

Governor's COVID-19 Equity Response Team
Initial Report and Recommendations

July 12, 2020





CHRISTOPHER T. SUNUNU
Governor

Governor's COVID-19 Equity Response Team

July 12, 2020

Dr. Trinidad Tellez, Chair
Bobbie D. Bagley
Kirsten Durzy
Rogers Johnson
Dr. Dottie Morris

His Excellency Christopher T. Sununu
Governor of the State of New Hampshire
State House
107 North Main Street
Concord, New Hampshire 03301

Dear Governor Sununu,

Pursuant to the Charge issued on May 28, 2020, please accept the enclosed report of the Governor's COVID-19 Equity Response Team. The purpose of this report is to develop a recommended strategy and plan to address the disproportionate impacts of the COVID-19 pandemic and to oversee the implementation of the recommended plan.

This report includes background information and initial recommendations gathered and formulated during the first 36 days of the Governor's COVID-19 Equity Response Team's work together. We are deeply appreciative of the opportunity to advance equity in response to COVID-19 and across our state. We genuinely appreciate and acknowledge the input of various stakeholders for supporting this work and the many community members who have shared their lives, hopes and dreams with us for this imperative call to action. We acknowledge the work that has come before us and has guided us in this endeavor.

We would like to acknowledge that this document is an initial report and set of recommendations and do not consider it all-inclusive in scope. We welcome the opportunity, and very much look forward, to further engaging a broader community voice and increase the inclusivity of this work.

Sincerely,

A handwritten signature in cursive script that reads "Trinidad Tellez".

Trinidad Tellez, MD, Chair

Table of Contents

I. Executive Summary	4
II. Summary of Recommendations	6
III. Foreword	9
IV. Context	9
1. The <i>Why?</i> – COVID-19 Disparities in Racial-Ethnic Minority Populations	9
a. The Governor’s COVID-19 Equity Response Team.....	10
b. Why Trust Us?	11
c. The Changing Demographics in New Hampshire.....	12
2. New Hampshire COVID Disparities Data: Collection and Ongoing Release of Demographic Data .	14
V. Background	18
1. Upstream Factors Contributing to COVID-19 Disparities	18
a. Social Determinants of Health (SDOH)	19
b. Race as a Social Construct and Impact on Health and Well-Being	20
c. Limitations of Race Categories.....	21
d. Institutional and Systemic Racism	22
VI. Strategies & Recommendations	23
1. COVID-19 Specific Recommendations.....	23
2. Permanence of Equity Response Team	26
3. Align Government Systems for Equity Capacity.....	27
4. Organizational Cultural Effectiveness.....	29
5. Equitable Data Practices.....	31
6. Increase Knowledge about New Hampshire Communities at Risk for Experiencing Disparities	33
7. Systems Accountability for Equity	34
8. Use of Effective Equity-Promoting Strategies	36
9. Equitable Resource Allocation.....	38
10. Community Engagement	39
11. Policy.....	40
VII. Conclusion: Discussion and Future Considerations	40
VIII. Recommendations Received through Public Comments.....	41
IX. Supporting Resources	46
X. Review of Other State-Level COVID-19 Equity Entities	47

I. Executive Summary

In May of 2020, Governor Sununu called upon a small team of Health Equity, Racial Equity and Public Health experts to form a *New Hampshire COVID-19 Equity Response Team*. The team was charged with developing a recommended strategy to address the disproportionate impacts of the COVID-19 pandemic and to oversee the implementation of the recommended plan. The group met 13 times from June 6 to July 12 and formulated the report that follows.

There were four key components in the request from the Governor's Advisory Council on Diversity and Inclusion (GACDI), which called for the formation of this group, and the Governor's resulting charge to the Equity Response Team:

- Collection and ongoing release of demographic data
- Conduct a thorough analysis of all available data using a cross-cultural research method to examine the social, cultural, and systemic factors contributing to differences and disparities in COVID-19 related outcomes.
- Identify and recommend specific resources that could be allocated to address these disparities
- Within 30 days, Identify and recommend achievable steps for the state and other stakeholders to consider undertaking to remedy the disparate impact of COVID-19, which is likely to be a public health concern for months, if not years to come.

Practitioners in Public Health and community members have long understood the truth – that a public health crisis will not create disparity, it will act upon the disparities and inequities already existing, and seize upon the moment to further widen the gap and amplify the divide. As cases of COVID-19 increased in New Hampshire, quantitative public health data, along with anecdotal evidence, began to tell the story we expected to hear: People of Color were more likely to contract COVID-19; more likely to work in essential industries and positions that placed them in hazardous situations; more likely to not be able to easily access testing; less likely to be able to socially/physically distance and less likely to be able to recover from the economic and social impact of the pandemic. This pandemic, like all others before, was quickly amplifying and widening the divide.

This report provides a multi-tiered approach with immediate, short and long term strategies and recommendations to address the four elements contained in the letter from GACDI. This *initial* plan seeks to establish the need for immediate and ongoing actions in order to adequately address the health disparities associated with race and ethnicity in New Hampshire. This report is the first step in the process of advancing the work called for in the charge.

Recommendations are grouped under the following Strategic Pillars:

1. COVID-19 Specific Recommendations
2. Permanence of Equity Response Team
3. Align Government Systems for Equity Capacity

4. Organizational Cultural Effectiveness
5. Equitable Data Practices
6. Increase Knowledge About New Hampshire Communities at Risk for Experiencing Disparities
7. Systems Accountability for Equity
8. Use of Effective Equity Promoting Strategies
9. Equitable Resource Allocation
10. Community Engagement
11. Policy

The report that follows is a roadmap for how we move forward in our work in response to COVID-19 and also guides how we move together as a state to address longstanding systemic inequities that impact the ability of everyone in New Hampshire to live a safe, happy and healthy life. As we acknowledge in the report, we are not the first to do this work. We stand on the shoulders of, and in awe of, those that have come before us, and we honor in anticipation those that will come after. This work is complex, but it is also worthy of our great state. This report offers a place to start.

II. Summary of Recommendations

Immediate (I) = within 3 months

Short-Term (S) = 3-9 months

Long-Term (L) = 9 months +

Strategy	Recommendation	I, S or L
1. COVID-19 Specific Recommendations	<ul style="list-style-type: none"> a. Robust disparity data dashboards b. Increase community testing c. Seek to test all high-risk populations, especially People of Color d. Assure testing sites have written protocols for community outreach and demographic identifier data e. Conduct Equity Review Analyses f. Mandate mask use in high infection rate areas and high risk situations or environments g. Assure worker protections h. Assure healthy food access i. Create communication channels to hear community voice j. Provide awareness of opportunities for redress and reporting bias, mistreatment and discrimination k. Deploy COVID-19 Response Community Health Workers (CHWs) l. Expand compassionate release for people at high risk for COVID-19 and remove barriers to administrative home confinement m. Provide isolation and quarantine housing support n. Listen and engage staff at all levels throughout crisis response processes. o. Fairly and equitably compensate staff at all levels and areas of the organization with hazard pay or additional paid time off; provide fair and liberal family/personal (paid) leave and extended sick time p. Provide trauma-focused care to staff in need q. Establish and fund community-led public-private partnerships to identify and implement strategies that address unemployment, job creation, and the fiscal loss and financial insecurity resulting from COVID -19 	All I
2. Permanence of Equity Response Team	<ul style="list-style-type: none"> a. Work upstream to address the underlying determinants of COVID-19 b. Focus on COVID-19 immediately; expand focus as work continues into the future c. Expand the team d. Co-create a plan e. Provide resources to support the team's work 	All I
3. Align Government Systems for Equity Capacity	<ul style="list-style-type: none"> a. Formalize the Equity Response Team as a Commission b. Assure diverse representation across all governmental commissions, councils, taskforces, etc. 	S L

	<ul style="list-style-type: none"> c. Ensure equity expertise in emergency response operations d. Build alignment and connection between existing efforts related to diversity, inclusion and equity e. Establish a cross-state agency Equity Council f. Implement use of equity review analysis processes g. Enhance data systems capacity to identify disparities h. Assure compliance with federal civil rights and state laws related to communication access i. Facilitate professional development of staff 	<ul style="list-style-type: none"> I L S S L I I
4. Organizational Cultural Effectiveness	<p>Implement the 7 elements of the Culturally Effective Organizations Framework:</p> <ul style="list-style-type: none"> a. Language and Communication Access b. Individual Level Staff Cultural Competence / Cultural Responsiveness c. Community Engagement d. Workforce Diversity and Inclusion e. Data Collection and Analysis f. Institutional Policies and Procedures g. Leadership 	All S
5. Equitable Data Practices	<ul style="list-style-type: none"> a. Adopt and follow best practices as outlined here in section five for: <ul style="list-style-type: none"> i. Equitable data collection ii. Equitable data analysis iii. Equitable data dissemination and utilization b. Dedicate staff with specific expertise in equitable data best practice methodologies c. Develop internal protocols that require the use of a vetted and approved Equity Review Tool analysis for all programmatic and policy work 	All I/S/L
6. Increase Knowledge About New Hampshire Communities At Risk for Experiencing Disparities	<ul style="list-style-type: none"> a. Continue work on an expansion of the initial data scan b. Create a centralized data hub or clearinghouse c. Implement an assessment of communities of color in New Hampshire d. Establish a cross-institution community-academic partnership for continued research and understanding of communities in need in New Hampshire 	<ul style="list-style-type: none"> S L S L
7. Systems Accountability for Equity	<ul style="list-style-type: none"> a. Seek to diversify the public health and social service workforce across all sectors and levels b. Provide opportunities for training for management level staff on how to understand and operationalize equity in their organizations c. Create a team of equity and inclusion thought leaders within each organization that is representative of every level and aspect of the organization 	<ul style="list-style-type: none"> I I L

	<ul style="list-style-type: none"> d. Hire and fund internal and external evaluators and improvement specialists that are skilled in equitable assessment practices and methodologies e. Engage in cross-sector and cross-department work to build clear strategic plans that center equity as an operationalized value 	<p>I</p> <p>S</p>
8. Use of Effective Equity-Promoting Strategies	<ul style="list-style-type: none"> a. Utilize community led, equity informed, asset based strategies b. Promote and engage the Community Health Worker (CHW) workforce c. Provide good quality jobs with fair livable wages and benefits d. Ensure access to affordable quality healthcare 	<p>S</p> <p>I</p> <p>L</p> <p>I</p>
9. Equitable Resource Allocation	<ul style="list-style-type: none"> a. Funding sources need to have guidelines reflective of considerations beyond the Eurocentric worldview b. Diversify review panels for funding opportunities and grants c. Target continued or new opportunities for the CARES Act funds to go into the hands of racial/ethnic minority, especially Black and Brown, organizations, businesses, nonprofits and communities d. Improve notification of the availability of funds e. Create a minority owned/led certification process for nonprofits and businesses f. Dedicate funding for minority owned/operated nonprofits and businesses g. Funders should value minority and immigrant/ refugee organizations' role and prioritize them for funding h. Funders should have practices and processes in place to ensure that funding and other resources are dispersed in a manner that supports the needs of People of Color living and working in New Hampshire 	<p>S</p> <p>S</p> <p>S</p> <p>S</p> <p>S</p> <p>I</p> <p>I</p> <p>I</p>
10. Community Engagement	Conduct Community Forums to disseminate this <i>Initial Report and Recommendations</i> and solicit feedback	I
11. Policy	Establish a policy committee of the Equity Response Team Commission	S

III. Foreword

*As a team of people who call New Hampshire home,
Who have lived and worked here, been raised here and raised families here,
Who have laughed and cried with our neighbors, families and friends here,
Who have wandered here near the salty ocean seas and the clear mountain lakes in the land of
the Abenaki, Pennacook and Wabanaki Peoples,¹
Who have dreamed together of an even better, more welcoming state for all,
We are acutely aware that we have only touched the surface of the work that must be done to
dismantle systems born of our shared history that continue to oppress and widen disparities.*

*We have sought in 30 days to unpack what took 400 years to build.²
Much more time, more thought, and, most importantly, more disparate voices are needed.*

We cannot do this alone, but we believe that it can be done together.

We thank Governor Sununu, the people of New Hampshire and the many community members who have shared their lives, hopes and dreams with us for this imperative call to action.

IV. Context

1. The *Why?* – COVID-19 Disparities in Racial-Ethnic Minority Populations

Health equity means that everyone has a fair and just opportunity to be as healthy as possible.³

In early 2020, as the world watched the spread of the SARS-CoV-2 virus (COVID-19 pandemic) towards the United States, there were many haunting questions: How quickly would it spread? How significant would the impact be? How long would this last? However, there was one question that was not in dispute – would this pandemic affect some groups of people to a greater degree than others? Practitioners in Public Health and community members have long understood the truth – that a public health crisis does not create disparity, it creates a tsunami of events that unveil the disparities and inequities already in existence, and further widen the gap and amplify the divide.

Since March, there has been significant attention paid to the disproportionate impact that COVID-19 is having in racial-ethnic minority populations across the country. The April 20 New Hampshire COVID-19 Weekly Summary Report revealed that COVID-19 outcomes in New Hampshire were mirroring the national trends.⁴

¹ Indigenous New Hampshire, <https://indigenoussnh.com/>

² A Brief History of New Hampshire, New Hampshire Almanac, <https://www.nh.gov/almanac/history.htm>

³ Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What Is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017
<https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html>

⁴ <https://www.dhhs.nh.gov/dphs/cdcs/covid19/covid-weekly-report-04202020.pdf>

Risk factors associated with COVID-19 include close contact with the respiratory droplets of an infected individual, older age population groups, those who have underlying chronic health conditions (diabetes, hypertension, heart disease, immunosuppression and obesity).⁵ In the US, racial and ethnic minority groups are disproportionately impacted by COVID-19, with inequities in underlying chronic health conditions and their risk factors, making them at increased risk for this disease. These issues, and their underlying context and determinants, will be explored in more depth in this report.

a. The Governor's COVID-19 Equity Response Team

The Governor's COVID-19 Equity Response Team (Equity Response Team) was established May 28, 2020 and charged with developing a recommended strategy to address the disproportionate impacts of the COVID-19 pandemic and to oversee the implementation of the recommended plan.

