

TWO YEARS IN Lessons from the COVID-19 pandemic



Connecticut Health
FOUNDATION
Changing Systems, Improving Lives.

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Page 3

Introduction

Page 5

Changes we can build on

Page 8

Lessons learned

Page 4

The toll

Page 6

COVID in context: Why were
people of color more vulnerable
before the pandemic?

Page 22

Conclusion



When the COVID-19 vaccine became available for all Connecticut adults in April 2021, Hartford's health department hosted a vaccine clinic in an untraditional location: the parking lot of a busy shopping plaza.

It was near Walmart, accessible by bus, a place many people were likely to visit in the days before Easter. City staff had gone door-to-door in nearby neighborhoods in the days leading up to the clinic to make sure local residents knew it was coming. Appointments weren't required, but the shots were intended for Hartford residents, who data showed were not getting vaccinated at the same rates as people from suburban communities.

Several people who attended the clinic told local media they had tried to book appointments online for other vaccine sites, but had given up in frustration.¹ In all, 230 people got vaccinated the first day. Another 800 or so got vaccinated in similar pop-up clinics held throughout the city that week.

The clinic was a striking example of accessibility, designed to remove as many barriers as possible.

That was far from the norm during the first two years of the COVID-19 pandemic, when distribution of COVID tests, vaccines, and other resources were often set up in ways that primarily met the needs of those who already had the most advantages.

The pattern seemed to repeat again and again — from the early days of COVID vaccines, when sign-ups were largely available online despite many residents lacking technology or reliable internet access, to recent local distributions of masks and home test kits, which many municipalities gave away on a first-come, first-served basis in a set time window, set up for people to drive through.

It begged the question: “What have we learned?”

The COVID-19 pandemic exposed deep inequities that existed long before the novel virus. At virtually every stage, people of color faced the starkest challenges and the worst outcomes. Black and Hispanic Connecticut residents were more likely to leave home for work during the pandemic,² to lack health insurance³ or a primary care provider,⁴ and face a level of economic vulnerability that made the consequences

of missed work more dire.⁵ They were the most likely to get COVID, to have underlying conditions that made complications more likely,⁶ and to die from the virus. They lost jobs at higher rates during the economic downturn.⁷ Often, they were the last to receive access to the resources that helped keep people safe, including tests and vaccines.⁸

The state's initial approach to many challenges seemed to prioritize reaching as many people as possible, without accounting for the additional challenges facing many of those who were hardest hit. Targeted interventions typically came later. As a result, those who were already disadvantaged were left even further behind.

Two years after Connecticut's first COVID case, it is critical to take stock of the lessons and consider how to address the inequities that made this crisis particularly painful and deadly.

In moving toward recovery from the pandemic, Connecticut can return to a society that resembles the old, deeply inequitable one we had before — or we can incorporate the lessons learned from this experience and produce a stronger, more resilient state.

The pandemic led us, the Connecticut Health Foundation, to shift how we operate as well. We created a health equity collaborative designed to bring together those seeing how interventions were working on the ground, and to share their feedback with state agency leaders and health systems. We supported community organizations to serve as trusted messengers to share information about the virus, resources, and, eventually, vaccines, with their communities. We are still reflecting on how to incorporate the lessons of the pandemic into our work going forward — and how to revise our approach to better serve communities of color.

This report is based on our observations, experiences, and interviews with members of the health equity collaborative, trusted messengers, and other foundation partners who are involved in the response to COVID-19. Our purpose is to assure that we all learn from the past two years and use these lessons to create a more equitable Connecticut, with policies that value and serve all residents. We hope others will join us in sharing what they learned and committing to working to create a state where all residents have the opportunity to thrive.

THE TOLL

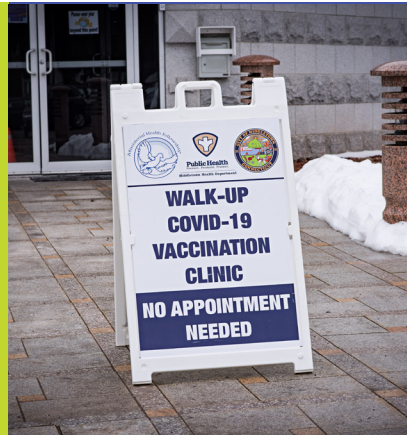
Nearly everyone in Connecticut has felt the toll of the pandemic in some way. But the burden has not been uniform.

As of February 2022, more than 10,000 Connecticut residents had died from COVID-19. The toll was particularly high among people of color. Compared to white residents, Black residents were twice as likely to die from the virus, while Hispanic residents were 1.7 times as likely to die from it. Multiracial residents died at nearly six times the rate of white residents.⁹

A survey conducted in the summer and fall of 2021 offers another view of the pandemic's impact. Nearly one in three Black survey respondents said they had a close friend or family member who died from COVID-19. So did one in four Hispanic respondents and nearly one in six white respondents.¹⁰

The economic disruption caused by the pandemic hit unevenly too. According to one analysis, in the first five months of the pandemic, 42.5% of Native American workers, 30.3% of Black workers, 27% of Hispanic workers, and 26.1% of Asian or Pacific Islander workers filed for unemployment, as did 20.7% of white workers.¹¹

More than
10,000
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Connecticut Black
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2x

more likely to die
from COVID

Connecticut Hispanic
residents were

1.7x

as likely to die
from COVID

Nearly
1 in 3

Black CT residents in a
survey said they had a
close friend or relative
die from COVID

CHANGES WE CAN BUILD ON

In the midst of this ongoing tragedy, some things became clearer. The pandemic opened many people's eyes to the steep racial inequities that exist in the state.

