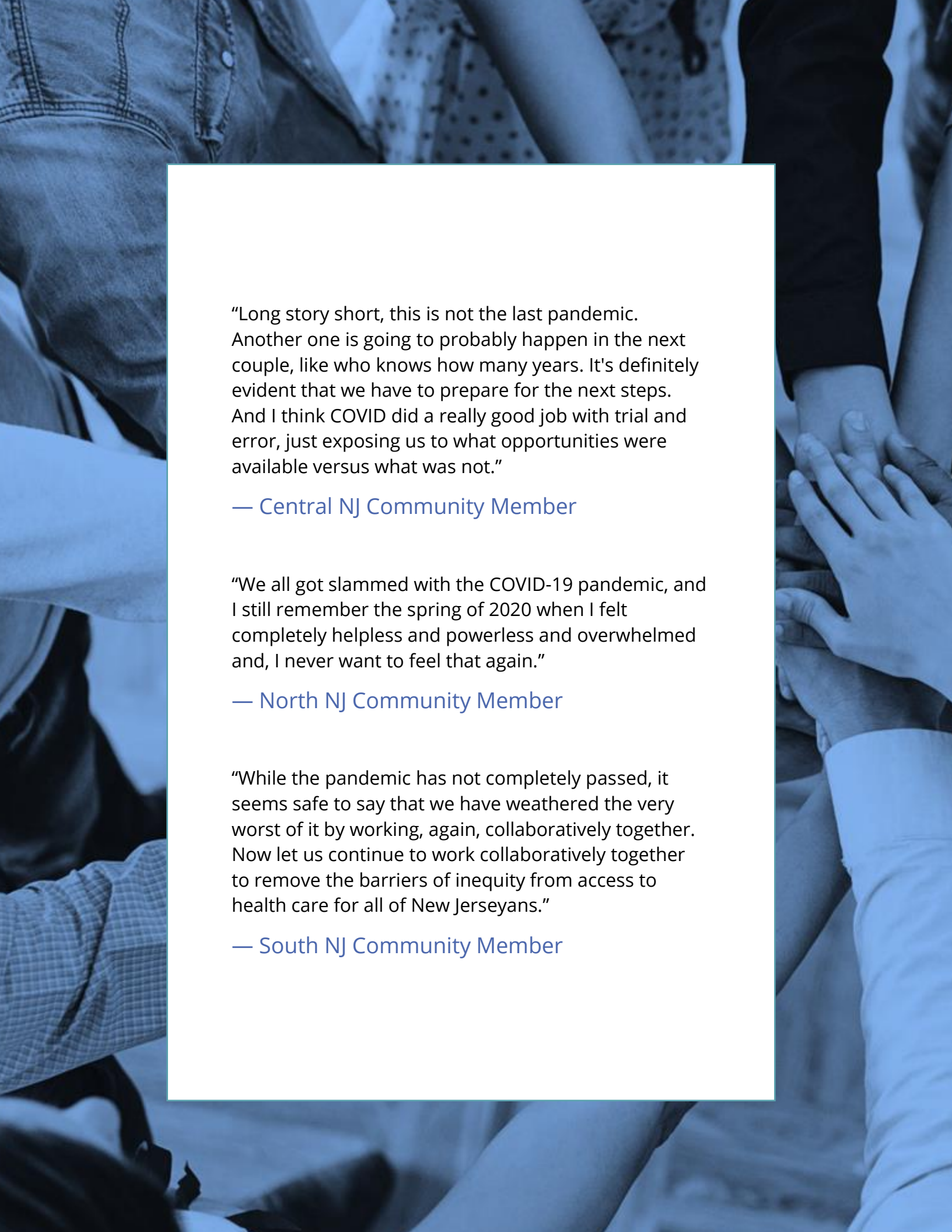
The New Jersey Coronavirus Disease 2019 (COVID-19) Pandemic Task Force

on Racial and Health Disparities

2024 FINAL REPORT



"Long story short, this is not the last pandemic. Another one is going to probably happen in the next couple, like who knows how many years. It's definitely evident that we have to prepare for the next steps. And I think COVID did a really good job with trial and error, just exposing us to what opportunities were available versus what was not."

— Central NJ Community Member

"We all got slammed with the COVID-19 pandemic, and I still remember the spring of 2020 when I felt completely helpless and powerless and overwhelmed and, I never want to feel that again."

— North NJ Community Member

"While the pandemic has not completely passed, it seems safe to say that we have weathered the very worst of it by working, again, collaboratively together. Now let us continue to work collaboratively together to remove the barriers of inequity from access to health care for all of New Jerseyans."

— South NJ Community Member

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Letter From the Chair

Serving as the Chair for the New Jersey Coronavirus Disease 2019 (COVID-19) Pandemic Task Force on Racial and Health Disparities has been an honor and privilege. My sincere gratitude goes to the Co-Chair Ms. Marilyn Cintron, all Task Force members, the New Jersey Legislators for creating the legislation, Governor Murphy for signing Bill A4004 into law, Commissioner Persichilli, Commissioner Baston, colleagues from the New Jersey Department of Health (NJDOH) and so many others for their unwavering support.

Appreciation and gratitude are due to all the individuals representing communities from across New Jersey. Their willingness to share their COVID-19 experiences, including the profound losses, and insightful recommendations have been instrumental to this report. Thank you to the health, public health, community, and faith-based organizations, the many volunteers, for your ongoing work to address disparities and improve inequities during the most challenging times. We appreciate the tremendous sacrifices you made at great risk to yourselves, and your families on behalf of the people of New Jersey! Thank you.

We will never really know how many people were infected as well as affected by COVID-19. As of today, the estimated cases exceed 704 million and deaths exceed 7 million globally[1], since the beginning of the pandemic. However, these are not just numbers they reflect the many New Jersey "souls" that were loss and impacted by the virus.

The persistence of inequities exposed by and related to COVID-19 is evident, with higher rates of infection, morbidity and mortality amongst seniors, racially and ethnically diverse communities, Hispanics/Latino/a/e/x,[2] African Americans/Blacks and Indigenous people; persons residing as well as working in urban and rural areas, people experiencing homelessness, living with disabilities, with substance use disorders, incarcerated, residing and working in congregate settings, and immigrants, essential and frontline workers[3]. Many

[1] **World Health Organization**, "WHO COVID-19 Dashboard," *World Health Organization*, n.d. [Online]. Available: https://data.who.int/dashboards/COVID19/cases?n=c.

[2] "Hispanics/Latino/a/e/x is referred as "Hispanic" and/or "Latino" throughout the report.

[3] **Centers for Disease Control and Prevention**, "COVID-19 and Health Equity," *Centers for Disease Control and Prevention*, n.d. [Online]. Available: https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/index.html.

of these individuals and so many more including children are now living with Long COVID19. Some will require life-time care to address the sequelae of the virus.

The Task Force's mission was to**:**

"Provide specific recommendations to the Governor and Legislature for mitigating inequities caused or exacerbated by COVID-19 and for preventing such inequities in the future."

In pursuit of this mission, the Task Force reviewed COVID-19 data, conducted a literature review and most importantly listened to many New Jersey community members' concerns at public hearings. The aim was to identify the disparate impact of COVID19on historically marginalized and other high-risk health persons in the state's 564 municipalities.

The Task Force recommendations are extensive and comprehensive, intending to address the multifaceted challenges faced by New Jersey's most marginalized and vulnerable residents and communities adversely impacted by COVID-19.

The recommendations go beyond the immediate challenges posed by COVID-19. They delve into historic public health disparities and social determinants of health, such as residential crowding, and lack of internet access and knowledge required to obtain vaccines. There was also a concern about prioritizing persons from outside of their communities for vaccinations, many of whom did not reflect the demographics of the community and were frequently much younger. The lessons learned and the recommendations provided by the Task Force and others are not confined to the COVID-19 pandemic; they extend to all future disasters. This includes providing equitable, affordable and timely access to life saving vaccines, screening for infection and treatment.

The report recommendations are meant to amplify the voices of New Jersey's most vulnerable residents and communities adversely impacted by COVID-19. The recommendations, therefore, address a plethora of "isms," including systemic and structural racism, considered a public health threat by the Centers for Disease Control and Prevention (CDC)[4].

Equitably addressing disasters requires a transformational change in our thinking, focusing on prevention and an inclusive strategy for all persons. This is not merely an obligation but a unique opportunity to do better, because the people of New Jersey deserve nothing less.

[4] **Centers for Disease Control and Prevention**, "Racism and Health," *Centers for Disease Control and Prevention*, 8 April 2021. [Online]. Available: https://archive.cdc.gov/www_cdc_gov/media/releases/2021/s0408-racism-health.html.

By embracing this collective wisdom and committing to lasting change, we can build a more resilient, and equitable inclusive society, ensuring that no one is left behind, we move forward, never back, never forget and learn from the past.

Most sincerely and respectfully,

Tanya Pagán Raggio-Ashley, MD, MPH, FAAP
Chair for the New Jersey COVID-19 Task Force on Racial and Health Disparities

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Acknowledgements

For their outstanding contribution throughout this venture, the Task Force would like to offer a special thanks to those listed below. Your commitment has significantly elevated our efforts.

We wish to extend our heartfelt gratitude to all individuals who have tirelessly dedicated themselves to the fight against COVID-19. Your commitment, sacrifices, and hard work have made a profound impact on our collective well-being. We also pause to remember the lives that have been tragically lost during this challenging period.

The Task Force would also like to express its sincere gratitude to all those who contributed to the success of this endeavor. Your participation, support, insightful expertise, and unique perspectives throughout this project have been invaluable in achieving our goals. You have enriched our project, providing a depth of understanding we could not have achieved without your involvement.

Thank you to the Legislative Sponsors:

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Assemblywoman Angelica M. Jimenez
District 32 (Bergen and Hudson)

Assemblywoman Linda S. Carter
District 22 (Middlesex, Somerset, and Union)

Senator Sandra B. Cunningham
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This work was supported by the following Centers for Disease Control and Prevention (CDC) grants:

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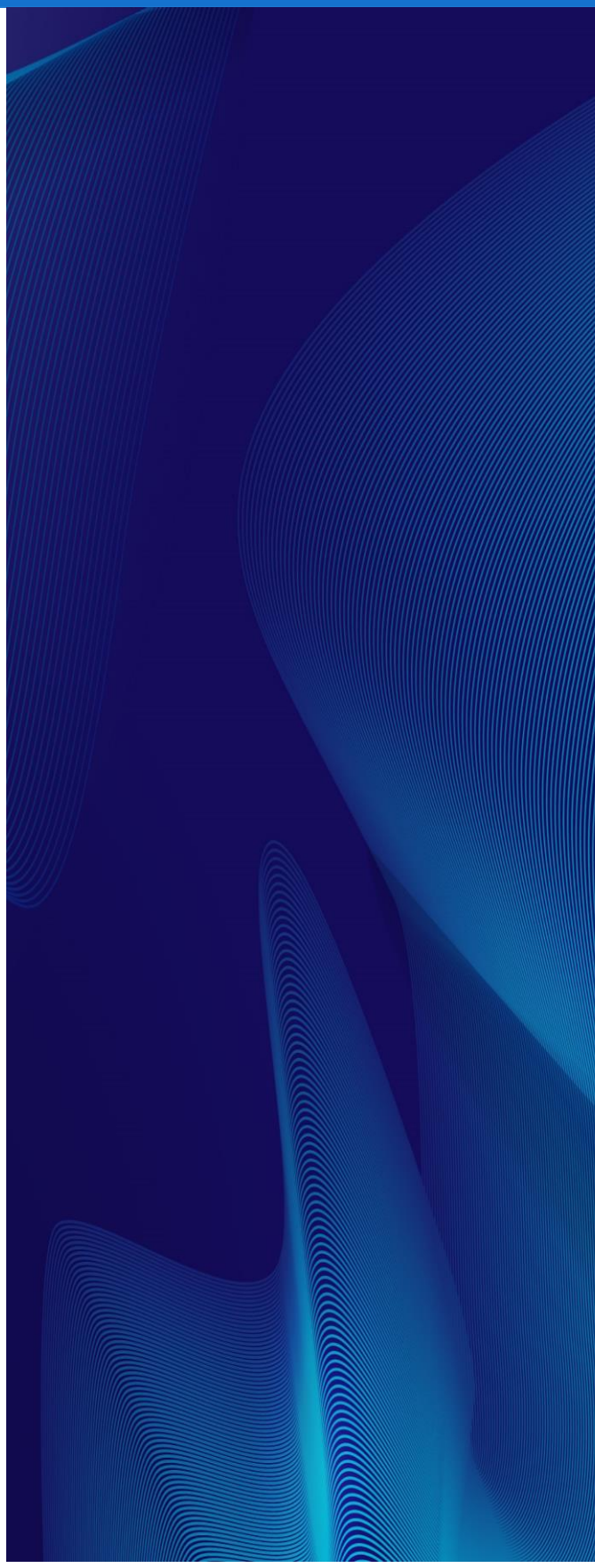
Immunization and Vaccines for Children; COVID Supplemental 4 Assistance Program: Immunization Cooperative Agreement (CDC-RFA-IP19-1901)

For a comprehensive list of contributors and acknowledgments, please refer to Appendix K.

***Disclaimer**: The views expressed in this report reflect the collective perspective of the Task Force, developed through extensive dialogue and compromise. They do not necessarily represent the positions of Governor Murphy's Administration, the State of New Jersey, its agencies, contractors, or individual members of the Task Force.*

The recommendations presented in this report were preliminarily drafted by spring 2022, with adjustments made during the report's development. Certain actions related to these recommendations may have been initiated or completed, but this report may not fully capture such developments.



Executive Summary

The COVID-19 pandemic has had an unequal impact on racially and ethnically diverse communities in New Jersey, exacerbating existing disparities in health outcomes. In 2020, COVID-19 was New Jersey's second leading cause of death and the leading cause of mortality among Black, Hispanic, Asian, and immigrant residents (of any race/ethnicity).[5]

To gain a clear understanding of how the COVID-19 pandemic disproportionately impacted racially and ethnically diverse communities in New Jersey, the Legislature passed and Governor Murphy signed a bill establishing the Coronavirus Disease 2019 (COVID-19) Pandemic Task Force (Task Force) on Racial and Health Disparities in 2021. This legislation, sponsored by Senators Sandra Cunningham and Nellie Pou and Assemblywomen Shavonda Sumter, Angelica Jimenez, and Linda Carter, reflects a proactive response to address the inequities caused or exacerbated by the pandemic.

The Task Force consisted of 23 members with diverse expertise and racial/ethnic backgrounds: 14 members appointed by the Governor and nine ex-officio members, who represent various New Jersey state departments.

The Task Force's mission was to provide specific recommendations to the Governor and the Legislature for addressing inequities caused and/or

[5] New Jersey Department of Health. (n.d.) Leading Causes of Death among New Jersey Residents Final 2020 Death Certificate Data. https://www.nj.gov/health/chs/documents/Final2020LCOD.pdf

exacerbated by COVID-19, and for preventing such inequities in the future. To achieve this, the Task Force was structured into four working groups, each dedicated to addressing distinct key issues as outlined in the legislation:

- Data Systems
- Health Communications
- Historical and Systemic Inequities/ Social Determinants of Health
- Physical/Mental Health Status and Health Care Disparities

Each working group gathered to deliberate and formulate recommendations based on quantitative data, public testimony, and testimonies from employees of the New Jersey Department of Health and local health departments. As a result, the four working groups developed a comprehensive list of recommendations that include policy and system changes, programmatic interventions, and community-driven initiatives aimed at eliminating health disparities and advancing health equity in New Jersey.

The Task Force determined a set of priority recommendations that should be considered for initial implementation efforts for addressing racial and ethnic health disparities and are highlighted in the recommendations section. The proposed recommendations of this report underscore a commitment to proactive, inclusive, and impactful strategies that address the root causes of disparities and establish a foundation for a more equitable healthcare system.

This Report

This report is a summary of the activities and actions that supported the development of the recommendations proposed by the Task Force. The sections of this report combine to craft a unified narrative, shedding light on the Task Force's journey and the structured approach that shaped its recommendations.

Section 1 – The NJ COVID-19 Pandemic Task Force on Racial and Health Disparities: This section provides an overview of the Task Force, encompassing its creation, members, mission, and operational activities.

Section 2 – Background: This segment entails an examination of pertinent data, an exploration of existing health disparities within New Jersey, and initiatives undertaken by similar state and national Task Force groups. This contextual backdrop serves as the foundational understanding necessary for comprehending the Task Force's subsequent efforts, notably their engagement with key stakeholders in the community. In addition, it highlights aspects of the New Jersey Department of Health's response to the COVID-19 crisis.

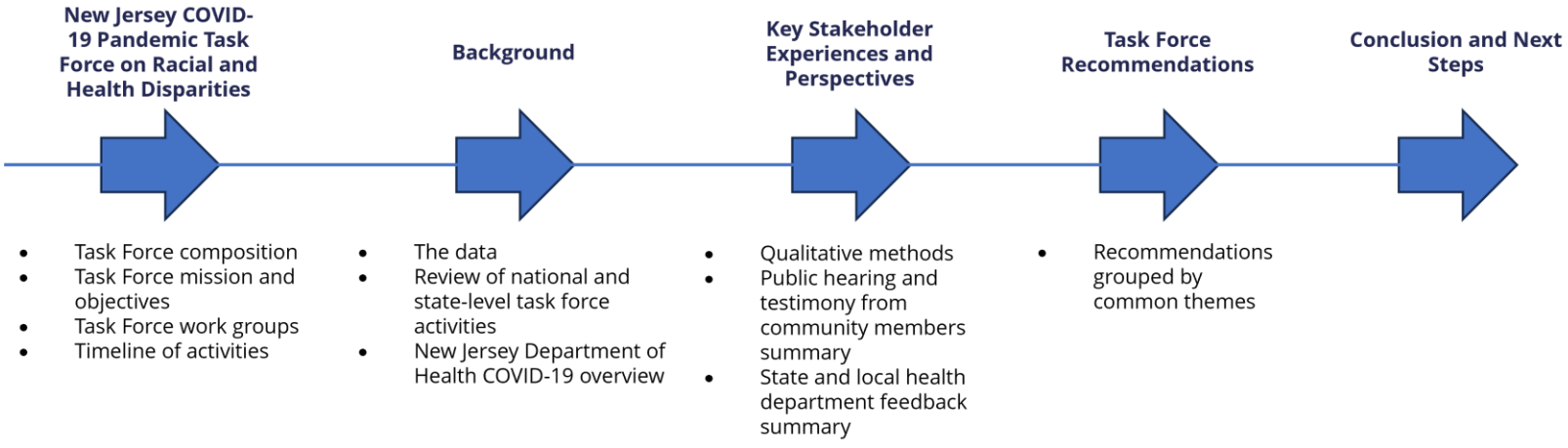
Section 3 – Key Stakeholder Experiences and Perspectives: This section shifts the focus to the Task Force's outreach endeavors. This includes a detailed account of public hearings, testimonial collection, and engagements with local and state government departments. These interactions were instrumental in providing information to the Task Force.

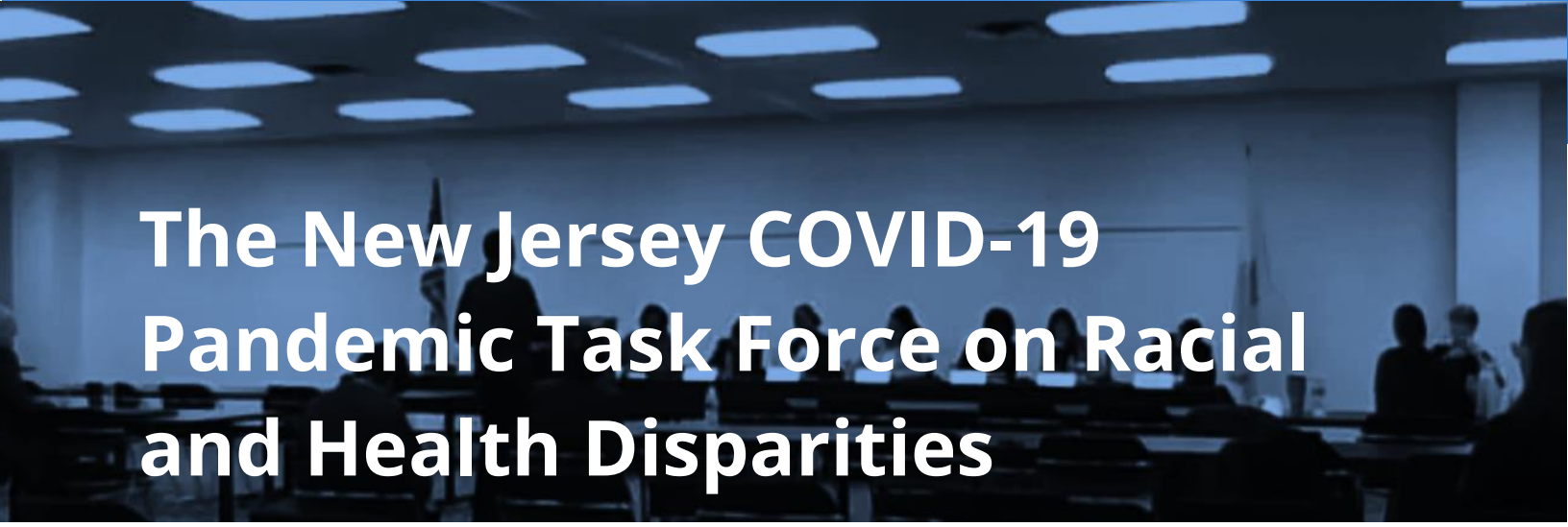
Section 4 – Task Force Recommendations: This section outlines the recommendations and actions identified by the Task Force to address the observed inequalities before, during, and after the pandemic.

Section 5 – Conclusion and Next Steps: This section provides conclusions based on the data, the testimonies, and the recommendations. It also addresses the limitations faced by the Task Force and sets the stage for the next steps based on the recommendations.

Terminology throughout the report aligns with the CDC's recommended terminology (see Appendix L for a full list of terminology).

The following graphic reference serves as a roadmap within the report.