There were four key components in the request from the Governor's Advisory Council on Diversity and Inclusion (GACDI)⁶, which called for the formation of this group, and the Governor's resulting charge to the Equity Response Team:

- Collection and ongoing release of demographic data.
- Conduct a thorough analysis of all available data using a cross-cultural research method to examine the social, cultural, and systemic factors contributing to differences and disparities in COVID-19 related outcomes.
- Identify and recommend specific resources that could be allocated to address these disparities.
- Within 30 days, Identify and recommend achievable steps for the state and other stakeholders to consider undertaking to remedy the disparate impact of COVID-19, which is likely to be a public health concern for months, if not years to come.

The report provides a multi-tiered approach with immediate, short, and long-term strategies and recommendations to address the four elements contained in the letter from GACDI. This *initial* plan seeks to establish the need for immediate and ongoing actions in order to adequately address the health disparities associated with race in New Hampshire. This report is the first step in the process of advancing the work called for in the charge.

The members of the Equity Response Team began with a review of what other states, with similar COVID-19 teams, are doing. At the beginning of June, the team was able to identify twelve of the other forty-nine states had a state-level entity dedicated to addressing the COVID-19 health disparities: Colorado, Illinois, Indiana, Louisiana, Michigan, Minnesota, Ohio, Pennsylvania, Tennessee, Utah, Virginia, and West Virginia.⁷ By the end of June, we learned that Massachusetts had released a plan for their Department of Public Health to address COVID-19 disparities. Numerous other local efforts, in cities and counties across the country, as well as non-governmental-led efforts, became evident as well.

⁵ People of Any Age with Underlying Medical Conditions, CDC https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fgroups-at-higher-risk.html

⁶ Established via Executive Order 2017-09 on December 14, 2017 <https://www.governor.nh.gov/diversity>

⁷ See Section X

These groups ranged significantly in size and charge; one state, Louisiana, also had \$500,000 of dedicated funding. The team also examined relevant and timely issue briefs and white papers that were appearing almost daily.

A significant additional consideration for the team was the need to hear from the people with “lived experience”. How could we develop a plan without hearing their voices and stories and really knowing how COVID-19 is actually affecting people in racial/ethnic minority communities in New Hampshire? The team dedicated significant time and thought considering how to balance the need for input with the charge for a plan to be delivered within thirty days. Ultimately, the team chose to conduct a quick scan of publically available New Hampshire data sets and briefs to see what is currently known about racial/ethnic minority populations to inform this report.

The team also laid out the following approach for engaging the community members with lived experiences to provide input, recognizing the significant amount of time needed when using the appropriate methodologies:

- Community engagement listening sessions to receive feedback on the initial plan;
- A more detailed review of existing data sets and briefs (mini-meta-analysis); and
- A detailed assessment with both quantitative (survey) and qualitative (focus groups and interviews) components.

Finally, it is clear that there are many considerations and contributing factors for why COVID-19 disparities in racial-ethnic minority populations exist. We know, however, that there are factors at play for who is tested, who receives treatment, who has access to masks and personal protective equipment, who are essential workers who cannot work remotely, and who is able to practice physical/social distancing. It is imperative that we focus specifically on tackling these inequities to prevent the gaps from widening and to save lives. Doing so requires that we recognize that the inequities unmasked by COVID-19 are longstanding and complex and thus, require a range of creative solutions that are immediate, short-term and long-term in their timeframe. These complex factors contributing to the current realities will require compound solutions.

b. Why Trust Us?

The Governor’s COVID-19 Equity Response Team members were selected based on their connection to the affected communities, their understanding of and thought leadership in racial/ethnic disparities and health equity, as well as their grounding in a systems-level approach to health and wellness:

- Chair: Trinidad Tellez, MD, Director
Office of Health Equity, Department of Health and Human Services
- Bobbie D. Bagley, MS, MPH, RN, CPH, Director
Division of Public Health & Community Services, City of Nashua
- Kirsten Durzy, MPH, Equity Council Lead
Public Health Evaluation and Narrative/Storytelling Expert
Division of Public Health Services, Department of Health and Human Services

- Rogers Johnson, MHP, President
Seacoast NAACP, Chair of Governors Advisory Council on Diversity and Inclusion
- Dottie Morris, PhD, Associate Vice President
Diversity and Inclusion, Keene State College

In addition to their formal, recognizable credentials, each of the team members also brings the lens of being a person of color in the United States with a wide range of lived experiences. The members have connections to their varied families and communities and feel the weight of the significant honor and responsibility in the creation of this plan.

Although this five-person team could never adequately represent all the needed voices/perspectives, constituencies, academic disciplines, and areas of specific expertise, the Governor charged this small focused team to develop a plan within 30 days. This report is the product of an initial phase of a larger body of work needed to address the tasks within the charge. The Equity Response Team anticipates engaging many other voices and people with significant expertise as this work continues forward (as proposed within this document).

As per requirements of RSA chapter 91-A: 2, no conversations about the team's business were conducted outside of team meetings if a quorum of members were together. Any and all decisions were made only in the course of the public meetings with a quorum in attendance. All members operated without oversight or input from our supervisors or any other authority or direction, besides the original charge from the Governor (which was drafted by the Chair in response to the letter from the GACDI).

The group met thirteen times from June 6 to July 12, in both nine general meetings and four focused topical subcommittee meetings. Notice of the meetings were posted on the Equity Response Team's website⁸, as well as the website of the Governor's Advisory Council on Diversity and Inclusion.⁹ As per the requirements of RSA chapter 91-A and Emergency Order 12, members of the public were welcome and could view and listen to the public meeting via online webinar or via phone. Public comment was welcomed, and could be submitted either in writing (by email) before, or by comment provided during, the meeting. Comments made by members of the public were documented in meeting notes. Recommendations from the various public comments submitted have been compiled in Section VII of this report, and any comments used in the body of this report are referenced in the footnotes.

c. The Changing Demographics in New Hampshire

New Hampshire's population size and demographic make-up has been continuously changing over time for decades. More recently, in addition to a population that is growing older, "New Hampshire is becoming more racially/[ethnically] diverse, particularly among children".¹⁰ Ten percent (10%) of the state's population were People of Color in 2018 (up from 4.9% in 2000); youth of color represented 15.5 % of New Hampshire's children in 2018, whereas adults of color were 8.7% (Figure 1).¹⁰ While our racial/ethnic diversity is concentrated "in the Concord-Manchester-Nashua urban corridor as well as in

⁸ <https://www.dhhs.nh.gov/omh/covid19-equity-response.htm>

⁹ <https://www.governor.nh.gov/diversity>

¹⁰ Johnson, K. *New Hampshire Demographic Trends in an Era of Economic Turbulence*. Carsey Research Regional Issue Brief #59. Fall 2019. <https://carsey.unh.edu/publication/nh-demographic-trends>

the Hanover-Lebanon region and in a few areas of the Seacoast”, people of every race/ethnicity are found living throughout the entire state.¹⁰

Figure 1 New Hampshire 10% People of Color Overall, 2018¹⁰

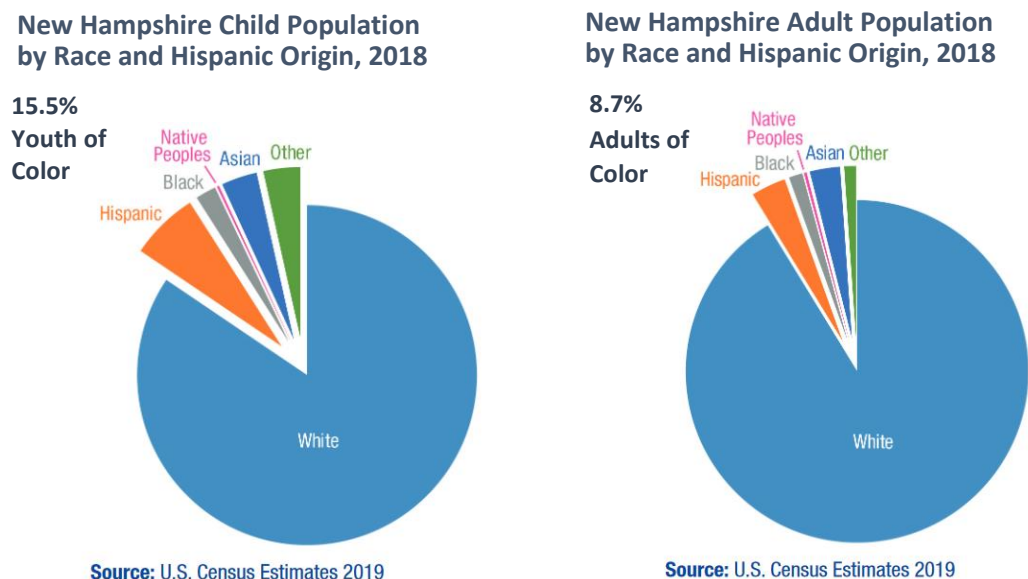


Table 1, below, contains the most recent state level population estimates available as of June 2020, which demonstrates that People of Color now comprise 10.2% of the New Hampshire population. The table lists the population by race or Hispanic/Latino origin as of 7/1/2018 and 7/1/2019. Hispanic/Latinos of any race are included in the Hispanic/Latino category. All other groups are non-Hispanic/Latino or Hispanic/Latino ethnicity unknown.

Table 1: New Hampshire Population by Race or Hispanic/Latino origin 2018 and 2019

Census Bureau Population Estimates	2018		2019		Growth
	Estimate	Percent	Estimate	Percent	
Total	1,356,458		1,359,711		3,253
White	1,220,322	89.96%	1,220,437	89.76%	115
Hispanic/Latino	52,663	3.88%	54,589	4.01%	1,926
Black or African American	19,146	1.41%	20,054	1.47%	908
American Indian and Alaska Native	2,903	0.21%	2,924	0.22%	21
Asian	39,954	2.95%	39,797	2.93%	-157
Native Hawaiian and Other Pacific Islander	383	0.03%	403	0.03%	20
Two or More Races	21,087	1.55%	21,507	1.58%	420

Census Bureau Population Estimates 7/1/19 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>, Table SC-EST2019-ALLDATA6.

Census Bureau Population Estimates 7/1/18 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-statedetail.html>. Analysis by K.M. Johnson, Demographer, Univ of New Hampshire, 4/19/20.

***Note:** Percentages may not exactly equal 100% due to rounding.

New Hampshire has long been a state that depends on people moving here from elsewhere – meaning, “migration is the biggest driver of population change in the state”.¹¹ “Migration is important to New Hampshire’s future because it brings in younger people of working age at a time when the state’s workforce is aging.”¹¹

*New Hampshire... has one of the most mobile populations in the country. Only 42 percent of the state’s residents were born in New Hampshire, far less than for New England (58 percent) or the United States (59 percent). Among those over the age of 25, only one-third were born in the state. Most of these adult migrants to the state (90 percent) were born elsewhere in the United States, and they bring in significant human capital. Compared to New Hampshire-born residents, both U.S.-born and foreign-born migrants are more likely to have a college degree and are nearly twice as likely to have a graduate degree. Thus, the recent upturn in migration brings more talented migrants to a state concerned about its aging labor force.*¹¹

The recession upended our longstanding migration patterns of receiving people from our neighboring New England states and other parts of the country, although this pattern has resumed since 2016.¹¹ The New Hampshire advantage is attractive to many people. In addition to people moving here from neighboring states or other parts of the country, people who settle in New Hampshire include (foreign-born) immigrants who may choose to immigrate here directly or who may move here from other parts of the country. Additionally, New Hampshire has welcomed refugee resettlement since the early 1980’s, participating in this humanitarian endeavor, as do all fifty states in the United States. Given the above factors and the declining natural increase (where births now only minimally exceed deaths), Racial/Ethnic Minorities produced two-thirds of New Hampshire’s small population gain from 2000-2018.¹¹

*New Hampshire’s future depends, in part, on the size, composition, and distribution of its population, including its age structure, racial-ethnic makeup, and migration patterns. For New Hampshire to thrive, policymakers, businesses, and nonprofits must be aware of the state’s population and demographic trends as they consider the needs of its people, institutions, and organizations.*¹¹

New Hampshire is dependent on our diverse populations to fuel our current and future economic vitality. Creating a welcoming and inclusive climate where every person has equal opportunity to be healthy and thrive is an imperative for our success as a state.

2. New Hampshire COVID-19 Disparities Data: Collection and Ongoing Release of Demographic Data

Collecting appropriate race and ethnicity demographic data is foundational to identifying and understanding disparities in access, utilization, and outcomes. Though challenges continue to exist in consistently and accurately capturing this data, New Hampshire continues to improve its data collection

¹¹ Johnson, K. *New Hampshire Demographic Trends in an Era of Economic Turbulence*. Carsey Research Regional Issue Brief #59. Fall 2019. <https://carsey.unh.edu/publication/nh-demographic-trends>

effort in order to provide a clearer depiction of the impact of COVID-19 on all populations. The Equity Response Team was charged to work with the state Division of Public Health Services (DPHS) data team to help ensure race and ethnicity data continues to be accurately captured and utilized to respond to the disparities and inform change.

New Hampshire first released race/ethnicity data with the April 20 Weekly COVID-19 Summary Report, (see Table 2, below).¹² At that time, race/ethnicity was only identified for 1,158 of the 1447 person with COVID-19 infection. Which meant that only 80% of total cases had known race/ethnicity data.

The population percentages are presented for understanding where COVID-19 cases may be disproportionately aligned with population size. (The population values used in the table were from July 1, 2018 Census Bureau Population Estimates.) The data reveal that where Hispanic/Latinos comprise only 3.9% of the population, they comprised 6.1% of cases; and Black or African Americans comprise 1.4% of the population but they comprised 5.4% of the state's cases, meaning these groups appear to be affected 1.6 and 3.9 times their frequency in the population. While further statistical analyses are needed to produce reliable rate ratios, the mirroring of national trends was noticeable and concerning.