"The pandemic helped expose the racial disparities in healthcare," Gov. Ned Lamont told an interviewer in September 2020. "Black and brown people, especially in urban communities, are much more likely to be infected, much more likely to suffer complications, and much more likely to have a preexisting condition."¹²

Emanuela Palmares saw another change: attitudes toward Connecticut's approximately 113,000 residents¹³ who are undocumented.

For years, Palmares saw state and local policies that treated people based on their citizenship — or lack of it. When the public health crisis made clear how much everyone's health is connected, Palmares saw something else: policies that treated people as residents, regardless of their immigration status. Undocumented residents faced steep hardships during the pandemic; although many lost jobs, they were ineligible for unemployment insurance or other federal relief. Connecticut provided some assistance, including a limited form of health care coverage for COVID-related care.

"It's a horrible thing that's happened to us, but I couldn't think of any other scenario to normalize language access, to normalize health care access, to normalize access to supportive services during this pandemic," said Palmares, editor and partner of Danbury-based Tribuna Newspaper, which publishes in Spanish, Portuguese, and English.

The pandemic also brought about relationships, collaborations, and new ways of doing things. Hartford HealthCare built on the experiences of the pandemic — mass testing and vaccination sites, mobile vaccine outreach — in creating a neighborhood health initiative now being piloted in Hartford. It includes a team of eight health care providers who visit community sites to give check-ups, vaccines, and other medical treatment, as well as connect people to resources to address other needs such as legal services or applying for benefits.¹⁴

There were large-scale efforts at community outreach, often led by public health departments and community-based organizations.

Mutual aid groups — people working together to meet fellow community members' needs, including food, diapers, cleaning supplies, job opportunities, or money to help pay bills — sprung up and surged in activity, filling significant gaps in support and demonstrating the resourcefulness of community members in finding solutions to assist their neighbors.

The awareness of the inequities of the pandemic, along with the strong push for racial justice following the murder of George Floyd, led to significant changes in Connecticut law and policies. These include declaring racism a public health crisis; the creation of a commission focused on racism and public health; new requirements for health care providers to collect self-reported race, ethnicity, and language preference information from patients or clients and for state agencies to standardize how they do so; and a study of how to recruit and retain health care workers of color.¹⁵

In the response to these tragedies, there are lessons that we can build on — and must, to make Connecticut a fair and healthy place for all of its residents.

"What have you seen that you can't unsee, that the pandemic made you see?" asked Sarah Lewis, Hartford HealthCare's vice president of health equity, diversity and inclusion. "I think it's really important that we keep asking ourselves that."

"What have you learned that you can't unsee, that the pandemic made you see? I think it's really important that we keep asking ourselves that."

COVID IN CONTEXT: Why were people of color more vulnerable before the pandemic?

The COVID-19 pandemic was in many ways a perfect storm to compound Connecticut's existing inequities. People with underlying health conditions were at greater risk of severe illness and death from the virus, while those in more precarious financial situations were especially vulnerable to the sudden economic downturn.

Health and economic well-being were both indicators of a person's ability to stay safe and healthy during the pandemic — and in both measures, people of color were at a disadvantage. This was not coincidental. Instead, these gaps can be traced to generations of laws and policies.

“The current racial wealth gap is the consequence of many decades of racial inequality that imposed barriers to wealth accumulation either through explicit prohibition during slavery or unequal treatment after emancipation,” economists at the Federal Reserve Bank of Cleveland wrote in 2019.

These policies include “redlining” — a practice started in the 1930s that deemed neighborhoods with more residents of color to be “high risk,” and used the designations to deny home loans in these neighborhoods. Combined with rules that prohibited people of color from buying homes in many suburban developments, redlining effectively shut many Black and Hispanic families out of buying homes and accumulating wealth, as was common among white families. Instead, redlined communities faced decades of disinvestment; even today, schools in these neighborhoods have lower funding levels and test scores.¹⁶

These and other challenges have resulted in enduring gaps in wealth and income.

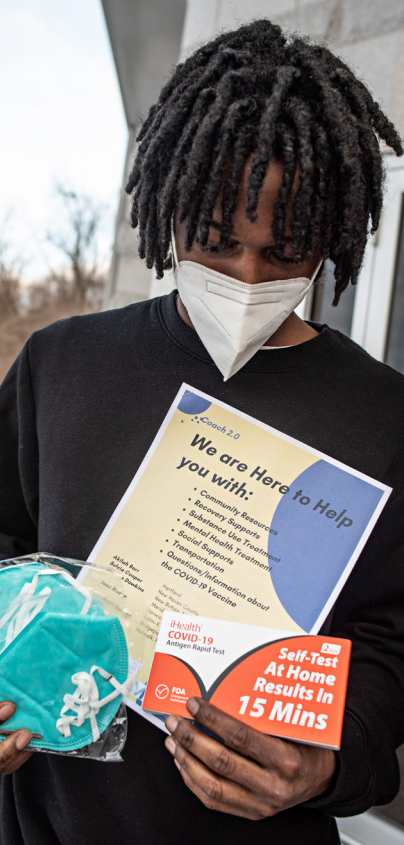
- In 2019, the median wealth of Black families was \$24,100 and for Hispanic families, \$36,100, compared to \$189,100 among white families.¹⁷
- In an April 2020 survey, 46% of Black adults said they could not pay all their bills in full in a typical month, compared to 28% of Hispanic respondents and 20% of white respondents.¹⁸
- That month, 73% of Black adults and 70% of Hispanic adults surveyed said they did not have emergency funds to cover three months of expenses, compared to 47% of white adults.¹⁹

In Connecticut, the gaps in homeownership and income are especially wide.