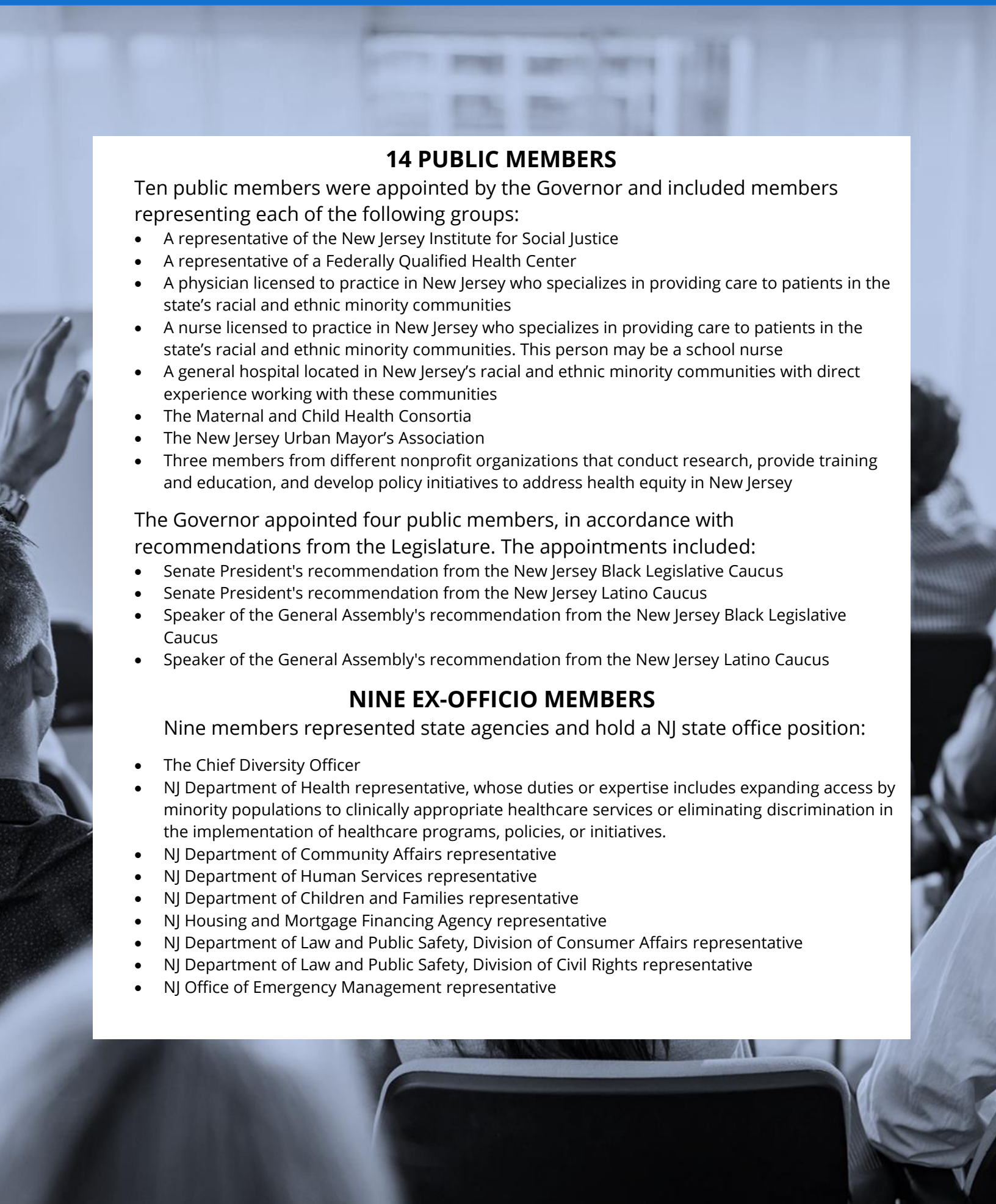


The New Jersey COVID-19 Pandemic Task Force on Racial and Health Disparities

In response to the disproportionate impact of COVID-19 on New Jersey community members, and the growing focus on health equity in the United States, the New Jersey State Legislature established the New Jersey Coronavirus Disease 2019 (COVID-19) Pandemic Task Force on Racial and Health Disparities (the Task Force) to examine the impact that COVID-19 had on racially and ethnically diverse groups in the state. Governor Phil Murphy signed the legislation on June 11, 2021, to officially establish the Task Force. New Jersey joined several other states that had formed a task force or working groups to examine the issues of health equity related to COVID-19 and the response to the pandemic.

Task Force Composition

As described in the legislation P.L 2021-106 (Appendix C), the Coronavirus Disease 2019 Pandemic Task Force was comprised of 23 members, including 14 public members appointed by the Governor, some of whom were selected based upon recommendations from the Legislature, and others based upon requirements stipulated in the legislation. The remaining nine members were Ex-Officio members who hold leadership roles within different state government agencies. The Task Force membership highlights a commitment to inclusivity and representation, reflecting a rich diversity of expertise across various fields. This deliberate emphasis on diversity was instrumental in addressing the objectives of the Task Force.



14 PUBLIC MEMBERS

Ten public members were appointed by the Governor and included members representing each of the following groups:

- A representative of the New Jersey Institute for Social Justice
- A representative of a Federally Qualified Health Center
- A physician licensed to practice in New Jersey who specializes in providing care to patients in the state's racial and ethnic minority communities
- A nurse licensed to practice in New Jersey who specializes in providing care to patients in the state's racial and ethnic minority communities. This person may be a school nurse
- A general hospital located in New Jersey's racial and ethnic minority communities with direct experience working with these communities
- The Maternal and Child Health Consortia
- The New Jersey Urban Mayor's Association
- Three members from different nonprofit organizations that conduct research, provide training and education, and develop policy initiatives to address health equity in New Jersey

The Governor appointed four public members, in accordance with recommendations from the Legislature. The appointments included:

- Senate President's recommendation from the New Jersey Black Legislative Caucus
- Senate President's recommendation from the New Jersey Latino Caucus
- Speaker of the General Assembly's recommendation from the New Jersey Black Legislative Caucus
- Speaker of the General Assembly's recommendation from the New Jersey Latino Caucus

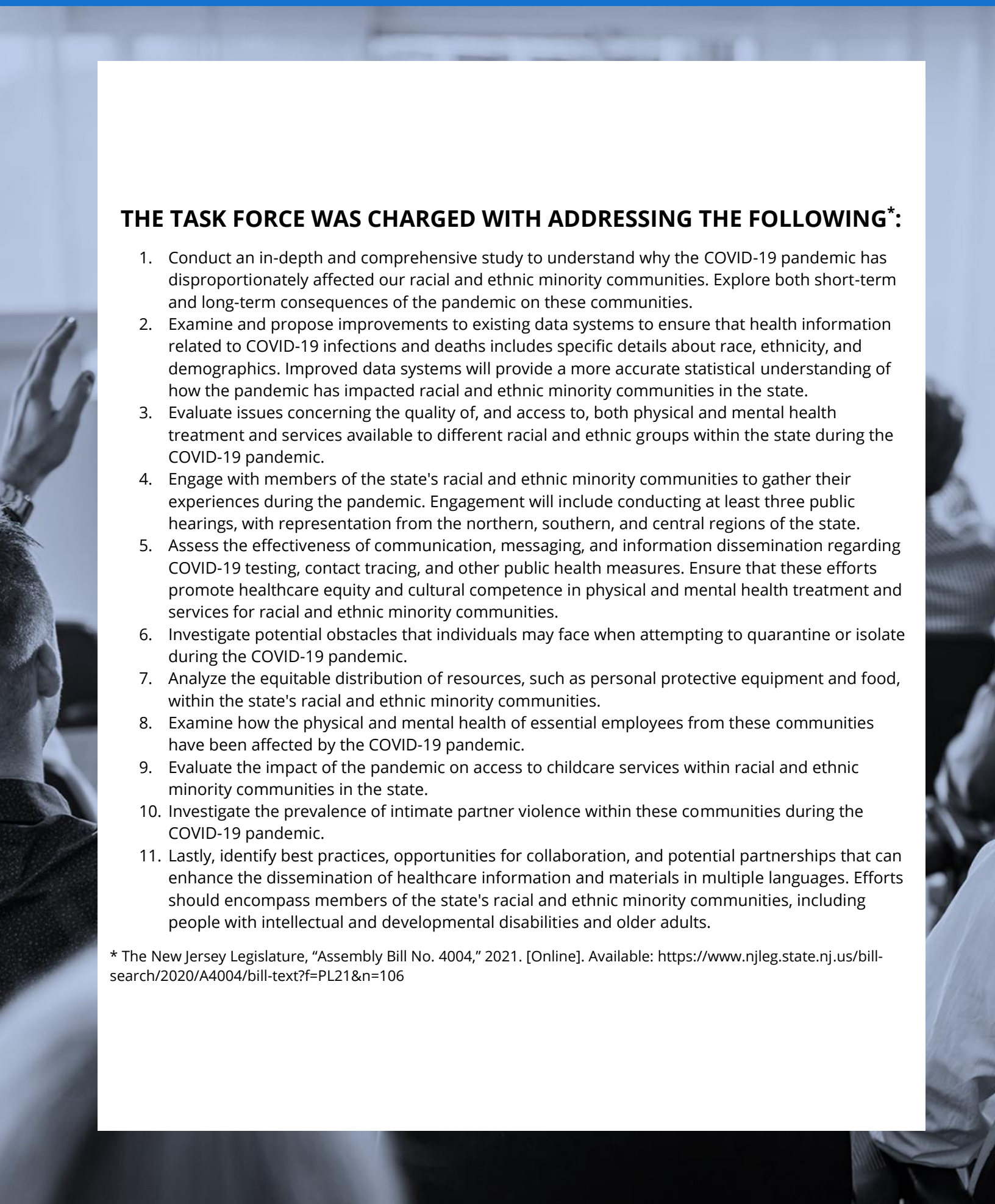
NINE EX-OFFICIO MEMBERS

Nine members represented state agencies and hold a NJ state office position:

- The Chief Diversity Officer
- NJ Department of Health representative, whose duties or expertise includes expanding access by minority populations to clinically appropriate healthcare services or eliminating discrimination in the implementation of healthcare programs, policies, or initiatives.
- NJ Department of Community Affairs representative
- NJ Department of Human Services representative
- NJ Department of Children and Families representative
- NJ Housing and Mortgage Financing Agency representative
- NJ Department of Law and Public Safety, Division of Consumer Affairs representative
- NJ Department of Law and Public Safety, Division of Civil Rights representative
- NJ Office of Emergency Management representative

Task Force Mission and Objectives

Commencing its mission in June 2022, the Task Force undertook the critical task of assessing the disproportionate impact of the COVID-19 pandemic on racially and ethnically diverse communities. As part of their mission, the Task Force solicited and received testimonies from individuals within these communities as well as insights from members of the New Jersey Department of Health and New Jersey local health departments who were involved in the COVID-19 response to formulate recommendations. These recommendations aim to address and rectify the exacerbated racial and health disparities that emerged during the pandemic, with a commitment to fostering equity and resilience in these communities.



THE TASK FORCE WAS CHARGED WITH ADDRESSING THE FOLLOWING*:

1. Conduct an in-depth and comprehensive study to understand why the COVID-19 pandemic has disproportionately affected our racial and ethnic minority communities. Explore both short-term and long-term consequences of the pandemic on these communities.
2. Examine and propose improvements to existing data systems to ensure that health information related to COVID-19 infections and deaths includes specific details about race, ethnicity, and demographics. Improved data systems will provide a more accurate statistical understanding of how the pandemic has impacted racial and ethnic minority communities in the state.
3. Evaluate issues concerning the quality of, and access to, both physical and mental health treatment and services available to different racial and ethnic groups within the state during the COVID-19 pandemic.
4. Engage with members of the state's racial and ethnic minority communities to gather their experiences during the pandemic. Engagement will include conducting at least three public hearings, with representation from the northern, southern, and central regions of the state.
5. Assess the effectiveness of communication, messaging, and information dissemination regarding COVID-19 testing, contact tracing, and other public health measures. Ensure that these efforts promote healthcare equity and cultural competence in physical and mental health treatment and services for racial and ethnic minority communities.
6. Investigate potential obstacles that individuals may face when attempting to quarantine or isolate during the COVID-19 pandemic.
7. Analyze the equitable distribution of resources, such as personal protective equipment and food, within the state's racial and ethnic minority communities.
8. Examine how the physical and mental health of essential employees from these communities have been affected by the COVID-19 pandemic.
9. Evaluate the impact of the pandemic on access to childcare services within racial and ethnic minority communities in the state.
10. Investigate the prevalence of intimate partner violence within these communities during the COVID-19 pandemic.
11. Lastly, identify best practices, opportunities for collaboration, and potential partnerships that can enhance the dissemination of healthcare information and materials in multiple languages. Efforts should encompass members of the state's racial and ethnic minority communities, including people with intellectual and developmental disabilities and older adults.

* The New Jersey Legislature, “Assembly Bill No. 4004,” 2021. [Online]. Available: https://www.njleg.state.nj.us/bill-search/2020/A4004/bill-text?f=PL21&n=106

Task Force Work Groups

To fulfill its mission, the Task Force members were divided into four working groups that addressed specific aspects of the pandemic response and impacts on the community. The working groups aligned with the thematic pillars of:

- **Data Systems:**
  Dedicated to recommending improvements to data systems, ensuring that COVID-19 health information includes race, ethnicity, and other demographic identifiers to better understand the impact of COVID-19 on the State's marginalized and high-risk populations.
- **Health Communication:**
  Focused on researching and evaluating communication strategies for testing, contact tracing, and healthcare approaches during the pandemic. It aimed to identify best practices for communicating healthcare information that is accessible to all, particularly for members of minority and other high-risk communities.
- **Historical and Systemic Inequities/Social Determinants of Health:**
  Dedicated to developing recommendations to address disparities, evaluate quarantine impediments, analyze resource distribution, examine childcare access impact, and to investigate intimate partner violence.
- **Physical/Mental Health Status and Healthcare Disparities:**
  Focused on creating recommendations to reduce disparities in health status and healthcare utilization among different population within minority and other high-risk populations.

Appendix A describes the working groups' objectives that framed their recommendations.

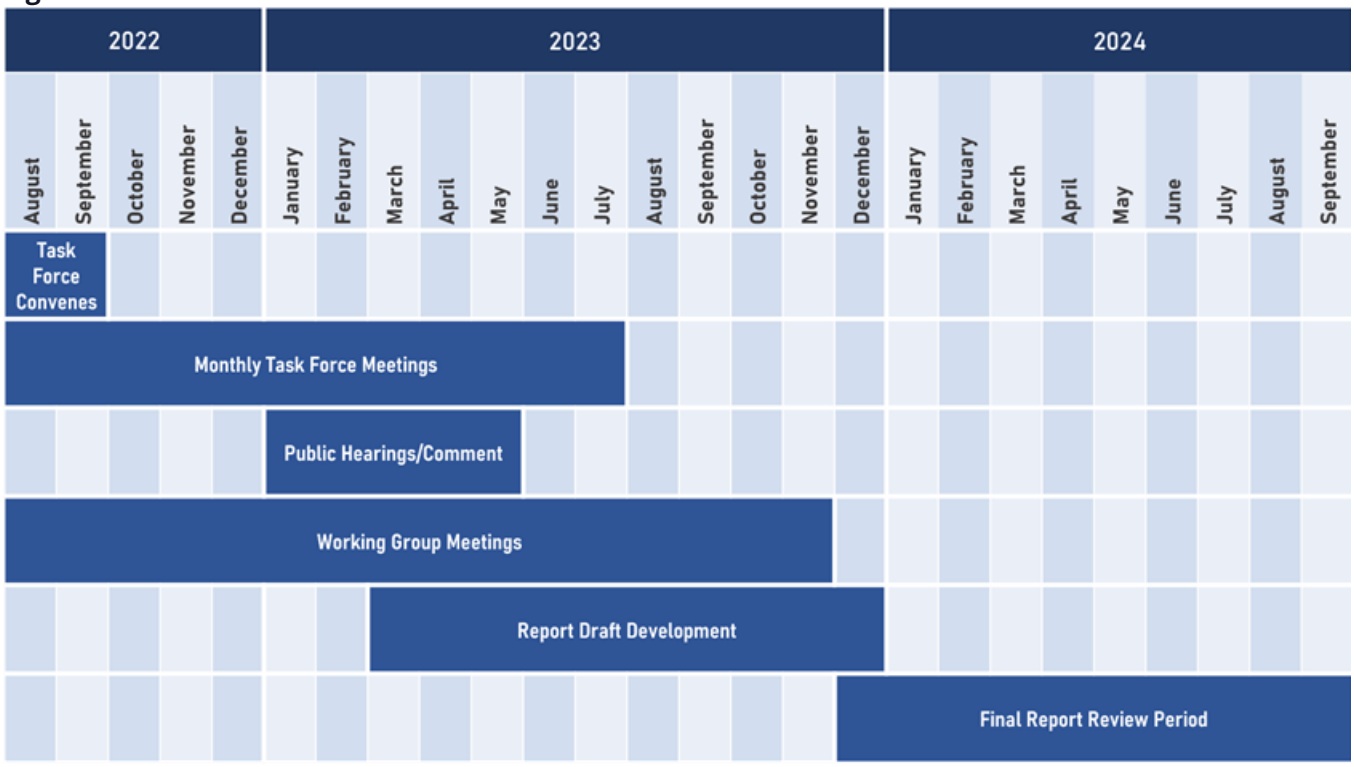
Working groups had a guidance template (Appendix L) to develop their recommendations and provide consistent reporting among the four different groups.

In addition, the Task Force formed a Public Hearing Planning Work Group. This work group was assigned the responsibility of planning, organizing, and executing public hearings, ensuring the active participation of all Task Force members.

Timeline of Activities

After its inaugural meeting in June 2022, the Task Force consistently met on monthly basis until February 2023, while the working groups continued their regular sessions until October 2023. These meetings included, brainstorm sessions, presentations by guest speakers, and the development of the recommendations. In addition, the Task Force held five public meetings between October and December 2022. Figure 1 is a visual representation of the Task Force Activity Timeline.

Figure 1. Task Force Activities Timeline



Aligned with the Task Force's mission to formulate recommendations addressing the disproportionate impact of COVID-19 on racially and ethnically diverse communities, they incorporated experts' opinions, data, insights from individuals within these communities, and information about ongoing community initiatives. The Task Force, along with invited speakers, engaged in exhaustive discussions covering the following areas:

Policy development process

Systemic racism and health disparities specific to New Jersey

Data extraction from the COVID-19 Data HUB/Dashboard

YMCA NJ COVID-19 Storytelling project-Community Conversations

Phase 1

Phase 2

Background

The Data

While New Jersey is the most densely populated state in the country, it also has pockets of rural communities. It is also one of the most racially and ethnically diverse states. Nearly 45 percent of New Jersey residents are people of color,[6] one-fifth are immigrants, and one-third speak a language other than English at home (60 percent of whom speak English less than very well[7]). The state's diversity index score is nearly 66 percent, meaning statewide, any two people chosen at random will be members of different racial and ethnic groups.[8] Understanding the diversity of the New Jersey communities and the distribution of minority and marginalized communities throughout the state is important for contextualizing the extent of the racial and ethnic disparities in COVID-19's overall impact, as well as these communities' access to vaccines, testing, and treatment—an important component of their long-term resilience and recovery.

[6]Alfonso, Esq., C. M. (n.d.). Welcome. New Jersey Office of Diversity and Inclusion. https://www.nj.gov/treasury/diversity/welcome.shtml

[7]New American Economy, "Analysis of 2018 America Community Survey, 5-year sample, New Jersey lanuage and demographic data report," New American Economy, 2018 . NJ_Language-and-Demographic-Report_Dec-2020.pdf (newamericaneconomy.org) [Accessed 3/15/2024].

[8] U.S. Census, (2020). Racial and Ethnic Diversity by State. Available at https://www.census.gov/content/dam/Census/library/visualizations/2021/dec/diversity-index.pdf, accessed August 22, 2023

COVID-19's Disproportionate Impact on Racially and Ethnically Diverse Communities in New Jersey and Throughout the United States.

COVID-19 has had a disproportionate impact on racially and ethnically diverse groups in New Jersey, exacerbating disparities in health outcomes within the state. As of June 2023, COVID-19 is known or suspected to have resulted in over 36,000 deaths among New Jersey residents, with 33,000 confirmed cases and an additional 3,000 deaths classified as probable due to the virus. Nearly half of resident deaths, or 19,689 mortalities, occurred in 2020 alone.[9] During that year, COVID-19 emerged as the second leading cause of death in New Jersey overall; however, notably, it constituted the primary cause of mortality among non-Hispanic Black persons, among Hispanic or Latino persons, among Asian persons, and among immigrants of any race/ethnicity.[10] This devastating impact was particularly pronounced in Bergen, Essex, Hudson, Passaic, and Union Counties, where COVID-19 stood as the leading cause of death.[11] Three of these counties, Essex, Hudson, and Union are among the five most racially and ethnically diverse counties in the state, emphasizing the disproportionate toll on these communities.[12]

Racial and ethnic disparities in confirmed COVID-19 cases, hospitalizations, and death rates in New Jersey mirror the nationwide trend. After adjusting for age, Black and Hispanic or Latino New Jersey residents experienced higher rates of illness, hospitalization, and mortality in comparison to White New Jersey residents, as depicted in Figure 2[13]. These rates aligned with national observations, where Black and Hispanic or Latino persons more likely to be hospitalized and faced higher mortality rates from COVID-19 than their white counterparts, as shown in Table 1.[14]

[9] New Jersey Department of Health. (n.d.) Leading Causes of Death among New Jersey Residents Final 2020 Death Certificate Data. https://www.nj.gov/health/chs/documents/Final2020LCOD.pdf

[10] Ibid, pg. 7. [Accessed 3/15/2024].

[11] Ibid, pg. 10. [Accessed March 15, 2024].

[12]The United States Census Bureau, "State Profiles: 2020 Census," 25 August 2021. [Online]. Available: https://www.census.gov/library/stories/state-by-state/new-jersey-population-change-between-census-decade.html. [Accessed March 15, 2024].

[13] New Jersey Department of Health. "COVID-19 age-adjusted race/ethnicity case rates," (2021). [Online]. Available: https://www.nj.gov/health/cd/documents/topics/NCOV/COVID-Age_Adjusted_Race_Ethnicity.pdf

[14] National Center for Immunization and Respiratory Diseases (U.S.). Risk for COVID-19 infection, hospitalization, and death by race/ethnicity. (2021). [Online]. Available: Risk for COVID-19 infection, hospitalization, and death by race/ethnicity (cdc.gov).

Figure 2. Distribution of age-adjusted COVID-19 cases, hospitalizations, and deaths by race/ethnicity through July 26, 2022, in New Jersey

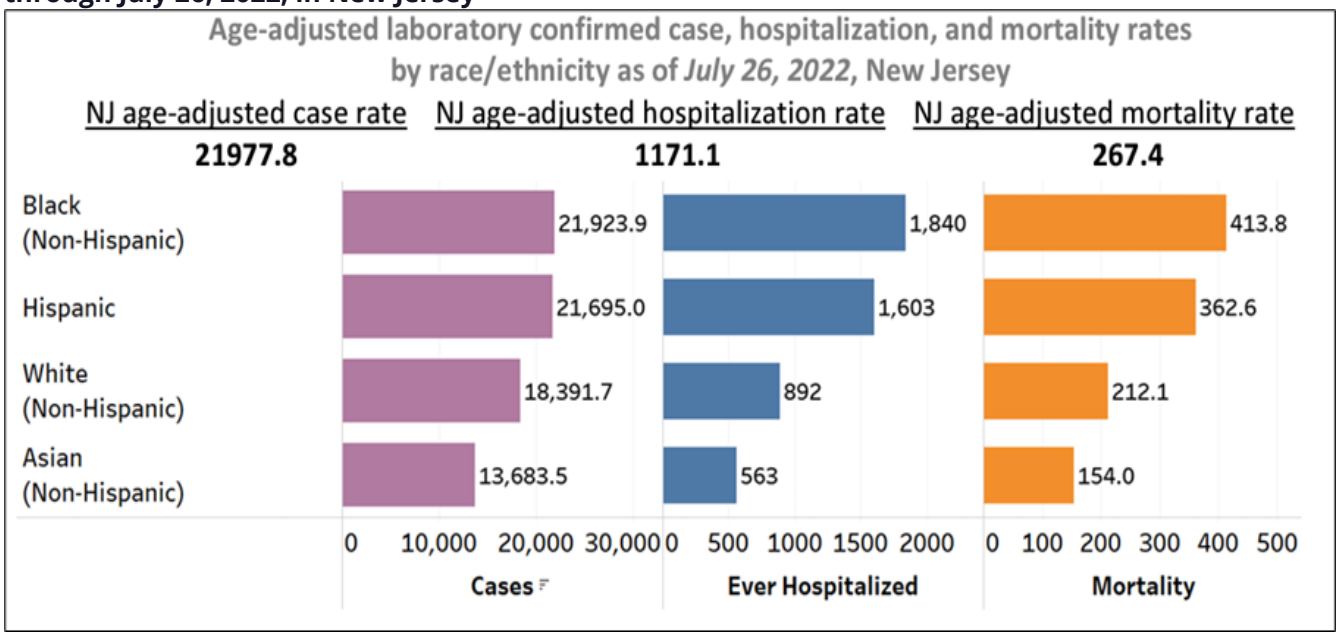


Table 1. Risk of COVID-19 infection, hospitalization, and death by race/ethnicity in the U.S.