Table 2: Race/Ethnicity Identified COVID-19 Cases in April 20 Weekly COVID-19 Summary Report¹²

Race/Ethnicity Identified COVID-19 Cases 80% of total cases have known Race/Ethnicity data.			
Race/Ethnicity	Cases	Percent (%)	Percent of NH Population⁴
White ²	937	81.0%	90.0%
Hispanic/Latino ¹	70	6.1%	3.9%
Black or African American ²	63	5.4%	1.4%
Other ³	51	4.4%	1.8%
Asian ²	37	3.2%	3.0%
Total Cases with Race/Ethnicity Information	1,158		

¹ Hispanic/Latino includes people of any race.
² All other races are non-Hispanic/Latino or Hispanic/Latino ethnicity unknown.
³ Other includes non-Hispanic: American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, Other race alone, or two or more races.
⁴ Census Bureau Population Estimates 7/1/18 from <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>. Analysis by K.M. Johnson, Demographer, Univ of New Hampshire, 4/19/20.
Note: Percentages may not exactly equal 100% due to rounding.

The April 27 Weekly Summary¹³ was expanded to include hospitalizations and mortality data as well as infections (cases). This time, race/ethnicity data was only known for 79% of infections, 86% of hospitalizations and 67% of deaths. This report revealed evidence that disease burden was higher in the Hispanic/Latino and Black or African American groups as compared to their frequency in the population.

¹² <https://www.dhhs.nh.gov/dphs/cdcs/covid19/covid-weekly-report-04202020.pdf>

¹³ <https://www.dhhs.nh.gov/dphs/cdcs/covid19/covid-weekly-report-04272020.pdf>

Beginning the week of May 25, a revised dashboard has displayed information that is continuously updated. The most current summary data, available at the time of the writing of this report, is displayed in Table 3, below. Race/ethnicity is identified in 82.6% of infections, 91.1% of hospitalizations and 82.6% of deaths.¹⁴

Table 3: Race/Ethnicity Identified COVID-19 Cases, NH COVID-19 Summary Dashboard, July 11, 2020¹⁴

Race / Ethnicity ?	% of NH P opu..	Infections		Hospitalizations		Deaths	
		Persons	% of Total	Persons	% of Total	Persons	% of Total
White**	90.0%	3,666	74.0%	421	79.0%	292	90.7%
Hispanic or Latino*	3.9%	567	11.5%	56	10.5%	10	3.1%
Black or African American**	1.4%	304	6.1%	25	4.7%	7	2.2%
Other***	1.8%	263	5.3%	16	3.0%	10	3.1%
Asian**	3.0%	151	3.0%	15	2.8%	3	0.9%
Grand Total		4,951		533		322	

Race/Ethnicity is known for 82.6% of COVID-19 infections, 91.1% of hospitalizations, and 82.6% of deaths

Since receipt of the letter from the Governor’s Advisory Council on Diversity and Inclusion, which stimulated the formation of this group, two of the Equity Response Team members, Dr. Tellez and Ms. Durzy, have helped lead efforts within the Department of Health and Human Services (DHHS) and the Division of Public Health Services (DPHS) to address the data improvement needs. DPHS has formed a data analytics team that includes internal experts as well as external consultants to build and manage a variety of public dashboards. Improvements already in the works include reporting on case rates to more clearly quantify the resulting disparities in health outcomes from the pandemic, and various means of visualizing the data to make it more readily understandable. Efforts are underway for more complex analysis to explore underlying conditions/comorbidities present at the time of death. Capacity to disaggregate important COVID-19 indicators by other significant socio-demographic identifiers is being explored and developed. These enhancements will be evident with the release of a new COVID-19 data dashboard format set to go live around the time of this report submission, and efforts at further improvement will continue ongoing. The continuously current data dashboard will be accessible from the homepage of the New Hampshire COVID-19 website: www.nh.gov/covid19/.

The flow of public health data is a complex, multi-organizational and has many opportunities for both system and human error. Of significant concern is the availability of high quality and complete race/ethnicity datasets to permit reporting on COVID-19 outcomes with the highest confidence and certainty. Processes internal to the Division of Public Health Services have already been implemented to increase the availability of race/ethnicity identifiers on individuals who test positive for COVID-19. As well, internal process assessments and quality assurance scans have revealed further opportunities for improvement. It is of vital importance to have race/ethnicity demographic identifiers available for everyone who is tested, regardless of result, in order to assure equitable access to testing for all populations is happening. However, the challenges inherent in capturing this information reliably from the complex network of stakeholders and processes are revealed by a high-level description of a few contributing factors:

¹⁴ <https://www.nh.gov/covid19/dashboard/summary.htm>, accessed July 11, 2020

1. One can envision there is a flow of data starting from an individual deciding to get tested all the way to the data ending up in the DPHS reporting system from which reports are drawn.
 - a. An Individual seeks testing location – this could be at a local primary care provider, free-standing lab, hospital, community health center, Convenient MD, pharmacy, drive-through testing site, local health department site, or a regional testing site put up by the State.
 - b. The individual registers self to get tested – this could be by phone or online or perhaps no advance registration required
 - The individual’s race/ethnicity may or may not be collected then

OR
 - c. The person’s primary care provider sends the order for the individual to get tested
 - The patient’s race/ethnicity may or may not be recorded then
 - d. The person presents to the designated location for testing (specimen collection).
 - The individual’s race/ethnicity may or may not be collected/verified then
 - e. The specimen is processed and the result is entered into the testing site’s (lab or hospital) database.
 - The individual’s race/ethnicity may or may not be entered then
 - f. The data is transferred/uploaded to the state DPHS central lab repository.
2. There are additional potential permutations including whether race/ethnicity are being asked correctly, such as how the question is asked, whether the individual is being asked to self-identify, and whether the response options (categories) are the latest best-practice standards. Additionally, if the individual has a communication access need that is not being met, the language/communication barrier may prohibit the collection of the needed information correctly. One other variable, is how the response options at the collecting site align with the response options in our DPHS data reporting systems.

Seeking to make improvements in this complicated system requires hands-on quality improvement efforts at every possible point along the network of pathways – which involves engaging with all the various stakeholder organizations and multiple people. The Division of Public Health Services has secured funding to hire a COVID-19 Disparities Data Quality Coordinator dedicated to this work to begin as soon as possible.

Additionally, the Equity Response Team is confident we will see additional improvements resulting from the new CARES Act Section 18115 requirement from June 4, that all laboratories “include detailed demographic data when they report the results of coronavirus tests to the federal government, including the age, sex, race and ethnicity of the person tested”, beginning August 1, 2020.¹⁵ It is only

¹⁵ Race, Ethnicity Data To Be Required With Coronavirus Tests in U.S. NPR, June 4, 2020
<https://www.npr.org/sections/coronavirus-live-updates/2020/06/04/869815033/race-ethnicity-data-to-be-required-with-coronavirus-tests-in-u-s>

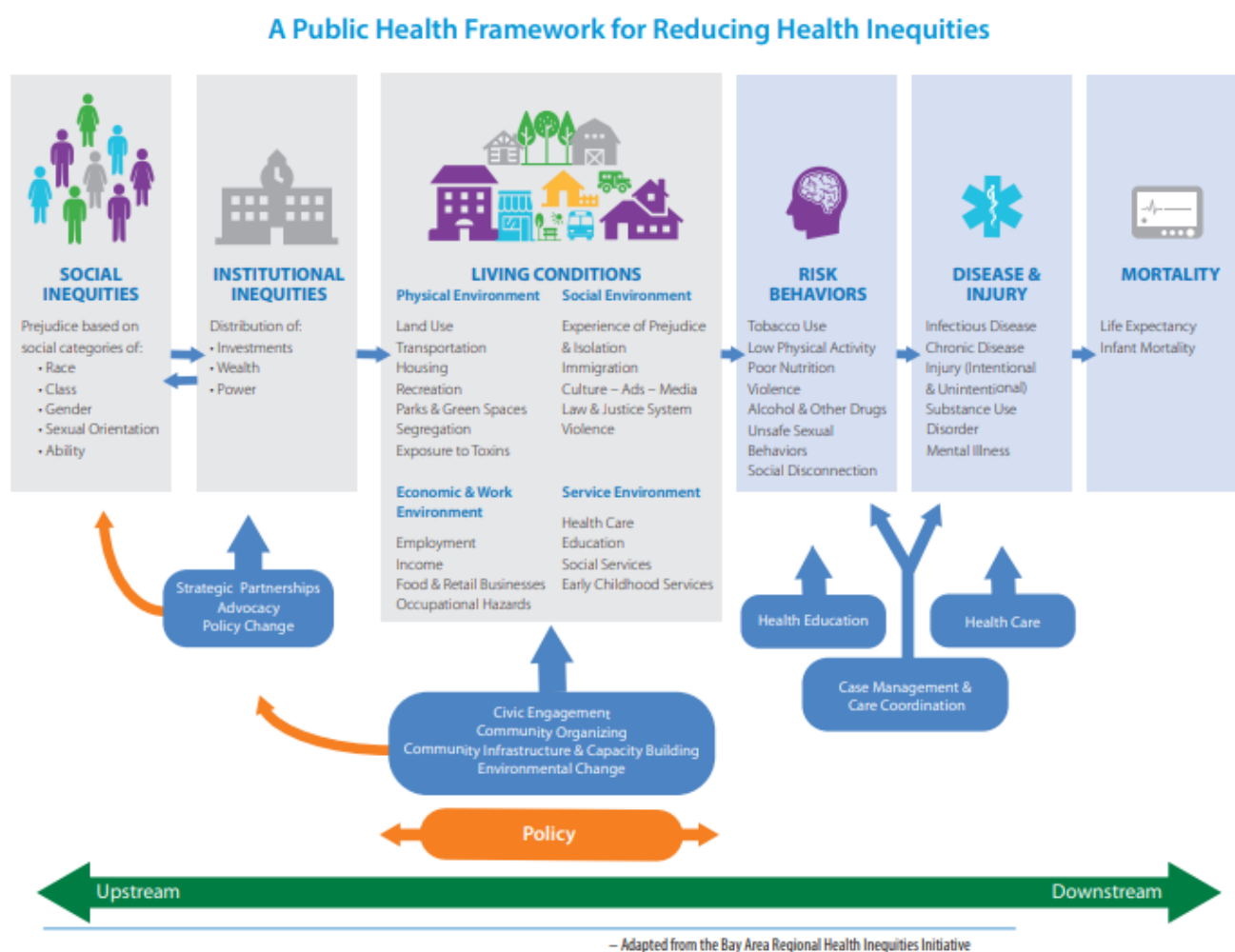
through a combination of these multiple approaches that we will achieve measurable improvements.

V. Background

1. Upstream Factors Contributing to COVID-19 Disparities

What produces health equity is depicted in this framework from the Vermont Department of Health,¹⁶ which is adapted from the Bay Area Regional Health Inequities Initiative “conceptual framework that illustrates the connection between social inequalities and health, and focuses attention on measures which have not characteristically been within the scope of public health department epidemiology.”¹⁷

Figure 2: Upstream and downstream factors that contribute to health equity¹⁶



¹⁶ Vermont State Health Improvement Plan 2019-2023, <https://www.healthvermont.gov/about-us/how-are-we-doing/state-health-improvement-plan>

¹⁷ <http://barhii.org/framework/>

a. Social Determinants of Health (SDOH)

For over 10 years, we have known that despite the significant resources dedicated to health care in this country, clinical care contributes only about 10-20% towards determining our health.¹⁸

*Social determinants of health are the conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care.*¹⁹

Underlying structural factors have contributed to the health inequities experienced by racial/ethnic minority populations for centuries. These structural factors are institutionalized in the fabric of the United States constructs of health, housing, education, transportation, and employment. Social determinants of health are determined by the very real circumstances of people's lives that are related to their everyday social context. This socio-environmental context includes neighborhoods where people live, work place environments, educational systems, as well as attitudes, perceptions or beliefs, and the accessibility of resources within these social constructs that support healthy thriving communities. The impact of SDOH can be understood through the conceptualization of safety, belonging, and the ability of population groups to live and thrive in sound health and economic stability.

The inability to address equity appropriately leads to disproportionate health outcomes for racial/ethnic minority populations regardless of their education level, income level, political affiliation or geographic location in our country.²⁰ The health and wealth gradient has been a predictor of health outcomes for decades.

Intentionally examining inequities in SDOH from a historical perspective, with the goal of closing the gap for communities of color, requires an upstream approach to solve the longstanding health inequities and the disproportionate impacts of COVID-19. Health equity requires "the removal of obstacles that prevent it, such as poverty, discrimination and the related consequences of powerlessness, lack of access to jobs, fair pay, quality education, housing, safe environments and health care".²¹ There is also a great deal of scientific and policy initiatives developed to address disparities in healthcare and with health status. Evidence indicates the persistence of large disparities in treatment by race and ethnicity and socioeconomic status. The social gap that needs to be reduced across health is a function of improving lifestyles and efforts to improve health need to be centered on upstream factors such as social and economic policies that improve the underlying conditions that impact health outcomes.

To achieve health equity, change is needed across multiple systems at multiple levels using a community informed asset-based approach. Intervention outside of the healthcare system will have a larger impact on reducing the incidence of illness and disease. Six key areas have been identified by a United States

¹⁸ Magnan, S. Social Determinants of Health 101 for Health Care: Five Plus Five. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC. 2017 doi: 10.31478/201710c <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>

¹⁹ Artiga S, Hinton E. *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*. Kaiser Family Foundation Issue Brief. May 2018 <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

²⁰ Unnatural Causes video documentary, 2008

²¹ Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What Is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017 <https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html>

Task Force that affect health: 1) neighborhood living conditions; 2) opportunities for learning and capacity for development; 3) employment opportunities and community development; 4) prevailing norms, customs and processes; 5) social cohesion, civic engagement and collective efficacy; and 6) health promotion, disease prevention and healthcare opportunities.²² Social determinants linked to these key areas that impact access to health care, income instability, housing instability, racism, discrimination, wage inequity, and even cultural beliefs about seeking care for and treatment of disease may influence COVID-19 incidence among racial and ethnically diverse population groups. The six key areas are also linked to the social determinants of underlying health conditions making racial and ethnic minority population groups more vulnerable to the virus.