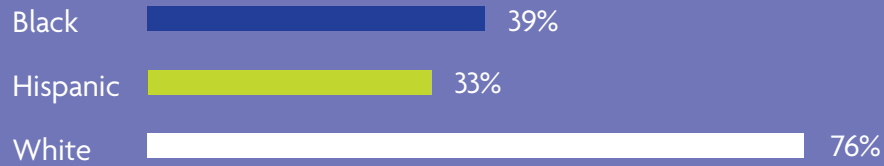
- In 2018, the median income for a household headed by a white person was approximately \$89,000, while the median income was below \$50,000 for Black or Latino-led households.²⁰
- According to a 2020 analysis, 76% of white heads-of-households in Connecticut owned their own home, compared to 39% of Black and 33% of Latino heads-of-households.²¹



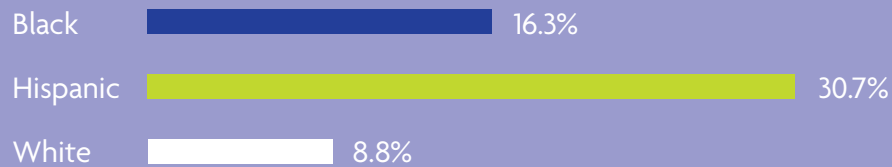
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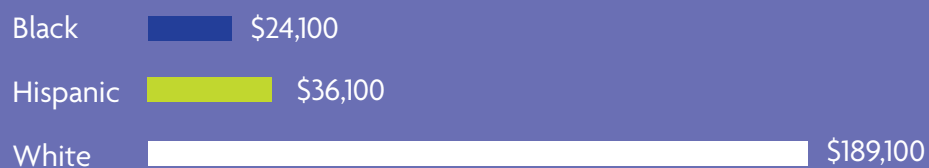
Homeownership in Connecticut



Connecticut Residents Without a Personal Doctor, 2020



Median Family Wealth in the United States, 2019



In a 2021 Connecticut survey, 25% of Hispanic adults said they were worse off financially than they had been 12 months earlier, as did 22% of Black adults and 17% of white adults.²²

Federal assistance for housing, food, and health care coverage helped many families avoid the worst of the economic consequences of the pandemic. Yet when these temporary supports end, people of color will remain disadvantaged. While emergency funding has been vital, it did not change the underlying systems that produced so much inequity.

Longstanding health inequities also played a role in vulnerability to COVID-19.

Before the pandemic, Black and Hispanic Connecticut residents had higher rates of asthma²³ and diabetes,²⁴ two conditions that put people at higher risk for getting severely ill from COVID-19.

People of color in Connecticut also had less access to some of the key tools to staying healthy. Hispanic residents have particularly high uninsured rates — 14.4% of Hispanic state residents lacked health care coverage in 2019, as did 7% of Black residents and 4.8% of white residents.²⁵

In the early days of the pandemic, many people were told to call their doctor to get referred to a test. But nearly one in three Hispanic Connecticut residents — 30.7% — did not have a personal doctor or health care provider. Among Black residents, 16.3% did not have a personal doctor, nearly twice the rate among white residents, 8.8%.²⁶

Yet even when Black and Hispanic residents have insurance and a regular care provider, research shows they often receive less aggressive medical treatment than white patients.²⁷

Taken together, these inequities created a particularly deadly situation when COVID-19 hit.

LESSONS LEARNED

As the pandemic drags into the third year, it can be easy to lose sight of the lessons from the first two years. Yet they offer the opportunity to rethink how things work.

The recommendations in this section are focused on state and local governments, but everyone has a role to play in making our state more equitable and can apply many of these lessons to their own organizations.

For changes to be most effective, they must be incorporated widely and into regular practice — not just in temporary programs or individual organizations.



People of color were more at-risk in the pandemic because of existing inequities. Making Connecticut more resilient will require addressing these inequities, not just restoring what existed before.

It was not a coincidence that people of color were more vulnerable to the effects of COVID-19 and the economic disruption it caused. Even before the pandemic, people of color faced higher rates of illness and premature death than their white peers, and many struggled financially. Connecticut must prioritize changes that will reverse these inequities in economic well-being and health.

Connecticut has an opportunity to take on the underlying inequities that have produced some of the most glaring health disparities in the country. But only if policymakers take intentional steps to do so.

One community considering this is New Haven, where city officials have proposed using funding from the federal American Rescue Plan Act for programs to build wealth in communities of color to close the racial wealth gap. This includes facilitating homeownership (with funds to support, among other things, down payment assistance and closing costs), educational and career opportunities, and support for small businesses.²⁸



Funding from the American Rescue Plan Act offers Connecticut the flexibility to think differently. While much of this funding was used to pay down long-term debt and maintain basic services, there is additional money to be allocated. More broadly, any new funding the state receives can provide an opportunity to operate in new ways or address deeper problems.

There is an opportunity to be more transparent about the decision-making behind how federal and state funds are distributed, and to allow the communities most affected to provide expertise on what investments would be most effective.