Rate Ratios compared to White, Non-Hispanic or Latino persons	**Cases**	**Hospitali-zations**	**Death**
American Indian or Alaska Native, Non-Hispanic or Latino persons	1.6x	3.5x	2.4x
Asian, non-Hispanic or Latino persons	0.7x	1.0x	1.0x
Black or African American, non-Hispanic or Latino persons	1.1x	2.8x	1.9x
Hispanic or Latino persons	2.0x	3.0x	2.3x

Health Disparities Predate COVID-19

To gain insight into the evident disproportionate impact of COVID-19 on these communities, it is important to also consider the societal conditions before the pandemic. Analyzing data from earlier periods enables an understanding of existing healthcare and exposure disparities among different racially and ethnically diverse groups, shedding light on the factors that may have contributed to the observed inequalities.

Before the onset of the COVID-19 pandemic, health disparities were already evident among racially and ethnically diverse groups in the U.S and New Jersey. For instance, in New Jersey, Black residents already faced higher rates of conditions like asthma, cancer, high blood pressure and diabetes, along with elevated mortality rates due to kidney disease. Similarly, the Latino population presented increased prevalence of high blood pressure and diabetes compared to their white counterparts. Additionally, these populations had lower rates of healthcare access, further exacerbating the observed health inequities. Importantly, chronic conditions including diabetes, heart disease, chronic kidney disease, cancer, chronic obstructive pulmonary disease are among conditions that increase the risk of severe illness from COVID-19.[15]

These inequities are NOT rooted in genetic differences. They arise from social determinants of health (SDOH) and systemic factors. Key SDOH such as access to quality education, healthcare availability and quality, neighborhood and built environment, social and community context, and economic stability significantly impact people's health. Additionally, systemic racism, direct bias, and implicit bias further exacerbate these disparities, leading to unequal health outcomes for individuals with similar genetic risk factors.

The existing inequalities among racially and ethnically diverse groups, exemplified by higher rates of chronic disease and mortality, coupled with less access to healthcare and other poor SDOHs, and systemic racism, set the stage for the exacerbated disparities observed during the pandemic.

[15] Hacker KA, Briss PA, Richardson L, Wright J, Peterson R. COVID-19 and Chronic Disease: The Impact Now and in the Future. Centers for Disease control and Prevention, Volume 18, E62, June 2021. https://www.cdc.gov/pcd/issues/2021/pdf/21_0086.pdf [Accessed 3/15/2024].

Social Vulnerability Indicators Align with Existing Barriers

Many of the barriers to care, resources, and vaccine access are commonly experienced in New Jersey's racially and ethnically diverse communities, such as lack of transportation and language accessibility, are also indicators of social vulnerability.

Social vulnerability is a measure of the potential negative effects that external stresses can have on the health of communities. The CDC's social vulnerability index (SVI) is made up of 16 indicators across four themes: socio-economic status, household characteristics, racial and ethnic minority status, and housing type and transportation.

What are the social determinants of health (SDOH)?
The CDC defines SDOH as, "the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and a wide set of forces and systems shaping the conditions of life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems."

Each theme touches upon a community's social conditions and how that might impact the community's ability to demonstrate resilience and how individuals and communities might experience and respond in an emergency or disaster, such as a disease outbreak or hurricane.[16] The higher the SVI in a community, the more social vulnerability exists in that area, which indicates that the area may need more resources and investment. The

[16] Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry. Place and Health Social Vulnerability Index (SVI), At a Glance: CDC/ATSDR Social Vulnerability Index. October 26, 2022. At A Glance: CDC/ATSDR Social Vulnerability Index | Place and Health | ATSDR [Accessed 3/15/2024].

following maps, Figures 3[17] and 4[18] compare social vulnerability in New Jersey to all-time COVID-19 morbidity in New Jersey.

The comparison suggests that many of the state's most socially vulnerable or underserved communities also had the greatest COVID-19 morbidity or number of cases. Many of the underserved communities are consistent with the communities New Jersey prioritized for more intensive COVID-19 vaccine outreach and distribution of needed resources.

Figure 3. CDC Social Vulnerability Index Map, New Jersey

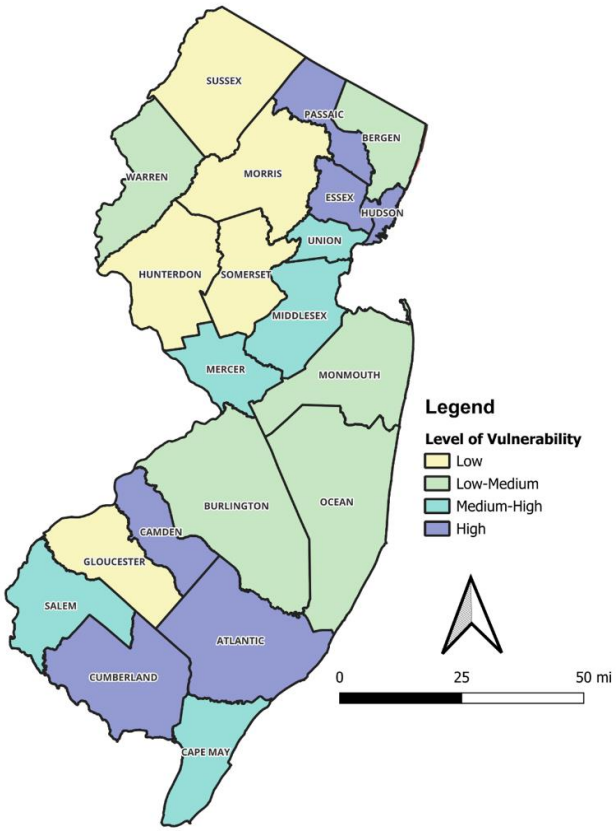
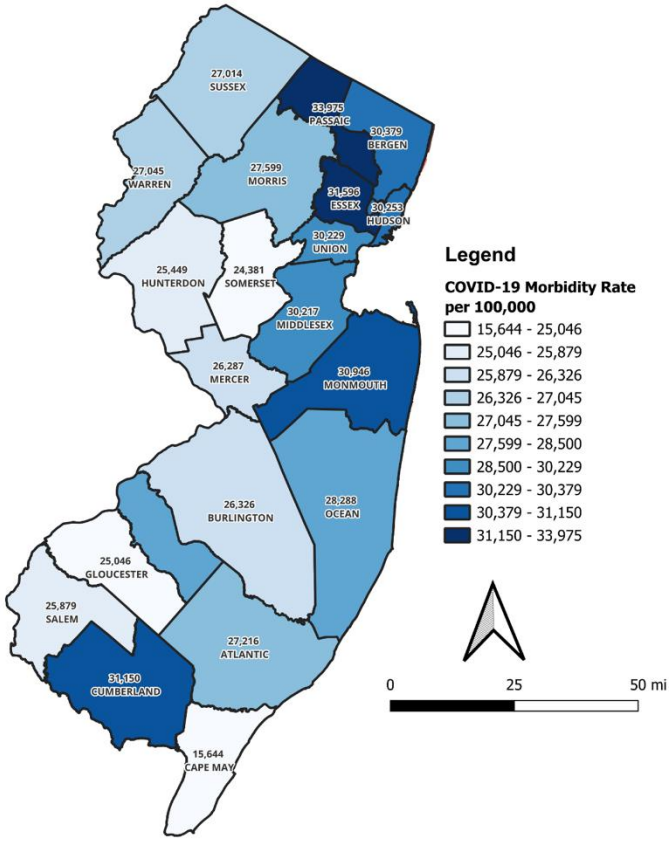


Figure 4. COVID-19 Morbidity in New Jersey



[17] Centers for Disease Control and Prevention/ Agency for Toxic Substances and Disease Registry/ Geospatial Research, Analysis, and Services Program. CDC/ATSDR Social Vulnerability Index 2020 Database, New Jersey. 2023; CDC/ATSDR Social Vulnerability Index (SVI) | Place and Health | ATSDR [Accessed 3/15/2024].

[18] NJ Department of Health, "New Jersey COVID-19 Case and Mortality Summaries," NJ Department of Health , 14 March 2024. [Online]. Available: https://njhealth.maps.arcgis.com/apps/MapSeries/index.html?appid=50c2c6af93364b4da9c0bf6327c04b45 [Accessed 15 March 2024]

Review of National and State-Level Task Force Activities

The New Jersey Task Force proactively sought insights from the Presidential COVID-19 Health Equity Task Force Final Report and Recommendations and the activities from similar task forces in other states. Recognizing the national and regional dimensions of the crisis, the New Jersey Task Force strategically examined the approaches and recommendations put forth by its counterparts to distill best practices and review the unique challenges faced by each state. Importantly, the Presidential Task Force Chair played a pivotal role in setting the stage for the New Jersey Task Force's work by presenting national efforts at one of the first New Jersey Task Force meetings. This collaborative and informed approach underscores the commitment to leveraging collective expertise and resources to navigate the complexities of the pandemic response cohesively.

Presidential COVID-19 Task Force Activities

The disparities that New Jersey's racially and ethnically diverse communities experienced throughout the COVID-19 pandemic are consistent with patterns seen nationwide and have contributed to a national conversation on the healthcare challenges that racially and ethnically diverse populations face.

As part of President Biden's response to the COVID-19 pandemic, Executive Order 13995 established the Presidential COVID-19 Health Equity Task Force in February 2021. The Presidential Task Force's mission was also to make specific recommendations to the President for mitigating inequities that the pandemic caused or exacerbated and for preventing these disparities in the future. The Presidential Task Force set the following proposed priority actions to address these issues:

Presidential Task Force's Proposed Priority Actions

- Invest in community-led solutions to address health equity.
- Enforce a data ecosystem that promotes equity-driven decision making.
- Increase accountability for health equity outcomes.
- Invest in a representative healthcare workforce and increase equitable access to quality care for all.
- Lead and coordinate implementation of the COVID-19 Health Equity Task Force's recommendations from a permanent health equity infrastructure in the White House.

State-Level COVID-19 Task Force Activities Across the United States

The New Jersey Task Force identified and analyzed 14 other states that responded to the disproportionate impact of COVID-19 with a health equity-focused task force or work group to identify and address health disparities amplified by COVID-19. These task force groups' activities and actions across were analyzed for similarities and differences in structure, goals, and actions and helped to inform the New Jersey Task Force. The goals and objectives of other states' COVID-19 Health Equity Focus Groups are provided in Appendix I.

New Jersey Department of Health Overview

New Jersey Department of Health COVID-19 Response Highlights

The New Jersey Department of Health (NJDOH), in collaboration with local health departments (LHDs), other state agencies, community-based organizations (CBOs), faith-based organizations (FBOs), and local federally qualified health center (FQHC) providers, deployed strategies, policies, and programs to address the urgent need for direct assistance to the public through disease monitoring, education, health promotion and disease prevention, and vaccination outreach during the COVID-19 pandemic. The Task Force aims to spotlight some of the programs that emerged from these collaborative efforts, offering invaluable insights and best practices applicable to future public health emergencies and beyond. Table 2 highlights some of the activities led by NJDOH, in collaboration with community partners and other State agencies, to respond to the COVID-19 pandemic. It is important to note New Jersey is comprised of 564 different municipalities and 21 counties, and COVID-19 response activities were implemented in an array of ways to meet the unique needs of diverse communities.

Table 2. Activities led by NJDOH, in collaboration with community partners and other State agencies.

Programs/Agencies	Activities
Family Health Service (FHS)	FHS facilitated statewide intensive community engagement to support contact tracing, prevention education, testing, and vaccine promotion. In partnership with CBOs and FBOs, FHS deployed community health workers and established community-led health education, disease prevention, and vaccine promotion programs, such as community-based testing sites, distribution points for vaccines and direct assistance, home testing kits, and other initiatives like the FBO-led Grateful for the Shot program.
Grateful for the Shot Program	Campaign developed to ensure that vulnerable populations had access to COVID-19 vaccinations through strategic collaborations between faith-based organizations – trusted community partners – and vaccinators, with a specific target on reaching residents in communities that are disparately impacted in connection with vaccination rates. The Community

	Foundation of New Jersey received grant funds that were dispersed, with the approval of the Department of Health, to houses of worship that held vaccination events in underserved communities. These funds helped partnering faith-based organizations to defray the costs of hosting events or providing support around off-site events.
Multilingual Public Awareness Campaign	NJDOH's Office of Communications deployed ongoing statewide, multi-channel, multilingual campaigns to increase COVID-19 education awareness, increase testing, encourage vaccine adherence, promote disease mitigation strategies in high-risk settings and communities, as well as statewide, and to respond to vaccine misinformation. The campaigns provided outreach materials in NJ's top 8 to 10 spoken languages and increased NJDOH's digital presence.
COVID-19 Mitigation Call Center	Starting in mid-2021, the Call Center supported Local Health Departments (LHDs) in NJ with mitigation services for targeted high-risk and/or highly impacted populations, including homebound persons, older people living in high-rise buildings, and residents of long-term care facilities. Messaging and navigation via inbound and outbound calls and text messages to all residents registered with the New Jersey Immunization Information System (NJIIS) included the promotion of free test kits, quarantine and isolation resources, and other services.
COVID Community Corps (CCC)	The NJDOH Office of Minority and Multicultural Health (OMMH) deployed an outreach team to provide on the ground support to the public during the COVID-19 pandemic. Their outreach method of high traffic canvassing was vital to connect with the greatest number of residents in underserved populations and municipalities with the highest COVID-19 burden. CCC's strategic efforts strengthened public confidence in the vaccine efficacy by providing fact-based information and education to those who were more hesitant to consider vaccination.
Rapid Mobile Response Team (RMRT)	RMRT supported testing and education operations by working to disseminate information, facilitate trust, and combat misinformation and disinformation throughout the state's historically marginalized communities, including people experiencing homelessness, racially and ethnically diverse

	groups, and LGBTQ+ persons. RMRT also partnered with high-risk congregate settings, like corrections facilities, to address vaccine hesitancy and misinformation and disinformation with the goal of mitigating risk of mass disease outbreak.
Data Transparency	DOH implemented daily and weekly public reporting mechanisms to ensure that data on cases, deaths, testing, vaccination uptake, and other key indicators were accessible to the public. These reports were made available through various platforms, including a user-friendly dashboard and press briefings. DOH prioritized data transparency as a cornerstone of its public health response during the COVID-19 pandemic. The department systematically collected, analyzed, and published data disaggregated by race, ethnicity, geography, and other relevant demographics. This data-driven approach was essential for understanding the virus's impact across different communities and ensuring that the response was equitable and informed.

County Ambassador Program

The Ambassador Program was developed as a locally responsive program to help the state achieve equitable community protection from COVID-19. Several hard-to-reach, high-risk locations with lower vaccination rates were targeted.

County Ambassadors, deputized by the Commissioner of Health, oversaw and organized vaccination efforts in 11 counties. Ambassadors reviewed weekly data packages that detailed vaccine coverage at the zip code level, weekly vaccine administration per site in each municipality, information on any known vaccination events and their vaccination rates, and identified which community partners, such as CBOs, FBOs, employers, schools, and other partners, were interested in sponsoring events. Ambassadors used these data and insights to:

- Support vaccine stewardship and allocations for providers.
- Expand the number of vaccination access points.
- Deploy mobile vaccination clinics to support vaccine access in harder to reach and transient communities.

Further insights from the Ambassador Program informed statewide efforts to expand vaccine access, leading to:

- Increased public communications to increase vaccine confidence.
- Increased in-person support to raise public awareness, increase vaccine confidence, and schedule appointments.
- Targeted public outreach by the COVID-19 Mitigation Call Center.

Communities Experiencing Disparities

At the pandemic's outset, the New Jersey Department of Health noticed patterns in the communities that were most burdened by COVID-19 and faced considerable barriers to care and resources. New Jersey set out to develop a strategy to address the disparate toll that COVID-19 was taking on diverse communities, with an imperative to implement an equity-informed response to the pandemic. This strategy was data-driven, informed by daily reports of morbidity and mortality. In addition, the activities on the ground were informed by the national response strategy that emerged from the Centers for Disease Control and Prevention (CDC) and the White House. With this information, the State identified these groups for specific engagement in the COVID-19 response due to their elevated risk and/or risk of severe outcomes:

- Racially and ethnically diverse communities (Black, Hispanic, or Latino persons, Asian, others)
- Members of tribal nations
- Orthodox Jewish community
- Persons experiencing homelessness
- Persons experiencing domestic violence
- Individuals with substance use disorders
- Residents of psychiatric hospitals
- Residents of long-term care facilities (includes nursing homes and assisted living)
- Older adults
- Migrant workers
- Day laborers
- Individuals detained in carceral settings
- People with intellectual/developmental disabilities residing in institutions or group homes
- People residing in veterans' facilities

New Jersey Priority Counties

As the state identified communities disproportionately burdened by COVID-19, New Jersey Department of Health, in collaboration with LHDs, developed a targeted strategy to prioritize vaccination efforts in communities at highest risk for adverse outcomes based on the most significant gaps in vaccination coverage after the first six months of COVID-19 vaccine availability. The eleven highest COVID-19 burden counties were identified through NJDOH's County Ambassadors program for vaccination efforts starting in summer 2021. These counties were identified by reviewing weekly data of COVID-19 vaccination rates (by county, municipality, and zip code) and considering vaccination events sponsored by community-based and faith-based organizations. Table 3 lists New Jersey's Priority Municipalities for Vaccine Distribution, as of February 2022. Over time, as COVID-19 response shifted from mitigation to prevention, the state's geographic priorities shifted as well.

Table 3. New Jersey Priority municipalities for COVID-19 Vaccine Distribution, February 2022

County	City/Town
Atlantic	Atlantic City, Pleasantville
Bergen	Cliffside Park Borough, Elmwood Park Borough, Fairview Borough, Garfield, Hackensack, Lodi Borough, Lyndhurst Township, Mahwah Township, Wallington Borough
Burlington	Chesterfield Township, Easthampton Township, Maple Shade Township, North Hanover Township, Pemberton Township, Willingboro Township
Camden	Camden, Gloucester Township, Lindenwold Borough, Winslow Township
Cumberland	Bridgeton, Millville, Vineland
Essex	City of Orange Township, East Orange, Irvington Township, Newark
Gloucester	Woodbury
Hudson	Bayonne City, Guttenberg Town, Harrison Town, Jersey City, Kearny Town, North Bergen Township, Union City, Weehawken Township, West New York Town
Mercer	Ewing Township, Hamilton Township, Hightstown Borough, Trenton
Middlesex	Carteret Borough, New Brunswick City, Old Bridge Township, Perth Amboy City, Piscataway Township, Woodbridge Township
Monmouth	Asbury Park, Freehold Borough, Hazlet Township, Keansburg Borough, Keyport Borough, Long Branch, Middletown Township, Millstone Township, Neptune Township, Red Bank Borough, West Long Branch Borough
Morris	Dover Town
Ocean	Brick Township, Jackson Township, Lacey Township, Lakewood Township, Toms River Township
Passaic	Haledon Borough, Passaic, Paterson
Union	Elizabeth, Linden, Plainfield, Roselle Borough

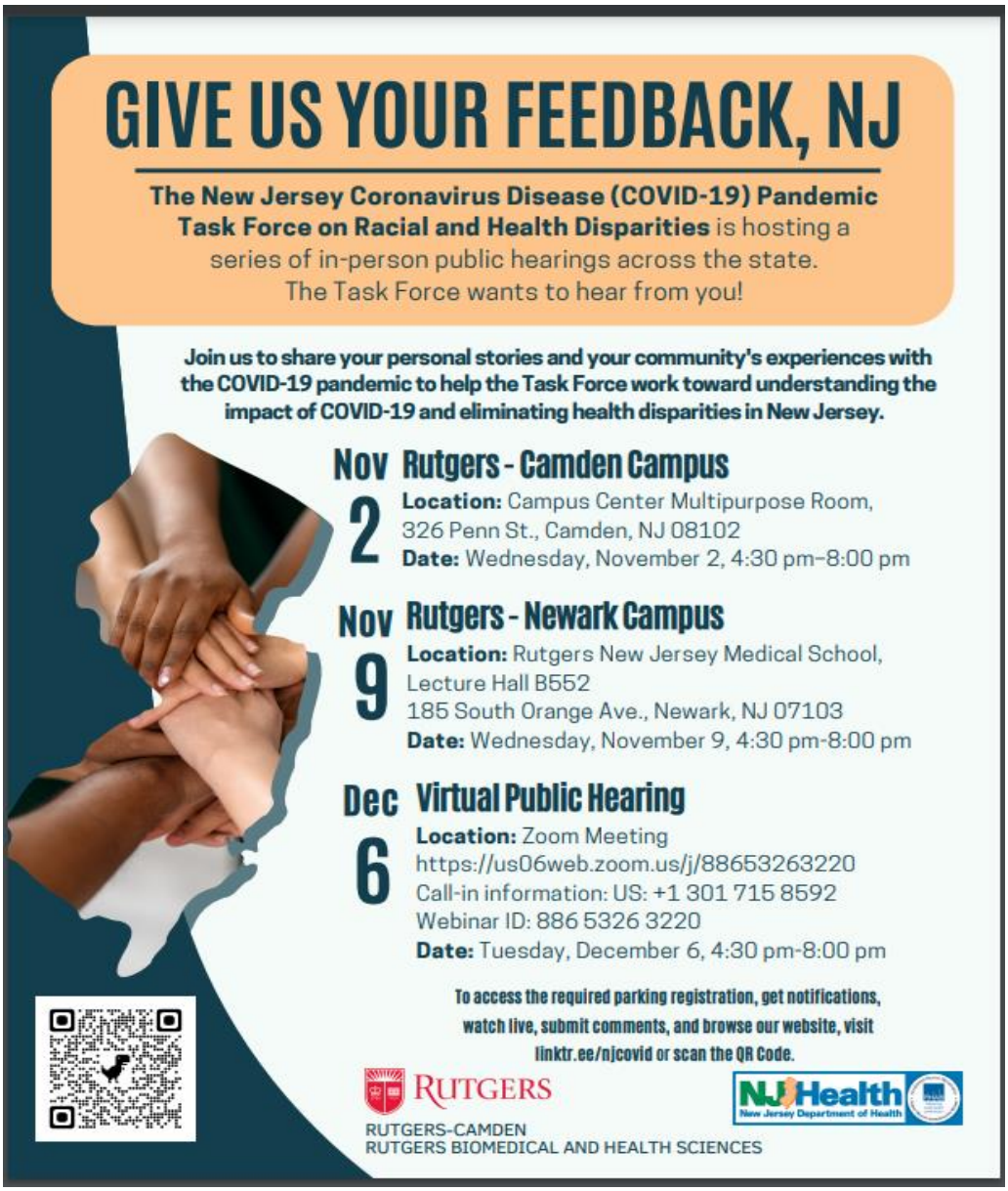
Key Stakeholder Experiences and Perspectives

To fulfill the New Jersey Task Force's mission of providing recommendations to the Governor and the Legislature to address health inequities caused or exacerbated during the pandemic, it was crucial to actively listen and gather the experiences and perspectives of key stakeholders. Therefore, the Task Force conducted public hearings with members of the community, as well as listening sessions and interviews with leaders from LHDs and NJDOH who were directly involved in the State's COVID-19 response.

