed ageism at any age. Ageism intersects and exacerbates other forms of disadvantage including those related to sex, race, and disability.” ⁷¹ Ageist discourse has been prevalent through the pandemic, “with older people being potentially disadvantaged and positioned as more expendable than persons in other age groups.” ⁷²
Behavioral Health	SAMHSA and HRSA define behavioral health as a general term “used to refer to both mental health and substance use.” ⁷³
Communities	When we mention “Communities” in this report, we are referring to any subset of people who share a common identity, live near each other, or work together. This includes the Black community, the Latino community, the Asian/Asian American, Native Hawaiian, and Pacific Islander communities, the LGBTQIA+ community, rural communities, urban communities, the disability community, older adults, young people, people experiencing homelessness, people in carceral settings, people in group homes, essential workers, and many others. <i>For a full list of communities and settings considered in the development of this report, please see “Key Populations and Settings” on page 9.</i>
Congregate Settings	“A congregate setting is an environment where a number of people reside, meet, or gather in close proximity for either a limited or extended period of time. Examples of congregate settings include transitional housing, group homes, prisons, detention centers, schools, and workplaces. These facilities must implement activities to minimize the impact of COVID-19 in their settings.” ⁷⁴
Disability	The Americans with Disabilities Act defines a person with a disability as “a person who has a physical or mental impairment that substantially limits one or more major life activity. This includes people who have a record of such an impairment, even if they do not currently have a disability. It also includes individuals who do not have a disability but are regarded as having a disability. It is unlawful to discriminate against a person based on that person’s association with a person with a disability.” ⁷⁵
Disparity	The Cambridge Dictionary defines “disparity” as “a lack of equality or similarity, especially in a way that is not fair.” ⁷⁶ See “ <i>health disparity</i> ” for additional information.

TERM	DEFINITION
Essential Workers	The CDC defines “essential workers” as “those who conduct a range of operations and services in industries that are essential to ensure the continuity of critical functions in the United States.” This includes all health care workers and some non-health care workers who are needed to maintain critical physical and human infrastructure and continue urgent services and functions. ⁷⁷ The industries essential workers represent include, but are not limited to, medical and health care, telecommunications, information technology systems, defense, food and agriculture, transportation and logistics, energy, water and wastewater, law enforcement, and public works. ⁷⁸ The term “frontline workers” may also be used to refer to this group. ⁷⁹
Food Insecurity	USDA defines food insecurity as “a lack of consistent access to enough food for an active, healthy life ... though hunger and food insecurity are closely related, they are distinct concepts. Hunger refers to a personal, physical sensation of discomfort, while food insecurity refers to a lack of available financial resources for food at the household level.” Food insecurity is a common social determinant of health. In 2018, over 37 million Americans were food insecure. ⁸⁰
Health Disparity	Health disparity is defined as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.” ⁸¹
Health Equity	Health equity is “the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.” ⁸²
Health Justice	“Health justice is an emerging framework for using law and policy to eliminate unjust health disparities.” ⁸³ “Health justice requires that all persons have equal ability to be free from the social determinants that jeopardize their health and well-being ... require[ing] equal access to opportunity and the ability to fully participate in society.” ⁸⁴
Housing Insecurity	“An umbrella term that encompasses several dimensions of housing problems people may experience, including affordability, safety, quality, insecurity, and loss of housing.” ⁸⁵
Intersectionality	Originally coined by Kimberle Crenshaw to “map the intersections of race and gender ... [to] disrupt the tendencies of race and gender as exclusive or separable,” ⁸⁶ intersectionality offers an analytical approach considering “systems of race, social class, gender, sexuality, ethnicity, nation, and age from mutually constructing features of social organization” particularly in the context of Black women’s experiences. ⁸⁷
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Questioning or Queer, Intersex, Asexual, and more. ⁸⁸ This is an inclusive way to refer to people who broadly fall into the queer community and is used throughout this report except when sources cited specifically used other terminology.

TERM	DEFINITION
Marginalized	“Marginalized communities are those excluded from mainstream social, economic, educational, and/or cultural life. Examples of marginalized populations include, but are not limited to, groups excluded due to race, gender identity, sexual orientation, age, physical ability, language, and/or immigration status. Marginalization occurs due to unequal power relationships between social groups.” ⁸⁹
Medical Respite (also known as Recuperative Care)	“Acute and post-acute care for persons experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. Unlike ‘respite’ for caregivers, ‘medical respite’ is short-term residential care that allows individuals experiencing homelessness the opportunity to rest in a safe environment while accessing medical care and other supportive services. Medical respite/recuperative care is offered in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing.” ⁹⁰
Medically Underserved	“Medically Underserved Areas/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population. Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), population (e.g., low income or Medicaid eligible) or facilities (e.g., federally qualified health center or other state or federal prisons).” ⁹¹
Pandemic	The CDC defines a pandemic as an “event in which a disease spreads across several countries and affects a large number of people.” They note, “an outbreak is called an epidemic when there is a sudden increase in cases. As COVID-19 began spreading in Wuhan, China, it became an epidemic. Because the disease then spread across several countries and affected a large number of people, it was classified as a pandemic.” ⁹²
Public Health	“Public health is the science of protecting and improving the health of people and their communities. This work is achieved by promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing and responding to infectious diseases. Overall, public health is concerned with protecting the health of entire populations. These populations can be as small as a local neighborhood, or as big as an entire country or region of the world.” ⁹³
Recuperative Care	<i>See “Medical Respite” above.</i>
Social Determinants of Health	“Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” ⁹⁴
Syndemic	“A set of linked health problems involving two or more afflictions, interacting synergistically, and contributing to excess burden of disease in a population. Syndemics occur when health-related problems cluster by person, place, or time.” ⁹⁵ The United States is currently experiencing a syndemic of COVID-19, mental illness, and racism. ⁹⁶
Xenophobia	The UN Special Rapporteur on contemporary forms of racism says xenophobia “denotes behavior specifically based on the perception that the other is foreign to or originates from outside the community or nation” and exists when “individuals are denied equal rights on account of real or perceived geographic origins of the said individuals or groups, or the values, beliefs and/or practices associated with such individuals or groups that make them appear as foreigners or outsiders.” ⁹⁷

Spotlight on:

Pediatric Mental Health Care Access Program

The Department of Health and Human Services (HHS) awarded approximately \$10.7 million in 2021 from the American Rescue Plan to expand the Pediatric Mental Health Care Access (PMHCA) Program. This program integrates behavioral health support into primary care through telehealth. State and regional networks of pediatric mental health teams help pediatric primary care providers diagnose, treat, and refer children with behavioral health conditions. The networks offer services including training, care coordination, and teleconsultation. Since the program began in 2018, HHS has funded 45 PMCHA projects in states, jurisdictions, and Tribal entities.

The pandemic has disrupted the lives of children, leading to an increase in stress, anxiety, and depression for many. Dr. Warren Ng, President-elect for the American Academy of Child and Adolescent Psychiatry, says, “The PMHCA programs allow us to be able to optimize our expertise as child and adolescent psychiatrists ... because of stigma, there are some families that will never come, at least not easily, to see a child or adolescent psychiatrist or a mental health provider, but they trust their pediatricians, and that’s a relationship that we can leverage to help have that dialogue around your child having anxiety, depression, or suicidal thoughts and actions.”

Dr. Sandy Chung, President-elect for the American Academy of Pediatrics, finds the PMHCA programs to provide essential support. “As a primary care pediatrician, I was not trained to treat depression. I was trained to recognize it, but then was taught to refer to a specialist for the diagnosis and management. However, over the years, the number of mental health providers available for my pediatric patients has dwindled, the prevalence of mental health issues in children has increased, and the cost of health care for families has skyrocketed. As a result, parents and caregivers have turned to their primary care providers for help,” she says.

Simmons-Duffin, Selena, and Rhitu Chatterjee. “Children’s Mental Health Gets Millions in Funding From the Biden Administration.” NPR. August 27, 2021. <https://www.npr.org/sections/back-to-school-live-updates/2021/08/27/1031493941/childrens-mental-health-gets-millions-in-funding-from-the-biden-administration>.

Virginia Mental Health Access Program. Department of Behavioral Health and Developmental Services, 2020. <https://www.globalnpo.org/XX/Unknown/100666812010640/Virginia-Mental-Health-Access-Program---VMAP>.

Resource: PMHCA Web Page

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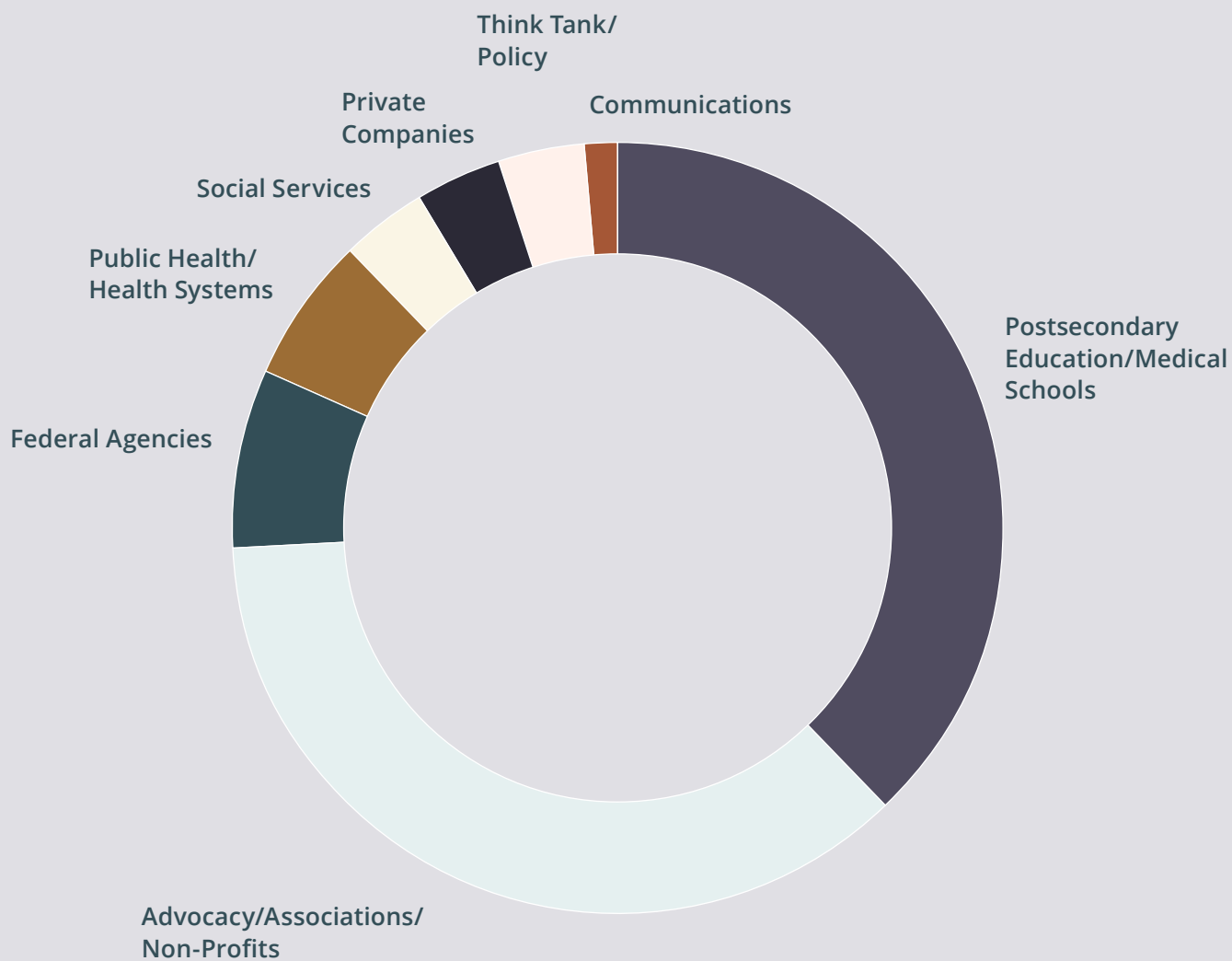
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Ad Council	GLMA: Health Professionals Advancing LGBTQ Equality	New York University Grossman School of Medicine	University of California San Francisco
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American Association of People with Disabilities	Harvard T.H. Chan School of Public Health	Patient-Led Research Collective	University of Colorado Colorado School of Public Health
American Diabetes Association	Harvard University	Project on Government Oversight Data Tracker	University of Miami
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Association of American Medical Colleges	Maine Rural Health Research Center	UC Davis Center for Reducing Health Disparities	Yale University
Association of State and Territorial Health Officials (ASTHO)	Marked By COVID	UC Davis Social Determinants of Mental Health	Your Change Provider
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Columbia University	National Association of State Mental Health Directors		
Johns Hopkins Bloomberg School of Public Health	National Council of Asian Pacific Islander Physicians		
	National Hispanic Medical Association		
	National Medical Association		

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The Task Force sought input from diverse sectors, organizations, and institutions:



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Subject-matter Presentation Topics

The Task Force engaged more than 100 leaders on their expertise, including but not limited to the following topics and affected communities:

Agricultural industry workers	People with chronic medical conditions
Asian/Asian Americans, Native Hawaiians, and Pacific Islanders	People with disabilities
Black/African American	People with low income
Carceral settings	Personal narratives on COVID-19 and Long COVID
Children (younger than 12)	Populations experiencing homelessness
Community health workers	Populations in urban/densely populated cities/neighborhood
Frontline/Essential workers	Rural/Remote/Tribal/Territorial communities
Hispanic/Latino	Schools (early childhood, K-12, and postsecondary educational institutions)
Immigrants/refugees/asylees	Socially disadvantaged populations
Indigenous and Native Americans	Underserved/Underrepresented Communities
LGBTQIA+ people	Women and girls
Limited English Proficient (LEP)	Young adults (18-25)
Multigenerational families	Youth (12-17)
People who experience religious discrimination	
People who require long-term services and support	
People with behavioral health conditions, including substance use disorder and mental health conditions	

Recommendation Development Process

Establishment of the Task Force

On January 21, 2021, President Joseph R. Biden issued Executive Order 13995, followed by the COVID-19 Health Equity Task Force Charter on February 4, 2021, to establish the Presidential COVID-19 Health Equity Task Force in response to the National Strategy for the COVID-19 Response and Pandemic Preparedness and legislation proposed by Vice President Kamala D. Harris during her time as Senator.