The newly observed disparities in the incidence, prevalence, and mortality associated with COVID-19 in communities of color provides a context for health outcomes, which gives opportunity to leverage knowledge, capacity and support to the community to close the gap on these disparities. People of Color need to be able to trust the systems in place including the health care system. Longstanding historical events make this challenging. Genuinely working with the population and developing upstream strategies together will enhance the building of trust among individuals and stakeholders from communities of color. Interventions need to be incorporated to mitigate transmission in these populations. A focus on tackling the social determinants of health is imperative to improving the underlying conditions that impact communities of color.

b. Race as a Social Construct and Impact on Health and Well-Being

Race is a social construct. There is no support to the assertion that it is biologically based. Even though race is not biologically based, racism is real. Race is usually defined by those in power. Social definition and determination of race create soil for racism to grow. Within these definitions and determinations are projected judgments, assumptions, beliefs and attitudes about groups people based on ethnocentrism (evaluating others based your experience and belief system that you view as superior). These judgments, assumptions, beliefs and attitudes will have an impact on behavior and that behavior will have an impact on the environment (systems created). If power is added to this equation, especially if it is reinforced and supported by policies, procedures and practices, this is how systemic and institutional racism can exist within the United States in a systematic manner.

The physical characteristics (phenotype) one is born with such as skin color, hair texture, shape of eyes, etc. become associated with certain qualities, values and positions within society. The act of dividing people based on these physical characteristics and providing values to these can be seen as the root of racism. The idea that some people are seen as intelligent, dangerous, athletic, kind, gentle, deserving, etc. based on physical characteristics is core to how people are treated within an environment. These attitudes, assumptions and beliefs about people have an impact on behavior and that behavior will have an impact on the environment.

In order to enslave other human beings or use cruelty and, at times, brutality to engage in dispossession (depriving people of land, property or other possessions) the mental process of dehumanization/

²² Moving Upstream: How Interventions That Address the Social Determinants of Health Can Improve Health and Reduce Disparities. Williams, D.R; Costa, M.; Odunlami, A.; Mohammed, S.
<https://pubmed.ncbi.nlm.nih.gov/18843244/> , <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3431152/>

inhumanization (belief that a group of people lack human qualities) allowed for these actions to go unchallenged. These legacies (something from the past that had such a major impact that we continue to “feel” the influence and impact today) continue to haunt the social and political systems within the United States. It is essential, if we are going to make progress, for all of these systems to be examined through a new lens of equity.

The argument of “intentionality” is not the main focus of the determination of the existence of racism within any social or political system, it is the “outcome” that is core to dismantling the impact of how these systems are disproportionately disadvantaging some groups while advantaging others. The question then becomes, “To what degree does systemic racism play a role in the disparities between groups of people living in the United States?” rather than “Does systemic racism exist within a given United States system?” The question to what degree will allow for the outcome of decreasing and eliminating these disparities faster, with greater depth and sustainable over time.

The act of addressing structural and systemic racism within all of the interlocking social and political systems (criminal justice, educational, government, employment, health care, housing, etc.) will create healthier Granite Staters. The impact of racism on physical and mental health and well-being is documented and established in the literature. Through the works of individuals such as Arline Geronimus (“weathering”) and William Smith (“racial battle fatigue”), we have learned it is essential to look, not only, at access to health care and personal behavior, but also to address the social and political systems that allow racism to exist and disparities to grow. This means going beyond the analysis of individuals within systems who might engage in overt racist behavior or engage in behavior consistent with having implicit bias. This analysis means a thorough examination of all policies, procedures and practices and how these are disproportionately having a negative impact on people from racial/ethnic minority groups, immigrants and refugees. Once this analysis is completed, new and innovative approaches can be employed that are beneficial to everyone.

c. Limitations of Race Categories

The categories for how people are divided and labeled into “races” are inherently problematic and have significant limitations. The 1997 United States Office of Management and Budget (OMB) standards on race and ethnicity are used throughout the branches of the federal government, including the United States Census Bureau. The data standards provide guidance for how to collect the information (ask people to self-identify), and how to facilitate the provision of accurate responses (train staff effectively) – each of these is fraught with complications as they are operationalized.

“The racial categories included in the census questionnaire generally reflect a social definition of race recognized in this country and not an attempt to define race biologically, anthropologically, or genetically. In addition, it is recognized that the categories of the race item include racial and national origin or sociocultural groups.”²³

In addition to the challenge of assuring that individuals be able to self-identify, other challenges include the confusion caused by the various available categories, as well as the difficulty for some people of not

²³ <https://www.census.gov/topics/population/race/about.html>

“seeing themselves” reflected in the available categories.²⁴ Changes to the data standards for the United States Census are always being researched and a new category “Middle Eastern or North African” (MENA) was under exploration but did not make it into the 2020 Census. Additionally, the growing responses to “Some Other Race” reflect the large number of Hispanic/Latinos who do not identify with any of the OMB race categories, as well as “segments of other populations, such as Afro-Caribbean and Middle Eastern or North African populations, [who] did not identify with any of the OMB race categories and identified as SOR”, “Some Other Race”.²⁴

d. Institutional and Systemic Racism

*Institutional racism is discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race.*²⁵

Organizations and institutions are the backbone of systems that create opportunity for some and limit opportunity for others – like a swinging gate that opens for some, and closes for others. Human made social and political systems have the potential of having bias (in favor of, or against, an idea, group, belief, etc.) buried deep in their structure. These systems are designed based on individual perspectives, perceptions, worldview and experiences, and there is little or no variation between those who are at the center of development of these systems. This is the process by which power is established and perpetually held. By design, systems are established to be of benefit to those at their center.

The inability to see beyond one’s own experience can lead to imposed etic (assertion that certain behaviors and beliefs are universal, when in reality there is variation between groups) or belief that everyone is experiencing a situation or environment in the same way. If something happens especially if it is negative, it is due to an internal quality of the individual. The tendency to ignore environmental factors contributing to the quality of life of others is core to blaming individuals for their “misfortunes”. Within the United States, the dominant worldview is individualism so there is little or no tolerance for examining the impact the environment (system) might be having on individuals. Often people don't know what they don't know and when they hear something that is counter to what is held true for them, there is a tendency to deny the possibility or probability that another experience exists within the environment. This difference of experience is the result of how the identities they hold (such as race, gender, and class, etc.) are constructed and viewed within the culture.

Given the tendency to develop and maintain structures built on the foundation of bias held by those in power with only their view of the world, it becomes essential to examine the construction of the social and political systems. It is through understanding and acknowledging this foundation that we will be able to transform these systems and reduce the impact of bias leading to the reduction and elimination of racial health disparities. The overt manifestations of the bias, discrimination, and racism may not be observed, yet the subtle ways continue to have the same results, disproportionate negative impact on communities of color. The buildup of years of ignoring, denying and rejecting this reality created the perfect storm for what we are currently experiencing during this COVID-19 pandemic. This shaky foundation has been crumbling for decades and the weight of COVID-19 has caused the structure to fall.

²⁴ <https://www.census.gov/about/our-research/race-ethnicity.html>

²⁵ Durzy K, Richards M, Tellez, T, DeNubila M, Cherala S. *Equity Review Toolkit*, New Hampshire Division of Public Health Services’ Equity Council, June 2020

The Social Determinants of Health such as adequate housing, livable wages with good benefits, ability to relax, freedom from distress, access to healthy food, education access, etc. are dependent on systems rooted in bias. Merely addressing the health care system in isolation is not sufficient to decreasing and eliminating racial health disparities. There must be a comprehensive approach to address bias, discrimination and racism in all human-made systems responsible for oversight of various services.

VI. Strategies & Recommendations

1. COVID-19 Specific Recommendations

*“The COVID-19 pandemic has shone a harsh light on existing disparities in health and healthcare... disparities [which] stem from health inequities rooted in systemic and unjust social and economic policies”.*²⁶

Recommendations:

- a. **Robust disparity data dashboards** – New Hampshire COVID-19 data dashboards should include data that can be utilized by service providers and community members to understand the impact to their specific communities and to inform preventive, mitigation and response work. In addition to current indicators, dashboards should be established that include (1) indicators of quality and spread of contact tracing in affected communities and (2) testing availability and uptake in affected communities. For each of these, data should be able to be stratified by race and ethnicity, within constraints of data suppression rules. In addition, a dashboard should be created that monitors trend over time of percentage of complete race and ethnicity data received by facility type.
- b. **Increase community testing** – Offer community-based hyperlocal testing clinics and mobile outreach vans to reach people where they are, at sites that are known and trusted, by well-trained staff, with language assistance provided, in order to increase access to testing for high-risk, vulnerable populations. Efforts to increase the amount of diagnostic testing must be coupled with efforts to assure access for those populations most at disproportionate risk. Partner with ethnic, faith-based and local community organizations, as well as small businesses, to reach historically marginalized communities.
- c. **Seek to test all high-risk populations, especially People of Color** – Promote awareness of the availability and importance of testing for vulnerable populations, which include racial and ethnic minority populations, with underlying health conditions and other risk factors. Assure access to testing and follow up services.
- d. **Assure testing sites have written protocols for community outreach and demographic identifier data** - All established state-sponsored or operated testing sites should have written

²⁶ Hewitt A, et.al. The Fierce Urgency of Now: Federal and State Policy Recommendations to Address Health Inequities in the Era of COVID-19. FamiliesUSA. May 2020. <https://familiesusa.org/resources/the-fierce-urgency-of-now-federal-and-state-policy-recommendations-to-address-health-inequities-in-the-era-of-covid-19/>

protocols identifying plans for community outreach and engagement, and collection of race and ethnicity.

- e. **Conduct Equity Review Analyses** - All state COVID-19 guidance should be reviewed for equity in practices, either by an established equity review team or by utilization of an Equity Review Analysis Tool such as the one available from the Division of Public Health Services' Equity Council.²⁷
- f. **Mandate mask use in high infection rate areas and high-risk situations or environments** – There is scientific certainty about the importance of universal mask wearing. Issuing a mandate would help ensure everyone provides the same clear and consistent messaging about this essential strategy to contain COVID-19 spread and will help limit confusion and dispel the “mandatory/arbitrary outlook on COVID-19”. Additionally, “when we tell essential workers (many of whom are teens, low income workers, and /or racialized minorities) that they have no choice but to wear masks at work, but that this rule is not a mandate for customers, we downgrade these workers’ status from ‘essential’ to ‘disposable.’”²⁸ New Hampshire will only succeed at containing the COVID-19 pandemic and advancing our economic recovery if we feel a shared common purpose and work collectively for the well-being of all Granite-Staters to secure the future of our State.
- g. **Assure worker protections** – COVID-19 has revealed the divide between essential workers who can continue to earn a living by working remotely, and those who must put themselves at risk on a daily basis. Protecting the health of workers is central to protecting the public’s health. The need for hazard pay, on-site education and testing, adequate supplies of personal protective equipment (PPE) and other physical safeguards in work settings, and guaranteed sick leave policies has been described elsewhere extensively. We reiterate the need here because low-income People of Color and immigrants “are overrepresented in service industry jobs that have less access to paid sick leave protections, and women of color are more likely to be considered ‘essential’ workers” with higher risk of exposure which “also increases the risk of exposure for their family and neighbors, as People of Color are more likely to live in multi-unit dwellings or intergenerational households”.²⁹
- h. **Assure healthy food access** – People are going hungry as a result of this pandemic. Provide food access without eligibility requirements to assure people who can’t access mainstream programs don’t starve. Fund the network of food pantries to allow for expansion of service area and reduction of service limitation. Reduce barriers to the Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Temporary Assistance for Needy Families (TANF) program, and maintain the CARES Act changes. Assure the availability of culturally tailored food options at food pantries and provide food gift cards that can be redeemed at mainstream grocery stores as well as smaller ethnic foods stores. Seek creative solutions to bridge

²⁷ Durzy K, Richards M, Tellez, T, DeNubila M, Cherala S. *Equity Review Toolkit*, New Hampshire Division of Public Health Services' Equity Council, June 2020

²⁸ Written public comment received from Rane Hall July 2, 2020

²⁹ Hewitt A, et.al. *The Fierce Urgency of Now: Federal and State Policy Recommendations to Address Health Inequities in the Era of COVID-19*. FamiliesUSA. May 2020. <https://familiesusa.org/resources/the-fierce-urgency-of-now-federal-and-state-policy-recommendations-to-address-health-inequities-in-the-era-of-covid-19/>

challenges – for example, members of two work groups of the COVID-19 Equity Task Force³⁰ dedicated to Food Insecurity and concerns related to Immigrants, partnered to outreach to ethnic community members to create a “Shopping List of Cultural Foods” for the network of food pantries across the state.

- i. **Create communication channels to hear community voice** - Reaching out for authentic voice for understanding of what people are actually going through would make for a better response. Not having a way to hear community specific needs in a way that is accessible for at-risk populations is a missing link for the response. Possible examples include warm (telephone) lines and social media sites (like “WhatsApp”), for culturally and linguistically tailored feedback mechanisms to receive input directly from people on the ground about what they’re seeing or what the needs are, as well as what’s working well and news about resources and assets that would be beneficial to share.
- j. **Provide awareness of opportunities for redress and reporting bias, mistreatment and discrimination** – Provide education to communities on “Know your rights” related to COVID-19 testing and treatment, eviction, utilities shut-off, loss of employment, and how to report concerns and file discrimination complaints appropriately – safely, confidentially, culturally and linguistically competently, and without fear of retaliation.
- k. **Deploy COVID-19 Response Community Health Workers (CHWs)** – Employ COVID-19 Response Community Health Workers / *Promotores de Salud* / Community Health Representatives to serve in the affected communities who are suffering disproportionately from COVID-19.