Public Hearings and Testimony from Community Members

The Task Force solicited the experiences and perspectives from the public by convening a series of public hearings where Task Force members heard testimony of multiple firsthand accounts from New Jersey community members living in racially and ethnically diverse communities across the state. The public was invited to attend hearings, both in-person or virtually, and to submit written testimony. Four in-person hearings and one virtual hearing were held. The Task Force created a Task Force Public Hearings and Testimony Toolkit (See Appendix E) that provided the framework for communicating with the public about the hearings, and it offered instructions on how to solicit feedback to the Task Force. In addition, the New Jersey COVID-19 Task Force on Racial and Health Disparities created a website with information on submitting public comment. The link to the website is: NJ COVID-19 Task Force on Racial and Health Disparities (nj.gov/health/njcdtf).

Figure 5. Public Hearing Announcement



Public Hearing and Testimony from Community Members Summary

Public hearing and testimony participants provided statements on barriers and challenges they faced accessing care and resources throughout the pandemic. Barriers included:

- Difficulty accessing vaccination
- The long-lasting social and economic impacts of COVID-19 on communities
- The lack of adequate language-accessible care and services, including for people using assistive devices
- Distance to care, resources, and vaccination sites without transportation
- Challenges for people with no or limited access to technology, low digital literacy, lack of broadband access, and other issues such as limited mobile data.

Testimonies from the public hearings heavily emphasized the need for consistent and timely health information from trusted sources. Community members expressed a need for trusted messengers – local and representative voices that understand community needs, history, and concerns, and communicate in the appropriate languages. Trusted voices foster effective information and resource distribution, and address misinformation and disinformation rooted in distrust of healthcare and governmental institutions.

Community members in public hearings also spoke about the relationship between healthcare financing (e.g., Medicaid payment rates) and limited access to care in underserved racially and ethnically diverse communities. They discussed the disproportionate burden that Medicaid payment rates have on healthcare providers of color working in minority communities, and participants raised concerns over access to primary care, asserting that medical education debt is a driver of the primary care workforce shortage.

In addition, many public hearing participants offered testimony on their limited access to language accessible care. Participants also described the lack of communication that is compatible with Americans with Disabilities Act (ADA)-accessible communication devices for people with disabilities, such as screen readers for people who are blind or visually impaired.

Appendix F presents a summary of the public hearings, organized by the following themes:

- Linguistically Accessible Care and Communication Accommodations
- Trusted Messengers and Community Engagement
- Access to Technology, Broadband, and Digital Literacy
- Access to Healthcare, Resources and Supports, and other Protective Factors for Community Resilience
- Healthcare Financing Policy's Impact on Access to Care
- Long-Term Economic and Social Impact of COVID-19

State and Local Health Department Feedback Summary

The New Jersey Department of Health Office of Minority and Multicultural Health (OMMH), on behalf of the Task Force, sought input from state and local health department health officers and their staff who were involved in the COVID-19 response. Their insights and perspectives are integral to understanding the challenges experienced throughout the pandemic and provide important context for the Task Force recommendations.
The perspectives and experiences of these individuals were elicited through key informant interviews with NJDOH staff, surveys conducted among staff from other New Jersey agencies, and listening sessions involving officials from local health departments.
The information collected from these engagements was consolidated in aggregates to form the following themes:

- **Access to testing and vaccines**
- **Collaboration with local health departments**
- **COVID-19 fatigue**
- **Data-driven decision making**
- **Lack of funding and the need for sustainable funding**
- **Language access and barriers**
- **Trusted community voices**
- **Mis/disinformation**
- **Distrust in institutions**
- **Diversity in the workplace**
- **Equity at the center of public health**
- **Social determinants of health**
- **Staffing challenges**
- **Technology access and digital literacy**
- **Task Force Priority Recommendations**

These themes underscore the intricate challenges facing public health. Central to these considerations is equity, extending beyond individual actions to become a comprehensive commitment by leadership and through all aspects of public health work. They also emphasize the urgent need for a community-centered and culturally competent approach to public health that considers not only immediate medical need but also the broader social determinants influencing health outcomes.

A detailed description of each theme is provided in Appendices G and H.

Recommendations

Drawing on legislative objectives and the feedback and collective expertise of key stakeholders, the Task Force deliberated to formulate short-term and long-term recommendations listed below. The Task Force emphasizes the need for the implementation of these recommendations and actions to effectively mitigate the inequalities caused or exacerbated by the COVID-19 pandemic, addressing the needs faced by racially and ethnically diverse groups, now and during future public health emergencies. While recognizing the importance of all the recommendations, the Task Force underscores the strategic prioritization of some points that have been highlighted within the full list of recommendations. Recommendations have been organized by themes (i.e., Data Systems, Health Communications, Historical and Systemic Inequities/Social Determinants of Health, Healthcare Disparities, Mental Health) and into short-term (next two years) and long-term (beyond two years) strategies.

Full List of Task Force Recommendations by Theme

Historical and Systemic Inequities/ Social Determinants of Health

Structural and systemic racism played a significant role in exacerbating COVID-19 disparities by contributing to pre-existing social and economic inequalities. Communities of color often face barriers such as limited access to quality healthcare, crowded living conditions, and employment in essential but high-risk sectors. These systemic issues, rooted in historical inequities, left marginalized populations more vulnerable to the virus's impact. Moreover, biases in healthcare delivery and information dissemination further widened the gap, hindering timely and appropriate responses. Discrimination could be observed in the unequal distribution of resources, testing, and vaccination efforts, amplifying the health disparities experienced by marginalized groups during the pandemic. Addressing structural racism is crucial for creating a more resilient and equitable public health system.

By declaring racism, a public health crisis and establishing a Council on New Jersey Racial Health Disparities, the State can systematically tackle the root causes of health inequities, focusing on systemic and structural issues rather than individual blame. These recommendations emphasize proactive measures, from mandatory implicit bias training for healthcare providers to creating channels for filing discrimination complaints, promoting transparency, and holding institutions accountable. Additionally, supporting small businesses, addressing economic and racial inequalities, and endorsing reparations initiatives that contribute to a comprehensive and holistic approach, which not only mitigates the immediate impacts of pandemics but also fosters a more resilient and equitable public health system for the long term and future pandemics.

"...Was there racism? Absolutely. And I think it was really seen in institutional racism with respects to COVID-19, right? Not recognizing, especially with our lower and moderate-income families, who generally are our Black and Brown communities, immigrant communities. Not having these resources and only being able to get appointments through these [technological] resources is indicative of not recognizing or representing the needs of the people that's needed."

- Central NJ Community Member

(Bolded recommendations are the priority recommendations of the Task Force.)

Short-term

1. **Formally recognize racism as a public health crisis in New Jersey. By doing so, the aim is to shift the focus towards systemic and structural issues, moving away from attributing inequalities as the fault of individuals. This acknowledgement is crucial in understanding the negative impacts of historical racist policies on health disparities and life expectancy in the U.S.**
2. **Create a Council on New Jersey Racial Health Disparities to prevent and address issues that consistently arise due to racial health disparities overall and especially pertaining to pandemics.**
    a. **This group should publicly and periodically report their progress to the community via town halls and public report documents.**
    b. **This group shall consist of representatives from State agencies including but not limited to the Department of Education (scholarships and educational opportunities); Division of Consumer Affairs (licensing and enforcement); Department of Health (preventive measures and healthcare access); Department of Children and Families; Division on Civil Rights; and the Economic Development Authority, etc.; representatives from the New Jersey Maternal and Infant Health Innovation Authority; mayors (or their designees, such as a municipal health officer, director of health, or economic development director) from the 15 most diverse and distressed municipalities in the state according to the 2023 Municipal Revitalization Index data; a representative from the NJ Academy of Family Physicians; NJ Medical Society (sub-specialty doctors); Advanced Practice Nurses of New Jersey; deans from the four NJ medical schools; chancellor from Rutgers Biomedical and Health Sciences; Rutgers School of Public Health (re: mental health studies); and other entities or institutions as the council sees fit.**
    c. **The Council must integrate community voices in the planning processes of addressing healthcare disparities by identifying community leaders, particularly those leaders that have the "ear" of the people in the community. Establishing a formal way of recruiting and keeping a relationship with such leaders and organizations will ensure consistent communication that will support dissemination of culturally and linguistically competent information into their area of influence. This would be another way that is culturally appropriate and responsive to update information to these vulnerable populations. This needs to be an ongoing process to make sure that these populations can remain connected, particularly during longer states of emergency.**
3. **Recommend legislation that would require the presence of health equity officers (HEOs) at major hospitals who provide monitoring and remedying of bias and discrimination. HEOs would oversee, implement, and maintain health equity plans, policies, and procedures. This position will monitor quality assurance requirements for professional health equity standards and submit annual reports to a standing group focused on identifying and addressing disparities (such as the council recommended in #2).**
4. **Recommend policy change, legislation or other action that would allow community-based organizations (CBOs) who perform essential services, such as translation services or social services assistance, to be designated as essential for the purposes of emergency management to ensure: (a) such organizations are able to operate during states of emergency to assist clients, and (b) allow for such organizations to receive state and federal**

funding that is available to qualified entities to continue to provide services during similar pandemics or health emergencies.

5. Public awareness campaign about essential workers, their roles, and their rights.
6. Work directly with CBOs to register community members for vaccinations. Many populations need access to the technology required to obtain relevant information, registration, and navigation for vaccinations; CBOs can effectively provide these services.
7. Expand and ensure the sustainability of funding for public health initiatives. Funding public health initiatives can be complicated due to the responsibilities across all state agencies, which occasionally overlap and are occasionally siloed. The Governor's Office could be well-positioned to examine this dynamic and explore solutions such as:
    a. More stable and reliable funding made available to CBOs to support public health programming in a way that leaves room for ad hoc initiatives and flexibility to respond to communities' unique challenges.
    b. Expansion of funding for programs like Housing First and other evidence-based models.
    c. Continued use of entities such as regional health hubs, maternal-child health consortia, etc., as community-based vehicles for funding mechanisms to small CBOs (those that can reach the individuals who are not easy to find/engage) and to support the public health response.
    d. Small, underfunded organizations do best with multi-year funding streams that allow them to plan, launch, scale, and sustain. Funding amounts can start small to fund planning and start-up costs and increase over time as the number of individuals served increases. It is important to ensure that reporting requirements and deliverables are not so burdensome that the organizations don't have the capacity to do the actual work well.
8. Leverage the COVID-19 public health infrastructure, including investments in Community Health Workers and pop-up clinics, to address other health priorities that may have lagged during the public health emergency. Ensure continued funding for communities, allowing them to shift focus toward other critical public health needs.
9. Engage with re-entry service providers, social service organizations, and state agencies (i.e. Department of Human Services, Department of Children and Families, Department of Corrections, local jails, New Jersey State Parole Board, Office of Transitional Services, and CBOs) who provide services for women and children and those not within the parole system to ensure they have healthcare and insurance access.
10. Require the Divisions on Civil Rights and Consumer Affairs (DCR and DCA) to establish a comprehensive directory for individuals to file complaints against providers. The information in these complaints should remain confidential and only be released to government agencies to facilitate the appropriate discharge. Additionally, share healthcare bias and discrimination complaints among the agencies when filed by members of the Black, indigenous, people of color (BIPOC) communities, people with disabilities, and other marginalized populations. Finally, ensure the outcome of these complaints is shared with the licensing board.
11. Implement and sustain a mandatory, evidence-based training program on explicit and implicit bias for all healthcare providers. Expand on P.L. 2021, c. 79
12. All healthcare agencies and entities shall actively ensure they are in compliance with the NJ LAD and NJFLA N.J.A.C. 13:8-1.2, 1.3, 1.4, 1.5 and 2.2-, requiring all entities to display anti-discrimination posters in their facilities. All state, local, and municipal agencies should also regularly distribute these posters in compliance with the law, to ensure anti-discrimination is a bedrock of our state.
13. Continue work with the DCR under the Office of the Attorney General to ensure NJ-based medical and pharmaceutical companies are complying with the state's anti-discrimination laws.

14. Continue strengthening vaccination efforts by targeting vaccination drives at lower-income communities where having private health insurance is less common.
15. Provide support for small businesses, especially minority, BIPOC, "mom-and-pop shops," and woman-owned businesses, that were hard-hit due to the COVID-19 pandemic through grant funding and capacity-building to provide service that minimizes the possibility of spreading COVID-19.
16. Develop and strengthen strategies that promote and sustain food and financial security for high-risk households and encourage living wage employment. This can include utility, rental assistance, and workforce development programs. This may hold some promise in reducing mental health and COVID-19 disparities among Hispanic or Latino, Black, and Asian adults relative to White adults.
17. Support similar legislation to bill S322 introduced in 2020 that proposes the establishment of a New Jersey Reparations Task Force. The task force "will research, write and publish a report that will make the case for state-based reparations in New Jersey and outline policy recommendations that seek to repair the harm" that has stemmed from slavery. If passed, these legislative efforts will aid the state in beginning the process of adequately compensating African Americans for centuries of disenfranchisement, mistreatment – including medical mistreatment – and help to close the wealth gap that exists due to being disenfranchised historically and presently.
18. Promote the law: P.L. 2017, c. 294, the Single License Law, which promotes the integration of primary and behavioral healthcare by simplifying the licensing process and removing the need to secure a primary care license from the New Jersey Department of Health and a behavioral health license from the Department of Human Services.
19. Proactively address and prevent domestic violence during future pandemics using a multifaceted approach to tackle root causes by acting to:
    a. Allocate financial resources to address the long-term affordable housing needs of domestic violence survivors.
    b. Provide financial support to maximize access for survivors and their children to mental health treatment, including services which meet their linguistically and culturally diverse needs.
    c. Increase transparency in reporting of domestic violence related data and examining data collection practices to ensure that timely review of comprehensive data will inform best practices and policy choices.
    d. Pursue policies designed to address structural economic and racial inequalities which contribute substantially to the problem of domestic violence.[19]

[19] National Network to End Domestic Violence, "The Impact of COVID-19 on Domestic Violence," December 2020. [Online]. Available: https://nnedv.org/wp-content/uploads/2021/01/Partners-CSJ-The-Impact-of-COVID-19-on-Domestic-Violence-December-2020.pdf

Data Systems

The COVID-19 pandemic highlighted the necessity of a robust public health data collection system, as it is critical to understand and address disparities, especially among vulnerable populations. The following recommendations establish a resilient foundation for data management and utilization. They also aim to enhance the efficiency, legality, and ethics of data sharing and alignment across state agencies and state-designated agencies. In addition, they set a foundation for a comprehensive approach to leverage data as a strategic tool to address and mitigate COVID-19 disparities.

"[Robert Wood Johnson] dealt with looking at how marginalized communities are often not counted in our health system. And we saw that definitely during the COVID-19 pandemic, where people were not keeping track of, not just individuals' races, but where they came from; but in particular, disabilities. So, we don't really have, in the state of New Jersey, any way, at this point, to track how many people with disabilities actually died during the COVID-19 pandemic because that information was not collected, if someone showed up to an emergency room or any other facility. So, obviously that's problematic because we don't know information that could be helpful for the future..." - Central NJ Community Member

(Bolded recommendations are the priority recommendations of the Task Force.)

Short-term

1. **State-designated entities should be empowered and funded to analyze state data sets (e.g.: New Jersey Immunization and Information System and others) activating more local and community-based engagement strategies that improve NJ's public health data. These strategies should define success, provide benchmarks for growth, and incorporate an ongoing equity review process focused on communities most impacted by disparities.**
2. **Allocate funding and provide guidance to healthcare providers and other healthcare agencies to improve data collection practices in accordance with uniform standards: implement reporting quality improvement/assurance strategies to analyze any data gaps; integrate best practices for measurement and tools for collection/reporting; and track impact of quality improvement strategies (e.g., reliability completeness, frequency).**
3. Integrate immunization information systems with state-designated entities. With other states' best practices, the removal of any statute that prevents vaccine data in NJIS (and other state data sets) from being shared at an identified, population level. The accessibility of the data can become accessible not just at the point of care but to amplify population-level outreach and healthcare workflows.
4. Leverage the strong technological foundation to support communication between the regional health information exchanges (HIE) and the health information network (HIN). Since the HIEs predate the NJHIN and have established connections with many of the hospitals in NJ's most

vulnerable communities, the HIEs may have access to the same data sets that the NJHIN does (e.g., EMS data, etc.).

5. Build a master list of programmatic eligibility criteria into the NJ 211 (or other state centralized repository). This will allow New Jersey residents and visitors to easily search and access all state, county, and municipal-level programs through the state. Ensure that this master list is interoperable with any social service referral platform or other relevant platforms, providing a seamless and comprehensive resource for individuals seeking assistance or information on available programs.
6. Collaborate with State-designated entities, such as regional health hubs and maternal child health consortia, and other community-based hubs as pilot sites for new data infrastructure projects that can be approached in partnership with hospitals.
7. Allocate funding for healthcare entities on data improvement projects, such as updating race/ethnicity fields, as this can add burden to hospitals and providers who are already stretched. Support smaller organizations with funding opportunities to upgrade their data infrastructure and build higher demographic data collection and reporting standards. This is an opportunity to update race/ethnicity, Sexual Orientation and Gender Identity (SOGI) and other equity-focused data collection standards.
8. Develop detailed and effective data improvement plan to ensure patient-level data is collected accurately in a culturally competent and sensitive manner.
9. Engage diverse community-based organizations and community members in the discovery and design process of state-level data improvements. Specific communities, such as jails, schools, shelters, long-term care residents, tribal communities, are essential in providing guidance and importance of demographic and program data to reduce health disparities.
10. Mandate provider and staff trainings on cultural sensitivity, appropriateness, and humility when approaching patient for their information.

Long-term

11. **Develop, fund, and implement a multi-year interoperability plan that enables the state to move toward systems that link to each other and are supported by the appropriate data sharing agreements and policies.**
12. **Develop an efficient technical, legal, and ethical mechanism for data sharing and alignment between state agencies and state-designated entities, especially the regional health hubs and their HIEs, that facilitates effective public health programming to reach communities most impacted by disparities**.
13. Enhance the transparency, access, and utilization of data. State data should be readily available for program and policy planning. Prior to release of data, the datasets should also have a health literacy scan to provide clear and simple descriptions for every variable and category.
14. Ensure providers and other local entities are correctly collecting and reporting demographic data. Work closely with providers and other state entities to ensure that sufficient and standardized demographic and disease state data variables are requested and collected from each patient in a culturally sensitive and appropriate manner.
15. Develop clear legal and ethical policies that allows state and other local-level entities to share patient-level and municipality-level data for smaller organizations to prepare and distribute resources wisely, to prepare for public health crises.
16. Develop policies that ensure data collection, reporting and management is instilled in various levels of state and local providers. Without policies, this equity strategy will not be taken seriously.

Health Communications

During the COVID-19 pandemic, communication strategies presented challenges in effectiveness, characterized by limited availability of materials in multiple languages and formats. This created difficulties in accessibility exacerbating disparities, especially among vulnerable populations. The following recommendations emphasize the critical need for strategic, inclusive, and culturally sensitive communication measures. Each recommendation addresses a specific facet of the complex communication landscape during public health crises. By prioritizing trusted voices, diversifying communication channels, and establishing inclusive frameworks, the recommendations collectively form a comprehensive blueprint for strengthening New Jersey's resilience and responsiveness in the face of ongoing and future public health challenges.

"Our patients presented with, I'll say, the Tuskegee Experiment mentality. The was fear, lack of education. There was a lot of miscommunication from a lot of the pharmaceutical companies. Social media played a huge part in negative influences. Our own personal opinions and our faith-based opinions had a lot of impact on our population being vaccinated. Latinos and African Americans are a huge part of our community and population and there was a lot of resistance there, a lot of questions. At the very beginning, no one - even the highest of the educated - had answers. And unfortunately due to that, I believe a lot of distrust hit the communities as well. So it was almost like we had to persuade and try to come up with the best information that we possibly could."
-South NJ Community Member

(Bolded recommendations are the priority recommendations of the Task Force.)

Short-term

1. **Ensure that all NJ residents would have access to the same information real time. At the height of the first wave of the pandemic, limited materials were available in multiple languages and formats. Ensure that all departments share the same health communications practice.**
2. **Create a playbook for municipalities that include local government and the State guidance on opening and closing of facilities, with actionable steps on how communication will take place, ensuring that it is always inclusive and set by the Governor's Office.**
3. **Develop policies around communication to all residents in a manner that is understandable, accessible, culturally appropriate, and specific to all.**
4. **Ensure that information reaches all communities within the State, including accessibility of local and state websites for all our residents regardless of language, literacy level, visible and nonvisible disabilities, or any other challenges.**
5. Take the digital divide into consideration. Dissemination of information for access to care. There must be a better approach to assist with registration for testing and vaccinations. Many have Wi-Fi limitations, and not everyone can use their electronic equipment. In addition, there were glitches in

the system announcements on where to go for testing and vaccines, therefore all systems need to be Beta tested before release, with all segments of the population. Use emergency and non-emergency health awareness messages to test the systems throughout the year.

6. Use of trusted voices and entities. This includes places of worship, school nurses, community centers, Federally Qualified Health Centers, family planning clinics, senior centers/buildings and other community-based organizations, consulates, cultural clubs, community health workers, local/community newspapers or online news sources, English as Second Language centers, local radio stations, barber shops, beauty salons, bodegas, libraries, after-school programs, childcare centers, rotary clubs, utilizing affinity organizations, neighborhood supermarkets, etc. Utilize the resources of the State Division of Consumer Affairs (DCA) to communicate to licensed healthcare workers, offering guidance on persuading patients to seek medical care in their local communities. Provide comprehensive training as well as evaluation for trusted voices/entities. Create linkages to existing Department of Community Affairs grantees as many do fall into these categories.
7. A social media scan of other countries or states that had successful social media campaigns and what is defined as successful. Utilize campaigns that incorporate the participation of youth which may evolve to be more intergenerational. Use of evidence-based communication strategies such as mass texts, radio, and social media as well as any other platform that will reach a wide audience. At the beginning of the pandemic, there were confusing messages which increased the distrust in vaccines/testing. Recognizing the historical mistrust by communities regarding entering the healthcare system and listening to messages by government or healthcare systems.
8. Ensure that all sub-groups of NJ (i.e., cultural, linguistic, visible, and nonvisible disabilities, gender, age, race, sexual orientation, gender identity, urban/rural, etc.) have messages tailored for these diverse populations to ensure the right message and vehicles are considered when developing a communication strategy.
9. Utilize existing systems that are a non-Internet-based method to help get the word out to individuals. Local papers, grassroots organizations, Governor's addresses, local health departments, schools, and robocalls.
10. Set access parameters to serve all New Jersey community members when utilizing private business, by following the State's policies and guidance, such as Culturally and Linguistically Appropriate Services (CLAS) on access and communication which FQHCs and local health departments already follow. This will ensure that they are not turning people away because of language barriers or because people did not have access or the ability to pre-register for the test or vaccine. When this discriminatory act occurs, people should be educated on their rights and receive the proper communication and information on how to report.
11. Figure out creative ways to fund non-traditional avenues or community advocates. They are most effective in getting the word out and communicating with our most high-risk, historically marginalized populations but need to be funded without a heavy administrative burden. Easing the burden on administration requirements should also apply to any sort of reporting requirements.
12. Establish an after-action report for any event of this scale to assess timely communication, information dissemination and lessons learned immediately after a pandemic or other public health crises.