The mission of the COVID-19 Health Equity Task Force is to provide specific recommendations to the President of the United States for mitigating the health inequities caused or exacerbated by the COVID-19 pandemic and to prevent such inequities in the future. The National Strategy, Executive Order 13995, and the Task Force Charter charged the Task Force with addressing the following:

- Allocation of COVID-19 resources based on disparities in COVID-19 outcomes by race, ethnicity, and other factors.
- Distribution of COVID-19 relief funds in a manner that advances equity.
- Creation of effective, culturally aligned communication, messaging, and outreach to communities of color and other underserved populations.
- Expansion and acceleration of data collection for communities of color and other underserved populations, including identification of existing data sources.
- Recommendations on incorporating cultural competency, language access, and sensitivity towards Asian/Asian Americans, Native Hawaiians, and Pacific Islanders in the Federal COVID-19 response.

The COVID-19 Health Equity Task Force included 12 members appointed by the President and Vice President to speak to their lived experience and expertise relevant to groups suffering disproportionate rates of illness and death in the United States, equity in public health, health care, education, housing, and community-based services. The President appointed Marcella Nunez-Smith, M.D., M.H.S. to chair the Task Force and she subsequently asked eight Federal agencies to be represented on the COVID-19 Health Equity Task Force as ex-officio Federal members, including senior leaders from the United States Department of Agriculture, Department of Education, Department of Health and Human Services, Department of Housing and Urban Development, Department of Justice, Department of Labor, Department of Homeland Security, and the Federal Emergency Management Agency.

Due to the urgent nature of the Task Force mission, four subcommittees were created as part of the Task Force, with chairs designated to facilitate discussion and lead development of problem statements and corresponding recommendations aligned to the committee’s focus area. Each subcommittee focused on one of four topics relevant to health equity in pandemics:

The Four Subcommittees of the COVID-19 Health Equity Task Force



The four subcommittees followed a monthly sprint cadence to focus on key issue areas cutting across the National Strategy, Executive Order 13995, and the Task Force Charter. The topics were:

- 1. Data Challenges and Opportunities
- 2. Equitable Vaccine Access and Acceptance
- 3. Behavioral Health
- 4. Xenophobia and Discrimination
- 5. Long COVID, Personal Protective Equipment, Testing, and Therapeutics
- 6. Future Pandemic Preparedness

Each month, the committees reviewed extensive literature, obtained Federal agency data to understand the current landscape of problems and solutions at the Federal, state, local, Tribal, and territorial level, and heard from leading experts across the private and public sectors with relevant perspectives on the monthly topic and/or the experience of a specific at-risk population. The committees held working sessions to develop problem statements and draft recommendations; collected feedback from members to finalize language in problem statements and recommendations; and briefed and voted on problem statements and recommendations in Task Force monthly public meetings. In total, the committees held over 200 working sessions, met with over 100 experts, and generated over 300 recommendations for the identified problems relating to monthly sprint topic areas.

Recommendation Refinement

After developing an initial list of over 300 recommendations, the Task Force shifted from recommendation generation to recommendation refinement. The Task Force members were organized into two committees: Implementation Working Group and Refinement and Prioritization sub-groups.

As part of the Refinement and Prioritization sub-group, the Task Force reviewed a landscape analysis of Federal data calls and national policy scans to inform developing a transformative, cohesive, achievable slate of final recommendations. The Task Force first prioritized 316 recommendations across two criteria (impact and evidence) to determine the most impactful or tested recommendations for consideration in the final report. To determine impact, the Task Force considered the extent to which each recommendation addressed systemic and structural racism, ensured an equitable pandemic response, saved lives, reduced harm, improved quality of life, and improved resiliency of individuals and communities, specifically among communities of color and other underserved individuals during and after a pandemic. The evidence criterion assessed the extent to which each recommendation had a proven record of achieving health equity in pandemic preparedness, response, recovery, and resilience (i.e., individual, community, or organizational resiliency), as measured by evidence-based research, promising practice, and equity-centered policy. Key overarching themes across the 300+ recommendations were also identified, and similar recommendations included under the same theme were combined. The Task Force also assessed and addressed gaps against the National Strategy, Executive Order 13995, and the Task Force Charter.

The Task Force then evaluated the recommendations based on feasibility, considering to what extent the recommendation is implementable. Considerations included available funds, existing programs, adequate capacity, policy viability and strategy, and measurability and accountability.

The Task Force then presented, deliberated, and voted on a final slate of 55 actionable recommendations in addition to voting to advance all recommendations to final. These recommendations were synthesized into this final report and delivered to the COVID-19 Response Coordinator. Also, the Task Force proposed an implementation plan for the 55 final recommendations, as well as proposed evaluation metrics, and dashboard, to complement the recommendations and outcomes.

Full List of Recommendations

This appendix includes a full list of the recommendations generated by the Task Force between February and July 2021. For additional context on each of these recommendations, please see the official meetings materials available on the [Office of Minority Health website](#).

Vaccine Access

Communications and Collaboration

- 1 The Federal Government should lead a multi-pronged vaccine education, outreach, and communications campaign.*
- 2 The Federal Government should provide clear guidance to states and localities on vaccine outreach protocols and identification of high-risk populations and critical locations for deployment, including community health centers, public libraries, schools, and child care centers.*
- 3 The Federal Government should operate a coordinated clearinghouse on vaccine eligibility access and allocation across the country.
- 4 The Federal Government should host regular, monthly calls on vaccine access and allocation with various stakeholder groups.
- 5 The Federal Government should identify opportunities to draw public attention to the pandemic emergency, such as: inclusion of COVID-19-related information in the President's weekly address; a weekly fireside chat between the President and various pandemic response leaders (both within the government and with state and community leaders); and a Cabinet-wide meeting on the public health emergency, including opportunities to respond.
- 6 Federal departments should strengthen collaboration with community-based organizations by providing robust funding for community-based organizations to reach communities of color and other underserved populations and address access barriers to the vaccine, while requiring grantees to help amplify a Federal Government-coordinated communications campaign.*
- 7 In the short term, Federal departments should provide clear standards on best practices for reaching communities of color and other underserved populations, including ways to eliminate structural barriers, and should do so in partnership with trusted national partners with state and local reach.
- 8 The Federal Government, through interdepartmental collaboration and in partnership with private industry, should host a series of televised local town halls, utilizing agency initiatives that are known and trusted.
- 9 Federally-supported vaccination sites should be expanded in partnership with local leaders and grassroots organizations in order to be most effective, leveraging parallel vaccination programs and centering the leadership of community partners.*
- 10 Federal civil rights enforcement agencies should provide clear guidance and oversight to ensure that vaccine deployment is fully accessible to people with disabilities and people who need access in languages other than English.*
- 11 Federal departments should engage in a coordinated effort to fund community health workers across health, housing, agriculture, nutrition, child care, and other programs, to support short-term COVID-19 deployment and response.
- 12 Over the long term, the Federal Government should commit to identifying a sustainable career pathway, classification structure, and scope of work that provides community health workers the support they need to be necessary partners in the work of achieving healthy communities.

 * Recommendations advanced as prioritized recommendations.

- 13 In the short term, the Federal Government should provide guidance on working with community leaders, including community health workers, promotoras, independent living centers, and other disability service providers, to support state and local health departments in their efforts to better reach communities of color and other underserved populations. Such guidance should include providing examples of successful programs or initiatives.
- 14 In the short term, the Federal Government should leverage and mobilize its networks of regional partners.
- 15 The Federal Government should coordinate with relevant associations (e.g., Association of State and Territorial Health Officials, National Association of County and City Health Officials, National Governors Association) to distribute information and leverage its coordinated communications campaign. The Federal Government should also strengthen knowledge of who trusted providers are and expand the number of community members available to distribute vaccines to communities of color and other underserved populations.
- 16 The Federal Government should require and invest in state-specific vaccine distribution registry sites in every state to assist municipal governments, hospitals and clinical providers, community health centers, regional centers, and other eligible administrators in achieving the logistics of equitable vaccine allocation.
- 18 The Federal Government should develop a COVID-19 equity dashboard that tracks key disaggregated metrics across state, local, Tribal, and territorial governments that include data on testing, treatment, and vaccinations. The Federal Government should share best and promising practice guidance on how these data can be shared appropriately between state, local, Tribal, and territorial governments and health care providers to ensure proper understanding of the virus spread and its impact on different communities.*
- 19 State, local, Tribal, and territorial health departments should leverage existing sources of quantitative and qualitative data, including Emergency Medical Services, Medicaid, state and local community health assessments, and hospital community health needs assessments, in guiding outreach and vaccination strategies as well as understanding the impact of COVID-19 on communities of color and other underserved populations. Incomplete data should not prevent health authorities from prioritizing groups who have increased risks associated with their underlying health conditions or other risk factors.*
- 20 The Federal Government should provide funding and incentives to advance data modernization initiatives for hospitals, community health centers, and state, local, Tribal, and territorial health departments to ensure interoperability and automatic electronic lab reporting of a robust set of standardized demographic data elements.*

Data, Analytics, and Research

- 17 The Federal Government should mandate state, local, Tribal, and territorial health departments collect and report on a comprehensive set of standardized equity-focused demographic data elements pertaining to COVID-19 testing, hospitalizations, deaths, congregate setting (including homeless shelters, jails, and prisons), type of employment, and vaccinations to support strategies to protect communities of color and other underserved populations.*

Structural Drivers and Xenophobia

- 21 Federal, state, local, Tribal, and territorial governments should diversify supported vaccine registration and appointment mechanisms. Support Federal, state, local, Tribal, and territorial vaccination sites to require and offer other mechanisms, in addition to on-line appointments, for the public to sign up for vaccinations.

 * Recommendations advanced as prioritized recommendations.

22 The Federal Government should localize venues to bring vaccines closer to communities, particularly underserved communities. In partnership with local and state governments, the Federal Government should create as many venues as needed in communities and settings that people trust for quick and efficient vaccination.

23 The Federal Government should take the following actions to improve vaccine access*:

- Identify targeted equity populations. States and cities should be required to provide a menu of options for appropriate documentation for individuals to prove identity and eligibility.
- Coordinate deployments of Corps support with communities and state and local governments.
- Invest in paid sick leave to encourage uptake of vaccines.
- Prohibit vaccination being made a condition of employment when workers are unable to obtain the vaccine and require that any vaccination passport system must be developed with equity at the center.
- Ensure that structural barriers that effectively prevent or hinder individuals from getting vaccinated are removed.
- Address climate conditions by considering alternate allocation strategies in geographically isolated communities.

24 The Federal Government should work with relevant Federal agencies and state, local, Tribal, and territorial governments to ensure there are community-centered solutions to target and reach Asian/Asian American, Native Hawaiian, and Pacific Islander communities to access vaccines.

25 The Federal Government should create an effective vaccine distribution infrastructure. Ensure a more equitable and targeted approach to vaccine allocation and distribution support, especially to the Pacific Islander communities that have less local vaccination distribution infrastructure.*

26 The Federal Government should collaborate with other relevant Federal agencies and stakeholders to collect and disaggregate data on Asian/Asian American, Native Hawaiian, and Pacific Islander communities, in terms of COVID-19 cases, deaths, socioeconomic and health impacts of the pandemic, and vaccination rates.

Health Care Access and Quality

27 Federal, state, local, Tribal, and territorial government should partner with local health care institutions, community organizations, and other trusted sources to promote vaccine awareness and uptake within local communities, with particular attention to institutions and organizations that serve communities who have borne the brunt of COVID-19 exposure, illness, and death.*

28 Federal, state, local, Tribal, and territorial government should prioritize vaccine distribution, testing, and treatment to adults and children from communities of color and other underserved populations and those who face mobility, geographic, or other barriers to receiving the vaccine.*

29 Federal, state, local, Tribal, and territorial governments should simplify registration procedures.

30 The Federal Government should ensure access to broadband and telehealth services in for communities of color and other underserved populations, including rural and Tribal communities.*

31 The Federal Government should engage with employers to provide paid time off for employees to receive the vaccine or accompany loved ones/dependents and allow up to two days paid time off for individuals experiencing significant side effects.*

32 The Federal Government should completely remove all insurance/billing barriers for people receiving and administering the vaccine.*

33 The Federal Government should deploy the Medical Reserve Corps and U.S. Public Health Service Commissioned Corps to communities that lack necessary public health staff upon their request.

 * Recommendations advanced as prioritized recommendations.

34 The Federal Government (and other stakeholders) should continue to expand the number of health care professionals who can be trained to provide vaccinations safely and effectively.

35 The Federal Government should support communities with mobile services upon their request.*

36 The Federal Government (and other stakeholders) should assign community health workers the role of screening for social determinants of health while people are waiting to get vaccines at community health centers, safety net providers, and other health care organizations administering vaccines.

37 As vaccine supply increases and age groups expand for adults and children, Federal, state, local, Tribal, and territorial governments should provide vaccines to all physician offices and health care agencies that are capable and willing to safely vaccinate, with priority given to providers who serve communities of color and other underserved populations.*

38 The Federal Government should strongly recommend states not prohibit priority groups identified by the Advisory Committee on Immunization Practices from receiving vaccines. Federal guidelines from the Advisory Committee on Immunization Practices regarding vaccine administration are based on scientific data and knowledge. We recognize that the Advisory Committee on Immunization Practices priority groups are not a comprehensive list and that states, Tribes, and territories have the right to adjust priority groups based on the local situation.