But some worry that hasn't been the case yet and wonder how the funding is being spent.

Moving forward, having community engagement strategies in place to identify ways to handle an influx of funding would make it easier to identify potential options in advance, and to garner community input on how the money is used.

So would having a list of policy goals that have been assessed for impact using a racial equity framework²⁹ and could help to address underlying inequities, even without new money.

In Wisconsin, a task force that included the state's Department of Health Services and the governor's office developed [recommendations](#) to produce a just recovery for racial equity. The recommendations address topics including power and representation in decisions about how resources are distributed, housing, health care and emergency management, mental health, economic stability and wealth building, and employment.³⁰

Illinois developed a seven-question [health equity checklist](#) that could be used by state and local agencies to determine how any proposed intervention would improve health and advance equity and identify potential negative consequences on specific communities.³¹ The questions include what communities are most likely to benefit from a given strategy, and how an intervention would benefit disparately impacted communities.



■ **SPOTLIGHT:** **How one city is thinking differently**

New Haven used recovery act funding to create a Department of Community Resilience, which oversees the city's approach to issues including violence prevention, housing and homelessness, re-entry services for people who were incarcerated, mental health, and substance use. Rather than dealing with them individually and reactively, the department is intended to address people's needs cohesively and intervene earlier. The new department takes a strengths-based approach, emphasizing the skills and strengths of clients, not just the challenges they face.

"If the pandemic will have any major impact on how government sees social services, I hope this is one of them, to move upstream and contend with the underlying issues," said Dr. Mehul Dalal, New Haven's community services administrator.



RECOMMENDATIONS

- Use the pandemic recovery as an opportunity to identify policies and programs that can address underlying inequities in economic well-being and health. Create a running list of policy goals and outcomes that will address underlying inequities and commit state agencies to achieving them.
- Develop processes for community input on how federal funding is used and prioritize transparency so we can all see how our tax money is being spent.
- Use a checklist like the one developed in Illinois to assess how equitable potential interventions are. For another useful tool, see [this framework](#) for assessing racial equity implications of health policy, which could be applicable to policies beyond health.
- Make use of racial and ethnic impact statements to assess pending legislation. State law allows any legislator to request these statements for certain bills.³²

Making something “accessible” requires addressing barriers people face.

Making sure everyone has a fair opportunity to access something — whether it’s a vaccine clinic or a home test kit — requires more than simply making something available. It requires considering and accommodating varying needs.

Hartford’s vaccine clinic in the parking lot near Walmart was the result of many choices designed to best serve city residents. They were rooted in a deep understanding of residents’ experiences and a goal of being as accommodating as possible. Liany Arroyo, the city’s director of health, thought about the time constraints of a mom with young children, and the unpredictable schedule of someone juggling many priorities.

“The big thing is that our community members’ lives are so complicated as it is,” Arroyo said. In setting the clinic locations and hours, she and her team tried to make it possible for people to get a vaccine without having to go out of their way or miss work.

Access is often considered in its most basic way: Can people get there?

But public health leaders say an equitable definition of access requires changing what’s traditionally been done. Instead of just making something available and hoping people show up to get it, it means doing what’s needed to get things to the people who need it.

What goes into making something accessible?

As a local public health official, Jen Muggeo is used to thinking about how to make sure access is truly equitable. To her, the question “will people be able to get there?” means addressing many things, including:

1 LOCATION

Is it in a place people can get to if they don’t have a car or a reliable source of transportation? Is it safe to walk and physically accessible for someone with limited mobility?

2 TIME AND DAY OF THE WEEK

For hourly workers, taking a couple hours off work to wait in line means not getting paid. For people with young children, getting to a clinic or distribution might require figuring out child care. Offering a wide window can make a big difference.

3 LANGUAGE

Twenty-two percent of Connecticut residents — more than one in five — speak a language other than English at home. Is information in their language? Is it written at a level people can understand? People won’t go to a clinic or distribution site if they don’t know about it.

4 MESSAGING

How was information about the clinic or distribution sent out? Was it sent by press release or posted on the municipal Facebook page, or shared more widely with people who are trusted in their communities and can help spread the word? Was it shared once or several times in different ways?

5 SAFETY AND TRUST

Do community members feel both physically and emotionally safe coming to the event? Are there trusted partners involved? Have community members received support and services in this setting without judgment and stigma or might they avoid coming because of previous negative and harmful interactions?

“We’re never going to find the perfect solution to reach everybody, but we have allowed our systems to use that as an excuse to throw up their hands and take the path of least resistance, which generally ends up centering and benefitting the people who have lots of access,” said Jen Muggeo, deputy director of Ledge Light Health District, which serves nine communities including New London. “Building health equity involves flipping that.”

Access includes considering factors including location, time and day of the week, language, and how information is shared — and by whom.

“Part of access is trust,” Dalal said. New Haven’s campaign to get people vaccinated included going door-to-door to offer appointments. For residents with specific needs, the city provided transportation to the appointments or offered to bring vaccinations to their homes.

It was a lot of work, Dalal said, but reflects what it means to be equitable in providing access.

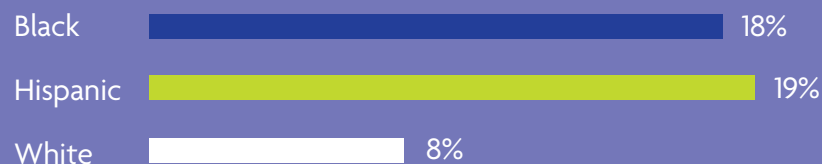
“It’s got to be seen as an active and proactive process, not just a passive process,” he said.