Healthcare Disparities

The emergence of the COVID-19 pandemic highlighted a pressing need for a healthcare system that is not only robust and adaptable but fundamentally equitable. Importantly, the pandemic served as a magnifying glass on existing health disparities, disproportionately affecting marginalized populations. To advance health equity, the following recommendations emphasize measures essential for building a healthcare system that not only responds effectively to crises but also actively works towards inclusivity, and equitable access to quality care for all.

"Undocumented people, since they don't have health insurance for the most part... they would have to pay $100. They would have to pay $75, $125 for these tests, and we were running into an issue where these families who have multiple members in their household, if someone is symptomatic, we can assume or it has been assumed that everyone in the household who has shared bathrooms, who has shared food, are all sick, so that would mean one person would have to pay $100 for their test, and someone else would have to pay $100 for their test, and it's just harder when... it's a single mother and she has four kids, or it's a family of 8 who are newly arrived in the United States and don't have that financial stability to be able to pay for these tests." *- North NJ Community Member*

(Bolded Recommendations are the priority recommendations of the Task Force.)

Short-term

1. **Create a high-profile task force or committee to thoroughly examine the impact of current policies including:**
    a. **Medicaid and private insurance coverage for individuals, including behavioral healthcare.**
    b. **Healthcare access for undocumented individuals, including behavioral healthcare.**
    c. **Medicaid reimbursement rates for physical and mental health providers (creating more parity between physical and mental health reimbursement rates; examining other states' reimbursement rates and how they have implemented the Mental Health Parity and Addiction Equity Act (MHPAEA)).**
    d. **Holding Medicaid managed care organizations accountable for the barriers to care that they create by establishing periodic "equity and access reviews" of the State Medicaid MCO contracts and an exploration of changes to those contracts when they are up for renewal.**
    e. **Expansion of how Medicaid dollars can fund social determinants of health (Refer to and provide recommendations to medical directors to act on the federal government's January 2021 letter that gives state Medicaid directors more flexibility to pay for social determinants of health).**
    f. **To expand access to mental health services, ensure licensed behavioral health professionals (e.g., Licensed Professional Counselor, Licensed Clinical Social Worker, and Licensed Marriage and Family Therapist) are able to be reimbursed by Medicaid.**

2. Invest in the state's physical and mental health workforce to facilitate inclusion of BIPOC workers in all healthcare settings by considering continuation of initiatives that were in place during the pandemic (that will otherwise expire at the end of the State of Emergency), such as expediting licensure, relaxing telemedicine requirements, and providing continuing education credit to mental health professionals providing volunteer services to low-income clients. Additionally, NJ should explore solutions such as:
    a. Funding to expand the community health worker and peer support workforce and invest in the programs that will create viable career paths for these individuals to move up within organizations. Invest in trauma-informed workplaces to be more inclusive of workers with trauma, mental health, and substance use disorder (SUD) histories.
    b. More programming to cultivate a pipeline of healthcare providers across the professional continuum that reflect traditionally underrepresented communities (e.g.: funding incentive programs to recruit BIPOC individuals to study, train, and practice in NJ).
3. Increase funding for the mental health workforce in schools.
4. Design and rapidly implement incentive, scholarship, and funding programs to replenish and build a pipeline of frontline healthcare providers, workers, and staff, including actively recruiting unemployed individuals into healthcare roles, and expanding job portal reach/functionality.
5. Ensure that policymakers are considering the impacts of Long COVID and how to support individuals who have experienced it by working to:
    a. Ensure that Medicare/Medicaid and private payers, as well as health systems and providers, think through how they will provide services and care associated with Long COVID.
    b. Secure and enforce employment protections, paid leave, paid sick time, intermittent leave, etc.
    c. Continue to invest in and stay abreast of the research on Long COVID.
6. Incentivize healthcare facilities in underserved communities to improve access to and the quality of healthcare in these communities where many households are financially challenged and without private insurance, which may be effective in reducing the sizable Black/White disparity in severe COVID-19 cases.
7. Pay for medical school full tuition for qualified students from marginalized communities committed to serving professionally in underserved communities in NJ consistent with the geographic areas designated health enterprise zones. The evidence supports that BIPOC have greater health outcomes when treated by someone of their own race/ethnicity.
8. Direct medical schools to produce more students entering primary care specialties or lose Graduate Medical Education and other funding source.
9. Provide mentorships/support/resources to students early in academic careers, to expose them to opportunities in the health profession. Opportunities at an earlier age (elementary schools and middle schools) to inform their choices as they continue to rise within the school system. Work with the New Jersey Department of Education to set benchmarks for guidance counselors at those schools to ensure students are receiving information and resources. The Office of the Secretary of Higher Education's NJ Pathways programs have been leading similar efforts for high school and community college students. Begin early recruitment of minority students for healthcare professions with a mentorship program in every high school.
10. Develop processes to address/eradicate the adverse impacts to Black communities and other POC of some medical practices (including risk assessments for health), tools, and equipment.
11. Develop a race equity checklist for vendors who provide healthcare services.

12. Draft regulations prohibiting healthcare practices and policies that disparately impact BIPOC, vulnerable and people with disabilities communities, such as medical assessment tools that are not calibrated to address the communities' health.
13. Improve outreach to BIPOC, vulnerable populations and people with disabilities to engage communities in preventative and necessary healthcare measures such as diabetes, and other pre-existing diseases and illnesses that plague these communities prevalently and which exacerbate COVID-19 symptoms. Some methods healthcare/major hospitals could use to engage include advertising, publishable pamphlets, and information, outreach, online campaign ad. Methods to engage with communities must be done in a culturally and linguistically appropriate way. There should be an evaluation component to ensure that outreach efforts are effective.
14. Strengthen outreach efforts in healthcare education and development of systems to eliminate and minimize healthcare disparities by including trusted voices from the community such as (A) diverse community partners and experts in healthcare disparities; (B) health equity officers; and (C) community organizations.
15. Implement audits on healthcare providers, including pharmacists, to ensure the accommodation of non-English speaking communities with language and cultural interpretation for services.
16. Strengthen efforts to ensure health information and messaging is available in multiple languages to address language barriers.
17. Develop a database of BIPOC doctors so that BIPOC have a resource for connecting with medical providers in their communities who have identified as BIPOC.
18. Improve and increase education bias and cultural competency training for all medical professions as a requirement for license and made available for healthcare workers outside of the medical field. Biannual mandatory training for everyone in a health profession.
19. Continue efforts for healthcare professional boards (those overseen by the Division of Consumer Affairs) to require implicit bias training or cultural competency training, including through the Office of the Attorney General's Racial Justice Initiative under Combatting Bias, Discrimination and Hate that has been rolled out by the Division of Consumer Affairs.

Long-term

20. **Declare healthcare a human right in NJ, and NJ should consider following the example of states such as California and Massachusetts where healthcare is more universally accessible, even to undocumented individuals. Without such steps, health inequity will persist. To actualize this recommendation, a Cabinet position or high-level Governor's office function should work closely with the NJ Legislature.**
21. **Provide universal health insurance coverage to provide all New Jerseyans with health equity access to quality care especially for all current uninsured and underinsured racially and ethnically diverse groups in NJ, given that Blacks and Latinos are more likely to not have health insurance coverage compared to their White counterparts. This can be achieved by providing open access to NJ Medicaid/Family Care programs via a public health option into which all individuals can enroll to receive full benefits to access primary and specialty care, emergency care and hospitalization, subacute care and an open formulary of medications.**
22. Improve access to primary care by providing more primary care physicians in the state – especially those from diverse backgrounds who are culturally and linguistically competent and would be willing to work in underserved communities. This is necessary to change the fact that New Jersey has been declared a primary care desert for the past 20 years. Areas of need should be identified through methods such as mapping or neighborhood analysis of primary care providers.

23. Develop strategies to make healthcare accessible and located in community hubs, such as one-stop access points where the public can obtain information, get tested, and get registered.
24. Expand on student loan forgiveness, such as the Primary Care Practitioner Loan Redemption Program, as well as health enterprise zones to promote and provide enhanced scholarships and incentives to NJ medical schools and students from diverse backgrounds to become primary care physicians who stay to practice in NJ. Provide a rich loan redemption program aimed at recruiting quality minority students committed to serving professionally in underserved communities in NJ, consistent with the geographic areas designated as health enterprise zones.
25. Improve investments in solutions that make it easier for current and prospective staff entering the workforce through better funding and expanded eligibility for loan redemption /forgiveness programs that focus on primary care, behavioral health, and nursing; updating the process of licensing applications; easing the process of out-of-state practitioners coming to practice in NJ.
26. Improve healthcare pay rates and improve Medicaid pay rates to permanent parity with Medicare rates, so that NJ practitioners can sustain value-based primary care practice in the state. Too many physicians are not accepting Medicaid because of the hassle of the administrative steps it takes to receive payment.

Mental Health

Marginalized communities faced substantial disparities in accessing mental healthcare due to barriers exacerbated by the COVID-19 pandemic. Existing mental health issues have heightened, and new challenges have emerged, emphasizing the immediate need to address unequal access to mental health resources. These recommendations provide targeted strategies and interventions to ensure equitable access, bridging the access gap, and promoting mental health equity.

"I wanted to bring that to the table, especially centered around this COVID-19 pandemic. A lot of mental health issues did arise... Everyone has to address their mental health. Everyone. It's not an issue of this person, that person, this community, that community. If you're a human being, you want a good mental health and a good state of mind. So how do we address that, especially coming off of this pandemic? We believe in preventive measures."
-South NJ Community Member

(Bolded Recommendations are the priority recommendations of the Task Force.)

Short-term

1. **Recognize and address the disparity of mental health and other silent killers among BIPOC with a goal of taking preventative measures to decrease the conditions in these communities. Medical providers should make an action statement, that they are aware of these issues, so that their patients understand mental health is a priority.**
2. Provide mental health and substance abuse pop-up clinics that are fashioned after pop-up vaccine clinics.
3. Continue NJ's investment in pediatric and adolescent mental health.
4. Remove barriers for licensed and masters-level social workers to bill Medicaid.
5. Better promotion of and access to mental health services for healthcare workers (of all levels and in all settings) in acknowledgement of the transferred trauma that these workers experience through their roles.

Long-Term

6. Remove barriers for youth seeking mental health services such as requiring consent from a parent/guardian.
7. Invest in programs and policies that will expand access to mental health, such as:
    a. Maintain flexibility afforded by the public health emergency so that health systems, smaller practices, and community-based providers can continue to offer robust telehealth services.
    b. Additional funding for settings like jails, shelters, domestic violence organizations, etc. to co-locate health and mental health services.
8. Increase funding for the mental health workforce in schools.
9. Explore the investments made in testing/vaccination and how they could support future programming around mental health access (e.g.: pop-up mental health events; community health workers (CHWs) trained in mental health first aid; etc.).

10. Integrate mental healthcare into the medical model – make mental healthcare checks as normal as physical health checks to determine mental health status as early and as often as possible.
11. Create a culturally competent mental health program that provides counseling and specialized care, especially to front-line healthcare workers.

Conclusions and Next Steps

After several meetings, public hearings, listening sessions, and interviews with the community, state employees, and public health experts, the Task Force developed a comprehensive list of recommendations aimed to tackle the racial and ethnic health disparities exacerbated by the COVID-19 pandemic in New Jersey. These recommendations serve as the foundation of an action plan that lawmakers, State departments with rulemaking authority, advocates, and other policy-makers should use to continue to address issues related to racial and minority health inequities.

The recommendations outlined in this report address multiple areas of healthcare, emphasizing linguistically accessible care, data-driven evaluation, trusted messenger and community engagement, healthcare access, impact of financing policies, and importance of sustainable change. In addition, these recommendations address social determinants of health—factors like housing, transportation, employment, education, and food security— that affect individuals' lives and health outcomes that are significantly impacted by racial and minority health inequities.

While information and data about Long COVID-19 and post-COVID-19 are currently limited, it is essential to acknowledge that the recommendations outlined in this report can effectively address the needs of individuals facing these issues. Despite the challenges posed by the scarcity of information on long-term COVID-19 effects, the proactive measures suggested by the Task Force are designed to provide support and assistance to those dealing with such health concerns.

Overall, and crucially, these recommendations amplify the voices of those more affected by the pandemic and the prevailing health disparities present in New Jersey. Therefore, together, these recommendations outline a holistic and proactive pathway to build a more equitable and resilient healthcare system in New Jersey.

Appendix

Appendix A: Task Force Work Group Objectives

Within the remit set forth in the statute, each Task Force work group was given objectives to guide their efforts to address the racial and health disparities during the COVID-19 pandemic.

Historical and Systemic Inequities/Social Determinants of Health Work Group Objectives:

- To conduct a thorough and comprehensive study on the ways in which, and the reasons why, the COVID-19 pandemic has disproportionately affected the State's minority and vulnerable communities, and the short-term and long-term consequences of the pandemic on these communities.
- To develop effective strategies to address the racial, ethnic, and health disparities, and historical and systematic inequalities pertaining to race and ethnicity that have amplified the death rate in the state's minority and vulnerable communities during the COVID-19 pandemic.
- To evaluate impediments that may interfere with an individual's ability to quarantine or isolate during the COVID-19 pandemic.
- To analyze the distribution of resources, including personal protective equipment and food, in the state's minority and vulnerable communities.
- To examine the impact of the COVID-19 pandemic on access to childcare services in the state's minority and vulnerable communities.
- To investigate the prevalence of intimate partner violence in the state's minority and vulnerable communities during the COVID-19 pandemic.

Health Communications Work Group Objectives:

- To evaluate the communication, messaging, and dissemination of information regarding testing, contact tracing, and other related public health approaches necessary to achieve health care equity and cultural competence in the provision of physical and mental health treatment and services to the state's minority and vulnerable communities during the COVID-19 pandemic.
- To identify best practices, opportunities for shared services, or potential partnerships that would increase the communication of health care information and materials in multiple languages for members of the state's minority and vulnerable communities, including persons with developmental disabilities and senior citizens.

Data Systems Work Group Objectives:

- To study and make recommendations to improve existing data systems to ensure that the health information that is collected relating to COVID-19 infections and deaths includes specific race, ethnicity, and demographic identifiers to develop a better statistical understanding of how the COVID-19 pandemic has affected the State's minority and vulnerable communities.

Physical and Mental Health Work Group Objectives:

- To evaluate the issues relating to the quality of, and access to, physical and mental health treatment and services provided to various racially and ethnically diverse populations in the state during the COVID-19 pandemic.
- To examine the impact of the COVID-19 pandemic on the physical and mental health of essential employees from the state's minority and vulnerable communities.
- To develop effective strategies to reduce and eliminate disparities among the various racially and ethnically diverse populations within the state's minority and vulnerable communities with respect to health status, access to high-quality health care, and utilization of health care services.

Appendix B: Task Force Legislation

CHAPTER 106

AN ACT establishing the Coronavirus Disease 2019 (COVID-19) Pandemic Task Force on Racial and Health Disparities.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. There is established the Coronavirus Disease 2019 (COVID-19) Pandemic Task Force on Racial and Health Disparities in the Department of Health.

a. The task force shall consist of 23 members as follows:

(1) the Chief Diversity Officer; a representative of the Department of Health whose duties or expertise includes expanding access by minority populations to clinically appropriate healthcare services or eliminating discrimination in the implementation of healthcare programs, policies, or initiatives; a representative of the Department of Community Affairs; a representative of the Department of Human Services; a representative of the Department of Children and Families; a representative of the Housing and Mortgage Financing Agency; a representative of the Division of Consumer Affairs in the Department of Law and Public Safety; a representative of the Division on Civil Rights in the Department of Law and Public Safety; and a representative of the Office of Emergency Management;

(2) two public members appointed by the Governor, upon recommendation by the Senate President, one of whom shall be recommended based on the recommendation of the New Jersey Black Legislative Caucus, and one of whom shall be recommended based on the recommendation of the New Jersey Latino Caucus;

(3) two public members appointed by the Governor, upon recommendation by the Speaker of the General Assembly, one of whom shall be recommended based on the recommendation of the New Jersey Black Legislative Caucus, and one whom shall be recommended based on the recommendation of the New Jersey Latino Caucus; and

(4) ten public members appointed by the Governor, who shall include: a representative of the New Jersey Institute for Social Justice; a representative of a federally qualified health center; a physician licensed to practice in this State who specializes in providing care to patients in the State's minority and vulnerable communities; a nurse licensed to practice in this State who specializes in providing care to patients in the State's minority and vulnerable communities who may be a school nurse; a representative of a general hospital located in the State's minority and vulnerable communities with direct experience working with minority and vulnerable communities; a representative of the Maternal and Child Health Consortia; a representative of the New Jersey Urban Mayor's Association; and three representatives of three different non-profit organizations that conduct research, education, and training on, and develop policy initiatives to address, health equity in this State.

b. Vacancies in the membership of the task force shall be filled in the same manner provided for the original appointments. The public members of the task force shall serve without compensation but may be reimbursed for traveling and other miscellaneous expenses necessary to perform their duties within the limits of funds made available to the task force for its purposes.

c. The task force shall organize as soon as practicable after the appointment of its members and shall select a chairperson and vice-chairperson from among its members. The chairperson shall appoint a secretary who need not be a member of the task force.

d. The task force may meet at the call of its chairperson and hold at a minimum, three public hearings, with at least one hearing to be held in each of the northern, southern, and central regions of the State, which hearings shall be conducted remotely, as appropriate, by telephone, computer, or other means of live audio or video communication, at the times and in the places it deems appropriate and necessary to fulfill its charge. The task force shall be

entitled to call to its assistance, and avail itself of the services of the employees of, any State, county, or municipal department, board, bureau, commission, or agency as it may require and as may be available to it for its purposes.

e. The Department of Health shall provide staff services to the task force.

2. The purpose of the task force shall be to:

a. conduct a thorough and comprehensive study on the ways in which, and the reasons why the coronavirus disease 2019 (COVID-19) pandemic has disproportionately affected the State's minority and vulnerable communities, and the short-term and long-term consequences of the pandemic on these communities;

b. study and make recommendations to improve existing data systems to ensure that the health information that is collected relating to COVID-19 infections and deaths, includes specific race, ethnicity, and demographic identifiers to develop a better statistical understanding of how the COVID-19 pandemic has affected the State's minority and vulnerable communities;

c. evaluate the issues relating to the quality of, and access to, physical and mental health treatment and services provided to various racial and ethnic populations in the State during the COVID-19 pandemic;

d. solicit and receive testimony from members of the State's minority and vulnerable communities based on their experiences during the COVID-19 pandemic;

e. develop effective strategies to:

(1) address the racial, ethnic, and health disparities, and historical and systematic inequalities pertaining to race and ethnicity that have amplified the death rate in the State's minority and vulnerable communities during the COVID-19 pandemic; and

(2) reduce and eliminate disparities among the various racial and ethnic populations within the State's minority and vulnerable communities with respect to health status, access to high-quality health care, and utilization of health care services;

f. evaluate the communication, messaging, and dissemination of information regarding testing, contact tracing, and other related public health approaches necessary to achieve health care equity and cultural competence in the provision of physical and mental health treatment and services to the State's minority and vulnerable communities during the COVID-19 pandemic;

g. evaluate impediments that may interfere with an individual's ability to quarantine or isolate during the COVID-19 pandemic;

h. analyze the distribution of resources, including personal protective equipment and food, in the State's minority and vulnerable communities;

i. examine the impact of the COVID-19 pandemic on the physical and mental health of essential employees from the State's minority and vulnerable communities;

j. examine the impact of the COVID-19 pandemic on access to child care services in the State's minority and vulnerable communities;

k. investigate the prevalence of intimate partner violence in the State's minority and vulnerable communities during the COVID-19 pandemic; and

l. identify best practices, opportunities for shared services, or potential partnerships that would increase the communication of health care information and materials in multiple languages for members of the State's minority and vulnerable communities, including persons with developmental disabilities and senior citizens.

3. a. No later than one year after the public health emergency declared in response to the coronavirus disease 2019 (COVID-19) is lifted, the task force shall report to the

Governor and, pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), to the Legislature, on the activities of the task force and its findings and recommendations on strategies to:

(1) address the racial, ethnic, and health disparities and historical and systematic inequalities pertaining to race and ethnicity that have amplified the death rate in the State's minority and vulnerable communities during the COVID-19 pandemic;

(2) address the short- and long-term consequences of the COVID-19 pandemic on the State's minority and vulnerable communities; and

(3) reduce and eliminate disparities among the various racial and ethnic populations within the State's minority and vulnerable communities with respect to health status, access to high-quality health care, and utilization of health care services.

b. The task force shall expire 30 days after the issuance of its report.

4. This act shall take effect immediately.

Approved June 11, 2021.

Appendix C: Task Force Member Biographies

Public Members

Task Force Chair:
Tanya Pagán Raggio Ashley, MD, MPH, FAAP

Title: Pediatrician, Preventative Medicine Specialist and Minister

Biography: Dr. Raggio has a background in clinical medicine, academia, research, public health, hospital administration and private practice. She also has extensive experience in creating, writing, and reviewing grants, policy, legislation, implementing and overseeing Federal health programs. She has contributed to writing and implementation of the Affordable Care Act, Women's Preventive Services Guidelines, Healthy Start to decrease infant mortality and more. Over the past several years, Dr. Raggio has been very involved in creating and implementing COVID-19 prevention, screening, testing, care, treatment, and vaccinations throughout the country, especially for African American, Latino/a/x/Hispanic communities, persons who are homeless, migrant seasonal farmworkers, immigrants and other vulnerable underserved populations. She has served as a clinician, consultant and on health center boards providing primary care, mental and oral health, Ryan White HIV AIDs, substance use disorder services, healthcare for the homeless, school-based health centers, birthing centers, mixed use senior housing, migrant and seasonal farm workers programs. She mentors students in Science, Technology, Religion, Engineering, Arts and Math (STREAM). She is also involved in programs addressing Reentry.

Dr. Raggio is a graduate of Livingston College Rutgers University, Rutgers Medical School, and the University of Pittsburgh Graduate School of Public Health. She completed her residency training at Montefiore Hospital and Medical Center, in the Bronx. A master's in public health and a Cardiovascular Epidemiology Fellowship with a focus on women and Dr. Raggio has attended New York Theological Seminary and the Semanario Teologico in Rio Piedras Puerto Rico.

Dr. Raggio is a licensed clergy (minister) at Abundant Joy Church, where her husband Rev. Dr. Willard W.C. Ashley is the founder and Pastor. Her ministry is dedicated to health equity especially for minority, underserved and vulnerable communities. She collaborates with physician clergy providing conducting webinars on COVID-19 for faith-based and community organizations.