39 Federal, state, local, Tribal, and territorial governments should utilize credible data (e.g., zip code data) to prioritize vaccine allocation and distribution to support localities that have historically low life expectancy, greater COVID-19 mortality, and high rates of economic hardship.*

40 States should have set-aside allotments of vaccines for providers to vaccinate hard-to-reach populations, such as the incarcerated and migrant workers.*

41 The Federal Government should provide additional vaccines or other incentives to states that collect data and hit or exceed equity targets based on collection and reporting of equity data (e.g., race, ethnicity, housing status, language).

Behavioral Health

Communications and Collaboration

42 The Federal Government should identify opportunities to draw public attention to the behavioral health impacts of the pandemic, such as inclusion of behavioral health and COVID-19-related information and coping mechanisms in the President's weekly address, a weekly fireside chat between the President and various mental health leaders (both within the government and with state and community leaders); and a Cabinet-wide meeting on the mental health implications of the public health emergency, including opportunities to respond.

43 The Federal Government should support a robust collaboration between relevant departments to invest in alternatives to policing, including mobile crisis teams, release guidance on such alternatives, and require appropriate input from individuals with lived experience to determine how funds should be utilized in the community.

44 The Federal Government should lead a multi-pronged, public-private behavioral health awareness, education, and communications campaign, centering equity and the unique impacts of the multiple pandemics on communities of color and other underserved populations who have been disproportionately harmed by COVID-19.

45 The Federal Government should launch a comprehensive initiative to support the children of parents who have died from COVID-19, deaths that have disproportionately impacted Black and Brown children. The initiative should partner local and national leaders in philanthropy, business, government, faith communities, and media and should include the creation of an Interagency Task Force to work across executive departments and agencies to address the broad and multidimensional challenges facing these children.

 * Recommendations advanced as prioritized recommendations.

- 46 The Federal Government should offer guidance to school districts to inform the development of a comprehensive plan to address the potential behavioral health needs of their students, particularly through uplifting community schools and other systems of care approaches that center equity.*
- 47 The Federal Government should invest in school-based health centers and strengthen its commitment to ensuring such centers are open to both students and families.*
- 48 The Federal Government should fund a technical assistance collaborative and professional learning network to support early childhood learning, care, and development staff working with young children.
- 49 The Federal Government should invest in building states' capacity to support the hiring of more counselors and training of teachers and administrators on social-emotional learning techniques.
- 50 The Federal Government should invest in the availability of dyadic care models to strengthen access to whole child and family-centered behavioral health care services.
- 51 The Federal Government should invest in youth-led movements through grants for the integration of behavioral health into the programming of youth-led national organizations, as well as support for existing youth-focused networks in states across the country.
- 52 The Federal Government should require states to have a youth behavioral health board, similar to requirements included in Substance Abuse and Mental Health Services Administration Block Grants. This requirement would allow young people to influence decision making on the delivery of behavioral health services in response to the pandemic and other child-serving systems.
- 53 The Federal Government should launch a national outreach and education campaign focused on young people, particularly Generation Z and younger populations, and include listening sessions across the country. The campaign should utilize social media and other channels where youth are connected, as well as leverage existing peer-based programs.
- 54 The Federal Government should create the position of a "Youth Health Liaison" to work alongside the U.S. Surgeon General in shared efforts to uplift the behavioral health impacts of the pandemic and ways to support young people.
- 55 The White House should host a syndemic symposium to draw attention to the multiple crises affecting communities of color and other underserved populations—racism, mental illness, and COVID-19—and offer opportunity for dialogue and solutions.
- 56 Federal departments should strengthen collaboration with community-based organizations by providing robust funding for community-based organizations to celebrate and build cultural identity in order to prevent mental illness and help address behavioral health impacts of the pandemic. Organizations should have a demonstrated record of working with and for communities of color, people with disabilities, rural communities, immigrants, LGBTQIA+ individuals, and other underserved populations with lived experience.
- 57 In the short term, Federal departments should provide clear standards on best practices for reaching communities of color and other underserved populations with behavioral health supports and services, including ways to eliminate structural barriers, and do so in partnership with trusted national partners with state and local reach.*
- 58 The Federal Government should require the creation of community advisory boards for behavioral health as part of receiving funding for behavioral health interventions.

 * Recommendations advanced as prioritized recommendations.

- 59 Federal departments should engage in a coordinated effort to fund peer support specialists (community health workers), including youth, to address the behavioral health impacts of COVID-19 and assist the public in accessing care and support. When necessary, peer support programs should supplement behavioral health treatment by licensed professionals, not supplant it.
- 60 The issue of social isolation should be integrated into a Federally-led, multi-pronged public-private behavioral health awareness, education, and communications campaign, centering equity and the unique impacts of the multiple pandemics on communities of color and other underserved populations who have been disproportionately harmed by COVID-19.
- 61 The Federal Government should launch a robust communications campaign around the availability, security, and quality of telehealth and its connection to the importance of accessing behavioral health services.
- 62 In the short term, the Federal Government (and other stakeholders) should strengthen access to broadband internet to minimize structural barriers to accessing behavioral health services via telehealth.*
- 65 The Federal Government should provide guidance to support research efforts that engage community members. Those with lived experience with behavioral health conditions should be involved in defining problems, gathering and interpreting data, and developing solutions.
- 66 The Federal Government should conduct targeted oversampling of communities of color and other underserved populations in population-based surveys (e.g., National Health Interview Survey) and other public health data systems to routinely provide information pertaining to behavioral health and suicide.
- 67 The Federal Government should convene an interagency group that promotes and aligns the collection, reporting, and sharing of data to understand and drive responses to prevent and treat behavioral health conditions and support the health and well-being of people living with mental health conditions or substance use disorders.
- 68 The Federal Government should implement a robust analysis of the impact of COVID-19 on behavioral health in all communities. This analysis should include specifically how COVID-19 has impacted youth, health care workers, older adults, Black and Brown people, Indigenous and Native American persons, LGBTQIA+ individuals, religious minorities, people with disabilities, people who are incarcerated, and other underserved populations. The analysis should address the intersectionality across different groups.

Data, Analytics, and Research

- 63 The Federal Government should collect, integrate, and share data related to behavioral health. Data should be collected as it relates to COVID-19, including testing, hospitalizations, prescriptions, utilization of community-based therapy, intensive care unit admissions, and fatalities, and disaggregate this data by age, race, ethnicity, sexual orientation, gender identity, primary language spoken at home, disability status, and income level at the Federal, state, local, Tribal, and territorial level to help understand the impact of COVID-19 on local communities and guide improvement and expansion of resources for behavioral health.*
- 64 The Federal Government (and other stakeholders) should conduct a robust analysis of the drivers of depression, increased substance use, and suicidality and the widening disparities identified during COVID-19.
- 69 The Federal Government should issue guidelines and provide resources to implement widespread behavioral health and interpersonal violence screening, including screening of children, health care workers, LGBTQIA+ individuals, Indigenous and Native American persons, remote and/or rural communities, people with disabilities, those living in congregate settings (e.g., skilled nursing facilities, group homes, rehabilitation facilities, intermediate care facilities, homeless shelters, state hospitals, jails, prisons), and older adults.
- 70 The Federal Government should expand incentive programs to improve surveillance and the collection of data in public and private behavioral health services, psychiatric hospitals, and carceral settings.

 * Recommendations advanced as prioritized recommendations.

71 The Federal Government should improve the collection of data on the Asian/Asian American, Native Hawaiian, and Pacific Islander communities, included disaggregated data where feasible, to ensure a more accurate understanding and depiction of behavioral health in the Asian/Asian American, Native Hawaiian, and Pacific Islander community.*

72 The Federal Government should take stringent measures to ensure the security and privacy of all data.

73 The Federal Government should incentivize research that analyzes the impacts of COVID-19 on all substance use disorders and co-occurring disorders, including the disparate impact on communities of color and other underserved populations.

74 The Federal Government should evaluate policy changes to identify best practices during the pandemic that expanded access to behavioral health care.

75 The Federal Government should evaluate the efficacy and accessibility of expanded telehealth services in the context of the pandemic.

76 The Federal Government should evaluate the impact of the many structural and economic policy changes that were made during the pandemic, including those involving housing, criminal justice, and Medicaid.

Structural Drivers and Xenophobia

77 The Federal Government should increase Federal funding to support local governments, as well as community and health organizations that work directly with survivors of violence and groups that create community-driven solutions.

78 The Federal Government should strengthen anti-discrimination protections for Asian/Asian American, Native Hawaiian, and Pacific Islander communities and support investigation and prosecution of hate crimes.*

79 The Federal Government should promote inclusion of histories, cultures, and experiences of diverse Asian/Asian American, Native Hawaiian, and Pacific Islander communities in elementary and secondary school curricula and development of ethnic studies programs in tertiary education levels.*

80 The Federal Government should work to pass jobs and economic recovery legislation to ensure that all working families can earn family sustaining wages, have access to benefits (health insurance, paid time off), and have strong worker protections in order that they have a real shot at economic security and opportunity.*

81 The Federal Government should issue emergency temporary health and safety standards to protect workers from hazardous COVID-19-related working conditions.*

82 The Federal Government should increase funding for worker protections in order for Federal labor and employment agencies to have sufficient resources to protect workers from hazardous and substandard working conditions.

83 The Federal Government should fund housing assistance, including renewal of the eviction moratorium.*

84 The Federal Government should continue to support quarantine shelters to prevent the spread of COVID-19 for people living in congregate housing or those that need shelter (e.g., people experiencing homelessness, people living in multigenerational housing).*

85 The Federal Government should prohibit local housing authorities from disqualifying individuals from eligibility for Department of Housing and Urban Development vouchers (e.g., American Rescue Plan, Coronavirus Aid, Relief, and Economic Security Act) on the basis of criminal drug history.*

 * Recommendations advanced as prioritized recommendations.

86 The Federal Government should invest Federal funding in the development of a racially, ethnically, and culturally diverse behavioral health workforce that includes a full range of licensed health care professionals and should acknowledge structural urbanism and establish programs, policies, and funding to support thriving rural communities (including clinics, treatment centers, rural hospitals, and mobile health vans to transport licensed health care professionals where needed).*

87 The Federal Government should develop a broad public awareness campaign focused on increasing knowledge of behavioral health conditions among children, youth, and adults. The Federal Government should also partner with school districts, institutions of higher education, and community-based organizations to implement in order to reduce the stigma associated with behavioral health.

88 The Federal Government should invest in expanding affordable broadband internet access to low income and rural communities and invest in people, processes, support, and regulations for telehealth/tele-psychiatry and education.*

89 The Federal Government should increase funding for Tribal early childhood programs with culturally and linguistically responsive interventions needed for their well-being.

90 Federal, state, local, Tribal, and territorial governments should shift response to behavioral health crises from disciplinary responses and law enforcement to community-driven and health-orientated crisis response teams.*

91 The Federal Government should enact health insurance payment policies for behavioral health treatment.*

92 Federal, state, local, Tribal, and territorial governments should provide alternatives to police response for apparent behavioral health conditions and crises.*

93 To improve access to quality health care, both psychological and medical issues must be assessed by a licensed health professional.

94 The Federal Government should build an even stronger, more resilient nutrition safety net that is responsive to the co-occurrence of food insecurity and diet-related illness and better prepared to protect our most vulnerable citizens generally and against future pandemics and other unforeseen circumstances.*

95 The Federal Government should leverage technology to maximize participation, retention, and streamline onboarding for Federal nutrition assistance programs to create a hassle-free system that provides more convenient access.*

96 The Federal Government should expand access to healthier food and beverage choices across nutrition assistance programs and apply the latest nutritional science.

97 The Federal Government (and other stakeholders) should expand access to online grocery shopping, especially for program participants in areas with limited access to healthy foods.

98 The Federal Government (and other stakeholders) should strengthen local and regional food production by providing flexibility of production and distribution, a shift that will open new revenue streams for farmers and help with the nation's food assistance response.

99 The Federal Government should authorize hunting and fishing openings to compensate for hardships brought on by the impact of a pandemic (i.e., increased cost of merchandise and freight).

Health Care Access and Quality

100 The Federal Government should assess Medicare and Medicaid payment parity for behavioral health from a perspective of equity and create a process to resolve the discrepancy that leads to inequity of care. Enforce acts that promote behavioral health parity (e.g., Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008).*

101 The Federal Government should target funding to programs in communities of color and other underserved populations that recognize behavioral health care needs to be culturally appropriate and consider the nuances of systemic racism, discrimination, and other institutionalized biases.

 * Recommendations advanced as prioritized recommendations.

- 102 The Federal Government should create an Indian Health Care Provider Safe Harbor akin to the Federally Qualified Health Center Safe Harbor that allows Tribal health providers to provide devices for telehealth.
- 103 The Federal Government should expand Self-Governance, replacing the competitive behavioral health grant funding mechanism to contracts and/or compacts. The Federal Government should examine the feasibility of applying Title 5 (of the Indian Self Determination Education Assistant Act) to multiple agencies.
- 104 The Federal Government should increase access to clinical treatment during behavioral health crises, especially in communities and settings where a law enforcement or corrections officer response predominates.*
- 105 The Federal Government should increase immediate funding to Medicaid and Medicare providers serving communities of color and other underserved populations along the pathways of licensed health care professionals' reimbursement rates, peer support programs, and social determinants of behavioral health. Peer support programs should supplement behavioral health treatment by licensed professionals, not supplant it.*
- 106 The Federal Government should authorize telehealth in public health care systems [e.g., Medicaid], particularly telephonic delivery and reimbursement for audio-only behavioral health services when dependable and effective video-based telehealth is unavailable. The Federal Government should also address barriers and disruptions to behavioral health services during the COVID-19 pandemic through telehealth and with the expansion of health care coverage and access among other options and increase access to in-person behavioral health treatment with behavioral health professionals by ensuring sufficient personal protective equipment, ventilation, and other protections to mitigate potential exposure to COVID-19.*
- 107 The Federal Government should increase funding to domestic violence shelters that primarily serve communities of color and other underserved populations.
- 108 The Federal Government should expand supportive housing and housing-first type programs.*
- 109 The Federal Government should increase funding for behavioral health research specific to communities of color and other underserved populations (e.g., youth, health care workers) through all applicable Federal programs.
- 110 Increasing the availability of behavioral health resources would greatly reduce suicide risk among communities of color and other underserved populations, specifically youth; therefore, the Federal Government should increase funding for suicide interventions through faith-based and community organizations and increase access to on-demand telehealth and in-person care for suicide assessment, intervention, and prevention in hospital emergency departments, community centers, and schools.
- 111 The Federal Government should target behavioral health care funding based on need, including education of culturally competent licensed behavioral health professionals and supporting medical offices, clinics, and psychiatric beds.*
- 112 The Federal Government (and other stakeholders) should fast-track immigrant health care professionals who face significant barriers to practicing their profession.
- 113 The Federal Government should offer people from communities of color and other underserved populations grants, scholarships, Federal loan repayment programs, and clinical training to increase the number of culturally competent licensed behavioral health professionals.*
- 114 The Federal Government should expand the role of peer navigators and support programs designed to increase behavioral health care capacity. Peer support programs should supplement behavioral health treatment by licensed professionals, not supplant it.*

 * Recommendations advanced as prioritized recommendations.

