The Disproportionate Impact of the COVID-19 Pandemic on Communities of Color in Delaware

A Report of the
Delaware Advisory Committee to the
U.S. Commission on Civil Rights

June 2024

Advisory Committees to the U.S. Commission on Civil Rights

The U.S. Commission on Civil Rights has established an advisory committee in each of the 50 states, the District of Columbia, and five U.S. territories. The committees are composed of citizens who serve without compensation. The committees advise the Commission of civil-rights issues in their state or territory that are within the Commission's jurisdiction. They are authorized to advise the Commission in writing of any knowledge or information they have of any alleged deprivation of voting rights and alleged discrimination based on race, color, religion, sex, age, disability, national origin, or in the administration of justice; advise the Commission on matters of their state or territory's concern in the preparation of Commission reports to the President and the Congress; receive reports, suggestions, and recommendations from individuals, public officials, and representatives of public and private organizations to committee inquiries; forward advice and recommendations to the Commission, as requested; and observe any open hearing or conference conducted by the Commission in their states.

Acknowledgments

The Delaware Advisory Committee would like to acknowledge the speakers who presented during the Committee's series of public as part of this study. The Committee is also grateful to those who contributed to this work during public comment and via written testimony.

Delaware Advisory Committee to the
U.S. Commission on Civil Rights

The Delaware Advisory Committee to the U.S. Commission on Civil Rights submits this report regarding the disparate impact of the COVID-19 pandemic on communities of color in Delaware. The contents of this report are primarily based on testimony the Committee heard during public meetings held via videoconference between September of 2021 and April of 2022. The Committee also includes related testimony submitted in writing during the relevant period of public comment.

This report begins with a brief background of the issues to be considered by the Committee. It then presents primary findings as they emerged from the relevant testimony, as well as recommendations for addressing areas of civil-rights concern. This report is intended to focus on civil-rights concerns regarding the disparate impact of the COVID-19 pandemic on communities of color in Delaware. The Committee considered the extent to which specific state or local policies and practices may contribute to identified disparities, as well as alternative practices or recommendations with the demonstrated potential to address such concerns. While additional important topics may have surfaced throughout the Committee's inquiry, those matters that are outside the scope of this specific civil-rights mandate are left for another discussion.

Overview

The Delaware Advisory Committee, as part of its responsibility to advise the Commission about civil rights issues within the state, submits this report titled, *The Disproportionate Impact of the COVID-19 Pandemic on Communities of Color in Delaware*. The Committee conducted several virtual briefings.[1] Agendas for each briefing can be found at Appendix A. The Committee heard testimony from a variety of subject-matter experts with diverse points of view.[2]

Although the Delaware Committee held briefings in 2021 and 2022 and the report is just now being presented to the Commission, Committee members believe that there will be future public emergencies and that the lessons learned from this review can be applied to such emergencies whatever the cause.

The Committee's review focused on testing, vaccinations, treatment, and the social determinants that impact health care, especially to communities of color in Delaware during the COVID-19 pandemic. However, the Committee recognized that what it learned during its review, including the findings and recommendations, can help inform all stakeholders to collaboratively establish policies, practices, procedures and supportive structures that will be in place well in advance of any future public emergencies. Doing so as soon as is possible and practicable can help ensure that no matter the cause of such emergencies, the responses can be more effective, efficient, and timely and viewed by all stakeholders as more trustworthy, than during the COVID-19 pandemic, especially in communities of color in Delaware.

Methodology

As a matter of historical precedent, and to achieve transparency, Committee studies involve a collection of public, testimonial evidence and written comments from individuals directly impacted by the civil rights topic at hand; researchers and experts who have rigorously studied and reported on the topic; community organizations and advocates representing a broad range of

[1] Virtual Panel Briefing of National Experts before the Delaware Advisory Committee to the U.S. Commission on Civil Rights, Wednesday afternoon, September 15, 2021, Transcript 1, (hereafter cited as Transcript 1).
Virtual Panel Briefing of National Experts before the Delaware Advisory Committee to the U.S. Commission on Civil Rights, Tuesday afternoon, October 12, 2021, Transcript 2, (hereafter cited as Transcript 2).
Virtual Panel Briefing before the Delaware Advisory Committee to the U.S. Commission on Civil Rights, Wednesday morning, March 23, 2022, Transcript 3, (hereafter cited as Transcript 3).
Virtual Panel Briefing before the Delaware Advisory Committee to the U.S. Commission on Civil Rights, Wednesday afternoon, March 23, 2022, Transcript 4, (hereafter cited as Transcript 4).
Virtual Panel Briefing before the Delaware Advisory Committee to the U.S. Commission on Civil Rights, Monday morning, March 28, 2022, Transcript 5, (hereafter cited as Transcript 5).
Virtual Panel Briefing before the Delaware Advisory Committee to the U.S. Commission on Civil Rights, Monday afternoon, March 28, 2022, Transcript 6, (hereafter cited as Transcript 6).
Virtual Panel Briefing before the Delaware Advisory Committee to the U.S. Commission on Civil Rights, Wednesday morning, March 30, 2022, Transcript 7, (hereafter cited as Transcript 7).
Virtual Panel Briefing before the Delaware Advisory Committee to the U.S. Commission on Civil Rights, Friday afternoon, April 1, 2022, Transcript 8, (hereafter cited as Transcript 8).

[2] *See*, panelists' Written Opening Statements (hereafter Panelists' Statements), at: Appendix A.

backgrounds and perspectives related to the topic; and government officials charged with related policy decisions and administrating those policies.

Committee studies require Committee members to use their expertise in selecting a sample of panelists that is the most useful to the purposes of the study and will result in a broad and diverse understanding of the issue. This method of (non-probability) judgment sampling requires Committee members to draw from their own experiences, knowledge, opinions, and views to gain understanding of the issue and possible policy solutions. Committees are composed of volunteer professionals who are familiar with civil-rights issues in their state or territory. Members represent a variety of political viewpoints, occupations, races, ages, and gender identities, as well as a variety of backgrounds, skills, and experiences. The intentional diversity of each Committee promotes vigorous debate and full exploration of the issues. It also serves to assist in offsetting biases that can result in oversight of nuances in the testimony.

In fulfillment of Committees' responsibility to advise the Commission of civil-rights matters in their locales, Committees conduct an in-depth review and thematic analysis of the testimony received and other data gathered throughout the course of their inquiry. Committee members use this publicly collected information, often from those directly impacted by the civil-rights topic of study, or others with direct expert knowledge of such matters, to identify findings and recommendations to report to the Commission. Drafts of the Committee's report are publicly available and shared with panelists and other contributors to ensure that their testimony was accurately captured. Reports are also shared with affected agencies to request for clarification regarding allegations noted in testimony.

For the purposes of this study, **Findings** are defined as what the testimony and other data *suggested, revealed, or indicated* based upon the data collected by the Committee. Findings refer to a synthesis of observations confirmed by majority vote of members, rather than conclusions drawn by any one member. **Recommendations** are specific actions or proposed policy interventions intended to address or alleviate the civil-rights concerns raised in the related finding(s). Where findings indicate a lack of sufficient knowledge or available data to fully understand the civil-rights issues at hand, recommendations may also target specific directed areas in need of further, more rigorous study. Recommendations are directed to the Commission; they request that the Commission itself take specific action, or that the Commission forward recommendations to other federal or state agencies, policy makers, or stakeholders.

Part I. Introduction

The Delaware Advisory Committee to the U.S. Commission on Civil Rights submits this report regarding the factors that contribute to the disproportionate rate of infections and deaths among people of color in Delaware. This report includes comorbidities and socio-economic determinants that may produce disparities along with health care access. The report also includes how disparities can be mitigated during the COVID-19 pandemic. The Committee submits this report as part of its responsibility to study and report on civil rights issues in the state. The contents of ILD lower to the COVID-19 pandemic and the impacts on a national level. It then presents an overview of the state level findings based on testimony received. Finally, it identifies the primary findings as

emerged from the testimony, and the recommendations for addressing areas of civil rights concerns.

This report is intended to focus on civil rights concerns regarding the disproportionate impact the COVID-19 pandemic has on communities of color nationally and in Delaware. Specifically, the Committee sought to examine the impact of the pandemic on access for federally protected classes, including race, color, religion, sex, age, disability, or national origin. While additional important topics may have surfaced throughout the Committee's inquiry, those matters that are outside the scope of this specific civil rights mandate are left for another discussion.

How We Got Here - Background on the COVID-19 Pandemic and Spread

Early in 2020, it was becoming clear that the 2019 Novel Coronavirus had originated in Wuhan, China and was spreading from there. Almost immediately following the first COVID-19 reports in the United States beginning in the state of Washington on January 20, 2020, the health and health care disparities in communities of color as compared with the white communities were becoming apparent as the virus spread across the country. By early April state and federal government sources began releasing data on the impact of COVID-19 on communities of color. African Americans accounted for 68% of deaths related to COVID-19 in Chicago, Illinois even though they accounted for only 30% of the population. This was six times greater than their white counterparts. In September 2020, the CDC released a Morbidity and Mortality Weekly Report showing about 41% of Americans avoided medical treatment or delayed it during the pandemic to date. People of color, women, and ones with disabilities were the most impacted.[3]

Unemployment was reported at 14.7% in early May 2020. This was the highest since the Great Depression in the 1930s. It affected people of color with lower incomes. Most were living in densely populated areas within extended family arrangements, which saw higher infection, hospitalization, and death rates. These were locations of "food deserts" where it was difficult to locate nutritious foods.[4]

Contact tracing and testing was lacking but did improve. Nonetheless, there were disparities in communities of color. Lacking data, it was difficult to target communities that showed disparities

[3] Stacy Tessler Lindau, MD, Catherine Lindsay Dobson Professor of Obstetrics & Gynecology and Medicine-Geriatrics, University of Chicago School of Medicine, Chicago, Il, Transcript 1, p. 12, (hereafter cited as Lindau, Transcript 1). Douglas A. McIntyre, "New Poverty Data Shows Rate in this State is Nearly 20% and Here's the Rate in All 50," *Economy*, (September 16, 2020): https://247wallst.com/economy/2020/09/16/new-poverty-data-shows-rate-in-this-state-is-nearly-20-and-heres-the-rate-in-all-50/. "Population Below Poverty Level by State," *World Population Review,* (2023); https://worldpopulationreview.com/state-rankings/poverty-rate-by-state. About Poverty in the U.S. Population, United States Census Bureau, (page last revised September 13, 2022): https://www.census.gov/topics/income-poverty/poverty/about.html. Meredith Newman, "We know COVID-19 hospitalizations are shooting up, but Delaware isn't tracking age, race," *Delaware News Journal*, October 15, 2020.

[4] Brietta Clark, Professor of Law, Loyola Marymount University School of Law, Los Angeles, California, Transcript 2, pp. 2-3, (hereafter cited as Clark, Transcript 2). Ruqaiijah Yearby, Professor of Law, Center for Health Law Studies and Executive Director, Institute for Healing Justice and Equity, St. Louis University, St. Louis, MO, Transcript 2, pp. 5-6, (hereafter cited as Yearby, Transcript 2). Dayna Bowen Matthew, Dean and Harold H. Greene Professor of Law, George Washington University Law School, Washington, DC, Transcript 2, p. 8, (hereafter cited as Matthew, Transcript 2).

early in the pandemic. It became apparent that there was a need for improved data collection and tracking requiring widespread testing availability for better data analytics to connect multiple social and medical services to where they are needed the most. This extended to health care accessibility. Additionally, it became apparent that food and nutrition, housing and access to social services played into the high levels of death, hospitalizations, and infections in communities of color and needed to be addressed in systemic ways. These disparities are rooted in non-clinical factors that include socioeconomic factors, race, level of education age and residence or where people live. These are social determinants of health. The difference in life expectancy can often be discerned by one's address. "It's about understanding that even if Black and Brown people have equal access to good quality medical care, they may lack access to resources and reliable information about resources that enable high-quality self-care," says Stacy Lindau, NowPow's founder and chief innovation officer. NowPow is an information technology company that provides wellness information for individuals and caregivers to manage diseases through self-care according to the company. Lindau goes on to say that communities must address "true structural determinants of health and health disparities." These include access to transportation, housing, and healthy foods along with primary care services such as behavioral health support, chronic disease management, and substance abuse treatment.[5]

It was critical that once needs were identified, steps were to be taken to target areas to address these disparities. For example, once identified as a COVID-19 hot spot, the State of Delaware marshalled resources to address the growing rate of infections.