Task Force Vice-Chair:
Marilyn Cintron, FACHE, CPM

Tittle: President/CEO
Organization: Horizon Health Center D/B/A Alliance Community Health

Biography: Marilyn Rivera-Cintron was born in Jersey City. She attended Rutgers University where she matriculated at Douglass College (New Brunswick, NJ). She did some graduate work in NJIT and completed UCLA's Anderson School of Business training for Healthcare Executives in 2004. In 2005 she became the CEO of Alliance Community Healthcare, where she held various leadership positions. Ms. Cintron is currently finishing up her MPA/MHA at Farleigh Dickinson University in 2025.

Ms. Cintron has been with the ACH organization for nearly thirty years. She is a fellow of UCLA's Healthcare Executive Program and a fellow of the Women's Policy Institute sponsored by the Women's Fund of New Jersey. Ms. Cintron is currently a Vice Chair and Board Member of the New Jersey Primary Care Association, Board Member of the Partnership for Maternal & Child Health of Northern New Jersey Treasurer, Steering Committee Member of Inclusive Health Communities for Hudson County, Co-Chair of Ending the Epidemic Task Force and Board Member of the New Jersey Family Planning Association Board Member and Co-chair of Provider Committee. Member of Espiritu Latino for Re-entry in Jersey City with Gov. McGreevey and Appointed by Governor Phil Murphy to both the NJ Maternal Care Quality Collaborative and the COVID 19 Pandemic Taskforce on Health and Racial Disparities. She serves as Co-Chair of the COVID 19 Taskforce. Is on the statewide NJ Health Information Network Advisory Council. Board Member of the YWCA of Union County. Board Member of CarePoint Health System.

Ms. Cintron has received several awards over her years of service from various organizations, Hispanic, civic and faith-based organizations as well.

Marilyn Cintron is married with one daughter. Grew up in Jersey City NJ and is an active member of her church.

Member Name:
Damali M. Campbell-Oparaji, MD, FACOG

Title: Associate Professor
Organization: Department of Obstetrics, Gynecology and Reproductive Health, Rutgers New Jersey Medical School

Biography: Damali M. Campbell-Oparaji MD, FACOG, is currently an Associate Professor in the Department of Obstetrics, Gynecology, and Reproductive Health at Rutgers Health, New Jersey Medical School and Executive Medical Director of the NJ Department of Health Maternal Care Quality Collaborative. She received her Doctor of Medicine from Temple University School of Medicine and performed her residency at Mount Sinai School of Medicine (Jersey City Medical Center program). She has been a licensed medical doctor in New Jersey since 1997 and has served at Jersey City Medical Center, Raritan Bay Medical Center via Robert Wood Johnson Medical School and currently clinically works at University Hospital in Newark. She currently serves on the board of Planned Parenthood of Metropolitan New Jersey and the National Medical Association. She is the current president of the New Jersey Medical Association and the treasurer for NJ Section of American College of Obstetrics and Gynecology (ACOG). Her work has been acknowledged by the Society for Academic Specialists in General Obstetrics and Gynecology, Student National Medical Association, the College of American Pathology (CAP)and the partnership for Maternal Child health of Northern NJ.

Member Name:
Natasha Dravid, MBA

Title: Chief Strategy Officer
Organization: Camden Coalition of Healthcare Providers

Biography: Natasha Dravid joined the Coalition in 2013 and serves as Chief Strategy Officer, working to drive forward the Coalition's mission of strengthening equitable ecosystems of care in Camden, the state of NJ, and across the country. In this role she leverages over a decade of experience in complex care, clinical redesign and data-driven practice spanning a wide range of clinical and social focus areas. She brings deep expertise in operationalizing innovation projects that bring together CBOs, providers, payers, policymakers, and community members to reimagine healthcare delivery. She

holds an MBA from the Yale School of Management, and a BA in English from Haverford College.

Member Name:
Marissa Davis

Title: Vice President, Community & Equity
Organization: NJ YMCA State Alliance

Biography: Marissa Davis has over 20 years of experience in public and community health. As Vice President of Community & Equity Initiatives, she is responsible for developing public-private partnerships, implementing population health policies and initiatives to expand community outreach and services to New Jersey's most vulnerable residents.

Her expertise extends to providing valuable input on the planning, design, implementation, and evaluation of both existing and new projects. She creates and executes strategies to address complex issues such as food and housing insecurity, childcare, and poverty with a focus on equity, scalability, and relationship building. She provides technical assistance and direction to local YMCAs, SNAP-Educators, partnering state agencies, and other community-based organizations. Marissa's commitment to equity and community health continues to drive positive change across New Jersey.

Prior to her role at the NJ YMCA State Alliance, Marissa was Director of the NJ Partnership for the Healthy Kids, where she was pivotal in uniting Trenton's partners and the community to improve access to healthy foods and physical activity, such as launching the Greenwood Ave. Farmers Market, establishing salad bars in schools, securing grants for fresh produce, building two playgrounds, and enhancing the healthy corner store initiative while coordinating city-wide food pantries.

During the pandemic, Marissa initiated Community Conversations: Pandemic Perspectives, NJ's COVID-19 Storytelling Project in partnership with the New Jersey Department of Health. The project is comprised of nearly 800 collected experiences of vulnerable populations and the impact that COVID-19 has had in their lives. Transforming lived experience into policy and program change, the long-term goal is to improve systems while documenting a critical time in New Jersey's (and the world's) history. Analysis of the collection is being used, in part, to inform the development of New Jersey's State Health Improvement Plan with Healthy NJ 2030.

In addition to her extensive work at the Y, Marissa has served on the Mercer County Park Commission for six years, including three years as Vice President. Marissa has a dual certificate in Diversity, Equity & Inclusion and Dialogue for Change from Cornell University, and a bachelor's degree in Women's Studies and African American/Black Studies from the University of Delaware.

Member Name:
Reva Foster
Title: Executive Director
Organization: Willingboro Township, Community Affairs, Veterans Affairs.

Biography: Reva Foster graduated Cum Laude from Allen University in Columbia, South Carolina with a Bachelor Science degree in Biology. She went on to pursue Graduate work in Microbiology at Miami. She received an Honorable Discharge from the United States Air Force. Reva has held several positions of responsibility throughout her professional career. Some of her past employers include Park Davis Pharmaceutical, Warner Lambert, Johnson & Johnson Eastern Surgical Dressing Plant where she served as Quality Assurance Supervisor, Domestic Operating Company, served as a Scientist Technical Assurance. Throughout her career with Johnson & Johnson she climbed the corporate ladder with increasing responsibilities, which included Manufacturing Manager, Quality Assurance Coordinator, Manager of Specification Department and International Auditor for North America, Central America and South America.

Reva started AVER Designs, a professional artistic company. Her company provided business plans, sales strategies and sample products for new businesses using a personalized template. In 1993, she was hired as the Director of the Willingboro Township Senior Citizen Center. She now serves as Executive Director of the Department on Aging where she is the chief administrator responsible for the day-to-day operation of the Senior Center programs; coordinate community resources, and collaborations, liaison with federal, state, and local organizations concerned with elderly issues. Her goal was to establish a state-of-the-art Senior Citizen Center and Program that would be continually recognized statewide and be a welcoming home away from home for our senior population. In 2007, her responsibilities for the Willingboro Township were expanded when she was chosen to head Community Affairs and subsequently Veterans Affairs Departments. She has served nine years as the Chairman of the New Jersey Black Issues Senior Symposium, four years as 1st Vice Chairman and is currently State Chairman of the

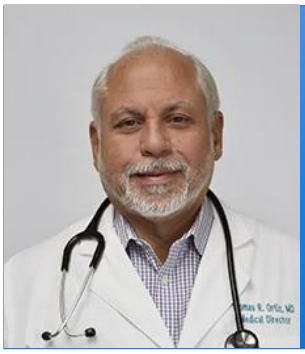
New Jersey Black Issues Convention. She was selected as the 2012 New Jersey State Delegate for United States President Obama.

Member Name:
Gina Marie Miranda-Diaz DNP, MSN, MPH, APHN-BC, H-O
Title: Health Officer **Organization:** City of East Orange Department of Health and Human Services

Biography: Gina Marie Miranda-Diaz is Health Officer (CEO) of the City of East Orange Department of Health and Human Services.
She received a Doctor of Nursing Practice from UMDNJ-Public/Minority Health and a Master's in public health (Community Health Education) and Nursing from Hunter College.

She is a registered professional nurse in both NJ and NY, and is board certified as an Advanced Practice Public Health Nurse. Dr. Miranda-Diaz is a certified contact tracer, health education specialist, Home-Health Aide (HHA) program instructor, and advanced public health nurse. Prior to their role at Teaneck Department of Health, she was faculty at academic settings at Rutgers University School of Nursing (Education Opportunity Fund), Ramapo College, Felician University, and Lehman College. As a health officer and director, she was charged with heading up Health Departments in municipalities in Northern New Jersey.

Her work in culturally competent care has been published in peer-reviewed journals, including the American Journal of Nursing and Journal of Oncology Navigation and Survivorship. She has published chapters in two editions of the Policy and Politics in Nursing and Healthcare and medical surgical textbooks. She has presented her work and research both in the United States, Puerto Rico, and at international conferences. Her work has been recognized by the National Association of Hispanic Nurses, Institute for Nursing-New Jersey State Nurses Association, and she was inducted as a Fellow of the New York Academy of Medicine.



Member Name:
Thomas Rafael Ortiz, MD, FAAFP, DABFP
Title: Medical Director
Organization: The Center of Excellence for Latino Health at Clara Maass Medical Center and Angelic Health at Forest Hill Family health associates

Biography: Dr. Thomas R. Ortiz, a board-certified Family Physician, has been in the private practice of Family Medicine as the Founder and Medical Director of Forest Hill Family Health Associates, PA (www.fhfha.com) in Newark, NJ Northward since 1984. As Founding CEO of Health Practice Management Corp., a Health Care

Consulting firm, he has established the Forest Hill Medical Arts Center for Specialty Care, bringing 16 subspecialty physicians into Newark's Northward, expanding access to specialty care to a community in great need.

Most recently, Dr. Ortiz has been named the Medical Director of the NJ Innovations Institute for Health Care, CMS funded Garden Practice Transformation Network, tasked with bringing practice transformation support services into a value based alternative payment models to primary care practitioners. He has also been tapped Clara Mass Medical Center, a, RWJ Barnabas Hospital, to be the first Medical Director for the Center of Excellence for Latino Health, serving the growing Latino communities with health promotions, awareness, career development, staff cultural competency and direct medical services, through the school systems and the churches.

With the advent of a national movement for healthcare reform and the passage of the Affordable Care Act, Dr. Ortiz has been leading the charge for urban primary care infrastructure development, medical neighborhood integration, value-based payment reform, technology innovation and an advocate for Patient Centered Medical Home principles for healthcare delivery. Leading physicians and other NJ healthcare stake holders, he served as past President of the NJ Academy of Family Physicians, representing over 1200 Family Physicians and other primary care practitioners in NJ.

A graduate of New Jersey Medical School in Newark, NJ and Mountainside Family Practice Residency Program in Montclair, NJ, Dr. Ortiz joined the National Health Service Corp. and has made a career as a public health advocate for universal access to primary care for all, focused on the poor and vulnerable populations.

Member Name:
Natalie E. Roche, MD

Title: Associate Professor
Organization: New Jersey Medical School, Department of Obstetrics, Gynecology and Women's Health

Biography: Dr. Natalie Roche received her Baccalaureate degree in Biology from Barnard College, and Doctor of Medicine degree from Mt. Sinai School of Medicine, both in New York. She completed her residency in Obstetrics at Beth Israel Medical Center in New York City in 1984. Dr. Roche began her career as a clinical instructor of Obstetrics and Gynecology at Yale University 1984-85, and subsequently became an

Assistant Professor at Charles Drew University School of Medicine and Science in Los Angeles. She served as an attending physician at King/Drew Medical Center, as well as the Medical Director of the Women's Healthcare Team, part of the Public Health Programs in Los Angeles. In 1987, Dr. Roche came back to the East Coast as an Attending physician at the Hospital of St. Raphael's Obstetrics, Gynecology Department in New Haven, CT. From 1988 to 2000, she worked in the Department of Obstetrics and Gynecology at Beth Israel Medical Center in New York City. During her tenure at Beth Israel, Dr. Roche served in a variety of roles including physician in charge of ambulatory Ob/Gyn, obstetrics service and gynecology service. She became Associate Chairperson of Ob/Gyn in 1991 and subsequently became Associate Medical Director of the Philipp's ambulatory care center. From 1991 to 2000, Dr. Roche was Assistant Professor of Obstetrics and Gynecology at Albert Einstein School of Medicine in New York. In 2000, Dr. Roche became the Attending Physician at University Hospital's Department of Obstetrics and Gynecology in Newark and Assistant Professor of Obstetrics and Gynecology at UMDNJ New Jersey Medical School. She is currently Director of Gynecology Services and a member of Addiction Medicine consult service at University Hospital. Dr. Roche is presently an Associate Professor in the Department of Obstetrics, Gynecology and Women's Health at the Rutgers New Jersey Medical School where she is the Director of the Generalist Division.

Member Name:
Mariekarl Vilceus-Talty, RN, BSN, MA

Title: President and Chief Executive Officer
Organization: Partnership for Maternal & Child Health of Northern New Jersey

Biography: Mariekarl Vilceus-Talty, President and CEO of the Partnership for Maternal and Child Health of Northern New Jersey since early 2021, has been dedicated to transforming maternal health. She has redefined the organization's vision, focusing on eliminating healthcare disparities and innovating new programs. Under her leadership, the Partnership is becoming an anti-racist organization, expanding community partnerships, and ensuring diverse voices are heard. She secured legislative funding for a diverse doula workforce training program and established the Center for Clinical Impact to enhance clinical expertise and patient outcomes.

Mariekarl has received numerous awards, including the 2024 EWNJ Salute to Policy Makers Honoree, the Nurses with Global Impact Award, and the March of Dimes' Nurse Leader of the Year. She actively participates in various task forces and committees, such as the COVID-19 Advisory Taskforce and the Maternal Mortality Review Committee. Her extensive nursing career, including her Senior Director of Nursing and Patient Experience role at Jersey City Medical Center, shapes her perspective on patient-centered care.

Mariekarl holds an MA in Nurse Executive from Columbia University and a BS in Nursing from Adelphi University. She is a member of several professional organizations and serves as Chairwoman of Mission Granbois, a non-profit focused on improving health outcomes in Haiti.

Member Name:
Anthony S. Welch
Title: Vice President and Chief Government Relations Officer
Organization: Cooper University Health Care

Biography: Anthony Welch is the Vice President and Chief Government Relations Officer at Cooper University Health Care, based in Camden, New Jersey. Mr. Welch, who came to Cooper in 2017, provides strategic guidance on public policy issues affecting healthcare and Cooper, and helps to oversee Cooper's advocacy efforts in connection with legislative, policy, and regulatory initiatives at the federal, state, county, and local levels of government. Mr. Welch also serves as a board member of the Camden Coalition of Health Care Providers. Prior to joining Cooper, Mr. Welch served as Director of Policy and Strategic Planning for the New Jersey Department of Health. Previously, he served as a senior policy advisor in the Office of Governor Chris Christie. He has also served as Vice President and chief operating officer for Newark Now, a community organization co-founded by Senator Cory Booker. In addition, he has served as a program officer at The Nicholson Foundation, a project coordinator at Rutgers University, and President of the national youth leadership organization Do Something, Inc. He received his undergraduate degree in biochemistry from Rutgers University-New Brunswick, and a Master of Business Administration degree from Rutgers University-Newark.

Ex-Officio Members

Member Name:
Candice M. Alfonso, JD, MPA
Title: Chief Diversity Officer
Department/Division/Office: Office of Diversity and Inclusion, Department of the Treasury

Biography: Candice M. Alfonso is New Jersey's Chief Diversity Officer (CDO) and Director of the Office of Diversity and Inclusion in the Department of the Treasury. Ms. Alfonso, who joined Treasury in 2022, responsible for monitoring the State's public contracting process for participation by small and diverse businesses focusing on ways to execute strategies targeted toward greater utilization of these business enterprises. As CDO and Director of ODI, Candice also conducts outreach to diverse business enterprises and other entities regarding awareness of public contracting opportunities.

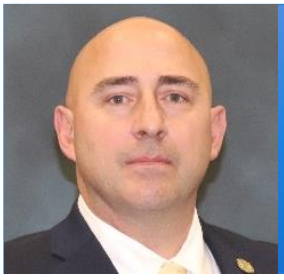
Prior to her role as CDO, Candice served as Chief of Staff of the New Jersey Housing and Mortgage Finance Agency (NJHMFA), overseeing the day-to-day operations of the Agency, information technology systems, operations and facilities management, human capital management, marketing, budgeting, and strategic planning along with other duties essential to the efficient administration of the Agency. Prior to her appointment as Chief of Staff, Candice staffed the Governor's Office of Economic Growth as a Senior Advisor for Economic Development where she helped business and industry navigate through the economic challenges brought on by the COVID-19 pandemic, advising the Governor directly on a number of important policies that impacted industry and all New Jerseyans. She also played a significant role in the Administration's successful effort to bring the 2026 FIFA World Cup™ to the New Jersey/New York region. Central to her duties was the consideration of equity and inclusion presented in the State's winning bid strategy. Candice has remained part of the Administration's World Cup team throughout her tenure with the NJHMFA and in her role as CDO in Treasury.

Ms. Alfonso has over 20 years of multi-disciplinary supervisory, administrative management, and leadership experience and has served in all three branches of State government. Ms. Alfonso holds a BA degree in Sociology from St. Lawrence University, a Master of Public Administration from New York University, and a Juris Doctor from Seton Hall University School of Law. She is licensed to practice law in New Jersey, New York, and the U.S. District Court for the District of New Jersey. Candice M. Alfonso is the Chief Diversity Officer of the Office of Diversity and Inclusion, Department of Treasury, located in Trenton, New Jersey. Ms. Alfonso, who joined NJHMFA in 2021, oversaw the day-to-day operations of the Agency, information technology systems, operations and facilities management, human capital management, marketing, budgeting and strategic planning along with other duties essential to the efficient administration of the Agency. Prior to her appointment as Chief of Staff, Ms. Alfonso served as Senior Advisor for Economic Development for New Jersey Governor Phil D. Murphy, with primary focus on the State’s economic response to COVID-19. She has over 20 years of multi-disciplinary supervisory, administrative management, and leadership experience and has served in all three branches of State government. Ms. Alfonso holds a BA degree in Sociology from St. Lawrence University, a Master of Public Administration from New York University, and a Juris Doctor from Seton Hall University School of Law. She is licensed to practice law in New Jersey, New York, and the U.S. District Court for the District of New Jersey. In December 2021, Ms. Alfonso was appointed as a Board Member to the Advisory Council for the Customer Experience Certificate Program at Seton Hall University, Stillman School of Business.

Member Name:
Susan Bergin, JD, MPA

Title: Assistant Deputy Director, Policy and Strategic Planning
Department/Division/Office: Division of Consumer Affairs, Director's Office

Biography: Susan is an Assistant Deputy Director with the Division of Consumer Affairs in the Department of Law and Public Safety, where she works with the Division's healthcare professional licensing boards and Drug Control Unit. Susan analyzes legislation and drafts rules on topics such as implicit bias, sexual misconduct, contraception, drug pricing, and medical cannabis. Before joining the Division, Susan spent six years as a healthcare attorney, counseling healthcare providers in regulatory matters in New York and New Jersey. Susan holds a J.D. from Harvard Law School and an M.P.A. from the School of International and Public Affairs at Columbia University.



Member Name:
Lt. Licinio (Lee) Carvalho

Title: Head of the New Jersey State Emergency Operations Center Unit
Department/Division/Office: State Police OEM

Biography: In 2004, I joined the New Jersey State Police. I have been with the Homeland Security Branch, Emergency Management Section for the majority of my NJSP career. I worked within the Emergency Response Bureau as a regional representative. My role included representing the Governor and State Director of

Emergency Management at all emergency and disaster situations in the State. I monitored all hazards situations and assured proper response and recovery activities. Response to any activity provided interaction between local and state government to expedite the State's response. These activities included State, County and Municipal EOC activations, participation in actual operations, and technical assistance during the response and recovery phase. Presently, I oversee the State Emergency Operations Unit. The unit serves as a liaison to the State Director and/or their designee to provide situational awareness and resource management. The State Emergency Operations Center Unit provides coordination of the emergency response efforts of state agencies, allied agencies, county Offices of Emergency Management, and the private sector. They serve as the conduit through which the unmet emergency resource needs of the counties affected by a disaster are acquired from other counties, New Jersey State governmental agencies, other

states, the Federal Government, allied agencies and private sector organizations.

Member Name:
Amanda Medina-Forrester, MA, MPH
Title: Executive Director, Office of Minority and Multicultural Health
Department/Division/Office: New Jersey Department of Health

Biography: As the Executive Director of the New Jersey Department's Office of Minority and Multicultural Health, Amanda Medina-Forrester is charged with ensuring health equity policies, practices and programs are implemented to reduce and eliminate health disparities among diverse and marginalized populations. She also co-leads the specific population team for the COVID-19 vaccine plan to ensure vaccine equity across marginalized populations in New Jersey. Mrs. Medina-Forrester developed and implemented COVID-19 testing and mitigation strategies for migrant and seasonal farm workers, establishing vaccine implementation committees comprised of community members with access to critical populations, enhancing communication plans to access specific populations, as well as the engagement and activation of key stakeholders, community organizers and tribal leaders. Mrs. Medina-Forrester serves as a resource on health equity, cultural competency, implicit/explicit bias and health literacy for community and provider education and awareness materials and content. In addition to COVID-19 work, she also has over 20 years of program and grant development and management for diverse, historically marginalized communities with a primary responsibility is to ensure any implementation and sustainability of grants is seen through a health equity lens.

Member Name:
Sybil R. Trotta, Esq.
Title: Division Director
Department/Division/Office: Office of Equal Employment Opportunity and Affirmative Action.

Biography: Sybil Trotta is the Division Director for the New Jersey Department of Children and Families' Office of Equal Employment Opportunity/ Affirmative Action (EEO/AA). Ms. Trotta directs the work program and staff of the Office of EEO/AA. In this role, she makes recommendations to executive leadership to ensure compliance with the federal and state EEO/AA guidelines. She is also responsible for ensuring that all Department employees work in an environment free from all forms of employment discrimination in accordance with the New Jersey State Policy Prohibiting Discrimination in the Workplace

and ensuring that the Department complies with applicable law, policies and procedures. In this capacity, she oversees investigations into complaints of discrimination submitted by employees, applicants for employment and persons doing business with the State of New Jersey.

Ms. Trotta is a member of the Department's Race Equity Steering Committee that is tasked with researching and implementing evidence-based practices to reduce racial disparity in child welfare outcomes. She received her Juris Doctor from New York Law School and her undergraduate degree in Philosophy and Religion from Christian Brothers University.

Member Name:
Tina Vignali
Title: Senior Compliance Officer
Department/Division/Office: New Jersey Housing and Mortgage Finance Agency

Biography: Tina is the Senior Compliance Officer at the New Jersey Housing and Mortgage Finance Agency (NJHMFA), where she works with the Agency's divisions on a wide range of initiatives. Prior to joining NJHMFA, Tina worked at the Department of Community Affairs, Division of Local Government Services (DLGS).