A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

*A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.*³¹

CHWs would create capacity to connect directly to people in communities, bridge the gaps, help people navigate systems, and obtain the information, services and resources they need from trusted members of their communities. Not only is there great need for basic health information about how to protect themselves and their families in the time of COVID-19 but also people need help connecting with other social services, such as food banks and transportation, in ways that are culturally and linguistically appropriate. Pressing social needs are being bottlenecked; we need to address the emerging social needs now to avoid greater downstream costs

³⁰ The New Hampshire COVID-19 Equity Task Force is a collective of over 50 individuals and organizations across New Hampshire representing multiple sectors and communities that has come together to address issues of equity arising from the COVID-19 pandemic and response. The task force is co-convened by the New Hampshire Public Health Association (NHPHA), in partnership with the New Hampshire Department of Health and Human Services (DHHS) Office of Health Equity (OHE) and the Division of Public Health Services (DPHS).

³¹ American Public Health Association Community Health Worker (CHW) Definition <https://www.apha.org/apha-communities/member-sections/community-health-workers>, which has been adopted by the New Hampshire CHW Coalition https://www.nchcnh.org/images/NCHCuplds/NH_CHW_Coalition_Brochure.pdf

and worsened ancillary health conditions. Additionally, this network of COVID-19 CHWs could provide much needed culturally and linguistically tailored capacity to help with contact tracing. (See also Recommendation 8.b.)

- l. Expand compassionate release for people at high risk for COVID-19 and remove barriers to administrative home confinement** – “Also called medical or geriatric parole, [compassionate release] grants early release for the elderly, those facing imminent death, and those in prison with debilitating medical conditions or serious sicknesses.”³² Prisons and jails have compressed populations with lots of opportunity for interaction and potential for disease transmission. When we consider the disproportionate number of People of Color in the prison system, it is an equity and public health issue. It’s a dangerous situation, and particularly dangerous for People of Color because they’re disproportionately impacted in the prison system.³³
- m. Provide isolation and quarantine housing support** – Individuals who contract COVID-19 who cannot go home to their families need housing. Target equitably distributed funds directly to municipal or community organizations for providing isolation and quarantine housing support in safe locations.
- n. Listen and engage staff at all levels throughout crisis response processes.**
- o. Fairly and equitably compensate staff at all levels and areas of the organization with hazard pay or additional paid time off; provide fair and liberal family/personal (paid) leave and extended sick time.**
- p. Provide trauma-focused care to staff in need**
- q. Establish and fund community-led public-private partnerships to identify and implement strategies that address unemployment, job creation, and the fiscal loss and financial insecurity resulting from COVID -19.**

2. Permanence of Equity Response Team

This initial phase of intense effort to write a plan in a short amount of time has clearly revealed the substantial amount of work that needs to be done to move New Hampshire forward in addressing the disproportionate impacts of the COVID-19 pandemic and to oversee the implementation of the recommended plan. The GACDI letter and the Governor’s initial charge both indicate that “the disparate impact of COVID-19... is likely to be a public health concern for months, if not years to come”.³⁴

Recommendations:

- a. Work upstream to address the underlying determinants of COVID-19** – The immediate COVID-19 specific needs reflect significant and longstanding upstream inequities in both the social and

³² Matei, A. *States Could Save Lives by Expanding Compassionate Release during COVID-19 and Beyond*. Urban Institute Urban Wire blog, June 24, 2020. <https://www.urban.org/urban-wire/states-could-save-lives-expanding-compassionate-release-during-covid-19-and-beyond>

³³ Public Comment received from Jennifer Smith, July 2, 2020

³⁴ Governor’s COVID-19 Equity Response Team Charge, May 28, 2020. <https://www.governor.nh.gov/sites/g/files/ehbemt336/files/documents/covid-equity-response.pdf>

structural determinants as predisposing health conditions that must be addressed in order to mitigate the long-term effects of the pandemic.

- b. **Focus on COVID-19 immediately; expand focus as work continues into the future.** Realistically, this work requires an anticipated 9 months of COVID-focused response effort, and then a sustained effort beyond the 9 months, in the form of a standing Equity Response Team.
- c. **Expand the team** - Advisory members representing needed additional voices/perspectives, constituencies, academic disciplines, and areas of specific expertise need to be engaged as this work continues forward.
- d. **Co-create a plan** – This *Initial Report and Recommendations* requires significant input to produce a plan. As previously described, hearing from affected community members is requisite to creating a valid plan for addressing the needs of people disproportionately affected by the COVID-19 pandemic. The methods for obtaining such input have been described in Section IV.1.a. and are further elaborated in Recommendations 6 and 10.
- e. **Provide resources to support the team’s work** - This work requires resources to move forward. We have presented evidence herein for the investment of time and resources to support this Equity Response Team going forward.
 - **UPDATE:** Members of the Equity Response Team have facilitated the securing of limited funding through a Centers for Disease Control and Prevention (CDC) grant that will assist with the assessment work (Recommendation 6).

3. Align Government Systems for Equity Capacity.

The Equity Response Team was charged with identifying sustainable opportunities to address, mitigate and remedy the disparate impact of COVID-19. Given what we know about the role of upstream factors in COVID-19 disparities, Government plays a significant role in creating or perpetuating institutional inequities that then contribute to conditions (the social determinants of health) that are being exacerbated by the pandemic, and ultimately result in COVID-19 (and other kinds of health) disparities. Government agencies, thus, have a unique opportunity to “change structures, policies and institutional practices that create and maintain inequities” as well as to “change policies/systems and programs to provide community conditions [the social determinants] that support health and well-being”.³⁵ Building capacity for a formalized long-standing government response to COVID-19 equity issues, and implementing well-established best practices for promoting equity throughout State Government, is a sustainable way to address, mitigate and remedy the disparate impact of COVID-19, its consequences, and its contributing factors.

Recommendations:

- a. **Formalize the Equity Response Team as a Commission** – Use the Governor’s budgetary authority and pursue legislative action for establishment as a longstanding State Commission on Equity.

³⁵ Vermont State Health Improvement Plan, 2019-2023, <https://www.healthvermont.gov/about-us/how-are-we-doing/state-health-improvement-plan>

- b. **Assure diverse representation across all governmental commissions, councils, taskforces, etc.** – Create processes to assure that any/all future standing committees, commissions, councils, advisory groups, or task forces must include representation from people with lived experience and/or community leaders/members who can bring an equity lens (e.g. GOFERR and other COVID-related advisory groups and task forces).
- c. **Ensure equity expertise in emergency response operations** – Create an Equity Subject Matter Expert position on the Incident Management Team. Assure all the emergency response operations teams are engaging equity expertise.
- d. **Build alignment and connection between existing efforts related to diversity, inclusion and equity** – There are a number of entities that have an awareness of the need for, or an intentional focus on, equity. Engage in communication; explore opportunities for mutual coordination and collaboration. Partner and leverage where possible.
 - i. Governor’s Commission on Police Accountability, Community and Transparency
 - ii. Governor’s Advisory Council on Diversity and Inclusion (GACDI)
 - iii. State Health Assessment/State Health Improvement Plan (SHA/SHIP)
 - iv. New Hampshire COVID-19 Equity Task Force (co-convened by the New Hampshire Public Health Association, the Office of Health Equity, and the Division of Public Health Services) is comprised of over 50 individuals and organizations across New Hampshire representing multiple sectors and communities who came together to address issues of equity, for historically marginalized groups, arising from the COVID-19 pandemic and response.
- e. **Establish a cross-state agency state Equity Council** – Identify Equity liaisons/leads in each Agency across state government (e.g. as there is already at the Department of Health and Human Services, DHHS, and the Attorney General’s Office, AG’s).
 - i. Establish a Department of Education (DOE) Equity Senior Leader, per the recommendations of the GACDI January report
- f. **Implement use of equity review analysis processes** - Build capacity for equity among staff in all agencies.
 - i. DPHS/DHHS is launching their “Equity Review Toolkit”³⁶ to facilitate intentional consideration of equity and to examine how historically marginalized communities will be affected by a proposed policy, plan, activity, action or decision before embarking on the work/initiative.
 - ii. Other Agency staff and legislators can use adaptations of the Equity Review Toolkit that are created for their tailored purposes.
- g. **Enhance data systems capacity to identify disparities** – State agencies must build capacity to identify COVID-related, and other, disparities through correct and consistent collection of race/ethnicity (and other sociodemographic identifiers) data according to best practices. This

³⁶ Durzy K, Richards M, Tellez, T, DeNubila M, Cherala S. *Equity Review Toolkit*, New Hampshire Division of Public Health Services’ Equity Council, June 2020

requires having systems and processes in place as well as staff training and coaching. This is explored in detail in Recommendation five (5).

- h. **Assure compliance with federal civil rights and state laws related to communication access** – Systems, processes, and training for communication access will be created, or made more robust, throughout all branches of state Government.
- i. **Facilitate professional development of staff** - Established public health program staff participate in anti-bias and cultural responsiveness training (beginning with COVID-related efforts and response staff). Spread similar training opportunities among all agencies.

4. Organizational Cultural Effectiveness

Organizations strive to ensure everyone has equal opportunity to thrive by providing high quality services that are accessible to all in New Hampshire – yet achieving this can be challenging. Many of us have simply not had access to an effective approach that would turn our goals into broader success. **The Culturally Effective Organizations (CEOrgs) Framework**³⁷ is the roadmap that enables, cultivates, and supports the delivery of high-quality care and services for all people.

The framework is grounded in literature from nationally-recognized entities. The seven key elements are drawn from an analysis of the overlaps and similarities of the recommendations established by various industry accrediting and standard-setting organizations, as well as subject matter experts and the National CLAS Standards.³⁸

The framework outlines strategies that organizations working to provide high quality care and services to a diversifying population can take to embark on an ongoing organizational process of improvement to keep pace with changing patient/client and workforce demographics, and to work towards advancing equity. **The Culturally Effective Organizations Work Group**³⁹ is focused on supporting organizations to learn about the essential pathways for success; members provide helpful co-learning and resources to assist on the journey to becoming a culturally effective organization and providing high quality services for all.

Recommendation:

Implement the seven (7) elements of the Culturally Effective Organizations Framework:

- a. **Language and Communication Access** - Effective communication is essential to the provision of quality, culturally competent care. Several federal civil rights laws require communication assistance: Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and Section 504 of the Rehabilitation Act of 1973. In response, organizations are establishing policies and systems to identify and track patients' communication access needs, including

³⁷ Culturally Effective Healthcare Organizations: A Framework for Success, April 2015
<http://heller.brandeis.edu/iasp/pdfs/jobs/culturally-effective.pdf>

³⁸ National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, available at the Office of Minority Health's Cultural and Linguistic Competency site
<https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6>

³⁹ The Culturally Effective Organizations Work Group <http://equitynh.org/culturally-effective-organizations/>

preferred language, and to provide qualified appropriate interpretation, translation, and communication assistance services.⁴⁰

- b. **Individual Level Staff Cultural Competence / Cultural Responsiveness** - Organizations implement a range of practices to ensure that patients from all racial and ethnic backgrounds receive optimal patient care. To meet accreditation standards, healthcare organizations are integrating patient preferences into care delivery and supporting these changes with organizational policies and procedures which enable staff members to fulfill these expectations. The cultural competence of all staff requires continuous learning and professional development.⁴⁰
- c. **Community Engagement** - Organizations are more effective when they engage the community in a two-way process to learn, communicate, and share knowledge. This requires establishing relationships that position the community as an active partner in organizational decision-making.⁴⁰
- d. **Workforce Diversity and Inclusion** - The nation and the state are becoming more diverse, and this diversity is reflected in the patient population and the workforce. However, racial and ethnic minority groups are underrepresented in health occupations and workplace settings that pay better and offer opportunities for advancement. Meanwhile, nursing and residential care facilities and home healthcare agencies are increasingly recruiting and employing professionals from diverse backgrounds and seeking ways to nurture increased multiculturalism among patients and staff. Healthcare organizations can address underrepresentation by diversifying their workforce and introducing practices to ensure that employees from all backgrounds have the opportunity to contribute meaningfully to the workplace.⁴⁰
- e. **Data Collection and Analysis** (discussed in more depth below) - Data related to cultural effectiveness and workforce diversity informs strategic planning and tailors service delivery to meet community needs. Data is also used to identify treatment variation and differences in patient outcomes and satisfaction across groups, and to monitor the impact of cultural effectiveness-related policies and activities on health equity and outcomes.⁴⁰
- f. **Institutional Policies and Procedures** - Organizations take a systematic approach to formalizing their commitment to cultural effectiveness by articulating their vision through written policies, procedures, goals, and practices.⁴⁰
- g. **Leadership** - Executive leadership and boards of directors formally model the organization's commitment by including consideration of cultural effectiveness in the strategic planning process and overall organizational expectations and practices. Leadership is responsible for guiding the organization to address biases and overcome resistance to change.⁴⁰

⁴⁰ Culturally Effective Healthcare Organizations: A Framework for Success, April 2015
<http://heller.brandeis.edu/iasp/pdfs/jobs/culturally-effective.pdf>

5. Equitable Data Practices

Data is the language of public health – it is how we measure our work and identify need. It can be used to guide, inform and evaluate both the quality and responsiveness of the work that is done to protect the public's health.

Historically, data that is required to clarify need and inform best practice in marginalized and communities of color has not always been collected thoroughly nor guided by best practice. Collecting key socio-demographic indicators, such as race and ethnicity, sexual orientation and gender identity, economic status, housing status, age, zip code, educational status, co-occurring disorders and primary language can help to identify where disparate or disproportionate impact may be occurring. When there are significant gaps in this data, or the data is collected without attention to best practice, disparities and needs may become invisible. When systems work to collect robust data sets, they are better able to inform targeted action in a thoughtful manner, and to disseminate the data in a way that is community-focused and does not seek to disparage or further widen existing inequities. Additionally critical to the amount of data is how it was collected, analyzed and disseminated. Traditional data collection methods will only ever tell a portion of the story. Less mainstream methods such as storytelling may help to fill in gaps and produce a tapestry of understanding. Communities in need and the public/private sectors that serve communities in need deserve access to good and robust data sets to help inform and guide work, increase understanding, build compassion and care and support creating a just and equitable society.