Part II. National Impacts

Public Health Response

The United States healthcare system is primarily predicated on providing care through an illness interventional model, not a health prevention or a disease prevention model.[6] An illness healthcare model is not designed to respond to disasters and pandemics.[7] Instead, our public health system focuses on lifestyle, researching diseases, injury prevention, and responding to infectious diseases.[8] Globally, the public health systems have been underfunded for decades. The underfunding impacted staffing and other type of resources.[9]

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[5] Julia Raifman, ScD, Asst. Professor, Health Law, Policy and Management, Boston University School of Public Health, Boston, MA, Transcript, 1, p. 3, hereafter cited as Raifman, Transcript 1). Jayanta Bhattacharya, MD, PhD, Center for Primary Care and Outcomes Research, Stanford School of Medicine, Stanford, CA, Transcript 1, p. 6, (hereafter cited as Bhattacharya, Transcript 1). Lindau, Transcript 1, pp. 10-11. Martha Dawson, DNP, RN, FACHE, President National Black Nurses Association and Associate Professor of Nursing, University of Alabama, Birmingham, AL, Transcript, 2, p. 382-437, (hereafter cited as Dawson, Transcript 2). "Prescribing and Personalizing Whole-Person Care at NowPow," *Chicago Booth Magazine*. (Chicago): The University of Chicago Booth School of Business: https://www.chicagobooth.edu/magazine/nowpow-rachel-kohler-stacy-lindau; Bethany Hall-Long, press conference, October 16, 2020.

[6] Dawson, Transcript 2, p. 10.

[7] Ibid.

[8] Ibid.

[9] Ibid.

The public health system, or faith in the public health system, did not have the public nor the political influence to help with the intervention and develop communication strategies so that we could effectively control and manage the spread of COVID-19.[10] From the national perspective, the public has been inundated with "so many mixed messages from the medical profession, from media sources, from government officials…and because of that, a lot of the public has lost faith and won't listen."[6]

Gaining and maintaining public trust regarding the correct approach to COVID-19 was lacking. Often, the leading stories focused on hostile emissions, lack of beds, and death rather than taking the opportunity to educate and to warn the public.[7] In particular black communities have real reason for distrust in the healthcare system and have been experimented on, through programs that involve our own government.[8]

Nevertheless, the effectiveness of the public health response depended in large part on the response by state governors. Two medical doctors stressed the importance of early treatment.[11] Studies show that early outpatient treatment protocols can save lives and decrease hospitalizations and death by 85 to 86%. Monoclonal antibodies can decrease hospitalization and death by 50% when given early.[12] "But, for some reason, it seems like it's taboo to talk about the availability of these early treatments. This is one of the things that can save lives."[13]

Also, Dr. Bhattacharya stressed the importance of having a focused medical approach and considering who is at risk of COVID-19, such as older individuals who face a "1000-fold greater risk of death if infected with COVID-19 than younger populations."[14] Therefore, a much more focused approach that takes into account who's really at risk, as well as a realistic understanding of life circumstances should have been adopted.[15]

Lockdowns

The scope of human activity touched by lockdowns, that states adopted, to address the COVID-19 pandemic is overwhelming. Lockdowns cancelled many different aspects of our daily life including access to health care, leisure, and seeing loved ones.[16] Given the vast scope of activities touched by the lockdown, it should come as no surprise that people of different means and life situations were affected differently by the suite of policies.

Generally speaking, wealthier individuals with stable jobs that allowed them to work remotely, which research has suggested is about 37% of U.S. jobs, were better able to cope with the economic

[10] Ibid.
[6] Ryan Cole, MD, CEO and Medical Director, Cole Diagnostics, Garden City, ID, Transcript 1, p. 18, (hereafter cited as Cole, Transcript 1).
[7] Dawson, Transcript 1, p. 11.
[8] Lindau, Transcript 1, p. 16.
[11] Bhattacharya, Transcript 1, p. 27; Cole, Transcript 1, p. 10.
[12] Cole, Ibid.
[13] Bhattacharya, Transcript 1, p. 26.
[14] Ibid., page 14.
[15] Ibid.
[16] Ibid.

and other dislocations caused by lockdowns.[17] According the Federal Bureau of Labor Statistics, in 2017-2018, 29.9% of white workers had jobs that allowed them to work at home, and 25.6% did work from home. By contrast, just 19.7% of black workers could work at home, and 17.6% did.[18] Moreover, children in public schools tended to be much more likely to miss school, whereas children in private schools stayed in school for much of the year. That's going to have long-run consequences in terms of learning loss and inequality.[19]

Lockdowns adversely impacted people's health. Lockdowns increased body weight, particularly affecting minority communities.[20] Obesity was the number one risk factor for severe illness from COVID. The Center for Disease Control (CDC) reported that Non-Hispanic Black adults (49.9%) had the highest age-adjusted prevalence of obesity, followed by Hispanic adults (45.6%), non-Hispanic White adults (41.4%) and non-Hispanic Asian adults (16.1%).[21]

The second factor was fear and anxiety disorders. The rates of depression and anxiety were similar across racial and ethnic groups nationally, 15% of white women compared to 19% to 25% of women of color reported traumatic stress symptoms. These numbers corroborate concerns about the status and wellbeing of women, especially women of color during the COVID-19 pandemic.[22]

It is important to understand the broad context of what the lockdowns have done to mental health. A survey published by the CDC states that one in four young adults seriously contemplated suicide in June of 2021. "I've seen surveys stating that one in three people have expressed anxiety or have symptoms of anxiety or depression, [there is] a mental health crisis in children as well."[23] Rates of these risk factors tended to be the highest in the Northeastern portion of the United States,[24] specifically eight of the top 10 highest suicide states in the U.S. are located in Northern-tiered states.[25]

Lockdown Separated Essential and/from Nonessential Workers

The lockdowns separated "essential" from "non-essential" workers with the former class of workers exempted from lockdown mandates and required them to be exposed to COVID-19 risk in their workplace to keep their jobs regardless of their vulnerability to severe disease from COVID-19.[26]

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[17] Ibid., p. 6.
[18] Dayna Bowen Matthew, Dean and Harold H. Greene Professor of Law, George Washington University Law School, Washington, DC Matthew, Written Opening Statement submitted for September 15, 2021Virtual Briefing, p. 4, (hereafter cited as Matthew, Written Statement).
[19] Bhattacharya, Transcript 1, p. 21.
[20] Ibid, p. 6.
[21] Overweight and Obesity, https://www.cdc.gov/obesity/data/adult.html.
[22] Lindau, Transcript 1, p. 13.
[23] Bhattacharya, Transcript 1, p. 21.
[24] Stacy Tessler Lindau, MD, Catherine Lindsay Dobson Professor of Obstetrics & Gynecology and Medicine-Geriatrics, University of Chicago School of Medicine, Chicago, Il Lindau, Written Opening Statement submitted for September 15, 2021, Virtual Briefing, p. 7, (hereafter cited as Lindau, Written Statement).
[25] Cole, Transcript 1, p. 21.
[26] Bhattacharya, Transcript 1, p. 6.

More than 55 million Americans have been labeled as "essential" workers during COVID-19 pandemic. Healthcare workers provided critical medical care to patients, while housekeeping and cleaning workers kept those institutions clean. Nationwide, these jobs have been associated with increased percentages of COVID-19 deaths.[27] Women in the U.S. and Delaware hold a majority of essential worker jobs.[28]

Minority populations are overrepresented among the class of essential workers. Though Whites constitute 76.5% of the U.S. population, they constituted only 55% of essential workers. By contrast, Blacks constitute about 13.4% of the U.S. population and 15% of essential workers. Hispanics constitute 18.3% of the U.S. population, but 21% of essential workers.[29]

Laws and Policies passed to slow the spread of COVID-19 did not protect infections and death among essential workers and the communities in which they live.[30] Even though the federal government enacted four major COVID-19 laws (*Families First Coronavirus Response Act*,[31] *Coronavirus Aid, Relief, and Economic Security Act*,[32] *Consolidated Appropriations Act*[33] and *The American Rescue Plan Act*)[34] that provided economic relief, including paid sick leave for workers, most of those laws did not protect essential workers, particularly racial and ethnic minority essential workers. One, because they were either exempted out and that includes home healthcare workers and undocumented immigrants, or two because it only covered essential businesses that employed more than 500 workers. So many of the essential workers were not covered.[35]

Jobs identified as essential during the COVID-19 pandemic have been associated with increased percentages of COVID-19 deaths.[36] But, not all states had the same results. Massachusetts data shows the highest number of COVID-19 cases were concentrated in communities with a very high proportion of both COVID-19 essential workers and residents of color.[37] In Los Angeles County, minority populations were several times more likely to die from COVID-19 during the pandemic than white populations.[38] Specifically, the death rate data, by race, shows that the white population had 118 deaths per 100,000. The black population had 187 COVID-19 associated deaths per 100,000 and Hispanics had almost three times as many whites, with 337 deaths per 100,000.[39]

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[27] Ruqaiijah Yearby, Professor of Law, Center for Health Law Studies and Executive Director, Institute for Healing Justice and Equity, St. Louis University, St. Louis, MO, Written Opening Statement submitted for October 21, 2022, Virtual Briefing, p. 3, (hereafter cited as Yearby, Written Statement).
[28] Lindau, Transcript 1, p. 12.
[29] Bhattacharya, Transcript 1, p. 6, and his Written Opening Statement submitted for September 21, 2021Virtual Briefing, (hereafter cited as Bhattacharya, Written Statement).
[30] Yearby, Transcript 1, p. 6.
[31] Pub. L. No. 116-127, 134 STAT. 177 (2020).
[32] Pub. L. No. 116-136, 134 STAT. 281 (codified at 15 U.S.C. § 9001 note (2020).
[33] Pub. L. No. 116-260.
[34] Pub. L. No. 117-2, 135 STAT. 4 (2021).
[35] Ibid.
[36] Ibid.
[37] Ibid.
[38] Bhattacharya, Transcript 1, p. 6.
[1] Bhattacharya, Transcript, Ibid., and Bhattacharya, Witten Statement.

Furthermore, an April 2021 report showed that essential workers in California accounted for 87% of the COVID deaths in adults aged 18 to 65.[40]

This disparity is not consistently found in every state. By contrast, when Florida opened its economy early in the pandemic, May 2020, the essential/nonessential distinction was less important, and as a result had much more equal outcomes by race. In Florida, the COVID deaths correspond to the portion of the populations for Latinos, Blacks and Whites.[41] Consequently, the disparate impact tends to be found in states that implemented the lockdown policies for longer periods of time.[42]

Disproportionate Workplace

Prior pandemics have shown that employment factors, including lack of paid sick leave and failure to adopt workplace practices to limit the spread of disease, resulted in higher rates of infections and deaths, among essential workers, especially racial and ethnic minority workers. We saw this during the 2009 Swine Flu pandemic (caused by the H1N1 virus), and we continue to see it during the COVID-19 pandemic.[43]

Research shows that without paid sick leave, working people are 1.5 times more likely to go to work with a contagious disease and three times more likely to go without medical care compared to those with paid sick days. Compared to white workers, black and Latino workers are less likely to have paid sick leave.[44] More specifically, many racial and ethnic minority workers, especially those employed as essential workers, do not have paid sick leave[45] "forcing them to go to work when they were sick, increasing inequalities in their exposure to pandemic viruses, like COVID-19."[46]

Of the jobs associated with a higher increase in infections and COVID-19 deaths, black individuals disproportionately occupied the top nine occupations that place them at higher risk for contracting COVID-19 and affecting their household.[47]

Racial and ethnic disparities in COVID infection and deaths

There is growing evidence that healthcare inequities are directly impacting minorities' access to quality COVID-19 care. And thus, likely contributing factors to COVID-19 outcome disparities.[48] Medicaid beneficiaries experience greater barriers to care and receive poorer quality care than those who are privately insured [49] Minorities are also more likely to reside in areas that suffer from