- 115 Given the success of the integrated care Collaborative Management program for expanding psychiatric support to primary care providers, the Federal Government should develop a nationwide service to provide resources to primary care providers and psychiatric medical professionals to support Collaborative Management and similar behavioral health and primary care collaborations.
- 116 Federal funding should be targeted toward a system that corrects inequities and supports youth in communities of color and other underserved populations. This system should also include support for parents in communities of color and other underserved populations. The Federal Government should increase investment in programs with documented success in increasing numbers of underrepresented communities, such as minority serving institutions, Tribal Colleges, and Historically Black Colleges and Universities.
- 117 The Federal Government (and other stakeholders) should ensure young people have access to comprehensive behavioral health services and grief counseling from licensed health care professionals to deal with the behavioral health effects of the pandemic.
- 118 Formalized guided peer support programs should be part of the Federal response for youth.
- 119 Programs to treat more severe mental illness should be operated and distributed through Federally-funded health centers, rural health clinics, primary care and pediatricians' offices, and schools, to increase support for screening, education, and referrals.
- 120 Formalized guided peer support programs should be part of the Federal response for health care workers.
- 121 The Federal Government should protect frontline workers' health and safety at workplace through Issuance of an Occupational Safety and Health Administration Emergency Temporary Standard on COVID-19 to create standard guidelines for protecting ALL workers from COVID-19.*
- 122 The Federal Government should ban the reuse of single-use personal protective equipment and ramp up personal protective equipment production (e.g., with the Defense Protection Act).
- 123 The Federal Government should encourage states to adopt Federal guidance authorizing physicians to start buprenorphine treatment via telephone evaluation.
- 124 The Federal Government should allow states blanket exemptions to allow patients to receive take-home doses of medication for opioid use disorder.
- 125 The Federal Government (and other stakeholders) should remove requirements of one-to-one exchange at needle exchange during the COVID-19 pandemic.
- 126 The Federal Government should pilot and fund harm-reduction initiatives with community involvement and health equity in mind.
- 127 The Federal Government should explore empirical implications of drug decriminalization and regulation as part of an end to the war on drugs, the promotion of a safer drug supply, and reduction in mass incarceration.
- 128 The Federal Government should massively scale up of the financial investment into behavioral health treatment, prevention, and harm reduction services and pass legislation (e.g., CARES Act of 2020).*
- 129 The Federal Government should declare health care access and coverage a human right.*
- 130 The Federal Government should align Federal policies and funding to secure health care as a human right.*

 * Recommendations advanced as prioritized recommendations.

Discrimination and Xenophobia

Communications and Collaboration

- 131 The Federal Government should lead a multi-pronged, public-private awareness, education, and communications campaign focused on clarifying misinformation associated with vaccines and rebuilding trust in government. To strengthen and inform the campaign, the Federal Government should regularly engage stakeholders from diverse communities in order for the Government to have a more comprehensive understanding of incidences of misinformation. The campaign should also include a robust paid media strategy targeting communities of color and other underserved populations.
- 132 The Federal Government should launch a formal partnership with national medical associations and allied health professional organizations to acknowledge racism and ensure involved parties are inclusive and advance equity.
- 133 Federal civil rights enforcement agencies should develop Crisis Standards of Care guidelines that do not violate Federal civil rights laws. The Federal Government should work with state, local, Tribal, and territorial governments to help them be better prepared for the next pandemic so that we can avoid shortages that lead to Crisis Standards of Care.*
- 134 The Federal Government should lead a multi-pronged public education campaign to educate and raise public consciousness about anti-Asian hate and ensure transparent, accurate communications to Asian/Asian American, Native Hawaiian, and Pacific Islander communities to support access to vaccines and other related supports and services.*
- 135 The Federal Government should collaborate with state, local, Tribal, and territorial law enforcement partners and community groups to educate the public about available resources related to pandemic-related hate- or bias-related incidents (including best practices for reporting such incidents).
- 136 The Federal Government should launch a public-private partnership to disseminate information and provide support to Asian/Asian American, Native Hawaiian, and Pacific Islander-owned small businesses to access COVID-19-related assistance and support their economic recovery.
- 137 The Federal Government should develop best practices for testing and vaccination sites in areas with large immigrant populations, including, but not limited to*:
- Avoid having any military, National Guard, law enforcement or other uniformed personnel present onsite.
 - Provide vetted, translated information on arrival and have trained and culturally competent interpreters on site.
 - Provide access to in-person or telephonic language services and advertise that these services are available for patients with limited English proficiency or who are more comfortable speaking another language and ensure family members or untrained staff do not provide interpretation unless in an emergency.
 - Partner with trusted faith and community organizations that are already providing aid to sites.
- 138 The Federal Government should launch a formal partnership with farmworker unions, whose members are disproportionately from immigrant backgrounds, to distribute testing- and vaccine-related information and related supports and services.*
- 139 The Federal Government should release specific guidance that further clarifies that it will not seek social security numbers, driver's license numbers, or passport numbers from vaccine providers. The base Federal Government data agreement should further clarify how the Federal Government will assure that personal data is not inappropriately used or shared, such as retained and sold by third party contractors.

 * Recommendations advanced as prioritized recommendations.

- 140 The Federal Government should create a Truth and Reconciliation Commission to recognize “the dignity of individuals, the redress and acknowledgment of violations, and the aim to prevent them from happening again,” as put forward by the International Center for Transitional Justice. The Commission would acknowledge the long history of racism in the United States, as well as its persistence into the present, including its connection to COVID-19 inequities and the millions of living Americans who could be considered victims. As such, the Commission would address issues ranging from the history of slavery to school segregation to policing to disability to employment and wealth disparity.
- 141 The Federal Government should launch a robust initiative centered on uplifting the diversity of Americans and highlighting the multiple cultures, ethnicities, backgrounds, and experiences that contribute to American society. The initiative would highlight how equity is critical to our collective success and build on the Executive Order 13985 on Advancing Racial Equity and include the creation of an Interagency Task Force to work across executive departments and agencies to engage in efforts to educate the American public on the value of equity.
- 142 The Federal Government should partner with national, youth-led organizations and influencers to increase direct education and promote authentic messaging around pandemic preparedness and immunizations (including vaccine safety) towards the American youth. This includes age-appropriate channels of communication, including sharing information via television, online videos, mobile apps, and educational shows, social media campaigns with personalized messages focused on youth interests and motivations, and informative videos with celebrities.
- 144 State, local, Tribal, and territorial jurisdictions should continue to support and expand reporting mechanisms through helplines, online systems, interagency centers, and partnerships with academic institutions and non-profits.
- 145 The Federal Government should promote deployment of more robust victimization surveys to assess the extent and causes of hate crime underreporting.
- 146 The Federal Government (and other stakeholders) should make efforts to partner with trusted community members and organizations to help build trust in the criminal justice system and facilitate reporting.
- 147 The Federal Government should conduct a national survey to understand people’s experiences with discrimination and racist acts, whether their experiences have changed during COVID-19, and how the pandemic may have impacted their experiences seeking and receiving health care services during the pandemic.
- 148 The Federal Government should expand existing national surveys, such as the Behavioral Risk Factor Surveillance System and the National Health Interview Survey, to include questions about discrimination and people’s experiences with discrimination across their lifespan. The Federal Government should oversample certain demographic groups to assure data can be disaggregated.
- 149 The Federal Government should continue to link existing state and Federal administrative data sets with national population-based surveys for data disaggregation.
- 150 As the CDC, several states, Tribes, and local jurisdictions have acknowledged, since racism is a public health issue, it should be incorporated into the work of Federal, state, local, Tribal, and territorial governments through tracking, evaluation, reporting, and implementing prevention and mitigation measures. The Federal Government should make funding available to local health departments to understand and prevent hate crimes and other racist acts.

Data, Analytics, and Research

- 143 The Federal Government should create a coordination mechanism on hate crime data collection, adopt a clear definition of hate crime, develop a standardized database and reporting forms, use data to inform policy, and publicize data.

 * Recommendations advanced as prioritized recommendations.

- 151 The Federal Government should incentivize and promote research to understand health care discrimination, such as by measuring effects of interpersonal racism in health care, evaluating organizations’ adherence to anti-racism efforts, and developing better methods of quantifying discrimination, including settings that may be missed by current health surveys, such as carceral and inpatient psychiatric settings.*
- 152 Federal, state, local, Tribal, and territorial governments should incentivize and promote initiatives that educate people about their civil rights so that discrimination and racist acts can be properly reported and addressed.
- 153 The Federal Government should support large-scale, rigorous research on the prevalence, patterns, causes, and long-term implications of COVID-19-related anti-Asian/Asian American, Pacific Islander, and Native Hawaiian discrimination.
- 154 The Federal Government should assure oversampling in existing national surveys and disaggregate reporting and surveillance data to enable full documentation of the Asian/Asian American, Native Hawaiian, Pacific Islander, and American Indian/Alaska Native subgroups most affected by the pandemic.
- 155 The Federal Government should improve Asian/Asian American, Native Hawaiian, and Pacific Islander representation in research through inclusion and disaggregation of Asian/Asian American, Native Hawaiian, and Pacific Islander data, funds to increase diversity in research populations, and addressing linguistic barriers.
- 156 The Federal Government should make large investments in Tribal research and promote oversampling in Tribal public health and Tribal-led research.
- 157 The Federal Government should collaborate with communities of color and other underserved populations in the governance, analysis, and sharing of research involving their communities.*
- 158 The Federal Government should support research to better understand the ways in which states’ Crisis Standards of Care intersect with ableism and ageism, as well as how disproportionately impacted communities of color and other underserved populations should be supported.
- 159 The Federal Government should establish efforts to track and report in real time the health and health outcomes of incarcerated people and develop evidence-based programs to protect and improve their health.*
- 160 The Federal Government should promote research on the effectiveness of interventions to prevent death in carceral settings during COVID-19, such as early release.*

Structural Drivers and Xenophobia

- 161 The Federal Government should examine its existing COVID-19-related support for Asian/Asian American, Native Hawaiian, and Pacific Islander-operated small businesses to identify any key barriers to utilization. The Federal Government should develop and implement a plan to address identified barriers to maximize effectiveness for economic recovery.
- 162 The Federal Government should plan, identify, and address any application or administration barriers unique to Asian/Asian American, Native Hawaiian, and Pacific Islander farmers receiving debt relief under the American Rescue Plan.
- 163 The Federal Government should translate its web-based financial-relief services into the most spoken Asian languages.
- 164 The Federal Government should develop and disseminate new web-based resources and training for state, local, Tribal, and territorial law enforcement and first responders on how to identify pandemic-related hate- or bias-motivated incidents.
- 165 The Federal Government should develop and disseminate best practices for reporting crimes.

 * Recommendations advanced as prioritized recommendations.

- 166 The Federal Government should encourage states, cities, Tribes, and territories to implement safe and convenient reporting channels and protocols for investigation/prosecution, informed by best practices.
- 167 The Federal Government should continue to fund assistance programs for missed rent/ utilities during eviction moratoria and borrowers exiting forbearance (e.g., housing counseling, loss mitigation) and fund additional legal services to those facing eviction.*
- 168 Strengthen and enforce housing and lending discrimination laws, including restoring the Affirmatively Further Fair Housing rule that was previously cancelled.*
- 169 Increase the supply of affordable, accessible housing, supportive housing, and supports that enable people to remain housed.*
- 170 The Federal Government should prohibit discrimination by landlords based on prospective and current tenants' housing vouchers or source of income.
- 171 Encourage eligible schools to participate in the USDA Community Eligibility Program to allow high-poverty schools to provide meals free of charge to all of their students.*
- 172 Increase investments in Full-Service Community Schools that partner with a broad array of social service agencies and trusted community-based organizations to provide a one-stop shop for enrolled students and families to access services that can address the impact of COVID-19 and prioritize their expansion in communities of color and other underserved populations.*
- 173 The Federal Government should support state-level, cross-agency partnerships to provide students with free meals during after-school and summer learning and enrichment programs, without the requirement of additional documentation.
- 174 The Federal Government should encourage state, local, Tribal, and territorial governments to provide information and maps of meal sites in multiple languages, in multiple accessible formats, and using community partnerships.*
- 175 The Federal Government should work with Congress (e.g., American Families Plan) to rebuild and invest in our nation's childcare and early learning system to allow families to access quality and affordable childcare and rejoin the workforce.*
- 176 The Federal Government should increase funding (e.g., under Title IV of the Elementary and Secondary Education Act) to increase the availability of before-school, after-school, and summer learning programs for students, to align with different work schedules.
- 177 The Federal Government should increase funding for programs that support greater integration of health and social services with early learning programs in order to strengthen families' access to a continuum of services.
- 178 Fully fund the Indian Health Service as recommended by the Indian Health Service budget formulation committee.*
- 179 Expand the 638 authority of Tribes to administer the Supplemental Nutritional Assistance Program and determine whether all Tribal children have access to pandemic electronic benefit transfer.*
- 180 The Federal Government should invest in national monitoring and surveillance systems that include communities of color and other underserved populations to promote equity.
- 181 The Federal Government should provide sustained and increased funding to Tribes for environmental health infrastructure to better address community needs and prioritize delivery of necessary supplies for those exposed to COVID-19.*
- 182 The Federal Government should direct more and equitable resources to the Indian Health Service, including funds to reduce administrative, cultural, and linguistic barriers to health care, bring the workforce to the required level, and address the health professional shortage.*

 * Recommendations advanced as prioritized recommendations.