Not taking common barriers into account risks compounding inequities. Black and Hispanic Connecticut residents are more than twice as likely as white residents to lack access to a car or reliable transportation, for example.

While not accounting for barriers to access tends to harm those with the least advantages, doing the opposite — providing multiple options, eliminating as many barriers as possible — can benefit everyone.

In one recent survey, 18% of Black residents and 19% of Hispanic residents said they had stayed home when they needed or wanted to go someplace because they had no access to reliable transportation during the past year, compared to 8% of white residents. (DataHaven, 2021)

Connecticut Residents that Stayed Home Because They Lack Reliable Transportation



RECOMMENDATIONS

- Expect that one-size-fits-all approaches won’t effectively reach those who most need services and plan for multiple strategies from the beginning.
- State and local officials should anticipate varying needs within each community by identifying barriers and resources on a regular basis. This includes knowing what the biggest challenges are in areas that include transportation and language, as well as ways to accommodate them and trusted information sources. Many local government staffers know much of this information and can help design the best way to assure people’s needs are met. DataHaven’s town-by-town health equity reports³³ offer additional data that could help fill in gaps.
- Include people who face access barriers in planning. Incorporating their input will help to design approaches that are accessible to more people, and will strengthen the overall reach by taking a broader range of perspectives into account.
- Apply these concepts beyond the pandemic. Access is often a key consideration in decisions about where health care facilities are located, plans to eliminate services, or adequacy of insurance networks. Physical distance isn’t the only factor that matters.



“Trusted messengers” are critical in a crisis – and are necessary partners in advancing health and well-being in regular times.

Throughout the pandemic, faith leaders, community-based organizations, and others who earned trust at the local level played an important role in providing information and helping their communities stay safe. State and local agencies should support these messengers beyond the pandemic as they can reach communities that are often not well-served by government.

In the early months of the pandemic, the Rev. Robyn Anderson saw a glaring problem. People of color, including those in her congregation, were disproportionately likely to work frontline jobs that put them at risk of the virus, yet seemed to have less access to cleaning supplies, masks, testing, or other resources that could help them stay safe. Information about the virus was changing frequently.

Anderson leads the Ministerial Health Fellowship, a group of Black pastors and church leaders. Working with Middlesex Health and with a small grant from the Connecticut Health Foundation, the Ministerial Health Fellowship developed a curriculum to educate “trusted messengers” about COVID-19 prevention and safety. They trained young people to share information with older members of their church communities, and went door-to-door, distributing wellness kits with educational graphics, masks, hand sanitizer, soap, and thermometers.

They built upon this messaging work when the COVID-19 vaccines became available. The Ministerial Health Fellowship began hosting weekly vaccine clinics at a Middletown church. The clinic marked its first anniversary on Feb. 9, 2022; by then, it had vaccinated more than 15,000 people.

To Anderson, pastor of Blackwell AME Zion Church in Hartford, it was no accident that the trusted messengers were able to reach so many people others could not.

“People feel comfortable,” she said. “It’s in their neighborhood. People look like them and understand them. They feel safe enough to receive the information that’s being given out.”

In times of crisis, when guidance can change quickly and misinformation is rampant, getting reliable information out widely is critical. Often, the messenger can be more important than the message itself, particularly in communities that have not always been well-served by government agencies and other authorities.

During the pandemic, trusted messengers drew on their existing relationships and credibility, serving as both a source of reliable information and a resource for those with questions.

State agencies turned to them when they needed help getting the word out about COVID safety, vaccines, or assistance programs.

The value of trusted messengers won’t end when the pandemic recedes. In fact, if government agencies and health institutions seek to better serve communities of color, it will be critical to support those who have the ability to build trusting and meaningful relationships in their communities.

Trusted messengers can and should play a valuable role in ongoing outreach efforts, whether related to health, social services, or emergency preparedness. Their work has the potential to help improve health outcomes, help people use services, and get the word out during emergencies.

Trusted messengers can also provide input into the work of state and local agencies, offering a view of the concerns and successes they see and hear on the ground. Government agencies could test outreach plans with trusted messengers before launching them, to help identify and troubleshoot any potential challenges.

There is precedent for this. Research has found that barbershops and hair salons can be effective places to share information about cancer screenings, diabetes, heart disease, and other health issues, for example.³⁴ Well before the pandemic, Greater Bridgeport Area Prevention Program had a network of hair salons and barbershops to share information about HIV and other health topics. During the pandemic, the organization shared information through this network, and expanded its outreach efforts by hosting virtual community conversations about COVID-19 and hiring community ambassadors to go door-to-door to talk to residents about the vaccines.



RECOMMENDATIONS

- State agencies should build relationships with and fund community-based organizations to share information, conduct outreach, and solicit feedback from community members. Relying on their outreach services without funding perpetuates existing inequities and limits their capacity and potential impact.
- Outreach campaigns should include specific funding for ethnic media that has strong reach in communities of color.

Connecticut must invest in public health, social services, and regional coordination.

The pandemic hit Connecticut and other states after years of eroding funding for public health and social services, making the response to the needs that arose — particularly early on — more difficult. In addition to funding, coordination between the various systems that serve people and between municipalities is critical in making crisis response more efficient and effective.