[40] Yearby, Transcript 2, p. 7 and Yearby, Written Statement.
[41] Bhattacharya, Transcript 1, p. 7.
[42] Ibid, and Bhattacharya, Written Statement, p. 3
[43] Clark, Transcript 2, p. 3.
[44] Yearby, Transcript 2, p. 6.
[45] Yearby, Written Statement, p. 5.
[46] Ibid.
[47] Ibid.
[48] Clark, p. 3, lines 113-115.
[49] Clark, p. 3, lines 95-97.

physician shortages, and they must rely on safety net hospitals and clinics that are under-resourced.[50]

The Affordable Care Act[51] did significantly reduce coverage disparities, but in states that have not expanded Medicaid, racial and ethnic minorities are disproportionately uninsured; therefore, this is likely to experience greater barriers to care.[52] The two reasons consistently given for these disparities are low Medicaid reimbursement and a complex bureaucracy.[53] Eligibility restrictions based on immigration status, and possible immigration actions have a chilling effect on the willingness of many uninsured non-citizens to seek care, regardless of eligibility.[54]

A study of a California major health system – Sutter health, found increased hospitalization for black patients even after controlling for diabetes mellitus, chronic lung disease, and cardiovascular disease -- the most commonly reported conditions co-occurring with COVID-19. According to the study, "[t]he greater odds of hospital admission may indicate that African Americans have more advanced or severe illness at the time of presenting for COVID-19 testing and medical care."[55] Yet other information indicates that Latinos in California were vastly overrepresented in COVID deaths; they represent 55% of COVID deaths, but only represent about 39% of the population. In New York, Blacks represent about 14% of the population, and yet, had 23% of COVID deaths.[56]

In May 2020, data suggested that nursing homes with greater proportions of black and Latino residents were twice as likely to get hit by COVID as those where the population was overwhelmingly white. This was independent of nursing home location, size, and government rating.[57]

By January 2021, death rates for black, Hispanic, and Native American people under 65, were four to 14 times greater than those of white people. Excess deaths among Hispanic, black, Native American, and Asian people were three times those of white people. Working age people 25 to 44 had the largest increases in excess mortality.[58]

There are other factors that can contribute to health disparities. While minority populations had less knowledge about the virus, they were actually more likely than white populations to adhere to practices recommended by public health authorities. The implication is that adherence by minority populations to public health advice cannot explain the worse COVID associated outcomes. In fact, early in the epidemic, minority populations followed public health advice at higher rates according to the data from *The Journal of Public Health*.[59]

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[50] Clark, p. 3, lines 100-101.
[51] *Patient Protection and Affordable Care Act*, Pub. L. No. 111-148, 124 Stat. 119 (2010).
[52] Brietta Clark, Professor of Law, Loyola Marymount University School of Law, Los Angeles, California, Written Opening Statement submitted for October 21, 2022, Virtual Briefing, p. 3, (hereafter Clark, Written Statement).
[53] Ibid., p. 3.
[54] Ibid., p. 3.
[55] Ibid., p. 7.
[56] Bhattacharya, Transcript 1, p. 7.
[57] Clark, Transcript 2, p. 3.
[58] Raifman, Transcript 1, p. 3.
[59] Bhattacharya, Transcript 1, p. 7.

There were many mistakes and missteps regarding the approach to the COVID pandemic, which, depending upon the state, adversely impacted minorities populations. Communities that have been disproportionately affected because they have been underserved suffer from other kinds of deprivations that have been tied to healthcare outcome disparities.[60] Government has a lot of resources because of our tax dollars. There should be more accountability, the government should account for health disparities and explain what these institutions, that receive all of this money, are doing to really address those disparities.[61]

"Public health is not about manipulating people. Public health and medicine [are] about giving people tools to flourish, whoever they are. To take action in their lives, so that they can be healthy and live their lives in good ways."[62]

Part III. Delaware Impacts

Impact on Populations

The COVID-19 infection rate in Delaware disproportionately affected minority populations. Indeed, from April to May 2020, infection rates in the black and Latino communities of Delaware were more than four times that of white Delawareans.[63] In Delaware, COVID-19 rates among individuals self-identifying as black were 49% higher than among individuals self-identifying as white. Evidence also demonstrates that the black population in Delaware experiences more severe complications from COVID-19 due to the increased presence of comorbidities in their population.[64]

Further, individuals most greatly impacted by the COVID-19 pandemic were those in the minority community with occupations categorized as "frontline workers."[65] These minority communities were impacted not only by a lack of available jobs, but, to the extent they held "frontline worker" positions, they were expected to go to work, to drive buses and other public transportation, to be in the restaurants working, and to be in places where they could be exposed.[66] They worked in a

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[60] Clark, Transcript 2, p. 15.
[61] Ibid.
[62] Bhattacharya, Transcript 1, p. 19.
[63] Bernice Edwards, Executive Director, First State Community Action Ass., Inc, Georgetown, DE, Transcript 5, p. 5, (hereafter Edwards, Transcript 5). Mia Papas, PhD, MS, Corporate Director of the Christiana Care Health System Value Institute, Wilmington, DE, Transcript 3, p. 8, (hereafter cited as Papas, Transcript 3) and Written Opening Statement submitted for Mar. 23, 2022, morning Virtual Briefing, p. 27, (hereafter cited as Papas Written Statement - citing Delaware Health and Human Services, Coronavirus (COVID-19) Data Dashboard, My Healthy Community Delaware Environmental Public Health Tracking Network: https://myhealthycommunity.dhss.delaware.gov/locations/state/testing; Rattay PowerPoint, Slide 7 (citing Delaware Health and Human Services, Coronavirus (COVID-19) Data Dashboard, My Healthy Community Delaware Environmental Public Health Tracking Network: http://myhealthycommunity.dhss.delaware.gov/locations/state/vaccine-tracker.
[64] Neil Hockstein, MD, Member, Advisory Council Testing for America, and Surgeon, Christiana Care Hospital, Newark, DE, Transcript 6, p. 7, (hereafter cited as Hockstein, Transcript 6).
[65] Verona Mulgrave, Ph.D., RDN, LDN, Instructor/Extension Specialist in Food and Nutrition Specialist, Delaware State University, Dover, DE, Transcript 3, p. 7, (hereafter cited as Mulgrave, Transcript 3).
[66] Mulgrave, Ibid. Bethany Hall-Long, Lieutenant Governor of Delaware, Dover, DE, Transcript 6, p. 3, (hereafter cited as Hall-Long, Transcript 6).

variety of places in a variety of different industries, including retail service, chicken farms, food service, delivery services, and in the healthcare industry.[67]

In the Latino/Hispanic Community, issues compounding their vaccine uptake included family obligations, availability to take off employment, immigration status, and general misinformation about vaccines. For those who were low-paying wage earners, providing for their family was and remains crucial to ensuring that they have food on the table, and clothes to wear.[68] Many of those who were undocumented were scared to request services to alleviate some of the burdens brought on by COVID-19.[69] Another reason was because they were scared that government agencies that were helping provide the community with vaccine or crisis alleviation resources would later share their information with government immigration agencies, resulting in deportation.[70]

Social Determinants of Health

The disproportionate rate of exposure, infection, and symptom severity amongst black and brown communities corresponds with the social determinants of health. Many social determinants of health that have contributed to such a disproportionate rate of impact concern *infrastructure inequities*.[71] There are several barriers impeding healthcare access, food insecurity, transportation access, childcare access, housing, and health insurance access that limited the ability of members of minority communities to obtain care to address COVID-19. Further, things like sick leave flexibility from work and language barriers further exacerbated the impact of the COVID-19 pandemic on black and brown communities.[72] These social determinants limited access to testing, vaccination, and treatment for COVID-19, which resulted in higher infection rates and hospitalizations for communities of color.[73]

Food insecurity, another social determinant of health, exacerbated the impact of the COVID-19 pandemic on such minority groups. According to Feeding America's Map the Meal data, 114,190 people faced hunger in Delaware prior to the pandemic.[74] Thus, the food insecurity rate in Delaware stands at approximately 11.7%.[75] While Feeding America has not yet provided food insecurity numbers directly caused by the pandemic, data from other sources demonstrates a

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[67] Donna Patterson, Ph.D., Chairperson and Professor Department of History Political Science, Philosophy & Director of Africana Studies Delaware State University, Dover, DE, Transcript 8, p. 12, (hereafter cited as Patterson, Transcript 8).
[68] Alicia Dominguez, Program Manager for ConeXiones, Latin American Community Center, Wilmington, DE, Transcript 6, p. 5 (hereafter cited as Dominquez, Transcript 6).
[69] Ibid.
[70] Ibid.
[71] Hall-Long, Transcript 6, p. 3.
[72] Mulgrave, Transcript 3, p. 6.
[73] Marsha Lee, MD, MPH, Harrington Trust Physician Scholar and Harrington Trust Director within Christiana Care Institute for Research, Equity, and Community Health, Wilmington, DE, Transcript 3, p. 5, (hereafter cited as Lee, Transcript 3).
[74] Cathy Kanefsky, President & CEO, Food Bank of Delaware, Newark, DE, Transcript 7, p. 6, (hereafter cited as Kanefsky, Transcript 7). Mia Papas, Written Statement, p. 29 - citing Feeding America, Hunger in Delaware: http://www.feedingamerica.org/hunger-in-america/delaware. Mulgrave, Written Statement, p. 20 - citing Food Insecurity in Delaware: https://map.feedingamerica.org/county/2017/overall/delaware.
[75] Kanefsky, Transcript 7, p. 6.

significant increase in food insecurity. For instance, in fiscal year 2019, the Food Bank of Delaware distributed 8.7 million pounds of food throughout the state of Delaware.[76] This number increased to 14.5 million pounds of food in 2020, an approximately 68% increase.[77] And in 2021, the Food Bank distributed almost 16 million pounds of food.[78]

The food insecurity rate corresponds with the health of a population. People who are food insecure are at higher risk for obesity, hypertension, diabetes, and other comorbidities.[79] Food insecurity and comorbidity rates, in turn, correlate with poverty. In 2018, the poverty rate in Delaware was 12.5% overall. Race correlated directly with the poverty rate, with 18.8% of blacks, 24.3% of Hispanic, and 9.4% of whites living in poverty.[80]

Nationally, there is an eviction crisis that disproportionately harms black and brown people and female-headed households.[81] The U.S. Center for Disease Control and Prevention (CDC) eviction moratorium ended on July 31, 2021. Still, an extension was granted until October 3, 2021, for communities with high COVID-19 transmission and renters that present a declaration. The moratorium allowed renters during the COVID-19 pandemic to remain in homes without the fear of eviction due to the inability to pay rent or mortgages. However, the evictions resumed with the ending of the moratorium. In Delaware, independent research found that zip codes in communities of color had much higher eviction rates than predominantly white populated zip codes.[82] Delaware had an eviction crisis before the pandemic in that it had one of the five highest eviction filing rates and eviction rates of any state in the country.[83] Delaware's eviction system is relatively cheap, quick, and easy, which combined with the shortage of affordable housing, exacerbated the eviction crisis.[84] According to the Delaware Legal Aid Society, Inc., it cost approximately $45.00 for landlords to file suit to evict a tenant and landlords need not to hire an attorney because corporate landlords may utilize property managers to represent them in court.[85] Indeed, an independent study done by the University of Delaware found that landlords are represented either by an attorney or one of their agents in eviction cases approximately 90% of the time, while tenants are represented by an attorney in less than 5% of eviction cases.[86]

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[76] Ibid.
[77] Ibid.
[78] Ibid.
[79] Verona Mulgrave, Ph.D., RDN, LDN, Instructor/Extension Specialist in Food and Nutrition Specialist, Delaware State University, Dover, DE, Written Opening Statement submitted for March 23, 2022 morning Virtual Briefing, p. 21 (hereafter cited as Mulgrave, Written Statement) - citing Pruitt, S., Leonard, T., Xuan, L., Amory, R., Higashi, R., Nguyen, O., Swales, S. (2016, October 13). Who is food insecure? Implications for targeted recruitment and outreach, National Health and Nutrition Examination Survey, 2005-2010; https://www.cdc.gov/pcd/issues/2016/16_0103.htm.
[80] Mulgrave, Written Statement, p. 20 - citing Quick Facts: Delaware. US Census Bureau: https://www.census.gov/quickfacts/fact/table/DE/PST045218; Minimum Wage, State of Delaware: https://dia.delawareworks.com/labor-law/minimumwage.php).
[81] Daniel Atkins, Executive Director, Community Legal Aid Society, Inc., Wilmington, DE, Transcript 8, p. 8 (hereafter cited as Atkins, Transcript 8).
[82] Ibid.
[83] Ibid.
[84] Ibid.
[85] Ibid.
[86] Ibid.