Below are some equitable data best practice guidelines for collection, analysis, dissemination and utilization as well as recommendations for how organizations can operationalize best practice and build internal capacity to support equitable data practices.⁴¹

Best Practices for Data Collection

1. Organizations must consistently collect Race, Ethnicity and Linguistic (REaL) data and Sexual Orientation and Gender Identity (SOGI) data from patients at the point of services, allowing individuals to self-report their own identity. Data should be consistently confirmed and assessed for quality as it moves through the public health system.
2. Data should be self-reported, and collected without assumptions, and should be appropriately recorded while maintaining the highest level of patient confidentiality and data security.
3. Collect traditional and non-traditional data in collaboration with communities of concern and disseminate without shaming or blaming. Utilize collaborative data collection methodologies such as community based participatory research and participatory data analysis.
4. Data collection and surveillance systems must be modified to ensure they can capture and report data based on best practice REaL and SOGI categories. Quality Assurance systems must include processes that scan for completeness and quality of REaL and SOGI data.

⁴¹ Duzy, K, contributing author. Accountability As A Public Health Response: COVID-19's Impact on Communities of Color. NASTAD Minority Leadership Program network, May 2020.
<https://www.nastad.org/sites/default/files/Uploads/2020/covid-accountability.pdf>

5. Expand collection of additional variables that may expose or make clear other disparities, such as economic status, housing status, age, zip code, educational status, co-occurring disorders and primary language.
6. Any person responsible for the collection of REaL and SOGI data should be well trained in best practice collection methodologies. All new employees should receive training as part of their orientation and existing employees should receive annual update training to refresh their skills.
7. Work that is informed by data or utilizes data to monitor or evaluate impact should expand concept of data beyond traditional data sources and recognize that traditional data collection has often left marginalized communities invisible. Consider less traditional data collection processes, such as qualitative data processes (focus groups and interviews) and art-based data collection processes (story-work, digital storytelling, and photo voice) to round out a clear picture of community voice.

Best Practices for Data Analysis

8. Ensure inclusion of strengths-based narrative and not just a deficit-based narrative – highlight where community assets exist, and the body of knowledge held by communities of concern.
9. Utilize collaborative data analysis processes, such as participatory data analysis, to allow for creating a collective understanding of the data within a community context.
10. Ensure that all organizations have data analysts, epidemiologists and/or evaluators on staff that are skilled in the methodologies of disparity analysis. Host continuous internal workshops to help build this capacity in organizations.

Best Practices for Dissemination and Utilization

11. Create dashboards and systems of data distribution that are equitable in their design and dissemination. Allow for community screening in advance of publication to ensure information is accessible, understandable and not shaming or disparaging.
12. Utilize disaggregated data to monitor and report publicly on identified disparities and use this information to create targeted public health approaches that are intended to close the gaps between good health outcomes and poor health outcomes.
13. Hold public health systems accountable to monitoring and addressing indicators related to health disparities in communities. Identify teams of expertise within systems that can identify quality indicators, focus on analyzing disparities, and inform other public health partners in order to target response.
14. Be cautious and respectful in approach – do not demand or co-opt work already being done by marginalized communities. Create authentic partnerships with respect.

Recommendations:

- a. Adopt and follow best practices as outlined here in section five for:
 - i. Equitable data collection

- ii. Equitable data analysis
 - iii. Equitable data dissemination and utilization
- b. Dedicate staff with specific expertise in equitable data best practice methodologies.
- c. Develop internal protocols that require the use of a vetted and approved Equity Review Tool analysis for all programmatic and policy work. (See Recommendation 3f.)

6. Increase Knowledge about New Hampshire Communities at Risk for Experiencing Disparities

In order to meet the charge of the New Hampshire COVID-19 Equity Response Team fully, it is critical to increase our knowledge about New Hampshire communities at risk for experiencing disparities. Within our initial thirty-day window, the Equity Response Team completed a limited scan of publicly available data sets and reports across various domains in New Hampshire. While this scan was not comprehensive, we reviewed the available reports for inclusion of race and ethnicity, gender identity and other sociodemographic variables; methodology of data collection; timeliness of data; reporting of disparities and any other pertinent conclusions. Findings from this initial scan have indicated that publicly available data and reports related to race/ethnicity and other identifiers is limited. While this should not be considered entirely conclusive based on the time and scope limitations, it does support need for further investigation.

We must work in collaboration and coordination with communities to increase understanding of needs, desires, demographic and cultural make-up, deficits and assets, to co-create solutions and design appropriately tailored services. In order to do this in a methodologically sound and non-exploitative manner, we recommend the following approach.

Recommendations:

- a. **Continue work on an expansion of the initial data scan** in order to complete a sound and in-depth meta-analysis of the New Hampshire data landscape.
- b. **Create a centralized data hub or clearinghouse** that can house public health and other biopsychosocial data and data reports that may contain disparity information pertinent to New Hampshire. This would serve two purposes. First, it is a means to encourage organizations, community groups and academic researchers to increase their attention to collecting and reporting on disparity data in New Hampshire. Second, it provides a repository for data and reports that is easily accessible to both community members, researchers and organizations that seek to target services.
- c. **Implement an assessment of communities of color in New Hampshire** that would seek to identify their specific needs, barriers, and experiences before and during the COVID-19 pandemic, as well as non-COVID-19 related concerns. In addition, the assessment would seek to engage in a community asset identifying process. This assessment would be wide in scope and inclusive in nature and address, at minimum: direct impact that COVID-19 has had on people's lives; personal experiences as it relates to COVID-19; level of understanding and access to

information; challenges, including related to testing; worries and concerns; access to support networks; access to healthcare; and community assets and indications of resiliency.

- d. **Establish a cross-institution community-academic partnership for continued research and understanding of communities in need in New Hampshire**, and specifically, communities of color in New Hampshire, as well as investigation of state and local level system accomplishments and failures in serving these needs. This partnership would call on New Hampshire's academic partners to provide resource and support in a community based collaboration for engaging in equitable research and evaluation and development of recommendations. This collaboration would be non-exploitative, not engage in co-opting of community work, would be led equitably by persons of color and persons identifying to historically marginalized groups and other allies, and would be based in equitable principles of engagement and collaboration.⁴² We would recommend this group consider exploration of the following methodologies, practices and issues (this list should not be considered complete):

- Community Based Participatory Research
- Community Level Index Assessment⁴³
- Collective Impact
- Epigenetic impact of stress and historical oppression and trauma on communities of color
- Indigenous methods of learning and inquiry
- Narrative and Visual Storytelling
- Adverse Childhood Experiences
- The concept of myth and historical narrative
- Equitable Evaluation
- Participatory Data Analysis
- Strength-based asset mapping and identification
- Community Institutional Review Board

7. Systems Accountability for Equity

It is important to acknowledge that the critical work of serving marginalized communities often happens from within large organizations or systems of care, such as public health departments. During the COVID-19 response, service delivery and strategies for a statewide response have been centralized at the state and local health department level. These systems are by their very nature, complex and serve many disparate needs. In order to best serve all communities and needs with a focus on equity during a crisis, large organizations and systems must fully evaluate their actions prior to, during, and post-

⁴² Silka L, Cleghorn GD, Grullón M, Tellez T. "Creating Community-Based Participatory Research in a Diverse Community: A Case Study." *Journal Of Empirical Research on Human Research Ethics*. 2008;3(2):5-16

⁴³ Public Comment submitted in writing by Loretta Brady, PhD, MAC, July 6, 2020, discussed at July 2, 2020 meeting

response so they can utilize best practice methodologies and concretize lessons learned to operationalize equity in their policies, protocols and programming. This can be accomplished by seeking to gather feedback in real-time during a crisis rather than utilizing only traditional after-action feedback loops, which may be too slow and constricting in a long-term pandemic. Public Health activities such as evaluation and resources allocation assure systems are working for all, not just some.

Shifting internal culture of organizations requires foresight, courage, and the ability to operationalize stated values. It is messy and complicated work, but it is critical to achieving equity and building excellence into service. Long-standing historical societal issues have created systems and policies over time that do not support the needs and inclusion of all. Issues such as systemic racism have built inequities into our state and our country that continue to impact communities even today. It is not enough to simply acknowledge or even denounce these inequities any longer. We must do the hard work of actively disassembling systems and rebuilding anew if we truly seek to improve the health and wellbeing of all in our state. Racism is a public health crisis and we must openly and frequently acknowledge this, speak courageously, and do the hard and critical work of dismantling systems that continue to oppress and then rebuild a new paradigm centered in inclusion, celebration, diversity, equity, and excellence.

Below are some first steps and best practice for operationalizing accountability to equity in organizations.⁴⁴ (Specific action recommendations follow further below.)

- i. Examine internal policies and protocols and how they impact staff from every level of the organization; solicit feedback annually or more frequently.
- ii. Evaluate and examine issues of parity, equity and fairness in organizations during crisis moments and beyond.
- iii. Acknowledge that working for equity requires working equitably. It is a method as well as a process and an outcome. Creating relationships built in trust and understanding are not only part of the process, they are key to long term change and sustainability.
- iv. Speak openly about the historical impact of racism on communities of color and how that impacts staff of color on a daily basis – build systems that can support staff of color through this crisis and beyond.
- v. Assure that People of Color and other historically marginalized people are in key leadership roles with decision-making authority and responsibility.
- vi. Speak openly and frequently about how historical systems based in racism have led to policies that are unfair, not inclusive and widen the divide between those that are marginalized and oppressed and those that are not.
- vii. Create safety within systems for staff of color to speak about their experience without fear of repercussions.

⁴⁴ Duzy, K, contributing author. Accountability As A Public Health Response: COVID-19's Impact on Communities of Color. NASTAD Minority Leadership Program network, May 2020.
<https://www.nastad.org/sites/default/files/Uploads/2020/covid-accountability.pdf>

- viii. Be cautious to not further burden marginalized staff members with the responsibility to either share personal stories or teach others about their experience if they are not comfortable doing so.
- ix. Open opportunities to hear and listen to the human stories – support and celebrate an inclusive and authentic voice.
- x. Increase understanding and appreciation of the diversity and intersectionality of communities of color with other historically marginalized communities.
- xi. Build true community response that is co-created, co-led and co-credited across marginalized communities and traditional public health systems.
- xii. Address and hold accountable for change those systems that perpetuate oppression, racism and violence

Recommendations:

- a. **Seek to diversity the public health and social service workforce across all sectors and levels**, operationalize this in practice by modifying job descriptions and recruitment practices to attract a more diverse candidate pool and ensure that every hiring /interviewing team represents a diverse voice in the organization.
- b. **Provide opportunities for training for management level staff on how to understand and operationalize equity in their organizations** and, specifically, how to identify issues of racism in their own organizations and how to support staff that may feel unheard or unsafe. Require attendance and participation. Include specific training on implicit bias and incorporate opportunities for self-examination and self-growth. After initial training, provide continuous opportunity for discussion and learning at frequent and consistent intervals.
- c. **Create a team of equity and inclusion thought leaders within each organization that is representative of every level and aspect of the organization** that can lead internal organizational assessment and implementation of change. Provide this team with support and resources to get their work completed.
- d. **Hire and fund internal and external evaluators and improvement specialists that are skilled in equitable assessment practices and methodologies.**
- e. **Engage in cross-sector and cross-department work to build clear strategic plans that center equity as an operationalized value.** Engage all members of the organization in the development of these plans and speak about them frequently. Accept and celebrate the iterative nature of such plans and modify, change and expand as needed. Make sure that every employee has a direct tie and responsibility for at least one aspect of the plan.

8. Use of Effective Equity-Promoting Strategies

Key to developing strategies for COVID-19 and beyond is the co-creation of plan with - and not for - communities who are most affected. The informal and formal networks within the communities can provide a wealth of information that informs how data is collected in order to determine what is needed

and how to implement a plan once developed. The approach must be community driven with a level of respect for what groups can contribute to developing compound solutions for this complex problem. Each step taken needs to be strategic and intentional with community members involved at every phase. This approach will provide opportunities and will allow community members to be active participants in their own lives.

Recommendations:

- a. **Utilize community led, equity informed, asset based strategies**, for example:⁴⁵
 - i. Healing circles (discussion on self-care using Afro-centric Frameworks)
 - ii. Opportunities for various forms of artistic expressions to promote health and well-being
 - iii. Identify places of respite for self-renewal and restoration
 - iv. Dialogue and book studies promoting stimulation of the intellectual self
 - v. Support for elders and disabled community members to enable full participation in these events
 - vi. Access to appropriate services for community development to enhance community participation
 - vii. New Hampshire African American education to enhance and develop self-esteem to enhance healthier choices
 - viii. Decrease isolation of people of African descent in New Hampshire of all ages through various activities
 - ix. Employment counseling and upskilling case management supports to deal with shifting industry opportunities as a result of post-COVID economic changes
 - x. Financial planning and literacy programs that build wealth and protect from extractive financial services
- b. **Promote and engage the Community Health Worker (CHW) workforce** – CHWs (also described in Recommendation 1.k., above) are trusted community members and a proven equity promoting strategy. CHWs are assets within their communities, and essential members of the public health workforce, who can serve a critical role in the COVID-19 response and help create “innovative, community-centered solutions that protect and strengthen vulnerable communities.”⁴⁶ Additionally, CHWs are high value: only innovations using CHWs (of six types

⁴⁵ Activities proposed in May 31 letter to Governor Sununu from Rev. Renee Rouse and coalition of African descent organizations

⁴⁶ Hewitt A, et.al. *The Fierce Urgency of Now: Federal and State Policy Recommendations to Address Health Inequities in the Era of COVID-19*. FamiliesUSA. May 2020. <https://familiesusa.org/resources/the-fierce-urgency-of-now-federal-and-state-policy-recommendations-to-address-health-inequities-in-the-era-of-covid-19/>

of CMMI innovation components evaluated) were found to lower total costs; and CHWs save clinicians' time coordinating social services and referral.⁴⁷

- c. **Provide good quality jobs with fair livable wages and benefits**
- d. **Ensure access to affordable quality healthcare**

9. Equitable Resource Allocation

Current grant opportunities are inadequate to meet the needs of many People of Color and new Americans. Guidelines for grants and other funding are often rooted in Eurocentric worldviews that at times clash with other worldviews. The belief that other groups “should” assimilate and do things the way the dominant culture dictates is counter to the United States cultural myth related to the beauty and strength of “the melting pot”. Even though closer to acknowledging the importance that all the cultures contribute to make up the U. S. culture, the melting pot myth falls short. It is in the melting down of all the cultures that the richness of each is lost. The “tossed salad” metaphor allows for each ingredient to maintain distinct characteristics, and it is the blending of these different and distinct characteristics that makes for a richer experience.