While health departments received additional funds during the pandemic, many leaders are wary of a return to the longstanding practice of funds being cut once a crisis ends, rather than continued investment to allow them to remain prepared for — or prevent — future crises.³⁵

“What the pandemic showed me is that we cannot afford to compromise the public health infrastructure,” New Haven Director of Health Maritza Bond said. “I’m very sensitive about the fact that we struggled having to ramp up because we are so underfunded and understaffed.”

Beyond the day-to-day needs, Bond said it’s important for local public health to have a consistent presence in a community, so staff members can build trust over time, rather than having to quickly establish it during an emergency.

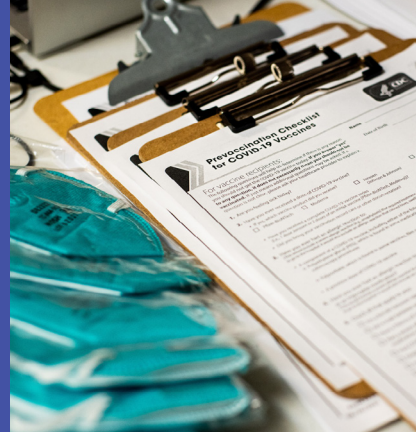
To get messages out, her department often relied on collaboration with community groups and small nonprofits, such as those serving people experiencing homelessness or undocumented residents. But she was quick to note that it often occurred “on the backs of small nonprofits.”

“Those same nonprofits are underfunded,” she said.



86%

Connecticut residents
trust in local health
officials and health
care workers



One clear lesson from the pandemic is that at their best, local public health departments know their communities well. They can play a larger role in helping to address disparities and identifying ways to make care more accessible.

Local health officials are among the most trusted government authorities in Connecticut. In a 2021 survey, 86% of respondents said they had a great or fair amount of trust in local health officials and health care workers, more than for local police or the local, state, or federal governments.³⁶

The capacity and funding levels of local health agencies vary widely across the state, from large departments with nurses and epidemiologists on staff to smaller departments or districts that primarily focus on environmental health issues such as monitoring septic systems and inspecting restaurants.

Many people cited better coordination as a need: within governments, between municipalities, and between state and local health departments. While Connecticut's public health functions happen largely on a local level, more coordination and guidance from the state could help assure all local health agencies can meet certain standards in their response. Regional coordination could also help to avoid duplication of efforts or conflicting messaging.

To Arroyo, one of the most important things that happened in the pandemic occurred early, the week before Hartford had its first case of COVID-19: The city held a meeting that brought together city staff, public schools superintendents and health staff, ambulance companies, the three hospitals in the city, and the local community health centers. It meant everyone knew who the key players were and who to call if they needed something.

"There's a need to continue to do that consistently, not just when there's an emergency," she said. "Finding ways to keep that going is really important, even if it's just on a quarterly basis."

Amos Smith, president and CEO of the Community Action Agency of New Haven, would like to see that type of coordination include social service providers as well. While COVID-19 was a public health crisis, some of the first needs people faced were economic — food and housing, he noted. Yet the social safety net has faced years of underinvestment and a lack of coordination among the different services — from emergency management to health care to basic needs such as food and housing — that affect people's lives.

"Government and those who serve vulnerable people need to be able to come to grips with how we weave together a true safety net for families," Smith said. "What the pandemic did was show us we don't have safeguards for vulnerable people who have transportation limitations or the absence of financial reserves."

RECOMMENDATIONS

- State and local governments should consistently fund local public health agencies and assure they have the resources and staffing to best serve their communities.
- Funding for social services should be able to keep pace with demand. Connecticut needs a robust safety net to meet people's needs during regular times and crises.
- Better coordination between the state and local agencies, and among local agencies, before and during crises, could help to avoid inefficiencies and inequities. State agencies could provide more guidance, and regional coordination could help local officials share ideas and resources.

■ SPOTLIGHT:

Community health workers, a key pandemic workforce

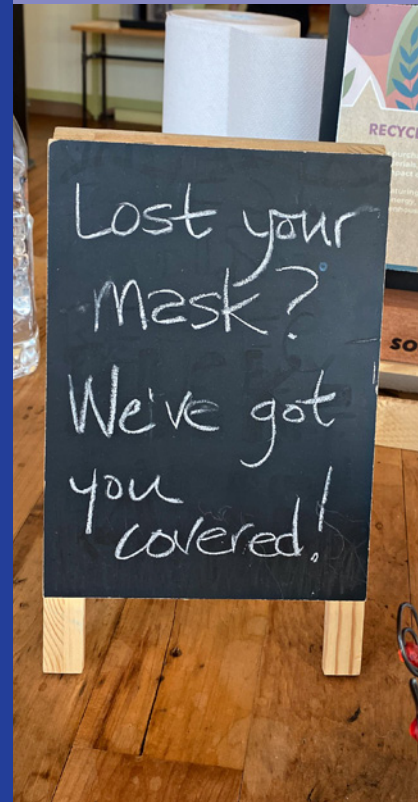
Community health workers — frontline public health workers who can help to bridge the gap between individuals and the clinical care and social service systems — played a vital role in the pandemic response in several Connecticut cities. They helped conduct outreach about vaccines, handled contact tracing, and helped to meet the needs of people who were isolating after a positive test.

Community health workers usually excel at many of the things that proved to be critical in the pandemic: building trust; meeting people's needs in a cohesive, holistic way; and sharing health information in an accessible way. They should be considered a key workforce during public health crises.