According to the Delaware Legal Aid Society, poor individuals lack the resources for legal representation in eviction cases, mortgage foreclosure cases, termination of food stamp benefits cases, protection from domestic violence matters, or other civil proceedings.[87] Research has found that 80% of the civil legal needs of poor people are unmet in the United States, with Delaware replicating this study in 2017 and seeing similar results.[88] For tenants, having legal representation can be outcome determinative.[89] "A 2013 Harvard study found that tenants were twice as likely to win eviction cases when they were represented by an attorney than if they were not. The pandemic has highlighted the eviction issue faced by low-income individuals and families with the lifting of the COVID-19 eviction moratorium.

Nonprofit and Government Responses

Darryl Chambers, Executive Director for the Center for Structural Equity (CFSE) looked at the Social Vulnerability Index and the socioeconomic status (SES) of some of the most vulnerable census tracts, 6.01,6.02, 30.02, and 9, located in the Northeast and Eastside sections of Wilmington, Delaware.[90] These census tracts are in historically black neighborhoods where approximately 80% of the residents identify as African American.[91] The CFSE operates under the premise that structural violence (inequities) in such forms as underperforming school systems, an overly aggressive criminal justice system, etc., leads to poor health outcomes.[92]

The Center for Disease Control and Prevention (CDC) Social Vulnerability Index (SVI) uses United States Census data to determine the social vulnerability of counties and tracts to determine the degree to which a community exhibits certain social conditions, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes.[93] The four themes include Socioeconomic, Household Composition, Race/Ethnicity/Language, and Housing/Transportation.[94] An SVI that falls anywhere between 0 and 1 is a vulnerable community.[95] Census tract 6.01 has an SVI of 0.81 and an socioeconomic status (SES) of 0.92; census track 6.02 has an SVI of 0.92 and SES of 1, census tract 30.02 has an SVI of.96 and SES of .87, census tract 9 has an SVI of .76, and SES of.94, and census tract 29 has an SVI of .99 and SES of .97.[96] These census tracts reflect communities that were predominantly black and brown and considered at risk with health disparities as a result of social, economic, and environmental barriers. Additionally, the abovementioned census tracks consist of the total population vaccinated with at least one dose ranges from 36.4% to 56% while New Castle County's total is 75.1%, nearly

[87] Ibid.
[88] Ibid.
[89] Ibid.
[90] Daryl Chambers, Executive Director, Center for Structural Inequalities, Wilmington, DE, Transcript 5, p. 3 (hereafter cited as Chambers, Transcript 5).
[91] Ibid.
[92] Ibid.
[93] Center for Disease Control and Prevention (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR). CDC/ATSDR Social Vulnerability Index (SVI), (March 15, 2022), p. 3: https://www.atsdr.cdc.gov/placeandhealth/svi/.
[94] Ibid.
[95] Ibid.
[96] Ibid.

a 20%-point differential.[97] These census tracts demonstrate disparities as a result of social, economic, and environmental barriers before COVID.[98]

Initially, Delaware did not capture data on race/ethnicity during testing and vaccination until the Governor mandated that future sites collect such information.[99] This data collection highlighted what appeared to be the unwillingness of black and brown communities to get tested and vaccinated.[100] Stories of abuse and horrific experiments in marginalized communities are passed down generationally, which has developed distrust in medical institutions, such as the Tuskegee Experiment and Acres of Skin: Humans Experiment at Holmesburg Prison.[101] This, coupled with misinformation and disinformation, led to an unwillingness to get tested or vaccinated in such minority communities.[102] The City of Wilmington addressed the issues of misinformation and disinformation and witnessed an increase in COVID-19 testing and vaccination by: (1) using employee-trusted messengers to deliver the importance of getting tested, such as notable black physicians, elected officials, community organizers, and teachers; (2) employed signage throughout the city to spread vital information about COVID-19.[103]

Establishing community partnerships with the State of Delaware was absolutely necessary, too. A coalition under the direction of the United Way, was formed in each county to get the black and brown and Latino communities vaccinated. [104] To combat transportation barriers, to the United Way conducted vaccine events in places accessible to the black, brown, and Latino communities, such as apartment complexes and housing developments, churches, parks, concerts, Boys and Girls Clubs, Delaware State University, beauty shops, barber shops, restaurants, schools, and in the streets.[105] The State of Delaware also built a robust COVID-19 testing network, that includes a significant number of permanent and rotating testing locations in communities of color, which provided access to at-home test kits and rapid test kits, which are used in many testing locations.[106] And, the State of Delaware also provided tests to direct support professionals before they served people with disabilities living in the community.[107]

Additionally, the distribution of the COVID-19 vaccine continues to be the largest public health response in Delaware's history.[108] Working with healthcare, government, and community leaders, the Delaware Department of Health and Social Services has used community centers, schools, places of worship, healthcare facilities, pharmacies, and drive through locations to provide the

[97] Ibid.
[98] Ibid.
[99] Ibid.
[100] Ibid.
[101] Ibid.
[102] Ibid, p. 4.
[103] Ibid.
[104] Rita Mishoe Paige, Chair of the Kent Coalition for Vaccine Equity, Pastor of new Beginnings Community AME Church, Frederica, DE, Transcript 6, p. 9, (hereafter cited as Paige, Transcript 6).
[105] Ibid, p. 10.
[106] Molly Magarik, Secretary, Delaware Department of Health and Social Services, Dover, DE, Transcript 7, p. 3. (hereafter cited as Magarik, Transcript 7).
[107] Ibid.
[108] Ibid.

vaccine as quickly, efficiently, and equitably as possible.[109] In June of 2020, there was an infusion of funds that came to New Castle County that quadrupled the testing capacity and expanded testing locations. Christiana Care was able to set up the first drive-thru testing site in New Castle County with those funds and worked closely with New Castle County government to open other testing sites.[110]

During the imposition of the stay-at-home order, when tens of thousands of Delawareans lost jobs or had their earnings substantial reduced due to work availability, the Delaware Department of Health and Social Services, Division of State Service Centers housed more than 9,400 individuals and families who were homeless in motels, including over a hundred individuals and their families who tested positive for COVID-19 due to housing insecurity caused by the inability to pay rent.[111] Today, the Department of Health and Social Services continues to support more than 500 households in motels who are experiencing continued homelessness.[112] And during the last two years, it has leveraged more than $23 million in federal funding to assist those in need of shelter.[113]

Each month, since March of 2020, and with the support of federal funding, the Delaware Department of Health and Social Services, Division of Social Services has issued emergency food and temporary assistance for needy families valued at more than $130 million.[114] And it has distributed monthly pandemic benefits to qualified families so that approximately 45,000 children per month in such families can continue to receive free or reduced-price meals in school.[115] Further, the Community Partner Support Unit in the Division of Social Services has delivered more than one million meals to people who are experiencing homelessness or isolated that are living in motels and hotels because of COVID-19.[116]

The need for childcare services was greatly decreased by the COVID-19 pandemic because more people were staying at or working from home. However, many essential or "frontline" workers still needed such services. By partnering with the Delaware Department of Education and the University of Delaware, the Delaware Department of Health and Social Services allocated more than $93 million in grants to providers through the childcare stabilization fund.[117] That helped keep the doors to childcare facilities open even when the number of children that the centers could take in was reduced. For parents who received subsidized childcare benefits through the Division of Social Services, this coalition was able to reduce the burden on families by providing monthly parental co-pays that totaled approximately $500,000 per month.[118]

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[109] Ibid.
[110] Papas Written Statement, p. 28 - citing Brooks M, Brown C, Liu W, Siegel, SD, Mapping the Christiana Care response to COVID-19, clinical insights from the Value Institute's Geospatial Analytics Core. *Delaware Journal of Public Health*, 2020, July 1).
[111] Magarik, Transcript 7, p. 4.
[112] Ibid.
[113] Ibid.
[114] Ibid.
[115] Ibid.
[116] Ibid.
[117] Ibid.
[118] Ibid.

Lastly, the Delaware Department of Health and Social Services, Division of Substance Abuse and Mental Health, in partnership with healthcare providers and nonprofits, provided extensive outreach to the existing Delaware homeless populations, and with funding and outreach provided by the Division of State Service Centers, many people accepted placements into motels and hotels.[119] Further, the Division of Substance Abuse and Mental Health created the 24/7 Delaware Hope Line, so that Delawareans with mental and emotional needs could consult with trained counselors.[120]

But state government was not the only entity responding to the needs of the Delaware community. As noted above, the Food Bank of Delaware increased food distribution to 14.5 million pounds.[121] And in 2021, the Food Bank distributed almost 16 million pounds of food.[122] This correlates to an 84% increase in food distribution from 2019 and a 10% increase from 2020.[123] As the end of 2022 approaches, the Food Bank of Delaware is on target to distribute over 16 million pounds of food.[124] This drastic increase to address the needs of the Delaware population was made possible by the Food Bank hosting a mass distribution event in each county every month since March of 2020 and through its partnerships with Amazon and DoorDash to deliver food to those unable to leave their homes.[125]

Vaccines and Testing

Donna Patterson, Ph.D. provided a historical perspective of the COVID-19 pandemic and its impact on black and brown populations in Delaware. Dr. Patterson reported that by April 2020, out of the 3,442 state-confirmed COVID-19 cases, 968 of those infected were Black, 912 were White, 519 were Hispanic, and 46 were Asian.[126] Given the number of black and brown residents in the State, the data demonstrated a higher rate of infection amongst such minority groups.[127] When the COVID-19 vaccine began to be distributed in late 2020 and early 2021, Delaware's initial vaccine rollout was slow.[128] This delay in vaccine availability impacted black and brown communities in Delaware in the early months of 2021 for various reasons.[129]

In some cases, people did not meet the age requirements to get the tests, or due to their work constraints, it may have been difficult for them to return to the original site where they received the first vaccine, in addition to issues involving communication, access, and internet accessibility.[130] Family members or community members had to intervene, particularly with elderly populations to help them get signed up for vaccinations.[131] There were incidences of

[119] Ibid, p. 5.
[120] Ibid.
[121] Kanefsky, Transcript 7, p. 6.
[122] Ibid.
[123] Ibid.
[124] Ibid.
[125] Ibid, p. 7.
[126] Patterson, Transcript 8, p. 12.
[127] Ibid.
[128] Ibid.
[129] Ibid.
[130] Ibid.
[131] Ibid.

vaccine hesitancy and, in some cases, anti-VAX sentiments.[132] It took longer to secure more buy-in from the black community than it did for the Hispanic community, whose trust in the vaccine was much quicker due the high number of 2020 COVID-19 infections in the Hispanic community.[133]

Additionally, Congress removed federal funding for COVID-19the budget for Fiscal Year 2022, which will have a significant impact on support for COVID-19 testing, treatment, and insurance reimbursements. It is expected there will be major implications, particularly for people who are uninsured or underinsured, in the distribution of the COVID-19 vaccine.[134]

Dr. Karyl Rattay, Director of Public Health, was instrumental in sharing how the Division of Public Health (DPH) administered vaccines and conducted testing in Delaware. DPH was challenged in its response to the COVID-19 pandemic due to the lack of data and data systems that could adequately handle the volume and track the number of tests and cases.[135] DPH's electronic reporting system tracks approximately 5,000 cases a year of reportable diseases, and with COVID-19, the system was overwhelmed.[136] It took time to get contact tracing in place, and eventually, DPH did develop a more robust system.[137]

Through *My Healthy Community*, DPH has provided publicly facing data, available since April 2020, to the public and continues to build on it. Data is available by census tract and zip code and can be stratified and downloaded. DPH has used this data to ensure that all Delawareans had access to COVID testing. They used the Social Vulnerability Index (SVI) to assess community vulnerability and ensure testing was available in communities of concern.[138] Overall, testing rates were the highest among Hispanics, followed by Black, Asian, and White populations.[139] DPH used data combining COVID-19 vaccination coverage by census tract with the SVI to identify communities requiring more intensive efforts.[140]

Early in 2021, when vaccines became available, the racial group that received the greatest number of vaccines was white.[141] DPH received additional funding that allowed them to work more community groups to support their efforts to increase education about and access to the vaccine in minority communities.[142] The Hispanic population was more receptive to receiving the vaccine than the black population. When the vaccine was widely available in all age groups, the vaccine rates in the Hispanic population increased as more families got the vaccine together as a family

[132] Ibid.
[133] Ibid.
[134] Ibid.
[135] Karyl Rattay, MD, MS, FAAP, Director Delaware Division of Public Health, Dover, DE, Transcript 8, p. 23, (Hereafter cited as Ratty, Transcript 7).
[136] Ibid.
[137] Ibid.
[138] Ibid., p. 4.
[139] Ibid.
[140] Ibid.
[141] Ibid.
[142] Ibid.

unit.[143] Overall, while more white Delawareans had received at least one dose of the vaccine, vaccine uptake has been equal among black and white seniors in Delaware since July 2021.[144]

DPH also reviewed geographical data concerning cases of COVID-19 and deaths resulting therefrom and noted that areas around Dover, Wilmington, and in Western Sussex County were most affected by the COVID-19 pandemic.[145] DPH noticed there was a correlation between the distribution of cases and deaths and the under-resourced regions.