Many cultures outside of the Eurocentric worldview are less formal and reflect more of a collectivist worldview. Many immigrant, refugee and racial/ethnic minority led nonprofits and businesses operate from the worldview that it is the action of “doing” and “being” in community that is more important than “talking” about doing. These organizations provide direct services with very few, if any, paid staff. In the majority of cases the founder and operator of the organization or business will have another source of employment in order to finance the nonprofit or business. These are the people who others within their community trust and depend on for food, counsel, shelter and comforting. These are the people who will wake up in the middle of the night to take a call from a distressed community member. They are the ones who have people knock on their doors and ask for food for their children. They are the ones who will exhaust every formal and informal network to help someone who is sick and in need of care. Within their home communities they would be the “village moms and papas” and this critical role does not change when they come to the United States or when living in predominately white environments. These nonprofits and businesses established by these individuals don't fit a Eurocentric worldview of how a nonprofit or business owner “should” operate. Current guidelines for the majority of available funding does not allow most of these organizations and businesses to meet the often too restrictive criteria for applying.

Recommendations:

- a. **Funding sources need to have guidelines reflective of considerations beyond the Eurocentric worldview** - Review of guidelines for funding need to be evaluated using an equity lens. The Equity Response Team can serve to review funding guidance.

⁴⁷ ASTHO. *State Health Agency Efforts to Support the CHW Workforce: Findings from a Multi-state Learning Community*, presented at APHA Annual Meeting, Philadelphia, PA, November 5, 2019
https://www.astho.org/Programs/Clinical-to-Community-Connections/Documents/Developing-and-Defining-the-CHW-Workforce_Slide-deck/

- b. **Diversify review panels for funding opportunities and grants**
- c. **Target continued or new opportunities for the CARES Act funds to go into the hands of racial/ethnic minority, especially Black and Brown, organizations, businesses, nonprofits and communities⁴⁸** - Consider issuing a second round of Main Street and Nonprofit Emergency funding to support minority owned businesses and organizations.
- d. **Improve notification of the availability of funds**
- e. **Create a minority owned/led certification process for nonprofits and businesses** – Creation of a comprehensive business enterprise list for New Hampshire that is certified (assures legitimacy for wholly minority owned and operated). Record appropriate demographic identifiers for business/organization leaders in state systems.
- f. **Dedicate funding for minority owned/operated nonprofits and businesses⁴⁸** - Funding needs to be set aside to have minority owned/operated nonprofits and businesses who function in similar ways to apply for resources where there is an ability to evaluate using criteria that fit. Create equitable funding processes that recognize that organizations are different.
- g. **Funders should value minority and immigrant/refugee organizations’ role and prioritize them for funding⁴⁹**
- h. **Funders should have practices and processes in place to ensure that funding and other resources are dispersed in a manner that supports the needs of People of Color living and working in New Hampshire⁵⁰**

10. Community Engagement

The Equity Response Team members will conduct a series of community forums to present the *Initial Report and Recommendations* and to solicit feedback and input towards creation of the final plan.

“Nothing about us without us” is the value of self-determination, and community members must have an opportunity to vet and provide input, towards the ideal of co-creation. The Equity Response Team members will plan to engage with different communities in different ways to assure there is a level of community ownership. Additionally, there are various constituencies at the stakeholder, community and policy levels, as well as various sectors, who will have the opportunity to participate in tailored sessions for raising their awareness and engaging their feedback.

Recommendation:

- a. Conduct Community Forums to disseminate this *Initial Report and Recommendations* and solicit feedback.

⁴⁸ Recommendation received from public: June 30, 2020 email submission from Deo Mwano. See Section VIII

⁴⁹ Recommendation received from public: June 11 Governor’s COVID Equity Response Team Meeting from Richard Minard, Executive Director of Building Community in New Hampshire (BCNH, formerly known as Bhutanese Community in New Hampshire), based in Manchester, See Section VIII

⁵⁰ Recommendation received from public: May 31 letter to Governor Sununu from Rev. Renee Rouse and coalition of African descent organizations, See Section VIII

11. Policy

In order to build a healthy community investing in a culture of health for all, public policy is essential. To better assist and prepare communities of color during the current COVID-19 pandemic as well as future state emergencies and emerging public health events, we will need to harness the power of evidence-based, data-driven, policy, systems and environmental change. Public policy is the means to creating systems that maximize everyone's ability to live long, healthy lives through improvements in the upstream social and structural determinants of health. Developing needed public policy assures the ability to create communities that are inclusive, resilient and thriving. Governor Sununu has taken action in response to the COVID-19 pandemic by having state agencies ensure housing, health insurance, telehealth, food assistance, and employment compensation to assist businesses, health care and individuals. These types of policy solutions to support the health and well-being for all must be ongoing as New Hampshire continues in the long recovery from the COVID-19 pandemic.

This phase of the Equity Response Team's work did not focus on policy solutions. We look forward to working collaboratively with New Hampshire community members to incorporate policy as a critical part of the next phase of the Equity Response Team's work.

Recommendation

- a. **Establish a policy committee of the Equity Response Team Commission** to review policy which impacts affected communities

VII. Conclusion: Discussion and Future Considerations

The New Hampshire Governor's COVID-19 Equity Response Team would like to acknowledge and thank professional colleagues, members of the public, and members of existing community task forces for sharing their thoughts and ideas through the public comment process. We value every idea brought forth. Every day we witness the tireless work that is being done to meet the needs of all. We recognize and honor that commitment. In recognition that we were unable to include all of the thoughtful comments in our *Initial Report and Recommendations*, we would like to offer a list of issues that we believe to be critical for future consideration.

While we acknowledge that the COVID-19 pandemic is a significant health, safety and economic event that has further widened the existing disparity gap, it is not adequate to the health of a state to address only one driver of disparity. In this report, we have focused our primary work on issues elevated by or significantly amplified by the COVID-19 Pandemic, but there is little question that the impact of COVID-19 is tied significantly to other societal concerns. It is critical that we openly address these underlying factors and their resulting marginalization for some members of our community. These issues have resulted in making communities more vulnerable and susceptible to the effects of a pandemic or any other public health crisis. If we do not adequately address these drivers of disparity and inequity, we will surely find ourselves here again.

Critical issues for future consideration include:

- Expansion of healthcare coverage and opportunities for telehealth for all
- Reduction of barriers to employment
- A process for assuring state-wide consistency for K-12 students' access to education when there is virtual learning
- Access to affordable and accessible higher education and job training
- Focus on intersectionality, which acknowledges the various different, overlapping and intersecting parts in people's identities
- Expansion of culturally and linguistically appropriate and accessible mental health, behavioral health, and Substance Use Disorder services
- Voting access for all
- Law Enforcement and Criminal Justice reform
- Exploration of the impact of COVID-19 on people with disabilities, including both physical and intellectual disabilities, to inform service expansion.
- Expansion of services intended to address food deserts and food insecurity
- Bail reform
- Services focused on the needs of LGBTQIA+ youth and adults, including welcoming healthcare providers
- Examination of redlining practices on communities of color
- Expansion of affordable housing – temporary and permanent

VIII. Recommendations Received through Public Comments

June 11, 2020: Public comment by member of public in attendance at Equity Response Team meeting

- Richard Minard, Executive Director of Building Community in New Hampshire (BCNH, formerly known as Bhutanese Community of New Hampshire), based in Manchester, a nonprofit serving refugees and immigrant populations in central New Hampshire.
 - BCNH has 3 Case Managers, 2 of whom work as community health workers who are doing work around COVID-19, but could be part of a coordinated effort.
 - State published rules for non-profits to apply for funding through CARES Act funds – Mr. Minard requested this group recommend to those making funding decisions, to give priority for minority and refugee organizations.

June 17, 2020: Email forwarded from Governor's Office - May 31 letter to Governor Sununu

- Rev. Renee Rouse and coalition of African descent: New Hampshire Black Women Health Project, Outreach for Black Unity, Requity Labs of Saint Anselm College, YWCA-New Hampshire,

Black Heritage Trail New Hampshire, Haitian Community Center of Manchester, and Victory Women of Vision.

- Request practices and Processes in place to ensure that funding and other resources are dispersed in a manner that supports the needs of people of African descent living and working in New Hampshire
- Coalition would like to seek funding to be used to provide support to people of African descent throughout the state. Coalition will engage in providing the following services and resources throughout our State where persons of African descent will have access to quality, African descent led, and non-predatory:
 - Healing circles (discussions on self-care using Afro-centric frameworks)
 - Opportunities for various forms of artistic expressions
 - Identify places of respite for self-renewal and restoration
 - Dialogue and gook studies promoting stimulation of the intellectual self
 - Support for elders and disabled community members to enable full participation in these events
 - Access to appropriate services for community development to enhance community participation
 - New Hampshire African American education to enhance and develop self-esteem to enhance healthier choices
 - Decrease isolation of peoples of African descent in New Hampshire of all ages through various activities
 - Employment counseling and upskilling case management supports to deal with shifting industry opportunities as a result of post-COVID economic changes
 - Financial planning and literacy programs that build wealth and protect from extractive financial services.

June 30, 2020: Email submission from Dennis Molnar (submitted also to Governor Sununu)

- RE: Masks for COVID most vulnerable
 - Recommendation that KN95 masks be made a certain color (caution yellow or road-cone orange) or marked in a way to demonstrate that the wearer really needs others to respect their health and keep their distance... look into a program that publicizes a design or color to indicate for others to respect the wearers' health and keep their distance... the state could also provide masks that indicated the wearer was an "at risk person" along with a simple education program to "help protect our most vulnerable citizens."

June 30, 2020: Email submission from Deo Mwano

- RE: Black, brown and New Immigrant COVID-19 Relief
 - The Governor and the GOFERR group should establish a black, brown and new immigrant COVID-19 relief fund... New Hampshire CARES Act Funds to black, brown and new immigrant businesses that (a) did not apply for the Mainstreet Fund because of lack of awareness; (b) are struggling and need help now; (c) need to see that our state believes in them and wants them to succeed.
 - Specifically, request that GOFERR allocate [\$5 million] in CARES Act funds to:

- Black, brown and new immigrant businesses
- Learning programs serving ELL students
- On-the-ground minority non-profits providing case management
- Creation of an interactive hub with videos and real time connections to resources that support the people in our community.
- Access to chamber [of commerce] memberships, which are out of reach for most of these businesses so they can have access to timely information and resources.

July 2, 2020: Email submission from Bruce McColl and Rane Hall

- RE: Help New Hampshire Parents
 - Requesting the Governor issue a mask mandate for New Hampshire

July 2, 2020: Email submission from Lisa Stryker CRNA

- RE: COVID New Hampshire testing lacking
 - New Hampshire needs COVID-19 testing to be available/accessible and results timely with a turn around time of 3 days or less to contain asymptomatic exposure and transfer.

July 2, 2020: Comment made by member of public in attendance at Equity Response Team meeting

- Jennifer Smith (public attendee)
 - Requesting the Governor address the risk of COVID-19 for incarcerated populations where there is disproportionate involvement of People of Color in the justice system and also consider commutation.

July 6, 2020: Email submission from Loretta Brady, PhD, MAC, Psychology Professor and Director of Requity Labs at Saint Anselm College

- RE: Letter to Governor's COVID-19 Equity Response Team
 - Encouraging the use of a Community Loss Indicator (CLI) to the work of examining inequity in our state and it's various economic regions.