- 183 The Federal Government should provide \$1.1 billion of additional nutrition assistance for the territories in the American Rescue Plan that operate nutrition assistance block grants to support those hard-hit by the pandemic. Further assess the feasibility of transitioning three U.S. territories to the Supplemental Nutrition Assistance Program instead of the Nutrition Assistance Program.
- 184 The Federal Government should provide funding directly to Tribes and avoid using the states as mechanisms for funding and resources, honoring the government-to-government relationship.
- 185 The Federal Government should work with Congress on legislation that protects workers (e.g., American Jobs and Families Plan, the Protecting the Right to Organize Act of 2021). This would ensure meaningful investments in the care economy and mechanisms to empower workers in the workplace.*
- 186 The Federal Government must fully recognize aerosol transmission of COVID-19 by updating all COVID-19 guidance and Occupational Safety and Health Administration Emergency Temporary Standards to effectively prevent inhalation exposure to the virus and end all crisis standards, including guidance, that allow for the reuse, rationing, extended use, and/or decontamination and reuse of single-use personal protective equipment.*
- 187 Federal labor and employment agencies should dedicate more resources to investigate and prosecute anti-discrimination and other workplace violations.*
- 190 The Federal Government should collaborate with local municipalities to assist with appropriate housing regulations for migrant workers.
- 191 The Federal Government should encourage the removal of legal and policy barriers that impede discrimination-free health care.
- 192 The Federal Government should require transparency in reasoning and computer coding as well as equity analyses for racial, ethnic, gender, and other biases in clinical practice guidelines as it relates to health-related algorithms, artificial intelligence, and health information technology.
- 193 The Federal Government (and other stakeholders) should assess clinical practice guidelines, health-related algorithms and artificial intelligence, and health information technology and correct for discrimination, racism, and biased practices. Require pulse oximeters to read accurately every patient's oxygen saturation regardless of skin thickness and pigmentation.*
- 194 Decisions related to vaccination distribution locations should be made by an independent authority that drives equity and the best interest of public health. This independent authority should establish mechanisms to hear regularly from diverse stakeholders to help inform their decision making.
- 195 Federal, state, local, Tribal, and territorial authorities should ensure that people in carceral settings are afforded access to testing, care, and vaccination and that release/decarceration is utilized as a public health intervention.*
- 196 The Federal Government should declare health care access and coverage a human right and align Federal policies and funding to secure this right.*

Health Care Access and Quality

- 188 The Federal Government should fund research to understand the impacts of structural racism, including the processes of implicit bias, and test interventions that disrupt and change these processes toward sustainable solutions.*
- 189 The Federal Government should create funding and incentives to research, identify, and implement interventions to address internet and food deserts and expand social service supports to affected communities.*
- 197 The Federal Government should examine health care funding approaches that allocate resources for building and staffing health care facilities based on need and eliminate financial barriers to care, including premiums, deductibles, and copayments.
- 198 Federal, state, local, Tribal, and territorial governments should increase funding for public health infrastructure and staff, targeting areas with the greatest health care disparities.*

 * Recommendations advanced as prioritized recommendations.

199 The Federal Government should support Federal funding for community purchase of distressed hospitals and provide financial and technical support to ensure that distressed hospitals can continue operating.

200 Increase Federal funding for the Indian Health Service so that, at a minimum, the Indian Health Service has the resources to match the U.S. National Health Expenditure per person annual spending rate.*

201 The Federal Government should require all Medicaid plans reimburse Critical Access Hospitals at a minimum of the Medicare cost-based reimbursement rate.

Long COVID, Personal Protective Equipment, Testing, and Therapeutics

Communications and Collaboration

202 The Federal Government should provide resources and collaborate with community-based organizations and providers to create a Long COVID Technical Assistance Center. This would include a hotline for community members and other stakeholders to learn more about the condition, share their experiences, and connect with local resources.*

203 The Federal Government should execute a robust communications campaign, collaborating with major professional associations to build awareness, educate, and solicit more data from the public on Long COVID. This campaign should include efforts to reach communities of color and other underserved populations, as well as health care workers that serve them, with the following information*:

- Health care should be considered a human right.

- Long COVID is real and patients are actively suffering from it (potentially list the top 5-7 symptoms: tiredness or fatigue, difficulty thinking or concentrating, headache, loss of smell or taste, dizziness on standing, fast-beating or pounding heart, chest pain).
- The lack of access to treatment for Long COVID will inhibit patients from being able to return to the workforce.
- Treatment for COVID-19 and Long COVID is disproportionately denied for patients without insurance.

204 In order to have a full recovery, we need to address the long-term impacts of the pandemic. Thus, the Federal Government should establish a Federal Advisory Committee, specifically on Long COVID. The Committee should be comprised mostly of Long COVID patients and should include external experts in researching and treating post-infectious chronic illnesses and their comorbidities and disability advocates. The Committee should develop recommendations on the Federal response to Long COVID as it works with relevant departments.

205 The Federal Government should create a public-private partnership to fund health care providers and community-based organizations serving communities most affected by Long COVID. Funds will support local efforts to reach communities of color and other underserved populations with information, supports, and services regarding Long COVID.

206 The Federal Government should lead the development of a Long COVID health equity learning community infrastructure, in partnership with Long COVID centers and clinics that are developing across the country to research, understand, develop interventions for, and treat Long COVID. The Long COVID health equity learning community infrastructure will facilitate collaborations and the exchange of knowledge between all Long COVID centers and clinics.

 * Recommendations advanced as prioritized recommendations.

207 The Federal Government should launch an interagency-led campaign that focuses on Long COVID patients' rights and support services such as legal aid, vocational rehabilitation services, housing, and occupational therapy. Through this initiative, the Federal Government should advance programs that help patients with Long COVID learn about and navigate these services so they can get the support and care they need as they manage the impacts of Long COVID.

208 The Federal Government should create a tip line for employees to address health and safety violations of employers. The tip line should provide a protected channel of communication for employees to express concerns related to Long COVID health and safety.

Data, Analytics, and Research

209 The Federal Government should set a national research agenda centering on health equity and COVID-19. All research should encompass a diverse group of participants across communities of color and other underserved populations as well as pediatric populations so that data can be disaggregated for these high-risk populations. The government should promote public-private partnerships and investments in a variety of research methods (e.g., clinical trials, case-control studies, longitudinal studies, real-time technology solutions) to meet the research aims identified below.*

- Understand the cause, prevalence, rates of diagnosis, and treatment effects associated with Long COVID morbidities and mortality;
- Understand the scope of Long COVID infection that was undiagnosed or untreated, particularly in congregate settings (e.g., jails, prisons, and immigration detention centers);
- Understand how racism and discrimination are associated with symptoms, disease progression, and severity of Long COVID for communities of color and other underserved populations; and

- Understand how the diversity of the health care workforce affects diagnosis, patient experiences, access to care, and referral patterns of people with Long COVID from communities of color and other underserved populations.

210 The Federal Government should create a national coordination of research standards and a standardized method to disseminate research, diagnostic, and therapeutic practices related to Long COVID to support informed and inclusive clinical decision making.

211 The Federal Government should create data transparency related to the demographics of those receiving therapeutics (e.g., monoclonal antibodies) and should understand who has access, who is providing services, and who is eligible for and receives therapeutics, as well as rates of associated hospitalization, pre- and post-therapeutic administration.

212 The Federal Government should sponsor a research project to compare infection rates to monoclonal antibody use and severity of illness across communities of color and other underserved populations, in addition to examining variability of monoclonal antibody use and Long COVID incidence.

213 The Federal Government should conduct research to survey the general population to understand eligibility for, patient knowledge of, and access to therapeutics and how these may differ across communities (e.g., home-based, nursing home, and outpatient facilities).

Structural Drivers and Xenophobia

214 The Federal Government should provide funding and guidance to ensure safe ventilation practices and evaluate air-quality standards for publicly-provided housing, shelters, and centers. These settings support communities of color and other underserved populations who are at risk of Long COVID and its ongoing effects.*

 * Recommendations advanced as prioritized recommendations.

- 215 Building upon the executive order and Presidential Memorandum to combat systemic racism, the Federal Government should work with public and private hospitals and the health care industry to address discrimination faced by Asian/Asian American, Native Hawaiian, and Pacific Islander health care professionals, as there is a continued negative impact on the treatment of COVID-19 and Long COVID for Asian/Asian Americans, Pacific Islanders, and Native Hawaiians, among others.*
- 216 Building off of U.S. efforts to combat systemic racism, the Federal Government should establish baseline on-the-job protections for communities of color and other underserved populations in the health care sector, including those workers treating COVID-19 and Long COVID.
- 217 Congress should pass public policies that invest in children and families and ensure that the benefits support the needs of communities of color and other underserved populations with Long COVID and their overburdened, unpaid caregivers.*
- 218 Congress should pass public policies that create jobs and rebuild the country's infrastructure and ensure that the benefits support the needs of communities of color and other underserved populations with Long COVID and their overburdened, unpaid caregivers.
- 219 The Federal Government should enhance temporary disability benefits to support communities of color and other underserved populations with Long COVID.*
- 220 The Federal Government should clarify its educational accommodations for those experiencing Long COVID, including eligibility requirements for special education and related services, in addition to helping students and caregivers navigate the systems and programs that exist to support them.
- 221 The Federal Government should create an updated Frequently Asked Questions document to clarify that people who have faced financial hardship due to long COVID are eligible for rental assistance through the Emergency Rental Assistance Program (ERAP 1 and ERAP 2) today and after the Federal emergency declaration for COVID-19 ends.

Health Care Access and Quality

- 222 The Federal Government should communicate unified ICD-10 Codes for Long COVID so that medical providers can accurately classify the diagnosis, treatment, and billing for Long COVID. This is intended to prevent patients from being denied coverage for the diagnosis and treatment of Long COVID.*
- 223 The Federal Government should expand the recruitment of and funding for community health workers who are referring people impacted by Long COVID to community resources (e.g., health care, housing, and food), in addition to providing resources to assist them with signing up for health insurance coverage, including Medicaid and other forms of coverage.
- 224 The Federal Government should provide funding to encourage targeted training for providers serving communities of color and other underserved populations, focused on Continuing Medical Education for COVID-19 that is also inclusive of Long COVID.
- 225 The Federal Government should mandate that any funding for multidisciplinary post-COVID-19 care centers to treat Long COVID populations must simultaneously require these centers to accept patients regardless of insurance coverage and deliver training for providers treating patients in safety net health systems like Federally Qualified Health Centers, Indian Health Service, and Rural Health Clinics.*
- 226 The Federal Government should provide funding for clinics, including Federally Qualified Health Centers, Indian Health Service, and Rural Health Clinics to disseminate medical equipment (e.g., pulse oximeters, spirometers) to patients, expanding access to treatment to prevent the exacerbation of Long COVID by enabling patients to monitor symptoms and promote rehabilitation safely at home.
- 227 The Federal Government shall continue to update and disseminate standards and protocols for diagnosis and management of Long COVID.*

 * Recommendations advanced as prioritized recommendations.

- 228 The Federal Government should increase staffing in areas with health professional shortages to treat communities of color and other underserved populations and in areas with the highest COVID-19 infection rates. Dramatically increase funding for education in medical fields and graduate medical education for people raised in or committed to serve health professional shortage areas. Expand National Public Health Service Corps, Public Service Loan Forgiveness, and grants (e.g., Public Health Service Act Title VII and Title VIII grants), scholarships, and loan forgiveness.*
- 229 The Federal Government should create more inclusive health insurance disability policies that recognize Long COVID as a health condition with a diagnostic schema that identifies people who have Long COVID without a positive COVID-19 test.*
- 230 The Federal Government should ensure that the pediatric patient population has access to primary care providers and clinics that treat Long COVID.*
- 231 The Federal Government should consult with the appropriate health care professionals to ensure that Long COVID treatment incorporates patient-centered approaches and adequate clinical encounter time to optimize the quality of life and function in affected patients.
- 232 The Federal Government should explicitly ban coverage limits for Long COVID and ensure treatment regardless of insurance status to extend existing protections during the pandemic.*
- 233 Health care providers should be required to complete ongoing training addressing unconscious and explicit bias. The training should utilize standardized metrics to monitor and report the effectiveness of the training over time. Training requirements should be part of Federal Government health care provider compliance training.
- 233 Patients should receive access to treatment for Long COVID, irrespective of whether they received a positive test for acute COVID-19, for which they were or were not hospitalized. The patient population should be inclusive of people living in congregate settings such as carceral settings and inpatient psychiatric settings.*
- 235 The Federal Government should maintain an adequate stockpile and create a rapid emergency production plan for personal protective equipment for health care providers and all essential workers.*
- 236 The Federal Government should develop and enforce the standards used to produce personal protective equipment during public health emergencies requiring such equipment.*
- 237 The Federal Government should leverage available Federal funding tools to provide temporary funding to state, local, Tribal, and territorial governments for vaccine uptake in employees of congregate settings, such as long-term care facilities, hospitals, End-Stage Renal Disease facilities, shelters, and prisons. Vaccine uptake in these settings protects employees, residents, and patients, all of which are often from communities of color and other underserved populations.
- 238 The Federal Government should partner with COVID-19 test kit manufacturers to expand at-home COVID-19 test kits with results that are entered into a public health data system, expanding access to communities not able to access traditional testing sites, while providing access to data that builds transparency around spreadable diseases.
- 239 The Federal Government should develop policies that require public and private health insurance to cover COVID-19 testing and ensure testing is at no cost to the patient if the patient is uninsured.*
- 240 The Federal Government should issue guidance to recipients of Emergency Solutions Grants to address how and why shelters should allow people to rest, as needed.
- 241 The Federal Government should encourage and incentivize state homeless service providers and state, local, Tribal, and territorial continua of care to address homelessness, to ensure that the people experiencing homelessness with Long COVID have places to rest during the day by extending shelter operations to include daytime hours and/or expanding day-time drop-in center capacity.*

 * Recommendations advanced as prioritized recommendations.