There also appeared to be a correlation between Supplemental Nutrition Assistance Program (SNAP) usage, violent crimes, poverty, and other social determinants of health and COVID-19 cases.[146] DPH noticed this correlation most heavily in the Wilmington and Western Sussex areas.[147] DPH concluded that the COVID-19 pandemic has had a disproportionate impact on Black, Hispanic, and Native American communities through this data.

Community partnerships were instrumental in helping DPH reach black and brown communities. During the first year of the COVID-19 pandemic, DPH worked with community partners to provide community testing to ensure that all Delawareans had access to healthcare and the COVID-19 vaccine.[148] For example, The Healthy Communities Delaware provided over 600 care kits, including masks and disinfecting wipes, and distributed education material vulnerable to communities.[149]DPH also partnered with pharmacies to provide vaccines and testing to vulnerable communities. Through mobile clinics, DPH offered vaccines at numerous community events, including seven hundred homes where individuals had barriers to obtaining the vaccine outside their homes.[150]

Christopher Casscells, MD, shared data from the Kaiser Family Foundation and the National Center for Health Statistics as of November 10, 2021.[151] According to Dr. Casscells, in Delaware, the African American population was responsible for 21% of COVID-19 deaths while accounting for only 10% of Delaware's population, the white population was responsible for 73% of the COVID-19 deaths while accounting for 61% of the Delaware population.[152] In the surrounding states of New Jersey, Maryland, and Pennsylvania, data shows a slight increase in the COVID-19 death rate of African Americans over the African American population percentage, while the Hispanic COVID-19 death rate in all four states was lower than corresponding Hispanic population percentage.[153] Dr. Cassell indicated that the Delaware data in the Kaiser Family Foundation or

[143] Ibid.
[144] Ibid.
[145] Ibid.
[146] Ibid., p. 5.
[147] Ibid.
[148] Ibid.
[149] Ibid., p. 6.
[150] Ibid., p. 4.
[151] Christopher Cassells, MD, MS, FAAP, Director, Center for Health Policy Caesar Rodney Institute, (city, DE, Transcript 8, p. 6, (hereafter cited as Cassells, Transcript 8).
[152] Ibid.
[153] Ibid., p. 7.

kff.org health facts were inconsistent with the neighboring states previously mentioned and the United States' data in general.[154]

It was also noted that Delaware does not produce statistically significant data on Asian or Native American subgroups.[155] In addition, there was debate among political leaders and health experts about the prevalence of asymptomatic transmission and whether chloroquine and hydroxychloroquine were effective in treating COVID-19. This disagreement helped fuel public confusion. The COVID-19 physician, medical experts and researchers who testified before this Committee debated the merits of Ivermectin as an effective treatment for COVID-10. Indeed these therapeutics were removed from CDC recommended treatments.[156]

Leroi Hicks, MD, MPH, FACP, shared that for about 30 years, it has been known that there is a lower life expectancy for African Americans in the United States compared to those in the white population, and that for more than 20 years, it has been known that the life expectancy is lower for Hispanics in the compared to their white counterparts.[157] Five challenges may be related to these varying healthcare and life expectancy outcomes among these racial lines:

- differences in risk factors for underlying transmission;
- disparities in access to, communication to receive, and general effectiveness of healthcare modalities;
- differences in utilization of testing and evaluation;
- constructs within the healthcare system that do not allow for deferential delivery of services that matched the needs of a given community[158] Treatment differences are largely related to the complexity of the healthcare system, particularly complexities caused by a brand new pandemic and the rapid advent of telemedicine;[159]
- differences in health outcomes caused by the availability and transparency of care early on in the pandemic.[160]

[154] Ibid.
[155] Ibid.
[156] David J. Sencer, "CDC Museum COVID-19 Timeline," *Centers for Disease Control and Prevention* (March 15, 2023): https://www.cdc.gov/museum/timeline/covid19.html.
[157] LeRoi Hicks, MD, MPH, FACP, Chief Medical Officer, Wilmington Hospital Physician Leader, Institute for Research in Equity and Community Health (iREACH) Christiana Care, President-Elect, Society of General Internal Medicine, Transcript 8, p. 7, (hereafter cited as Hicks, Transcript 8).
[158] Ibid.
[159] Ibid.
[160] Ibid.

FINDINGS AND RECOMMENDATIONS

Among their duties, advisory committees to the U.S. Commission on Civil Rights are authorized to: (1) advise the Commission concerning matters related to discrimination or a denial of equal protection of the laws under the Constitution and the effect of the laws and policies of the federal government with respect to equal protection of the laws, and (2) initiate and forward advice and recommendations to the Commission upon matters the advisory committees have examined.[161]

Part IV. Findings

Health and Social Disparities

Inequities in health disparities existed in Black and brown communities before the advent of COVID 19. Areas where structural inequities are compounded predict the magnitude of health and social inequalities. Structural inequities refer to underperforming schools, underemployment, lack of affordable housing, and inadequate healthcare systems.[162]

Black and Hispanic households are almost twice as likely as white households to be "cost-burdened," defined as paying more than 30 percent of their income for housing. The national low-income housing coalition reported, in Delaware, before the pandemic that there were about 19,000 households that were severely cost burdened (spending more than half of their income on housing costs and utilities) and had incomes less than 30% of the state's median of $24,600 for a family of four.[163]

Based on the latest data available as of 2019, 38% of Delaware households are classified as the working poor.[164] Of the working poor, 11% are below the federal poverty line, with 27% being classified as ALICE, asset limited income constraint employed.[165] ALICE households earn above the federal poverty line but not enough to afford basic household necessities. [166]

Moreover, 47% of Delaware renters and 27% of homeowners have substandard housing, including incomplete kitchens, plumbing, and overcrowding. They live in less desirable locations, in communities with low-quality education, scarce healthcare providers, food deserts, exposure to environmental risk, longer commutes, and higher transportation costs. [167]Living in crowded housing, utilizing public transportation, and having difficulty accessing healthcare all increase the risk of being affected during COVID 19.[168]

Black and Hispanic households have systemically been unable to capitalize on wealth accumulation through homeownership due to inequities in lending, access to credit, income inequality, redlining, gentrification, and housing discrimination. Black and Hispanic households are denied mortgages at twice the rate of white applicants. If Black and Hispanic households get a loan, they are three times more likely than White

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[161] 45 C.F.R. § 703.2.
[162] Chambers, Transcript 5, p. 3.
[163] "The State of Housing in The First State," *Housing Alliance Delaware*, (2019): https://static1.squarespace.com/static/59ca9d72268b96cb977e74fd/t/5dbc27a09bac7a09c94b643f/1572612003706/2019StateofHousingandHomelessness.pdf.
[164] United Way of Delaware. ALICE IN DELAWARE: A FINANCIAL HARDSHIP STUDY. 2021: https://www.unitedforalice.org/state-overview/Delaware.
[165] Ibid.
[166] Ibid.
[167] Ibid.
[168] Ibid.

borrowers to have higher interest rates. Because of the pandemic's continued health, social, and economic impacts and the exacerbation of long-held disparities, reductions in U.S. life expectancy are 3 to 4 times that for Black and Latino people than White people.[169]

Mistrust of the Healthcare Industry

Distrust in institutions played a pivotal role in the reluctance of Black and brown people to get tested or vaccinated in the city of Wilmington, Delaware.[170] Stories of abuse and horrific experiments in marginalized communities are passed down generationally, which has developed distrust in the medical institutions. The most well-known story of abuse and experimentation that routinely has been cited as a reason for Black people's reluctance to trust healthcare industries includes the Tuskegee Study of Untreated Syphilis in the Negro Male ("Tuskegee Study"), which was conducted by the United States Public Health Service. The study began in 1932, recording the history of syphilis.[171] In 1943, penicillin became an effective and widely available treatment for syphilis, yet the participants of the Tuskegee Study were not offered the treatment.[172] The federal government was responsible for hundreds of Black men going untreated for syphilis for 40 years. [173]

As recently as the 1990s, a U.S. university recruited Black boys into a study that theorized a genetic cause of aggressive behavior. Methods of the study, using monetary incentives, included:

> …withdrawal from all medications (including asthma medications), ingesting a mono-amine (low protein) diet, an overnight stay (without parents), withholding of water, hourly blood draws, and the administration of fenfluramine, a drug known to increase Iserotonin levels and suspected to be associated with aggressive behaviors.[174]

Furthermore, Georgetown university's study of the Latino and African American populations discusses the mistrust in the fear and the unknown. So, there existed long-lived infrastructural concerns with biases and disparities[175] Unethical biomedical research of Black people extends long before and after the Tuskegee Study. Indeed, this distrust in healthcare industries influences healthcare-seeking behavior, including seeking care and following recommendations.[176]

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[169] Theresa Andrasfay, Noreen Goldman, "Reductions in 2020 US life expectancy due to COVID-19 and the disproportionate impact on the Black and Latino populations," *The Proceedings of the National Academy of Sciences (PNAS)*, (January 14, 2021), 118 (5) e2014746118, p. 1: https://www.pnas.org/doi/10.1073/pnas.2014746118.

[170] Chambers, Transcript 5, p. 2.

[171] "The Syphilis Study at Tuskegee Timeline," *Center for Disease Control*, (April 22, 2021): https://www.cdc.gov/tuskegee/timeline.htm.

[172] Ibid.

[173] Jean Heller, "AP WAS THERE: Black men untreated in Tuskegee Syphilis Study," Associated Press, May, 10, 2017: https://apnews.com/article/business-science-health-race-and-ethnicity-syphilis-e9dd07eaa4e74052878a68132cd3803a.

[174] Dorothy Edwards, Jonathan Hoffsuemmer, Pamela Jackson, Emeobong Martin, Katherine J. Matthews, Darcell P. Scharff, More than Tuskegee: understanding mistrust about research participation," *Journal of health care for the poor and underserved,* (2010), vol. 21, 3: 879-97: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4354806/pdf/nihms440472.pdf.

[175] Hall-Long, Transcript 6, p. 3.

[176] Carol Estwing Ferrans, Elizabeth A Jacobs, Italia Rolle, Richard B Warnecke, Eric E Whitaker, "Understanding African Americans Views of the Trustworthiness of Physicians," *Journal of general internal medicine*, (March 6, 2006), 21(6), 642–647: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1924632/pdf/jgi0021-0642.pdf.

There has been an attempt to differentiate the legacy of unethical medical research from medical care. However, a study of Black men and women in Chicago to understand views of the trustworthiness of physicians found that participants expected to be experimented on during routine medical care.[177]

Implicit Bias in the Medical Field

Mistrust of the healthcare industry stems from historical events like the Tuskegee study but continues to be reinforced by healthcare industry issues and discriminatory actions that continue today.

Implicit bias refers to how unconscious stereotypes and attitudes can affect what we say and do.[178] Implicit bias is not limited to race, gender, or sexual orientation and can extend to many identities or intersections. Studies have found that implicit bias has resulted in groups of people being less likely to be referred to treatment, receive treatment, or receive information based on a physician's preconceived notion about a group of people.[179] It is reasonable to suggest that implicit biases have impacted the conversations that health care physicians have had with Black people and other people of color, resulting in distrust of medical personnel. It is also reasonable to suggest that despite the explicitly held eagerness of healthcare industries to outreach to people of color, implicit biases exist in conversations and education about COVID-19.