While at DLGS, she conducted ethics investigations under the Local Finance Board. She also collaborated with the cities of Camden and Trenton as part of the DLGS Transitional Aid Program.

Tina received her undergraduate degree in foreign languages from the University of Delaware. She earned a master's in government administration from the University of Pennsylvania and a Juris Doctor from Rutgers University-Camden.

Member Name:
Christopher Wheeler, PhD
Title: Chief Data Officer
Department/Division/Office: Department of Community Affairs

Biography: Christopher Wheeler, PhD is the Chief Data Officer of the New Jersey Department of Community Affairs. He is responsible for managing the Department's data analysis and reporting functions. Before becoming Chief Data Officer, he served as the DCA's local Government Services Research Economist, responsible for data and policy

analysis and program evaluation for the Commissioner's Office and the Division of Local Government Services. Dr. Wheeler holds a PhD in Public Affairs from Rutgers University-Camden, a master's degree in government administration from the University of Pennsylvania, and a bachelor's degree in political science from Temple University.

Member Name:
Aarin Michele Williams

Title: Chief Advisor of the Director

Organization: Division on Civil Rights in the Department of Law and Public Safety

Biography: Aarin Michele Williams, Esq. (she/her) is an experienced and versatile attorney who works to champion the principles of equity, justice, and opportunity, over civility or respectability. She is barred in New Jersey, New York and the Southern District of New York and has appeared in various courts around the nation. She is an experienced civil rights litigator, social, racial, and reproductive justice movement lawyer. Aarin serves as the Chief Advisor to the Director at the New Jersey Division on Civil Rights where she leads on special projects as designated by the Director. She has held various leadership roles with DCR leading teams in a landmark mortgage redlining matter with the DOJ, published civil rights reports on issues including the spread of white supremacy and bias in the state, promulgated our nation's first of its kind Fair Chance in Housing Act and heads the Divisions home appraisal task force. Aarin represents the Division on various task forces including the Reproductive Rights Strike Force, Wealth Disparity Task Force, COVID-19 Task Force on Racial & Health Disparities and more.

Prior to DCR, Aarin worked as a reproductive justice and criminal defense lawyer with a national non-profit advocating for and representing, pregnant people who were charged with crimes or who faced punishment related to their pregnancy. In her role she provided legal advice, engaged in impact litigation, direct representation, coalition building, developed case strategies, worked to shift culture around drug policy, bodily autonomy, and state-sanctioned violence, and developed of legal and public education on various issues. For nearly a decade prior, Aarin was a zealous trial attorney as a New Jersey State Public Defender where she was a trial strategy trainer and lead lawyer handling complex felony criminal cases.

Aarin is originally from Georgia, graduate of Howard University and Rutgers School of Law-Newark and has served as an Adjunct Professor at Seton Hall Law School and the New Jersey Institute of Technology.

Former Task Force Members

Member Name:
Lisa Asare, MPH

Title: President and Chief Executive Officer
Department/Division/Office: New Jersey Maternal and Infant Health Innovation Authority

Biography: Lisa Asare was appointed the President and Chief Executive Officer of the NJ Maternal and Infant Health Innovation Authority in March 2024, the first and only such state authority in the nation. In addition to leading the authority, she will also serve as a newly appointed member of Governor Phil Murphy's cabinet.

Prior to this appointment, Ms. Asare served as Deputy Commissioner of Health Services within the New Jersey Department of Human Services. In this role, she oversaw the Division of Medical Assistance and Health Services that administers NJ FamilyCare and the Division of Mental Health and Addiction Services. She also served as the Department lead on First Lady Murphy's Nurture NJ maternal health initiative.

Ms. Asare previously worked as the Assistant Commissioner of the Division of Family Health Services at the New Jersey Department of Health, for more than 20 years. During that time, she retooled the Division's approach to addressing black infant mortality and maternal mortality, contributed to the Nurture NJ strategic plan, addressed the social determinants of health by collaborating with sister state agencies and non-traditional partners, and leveraged additional state, federal, and philanthropic funding to address emerging issues and the COVID-19 pandemic. She is happiest moving from data to action through engagement with the community.

Ms. Asare also serves as the President on the Board of Directors of the Association of Maternal and Child Health Programs (AMCHP).

She received a bachelor's degree in economics from the University of Toronto and a master's degree in public health from the Rutgers School of Biomedical and Health Sciences.

Throughout her career, she has received many awards for her work in the maternal child health space. She received the Distinguished Alumni Award from the Rutgers School of Public Health, the President's Award from the NJ Public Health Association and the 2023 HRSA Maternal and Child Bureau (MCHB) Director's award.

Member Name:
Ishyia Hayes, MPSL

Title: Former Director of Policy and Planning
Department/Division/Office: City of Paterson, NJ

Biography: Ishiya A. Hayes was the Director of Policy and Planning at the City of Paterson. She received her Bachelor of Arts in English and Africana Studies from Rutgers University and Master of Public Service Leadership in public health/public policy from Thomas Edison State University. She currently serves New Jersey's third largest and most diverse municipality by acting as the community liaison for American Rescue Plan (ARP) priorities and programs in light of the COVID-19 pandemic, mitigating environmental issues, and providing policy analysis on a wide range of issues including public health and public safety. Prior to this role, she served the New Jersey Urban Mayors Association (NJUMA) an organization comprised of over 30 mayors who represent urban and rural municipalities in the state of New Jersey. In addition, her research focuses on trauma-informed care, poverty alleviation, and zoning in New Jersey Cities. She currently serves on the New Jersey State League of Municipalities Legislative Committee, Lead in Drinking Water Taskforce for Jersey Water Works, and the Environmental Justice Municipal Guidance Project Working Group.

Member Name:
Kia King, Ex-Officio

Title: Chief of Staff
Department/Division/Office: Department of Community Affairs

Biography: Kia King served as the Director of Policy and External Affairs for the Department of Community Affairs, handling various legislative and policy matters that impact the Department. Kia King began her legal career clerking for the Honorable Lisa P. Thornton, A.J.S.C. of the Monmouth Vicinage. She served as Assistant Counsel for the Monmouth County Division of Social Services handling family dissolution and public assistance cases and then as Special County Counsel for the County of Monmouth working on public procurement matters. Kia then worked for the New Jersey Office of the State Comptroller as their Chief Administrative Officer for several years managing various administrative and human resources functions for the agency. Thereafter, Kia worked for the New Jersey Department of Labor and Workforce Development as the Equal Employment Opportunity (EEO) Officer and Ethics Liaison Officer, overseeing the

Department's Office of Diversity and Compliance. Kia then joined the Department of Community Affairs as their Director of Policy and External Affairs, before becoming DCA's Chief of Staff in October 2023. Kia is a graduate of Colgate University (magna cum laude) where she majored in Africana Studies and minored in Film and Media Studies. Kia received her Juris Doctor from William and Mary Law School.

Member Name:
Dr. Julia M. Presley, Ex-Officio

Title: Gov. Rep. I (Diversity Specialist)
Department/Division/Office: Office of Diversity and Inclusion, Department of Treasury

Biography: Dr. Julia M. Presley joined The NJ Office of Diversity and Inclusion in October of 2018. She serves as the Diversity and Inclusion Manager overseeing Programs, special projects, and Analytics. Dr. Presley represents the Chief Diversity Officer in her absence on committees, boards, speaking engagements; and managing the day-to-day operations of the office.

She serves on the Board of Public Utilities Supplier Diversity Development Council (SDDC), NJWP Diversity and Local Engagement Advisory Committee, and the NJ COVID-19 Taskforce on Racial and Health Disparities.

Dr. Presley has over 30 years of professional and leadership experience that spans the academia, non-profit, private, and government sectors. Prior to joining the State Office of Diversity and inclusion she served as a Professor with the Rutgers University Business School, Acting President/Vice President of Operations and Business Development with the New York and New Jersey Minority Supplier Development Council, and has held leadership roles with various volunteer, non-profit and corporate entities. She is a management consultant and has an affinity for diverse business health, development, and sustainable economic growth.

Dr. Presley is bi-vocational and serves as an ordained Associate Pastor at First Baptist Church of Lincoln Gardens.

Doctor Julia M. Presley earned a doctorate in Metro Urban Ministry from New Brunswick Theological Seminary (NBTS) & Rutgers University's Edward J. Bloustein School of Urban Policy, Planning and Public Health; a Master of Divinity (M.Div.), NBTS; and Master of Business Administration (MBA) and Bachelor of Science (BS) from Rutgers University.

Member Name:
Magda Schaler-Haynes, JD, MPH

Title: Former Senior Advisor
Department/Division/Office: Division of Consumer Affairs, Department of Law and Public Safety

Biography: Magda Schaler-Haynes is a Professor of Health Policy and Management at the Mailman School of Public Health at Columbia University Irving Medical Center. Her scholarship and teaching focus on the use of law to advance equitable public health policy in multiple arenas including healthcare professional licensing, reproductive and maternal health, antidiscrimination initiatives and pandemic response.

Prior to joining the fulltime faculty, Schaler-Haynes spent over two decades working in health law and policy including multiple roles in public service at state and federal levels. From 2017-2022, she served in the administration of New Jersey Governor Phil Murphy, most recently as Senior Advisor at the New Jersey Office of the Attorney General. She also previously served as Director of Policy and Strategic Planning at the New Jersey Department of Health; as Special Advisor for healthcare and women's issues to a U.S. Senator; and as Senior Health Policy Advisor at the New York State Insurance Department. Schaler-Haynes holds J.D. and M.P.H. degrees from Columbia University and B.A. from Brandeis University.

Member Name:
Eric Apar

Title: Deputy Director for Policy and Strategic Planning
Department/Division/Office: Division of Consumer Affairs, Director's Office, Department of Law and Public Safety

Biography: Eric is the Deputy Director for Policy and Strategic Planning at the New Jersey Division of Consumer Affairs, where he oversees the implementation of the Division's legislative regulatory, and policy agenda. He has worked on legislative, regulatory, and policy initiatives relating to health equity, racial justice, sexual misconduct, and consumer protection. Before becoming the Deputy Director for Policy and Strategic Planning, Eric served as the Director of Legislative and Regulatory Affairs and the Assistant Deputy Director for Policy and Strategic Planning at the Division of Consumer Affairs. Prior to joining the Division of Consumer Affairs, Eric spent five years as a Deputy Attorney General in the Division of Law, where he worked in the Transportation, Education, and Special Litigation sections. He holds a JD from the Georgetown University Law Center and

a master's degree in political science from the CUNY Graduate Center.

Member Name:
Maisha Simmons, MPA
Title: Director, NJ Team/Strategic Relationships
Organization: Robert Wood Johnson Foundation

Biography: Maisha Simmons is the Director of NJ Team/Strategic Relationships at Robert Wood Johnson Foundation. They received their Bachelor of Arts in Psychology from Rutgers University and Master of Public Administration from Baruch College School of Public Affairs. The focus of their professional experience

has been to catalyze and galvanize change in communities by leveraging resources for the empowerment of communities often marginalized by structural inequities. As Director of NJ Grant Making at RWJ Foundation, they represent the Foundation at state and community level events as an ambassador for Foundation's local presence to improve health equity. In this role, they also serve as a lead in the Strategic Relationships with a focus on healthy equity and social justice in partnership with leading organizations across the country. They serve as board member of the Association of Black Foundation Executives (ABFE) and Council of NJ Grantmakers, with their work recognized by ABFE.

Member Name:
Tenisha Malcolm
Title: Director
Organization: Girls Scouts Heart of New Jersey Girls

Biography: Tenisha Malcolm-Wint's career has been marked by impactful leadership roles and an unwavering passion for community advancement. She previously served as the Director of the Urban Mayors Policy Center at the John S. Watson Institute for Urban Policy and Research at Kean University. In this role, she played a pivotal part in assisting 33 member mayors of the New Jersey Urban Mayors Association in navigating the complex challenges that urban municipalities face.

Before her tenure at the Watson Institute, Malcolm-Wint made significant contributions to a range of national and community-based nonprofits. She spearheaded large-scale, innovative programs, led successful fundraising campaigns, and drove strategic

development initiatives, all while fostering positive social change. Her dedication to social causes extends beyond her professional roles, demonstrated by her active involvement as a board member for organizations such as New Jersey Future, Urban Agriculture Cooperative, Boys & Girls Club of Union County, National Association of Double Dutch Organizations, and New Jersey School of Conservation.

Currently, Malcolm-Wint serves as the Director of the Girl Scouts Heart of New Jersey Girls Leadership Center in Newark. She also leads TNM Consulting, LLC, and is the Founder & Chief Outdoor Experience Officer of Outdoors On Purpose (OOP), a nonprofit organization dedicated to dismantling systemic racism within New Jersey's natural and built environments. OOP focuses on empowering Black and Brown communities by fostering connections with the outdoors, advocating for equitable access to green spaces, addressing issues such as food deserts and urban agriculture, and providing pathways for young Black and Brown individuals to explore and pursue careers in the green sector.

Tenisha’s commitment to fostering community growth and driving innovation remains at the forefront of her professional endeavors. She holds a Bachelor of Arts degree from Bloomfield College and is currently pursuing a Master of Public Administration (MPA) in Nonprofit Leadership at Kean University. Additionally, she has earned a Professional Certificate in Creative Placemaking from the New Jersey Institute of Technology.

Appendix D: Task Force Public Hearings and Testimony Toolkit

INTRODUCTION

The COVID–19 pandemic (COVID-19) has exposed and worsened persistent racial and health inequities across the nation. Individuals from communities of color and other marginalized populations have been disproportionately affected, and as a result, have borne a higher burden of COVID-19.

To more clearly understand how COVID-19 has disproportionately impacted minorities and marginalized communities in New Jersey, legislation was sponsored by Assembly members Shavonda Sumter, Angelica Jimenez and Linda Carter to establish a task force examining racial and health disparities related to COVID-19. This legislation was signed into law by Governor Murphy on June 11, 2021.

The law created the New Jersey Coronavirus Disease 2019 (COVID-19) Pandemic Task Force on Racial and Health Disparities (the Task Force), which is staffed by the New Jersey Department of Health. The Task Force is comprised of 23 members, including 14 public members appointed by the Governor, some of whom were selected based upon recommendations from the Legislature, and others based upon requirements stipulated in the legislation. The remaining nine are Ex-Officio members from various relevant state departments. Members represent a diversity of expertise and racial and ethnic backgrounds.

Its mission is to provide specific recommendations to the Governor and Legislature for mitigating inequities caused or exacerbated by COVID-19 and for preventing such inequities in the future.

Prior to providing recommendations, the Task Force will assess how and why the pandemic has affected minorities and high-risk burden communities in New Jersey, as well as the short- and long-term consequences for these communities.

To accomplish this, the Task Force would like to solicit and receive testimony from New Jersey residents from all minorities and high-risk burden communities based on their experiences during COVID-19.

ABOUT THE TOOLKIT AND HOW TO USE IT

The Task Force needs your input to successfully develop recommendations that address racial and health disparities as they relate to COVID-19 in New Jersey.

We will use your stories and ideas to inform the Task Force's recommendations that will be submitted to the New Jersey Governor and Legislature in March 2023.

This toolkit is designed to help you in two ways:

1. Provide you with ideas on how to give your testimony

2. Help guide conversations with your communities, other organizations, and individuals about the challenges experienced during COVID-19.

   You may then consider submitting the information collected during these conversations in writing, in representation of the communities you serve.

COMMUNITIES OF FOCUS

We are specifically interested in stories and ideas from the state's minority and marginalized communities that will help eliminate racial and health disparities and support the diverse range of individuals and communities that have been disproportionally impacted by COVID-19 including but not limited to:

- Communities of color
- Rural communities
- People with disabilities
- Adults aged 65+ years

THREE OPTIONS TO PROVIDE TESTIMONY

In-Person

Attend a public hearing in-person and provide oral comments (limited to three minutes) at the next following location:

- **New Brunswick**
  - Location: DCF Training Academy
    30 Van Dyke Ave.,
    New Brunswick, NJ 08901
  - Date: Saturday, December 3, 2022
  - Time: 10:00 am – 1:00 pm

Virtually

Attend a public hearing virtually and provide oral comments (limited to three minutes):

Zoom Meeting

- Link:https://us06web.zoom.us/j/85656596288
- Date: December 6, 2022
- Time: 4:30 pm – 8:00 pm
- Call-in information: US +1 929 436 2866
  +1 646 931 3860 US
  +1 301 715 8592 US
- Meeting ID: 856 5659 6288

Written

Your written comments or comments you collected can be submitted electronically via email at *njcdtf@doh.nj.gov*. We suggest limiting your written comments to three pages. Please submit no later than *Friday, December 16, 2022*. You may also mail your written comments to the following address; comments must be received by the same deadline:

New Jersey Department of Health Office of Minority and Multicultural Health

55 N. Willow St., 4th Floor

P.O. Box 360

Trenton, New Jersey 08625-0360

Attention: Aracely Macias

PILLARS

The pillars below define the scope of the legislative charge of the Task Force. They will help guide topic areas of testimony.





Data Systems:	Health Communication:	Historical & Systemic Inequities:	Social Indicators of Health:	Physical/Mental Health Status & Health Care Disparities:
How can existing data systems be improved to ensure that health information collected relating to COVID-19 infections and deaths include specific race, ethnicity, and demographic identifiers?	How can the communication, messaging, and dissemination of information regarding testing, contact tracing, vaccination, and other related public health approaches during COVID-19 be improved to be more effective?	What are the historical and systematic inequalities pertaining to race and ethnicity that have exacerbated the death rate in the state's minority and marginalized communities during COVID-19?	What conditions in the environments where people live, learn, work, play, and worship affected their health risks and outcomes relating to COVID-19?	What are issues relating to the quality of, and access to, physical and mental health treatment and services during COVID-19?

Please share your stories and your ideas for success under each pillar. You may choose to focus on one pillar, multiple pillars, all five, or none. For stakeholders, please share the five pillars and related questions ahead of time to help your community prepare for the conversation.

ADDITIONAL OPTIONS FOR STAKEHOLDERS/ ORGANIZATIONS TO PARTICIPATE

Host a Watch *Party*

Stakeholders can gather their constituents and host a watch party to encourage participation in their communities. A watch party can allow communities to gather and promote robust group discussions around the issues being addressed. This can be captured by the stakeholder/organization and submitted in writing to the Task Force before the deadline.

Host a Discussion

Hosting a roundtable, panel discussion or informal conversation promotes engagement and can foster insightful discussions and interest. These events can be virtual, in person, or a combination of both. When you host your own convening, you may use the Pillars (page 6) and Questions (page 8) to guide your conversations. Decide how you will and capture information from the discussions.

After your discussions, please collect or submit your stories and your feedback. Make them as specific as possible. Please share your responses via email at njcdtf@doh.nj.gov by Friday, December 16, 2022, to be sure they are considered. When you submit your responses, include the name of your organization (if applicable), where your convening took place, describe the number of members in your group and a general description of who was there (i.e., community members from a specific town, advocates, physicians, etc.).

SAMPLE QUESTIONS TO AID YOUR TESTIMONY OR DISCUSSION

- How has COVID-19 impacted you, your family, or your community: the places or environments where you live, learn, work, play, worship, and age?
- What steps would you like to see the government take to address these issues?
- Do you feel your race and/or ethnicity affected your access to COVID-19 related information, testing, vaccination, and/or health care?
- In what ways could primary care better serve marginalized communities during the pandemic?
- How can community members be a resource in times of crisis?
- Were you ever a victim of a scam/fraud relating to COVID-19? If so, please describe.
- What are your suggestions for best practices individuals/ stakeholders/organizations/employers can take to prepare for future public health crises?

THINGS TO NOTE

- **All in-person public hearings will be livestreamed as listen-in only sessions to ensure that individuals can listen to other community members.**
- **Listening to other community members might inspire you to give your own testimony at either another public hearing (in-person or virtually) or to submit in writing.**
- **Please submit written comments no later than Friday, December 16, 2022.**
- **For more information about the Task Force or to watch the hearings and submit comments, visit https://linktr.ee/njcovid**

Appendix E: New Jersey Department of Health Key Informant Interview Methods

HMA and the New Jersey (NJ) Department of Health's Office of Minority and Multicultural Health collaborated and generated a standard set of interview questions. To ensure consistency and reliability of the stakeholder interview process, HMA developed an Interview Guide (PowerPoint slide deck) for use during interviews, most of which were conducted remotely. The Interview Guide met accessibility standards for people with visual, auditory, motor, and/or cognitive disabilities. It was shared with interview subjects in advance of the meeting, as well as attached to the emailed meeting invitation. Interview subjects were offered reasonable accommodations to ensure that interviewees understood questions and interviewers understood responses.

The Interview Guide included brief information and history of the NJ COVID-19 Pandemic Task Force of Racial Health Disparities. The Interview Guide also included information on the purpose of the interviews. Participants were informed that the final report would be aggregated in nature, and quotes would not be attributed to interviewees without their explicit consent. Participants were asked their permission to record and transcribe the interview to ensure accuracy.

For the purposes of the interview, the pandemic was segmented into three phases with defining moments within each of three phases. The phases were identified as "Outbreak" (March 2020 through May 2020), "Social Distancing & Vaccines" (October 2020 through February 2021), and "Prevention & Return" (December 2021 through May 2023).

The same five questions that were asked for each of the three identified phases:

What health equity challenges did you observe?

What programs or policies were implemented to address these challenges?

Did programs or policies initiated during this time contribute to making health inequities better or worse?

What were some of the lessons learned and recommendations that you would give from that insight?

Are there any health equity concerns that you believe were unaddressed during the pandemic and what could have been done?

Near the conclusion of each interview, participants were also asked:

What should NJDOH prioritize moving forward to reduce or eliminate racial disparities in health-related outcomes?

Is there anything we have not asked you that you want to share with us?

Prior to use with interview subjects, all interview tools, including the interview guide and any technology used for interviews was tested. Pilot interviews with leadership of OMMH were included in this testing process.

Approximately 30 interviews were conducted of NJDOH employees between Monday, July 10, 2023, and Friday, August 4, 2023. Interviews were conducted via video teleconferencing technology during weekday business hours at mutually agreed upon times.

Each stakeholder interview was led by two members of the project team. One team member was a primary facilitator, while the second team member functioned primarily as a note taker and timekeeper.

Participants were provided with the interviewers' email and encouraged to reach out with additional thoughts, comments, or questions.

Additionally, 5 listening sessions were also conducted, involving participants from Local Health Departments. Interview questions listed above were also used in this group setting. A survey was also developed using the listed questions, which was then administered to state agencies represented in the Task Force.

Recordings, transcripts, and notes summaries of interviews were analyzed and the findings are summarized in Appendix H and I.