- 242 The Federal Government should establish funding for Medical Respite (also known as Recuperative Care) programs, which provide safe places for people experiencing homelessness to receive medical care and wrap-around services to stabilize their health and recover from conditions such as Long COVID. Encouragement and support should be extended to communities seeking to convert hotels to house people experiencing homelessness during the pandemic.*
- 243 The Federal Government should provide public health intervention funding to address barriers to care, such as transportation to treatment centers from homeless shelters, to increase access to quality treatment for Long COVID for communities of color and other underserved populations, with a special focus on populations experiencing homelessness.*
- 244 The Federal Government should leverage telehealth and telephone visits where medical resources are limited and ensure that providers are reimbursed at equitable rates.*
- 245 The Federal Government should provide incentives and equipment to health care providers who treat Long COVID patients within known remote, Tribal, and other medically underserved areas. Such incentives include funding, machines, therapeutics, and training.
- 246 The Federal Government should prioritize access to in-person care when possible and should expand access to and reimbursement for telemedicine and telephone visits when in-person care is not feasible or would delay treatment.

Future Pandemic Preparedness

Communications and Collaboration

- 247 All levels of government should foster a culture of collaboration between public health officials and public emergency management. Government entities should leverage these collaborations, develop an adaptive pandemic preparedness and response plan, and commit to exercising it at appropriate intervals and against various scenarios. Government entities should ensure adequate funding for the planning process, steady-state collaboration, and relevant exercises.
- 248 The U.S. should take an active leadership role in bringing an equity lens to international pandemic preparedness efforts and should encourage American health care leaders to take a global approach to global problems. The U.S. should develop a policy point of view on the international proposals (e.g., the U.S. should review and identify appropriate recommendations from the Independent Panel for Pandemic Preparedness and Response).
- 249 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, Tribal, and territorial levels, including their respective roles in pandemic response. The analysis should seek input from diverse, non-governmental stakeholders.*
- 250 In future pandemics, the Federal Government should establish consistent communication to educate the public about personal protective equipment, 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, Tribal, and territorial leaders and trusted private sector entities to ensure the message is clear, credible, consistent, and adapted to the cultural context of communities of color and other underserved populations.*

 * Recommendations advanced as prioritized recommendations.

- 251 The Federal Government should establish consistent funding for pandemic response.*
- 252 The Federal Government should provide guidance to state, local, Tribal, and territorial governments, 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.
- 253 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 communities of color and other underserved populations, their family communication, and social network dynamics.
- 254 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.
- 255 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 communities of color and other underserved populations, their family communication, and social network dynamics.
- 256 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.
- 257 The Federal Government should provide guidance to public health agencies on the collaboration between governmental and non-governmental entities that have stronger relationships with communities of color and other underserved populations and work to build a pipeline for talent of individuals that come from these communities.
- 258 Informed by collaboration successes and missteps from other pandemics, the Federal Government should improve collaboration to ensure that communities of color and other underserved populations are not the last groups to benefit from diagnostics, pharmaceutical interventions, and public health solutions during the next pandemic.*
- ### Data, Analytics, and Research
- 259 The Federal Government should 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.*
- 260 The Federal Government should assess opportunities to use data to close equity gaps in special pathogens care delivery.
- 261 The Federal Government should develop a tool for facilities and health systems to help track personal protective equipment and other essential supplies' availability.
- 262 The Federal Government should strengthen, streamline, and make more transparent data collection processes to enable reporting on personal protective equipment and other essential supplies' availability to Federal, state, local, Tribal, and territorial public health authorities to support tracking of local supplies.
- 263 The Federal Government should properly maintain personal protective equipment and other essential supplies in local stockpiles and use sharing agreements.*
- 264 The Federal Government should incentivize training of health care entities on personal protective equipment donning and doffing on a regular schedule and monitor training compliance.

 * Recommendations advanced as prioritized recommendations.

- 265 The Federal Government should conduct a retrospective analysis to determine recommendations for Federal, state, local, Tribal, and territorial stockpiles.
- 266 The Federal Government should leverage existing frameworks that explore the equity gap between personal protective equipment supply and demand and distribute personal protective equipment to those who lack protection in pandemic response.
- 267 The Federal Government should create standardized expectations around disaggregated data collection and include incentives to collect and report disaggregated data.
- 268 The Federal Government should leverage existing Federal, state, local, Tribal, and territorial data to create a centralized dashboard that displays timely, reliable, transparent, and accessible data.
- 269 The Federal Government should invest in state, local, Tribal, and territorial data and surveillance infrastructure to ensure real time threat information can be shared quickly.*
- 270 The Federal Government should 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.
- 271 The Federal Government should incentivize novel partnerships and data use (including administrative data) to better reflect American Indians, Alaska Natives, Native Hawaiians, Pacific Islanders, veterans, people with disabilities, and people in carceral settings and address equity in preparedness.
- 272 The Federal Government should develop standards and expectations to collect and require reporting of disaggregated data for all communities of color and other underserved populations.
- 273 The Federal Government should 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).
- 274 The Federal Government should assess compliance with existing standards related to data capabilities, collecting feedback on challenges and barriers to compliance.
- 275 The Federal Government should 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.
- 276 The Federal Government should conduct an environmental scan to understand various data reporting requirements across Federal, state, local, Tribal, territorial, and private health care entities to find areas for collaboration, standardization, alignment, and use.
- 277 The Federal Government should leverage existing data reporting processes on specific data types, set expectations, and create new processes to enable real-time data reporting in a centralized and standardized manner.
- 278 The Federal Government should use improved data to improve collaboration, care coordination, and resource allocation in future pandemics.
- 279 The Federal Government should streamline data requests and collection efforts to make informed decisions about addressing health needs.
- 280 The Federal Government should conduct an analysis to determine inequities in research funding and structural barriers to access for different types of individuals, communities, and organizations.
- 281 The Federal Government should develop a research network that enables timely sharing of research that is accessible to all, promoting greater understanding in rapidly changing environments and enabling more research to be conducted specifically on communities of color and other underserved populations.
- 282 The Federal Government should require Federally supported biomedical research to include individuals from communities of color and other underserved populations in ethical research design and as subjects of ethical research.

 * Recommendations advanced as prioritized recommendations.

- 283 The Federal Government should 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 communities of color and other underserved populations that result from collective (or cumulative) exposure to health risks.
- 284 The Federal Government should conduct a retrospective analysis to determine inequities in COVID-19 clinical trials for therapeutics and vaccines and understand barriers and challenges for those who wanted to participate in trials but could not.
- 285 The Federal Government should develop standards and recommendations for future clinical trials for special pathogen treatments and vaccines that break down barriers and enable more equity.
- 286 The Federal Government should include diversity enrollment targets in clinical trials that are related to special pathogens and oversample for populations hit hard by a special pathogen event.*
- 287 The Federal Government should 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.
- 288 The Federal Government should invest in a genomic epidemiology data infrastructure and communication plan so that local health threat responses can occur in real time and data can be communicated and shared rapidly across the country.
- 289 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 health care, travel, and lodging as well as family care needs.*
- 290 The Federal Government should institute a national moratorium on water and utility shutoffs to improve sanitation efforts and address immediate, emergency needs in future pandemics.*
- 291 The Federal Government should allocate funding for grants and funding for states, cities, and Tribes technical assistance to replace household plumbing and lead services lines in advance of a future pandemic.
- 292 The Federal Government should establish a permanent low-income utility (e.g., water, electricity, waste management) assistance program akin to the Low-Income Home Energy Assistance Program.*
- 293 The Federal Government must ensure that, through public utilities, every dwelling in the U.S. has access to clean water and sanitation. They should also use a reliable indicator, such as the Health Social Vulnerability Index and/or Centers for Disease Control and Prevention Social Vulnerability Index, to accurately assess the level of exposure to hazards within our highest risk communities, including but not limited to Tribal Nations. The Federal Government should 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.*
- 294 The Federal Government should practice and incentivize health care 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 health care data, surveillance and risk reduction strategies, and medical tools, devices, and technologies.

 * Recommendations advanced as prioritized recommendations.

295 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, providing a home internet stipend that covers the total cost of internet during any stay-at-home order issued in response to a pandemic, and providing other essential educational materials.*

296 The Federal Government should increase the amount of racial, ethnic, and disability data on the health care workforce and educational pipeline across health care professions and centralize the data 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.

Health Care Access and Quality

297 The Federal Government should 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 health care system, to effectively decrease health inequity throughout the health care delivery system. The Federal Government should incentivize equity in health care systems by encouraging data- and community-driven approaches focused on decreasing distrust in the health care system for communities of color and other underserved populations. The Federal Government should then analyze data to improve both health care quality and the patient experience across these communities.*

298 The Federal Government should invest in evidence-based solutions (e.g., 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.

299 The Federal Government should evaluate the link between comorbidities (e.g., diabetes, hypertension, unhealthy cholesterol levels), which exist at a higher rate in communities of color and other underserved 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 people in the United States, especially those in communities of color and other underserved populations that often have limited access to such options.*

300 The Federal Government should expand the Federally-funded National Public Health Corps to address health care worker shortages. Prioritize training and hiring of members of communities of color and other underserved populations.

301 The Federal Government should 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. The Federal Government (and other stakeholders) should 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.

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

 * Recommendations advanced as prioritized recommendations.

- 303 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 communities of color and other underserved populations. 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 Historically Black Colleges and Universities, Tribal Colleges and Universities, and institutions that graduate licensed health professionals from communities of color and other underserved populations equal to or greater than their share of the general population. The Federal Government should provide additional resources to U.S. 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.*
- 304 The Federal Government should form a Federal commission to curtail hospital closures that negatively impact vulnerable populations. This commission shall do the following:*
- 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. 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.
- 305 The Federal Government should fund the National Health Care Workforce Commission to provide data on the health care workforce, train health care workers, and provide policy advice and recommendations to both Congress and the current administration.
- 306 The Federal Government should expand adequate and evidence-based health care access to treat patients in congregate settings.*
- 307 The Federal Government should fund infrastructure to build quarantine space to house ill patients that reside in congregate settings.
- 308 Federal, state, local, Tribal, and territorial governments should 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.*
- 309 The Federal Government should 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.
- 310 The Federal Government should 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.*
- 311 The Federal Government (and other stakeholders) should ensure that testing is accompanied from the start by a robust system of contact tracing.*

 * Recommendations advanced as prioritized recommendations.

312 The Federal Government should create a pandemic preparedness team model to do the following:*

- 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.
- 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.
- 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.
- Ensure that research is ethical and inclusive of communities of color and other underserved populations.
- Support a permanent infectious disease standard by the end of 2021 that requires pandemic preparedness plans and funded science-based training.

313 The U.S. should recognize health care 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 health care as a human right, regardless of immigration status, especially during a pandemic to reduce the possibility of infection. The Federal Government should engage the public and make the economic benefit case to support comprehensive health care reform for all.*

314 The Federal Government should 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 (e.g., Medicaid, Children’s Health Insurance Program).
- 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 and 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.

315 The Federal Government should create comprehensive and effective health care systems that cover the costs of essential health care 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 health care needs during a pandemic.*

316 During a pandemic, the Federal Government should expand access to Consolidated Omnibus Budget Reconciliation Act, 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.*

 * Recommendations advanced as prioritized recommendations.

Task Force Executive Order

Executive Order on Ensuring an Equitable Pandemic Response and Recovery

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to address the disproportionate and severe impact of coronavirus disease 2019 (COVID-19) on communities of color and other underserved populations, it is hereby ordered as follows:

Section 1. Purpose. The COVID-19 pandemic has exposed and exacerbated severe and pervasive health and social inequities in America. For instance, people of color experience systemic and structural racism in many facets of our society and are more likely to become sick and die from COVID-19. The lack of complete data, disaggregated by race and ethnicity, on COVID-19 infection, hospitalization, and mortality rates, as well as underlying health and social vulnerabilities, has further hampered efforts to ensure an equitable pandemic response. Other communities, often obscured in the data, are also disproportionately affected by COVID-19, including sexual and gender minority groups, those living with disabilities, and those living at the margins of our economy. Observed inequities in rural and Tribal communities, territories, and other geographically isolated communities require a place-based approach to data collection and the response. Despite increased State and local efforts to address these inequities, COVID-19's disparate impact on communities of color and other underserved populations remains unrelenting.

Addressing this devastating toll is both a moral imperative and pragmatic policy. It is impossible to change the course of the pandemic without tackling it in the hardest-hit communities. In order to identify and eliminate health and social inequities resulting in disproportionately higher rates of exposure, illness, and death, I am directing a Government-wide effort to address health equity. The Federal Government must take swift action to prevent and

remedy differences in COVID-19 care and outcomes within communities of color and other underserved populations.

Sec. 2. COVID-19 Health Equity Task Force. There is established within the Department of Health and Human Services (HHS) a COVID-19 Health Equity Task Force (Task Force).

(a) Membership. The Task Force shall consist of the Secretary of HHS; an individual designated by the Secretary of HHS to Chair the Task Force (COVID-19 Health Equity Task Force Chair); the heads of such other executive departments, agencies, or offices (agencies) as the Chair may invite; and up to 20 members from sectors outside of the Federal Government appointed by the President.

(i) Federal members may designate, to perform the Task Force functions of the member, a senior-level official who is a part of the member's agency and a full-time officer or employee of the Federal Government.