Moreover, even an expectation of discrimination can lead to avoidance of medical care, thus disparities in medical care. Jacobs et al. further express that this expectation of discrimination "is not to blame African Americans for health care disparities but rather to highlight that even when discrimination is not a conscious or unconscious intent, expectations likely have an impact and need to be addressed.[180]

Misinformation and Disinformation

Justified distrust in the medical healthcare industry, coupled with misinformation (false or inaccurate information), disinformation (incorrect information deliberately intended to mislead), and conflicting information (two or more health-related proposals that are inconsistent with one another),[181] led to an unwillingness to get tested or vaccinated.[182]

From the onset of the pandemic, conflicting information has been reported at different junctures of the pandemic – conflicting information about who is most at risk for COVID-19, how dangerous the infection is, whether there is access to testing, how effective treatments are, and how effective strategies are in preventing the virus' spread. Once cases began to permeate the United States, there was conflicting information about the effectiveness of face masks in preventing viral transmission and competing claims about the promise of certain treatments. For example, there were disagreements about how effective face masks were. In February 2020, U.S. Surgeon General Jerome Adams told people through social media to

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[177] Ibid.

[178] Sandra DiBrito, Christiana Jones, Carla M. Lopez, Aarti Mathur, "Reducing Implicit Bias: Association of Women Surgeons #HeForShe Taskforce Best Practices Recommendations," *Journal of the American College of Surgeons* vol. 228,3 (2019): 303-309: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7170165/pdf/nihms-1580342.pdf.

[179] Ibid.

[180] Carol Estwing Ferrans, Elizabeth A Jacobs, Italia Rolle, Richard B Warnecke, Eric E Whitaker, "Understanding African Americans Views of the Trustworthiness of Physicians," *Journal of general internal medicine,* (March 6, 2006), 21(6), pp. 642–647: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1924632/pdf/jgi0021-0642.pdf.

[181] Sarah E. Gollust, Erika Franklin Fowler, Rebekah H. Nagler, Alexander J. Rothman, Rachel I. Vogel, Marco C. Yzer, " Public perceptions of conflicting information surrounding COVID-19: Results from a nationally representative survey of U.S. adults," *PLOS ONE,* (October 21, 2020), 15(10): https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0240776.

[182] Chambers, Transcript 5, p. 4.

stop buying masks because they were not effective.[183] However, by early April, the Center for Disease Control recommended that people wear face coverings in public.[184] Even so, at the same time, Delaware's Department of Correction was not allowing incarcerated people to wear protective masks to protect themselves,[185] even though incarcerated people residing at one of the state's correctional centers were tasked with producing masks for the correctional system and first responders earlier that month.[186] By June of the same year, just half of all incarcerated people were provided masks.[187]

There was also disagreement about the prevalence of asymptomatic transmission and whether chloroquine and hydroxychloroquine were effective in treating COVID-19. It is important to note that confusion about information was based on disagreement among political leaders and health experts. This was even evident by the panel commissioned by the Delaware Advisory Committee to the U.S. Commission on Civil Rights, where physicians debated the merits of Ivermectin as an effective treatment for COVID-19.

The scientific discovery and research process leads to the rise in conflicting health information. Because scientists were researching the novel coronavirus in real-time and with urgency, the scientific data on the disease changed fast, resulting in ever-changing advice and recommendations.[188] Furthermore, the ever-changing findings and recommendations played out in the broader public information environment, including journalism, media, and political influences, without admitting and normalizing the uncertainty of the trajectory of the pandemic and normalizing advancing scientific advice. Several studies have found that conflicting health information can result in confusion, negative attitudes toward the health topic, and ambivalence that can translate to reduced compliance with mitigating behaviors.[189] In the case of COVID-19, the confusion by conflicting information could lead to a reduced willingness to hand washing, wearing a mask, social distancing, and vaccine uptake.

There are situations where the parents are vaccinated, but the children are not. Some of the main concerns when vaccinating children are potential unknown long-term effects and side effects of the vaccine. And specifically, in families with girls, parents express that they're afraid they will risk their daughter's ability to conceive in the future.[190] Information availability is a key factor for vaccine uptake and efforts were

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[183] Jason Breslow, "Fauci: Mixed Messaging on Masks Set U.S. Public Health Response Back," National Public Radio, July 1, 2020: https://www.npr.org/sections/health-shots/2020/07/01/886299190/it-does-not-have-to-be-100-000-cases-a-day-fauci-urges-u-s-to-follow-guidelines.

[184] Ibid.

[185] Xerxes Wilson, Delaware Online. "Delaware officials: Prisoners won't get masks or release during COVID-19 fight," Delaware News Journal, (April 16, 2020): https://www.delawareonline.com/story/news/2020/04/16/delaware-officials-prisoners-wont-get-masks-release-during-coronavirus-fight/2988586001/.

[186] Department of Correction, Governor John Carney, Office of the Governor, "Delaware Correctional Officers and Inmates Contribute to Delaware's COVID-19 Response," (April 2, 2020): https://news.delaware.gov/2020/04/02/delaware-correctional-officers-and-inmates-contribute-to-delawares-covid-19-response/.

[187] Delaware Department of Correction, "How the Delaware Department of Correction is containing COVID-19," (June 3, 2020): https://doc.delaware.gov/assets/documents/How_the_Delaware_DOC_is_containing_COVID19.pdf.

[188] Sarah E. Gollust, Erika Franklin Fowler, Rebekah H. Nagler, Alexander J. Rothman, Rachel I. Vogel, Marco C. Yzer, " Public perceptions of conflicting information surrounding COVID-19: Results from a nationally representative survey of U.S. adults," *PLOS ONE,* (October 21, 2020), 15(10): https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0240776.

[189] Ibid.

[190] Dominquez, Transcript 6, p. 6.

shattered because of differing or false information given by various government authorities with contradicting messages.[191]

Exposure and Risk from Work

The lack of paid sick and family leave was disastrous for many families. Between March 2020 and February 2022, closely tracking the rate of COVID-19 infections, absences from work increased by more than 50 percent compared to the two years prior.[192] Less than half of absences from work were paid, and workers with annual income under $25,000 were three times more likely to be absent without pay compared to workers in households with incomes over 100,000. Before the pandemic, 30% of Delaware's workers were low-wage workers employed at positions with a high risk for COVID 19 impact.[193]

For those without the opportunity to work from home, many had to continue going to work regardless of whether they were sick or at risk of contracting the virus. Workers without access to paid leave are more likely to show up to work despite being symptomatic of the disease.[194] Many people went to work sick because they could not afford to take off from work.[195]

Rita Paige testified that when testing in some of the Delaware state housing authority developments, some residents refused to get tested. They feared losing their jobs if they tested positive because of having to take off from work. This type of action is attributed to some of the infections and deaths in the black community.[196]

Part V. Recommendations

The Committee offers the Commission the following ten recommendations.

A. Implicit Bias

1. The Committee's previous report, *Implicit Bias and Policing in Communities of Color in Delaware,* (January 2020): 01-22-DE-Implicit-Bias-Policing-Report examined implicit bias and policing in Delaware's communities of color. Indeed, implicit bias exists throughout various facets of society, including in the healthcare system. Implicit bias in the healthcare system and in the social determinants of health played a role in the reluctance of people of color to get tested or vaccinated, and contributed to health outcome disparities, during the COVID-19 pandemic. Implicit bias present in medical care and social determinants of health must be addressed on a systemic basis. The Committee recommends that:

[191] Ibid.
[192] Chanel Boyens, Julia Raifman, Kevin Werner, "Out Sick Without Pay Missed Wages and Worker Absences during the COVID-19 pandemic," Urban Institute, (August 2022): https://www.urban.org/research/publication/out-sick-without-pay.
[193] Michelle Taylor, EdD, President and Chief Operating Officer, United Way of Delaware, Wilmington, DE, Transcript 7, p. 8.
[194] Marissa G. Baker, Trevor K. Peckham, Noah S. Seixas, "Estimating the burden of United States workers exposed to infection or disease: A key factor in containing risk of COVID-19 infection," *PLOS ONE* (April 28, 2020): https://doi.org/10.1371/journal.pone.0232452.
[195] Dominguez, Transcript 6, March 28, 2022, 174-175, p. 5.
[196] Paige, Transcript 6, March 28, 2022, 2:00 p.m., 348-352, p. 9.

a. state and local government and medical care providers work together with community-based organizations to eliminate implicit bias in our healthcare system and in the social determinants of health, and

b. DHSS develop implicit bias training modules to increase awareness and understanding about the topic and make it available to the public. The training should provide guidance for identifying and reducing implicit bias and stereotypical thinking in the delivery of healthcare and social services to people of color.

These recommendations are the initial steps required to help overcome implicit bias in our healthcare system and in the social determinants of health. The recommendations will help to enhance basic trust in our health care, public health and social service systems. Overcoming implicit bias and enhancing trust is likely to reduce health disparities and improve overall health outcomes for people of color, including in times of health emergencies.

B. Emergency Action Council

2. Like government officials everywhere, DE officials failed to recognize and respond to the gravity of COVID-19. Communities of color in DE were disproportionately impacted by this failure. Government officials, policy makers and public and private sector stakeholders, including those representing businesses, community-based and faith-based organizations, communities of color and public and private sector think tanks and care givers – must act now to prepare for future public emergencies. The Committee recommends that the:

a. Delaware legislature create an Emergency Action Council that will establish a framework to develop comprehensive responses to future public health emergencies,

b. Governor appoint to the Emergency Action Council a broad cross-section of stakeholders from across the state, including those representing communities of color,

c. state and local government agencies at each stage in the planning process request input from health care providers, advocates from the private and public sectors, and representatives from communities of color.

Implementing this recommendation will help to ensure improved readiness for future public emergencies. It will assist state and local government agencies, private and public sector health care providers, and communities of color throughout the state to make effective, efficient and timely assessments and deliver health care to those in need.

C. Access: Testing, Vaccines, Treatment, Essentials

3. The Committee learned that insecurities about essentials such as food, housing, and income are the social determinants that disproportionately impact access to health care in communities of color. Such insecurities were exacerbated during the COVID-19 pandemic. The Committee recommends that the Delaware Legislature increase resources to and that the Department of Social Services, collaborate with private sector and public sector advocates and providers to develop innovative policies and practices that will help to improve individuals' and families' access to essentials such as food, housing, income, and to medical assessments, and medical and mental health care. These enhancements will help mitigate long-term damages created by the COVID-19 pandemic and reduce health care disparities among people of differing income levels. A collaborative and coordinated effort can help to reduce redundancies and promote

streamlined efforts that can expedite the delivery of these essentials to communities of color where often they are most needed.

4. Early in the COVID-19 pandemic, communities of color were unable to get tested, vaccinated and treated because of barriers such as the: (i) limited number of venues, (ii) transportation challenges and (iii) denied leave time requests. The Committee recommends that the Department of Health and Human Services (DHSS) collaborate and coordinate with other state agencies, and community-based organizations to create and expand both virtual and on-site access to information, tests, vaccinations and treatment, including mental health care in Delaware. Whether described as virtual health care hubs or placed in churches or stores, these virtual and on-site changes will expand the capacity to conduct certain tasks or functions to help ensure that needed medical care is accessible to communities of color.

5. The COVID-19 pandemic exacerbated the housing challenges that communities of color already faced due to the lack of affordable housing, overcrowded living conditions, and high eviction rates. Furthermore, communities of color often lack the resources needed to defend against evictions, mortgage foreclosures, and food stamp denials. The Committee recommends that state and local governments:

a. collaborate with private sector and public sector housing advocates and providers to help create more affordable housing in Delaware,

b. develop and publicize innovative policies and practices to help people in communities of color, remain in their homes during public emergencies, and

c. incentivize landlords to prioritize long-term renters, be more flexible with renters, and provide legal representation for all families facing eviction. (84 Del. Laws, c. 112, § 1).

Implementation of these recommendations will help to ensure increased home stability, reduce overcrowded living conditions, reduce evictions, and ultimately help to address the impact that housing insecurities may have on the health care disparities experienced by communities of color.