Appendix F: Public Hearings on Community Experience and Perspectives' Common Themes Expanded

Common Themes	Description
Access to Healthcare, Resources and Supports, and other Protective Factors for Community Resilience	Community members highlighted their experiences surrounding access to healthcare resources, and the importance of supportive factors crucial to community resilience. In rural areas, individuals faced isolation and the inability to access essential services like grocery shopping or accessing a pharmacy due to transportation limitations. Community members struggled to access quality food; one participant expressed frustration about living in a food desert and the difficulty reaching affordable grocery stores. Another community member emphasized the disparities experienced in healthcare access, stating that low-income individuals often resort to using emergency rooms in place of primary care, necessitating the need for a conversation about engagement with healthcare providers. Additionally, members of the undocumented community described many barriers including the federal at-home COVID-19 test system falling short for multi-generational households. Community members vividly described their needs in the pandemic and called for information surrounding essential services, such as food stamp and unemployment support, revealing the urgent needs for a comprehensive support system. These experiences emphasize the critical need for improved access to healthcare, quality food, and a robust support system to enhance community resilience, particularly in racially and ethnically diverse communities.
Access to Technology, Broadband, and Digital Literacy	Community members stressed the critical role technology played in the pandemic, while pointing out the digital disparities (the digital divide) in racially and ethnically diverse communities. The reliance on technology for vaccine appointments became a barrier, particularly for those lacking access to technology or those with limited digital literacy. This reliance on technology enabled persons from other communities to come to community clinics where there was limited digital literacy, taking

	up those communities' vaccines and resources. Technology-related barriers contributed to a lag in vaccine rates among at-risk communities in New Jersey. In response to these disparities, a local church demonstrated a grassroots approach, mobilizing young volunteers to assist older adult community members with online registration and navigate Internet challenges. This approach underscores the importance of community-driven solutions to bridge the digital divide. The community further emphasized that exclusive reliance on technology for vaccine or healthcare access perpetuates institutional racism, disproportionately impacting lower-income and immigrant racially and ethnically diverse groups who lack adequate resources and support. Addressing digital disparities is crucial for ensuring equitable access to essential health services.
Healthcare Financing Policy's Impact on Access to Care	Community experiences shed light on the complexities of healthcare financing policies and their impact on residents' ability to access healthcare services. The discussion underscored the disparity in Medicaid payment rates compared to Medicare and commercial insurance companies, noting how fee structures impact the number of providers in racially and ethnically diverse communities. Increasing the number of minority providers and incentivizing primary care in training programs was highlighted as essential. Additionally, the lack of health insurance in the undocumented community was a significant barrier to accessing care, including putting the financial burden of COVID-19 tests on community members. These narratives show the critical need for comprehensive healthcare finance reform to ensure equitable access to care for all, addressing both payment structures and workforce initiatives.
Language Access and Language Barriers	Community members expressed concerns regarding the inadequacy of linguistically accessible care and communication accommodations. They highlight difficulties faced by people with language barriers or disabilities in accessing crucial information throughout the pandemic. Additionally, the shortage of culturally and linguistically competent physicians was emphasized as critical for effective communication and understanding. Specifically, the challenges the Hispanic or Latino community experienced, including language barriers and immigration status, lead to misinformation and fear. Overall, these narratives

	underscore systemic issues in communication during the pandemic response, particularly affecting racially and ethnically diverse communities. The collective message calls for urgent improvements in linguistic accessibility and culturally competent communication in healthcare to ensure equitable and effective response measures
Long-Term Economic and Social	The community had a broader discussion on the enduring economic and social consequences of COVID-19 in racially and ethnically diverse communities. It is important to recognize that many people are still struggling with debt, the loss of family members, and increased rent payments. While some resources exist for people in need, stigma for those that seek support make access to services challenging for some. There is a need for sustained assistance and awareness of the ongoing needs to address the long-term and multifaceted consequences that many individuals are still facing.
Trusted Messengers and Community Engagement	Community members spoke about the importance of having a comprehensive system to disseminate information from health authorities to racially and ethnically diverse communities, while also describing various barriers that impeded communication and understanding. Additionally, concerns were raised about vaccine hesitancy rooted in historical distrust, misinformation, and the impact of social media on racially and ethnically diverse communities. They recognized the importance in engaging communities through local events and meetings on familiar grounds. The use of trusted messengers, including community-based organization, clergy leaders, and local business owners, were suggested for effective communication at the community level. Further, it was recommended to leverage existing nonprofit organizations to build community trust and disseminate information during health crises. They described the lack of Black, Hispanic, or Latino, and Spanish-speaking input, one potential example being physicians, in official communications and community outreach.

Appendix G: NJDOH Staff Experience and Perspectives' Common Themes Expanded

Common Themes	Description
Access to Testing and Vaccination Clinics	Participants noted that services are effective only if intended recipients have both awareness and access. They noted that access to vehicles or public transportation were initially major barriers to both COVID-19 testing and vaccinations. Participants recognized that the State had set a goal of having all testing sites within a 15-minute walk, with due recognition that some people are unable to walk 15 minutes. Participants also observed digital literacy and technology access barriers for some populations, particularly older adults, limited access to vaccines when they were initially available through appointments.
Collaboration with Local Health Departments	Participants emphasized the value of intergovernmental collaboration between state agencies that set policy and LHDs that connect to the immediate community when implementing programs like testing sites and vaccine distribution. Participants strongly suggested that LHD staff members' knowledge of their own communities' cultures was useful in building the trust necessary to successfully implement COVID-19 response efforts. In addition, participants suggested several factors that may help LHDs potentially mitigate the negative consequences of policies and programs in their most disproportionately impacted communities, including ensuring LHDs have a voice in how resources are deployed, having representative LHD staff who look and sound like the population of the communities they serve, and using LHD staff's local understanding of program gaps to inform decision making.

COVID Fatigue	Several interviewees shared that, over time, they experienced fatigue from long hours focused on COVID-19 and the constant criticism, challenges, and barriers faced while attempting to serve the public. Interview participants also commented that the constant focus on the COVID-19 response affected the day-to-day work they had been responsible for before COVID, and they were sometimes unable to prioritize their primary responsibilities. Participants said they took pride in their hard work and their accomplishments, but it was apparent that they were unable to perform their best work—work that helps disproportionately impacted communities in New Jersey stay healthy—because of the constant demands of the COVID-19 response.
Data Should Drive Decisions	Early on, race and ethnicity data were either unavailable or inefficiently collected to support decision making. Participants noted the lack of data limited the state's ability to recognize and respond to inequitable outcomes that were becoming apparent at the local level. The collection of race and ethnicity data improved over time, and the added information was helpful to identify areas that were underutilized or underserved. Participants agreed, without data, only the loudest voices get served, often leaving underrepresented communities short on services, contributing to inequities. Conceptually, the lack of consistent data for decision making was tied to participants' notion of the importance of centering equity in all aspects of work, not only in times of crisis.
Diversity of Communities Facing Health Disparities	Though stakeholder interviews focused on COVID-19 health equity and health disparities among racially and ethnically diverse populations, interview participants frequently noted the importance of recognizing the health-related social needs of other groups of underrepresented populations, including older adults, children, people with intellectual/developmental disabilities (I/DD), people who are homebound, individuals who are justice-involved, shelter residents, migrant workers, and residents of congregate settings.
Distrust of Institutions (Government and Healthcare)	As testing and vaccine programs were implemented, it became evident that community members' distrust of government organizations and affiliated programs would be a barrier to successfully reducing the spread of COVID-19. To efficiently

	address and implement an effective pandemic response, NJDOH needed to recognize the diversity of communities and understand the assorted reasons why community members were vaccine-hesitant or vaccine-resistant. Interview participants noted some populations hesitated to get vaccinated because they received misinformation or disinformation and/or distrusted oft-changing advice. Other populations were resistant because of historic racism and medical maltreatment of minority communities; specifically, and frequently cited during stakeholder interviews was distrust related to historic medical testing on minority communities (e.g., the Tuskegee Syphilis Study). Many interview participants reflected that for undocumented individuals, accessing resources and services came with fear of unintended consequences, such as involvement with the US Department of Immigration, Customs, and Enforcement (ICE). Specifically, fear of deportation presented barriers to contract tracing, treatment, and vaccination.
Equity at the Center of Public Health	Many interview participants noted that focusing on equity is not simply one individual on a committee's assignment. They agreed that leadership must model a focus on equity, which should be embedded in everyone's work. By ensuring common awareness of the parity implications of policies and programs (e.g., testing access, vaccine distribution), it is possible to mitigate disparate outcomes.
Lack of Funding and Funding Sustainability	Multiple interview participants noted that federal COVID-19 relief funds provided important resources to ramp up testing and vaccine outreach efforts, including financial support for the Vaccine Call Center and COVID Community Corps programs. Many interviewees commented on the impending loss of this funding and shared concerns that groups of people, notably undocumented and newly arrived New Jersey community members, would lose access to testing, vaccines, and healthcare services.

Language Access and Language Barriers	Language barriers were consistently identified as a challenge to ensuring equitable access to testing, vaccines, healthcare and Health Related Social Needs (HRSN) supports to address SDOH. Participants observed that though some outreach and education was distributed in languages other than English, other languages were overlooked. Additionally, many languages have multiple dialects, and nuances to communication were missing in some written material. Participants observed that the COVID-19 pandemic was particularly challenging because of the emergence of new terms, phrases, and concepts that required translation (e.g., personal protective equipment, coronavirus) that may have been difficult to translate. The lack of interpretation services for all languages and dialects was seen as a driver of inequitable outcomes for racially and ethnically diverse communities. In addition, participants noted that translated educational material was needed in verbal and written formats. Having only written translated material was seen as ineffective because it does not consider the needs of people with limited literacy or who are illiterate.
Meet the Community Where They Are/Trusted Community Voices	Participants noted the importance of providing accurate, real-time verbal messages to local communities. Effective mitigation strategies that participants observed were sending messages into the community via trusted voices through the Ambassador Program, creating access to support through the call center, and engaging with the public via the COVID-19 Community Corps. Reliance on the Internet and TV for messaging was inadequate for engaging certain groups of community members who had limited or no access or comfort with technology. The Ambassador Program, a concerted effort to engage community members with familiar, trusted community members, was frequently cited in stakeholder interviews as a key component that facilitated COVID-19 testing, vaccines, and access to medical services. Many interviewees credited partnerships with local FBOs and their role in driving successful vaccine efforts.
Social Determinants of	Participants noted that inequitable health outcomes for minority communities already were a significant issue before the pandemic. Limited access to healthy food, safe housing, and

Health Worsened by the Pandemic	trusted, accessible medical care existed before the pandemic, which only exacerbated these challenges. For example, at the onset of the pandemic, many routine medical services were delayed or canceled, leaving people with preexisting conditions most susceptible to the virus and complications related to significant chronic conditions like hypertension and diabetes. Some participants relayed that social distancing was challenging for certain community members, including individuals living in multigenerational homes and congregate settings. The inability to socially distance or quarantine proved to be doubly challenging. Members of high-risk settings, particularly people living in crowded or communal settings, were both unable to avoid exposure to COVID-19 and were prevented from obtaining many healthcare and HRSN supports.

See page 90 for methods.

Appendix H: Local Health Department Listening Sessions' Common Themes Expanded

Common Themes	Description
Access to Testing and Vaccine Clinics	LHD participants noted many barriers to making vaccines accessible. Challenges included transportation, hours of operation, vaccine parameters and logistics, and lack of trust for institutions. Persons coming into municipalities being prioritized over persons of color and seniors living in those municipalities for vaccines. Over the course of the vaccine rollout, it became apparent that vaccination mega-sites were inaccessible for many groups, including people working multiple jobs, people without cars, unhoused people, homebound people, and more. In response to these challenges, LHDs began to deploy pop-up and mobile vaccination sites, which quickly became a best practice, allowing municipalities to track COVID-19 trends and embed in communities. Successful locations for pop-up and mobile vaccination sites included schools, libraries, daycare centers, FBOs, parks, street fairs, and places where communities gather. LHDs reflected that though these smaller community-based events brought in harder to reach populations, they also were logistically more difficult to staff and operate.
Collaboration with Local Health Departments	LHDs reflected that the COVID-19 response often felt disjointed and confusing for both public health workers and the communities they serve, often because of the parties working independently of one another. They noted the importance of collaboration between state, federal, and LHD partners to facilitate strategy development and implementation to ensure a cohesive response. Participants also noted that physical presence from LHDs was most impactful for engagement with communities. LHDs could leverage local staff who know their communities and could facilitate meaningful communication. LHDs have many community relationships, know what is happening locally, and are the boots on the ground.

COVID-19 Fatigue	LHD participants noted that as COVID-19 has become a part of life, public health and healthcare, and as the government has moved into a recovery phase, it is clear the public and public health workers are experiencing fatigue. They have observed increasing disinterest in vaccination and a lack of ongoing information about COVID-19. Furthermore, many public health workers' experience during the pandemic was traumatic, and they are experiencing burnout and fatigue. As a result, many are leaving the workforce.
Data Should Drive Decisions	LHDs noted that an inconsistent vaccine distribution strategy created inequities in some counties. Though some counties had restrictions on who could get vaccinated in their county, others did not. Consequently, community members with more time and money available travelled to other counties to be vaccinated, leaving less vaccines for the intended populations. Participants recommended future vaccine distribution by zip code. Additionally, participants noted that knowing vaccine rate by zip code is insufficient to address inequity, more detailed demographic data would be helpful for targeted outreach.
Distrust of Institutions (Government and Healthcare)	Listening session participants noted that, in many communities, distrust of the government and healthcare influenced community members' reception to COVID-19 messaging and their decision about whether to get vaccinated. Many people of color, including members of the Hispanic or Latino community, and some community members who are undocumented often felt uncomfortable with police/national guard presence at vaccine sites, use of government buildings, willingness to receive hospital care and were wary of government officials knocking on their door without notice for contact tracing. Though these kinds of interactions made some community members feel more secure, they historically have been a danger for others. Additionally, the community members who were unhoused initially were urged to receive the Johnson & Johnson one-dose vaccine, which seeded distrust in the community once vaccination recommendations were updated to note that two-dose vaccine courses were more effective.
Diversity in the Workplace	LHD staff noted the need for increased diversity in the public health workforce. They discussed the realization that lacking staff who reflected the communities they serve affected their

	success. For example, a community with many Spanish-speaking community members had few, if any, Spanish speakers on staff. Other participants reported that representative staff increased trust in the community and improved services and communications.
Equity at the Center of Public Health	The pandemic affected everyone, but people of color and low-income communities experienced disproportionate negative consequences. Many members of these populations were essential workers, and/or lived in multi-generational homes. These factors led to increased transmission and cases of COVID-19. Many LHDs noted that they struggled to identify disparities in a timely manner because of a lack of epidemiologists to track trends. LHDs noted that the loss of free testing and vaccine sites will lead to greater disparities. Participants emphasized the importance of ensuring all services are equitably provided and accessible.
Lack of Funding and Funding Sustainability	LHD staff felt their departments lacked timely emergency funding. They said that LHDs were financially unprepared for a public health crisis, and that federal and state funding was delayed. They also noted that LHDs lack long-term, sustainable public health funding. Despite eventual emergency assistance, in general, LHDs and public health departments are without sustainable ongoing funding to prepare for the next crisis. Participants recommend using tax levies in addition to grant funding to build long-term investment and sustainability like other government entities, such as law enforcement.
Language Access and Language Barriers	Most LHDs struggled to provide accessible services for community members who speak a primary language other than English. Many departments did not have any Spanish-speaking employees and struggled to hire people quickly without additional financial resources to support them. Community educators and contact tracers often faced language barriers across communities. LHDs hired out of state contact tracers and used mobile apps to translate, such as PocketTalk to translate, but noted it is important moving forward to address this gap in the LHD workforce.

Meet the Community Where They Are/Trusted Community Voices	LHDs faced many challenges reaching out to the community, including building new relationships, language barriers, and facing distrust of government. The value of meeting communities where they were in terms of time of day, location, and mindset were emphasized. LHDs noted it was critical to work with community members to get the message out, and partners like FBOs, CBOs, libraries, schools, and many others were key to building trust in the community, especially in historically marginalized communities. LHD staff noted while in-person outreach worked for some populations, it created more fear for others, including undocumented people. Representatives from these communities need to be involved in the outreach and communication in ensure effective engagement.
Misinformation and Disinformation	Misinformation and disinformation, much of it coming from social media, were massive barriers to COVID-19 response work and vaccine rollout. LHDs had to combat vaccine hesitancy, stigma, politicization, and ever-changing messaging. Vaccine hesitancy was a challenge across all racially and ethnically diverse groups as well as an issue within some health departments. As more vaccines and boosters rolled out information became more confusing and challenging to communicate. Many LHDs expressed they would have had more success if they had more control over communication with the community through existing trusted relationships. LHDs acknowledged that while these challenges still exist, they recommend the following, which were helpful: getting the right information out on social media, working to understand people's fears, educating throughout the community, and leading by example.
Social Determinants of Health Worsened by the Pandemic	Across all counties, communities experienced increased needs related to housing, food insecurity, and access to physical and mental healthcare. LHDs noted that pandemic worsened challenges related to the accessibility of safe and secure housing, nutritious and affordable food, and healthcare services as hospitals became overwhelmed. LHD official said it was important to address not only the pandemic, but also the other difficulties people were facing. They expressed that connecting

	people with social services was an essential component of their response.
Staffing Challenges	LHDs had trouble funding all activities necessary to respond to COVID-19 and provide necessary services to the community. They cited challenges staffing clinics and maintaining enough contact tracers to keep pace with the number of cases. These staffing challenges affected the quality of services provided, from points of dispensing not going as planned, contact tracers who were unable to fulfill their duties, to difficulty tracking COVID-19 trends without an epidemiologist. LHD staff expressed the need for proper funding and staff who can respond better in a crisis. LHDs noted staffing will be an ongoing issue as public health emergency funds dwindle.
Technology Access and Literacy	Though technology can improve access to services, it can also create barriers and disparities. LHDs noted that most vaccination sites initially used online registration to schedule appointments. This arrangement led to disparities in access for people with limited access to technology, online literacy, and English proficiency. LHDs said it is important to provide options for those without technology access. Some LHDs established hotlines for vaccination registration to address this gap.

See page 90 for methods.

Appendix I: Other State COVID-19 Health Equity Task Force Findings:

Across Task Force groups, goals and objectives fell broadly into two categories of focus, with some groups undertaking activities in both. The areas of focus were:

COVID-19 Response and Recovery:

Task Force groups, while they incorporated health equity and health disparities, were more focused on addressing COVID-19 during the response and recovery phases with an equity lens.

Health Equity, Health Disparities, and Social Determinants of Health (SDOH): Task Force groups were more generally focused on health equity, health disparities, and the Social Determinants of Health and how COVID-19 exacerbated existing challenges and disparities among racially and ethnically diverse groups.

COVID-19 Response and Recovery Task Force Groups: Summary of Activities

Making COVID-19 testing more accessible to all populations through actions including creating guidance, testing models (drive-through/walk-in), testing mandates around equity, and mapping testing sites to reach disproportionately impacted populations.

Improving equity around distribution of public health information through actions including a communications toolkit, culturally sensitive communication, and increased availability of information communicated in multiple languages.

Creating and advocating for policy change throughout COVID-19, including a housing eviction moratorium.

Increasing engagement with communities experiencing disparities through improved prevention strategies, including stepping up outreach and delivering personal protective equipment, like masks to disproportionately impacted communities.

Training public health workforce and frontline workers in cultural sensitivity and implicit bias awareness.

Increasing equity in data through improving data collection, increasing data sharing, disaggregating data by race, ethnicity, gender, and other SDOH indicators including creating actionable data dashboards.

Providing support to frontline workers, such as housing.

Incorporating equity into post-COVID-19 response work, including making recommendations.

Including the public's experience during COVID-19 through testimony to the legislature, public information gathering efforts, and town halls.

Health Equity, Health Disparities, and Social Determinants of Health (SDOH)

Building up public health infrastructure and implementing new programs to address SDOH through increased funding opportunities, including grant funding from public and private entities.

Training public health workforce and frontline workers in cultural sensitivity and implicit bias awareness.

Increasing equity in data through improved data collection, more data sharing, disaggregated data by race, ethnicity, gender, and other SDOH indicators, and creating actionable data dashboards.

Appendix J: Full List of Acknowledgments

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New Jersey Department of Health

Paramus Health Department

Princeton Health Department

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Rutgers University – Newark

Rutgers University – Camden

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Appendix K: Preferred Terms and Terminology

In an effort to use non-stigmatizing language, the Task Force Report used preferred terms for select populations, groups and communities that reflect the communities that have been impacted by the COVID-19 pandemic. The preferred terms listed below are from the Centers of Disease Control and Prevention (CDC) used in this Report [20].

- Corrections and Detentions
- People/persons who are incarcerated or detained (often used for shorter jail stays, for youth in detention facilities or for other persons awaiting immigration proceedings in detention facilities)
- People who were formerly incarcerated
- People who were formerly incarcerated
- Disability
- People with disabilities/a disability
- People who are deaf or hard of hearing or who are blind or have low vision
- People with an intellectual or developmental disability
- People who use a wheelchair or mobility device
- Healthcare Access and Access to Services and Resources
- People who are underserved by [specific services/resource]
- People who are underserved by mental health/behavioral health resources
- People who are medically underserved
- People who are uninsured/people who are underinsured /people who do not have health insurance
- Homelessness
- People experiencing homelessness
- Persons experiencing housing/housing insecurity/persons who are not securely housed
- People experiencing unsheltered homelessness
- Lower Socioeconomic Status (SES)
- People with lower incomes
- People/households with incomes below the federal poverty level
- People with self-reported income in the lowest income bracket
- People experiencing poverty
- Mental Health/Behavioral Health
- People with a mental illness
- People with a diagnosis of a mental illness/mental health disorder/behavioral health disorder
- Non-U.S.-born Persons/Immigration Status
- People with undocumented status
- Mixed-status households
- Immigrant, migrant
- Refugee or refugee populations
- Non-U.D.-born persons/foreign-born persons
- Older Adults
- Older adults
- Persons aged [numeric age group]

[20] Centers for Disease Control and Prevention. Health equity guiding principles for inclusive communication. 2022. Accessed November 1, 2023. https://www.cdc.gov/healthcommunication/Health_Equity.html

- Elders when referring to older adults in a cultural context
- People Who are at Increased/Higher Risk
- People who are at increased/higher risk for [condition]
- People who live/work in settings that put them at increased/higher risk of becoming infected or exposed to hazards
- Race/Ethnicity
- Racial Groups
- American Indian or Alaska Native persons/communities/populations
- Asian persons
- Black or African American persons; Black persons
- Native Hawaiian persons
- Pacific Islander persons
- White persons
- People who identify with more than one race; people of more than one race; persons of multiple races
- Ethnic groups:
- Hispanic or Latino persons
- People from racial and ethnic minority groups
- Rural
- People who live in rural/sparsely populated areas
- Residents/populations of rural areas
- Rural communities

Appendix L: Task Force Guidance Template

Statement of the Problem:	17. Clearly identify the problem or issue you are trying to address. 18. Frame the problem or issue in a way that lends itself to potential policy solution
Background:	19. Collect and summarize information relevant to a problem or issue (e.g., nature of the problem, causes of the problem) 20. Define the characteristics (e.g., frequency, severity, scope, economic and budgetary impacts) of the problem or issue.
Supporting Data/Evidence:	21. Use quantitative and/or qualitative data as supporting evidence for the problem statement.
Summary of Findings:	22. Interpret the information collected
Data Limitations (if applicable):	23. Identify gaps in the data
Recommendations (based on priorities):	24. Identify different policy options (recommendations) to address the problem/issue, evaluating the policy options to determine the most effective, efficient, and feasible option. 25. Assess and prioritize policy options
Responsible Parties and Timeline for Completion (if applicable):**	26. Identify how the policy will operate and what is needed for policy enactment and implementation (e.g., understand jurisdictional context and identify information and capacity needs) 27. **No need for the Task Force to do this, but it was discussed in one of the working groups for the desire to do a piece of this, i.e., identify which state agency would take ownership to help with more accountability.
Working Group Chair:	

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