July 7, 2020: Email submission from Joan Ascheim, Executive Director of New Hampshire Public Health Association

- RE: Letters from the COVID-19 Equity Task Force
 - Nine letters the COVID-19 Equity Task Force has written to voice concern relative to the effects of the pandemic on already marginalized communities
 - *The New Hampshire COVID-19 Equity Task Force is a collective of over 50 individuals and organizations across New Hampshire representing multiple sectors and communities that has come together to address issues of equity arising from the COVID-19 pandemic and response. The task force is co-convened by the New Hampshire Public Health Association (NHPHA), in partnership with the New Hampshire Department of Health and Human Services (DHHS) Office of Health Equity (OHE) and the Division of Public Health Services (DPHS).*
 - Table 4 presents a compilation of the recommendations made in the nine letters

Table 4: Recommendations contained in the letters written by the COVID-19 Equity Task Force to voice concern relative to the effects of the pandemic on already marginalized communities and submitted to the Equity Response Team

SNAP WIC School Food Delivery (Food Insecurity)
WIC Waiver of in person recertification, food packaging, and online purchases till September 30th to provide stability/proper planning of supporting organizations and additional safety for beneficiaries.
SNAP benefit waiver for virtual purchases and inclusion of curbside or home delivery fees.
School delivered meal transportation cost reimbursement.
Spanish version of NH State support websites
Recommendations for keeping workers safe during the COVID-19 Pandemic (Concerns Related to Immigrants)
Implement a toll-free hotline to allow employees to anonymously and without fear of repercussions, file complaints when employers are not following safety guidelines. (We have heard instances of employers forcing workers to engage in unsafe conditions and/or being threatened with termination.)
Establish a hazard pay fund for essentials works to ensure their gross pay exceeds \$20 per hour.
Designate grocery store and drug store/pharmacy workers as first responders or emergency personnel to ensure access to priority testing, childcare, and access to any hazard pay funds that may become available.
Antibody testing should be prioritized to healthcare workers and customer facing employees.
In restaurants, individuals sitting together should be from the same household.
Adjust indoor retail capacities to 5 people per 1000 square feet. This would allow for all persons to maintain roughly 6-8 feet of separation.
Restrict facial covering with exhaust valves
Ensure employees who are or are caring for someone who is at risk for complications from contracting COVID-19, defined by the CDC, should continue to work from home or be eligible for continued unemployment benefits.
Clarify the Families First Coronavirus Response Act to include persons caring for a person diagnosed with COVID-19.
Publish economic reopening guidelines in multiple languages to ensure instructions on how to remain safe are available to all NH residents
Ensure that workers that are fearful of exposure to COVID-19 at their workplace be able to continue to access unemployment benefits.
Ensure that at other business, such as gyms, rehab centers, and places of worship, where social distance is simply too difficult to maintain, that all persons be required to wear facial coverings and increased ventilation standards be required.
○ <i>Recommendations for Educating the Public:</i>
Issue a press release with detailed information on how people can safely navigate returning to work with significant emphasis placed on face coverings and frequent hand washing.
Discourage use of face coverings/masks with exhaust valves.
Conduct live demonstrations on how to wear a face covering to capture all water droplets, how to wash your hands, how to properly remove gloves, and surface decontamination. Require news outlets to cover these demonstrations for 14 consecutive days.
Issue public information about testing sites, particularly those serving uninsured and underinsured persons in multiple languages and advertise information in communities of concern.
Assure that any printed resources, or other resources (such as the hotline) shared with communities be accessible to those whose preferred languages are not English.
Consider including a member of the NH COVID-19 Equity Task Force who is well-versed in issues of public health, minority health and health equity on the NH Economic Re-Opening Task Force (in order to ensure issues specific to communities of color and other marginalized persons are included in the considerations of the Re-Opening Task Force).

Recommendations for Protecting the Safety of Residents in Correctional Settings (Justice Involved)
Enable social distancing by reducing census in each facility.
Expediently commute sentences where appropriate.
Expedite probation and parole proceedings for eligible residents and, if necessary, expanding the use of GPS monitoring and at home confinement.
Release immigrant detainees pending resolution of their immigration cases.
Avoid increasing prison populations by employing different remedies for probation/parole violations whenever feasible.
In each such situation, public safety must be assured to the greatest extent possible including with notification of release to victims.
Remove vulnerable individuals from the correctional setting.
This includes older adults, immunocompromised individuals, pregnant women, and those living with serious co-morbidities.
Enable staff and residents of correctional facilities to adhere to universal source control guidelines (by enabling use of cloth face coverings or facemasks as appropriate).
Enable widespread testing of residents in correctional facilities, utilizing models for testing exemplified by other state correctional facilities. This is critical to identify those who are asymptomatic and prevent further spread.
Enable adherence to CDC infection prevention and control guidelines for correctional facilities.
Make available handwashing stations equipped with soap and water and/or access to alcohol-based hand rub
Ensure frequent and proper cleaning and disinfecting of surfaces within the facility.
Congressional Delegation (Justice Involved)
Advocate with ICE for a review of every individual in their custody at Strafford so that all who are neither a flight risk nor a threat to public safety might be released to their family and friends.
Ask for a congressional inquiry into the problem of spread in Federal prisons and bring data regarding that facility to public attention
Flex Reopening Guidelines (Aging and People with Disabilities)
Expand routine testing for home care and direct support professionals, the families they serve, along with other essential workers in similar settings.
Ensure adequate PPE supplies for home care and direct support professionals and the families they serve working with aging populations and people with disabilities
Provide funding to home care and direct support professionals and the families they serve for appropriate training on COVID-19 prevention and safety, along with a starting wage of \$12.00
Addressing Equity in Education and the Digital Divide in the Wake of COVID-19 (Ed/Dig.Divide)
That the DOE collect and share data related to the number/percent of students meaningfully engaged and create needs assessment for SAUs to help determine what resources are needed to adequately provide for students. The SAU needs assessment data combined with the data about the number of students being reached will provide a clear picture for us to create new strategies to reach those students. It will be important to collect demographic data about the students in order to develop more culturally responsive approaches to meeting the needs of all children and their families.
Commissioner Edelblut share a plan specific to addressing remote learning inequities, including access to computers and internet access across the entire state.
Encouraging SAUs to make online learning plans easily accessible, on a user-friendly, multilingual platform.
Adopting regulations that identify how students' learning will be measured and how student support will be available to ensure all students have access, including those who may fall behind.
That the Governor's Advisory Council for Diversity and Inclusion hold a special listening session regarding remote learning / instruction.

Assuring the DOE website, the NH Learns Remotely website, and any printed resources, or other resources (such as the hotline) that are shared with communities, be accessible to those whose preferred languages are not English. This should include videos in ASL.
That multiple modes of communicating (i.e., electronic, physical flyers, partnering with key nonprofits to help with communication, etc.) resources for assisting with remote learning for parents.
Creating an 800 hotline for parents who are having difficulties with remote learning (with language access for all.)
Consider including a member of the NH Equity COVID-19 Task Force who is well-versed in issues of equity in education, minority health and health equity on the School Transition Reopening and Redesign Taskforce, STRRT, (in order to ensure issues specific to historically marginalized students and families are included in the considerations of the STRRT).
Reopening Task Force re: Housing (Mental Health and Substance Use)
Urge consideration of using the CARES Act and other funding for rent subsidies and expanded capacity
NH CORR has provided financial support totaling about \$38,000 to nearly 80 individuals in need. This assistance has covered less than half the requests for assistance that have come in – about 180 requests have come in, totaling more than \$90,000 in total, and more are coming in each day, according to CORR.
CORR estimates that another \$250,000 – 500,000 is needed in the rental assistance program, to assist individuals through the end of the next fiscal year. Additionally, \$825,000 – 1, 2000,000 is needed to build additional capacity for individuals needing recovery housing. NH CORR expects that once people are no longer in fear of going to health care settings that there will be a surge of individuals entering into treatment and then recovery.
This funding to build capacity could be provided as a zero interest loan that could be turned into a grant if the home were either certified through NH CORR or registered with the state. The money could be used to build extra bathrooms or to convert new homes into recovery housing.
Funding for individual rent subsidies and to expand capacity could play a critical role helping secure stable housing for these individuals looking to achieve and maintain long-term recovery from substance use disorders. This would go far to protect the gains New Hampshire has made against the addiction epidemic, and to support these critical housing resources now and into the future.

IX. Supporting Resources

Articles / Issue Briefs

- [Racism and Health: Evidence and Needed Research](#). David Williams et al. Annual Review of Public Health, January 2019
- [Health Equity Principles for State and Local Leaders in Responding to, Reopening and Recovering from COVID-19](#). Robert Wood Johnson Foundation
- [Accountability As A Public Health Response: COVID-19's Impact on Communities of Color](#). NASTAD Minority Leadership Program network, May 2020.
- [The Fierce Urgency Of Now: Closing Glaring Gaps In US Surveillance Data On COVID-19](#). Nancy Krieger, et al., Health Affairs, April 14, 2020
- [3 Principles for an Anti-Racist, Equitable State Response to COVID-19 — and a Stronger Recovery](#). Center on Budget & Policy Priorities, 5/21/20

- [COVID-19: Equity in Recovery](#). Federal Reserve Bank of Philadelphia, April 2020
- [COVID-19 Is Crushing Black Communities. Some States Are Paying Attention](#). PEW Stateline, May 27, 2020

Equity Review Toolkit

- Division of Public Health Services *Equity Review Toolkit*, June 2020, DPHS Equity Council

DATA sites

- [New Hampshire COVID-19 Summary Dashboard](#)
- [City of Nashua Division of Public Health and Communities Services COVID-19 Data Dashboard](#)
- [City of Manchester Health Department COVID-19 Dashboard](#)
- [New Hampshire Health Center COVID-19 Survey Summary Report](#). Biweekly report from health centers to Health Resources & Services Administration (HRSA)
- [State Health & Value Strategies website: States' Reporting of COVID-19 Health Equity Data](#). Woodrow Wilson School at Princeton, funded by Robert Wood Johnson Foundation, May 28, 2020
- [The COVID Racial Data Tracker](#), The COVID Tracking Project at The Atlantic

X. Review of Other State-Level COVID-19 Equity Entities

Table 5: State-level COVID-19 Equity entities as of June 6, 2020, from a scan of all 49 states

State	Website
Colorado	COVID-19 Health Equity Response Team <ul style="list-style-type: none"> • Ensure racial and ethnicity COVID-19 data are accessible, transparent and used in decision-making, • Determine proactive measures to prevent the spread of COVID-19 in specific communities, • Work with state teams coordinating resources and logistics to help curb health disparities related to COVID-19, • Increase access to testing and care services, • Share time-sensitive information about how Colorado communities are experiencing particular challenges related to the COVID-19 response, and • Develop policy recommendations to better assist and prepare communities of color during the current COVID-19 pandemic as well as future state emergencies.
Illinois	IL DPH COVID-19 Health Equity Task Force Serve as liaison between the SEOC, Incident Command Structure, communities of color, and other vulnerable populations. 1. Identify emerging issues and patterns impacting medically and socially vulnerable communities and then assess and propose specific actionable recommendations.

	<p>2. Amplify critical unmet needs to key SEOC leaders and proposed solutions from Equity Team and communities of concern.</p> <p>3. Provide timely equity analysis on community related SEOC discussions and decisions to maximize benefit and avoid harm and inequitable outcomes for communities of concern.</p> <p>4. Track and follow issues and recommendations to resolution, and communicate back to Equity Team, and communities of concern.</p>
Indiana	<p>Racial Disparity Task Force To Meet On COVID-19 article, May 18, 2020</p> <p>The task force has until June 30 to come up with a corrective action plan to address these disparities and the rising infection rate in the state prison system</p>
Louisiana	<p>Louisiana COVID-19 Health Equity Task Force; \$500,000 from Governors COVID Response Fund to the Health Equity Task Force to Examine Causes and Solutions to COVID-19 Racial Disparities; Louisiana task force creating Dashboard on Health Equity article</p>
Michigan	<p>Michigan Coronavirus Task Force on Racial Disparities to study the causes of racial disparities and recommend actions to address the historical and systemic inequities.</p> <ul style="list-style-type: none"> • Study the causes of racial disparities in the impact of COVID-19 and recommend actions to address such disparities. • Recommend actions to increase transparency in reporting data regarding the racial and ethnic impact of COVID-19; remove barriers to accessing physical and mental health care; reduce the impact of medical bias in testing and treatment; mitigate environmental and infrastructure factors contributing to increased exposure during pandemics resulting in mortality; and develop and improve systems for supporting long-term economic recovery and physical and mental health care following a pandemic. • Perform outreach to ensure all stakeholders in impacted areas are informed, educated, and empowered. • Perform outreach to ensure the general public is informed about racial disparities in the impact of COVID-19, and the work of the Task Force. • Identify avenues of funding for combatting racial disparities in the impact of COVID-19. • Recommend changes in Michigan law relevant to combatting racial disparities in the impact of and response to pandemics. • Identify other issues and provide recommendations to the governor on any other matters relevant to addressing racial disparities in the impact of and response to pandemics. <p>Created by Executive Order</p>
Minnesota	<p>Community Resilience and Recovery Work Group to coordinate across sectors to monitor COVID-19 impacts on communities most impacted currently by inequities and identify solutions and swift responses. CHE Director is a member.</p> <p>Has recommendations for</p> <ul style="list-style-type: none"> ○ Healthcare ○ Education ○ Corrections ○ Housing ○ Economic Advancement
Ohio	<p>Minority Health Strike Force (lots of subcommittees)</p> <ul style="list-style-type: none"> • Healthcare • Education and Outreach • Resources • Data and Research <p>COVID-19 Update: Efforts to Improve Minority Health, May 21, 2020</p> <p>Examples of recommendations include:</p> <ul style="list-style-type: none"> • Establishing culturally appropriate and accessible COVID-19 exposure notification services for communities of color. • Expanding testing capacity and access for minorities and high-risk populations. • Using data to prioritize resources in the communities that have the highest need.

	<ul style="list-style-type: none"> Developing and launching a statewide, culturally-sensitive outreach campaign that educates African Americans and communities of color on COVID-19, health disparities, and social determinants of health. <p>State Task Force Grapples With COVID-19 Health Disparities, May 6, 2020</p>
Pennsylvania	<p>Pennsylvania New Task Force for Health Disparity to Address How COVID-19 Affects Minorities, 4/15/20</p> <p>Pennsylvania COVID-19 Response Task Force on Health Disparity Announces One-Month Milestones, 5/21/20</p> <p>(no actual website for group found)</p> <ul style="list-style-type: none"> Dr. Rachel Levine, Secretary of the Department of Health. “Yesterday we <u>issued a reminder</u> to hospitals and other providers that it is mandatory to report race data.
Tennessee	<p>COVID-19 Statewide Health Disparities Task Force</p> <p>examine existing data, monitor trends, and hear from those living, working and serving our communities to generate responsive solutions and policies to reduce these disparities.</p> <p>The Equity Alliance makes CARES Act spending recommendations to Mayor Cooper</p>
Utah	<p>Multicultural Subcommittee of the COVID-19 Task Force to address disparities, increase equity and respond with inclusion to the COVID-19 pandemic.</p>
Virginia	<p>Commonwealth of Virginia COVID-19 Equity Leadership Task Force directs the work of the Health Equity Work Group (HEWG) as part of the unified command for the Commonwealth of Virginia</p>
West Virginia	<p>COVID-19 Advisory Commission on African American Disparities, May 12, 2020 to educate at-risk minority communities in prevention, testing and treatment; consider strategies to remove barriers to testing, and; make recommendations to broaden the inclusion of underserved communities in the state’s expanded testing plan</p> <p>COVID-19 advisory task force is in the works, May 7, 2020</p>