D. Work Force Capacity, Accommodations, Barriers

6. During the pandemic essential workers:(i) were more likely to work when sick – increasing virus exposure for themselves, family members and their communities – and less likely to have paid sick leave, (ii) had less available and more costly childcare, (iii) experienced limited or nonexistent public transportation, and (iv) were unable to work remotely. Furthermore, employers did not have workplace policies and initiatives in place to address their needs, as well as the needs of their employees. The Committee recommends that the Department of Labor collaborate and coordinate with other state agencies, businesses and employees to improve workforce development initiatives, including providing needed accommodations such as paid sick leave, childcare assistance, transportation and, where possible, expand opportunities for employees to work remotely. Implementing this recommendation will help to ensure that businesses establish policies and practices that will help essential workers perform their tasks during public emergencies.

E. Messaging

7. The mistrust and medical choices made by many in communities of color are a consequence of the medical community's established record of harmful medical experimentation and how implicit bias can affect the medical decisions and care provided to communities of color. COVID-related information was conflicting, wrong, and deliberately misleading. Communities of color are more accepting and responsive when public health messages are delivered by trusted leaders and representatives. The Committee

recommends that Delaware officials enlist representatives who are known and trusted in communities of color to deliver public health messaging, including physicians-other health care providers, representatives from community and faith-based organizations, and other leaders. Messaging from trusted sources will help provide more accurate medical-health care information to communities of color and help to ensure better fact-based choices about medical assessments and choices may be made in communities of color. Although the state did seek assistance from some trusted messengers, going forward, trusted messengers should be utilized from the initial communication stages of public health information, and a broader selection of trusted messengers should be included in the communication plan.

F. Funding, Streamline

8. The COVID-19 pandemic magnified that there is a need for increased funding to improve public health responses. The pandemic highlighted the lack of study and analysis of health and disease determinants, public health staffing, public health infrastructure and funding to community services that exist even in the absence of a pandemic. There also are expected to be long-term damages from the pandemic, including economic and health impacts, that will need to be addressed well into the future.

During public emergencies, it is critical that trusted community-based organizations be funded to help ensure that communities of color, especially in inaccessible locations, receive testing, vaccinations, medical treatment, including mental health care, and essentials such as food, employment, and housing. Effective outreach and delivery of health care can be improved when provided by organizations that communities of color trust. The Committee recommends that the Delaware General Assembly provide continued and increased funding to community-based organizations to provide outreach and services to communities of color and adopt payment policies to ensure timely compensation to these trusted organizations. Providing continued funding to organizations that relate to and are connected with communities of color will help to ensure that these communities receive needed health assessments and heath care, as well as help to address in these communities the insecurities associated with inadequate essentials such as food, employment and housing.

9. Communities of color often are frustrated when seeking needed health care and essentials such as food, employment, and housing for themselves and family members because of bureaucratic requirements imposed on them and organizations that assist them. The Committee was also advised that current government funding formulas restrict access to needed services for persons living at or below the federal and state thresholds. The Committee recommends that state and local governments streamline the application process and reporting requirements for access to social services, and revisit and revise existing poverty level thresholds that restrict access to social services for essentials. Streamlining the application and the subsequent reporting processes will most efficiently allow for improved delivery of necessary resources and services. This would free staff from burdensome procedures allowing them to better serve the needs of communities of color. Reexamining poverty thresholds that restrict access to essential services will hopefully lead to an increase in access to those services for people who cannot otherwise afford them but do not qualify under existing standards.

G. Databases

10. The DE Department of Health and Social Services (DHSS) is the state agency responsible for protecting public health and providing access to social services in Delaware. Currently, social services-related data and reports are posted on the multiple DHSS division websites and across other state agency websites. Although the posted information helps inform members of the public, academics, and researchers, appointed and elected government officials, policy makers, community-based organizations, and public-sector and private-sector think tanks, often it is not available to low-income or technology-challenged populations throughout the state. Furthermore, navigating multiple websites can be frustrating. It is important that the published data and reports be accurate and current. The Committee recommends that:

a. Delaware state and local government departments and agencies collaborate with representatives of these end users to provide accessible, current and transparent data on state and local government websites,

b. DHSS divisions coordinate and advertise social service benefits more comprehensively and at a centralized location on its website, and

c. the state, in collaboration with end users, develop a digital equity plan to help address the digital divide in low-income or technology-challenged populations throughout the state to help ensure that these populations have equal access to information, health care and other social services.

Implementing this recommendation will help to promote greater government transparency and accountability. It will help to improve data sharing for planning purposes, and for conducting performance assessments of government healthcare policies and programs. It will help to make the data and reports more available statewide and more user-friendly.

Appendix

A. Briefing materials[197]

   a. Transcript

   b. Agenda

   c. Minutes

   d. Panelist statements and presentations (PPT)

   e. Meeting recording

   f. Other records

B. Committee Member Statements

   a. Susan Dixon, Dissenting

   b. Bradley Skelcher, Concurring (joined by Brad Baldia, Calvin Christopher, Danielle Craig, Corinthia Pierce, Mark Purpua, Javonne Reich, Patricia Rodriguez, Enid Wallace-Simms)

[197] Briefing materials available at: https://usccr.box.com/s/z024hbqvnedj1civtxvfhbu1ie013jv8.

Appendix B: Committee Member Statements

Susan Dixon, Vice Chair, Dissenting

The mission of the U. S. Commission on Civil Rights is to be a "bipartisan fact-finding federal agency…advancing civil rights through objective and comprehensive investigation."[198] This report fails that mission. This entire project was designed to maintain a pre-determined and bias narrative about COVID-19 disparities, even as evidence undermined that "narrative." Experts who were not in agreement with this narrative were placed under greater scrutiny than their Democrat counterparts and as a result, some declined to participate. There were eight panels and 29 experts, only three of these experts, who correctly countered the biased narrative, were not Democrat experts. The following Dissent addresses just some of these concerns.

In Part II, National Impacts, Dr. Ryan N. Cole, a medical research expert, who has testified before several U.S. Congressional Subcommittees, explained that Vitamin D is vital to immune health.[199] He stated that 70 to 80% of all Americans are Vitamin D deficient. Specifically, 82-88% of nursing home patients, 82% of African-Americans; 63-73% of Latinos; 72% of Native Americans, 27-60% of Asian Americans, and 47% of Caucasian Americans.[200] He further stated that "Normal D levels significantly decrease COVID system severity and risk for hospitalization, noting that 80% of all hospitalized patients and 96% of ICU patients are D deficient.[201] In a 191,000 look back study, there was a direct correlation between Vitamin D deficiency in terms of one's acquisition of COVID.[202]

His testimony, which was included as an *additional factor* as to why COVID-19 could adversely impact the black community was excluded in the final report. In explaining the reasons for including Vitamin D testimony, there are many black professionals who promoted Vitamin D to the black community. World-renown dermatologist, Dr. Pearl Grimes, created a video titled *Project D-Z-C* to communicate this message.[203] In her video, there were doctors from various ethnic backgrounds as well as actors, Angela Bassett, Jenifer Lewis, Nicole Ari Parker and Tyler Perry all promoting Vitamin D to the black community.[204] In July 2020, Dr. Grimes co-authored a peer-review article "The Relevance of Vitamin D Supplementation for People of Color in the Era of Covid-19."[205] In April 2020, Tyler Perry posted a video on his Instagram page, alerting his followers to the fact that a lot of people in the black community, who died of COVID-19, were low in Vitamin D.[206]

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[198] U.S. Commission on Civil Rights, Our Mission, 45 CFR Part 701, Section 701.1, https://www.usccr.gov/about/mission.
[199] Ryan N. Cole, MD, CEO and Medical Director, Cole Diagnostics, Garden City, ID, Power Point Presentation submitted for Virtual Panel Briefing Sept. 15, 2021, slide 4, (hereafter Cole, Power Point).
[200] Cole, Power Point, slide 5.
[201] Cole, Transcript 1, page 9.
[202] Ibid. p. 31
[203] Pearl E. Grimes, MD, "The Colors of Covid: Saving Lives & the Benefits of D-Z-C," *YouTube*, Nov. 21, 2020, Video, 13:35, https://youtu.be/JpE4uN2ntvo.
[204] Ibid.
[205] Pearl E. Grimes, MD, Nada Elbuluk, MD, MSc, Andrew F. Alexis, MD, MPH, "The Relevance of Vitamin D Supplementation for People of Color in the Era of Covid-19." *Journal of Drugs in Dermatology*, (July 2020), Volume 19, Issue 7, pp. 782-783.
[206] Tyler Perry, (@tylerperry) 2020 Instagram, April 27, 2020, "Hi Everybody, hope you're staying safe," https://www.instagram.com/tv/B_gE3IxHFZ1/?utm_source=ig embed.

Terri Huggins Hart, a black female blogger, investigated Perry's video and wrote "What Black People Need to Know about Vitamin D and Covid-19" on June 29, 2020.[207] Additional bloggers raised awareness of the importance of Vitamin D for the black community in combating COVID-19.[208,209] There are numerous studies about Vitamin D deficiency and its beneficial impact on those with COVID-19.[210,211,212,213] A Report about the disparities that contribute to the disproportionate rate of infections and deaths particularly in the black community due to COVID-19 is insufficient without mentioning Vitamin D as a contributing factor to this disparity, especially when information about Vitamin D is beneficial to the black community.

There are additional shortcomings in this Report. In Part III, Delaware Impacts, the Report fails to include the disparate impact that lockdowns had on Delawareans of color. Lockdowns were a significant feature of the COVID-19 pandemic, responsible for disparities in health[214] and resulting in closure of businesses, increased unemployment, and the closure of public schools.[215, 216]

Instead of focusing on these critical factors, COVID-19 disparities were linked to social determinants and that testimony was often contradictory or not supported by the evidence. The Report claims that "social determinants limited access to testing, vaccination, and treatment for COVID-19."[217] However, the Report later contradicts that statement, stating that the State and "[a] coalition under the direction of the United Way was formed in each county to get the black and brown and Latino communities vaccinated"[218] and to make vaccinations accessible.[219] The Division of Public Health "ensure[d] that all Delawareans had access to healthcare and the COVID-19 vaccine"[220] and "partnered with pharmacies to provide vaccines and testing to

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[207] Terri Higgins Hart, "What Black People Need to Know about Vitamin D and Covid-19", *Medium*, (June 29, 2020). https://elemental.medium.com/what-black-people-need-to-know-about-vitamin-d-and-covid-19-5bf5885d5288.
[208] Dana G. Smith, "Vitamin D Deficiency Could Exacerbate Covid-19 Racial Health Disparities," *Medium*, (October 2, 2020), https://momentum.medium.com/vitamin-d-deficiency-could-exacerbate-covid-19-racial-health-disparities-50d0764d52a9.
[209] Maria C. Hunt, "Vitamin D Deficiency Is an Overlooked Source of Health Disparities for Black Americans," *Medium*, (July 9, 2020), https://elemental.medium.com/vitamin-d-deficiency-is-an-overlooked-source-of-racial-health-disparity-29bb47803a45.
[210] Hermann Brenner, Ben Schottker, "Vitamin D Insufficiency May Account for Almost Nine out of Ten COVID-19 Deaths: Time to Act Comment on: Vitamin D Deficiency and Outcome of COVID-19 Patients" *Nutrients* (Dec. 2020); 12(12): 3642. Published online 2020 Nov 27. doi: 10.3390/nu12123642, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7761047/.
[211] Patrick Zemb, Peter Bergman, Carlos A. Camargo, Jr, Etienne Cavalier, Catherine Cormier, Marie Courbebaisse, Bruce Hollis, Fabrice Joulia, Salvatore Minisola, Stefan Pilz, Pawel Pludowski, François Schmitt, Mihnea Zdrenghea, and Jean-Claude Souberbiellem, "Vitamin D deficiency and the COVID-19 pandemic," *Journal Glob Antimicrob Resist,* (Sep. 2020); 22: 133–134.Published online 2020 May 29. doi: 10.1016/j.jgar.2020.05.006, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7256612/.
[212] Mradul Mohan, Jerin Jose Cherian, Amit Sharma, "Exploring links between vitamin D deficiency and COVID-19" *PLoS Pathog,* (Sep. 18, 2020);16(9):e1008874. doi: 10.1371/journal.ppat.1008874. eCollection 2020 Sep., https://pubmed.ncbi.nlm.nih.gov/32946517/.
[213] Becky McCall, Vitamin D Deficiency in COVID-19 Quadrupled Death Rate," *Medscape* (Dec. 11, 2020), http://www.medscape.com/viewarticle/942497.
[214] Jayanta Bhattacharya, MD, PhD, Center for Primary Care and Outcomes Research, Stanford University School of Medicine, Stanford, CA, Transcript 1, p. 6.
[215] Kathleen Rutherford, "It's time to bid the pandemic emergency goodbye" Special to the USA TODAY Network, (June 18, 2021) https://www.delawareonline.com/story/opinion/2021/06/18/delaware-covid-19-its-time-end-carneys-state-emergency/7736780002/.
[216] Jeffrey A. Tucker, "Twenty Grim Realities Unearthed by Lockdowns," Brownstone Institute, (June 5, 2023) https://brownstone.org/articles/twenty-grim-realities-unearthed-by-lockdowns/.
[217] Marsha Lee, MD, MPH, Harrington Trust Physician Scholar and Harrington Trust Director within ChristianaCare's Institute for Research, Equity, and Community Health, Transcript 3, p. 5.
[218] Rita Mishoe Paige, Chair of the Kent Coalition for Vaccine Equity, Pastor of New Beginnings Community AME Church, Virtual Panel Briefing, Mar. 28, 2022, Transcript 6, p. 9.
[219] Ibid, p.10
[220] Karly Rattay, MD, MS, FAAP, Director Delaware Division of Public Health, Virtual Panel Briefing, April 1, 2022, Transcript 8, p. 23.