(ii) Nonfederal members shall include individuals with expertise and lived experience relevant to groups suffering disproportionate rates of illness and death in the United States; individuals with expertise and lived experience relevant to equity in public health, health care, education, housing, and community-based services; and any other individuals with expertise the President deems relevant. Appointments shall be made without regard to political affiliation and shall reflect a diverse set of perspectives.

(iii) Members of the Task Force shall serve without compensation for their work on the Task Force, but members shall be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in the Government service (5 U.S.C. 5701-5707).

(iv) At the direction of the Chair, the Task Force may establish subgroups consisting exclusively of Task Force members or their designees under this section, as appropriate.

(b) Mission and Work.

(i) Consistent with applicable law and as soon as practicable, the Task Force shall provide specific recommendations to the President, through the Coordinator of the COVID-19 Response and Counselor to the President (COVID-19 Response Coordinator), for mitigating the health inequities caused or exacerbated by the COVID-19 pandemic and for preventing such inequities in the future. The recommendations shall include:

(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.

(ii) The Task Force shall submit a final report to the COVID-19 Response Coordinator addressing any ongoing health inequities faced by COVID-19 survivors that may merit a public health response, describing the factors that contributed to disparities in COVID-19 outcomes, and recommending actions to combat such disparities in future pandemic responses.

(c) Data Collection. To address the data shortfalls identified in section 1 of this order, and consistent with applicable law, the Task Force shall:

(i) collaborate with the heads of relevant

agencies, consistent with the Executive Order entitled “Ensuring a Data-Driven Response to COVID-19 and Future High-Consequence Public Health Threats,” to develop recommendations for expediting data collection for communities of color and other underserved populations and identifying data sources, proxies, or indices that would enable development of short-term targets for pandemic-related actions for such communities and populations;

(ii) develop, in collaboration with the heads of relevant agencies, a set of longer-term recommendations to address these data shortfalls and other foundational data challenges, including those relating to data intersectionality, that must be tackled in order to better prepare and respond to future pandemics; and

(iii) submit the recommendations described in this subsection to the President, through the COVID-19 Response Coordinator.

(d) External Engagement. Consistent with the objectives set out in this order and with applicable law, the Task Force may seek the views of health professionals; policy experts; State, local, Tribal, and territorial health officials; faith-based leaders; businesses; health providers; community organizations; those with lived experience with homelessness, incarceration, discrimination, and other relevant issues; and other stakeholders.

(e) Administration. Insofar as the Federal Advisory Committee Act, as amended (5 U.S.C. App.), may apply to the Task Force, any functions of the President under the Act, except for those in section 6 of the Act, shall be performed by the Secretary of HHS in accordance with the guidelines that have been issued by the Administrator of General Services. HHS shall provide funding and administrative support for the Task Force to the extent permitted by law and within existing appropriations. The Chair shall convene regular meetings of the Task Force, determine its agenda, and direct its work. The Chair shall designate an Executive Director of the Task Force, who shall coordinate the work of the Task Force and head any staff assigned to the Task Force.

(f) Termination. Unless extended by the President, the Task Force shall terminate within 30 days of accomplishing the objectives set forth in this order, including the delivery of the report and recommendations specified in this section, or 2 years from the date of this order, whichever comes first.

Sec. 3. Ensuring an Equitable Pandemic Response.

To address the inequities identified in section 1 of this order, it is hereby directed that:

(a) The Secretary of Agriculture, the Secretary of Labor, the Secretary of HHS, the Secretary of Housing and Urban Development, the Secretary of Education, the Administrator of the Environmental Protection Agency, and the heads of all other agencies with authorities or responsibilities relating to the pandemic response and recovery shall, as appropriate and consistent with applicable law:

(i) consult with the Task Force to strengthen equity data collection, reporting, and use related to COVID-19;

(ii) assess pandemic response plans and policies to determine whether personal protective equipment, tests, vaccines, therapeutics, and other resources have been or will be allocated equitably, including by considering:

(A) the disproportionately high rates of COVID-19 infection, hospitalization, and mortality in certain communities; and

(B) any barriers that have restricted access to preventive measures, treatment, and other health services for high-risk populations;

(iii) based on the assessments described in subsection (a)(ii) of this section, modify pandemic response plans and policies to advance equity, with consideration to:

(A) the effect of proposed policy changes on the distribution of resources to, and access to health care by, communities of color and other underserved populations;

(B) the effect of proposed policy changes on

agencies' ability to collect, analyze, and report data necessary to monitor and evaluate the impact of pandemic response plans and policies on communities of color and other underserved populations; and

(C) policy priorities expressed by communities that have suffered disproportionate rates of illness and death as a result of the pandemic;

(iv) strengthen enforcement of anti-discrimination requirements pertaining to the availability of, and access to, COVID-19 care and treatment; and

(v) partner with States, localities, Tribes, and territories to explore mechanisms to provide greater assistance to individuals and families experiencing disproportionate economic or health effects from COVID-19, such as by expanding access to food, housing, child care, or income support.

(b) The Secretary of HHS shall:

(i) provide recommendations to State, local, Tribal, and territorial leaders on how to facilitate the placement of contact tracers and other workers in communities that have been hardest hit by the pandemic, recruit such workers from those communities, and connect such workers to existing health workforce training programs and other career advancement programs; and

(ii) conduct an outreach campaign to promote vaccine trust and uptake among communities of color and other underserved populations with higher levels of vaccine mistrust due to discriminatory medical treatment and research, and engage with leaders within those communities.

Sec. 4. General Provisions.

(a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

JOSEPH R. BIDEN, JR.

THE WHITE HOUSE,
January 21, 2021.



Task Force Charter, Health and Human Services

COVID-19 Health Equity Task Force

Committee's Official Designation

COVID-19 Health Equity Task Force

Authority

Executive Order (E.O.) 13995, dated January 21, 2021. The COVID-19 Health Equity Task Force (Task Force) is governed by provisions of the Federal Advisory Committee Act (FACA), P.L. 92-463, as amended (5 U.S.C. App. 2).

Objectives and Scope of Activities

The Task Force shall provide specific recommendations to the President, through the Coordinator of the COVID-19 Response and Counselor to the President (COVID-19 Response Coordinator), for mitigating the health inequities caused or exacerbated by the COVID-19 pandemic and for preventing such inequities in the future.

Description of Duties

In carrying out its mission, the Task Force shall advise and provide recommendations to the President, through the COVID-19 Response Coordinator. The recommendations shall include:

- (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;
- (C) recommendations for agencies regarding effective, culturally aligned communication, messaging, and outreach to communities of color and other underserved populations; and
- (D) recommendations for advancing cultural competency, language access, and sensitivity towards Asian Americans and Pacific Islanders in the context of the Federal Government's COVID-19 response in accordance with the Presidential Memorandum Condemning and Combating Racism, Xenophobia, and Intolerance Against Asian Americans and Pacific Islanders in the United States issued on January 26, 2021.

Data Collection

To address the data shortfalls identified in Section 1 of E.O. 13995, and consistent with applicable law, the Task Force shall:

- (1) collaborate with the heads of relevant agencies, consistent with the Executive Order entitled "Ensuring a Data-Driven Response to COVID-19 and Future High-Consequence Public Health Threats," to develop recommendations for expediting data collection for communities of color and other underserved populations and identifying data sources, proxies, or indices that would enable development of short-term targets for pandemic-related actions for such communities and populations;
- (2) develop, in collaboration with the heads of relevant agencies, a set of longer-term recommendations to address these data shortfalls and other foundational data challenges, including those relating to data intersectionality, that must be tackled in order to better prepare and respond to future pandemics; and
- (3) submit the recommendations described in this subsection to the President, through the COVID-19 Response Coordinator.

The Task Force shall submit a final report to the COVID-19 Response Coordinator addressing any ongoing health inequities faced by COVID-19 survivors that may merit a public health response, describing the factors that contributed to disparities in COVID-19 outcomes, and recommending actions to combat such disparities in future pandemic responses.

The function of the Task Force is solely advisory.

Agency or Official to Whom the Committee Reports

The Task Force shall report to the President, through the COVID-19 Response Coordinator. The President, or his delegate, shall be responsible for ensuring the reporting requirements of 6(b) of Act are appropriately fulfilled.

Support

The U.S. Department of Health and Human Services (HHS) shall provide funding and administrative support for the Task Force to the extent permitted by law and within existing appropriations.

Management and support services for the Task Force will be provided by the Office of Minority Health (OMH), which is organizationally located within the Office of the Secretary in HHS. OMH is administratively supported by the Office of the Assistant Secretary for Health, which is a staff division in the Office of the Secretary, HHS.

The COVID-19 Health Equity Task Force Chair (Task Force Chair), who is designated by the HHS Secretary, shall designate an Executive Director, who shall be a full-time federal employee.

The Executive Director shall coordinate the work of the Task Force and head any staff assigned to the Task Force.

Estimated Annual Operating Costs and Staff Years

The estimated annual cost for operating the Task Force, including travel expenses for members, but excluding staff support, is \$51,000. The estimate for annual person years of staff support required is 2.1, at an estimated annual cost of \$303,548.

Members of the Task Force will serve without compensation. Travel expenses will be allowed, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in Government service (5 U.S.C. 5701-5707), consistent with the availability of funds.

Designated Federal Officer (DFO)

HHS will designate either a full-time or permanent part-time, federal employee to serve as the DFO. The DFO will approve or call the advisory committee's and subcommittees' meetings, prepare the meeting agendas, attend all the committee and subcommittee meetings, adjourning any meeting when the DFO determines adjournment to be in the public interest, and chair a meeting when so directed by the agency head. An Alternate DFO may also be appointed in the same manner as the DFO.

Estimated Number and Frequency of Meetings

The Task Force Chair, in consultation with the DFO, will determine when the Task Force will meet. It is anticipated that the Task Force will meet approximately four times a year.

Duration

Continuing.

Termination

Unless extended by the President, the Task Force shall terminate within 30 days of accomplishing the objectives set forth in E.O. 13995, including the delivery of the report and recommendations specified in Sec. 2 of E.O. 13995, or 2 years from January 21, 2021, whichever comes first.

Membership and Designation

The Task Force shall consist of the Secretary of HHS; an individual designated by the Secretary of HHS to Chair the Task Force (COVID-19 Health Equity Task Force Chair); the heads of such other executive departments, agencies, or offices (agencies) as the Chair may invite; and up to 20 members from sectors outside of the Federal Government appointed by the President. The Task Force Chair shall convene and preside at meetings of the Task Force, determine its agenda, and direct its work.

Federal members may designate, to perform the Task Force functions of the member, a senior-level official who is a part of the member's agency and a full-time officer or employee of the Federal Government.

Non-federal members shall include individuals with expertise and lived experience relevant to groups suffering disproportionate rates of illness and death in the United States; individuals with expertise and lived experience relevant to equity in public health, health care, education, housing, and community-based services; and any other individuals with expertise the President deems relevant. Appointments shall be made without regard to political affiliation and shall reflect a diverse set of perspectives.

Federal members shall serve as ex-officio members or Regular Government Employees and non-federal members shall serve as Special Government Employees. All members shall be appointed to serve for the duration of the time that the Task Force is authorized to operate. Any vacancy of a non-federal member shall be filled in the same manner as the original appointments. Any non-federal member who is appointed to fill the vacancy of an unexpired term shall be appointed to serve for the remainder of that term.

Subcommittees

At the direction of the Chair, the Task Force may establish subgroups consisting exclusively of Task Force members or their designees under this section, as appropriate. All such subcommittees must report directly to the Task Force and must not provide advice or work products directly to the President, or any other official or agency. Subcommittees of the Task Force will meet as determined by the Task Force Chair.

The Department Committee Management Officer will be notified upon establishment of each subcommittee and will be provided information regarding the name of the subcommittee, function, membership, and estimated frequency of meetings.

Recordkeeping

The records of the Task Force and subcommittees of the Task Force shall be handled in accordance with the General Records Schedule 6.2. These records shall be available for public inspection and copying, subject to the Freedom of Information Act, 5 U.S.C. 552.

Establishment Filing Date:

Approved: February 4, 2021

Norris Cochran, Acting Secretary

Task Force Members' Biographies

Task Force Subcommittees



Communications and Collaboration



Structural Drivers and Xenophobia



Data, Analytics, and Research



Health Care Access and Quality



Implementation Working Group



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

Chair of Presidential COVID-19 Health Equity Task Force



Dr. Marcella Nunez-Smith is Associate Dean for Health Equity Research; C.N.H. Long Professor of Medicine, Public Health, and Management; and Director of the Equity Research and Innovation Center at Yale. Her research focuses on health and health care equity for marginalized populations with an emphasis on the social and structural determinants of health, the influence of health care systems on health disparities, and the advancement of community-academic partnered scholarship. Previously, she served as co-chair of the Biden-Harris Transition COVID-19 Advisory Board and chair of the governor's ReOpen CT Advisory Group Community Committee. Originally from the U.S. Virgin Islands, she received her B.A. from Swarthmore College, attended Jefferson Medical College, residency at Harvard's Brigham and Women's Hospital, and fellowship at the Yale Robert Wood Johnson Foundation Clinical Scholars Program.



Mayra E. Alvarez, M.H.A.

Communications and Collaboration Subcommittee Chair



Mayra E. Alvarez, M.H.A. is President of The Children's Partnership, a California advocacy organization working to advance child health equity. Previously, she served in the U.S. Department of Health and Human Services during the Obama-Biden administration, including at the Centers for Medicare & Medicaid Services, the Office of Minority Health, and the Office of Health Reform. She has also served as a Legislative Assistant in the U.S. Senate and House of Representatives. A native of California, she graduated from the School of Public Health at the University of North Carolina at Chapel Hill and the University of California at Berkeley.



Andrew Imparato, J.D.