Beyond the pandemic, their inclusion in health and social services can help to assure that they reach those who would benefit, that they are accessible, and truly meet participants' needs. They can also be a valuable source of information for public health officials and others on what needs exist in the community, what interventions and messages are working, and what needs to be revised.

One of the biggest challenges facing community health workers is the lack of sustainable funding for their services. The Connecticut Health Foundation and 4-CT funded community health workers in local health departments through grants, but given the potential to improve health and well-being, finding sustainable ways to fund community health worker services should be a key priority for policymakers.

Research has found these interventions are cost-effective — including during the pandemic. In Danbury and Norwalk, community health workers served as contact tracers and helped people address needs such as food, medical care, and help paying bills. An evaluation found that the community health worker services enabled residents to quarantine and reduced the spread of COVID-19 — and that the savings associated with those avoided cases more than offset the cost of the community health worker services.



A key way to catch disparities in real-time is to regularly collect and report data on race and ethnicity.



Data on race, ethnicity, and language preference are critical tools in tracking equity.

A key way to catch disparities in real-time is to regularly collect and report data on race, ethnicity, and other relevant information. During the pandemic, this information helped leaders recognize the need for additional strategies when vaccines were not reaching everyone equitably. Still, data collection and reporting remain uneven in the state.

In early April 2020, the second month of the pandemic, Connecticut officials began reporting the rate of positive cases and deaths by race and ethnicity, following urging by advocates. The findings confirmed what many suspected: Black and Hispanic residents were disproportionately getting COVID-19, and Black residents were more likely to die from it.³⁷

Having this information was critical to understanding who was most affected by the virus. The reported data also showed a significant gap: The vast majority of positive cases had no known race information.

Data is key to developing interventions that will be most effective, a critical tool in a crisis. It can help to determine if complaints represent isolated problems or broader patterns. It can help leaders identify where to deploy resources and where strategies aren't working.

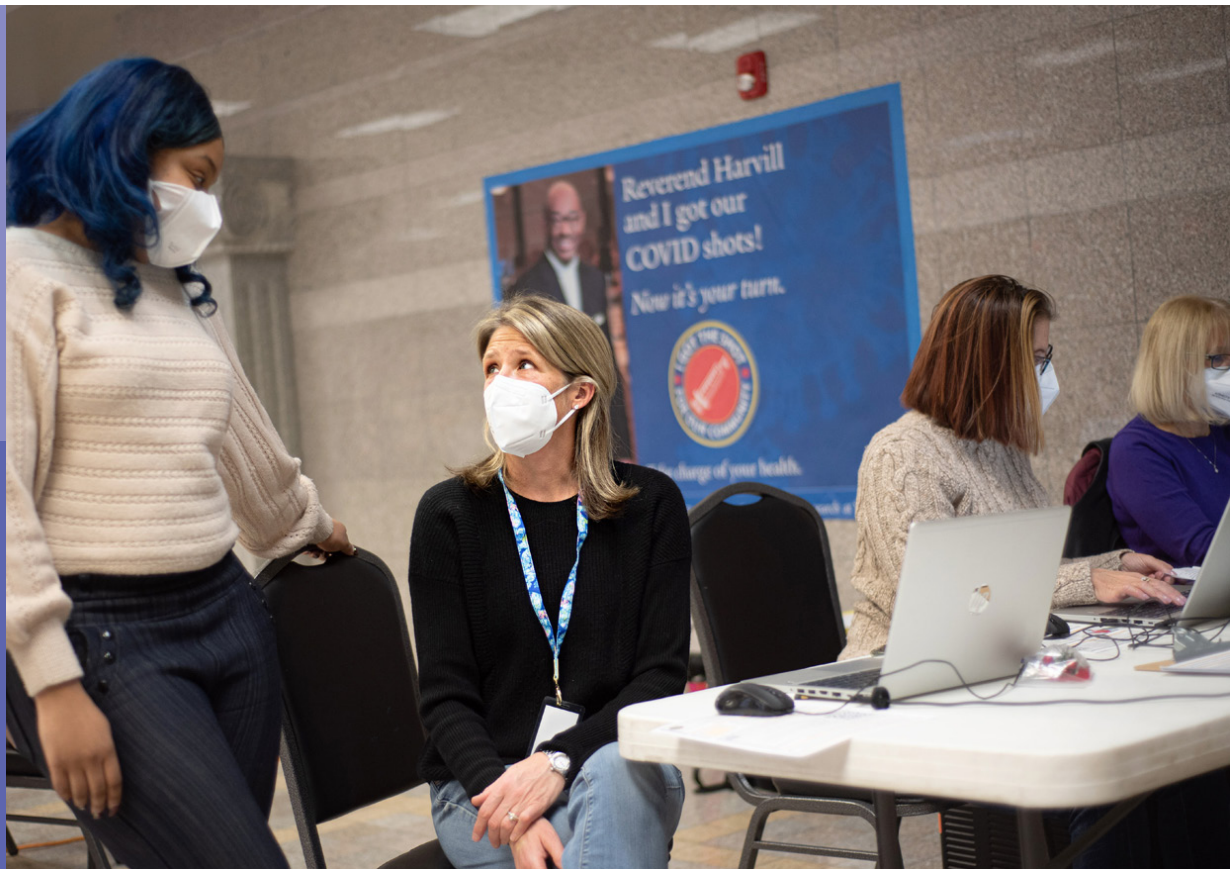
While some race and ethnicity data has been reported regularly, advocates were frustrated by other data gaps that could have helped to identify challenges on the ground. Early in the pandemic, for example, many people of color reported being denied tests when they needed them. Data on race and ethnicity of all tests conducted, rather than just the positive ones, could have shed light on whether certain groups were underrepresented in testing.

