Health Equity Data: Position Statement

1. **High-priority population data should be disaggregated in all published data.**
   All published NY population data used in COVID-19 health, economic stimulus, and city reopening strategies should be able to be analyzed by:
   - Race
   - Sex
   - Gender
   - Age
   - Ethnicity
   - Language spoken at home
   - Income
   - Zip code
   - Housing status
   - Pre-existing condition.

2. **Additional data related to COVID-19 is necessary for planning and evaluation of inequity impacts on policy interventions.**
   For COVID-19 it is also desirable to provide disaggregated data by employment category, particularly:
   - Healthcare worker status (including home care, personal attendants, childcare, and nursing home workers)
   - Essential services worker status (including MTA, sanitation, grocery store, DoC staff, security workers)
   - Gig worker status (including rideshare, and delivery workers)
   - Community/social services worker status.

   As primary care and public health interventions are implemented, it will also be necessary to disaggregate data on outcomes from:
   - Contact tracing implementations
   - Follow-up care for COVID-19 patients following discharge.

   Consideration should be given to ensuring that this disaggregated data is published at a sufficiently high level so as to ensure individuals cannot be de-anonymized.

3. **NYC and NYS must collect hard-to-reach data in partnership with impacted communities.**
In addition, NY must work with local communities to rebuild trust and support the collection and use of new data to fill gaps in knowledge about populations underrepresented by current methods including:

- People with co-morbidities including diabetes, and asthma
- LGBT populations
- People with a history of engagement with the criminal justice system or who have been released from incarceration
- Homeless populations
- People with disabilities
- People experiencing social isolation and those with mental health risks
- People at risk of overcrowding
- People at risk of domestic and residential violence
- People who use drugs and those in recovery.

Where possible, this data should be disaggregated, for example, Department of Corrections data should be disaggregated in published data on COVID-19 totals. The NYC Department of Social Services and Department of Health already share some daily data reporting on homelessness and housing related impacts.

Where NY is unable to collect and 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.

In particular, NYC and NYS 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.

3. **Disaggregated data must be used in transparency and trust-building, planning, and evaluation of impacts.**

These data characteristics will help the City and State of New York rebuild trust and demonstrate transparency in working with those most impacted populations who have been under-represented in levels of care and support received to date, and highly over-represented in fatalities. Despite new reports on differential impacts, communities still feel disenfranchised as daily data published continues to invisibilize those most impacted by COVID-19. There is a lack of clarity in the city’s discussion of how this disaggregated data is being used to allocate resources to those most vulnerable to COVID-19.

Disaggregated data should form the basis of all population data collected and published by NYC and NYS. Data should be used for:

- Health planning (i.e. where to allocate resources) eg. current planning for identifying where to increase testing. The use of data to make these decisions should be explained and demonstrated.
• Health access opportunities (eg. use of ventilators, hospital admissions, discharge planning strategies)
• Health outcomes
• City reopening strategies
• Discrimination and hate crime reporting
• Economic stimulus measures
• Measuring the impact of any policy interventions implemented
• Measuring the reduction or widening of existing inequity from the implementation of any interventions.
• Increase efforts for prevention especially when utilizing contact-tracing.

4. **Data must be provided in accessible formats that allow for greater cross-analysis.**
   It is essential that communities, groups, healthcare, and policy intervention planners can analyze data by correlating multiple characteristics. For example, data should be presented so that it is possible to analyze incidences by race and location, race and age, race and gender, race/age/sex/gender/comorbidity, etc.

Current data, including disaggregated data, is not provided with sufficient flexibility to support community planning and responses.

Data should be shared in accessible formats:
• CSV
• HTML
• Data can be displayed in PDF and spreadsheet or Tableau/dashboard format for dissemination but should be accompanied by raw datasets to allow greater analysis
• Longer term, NYC and NYS 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.

5. **Data must be presented in a manner that respects those most impacted.**
   When presenting data, NY must:
• Avoid analyses that privilege a population as being “normal” or “desirable” compared to others
• Ensure data visualizations and graphics do not stigmatize any community, particularly those most-impacted or at risk of COVID-19 infection
• Be honest on any shortcomings in being able to collect and disaggregate data
• Discuss any choices made when analyzing data and be transparent about the limitations of analyses
• Describe how this data is reorienting health service access and informing policy planning and interventions.