To: Governor Andrew M. Cuomo  
Mayor Bill De Blasio  
Dr. Howard Zucker, Commissioner of Health, NYS  
Dr. Oxiris Barbot, Commissioner, NYC DOHMH  
Dr. Demetre Daskalakis, Deputy Commissioner for Communicable Disease, NYC DOHMH  
Dr. Mitchell Katz, CEO, New York Health + Hospitals (H+H)  
New York City Council Speaker Corey Johnson  
New York City Council Health Committee Chair Mark Levine  
New York City Council General Welfare Committee Chair Stephen Levin  
New York City Council Hospital Committee Chair Carlina Rivera  
New York City Council Member Richie Torres, Chair-Committee on Investigation and Oversight  

From: C. Virginia Fields, President & CEO, National Black Leadership Commission on Health, Inc.  
Mark Boyd, Founder, Platformable  
Sarit Golub, Professor, Department of Psychology, Director, Hunter Alliance for Research and Translation (HART), Hunter College of the City University of New York  
Brittany Smith, MPH, CHES, Data and Evaluation Coordinator, NBLCH  
Jeremiah Johnson, MPH, HIV Project Director, Treatment Action Group  

On Behalf of the New York COVID-19 Working Group  

Dear Governor Cuomo, Mayor de Blasio, et al:  

We are writing to request a meeting between the New York COVID-19 Working Group (CWG-NY), the New York City Department of Health and Mental Hygiene (DOHMH), and the New York State Department of Health (DOH) to advocate for enhanced data collection, dissemination, and utilization to mitigate growing health disparities in the COVID-19 epidemic in New York City and New York State. We acknowledge both the city and state’s recent efforts to provide some data by race/ethnicity and zip code/county, and we are appreciative of the challenges of both data collection and reporting. These data have made an important contribution to growing awareness of health inequities in both our city and our state. However, successful efforts to address and reverse these disturbing trends will require an increased investment in: (1) data transparency; (2) enhanced data collection capacity in collaboration with community-based partners; (3) routine communication regarding both efforts.
and outcomes; (4) attention to reducing unintended consequences of data dissemination; and (5) clear application of data to policy, programs, and milestones.

1. Data Transparency. Policy makers, community-based organizations, and advocates need access to detailed, disaggregated testing, case, hospitalization, and fatality data by race/ethnicity, gender, age, language spoken at home, pre-existing health conditions, and zip code. At present, some of these variables are available on the city and state websites, but they are presented separately, without the ability to examine intersecting trends and vulnerabilities. Disturbingly, race and ethnicity data are only reported in fatalities data. Both DOH and DOHMH should provide data with sufficient flexibility to support community planning and responses, allowing cross-tabulation by multiple characteristics. Where numbers are large enough to avoid de-anonymization, data should be accompanied by raw, disaggregated datasets to allow greater flexibility in analysis (that is, so that community agencies can analyze by race and gender, race/age/gender/comorbidities, etc). Longer term, New York City and State should commence efforts to move towards API-enabled data so that population and equity data is available in real-time and able to be integrated into mapping and planning tools.

2. Enhanced Data Collection in Collaboration with Community-Based Partners. Given the unprecedented nature of the current crisis, it will be critical to collect additional data about cases and COVID-related impacts in partnership with high-priority communities. First, there is an urgent need to better understand case, hospitalization, and fatality rates by employment status, including homecare workers (home health aides, personal attendants, child care providers), essential city workers (MTA, sanitation department, DoC), essential workers who don’t work for the city (e.g., grocery store, pharmacy, doormen and other security staff, construction workers), gig workers (including rideshare and delivery workers) and community/social services. The city and state should invest in collaborative efforts to collect data from community-based organizations, unions, and other organizations that serve these workers, in order to enhance our ability to understand and address challenges to mitigation behaviors and rollout of other interventions, such as testing and contact tracing. Collaborations with community-based partners will also be critical to fill gaps in knowledge about the impact of COVID-19 on LGBT populations, people with a history of interaction with the criminal justice system, homeless populations, people with disabilities and co-morbidities, people at risk of overcrowding, and people at risk of domestic and residential violence.

3. Routine Communication Regarding both Efforts and Outcomes. Both the city and state health departments have strong track-records of community responsiveness and engagement, and as we know, transparency builds trust. The city and state must work with communities and community groups representing those most affected by COVID-19 to discuss the data and share analysis, reporting and ownership of findings. Reporting of disaggregated data and gaps in knowledge, for example, should be discussed at the COVID-19 weekly information calls held with community and faith leaders. Where NY is unable to collect, disaggregate or publish data describing key populations impacted by COVID-19, they must be transparent in the challenges in doing so. This will help to rebuild trust with communities and drive alternative methods to identify most at-risk and impacted populations for planning and outcomes monitoring purposes.
4. **Attention to Reducing Unintended Consequences of Data Dissemination.** As data are presented to draw attention to health inequities, they must be presented in a manner that respects those most impacted and avoids unintentional stigmatization of individuals or communities. To this end, we recommend that NY avoid analyses that privilege a population as being “normal” or “desirable” compared to others. Data visualizations and graphics must be presented in ways that do not stigmatize any community, particularly those most-impacted or at risk of COVID-19 infection. Both the city and state must discuss any choices made when analyzing data and be transparent about the limitations of analyses. And finally, data must always be presented in the context of its utilization, i.e., reorienting health service access and informing policy planning and interventions.

5. **Clear Application of Data to Policy, Programs, and Milestones.** As we are all aware, documenting health disparities does not reduce them. Despite new reports on differential impacts, there is a lack of clarity in the city and state’s discussion of how these data are being used to allocate resources. The most important utilization of the data outlined above is in the development of policies and programs designed specifically to address identified disparities and mitigate against them. Both the city and state should be clear about the ways in which data are being used for health planning (e.g., where to allocate resources), health access opportunities, economic stimulus measures, and/or city reopening strategies. Perhaps most important, the city and state should be clear about: a) which disparities a novel implementation strategy is designed to address (i.e., what the program is trying to achieve); b) the rationale behind the choice of a given strategy (i.e., why this particular strategy is likely to have the desired result); and c) a mechanism for evaluating whether or not the new strategy is working as intended (i.e., milestones based on increasing health equity).

**Moving forward**
As a priority, we strongly recommend that daily reporting of data include race and ethnicity disaggregation and that data be made in more accessible, cross-tabulated formats rather than PDF publications.

The NY COVID-19 Working Group requests to meet with the New York State Department of Health and NYC Department of Health and Mental Hygiene to clarify how data can be used in reporting, planning and evaluating health and policy interventions with disproportionately affected communities on these matters going forward.

Sincerely,

C. Virginia Fields  
Mark Boyd  
Sarit Golub  
Brittany Smith  
Jeremiah Johnson  
On Behalf of the COVID-19 Working Group (CWG-NY)