vulnerable communities."[221] "Vaccine uptake has been equal among black and white seniors in Delaware since July 2021."[222]

"The State of Delaware built a robust COVID-19 testing network[223] "quadrupled testing capacity and expanded testing locations;"[224] "overall testing rates were highest among Hispanics, followed by Black, Asian, and White populations."[225] Delaware's rigorous testing led to higher rates of infection for people of color; but, in fact, COVID "testing" was incorrectly used, issued false positives, and the "COVID test" could not accurately detect COVID.[226,227]

There "appeared to be an unwillingness of black and brown communities to get tested and vaccinated."[228] "There were incidences of vaccine hesitancy and, in some cases, anti-VAX sentiments" in the black community.[229] It appears that any disparities under these categories were based on personal choices.

The Report failed to establish "food insecurity." The Report stated that, "Feeding America has not provided food insecurity numbers directly caused by the pandemic."[230] Delaware issued emergency food and assistance valued at $130 million to a population of 114,190 people;[231] delivered over one million meals to the homeless[232] and paid monthly pandemic benefits so that about 45,000 children per month received free or reduced-price meals in school."[233] Within the City of Wilmington, there are at least 17 food stores,[234] including a 70,000 square foot supermarket, carrying organic fruits and vegetables;[235] and 28 food pantries and/or soup kitchens.[236] Amazon and DoorDash partnered with the Food Bank of Delaware to deliver food for free within a 15-mile radius.[237] Even when wholesome items are offered, "[t]he problem was that

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[221] Ibid. p. 4.
[222] Ibid. p. 4.
[223] Molly Magarik, Secretary, Delaware Department of Health and Social Services, Virtual Panel Briefing, Mar. 30, 2022, Transcript 7, p. 3.
[224] Mia Papas, Ph.D., Corporate Director of the Christina Care Health System Value Institute, Mar. 23, 2022, Written Statement, p. 29 (citing Brooks M, Brown C, Liu W, Siegel, SD, Mapping the Christina Care response to COVID-19, clinical insights from the Value Institute's Geospatial Core. *Delaware Journal of Public Health*, (2020, July 1) (hereafter cite as Papas Written Statement).
[225] Rattay, Transcript 8, p. 3.
[226] Dr. Sam Bailey, "The Truth About PCR Tests," *Rumble*, Video, 17:42, https://rumble.com/vlawj2-dr-sam-bailey-the-truth-about-pcr-tests.html
[227]Off-Guardian.org "COVID-19 Tests are scientifically meaningless" by Torsten Englebrecht and Konstantin Demeter, July 1, 2020 – https://off-guardian.org/2020/06/27/covid19-pcr-tests-are-scientifically-meaningless/.
[228] Daryl Chamber, Executive Director, Center for Structural Inequities, Virtual Panel Briefing, Transcript 5, p. 3.
[229] Donna Patterson, Ph.D., Chairperson and Professor Department of History Political Science, Philosophy & Director of Africana Studies Delaware State University, Virtual Panel Briefing, Transcript 8, p. 12.
[230] Cathy Kanefsky, President and CEO, Food Bank of Delaware, Virtual Panel Briefing, Transcript 7, p. 6. *See*, Papas, Written Statement, p. 29, citing Feeding America, Hunger in Delaware; http://www.feedingamerica.org/hunger-in-america/delaware. Verona Mulgrave, Ph.D., RDN, LDN, Instructor/Extension Specialist in Food and Nutrition Specialist, Written Statement, p. 20, citing Food Insecurity in Delaware; https://map.feedingamerica.org/county/2017/overall/delaware.
[231] Ibid.
[232] Ibid.
[233] Ibid.
[234] Google Search, Food Stores in the City of Wilmington, Delaware https://www.google.com/search?sca_esv=1a57d827cf09faae&tbs=lf:1,lf_ui:10&tbm=lcl&q=food+stores+in+the+city+of+wilmington+delaware&rflfq=1&num=10&sa=X&ved=2ahUKEwid9_jrpceFAxWZFlkFHVbgDhgQjGp6BAgwEAE&biw=1920&bih=945&dpr=1#rlfi=hd:;si:;mv:[[39.7584216,-75.5056662],[39.7347034,-75.5970561]];tbs:lrf:!1m4!1u3!2m2!3m1!1e1!1m4!1u2!2m2!2m1!1e1!2m1!1e2!2m1!1e3!3sIAE,lf:1,lf_ui:10.
[235] *In Wilmington*, ShopRite, https://inwilmde.com/places/shoprite/
[236] FoodPantries.org, https://www.foodpantries.org/ci/de-wilmington.
[237] Kelli Steele, "Food Bank of Delaware partners with Amazon, DoorDash to deliver food," *Delaware Public Media* (January 18, 2022) https://www.delawarepublic.org/delaware-headlines/2022-01-18/food-bank-of-delaware-partners-with-amazon-doordash-to-deliver-food.

these items just didn't sell. You can lead human beings to Whole Foods, but you can't make them buy organic kale," writes Elizabeth Nolan Brown.[238]

Regarding the terms, "misinformation" and "disinformation," the implication in this Report is that whatever information countered the "narrative" was deemed "misinformation" or "disinformation," especially regarding the vaccine.[239] There is "[j]ustified distrust in the medical healthcare industry"[240] in the black community. The Twitter files revealed conclusive proof that medical information, contradicting the vaccine narrative was censored and suppressed by Twitter and the U.S. government.[241] Further evidence reveals how Facebook coordinated with the CDC to manipulate COVID-19 "messaging."[242] Pollster, Fred Luntz, surveyed Americans across all demographics to craft messaging, such as "words to use" and "words not to use"[243] to change people's behavior.

The characterization of differing medical views as "conflicting information" is inaccurate.[244] Early treatments, that countered the "narrative" and which could have lessened or eliminated disparities and saved lives, were denounced and censored.[245,246] In a Stipulation of Dismissal, HHS and the FDA settled a lawsuit brought by a medical doctor against the government for publishing social media posts that maligned prescribing Ivermectin to treat COVID-19: HHS and the FDA agreed to remove social media posts and webpages, describing it as a "horse dewormer" and urging people not to take Ivermectin.[247] All of this information was known at the time of the panel briefings.

Findings and Recommendations mention implicit bias in general terms and there is no direct evidence of implicit bias in the Delaware medical community. Moreover, implicit bias is an amorphous concept; recent studies confirm that the Implicit Association Test (IAT), used for testing/proving implicit bias, is unreliable and invalid as a test. "The IAT bias scores have a lower rate of consistency than is deemed acceptable for use in the real world" (R = .42, at best R = .55, well below the standard R=.8) "There are concerns over the validity of the test and even Greenwald and Banaji (creators of the test) admit that the IAT does not predict biased behavior.[248]

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[238] Elizabeth Nolan Brown, "Five Years and $500 Million Larter, USDA Admits that 'Food Deserts' Don't Matter: You can lead people to Whole Foods, but you can't make them buy organic kale," *Reason*, (June 13, 2016), https://reason.com/2016/06/13/500-million-later-usda-on-food-deserts/.

[239] Robert F. Kennedy, Jr., *The Real Anthony Fauci; Bill Gates, Big Pharma, and the Global War on Democracy and Public Health*, Skyhouse Publishing, New York, (2021), pp. 70-95.

[240] U.S. Commission on Civil Rights, Delaware Advisory Committee Report, 2024, p. 26.

[241] Matt Taibbi, (@mtaibbi), "The Great Covid-19 Lie machine Stanford, the Virality Project, & the Censorship of 'True Stories'," *Twitter,* Mar 17, 2023, 9:00AM, https://twitter.com/mtaibbi/status/1636729166631432195?lang=en.

[242] Judicial Watch, "CDC Coordinated with Facebook On COVID Messaging and 'Misinformation'," (July 28, 2021) https://www.judicialwatch.org/cdc-facebook-covid-messagging/.

[243] Judicial Watch, "Michigan Health Director, Robert Gordon April 2021," (June 1, 2021) https://www.judicialwatch.org/documents/michigan-health-director-robert-gordon-april-2021-pg-823/.

[244] Bret Weinstein Interviews Dr. Pierre Kory, "The War on Ivermectin," *Rumble*, Video 2:56:38, https://rumble.com/v2y5aq2-the-war-on-ivermectin-bret-weinstein-interviews-dr.-pierre-kory.html.

[245] Cole, Transcript 1, p.10.

[246] Brian Rose and Dr. Sherry Tenpenny, "How & Why Hydroxychloroquine Was Attacked & Censored All Over The World," London Real Transform Yourself, *Rumble,* July 28, 2020, Video, 11:29, https://rumble.com/v481vnr-how-and-why-hydroxychloroquine-was-attacked-and-censored-all-over-the-world.html.

[247] *Bowden v. U.S. Department of Health and Human Services, et al.*, Case No. 3:22 cv 184, (U.S. Dist. Ct. S.D. Tex. March 21, 2024). Note: This case was reversed and remanded by *Apter v. Dep't of Heath & Hum. Servs.*, 80 F.4th 579 (5th Cir. 2023).

[248] Heather MacDonald, "Are We All Unconscious Racists?" *City Journal*, (Autumn 2017), https://www.city-journal.org/article/are-we-all-unconscious-racists.

A report that does not consider all factors contributing to a problem cannot produce a result that will be effective. Vitamin D is a critical factor in addressing health disparities in communities of color and that factor is missing from the Report. It did not address the disparate impact of lockdowns on Delawareans of color. Instead, it linked COVID-19 disparities to social determinants, many of which were either ameliorated by the State, based on personal choices, or did not exist. When examining individual and public health disparities involving COVID-19, it is important to fully and fairly examine all factors. This Report fails to do so.

Bradley Skelcher, Concurring

Joined by: Brad Baldia (6/17), Calvin Christopher (6/17), Danielle Craig (6/21), Corinthia Pierce (6/20), Mark Purpua (6/17), Javonne Rich (6/20), Patricia Rodriquez (7/17), Enid Wallace-Simms (6/20)

At the end of our four-year study on COVID-19 and health and health care disparities in Delaware communities of color, this study contains important information and significant recommendations for government and non-government officials to follow and implement.

It is important to note that the leadership of the Delaware Advisory Committee provided opportunities for everyone to offer input. Then, the process of discovery through expert testimony followed allowing different perspectives and ideas to be shared with the Advisory Committee. Furthermore, the members worked diligently to complete the report with a review process of each section of the report. At that time, individuals could offer input or any criticism that they may have had. Then, the Committee held votes on each section of the report for approval. It was notable that the Committee members worked together without political partisanship and in a collegial manner. In fact, at no time was political affiliation mentioned.

This well thought out report provides a comprehensive and logical timeline of the COVID-19 pandemic and its impact on communities of color in Delaware offering the latest information from science, the medical community, and the community at-large with experience in health, nutrition, and other social aspects of the community. The report also addresses the misinformation that surrounded the pandemic as well as medical treatments that proved ineffective or some even dangerous.

In all, this Report is a comprehensive study of the COVID-19 pandemic and its impact on communities of color in Delaware.

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