Implementation Working Group Chair



Andrew Imparato is a disability rights lawyer and the Executive Director of Disability Rights California (DRC), where he has spearheaded advocacy on crisis standards of care and vaccine prioritization in the last year. Imparato joined DRC after a 26-year career in Washington, D.C., where he served as the chief executive of the Association of University Centers on Disabilities and the American Association of People with Disabilities. From 2010 to 2013, Imparato served as Chairman Tom Harkin's Disability Policy Director on the U.S. Senate Committee on Health, Education, Labor and Pensions. Imparato's perspective is informed by his lived experience with bipolar disorder.



Joneigh Khaldun, M.D., M.P.H., FACEP

Data, Analytics, and Research Subcommittee Chair

Dr. Joneigh S. Khaldun served as the Chief Medical Executive for the State of Michigan and Chief Deputy Director for Health in the Michigan Department of Health and Human Services from April 2019 through September 2021. She was the top public health advisor guiding Michigan's COVID-19 response. Prior to her role in Michigan, she was the Director of the Detroit Health Department, where she established robust programs to combat the opioid crisis, infant mortality, and led Detroit's response to the largest Hepatitis A outbreak in modern U.S. history. Dr. Khaldun has held former roles as the Baltimore City Health Department's Chief Medical Officer and Fellow in the Obama-Biden Administration's Office of Health Reform in the U.S. Department of Health and Human Services. She obtained her B.S. from the University of Michigan, M.D. from the Perelman School of Medicine at the University of Pennsylvania, and M.P.H. in health policy from George Washington University. She practices emergency medicine at Henry Ford Hospital in Detroit. In October of 2021, she became the inaugural Vice President and Chief Health Equity Officer for CVS Health.



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

Health Care Access and Quality Subcommittee Chair

Tim Putnam has been a leader in the health care sector for 38 years. Dr. Putnam spent nearly 20 years as President and CEO at a medical center and community hospitals in Illinois and Indiana. He served as president of the Indiana Rural Health Association, the National Rural Health Association, and in 2015, was appointed by the Governor of Indiana as chair of the newly created Board of Graduate Medical Education. Prior to being President and CEO, he was in the field of laser surgery research and earned his certification as an Emergency Medical Technician. Dr. Putnam also holds a master's degree in business administration from the University of Southern Indiana and a doctorate of health administration in health policy and administration from the Medical University of South Carolina, where his dissertation focused on acute stroke care in community hospitals.



Haeyoung Yoon, J.D.

Structural Drivers and Xenophobia Subcommittee Chair

Haeyoung Yoon is Senior Policy Director at the National Domestic Workers Alliance. Over the course of her career, Yoon has worked on low-wage and immigrant workers' rights issues. Prior to National Domestic Workers Alliance, Yoon was a Distinguished Taconic Fellow at Community Change. Yoon also has extensive litigation experience and taught at the New York University School of Law and Brooklyn Law School. She recently testified before the House Judiciary Committee's Subcommittee on Immigration and Citizenship regarding Immigrants as Essential Workers during COVID-19. Yoon received her J.D. from CUNY School of Law, her M.A. from Harvard University, and her B.A. from Barnard College.



James E.K. Hildreth, Sr., Ph.D., M.D.



Dr. James Hildreth, Sr., is President and Chief Executive Officer of Meharry Medical College, the nation's largest private, independent, historically Black academic health sciences center. Dr. Hildreth served previously as dean of the College of Biological Sciences at University of California, Davis and as a professor and associate dean at Johns Hopkins University School of Medicine. Dr. Hildreth is a member of the National Academy of Medicine and an internationally acclaimed immunologist whose work has focused on several human viruses, including HIV. He currently serves as chair of the National Academic Affiliations Council for VA, on the advisory council for the NIH director, and as a member of the FDA Vaccines and Related Biological Products Advisory Committee. Dr. Hildreth has led Meharry's efforts to ensure that disadvantaged communities have access to COVID-19 testing and vaccines. He graduated from Harvard University as a Rhodes Scholar, from Oxford University with a Ph.D. in immunology, and obtained an M.D. from Johns Hopkins School of Medicine.



Victor Joseph

Victor Joseph was elected by the 42 member Tribes to the position of Tanana Chiefs Conference (TCC) Chief/Chairman in March of 2014 and served through October of 2020. As the Chief Chairman, he was the principal executive officer for the corporation and presided over all corporate meetings of the member Tribes. Prior to being elected TCC's Chief Chairman, Joseph was employed as TCC's Health Director from 2007 to 2014. He worked for TCC a total of 28 years in a variety of leadership positions. He has also served as Alaska Representative on the U.S. Department of Health and Human Services Secretary's Tribal Advisory Committee and on the Indian Health Service Budget Formulation Committee. Joseph is a Tribal member of the Native Village of Tanana. He has extensive experience building strong working relationships with Tribal leaders, colleagues, staff, funding agencies, and corporate beneficiaries.



Octavio N. Martinez, Jr., M.D., M.P.H., M.B.A.



Octavio N. Martinez, Jr., is the Executive Director of the Hogg Foundation for Mental Health at The University of Texas at Austin. Additionally, Dr. Martinez is a Senior Associate Vice President within the university’s Division of Diversity and Community Engagement; clinical professor in the Steve Hicks School of Social Work; and professor of psychiatry at Dell Medical School. A native Texan, Dr. Martinez has an M.P.H. from Harvard University’s School of Public Health, an M.D. from Baylor College of Medicine, and an M.B.A. and B.B.A. in Finance from The University of Texas at Austin.



Vincent C. Toranzo

Vincent C. Toranzo is an active student majoring in political science at Florida International University. He has extensive experience with the inner workings of local government functions and partnered with municipal management individuals with the intent to better serve South Florida communities. Toranzo served as the State Secretary of the Florida Association of Student Councils, advocating for the inclusion of student voices in their community. In addition, he assisted in providing resources for foster children and participated in discussions to ensure students’ safety during the pandemic. Toranzo was awarded the U.S. President’s Award for Educational Excellence and a Citizenship Award for School and Public Service by U.S. House Representative Debbie Wasserman Schultz.



Mary Turner, R.N.

Mary Turner is an ICU nurse at North Memorial Medical Center in Robbinsdale and in her sixth year as President of the Minnesota Nurses Association union—the Minnesota affiliate of National Nurses United. She previously worked at Abbott Northwestern Hospital in Minneapolis for 10 years. Turner has been on the National Nurses United’s Joint Nursing Commission since 2011. She serves as the Chair of the Board for Isuroon, which provides empowerment, culturally sensitive health education, and advocacy for Somali women.



Homer Venters, M.D.

Homer Venters is a physician and epidemiologist working at the intersection of incarceration, health, and human rights. Dr. Venters is currently focused on addressing COVID-19 responses in jails, prisons, and immigration detention facilities. Dr. Venters is the former Chief Medical Officer of the NYC Correctional Health Services and author of *Life and Death in Rikers Island*. Dr. Venters has also worked in the nonprofit sector as the Director of Programs of Physicians for Human Rights and President of Community Oriented Correctional Health Service. Dr. Venters is Adjunct Faculty of the New York University College of Global Public Health.



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

G. Robert (“Bobby”) Watts is CEO of the National Health Care for the Homeless Council, which supports 300 Health Care for the Homeless FQHCs and 100 Medical Respite programs with training, research, and advocacy to end homelessness. Watts has 25 years’ experience in administration, direct service, and implementation of homeless health and shelter services. Watts served as Executive Director of Care for the Homeless in New York City for 12 years. He is a graduate of Cornell University and Columbia University’s Mailman School of Public Health from which he holds an M.P.H. in health administration and an M.S. in epidemiology.

Federal Ex-Officio Members

U.S. Department of Agriculture



Sara Bleich, Ph.D. is the Senior Advisor, COVID-19, in the Office of the Secretary. Previously, Dr. Bleich served as a Professor of Public Health Policy at the Harvard T.H. Chan School of Public Health. She is a policy expert and researcher who specializes in diet-related diseases, food insecurity, and racial inequality. Dr. Bleich is the author of more than 160 peer-reviewed publications. From 2015 to 2016, she served as a White House Fellow in the Obama Administration, where she worked in USDA as a Senior Policy Advisor for Food, Nutrition and Consumer Services. Dr. Bleich holds a Ph.D. in Health Policy from Harvard University and a bachelor’s degree in psychology from Columbia University.

U.S. Department of Education



Jessica Cardichon, Ed.D., J.D. serves as the Deputy Assistant Secretary for P-12 in the Office of Planning, Evaluation, and Policy Development at the U.S. Department of Education. Prior to this position, Dr. Cardichon served as the Director of the Washington, D.C., Office and Director of Federal Policy at the Learning Policy Institute (LPI) where she played a leadership role in the organization, including developing and advancing LPI’s Federal policy agenda. She is also the lead author of *Advancing Educational Equity for Underserved Youth*, among numerous other LPI publications. Dr. Cardichon began her career teaching in New York City for seven years and then working for Teachers College, Columbia University, as a program manager for implementation of early career educator induction programs. Upon moving to Washington, D.C., she served as education counsel to Senator Bernie Sanders, a member of the Senate Health, Education, Labor, and Pensions committee. She then served as Senior Director for Federal Policy and Advocacy at the Alliance for Excellent Education.

U.S. Department of Housing and Urban Development



Richard Cho, Ph.D., serves as Senior Advisor for Housing and Services in the Office of the Secretary. In this role, Dr. Cho advises the Secretary on HUD's efforts to end homelessness, protect HUD-assisted households from COVID-19, advance the community integration of people with disabilities, connect housing with health care, and create housing options for returning citizens. Dr. Cho brings to this role two decades of experience at the community, state, and Federal levels building collaboration between the housing, health care, social services, and criminal justice sectors to address the housing and services needs of vulnerable Americans.

U.S. Department of Homeland Security



Pritesh Gandhi, M.D., M.P.H. serves as the Chief Medical Officer at the Department of Homeland Security (DHS), as appointed by President Biden in January 2021. In this role, he serves as the principal advisor to the DHS Secretary, Assistant Secretary for the Countering Weapons of Mass Destruction (CWMD), the FEMA Administrator, and DHS senior leadership on medical and public health issues related to natural disasters, border health, pandemic response, acts of terrorism, and other human-made disasters. Dr. Gandhi is a public health trained and board-certified internal medicine specialist. He most recently served as the Associate Chief Medical Officer and Director of Adult Medicine at People's Community Clinic. He co-led the COVID-19 response team and recently served as an affiliate faculty at the University of Texas at Austin Dell Medical School. He is a Fulbright Scholar, Schweitzer Fellow, National Health Service Corps Scholar, and was named a Presidential Leadership Scholar in 2018. Dr. Gandhi completed a dual internal medicine and pediatrics residency at Tulane University in New Orleans and holds a degree in International Relations & Economics from Tufts University where he also completed his M.D. and M.P.H.

U.S. Department of Labor



Jamila Minnicks Gleason, Esq. is a Senior Counselor to the Solicitor of Labor. In this role, she has advised the Solicitor on issues arising under the Employee Retirement Income Security Act (ERISA), Executive Order 11246, the Mine Safety and Health Act, and the Occupational Safety and Health Act. During her tenure at the Department, Gleason litigated Title VII cases before administrative tribunals, and ERISA matters in both district and appellate court litigation under The Employee Retirement Income Security Act, working to safeguard employees' hard-earned pension and health benefits. Prior to joining the Solicitor's Office, Gleason litigated civil rights matters arising under the Voting Rights Act and Title VII in private practice. Gleason is also an award-winning novelist. Both her debut, *Hydrangeas of New Jessup*, which won the 2021 PEN/Bellwether Prize for Socially Engaged Fiction, and her current work-in-progress delve into the detrimental impact of racism on Black women, as well as the challenges that Black women historically faced accessing and navigating the health care system—a topic of passion informed by familial and personal experience.

U.S. Department of Health and Human Services



ADM Rachel L. Levine, M.D. serves as the 17th Assistant Secretary for Health for the U.S. Department of Health and Human Services (HHS) and the head of the U.S. Public Health Service Commissioned Corps. She fights every day to improve the health and well-being of all Americans. She's working to help our nation overcome the COVID-19 pandemic and build a stronger foundation for a healthier future—one in which every American can attain their full health potential. ADM Levine's storied career, first as a physician in academic medicine, has been focused on the intersection between mental and physical health, treating children, adolescents, and young adults. Then as Pennsylvania's Physician General and later as Pennsylvania's Secretary of Health, she addressed COVID-19, the opioid crisis, behavioral health, and other public health challenges.

U.S. Federal Emergency Management Agency



Jo Linda Johnson, Esq. serves as the Director of the FEMA Office of Equal Rights (OER), within the Department of Homeland Security (DHS), where she leads efforts to ensure the civil rights of approximately 20,000 FEMA employees internally, and roughly 300 million Americans externally (i.e., all those who receive FEMA funding or services). She previously served as the Director of the Civil Rights Division at the Transportation Security Administration (TSA). Prior to her tenure with DHS, Johnson spent almost 13 years with the United States Equal Employment Opportunity Commission. While with the Commission, Johnson served in several roles, including that of appellate attorney with the Office of Federal Operations, Special Assistant to the Acting Vice Chair of the Commission, and National Director of Federal Training and Outreach. She is considered an expert on civil rights laws, diversity, equity and inclusion, building coalitions, and problem solving.

U.S. Department of Justice



Shannon Pazur, J.D. is a Senior Counsel in the Office of Legal Policy at the U.S. Department of Justice (DOJ). In this role, she assists in the development and implementation of the Department's significant policy initiatives, often in coordination with other Department components and Executive Branch agencies. Prior to joining DOJ, Pazur was a counsel in the Washington, D.C., office of O'Melveny & Myers, where she focused on appellate litigation. She is a graduate of Duke University and the University of Virginia School of Law.

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“We need to be ready for the next pandemic when it comes. I think there need to be policies put in place that will ensure that something like this will never happen again. And we won’t have to lose the amount of lives that we lost during COVID-19.”

- COVID-19 Health Equity Task Force member



Read more about the Presidential COVID-19 Health Equity Task Force: www.bit.ly/35tBj7i

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