Later, when vaccines became available, data made clear that “a disproportionate share of COVID-19 vaccine has gone to wealthier and whiter residents,” Department of Public Health officials noted in a February 2021 memo to vaccine providers.³⁸ While many doses were earmarked for community health centers and pharmacies in cities, many people from outside those areas managed to make appointments using the online sign-up system, sometimes leaving local residents unable to get appointments at facilities in their neighborhoods.

As the pandemic went on, more testing sites and vaccine clinics began collecting race and ethnicity data. Still, as of Jan. 27, 2022, 26% of reported positive cases had no data on race or ethnicity.³⁹

Connecticut has made progress on data collection. A law passed in 2021 requires health care providers to collect patients’ self-reported race, ethnicity, and language preference (while giving patients the ability to opt out). In addition, state agencies that collect this data are now required to do so in a standardized way. This is a tremendous advance, but its biggest value will be if the data is used to assure that everyone is receiving high-quality care — and to find and address gaps when they occur.

This data is important beyond health. Racial inequities exist in housing, education, employment, social services, and virtually every other sector, and being able to identify them is key to addressing them.



RECOMMENDATIONS

- Implement the new state requirements for health care providers and state agencies to collect race, ethnicity, and language preference data. Build on these first steps by incorporating data reporting and analysis to assure that the data is used to identify disparities and address them.
- During emergencies, prioritize transparency with data and report data by race and ethnicity whenever it is available. This can help identify problems and point the way to potential solutions as quickly as possible.
- Expand the collection and use of race, ethnicity, and language data beyond health care to assure that services and outcomes are equitable.

Taking time to get community feedback is critical.

In a crisis, it often seems as though there is little time to spare. But gathering community feedback is critical to making sure that services are designed in a way that meet people where they are and serve the most pressing needs.

Early in the pandemic, two groups in Southeastern Connecticut — the Health Improvement Collaborative and Human Services Network — put together a rapid-response survey of local residents. Through it, they learned that food insecurity and mental health were among the most severe needs.

In response, they developed Food to People, a food distribution effort that included deliveries. Those building the program did so with people's dignity and trust in mind. Over time, it became a weekly touchpoint for people to access not just food, but information about COVID-19, supplies such as masks and tests, and vaccines.

It can be difficult to take time to gather community feedback while trying to respond to a crisis. Yet doing so is essential to assuring that the response best reflects the needs of the community. Equally important is maintaining a way to gather input throughout the response, to monitor how things are working and where to adjust to better meet people's needs.

When this process goes well, and those offering feedback feel heard, it can build trust, interventions are more effective, and community leaders and organizations can help to spread the word about programs and resources. Word-of-mouth is powerful, and when something isn't working well, word of people's frustrations can spread widely and discourage others from participating.

Those gathering feedback must be mindful of power dynamics. Some people who rely on services or funding might be hesitant to provide critical feedback for fear that pointing out problems could lead them to lose funding or services.



In 2020, the Connecticut Health Foundation convened a collaborative to bring feedback from communities of color to state leaders and health systems leaders. The collaborative included leaders of community-based organizations from throughout the state and initially served as a place to bring forward issues their communities were facing with the state's pandemic response. The collaborative members met with state and health system officials to explain how the responses were translating in their communities.

Nancy Kingwood, president and executive director of Greater Bridgeport Area Prevention Program and a member of the collaborative, noted that in the past, health care providers and some community-based organizations designed programs for communities without first getting input from those they aimed to serve. That needs to change, she said.

"We do not have all the answers. People in the community, the residents, they know what they need," she said. "Community people have solutions too."



"People in the community, the residents, they know what they need. Community people have solutions too."

RECOMMENDATIONS

- In developing plans, state agencies should be sure to solicit information from community members to inform their plans from the beginning, and, if possible, build in touch points throughout.
- State agencies should also draw on trusted relationships to know when and how problems are arising in underserved communities. This will allow them to learn about emerging issues and better understand the nuances of issues that arise.
- Getting feedback isn't a one-and-done event; there are always more people to hear from and perspectives to consider, and more to learn. Those providing or funding services should be willing to listen and learn continuously.



There is a momentum that is built
in crisis that can lead to action.



Conclusion

The COVID-19 pandemic made clear that the inequities that existed in Connecticut before March 2020 made us more vulnerable. As we look ahead, it will be critical to reflect, to remember the lessons learned, and to work together to create a more equitable and resilient state. We offer these lessons in that spirit.

Many of these lessons share themes related to the importance of building and sustaining trust, meeting people where they are, and investing in communities. Another is the importance of designing interventions to reach those who are most affected. In a crisis, it can be easy to focus on the fastest way to reach as many people as possible, but without deliberate focus, these approaches almost always leave behind those already facing the most challenges.

Instead, state and local leaders and others would be well-served to take a targeted and universal approach — that is, setting goals that benefit everyone and then using targeted approaches to reach people in varying circumstances.

Beyond that, Connecticut has an opportunity to focus on addressing the underlying inequities that existed before the pandemic.

There is a momentum that is built in crisis that leads to action, but it can fade over time. We can all work together to embrace this opportunity and momentum — toward recognizing and eliminating inequities and building systems that will leave everyone more resilient.

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